NHS
Kent and Medway
Clinical Commissioning Group

Kent and Medway CCG Position Statement on Opioid Prescribing

Document history:

Version	Date	Main Changes/Comments
1	December 2021	Initial document produced and adapted based on comments received from KCHFT, EKUFT and DVH.
1.1	February 2022	Additional point included regarding support to general practice in refusing to take over the prescribing of opioid dose increases that they feel is inappropriate following comments received at JFG.
1.2	March 2022	Formatting change to create a footnote on page 1

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Summary:

Kent and Medway CCG **DOES NOT** support:

- The long-term prescribing (greater than 3 months) of opioids for non-cancer, chronic pain in adults*
- The use of high dose opioids (more than 120mg/24 hours of oral morphine (or equivalent) for non-cancer, chronic pain in adults.

GP practices within Kent and Medway CCG have the full support of the CCG in reviewing patients prescribed high dose or long-term opioids and reducing opioid doses to safer levels.

Kent and Medway CCG fully support and encourage any decision to refuse to prescribe opioids if drug-seeking behaviour is suspected from a patient in any setting.

Recommendations:

The recommendations summarised above aim to:

- Reduce the prescribing of opioids that is not in line with national guidance
- Improve outcomes for chronic pain through more effective prescribing
- Reduce the incidence of opioid use related harm associated with long-term prescribing and high doses listed below under Key Issues

National guidance and resources for clinicians that support this position statement

- National Institute for Health and Care Excellence: Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain
- Royal College of Anaesthetists, Faculty of Pain Medicine: Opioids Aware
- Live Well with Pain
- PrescQIPP CIC – Reducing Opioid Prescribing in Chronic Pain
- Other educational resources can be found on your local formulary website

Key issues:

Patients with non-malignant chronic pain should not routinely be prescribed opioids in the long term and Kent and Medway CCG fully support the deprescribing of opioids in this cohort of patients.

Kent and Medway CCG does NOT support:

- The long-term prescribing (greater than 3 months) of opioids for non-cancer, chronic pain in adults*
- The use of high dose opioids (more than 120mg/24 hours of oral morphine (or equivalent) for non-cancer, chronic pain in adults.

The CCG supports the option for primary care prescribers to refuse to take back the prescribing responsibilities of an opioid from another healthcare professional, in situations where they deem the opioid dose increase undertaken by that healthcare professional to be inappropriate.

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*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 their use is intermittent (however it is difficult to identify these people at the point of opioid initiation). [1] Where opioids are prescribed as a trial for a suitable pain indication, careful follow-up should demonstrate a clear reduction in pain and increase in function, provided dosing remains well within guidelines. Care should also be taken that dosing does not keep escalating. Frequent initial review is advised. Annual review (including whether reduction/ de-prescribing can take place) is advised once stable.

It is estimated that between 8-12% of long-term prescribed opioid users meet the criteria for a current or past opioid use disorder. Kent and Medway CCG fully support and encourage any decision to refuse to prescribe opioids if drugseeking behaviour is suspected from your patient in any setting.[1]

Healthcare professionals should be aware that:

- There is little evidence that opioids are helpful for long term pain and 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. [1]

- 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 experience is essential. [1]

- The Faculty of Pain Medicine advises that if a patient 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.[1]

- If a shared decision to reduce or withdraw opioid medication cannot be agreed or is refused and continuing the current prescription is not in the person's best interest the General Medical Council prescribing guidance on 'handling patient requests for medicines you don't think will benefit them' should be followed. This states:
  'If, after discussion, you still think the treatment or care would not serve the patient's needs, you should not provide it. You should explain your reasons to the patient and explore other options that might be available, including their right to seek a second opinion.'[3] Please be aware that medicines associated with dependence and withdrawal symptoms cannot be stopped abruptly in the majority of cases and need to be reduced in line with current guidance [2,3]

- Prescribers should be mindful of the risk of diversion of opioids and other dependence forming medication and should consider the safeguarding implications of prescribing.

- When calculating whether a patients total daily opioid intake exceeds the 120mg oral morphine equivalent threshold, all opioids taken by the patient should be incorporated including those of lower potency e.g., tramadol and codeine. An opioid calculator to calculate the total oral morphine equivalent daily dose has been developed by the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (FPM ANZCA) and is available here to assist with these calculations. NB: this should only be used to calculate the total oral morphine equivalent daily dose and **not** to support opioid rotation or switching from one opioid to another

- Concurrent use of benzodiazepine, gabapentinoids and other sedating drugs should be considered as part of the overall assessment and management of the patient as these have the potential to increase the risk of patient harm.

Side effects:

- The most common side effects of opioid therapy include nausea, vomiting, constipation, pruritus, dizziness, dry mouth and sedation.[1] Opioids also have multiple effects on respiratory physiology, including decreased central respiratory drive, respiratory rate, and tidal volume. [1]

- The long-term effects of opioids may include depression and fatigue, reduced fertility, irregular periods, erectile dysfunction, increased levels of pain (opioid induced hyperalgesia) and increased risk and incidence of falls.[6]

- Inadequate management of side effects (intractable constipation, faecal impaction, bowel obstruction) and consequences of opioid treatment (falls, fractures and acute confusional state) may contribute to unplanned hospital admissions and contribute to the overall costs associated with opioid treatment [1]

This position statement is intended for use alongside clinical and professional judgment

References:

1. Royal College of Anaesthetists (The), Faculty of Pain Medicine. Opioids Aware

2. National Institute for Health and Care Excellence. Draft Guideline for consultation 'Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults'

3. General Medical Council, Good practice in prescribing and managing medicines and devices

4. MHRA Drug Safety Update September 2020: Opioids: risk of dependence and addiction

5. MHRA Drug Safety Update March 2020: Benzodiazepines and opioids: reminder of risk of potentially fatal respiratory depression

6. Morphine Sulfate 10mg/5ml Oral solution Summary of Product Characteristics available at: https://www.medicines.org.uk/emc/product/2629/smpc

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