NHS
Derby and Derbyshire
Integrated Care Board

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Greater Manchester Integrated Care Board Opioid Prescribing for Chronic Pain: Resource Pack With permission

Based on Faculty of Pain Medicine - Opioid aware website

JAPC Opioid Prescribing for Chronic Pain: Resource Pack

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Contents

Foreword

1. This document brings together several resources' clinicians can use to support the appropriate use and review of opioids used for chronic pain. The information included refers to the management of adults although some of the principles may also apply to use in older children. The information in this document does not apply to palliative care and end of life care where use of opioids should follow the World Health Organisation (WHO) pain ladder and relevant guidance.

2. The document is based on The Faculty of Pain Medicine website - Opioids Aware and NICE NG 215 - Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults.

3. The term chronic pain is used throughout this document. Chronic pain (sometimes known as long-term pain or persistent pain) is pain that lasts for more than 3 months.

4. Chronic pain can be secondary to an underlying condition, for example, osteoarthritis, rheumatoid arthritis, ulcerative colitis, endometriosis. Chronic pain can also be primary. Chronic primary pain has no clear underlying condition or the pain (or its impact) appears to be out of proportion to any observable injury or disease, examples include fibromyalgia (chronic widespread pain), complex regional pain syndrome, chronic primary headache and orofacial pain, chronic primary visceral pain and chronic primary musculoskeletal pain (1) .

5. Historically, opioids have been prescribed to manage chronic pain; however, the clinical evidence shows limited effectiveness and patient safety concerns due to the risks associated with long-term use of opioids such as fractures and falls, endocrine abnormalities, immunomodulation, opioid induced hyperalgesia and dependence.

6. Based on the clinical evidence Public Health England and The Faculty of Pain Medicine have advised (2):
    - Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain.
    - A small proportion of people may obtain good pain relief with opioids in the long term if the dose can be kept low and especially if use is intermittent (however it is difficult to identify these people at the point of initiation).
    - The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit: tapering or stopping high dose opioids needs careful planning and collaboration.
    - If a person has pain that remains severe despite opioid treatment it means they are not working and should be stopped, even if no other treatment is available.
    - Chronic pain is very complex and if people have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

7. Drug treatments:
   - Should be reserved for when appropriate non-pharmacological therapies alone have failed.
   - Should be given on a trial basis initially.
   - Should only be continued with good objective evidence of improved function (not just pain perception). It is usually expected that a reduction in pain of at least 30% should be demonstrable to justify longer term prescribing (2).

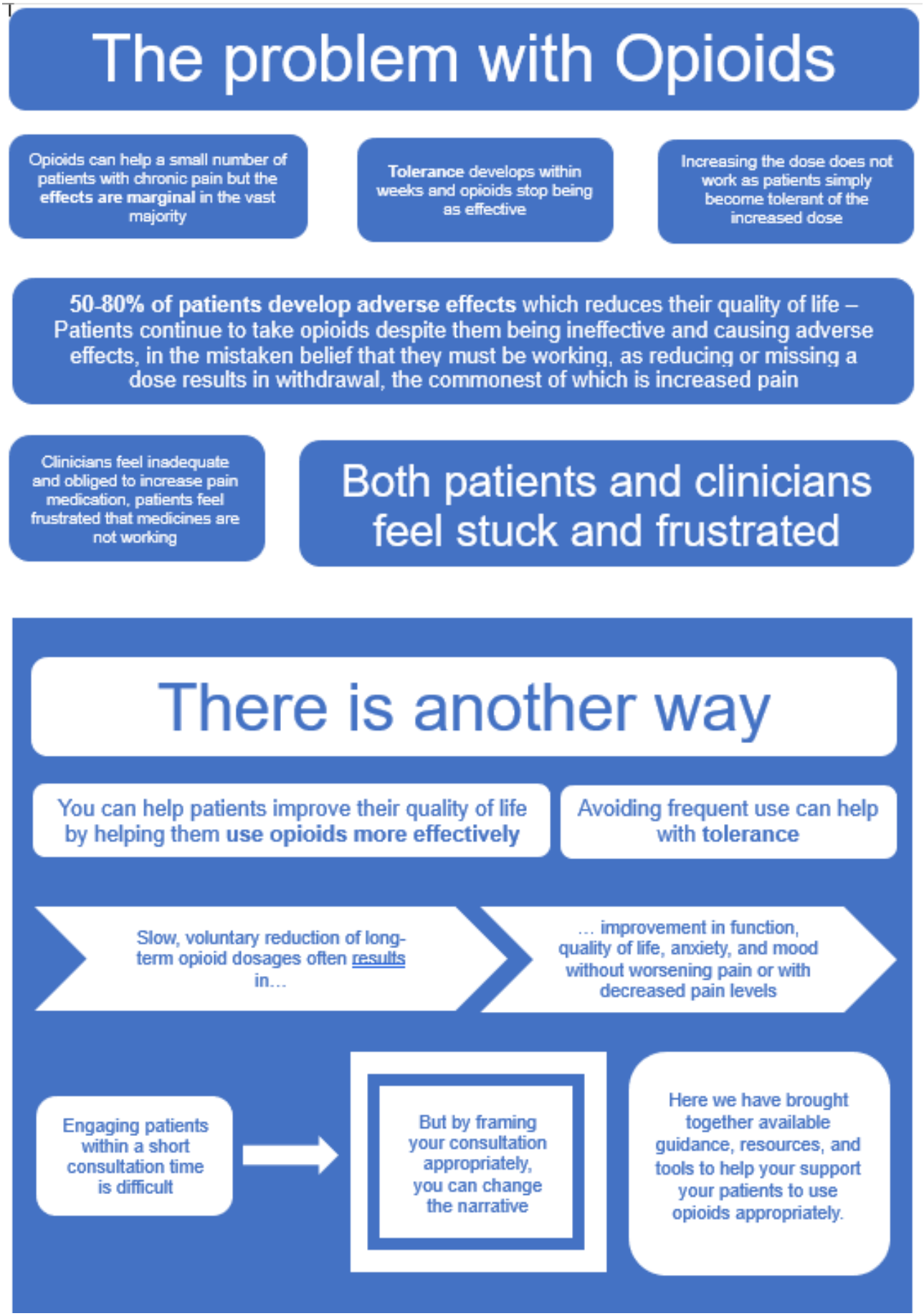
8. The British National Formulary (BNF) advises that the prescriber has three main responsibilities (3):
   - To avoid creating dependence by introducing drugs to patients without sufficient reason.
   - To see that the patient does not gradually increase the dose of a drug, given for good medical reasons, to the point where dependence becomes more likely.
   - To avoid being used as an unwitting source of supply for addicts and being vigilant to methods for obtaining medicines.

9. Appendix 1, Faye's story, provides a patient story highlighting the issues that can occur with long term opioid use.

Practice Resources

Appendix 1 – Faye's Story

Key Points


The problem with Opioids
Opioids can help a small number of patients with chronic pain but the **effects are marginal** in the vast majority
Tolerance develops within weeks and opioids stop being as effective
Increasing the dose does not work as patients simply become tolerant of the increased dose
50-80% of patients develop adverse effects which reduces their quality of life – Patients continue to take opioids despite them being ineffective and causing adverse effects, in the mistaken belief that they must be working, as reducing or missing a dose results in withdrawal, the commonest of which is increased pain
Clinicians feel inadequate and obliged to increase pain medication, patients feel frustrated that medicines are not working
Both patients and clinicians feel stuck and frustrated
There is another way
You can help patients improve their quality of life by helping them **use opioids more effectively**
Avoiding frequent use can help with **tolerance**
Slow, voluntary reduction of long-term opioid dosages often results in…
… improvement in function, quality of life, anxiety, and mood without worsening pain or with decreased pain levels
Engaging patients within a short consultation time is difficult
But by framing your consultation appropriately, you can change the narrative
Here we have brought together available guidance, resources, and tools to help your support your patients to use opioids appropriately.

Myths and Facts about Pain Medication

MYTH	FACT
Opioids are pain-killers	Opioids can help reducepain but they do not 'kill' pain. This is especially true in the context of chronic pain. Replacing the term 'pain-killers' with 'medicines used to manage pain' can reduce confusion and manage expectations. The pursuit of complete pain relief leads to the escalating prescription of opioids Patients should be encouraged to use opioids to improve function rather than to manage their daily pain.
Opioids are the best way to manage pain	There are many times when opioids are a recommended course of treatment. However, there are other non -opioid options for managing chronic pain such as nonopioid analgesics, physical therapy, exercise, and psychological strategies.
Opioids should be taken regularly to manage pain	Opioids are often prescribed as a fixed regime without taking into consideration the fluctuating intensity of the pain (for example, 60 mg codeine qds). Patients often have good days and bad days which are interspersed with flareups. Patients should be encouraged to use the least possible dose so that they can take less on a good day and more on a bad day.
Opioids continue to be effective in the long term	There is little evidence to support the use of opioids in the long term. This is likely because tolerance develops quickly, often within a few weeks, especially if patients use opioids daily.Regular review and reduction or even stopping opioids if they are no longer effective are essential
Opioids increase the quality of life in all patients with chronic pain	Some patients do benefit from the use of opioids. It is essential to conduct an opioid trial to identify those patients where they might be effective. If they are helpful, we would expect to see benefits after 2 -4 weeks. However, they are associated with significant side effects such as drowsiness, impaired concentration, falls and constipation that can have a detrimental effect on the quality of life. Some patients continue to take opioids as they mistakenly believe that they must persist with taking prescribed medications even if they are experiencing side effects.
Prescription opioids are safe	All opioids carry risks, even when they have been prescribed for legitimate reasons. Most prescribers are aware of the risks of highdose opioids such as respiratory depression. However, even smaller doses of opioids can cause harm, especially in the frail population by increasing the risk of falls due to increased sedation and dizziness.
Only patients addicted to opioids are at risk of overdosing	Anyone who uses opioids is at risk, although some patients are at a higher riskFor example, patients on high-dose opioids, coprescribed gabapentinoids, and benzodiazepines, respiratory comorbidites and frailty.
Opioid addiction is rare when it is used for managing pain	Opioid use, even in the short term can cause addiction in vulnerable patients .There are many factors- genetic, psychological and environmental that play a role in addiction. However, research clearly shows that longterm prescription of opioids increases the risk of addiction.

This document has been developed by Salford Pain Centre and Manchester Pain Collaborative with support from Health Innovation Manchester

Managing Patient Expectation

10. Chronic pain is difficult to treat with most types of treatment helping less than a third of people. Complete relief of pain is rarely achieved with opioids. The goal of therapy should be to reduce symptoms sufficiently to support improvement in physical, social and emotional functioning.

11. 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 on average only providing a 30% reduction in pain. This means that for every 10 people initiated on opioids for chronic pain they will be ineffective and so should be stopped for 7 - 8 people.

12. Up to 80% of people taking opioids will experience at least one adverse effect. These should be discussed with the person before treatment begins including whether these are likely to be temporary or permanent and whether they might improve or worsen over time.

13. People who do not achieve useful pain relief from opioids within 2-4 weeks are unlikely to gain benefit in the long term.

14. Short-term efficacy does not guarantee long-term efficacy, therefore, regardless of which opioid analgesic is used, regular review and reassessment to determine that there is continued value from using a particular medication is important in providing on-going good quality chronic pain management.

15. The decision to start long term opioid therapy should be considered carefully by the prescriber, the person and his/her carers and other members of the healthcare team.

16. Consider non-drug options and refer to appropriate services.

17. Provide people with useful resources such as:
Sean's Story (Appendix 2),
Live Well With Pain Home - Live Well with Pain
Flippin Pain Home - Flippin' Pain (flippinpain.co.uk)
Escape Pain - ESCAPE-pain home
NHS Better help: Every mind matters How to fall asleep faster & sleep better

Practice Resources

Appendix 2 – Sean's Story
Appendix 3 – What to Discuss with the Patient when Considering Opioid Treatment
Appendix 4 – Ten Footsteps Patient Information Leaflet
Appendix 34 – Pain Self-Management Strategies
Appendix 5 – About Pain Patient Information Leaflet
Appendix 32 - case study seeking stronger opioids
Appendix 33 – case study chronic pain consultation

Considering Use of an Opioid

18. When considering if an opioid might be appropriate for chronic pain be aware of relevant NICE guidelines and the specific NICE 'Do Not Do' statements with regards pain medication (see Appendix 6 for details).

19. For chronic primary pain (pain which no underlying condition adequately accounts for the pain or its impact) opioids, paracetamol, NSAIDs, antiepileptics including gabapentinoids and a range of other drugs should not be used. Where medication is required, it may be appropriate to consider use of an antidepressant in line with NICE guidance (1).

20. Before starting treatment with an opioid ensure that all suitable management options, including non-pharmacological approaches and watchful waiting, have been discussed with, and offered to, the person (4).

21. Before starting treatment with an opioid explain and discuss with the person:

- that dependence is an expected effect of these medicines and is not a reason in itself to avoid the medicine,
- the potential for developing problems associated with dependence,
- the symptoms that suggest the development of problems associated with dependence and, if appropriate, the importance of making family members, carers or other people close to them aware of these symptoms.

22. Where opioids are to be prescribed the person should have a carefully supervised trial of opioid therapy with evaluation of analgesic efficacy and adverse effects.

Practice Resources

Appendix 4 – Ten Footsteps Patient Information Leaflet
Appendix 34 – Pain Self-Management Strategies
Appendix 6 – Summary of NICE Guidance: Related to Pain Relief and Opioids
Appendix 7 – Thinking About Opioid Treatment for Pain Patient Information Leaflet
Appendix 8 – Pain Diary
Appendix 9 – NICE Visual Summary – Before Starting Medicines Associated with Dependence or Withdrawal Symptoms
Appendix 10 - Opioids and the Risk of Addiction Patient Information Leaflet
Appendix 32 - case study seeking stronger opioids
Appendix 33 – case study chronic pain consultation

Opioid Trial

23. The opioid trial establishes whether the person achieves any reduction in pain with use of opioids. Achieving optimal doses and managing side effects of opioids is not the purpose of the trial; these can be explored once it has been shown whether opioids are helpful for the person.

24. It is important to remember that short term response to opioid therapy does not predict long term response which may be limited by adverse effects or declining efficacy.

Patient Agreement

25. A written, structured agreement including information on the desired outcomes of treatment, frequency of review, dose prescribed and circumstances in which opioid treatment may be stopped e.g., evidence of dependence, should be part of routine practice and can act as a helpful starting point when discussing progress and therapy.

Starting the Trial

26. Agree some readily assessable outcomes that indicate that opioids may play a role in the person's management. These will usually include reduction in pain intensity and ability to achieve specific functional improvement facilitated by the medication. For people in whom sleep is significantly impaired by pain, improved sleep would be a reasonable outcome.

27. Before starting treatment with an opioid, give the person verbal and written information (in their preferred format) about the medicine. Ensure that the information is evidence-based and understandable by the person. Explain to the person:
    - the potential side effects of the medicine, whether these are likely to be temporary or permanent and whether they might improve or worsen over time,
    - any additional implications of taking the medicine if the person is pregnant or planning pregnancy,
    - what the options might be if the medicine does not work,
    - how difficult it might be to stop the medicine later and how that might be managed,
    - that missing doses may lead to symptoms of withdrawal,
    - how to store medicines safely.

Duration of the Opioid Trial

28. If the person has constant pain, the opioid trial may be concluded in one or two weeks.

29. If the person has intermittent disabling flare ups of pain on a background of more manageable symptoms, the trial should be long enough to observe the effect of opioids on two or three episodes of increased pain.

Choice of Opioid Formulation and Dose

30. Where possible, the usefulness of opioids should be explored by prescribing a short supply (1-2 weeks) of immediate release oral opioid.

31. If a weak opioid is required codeine should be used.

32. If a strong opioid is required immediate release morphine should be used.

33. Fentanyl patches must **not** be used in opioid naïve people for non-cancer pain (5).

34. The person may be advised to explore different doses within a specified range eg, morphine 5-10mg. If reduction in pain is not achieved following a single dose of immediate relief morphine 20mg, opioids are unlikely to be beneficial in the long term.

35. A trial of fixed dose regimens using modified release preparations needs to allow for one or two upwards dose adjustments and may therefore take three weeks or more.

Patient Monitoring

36. The person should keep a diary during the opioid trial. This should include a twice-daily report of pain intensity, comment on sleep, note of activity levels and how any of these are changed following a dose of opioid. All doses of opioid should be recorded in the diary with a comment on side effects.

Documentation

37. Clinical records should include:
    - Relevant clinical findings that support the decision to prescribe opioids.
    - Agreed outcomes of opioid therapy.
    - The choice of drug, formulation, starting dose, details of any planned dose escalation and duration of treatment. A maximum dose of drug should be defined at initiation and this should not exceed oral morphine equivalent 120mg/day.
    - The circumstances under which opioid therapy should be discontinued.
    - Arrangements for review.
    - The information given to people.

Assessing Whether the Opioid Trial is a Success

38. The person should be reviewed **within** four weeks of initiation of opioid treatment.

39. If the opioid trial demonstrates that the medicine is helpful, discuss with the person the range of doses likely to be safe and effective. Agree frequent, regular reviews to ensure that timely adjustments can be made to test effectiveness, safety and acceptability and to find the lowest effective dose. Once an effective dose has been established, avoid automatically increasing the dose if the response is not sustained.

40. If the opioid trial demonstrates that the medicines are unhelpful, the reasons for this should be clearly documented e.g. lack of efficacy, intolerable adverse effects.

41. If the person reports no improvement in symptoms following the trial, it is very unlikely that long-term opioid therapy will be helpful.

42. If the opioid trial is not successful, the drugs should be tapered and stopped within one week.

43. There is little evidence that one opioid is more effective and associated with fewer side effects than others. If the person reports reduction in pain but at the cost of side effects that preclude achievement of functional goals, it is reasonable to explore different dosing regimens with active management of side effects to see if a useful balance between benefits and harms can be achieved.

Practice Resources

Appendix 3 – What to Discuss with the Patient when Considering Opioid Treatment
Appendix 4 – Ten Footsteps Patient Information Leaflet
Appendix 34 – Pain Self-Management Strategies
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Appendix 6 – Summary of NICE Guidance: Related to Pain Relief and Opioids
Appendix 7 – Thinking About Opioid Treatment for Pain Patient Information Leaflet
Appendix 8 – Pain Diary
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Appendix 11 – Opioid Management Plan: Treatment Agreement
Appendix 12 – Taking Opioids for Pain Patient Information Leaflet
Appendix 13 – Driving and Pain Patient Information Leaflet
Appendix 14 – Useful SNOMED Codes
Appendix 15 – NICE Visual Summary – Reviewing Medicines Associated with Dependence or Withdrawal Symptoms

Arrangement for Review

44. Where practical, review of long-term opioid therapy should be carried out by the initial prescriber.

45. The value of adequate consultation times is particularly important for people that have complex conditions which may require greater exploration, as is often the case for people suffering from chronic pain. (6)

46. 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.

47. When a regimen is stable and the person reports substantial relief of symptoms and where additional concerns do not dictate otherwise, opioid treatment should be reviewed **at least** six monthly.

48. Offer extra, unscheduled reviews when needed, for example if the person:

- reports adverse effects from the medicine,
- becomes pregnant or is planning pregnancy,
- has a change in their physical or mental health condition, or social circumstances,
- starts taking medicines from a different prescriber,
- requests a change in dose.

49. Consider intermittent dose reductions or drug holidays to demonstrate that on-going prescriptions are clinically appropriate and beneficial.

50. See Stopping Opioids in Primary Care section for advice on discontinuing opioids where they are no longer needed, ineffective, not tolerated or dependence/problematic use is identified.

Practice Resources

Appendix 10 - Opioids and the Risk of Addiction Patient Information Leaflet
Appendix 14 – Useful SNOMED Codes
Appendix 15 – NICE Visual Summary – Reviewing Medicines Associated with Dependence or Withdrawal Symptoms
Appendix 17 – Letter Inviting Patients for Review
Appendix 18 – Letter Suggesting Drug Holiday
Appendix 19 – Letter Inviting Patients for Review Due to Tramadol and Antidepressant Serotonin Syndrome Risk
Appendix 20 – Letter Suggesting Review of Oxycodone and Amitriptyline
Appendix 32 – case study seeking stronger opioids
Appendix 33 – case study chronic pain consultation

Content of reviews

51. During opioid review, discuss with the person the benefits and risks of continuing the current dose, adjusting the dose, or stopping the medicine. Base decisions on this discussion, taking into account, for example:

- the benefits or harms the person is experiencing from continuing the medicine,
- any signs that the person is developing problems associated with dependence (such as running out of a medicine early, making frequent requests for dose increases or reporting loss of efficacy of a medicine that was previously working well),
- the person's preferences.

52. Agree and update the management plan with the person after each review and give them a copy. Check that they know who to contact if they have problems or concerns.

Practice Resources

Appendix 10 - Opioids and the Risk of Addiction Patient Information Leaflet
Appendix 15 – NICE Visual Summary – Reviewing Medicines Associated with Dependence or Withdrawal Symptoms
Appendix 31 – Structured medication review including opioids

Prescribing

53. The duration of each individual prescription:

- should reflect the management plan,
- should comply with best practice in controlled drugs prescribing,
- must comply with relevant legislation.

54. Opioids being used for a short term indication e.g. acute pain, post-operative pain, severe anxiety must NOT be added to repeat medication.

55. When considering adding an opioid to repeat the Prescriber must consider:

- Is prescribing in-line with national guidance and clinically indicated?
- Is the opioid effective?
- Is the dose likely to change frequently?
- Is there a risk of dependence or diversion?
- When is the next review due?

56. When authorising repeat prescription of an opioid drug ensure the authorisation period is set to the date of next review. Consider the opioid and the patient's individual circumstances to determine the frequency of review which should be no more than 6 months.

57. The prescriber and person should, together, review the continuing benefit of opioid therapy and potential harms at regular intervals (at least twice each year). Offer extra, unscheduled reviews when needed, for example if the person:

- reports adverse effects from the medicine,
- becomes pregnant or is planning pregnancy,
- has a change in their physical or mental health condition, or social circumstances,
- starts taking medicines from a different prescriber,
- requests a change in dose.

Practice Resources

Appendix 10 - Opioids and the Risk of Addiction Patient Information Leaflet
Appendix 15 – NICE Visual Summary – Reviewing Medicines Associated with Dependence or Withdrawal Symptoms
Appendix 21 – Opioid Policy New Patients
Appendix 22 – Opioid Policy - Issuing Prescriptions
Appendix 23 – Practice Procedure for Lost/Stolen Controlled Drug Prescriptions
Appendix 24 – Practice Procedure for Patients where Dependence on, or Diversion of, Controlled Drugs has been Identified
Appendix 25 – Reporting of Controlled Drug Incidents via cdreporting.co.uk
Appendix 32 – case study seeking stronger opioids
Appendix 33 – case study chronic pain consultation

Responsibility for Prescribing

58. Where practical, the person should receive prescriptions from a single prescriber.

59. If the person needs a prescription from someone other than the usual prescriber, documentation should be clear and accurate to support consistency of safe care.

60. All people prescribed opioids should have a clearly documented management plan that includes:

- what the medicine has been prescribed for, the intended outcomes of treatment and how these might be assessed,
- the starting dose and intervals between dose adjustments or titrations,
- who to contact if problems occur,
- information about how long the medicine will take to work and how long they might be taking it for,
- the duration of each prescription that will be issued,
- the risks of taking more than the prescribed dose,
- the symptoms and signs of an overdose and what they should do if this happens,
- the plans for reviewing the medicine (including where and by whom this will be done) and the date of their next review.

Practice Resources

Appendix 21 – Opioid Policy New Patients
Appendix 22 – Opioid Policy – Issuing Prescriptions

Rational Prescribing

Keep pain relief simple and effective

61. Follow these **S.T.E.P.S.** to answer the following questions:
    - Is it **S**afe for the person to continue on this medication long term?
    - Can they **T**olerate this medication with its side effects?
    - Is the medication **E**ffective? Some people cannot tell one way or another.
    - Are they on the best **P**riced treatment? (Expensive treatment is acceptable if it works.)
    - Is the taking of analgesics as **S**imple as possible? Would a long-acting preparation be preferable to frequent doses of short-acting analgesics?

62. It is easier to manage opioid prescribing if a single opioid is used rather than combining several opioids.

63. Use a recognised opioid dose conversion guide when prescribing, reviewing or changing opioid prescriptions to ensure that the total opioid load is considered (3) see appendix 26. Oxford University Hospital NHST have produced an opioid calculator available here: Opioid calculator for calculation of oral Morphine Equivalent Daily Dose (MED) in mg/day (Excel, 21 KB)

64. Medicines should be used for their licensed indication only.

65. The oral route should **always** be used where possible.

66. Use of opioid formulations with a rapid onset, such as fentanyl for transmucosal or sublingual administration, is **inappropriate** for the management of chronic pain.

67. Injectable opioids should **not** be used in the management of people with chronic non-cancer pain.

68. Patches should only be used if oral opioids are not suitable and analgesic requirements are stable.

69. The minimum effective dose should always be used. When medicines do not give sufficient analgesia there is a risk of dose escalation which is rarely helpful.

70. For chronic pain, do **NOT** exceed 120mg oral morphine equivalent/24hours. Increasing opioid load above this dose is unlikely to yield further benefits but exposes the person to increased harm.

JAPC Formulary

	First Choice	Alternative
Weak opioid	Codeine	Dihydrocodeine Tramadol (NOTE: Classification as GREY)
Strong opioid	Morphine	Oxycodone

	Dose approximately equivalent to 120mg morphine	For chronic pain do not exceed*
Morphine	120mg	60mg MR bd or 120mg XL od
Oxycodone	80mg	40mg MR bd
Fentanyl patch	50mcg/hr	50 mcg/hr
Buprenorphine patch	50mcg/hr	52.5mcg/hr

*All patient receiving opioid doses of >50mg/day morphine equivalent should be reviewed regularly (at least 6-monthly) to detect emerging harms and consider ongoing effectiveness. Pain specialist advice should be sought at doses >90mg/day morphine equivalent.

Fentanyl Safety Concerns

71. The Commission on Human Medicines (CHM) has recommended that fentanyl transdermal patches are contraindicated in opioid-naive people in the UK (5).

72. The MHRA continue to receive reports of unintentional opioid toxicity and overdose of fentanyl due to accidental exposure to patches. If prescribing fentanyl patches provide clear information to the person and caregivers about how to minimise the risk of accidental exposure and the importance of appropriate disposal of patches (8).

73. Fentanyl is a potent opioid – a 12 microgram per hour fentanyl patch equates to daily doses of oral morphine of up to 45mg a day.

74. Do not use fentanyl patches in opioid-naive people.

75. Use other analgesics and other opioid medicines (opioids) for non-cancer pain before prescribing fentanyl patches.

76. If prescribing fentanyl patches, remind people of the importance of:

- not exceeding the prescribed dose,
- following the correct frequency of patch application, avoiding touching the adhesive side of patches, and washing hands after application,
- not cutting patches and avoiding exposure of patches to heat including via hot water (bath, shower),

- ensuring that old patches are removed before applying a new one,
- following instructions for safe storage and properly disposing of used patches or patches that are not needed; it is particularly important to keep patches out of sight and reach of children at all times.

77. Make the person and caregivers aware of the signs and symptoms of fentanyl overdose and advise them to seek medical attention immediately (by dialling 999 and requesting an ambulance) if overdose is suspected.

78. Remind people that long-term use of opioids in non-cancer pain (longer than 3 months) carries an increased risk of dependence and addiction, even at therapeutic doses; before starting treatment with opioids, agree with the person a treatment strategy and plan for end of treatment.

79. Report suspected adverse drug reactions, including dependence, accidental exposure, or overdose associated with fentanyl patches, via the Yellow Card scheme.

Practice Resources

Appendix 6 – Summary of NICE Guidance: Related to Pain Relief and Opioids
Appendix 26 – Approximate Equi-analgesic Potencies of Opioids
Appendix 27 – CQC and NHSE Guidance on Safer Use of Fentanyl and Buprenorphine Transdermal Patches
Appendix 28 – MHRA Fentanyl Skin Patches Patient Information Leaflet
Appendix 29 – CQC and NHSE Guidance on Safer Use of Oxycodone Medicines

Appendix 32 - case study seeking stronger opioids
Appendix 33 – case study chronic pain consultation

Stopping Opioids in Primary Care

79. It is important to taper or stop the opioid regimen if:

- the medication is not providing useful pain relief,
- the underlying painful condition resolves,
- the person receives a definitive pain-relieving intervention (e.g. joint replacement),
- the person develops intolerable side effects,
- there is strong evidence that the person is diverting his/her medications to others.

80. Do not stop opioids abruptly (complete cessation with immediate effect) unless there are exceptional medical circumstances, such as the occurrence of serious side effects (for example, respiratory depression from an opioid). In these circumstances, consider:

- scheduling more frequent reviews,
- short-term use of medicines to treat the physical symptoms of withdrawal (for example, abdominal cramps and diarrhoea during opioid withdrawal).

81. The decision to taper/stop an established opioid regimen needs to be discussed carefully with the person including:

- the rationale for stopping opioids including the potential benefits of opioid reduction (avoidance of long-term harms and improvement in ability to engage in self-management strategies),

- agreeing outcomes of opioid tapering, e.g. stopping opioid completely, people on high doses reducing dose to 120mg/day morphine equivalence,
- arrangements for monitoring and support during opioid taper,
- documented agreement of tapering schedule.

82. The person might be reluctant or anxious about discussing problems associated with dependence. Reassure them that dependence is an expected effect of these medicines and that problems associated with dependence sometimes develop. Be sensitive to the use of terminology that may apportion blame to the person or be perceived adversely.

83. Acknowledge and discuss with the person any differences between their views and your own about the risks and benefits of the medicine.

84. Be prepared for queries about prescribing decisions made previously. Explain that our understanding of the balance of risks and benefits of a medicine can change over time. If sufficient clinical detail is available, discuss the possibility that past prescribing was done in the person's best interests using the knowledge available at the time.

85. When planning withdrawal from an opioid, take into account:

- the urgency of the withdrawal, for example gradual withdrawal of a medicine that is no longer effective or necessary, or more rapid withdrawal of a medicine that is causing significant harm (the speed of rapid withdrawal depends on the type of medicine and the person's circumstances),
- whether the initial goal should be complete withdrawal or, for people who find complete withdrawal too difficult, whether dose reduction with ongoing review is a more realistic initial aim,
- which medicine to reduce first if the person will be withdrawing from more than one medicine,

- factors that might increase the person's risk of problems during withdrawal, include:
  - long duration of medicine use,
  - high dose of medicine,
  - history of withdrawal symptoms,
  - history of problems associated with dependence.
- any concurrent medicines and how these might affect the person's response to withdrawal,
- factors that might influence the timing of the start of the dose reduction, such as the person's circumstances and available support.

86. When agreeing a dose reduction schedule with the person:

- explain the risk of abrupt discontinuation and that the rate of safe withdrawal varies between people and can vary over time for the same person,
- balance the risk of adverse events from continued exposure to the medicine with minimising the risk of withdrawal symptoms by slow dose reduction and withdrawal,
- ensure that the planned rate of reduction is acceptable to the person,
- explain that although withdrawal symptoms are to be expected, the reduction schedule can be modified to allow intolerable withdrawal symptoms to improve before making the next reduction,
- consider giving the person additional control over the process of dose reduction (for example, by issuing their usual daily dose in a form that allows them to reduce the amount in small decrements at a pace of their choosing, rather than issuing successive prescriptions for reduced daily doses),
- agree regular intervals for reviewing and adjusting the reduction schedule as needed,
- ensure the person knows who to contact if problems occur.

87. When withdrawing from an opioid, suggest a slow, stepwise rate of reduction proportionate to the existing dose, so that decrements become smaller as the dose is lowered, unless clinical risk is such that rapid withdrawal is needed. The Faculty of Medicine advises opioids can be tapered by 10% weekly or two weekly.

88. If using a published withdrawal schedule, apply it flexibly to accommodate the person's preferences, changes to their circumstances and the response to dose reductions.

89. During withdrawal, offer continued management of the underlying condition for which the medicine was prescribed, if needed.

90. Ensure the plan for dose reduction or withdrawal is clearly recorded in the overall management plan.

91. Oxford University Hospitals NHSFT have produced some templates for opioid reduction which may be useful and are available here [For GPs: Opioids and Chronic Pain - Oxford University Hospitals (ouh.nhs.uk)]

92. Tapering can be paused but should not be reversed except in exceptional circumstances.

93. Before starting withdrawal:

- give the person information about the process of withdrawal that is tailored to their situation and the medicine they are taking,
- explain how the withdrawal will be carried out,
- consider providing details of sources of peer support, national and local support groups for people who are withdrawing from a medicine.

94. Discuss withdrawal symptoms with the person and tell them about the support that is available. When discussing withdrawal symptoms, explain that:

- withdrawal can be difficult and may take several months or more,
- support will be available throughout the withdrawal process,
- withdrawal symptoms do not affect everyone, and it is not possible to predict who will be affected,
- withdrawal symptoms vary widely in type and severity, can affect both physical and mental health, may occur at any time during withdrawal or be delayed in onset and can change over time or persist over a prolonged period,
- there are options for managing withdrawal symptoms,
- some people may experience withdrawal symptoms that can be difficult to distinguish from a re-emergence of their original symptoms or a new disorder and it is important to discuss these with a healthcare professional if they occur.

95. People who are failing to derive benefit from large doses of opioids (greater than oral morphine equivalent of around 300mg/day) may need support from specialist services in order to reduce medication. Opioid tapering/cessation when people are taking high doses is more likely to succeed if the persons emotional and mental health needs are identified and an appropriate plan for support established.

Five practical steps to reduce high dose opioids (9)

i. **Education**: explain the importance of reducing opioids to the person.

ii. **Engagement**: give the person as much choice as possible around how to reduce their opioids.

iii. **Effecting** the weaning plan.

iv. **Emotional impact**: manage anxiety and depression.

v. **Expectations**: ensure the person understands that this can be difficult, and that they need support.

Strategies if Withdrawal Cannot be Agreed or is Unsuccessful

96. If a prescriber thinks that a medicine is not in the person's best interests but a shared decision about reducing or stopping a medicine cannot be reached with the person, the prescriber should follow the advice on 'handling patient requests for medicines you don't think will benefit them' in the General Medical Council guidance: Good Practice in Prescribing and Managing Medicines and Devices. The prescriber should:

- not prescribe a medicine if they believe it is not in the person's best interests,
- explain the reasons for their decision to the person,
- document all discussions carefully and give a copy to the person,
- offer the person a second opinion.

97. Be aware that medicines associated with dependence and withdrawal symptoms should not be stopped abruptly in most cases and follow the guidance on dose reduction above. Document your reasons for embarking on an enforced wean and on your attempts to gain agreement. A documented multi-disciplinary team (MDT) discussion is advisable. Consider contacting secondary care (such as the pain clinic) for advice.

98. A suggested strategy for an enforced wean:

- Pick a reduction dose (e.g. 10% monthly).
- Inform the person 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 person 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.

99. If continued use of the medicine may be particularly harmful for the person or others and a dose reduction, or a more rapid reduction than the person wishes, is the safest option, consider:

- scheduling more frequent reviews,
- short-term use of medicines to treat the physical symptoms of withdrawal (for example, abdominal cramps and diarrhoea during withdrawal of an opioid).

100. If dose reduction has been unsuccessful (for example because of intolerable withdrawal symptoms or a change in the person's physical, mental, or social circumstances) and the current prescription needs to be continued:

- aim to stop any further escalation in dose,
- make a plan to attempt dose reduction again at a later date,
- clearly record the advice given to the person about the potential harms of continuing the medicine, and the reasons for continuing without a reduction, in the management plan.

Practice Resources

Appendix 14 – Useful SNOMED Codes
Appendix 15 – NICE Visual Summary – Reviewing Medicines Associated with Dependence or Withdrawal Symptoms
Appendix 16 – Stopping Your Medicine – Opioids
Appendix 17 – Letter Inviting Patients for Review

Appendix 18 – Letter Suggesting Drug Holiday
Appendix 19 – Letter Inviting Patients for Review Due to Tramadol and Antidepressant Serotonin Syndrome Risk
Appendix 20 – Letter Suggesting Review of Oxycodone and Amitriptyline
Appendix 22 – Opioid Policy – Issuing Prescriptions
Appendix 24 – Practice procedure for Patient's where Dependence on, or Diversion of, Controlled Drugs has been Identified
Appendix 30 – Preparation for Dose Reduction

Converting Opioids

101. Conversion factors are an approximate guide because comprehensive data are lacking and there is significant inter-individual variation.

102. In most cases, when switching between different opioids, the calculated dose-equivalent must be reduced to ensure safety.

103. The starting point for dose reduction from the calculated equi-analgesic dose is around 25-50%.

104. A dose reduction of at least 50% is recommended when switching at high doses, in elderly or frail people, or because of intolerable side effects.

105. The half-life and time to onset of action of the two drugs needs to be considered when converting so that the person does not experience breakthrough pain or receive too much opioid during the conversion period. Patches have a particularly long half-life.

106. Once the conversion has occurred, the dose of new opioid should be titrated carefully according to individual response and the person monitored closely for side effects and efficacy, especially when switching at high doses.

Practice Resources
Appendix 26 – Approximate Equi-analgesic Potencies of Opioids
Appendix 27 – CQC and NHSE Guidance on Safer Use of Fentanyl and Buprenorphine Transdermal Patches
Appendix 29 – CQC and NHSE Guidance on Safer Use of Oxycodone Medicines

Prescribing Drugs Likely to Cause Dependence or Misuse

107. Before starting or continuing treatment with an opioid, ensure that all suitable management options, including non-pharmacological approaches and watchful waiting have been discussed with and offered to the person.

108. When making decisions about prescribing medicines, determine whether there are any factors that might increase the person's risk of developing problems associated with dependence, but do not withhold the medicine solely on the basis of one of these factors. Explain and discuss the risk with the person. Factors that might increase risk include:

- a comorbid mental health diagnosis,
- a history of drug or alcohol misuse,
- not having a clear, defined diagnosis to support the prescription,

- taking an opioid together with a benzodiazepine.

109. During the first discussion about prescribing, give the person information and advice (in their preferred format) to help them balance the potential benefit of the medicine and other treatment options with the risk of long-term consequences.

110. Recognise and acknowledge that decisions about medicines can be difficult for a person who is in distress.

111. Acknowledge that these decisions are also difficult for the prescriber particularly when supporting a person who is distressed, and in the presence of risk factors for developing problems associated with dependence, and that additional time may be required to consider options and consult with colleagues.

112. Consider delaying prescribing if the person needs more time to think about their options or the prescriber needs to consult with other members of the healthcare team. If prescribing is delayed, ensure that a follow-up appointment is arranged.

113. For people who find it difficult to communicate their symptoms, for example people with a learning disability or cognitive impairment:

- explore a range of methods to understand the person's symptoms, including discussion with family members, carers or an advocate if appropriate,
- make necessary reasonable adjustments, for example increasing the appointment length, using short clear sentences or alternative methods of communication and visual aids during consultations, to help the person understand their options for treatment and the associated risks and benefits of each, and to express their view,
- ensure that family members or carers are aware of the properties of any medicine prescribed, if appropriate.

114. Ensure that people with a learning disability or mental health problem have had a full assessment before prescribing a dependence-forming medicine, to ensure that they do not have other unmet needs and that prescribing is the appropriate option. Consider involving the relevant specialist teams.

Practice Resources

Appendix 9 – NICE Visual Summary – Before Starting Treatment
Appendix 14 – Useful SNOMED Codes
Appendix 15 – NICE Visual Summary – Reviewing Medicines Associated with Dependence or Withdrawal Symptoms
Appendix 21 – Opioid Policy New Patients
Appendix 22 – Opioid Policy-Issuing Prescriptions
Appendix 23 – Practice Procedure for Lost/Stolen Controlled Drug Prescriptions
Appendix 24 – Practice Procedure for Patients where Dependence on, or Diversion of, Controlled Drugs has been Identified
Appendix 25 – Reporting of Controlled Drug Incidents via cdreporting.co.uk
Appendix 30 – Preparation for Dose Reduction

Identification of Prescription Opioid Dependency

115. Recognition of dependence is not easy, and it may be difficult to distinguish between the re-emergence of underlying conditions and the emergence of withdrawal symptoms.

116. Signs that may indicate that a person is developing problems associated with dependence include:

- running out of a medicine early,
- making frequent requests for dose increases,
- reporting loss of efficacy of a medicine that was previously working well.

117. Prescribers should avoid being used as an unwitting source of supply for people with problems associated with dependence and be vigilant to methods for obtaining medicines. Methods include visiting more than one doctor, fabricating stories, and forging prescriptions. People under temporary care should only be given small supplies of medicines unless they present an unequivocal letter from their own doctor.

118. Prescribers should also remember that their own patients may be attempting to collect prescriptions from other prescribers, especially in hospitals.

119. Indicators that suggest the possibility of dependence should be explored in those on a long-term opioid prescription:

- Long-term prescribing of opioids for non-cancer conditions.
- Current or past psychiatric illness or profound emotional trauma.
- Reports of concern by family members or carers about opioid use.
- Concerns expressed by a pharmacist or other healthcare professionals about long-term opioid use.
- Insistence 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 addiction assessment.
- The repeated seeking of prescriptions for opioids with no review by a clinician.
- Repeatedly losing medications or prescriptions.
- Taking doses larger than those prescribed or increasing dosage without consulting the clinician; often coupled with seeking early replacement prescriptions, associated with continued requests for dose escalations.
- Seeking opioids from different doctors and other prescribers. This can take place within GP practices, often identifying locum doctors or doctors unfamiliar with their case. This may be associated with attempting unscheduled visits.
- Obtaining medication from multiple different providers, NHS and private GPs, repeatedly and rapidly deregistering and registering with GPs, seeking treatment for the same condition from both specialists and GP; or seeking treatment from multiple specialists. This may be coupled with a refusal to agree to writing to the main primary care provider.
- Obtaining medications from the internet or from family members or friends.
- Resisting referrals to acute specialists about complex physical conditions or failing to attend specialist appointments.
- Appearing sedated in clinic appointments.
- Misusing alcohol or using illicit or over-the counter, internet or other prescribed drugs or a past history of alcohol or other drug dependence.
- Deteriorating social functioning including at work and at home.

- Resisting or refusing drug screening.
- Signs or symptoms of injecting opioids or snorting oral formulations.

120. It is sensible to reduce dosages steadily or to issue weekly or daily prescriptions for small amounts if it is apparent that dependence is occurring see Prescribing Drugs Likely to Cause Dependence or Misuse Section.

Practice Resources

Appendix 10 - Opioids and the Risk of Addiction Patient Information Leaflet
Appendix 14 – Useful Read Codes
Appendix 21 – Opioid Policy New Patients
Appendix 22 – Opioid Policy – Issuing Prescriptions
Appendix 24 – Practice Procedure for Patients where Dependence on, or Diversion of, Controlled Drugs has been Identified
Appendix 25 – Reporting of Controlled Drug Incidents via cdreporting.co.uk
Appendix 30 – Preparation for Dose Reduction

Appendix 1 – Faye's Story

CONTROLLED DRUGS NEWSLETTER

NHS South Region South West

SHARING GOOD PRACTICE IN THE SOUTH WEST

April 2017

SPECIAL EDITION – FAYE'S STORY

What can happen when things go wrong with prescribing for chronic pain – lessons that must be learned by all healthcare professionals

As told by her parents, Linda and Steve

Faye (right), when she was well

Our daughter Faye injured her back lifting an empty fish tank into a car boot in 2009. Her pain did not resolve, so she was referred for surgery in 2010. This did not go well, and she left hospital still in pain, on oxycodone. As her pain continued, the doses and numbers of medications prescribed increased. Faye put on 7 stone, and developed sleep apnoea, and then in June 2013, she developed diabetes. In September 2013 Faye had a respiratory arrest, and died – she was just 32 years old.

Before Faye injured her back, her life was pretty normal. She worked as deputy manager at a major pet store, and she was planning to get married, and start a family. She and her fiancé both had a horse, and a social life that revolved around this.

Following her operation in May 2010, Faye was taking 80mg oxycodone daily, and by June 2013, she was taking more than 200mg oxycodone daily, along with diazepam, amitriptyline, prochlorperazine, sertraline, diclofenac, esomeprazole and paracetamol. Gabapentin had been tried, and withdrawn. Her symptoms and health problems had become steadily worse as the dose of oxycodone increased, and more medicines were added in to manage the side effects. As well as the pain, she suffered from nausea, sleepiness, fainting, muscle spasms, blistering skin problems and depression. She had become a compulsive home shopper. Despite the prochlorperazine, her nausea was so bad she sometimes could not bear to use the CPAP face mask at night, for her sleep apnoea.

Whilst waiting inpatient rehabilitation (for 20 months), Faye had some sessions of cognitive behaviour therapy from the NHS counselling service, and also started a pain management course. She did show signs of improvement – she managed to lose 3 stone, started to look after her appearance again, and managed to go out for a walk with her Dad. We really thought that

she had turned a corner, and would finally start getting better. Then out of the blue, she had a respiratory arrest and died.

We believe that her death was avoidable, and that there are still a lot of people like Faye receiving unsafe treatment for long term pain, who are, at worst, at risk of dying suddenly, or at least, of leading a twilight life.

What went wrong?

How did our daughter go from having a normal life in July 2009, to dying suddenly in September 2013? Was the treatment she received to blame? The inquest did not supply the answers that we had hoped for, so we set about trying to find out for ourselves. There are several ways that her medicines could have been doing more harm than good;

- Her dose of oxycodone was repeatedly increased, against the advice of the pain clinic, and despite her pain not being effectively managed by it. It was way above the safe limit, now set at 120mg morphine daily equivalent dose (see Opioids Aware http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
- She was taking oxycodone with diazepam - opioid and benzodiazepine medications taken together can lead to respiratory depression, and she already had sleep apnoea https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm518110.htm
- Several of her medicines are known to increase the QT interval, especially in combination – long QT syndrome is a leading cause of sudden cardiac death in young, otherwise healthy people
- Diclofenac - there is a small risk of heart attack or stroke in patients taking systemic diclofenac regularly, especially at high doses (150 mg daily) and for long periods
- Erythromycin – just before her death, Faye received a course of erythromycin for infected in-growing toenails. There is a small risk that when taken with amitriptyline or prochlorperazine, erythromycin can increase the risk of an irregular heart rhythm. Although Faye was told to stop taking the amitriptyline and prochlorperazine whilst on the erythromycin, the long half-life of amitriptyline may not have been taken into consideration. On the day she died, Faye had texted a friend to say that the erythromycin was making her feel strange
- Faye may have had an allergic reaction to erythromycin – her face and upper body were very swollen after death

Any or all of the above could have contributed to Faye's death. Also, given that her MRI scan showed nothing clinically significant, should Faye have been offered the operation on her back? That seemed to make things worse too.

Faye's state of mind

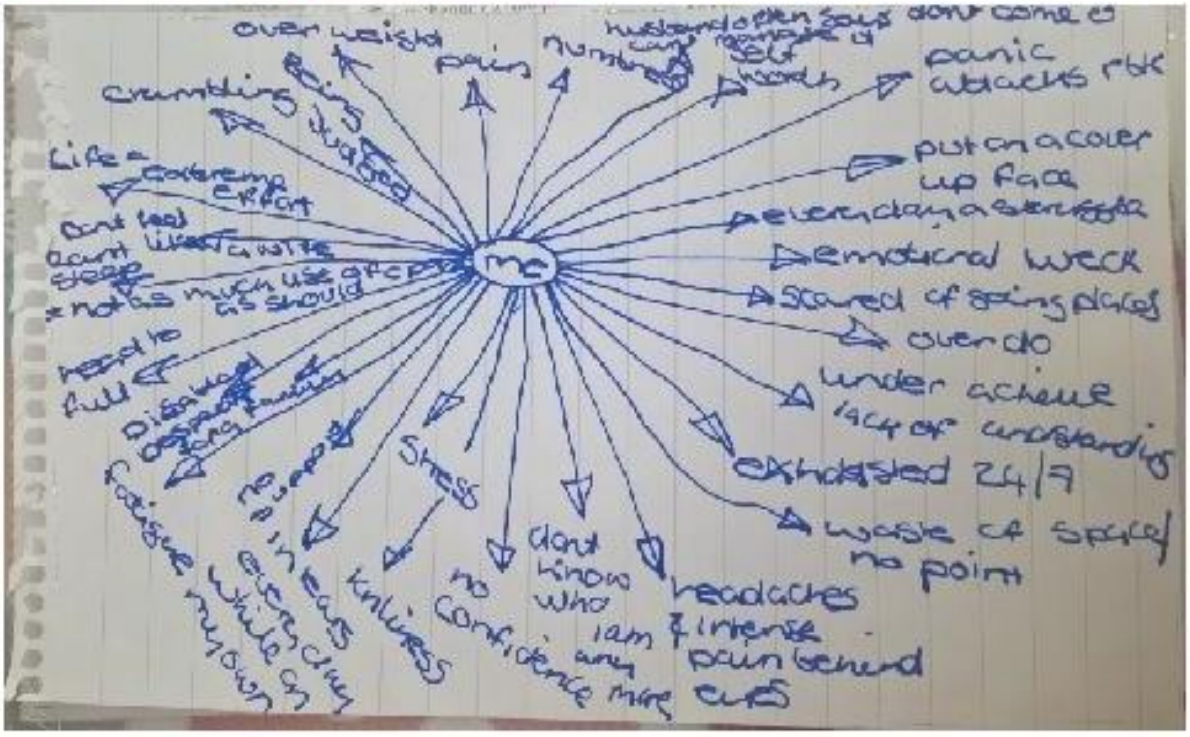
As a nine year old, Faye suffered from a nine month long period of intense pain and illness, which was diagnosed at the time as ME. It left her, as an adult, with a tendency to headaches and joint pains. We don't think that doctors treating her as an adult were aware of this.

Faye put herself under a lot of pressure to succeed in her plans. She was determined and ambitious. Her job was difficult and she worked very long hours. She had to go and look after her horse after work, and got home late most nights.

Faye did not smoke, rarely drank alcohol, and had a real aversion to swallowing tablets. She ended up taking 40-50 tablets a day, using fruit pastilles and grapes to help her swallow them.

When all of this started, if she had been questioned about her mood, and her past experiences of pain, would this have made the doctors think twice about giving her opioids? Or increasing the dose, when they were clearly not working?

Faye's mind map, which was found after she died



What could have been done differently?

Nobody should end up dying of a bad back, especially a young woman like Faye with her whole life ahead of her. Yet we know that there are a lot of people with bad backs, and other sorts of

long term pain. Many are still on high dose opioids, and medicine combinations which may well be doing more harm than good.

We discussed these concerns with the new larger GP practice, which has incorporated Faye's GP practice. They have given this a lot of thought, and have made the following changes, to try to avoid another person like Faye dying unnecessarily.

The GPs at the practice are now focusing on these key learning points:

- Safety issues around opiate prescribing
- The role of oxycodone, and an understanding of the dose equivalence of different opiates
- Alternatives to opiates for managing ongoing pain
- Mechanisms for reducing high doses of medication, e.g. weekly scripts, MDS
- Review of current prescribing in the practice
- Mechanisms for group discussions around difficult to manage cases, including a monthly patient safety meeting to review concerns about medication levels

We have thought about what message we want to send out ourselves, as grieving parents, and we believe that all healthcare professionals in every GP practice in the country should think about these points:

- First, do no harm
- Follow evidence based practice
- You have a duty of care
- Do not authorise prescriptions, even on specialist recommendation, if you don't think they are safe

Guidelines are published, and circulated, and yet change in practice is too slow, in the face of new safety evidence. What should your practice be doing differently, today? How could you spot another person like Faye, struggling and failing on their medicines, and save them?

Sue Mulvenna CD Accountable Officer 09.06.17

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We can no longer receive or send faxes.

Video available here [Faye's Story - YouTube]

Appendix 2 – Sean's Story

'Sean's Story' is a video that tells the story of Sean Jennings from Cornwall who had a hernia operation 25 years ago and due to an infection, ended up suffering chronic pain. For many years, Sean was taking large doses of opioids which presented numerous side effects and yet he still suffered from continued chronic pain. The film shows how long-term use of high-dose opioid prescribing had a devastating impact on his quality of life and how non-drug therapy has been life changing for Sean.

As the pain continued to get worse without relief from opioids, Sean asked his GP to be put on a pain management programme. The pain management programme is specifically designed to help patients develop appropriate long-term coping strategies for living with long term pain.

Sean said: "Every day I was taking more and more painkillers, and I thought I was all right, but I really wasn't very well. I realised that I wasn't functioning properly and sought further help from my GP as I just couldn't cope. He put me on the pain management programme and that changed my life."

Through alternative therapies such as mindfulness and meditation, Sean has been able to deal with his pain without the reliance on opioids to manage. The film aims to encourage and inspire patients with chronic pain to seek alternatives to prescription opioids to help deal with their condition.

Sean added: "I learnt how to exercise gently and do a little bit of Tai Chi and mindfulness. To start with – mindfulness, I didn't understand that but, as a sceptic, it works. I'm 18 months now without taking opioids, no gabapentin, nothing for pain whatsoever. The pain hasn't gone away – it's simply the way I deal with it now, and I do this through mindfulness."

The film is also aimed at medical professionals to encourage them to consider incorporating psychological therapies into their patient's care when they are prescribing opioids for pain. It aims to highlight the over-medication of some patients and to consider referrals to pain management courses which are widely available.

Dr Jim Huddy, who leads on chronic pain at Kernow Clinical Commissioning Group, said: "What we're hoping for is that Sean's story can implant what you might call a lightbulb moment for people who are in a similar situation with chronic pain, on high doses of opioids and who haven't considered that there could be another way to manage their pain and lead their lives.

"For prescribers, I sympathise with the time-constraints and the pressures that we have in consultations. Chronic pain consultations are really challenging, and patient expectations can sometimes be high. They expect a prescription and to start the process of changing that can be really difficult. So, we totally understand why doctors often reach for the prescription pad. Hopefully that will slowly change, but it will be a slow change."

NHS England SouthWest Medical Director, Dr Michael Marsh, said: "This film aims to highlight to prescribers, such as GPs, and to also make patients aware that there are alternatives to opioids to help deal with chronic pain. By integrating psychological therapy with physical health services, the NHS can provide a more efficient support to this group of people with chronic pain and achieve better outcomes."

To view the film, click here

Appendix 3 – What to discuss with the Person when considering Opioid Treatment

- During the first discussion about prescribing, give the person information and advice (in their preferred format) to help them balance the potential benefit of the medicine and other treatment options with the risk of long-term consequences.
- Explain that the evidence for the use of opioids as analgesics is best when used in the management of acute pain, over a period of hours from onset but tapering dose over days to a few weeks.
- Explain that opioids are poorly effective for long-term pain. For a small proportion of people, opioids may be successfully used as part of a broader plan including non-medication treatments and self-management.
- Discuss the degree of pain relief that might be expected and understand that the aim is not complete pain relief but rather reducing pain sufficiently to engage in self-management.
- Agree specific functional goals that might be achieved.
- Discuss the potential harms of opioid treatment, whether these are likely to be temporary or permanent and whether they might improve or worsen over time, including:
    - Sedation
    - Nausea
    - Constipation
    - Effects on hormones
    - Effects on the immune system
    - Potential for the drugs to worsen pain
    - Potential for problematic drug use and addiction.

- Discuss that dependence is an expected effect of these medicines and is not a reason in itself to avoid the medicine.
- Discuss the potential for developing problems associated with dependence.
- Discuss the symptoms that suggest the development of problems associated with dependence and, if appropriate, the importance of making family members, carers or other people close to them aware of these symptoms.
- Discuss opioids and impairment of driving skills.
- If relevant discuss the implications of taking the medicine if the person is pregnant or planning pregnancy.
- Discuss how difficult if might be to stop the medicine later and how that might be managed.
- Discuss the opioid trial.
- Discuss that missing doses may lead to symptoms of withdrawal.
- Discuss the circumstances in which opioid therapy will be stopped.
- Discuss what the options might be if the medicine does not work.
- Discuss how to store medicines safely.
- Discuss arrangements for review.

For people who find it difficult to communicate their symptoms, for example people with a learning disability or cognitive impairment:

- Explore a range of methods to understand the person's symptoms, including discussion with family members, carers or an advocate if appropriate.

- Make necessary reasonable adjustments, for example increasing the appointment length, using short clear sentences or alternative methods of communication and visual aids during consultations, to help the person understand their options for treatment and the associated risks and benefits of each, and to express their view.
- Ensure that family members or carers are aware of the properties of any medicine prescribed, if appropriate.

Ensure that people with a learning disability or mental health problem have had a full assessment before prescribing a dependence-forming medicine, to ensure that they do not have other unmet needs and that prescribing is the appropriate option. Consider involving the relevant specialist teams.

Appendix 4 – Ten Footsteps Patient Information Leaflet (10)

Ten footsteps – a practitioners guide available here [Ten Footsteps – a practitioners' guide - Live Well with Pain]

Ten Footsteps

Your Journey to Living Well with Pain

Live Well with pain

Learning how to manage your pain is a journey. Like any journey, it takes time and everyone's experience is different. We know from people living with pain that there are some things which can be really helpful. We've called these the Ten Footsteps and we'll tell you something about them in this leaflet.

Footstep 1: What do we know about persistent pain?

Persistent pain is very different from the kind of pain you experience when you touch something hot or injure yourself. It goes on long after normal healing and repair time, and affects different parts of the brain and nervous system.

The best way of reducing pain is to help your mind and brain to turn it down. *Read the other nine footsteps to find out how to do this.*

Persistent pain can cause a range of problems, including:

- **Excitable nerves.** Slight pressure can cause unpleasant and painful sensations like pins and needles or electric shocks.
- **Sensitivity.** Skin, muscles or nerves can be more sensitive to pressure, touch or heat.
- **Faulty brain activity.** The systems that turn down pain don't work.
- **Low mood.** Living with persistent pain can cause strong feelings such as anger and frustration.

Footstep 2: Acceptance

Accepting persistent pain as part of your everyday life is a huge help. Rather than struggling to avoid or reduce your pain, you can learn to observe, understand and accept it. This is not easy – it can be hard to accept that you are not the person you were. However, as you accept things have changed, you can switch your energy and focus to living well.

The long and winding road to acceptance

Things that help with acceptance:

- Slowly adjust how you do things.
- Try to think and view yourself and life differently.
- Patiently shift your focus to what you really want to do each day.
- Learn how to switch your attention from your pain to other things – your breathing, for example.
- Use some techniques from mindfulness, such as mindful stretching.
- Find the best type of support and help.

Footstep 3: Pacing every day for better times

Pacing is taking a break before pain, tiredness or exhaustion force you to stop. Many people use pain to guide their activity levels. On a 'good day' they try to get as much done as possible until their pain and tiredness increase, forcing them to stop and rest for much longer. This is called the 'boom-and-bust' cycle.

Activity – Rest – Repeat!

How to pace well:

1. Decide which activities you need to pace. If any daily activities are difficult because of your pain or they cause your pain to increase, they probably need to be paced.
2. Work out how much effort to put into each activity without causing more pain. Reduce your activity so that you stop or take a rest long before you would usually experience pain. Then, steadily build up your body stamina by increasing what you do before each break.
3. Find the balance of activity and rest breaks so if your body is feeling stiffer, more tired or pain than usual, you can adjust the balance. This means you take more breaks, use less effort or go more slowly or change to an easier activity at that time.

Footstep 4: Set goals, action plans and rewards

Goal setting is about focusing on the things in your life that you want to change. Your goals need to be SMART:

SMART goals

S = Specific. State clearly what you want to achieve.

M = Meaningful. The goals really matter to you.

A = Achievable. They require some effort but are not too difficult.

R = Realistic. You can fit them into your life.

T = Time-based. They can be achieved within the next few weeks or a couple of months.

A few examples of SMART goals:

- Read a good book within the next month.
- Pot plants in the greenhouse by the end of the month.
- Try out a new recipe every weekend.
- Go to the next midweek football match with friends.
- Swim and relax in the sauna every week.

Action plans help you work out how to achieve your goal, what you need to do, when you will do it, how often and who else you can involve.

Regular rewards can help you to make progress. Whether big or small, make sure that your rewards are things you really value and make them pleasurable.

To get from A to B... you're going to need a plan!

Footstep 5: Getting fit and staying active

Being more active and building fitness can help – even if it was not really part of your life before pain arrived. Three things are important:

1. **Stretching** helps loosen tight muscles, ligaments and joints and increases flexibility.
2. **Strengthening exercises** will build stronger muscles and joints and improve balance.
3. **Stamina activities** help you to do things for longer without more pain or tiredness.

Fitness is more fun with friends!

Things that will help you to get fitter and stay active:

- Create SMART goals and an action plan to guide you (see Footstep 4).
- Find out what's available in your local area.
- Choose things that are fun and easy to do.
- Enjoy activities with other people.
- Gently increase the amount of time spent doing activities.
- Give yourself regular rewards.
- Tell others about your progress.

Footstep 6: Managing moods

It is normal to struggle with moods when you have persistent pain. People often feel angry, frustrated, fearful and unmotivated because of it.

Focus on the good bits!

Here are some things that you can do to manage your moods better:

- Notice negative and unhelpful thoughts, and find ways to balance or soothe them.
- Practise balanced thinking – imagine what a best friend would say if they knew what you were thinking. Ask yourself, 'Are my thoughts 100 per cent true and believable?'
- Do things that unwind and soothe your mind, such as walking the dog, listening to music and breathing calmly.
- Create a list of positive things you have done that day or week.
- Practise being kind to yourself by pacing and giving yourself pleasurable rewards.
- Learn from others with similar pain issues.
- Find out about self-help resources to manage your moods.
- Share your plans with people you trust and get their support.

Footstep 7: Sleep well more often

Many people with pain find that their sleep is disrupted. New research shows that by adjusting what you do during the day, as well as night, it is possible to achieve a healthier sleep pattern.

Time for new sleep skills!

Four things are important for better sleep:

1. **Your daily routines.** Try to go to bed and get up at the same time each day.
2. **Your activity levels.** Increasing activity in the day can help you to sleep better at night. Take care to avoid energetic exercise shortly before sleep.
3. **Your food and drink habits.** Avoid caffeinated drinks late in the day and big meals late in the evening. You should also avoid drinking too much before bed.
4. **Your bedtime routine.** Follow the same wind-down routine every evening and make sure your bedroom is dark and used only for sleep – don't watch TV or do work in bed!

Footstep 8: Healthy eating, managing relationships and work

Healthy eating

Eating well and having a normal-range weight will help you to build better health and cope well with pain.

There are many things that you can do to help achieve a healthy weight – and they don't always involve a diet! Ask your doctor or pharmacist for a medication review, as some drugs can contribute to weight gain. Reducing portion sizes, cutting out snacks and switching to a Mediterranean diet can help, too.

Managing relationships

Connecting with others can feel like the last thing you want to do when pain dominates your life. Yet doing things with other people is likely to lift your mood and distract you from focusing on your pain. It can also motivate you to do more of the activities you enjoy.

Learn how to connect better with others

Coping with work

Staying at work or returning to work gives your life routine, structure and purpose. Here are some tips that can help:

- Think about what needs to happen for you to return to work.
- If you are looking for work, be flexible about what you might do.
- Ask for a phased return starting with just two to three hours per day and building up from there.
- Be prepared to accept any support that is offered at work.

Footstep 9: Relaxation and mindfulness

Unwinding your body and mind can make a positive difference to your life and your pain. We know that relaxation and mindfulness lessen pain levels, reduce stress and improve concentration.

Mindfulness is being aware of your body and mind in the 'now'. It's about noticing what you think, feel or want at this moment without being too critical or judging yourself. There is plenty of evidence showing that mindfulness can help us to live better with difficult health problems such as pain.

Like any other skill, mindfulness needs daily practice and guidance to use it confidently. You can learn it from someone who knows about mindfulness, sign up for an internet course or join a local class.

Here are the different types of relaxation that you can practise:

1. **Breathing and muscle relaxation.** This includes techniques such as 'belly breathing' or tightening and then relaxing parts of the body.
2. **Refocusing your attention.** You can do this by shifting your attention away from your pain using visualisation techniques.
3. **Choosing relaxing activities.** Anything that helps you to unwind will be good for your pain, such as reading a magazine, listening to music, walking the dog or doing a puzzle.

Footstep 10: Managing setbacks

Setbacks are common while managing pain. Having the confidence to deal with them is a 'must have' skill. A setback plan helps you to cope better and reduces the sense of panic that they sometimes cause.

Here are some things that you can include in your setback plan:

- Cut back on normal activities for a few days and take more regular breaks.
- Keep gently active and avoid long periods of bed rest.
- Begin gentle stretching as soon as possible to regain flexibility.
- Practise relaxation or mindfulness breathing.
- Try not to get into negative thinking – tell yourself this is temporary and you have a plan to get back on track.

Find out more

Discover more ways to manage pain...

Overcoming Chronic Pain self help CBT book, Cole et al, 2005 (ISBN 9781472105738)

Manage your Pain Nicolas et al, 2012 (ISBN 9780285640481)

Pain is Really Strange Steve Haines and Sophie Standing, 2015 (ISBN 9781848192645)

Find out about free books on prescription at libraries at **www.reading-well.org.uk**

www.painconcern.org.uk
– useful range of videos and sources of help

www.healthtalkonline.org
– people with pain share ways to cope and live well

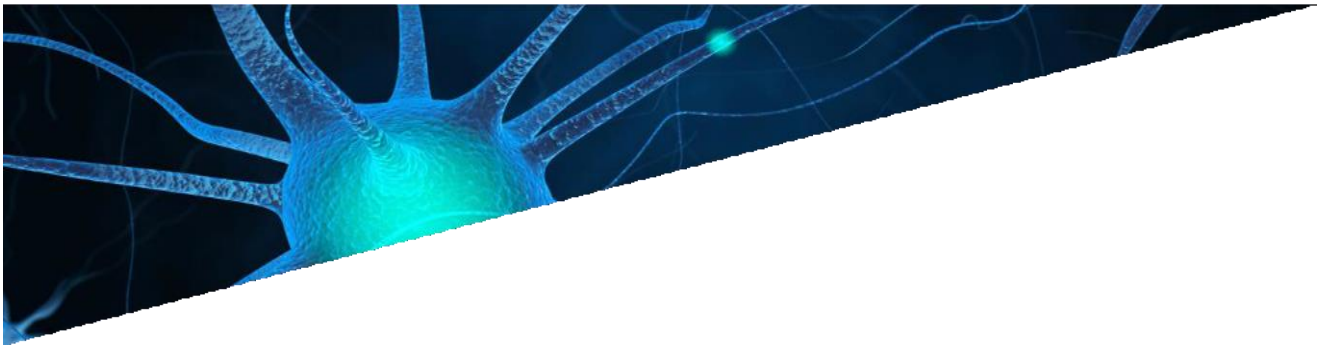
www.nhs.uk – for guides to healthy eating, exercise, fitness and a pain toolkit resource

www.breathworks-mindfulness.org.uk
– explores mindful practice with courses and resources

www.paincd.org.uk
– audio resource about ways to living with chronic pain

People with pain and clinicians in pain self management have created the *Ten Footsteps* to help you find your feet and start to live well with pain. Contact **info@livewellwithpain.co.uk** with ideas to share or feedback.
V1. 02/18

Appendix 5 – About Pain Patient Information Leaflet (2)



Most of us have experience of everyday pain including headaches, pain from minor injuries and muscular pain for example following exercise. These pains don't last long and often don't need treatment. All pain we feel is affected by how we are feeling generally, our past experience of pain and any concerns we have about the cause of the pain. If we are worried and distressed about how pain may affect us in the future, our pain will feel worse. Also, unpleasant thoughts, feelings and memories (even if these are not to do with pain) can influence how we feel pain. Anxiety, depression, Post-Traumatic Stress Disorder, previous emotional upsets or other mental health problems, are likely to worsen our experience of pain and make it more difficult to treat.

Types of Pain

Pain is usually described as acute (short-term) or chronic (long-term) pain (usually more than three months).

- **Acute pain** is usually related to an obvious injury such as dental infection, bone fracture or operation.
- **Chronic pain** sometimes begins with an injury but the pain doesn't get better as expected: often it is not clear how a chronic pain has started. Common types of chronic pain include low back pain, pain related to arthritis and pain related to injury to a nerve or other part of the nervous system (neuropathic pain). Chronic pain is usually not a sign of on-going injury or damage but may be to do with changes in the nervous system that occur over time so that the pain signalling becomes self-sustaining over a prolonged period.
- **Cancer pain** is usually described separately and may be short or long lasting. The pain can relate to the cancer itself or the cancer treatment. Additionally, people with cancer may experience acute or chronic pain unrelated to their cancer.

Acute and chronic pain can range from mild or severe with the difference being how long the symptoms last.

Treatments for different types of pain (you may have more than one type of pain)

Acute Pain

Acute pain can be severe but usually gets better quite quickly (days or weeks). Treatments usually only need to be given for a short time while healing of the injury begins. Acute pain is often straightforward to treat with a range of medicines and other treatments depending on how severe the pain is. Opioid medicines are useful for treating acute pain and usually only need to be given for a period of a few days. The dose of opioid should be reduced as healing occurs.

Chronic Pain

Chronic pain can cause low mood, irritability, poor sleep and reduced ability to move around. Unlike acute pain, chronic pain is difficult to treat with most types of treatment helping less than a third of patients. Most treatments aim to help you self-manage your pain and improve what you can do.

Different treatments work for different people. Medicines generally and opioids in particular are often not very effective for chronic pain. Other non-medicine treatments may be used such as electrical stimulating techniques (TENS machine), acupuncture, advice about activity and increasing physical fitness, and psychological treatments such as Cognitive Behaviour Therapy and meditation techniques such as mindfulness.

Helping you understand about chronic pain is important and in particular helping you understand that physical activity does not usually cause further injury and is therefore safe. It is important that you understand that treatments tend not to be very effective and that the aim is to support you in functioning as well as possible.

Neuropathic Pain

Neuropathic pain is a type of chronic pain associated with injury to nerves or the nervous system. Types of neuropathic pain include, sciatica following disc prolapse, nerve injury following spinal surgery, pain after infection such as shingles or HIV/AIDS, pain associated with diabetes, pain after amputation (phantom limb pain or stump pain) and pain associated with multiple sclerosis or stroke. Neuropathic pain is usually severe and unpleasant.

Medicines may be used to treat neuropathic pain but are usually not very effective and work for a small proportion of people. You may not benefit from the first drug tried so you may need to try more than one drug to try and improve symptoms.

Cancer Pain

Cancer pain is usually associated with an obvious source of tissue damage and may be acute or chronic. Neuropathic pain can occur with cancer diagnoses and treatments (such as radiotherapy). Because cancer pain treatment, particularly at the end of life, is often for a short duration, it is usually more successful than chronic pain treatment. People who recover from cancer or who survive a long time with cancer may have pain that is more difficult to treat.

Appendix 6 – Summary of NICE Guidance related to Pain Relief and Opioids

NICE Guidance	Non-pharmacological options	First choice medications	Alternative options
Chronic pain (primary and secondary) NG 193 (1) **o Not Do statements** Do not initiate any of the following medicines to manage chronic primary pain in people aged 16 years and over: • antiepileptic drugs including gabapentinoids, unless gabapentinoids are offered as part of a clinical trial for complex regional pain syndrome (see the recommendation for research on pharmacological interventions) • antipsychotic drugs • benzodiazepines • corticosteroid trigger point injections • ketamine • local anaesthetics (topical or intravenous), unless as part of a clinical trial for complex regional pain syndrome (see the recommendation for research on pharmacological interventions) • local anaesthetic/ corticosteroid combination trigger point injections • non-steroidal anti-inflammatory drugs	Offer a supervised group exercise programme. Encourage people with chronic primary pain to remain physically active for longer-term general health benefits. Consider acceptance and commitment therapy (ACT) or cognitive behavioural therapy (CBT) for chronic primary pain. Consider a single course of acupuncture or dry needling, within a traditional Chinese or Western acupuncture system, to manage chronic primary pain, but only if the course: is delivered in a community setting and • is delivered by a band 7 (equivalent or lower) healthcare professional with appropriate training and • is made up of no more than 5 hours of healthcare professional time (the number and length of sessions can be adapted within these boundaries) or • is delivered by another healthcare professional with appropriate training and/or in another setting for equivalent or lower cost.	Consider an antidepressant, either amitriptyline, citalopram, duloxetine, fluoxetine, paroxetine or sertraline, for people aged 18 years and over to manage chronic primary pain, after a full discussion of the benefits and harms. Seek specialist advice if pharmacological management with antidepressants is being considered for young people aged 16 to 17 years.	

NICE Guidance	Non-pharmacological options	First choice medications	Alternative options
• opioids • paracetamol **Low back pain (NG59)** (11) **Do Not Do statements:** Do not offer paracetamol alone for managing low back pain. Do not routinely offer opioids for managing acute low back pain. Do not offer opioids for managing chronic low back pain. Do not offer selective serotonin reuptake inhibitors, serotonin–norepinephrine reuptake inhibitors or tricyclic antidepressants for managing low back pain. Do not offer gabapentinoids or antiepileptics for managing low back pain. Do not offer gabapentinoids, other antiepileptics, oral corticosteroids or benzodiazepines for managing sciatica as there is no overall evidence of benefit and there is evidence of harm. Do not offer opioids for managing chronic sciatica.	**Self-management** Information on nature of low back pain and sciatica. Encouragement to continue with normal activities. **Non-pharmacological options** Exercise for people with a specific episode or flare-up of low back pain with or without sciatica. Manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy. Psychological therapies using a cognitive behavioural approach for managing low back pain with or without sciatica but only as part of a treatment package including exercise, with or without manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage). Combined physical and psychological programme, incorporating a cognitive behavioural approach (preferably in a group context that takes into account a person's specific needs and capabilities), for people with persistent low back pain or sciatica: • when they have significant psychosocial obstacles to recovery (for example, avoiding normal activities based on inappropriate beliefs about their condition) or • when previous treatments have not been effective. Promote and facilitate return to work or normal activities of daily living for people with low back pain with or without sciatica.	NSAIDs - lowest effective dose for the shortest possible period of time. Be aware of the risk of harms and limited evidence of benefit from the use of non-steroidal anti-inflammatory drugs (NSAIDs) in sciatica.	Consider weak opioids (with or without paracetamol) for managing acute low back pain only if an NSAID is contraindicated, not tolerated or has been ineffective.

NICE Guidance	Non-pharmacological options	First choice medications	Alternative options
Osteoarthritis (NG226) (12) **Do Not Do statements:** Do not routinely offer paracetamol or weak opioids unless: they are only used infrequently for short-term pain relief and all other pharmacological treatments are contraindicated, not tolerated or ineffective. Do not offer glucosamine or strong opioids to people to manage osteoarthritis. Do not offer intra-articular hyaluronan injections.	**Self-management** the core treatments for the condition are therapeutic exercise and weight management (if appropriate), along with information and support. **Non-pharmacological options** For all people with osteoarthritis, offer therapeutic exercise tailored to their needs (for example, local muscle strengthening, general aerobic fitness). For people with osteoarthritis who are living with overweight, or obesity advise them that weight loss will improve their quality of life and physical function, and reduce pain, support them to choose a weight loss goal, explain that any amount of weight loss is likely to be beneficial, but losing 10% of their body weight is likely to be better than 5%.	Topical non-steroidal anti-inflammatory drug (NSAID) to people with knee osteoarthritis. Consider a topical NSAID for people with osteoarthritis that affects other joints.	If topical medicines are ineffective or unsuitable, consider an oral NSAID for people with osteoarthritis. Consider intra-articular corticosteroid injections when other pharmacological treatments are ineffective or unsuitable, or to support therapeutic exercise. Explain to the person that these only provide short-term relief (2 to 10 weeks).
Neuropathic pain (CG173) (13) **Do Not Do statement:** Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so: • cannabis sativa extract • capsaicin patch • lacosamide • lamotrigine • levetiracetam • morphine • oxcarbazepine • topiramate • tramadol long-term • venlafaxine • sodium valproate		Amitriptyline, duloxetine, gabapentin or pregabalin. Trigeminal neuralgia. Carbamazepine.	If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated. Consider tramadol only if acute rescue therapy is needed. Consider capsaicin cream for people with localised neuropathic pain (except trigeminal neuralgia) who wish to avoid, or who cannot tolerate, oral treatments.

NICE Guidance	Non-pharmacological options	First choice medications	Alternative options
Tension headache (CG150) (14) **Do Not Do statement:** Do not offer opioids for the acute treatment of tension-type headache.		Aspirin (not if under 16), paracetamol or an NSAID.	
Migraine (CG150) (14) **Do Not Do statements:** Do not offer ergots or opioids for the acute treatment of migraine. Do not offer gabapentin for the prophylactic treatment of migraine.		Triptan together with either an NSAID or paracetamol.	For people who prefer to take only one drug, consider monotherapy with an oral triptan, NSAID, aspirin (900 mg) or paracetamol.
Cluster headache (CG150) (14) **Do Not Do statement:** Do not offer paracetamol, NSAIDS, opioids, ergots or oral triptans for the acute treatment of cluster headache.		Oxygen and/or a triptan	
Medication overuse headache (CG150) (14)		Advise people to stop taking all overused acute headache medications for at least 1 month and to stop abruptly rather than gradually.	
Rheumatoid arthritis (NG100) (15)	**Non-pharmacological options** • Physiotherapy • Occupational therapy • Hand exercising programmes • Podiatry • Psychological interventions	Conventional disease-modifying anti-rheumatic drugs (DMARDs)	Biological and targeted synthetic DMARDs. Short-term glucocorticoids for managing flares. Consider NSAIDs or COX-2 inhibitors when control of pain or stiffness is inadequate. Use the lowest effective dose fort the shortest possible time.

Appendix 7 – Thinking about Opioid Treatment for Pain Patient Information Leaflet (2)

Pain is complicated and influenced by many factors, including:

- how you are feeling in general,
- your previous experience of pain,
- your understanding of why you have pain and any worries you have about it,
- how you deal with your pain and how your pain affects your life.

Pain that doesn't get better tends to cause distress, tiredness and irritability. Your sleep may also be affected and it can cause problems with daytime activities and moving around. Because of this, it can also affect relationships with friends and family.

You should discuss, with your doctor, what you expect from the treatment. It is easier to treat pain after surgery or an injury with painkiller medicines; however, it is rarely possible to relieve long-term pain completely by using painkillers. The aim of treatment is to reduce your pain enough to help you get on with your life. In trials most medicines for long-term pain only benefit around one in every four or five people and on average only provide 30% reduction in pain.

Medicines work best if you combine them with other ways of managing symptoms such as regular activity and exercise, and doing things that are satisfying or enjoyable, such as work or study, and social activities. Setting goals to help improve your life is an important way to see if these drugs are helping.

'Why don't my painkillers work?' is a commonly asked question, and often one without any easy answers. Long-term pain arises through many different mechanisms, and most drugs only work for one of these. Some pains do not seem to respond to any painkilling medicines. You can get used to painkillers, including opioids, so that you need more and more to have the same effect (this is called building up tolerance). However, we know that high doses of opioid medicines taken for long periods are unlikely to give better pain relief and are associated with a number of problematic adverse effects.

You should also consider:

- if you are allergic to any drugs or medicines,
- if you are taking any other medicines or herbal medicines,
- if you are pregnant or breast feeding, or if you are planning to become pregnant in the future,
- if you have a kidney problem,
- if you have or have had a history of excessive alcohol use, recreational drug use or addiction to prescribed or over-the-counter medication.

Appendix 8 – Pain Diary

Pain Diary

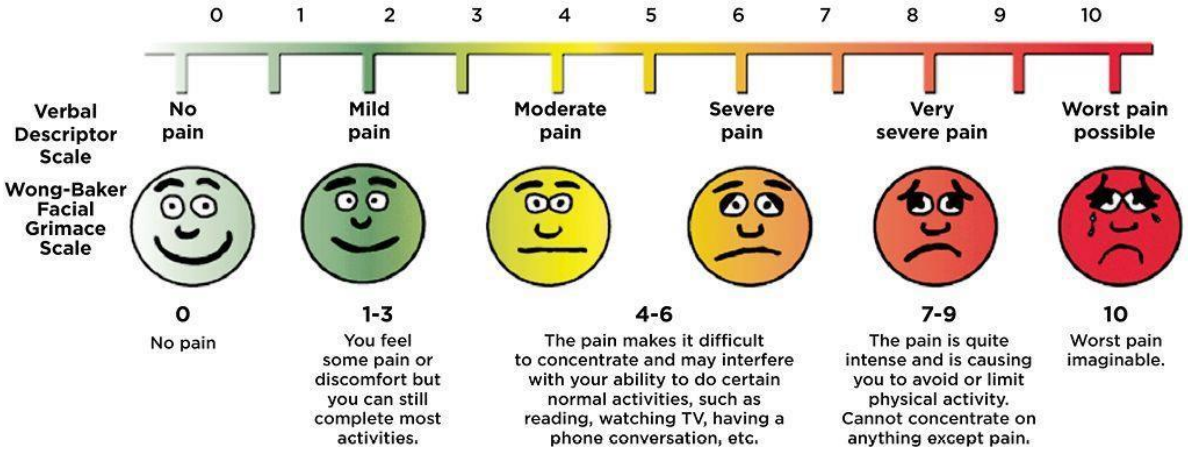
Your doctor, nurse or pharmacist will explain to you how to take your pain relief medications.

This diary will help you and your doctor, nurse or pharmacist to decide whether the pain relief medications you take are suitable for you.

Please fill in the pain diary every time you take your pain relief medication or at least twice a day.

When you fill in your pain intensity, please use the pain assessment tool below to help you describe the pain you are experiencing.

Record your pain intensity just before taking your pain relief medications, take your medications, then wait 30 – 60 minutes and record your pain intensity again.



Please keep a note of any side effects that your pain relief medications cause and how the pain is affecting your daily activities such as stopping you doing activities, or limiting how far you can walk.

Please bring the completed pain diary to the next appointment for your pain. You and your doctor, nurse or pharmacist can use the information you record to decide if your pain relief medications are right for you.

Date and time	Name of medication and dose taken	Pain intensity before taking pain relief	Pain intensity after taking pain relief	Any side effects? What are they?	Is your pain affecting daily activity? In what way?	Was my sleep disturbed by pain?
/ / ____am ____pm						
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Date and time	Name of medication and dose taken	Pain intensity before taking pain relief	Pain intensity after taking pain relief	Any side effects? What are they?	Is your pain affecting daily activity? In what way?	Was my sleep disturbed by pain?
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Date and time	Name of medication and dose taken	Pain intensity before taking pain relief	Pain intensity after taking pain relief	Any side effects? What are they?	Is your pain affecting daily activity? In what way?	Was my sleep disturbed by pain?
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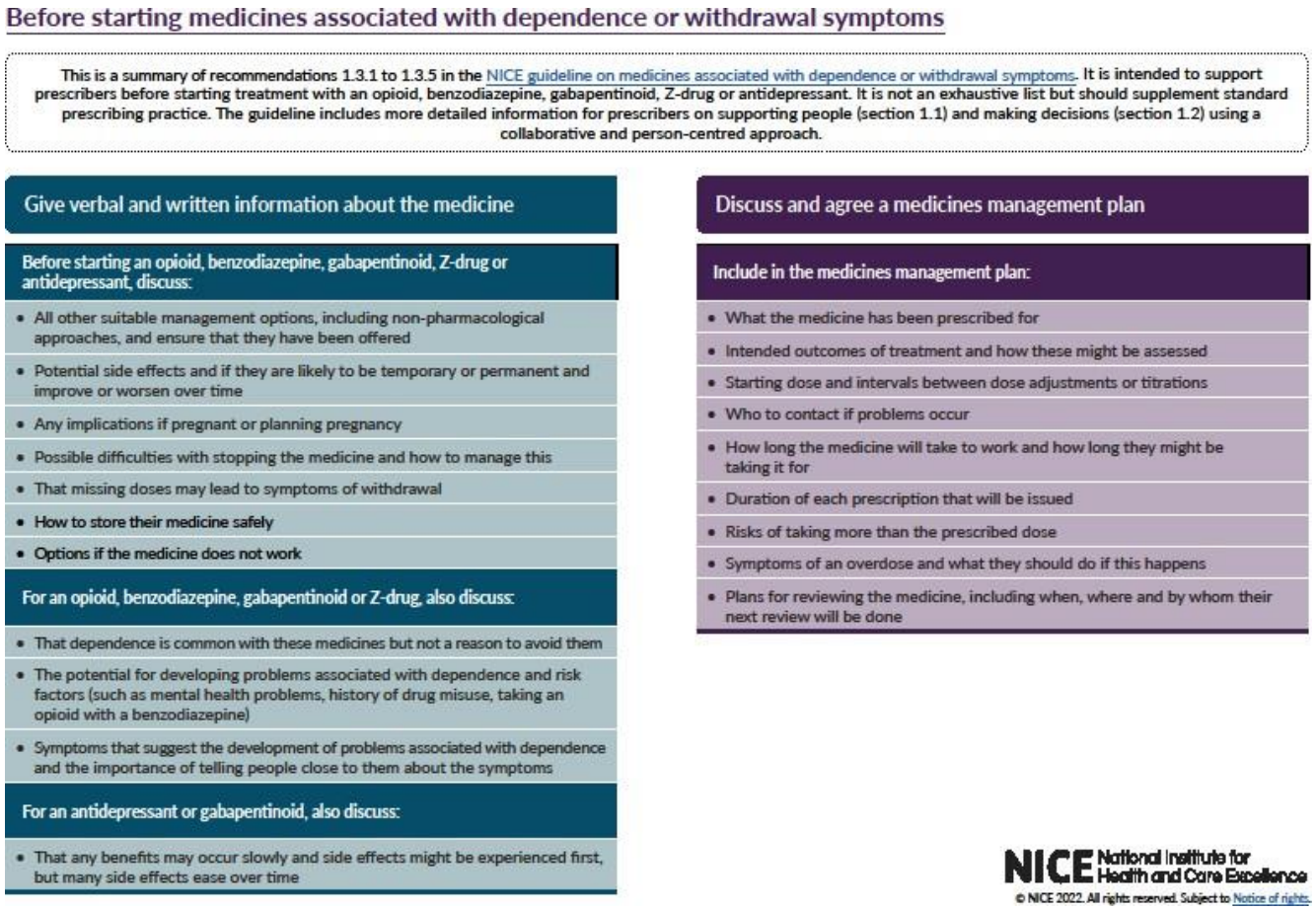
Appendix 9 NICE Visual Aid – Before Starting Medicines Associated with Dependence or Withdrawal Symptoms (1)



Before starting medicines associated with dependence or withdrawal symptoms

This is a summary of recommendations 1.3.1 to 1.3.5 in the NICE guideline on medicines associated with dependence or withdrawal symptoms. It is intended to support prescribers before starting treatment with an opioid, benzodiazepine, gabapentinoid, Z-drug or antidepressant. It is not an exhaustive list but should supplement standard prescribing practice. The guideline includes more detailed information for prescribers on supporting people (section 1.1) and making decisions (section 1.2) using a collaborative and person-centred approach.

Give verbal and written information about the medicine

Before starting an opioid, benzodiazepine, gabapentinoid, Z-drug or antidepressant, discuss:

- All other suitable management options, including non-pharmacological approaches, and ensure that they have been offered
- Potential side effects and if they are likely to be temporary or permanent and improve or worsen over time
- Any implications if pregnant or planning pregnancy
- Possible difficulties with stopping the medicine and how to manage this
- That missing doses may lead to symptoms of withdrawal
- How to store their medicine safely
- Options if the medicine does not work

For an opioid, benzodiazepine, gabapentinoid or Z-drug, also discuss:

- That dependence is common with these medicines but not a reason to avoid them
- The potential for developing problems associated with dependence and risk factors (such as mental health problems, history of drug misuse, taking an opioid with a benzodiazepine)
- Symptoms that suggest the development of problems associated with dependence and the importance of telling people close to them about the symptoms

For an antidepressant or gabapentinoid, also discuss:

- That any benefits may occur slowly and side effects might be experienced first, but many side effects ease over time

Discuss and agree a medicines management plan

Include in the medicines management plan:

- What the medicine has been prescribed for
- Intended outcomes of treatment and how these might be assessed
- Starting dose and intervals between dose adjustments or titrations
- Who to contact if problems occur
- How long the medicine will take to work and how long they might be taking it for
- Duration of each prescription that will be issued
- Risks of taking more than the prescribed dose
- Symptoms of an overdose and what they should do if this happens
- Plans for reviewing the medicine, including when, where and by whom their next review will be done

NICE National Institute for Health and Care Excellence

Appendix 10 – Opioids and the Risk of Addiction Patient Information Leaflet (16)

Medicines & Healthcare products Regulatory Agency

MHRA

OPIOID MEDICINES AND THE RISK OF ADDICTION

This safety leaflet is to help support you in using opioid medicines safely. Please keep it in a safe place.

Patients, family, friends, and carers can play an important role in the safe use of these medicines and in reducing the risk of harm. Please share this information with them.

What are opioid medicines and what's the risk with them?

Opioids are a type of medicine that help relieve pain. They are very effective over short periods, to relieve moderate to severe pain. They are also sometimes prescribed for long periods, to relieve pain in serious conditions. Examples of opioids include codeine (including co-codamol) tramadol, fentanyl and morphine.

Opioids have a serious risk of **addiction,** especially with long-term use. The person who prescribed an opioid or your pharmacist should explain how long it is safe for you to take your medicine for.

For further information on using opioids safely, and a full list of possible side effects, read the Patient Information Leaflet (PIL) that came with your medicine, and keep it handy.

How can I take my opioid medicine safely?

Only take the medicine as directed.

- **Do not** increase the dose or take an extra dose.
- **Do not** take any other medicines that contain opioids to "top up" your pain relief.
- **Do not** take opioid medicines if you are pregnant without health professional advice.

Do not do any of these without advice from the person who prescribed your medicine, or from a pharmacist. Taking more than you should can lead to overdose.
Babies born to women who took opioids during pregnancy may need to be carefully monitored for withdrawal effects after birth. Talk to your doctor or midwife if you are worried.

If you have any questions about your opioid medicine or side effects, or if you do not understand how to take your medicine, **talk to** the person who prescribed your opioid medicine or to a

pharmacist. **Keep talking** to them about your pain – there may be different treatments that can help.

- **Do not allow others** to take any opioid medicines given to you. Your medicine has been prescribed or specifically recommended for you by your doctor or pharmacist and can be dangerous if taken by other people – it could even cause fatal overdose.
- **Always keep medicines out of sight and reach of children.**

How do I know if I'm becoming addicted?

Addiction can happen gradually. It can make you feel that you are no longer in control of how much medicine you need to take or how often you need to take it. You might feel that you need to carry on taking your medicine, even when it doesn't help to relieve your pain.

If your pain is becoming difficult to manage, **talk to your doctor.** Your body may have stopped sensing the pain-relieving effect of your opioid. This is called **'opioid tolerance'.** It could be an early warning sign that you are at risk of becoming addicted.

This sheet has been produced by the Medicine and Healthcare products Regulatory Agency (MHRA), an executive agency of the Department of Health and Social Care. This information should be used as part of a discussion of the risks with a doctor, nurse, or pharmacist. Keep it safe in case you need it.

Signs that you may be addicted to opioids include:

- Craving for the medicine
- Feeling that you need to take more medicine than prescribed, or more than instructed on the pack – even though the medicine is causing unwanted effects on your overall health (for example, if you have noticed some of the withdrawal side effects in the next section)
- Feeling that you need to take additional medicines containing opioids or other pain relief medicines to achieve the same relief
- Taking opioid medicines for other reasons than pain: for instance, 'to stay calm' or 'help you sleep'
- Experiencing withdrawal side effects when you stop taking the medicine suddenly (see below).

If you notice any of the above, talk to your doctor or a pharmacist.

How can I safely stop taking my opioid medicine?

If you have been taking your opioid medicine for a long time, **do not stop taking it suddenly** as this may cause unpleasant withdrawal side effects. It is important to get the right help and support when you are ready to stop taking your medicine.

Talk to your doctor, nurse or a pharmacist. They will be able to help you to come off your opioid medicine slowly to reduce unpleasant withdrawal side effects. Safely coming off opioids can take a long time. Every person is different. Take any unused opioids back to a pharmacy for safe disposal.

Withdrawal side effects may include a combination of the following:

- Shivers
- Diarrhoea
- Difficulty sleeping
- Sweating
- Widespread or increased pain
- Body aches
- Irritability and agitation
- Nausea and vomiting

If you experience any of these, talk to the person who prescribed your medicine or a pharmacist.

What may happen if I have taken too much opioid medicine?

Taking too much opioid medicine is called an overdose, whether it's intentional or not. This can be very serious and may cause death.

Some of the signs of an overdose include:

- Confusion or hallucinations
- Slurred speech
- Lips or fingernails are blue or purple
- Poor coordination or balance
- Unresponsive or unconscious
- Heavy or unusual snoring
- Difficulty breathing or no breathing
- Very small pupils in the eyes

Your family, friends, and carers should know these signs so they can take immediate action.

If you think that you or someone else has taken too much of their opioid medicine, dial 999 immediately.

If you think you are experiencing any side effects of your opioid medicines, you can report these directly to the Medicines and Healthcare products Regulatory Agency at www.gov.uk/yellowcard, via the free apps ('Yellow Card Scheme' in the Google Play Store or 'Yellow Card – MHRA' in the Apple App Store), or by phoning the free phoneline (0800 731 6789).

Appendix 11 - Opioid Management Plan: Treatment Agreement (17)

Patient Name: …….…… NHS number: ……..

Condition(s) being managed with opioids:

New opioids being commenced as this agreement is being implemented:
(This is for a trial period during which the prescriber will need good evidence of improvement in function to embark on long term treatment)

Period before next mandatory review:
(For new trials 2-4 weeks, for long-term prescription 6–12 months)

Patient Declaration

In signing this agreement, the patient agrees to the following conditions regarding his/her treatment and the prescribing of an opioid medication:

1. I have read the Thinking About Opioid Treatment for Pain and Taking Opioids for Pain information leaflets and I will tell my GP if I experience on-going/intolerable side effects.
2. My GP is responsible for prescribing a safe and effective dose of the opioid medication. My GP will control my dose, perhaps with advice from one or more hospital specialist in a condition relevant to my pain.
3. I will follow the directions given to me by my GP; I will not increase my dose and will discuss any changes in my dose with my GP.
4. I will not use any other opioids in addition to those prescribed by my GP.
5. I will only obtain my opioid medication from my GP.
6. I understand that no early prescriptions will be provided.
7. Any evidence of unsafe use such as: drug hoarding, acquisition of any opioid medication or other pain medication from other sources, uncontrolled dose escalation, loss of prescriptions, or failure to follow the agreement may result in termination of the agreement and withdrawal of opioids.
8. I am responsible for the security of my opioid medication at home. Lost, misplaced or stolen medication or prescriptions for opioid medicines may not be replaced. In the event that opioid medication is stolen, I will report this to the police.
9. I am aware that giving my opioid medication to other people is illegal and could be dangerous to them.
10. I understand that if my level of activity has not improved, I do not show a significant reduction in my pain, or if I fail to comply with any of the conditions listed above my opioid prescription may be changed or stopped.

Patient's Signature: …….. ……. Date: …….

Medical Practitioner's Signature: …… Date: …….

Appendix 12 – Taking Opioids for Pain Patient Information Leaflet (2)

How do Opioids Work?

Opioids provide pain relief by acting on areas in the spinal cord and brain to block the transmission of pain signals. Opioids are considered to be some of the strongest painkillers available and are used to treat pain after surgery, serious injury and cancer. Opioid drugs can help manage some but not all types of chronic pain.

How are Opioids Taken?

Opioid medicines come in many different forms, such as injections, tablets, capsules, liquids, and patches.

When should I take my Opioid Medicines?

For continuous long-term pain you may be given a slow-release tablet which gives a steady level of medicine in the blood that is the best way to manage pain. Your healthcare team will adjust the dose to give you pain relief most of the time, and so you don't get too many side effects. Fast-acting opioid medicines and opioids that can be injected are not very useful for managing continuous pain.

What dose of Opioid should I take?

The correct dose of any medicine is the lowest dose that produces a noticeable benefit. It is not usual to get complete relief of pain from opioids.

You should always take the correct dose of prescribed medicines. If you feel the dose isn't enough, or if the side effects interfere with your life, you should discuss this with your healthcare team.

How long will it take to work?

This depends on the form that has been prescribed. Long-term pain tablets or skin patches are prescribed most commonly. Fast acting tablets may be used when you first start trying opioid treatment. They may work within an hour and last for around three to four hours. Slow release tablets or patches take longer, up to two or three days to begin to have any noticeable effect.

What are the possible side effects?

When you first start taking opioids you can get some side effects, which usually stop after a few days. These include:-

- feeling dizzy
- feeling sick (nausea)
- being sick (vomiting)
- feeling sleepy
- feeling confused

Sometimes these side effects can go on for longer than a few days. Your healthcare team may give you some other medicines to help, such as anti-sickness tablets. If pain has affected your sleep, opioids may help you to recover your normal pattern of sleep, but they should not make you drowsy in the daytime.

Opioid medicines can cause some problems when you take them for long periods of time. These problems include:-

- constipation*
- itching
- weight gain
- lack of sex drive
- difficulty breathing at night**

* *This is a common problem when taking opioids and does not tend to go away the longer you take opioid medicines. You may need to try laxatives to treat constipation. If you experience a lot of side effects your team may suggest changing to another opioid drug.*

** *This is most common if you are overweight and if you snore heavily. If you have a condition called obstructive sleep apnoea it may not be safe for you to take opioids.*

Can I drive when I'm taking Opioids?

The law in the UK allows you to drive if you are taking prescribed opioid medicines in accordance with the instructions from your prescriber (including what your prescriber advises you about driving safely). You should never drive if you feel unsafe. Your ability to drive may be affected by other medicines you are taking in addition to opioids, whether you feel tired and by your pain. You are responsible for making sure you are safe on each occasion that you drive.

The law on drugs and driving in the UK changed in 2015. If your driving is impaired for any reason, including taking medicines, it is illegal to drive. It is also now illegal to drive when you are taking opioid medicines without them being prescribed, even if you are not impaired. Preparation for the new drug driving laws involved extensive scientific research to investigate what effect opioid drugs have on ability to drive safely. We now know that if a person is taking more than 220mg of morphine a day they are likely to have a blood level of the medicine which impairs them nearly as much as someone who is over the legal limit of alcohol. All opioid medicines have the potential to impair driving and your prescriber will advise whether the dose of opioid you are taking is likely to impair you. If you are taking a high dose of opioid your prescriber will advise you that you are probably not safe to drive and will document this in your medical notes.

The doses of opioid medicine that are likely to affect your driving are quite high and are above the level that we know is safe and effective for pain treatment.

It is unsafe to drive in the first few days after starting an opioid and for a few days after dose change (up or down). Drinking alcohol reduces the amount of opioid medicine you can take and drive safely so do not drive if you have drunk alcohol and taken opioid medicines.

What if I forget or miss a dose?

Take it as soon as you remember. However, if it is almost time for your next dose, skip the missed dose and take your medication as normal.

Do not take two doses together.

Can I take this medicine long-term?

While opioids can have a positive benefit for some people living with long-term pain they can have serious consequences when they are not providing sufficient benefit or are being taken in a manner that was not intended.

It is important to consider the risks and benefits of continued opioid therapy with your prescriber on a regular basis. Recent medical literature suggests that the risks to your health increase significantly when prescribing opioids at high doses for a long period of time. If you take opioid drugs for many months or years it can affect your body in a number of ways. These problems include:-

- reduced fertility,
- low sex drive,
- irregular periods,
- erectile dysfunction in men (the inability to keep an erection),
- reduced ability to fight infection,
- increased levels of pain.

If you are worried about any of these problems, please discuss this with your healthcare team. Your team will be able to tell you whether you are at risk of developing these problems.

Everyone prescribed opioid medicines in the long-term should have them reviewed by their prescriber at regular intervals. If this does not happen ask your General Practitioner.

If you want to try reducing your dose, you should discuss this with your doctor and bring the dose down slowly.

Many people find that after a few months they can reduce their opioid dose without the pain increasing. Many individuals are able to reduce gradually their opioid dose and find that their pain is no worse. As fewer side effects are experienced, quality and enjoyment of life can improve. All of this contributes to greater physical fitness.

Can I drink alcohol?

Alcohol and opioids can both cause sleepiness and poor concentration. You should avoid alcohol completely when you first start on opioids or when your dose has just been increased. If you are taking opioids, you should avoid alcohol if you are going to drive or use tools or machines. When you get on a steady dose of opioid, you should be able to drink modest amounts of alcohol without getting any extra unusual effects.

Will my body get used to Opioid Medicines?

Opioids can become less effective with time (this is called tolerance) meaning your body has got used to the pain relieving effect of the medicine.

You can also become dependent on opioid medicines (dependence). This means that if you stop taking the drug suddenly, or lower the dose too quickly, you can get symptoms of withdrawal. If you run out of medicine, you can experience the same symptoms that include:-

- tiredness,
- sweating,
- a runny nose,
- stomach cramps,
- diarrhoea,
- aching muscles.

What about addiction to Opioids?

It is rare for people in pain to become addicted to opioids. People who are addicted to opioids can:-

- feel out of control about how much medicine they take or how often they take it
- crave the drug,
- continue to take the drug even when it has a negative effect on their physical or mental health.

We do not know exactly how many people get addicted when they are taking opioids for pain relief, but it is very uncommon. It is more common if you have been addicted to opioids (including heroin) or to other drugs (or alcohol) before. Addiction may be more common in people with severe depression or anxiety. This does not mean that if you have had an addiction problem before or you are very depressed and anxious you will become addicted. It only means that you are more likely to become addicted than someone who has not had these problems. Most people do not become addicted.

So, if you have had a problem with drug or alcohol addiction in the past this doesn't mean that you cannot take opioid medicines for your pain. However, your healthcare team will need to know about your past or current drug-taking to prescribe opioids safely and to help you watch out for warning signs.

What if I want to stop taking an Opioid?

Do not stop taking your opioid suddenly, you may experience withdrawal symptoms. Speak to your healthcare professional (doctor, nurse, pharmacist) who will be able to supervise a gradual reduction.

Is there anything else my prescriber needs to know?

- If you are allergic to any drugs or medicines.
- If you are taking any other medicines or herbal medicines.
- If you are pregnant or breast feeding, or if you are planning to become pregnant in the future.
- If you have a kidney problem.
- If you have or have had a history of excessive alcohol use, recreational drug use or addiction to prescribed or over-the counter medication.

Appendix 13 – Driving and Pain Patient Information Leaflet (2)

Am I able to drive whilst taking medications prescribed for pain?

Yes, but only if your ability to drive is not impaired.

Medications prescribed to help manage pain may cause side-effects such as dizziness or sleepiness and so may impair your driving.

It remains the responsibility of all drivers to decide whether they consider their driving is or might be impaired on any given occasion. Do not drive if this is the case. Sometimes your doctor may advise you not to drive. If this is the case, even if you do not feel impaired, you must not drive as it is against the law to do so.

What symptoms may mean I cannot drive safely?

Do not drive if you experience symptoms that may impair your driving such as sleepiness, poor coordination, impaired or slow thinking, dizziness, or visual problems.

These symptoms can occur as side effects of medication but be aware that pain itself can also affect sleep, concentration and impair physical function.

When might I be at risk of my driving being impaired?

This includes the following circumstances that may increase the risk of your driving being impaired:

- When first starting a new pain medication.
- When increasing or reducing the dose of pain medication.
- If another prescribed medication is added that could also impair your driving.
- If you take an over-the-counter medicine that could also impair your driving.
- If you have a pain condition that could physically impair your driving.

Be aware that alcohol taken in combination with some pain medications can substantially increase the risk of accidents.

Do I need to inform the DVLA when I start a new medication?

You do not need to routinely inform the DVLA when you start medications for pain. However, there may be other information about your illness that the DVLA needs to know. Your doctor or the DVLA can advise you about this.

Do I need to inform my Motor Vehicle Insurance Company?

We would strongly advise you to inform your motor vehicle insurance company about your current state of health and what medication you are taking to ensure your motor insurance is valid.

The 'Drug Driving' law

If you have been prescribed one of the following medications you may be affected by this law: **morphine or related drugs (such as codeine, tramadol or fentanyl)**, **ketamine**, **clonazepam**, **diazepam, methadone, oxazepam, temazepam, lorazepam, flunitrazepam, amphetamine (e.g. dexamphetamine or selegiline), cannabinoids (e.g. sativex).**

From 2015 there is a new offence of driving above a specified limit for these medications (like the current rules on alcohol and driving). If you are stopped and tested by the police, you may test above the legal limit - depending on the dose you have been prescribed or the type of medicine.

If you are taking these medications in line with advice from a doctor or pharmacist ***and your driving is not impaired,*** you may use a 'medical defence'.

If the police are satisfied that a driver is taking the relevant medicine on the advice of a healthcare professional, and their driving is not impaired, they should not be prosecuted.

It may be useful for you to keep suitable evidence with you (such as a copy of your clinic letter and prescription) to show the police if you are ever stopped.

However, if your doctor feels it is not safe for you to drive and you continue to do so, you will be breaking the law.

> ***The following government website provides further information on the drug driving law:***
> ***https://www.gov.uk/drug-driving-law***

Appendix 14 – Useful SNOMED Codes (18)

Chronic pain SCTID: 8242300

Primary chronic pain SCTID: 737305006

Chronic pain review SCTID: 860381000000107

Patient counselled SCTID: 170986003

Medication stopped - side effect SCTID: 395009001

Medication stopped - ineffective SCTID: 395007004

Treatment not tolerated SCTID: 407563006

Opioid abuse SCTID: 5602001

Harmful use of opioid SCTID: 1094231000000109

Opioid dosage tapering SCTID: 287041000000109

Opioid therapy stopped SCTID: 287201000000103

Review of opioid medication SCTID: 287031000000100

Opioid analgesic dependence SCTID: 1047881000000106

Appendix 15 – NICE Visual Aid - Reviewing Medicines Associated with Dependence or Withdrawal Symptoms (1)

Reviewing medicines associated with dependence or withdrawal symptoms

This is a summary of recommendations 1.4.5 and 1.4.6 in the NICE guideline on medicines associated with dependence or withdrawal symptoms. It is intended to support healthcare professionals carrying out medicines reviews for people taking an opioid, benzodiazepine, gabapentinoid, Z-drug or antidepressant. It is not an exhaustive list but should supplement standard practice for reviews, including the advice on reviewing medicines in the NICE guidelines on medicines optimisation and medicines adherence. The guideline includes more detailed information on reviewing medicines (section 1.4) and making decisions about withdrawing medicines (section 1.5) using a collaborative and person-centred approach.

Regularly review the person's medicines and update their management plan

At each medicines review for people taking an opioid, benzodiazepine, gabapentinoid, Z-drug or antidepressant, discuss:

- The benefits and risks of continuing the current dose, adjusting the dose or stopping the medicine
- The benefits or harms the person is experiencing from continuing the medicine
- Any signs that the person is developing problems associated with dependence such as:
  - running out of a medicine early
  - making frequent requests for dose increases
  - reporting that a medicine that was working well previously is no longer working
- The person's preferences for continuing the current dose, adjusting the dose or stopping the medicine
- Who to contact if they have problems or concerns

Agree and update the management plan with the person and give them a copy

Add your notes here

NICE National Institute for Health and Care Excellence

Appendix 16 – Stopping Your Medicine – Opioids Used for Persistent Pain Patient Information Leaflet

NHS
Greater Manchester
Integrated Care
Wigan Locality

Stopping Your Medicine: Opioids used for Persistent Pain

What are opioids, and why are they used?

Opioids are considered to be some of the strongest painkillers available and are used to treat pain after surgery, serious injury and cancer.

Opioids provide pain relief by acting on areas in the spinal cord and brain to block the transmission of pain signals and are very good at treating short term pain and cancer pain.

We used to think opioids helped persistent pain (pain that lasts for longer than 3 months, sometimes called chronic pain) but we now know opioids are not very good at treating this type of pain.

Sadly we now know that most persistent pain can not be cured. This does not mean that things can't change or improve and many people have found a way forward by self management and non -drug treatments such as exercise and talking therapies..

What are the long term risks of taking opioids?

Opioids may cause significant problems, which include:

- Falls
- Confusion/memory loss
- Lack of sex drive
- Increased levels of pain
- Withdrawal
- Affect your ability to drive safely
- Weight gain
- Sleep problems
- Difficulty breathing at night
- Addiction and dependence
- Death

What are the benefits if I stop taking an opioid?

If you have used your opioid for a long time and the medicine is not managing your pain it you should speak to your doctor about stopping it.

You may become, or may have already become, dependent on it.
If you stop, you will have fewer side effects, so you will be:

- More alert and able to concentrate
- Less likely to have an accident such as a fall or car accident
- Less likely to feel fatigue or have poor sleep
- Improved mood

Self Management

Self management is about shrinking the part of your life that is about pain and growing the other parts of your life, so that pain no longer dominates.
Sleep—many people find that poor sleep makes their pain worse
Retrain your brain—you can actually retrain your brain to turn the pain down
Learning to accept and live with your pain is difficult but can help in the long run.
Live well with pain is a website with lots of tools to help you manage your pain Home - Live Well with Pain

LiveWell with pain

How should I stop taking my Opioid?

1. Do NOT stop taking your medicine suddenly

You should discuss stopping your medicine with your doctor, pharmacist or practice nurse to make sure that you reduce your dose slowly. Different people will need to reduce their dose at different speeds. Once you have decided to stop, it is important that you make this a slow gradual process, as this will give you a better chance of long-term success. It is important that you take it at your own pace – one that feels right for you.

2. Plan how you will reduce and stop

Your doctor, pharmacist or practice nurse will give you advice on how you should reduce the dose of your medicine and help you think about other ways of dealing with your pain. Most people find that about two to four weeks between each dose reduction works for them, but everyone should find their own level.

3. Follow the self care advice your doctor gives you.

The Good Relaxation Guide - a guide to help you deal with tension, worry and difficult situations.

The Good Sleep Guide - which gives practical advice on how to develop a regular sleeping pattern.

Ten Footsteps — a guide to living well despite your persistent pain.

Regular exercise - can improve pain

4. Keep a diary

Keeping a diary can help as it records your progress and achievements. This will give you more confidence and encouragement to carry on.

5. Don't go back!

When people begin to reduce their dose, they often become more able to deal with normal day-to-day events and may feel much better. However, it is also common to have a bad patch at some time during the process. If you feel you are going through a bad patch, stick with the current dose until you feel ready to reduce again; this may take several weeks but it is important that you take it at your own pace. Any reduction in dose is a step in the right direction.

6. Be aware of possible withdrawal effects

If your medicine is reduced slowly it is unlikely that you will have any withdrawal effects, but it is a good idea to be aware of possible withdrawal symptoms. These could include: aches and pains; sinus problems; stomach and bowel problems; sleeping problems; restlessness, irritability, anxiety. If you do experience any of the side effects these usually only last for a few days to a few weeks. Speak to your doctor, nurse or pharmacist if you need help managing your withdrawal symptoms

With time these symptoms should pass - don't give up - good luck!

Adapted from Live Well with Pain and All Wales Medicines Strategy Group: Hypnotic and Anxiolytic reduction or withdrawal resources; and Wigan Borough CCG: Opioids for Persistent Pain PIL, with permission and thanks.

If you would like this leaflet in a different language or format (including Braille or Easy Read), please contact us at:

gm.icp@nhs.net. ☎Tel: 0161 742 6023(during office hours)
✉ 4th Floor, 3 Piccadilly Place, Manchester, M1 3BN

Publication date August 2023

Appendix 17 - 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.

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 (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 a face-to-face 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

Appendix 18 – Letter Suggesting Drug Holiday

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

[Date]

[Title/Initial/Surname]

[Patient Address Block]

Dear [Title] [Surname]

You have been given this information sheet because you have been taking painkillers for a time. We are particularly talking about painkillers in the opioid class like co-codamol, co-dydramol, codeine and dihydrocodeine.

Recent medical evidence questions the benefit of drugs like this (which are in the morphine family) for long-term 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.

There are some risks too – they can

- sometimes make pain worse
- cause side effects to the intestines and the stomach
- make the body feel dependent on them so if you miss a dose you feel a bit jittery and anxious
- increase the risk of falls
- there's even a risk of overdose and death, especially if taken in overdose with alcohol or benzodiazepines like diazepam.

For these reasons we suggest you try a "drug holiday" This means you taper off and stop your painkillers over a month or so to see for sure whether they're helping or not. It's not unusual for pain to flare up a bit when doses are reduced and discontinued but that's to be expected. Once you're off them for a month, you'll have a good idea as to whether they're making a positive difference to your life. If they are, feel free to restart them – try to find the lowest dose that works.

If you've got any questions about this, feel free to make an appointment with a doctor of your choice to discuss.

Best wishes and good luck!

Medical Team

Appendix 19 – Letter Suggesting Review of Tramadol Due to Serotonin Syndrome Risk

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

[Date]

[Title/Initial/Surname]

[Patient Address Block]

Dear [Title] [Surname]

Tramadol and Antidepressants

Our records show you are currently being prescribed both Tramadol and an antidepressant. The antidepressant may be prescribed for pain rather than depression.

We have recently been made aware of a potentially serious interaction between Tramadol and certain antidepressants. This interaction can lead to a condition called Serotonin Syndrome which can cause symptoms such as excessive sweating, fast pulse rate, high blood pressure and shaking. In rare circumstances it has contributed to the death of some patients.

At **<<Practice name>>** patient safety is our priority so in view of this recent information we have taken a decision that we need to review your tramadol with the aim of reducing and stopping your Tramadol.

Tramadol should not be stopped abruptly; we will need to discuss a withdrawal timetable with you and possibly the substitution of an alternative pain killer should this be necessary.

Please book an appointment within 28 days of receipt of this letter, as after that period Tramadol will be removed from your medication order list.

If you have any questions in the meantime, please don’t hesitate to get in touch.

Thank You for your understanding & co-operation.

Yours sincerely

Dr XXX and partners

Appendix 20 – Letter Suggesting Review of Oxycodone and Amitriptyline (19)

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

[Date]

[Title/Initial/Surname]

[Patient Address Block]

Dear [Title] [Surname]

Oxycodone and Amitriptyline

Our records show you are currently being prescribed both Oxycodone and Amitriptyline.

We have recently been made aware of a potentially serious interaction between Oxycodone and Amitriptyline. This interaction can lead to a risk of over-sedation. In rare circumstances it has contributed to the death of some patients.

At **<<Practice name>>** patient safety is our priority so in view of this recent information we have taken a decision that we need to review your Oxycodone and Amitriptyline with the aim of reducing and stopping one of these medications.

Neither drug should not be stopped abruptly; we will need to discuss a withdrawal timetable with you and possibly the substitution of an alternative medicine should this be necessary.

Please book an appointment within 28 days of receipt of this letter.

If you have any questions in the meantime please don't hesitate to get in touch.

Thank You for your understanding & co-operation.

Yours sincerely

Dr XXX and partners

Appendix 21 – Opioid Policy - New Patients

A **controlled** substance is generally a **drug** or chemical whose manufacture, possession, or use is regulated by the government because of the potential for abuse or addiction. Such **drugs** include those classified as narcotics, stimulants, depressants, hallucinogens, and cannabis.

A list of the most commonly encountered controlled drugs can be found at:

https://www.gov.uk/government/publications/controlled-drugs-list--2

Many of our patients require strong, potentially addictive medication to help manage their condition(s). Of concern are 'drugs of dependence' (e.g. opioid medications, gabapentinoids and benzodiazepines), particularly when these are prescribed on an on-going basis.

Due to increasing reports of abuse of prescription drugs and patient behavioural problems, **[insert practice name]** has established a policy to ensure adequate treatment of your condition, while reducing the risk of problems with drug prescriptions.

If you are a new patient to the practice:

- It may take time to get accurate medical information about your condition. Until such information is available, your GP may choose not to prescribe any medication. It is our policy that GPs do not prescribe drugs of dependence until they have a full clinical picture.
- Your GP may decide not to continue prescribing an opioid medication previously prescribed for you. It may be determined that such a medication is not suitable. It is our policy that GPs do not prescribe drugs of dependence if they feel that previous prescriptions were inappropriate.
- Your GP will evaluate your condition and only prescribe an opioid of the strength necessary for you. This may be different to the drug you had prescribed at your previous GP Practice.

General practice standards:

- If the decision to prescribe is taken after a shared discussion of goals, plans, risks and benefits, you may be required to confirm your consent in writing.
- You will be asked to complete the Opioid Management Plan: Treatment Agreement that will detail our practice's expectations when prescribing drugs of dependence. This agreement details your responsibilities as a patient taking a drug of dependence; any prescriptions issues; advice on taking your medications; how we will monitor your care; and the standards of behaviour that are expected.
- Patients may need to acknowledge that their care requirements may be complex, and that referral for on-going care for all or part of your healthcare may be required. It is our practice policy that patient care is matched with the level of complexity.
- Patients are reminded that we have a zero tolerance on issues relating to staff abuse.

Appendix 22 – Opioid Policy – Issuing Prescriptions

A **controlled** substance is generally a **drug** or chemical whose manufacture, possession, or use is regulated by the government because of the potential for abuse or addiction. Such **drugs** include those classified as narcotics, stimulants, depressants, hallucinogens, and cannabis.

A list of the most commonly encountered controlled drugs can be found at:

https://www.gov.uk/government/publications/controlled-drugs-list--2

Many of our patients require strong, potentially addictive medication to help manage their condition(s). Of concern are 'drugs of dependence' (e.g. opioid medications, gabapentinoids and benzodiazepines), particularly when these are prescribed on an on-going basis.

Due to increasing reports of abuse of prescription drugs and patient behavioural problems, **[insert practice name]** has established a policy to ensure adequate treatment of your condition, while reducing the risk of problems with drug prescriptions.

- Patients initiated on opioids will be asked to complete the Opioid Management Plan: Treatment Agreement.
- All new opioids will be issued as acute prescriptions and on a trial basis.
- Wherever possible, patients will see the same prescriber for review of the initial prescription.
- Where opioids are initiated by an external provider the Practice will only take over prescribing once a written request has been received.
- All patients will be reviewed within 4 weeks of initiation of an opioid prescription; pain assessed and a decision made as to the effectiveness of the drug.
- Whilst patients are being stabilised on medication this will be issued as an acute prescription.
- Where opioids are ineffective they will be stopped, even if no alternative is available.
- Where patients have been stabilised on an opioid which has been shown to be effective this may be added to the patients repeat medication at the prescribers discretion.
- Where opioids are added to repeat prescription the maximum re-authorisation period will be 6 months.
- Patients on long-term opioids will be reviewed every 6 months. Treatment will only be continued where there is on-going evidence of benefit.
- All opioids will be issued on prescriptions with a maximum duration of 1 month.
- All opioid prescriptions will include full directions wherever possible and use of PRN or MDU directions will be avoided.

Appendix 23 – Practice Procedure for Lost/Stolen Controlled Drug Prescriptions

A **controlled** substance is generally a **drug** or chemical whose manufacture, possession, or use is regulated by the government because of the potential for abuse or addiction. Such **drugs** include those classified as narcotics, stimulants, depressants, hallucinogens, and cannabis.

A list of all controlled drugs can be found at:

https://www.gov.uk/government/publications/controlled-drugs-list--2

For all controlled drugs which includes: benzodiazepine, codeine, dihydrocodeine or a product containing one of these drugs e.g. (Co-codamol, Kapake) in addition to the drugs in the link above:

1. The loss or theft of a controlled drug prescription must be recorded in the patients' medical record and a SNOMED code added to enable the Practice to monitor/audit.

2. If the prescription is stolen, the patient or the Practice must report the incident to the police and provide the Practice with a crime number.

3. The loss or theft of a controlled drug or prescription must be reported to the CD Accountable Officer via www.cdreporting.co.uk

4. If Practices need to send out an alert regarding lost or stolen prescriptions, this can be done by sending an alert template to: ENGLAND.EnglandCASalerts@nhs.net the alert template can obtained from the CD accountable officer.

5. The Practice must review the patient's records when considering if it is appropriate to re-issue a prescription. Notes should be assessed to identify if there is a pattern of regularly requesting additional prescriptions. Practices may consider reviewing ordering patterns for immediate family and household members when considering patterns of behaviour. If a pattern is identified this could indicate an underlying problem such as abuse, diversion or a safeguarding issue, report via cdreporting.co.uk and refer as appropriate. Colleagues should consider adding a special patient note, so that system partners are made aware of any potential concerns.

6. The patient should be invited in for review and the appropriate steps taken.

7. Practices may issue a small supply of medication to cover the period until the patient attends.

8. At the review, Practices should review the appropriateness of the current prescription and steps that can be taken to support the patient such as:
    - Reducing and withdrawing medication
    - Reducing script duration e.g. weekly prescriptions
    - Discussion about future action should there be further issues
    - Working with the community pharmacy e.g. if prescriptions are being stolen use of EPS or prescription delivery

Appendix 24 – Practice Procedure for Patients Where Dependence on, or Diversion of, Controlled Drugs has been Identified

A **controlled** substance is generally a **drug** or chemical whose manufacture, possession, or use is regulated by the government because of the potential for abuse or addiction. Such **drugs** include those classified as narcotics, stimulants, depressants, hallucinogens, and cannabis.

A list of all controlled drugs can be found at:

https://www.gov.uk/government/publications/controlled-drugs-list--2

For all controlled drugs which includes: benzodiazepine, codeine, dihydrocodeine or a product containing one of these drugs e.g. (Co-codamol, Kapake) in addition to the drugs in the link above:

1. If it has been identified that patients are either dependent on, or diverting, controlled drug prescriptions this must be recorded in the patient's medical record and a SNOMED code added to enable the Practice to monitor/audit.

2. The diversion of a controlled drug or prescription **must** be reported to the CD Accountable Officer via www.cdreporting.co.uk

3. If practices need to send out an alert regarding lost or stolen prescriptions, this can be done by sending an alert template to: ENGLAND.EnglandCASalerts@nhs.net the alert template can be obtained from the CD accountable officer.

4. The Practice must review the patient's records when considering if it is appropriate to continue to prescribe controlled drugs for the patient. Practices may consider reviewing ordering patterns for immediate family and household members when considering patterns of behaviour.

5. The patient should be invited in for review and the appropriate steps taken.

6. Practices may issue a small supply of medication to cover the period until the patient attends.

7. At the review, Practices should review the appropriateness of the current prescription and steps that can be taken to support the patient such as:
    - Reducing and withdrawing medication including an enforced wean
    - Reducing script duration e.g. weekly or daily prescriptions
    - Discussion about future action should there be further issues
    - Referral to substance misuse services

Appendix 25 – Reporting of Controlled Drug Incidents via cdreporting.co.uk

1. 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

2. **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.

3. 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

4. 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.

5. 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.

Appendix 26 – Approximate Equi-analgesic Potencies of Opioids (2)

Oral administration

	Potency ratio with oral morphine	Equivalent dose to 10mg oral morphine
Codeine phosphate	0.1	100mg
Dihydrocodeine	0.1	100mg
Tramadol	0.1	100mg
Morphine	1	10mg
Oxycodone	1.5	6.6mg
Tapentadol	0.4	25mg

Transdermal administration

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

Transdermal buprenorphine changed every three or four days (twice weekly)	35 microgram/hour	52 microgram/hour	70 microgram/hour
Morphine sulphate (mg/day)	84mg	126mg	168mg

Fentanyl patch strength (microgram/hour)	Oral morphine (mg/day)
12	30
25	60
50	120
75	180
100	240
200	480
300	720

Appendix 27 – CQC and NHSE Checklist for safer use of Fentanyl and Buprenorphine CD Transdermal Patches

1. CD transdermal fentanyl patches should be restricted to patients that are already receiving regular doses of opioids.
    i. Do not use for acute pain.
    ii. Do not use in opiate naïve patients.

2. Before using a CD transdermal patch, calculate the total daily dose of all the opioid analgesics that the patient has received previously. This is usually in morphine equivalence.

   Use locally or nationally approved dose conversion charts to do this. There are dose conversion charts in the 'Prescribing in Palliative Care' Section of the British National Formulary and in CD transdermal manufacturers guidance (SPC).

3. Determine a new dose of analgesia to be delivered by transdermal CD patch in morphine equivalents. For changes in analgesia, as a 'rule of thumb', the total daily dose should not be increased in steps greater than 50% of the previous daily dose.

   Again, use a conversion chart to determine the total daily dose of analgesia by CD transdermal patch(es) and where necessary divide by 24 to equate with the micrograms/hour strength of available products.

   To deliver the intended dose more than one CD patch may have to be used.

   NB - Formally double check the calculations and where possible have the patient's dose independently verified.

4. Ensure only those CD transdermal patches intended for current use are applied.

   Patches *may be* skin coloured or transparent, and so may not be easy to locate.

   Formally record the anatomical position of currently applied patches so that this information is readily available to inform future decisions and actions.

5. Prescribe by brand and ensure patients using CD transdermal patches have adequate prescriptions and supplies to minimise interruption and omission of therapy.

   Transdermal CD patches must be removed and replaced in accordance with the manufactures guidance (SPC).

6. Consider that patients may exhibit symptoms of opioid withdrawal when a CD transdermal patch has been omitted.

   The cause of these symptoms may not be recognised and patients may be treated with benzodiazepines for these symptoms, rather than have opioid therapy for their analgesia re-instated, if necessary at a reduced dose.

Appendix 28 – MHRA Fentanyl Skin Patches Patient Information Leaflet (20)

Medicines & Healthcare products Regulatory Agency

MHRA
Regulating Medicines and Medical Devices

Fentanyl skin patches: How to use and dispose of them safely

October 2018

Key messages

- Fentanyl skin ('transdermal') patches are used to relieve severe, long-lasting, pain. They must be used according to the instructions. Always **read the leaflet** that came with the patch (also available on the MHRA website), so you know about safe use and possible side effects

- A patch may cause **serious harm** if it accidentally touches or sticks to somebody else's skin or if a child puts it in their mouth

- It is very important to:
  - **Follow the instructions for use** – Read the instructions closely every time you use a patch (see instructions on the patch, on the box, and in the leaflet that accompanies your medicine). Never divide or cut the patch. Wash hands after application
  - **Ensure the patch is stuck on securely** – Choose the application site carefully and make sure that the patch is stuck, especially around the edges, by pressing it for 30 seconds
  - **Avoid heating patches** – Make sure the patch doesn't heat up (for example, with a hot-water bottle or a long hot bath); heat can cause a dangerous amount of medicine to come out of the patch
  - **Remove and fold old patches** – Always remove and dispose of old patches before adding a new one. Fold the patch in half as soon it is removed so that the sticky side sticks firmly to itself and put back in the original sachet
  - **Dispose of safely** – Keep patches out of sight and out of reach of children. Dispose of old patches as instructed by your pharmacist

- If a patch **transfers** to another person, remove it and get **medical help immediately** (dial 999 and ask for an ambulance)

- If a patch is **swallowed**, get **medical help immediately** (dial 999 and ask for an ambulance)

Version 1; produced October 2018

Medicines & Healthcare products Regulatory Agency

MHRA
Regulating Medicines and Medical Devices

What are fentanyl skin patches and what do they do?

Fentanyl skin (transdermal) patches contain a strong opioid painkiller called fentanyl. Patches are prescribed to help to relieve severe, long-lasting pain.

Why is this important information for you and your family?

A few people every year are harmed through accidental exposure to patches not meant for them (for example, when another person's patch accidentally stick to their skin or is swallowed).

In some cases, the patches had become detached in bed and stuck to someone sleeping next to them. In others, children have retrieved the patches from the bin and swallowed them, causing a fatal overdose. Used (old) patches still contain active medicine and can cause these effects too.

Signs of fentanyl poisoning or overdose

In the most serious cases, accidental transfer of patches can result in a dangerous overdose. Signs of an overdose are:

- Shallow breathing
- Drowsiness
- Extreme sedation.
- Small 'pin-prick' pupils in the eyes.

If you are using a fentanyl patch and your breathing becomes shallow and weak, take the patch off and **seek medical help immediately** by dialling 999.

What to do if you experience a side effect or reaction?

Fentanyl overdose or accidental exposure requires urgent medical attention.

Talk to your doctor, pharmacist, or healthcare professional if you have any concerns about your medicines or suspect you have had a side effect or an adverse reaction to a medicine.

You can also report any suspected side effects to any medicine or vaccine directly to the Yellow Card Scheme via the website (search for MHRA Yellow Card), Yellow Card App (search Apple App Store or Google Play Store for MHRA Yellow Card) or by calling 0800 731 6789 (freephone). By reporting side effects, you can improve the safety of medicines.

This sheet has been produced by the Medicine and Healthcare products Regulatory Agency (MHRA), an executive agency of the Department of Health and Social Care, to help healthcare professionals to discuss with patients the advice about fentanyl patches. A large print sheet is also available online. Always read the leaflet that accompanies your medicines.

Version 1; produced October 2018

Appendix 29 – CQC and NHSE Checklist for safer use of Oxycodone Medicines

1. Oxycodone should **only be used as a second-line strong opioid** if morphine is not suitable or cannot be tolerated.

   The specialist pain or palliative care team **should be consulted** for advice in cases of complex pain management.

2. Obtain details of the previous daily dose, and frequency of administration of previous analgesics used by the patient.

   i. Ensure where a dose increase is intended, that the calculated dose is safe for the patient (for oxycodone in adult patients, not normally more than 50% higher than the previous dose).

   ii. Where the patient was previously taking another opioid analgesic use a locally or nationally approved dose conversion chart to accurately determine the equivalent daily dose of oxycodone.

   Dose conversion charts can be found in the' Prescribing in Palliative Care' section of the British National Formulary (BNF).

3. Confirm the appropriate medicine formulation is being used. There are fast acting short duration (e.g. Oxynorm) and slow acting, long duration (e.g.Oxycontin) oxycodone products.

   There are significant risks of overdose when a fast-acting product of short duration is used in error for the slow acting, longer duration products.

   Where possible prescribe by brand name to reduce confusion.

4. Check for therapeutic duplication of strong analgesics by 2 different routes of administration. There may have been an error and the previous route of administration may not have been cancelled.

5. Confirm any use of oxycodone concentrate products.

   There are significant risks of overdose if a concentrate product is used in error for a normal strength product.

6. Any use of oxycodone medicines 'as required' should have clear guidance on the frequency that the doses can be administered.

Appendix 30 – Preparation for Dose Reduction

Factors in deciding whether to wean opioids, and how far to reduce the dose, include:

- the person wants to stop taking the medicine,
- the condition for which the medicine was prescribed has resolved,
- evidence that opioids are not helping – person complains of pain; person's function; reports from person's family or associates,
- risk of side effects or complications of opioids - the harms of the medicine outweigh the benefits,
- problems associated with dependence have developed,
- risk of drug theft or diversion,
- person's ability to cope with the effects of dose reduction,
- risk of person procuring more dangerous opioids from alternative sources,
- physical co-morbidities,
- mental health co-morbidities including significant emotional trauma.

Before weaning discuss the following with the person:

- Explain the rationale for stopping opioids including the potential benefits of opioid reduction (avoidance of long-term harms and improvement in ability to engage in self-management strategies) and aim to reach agreement using a shared decision-making approach.
- Understand that the person might be reluctant or anxious about discussing problems associated with dependence. Reassure them that dependence is an expected effect of these medicines and that problems associated with dependence sometimes develop. Be sensitive to the use of terminology that may apportion blame to the person or be perceived adversely.
- Acknowledge and discuss with the person any differences between their views and your own about the risks and benefits of the medicine.
- Be prepared for queries about prescribing decisions made previously. Explain that our understanding of the balance of risks and benefits of a medicine can change over time. If sufficient clinical detail is available, discuss the possibility that past prescribing was done in the person's best interests using the knowledge available at the time.
- Agreed outcomes of opioid tapering and whether the initial goal should be complete withdrawal or, for people who find complete withdrawal too difficult, whether dose reduction with ongoing review is a more realistic initial aim.
- Discuss factors that might influence the timing of the start of the dose reduction, such as the person's circumstances and available support.
- Give the person information about the process of withdrawal that is tailored to their situation and the medicine they are taking, explain how the withdrawal will be carried out and consider providing details of sources of peer support, national and local support groups for people who are withdrawing from a medicine.

Agree a dose reduction schedule with the person:

- explain the risk of abrupt discontinuation and that the rate of safe withdrawal varies between people and can vary over time for the same person,
- balance the risk of adverse events from continued exposure to the medicine with minimising the risk of withdrawal symptoms by slow dose reduction and withdrawal,
- ensure that the planned rate of reduction is acceptable to the person,

- consider giving the person additional control over the process of dose reduction (for example, by issuing their usual daily dose in a form that allows them to reduce the amount in small decrements at a pace of their choosing, rather than issuing successive prescriptions for reduced daily doses),
- If using a published withdrawal schedule, apply it flexibly to accommodate the person's preferences, changes to their circumstances and the response to dose reductions.

Discuss withdrawal symptoms with the person and tell them about the support that is available. When discussing withdrawal symptoms, explain that:

- withdrawal can be difficult, and may take several months or more,
- support will be available throughout the withdrawal process - ensure the person knows who to contact if problems occur,
- withdrawal symptoms do not affect everyone, and it is not possible to predict who will be affected,
- withdrawal symptoms vary widely in type and severity, can affect both physical and mental health, may occur at any time during withdrawal or be delayed in onset and can change over time or persist over a prolonged period,
- there are options for managing withdrawal symptoms and the reduction schedule can be modified to allow intolerable withdrawal symptoms to improve before making the next reduction,
- some people may experience withdrawal symptoms that can be difficult to distinguish from a re-emergence of their original symptoms or a new disorder, and it is important to discuss these with a healthcare professional if they occur.
- monitoring of pain during taper - agree regular intervals for reviewing and adjusting the reduction schedule as needed,
- defining the role of drug and alcohol services to support dose reduction,
- close collaboration between the person, his or her carers and all members of the health care team
- arrangements for follow-up including agreed prescribing responsibilities,
- distraction strategies, social support, help in reducing temptation to relapse.

factors that might increase the person's risk of problems during withdrawal, include:

- long duration of medicine use,
- high dose of medicine,
- history of withdrawal symptoms,
- history of problems associated with dependence.

Appendix 31 – Structured Medication Reviews including opioids

HCP Structured Medication Reviews

A Structured Medication Review (SMR) is an opportunity for individuals to discuss their medicines with a qualified clinician and provides:

- A review of all medicines to identify overlapping prescribing or drug interactions
- Ability to give extra information on what medicines are for
- Opportunity to discuss side effects of medicines
- Identification of problems associated with medicines

Faculty of Pain Medicine Guidance

- Patients who may benefit from opioids in the long term will demonstrate improvement in activity levels, pain intensity and sleep
- Patients who do not achieve useful pain relief from opioids within 2-4 weeks are unlikely to gain benefit in the long-term
- Short-term efficacy does not guarantee long term efficacy
- Data regarding improvement in quality of life with long term opioid use are inconclusive
- There is no evidence for efficacy of high dose opioids in long term pain
- Before increasing total opioid dosage to 50 morphine milligram equivalent/day, clinicians should pause and carefully reassess evidence of individual benefits and risks as the benefits beyond 50 morphine milligram equivalent/day are not going to be significant

Risk factors to consider during SMR

Patient Factors	Drug Factors
○ Depression, anxiety, and other mental health diagnoses	○ High doses (>50 mg/day oral morphine)
○ Previous history of alcohol or substance misuse	○ Multiple opioids
○ Previous history of opioid misuse	○ Multiple formulations of opioids
	○ More potent opioids
	○ Concurrent benzodiazepines/ sedative drugs

Top Tips — **Questions for patients taking pain medications**

- Do the pain medications allow you to improve your function or sleep better?
- Do you experience any side effects? Are you aware of your medications' side effects?
- Have you taken more doses than prescribed?
- During the past month have you often felt subdued, depressed, or hopeless?

Offer other interventions

- Lifestyle advice, including diet and exercise, and supported self-management of pain
- Improving protection against potentially harmful over-use of common analgesics such as paracetamol and NSAIDs available over the counter
- Enhance public understanding of self-management of pain and direct them to sources of support including referral to specialists
- Opening the way to an extended use of assessment instruments to identify the risk of persistent pain
- Signposting psychological and other care providers or facilitating patient use of relevant computer-based services

Scan for more guidance and resources

This document has been developed by Salford Pain Centre and Manchester Pain Collaborative with support from Health Innovation Manchester

Appendix 32 Patient scenario – Seeking Stronger Opioids

Opioid Patient Scenario: Seeking Stronger Opioids

James, a 45-year-old man developed low back pain about a year ago while he was lifting a heavy chair. His back suddenly gave away and he could barely move. His back was in severe spasm and the pain radiated down both his legs. After a few days, the pain got a bit better, and he was able to walk. He had back pain on and off for years, but it always went away before. This time however the pain persisted. He can walk unaided but only short distances. His sleep is quite disturbed as he cannot find a comfortable position. He could not continue in his work as a delivery driver and is off sick. He is worried that he is going to lose his job.

He had some input from physiotherapy, but it did not help. He has been taking regular ibuprofen and over the counter codeine/paracetamol which takes the edge off but are no longer working. He is now requesting stronger analgesics. No clinical 'red flag' features are present, but he is fearful of structural damage. The movement in his spine is very restricted but neurological examination is normal.

Standard History to include:

- ❑ When and how the pain started
- ❑ Whether the condition is improving or deteriorating
- ❑ What impact it is having on function – hobbies, work
- ❑ Is the patient concerned that they may be causing harm by being physically active
- ❑ What impact it is having on sleep, mood, relationships
- ❑ The patients understanding of why they are in pain and what they have been told by other HCP's
- ❑ What does the patient want out of the consultation

Examination

- ❑ Rule out red flags
- ❑ Ascertain how well the patient can move
- ❑ Don't underestimate the power of physical examination

Timing

It may not be possible to cover every aspect in a short consultation and information may need to be obtained over multiple consultations.

Patient Consultation

The next section describes some of the key messages that you need to deliver in the first consultation and is an example of one possible way that the consultation could proceed.

STEP 1	Rule out / screen for red flags. Ensure that it is safe to move
STEP 2	Communicate that it is safe to move
STEP 3	Assess the efficacy of medications and communicate the lack of efficacy in chronic pain
STEP 4	Take steps to ensure that the patient moves

Click on the steps above to read about each

STEP 1 Rule out / screen for red flags. Ensure that it is safe to move

Back pain is very common and often relapsing. Most recent-onset low back pain episodes settle but only about one in three resolves completely over a 12-month period. About three in five will recur in an on-going relapsing pattern and about one in 10 do not resolve at all. This is the natural presentation of back pain.

The examination and history should rule out any clinical red flags and imaging and surgical opinion are unnecessary because there are no clinical features to suggest a harmful underlying condition. A physical examination, with subsequent explanation to the patient can be hugely re-assuring. Back pain can radiate to the legs but if it does not extend below the knee, it is unlikely that there is nerve root compression.

You have had back pain for a year now. Are you concerned that there is something harmful going on? That we have missed something?

Unfortunately this is very common. Sometimes the back pain persists. We do not know why but from how you describe your pain and from the examination, I think we can be reasonably assured that there is nothing dangerous going on in your spine. I don't think you need an MRI of the back.

I have had back pain for years, but it always went away. I have never had it so bad. This pain is not going away. Surely, I must have done something to my back when I lifted that chair. I think I need a scan to see what is going on in my back.

Patients have unjustified faith in MRI scans and sometimes cannot be convinced that there is nothing wrong. Imaging is generally not required for most patients with back pain but sometimes may be required simply for assurance and should only be conducted if it will influence future management (as per NICE guideline).

STEP 2 (1 of 3) Communicate that it is safe to move

We know it is helpful is to keep muscles and joints working. Unfortunately, because of the pain and belief that moving is causing harm, patients start doing less and less which means muscles become weaker, and joints become stiffer with time. People can then lose their confidence with physical activity. The best way forward is to slowly start using your spine and try and do more.

What do you think is going on? How do you think we can help?

I can't carry on like this. It is affecting everything. My employer keeps asking when I am coming back. But I can't go back. I might lose my job. I need this fixed.

I don't know. If as you say my spine is fine, why is it still hurting?

Your back is structurally fine and your nerves are strong and working as they should be. You still feel pain because your nerves have become oversensitive. Normally, the nervous system will calm down and the pain goes away. For example, when you cut your finger, the nervous system becomes active, and you experience pain which stops you from using your finger until it heals. The pain disappears as you start healing. In chronic pain however, even though there is no ongoing injury, the nerves still think there is something wrong and they try to protect you. The nerves are making your back muscles go into spasm to try and stop you from moving, but this is not helping, it is just making the pain worse.

This is quite a complex concept that patients often fail to grasp. We often use the analogy of a fire alarm. The fire alarm should normally go off when there is a fire, to warn everyone of danger. But sometimes fire alarms can become faulty and can go off even when there isn't a fire. Similarly, the pain messaging system should normally only become active when there is damage. But in chronic pain, there is no damage. The pain messaging system is faulty and goes off even though there is no damage.

STEP 2 (2 of 3) Communicate that it is safe to move

Moving may not take the pain away but will help patients to do more despite pain. If patients don't move, their muscles will weaken and joints will stiffen up, and they will end up doing less and less. They will also lose confidence with movement and inactivity can lead to low mood. Any activity, whether it is housework or exercise has to be paced. Which means doing little and often rather than pushing themselves when they feel good, and then paying for it with more pain afterwards. Doing it this way means that it won't hurt as much, and patients will still be able to do more.

Will this pain go away? I cannot carry on like this. Something needs to be done to fix this.

I can see that the pain is affecting you a lot and you are naturally worried about what it means for your future. We cannot say for sure that this pain will go away. Often if the pain lasts for a couple of years, it does not go away. What we can say for certain is that if you do not move those muscles, they will become weaker and stiffer which means you will be able to do less and less. Unfortunately, because of the pain, you started doing less which meant your muscles became weaker with time. The only way forward is to slowly start using those muscles and try and do more. It is safe to move your back. Although it will be sore when you try doing it, it will slowly become easier.

It is essential to explore the psychological impact of the pain. The patient in this scenario seems quite distressed. It is important to acknowledge this distress.

STEP 2 (3 of 3) Communicate that it is safe to move

Patients should be advised that when they first start moving, they may notice stiffness and pain, but by gently increasing their activities, muscles will start to get more flexible, and they will ultimately be able to do more.

What a person in authority says about the pain can have a huge impact on pain perception. Although chronic pain is defined as any pain more than 3 months, it does not mean that it will continue to persist. The focus of the consultation should move away from prognosis to what can be done to help patients improve function and quality of life.

But I tried the physio, and it only made it worse. They just gave me a piece of paper with exercises to do at home. I can barely move; nothing works! I have tried everything; I think I need stronger pain killers.

Any activity you do, whether it is housework or exercise has to be paced. This means doing little and often rather than pushing yourself. Doing it this way means that you won't hurt as much and will still be able to do more. By gently increasing your activities, your muscles will start to get less stiff, and you will be able to do more. You will still get days when the pain is really bad; it does not mean there is anything changing in your body. It just means the nerves are more sensitive. It's ok to rest for a bit, but you should still try and keep moving.

Many patients find that by being able to move better, the back pain is improved as the spasms get easier.

STEP 3 Discuss the role of medications

We know opioid medicines do not work very well for chronic pain. They may provide initial relief but this impact fades as patients develop tolerance to the medication. These medications also have side effects that can cause harm over time. Patients should essentially use opioids as a tool to help them do more despite the ongoing pain.

Pain killers don't work very well for chronic pain; they can take the edge off at best. Stronger pain killers, particularly opioids also come with more side effects such as sedation, nausea, constipation, effects on the immune system and some patients can get addicted to them. If they are taken regularly, you will quickly develop tolerance and they will stop working.

Can you give me stronger pain killers?

But I would still like to try stronger pain killers. I can't do anything right now. I need to be able to work.

We can try stronger codeine if you wish but it does not always work. Opioids for chronic pain only work in one in every five patients at best. We can start the codeine, but this will be as part of a trial. If we do not see any improvements in your physical activity in the next 4-6 weeks, we will have to stop it.
The best way of using codeine is to not use it for everyday pain but use it to help you move. For example, if you know you are going to do something that will hurt, such as walking for longer or exercise, it is ok to take a pain killer to help you do that. What you should not do is take the codeine regularly as you will just get used to it and it won't work very well.

STEP 4 Take steps to ensure that the patient moves

Where investigations have shown that there is no dangerous cause of chronic pain, patients should be encouraged to move as over time this can increase function and reduce pain. There are options to refer to physiotherapy and social prescribers.

We have discussed a lot today. The one thing I would like you to take away is that although you are hurting, there is nothing dangerous going on. The best thing that you can do is to move those muscles, help them get less stiff so that you can do more. This is the only thing that will help in the long run.

What happens next?

I am going to refer you to my physiotherapy colleagues. But you do not have to wait for the referral, you can start the process yourself. I will contact you again in a few weeks' time to review your progress.

Patients often think that the purpose of physiotherapy is to get rid of the pain. This is probably true for acute pain but not for chronic. The purpose is to keep patients moving despite their pain. Physiotherapy does not primarily affect the pain intensity, although some patients might gain relief from reduced muscle spasm.

This document has been developed by Salford Pain Centre and Manchester Pain Collaborative with support from Health Innovation Manchester

Appendix 33 – Patient scenario - Chronic pain consultation

Opioid Patient Scenario: Chronic Pain

Louise is a 48-year-old female with a long history of back pain that started in her 20's. It was initially intermittent but progressively became persistent. She describes persistent low back pain with acute flareups that can make her bed bound. Flareups come on every 3 weeks or so and can last for 3-4 days. Some radiation of pain into her thighs, but this does not extend below the knee. No bladder or bowel dysfunction. She can perform activities of daily living, but her function is poor. She needs a walking stick to mobilise. She used to work as a cleaner but stopped working 10 years ago. She is currently on Zomorph 40 mg BD and Oromorph 5-10 mg prn, which she takes about 3-4 times per day. Despite this, her pain is not controlled, and she is becoming increasingly restricted at home. The pain is affecting her mood, and she was started on Fluoxetine for depression, without much effect. She has had MRI scans in the past that have shown degenerative changes at multiple levels, and disc bulges but no nerve root compression.

Standard History to include:

- ❑ When and how the pain started
- ❑ Whether the condition is improving or deteriorating
- ❑ What impact it is having on function – hobbies and work.
- ❑ Is the patient concerned that they may be causing harm by being physically active
- ❑ What impact it is having on sleep, mood, and relationships
- ❑ The patients understanding of why they are in pain, and what they have been told by other healthcare professionals
- ❑ What does the patient want out of the consultation

Examination

- ❑ Rule out red flags
- ❑ Ascertain how well the patient can move
- ❑ Don't underestimate the power of physical examination

Timing

It may not be possible to cover every aspect in a short consultation and information may need to be obtained over multiple consultations.

Patient Consultation

The next section describes some of the key messages that you need to deliver in the first consultation and is an example of one possible way that the consultation could proceed.

STEP 1	Rule out / screen for red flags. Ensure that it is safe to move
STEP 2	Communicate that it is safe to move
STEP 3	Assess the efficacy of medications and communicate the lack of efficacy in chronic pain
STEP 4	Communicate the benefits of reducing opioids
STEP 5	Take steps to ensure that the patient stays mobile
STEP 6	Encourage other pain self-management strategies
STEP 7	Consider a referral to a specialist pain service

Click on the steps above to read about each

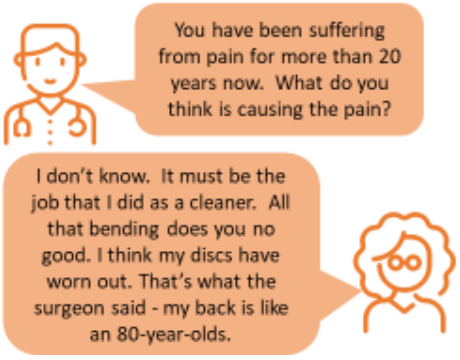
STEP 1 Ensure that it is safe to move

Are there any red flags for serious pathology? Is this pain a safe pain? Is the patient safe to move? What does the patient think the pain is due to? Are they worried about what it means? What are their specific concerns?

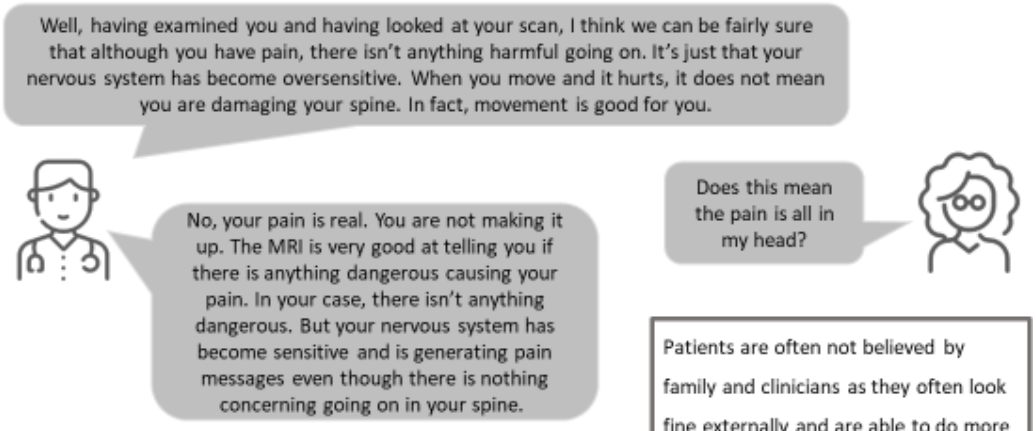
Most patients with musculoskeletal pain such as chronic low back pain do not have any ongoing sinister pathology. However, patients often worry that their pain means there is something dangerous going on and that the more they move, the more harm they are causing. This is a vicious cycle which leads to disability.

We know that most chronic musculoskeletal pain, such as lower back pain, is not due to a dangerous pathology. It is common for investigations such as MRI scans to show disc degeneration and bulging. Often clinicians and patients attribute their pain to these changes, but the evidence shows that there is often little correlation between imaging and pain. Even if there are changes such as spinal stenosis causing neurogenic pain, movement is still recommended.

The patient has made false assumptions about her condition which have been reinforced by negative and incorrect messages by clinicians. This means that she is less likely to be active. Being less active fits in with her understanding that the pain means harm. It is important to address these concerns.



STEP 2 (1 of 2) Communicate that it is safe to move



Communicate that the MRI scan changes are a normal finding, but use non-threatening terminology, such as 'age related changes' instead of wear and tear or arthritis. Avoid the term degeneration and discuss the benefit of movement. Targeted reassurance to individuals concerns about activity or the condition of their spine will be the most effective.

Patients are often not believed by family and clinicians as they often look fine externally and are able to do more on good days. It is essential to acknowledge this and reassure the patient that you do not think they are making it up. Pain is what the patient experiences, regardless of what investigations show.

STEP 2 (2 of 2) Communicate that it is safe to move

Moving may not take the pain away but will help patients to do more despite pain. If patients don't move, their muscles will weaken, and joints will stiffen up and they will end up doing less and less. They will also lose confidence with movement and inactivity can lead to low mood. Any activity, whether it is housework or exercise has to be paced, which means doing little and often rather than pushing themselves when they feel good, and then paying for it with more pain afterwards. Over time, doing small amounts consistently should lead to an overall increase in activity. Patients should be advised that when they first start increasing activity, they may notice stiffness and pain, but by gradually increasing their activities, muscles will start to get more flexible, and they will ultimately be able to do more.

But I have tried doing this, it hurts even more! Sometimes I cannot even get out of bed. I tried physiotherapy a few times; it made the pain worse!

Moving will not take the pain away but will help you do more despite your pain. If you don't move, your muscles will stiffen up and you will end up doing less and less. You will still get days when the pain is really bad. It does not mean there is anything changing in your body. It just means the nerves are more sensitive. It's ok to rest for a bit, but you should still try and keep moving.

STEP 3 Assess the efficacy of medications and communicate the lack of efficacy in chronic pain

We know opioid medicines do not work very well for chronic pain. They may provide initial relief but this impact fades as patients develop tolerance to the medication. These medications also have side effects that can cause harm over time. Patients should essentially use opioids as a tool to help them do more despite the ongoing pain.

You are on a fairly high dose of morphine. Is it working for you?

The morphine worked at first but is not working any more.

Unfortunately, we know medicines do not work very well for chronic pain. As you've described, the morphine worked well to start with, but doesn't anymore; this is called tolerance.

So, can you increase the dose?

You are already taking a lot of morphine, and we know that this sort of dose can cause harm. Even when they work, there are often side effects to this kind of medication. Some of these side effects can't be felt immediately, but over time can cause harm. These include making you more susceptible to infection, altering your hormones, causing confusion, making you constipated.

STEP 4 (1 of 2) Communicate the benefits of reducing opioids

A reduction in opioid medicines is the best way to address tolerance and improve efficacy. There is little point in just saying we need to reduce opioids as they are bad for you, or they are addictive. Humans are poor at appreciating risks that they cannot see. It is important to convey how the reduction might improve pain relief.

Now, this might seem a bit odd to you. But the best way to deal with this is to reduce the morphine. Cutting down will allow your body to recover and become sensitive to morphine again. It will also reduce the side effects that you are experiencing.

But I am in pain all the time. I need the pain killers! I once missed a dose and the pain was so bad. Surely the morphine must be doing something?

It just feels that way because your body is so used to morphine, it does not like being off it and the way it reacts is by hurting more. The only way we can deal with this is to reduce the morphine. We can do it slowly, at your own pace. You might notice the pain is worse initially, but it will settle down.

STEP 4 (2 of 2) Communicate the benefits of reducing opioids

Patients should be advised that pain medication is essentially a tool to help them do more despite ongoing pain. See step 6 for additional pain management advice.

What should I do then when I have a flareup?

You can take an extra dose if needed which might take the edge off, but no pain killer will completely take away the pain. The best way of using morphine is occasionally, but not every day, to help you be more active. If you know you are going to do something that will hurt, such as walking for longer or exercise, it is ok to take a pain killer to help you do that. What you should not do is take the morphine regularly as your body will just get used to it and it won't work very well.

There is no absolute rule for opioid reduction. You could tackle the long-acting medication first or the immediate release. As long as the trajectory is downwards, any approach is appropriate.

STEP 5 Take steps to ensure that the patient stays mobile

Where investigations have shown that there is no dangerous cause of chronic pain, patients should be encouraged to move, as over time this can increase function and reduce pain. There are options to refer to physiotherapy and social prescribers.

We have discussed a lot today. The one thing I would like you to take away is that although you are hurting, there is nothing dangerous going on. The best thing that you can do is to move those muscles, help them get less stiff so that you can do more. This is the only thing that will help in the long run.

What happens next?

I am going to refer you to my physiotherapy colleagues. But you do not have to wait for the referral, you can start the process yourself. I will contact you again in a few weeks' time to review your progress.

Patients often think that the purpose of physiotherapy is to get rid of the pain. This is probably true for acute pain but not for chronic. The purpose is to keep patients moving despite their pain. Physiotherapy does not primarily affect the pain intensity, although some patients might gain relief from reduced muscle spasm.

STEP 6 Encourage other pain self-management strategies

Direct patients to additional resourses and websites on chronic pain, so that they get a deeper understanding of chronic pain physiology and can develop their pain self-management skills. Based on individual needs, this may include stress management and relaxation skills, strategies to improve mood, better sleep hygiene and advice around staying in or returning to work.

This is all well and good , but I'm worried about how I'm going to cope. I'm hardly coping as it is, I'm really tearful these days, and I can't be bothered to go out.

It sounds like pain is making you feel very low, and perhaps a bit anxious. This won't be causing your pain but will make it more overwhelming to deal with. Have you had any support with your mood before? ...

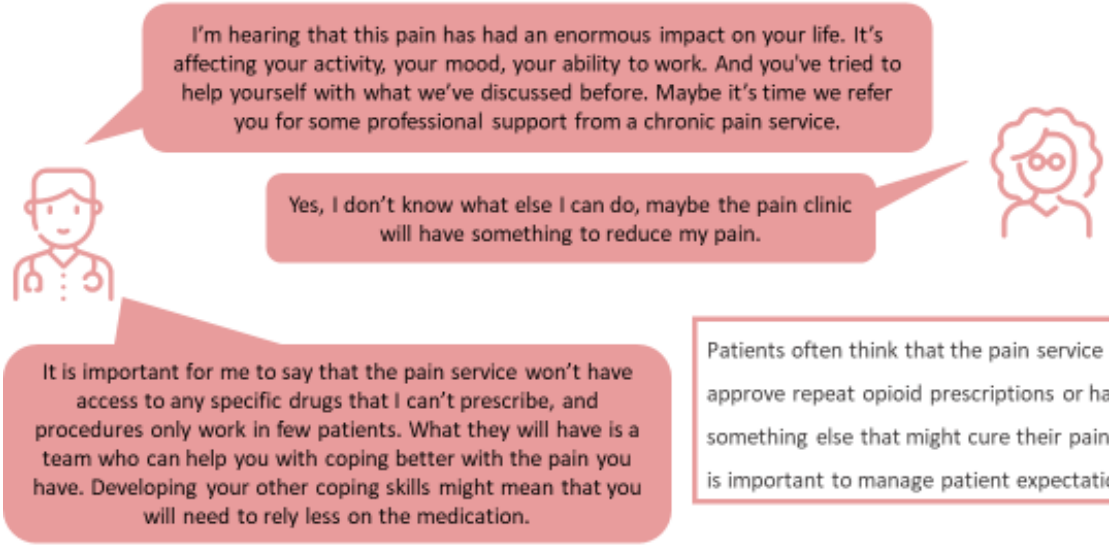
What about my sleep, is there anything I can have for that? If I could sleep, I think I could cope better with the pain.

Tell me more about your sleep. What are you doing currently to help? Medications to aid sleep come with lots of issues but there are a whole host of behavioural changes that could be helpful to you.

Patients might want to look for another quick fix, a medicine to help them sleep perhaps. This is an opportunity to speak about their role in pain management and direct them to self-management resources.

STEP 7 Consider a referral to a specialist pain service

When patients have considerable difficulty in reducing their opioids or when pain is having a significant impact on both pain and mood, it is possible that a pain service can be of assistance. For chronic pain such as this, medicines do not always help, and interventional procedures help in very specific conditions. A pain service that has an MDT (including pain specialist physiotherapy/occupational therapy/nursing/ psychology) and a Pain Management Programme could help with managing the impact of pain on mood and function.



Patients often think that the pain service will approve repeat opioid prescriptions or have something else that might cure their pain. It is important to manage patient expectations.

This document has been developed by Salford Pain Centre and Manchester Pain Collaborative with support from Health Innovation Manchester

Appendix 34 – Pain Self-Management Strategies

Pain Self-Management Strategies

Learn more about chronic pain - Direct patients to additional resources so that they get a deeper understanding of chronic pain physiology and can develop their pain self-management skills

Stay or become more active - Hopefully, you have reassured your patient about the safety of physical activity. Encourage them to aim for consistent levels of activity initially, rather than doing too much on a better day, and paying for it with more pain afterwards. Some may be able to increase activity independently, but others may benefit from physiotherapy or exercise referral schemes

Develop stress management skills - Stress and worry don't cause pain, but the additional muscle tension can make pain worse. Many people with pain find that understanding these emotions and developing coping techniques, or using relaxation and breathing strategies can be helpful

Improve or maintain mood - Low mood doesn't cause pain, but it can wind-up existing pain and make the experience of living with pain more overwhelming. Anything that creates a sense of enjoyment or achievement is a pain management tool. Some may benefit from more specialist psychological input or social prescribing services

Improve sleep - An irregular sleep pattern, reduced daytime activity, daytime napping, caffeine, the bedroom environment and worry or stress can all contribute to poor sleep. Direct patients to resources on sleep hygiene/management, where the emphasis is on behavioural changes to improve sleep quality rather than analgesics or sedatives

Encourage staying in or returning to work - Work can be good for physical health, mental health, personal finance and overall wellbeing. Employees do not always need to be 100% fit in order to return to work. Use the fit note to suggest a phased return to work or make recommendations for workplace modifications (with specific timeframes/review dates)

Consider a referral to a pain service with a Pain Management Programme (PMP) - For those who are struggling to reduce reliance on opioids and have difficulties with activity and mood , a PMP could be of use. This is multidisciplinary rehabilitation, where the aim is to help individuals improve function and quality of life, despite ongoing pain. Be sure to discuss the reason for referral with your patient, so as to manage their expectations

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