HSC | Department of Health · An Roinn Sláinte · Männystrie O Poustie · www.health-ni.gov.uk

NORTHERN IRELAND MEDICINES MANAGEMENT

Opioid Supplement

March 2026

EMIS Searches developed by SPPG to Identify High Risk Opioid Combinations

Opioids, gabapentinoids and benzo/zs are CDs and high-risk medicines**.** MHRA alerts highlight the risks of co-prescribing opioids with pregabalin, gabapentin and benzodiazepines. Prescribing more than one opioid further increases risks.

High-risk opioid combinations are commonly prescribed in NI (see table).

The combinations highlighted should be avoided where possible. Members of PMMT responded to requests from GP practices for tools to support structured review of high-risk opioid patients.

All GP Practices: October-December 2025	
Prescribed	No of Patients
More than one opioid entity*	11382
Opioid~ + Benzo/Z	9646
Opioid~ + Gabapentinoid	9666
Opioid~ + Gabapentinoid + Benzo/Z	4486

**The data does not differentiate between use for palliative/cancer care and chronic pain, or patients who stopped one opioid and started another during this time*
^Codeine and dihydrocodeine products are not included

Action for GP Practices

- Identify priority opioid combinations for review (COMPASS page 10)
- Search for relevant patients. EMISWeb practices: Download/run the EMISWeb Search Guide. Exclude patients as appropriate, e.g. palliative/cancer care, gabapentinoids for epilepsy.
- Review in line with evidence, good practice and shared decision making principles.
- Aim to slowly and carefully reduce/stop opioids and gabapentinoids (for chronic pain), and/or benzo/z, where appropriate.
- **Reduce only one drug at a time** (see Prescqipp Impact Tool).
- Counsel patients on risks, and alternatives to manage their condition.
- Refer to Pain and Mental Health sections for supporting resources.

In this issue

- EMIS Searches to Identify High Risk Opioid Combinations
- Avoid Oxycodone/ Naloxone Combinations
- Oral Morphine Equivalent Threshold Reduced
- Risk of self-harm and suicide with opioid analgesics
- GPNI Opioid Webinar 23rd April 2026

Further Resources

NIMM Newsletter Jan 2026

Chronic Pain Supplement April 2025

Primary Care Intranet

Avoid Oxycodone/Naloxone Combinations

No benefit has been shown for oxycodone / naloxone (Targinact®) in a single product, over other analgesia with laxatives if necessary. Hence this combination has been added to the Limited Evidence List. If a Schedule 2 strong opioid is required, morphine plus appropriate laxatives is first line. A combination of stool-softening and stimulant laxatives is standard practice (see Prescqipp Bulletin 199).

Reminder:

- Strong opioids[1] should not be offered for chronic non-cancer pain[2] as per NI Formulary
- Reducing harm from opioids is a priority
- Prescribers must review patients regularly and in line with latest guidance, to ensure prescribing is safe and appropriate

Action for Prescribers

- Don't initiate oxycodone/naloxone combination products in non-palliative patients
- Review patients prescribed these products (exclude palliative care / cancer patients)
- Aim to slowly reduce/stop the opioid, or consider specialist review
- If oxycodone MR is still necessary prescribe separately with suitable laxative(s) as required

[1]Strong opioids include tramadol, buprenorphine, morphine, oxycodone, fentanyl, tapentadol
[2] Neuropathic pain: Tramadol may be considered for acute rescue therapy. Tramadol and morphine may be considered long term on specialist advice. In NI, tapentadol should only be prescribed on advice of a pain specialist.

Oral Morphine Equivalent Threshold Reduced

New evidence highlights increased harm at higher opioid doses without proportional benefit. Hence the Faculty of Pain Medicine (FPM) has reduced its recommended upper daily oral morphine equivalent (OME) threshold from 120mg/day to 90mg/day, **with an ideal maximum of 50mg/day**, although noting that some exceptions may be clinically appropriate.

Patients exceeding the recommended dose should be assessed for efficacy, risks and side effects, and a careful management plan agreed in line with shared decision-making principles. Medication should not be discontinued abruptly. See link for further details and other changes to Opioids Aware resources.

FPM Update
Prescriber caution is advised if OME > 50mg/day
Specialist advice suggested if OME >90mg/day is considered

Reminder

Due to associated risks, in line with legislation and good practice, patients prescribed opioids must be reviewed regularly to ensure prescribing is safe and appropriate.

Action

- Ensure that all staff involved in chronic pain management are made aware of the reduced recommended maximum daily OME
- Identify patients prescribed >50mg/day OME and prioritise for review - NI Opioid Equivalent Guide
- Further prioritise higher OME doses, high risk populations, gabapentinoid / benzo / z combinations
- Exclude patients as appropriate, e.g. under palliative /cancer care
- Aim to slowly reduce/stop the opioid, or consider specialist review

Risk of self-harm and suicide with opioid analgesics

A 15-year retrospective population-based cohort study of 3,268,282 adults in Australia examined the relationship between opioid use, self-harm and suicide (opioids commenced 2003-2018). The results showed that intentional opioid poisoning was the least common method for both self-harm and suicide. The following were significantly associated with **greater risk** of opioid-related self-harm or suicide:

- Current opioid exposure
- Longer cumulative duration
- Higher opioid doses

Action for Prescribers

- screen and monitor suicide-related behaviours in patients prescribed opioids, especially if using long-term and/or at high-dose
- regularly review patients on long-term or high dose opioids

Reference

GPNI Opioid Webinar

Save the Date: **Thursday 23rd April: 1-2pm**

The webinar will cover:

- Using a new GPIP indicator (developed with input from Pharmacy Advisers) to identify patients on high dose OME (new FPM guidance)
- 'Opioids for Chronic Pain: Should we let the genie out of the bottle?' Dr Chogle (pain specialist)
- Resources to support opioid reduction

The session is aimed at the **whole practice team** – all healthcare professionals and reception teams. Those who are on the GPNI mailing list will receive a link to register in April. Those who are not on the mailing list can join here. Details will also be available on the GPNI website .

* Opioid combinations are included. Injectables, methadone, and non-transdermal buprenorphine and fentanyl are excluded.

This newsletter has been produced for GP practices and community pharmacies by the DoH Strategic Planning and Performance Group Regional Pharmacy and Medicines Management Team. If you have any queries or require further information on the contents, please contact one of the Pharmacy Advisers.
Every effort has been made to ensure that the information included in this newsletter is correct at the time of publication. Throughout the newsletter, external links are provided to other sites. These links are provided to improve access to information and exist only for the convenience of readers of the Newsletter; SPPG cannot accept responsibility for their content. The SPPG does not necessarily endorse the views expressed within these external websites. We cannot guarantee that these links will work all of the time and we have no control over the availability of the linked pages. This newsletter is not to be used for commercial purposes.