

Prescribing strong opioids in palliative care
Stakeholder Workshop: Group Notes

Group 1

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Dr Claire Butler	Mr Garth Baxter
Dr John Williams	Dr Lee Wilson
Dr Anna Taylor	Dr Miriam Johnson
Ms Judit Thornton	Ms Lily Huajie Jin
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General Comments

The group were concerned that the scope does not cover assessment of patients for treatment with opioids and queried which type of pain was being covered: background or breakthrough.

Title

The group felt that the title should specify treatment for pain only and asked for clarification on whether opioid treatment for breathlessness is also being covered.

Population

4.1.1 Groups that will be covered

The group felt that the population covered should be “Adults with advanced or progressive disease” instead of “Adults with advanced and progressive disease” to also cover the patients who may live for many years with advanced disease and chronic pain. The group also felt that HIV should be added to the examples of diseases being covered.

The group discussed the definition of “advanced and progressive disease”. There is a WHO definition which could be used to do this.

4.1.1 Groups that will be covered

The group had no comments to the groups that will not be covered.

Healthcare setting

The group felt that prisons should also be added and suggested rewording of 4.2 (a) from: “All settings in which NHS care is provided” to “All settings in which NHS care is commissioned”.

4.3.1 Key clinical issues that will be covered

- a) Development of a protocol for the effective and safe prescribing of strong opioids taking account of:
- *Primary pathology and comorbidities*
 - *Clinical effectiveness (including route of administration, dosage, formulation)*
 - *Cost effectiveness*
 - *Side effect profile including adverse events*
 - *Patient preference*
 - *Indications for switching*

The group felt very strongly that assessment should be included within the scope. It is also important to address the likely duration of treatment, monitoring and considerations for the prescribing of other drugs. The group discussed the principles of dose and starting dose and felt the guideline should look at making recommendations on a starting dose of opioid for each sub-group of patients; short or long acting..

The group noted that the evidence in this area is limited. They believed that the majority of data can be derived from cancer literature and this could be generalised. They noted that there were a lot of consensus based documents on this issue

- b) Patient information needs including:
- Information needed to consent to opioid treatment and participate in the choice of opioid
 - Information on monitoring the effectiveness of the opioid and options for switching.

The group suggested adding 'carer' to the clinical question.

The group felt that the word 'switching' is unclear as currently stated and is indicative of switching to an alternative opioid. However, this may not always be appropriate.

General

The group noted that patients should be offered counselling and information leaflets. It was also noted that re-assessment was also required once a patient was receiving opioids.

4.3.2. Clinical issues that will not be covered

- a) The use of opioids in people without advanced and progressive disease.
- b) The use of non-opioids in people with or without advanced or progressive disease.
- c) End of life care (in the last hours and days of life).

The group suggested changing bullet point c) and remove 'End of life care' as "End of life care" may be interpreted to reflect care in the last year of life.

4.4 Main outcomes

- a) Improved pain management
- b) Reduction of opioid side effects
- c) Number, frequency and duration of inpatient stays.
- d) Quality of life.

The group suggested re-wording bullet point c) to "Compliance including patient satisfaction and treatment including number, frequency and duration of inpatient stays".

The GDG Membership

- Anaesthetist
- General Practitioner
- 2 palliative care nurses (1 x community-based, 1 x hospital-based)
- Palliative care physician
- Pharmacist

- Pharmacologist
- Physician with an interest in end-of-life care (non-cancer related)
- PPIP x 2

The following adjustments to the GDG membership were suggested by the group:

- Anaesthetist involved in cancer related pain management
- GP with no interest in pain management
- Palliative care nurse should be a prescriber. Reduce quantity to 1.
- Palliative care physician with an interest in end of life care. Increase quantity to 2.
- Pharmacist with special interest in palliative care.
- Pharmacologist: remove

Add:

- Oncologist

Group 2

Mr Nick White
Dr Georgina Keenleyside
Dr Chris Kidson
Dr Elain McWilliams
Dr Cliff Richardson
Dr Mark Taubert
Ms Barbara Meredith
Mike Heath
Angela Bennett

General Comments

The group queried which type of pain was being covered by the scope as there can be many types of pain – not all of which will be affected by analgesia.

Title

It was suggested that the title should mention supportive care, in addition to palliative care, to make it link in with the IOG on ‘Supportive and palliative care for adults with cancer’.

Population

a) Groups that will be covered

It was queried why the scope did not cover children as well as adults, since children may also need strong opioids for pain and many of the same issues apply. It was noted that the remit from the DH only specified adults which restricts what can be covered by the scope. It was suggested that the topic of prescribing strong opioids for pain in children could be suggested via the NICE website.

The group queried if assessment was covered the scope. It was clarified that the scope of this guideline starts from the point at which the decision has already been made to prescribe strong opioids – in order to keep the guideline to a manageable size.

It was queried whether patients with reduced capacity for making decisions, reporting pain etc. were covered by the scope and if so, whether this should be specified in the population section.

The group suggested that “advanced and progressive disease” was defined for clarity. There is a WHO definition which could be used to do this.

The group felt that the term “failure” should be replaced by “condition” or “disease” because it would not only be people with organ failure who would be suitable for opioid treatment, They also thought HIV should be included in the list of examples.

b) Groups that will not be covered

No changes were suggested to this section

Healthcare setting

No changes were suggested to this section.

Clinical management

a) Key clinical issues that will be covered

Q1: Development of a protocol for the effective and safe prescribing of strong opioids taking account of:

- *Primary pathology and comorbidities*
- *Clinical effectiveness (including route of administration, dosage, formulation)*
- *Cost effectiveness*
- *Side effect profile including adverse events*
- *Patient preference*
- *Indications for switching*

The group noted that it was important that this topic covered the following issues:

- both physical and psychological comorbidities.
- The reduction and management of opioid side effects (although it was noted that there may be other literature which covers this and could be cross referenced)
- The impact of long-term drug dependency
- The variation in the mode of action of different opioids
- The management of breakthrough pain
- Switching opioids and determining the equi-analgesic dose – there are several different tables which include details on this but they are all different.

It was noted that patient adherence or concordance would be a better term than “patient preference”.

The group felt that “clinical effectiveness” would also need to cover duration of action, speed of onset, tolerance, previous analgesics and consistency of effect.

The group noted that the evidence in this area is limited. They believed that there was some comparative data but this typically didn't have common end-points. They noted that there were a lot of consensus based documents on this issue.

Q2: Patient information needs including:

- *Information needed to consent to opioid treatment and participate in the choice of opioid*
- *Information on monitoring the effectiveness of the opioid and options for switching*

It was noted that the British Pain Society have published literature on these issues to help empower people to be involved in the decisions regarding opioid treatment. Drug companies have also produced information on the side-effects of opioid treatment although these focus more on safety issues rather than choice.

It was noted that there are alternatives to strong opioids for managing pain, however this is outside the scope of this guideline.

The expert patient programme at Macmillan have looked at how information is communicated and how effective this was. However it was noted that most information has probably been produced by healthcare professionals based on what they think patients want to know – rather than what the patient actually wants.

The group discussed what issues specific to opioids, patients might need to be aware of when making a decision regarding their treatment. It was noted that fear of loss of control, fear of addiction and fear of death were common issues along with how to deal with side effects such as constipation, nausea and vomiting.

General

The group discussed the need for holistic assessment of patients in order to determine if they are suitable to receive strong opioids. They also noted that re-assessment was also

required once a patient was receiving opioids. It was mentioned that a validated tool for holistic assessment of patients had been developed in the United States.

b) Clinical issues that will not be covered

The group discussed end of life care being excluded from the clinical issues. They noted that there was already existing guidance on this area and felt that this exclusion was therefore appropriate.

Main outcomes

The group agreed that “number, frequency and duration of inpatient stays” should be removed from the list of outcomes because it will not be possible to separate out which inpatient stays result from opioid treatment.

It was suggested that holistic re-assessment be added to the list of outcomes.

They agreed that improved pain management should cover both quantitative and qualitative measures.

The GDG Membership

- Anaesthetist
- GP
- Palliative care nurses x2 (1 community based; 1 hospital based)
- Palliative care physician
- Pharmacist
- Pharmacologist
- Physician with an interest in end-of-life care (non-cancer related)
- PPIP x 2

The group felt that anaesthetist should be changed to pain specialist as this would probably encompass anaesthetists.

The agreed that a pharmacologist was not needed if a pharmacist and a pain specialist were on the list.

They also agreed that physician with an interest in end-of-life care would be covered by the palliative care physician and so could be removed from the list.

The group suggested that non-medical prescribers and a psychiatrist were added to the list.

Group 3

Dr Sarah Kelt
Dr Kath Mitchell
Dr Teresa Tate
Dr Nicky Cornelius
Dr Emma Husbands
Dr John Graham

Dr Elizabeth Lamerton
Dr Cathy Stannard
Ms Lynne Whitehead
Mr David Fakes
Dr Mia Schmidt-Hansen

General issues

The group felt that if the guideline does not deal with the assessment of patients for suitability for opioid treatment, this should be clearly and explicitly reflected in the scope.

Guideline title

1. Prescribing strong opioids in palliative care

The group felt that the title should reflect the emphasis of the guideline on the prescribing of strong opioids for pain (and not for other indications) by adding “for pain” to the title.

Population

4.1.1 Groups that will be covered

- a) Adults (18 years and older) with advanced and progressive disease, (such as cancer, heart failure, hepatic failure, respiratory failure and renal failure, and those who are dying from neurodegenerative conditions) who require strong opioids for pain.

The group felt that the population covered should be “Adults with advanced or progressive disease” instead of “Adults with advanced and progressive disease” to also cover the patients who may live for many years with advanced disease and chronic pain.

4.1.1 Groups that will be covered

The group had no comments to the groups that will not be covered.

Healthcare setting

The group discussed, but had no comments to, the healthcare setting.

4.3.1 Key clinical issues that will be covered

- c) Development of a protocol for the effective and safe prescribing of strong opioids taking account of:
 - Primary pathology and comorbidities
 - Clinical effectiveness (including route of administration, dosage, formulation)
 - Cost-effectiveness
 - Side effect profile including adverse events
 - Patient preference
 - Indications for switching opioids

The group felt it was important to also address the likely duration of treatment, monitoring and follow up, and the kind of pain experienced (background v episodic).

The group felt that the main important issues when prescribing strong opioids for pain were about whether patients were able to take oral medication and whether their co-morbidities included renal, hepatic and respiratory dysfunction.

d) Patient and carer information needs including:

- Information needed to consent to opioid treatment and participate in the choice of opioid
- Information on monitoring the effectiveness and adverse effects of the opioid

The group queried what exactly “participate in the choice of opioid” reflected as there was some concern that patients sometimes (attempt to) initiate instead of just participate in the choice of treatment.

The group queried why safety was not included and suggested adding “and safety” after “effectiveness” in the second bullet point. Otherwise the group agreed that all relevant information was covered in this question.

4.3.2. Clinical issues that will not be covered

- d) The use of opioids in people without advanced and progressive disease.
- e) The use of non-opioids in people with or without advanced or progressive disease.
- f) End of life care (in the last hours and days of life).

The group suggested changing bullet point c) to “Care in the last hours and days of life” as “End of life care” may be interpreted to reflect care in the last year of life.

4.4 Main outcomes

- e) Improved pain management
- f) Reduction of opioid side effects
- g) Number, frequency and duration of inpatient stays.
- h) Quality of life.

The group suggested changing “Improved pain management” to “Reduction in pain intensity” and adding “Long term harms” and “Reduction in prescribing errors” to the main outcomes.

The GDG Membership

- Anaesthetist
- General Practitioner
- 2 palliative care nurses (1 x community-based, 1 x hospital-based)
- Palliative care physician
- Pharmacist
- Pharmacologist
- Physician with an interest in end-of-life care (non-cancer related)
- PPIP x 2

The following adjustments to the GDG membership were suggested by the group:

- Community matron (instead of community-based palliative care nurse)
- Out-of-hours General Practitioner/physician
- Anaesthetist should have an interest in pain
- Palliative care physician should not just be hospice-based, but should work in both hospital-, community- and hospice-settings.
- No pharmacologist.