Primary Care Guidelines for the Management

Of Chronic Non-Cancer Pain in Adults

Important Update Sept 2022

This Bedford and Luton JPC approved guideline should now be read in conjunction with the BLMK Interim Chronic Non Cancer pain guidelines (for adults) and NICE NG 193, noting that the following pages and sections of this guideline are now to be DISGARDED:-

- ***Pages 4 (Assessment and Early Treatment of chronic Pain in Primary Care)***
- ***Page 9 and 10 (Pharmacological Treatment Pathway for Chronic Non-Neuropathic Pain)***
- ***Page 38 (Current Locally Commissioned Pain Services)***

Original document

Revised and approved by the JPC September 2018

Updated in April 2019 for use by: Bedfordshire Clinical Commissioning Group and Luton Clinical Commissioning Group

Introduction

The management of chronic pain is a major clinical challenge. It affects just under 28 million adults in the UK. Pain can often co-occur with emotional and mental health difficulties and be associated with anxiety and depression.

Medicines play only a minor part in managing persistent pain and therefore patients should be signposted to self-management strategies and non-pharmacological treatment options and encouraged to use them.

There have been safety concerns highlighted at a national level about the use of strong analgesics such as opioids and gabapentinoids (pregabalin and gabapentin) to manage chronic non-cancer pain. See the Office for National Statistics (ONS) bulletin Deaths related to drug poisoning in England and Wales, 2016 for further details.

Nevertheless, there has been a marked and progressive rise in the prescribing of opioid medicines over the past decade and this trend continues to increase. The Opioids Aware resource provides a helpful summary of the evidence considering the effectiveness of opioids for long-term pain. It concludes that:

- There is little evidence that opioids are helpful for chronic non-cancer 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 use is intermittent, but it is difficult to identify these people at the start of treatment.
- Opioids should be discontinued if the person is still in pain despite using opioids, even if no other treatment is available.

This guideline is applicable for patients within the areas commissioned by Bedfordshire CCG only.

Scope and aim of guideline

For use by primary care practitioners for the management of adult patients with chronic non-cancer pain.

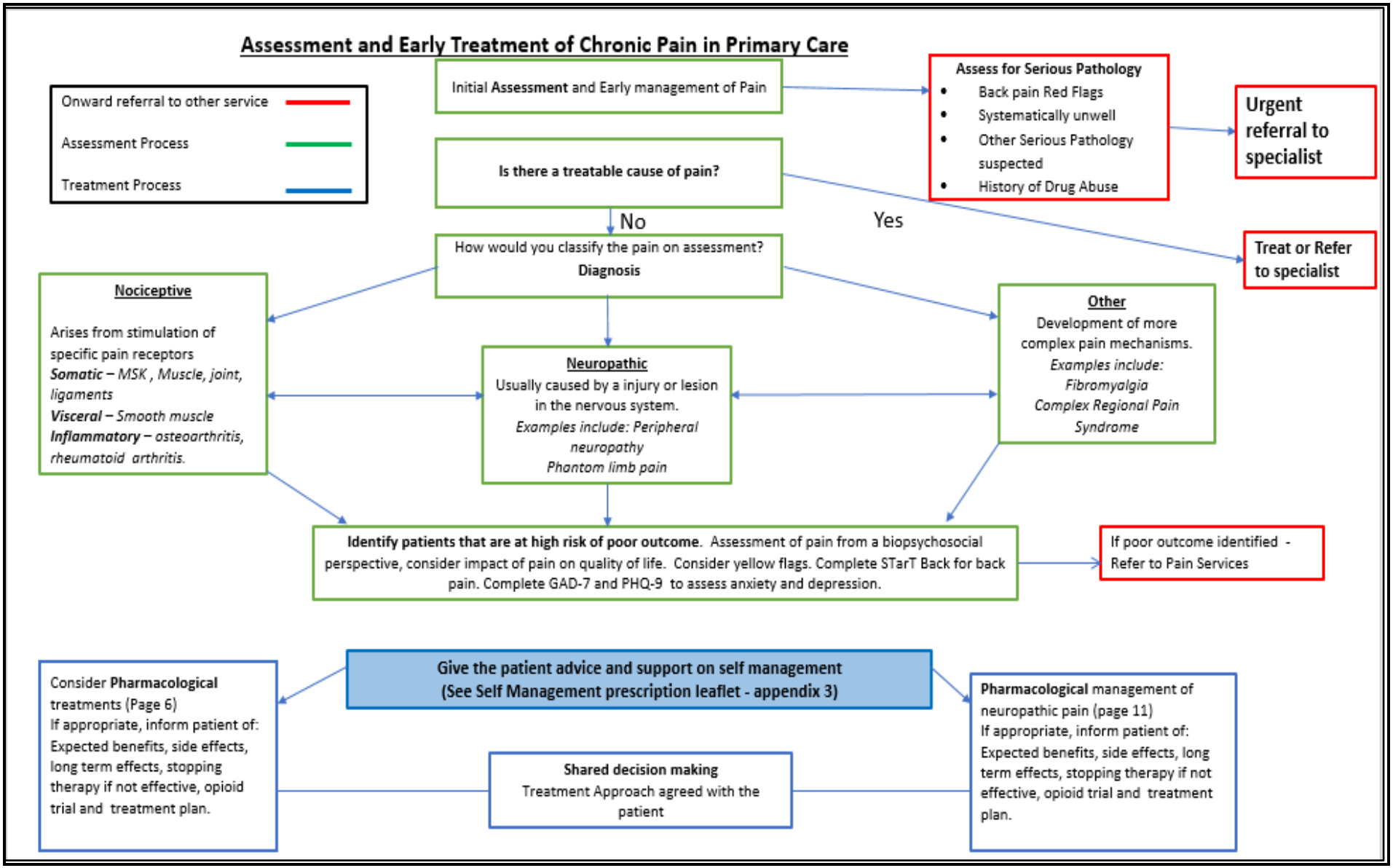
The principal aim of this Pain Management Guideline is to enable people with chronic pain to achieve as normal a life as possible by reducing physical disability and emotional distress.

1 Promote non-pharmacological treatment options to include:

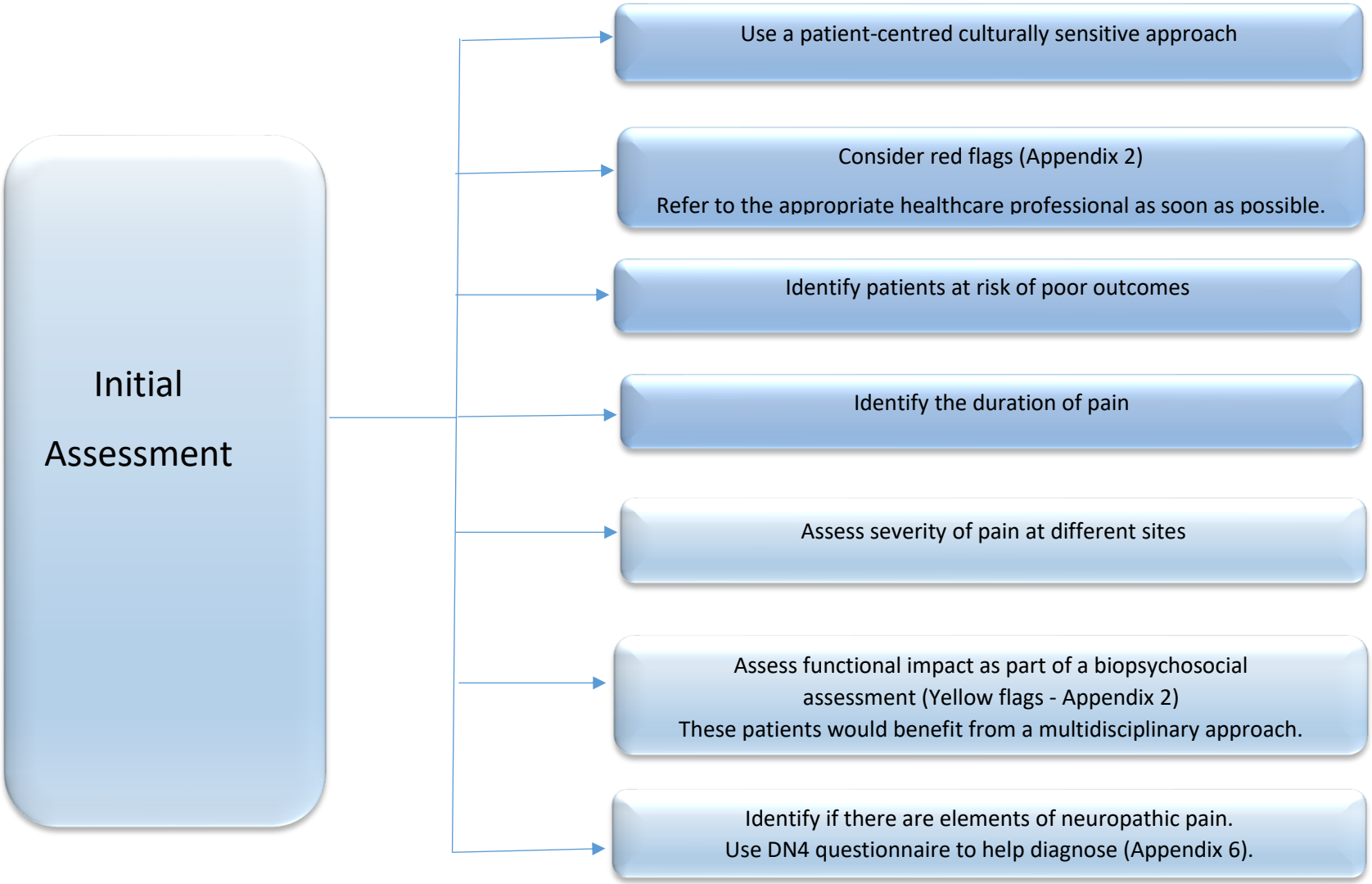
- Self-management
- Psychological approaches
- Physical activities and therapies

2 Pharmacological options - there should be:

- Regular reviews with planned re-assessment of ongoing efficacy and side effects. Treatment should only be continued if benefits outweigh risks, and limited to the shortest possible duration.
- De-prescribe treatment when no longer effective.


Assessment and Early Treatment of Chronic Pain in Primary Care
Onward referral to other service
Assessment Process
Treatment Process
Initial Assessment and Early management of Pain
Assess for Serious Pathology
Back pain Red Flags
Systematically unwell
Other Serious Pathology suspected
History of Drug Abuse
Urgent referral to specialist
Is there a treatable cause of pain?
No
Yes
Treat or Refer to specialist
How would you classify the pain on assessment?
Diagnosis
Nociceptive
Arises from stimulation of specific pain receptors
Somatic – MSK , Muscle, joint, ligaments
Visceral – Smooth muscle
Inflammatory – osteoarthritis, rheumatoid arthritis.
Neuropathic
Usually caused by a injury or lesion in the nervous system.
Examples include: Peripheral neuropathy
Phantom limb pain
Other
Development of more complex pain mechanisms.
Examples include:
Fibromyalgia
Complex Regional Pain Syndrome
Identify patients that are at high risk of poor outcome. Assessment of pain from a biopsychosocial perspective, consider impact of pain on quality of life. Consider yellow flags. Complete STarT Back for back pain. Complete GAD-7 and PHQ-9 to assess anxiety and depression.
If poor outcome identified - Refer to Pain Services
Give the patient advice and support on self management
(See Self Management prescription leaflet - appendix 3)
Consider Pharmacological treatments (Page 6)
If appropriate, inform patient of: Expected benefits, side effects, long term effects, stopping therapy if not effective, opioid trial and treatment plan.
Shared decision making
Treatment Approach agreed with the patient
Pharmacological management of neuropathic pain (page 11)
If appropriate, inform patient of: Expected benefits, side effects, long term effects, stopping therapy if not effective, opioid trial and treatment plan.

Patient Initial Assessment



Non-Pharmacological treatment options

- Supported self-management is a recognised intervention for chronic pain. It does not seek to cure, but it helps patients manage their condition and minimise the impact the pain has on their everyday life. (Appendix 4 – Pain Self-Management Prescription).

- It is important to explain to patients that it is normal for pain to affect mood and vice-versa, and that relaxation, mindfulness and valued activity can help reduce distress. This must be provided in a supportive manner.

- Develop patients' understanding of chronic pain, how it differs from acute pain and the impact this may have on goals of therapy. Difficult and honest conversations may be required to establish an understanding with the patient that it is highly unlikely that the therapeutic management plan will result in full resolution of their pain symptoms, but it may assist them with coping. There is no cure for chronic pain.

- The use of passive coping strategies (i.e. patient accepts/allows what others do without active response) has been found to be associated with higher rates of disability.

- For patients with chronic or recurrent pain not adequately managed in primary care referral can be made to community pain services or into the secondary care, Integrated Pain Service (IPS). Other non-pharmaceutical methods can be considered before referral to secondary care:

All these services may not be commissioned in your locality, please refer to your Local Commissioning Guide.

Service	Description
Back Essential Skills Training (BeST) for lower back pain	Best utilised earlier on in the patient pathway. A psychologically informed group based programme that improves physical activity and function through education, and training in important self-management skills like pacing and goal setting.
Pain Management Programme (PMP)	Multidisciplinary pain management team assess all patients for suitability into the programme.
Cognitive Behavioural Therapy	This can be done in a group or on an individual basis. Treatment of choice for people with persistent pain adversely affecting their quality of life and where there is significant impact on physical, psychological and social function.
Acceptance and Commitment therapy (ACT) with mindfulness	Designed to enhance the patient's openness and willingness to experience undesirable feelings, and to increase awareness of judgmental, evaluative and analytic thought content. The overall process that is the focus of this method is called "psychological flexibility".

Pharmacological Management for the Treatment of Chronic Non-Neuropathic Pain

This guidance should be used in conjunction with local and/or national guidance on the assessment and treatment of pain (e.g. British Pain Society guidance/NICE Guidance). It is expected that prescribers will utilise ScriptSwitch® messages to inform product choice.

Refer to the eBNF and/or SPC to inform dosing and prescribing decisions for individual patients (taking into account contraindications, dose adjustments, renal and hepatic function and adverse effects of pharmacological treatment).

The Faculty of Pain Medicine advises against the use of the WHO ladder in the treatment of chronic non-cancer pain as this pain has an unpredictable course, may continue for many years and does not always follow the WHO ladder pathway.

A small proportion of people may obtain good pain relief with opioids in the long term if the dose can be kept low and use is intermittent, but it is difficult to identify these people at the start of treatment.

The risk of harm increases substantially at doses above an oral morphine equivalent dose (MED) of 120mg/day, but there is no increased benefit.

Opioids should be discontinued if the person is still in pain despite using opioids, even if no other treatment is available.

Consider the following points before prescribing:

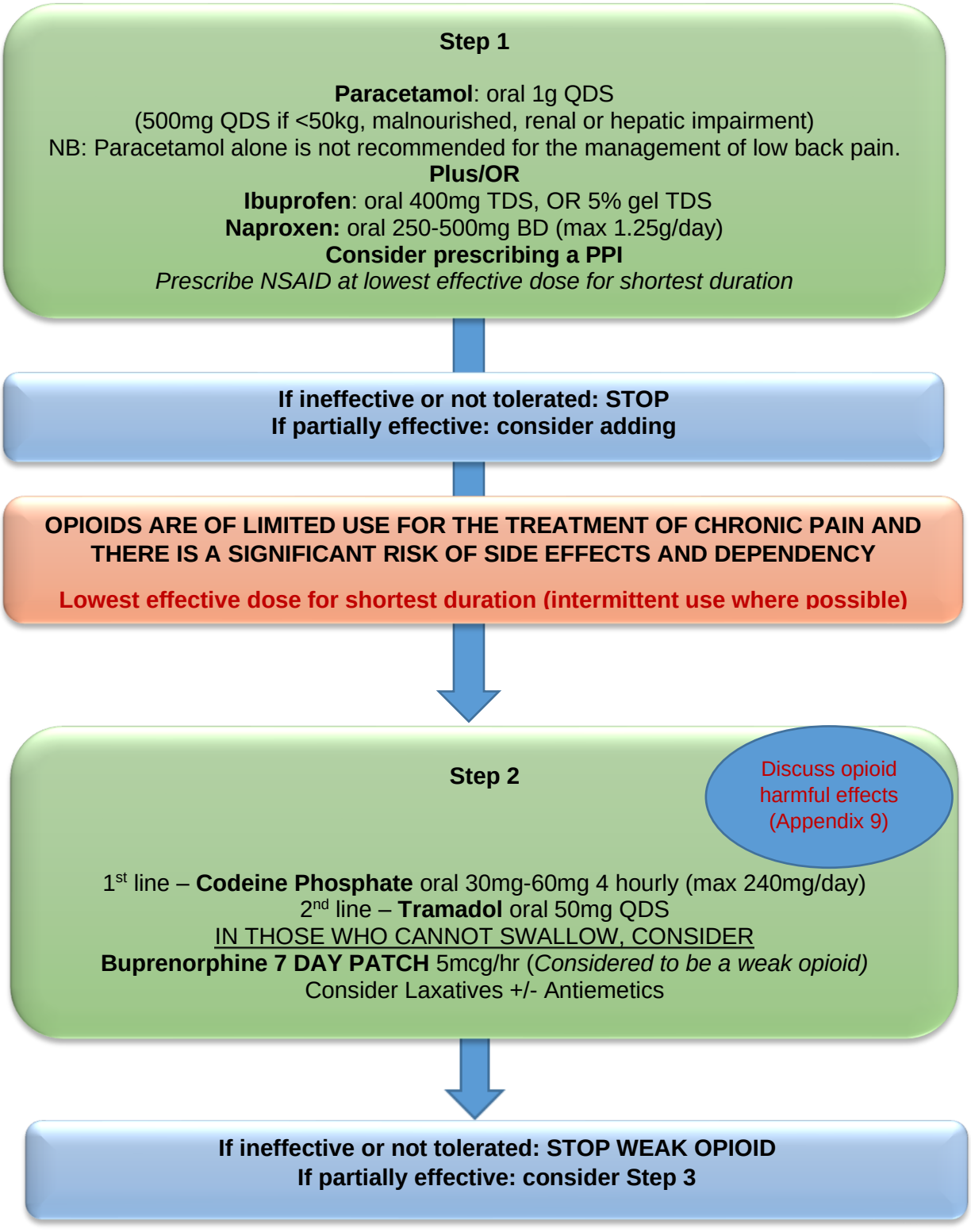
Points to consider	Explanation
Manage patient expectations	Complete pain relief is rarely achieved and is not a treatment goal. Only 30-50% pain relief may be obtained.
Signpost to self-management strategies	Optimise lifestyle factors such as fitness, weight control, carry on with normal activities and to lead a healthy lifestyle.
Type of pain	Poorly defined pain of uncertain aetiology – **less likely** to respond to opioid therapy. Clearly defined pain with known aetiology – **may** respond to opioids in a small proportion of people in the long term if the dose can be kept low and use is intermittent.
Risk-benefit analysis	Include family and social factors. Discuss and agree on a clearly defined treatment plan with treatment reviews (using patient daily diary – Appendix 12) including discontinuation of therapy.
Patient opioid treatment agreement (Appendix 8)	Could be either agreed verbally or signed and saved in patient's PMR.
Plan 1-2 week opioid trial	To establish whether the patient achieves a reduction in pain. Opioid treatment should only be continued if there is significant improvement (30-50% reduction in pain).
Treatment reviews	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
Avoid immediate release opioid formulations	Avoid the use of regular immediate release opioid medicines for breakthrough pain in chronic non-cancer pain, as they may increase the risk of dependency. They may be prescribed for emergency flare ups, but their use is discouraged otherwise.

Patients with a history of substance misuse

- Substance misuse includes misuse of illegal drugs (e.g. heroin), legal drugs (e.g. alcohol), over-the-counter medicines and prescription medicines (e.g. benzodiazepines).
- A comprehensive assessment of both pain and addiction is essential for their treatment management.
- These patients have greater than usual pain management needs.
- Opioids may be prescribed for pain relief if considered the most appropriate therapy, as part of a multidisciplinary treatment plan in this patient group.
- At the initial consultation, use The Opioid Risk Tool (Appendix 7)
- Therapy should be closely monitored jointly by primary care practitioner and substance-misuse management professionals (contact their key worker).

Pharmacological Treatment Pathway for Chronic Non-Neuropathic Pain

- Ensure non-pharmacological strategies have been adequately implemented when considering pharmacological treatment.
- Treatment in older people (65+) may need to be modified due to risks in this cohort of patients (Appendix 1).
- Low back pain: https://www.nice.org.uk/guidance/ng59
- Osteoarthritis: https://www.nice.org.uk/guidance/CG177



OPIOIDS ARE OF LIMITED USE FOR THE TREATMENT OF CHRONIC PAIN AND THERE IS A SIGNIFICANT RISK OF SIDE EFFECTS AND DEPENDENCY

Lowest effective dose for shortest duration (intermittent use where possible)

Step 3

Consider Strong Opioid Trial (see page 11)

Assess risk for long term opioid treatment: History of mental illness, substance abuse, concurrent benzodiazepine use and overdose.

Low risk:

Manage patient in primary care

High risk:
DO NOT INITIATE PRESCRIPTION
Refer patient to chronic pain service
OR seek specialist advice

Successful opioid trial:

- Convert to modified release (MR) (Appendix 10) and reduce morphine daily dose by 25% - 50%.
- Monitor: symptoms, activity, mood, sleep, side effects (Appendix 9)
- Once dose and symptoms are stable, review patient every 3-6 months
- Consider tapering down dose at reviews.

Unsuccessful opioid trial:

- Trial ineffective or not tolerated, taper down and discontinue opioid over ONE WEEK. Even if no other treatment is available.
- Consider referral to chronic pain service.

1st line - Morphine MR
OR
Tramadol 100mg QDS

Risk of harm >benefits at doses over 120mg MED

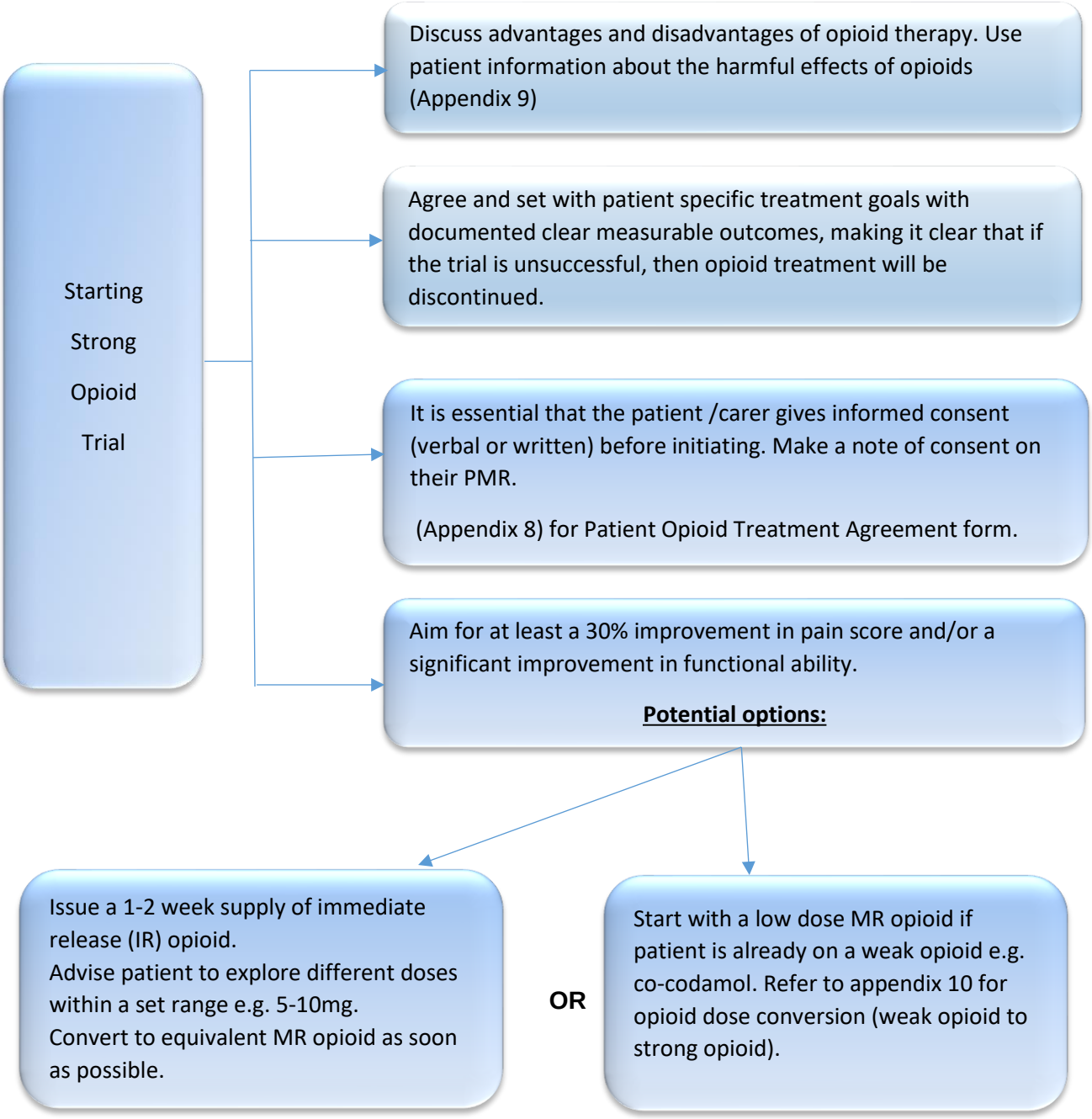
2nd line – Oxycodone MR
(Only initiate if Morphine is contraindicated or not tolerated)
OR
IN THOSE WHO CANNOT SWALLOW, CONSIDER

Buprenorphine 7 DAY PATCH 5mcg/hour

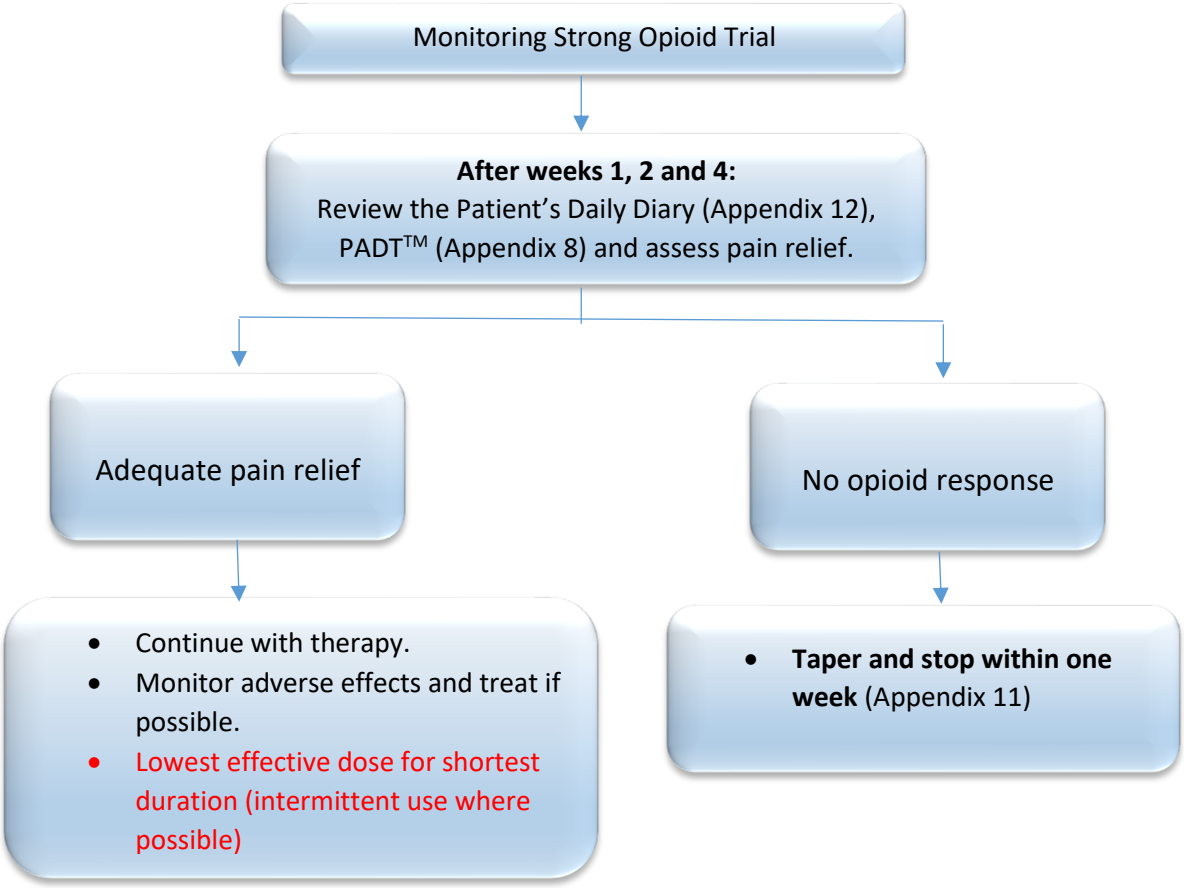
Strong Opioid Trial

The aim of the trial is to establish if the patient will achieve any reduction in pain with strong opioids. For patients who suffer intermittent disabling flare ups of pain on a background of more manageable pain, the trial should be long enough to observe the effect of 2-3 pain flare ups.

All stages of the opioid trial should be documented and a copy given to the patient.



Review



Documentation

- All stages of the opioid trial should be clearly documented and if appropriate, a copy of the agreed aims of therapy and how these may be monitored should be given to the patient.
- Include the agreed starting dose and formulation of drug and details of planned dose escalation.
- If the opioid trial demonstrates that the medicines are unhelpful, the reasons for this (lack of efficacy/intolerable adverse effects) should also be clearly documented. For example, no reduction in pain severity.
- If the patient reports a reduction in pain but at the cost of side effects that preclude achievement of functional goals, it is reasonable to explore different dosing regimens with active management of side effects to see if a useful balance between benefits and harms can be achieved.
- **If the patient reports no improvement in pain symptoms following the trial it is very unlikely that long-term opioid therapy will be helpful. Consider no opioids.**

On-going treatment review

- **Review opioids monthly for the first 3 months, then 3 monthly until patient's regimen is stable.**
- Subsequent reviews will depend on the early effectiveness of treatment, the frequency of side effects, the timing of additional interventions to control pain (e.g. surgery) and the presence of concerns in relation to problematic use of opioids.
- When a regimen is stable and the patient reports substantial relief of pain symptoms and where additional concerns do not dictate otherwise, opioid treatment should be reviewed at least every 6 months.
- Always consider weaning, stepping down or stopping opioids at every review.

Examples of when to refer to a chronic pain service

- Patients with persistent pain unresponsive to conventional treatment.
- Difficulty in tapering or modifying patient's medication.
- Patients who require opioid doses of ≥120mg morphine equivalent dose/day.

For current locally commissioned pain services, please refer to Appendix 13.

Pharmacological Treatment Pathway for the Management of Chronic Neuropathic Pain

[Modified with kind permission from West Hertfordshire Joint Prescribing Group - Neuropathic Pain Management.]

Interventions may not completely resolve the pain, but may reduce it. Consider the following:

- Wear loose clothing or cotton fabrics, as these will usually cause the least irritation.
- Consider frequent application of cold packs (unless allodynia is triggered by cold).
- Symptoms can resolve after a few months, or may persist for longer.

Week 0

Start with *either* amitriptyline *or* gabapentin*.

The choice will depend on co-morbidities such as cardiac disease and on the risk of side effects to the individual patient.

- Amitriptyline 10mg at night. If pain does not settle, increase the dose by 10mg doses at night every seven days up to a maximum of 75mg at night.

OR

- Gabapentin 300mg capsules (start at 100mg in elderly).
  Day ONE = 1 cap OD, Day TWO = 1 cap BD, and Day THREE = 1 cap TDS.
  If tolerated, increase the total daily dose by one capsule (300mg) every two to three days until the pain settles. Maximum dose 3,600mg in 24 hours

Week 6

If no response or if not tolerated: Try the alternative to the drug started

Partial response: Try amitriptyline plus gabapentin in combination.

Week 12

No response — try pregabalin* or duloxetine

(If gabapentin effective, but not tolerated, try pregabalin)

- Pregabalin capsules — start at 150mg per day (lower dose may be effective).
- Based on individual patient response and tolerability, the dose may be increased to 300mg per day after 3 to 7 days, and if needed, to a maximum of 600mg per day after a further week.

For those with **diabetic neuropathy**, consider duloxetine as 1st line treatment.
The starting and recommended maintenance dose is 60mg daily.
Up to a maximum of 60mg every 12 hours.

After Week 12

Inadequate response — refer patient to pain specialist.

Remember to list all previous medications tested

If diversion with gabapentinoids is an issue – use an alternative medicine.

Trigeminal Neuralgia

Offer carbamazepine as initial treatment for trigeminal neuralgia.

Also consider the following:

- Refer to the treatment pathway for the management of chronic non-cancer pain.
- Paracetamol as baseline analgesia.
- Tramadol only if **acute rescue therapy** is required while patient is waiting for specialist assessment – **maximum 4 weeks duration**.
- Discuss and issue patient Pain Self-Management Prescription (Appendix 4)
- Psychological interventions e.g. cognitive behavioural therapy.
- TENS machine
- Physiotherapy

Patients with localised pain:

Consider Capsaicin 0.075% cream for people with localised neuropathic pain. Capsaicin cream is licensed for post-herpetic neuralgia after the lesions have healed and for painful diabetic peripheral polyneuropathy.

The recommended duration of use in the first instance is 8 weeks, since there is no clinical trial evidence of efficacy for treatment of more than 8 weeks duration. After this time, it is recommended that the patient's condition should be fully clinically assessed prior to continuation of treatment, and regularly re-evaluated thereafter.

Information on Lidocaine 5% medicated plasters

Lidocaine medicated plasters are included in the NHS England document published in July 2017: Items which should not be routinely prescribed in primary care: Guidance for CCGs. Link: https://www.england.nhs.uk/wp-content/uploads/2017/11/items-which-should-not-be-routinely-precscribed-in-pc-ccg-guidance.pdf

The evidence for the effectiveness of lidocaine medicated plasters is limited, of low quality, and the clinical effectiveness remains unclear. However, low quality individual studies indicate that it may have a role in pain relief.

The INITIATION of Lidocaine medicated plasters must be restricted to specialist care for patients with post-herpetic neuralgia.

Response to treatment should be evaluated after 4 weeks of treatment.

Patients with an inadequate initial response after 4 weeks, (improvement after this time is unlikely) – **DISCONTINUE** treatment.

The therapeutic benefit should be reassessed regularly at least every three months**.**

Chronic Neuropathic Pain Treatment Withdrawal

If the treatment is well tolerated, continue titrating the dose upwards until either pain is well controlled or the maximum tolerated dose has been reached and maintained for a minimum recommended period of time. Then a dose reduction or withdrawal of treatment should be attempted.

Proposed withdrawal regimens as follows:

Medicine	**Proposed regimen**
Amitriptyline	Reduce daily dose by 10mg each week
Gabapentin (total daily dose > 900mg)	Reduce total daily dose by 300mg every 4 days
Gabapentin (total daily dose ≤ 900mg)	Reduce total daily dose by 100mg every 4 days
Pregabalin	Reduce total daily dose by 50mg every 4 days
Duloxetine	Reduce daily dose by 30mg each week, following a week of 30mg daily, take 30mg on alternate days for 1 week and then stop

If complete withdrawal of treatment is not successful, patient should continue on the last dose in the reduction regimen at which pain was tolerable and they should be engaged in discussions about long term goals and non-pharmacological management. Dose reduction or withdrawal should be reattempted twice a year.

Acknowledgements:

This guideline incorporates some of the content from Brighton and Hove CCG Chronic Non-Malignant Pain prescribing Guidelines (Non-Neuropathic & Neuropathic) with permission.

Many thanks to the members of the working group who have inputted to and commented on these guidelines. We would like to acknowledge the input of Bernadette Sebastian, Kelly Warfield, Sarah Thody, Jacqueline Clayton, Melanie Whittick, Indreet Anand, Divyang Shah, Dr Chirag Bakhai, Dr John Fsadni, Dr Jenny Wilson and Dr Simon Lowe.

We welcome any comments on the guidelines. Contact details: Bernadette Sebastian, c/o Suite 2. Capability House, Wrest Park, Silsoe, Bedfordshire. MK45 4HR. Email: Bernadette.sebastian@nhs.net or the Medicines Management team email: bedccg.bedsmeds@nhs.net Tel: 01525624375 or 01525624390.

These guidelines are based on the best available evidence but their application can always be modified by professional judgement.

References:

- NICE KTT21: Medicines optimisation in long-term pain. Published: 16 January 2017 https://www.nice.org.uk/advice/ktt21
- The British Pain Society - https://www.britishpainsociety.org/
- Opioid Risk Tool, Lynn Webster MD https://www.paintoolkit.org/
- Living with chronic pain http://painconcern.org.uk/
- SIGN 136 • Management of chronic pain https://www.sign.ac.uk/assets/sign136.pdf
- Neuropathic pain in adults: pharmacological management in non-specialist settings. NICE CG173 https://www.nice.org.uk/guidance/cg173
- Pain Rating Scale in multiple languages, The British Pain Society https://www.britishpainsociety.org/british-pain-society-publications/pain-scales-in-multiple-languages/
- Neuropathic Pain Scale. Development and preliminary validation of a pain measure specific to neuropathic pain: The Neuropathic Pain Scale, by B. S. Galer and M. P. Jensen, 1997, Neurology, 48, pp. 332-338.
- BNF 74 September 2017 – March 2018
- Pregabalin in Neuropathic Pain, PrescQIPP Bulletin 119, January 2016 https://www.prescqipp.info/newsfeed/bulletin-119-launched-neuropathic-pain

Opioids:

- Opioids Aware - A resource for patients and healthcare professionals developed by The Faculty of Pain Medicine of the Royal College of Anaesthetists to support prescribing of opioid medicines for pain.
- Management of Non-Neuropathic pain, PrescQipp bulletin 149, January 2019.
- Prescribed opioids in primary care: cross-sectional and longitudinal analyses of influence of patient and practice characteristics. BMJ Open, Vol 6, Issue 5. https://bmjopen.bmj.com/content/6/5/e010276
- Opioid Risk Tool, Lynn Webster MD.
- Opioids for Persistent Pain: Information for patients https://www.britishpainsociety.org/static/uploads/resources/files/book_opioid_patient.pdf
- Faculty of Pain medicine. Information for Patients. About Pain, Thinking About Opioid Treatment for Pain and Taking Opioids for Pain https://www.rcoa.ac.uk/node/21133
- Public Health England. Advice for prescribers on the risk of the misuse of pregabalin and gabapentin https://www.gov.uk/government/publications/pregabalin-and-gabapentin-advice-for-prescribers-on-the-risk-of-misuse

Appendix 1: Pain Management in Older People (65+)

Key Issues

Managing chronic pain in an older person may be very challenging for healthcare professionals. Pain in this cohort may become part of the ageing process. It may not be completely removed by treatment. The aim for many being to minimise pain to a level which maintains an acceptable quality of life.

The pain management process will take time and need frequent reviews until adequate maintenance is achieved.

Challenges to pain management

- Changes in pharmacokinetics and metabolism in the elderly make them vulnerable to side effects and overdosing associated with analgesic agents.
- Elderly patients may have depression and / or dementia which may make the detection and assessment of pain difficult.
- Communication problems such as loss of hearing and speech.
- The presence of multiple medical problems associated with ageing contributes to under-treatment of pain in this population.
- Attitudes and beliefs in coping with pain may result in denial of pain when asked.

Impact of under-treatment

Untreated and under-treated pain can have a major impact on physical and psychosocial function resulting in; depression, agitation, social withdrawal, increased falls, loss of appetite, aggression and sleeplessness. This is particularly significant in dementia patients when untreated pain can be interpreted as a progression of the dementia.

Assessment of pain

- The Abbey Pain Scale is a nationally recognised tool for pain assessments. (See appendix 1A).

In the care home environment staff need to be aware of how to identify and monitor pain.

‘FIRST – ONE’

Some general principles should be applied to prescribing analgesics for older people assuming the clinical factors causing the pain have been identified

F	**Formulation.** Effective analgesia requires good compliance and where issues such as swallowing difficulties or lack of cognitive understanding prevent compliance then alternative formulations or alternative routes should be used
I	**Individual monitoring.** Effective monitoring involves not only measuring pain relief and adverse effects but also functional status and quality of life. Dose adjustments and regimens should aim to improve efficacy and minimise adverse events.
R	**Regular dosing.** For continuous pain “prn” dosing is treating the breakthrough of the pain rather than keeping the pain controlled. Educate the patient or carer of the need to comply with the correct regimen.
S	**Start low - go slow.** A low initial dose, followed by slow titration to maximum response with managed side effects.
T	**Timing** of medication to optimise appropriate response. Severe episodic pain requires a rapid onset of action and short duration. Continuous pain requires regular analgesia with longer duration where possible such as modified-release.
ONE	**ONE** drug at a time. Maximise the effect and review the response before introducing another analgesic. Allow sufficient time intervals between introducing the drug to allow assessment of effects.

Deciding when to prescribe a Buprenorphine patch*

Absorption is initially slow, onset of side effects are delayed and slow to resolve if withdrawn.

Absorption is affected by heat which can have significant effect on bedbound patients.

Buprenorphine Patches are appropriate in the following:

- For patients where there is a high risk of confusion with self-administered doses and consequently a high risk of overdose.
- Difficulty / inability to swallow oral formulations.
- Predictable opioid sensitive pain in dementia patients who refuse oral medication and require sustained analgesia over an extended period. If deemed to lack capacity to understand pain management, a best interest decision will be needed.
- Poor absorption from the GI tract (short bowel / inflammatory bowel disease).
- Persistent excessive side effects from oral opioids due to peaks in plasma concentrations.

***N.B. The use of Fentanyl patches is not supported.**

Elderly Pain Medications - Considerations before Prescribing

Not all drugs included in the Treatment Pathway for Chronic Non – Cancer Pain are suitable for use in older people.

The table below contains information for consideration, it is not exhaustive and the corresponding SPCs should be consulted for further information.

Analgesic **STEP 1**	**Dose in the elderly**	**Recommendation**	**Risks**	**Comments**
Paracetamol 1st LINE	Recommended dose 2 x 500mg four times a day (MAX 4g in 24 hours) If patient weighs <50Kg reduce to maximum 2g/24 hours	Should be used as regular dose for management of chronic pain. Used in addition to other non-paracetamol medications if needed	Increasing concern regarding hepatic effects of prolonged use of maximum recommended doses.	When the patient is unable to swallow tablets prescribe Paracetamol sugar-free suspension 250mg/5ml Soluble tablets **should be avoided** due to high sodium content.
NSAIDS 2nd LINE	Ibuprofen 5% gel Oral dose Ibuprofen 200 – 400mg three times a day	Use topical preparation rather than oral preparation If deemed appropriate to prescribe an oral preparation then this should be based on the individual's risk profiles. Lowest dose for shortest time with regular reviews – ideally for acute flare-ups of pain. Prescribe with PPI for GI protection but stop PPI when NSAID is stopped.	High risk of potentially serious and life threatening side effects in older people. GI toxicity increases when prescribed with low dose aspirin. Higher doses of ibuprofen should be avoided as increased CV risk (2,400mg). Renal failure risks increase when prescribed with diuretics and ACE inhibitors. As with other NSAIDs, ibuprofen may mask the signs of infection.	**Use of oral preparations in the elderly is discouraged** NSAIDs have been implicated in up to 23.5% of hospital admissions due to adverse effects in older people. Opioid use may be associated with fewer risks than NSAIDs.

Analgesic STEP 2	Dose in the elderly	Recommendation	Risks	Comments
Codeine 1st LINE	Starting dose of 15mg up to 4 times a day at intervals of not less than 6 hours is recommended. Can be increased with caution to 30-60mg every 4-6 hours, up to a maximum total of 240mg/day.	Codeine should be used at the lowest effective dose for the shortest period of time Prescribe with a laxative Maximise the use of paracetamol first and **add in separately to enable titration.**	Risks of constipation high, potentially increasing risks of UTIs. Increased risk of falls and drowsiness.	Caution: The capacity to metabolise codeine to morphine can vary considerably between individuals.
Tramadol 2nd LINE	50 mg no more frequently than every 6 hours. In elderly patients over 75 years elimination may be prolonged. If necessary extend the dosage interval according to the patient's requirements.	If prescribed use lowest effective dose and review side effects.	High risks of falls, increased confusion and hallucinations Should not be used in those with a history of seizures. Risk of serotonin syndrome when prescribed with some antidepressants. Interaction with warfarin raising INR. Problem if used infrequently.	**Use with greater caution in the elderly.**
Buprenorphine patches 3rd LINE	IN SWALLOWING DIFFICULTY Initial patch dose of 5mcg/hour every 7 days.	No dose adjustment needed in renal impairment, so suitable for use in patients with renal impairment.	Risks of constipation, confusion, drowsiness, dizziness (increased risks of falls)	On initiation: Review analgesic effect after it has been worn for OVER 72 hours. Dose can be adjusted after at least every 3 days. In practice, assessment at 7 days maybe more clinically appropriate.

STEP 3 - Consider Opioid Trial
OPIOIDS ARE OF LIMITED USE FOR THE TREATMENT OF CHRONIC PAIN AND THERE IS SIGNIFICANT RISK OF SIDE EFFECTS AND DEPENDENCY.
ASSESS RISK FOR LONG TERM TREATMENT; MENTAL ILLNESS, BENZODIAZEPINE USE.
ASSESS SUCCESS OF TRIAL, IF INEFFECTIVE TAPER DOWN AND STOP **EVEN IF NO OTHER TREATMENT IS AVAILABLE.**
There is marked variability in how individual patients respond to individual opioids.
Cognitive function not impaired significantly in stable doses.

Analgesic STEP 3	**Dose in the elderly**	**Recommendation**	**Risks**	**Comments**
Morphine MR 1st LINE	Dose dependant on conversion from immediate release.	Zomorph capsules – (Current formulary choice). If previously used immediate release, use same daily dose of sustained-release capsules, but in two divided doses at 12-hourly intervals.	Consider laxatives +/- antiemetics Side effects are most common for up to 7 days after dose increase. Caution must be exercised when administering opioids to the debilitated elderly. Risks of constipation, confusion, drowsiness, dizziness (increased risks of falls)	Convert IR morphine to MR once pain control is stable. Oramorph solution to be available for breakthrough pain and readjust MR dose as needed.
Oxycodone MR 2nd LINE	See SPC for dose as dependant on whether opioid naïve. Use conversion chart where appropriate	Where there is renal impairment then starting dose should be reduced by 50%		**Only initiate if morphine is contraindicated or helpful but not tolerated**
Buprenorphine patches Alternative choice	IN SWALLOWING DIFFICULTY **Buprenorphine** patch 5mcg/hour every 7 days (BuTrans®) (Step 2) **Can use a patch of a higher strength or a combination of max 2 patches**	For **buprenorphine patches** no dose adjustment needed in renal impairment, so suitable for use in patients with renal impairment.		**Patch of choice in the elderly** Dose can be adjusted after at least every 3 days. (BNF/SPC recommendation) Specialist Teams advise that in practice, assessment at 7 days maybe more clinically appropriate.
Fentanyl patch	**Avoid use**			

Appendix 1 A: The Abbey Pain Scale

The Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise

How to use scale: While observing the resident, score questions 1 to 6.

Name of resident: .....

Name and designation of person completing the scale: .....

Date: ..... Time: .....

Latest pain relief given was ..... at .....hrs.

Q1. Vocalisation
eg whimpering, groaning, crying
Absent 0 *Mild 1* *Moderate 2* *Severe 3*
Q1 ☐

Q2. Facial expression
eg looking tense, frowning, grimacing, looking frightened
Absent 0 *Mild 1* *Moderate 2* *Severe 3*
Q2 ☐

Q3. Change in body language
eg fidgeting, rocking, guarding part of body, withdrawn
Absent 0 *Mild 1* *Moderate 2* *Severe 3*
Q3 ☐

Q4. Behavioural change
eg increased confusion, refusing to eat, alteration in usual patterns
Absent 0 *Mild 1* *Moderate 2* *Severe 3*
Q4 ☐

Q5. Physiological change
eg temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
Absent 0 *Mild 1* *Moderate 2* *Severe 3*
Q5 ☐

Q6. Physical changes
eg skin tears, pressure areas, arthritis, contractures, previous injuries
Absent 0 *Mild 1* *Moderate 2* *Severe 3*
Q6 ☐

Add scores for Q1 to Q6 and record here ⇒ Total pain score ☐

Now tick the box that matches the Total pain score ⇒

0–2 No pain	3–7 Mild	8–13 Moderate	14+ Severe

Finally, tick the box which matches the type of pain ⇒

Chronic	Acute	Acute on chronic

Abbey J, De Bellis A, Piller N, Esterman A, Giles L, Parker D, Lowcay B. The Abbey Pain Scale. Funded by the JH & JD Gunn Medical Research Foundation 1998–2002.

Appendix 2: Red and Yellow Flags

Red Flags

Red flags are clinical indicators of possible serious underlying conditions requiring further medical intervention.
They were designed for use in acute low back pain, but the concept can be applied broadly in the search for serious underlying pathology in any pain presentation.

Differential Diagnosis

- Possible fracture
- Possible tumour or infection
- Possible significant neurological deficit

Patient history

- Major trauma
- Age <20 or >50 years old
- Minor trauma in elderly patient
- History of cancer
- Immunosuppression
- Intravenous drug use
- Systemic upset – weight loss, fevers, chills
- Nocturnal pain
- Abnormal gait

Physical examination

- Evidence of neurological deficit (in legs or perineum in the case of low back pain)
- Blood test results

Yellow Flags

- Use clinical judgement. Consider the use of evidence based tools (e.g. Keele STarT Back Tool).
- Be aware of the presence of significant comorbidities. Mental health problems (including depression, anxiety, personality disorder, post-traumatic stress disorder), cognitive impairment, substance misuse, pregnancy, polypharmacy, significant renal or hepatic impairment.

Biomedical yellow flags

Severe pain or increased disability at presentation, previous significant pain episodes, multiple site pain, non-organic signs, iatrogenic factors.

Psychological yellow flags

Belief that pain indicates harm, an expectation that passive rather than active treatments are most helpful, fear avoidance behaviour, catastrophic thinking, poor problem solving ability, passive coping strategies, atypical health beliefs, psychosomatic perceptions, high levels of distress.

Social yellow flags

Low expectation of return to work, lack of confidence in performing work activities, heavier work, low levels of control over rate of work, poor work relationships, social dysfunction, medico-legal issues.

Appendix 3: Referral to L&D pain service

Patients that would benefit from a referral to L&D integrated pain service:

- Patients with persistent or recurrent pain not adequately managed in primary care.
- Patients whose pain is causing significant distress or functional impairment.
- Patients with analgesic misuse problems or who are taking recreational drugs/alcohol for pain relief - possibly in collaboration with addiction services.
- Patients with pain-related psychological and psychosocial problems (e.g. pain related fear, anxiety, reactive depression, functional impairment) that complicate their pain symptoms or rehabilitation. These patients require an interdisciplinary pain management approach delivered by a specialist or specialised pain management service.
- Patients requiring specific procedures as part of a pain management plan aimed at improving function and quality of life.
- 'Cancer survivors' i.e. patients with cancer who have undergone treatment (e.g. surgery, chemotherapy or radiotherapy) but who have persistent pain.
- Patients where referral is recommended by NICE guidelines

Patients who would not benefit from a referral to the L&D integrated Pain Service.

- Patients not responding to specialist pain service input should be considered for onward referral to a specialised (Tertiary) pain management centre.
- Young people (under 18yrs) with significant pain require referral to nationally recognised specialised services.
- Patients undergoing current surgical or medical interventions.
- Patients with significant mental health conditions that would prevent the patient from engaging in our service.
- Patients who have already accessed our service and did not opt to attend pain management program. If they are now engaged in a self-management approach this would be considered. A new pain condition would be considered for example: Complex Regional Pain Syndrome.

Appendix 4: Pain Self –Management Prescription

Focus on 1-2 areas initially

- **Education :** Get involved and learn all you can about your chronic pain. Get informed about how acute pain can differ from chronic pain. See resources.
- **"Flare Up" Plan:** when you have a bad day or a bad spell, have a plan for how to deal with it. Take frequent breaks but don't take to your bed. Change positions every 30 minutes. You can also use short term strategies like: heat packs, cold pack or gels, TENS that may help with your pain and use them regularly.

- **Set Realistic Goals**: Start thinking about what matters to you in spite of pain. Set yourself manageable goals and identify steps to work towards them. Be kind to yourself, small steps. Small changes can make big differences to your quality of life.
- **Exercise:** -keep active- investigate suitable classes locally such as Tai Chi, swimming, walking, Pilates, yoga.
- **Medication**: an important question to ask yourself when taking medication is: Does it reduce the pain experience and does it improve my quality of life? If the answer is no, then ask your doctor about reducing or think about alternatives.

- **Balancing activities:** Look at what you are doing in a day, begin to prioritise, plan and space out your activities across the week and not all in one day. Aim for one enjoyable activity a day.

- **Relaxation:** Set time aside each day.

- **Mindfulness:** Start to find out more about how this can help you manage your pain. See resources

- **Communication:** It's important to talk, catch up with friends, and keep your family up to date with how you feel.

- Try to maintain 3 regular well-balanced meals per day. Keep hydrated.

Websites

- Pain Concern - www.painconcern.org.uk
- The British Pain Society – www.britishpainsociety.org
- The Pain Toolkit – http://www.paintoolkit.org/
- HealthTalk online - http://www.healthtalk.org/peoples-experiences/long-term-conditions/chronic-pain/what-chronic-pain
- HealthTalk online - http://www.healthtalk.org/peoples-experiences/long-term-conditions/chronic-pain/what-chronic-pain
- Chartered Society of Physiotherapists, back pain – Myth Busters - http://www.csp.org.uk/your-health/healthy-living/public-information-leaflets/back-pain-myth-busters
- Arthritis Care – www.arthritiscare.org.uk
- Fibromyalgia Association – www.fmauk.org
- Total Well-Being Luton - https://www.totalwellbeingluton.org/
- Sleep Problems – www.sleepcouncil.org.uk
- Medication information (opioids): https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware

NHS Choices - https://www.nhs.uk/live-well/healthy-body/ways-to-manage-chronic-pain/

Video clips

5 minute clip 'understanding pain in 5 minutes.
https://www.youtube.com/watch?v=C_3phB93rvI
Tame the beast - https://www.youtube.com/watch?v=ikUzvSph7Z4

Books

Books on prescription - https://reading-well.org.uk/ or go to your local library and request following books to support in self-management.

- Living Beyond Your Pain – Using Acceptable and Commitment Therapy to Ease Chronic Pain. Joanne Dahl, Tobias Lundgren. (Self -help work book).
- Mindfulness for Health: A practical guide to relieving pain, reducing stress and restoring well-being. Vidyamala Birch and Danny Penman. (8 week mindfulness programme with CD) Visit http://www.breathworks-mindfulness.org.uk/
- Manage your Pain: Practical and positive ways of adapting to chronic pain. Michael Nicholas.

Appendix 5 – Pain Assessment and Documentation Tool (PADT™)

Pain Assessment and Documentation Tool (PADT™)

Patient Name:	**Record #:**
Assessment Date:	

Current Analgesic Regimen

Drug Name	Strength (e.g. mg)	Frequency	Maximum Total Daily Dose

The PADT is a clinician-directed interview; that is, the clinician asks the questions, and the clinician records the responses. The Analgesia, Activities of Daily Living and Adverse Events sections may be completed by physician, nurse practitioner, physician assistant or nurse. The Potential Aberrant Drug-Related Behaviour and Assessment sections must be completed by the physician. Ask the patient the questions below, except as noted.

Analgesia

If zero indicates "no pain" and ten indicates pain as bad as it can be, on a scale of 0 to 10, what is your level of pain for the following questions? (Please circle the appropriate number)

1. What was your pain level on average during the past week?

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as it can be

2. What was your pain level at its worst during the past week?

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as it can be

3. What percentage of your pain has been relieved during the past week?
(Write a percentage between 0% and 100%)
……

4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life?

Yes **No**

5. Query to clinician: Is the patient's pain relief clinically significant?

Yes **No** **Unsure**

Activities Of Daily Living

Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT™*.

(Please check the box for Better, Same or Worse for each item below.)

	Better	Same	Worse
1.Physical Functioning			
2.Family Relationships			
3.Social Relationships			
4. Mood			
5.Sleep Patterns			
6.Overall Functioning			

*If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.

Adverse Events

1. Is patient experiencing any side effects from current pain reliever?

Ask patient about potential side effects:

	None	Mild	Moderate	Severe
a. Nausea				
b. Vomiting				
c. Constipation				
d. Itching				
e. Mental cloudiness				
f. Sweating				
g. Fatigue				
h. Drowsiness				
i. Other				
j. Other				

2. Patients overall severity of side effects?

None	Mild	Moderate	Severe

Assessment:

(This section must be completed by the physician.)
Is your overall impression that this patient is benefitting (e.g. benefits, such as pain relief, outweigh side effects) from opioid therapy?

Yes	No	Unsure

Comments:

Potential Aberrant Drug-Related Behaviour

Please check any of the following items that you discovered during your interactions with the patient.

Please note that some of these are directly observable (e.g. appears intoxicated), while others may require more active listening and/or probing. Use the "Assessment" section below to note additional details.

Tick	
	Purposeful over-sedation
	Negative mood change
	Appears intoxicated
	Increasingly unkempt or impaired
	Involvement in car or other accident
	Requests frequent early renewals
	Increased dose without authorisation
	Reports lost or stolen prescriptions
	Attempts to obtain prescriptions from other doctors
	Changes route of administration
	Uses pain medication in response to situational stressor
	Insists on certain medications by name
	Contact with street drug culture
	Abusing alcohol or illicit drugs
	Hoarding (i.e. stockpiling) of medication
	Arrested by police
	Victim of abuse
	Other:

Specific Analgesic Plan:

	Continue present regimen		Add/Adjust concomitant therapy
	Adjust dose of present analgesic		Discontinue/taper off opioid therapy
	Switch analgesic		

Comments:

With permission from Mr Steve Passik (co-author)

Appendix 6: DN4 Questionnaire

To estimate the probability of neuropathic pain, please answer yes or no for each item of the following four questions.

INTERVIEW OF THE PATIENT

QUESTION 1:

Does the pain have one or more of the following characteristics?	**YES**	**NO**
Burning ……..	□	□
Painful cold……	□	□
Electric shocks ……	□	□

QUESTION 2:

Is the pain associated with one or more of the following symptoms in the same area?

	YES	**NO**
Tingling ……..	□	□
Pins and needles……..	□	□
Numbness …….	□	□
Itching …….	□	□

EXAMINATION OF PATIENT

QUESTION 3

Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?

	YES	**NO**
Hypoesthesia to touch ……...	□	□
Hypoesthesia to pinprick ……..	□	□

QUESTION 4:

In the painful area, can the pain be caused or increased by:	**YES**	**NO**
brushing …….	□	□

YES = 1
NO = 0

Patient's score:	**/10**

If the score is ≥4 then the pain is **likely** to be **neuropathic** pain
If the score is ≤4 then the pain is **unlikely** to be **neuropathic** pain

Appendix 7: Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management.

	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Prescription medicines	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Prescription medicines	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADHD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring Totals		

Results:

0-3 indicates **low risk** for future opioid abuse

4-7 indicates **moderate risk** for opioid abuse

≥8 indicates a **high risk** for opioid abuse

Questionnaire developed by Lynn R Webster, MD to assess risk of opioid addiction
https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf

Appendix 8: Patient Opioid Treatment Agreement (Optional)

Patient name	
Prescriber name	
Consultation date	

In signing this agreement, the patient agrees to the following conditions regarding his / her treatment and the prescribing of an opioid medication:

- ✓ This medicine is intended to:
  - Improve my level of mobility and ability to perform daily tasks.
  - Reduce my intensity of pain (not eliminate the pain completely)
  - Improve my quality of life.

- ✓ My GP (insert prescriber's name here) is responsible for prescribing a safe and effective dose of the opioid medication. My GP will control my dose, perhaps with advice from one or more specialists in a condition relevant to my pain ("relevant specialist"). I will not use an opioid medication other than at the dose prescribed and I will discuss any changes in my dose with my GP.

- ✓ I will only obtain my opioid medication from my GP or another doctor specifically authorised by them, or a relevant specialist. I understand that no early prescriptions will be provided.

- ✓ I have been informed of the common **(nausea, constipation, drowsiness, and anxiety**) and significant (**addiction/dependence, prone to infections, reduced sexual function & fertility**) side effects of taking opioids. I will tell my GP or specialist if I experience any of these.

- ✓ Any evidence of unsafe use such as: drug hoarding, acquisition of any opioid medication or other pain medication from other sources (which includes emergency departments), uncontrolled dose escalation, loss of prescriptions, or failure to follow the agreement may result in termination of the agreement and withdrawal of opioids.

- ✓ As possible dependence is important in the management of my pain, I have informed the clinician signing this contract of any present or past dependence on alcohol or drugs that I may have had, and of any illegal activity related to any drugs (including prescription medications) in which I may have been involved.

- ✓ 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, this must be reported 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 or 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.

We agree that my opioid medication will be provided as laid out in these documents.

Patient's name	
Patient's signature	
Prescriber's name	
Prescriber's signature	

At the end of the trial period the patient should be reviewed and if function is improved, opioids may be considered in the longer term.

Make a longer term plan, including regular (maximum 6 month) reviews. Consider intermittent dose reductions or drug holidays so as to demonstrate that ongoing prescriptions are clinically appropriate and beneficial.

Appendix 9: Patient Information about the harmful effects of using Opioids.

Effect	Description of effect
Constipation and nausea	Severe cases can cause a blockage of the intestine. This may need hospital treatment and/or surgery.
Cognitive impairment	Sedation Dizziness (can cause falls and injuries) Depression, anxiety and apathy Impaired concentration (can effect driving).
Addiction, misuse	Some people are prone to misuse of opioids, specifically if they have a history of depression or mental health issues. Misuse can occur if other people have access to your medication. It can result in overdoses.
Hormonal effects	Reduced production of hormones that control: Fertility and sexual function Osteoporosis
Immunosuppression	You may become prone to catching infections. A particular risk is pneumonia in the elderly.
Cardiac effects	Non-specific cardiac symptoms Heart attack Heart failure.
Tolerance and withdrawal	Medication will need to be reduced slowly to prevent withdrawal symptoms such as insomnia, anxiety, hot and cold sweats, nausea and vomiting and muscle aches and pains.
Respiratory depression (caused by overdose)	Your breathing may slow down, especially while asleep. Can worsen obstructive sleep apnoea.

Appendix 10: Opioid Dose Conversions

Switching a patient to oral morphine from a regular weaker analgesic

Follow this link Resources for GPs Regarding Opioids and Chronic pain to access the Oxford University Hospitals opioid calculator for dose conversions.

Switching from one opioid to another

- Switch opioids only if patient obtains pain relief from one opioid and is suffering severe side effects.
- No longer able to take via the same route, or due to renal / hepatic dysfunction.
- In most cases, 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% to 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.
- Withdrawal symptoms (sweating, yawning, abdominal cramps, restlessness, anxiety) occur if an opioid is stopped or if the dose is reduced abruptly.

Analgesia	**Dose equivalent to 10mg Morphine**
Codeine	100mg
Dihydrocodeine	100mg
Oxycodone	5mg
Tramadol	100mg

Appendix 11: Opioid Dose Tapering and Stopping

This information is taken from the Faculty of Pain Medicine (Royal College of Anaesthetists) https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware/structured-approach-to-prescribing/tapering-and-stopping (accessed on 11/5/18)

It is important to taper or stop the opioid regimen if:

- The medication is not providing useful pain relief.
- The risk of harm is substantially increased at doses above 120mg oral morphine equivalent/24hours. Increasing opioid load above this dose is unlikely to yield further benefits but exposes the patient to increased harm.
- 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/her medications to others.

Preparation for dose reduction includes:

- Explanation of the rationale for stopping opioids including the potential benefits of opioid reduction (avoidance of long term harms and improvement in ability to engage in self-management strategies).
- Agreeing outcomes of opioid tapering.
- Deciding which patients may need admission for opioid taper/cessation informed by existing opioid dose.
- Physical co-morbidities.
- Mental health co-morbidities including significant emotional trauma.
- Monitoring during taper of pain.
- Symptoms and signs of opioid withdrawal.
- Choice of opioid reduction scheme.
- Incremental taper of existing drug.
- Conversion to methadone or buprenorphine.
- Defining the 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.

It is currently proposed that the dose of an opioid can be tapered by 10% weekly or two weekly.

This amount could be lower and at a slower pace, depending on the individual patient and their circumstances.

Stopping opioids in existing patients in primary care

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

- Explanation of the rationale for stopping opioids including the potential benefits of opioid reduction (avoidance of long term harms and improvement in ability to engage in self-management strategies)
- Agreeing outcomes of opioid tapering
- Arrangements for monitoring and support during opioid taper documented agreement of tapering schedule.
- Patients who are failing to derive benefit from large doses of opioids (greater than oral morphine equivalent of around 300mg/day) may need support from specialist services in order to reduce medication.

This must include detailed exploration of emotional and mental health history (including addiction). Opioid tapering/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.

Patient education at discharge from secondary care

It may be appropriate to offer the patient a supply of opioid medicine sufficient for a few days after which opioids are unlikely to be needed. The patient must be given clear instructions regarding:

1: How to taper the dose of drug as natural recovery takes place.

2: Treatment plan, including the estimated time of cessation of opioid therapy.

Appendix 12: Patient Daily Diary

As discussed and agreed at your appointment to manage your pain, you may wish to use this sheet to record how you have been feeling at the end of the day. Please bring it with you to your pain appointments for discussion.

Start date:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Is your pain improving?							
How is your mood in general?							
How is your sleep?							
Have you been able to carry on with your daily tasks? Work/drive/go out of the house/jobs around the house?							
Have you experienced any side effects from your medicines?							

Appendix 13: Current locally commissioned pain services

Locality MSK pain	Locality Non-MSK pain
Bedford Circle MSK	Consider referring to other local hospitals i.e. LDH, MK (**BHT only has an inpatient commissioned service)**
IAPT (Improving Access to Psychological Therapies)	IAPT (Improving Access to Psychological Therapies)