Health and Social Care Board

Directorate of Integrated Care
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To: Trust Chief Executives
Trust Medical Directors
Trust Heads of Pharmacy

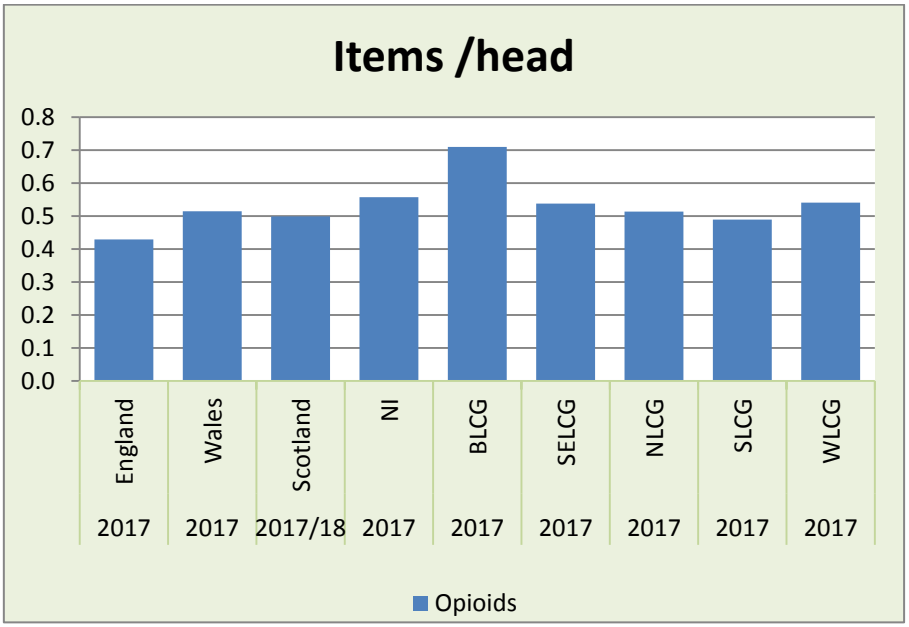
20th September 2018

Dear Colleague

OPIOID PRESCRIBING

I firstly wish to thank you for all the work undertaken to date in supporting HSCB in promoting the safe and effective prescribing of medicines including strong opioids.

The prescription of strong opioids is highest in NI compared to other UK countries:



HSCB is taking a number of actions to address the issues and potential risks associated with strong opioid prescribing. As part of this, we would like to engage with secondary care colleagues to ensure consistency of

appropriate prescribing of strong opioids across primary and secondary care.

In particular I wish to draw your attention to the following key points:

- Morphine remains the first line choice of strong opioid across N.Ireland – see HSCB letter (appendix 1) and NI Formulary guidance here.
- Prescribing of other opioids, and in particular oxycodone should be by exception.
- The maximum daily dose of oral morphine for non-palliative patients should not exceed 120mg https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware.
- HSCB Implementation support tool has recently been updated to reflect The Royal College of Anaesthetists, Faculty of Pain Medicine advice that **'the risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day but there is no increased benefit'[1]:** http://niformulary.hscni.net/Formulary/Adult/PDF/Opioids_in_Chronic_Pain.pdf.

I would therefore ask that you:

- Review all prescribing protocols to ensure recommendations, both inpatient and discharge, are consistent with both the HSC "Morphine first" policy and the recommendations from the Royal College of Anaesthetists contained in Opioids Aware[1] that the maximum daily dose of oral morphine for non-palliative patients should not exceed 120mg.
- Review discharge policies and procedures to ensure clear information is provided both to GPs and patients regarding the continued use of analgesia e.g. timeframe for GP to review the patient, likely duration of analgesia required.

Communication has also been issued to colleagues in Primary Care and may be viewed at http://www.hscboard.hscni.net/our-work/integrated-care/pharmacy-and-medicines-management/correspondence-pharmacy-medicines-management/.

Your help in supporting this important work is greatly appreciated.

[1] Royal College of Anaesthetists - Faculty of Pain Management: Opioids Aware Resources https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware

Yours sincerely,

Joe Brogan
Assistant Director of Integrated Care
Head of Pharmacy and Medicines Management

Enc. Appendix 1- “Morphine First”:

Health and Social Care Board

Public Health Agency

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LONDONDERRY
BT47 6FN

Tel : 02895 361010
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Web Site : www.hscboard.hscni.net

To: see distribution list
for onward cascade to relevant staff

Our Ref: ICPL/2016/013

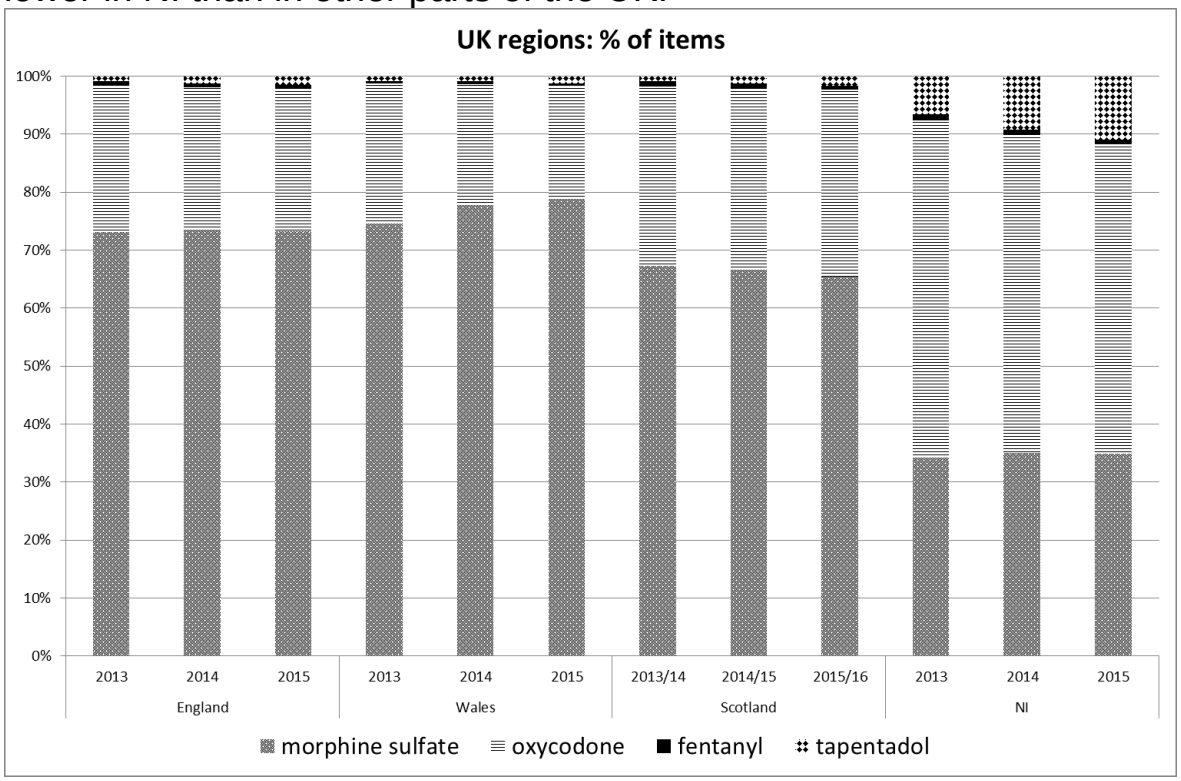
Date: 8th December 2016

Dear Colleague

"Morphine First": Sustained Release Morphine – First Line Choice of Strong Opioid in Primary and Secondary Care

NICE guidance on Opioids in Palliative Care and HSC guidance on Opioid Prescribing in Non-Malignant Pain (developed with the regional expert group on pain management) recommend that **modified release morphine** is the first line **strong** opioid for maintenance of pain control.

When compared with other parts of the UK, it is evident that the prescription of morphine as a proportion of all strong opioids is much lower in NI than in other parts of the UK:



The purpose of this letter is to:

- Highlight the current differences in prescribing use in NI
- Remind healthcare professionals involved in the selection of strong opioids, of the stepwise approach to prescribing:

    1. Oral sustained-release morphine should be used in preference to other oral strong opioids e.g. oxycodone, in all appropriate circumstances;

    2. If pain remains uncontrolled despite optimised first-line therapy, or if there is significant renal or hepatic impairment, review your analgesic strategy and consider seeking specialist advice;

    3. Opioid patches should not be offered as first-line maintenance therapy to patients. However, if oral opioids are unsuitable, and analgesic requirements are not changing rapidly, a transdermal opioid may be appropriate, supported by specialist advice where needed. In keeping with previously issued guidance, some patients on lower strength buprenorphine patches (5, 10, 15 or 20 mcg / hour for a period of 7 days) could progress to the higher strength buprenorphine patch (35, 52.5 or 70 mcg / hour over a period of 4 days) as their strong opioid. Please see the attached flowchart for detail.

Although immediate-release opioids can be used as rescue medication for breakthrough pain in palliative care, in non-malignant chronic pain patients should be encouraged not to use immediate-release opioids where possible.

Action Requested

HSC Trusts

- Please ensure sustained release morphine is prescribed as the first line choice of strong opioid whenever appropriate.

RQIA

- Please disseminate this letter to all relevant independent sector providers.

NIMDTA

- Please disseminate this letter to doctors in training in relevant specialties.

Primary care prescribers have also been reminded of these issues. The support of secondary care in prescribing in line with the guidance will

help provide a consistent message and treatment plan for patients across the HSC.

Thank you for your help in this matter.

Yours sincerely

Mr Joe Brogan
Assistant Director of Integrated Care
Head of Pharmacy & Medicines Management

Dr Carolyn Harper
Medical Director/ Director of Public Health

Implementation Support Tool for Opioid Prescribing in Chronic Pain

(for Non-Malignant and Non-Inflammatory Pain in Non-Specialist Settings)

Health and Social Care Board

Notes:

- Chronic non-malignant pain by definition is present when the reported pain is present for greater than 3 months.
- Short acting opioids ***may*** have a role in the management of pain in the initial period ***only*** (e.g. within the first 6 weeks). Thereafter only modified release preparations should be considered.
- There is no place for the use of immediate release strong opioids in maintenance treatment of chronic non-malignant pain.
- There may be a neuropathic element to the pain and treatment with opioid analgesics should be considered alongside the neuropathic pain agents e.g. amitriptyline, gabapentin etc.
- If strong opioid analgesic medication is to be considered in the management of chronic non-malignant pain then before treatment is commenced, patients should agree specific goals which will be considered as evidence of the effectiveness of treatment e.g.
  - ⇩ Sleep disturbance
  - ⇧ Function

  These targets should be achieved if treatment is to be continued in the long term.
  Patients should also be assessed for: depression, alcohol abuse and addictive traits prior to treatment and specialist input sought where appropriate.
- If pain relief is not achieved or pre-agreed functional goals are not met, dose titration can cease and the opioid stopped in an agreed stepwise reduction.
- Patients must be made aware of all the potential side-effects of long term opioid therapy.
- Physical therapies must be used in the management of chronic pain.
- The psychological aspects of pain must not be overlooked in the management of chronic pain. Coping strategies can be found within:
  - www.paintoolkit.org

Reference: Opioids for persistent pain: Good practice (2010) A consensus statement prepared on behalf of the British Pain Society, the Faculty of Pain Medicine of the Royal College of Anaesthetists, the Royal College of General Practitioners and the Faculty of Addictions, Royal College of Psychiatrists. January 2010.

Therapeutic Pathway

Paracetamol 500mg

↓

Co-Codamol
8/500mg or 15/500mg or 30/500mg
+/-
NSAID

for up to 6 weeks

If pain not resolved in 6 weeks ⇨
Modified Release preparations

Tramadol MR
+/- NSAID/Paracetamol

50mg BD
⇩
100mg BD
⇩
200mg BD

Titrate to lowest effective dose that achieves agreed goals of treatment.

Buprenorphine
patch as a sole agent.

5mcg/hr
⇩
10mcg/hr ⇩ 15mcg/hr ⇩ 20mcg/hr
35mcg/hr ⇩ 52.5mcg/hr ⇩ 70mcg/hr

Titrate to lowest effective dose that achieves agreed goals of treatment.

Morphine MR
or
Fentanyl (patch)

Dose titration to maximum upper limit between
120 -160mg morphine equivalent.

↓

If a patient does not respond or has unusually high opioid requirements consider investigations / imaging or referral to a specialist pain centre.

Morphine Equivalence: A guide to morphine equivalences and conversion between oral and transdermal preparations can be found in the summary GAIN Guidelines.

References:

1. Palliative care for adults: strong opioids for pain relief
   NICE guidelines [CG140] Published date: May 2012 last updated: August 2016
   https://www.nice.org.uk/guidance/cg140?unlid=510255509201685 19259 <12/9/16>

2. Northern Ireland guidelines on converting doses of opioid analgesics for adult
   http://primarycare.hscni.net/pdf/HSCB_Opioid_Equivalence_Tables_2014.pdf <12/9/16>

3. Implementation Support Tool for Opioid Prescribing in Chronic Pain (for Non-Malignant and Non-Inflammatory Pain in Non-Specialist Settings)
   http://niformulary.hscni.net/Formulary/Adult/PDF/Opioids%20_in_Chronic_Pain.pdf <12/9/16>

4. Pain Toolkit Booklet (for patients)
   http://www.paintoolkit.org/downloads/Pain_Toolkit_patient_booklet_copy_Short_Versions.pdf <12/9/16>

5. Cost effective choice list for Northern Ireland September 2016
   http://niformulary.hscni.net/PrescribingNewsletters/CEC/CECSep16/Pages/default.aspx <12/9/16>

HSC Health and Social Care Board

HSC Public Health Agency

RE: Morphine First Letter, December 2016 – Distribution List

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs	✓		CEX		✓
Medical Director		✓	Medical Director/Director of Public Health		✓
Directors of Nursing		✓	Director of Nursing/AHPs		✓
Directors of Social Services		✓	PHA Duty Room		
Governance Leads		✓	AD Health Protection		
Directors of Acute Services		✓	AD Service Development/Screening		✓
Directors of Community/Elderly Services		✓	AD Health Improvement		
Heads of Pharmacy		✓	AD Nursing		✓
Allied Health Professional Leads			AD Allied Health Professionals		
NIAS			Clinical Director Safety Forum		✓
CEX			**HSCB**		
Medical Director			CEX		✓
RQIA			Director of Integrated Care		✓
CEX	✓		Director of Social Services		
Medical Director		✓	Director of Commissioning		
Director of Nursing		✓	Alerts Office		✓
Director for Social Care			Dir PMSI & Corporate Services		
NIMDTA			**Primary Care (through Integrated Care)**		
CEX / PG Dean	✓		GPs		
QUB			Community Pharmacists		
Dean of Medical School		✓	Dentists		
Head of Nursing School		✓	**Open University**		
Head of Social Work School			Head of Nursing Branch		✓
Head of Pharmacy School		✓	**DHSSPS**		
Head of Dentistry School			CMO office		
UU			CNO office		
Head of Nursing School		✓	CPO office		
Head of Social Work School			CSSO office		
Head of Pharmacy School		✓	CDO office		
Head of School of Health Sciences (AHP Lead)			Safety, Quality & Standards Office		
Clinical Education Centre		✓	**NI Social Care Council**		
NIPEC		✓	**Safeguarding Board NI**		
GAIN Office		✓	**NICE Implementation Facilitator**		✓
NICPLD		✓	**Coroners Service for Northern Ireland**		