NHS
South Yorkshire
Integrated Care Board

Opioids (CROP) & Gender Dysphoria

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September 2024 BEST

NHS
South Yorkshire
Integrated Care Board

Reducing opioid use in chronic non-cancer pain

For every 62 people with chronic pain prescribed opioids for longer than 90 days, one will die who would not have if the chronic pain had been managed with biopsychosocial interventions alone *(Gomes et al, 2011), (Häuser et al, 2020).*

For people prescribed opioids for chronic pain, 1 in 10 suffer moderate harm.

National MO Target Area

Pharmacological management of chronic non-cancer pain is associated with minimal benefits, and potential harm, when compared to effective biopsychosocial interventions.

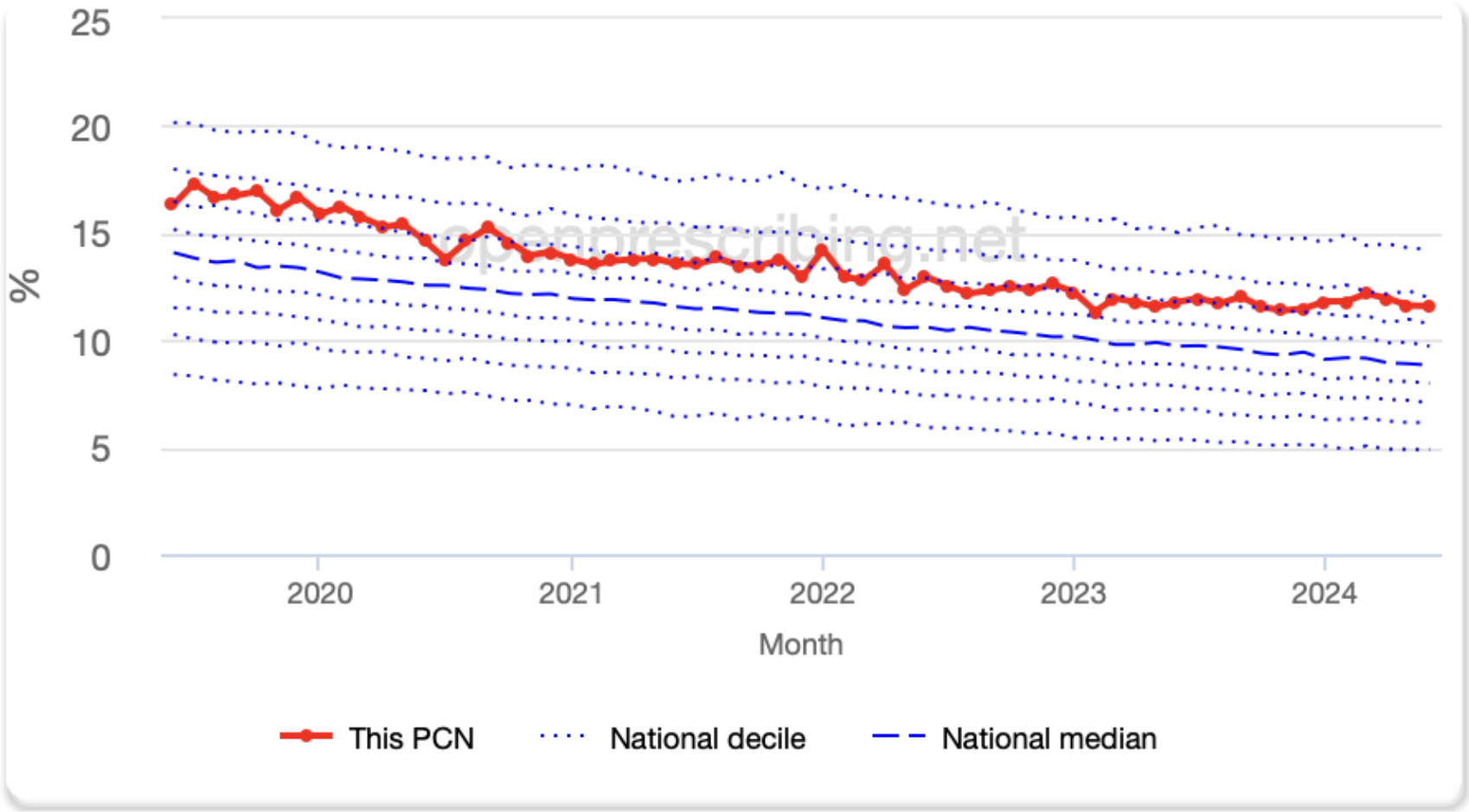
SY MO Target Area

Reduce prescribing high dose (>120mg OME) CNCP by 50%

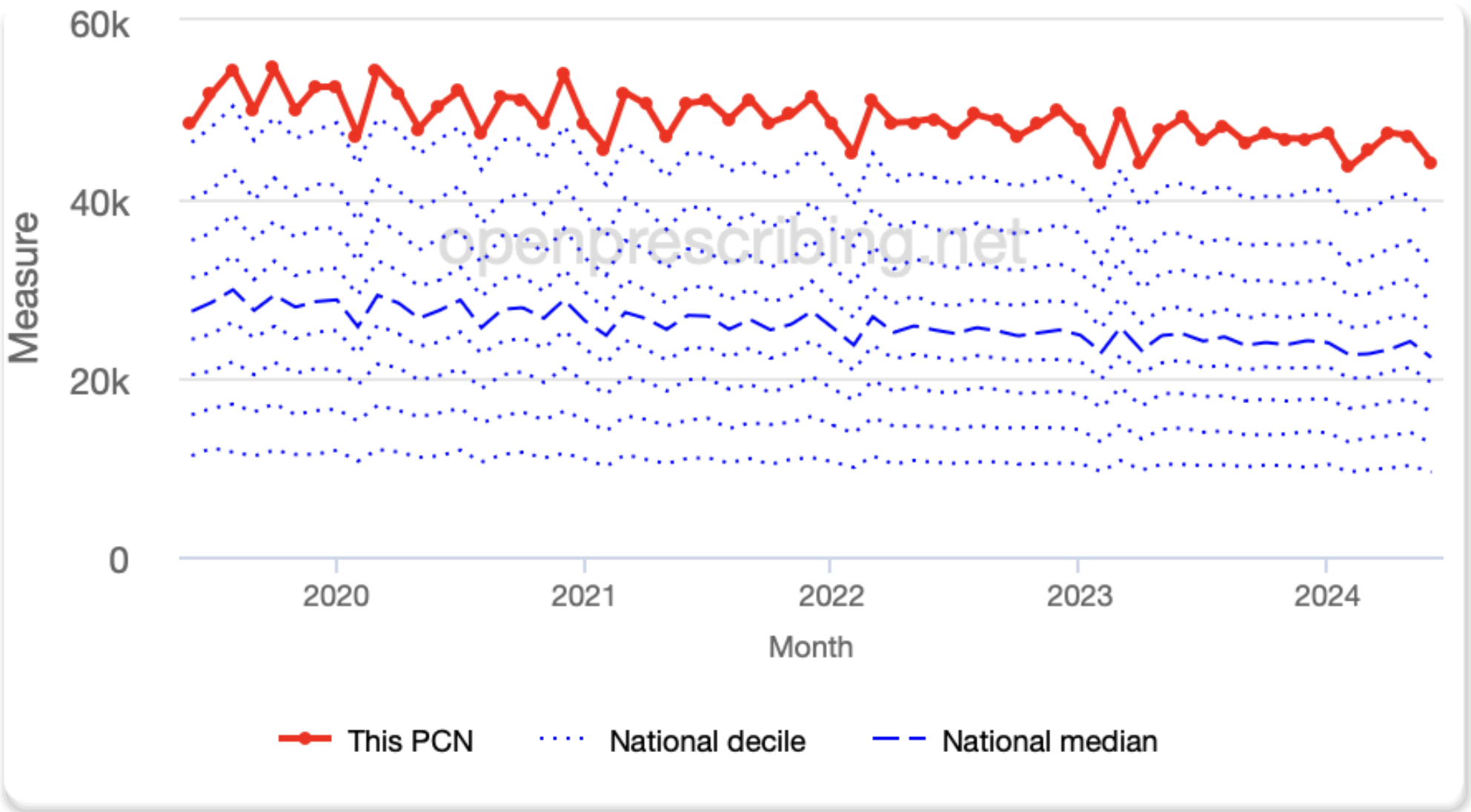
CROP (Campaign to Reduce Opiate Prescribing)

- SY national opioid triangle (Guardian) – Barnsley second highest below Doncaster.
- SYICS (Spring 2021) – ran for one year
- Extracted anonymised data from GP systems and reports collated for practices for discussion/ action
- Report identified 8 cohorts of patients @ high risk (varying degrees) of risk for review
- Practices had progress within reports highlighted

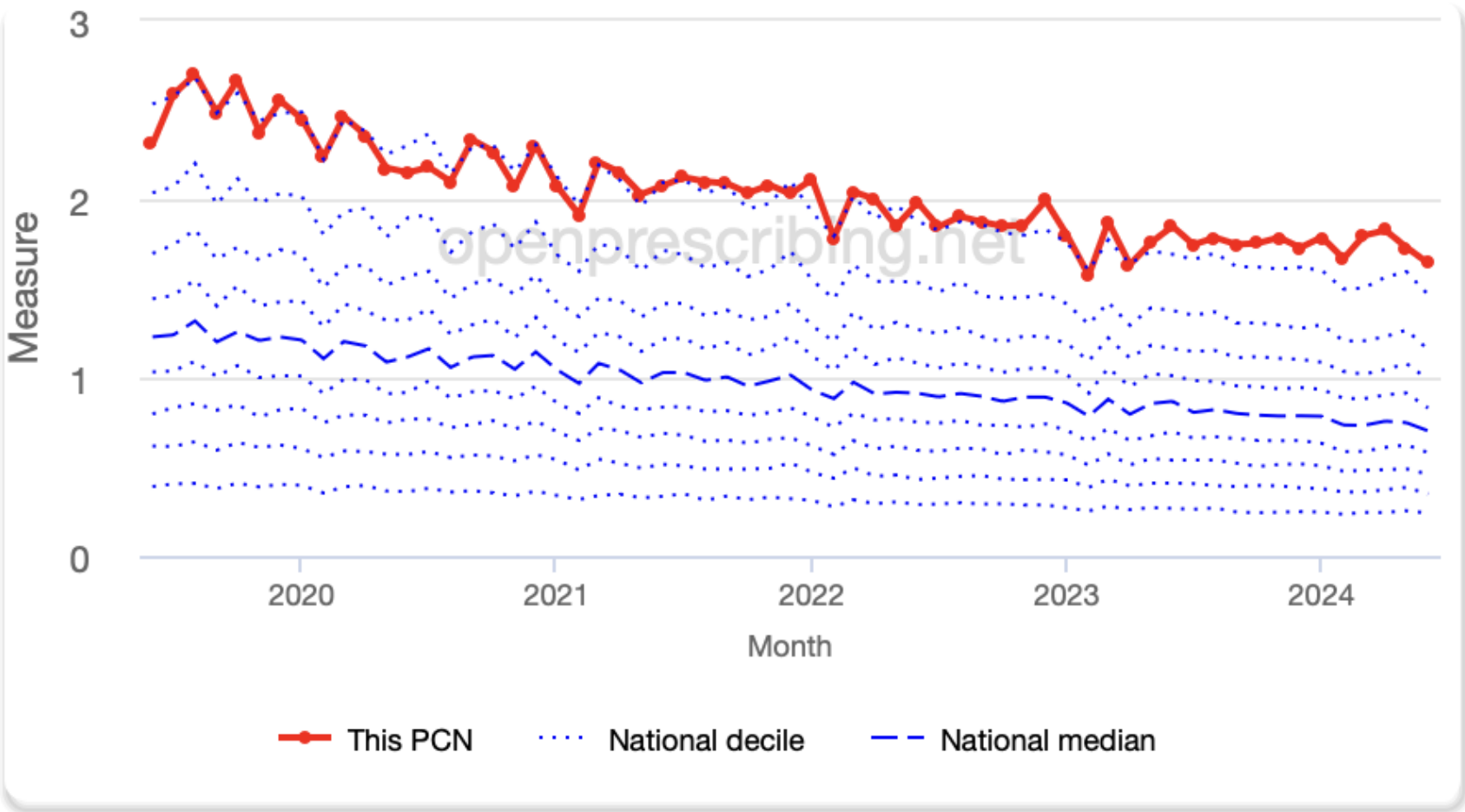
Opioid items with likely daily dose of ≥120mg morphine equivalence compared with prescribing of all items of these opioids



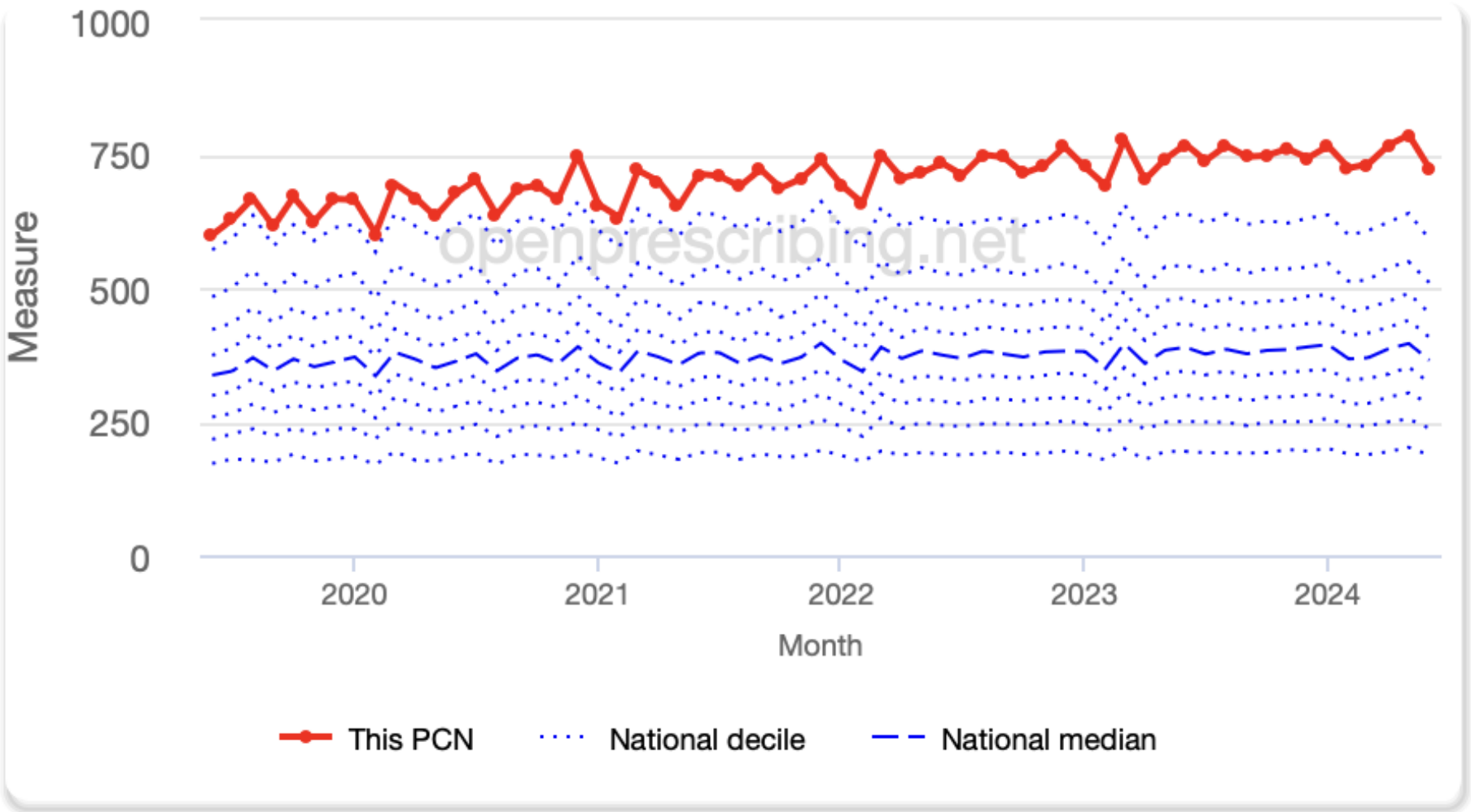
Total opioid prescribing (as oral morphine equivalence) per 1000 patients



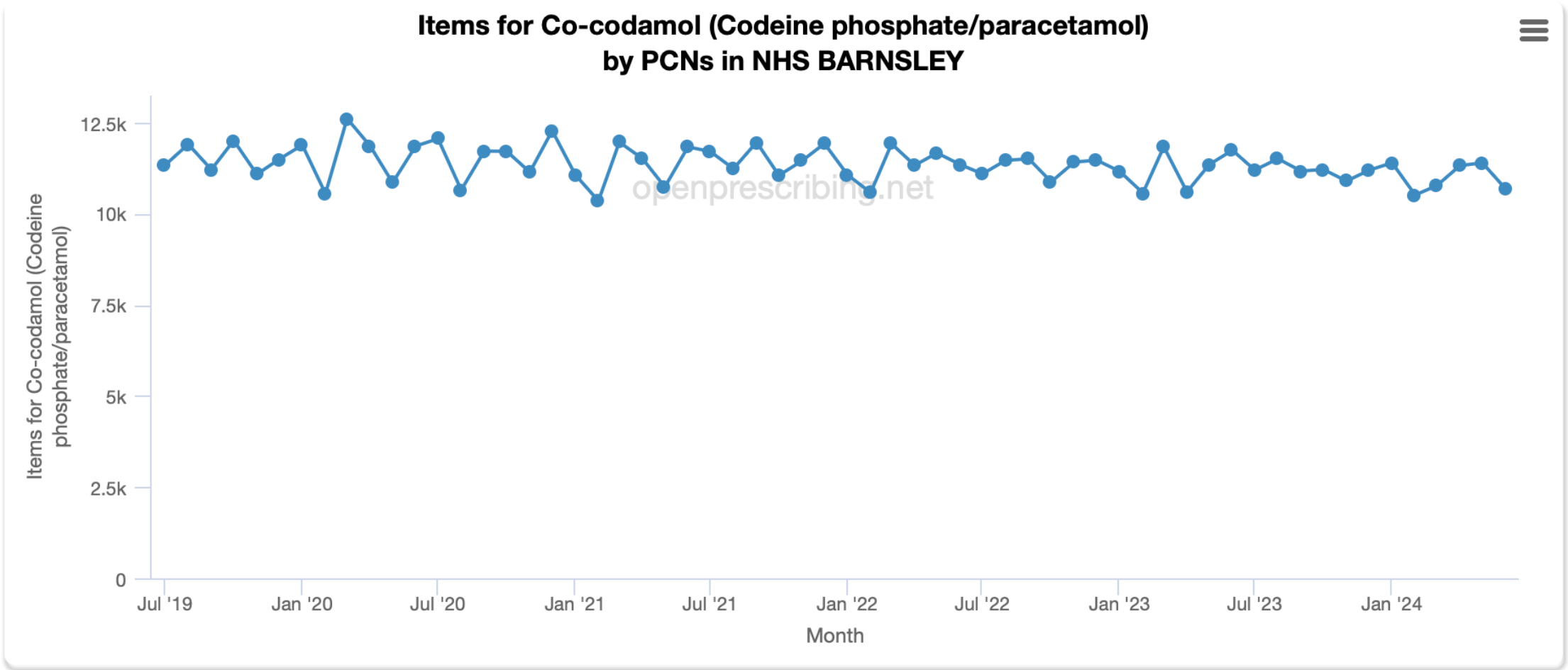
Opioids with likely daily dose of ≥120mg morphine equivalence per 1000 patients

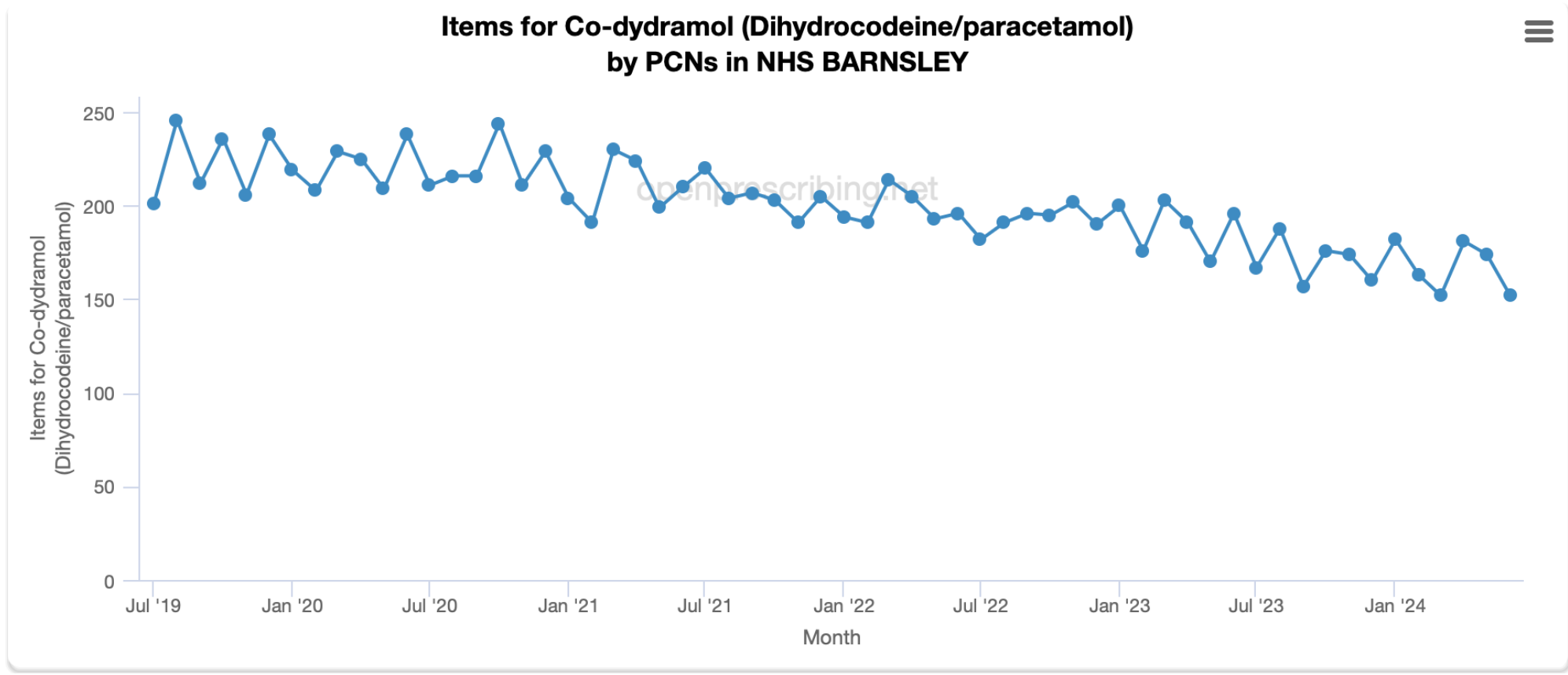


Total DDD of pregabalin + gabapentin per 1000 patients



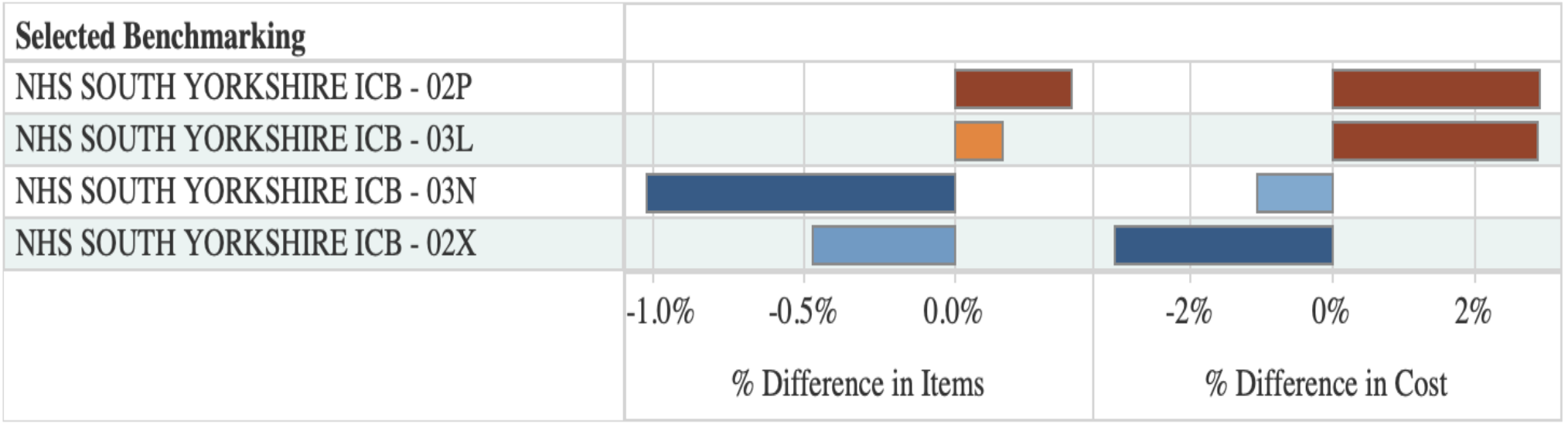
Show vs other PCNs | Time series | Share | Map | Download CSV




Items for Co-dydramol (Dihydrocodeine/paracetamol)
by PCNs in NHS BARNSLEY
openprescribing.net
Items for Co-dydramol (Dihydrocodeine/paracetamol)
250
200
150
100
50
0
Jul '19
Jan '20
Jul '20
Jan '21
Jul '21
Jan '22
Jul '22
Jan '23
Jul '23
Jan '24
Month

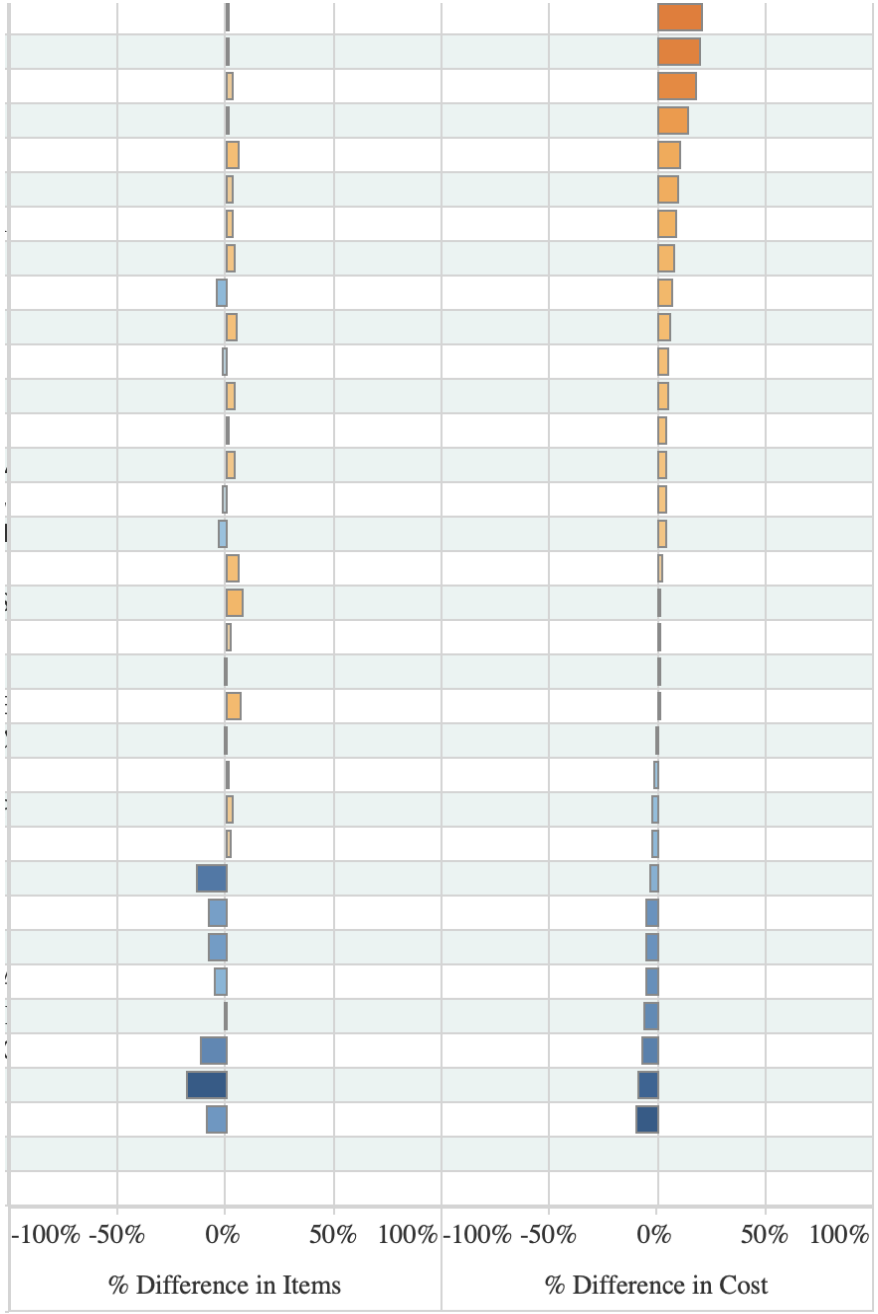
Prescribing Growth since CROP

336. Reducing opioid prescribing in chronic pain commissioner growth in cost; Aug23-Oct23 to Nov23-Jan24

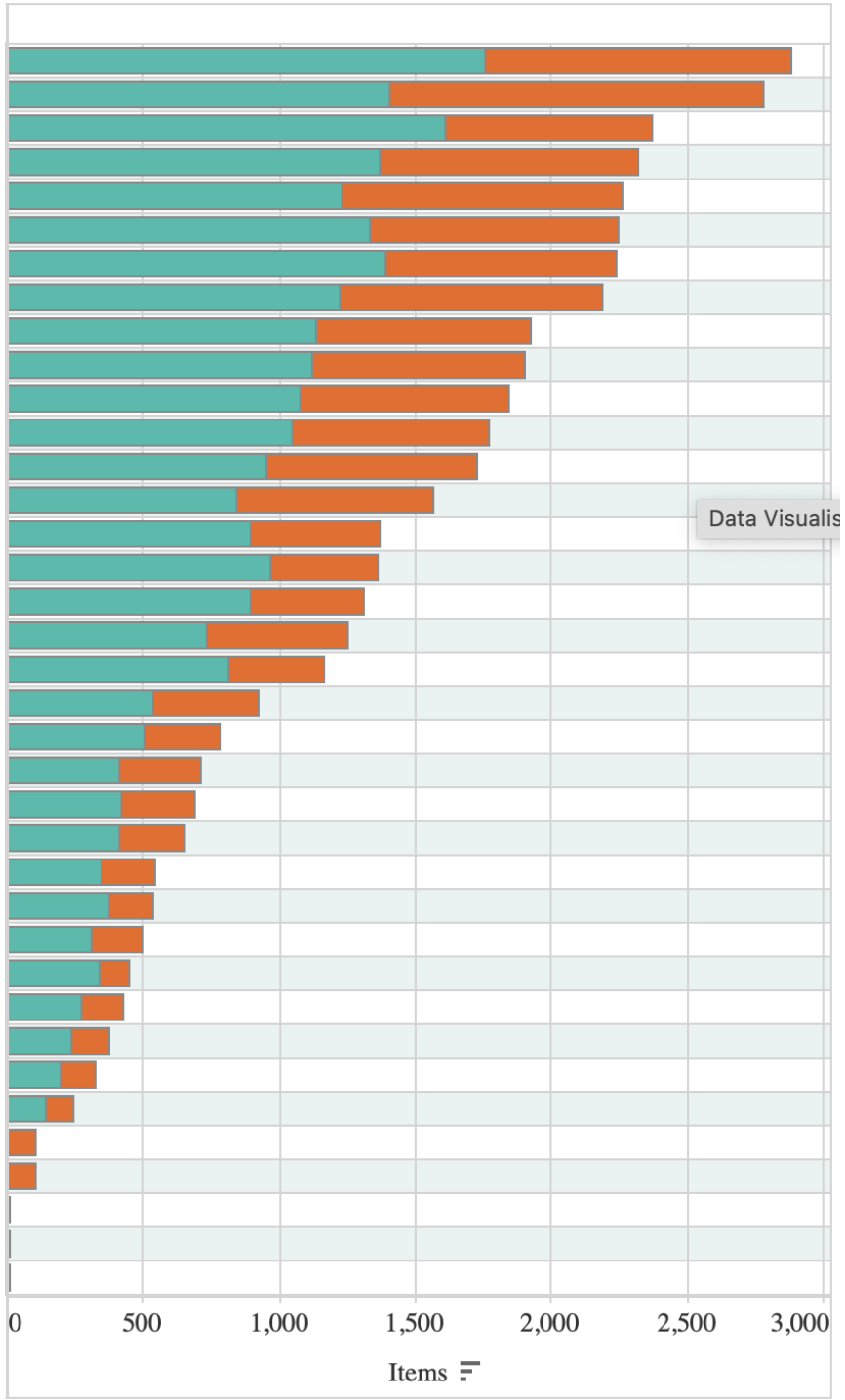


Barnsley 02P, Doncaster 02X, Rotherham 03L &
Sheffield 03N

Variation across Barnsley Practices - same six months



Growth in items across Barnsley practices; variation items per weighted denominator

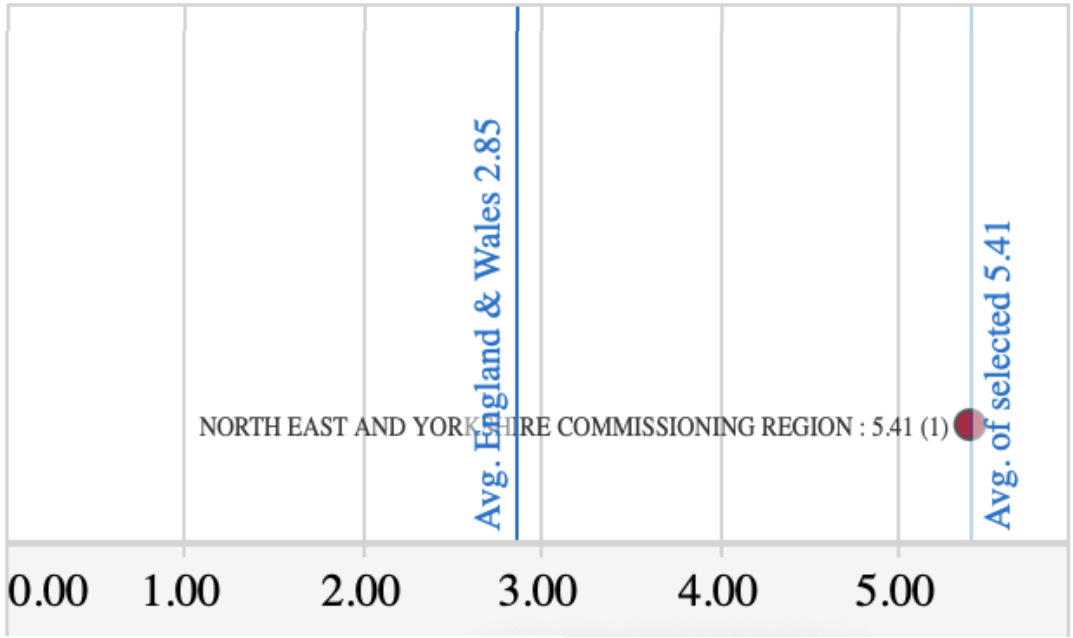


Reducing opioids in chronic pain

(Figures in this briefing represent average latest 3 months data; Nov23-Jan24)

Barnsley position against national @ Jan 24

Chart to show achievement across practices



In your organisation, the items per 1,000 patients for high dose opioids is 5.41
This compares to the England and Wales average of 2.85 per 1,000 patients.

Chart to show the number of patients on a combination of above a 120mg OME daily.

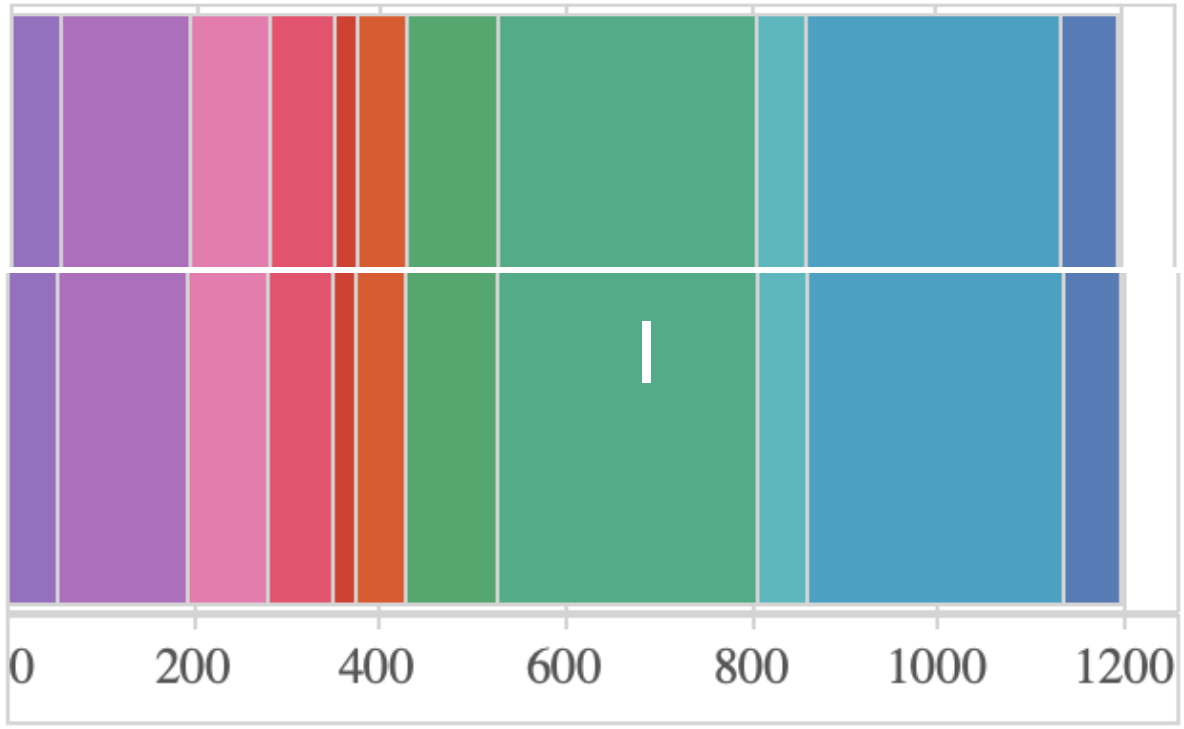
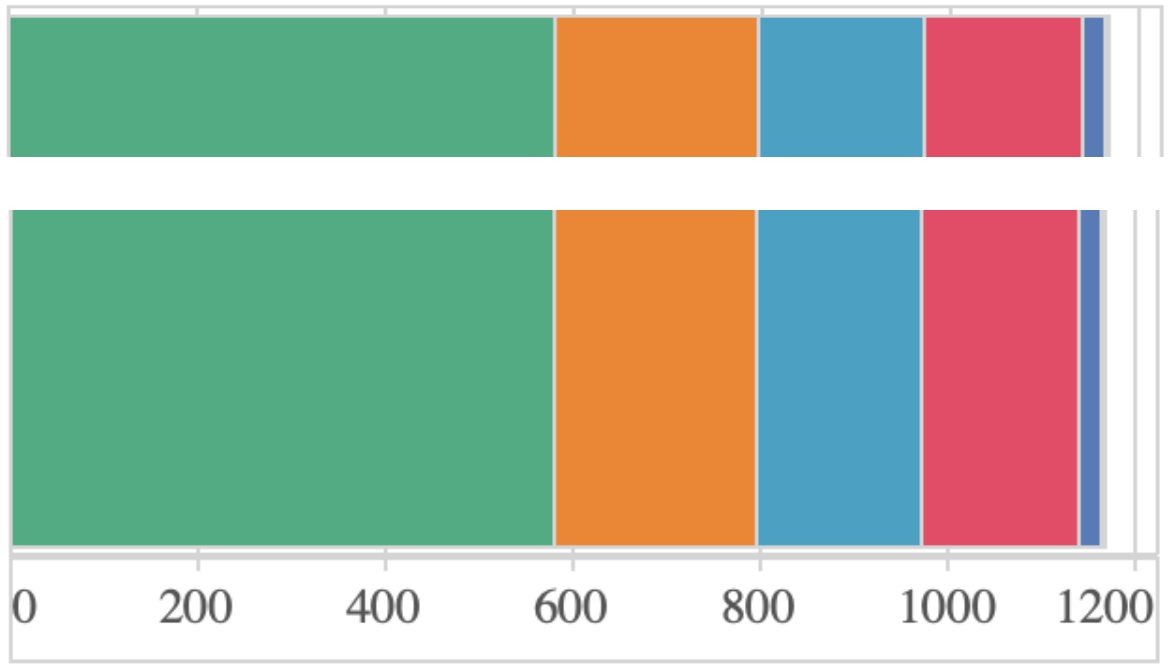


Chart to show the number of patients on high dose opioids above 120mg OME daily by chemical substance.

One individual patient may appear in more than one grouping.



Practice Delivery Agreement Areas 24/25 - workplan

- **High dose opioid review for chronic pain** Review as in previous years - collaborative area for opioid prescribing/national area. Expand to include other opioids inc <120mg/day Oral Morphine Equivalent. Aug – discussed with clinician, 8th Nov 24 monitor progress and 31st Jan 25 completion
- CROP and patient structured medication reviews (part of DES target areas).
- Practice SOP introduced for prescribing of Controlled drugs in practice
- Medication Reviews
- Pain management reviews - Review at least once every 6 months - Patients prescribed >120mg oral morphine equivalent, *excluding EOL*prescribed opioids <120mg/day of oral morphine or equivalent (including morphine sulphate 10mg/5ml oral solution and other liquid opioids) for chronic pain*. Patients who have ordered significant quantities of liquid opioids prioritised for review – small cohort identified.
- **Co-codamol review**

Points to consider before prescribing

Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults

NICE guideline [NG215]Published: 20 April 2022

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

PrescQIPP Bulletin 336 (November 23)

336. Reducing opioid prescribing in chronic pain 2.0 November 2023

Reducing opioid prescribing in chronic pain

This bulletin discusses the processes and resources available to support opioid reduction.

Key recommendations

- In England, Wales, and Northern Ireland - do not initiate opioids to manage chronic primary pain in people aged 16 years and over. In Scotland opioids should be considered for short or medium term treatment of chronic non-cancer pain, if other therapies have been insufficient, and the benefits outweigh the risks of serious harm.
- As there is little evidence that opioids are helpful for long term chronic non-cancer pain, review all opioids prescribed for chronic non-cancer pain. Use a shared decision-making approach to taper and stop the opioid if it is no longer providing useful pain relief or benefit or the risks of adverse effects outweigh the benefits of treatment.
- Prioritise a review for people prescribed high dose opioids above 120mg oral morphine equivalent daily (above 90mg in Scotland), use a shared decision-making approach to reduce and/or stop the opioid. The risk of harm increases substantially at doses above oral morphine equivalent of 120mg per day, and there is no increased benefit.
- Opioid treatment should be reviewed at least six monthly to ensure that the benefits of the medicine continue to outweigh the potential harms and to check whether the dose needs adjusting. Consider tapering the dose at regular intervals e.g. 6-12 monthly, to assess benefit or potential side effects and to minimise risk of harm. Consider increasing the frequency of reviews during dose adjustment.
- During the review, look for any signs that the person is developing problems associated with dependence (see appendix 1 of the bulletin).
- Discuss with the patient non-medicine treatments for chronic pain, such as TENS machine, acupuncture, advice about activity and increasing physical fitness and psychological treatments such as Cognitive Behaviour Therapy, Acceptance and Commitment Therapy (ACT) and meditation techniques such as mindfulness.
- If a person has pain that remains severe despite opioid treatment it means the opioid is not working and should be stopped, even if no other treatment is available.
- When discussing tapering or stopping an opioid explain the benefits the person can expect from reducing the dose and aim to reach an agreement using a shared decision-making approach.
- Suggest a slow, stepwise rate of reduction proportionate to the existing dose, to prevent withdrawal symptoms. The Faculty of Pain Medicine states that the dose of drug can be tapered by 10% weekly or every two weeks. However, the rate of reduction may need to be slower so should be adapted to suit the individual's needs based on how the withdrawal symptoms are tolerated.
- In England, review and implement the five actions listed for Integrated Care Systems to optimise personalised care for adults prescribed medicines associated with dependence and withdrawal symptoms.

Tapering or stopping opioids

Withdrawal symptoms (e.g. sweating, abdominal cramps, and anxiety) occur if an opioid is stopped or the dose is reduced abruptly.[1] The Faculty of Pain Medicine states that the dose of drug can be tapered by 10% weekly or every two weeks.[1] However, the rate of reduction may need to be slower so should be adapted to suit the individual's needs.[2] Patients should be reviewed at least every two weeks when reducing their opioid.

Cost and savings

£224million is spent annually on the prescribing of opioid medication in England, Wales, Isle of Man and Scotland. If reviewing opioid prescribing for chronic non-cancer pain and reducing and/or stopping treatment resulted in a 10% reduction this would lead to savings of **£18.7million in England, £1.2million in Wales, £34,914 in the Isle of Man and £2.5million in Scotland. This equates to £31,195 per 100,000 patients.** Data relates to NHSBSA (May-Jul23) and Public Health Scotland (Feb-Apr23). Additionally inadequate management of side effects 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]

DO

- Review opioid treatment at least six monthly to ensure that the benefits continue to outweigh the potential harms and to check whether the dose needs adjusting.
- During the review, look for any signs of opioid dependence.
- When discussing tapering or stopping an opioid explain the benefits the person can expect from reducing and aim to reach an agreement using a shared decision-making approach.
- Consider tapering the dose at regular intervals e.g. 6-12 monthly, to assess benefit or potential side effects and to minimise risk of harm. Consider increasing the frequency of reviews during dose adjustment.
- Suggest a slow, stepwise rate of reduction proportionate to the existing dose, to prevent withdrawal symptoms. The faculty of pain medicine suggests tapering by 10% weekly or every two weeks. The reduction rate may need to be slower so should be adapted to suit the individual's needs.

Tapering / Dose Reduction Resources

National & Local

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

Local Resources

- **SY Opioid Resource Pack – endorsed by IMOC, on website - lots of links and useful resource e.g.**
- *The Pain Toolkit gives practical advice and techniques to help manage pain. Website: www.paintoolkit.org*
- *Hunter Integrated Pain Service (Australia) An excellent five minute overview of chronic pain. Website: www.youtube.com/watch?v=5KrUL8tOaQs*
- *'Brainman stops his opioids' Website: www.youtube.com/watch?v=MI1myFQPdCE*
- *Another good explanation of how your mood can affect pain. Website: www.tamethebeast.org*
- *Videos about chronic pain and how to manage it Chronic pain: www.healthtalk.org*
- *Chartered Society of Physiotherapy Website: www.csp.org.uk/publications/10-things-you-need-know-about-your-back*
- *A very good video about back pain: https://youtu.be/24P7cTQjsVM · Word Health Organisation (WHO) animated videos Depression and Stress*
- *Apps: Mindfulness: www.headspace.com/headspace-meditation-app Active walking: www.nhs.uk/oneyou/active10/home#xfEeV0FM3W4Xo5gM.97*
- *Mood diary: https://itunes.apple.com/gb/app/wellmind/id918138339?mt=8*
- **Barnsley resource Pack – use for PDA revews , has been circulated to practices ; data collection, clinical audit & information to support reviews** *Opioids in Chronic Pain Practice Guide MOS 2024-25 V1.0 July 2024.docx (sharepoint.com)*

Appendix 1: Indicators that suggest the possibility of dependence[1]

Indicators that suggest the possibility of psychological 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.

Appendix 4: Checklist for agreeing a dose reduction schedule[1,2]

Action	Completed Y/N
Explain the rationale for stopping opioids including the potential benefits and risks of opioid reduction.	
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.	
Discuss balancing the risk of adverse events from continued exposure to the medicine with minimising the risk of withdrawal symptoms by slow dose reduction and withdrawal.	
Discuss symptoms and signs of opioid withdrawal.	
Review and decide if the person may need admission to specialist services for opioid taper/cessation informed by existing opioid dose	
Review any physical and mental health co-morbidities the person may have including significant emotional trauma.	
Suggest a slow, stepwise rate of reduction proportionate to the existing dose, so that decrements become smaller as the dose is lowered.	
Ensure that the planned rate of reduction is acceptable to the person and agree outcomes of opioid tapering.	
Ensure if using a published withdrawal schedule, it is applied flexibly to accommodate the person's preferences, changes to their circumstances and the response to dose reductions.	
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).	
Agree regular intervals for reviewing and adjusting the reduction schedule as needed.	
Consider providing details of sources of peer support, national and local support groups for people who are withdrawing from a medicine.	
Define the role of drug and alcohol services to support dose reduction.	
Consider referring to a specialist if conversion to methadone or buprenorphine is required.	
During withdrawal, offer continued management of the underlying condition for which the medicine was prescribed.	
Agree arrangements for monitoring of pain levels and support required during opioid tapering.	

Ensure close collaboration between the patient, carers and all members of the patient's health care team.	
Ensure the plan for dose reduction or withdrawal is clearly recorded in the overall management plan and document agreement of tapering schedule.	
Ensure the person knows the arrangements for follow-up including agreed prescribing responsibilities and who to contact if problems occur.	

References

1. Faculty of Pain Medicine of the Royal College of Anaesthetists. Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain. https://fpm.ac.uk/opioids-aware
2. NICE. Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults. NICE guideline [NG215]. April 2022. https://www.nice.org.uk/guidance/ng215

Appendix 3 – Summary of NICE Guidance for secondary pain[1-9]

Guidance	Title	Recommendations including opioids
CG150	Headaches in over 12s: diagnosis and management.	• Do not offer opioids for the acute treatment of tension-type headache, for the acute treatment of migraine or for the acute treatment of cluster headache.
NG59	Low back pain and sciatica in over 16s: assessment and management.	• Do not offer opioids for managing chronic sciatica or chronic low back pain. • Do not routinely offer opioids for managing acute low back pain. • 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.
NG100	Rheumatoid arthritis in adults: management.	• No recommendations for opioids.
NG226	Osteoarthritis in over 16s: diagnosis and management.	• Do not routinely offer 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 strong opioids to people to manage osteoarthritis.
NG65	Spondyloarthritis in over 16s: diagnosis and management.	• No recommendations for opioids.
NG73	Endometriosis: diagnosis and management.	• No recommendations for opioids.
CG173	Neuropathic pain in adults: pharmacological management in non-specialist settings.	• Consider tramadol only if acute rescue therapy is needed. • Do not start morphine or tramadol (for long term use) to treat neuropathic pain, unless advised by a specialist to do so.
NG206	Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management.	• No recommendations for opioids. • Refer to CG173 and CG150 for advice on treating neuropathic pain or headaches
NG61	Irritable bowel syndrome in adults: diagnosis and management.	• No recommendations for opioids.

Appendix 2: Opioid equivalence to morphine

Table 1: Approximate equi-analgesic potencies of opioids for oral administration[1,2]

Oral drug	Potency	Equivalent dose to 10mg oral morphine
Codeine	0.1	100mg
Dihydrocodeine	0.1	100mg
Oxycodone	1.5	6.6mg
Tapentadol	0.4	25mg
Tramadol	0.1	100mg

Table 2: Transdermal opioids – approximate equivalence of buprenorphine patches with oral morphine[1,2]

Oral morphine mg/day	12	24	36	48	84	126	168
Transdermal buprenorphine micrograms/hour (mcg/hr) - change every seven days	5mcg/hr	10mcg/hr	15mcg/hr	20mcg/hr			
Transdermal buprenorphine micrograms/hour (mcg/hr) - change twice weekly-apply every 72 hours or 96 hours					35mcg/hr	52mcg/hr	70mcg/hr

Table 3: Transdermal opioids – approximate equivalence of fentanyl patches with oral morphine.[1,2]

Fentanyl patch dose (microgram/hour)	Oral morphine dose (mg/day)
12	30
25	60
37.5	90
50	120
75	180
100	240

Total oral morphine equivalent (OME) dose calculation

An opioid calculator is available from: Oxford University Hospitals opioid calculator.

- Click on 'edit a copy' to download an editable version.
- Add in the opioid dose and frequency in the respective boxes in the table.
- The total OME in mg/day is automatically calculated.

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%.[1]

References

1. Faculty of Pain Medicine of the Royal College of Anaesthetists. Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain. https://fpm.ac.uk/opioids-aware
2. Joint Formulary Committee. British National Formulary (online) London: BMJ Group and Pharmaceutical Press. https://www.medicinescomplete.com/ accessed on 22/03/23.

Gender Dysphoria

* There have been payments for management of GD patients under the Specialist Drugs Scheme since 2019.

* In June 21 the Barnsley CCG agreed an increased rate per patient per annum for management & prescribing for patients with GD – currently £450 and training was offered – SY guidance in place and endocrinology A&G support (thro STH)

* It is a challenge to identify pt numbers; at the end of each financial year ask practices how many patients they are currently managing. Numbers have increased in 24/25 but remain in 35-50 range.

* We are still waiting for 5 practices to respond to 2023/24 request for numbers – keep going out at intervals, 3 of these practices have historically prescribed/managed

* System searches have been developed for use in 2024/25 but require verification checking by practices.

Feedback & Questions

Anything else MO can support with?