NHS
South West
Clinical Senate

Recommendations from the South-West Clinical Senate Council on how to support people in the region to live well with pain whilst reducing and preventing harm from opioids.

09 February 2023

1.0 Background

'Reducing and preventing harm from opioid prescribing' emerged as a deliberative topic for the Senate Council, from conversations with the South West Academic Health Science Network and the West of England Academic Health Science Network. Both networks had already embarked on programmes of work looking at this.

The discussions to date in these groups had engaged clinicians who are actively involved in the relevant clinical pathways and it was felt that the emerging themes could be usefully tested with a wider clinical audience. The Clinical Senate was asked to consider how people in the region could be supported to live well with chronic pain whilst reducing and preventing harm from opioid medication.

1.1 National context

In December 2021, The Lancet EClinicalMedicine[1] published research which showed that the UK has the highest consumption rate of prescription opioids for pain management per capita in the world when compared over ten years between 2009 - 2019. This ranking is based on the International Narcotics Control Board (INCB) which only includes substances regulated by the single convention on narcotic drugs which doesn't include drugs like tramadol, codeine, buprenorphine, and tapentadol. Although the UK's consumption of opioids has slightly declined since 2016, it is still leading in the use of these prescription drugs, as consumption in other countries have decreased.

This increased consumption has created public health concerns that the harms associated with these medications are increasing. These concerns are highlighted in the Public Health England's Prescribed Medicines Review 2019[2].

Opioids are a highly effective class of analgesics for acute pain, pain at the end of life, and

[1] Global consumption of prescription opioid analgesics between 2009-2019: a country-level observational study - eClinicalMedicine (thelancet.com)
[2] Prescribed medicines review: summary - GOV.UK (www.gov.uk)

when used judiciously may be a benefit to people living with pain[3]. However, in many cases of chronic non-cancer pain, where the source of the long-term pain does not have a cause that can be treated, opioids can do more harm than good.[4] It is right that the relief of chronic pain should be a clinical priority however, prescribing opioids is often not the most appropriate or effective treatment option for many patients with chronic pain – particularly non-cancer pain, rather it can expose patients to unnecessary harm, as demonstrated by the data which links primary care prescribing of opioids to hospital admissions for adverse events associated with opioids. (See Figure 1). It is predicted that around 6000 people a year will be hospitalized with adverse events whilst taking opioids for extended periods.

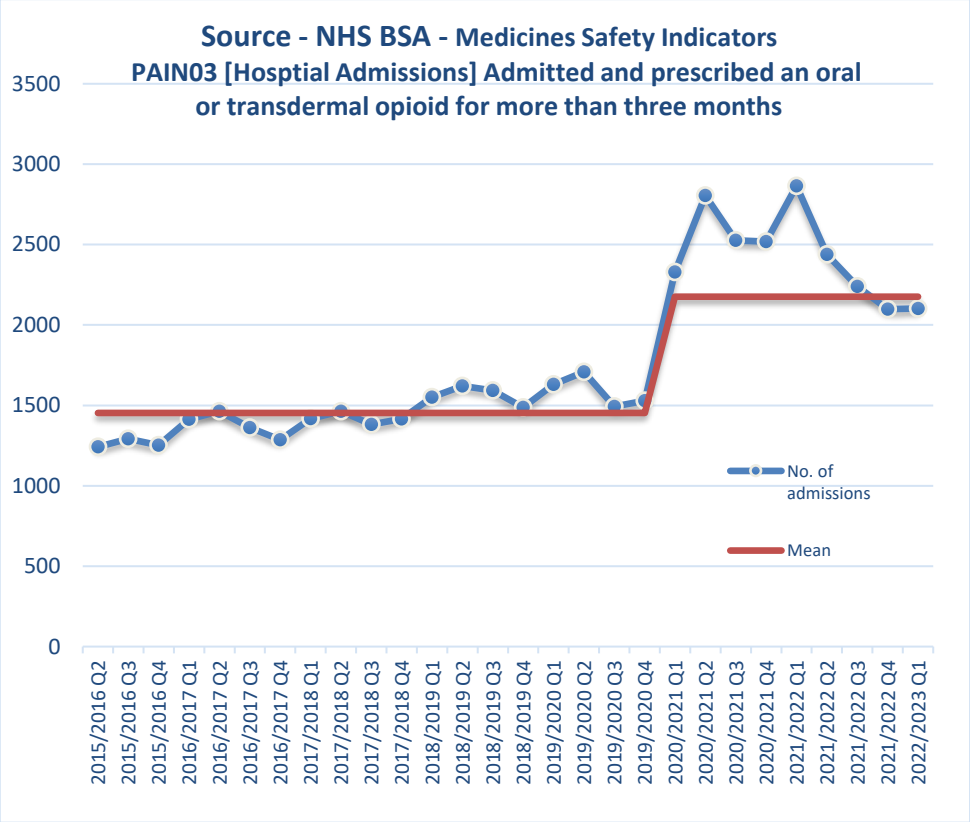

Figure 1: No of hospital admissions for respiratory depression, overdose or confusion for patients prescribed an orla or transdermal opioid for more than three months[5] (Data taken from: NHS BSA Medicines Safety Indicators Dashboard)

Despite this, in the UK, opioids are widely prescribed for chronic non-cancer pain and indeed prescribing has more than doubled from 1998 to 2018, and although prescribing has declined since 2016, opioids are still in significant use[6] and something needs to be

[3] Opioids Aware | Faculty of Pain Medicine (fpm.ac.uk)
[4] Improving-Chronic-Pain-Management-by-Reducing-Harm-from-Opioids-Report-2021.pdf (ahsnnetwork.com)
[5] Please note: Admissions and Opioid use data does not exclude admissions for respiratory depression for other factors, such as circulating respiratory conditions, for example COVID-19 / Influenza. Respiratory depression is however one risk factor of long-term opioid use, therefore data presented shows indirect causality rather than direct causation.

[6] Britain's opioid epidemic kills five every day | The Sunday Times (thetimes.co.uk)

done to address this.

The report will focus primarily on identifying approaches to reducing opioid prescribing in the Southwest region and sets out recommendations for systems and commissioners.

2.0 The Questions

The South West Clinical Senate sought to explore the following question relating to harm and opioid prescribing in the South West region:

- How can we support people in the South West to live well with pain whilst reducing and preventing harm from opioid medication?

3.0 Observations

During the meeting, the Senate Council split into breakout groups to further explore the deliberative topic and consider the following questions:

- What can be done (practically) to change the prescribing behaviour of clinicians in primary care and secondary care?
- How can the interface between primary care and secondary care settings be better managed, in terms of opioid prescribing?
- What can we do to support patients to live well with pain, whilst reducing and preventing harm from opioids?

Through these deliberations, the Senate Council made several observations:

Continuity of Care

- The Senate Council highlighted the importance of cross-system working and effective communication between primary care and secondary care, to develop interventions (including alternatives to opioid prescribing) to support patients with chronic pain. There may be differences in approaches in different regions: for example, in some regions secondary care may initiate and propose liberal and higher dose opioid prescribing as opposed to the more cautious approach in primary care. There are few evidenced-based interventions to support people living with pain that can't be offered in primary care.

- The Senate Council recognised the importance of the multi-disciplinary team (MDT) involving specialists, primary care professionals, and the network of providers, in providing a vehicle for better integration across the whole health and social care system.

- The use of electronic prescribing and other 'common information sharing systems' between primary care and secondary care are crucial to the continuity of care.

- Patient handheld records could be a helpful tool in managing the interface between care settings and supporting patients.

Education and Training

- The effective support of people with chronic pain requires health professionals with knowledge about the limitations of medical interventions for chronic pain, well developed consultation skills and sufficient time in consultations. The manifestation of chronic pain may be an indicator of underlying challenges including mental health diagnoses, trauma, and social context, and there should be time to explore these prior to agreeing any care plan.

- The management of chronic pain is not consistently included in either undergraduate or postgraduate training for health professionals. The Senate Council recognised the importance of education of healthcare professionals throughout their careers, to raise awareness and understanding around how to support patients with chronic pain. Health coaching is a key priority for the NHS and providing health coaching[7] training for staff as part of their 'education' will equip staff to be able to work with patients living with chronic pain, to promote patient self-care and self-management.

- Similarly, patients need knowledge and skills, so that they can self-manage their condition. It is recognised that patients are the best 'facilitators' of their continuity of care and should be empowered to carry out this role.

Communications

- The Senate Council reflected on whether the language of chronic pain socialises health professionals and patients to think primarily of medication interventions and whether using different language such as 'chronic distress management' would help clinicians consider other interventions. Whatever language is used, it is about how this is perceived by patients.

The role of other professionals

- The Senate Council highlighted the importance of engaging and involving other professionals such as pharmacists, occupational therapists, physiotherapists, social prescribers, health coaches, voluntary sector organisations and carers, all of whom can make valuable contributions to developing innovative solutions, for patients with chronic pain.

[7] Health coaching is a patient-centred process that is based on behaviour change theory and is delivered by health professionals with diverse backgrounds. Reference: Health coaching | Health Education England (hee.nhs.uk) <accessed 27/02/2023>

4.0 Recommendations

The South West Clinical Senate makes the following recommendations:

1. Systems should ensure they understand the demographics of people living with chronic pain in the following cohorts:
    a. Patients with established chronic pain/ Patients who have recently come into a situation of chronic pain.
    b. Patients with a diagnosis that has led to chronic pain/ Patients that have not had a diagnosis.
    c. Patients with high demand for services/ Patients with milder symptoms or better support with low demand for services and any correlation with areas of social deprivation or other health inequalities.
2. Systems should ensure they understand the impact of responding to people with chronic pain on their health systems.
3. Systems should understand the pattern of opioid prescribing in their area and review their approach to opioid stewardship. Opioid stewardship (which also requires strategic pharmacy involvement) is used to promote rational use, monitoring, and discontinuation of opioid therapy. This stewardship needs to be shared across primary care and secondary care and in the public domain.
4. The Senate Council noted the impact of continuity of care on the clinician/patient relationship and the prescribing behaviour of the clinician. Systems should explore how this continuity of care can be developed, not based on one person but on a 'team' around the patient. This should not be limited to 'healthcare' teams but should include teams in the third sector, and the wider community, to develop interventions for patients, that are built on a biopsychosocial model[8] [9]. This model is commonly used for patients with chronic pain, with the view that pain is a psychophysiological behaviour pattern and to understand it, the patient's biological (physiological pathology), psychological (thoughts, emotions, behaviours) and social (socio-economic, socio-environmental, and cultural) factors should be considered.
5. Patients have a key role in the management of their issues. They should be involved in the development of care plans and should be educated to understand the risks of opiates, the lack of long term benefit which may influence the demand

[8] Introducing the Biopsychosocial Model for good medicine and good doctors | The BMJ
[9] Biopsychosocial Model - Physiopedia (physio-pedia.com)

for initiation and reduction in dosages, and empowered to self-manage their condition.

6. Sharing information about the approach to chronic pain is of particular importance when there is an overlay of other conditions that might result in acute pain (e.g., post-surgery). Care plans should be shared prior to admission and the approach to pain management clearly set out in the discharge summary.[10]

7. Providers of undergraduate and postgraduate training programmes should review the content to ensure they provide opportunities for health professionals to raise their awareness and increase their understanding of how best to care for and support patients with chronic pain.

8. Each system should identify and give prominence to System Change Agents. These are individuals within Systems that are enthusiastic and advocate for change regarding chronic pain management approaches.

9. The Senate Council recommends that a formulary of interventions is co-produced with people with lived experience to ensure that interventions are appropriate and that people with lived experience are empowered to effect change to improve service delivery and the range and availability of interventions. This formulary of interventions will ensure that the interventions are accessible to all groups, relevant, and appropriate. It will be part of the rehabilitation pathway and shared across primary care and secondary care so that there is a clear plan to move patients from secondary care back to primary care (in the community). It should include interventions such as social prescribing, patient education programmes and facilitated peer support groups.

10. Prescribers play a crucial role in speaking with patients from the start, as to expectations and duration of the use of opioid medication i.e., there is no evidence that supports its long-term use. Hence prescribers must be clear as to their responsibilities. The Senate Council recommends that the role and responsibility of prescribers be reinforced and that they are empowered to challenge prescription requests, if, in their professional opinion, this would not be in the patient's best interest.

These recommendations will be shared with the South West Academic Health Science Network, the West of England Academic Health Science Network, the South West Region's ICB Leaders, Directors of Public Health, and the Medicine Safety National Leads. It will also be published on the website of the South West Clinical Senate.

[10] The Royal College of Physicians Health Informatics Unit has developed a learning resource to support the development of effective discharge summaries. Improving discharge summaries – learning resource materials | RCP London

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File path:

Appendices

Appendix 1: Links to speaker presentations

Please follow link to presentations listed below: Presentations contributed to "How can we support people in the South West to live well with pain whilst reducing and preventing harm from opioids medication? " - South West Senate (swsenate.nhs.uk)

Title	**Speaker**
Scene setting	**Dr. Cathy Stannard**, Clinical Lead, Pain Transformation Programme, NHS Gloucestershire ICB
Reflections from a PCN perspective	**Dr. Arpit Srivastava,** GP Clinical Lead for GWH PCN. Digital Lead Primary Care for BSW ICB. Member of NICE Technology Appraisal Committee
Reflections from an acute hospital perspective	**Dilesh Khandhia,** Deputy Pharmacy Director, Royal United Hospital **David Hutchins,** Consultant in Pain Medicine and Anaesthesia, University Hospitals Plymouth NHS Trust
Reflections from the Citizens Assembly: A patient and public perspective	**Nick Pennell,** Chair of the Citizens Assembly

Appendix 2: Further reading and useful resources

- Improving Chronic Pain Management by Reducing Harm from Opioids Report 2021, National Patient Safety Improvement Programmes, NHS England, NHS Improvement
- NICE guideline [NG215]Published: 20 April 2022
- NICE guideline [NG193] Published: 07 April 2021
- BMA Chronic pain: supporting safer prescribing of analgesics
- Public Health England's Review, Prescribed medicines review: report
- West of England AHSN Guide launched to help primary care reduce harm from opioids
- Home - Flippin' Pain (flippinpain.co.uk)
- Ten Footsteps to Living Well with Pain | My Live Well With Pain
- Curable: A Different Approach to Chronic Pain (curablehealth.com)
- NHS England » Optimising personalised care for adults prescribed medicines associated with dependence or withdrawal symptoms: Framework for action for integrated care boards (ICBs) and primary care