This policy statement is approved by Halton, Knowsley, Liverpool, South Sefton, Southport and Formby, St Helens, Warrington, and Wirral CCGs

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NHS
Midlands and Lancashire
Commissioning Support Unit

NHS
Pan Mersey
Area Prescribing Committee

Opioids

Considerations for safe and effective prescribing in Chronic Pain

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Prescribing safety guidance
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Contents

Introduction

This document brings together a number of 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 adult patients and is based largely on the recommendations provided from the Faculty of Pain Medicine: Opioids Aware [1] online resource. The information in this document does not apply to palliative care or end of life care where the use of opioids should follow the World Health Organisation (WHO) pain ladder and other relevant guidance.

The term chronic pain is used throughout this document and refers to a continuous pain that persists beyond the expected time of healing or for longer than three months excluding cancer-related pain and pain experienced at the end of life.

Opioids are increasingly being prescribed to manage chronic pain; however, the clinical evidence shows limited effectiveness and there are 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 [1].

Based on the clinical evidence, Public Health England and the Faculty of Pain Medicine have advised:

- Opioids are very good analgesics for acute pain and 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. 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 120 mg/day, but there is no increased benefit.
- If a patient is using opioids but is still in pain, the opioids are not effective and should be discontinued, even if no other treatment is available.

Chronic pain is very complex and if patients 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 is essential.

Drug treatments:

- Should be reserved for when 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).

The British National Formulary (BNF) advises that the prescriber has three main responsibilities:

- 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.

Faye's story

Faye's story puts the potential dangers into reality by describing, from her parent's perspective, the sequence of events that ultimately led to her untimely death from respiratory depression. They also outline the lessons learned by the GP practice involved in the case and the general messages they wish to communicate to all healthcare professionals.

Prescribing opioids for chronic pain: lessons for healthcare professionals

Managing patient expectation

Chronic pain is difficult to treat. 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.

The decision to start opioid therapy should be considered carefully by the prescriber, the patient and his or her carers, and other members of the healthcare team.

Between 50% and 80% of patients taking opioids in clinical trials experienced at least one adverse effect [1]. These should be discussed with the patient before treatment begins. Patients should be aware of uncertainty regarding the long-term effects of opioids, particularly in relation to endocrine and immune function [1].

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

Patients who do not achieve useful pain relief from opioids within two to four weeks are unlikely to gain benefit in the long term [1].

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.

The Opioid Risk Tool can also be used to assess patients before the initiation of opioid therapy.

Opioid trial

The opioid trial is a short course of up to 14 days intended to establish whether the patient achieves any reduction in pain with the opioid. 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 patient.

Patient agreement

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, for example, evidence of dependence, should be part of routine practice and can act as a helpful starting point when discussing progress and therapy. An example patient agreement can be found in Appendix 2.

What to discuss with a patient when considering opioid treatment:

- 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, and tapering the dose over days to a few weeks.
- Opioids are poorly effective for long-term pain. For a small proportion of patients, opioids may be successfully used as part of a broader plan including non-medication treatments and self-management.
- Prolonged use of opioids (longer than 3 months) may lead to drug dependence and addiction, even at therapeutic doses [2]
- 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.
- Specific functional goals that might be achieved.
- A treatment strategy and plan for the end of treatment [2]
- The potential harms of opioid treatment 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
  - Risks of tolerance and potentially fatal unintentional overdose [2]
  - Refer to the MHRA opioids safety information leaflet [2]
- Counsel patients and caregivers on signs and symptoms of opioid overdose [2]
- Discuss and document opioids and impairment of driving skills. Refer to Guidance for healthcare professionals on drug driving July 2014
- The opioid trial.
- The circumstances in which opioid therapy will be stopped.
- Arrangements for review.

Starting the trial

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

Duration of the opioid trial

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

If the patient 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

Where possible, the effectiveness of opioids should be explored by prescribing a short supply (one to two weeks) of an immediate-release oral opioid.

- If a weak opioid is required, codeine should be considered first-line in most cases.
- If a strong opioid is required, immediate-release morphine should be considered first-line in most cases.
- Individual patient factors also need to be considered.

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

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.

Ensure where a dose increase is intended, that the calculated dose is safe for the patient. This is not normally more than 50% higher than the previous dose. See product literature for specific information on dose increments.

Patient monitoring

The patient should keep a diary during the opioid trial. This should include a twice-daily report of pain intensity, comment on sleep, a 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

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.
- The circumstances under which opioid therapy should be discontinued.
- Arrangements for follow up.
- The information given to patients.

Assessing whether the opioid trial is a success

The patient should be reviewed within four weeks of initiation [1] of opioid treatment.

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

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

If the opioid trial is not successful, the drugs should be tapered and stopped within one week, even if there is no pharmacological alternative.

There is little evidence that one opioid is more effective or associated with fewer side effects than any other. There is a theoretical rationale for trying an alternative opioid if the first drug tried is helpful but causes intolerable side effects.

If the opioid trial has provided benefit and is to be continued, it should be used in conjunction with regular paracetamol unless contra-indicated.

Arrangement for review

Where practical, review of long-term opioid therapy should be carried out by the initial prescriber. The frequency of review, once the opioid regimen has been established, will depend on the early effectiveness of treatment; the frequency of troublesome side effects; the timing of additional interventions to control pain, for example, surgery; and the presence of concerns about the problematic use of opioids.

When a regimen is stable and the patient reports substantial relief of symptoms and where additional concerns do not dictate otherwise, opioid treatment should be reviewed at least six monthly [1].

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

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

Reviewing patients already prescribed opioids

- Establish a consistent approach to prescribing and reviewing opioids within your organisation.
- Prioritise patients prescribed greater than 120 mg/day morphine equivalent for review.
- Using a standardised template will support review and ensure all relevant points are considered. See Appendix 3 for a best practice template that can be adapted for use within individual organisations.
- Consider adverse effects such as constipation and ensure these are appropriately managed.
- Check prescribing history to establish compliance and indications of overuse.
- Be mindful of the impact short-acting opioids have on the total opioid dose and the risk of patients escalating their dose independently.
- Ensure the patient is fully aware of the potential for dependence and addiction [2].
- Agree a reasonable timescale for subsequent reviews with the patient.
- Develop a Clinical Management Plan with the patient ensuring a plan for dose reduction is considered.
- Additional safety considerations may be required if conducting a remote review. Refer to professional guidance on remote prescribing.
- Consider the risk of diversion.
- Refer to Appendix 1 for some useful patient resources.

Responsibility for prescribing

Consider prescribing recommendations from other prescribers or specialists and be prepared to challenge where these are deemed to be inappropriate.

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

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

Repeat prescribing

If an opioid has a demonstrable positive benefit for an individual patient and there is a robust system for monitoring use, then consideration may be given for short-term authorisation of repeat prescriptions.

Prescribe enough to meet the person's clinical needs up to a maximum of 30 days for all opioids, including those in schedules 4 and 5.

Do not prescribe with the instructions to be taken 'as directed'. State the dose frequency or the minimum dose interval suitable for 'when required' opioids, along with the maximum dose in 24 hours.

Rational Prescribing

Keep pain relief simple and effective.

Follow these **S.T.E.P.S.** to answer the following questions:

- Is it **S**afe for the patient to continue on this medication long term?
- Can they **T**olerate this medication with its side effects?
- Is the medication **E**ffective? Some patients can't tell one way or another.
- Are they on the best **P**riced treatment? (in line with formulary recommendations).
- Is the analgesic regimen as **S**imple as possible? Would a long-acting preparation be preferable to frequent doses of short-acting analgesics?

It is easier to manage opioid prescribing if a single opioid is used rather than combining several opioids. If several opioids are being used, when reviewing treatment, the total opioid load must be considered. Total opioid load is calculated by converting each opioid into its morphine equivalent dose.

Avoid co-prescribing of opioids where possible.

Drugs should be used for their licensed indication only. The oral route should always be used where possible. Alternative routes should only be considered for people who are unable to take oral medicines because of medical conditions or disability. Use of opioid formulations with a rapid onset, such as fentanyl for transmucosal or sublingual administration, is inappropriate for the management of chronic pain. Injectable opioids should not be used in the management of patients with chronic non-cancer pain.

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. For chronic pain, the dose above which harms outweigh benefits is 120 mg oral morphine equivalent/24 hours. Increasing opioid load above this dose is unlikely to yield further benefits but exposes the patient to increased harm.

Safe prescribing considerations

Before prescribing opioids, discuss with the patient the risks and features of tolerance, dependence, and addiction [2]

National Patient Safety Agency (NPSA) alert, Reducing dosing errors with opioid medicines 2008, advises when opioids are prescribed, dispensed or administered the health professional should:

- Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient
- where a dose increase is intended, that the calculated dose is safe for the patient
- ensure they are familiar with clinical particulars of the medicine: usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose, common side effects

Concomitant prescribing of respiratory depressants

Respiratory depression is associated with the use of opioids [1]. There is a well-documented risk of respiratory depression when opioids are co-prescribed with medications that also cause respiratory depression, for example:

- gabapentin [3], pregabalin
- benzodiazepines [4]

Only prescribe together if there is no alternative, using the lowest doses possible for the shortest duration of time, and carefully monitor patients for signs of respiratory depression.

Prescribing for special groups

Care is needed when prescribing in pregnancy, renal or hepatic impairment, elderly.

Patients with impaired renal or hepatic function may need dose reduction or choice of opioid reviewed.

Consider the potential for drug-drug interactions which may lead to opioid toxicity.

Risk of errors between interfaces

Prescribers are reminded that errors or inappropriate continuation of prescribing can occur when patients are transferred between care settings.

Ensure sufficient information is provided for safe and appropriate prescribing of opioids, including timescales for treatment and review.

Query any discrepancies or concerns before taking over prescribing responsibility.

Transdermal opioid prescribing

Fentanyl transdermal patches are contraindicated in opioid-naive patients for non-cancer pain [5].

All opioid analgesic patches must be prescribed by brand and applied at the correct dosing interval. Refer to the British National Formulary (BNF), Summary of Product Characteristics, and the Pan Mersey formulary for further information.

Ensure sufficient time is allowed for the maximum analgesic effect to be reached before evaluating efficacy as this varies between preparations.

In patients who experience serious adverse effects or signs of overdose, remove the patch immediately and monitor for up to 24 hours after patch removal.

Risk of accidental overdose

- Inappropriate strength of fentanyl patch prescribed.
- Failure to remove an old patch before applying a new patch. Patches still contain a significant amount of drug after removal.
- Exposure of the patch application site to a heat source (e.g. hot bath, hot water bottle, electric blanket, heating pad etc.) or increased body temperature (e.g. fever).

Risk of accidental ingestion

- Poorly affixed opioid patches transferring to another person for whom opioid is not intended [6].
- Applying improperly disposed patches to the body believing the patches to be stickers or plasters, for example, children, adults with dementia or visual impairment.

All healthcare professionals involved in patient care are responsible for ensuring the patient or their carer is adequately trained and competent to administer transdermal opioid preparations.

Oral opioid preparations

There are a number of weak and strong oral opioid preparations available as immediate-release and modified-release preparations. Modified-release preparations can also exist as both 12 hourly and 24 hourly dosage forms.

Prescribe modified-release oral opioid preparations using the brand name to avoid confusion and reduce the risk of errors.

For more information about brand prescribing refer to the UKMI document Which medicines should be considered for brand-name prescribing in primary care?

Oxycodone

Oxycodone is **more** potent than morphine.

There are significant risks of overdose when immediate release oxycodone is used in error for modified release oxycodone.

Prescribe by brand to reduce confusion.

Confirm any use of oxycodone concentrate solution with the prescriber as there are significant risks of overdose if a concentrate product is used in error for a normal strength product.

Any use of oxycodone medicines ‘as required’ should have clear guidance on the dose frequency or the minimum dose interval, and the maximum dose in 24 hours.

Refer to CQC for advice around safer use of oxycodone.

Serotonin syndrome

Consider the risk of serotonin syndrome when certain opioids, for example, tapentadol, are co-prescribed with other medication that affect the serotonin system [7]. Serotonin syndrome can cause symptoms such as excessive sweating, fast pulse rate, high blood pressure, shaking, and rarely death.

Refer to UKMI document, What is serotonin syndrome and which medicines cause it?

Stopping opioids in primary care

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 patient receives a definitive pain-relieving intervention (e.g., joint replacement).
- The patient develops intolerable side effects.
- There is strong evidence that the patient is diverting his or her medications to others.

The decision to taper or stop an established opioid regimen needs to be discussed carefully with the patient including:

- The rationale for stopping opioids and the potential benefits of opioid reduction (avoidance of long-term harms and improved ability to engage in self-management strategies).
- Agreeing outcomes of opioid tapering, for example, stopping opioid completely, or for patients on high doses, reducing the dose to 120 mg/day morphine equivalence.
- Arrangements for monitoring and support during opioid taper.
- Documented agreement of the tapering schedule.

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

- Evidence that opioids are not helping – patient's complaints of pain or loss off function; reports from the patient's family or associates.
- Risk of side effects or complications of opioids.
- Risk of drug theft or diversion.
- Patient's ability to cope with the effects of dose reduction.
- Risk of patient 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 patient:

- Incremental taper of existing drug.
- Agreed outcomes of opioid tapering.
- Monitoring of pain during taper.
- Symptoms and signs of opioid withdrawal.
- Choice of opioid reduction scheme and timing of weaning steps.
- GP or other healthcare support and monitoring during the wean.
- Role of drug and alcohol services to support dose reduction.

- Close collaboration between the patient, his or her carers, and all members of the patient's health care team.
- Arrangements for follow-up including agreed prescribing responsibilities.
- Distraction strategies, social support and help in reducing the temptation to relapse.
- Withdrawal symptoms (e.g., sweating, yawning and abdominal cramps, restlessness, and anxiety) occur if an opioid is stopped or the dose reduced abruptly, and so doses should be gradually reduced.

The opiate dose can be tapered by 10% every week or every other week [1].

The reduction becomes a larger proportion of the dose that the patient is taking as their dose reduces. This is why patients may run into difficulty as they reach lower doses. Consider smaller dose reductions as the dose becomes lower.

Tapering can be paused but should not be reversed unless there are exceptional circumstances.

Patients who are failing to derive benefit from large doses of opioids (greater than oral morphine equivalent of around 300 mg/day) may need support from specialist services [1]. Opioid tapering or cessation when patients are taking high doses is more likely to succeed if patients' emotional and mental health needs are identified and an appropriate plan for support established.

What if the patient isn't keen?

General Medical Council (GMC) guidance is that doctors have to act in the patient's best interests – this may involve reducing an opioid prescription against the patient's wishes.

Document your reasons for embarking on an enforced wean, and on your attempts to gain patient agreement. A documented multi-disciplinary team (MDT) discussion is advisable. Consider contacting secondary care (such as the pain clinic) for advice.

A suggested strategy for an enforced wean:

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

Converting opioids

Potent opioid analgesics are frequently involved in serious medication incidents, often because of incorrect dose calculations [1].

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

Approximate dose equivalence tables provided by Faculty of Pain Medicine: Opioids aware have been included as Appendix 4 and can be used as a guide.

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

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

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

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

Formally double-check the calculations and where possible have the patient's dose independently verified. Utilise pharmacist advice and support within your organisation if required.

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

Prescribing drugs likely to cause dependence or misuse

Particular care should be taken when considering prescribing opioids for patients under the care of drug and alcohol services. The service provider must have patients' consent to share information with GP practices about medication supplied by them to patients.

A comprehensive drug history is required to ensure potential interactions with 'medications prescribed elsewhere' are identified. Where appropriate, liaise with local service providers to ensure you have the most up to date drug history. Whenever possible document 'medication supplied elsewhere' on clinical systems to ensure the Summary Care Record (SCR) is complete and accurate.

Patients under temporary care should be given only small supplies of drugs unless they present an unequivocal letter from their own doctor.

Prescribers should be mindful that patients may be attempting to collect prescriptions from other prescribers, especially in hospitals.

Identification of prescription opioid dependent patients

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.
- 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 family members or friends.

Refer or signpost patients to suitable specialist services to allow multidisciplinary approach to management.

Reporting incidents or concerns

Concerns and incidents must be reported via local reporting systems. Concerns can also be raised to NHS Controlled Drug (CD) Reporting.

Reporting side effects or adverse effects

Opioid overdose or accidental exposure requires urgent medical attention.

If naloxone is indicated for treatment of suspected acute opioid overdose or intoxication, consider any safety advice relating to its use [8].

Report any cases of accidental exposure where harm has occurred or suspected side effects via the Yellow Card Scheme.

Appendix 1 – Information sources

Information for patients

Online resources

NHS Live Well - 10 ways to reduce pain

British Pain Society – Patient Publications

Information leaflets for patients

About Pain (Faculty of Pain Medicine)

Taking Opioids for Pain (Faculty of Pain Medicine)

Thinking about Opioid Treatment for Pain (Faculty of Pain Medicine)

Driving and Pain (Faculty of Pain Medicine)

MHRA patient leaflet: Opioid medicines and the risk of addiction

Information for clinicians

Live Well with Pain

Clinical Guidelines: National Institute for Health and Care Excellence (NICE)

Low back pain and sciatica in over 16s: assessment and management

Osteoarthritis: care and management

Neuropathic pain in adults: pharmacological management in non-specialist settings

Rheumatoid arthritis in adults: management

Headaches in over 12s: diagnosis and management

Appendix 2 Practice resources

Example opioid management plan: treatment agreement

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 consider long-term treatment.

Period before next mandatory review: .....

Patient declaration

By signing this declaration, the patient agrees to the following conditions regarding his or her treatment and the prescribing of opioid medication:

- I have read and understood the information provided to me and I will tell my GP if I experience on-going or intolerable side effects.
- My GP is responsible for prescribing a safe and effective dose of opioid medication. My GP will control my dose, perhaps with advice from one or more specialists in conditions relevant to my pain.
- 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.
- I will not use any other opioids in addition to those prescribed by my GP.
- I will only obtain my opioid medication from my GP.
- I understand that no early prescriptions will be provided unless there are exceptional circumstances.
- Any evidence of unsafe use such as loss of prescriptions, obtaining opioids from other sources, increasing the dose without prescriber authorisation, or failure to follow this agreement may result in termination of this agreement and withdrawal of opioids.
- 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.
- I am aware that giving my opioid medication to other people is illegal and could be dangerous to them.
- 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: .....

Example letter inviting patients for review

[Practice name]

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 medication 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 medication for chronic pain. Strange as it might sound – we don't think they are very good at helping with 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 prescription is due and we'll work together towards a safer, more effective treatment plan.

Yours sincerely,

Dr XXX and partners

Example opioid policy for new patients

Many of our patients take strong, potentially addictive medication to help manage their condition(s). Of concern are ‘drugs of dependence’ (e.g., opioid medications 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 prescription drugs.

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 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 strength 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 an opioid management plan treatment agreement that gives details of our practice’s expectations when prescribing drugs of dependence. This agreement also describes your responsibilities as a patient when 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 are complex, and that referral for on-going support 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 zero tolerance on issues relating to staff abuse.

Example opioid policy for issuing prescriptions

Many of our patients take strong, potentially addictive medication to help manage their condition(s). Of concern are ‘drugs of dependence’ (e.g., opioid medications 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 prescription drugs.

Patients initiated on opioids will be asked to complete an opioid management plan treatment agreement.

- All new opioids will be issued as acute prescriptions.
- Whilst the patients condition or dose are being stabilised, medication will be issued as an acute prescription.
- 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 four weeks of initiation of an opioid prescription and have their pain assessed and a decision made as to the effectiveness of the drug.
- 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 prescriber’s discretion.
- Where opioids are added to repeat prescription the maximum re-authorisation period will be six months. Patients on long-term opioids will be reviewed every six 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 one month unless under exceptional circumstances which should be documented by the prescriber.
- All opioid prescriptions will include fully written directions and use of ‘when required’ or ‘as directed’ will be avoided.

Appendix 3 Example opioid review template

High Dose Opioid Review Form

Opioid doses increased greater than 120 mg morphine equivalent daily (MED) are associated with little increased analgesic benefit but significantly greater risk of harm. This patient has been identified as receiving prescriptions that equate to greater than 120 mg MED within a 30 day period. Please complete this high dose opioid review form and ensure the information is saved in the patient record.

The patient should be invited for a **face to face clinical review** of prescribed opioids with a view to reducing doses. Please complete all boxes in the table below.

Patient number	**Date of birth**

Morphine equivalent daily (mg)

Opioids prescribed (drug, strength, formulation, dose, and quantity)

Name of clinician completing review	**Date of review**

Review of the effectiveness of treatment	
Pain related diagnosis	
Are opioids clinically indicated for this patient? "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." *Opioids Aware, Faculty of Pain Medicine.*	

Review of the effectiveness of treatment	
Has opioid therapy produced and maintained a measurable improvement in the patient's pain or functional capacity, or both? 30% reduction in pain intensity, or specific functional improvement or improvement in sleep.	

Safety review	
Is the patient experiencing any adverse effects from opioid therapy or at risk of long term adverse effects? **Have these been discussed with the patient?**	[ ] Falls [ ] Fractures [ ] Hyperalgesia [ ] Erectile dysfunction [ ] Infertility [ ] Hypogonadism [ ] Depression [ ]Anxiety [ ] Fatigue [ ] Drowsiness [ ] Respiratory Depression [ ] Immunosuppression [ ] Withdrawal symptoms [ ] Dry mouth [ ] Dental problems [ ] Constipation [ ] Nausea [ ] Vomiting [ ] Flushing [ ] Sweating [ ] Itching [ ] Headache [ ] Urinary retention [ ] Other: (please state) ..... Please provide details of risk discussion:
Is the patient co-prescribed other high risk medicines? **Has this risk been considered and discussed with the patient?** For example, gabapentinoids, benzodiazepines, antipsychotics, anti-epileptics or antidepressants.	[ ] Gabapentinoid [ ] Benzodiazepine [ ] Antipsychotic [ ] Anti-epileptic [ ] Antidepressant [ ] Other ..... Please provide details of risk discussion:

Safety review	
Has the patient been given information about drug driving and the law? Further information and patient leaflet available from the Department of Transport – Changes to drug driving law	
Constipation affects nearly all patients receiving strong opioid treatment. **Inform all patients that treatment for constipation takes time to work and adherence is important.** Pan Mersey APC guideline recommends prescribing a softener and stimulant first line, taken regularly at effective dose, for patients on strong opioids.	Softener ..... Stimulant ..... Other .....
Is there any risk of abuse, misuse, or diversion? Please detail any strategies in place to manage risk. Risk assessment tool available from the National Institute on Drug Abuse – Opioid Risk Tool	

Clinical management plan	
Has a reduction in opioid therapy been trialled? Please provide details including rationale for not initiating a reduction.	
Is a referral to secondary care pain management needed? **Is the patient currently under a specialist pain service?**	
Is there a clinical management plan in place? Please provide details and specific actions with dates. Consider holistic analgesia review. Include prescriber actions, e.g., arrange MDT, consult specialist.	

Clinical management plan	
Have non-pharmacological strategies been employed? **Has the patient been signposted to appropriate local services?**	
Date of next review “Opioid treatment should be reviewed at least six monthly for stable patients and more frequently when modifying doses.” *Opioids Aware, Faculty of Pain Medicine.*	

Appendix 4 Approximate equi-analgesic potencies of opioids

Taken from Faculty of Pain Medicine: Opioids Aware Dose equivalents and changing opioids.

(reference figures correct at the time of publishing)

Oral administration

Opioid	Potency ratio with oral morphine	Equivalent dose to 10 mg oral morphine
Codeine phosphate	0.1	100 mg
Dihydrocodeine	0.1	100 mg
Hydromorphone	5	2mg
Methadone	*	*
Morphine	1	10 mg
Oxycodone	1.5	6.6 mg
Tapentadol	0.4	25 mg
Tramadol	0.1	100mg

** The relative potency of methadone depends on the starting dose and the duration of administration. Conversions to and from methadone should always be undertaken with specialist advice*

Transdermal administration

Transdermal buprenorphine changed at weekly intervals

	5 micrograms per hour	10 micrograms per hour	20 micrograms per hour
Codeine phosphate	120 mg per day	240 mg per day	
Morphine sulphate	12 mg per day	24 mg per day	48 mg per day

Transdermal buprenorphine changed every three or four days (twice weekly)

	35 micrograms per hour	52.5 micrograms per hour	70 micrograms per hour
Morphine sulphate	84 mg per day	126 mg per day	168 mg per day

Fentanyl

Fentanyl patch strength (micrograms per hour)	**Oral morphine** (mg per day)
12	30
25	60
50	120
75	180
100	240

References

Adapted with kind permission from NHS Wigan Borough CCG from their Opioid Prescribing for Chronic Pain: Resource Pack.

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