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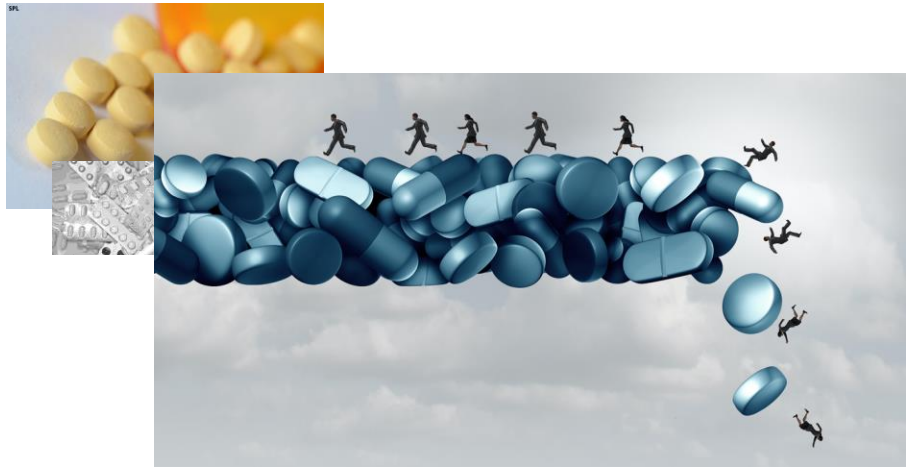
Lancashire and South Cumbria
Integrated Care Board

Bitesize Education and Training Session 6

Deprescribing of Opioids

21st May 2024



Speaker:

- Nilofer Patel, Senior PCN Pharmacist
- Samiya Islam, PCN Pharmacist
- Saleha Issa, PCN Pharmacist

Blackburn with Darwen PCN

Welcome & Housekeeping

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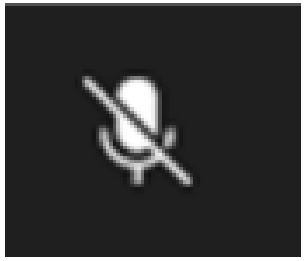
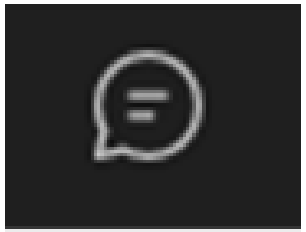
Thank you for joining us today!

- ✓ The session is for 30-minutes (20-minute presentation and 10-minute Q&A session).
- ✓ Please switch off your cameras and put yourselves on mute.
- ✓ Please use the chat function if you want to ask a question or for comments.
- ✓ Please respect others' views and opinions. (We have prescribers from across the system on the call – primary, secondary care and community).
- ✓ Please use the chat function to network with your peers and share ideas.
- ✓ At the end of the session there is a short feedback questionnaire – the link to access this will be put into the chat.





Please note the 20-minute presentation will be recorded, and the slides and the recording will be uploaded to the LSC Training Hub website for you to download.

After the session

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After the session (approx. 12.30pm) Stephen Doherty, will be joining us to talk about the DPP role and the support those in Practices / PCNs could provide to trainee Pharmacists in community settings during the IP placement.

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Deprescribing of Opioids

Blackburn East PCN Pharmacists

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Background

- A Danish cross-sectional study has suggested that when comparing opioid users with non-opioid users, opioid use appears to be associated with poorer self-related quality of life and employment status, increased healthcare use, and worse pain. (Faculty of Pain, 2024).

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Background

One of the aims of the DES contract is to complete structured medication reviews on patients using potentially addictive pain medication.

Higher than recommended doses (above 120mg morphine equivalent) increases the risk of harm and mortality with no increased benefit in pain relief (Faculty of Pain, 2024).

The position statement from LCSMMG states opioid doses should not exceed 80mg morphine equivalent unless recommended by a pain Specialist (LCSMMG, 2024).

Long term use is linked to tolerance and increased pain sensitivity.

Side effects: endocrine abnormalities and immunomodulating effects as well as increasing risk of falls.

Polypharmacy: Patients are more likely to take medication to counteract side effects.

Opportunities

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- If the pain remains severe despite use of opioids (especially doses above 80mg equivalent morphine) this means the treatment is not working and the opioid should be tapered and stopped.
- If the patient develops side effects.
- If the patient receives a pain-relieving intervention (for example, an operation).
- Multiple opioids.

Change in culture

Variation across practices. But key processes need to be in place for success.

Discussions via Practice meeting/ Partners/ GPs/nurses/NMPs/PAs. Regular check ins.

All clinicians need to be on board with the process.

All admin team need to be aware of procedures involving ordering and reviews. Add Alerts/Pop ups to patient records if they are on the reducing regime.

Letter

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Important information regarding your medication

Following the NHS England initiative to reduce inappropriate prescribing of high-strength painkillers and other addiction-causing medicines, we are getting in touch to arrange a review of your analgesia medication.

This is due to the following reasons;
1.The practice policy of adhering to safe prescribing according to the national guidelines.
2.The length of time you have been on this medication.
3.The highly addictive nature of this medication.
4.The long-term side effects and complications they can have on your health.

Recent medical 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, they are not very good at treating pain at all, when taken for more than a few months.

Our records show that you are being prescribed opioids for pain, equivalent to 120mgs of morphine, or more, per day for over the recommended prescribing time.

Your prescription is:

Matrifen 50micrograms/hour transdermal patches (Teva UK Ltd)	**Apply One Patch Every 72 Hours As Directed. Remove Old Patch Before Applying New Patch**
Oramorph 10mg/5ml oral solution (Glenwood GmbH)	5ml Four times a day when required

We would like to discuss this medication and dose with you, with the view to reducing the medication as per guidelines and to discuss alternative ways to manage your pain.

Please could you call 01254, to book an appointment with one of the Medicine Management Team members. We will work together towards a safer treatment plan.

This is the new action plan going forward by the NHS to make your medication safer for you. This is taking place nationally by all GP practices.

If we do not hear from you within the next four weeks, the medication reducing regime will commence and you will start to see a slow reduction in your dose or quantity of medication.

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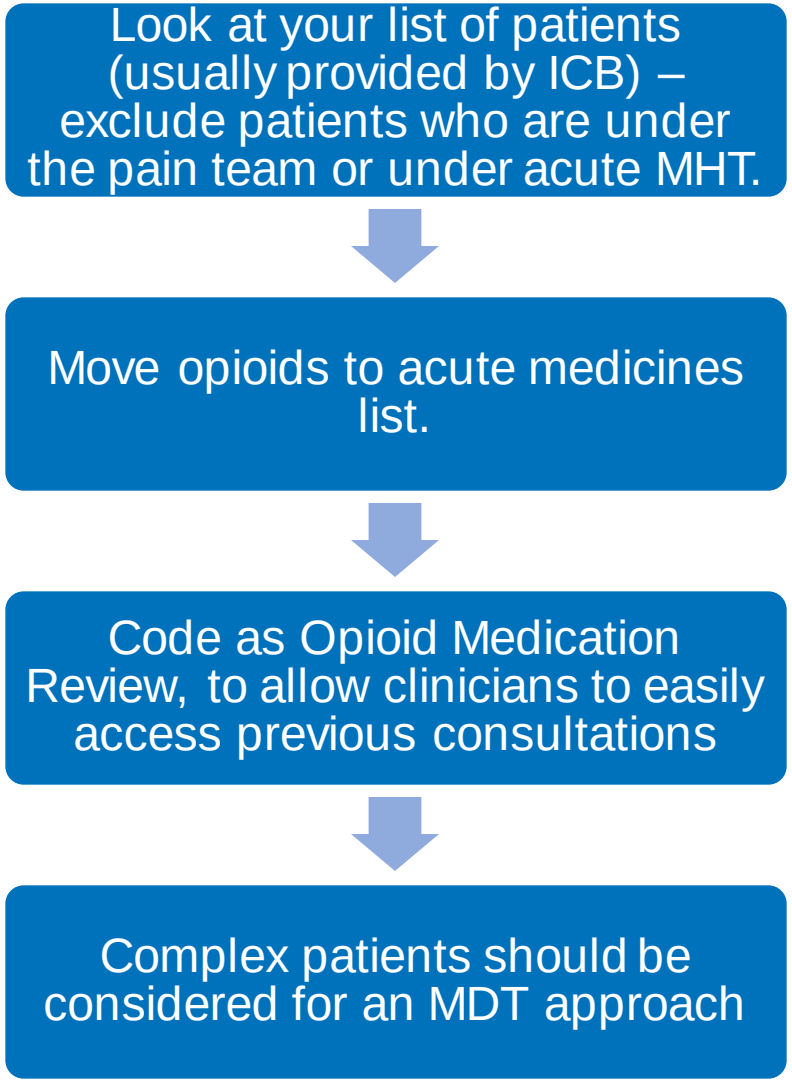
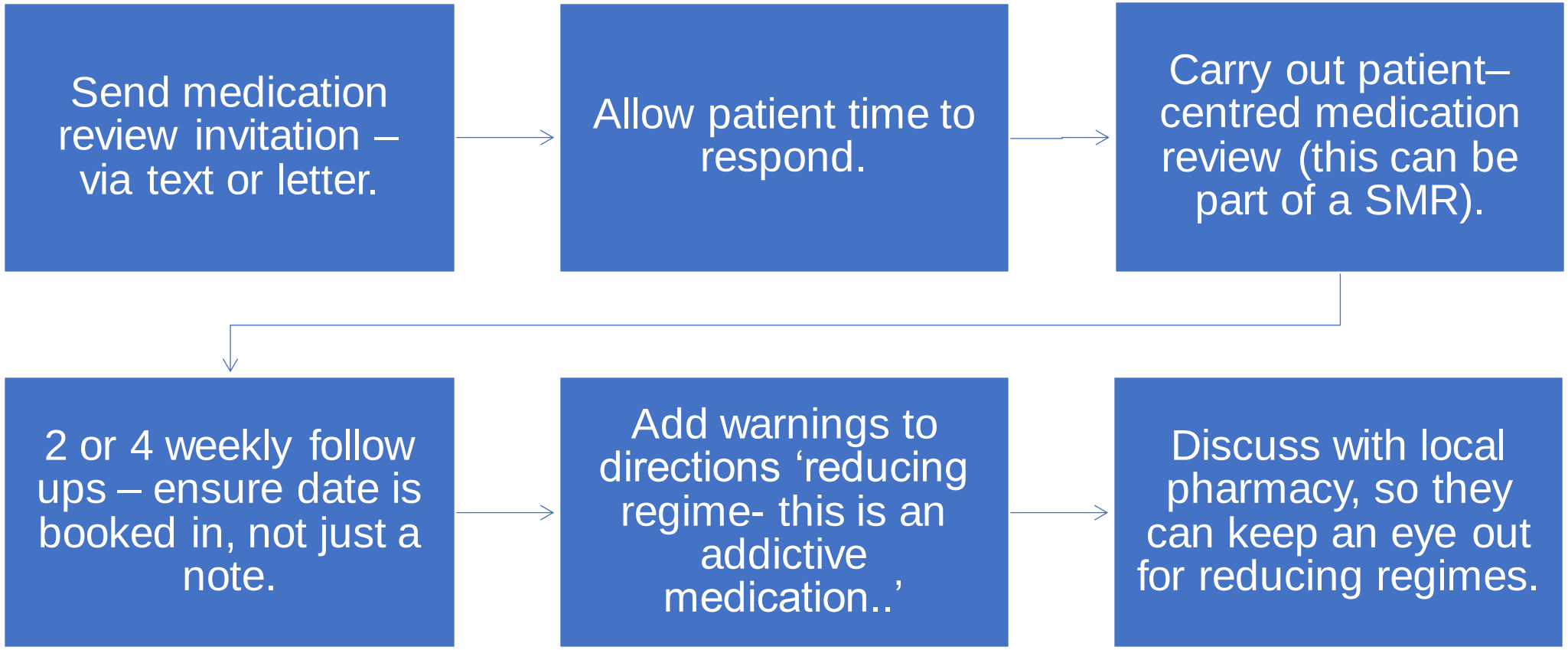
Process



Example


Send medication review invitation – via text or letter.
Allow patient time to respond.
Carry out patient–centred medication review (this can be part of a SMR).
2 or 4 weekly follow ups – ensure date is booked in, not just a note.
Add warnings to directions ‘reducing regime- this is an addictive medication..’
Discuss with local pharmacy, so they can keep an eye out for reducing regimes.

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Consultation

- Explain guidance, evidence, risks associated.
- Listen to the patient, acknowledge the pain
- Show empathy and listen actively.
- Discuss the complexity of chronic pain, look out for emotional influences on their experience of pain
- Talk about tolerance – ‘you may have noticed that it is not as effective as it used to be’.
- Make them reflect on their life and use this information to personalise the consultation
- Individualised plan. Allow pauses in reduction if appropriate.
- Stay on top of it- call when you say you will call. Be flexible with your availability.
- Agree a clear and robust plan.

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Reduction Plan

ICB advise maximum reduction of 10% 2 weekly – Individualised

Agree plan with patient, this may be a slower reduction of 5% every 4 weeks

When is the pain worse? if in the day, offer reduction on night dose

Success is more likely if the patient is on board and in agreement

Regular follow ups booked in the diary to review how the patient is getting on

Pause – do not increase.

Example of An Opioid Reduction Table

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Information about reducing your opioid treatment				
As we have discussed, we plan to start reducing your opioid treatment. Your dose will be reduced gradually over a number of weeks.				
Your name			Mr Joe Bloggs	
Your GPs name			Dr Who	
The change being made to your treatment			Gradually reducing your opioid treatment	
When do I need a review?			A telephone review will be needed every 4 weeks	
	Your 14 day prescription	Your daily dose (mg)	How you take your medication	
Your current dose	28 x 100mg m/r Tabs 28 x 30mg m/r Tabs	260	Morning	Evening
			1 x 100mg m/r Tab 1 x 30mg m/r Tab	1 x 100mg m/r Tab 1 x 30mg m/r Tab

Example

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	Your 14 day prescription	Your daily dose (mg)	How you take your medication			
			Morning		Evening	
Week 1-2	28 x 100mg m/r Tabs 14 x 30mg m/r Tabs 14 x 15mg m/r Tabs 14 x 10mg m/r Tabs	255	1 x 100mg m/r Tab 1 x 15mg m/r Tab 1 x 10mg m/r Tab	125mg	1 x 100mg m/r Tab 1 x 30mg m/r Tab	130mg
Week 3-4	28 x 100mg m/r Tabs 28 x 15mg m/r Tabs 28 x 10mg m/r Tabs	250	1 x 100mg m/r Tab 1 x 15mg m/r Tab 1 x 10mg m/r Tab	125mg	1 x 100mg m/r Tab 1 x 15mg m/r Tab 1 x 10mg m/r Tab	125mg
Week 5-6 –	28 x 100mg m/r Tabs 14 x 15mg m/r Tabs 42 x 10mg m/r Tabs	245	1 x 100mg m/r Tab 2 x 10mg m/r Tab	120mg	1 x 100mg m/r Tab 1 x 15mg m/r Tab 1 x 10mg m/r Tab	125mg
Week 7-8	28 x 100mg m/r Tabs 56 x 10mg m/r Tabs	240	1 x 100mg m/r Tab 2 x 10mg m/r Tab	120mg	1 x 100mg m/r Tab 2 x 10mg m/r Tab	120mg
Week 9-10	28 x 100mg m/r Tabs 14 x 15mg m/r Tabs 28 x 10mg m/r Tabs	235	1 x 100mg m/r Tab 1 x 15mg m/r Tab	115mg	1 x 100mg m/r Tab 2 x 10mg m/r Tab	120mg

Scenario

Example 1

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- Pt on multiple opioids:

  Buprenorphine 10mcg patch and tramadol 50mg twice a day
- Previous consultations states patient has been reluctant to reduce opioids.
- Upon investigation tramadol was only to be issued as an acute supply. However, it has been issued every month for 3 years.
- Patients on multiple opioid regimes- firstly discuss the concerns around safety of prescribing multiple opioids; secondly allow the patient to be given the opportunity to choose which opioid they would like to reduce; this discussion enables them to feel a part of the decision-making process which has proven to be a successful approach.
- In this case, after counselling, the patient chose to reduce and stop the tramadol.

Example 2

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- Pt on Fentanyl 75mcg/hr patches.
- Took a full history before speaking to the patient.
- Has raised concerns with the patch falling off due to excess sweating. Numerous early request and OOH request for fentanyl.
- MDT- Consultation with Pharmacist, GP and patient was recommended.
- Upon a detailed discussion there were clear signs of tolerance, poor outcomes with fentanyl, dip in patient's mental health plus issues with the patch falling off.
- Discussed pros and cons of switching.
- Decision was made to switch opioid
- Switching requires extreme caution and additional support may be needed from the wider MDT
- After a discussion around the link between mental health and how pain is felt, patient agreed to a referral to our mental health practitioner.
- Patient was switched to oral M/R preparation of oxycodone.
- 75mcg fentanyl = 180mg oral morphine / 1.5 = 120mg oxycodone.
- 75% = 90mg.
- Patient was successfully switched from fentanyl 75mcg/equivalent180mg morphine to oxycodone 90mg per day/equivalent 136mg.

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Successes

- Acknowledge pain.
- Face to face appointments where possible (especially the initial consultation).
- Build rapport and actively listen – let them be involved with their care.
- Time – double appointments if needed.
- Good explanation and terminology.
- Aim is to improve quality of life and safety of patient– not pain free.

Challenges

When GPs are not on board.

Non-engagement with services such as physiotherapy or mental health teams as they may be holding out for the next operation or drug which they believe will be the magic cure for their pain.

Not sticking to the plan or reducing too quickly.

Backlash from patient/family.

Patients asking what can be offered as an alternative.

Patient response : ‘I’m fine and it still works!’ Or ‘Why was I prescribed such a high dose if it wasn’t safe?’

Multiple medications – GPs starting second opioid or Gabapentinoid (better to replace the opioid that is no longer working).

Patients ordering early – especially if these request are sent to locum GPs.

Switching formulation for reduction e.g. Patches to oral – do this under MDT

Phrases

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The medication is working fine, I don't have any side effects:	• If on high doses- explain they didn't start on this dose, explain tolerance • Lower doses (co-codamol) if you want this medication to continue to be effective, and prevent tolerance, do not take regularly.
Why did the GP put me on this dose/medication if its unsafe	• Guidelines updated, more studies more evidence on the implications of chronic use.
What can you give me instead	• Be aware of services in the area, social prescribers, mental health practitioner etc, topical NSAIDs.

Phrases

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I don't what you touching my meds	• Reassure Make it clear you will be there every step of the way and reductions do not need to be made during the first consultation, concentrate on building a rapport. • Good terminology around the risks • If on more than ONE pain relief medication, offer them a choice. • Slow reductions.
I'm just in too much pain, how can you reduce it?	• Explain hyperalgesia with chronic opioid use
Family involvement- if you reduce, he isn't going to sleep, I'm going to have to deal with him	• It's about finding a balance, where your pain is well managed, but at the safest possible dose. • Explain risk of increased dependence with chronic opioid use • Future planning- if you are carrying on with this dose, it will cause problems in the future, likely more dependence.

Consequences of Opioid Reductions

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- Practices with successful opioid reductions usually found an increase in the prescribing of gabapentinoids and sometimes other drugs including benzodiazepines, z drugs, and amitriptyline.
  - Safer prescribing can be promoted by reviewing their initial opioids prior to initiating a gabapentinoid.
  - If opioid is providing little or reduced benefit, a trial period can take place where one dose of the opioids is replaced by one dose of a gabapentinoid.
  - This enables the patient to judge whether there is a clear benefit from the gabapentinoid, and potentially aid a reduction in opioid use.
- Increased workload
  - Utilise the whole team- once a reduction plan has been agreed, can pharmacy technicians support with follow up?
  - Review as part of SMRs, this year 4x SMRs for high-risk patients.
  - Change in culture, this is not a 'piece' of work to be done once; review systems to promote safer prescribing from the first opioid prescription eg, review dates added to the directions.

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Resources

- Opioids Aware - Faculty of Pain. Opioids Aware | Faculty of Pain Medicine (fpm.ac.uk)
- PrescQipp (Reducing opioid prescribing and Dependence forming medication) PrescQIPP C.I.C.
- ICB resource pack Chronic Pain Patient Resources: Managing Opioid Medication - Lancashire and South Cumbria Medicines Management Group (lancsmmg.nhs.uk)
- NICE NG 193 Recommendations | Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain | Guidance | NICE

Thank you for listening

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Please complete our short feedback questionnaire by clicking on the link that has been put into the chat.

Please note: all feedback will be anonymous

Next session: 18th June 2024
Part 1: Paramedic Independent Prescribers: Roles and responsibilities in Primary Care
Speaker: Helen Beaumont-Waters, Head of Clinical Development for Primary Care and Urgent Care at College of Paramedics

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Question and Answer

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