NHS
Rotherham
Clinical Commissioning Group

Campaign to Reduce Opioid Prescribing (CROP):
A Resource Pack for GP Practices
Produced by the Medicines Management Team

Introduction

The US, Canada and the UK have seen a large increase in opioid prescribing for chronic non-cancer pain. The prescribing of strong opioids (oxycodone, fentanyl and morphine) has increased over the last 20 years by upwards of 300%. This is sometimes referred to as the 'opiate epidemic'.

Opiate doses of above 120mg OME (oral morphine equivalent) are known to greatly increase the risk of ADRs without necessarily increasing benefit. Opinion is now that these powerful drugs do not work in the long-term for chronic non-cancer pain and are associated with serious ADRs including dependence, addiction and an increased risk of death, especially when combined with certain other drugs such as gabapentinoids.

It is expected that clinicians should use this review document in conjunction with NICE Guidance NG 193: Chronic Pain (primary and secondary) in over 16s assessment of all chronic pain and management of chronic primary pain. (Apr 2021)[1] and NICE Guidance NG 59: Low back pain and sciatica in over 16s: assessment and management (Nov 2016)[2]. Both these guidelines emphasise the advice of not using opiates for long-term pain management and looking towards non-pharmacological ways of managing pain.

From October 2020, all Primary Care Networks are required to identify patients who would benefit from a Structured Medication Review (SMR) and specifically include patients who are 'using potentially addictive pain medication'

Practices in Rotherham are now receiving regular prescribing rate updates from the CROP team and should now be asking themselves how they are going to tackle these groups of patients. This resource should help practices formulate and implement their plans on how they will do this.

Openprescribing will reveal huge variation between practices regarding high dose opioid prescribing. Follow this link for details:
https://openprescribing.net/ccg/03L/opioidper1000/

Identifying Patients for Priority Review

The following cohorts of patients could be a starting point for your reviews:

- OME >120mg
- Opiate (strong or weak) and concomitant gabapentinoid
- Opiate (strong or weak) and concomitant hypnotic
- Tramadol and concomitant antidepressant
- Long-term opioid therapy suggestive of chronic non-cancer pain (> 3 months)

- Possible diverting/dependent/addicted patients
- Problems suggestive of ADR eg sleep apnoea/menstrual irregularities/ED

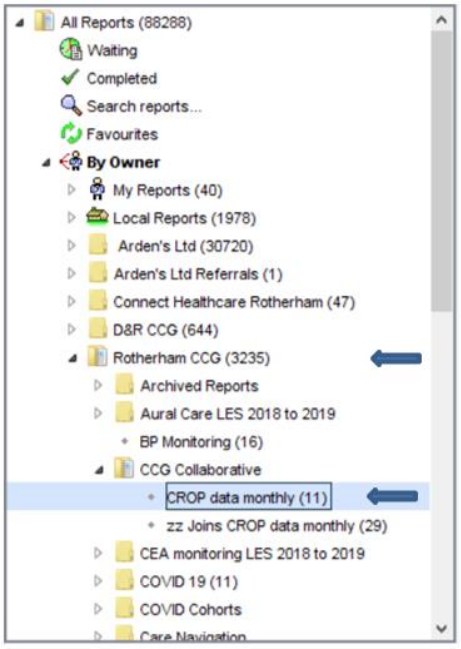
What is a weak or strong opioid?

When talking about opioids they are divided into weak and strong. Weaker opioids include codeine (with or without paracetamol or ibuprofen), dihydrocodeine (with or without paracetamol), tramadol, pethidine, meptazinol and tapentadol. Stronger opioids comprise of diamorphine, morphine, oxycodone, fentanyl, hydromorphone, buprenorphine, pentazocine, dipipanone and papaveretum.

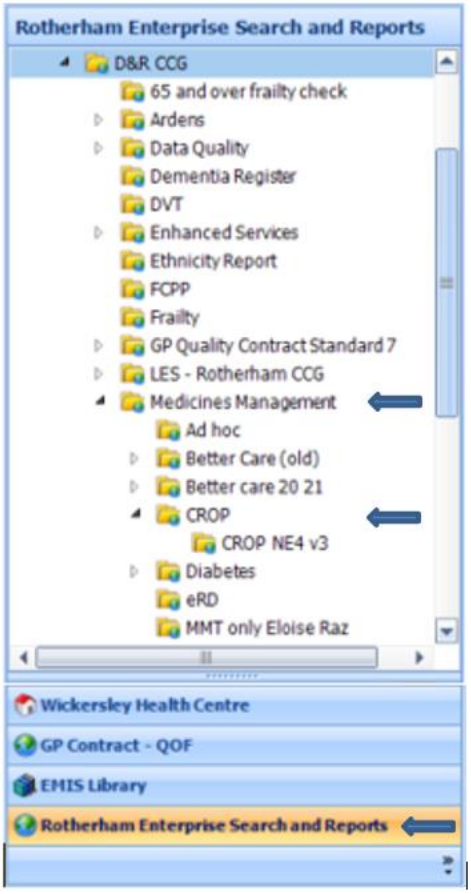
Location of CROP searches:

Clinical system searches have been created and can be found as detailed below:

SystmOne:
Rotherham CCG ➔CCG Collaborative ➔CROP data monthly



EMIS Web:
NHS Rotherham Enterprise Searches ➔D&R CCG ➔Medicines Management ➔CROP



Arrangement for Review

How are practices going to arrange for review? By letter? Telephone call?
See **Appendix 1** for a suggested letter.
Where possible, the review ought to be carried out by the initial prescriber.
The frequency of review once the opioid regimen has been established will depend on the early effectiveness of treatment, the frequency of troublesome side effects, the timing of additional interventions to control pain e.g. surgery, and the presence of concerns in relation to problematic use of opioids.
When a regimen is stable and the patient reports substantial relief of symptoms and where additional concerns do not dictate otherwise, opioid treatment should be reviewed **at least** six monthly.

Managing Patient Expectation

Chronic pain is difficult to treat. Complete relief can rarely be achieved with opioids. Improvement in function should be the aim of therapy and not just eradication of pain. It is difficult to predict how individual people with chronic pain will respond to any given medicine. Opioids for long-term pain only benefit around one in every four or five people achieving a 30-50% reduction in pain at best. This means that for every 10 patients initiated on opioids for chronic pain they will be ineffective and so should be stopped for 7 - 8 patients.

What if the patient is resistant?

General Medical Council (GMC) guidance is that doctors must act in the patient's best interests – this may involve reducing an opioid prescription against the patient's wishes. Document your reasons for embarking on an enforced wean, and on your attempts to gain patient agreement. A documented multi-disciplinary team (MDT) discussion is advisable. Consider contacting secondary care (such as the pain clinic) for advice.
A suggested strategy for an enforced wean:

- Pick a reduction dose (e.g. 10%).
- Inform the patient that you will reduce their prescription by that amount every month. They can decide at what point during the month they wish to reduce their intake but need to be ready for the lower dose when they collect their next prescription.
- Make sure you implement the dose reductions.
- You will need to ensure that the patient is not inadvertently prescribed opioids by colleagues. This requires good communication within the practice, with locum services and if necessary, out of hours and emergency services.

Resources for Practices

Read codes

- Chronic pain – 1M52
- High dose-X90YT
- Chronic pain review – 66n
- Patient counselled - 6721
- Medication stopped ineffective – 8BI7
- Doctor stopped drug ineffective – 8B350
- Treatment not tolerated – 8I7
- Opioid drug dependence – E240z
- Non-dependent opioid abuse – E255z
- Poisoning by opioids - SyuFB

Reporting of Controlled Drug Incidents via cdreporting.co.uk

All Practices need to be registered to report controlled drug incidents via the CD reporting tool. Register here: https://www.cdreporting.co.uk/reporting_v2/register
All controlled drug incidents should be reported via the cdreporting.co.uk tool. Please note: a controlled drug incident may occur within your Practice or be reported by a third party.
A controlled drug incident which you need to report includes:

- Prescribing errors: before or after they reach the patient
- Administration errors
- Dispensing errors
- Theft or diversion of prescriptions or drugs
- Incorrect storage or stock control
- Safeguarding

Every year you will need to submit an annual declaration for controlled drugs via the reporting tool and disclose whether any staff member has been cautioned or charged by the Police in relation to a controlled substance.
If you need to have controlled drugs on your premises destroyed there is a module on cdreporting.co.uk to book an authorised witness destruction.

Converting Opiates (to potentially allow tapering down of doses)

Conversion factors are an approximate guide only because comprehensive data are lacking and there is significant inter-individual variation. In most cases, when switching between different opioids, the calculated dose-equivalent must be reduced to ensure safety. The starting point for dose reduction from the calculated equi-analgesic dose is around 25-50%. A dose reduction of at least 50% is recommended when switching at high doses, in the elderly or frail patients, or because of intolerable side effects.

Approximate Eqi-analgesic Potencies of Opioids (Taken from the eBNF https://www.medicinescomplete.com/#/content/bnf/PHP107735 -Accessed 26.7.21)

Oral route

	Potency ratio with oral morphine	**Equivalent dose to 10mg oral morphine**
Codeine phosphate	0.1	100mg
Dihydrocodeine	0.1	100mg
Tramadol	0.15	67mg
Morphine	1	10mg
Oxycodone	2	5mg
Tapentadol	0.4	25mg

Transdermal route

Transdermal buprenorphine changed at weekly intervals	**5 microgram/hour**	**10 microgram/hour**	**20 microgram/hour**
Codeine phosphate (mg/day)	120mg	240mg	
Tramadol (mg/day)	100mg	200mg	400mg
Morphine sulphate (mg/day)	12mg	24mg	48mg

72-hour Fentanyl patches are *approximately* equivalent to the following 24-hour doses of oral morphine

morphine salt 30 mg daily	≡ fentanyl '12' patch
morphine salt 60 mg daily	≡ fentanyl '25' patch
morphine salt 120 mg daily	≡ fentanyl '50' patch
morphine salt 180 mg daily	≡ fentanyl '75' patch
morphine salt 240 mg daily	≡ fentanyl '100' patch

Opioid Safety Concerns

Pregabalin (Lyrica): reports of severe respiratory depression

https://www.gov.uk/drug-safety-update/pregabalin-lyrica-reports-of-severe-respiratory-depression

Transdermal fentanyl patches for non-cancer pain: do not use in opioid-naive patients

https://www.gov.uk/drug-safety-update/transdermal-fentanyl-patches-for-non-cancer-pain-do-not-use-in-opioid-naive-patients

Opioid medicines and the risk of addiction

https://www.gov.uk/guidance/opioid-medicines-and-the-risk-of-addiction

Information for Patients (Taken from the Faculty of Pain Medicine's 'Opioids Aware' Campaign)

About Pain

https://www.fpm.ac.uk/sites/fpm/files/documents/2019-09/FPM-OA-About-Pain.pdf

Thinking about opioid treatment for pain

https://www.fpm.ac.uk/sites/fpm/files/documents/2019-09/FPM-OA-About-Pain.pdf

Taking opioids for pain

https://www.fpm.ac.uk/sites/fpm/files/documents/2019-09/FPM-OA-taking-opioids.pdf

Recognising diversion/misuse

There can be an element of naivety regarding diversion and misuse. When discussing opioid use with patients, it is useful to recognise the following patient behaviours:

- Asking for another prescription as their medicines have been lost/stolen or left somewhere.
- Asking for prescriptions early (repeatedly) because they are going on holiday
- Accessing A&E, out of hour providers or 111 for additional supplies of medication – it is recommended that you monitor this activity
- Insisting that only opioid treatment will alleviate pain and refusal to explore other avenues of treatment
- Refusal to attend or failure to attend appointments to review opioid prescription
- Resisting referral for specialist assessment
- Taking doses larger than those prescribed or increasing dosage without consulting the clinician
- Alluding to the purchase of medicines via internet or illicit use
- Appearing sedated during clinic appointments

Ordering extra medication does not necessarily indicate that the patient is taking more than the recommended amount, they could be diverting their medication e.g., family member/friend. When implementing a regimen or switching to an alternative opioid to facilitate a stepped reduction, open and honest conversations need to take place to confirm what the person is currently taking.

When facilitating a reduction regimen and/or minimising the opportunities for a patient to access opioids/gabapentinoids from a different healthcare provider, the Controlled Drug Accountable Officer team recommends that the following wording is added to the labelling directions of the opioid/gabapentinoid 'Supplies only to be made by authorising prescriber'. This will then alert A&E, 111 and out of hour providers that this medication should not be issued to the patient.

Consideration should be given to removing the medication from repeat prescription and continuing to issue via acute prescription and where practicable, the patient to be managed by one clinician (where practicable).

Moving Forward

Consider how are you going to collectively change the prescribing behaviour of the practice (as a whole), to ensure that no new patients are prescribed OME >120mg in non-cancer pain.

Should you provide information on your practice website about your stance on prescribing pain killers in chronic non-cancer pain?

Summary

This resource pack is intended as a guide to help practices develop a coherent and practical strategy to tackling the problem of opioid prescribing in Rotherham. Each section contains important resources that should be explored further as part of a comprehensive approach to reviewing these patients.

Having read the resource pack and attached links, practices will be able to:

- Realise the importance of a multidisciplinary team approach to managing patients
- Identify what education and training resources are needed to fill skills gaps in the workforce to help manage these patients
- Utilise prescribing data to target the highest risk patients from a medicine's safety perspective

- Outline the pharmacological and non-pharmacological tools they will deploy
- Understand the procedure for reporting controlled drug incidents
- Share information with all practice staff who handle prescriptions about how to recognise misuse/diversion practises and behaviours

References

1. NICE Guidance NG 193: Chronic pain (primary and secondary) in over 16s assessment of all chronic pain and management of chronic primary pain. Available at: https://www.nice.org.uk/guidance/ng193

2. NICE Guidance NG 59-Low back pain and sciatica in over 16s: assessment and management. Available at: https://www.nice.org.uk/guidance/ng59

Further reading:
Jani M, Birlie Yimer B, Sheppard T, Lunt M, Dixon WG (2020) Time trends and prescribing patterns of opioid drugs in UK primary care patients with non-cancer pain: A retrospective cohort study. PLoS Med 17(10): e1003270. Available at: https://doi.org/10.1371/journal.pmed.1003270

Faye's story. Available at: https://improvement.nhs.uk/documents/1770/NHS_CD_Newsletter_Fayes_story_0617.pdf

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Appendix 1 - Letter Inviting Patients for Review

[Practice name]
[Address]
[Tel]
[Fax]
[Email]
[Date]

[Title/Initial/Surname]
[Patient Address Block]
Dear [Title] [Surname]

At ..... Surgery we take patient safety very seriously. We follow the latest advances in medical research and continually update and review our clinical practice to ensure patient care is of the highest standard.

Recent research has highlighted a significant risk to patient safety around the use of opioid type painkillers for chronic pain especially when taken with pregabalin or gabapentin.

We know that these drugs are helpful in pain of recent onset for example a broken bone and they are also effective in patients with cancer related pain. However, recent medical evidence questions the benefit of opioid type painkillers for chronic pain. Strange as it might sound – we don't think they are very good at killing pain at all when taken for more than a few months.

Our records suggest that you are being prescribed opioids for chronic pain and pregabalin/gabapentin (delete as appropriate) (please tell us if that's incorrect) and, because we don't want our patients put at risk, we would like to see you to discuss the current research and new methods of managing chronic pain with less emphasis on drug therapy.

Please book an appointment with a doctor of your choice before your next medication repeat is due and we'll work together towards a safer, more effective treatment plan.

Yours sincerely

Dr XXX and partners