Opioid Optimisation Guidance for Pain Medicine Specialists

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

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Purpose Statement

This document provides educational and supportive guidance to physicians practising as Pain Medicine Specialists[1] (hereafter referred to as Pain Medicine Specialists) required for opioid optimisation. The term, as used in this document, refers to doctors who have been trained to the highest standards under the governance of the Faculty of Pain Medicine (FPM).[1] The FPM defines the skills and training across all areas of pain medicine, from acute, in-hospital pain to chronic pain in community, primary, secondary and tertiary care. They maintain standards of practice aligned with the General Medical Council (GMC).[2]

The FPM recognises that the Pain Medicine Specialist works within and as a part of a multi-disciplinary pain management team. This document is intended as a supportive resource in opioid optimisation and to serve as an adjunct to other valuable therapies offered by the wider multi-disciplinary team.

Pain Medicine Specialists manage patients with complex pain, often where pain is a condition in its own right. They often work within multi-disciplinary teams with specific and overlapping roles. This document emphasises integrated access to a range of specialist medical and multi-disciplinary treatments instead of unidisciplinary or mono-therapeutic care – the latter is often inappropriate for patients with complex pain problems. Pain Medicine Specialists are also uniquely qualified to provide expert medical evidence on pain conditions. The FPM defines Pain Medicine Specialists' roles and sets their expected professional standards[2]. Similarly, other highly specialised health professionals working within multi-disciplinary pain teams abide by regulations and standards set by their respective regulatory bodies.

In a recent statement on opioids, the FPM stated:

> *"Effective, personalised care should include shared decision-making with patients and regular reviews to assess if the treatment is working. Patients who want to stop using a medicine must be able to access appropriate medical advice and treatment and must never be stigmatised". The FPM would caution that it is important to recognise that the reverse is also true; that the "effective personalised care with shared decision making with the patients and regular reviews of treatment" will also reveal a group of patients where medications may be associated with dependence or withdrawal symptoms but still be providing a significant degree of pain relief and improvement in overall function and quality of life. This group of patients must also never be stigmatised and/or taken off their medication inappropriately without a thorough risk benefit assessment.*
>
> *The FPM advocates personalised care and shared decision making with each patient suffering from chronic pain, using multi-modal evidence-based pain management appropriately and may often include using such medication. It is vital that such medication usage is regularly reviewed and only continued if there is evidence of improvement in pain, quality of life and levels of function, always balanced against a clear understanding of potential risks and side effects associated with such medication."*

Executive summary

1) This publication provides educational and supportive guidance for Pain Medicine Specialists in managing opioid optimisation for people suffering from complex pain conditions.

2) The responsibilities of a Pain Medicine Specialist extend beyond assessing and treating pain and managing opioid-related issues. These include enabling best commissioning, collaborative working, and interdisciplinary assessment.

3) There are multiple models of care to help establish the best effective local practice.

4) The benefits and harm of long-term opioids must be carefully considered before and during opioid prescribing.

5) Risk factors for problematic opioid use and clinical evidence of emerging problems should be identified.

6) The Faculty of Pain Medicine Opioids Aware Guidance[3,4,5] provides detailed advice to consider when initiating or continuing to prescribe opioids.

7) A patient-centred approach with shared decision-making should be adopted for patients on high doses of opioids. This can be enabled by providing information about the long-term harms of opioids and agreeing on an individualised care plan for these patients.

8) When opioid optimisation and reduction is undertaken in secondary care, this should ideally be undertaken within a multi-disciplinary framework to facilitate appropriate assessment and treatment of pain, and to optimise patient engagement and compliance.

9) The rate of opioid reduction and the choice of opioid preparations should be individualised and carefully considered in each clinical context[5,6].

10) During the reduction process, psychological support to the patient and signposting to other services may be required.

11) Appropriate, timely follow-up is integral to the process of opioid optimisation.

12) In exceptional circumstances, and only after exhausting efforts to achieve shared decision-making, a unilateral opioid dose reduction decision may be necessary to ensure the safety of the patient, in keeping with the GMC's Guidance of Best Medical Practice[7].

13) Opioid reduction[5,6] in individuals on longstanding high-dose opioids carries a significant risk of destabilising their condition, increasing the risks of self-harm or even death. A multi-disciplinary team is critical to appropriate decision-making.

14) Documentation of the assessment, communications, and agreed shared decisions should be made throughout the process of opioid optimisation.

Introduction

In response to increasing public and professional concern regarding the increase in opioid prescriptions in the United Kingdom, in 2018, the FPM produced a briefing statement[8] encouraging the screening and assessment of people currently taking opioids for chronic non-malignant pain. The briefing statement provided direction on much-needed guidance for its doctors and led to the creation of an FPM working group for opioid optimisation. The working group started developing this document in 2019. Following unavoidable delays due to the Covid-19 Pandemic, the document underwent several revisions, incorporating data and evidence in relevant documents published by other governing bodies in the interim, till this publication to date.

Most medicines optimisation will occur in the community setting by General Practitioners (GPs) and clinical pharmacists. However, Pain Medicine Specialists will provide clinical support for patients with complex needs. This can occur in community services, outpatients or during inpatient admissions in secondary or tertiary care.

There can be no formulaic prescription of care in this complex cohort of patients. This document encourages a holistic approach to managing these complex scenarios involving multiple clinical issues. A highly skilled, integrated, individualised treatment and care plan is crucial for a successful outcome.

Aims

The prime purpose of this publication is to provide education and supportive guidance for Pain Medicine Specialists in managing opioid optimisation. It does not define professional standards, although guidance on necessary standards of practice is offered where appropriate.

The focus is predominantly on opioids, although reference is made to other group of drugs. **The rationale of prescribing opioids should be to use the minimal effective opioid dose whilst frequently reviewing and balancing the potential benefits against the harm.** A multi-disciplinary assessment and management plan is vital for helping patients with complex pain conditions, focusing on other non-pharmacological strategies.

An overarching medicine optimisation strategy

This document is one component of a far-reaching strategy from the FPM to encourage the best prescribing practices for opioids and other analgesics in pain management.

The FPM has published the following:

- Opioids Aware[3] a resource for patients and healthcare professionals to support prescribing opioid medicines for pain.
- Guidance related to surgery and opioids highlighting best practices to optimise opioid use after surgery in the community[9].
- Patient information leaflets about common pain medicines for patients[10]

Responsibilities of a Pain Medicine Specialist

The role of a Pain Medicine Specialist[1] is constantly evolving. With newer commissioning and service provision challenges and a constant focus on resource optimisation, these responsibilities often extend beyond assessing and treating pain. Please refer to the glossary for a detailed description of a Specialist in Pain Medicine.

Models of Practice

Various models of opioid reduction and optimisation have been described in primary and secondary care within the NHS. Beyond the NHS, other service providers have facilitated opioid optimisation in clinics.

Examples of Models of care include:

- GP-led medication review and optimisation.
- Advanced Nurse Practitioner, Specialist Nurse led review and optimisation.
- Community Pharmacist led medication review and optimisation.
- Community Multi-disciplinary Team (MDT) approach in combination of the above
- MDT with liaison Pain Medicine Specialist in secondary care.
- Patient-led optimisation (with ongoing assessment and review by healthcare professionals)

The purpose of this document is not to recommend any one model of care above another but to share the resources to facilitate the development of effective opioid optimisation and opioid stewardship within the local NHS framework.

The document identifies some common generic themes on patient safety and clinical management and signposts the key considerations. Some examples of models of care can be found as follows:

- East Kent Prescribing Opioid Tapering Resource Pack[11]
- Oxford Model: Guidance for the opioid reduction in primary care[12]
- Wigan Borough CCG Opioid Prescribing for Chronic Pain: Resource Pack 2018[13]
- South and West Devon Formulary and Referral[14]
- The I-WOTCH study: an opioid tapering support programme for people with chronic non-malignant pain[15]
- FPM Opioids Aware – Tapering and Stopping[6] Website - Benefits and harms of long-term opioids

Opioids can be prescribed only after a thorough risk-benefit assessment[4]. Opioids may help reduce pain intensity, improve sleep, and improve daily function and activity levels in some chronic pain conditions. There is a lack of evidence to support the effectiveness of long-term (> 3 months) opioid therapy for reducing chronic pain or improving function[16].

Use of opioids in the long-term, if already established, must be continued with caution and with meticulous monitoring of outcome, using an individualised care approach[17,18,19,20,21].

There is evidence of significant potential harms associated with long-term use of opioids. These include increased incidence of falls and fractures, endocrine abnormalities including significant adrenal insufficiency precipitating adrenal crisis[21] risk of immunosuppression, worsening of pain (Opioid Induced Hyperalgesia), myocardial infarction and accidental overdose and death[20,21,22].

The side effects of opioids are listed in Table 1.

Table 1

Side effects of long-term opioid use[21,22]
• Constipation
• Nausea
• Daytime somnolence
• Poor concentration and memory loss
• Increased risk of falls
• Opioid Induced Ventilatory Impairment (OIVI), compounded by co-prescriptions, e.g., gabapentinoids, benzodiazepines and Z drugs
• Effects on hormones, particularly reduced testosterone levels (in men and women), leading to infertility, decreased libido, amenorrhoea, sexual dysfunction, fatigue, hot flushes, depression and osteoporosis
• Effects on the immune system. Both animal and human studies have demonstrated that opioids have an immunomodulation effect
• Opioid-Induced Hyperalgesia (OIH): OIH should be considered if a patient on long-term opioid therapy presents with increased pain. This might be qualitatively and anatomically distinct from pain related to disease progression or breakthrough pain resulting from opioid tolerance. Pain associated with hyperalgesia tends to be more diffuse than the pre-existing pain and less defined in quality
• Problematic opioid use, opioid and other analgesic dependence and misuse
• There is a seven-fold increase in mortality risk when Oral Morphine Equivalence (OME) is escalated from 20mg to 100mg.

Identification and assessment of patients with problematic opioid use

The risk factors for opioid dependence include a previous and family history of a substance use disorder, reluctance to acknowledge psychological contributors to pain and significant psychiatric comorbidities, among others[4].

Red flags and assessment tools can help assess patients at risk of misusing prescription opioids. Lawrence et al.[23] conducted a comprehensive systemic review to determine validated measurement tools that can be used to evaluate the risks of problematic analgesic use in patients with chronic pain.

- The Screener and Opioid Assessment for Patients with Pain (SOAPP)[23] is a predictive tool for problematic opioid use and is often used in clinic settings. It is a questionnaire of 24 items using a five-point scale that has been validated.
- The Current Opioid Misuse Measure (COMM)[25] is a patient self-assessment questionnaire consisting of 17 items. It aims to identify patients on long-term opioid therapy who may be showing signs of prescription opioid misuse.

Table 2

Red flags for misuse in patients on long-term opioids[3,26,27,28]
Patient report of increasing pain with requests for an increased opioid dose
Psychological deterioration
Reliance / focus on pharmacological treatment only, with no engagement with self-management strategies, exercise, physiotherapy, psychological support etc.
Lost prescriptions / dropped bottles / extra doses requests needed for trips away etc.
Continued use despite side effects (constipation, sedation)[29]

Patient engagement strategies

In light of the recent increase in public awareness of the problems of long-term opioids, safe prescribing of opioids and opioid stewardship is now on the radar of every healthcare professional involved in pain management[29,30]. Appropriate experience, expertise, and dedicated time for the opioid optimisation consultation are essential to achieve the desired outcome[31,32,33].

A key factor that often drives a patient to optimise their opioids is the impact of opioids on their quality of life. A patient-centred approach with shared decision-making is central to this process. It often requires more than one consultation to develop a trusting and therapeutic relationship.

When initiating discussions about opioid optimisation, it is helpful to contextualise the risks and concerns for the individual on high-dose opioids and formulate an optimisation plan tailored to the individual. For example, a discussion about the common side effects of opioids is often helpful. This may include constipation, worsening pain while on opioids (opioid-induced hyperalgesia), declining or worsening of underlying pain condition, loss of libido (hypogonadism), generalised fatigue, hormonal imbalances, increased risk of infections from immunosuppression and worsening of any underlying sleep apnoea.

Older patients may have renal impairment. When they suffer from acute illnesses such as diarrhoea and vomiting, they may become more vulnerable to the harmful effects of opioids, such as excessive sedation and respiratory depression.

There is an increased risk of asymptomatic (silent) aspiration and chest infection in older patients from a progressive decline in airway reflexes and swallowing. Opioids impact cognition, too, especially in the presence of other concomitant illnesses such as urinary tract infections (UTIs). These risks and side effects must be balanced against the perceived benefits of taking long-term opioids.

When reducing opioids, it is necessary to discuss and agree on a start date, estimated time frame, and an agreed, realistic endpoint of reduction, with clear documentation and communication, so patient expectations about the process can be managed accordingly.

Some individuals may be keen to reduce their opioids but are anxious about withdrawal risks, side effects and fear of worsening their pain. Reassurance, motivational interviewing, empowering through self-management strategies and providing access to a rescue analgesia plan to manage their symptoms can be helpful. Patients may also want to engage with other pain management services, e.g. pain psychology or pain management programmes to facilitate or progress

with an opioid optimisation plan. Hence, a multi-disciplinary team (MDT) approach is often essential to achieve optimisation for these people living with chronic pain.
It is necessary to have a detailed discussion with patients about the withdrawal symptoms and management plan before any reduction of their opioids is initiated. Opioid withdrawal can be unpleasant and may be associated with flu-like symptoms. Symptoms of opioid withdrawal can include nausea and vomiting, anxiety, insomnia, hot and cold flushes, perspiration, muscle cramps, watery discharges from the eyes, nose, and diarrhoea. While opioid withdrawal is usually not life-threatening[4] and settles down with time, it may need symptomatic management.

The following can be powerful indicators to consider opioid reduction:

- Self-motivation of the patient following information about opioids.
- No clinically meaningful improvement in pain and function while taking opioids.
- Patients on high-dose opioids without demonstrable improvement in pain, combined with benzodiazepines and other sedative medications, that increases the risk of side effects and accidental overdose.
- Signs of substance use disorder (e.g., work or family problems related to opioid use, difficulty in managing opioid use)
- Patients experiencing an overdose or serious adverse events or showing early warning signs of overdose risk, such as confusion, sedation, or slurred speech.

Strategies for Opioid Optimisation

Opioid optimisation must be undertaken within a comprehensive shared decision-making framework, including a broader assessment of pain, alternative treatments and co-prescribing (Table 3).

A Cochrane review from 2017[34] identified several adverse events associated with the medium- and long-term use of opioids for chronic non-cancer pain. The authors concluded that clinically relevant benefits must be demonstrated before long-term use can be considered in clinical practice in people with chronic non-malignant pain.

A pragmatic plan to support an opioid reduction in patients with chronic non-malignant pain may include several interventions such as multi-disciplinary pain management programmes, acupuncture, behavioural strategies such as motivational interviewing, cognitive behavioural therapy, mindfulness, and education in self-management of pain, as well as rational use of other pain medications besides opioids. The quality of evidence for any specific intervention is often low because of methodological limitations of studies, variable interventions, and overall outcome measures. Therefore, the management of opioid optimisation is based on **sound pragmatic clinical judgement and shared decision-making with the patient.**

The salient points of opioid optimisation are:

- Goals of opioid therapy.
- Identifying shared treatment goals.
- Planning an opioid prescription with the lowest dose of opioids that enables function and reduces side effects.
- Supporting and planning for flare-up and withdrawal symptoms management.
- Reviewing progress with documentation and communication to other health care professionals involved.

Table 3

	Managing opioid reduction within a shared decision-making framework[11,35,36],
A	Assessment of chronic pain, including mechanism, diagnosis and opioid responsiveness and explanation to the patient, ideally in a face-to-face consultation. Provision of patient information leaflets / resources at the time of consultation.
B	Calculation of current Oral Morphine Equivalence (OME) through an opioid calculator, adding up all doses and types of opioids (Extended release, modified release, immediate release oral, sublingual preparations, and transdermal patches).
C	Review the use of other concurrent sedative medications such as gabapentinoids, antidepressants, benzodiazepines, and Z-drugs. Review of the use of supplements and other non-prescribed medications.
D	Discussion with the patient regarding potential side effects and risk-benefits of long-term opioids, signposting to FPM Opioids Aware[4] website information and highlighting the need to limit opioid use. Interactive discussion using images, analogies and relevant web resources.
E	Reduction of long-acting opioids, provision of using short-acting opioids on a PRN basis to address the flare-ups and activity-related pain, setting a maximum daily dose limit.
F	Exploring options of other non-opioid medications where feasible, including simple analgesics, NSAIDs and anti-neuropathic medications as indicated, to facilitate the process of opioid optimisation. In selected cases, ketamine infusion and sublingual buprenorphine opioid rotation can be considered.
G	Timely communication with the primary care provider of the opioid plan, with an appropriate planned review.
H	Provision of MDT support including nurse specialist, pharmacist, physiotherapist and psychologist.

Frequently Asked Questions

How rapidly can the opioid daily dose be decreased?

A common rate of decrease quoted is a 10% at a time[1]. However, when there is a large reduction in the dosage to be carried out, and the patient is motivated for reduction, consideration may be given to a higher percentage step change, after a detailed risk-benefit assessment and with appropriate support in place.

Stepwise decrease in opioid reduction plans can be implemented weekly, fortnightly or every four weeks and an individual plan should be formulised in discussion with the patient. Clear, concise communication must be maintained with the patient's GP to ensure prescriptions are amended accordingly.

There are several models[36,37] to decrease daily opioids use e.g.

(A)The Oxford Model of the opioid reduction[12]

Option 1:
Keeping Modified Release (MR) opioid dose stable, weaning Immediate Release (IR) opioid doses by

- Keeping the same frequency; reducing the doses (20mg to 10mg to 5mg), OR
- Keeping the same dose, reducing the frequency (QDS to TDS to BD)

Option 2:

- Reducing the Sustained Release (SR) or Modified Release (MR) dose by 10% reduction per dose per week while keeping the PRN Immediate Release (IR) opioid dose unchanged.

(B)The CDC USA Model[33]

- The CDC model aims at reducing and stopping long-acting opioids and using only Immediate Release (IR) opioids, where appropriate, for activity-related pain and breakthrough pain management.

How rapidly can the transdermal Fentanyl patches be decreased[11]

Transdermal fentanyl patches can be decreased by 12 -25 micrograms/hr reduction every two to four weeks. There can be up to 24 hours lag between dose reduction and exhaustion of the reservoir of the drug. At lower doses, the percentage reduction of the fentanyl patch can be high, risking opioid withdrawal. Hence, additional opioid cover with a short-acting opioid may be required, or the fentanyl patch can be switched to an alternative opioid in an equivalent dose. While formulating a dose reduction plan, consideration must be given to the individual's life circumstances, **acknowledging that it may take longer in some instances because of life events or unforeseen flare-ups.**

Which opioid to use in long-term prescribing?

Oral morphine is considered the drug of the first choice[3] however, there is little evidence that one opioid is more effective and associated with fewer side effects than others. It is reasonable to try an alternative opioid if the initial opioid has been helpful but causes intolerable side effects. Careful considerations are given to comorbidities and other prescribed medications while choosing the most appropriate opioid for optimisation.

Solution v Tablet Formulations

The Immediate Release (IR) solution and tablet preparations of morphine and oxycodone have similar absorption times and duration of action at the same doses. When there is clinical concern about the possible overuse of opioids above the prescribed doses, dispensing calculated doses of opioids in tablet preparations may be helpful. This can help with compliance with the optimisation process, support monitoring, and reduce the risk of bottle "swigging". It is also important to note that IR morphine solution contains 10% alcohol.

Excessive patient focus on opioid prescription may be a clue to drug dependence behaviour[40]. As a part of an opioid reduction strategy, changing from solution to tablet form of IR opioid may be an effective strategy in specific patient cohorts.

MDT in Pain Management

Multi-professional care requirements

Best practices for treating people with chronic pain require a coordinated multi-professional team approach[36,37]. There is considerable evidence to suggest that individuals who use inappropriately high doses of prescribed opioids are often those for whom opioids are least appropriate[4]. Within this group, there is a high incidence of concurrent mental health conditions, including anxiety and depression. There are challenges like unrealistic expectations from treatments and

interventions, failure to cope or manage pain using alternative pain-reducing strategies, unhelpful belief structures and difficulties in engaging and applying self-management strategies for pain management.

When opioid optimisation is undertaken in a specialist setting, this should be undertaken within a multi-disciplinary team framework. It will enable appropriate assessment and treatment of pain, with the highest standards of care to promote acceptance of necessary medicine optimisation and engagement with the optimisation process. Individuals may be at risk of undergoing additional psychological distress during the optimisation process, requiring careful management. Opioid reduction for people on longstanding opioids carries a significant risk of destabilising their pain condition, causing self-harm or even death.

The structure and function of the multi-disciplinary pain management team for complex patients in a secondary care setting are outlined in *Core Standards for Pain Management Services in the UK*[2]. In the primary care setup, motivational interviewing of individuals on high doses of opioids by the GP and other primary care health care professionals can help initiate and facilitate opioid optimisation.

Approaches to follow-up

Follow-up[3] is integral to the process of opioid optimisation. Timely support during optimisation is crucial, especially in the early stages when positive reinforcement and reassurance can help individuals progress with the optimisation strategy. Timely communication of the agreed timelines and treatment goals to all stakeholders in this process is vital to ensure a successful outcome. In certain exceptional circumstances, seeking advice and guidance from local substance misuse services may be needed to enable opioid optimisation and safe medication prescribing. Motivational interviewing[41] techniques can be adopted in challenging consultations. The process of opioid optimisation could be initiated within the secondary care pain service and followed up in the primary care and/or the substance misuse service as locally feasible and needed.

Dealing with non-engagement

Pain Medicine Specialists must always strive for shared decision-making after detailed explanations and careful management of patient concerns. In clinical practice, significant problems and friction arise when a collective view of healthcare professionals to decrease opioids for safety reasons is met with continued resistance and non-compliance by the patient. An MDT assessment of the risks and clear communication between primary and secondary care is crucial in these extreme situations. The assessment must quantify the risk of functional and psychological destabilisation and possible risks of obtaining opioids from illegal sources: supervised consumption and daily pickup of medications approaches have been used to support individuals with substance misuse disorders[39].

When individuals on high-dose opioids do not engage in an opioid optimisation process, it poses an ethical dilemma for clinicians. While patient autonomy to determine their treatment should be respected, the General Medical Council (GMC) guidance prompts all doctors to work in the best interest of patient care and safety. Only after exhausting all available avenues of patient engagement, an approach of unilateral opioid reduction may be considered to reduce high doses of opioids with further consideration to stop if needed for patient safety. This situation can be challenging for both the patient and the healthcare professional and should only be reserved as an absolute last resort.

Ethical and legal challenges

The FPM acknowledges that healthcare professionals are increasingly being placed under ethical or legal scrutiny around frameworks of care involving the prescription of opioids[3]. There are medicolegal cases challenging the decision-making process around opioid prescribing from primary and secondary care pain management teams.

When initiating opioids for pain management, clinicians need to be meticulous in assessing and documenting the risks and benefits of prescribed opioids with informed consent, including consideration of alternative available treatments. There should be a written detailed clinical assessment of the pain and an overview of the other treatments available and tried before prescribing opioids for pain. Pain Medicine Specialists should aim for shared decision-making with informed patient consent through effective consultations. The clinical note from the patient interaction episodes should reflect this process for medicolegal purposes. The opioid optimisation framework should involve a multi-disciplinary approach, with regular and timely assessment and reviews during the optimisation process.

Glossary

Definitions

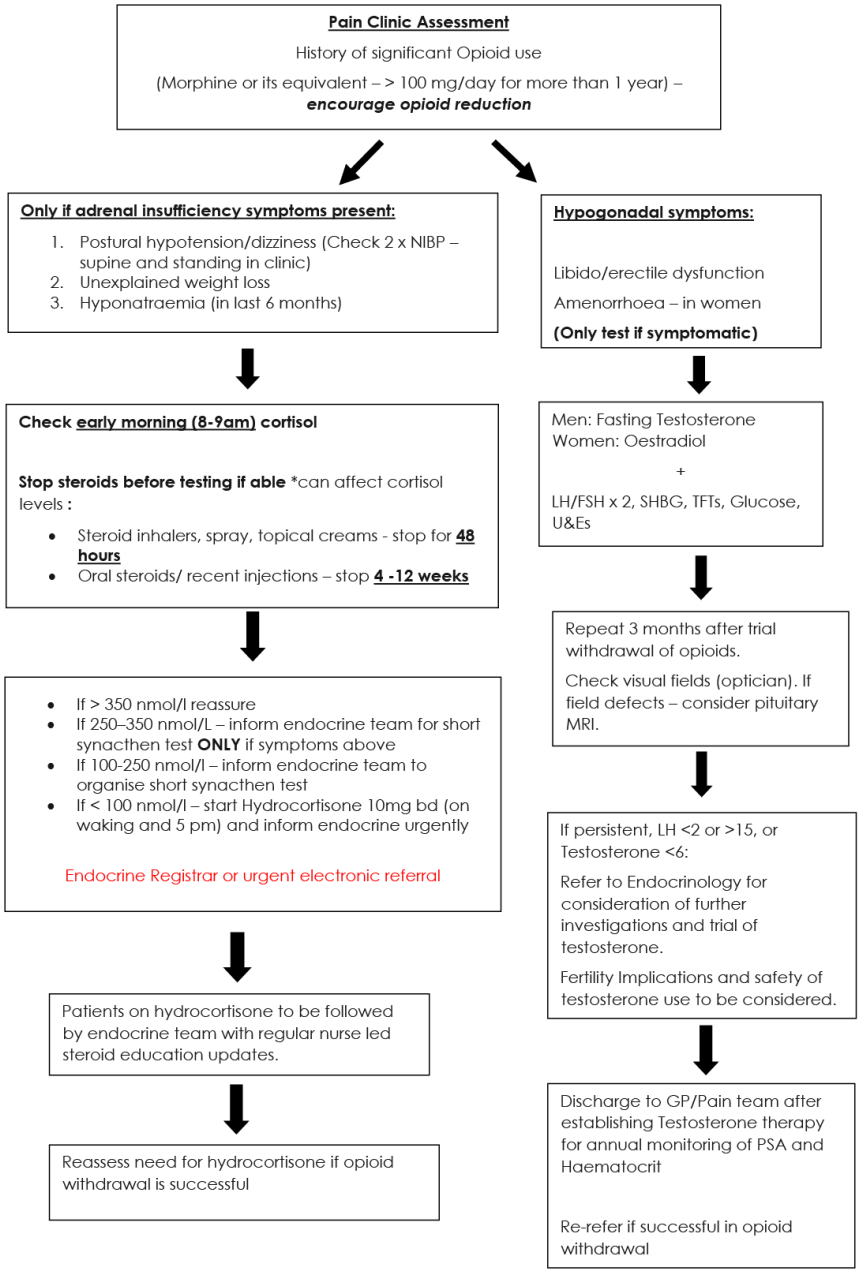
1. **Medicines Optimisation**[39] looks at the value which medicines deliver, making sure they are clinically effective and cost-effective. It is about ensuring people get the right choice of medicines at the right time and are engaged in the process by their clinical team.
2. **Pain Medicine Specialists** are doctors who are specially trained, qualified and revalidated to offer integrated, expert assessment and pain management using their unique knowledge and skill set, usually within the context of a multi-disciplinary team[1].
3. **Community Services** are services mainly delivered in people's homes, community hospitals, intermediate care facilities, clinics and schools. They are made up of a wide variety of professionals including community nurses, therapists, allied health care workers, social care workers.
4. **Transitional Pain service** is a multidisciplinary service that employs a multi-faceted approach to monitoring opioid use after discharge from surgery, and aims to safely wean patients from opioids while maintaining effective pain management

Pain Medicine Specialists are involved in the following:

- Commissioning of pain services in primary and secondary care.
- Liaising with primary and secondary care clinicians, GPs and community pharmacists.
- Multi-disciplinary working within pain management teams and on a broader basis with mental health, musculoskeletal and social services. Links with psychiatry and substance misuse teams.
- Assessing risk factors for sedation, respiratory depression, dependence, and substance use disorder.
- Working in collaboration with acute, in-hospital and transitional pain service teams.
- Participating in perioperative care and enhanced recovery pathways.
- Developing specialist services such as opioid stewardship and medication optimisation clinics.
- Supporting training and education of pain medicine to other specialities and allied healthcare professionals.

Useful Resources

- Health and Social Care Professions Council. Standards for Prescribing. 2019. https://www.hcpc-uk.org/standards/standards-relevant-to-education-and-training/standards-for-prescribing/
- Nursing and Midwifery Council. Standards of record keeping proficiency for guidance for nurses and midwives nurse and midwife prescribers. 2006. https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-proficiency-nurse-and-midwife-prescribers.pdf
- Royal Pharmaceutical Society. Prescribing competency framework. 2016. (updated 2021). https://www.rpharms.com/resources/frameworks/prescribing-competency-framework/competency-framework
- Opioid and endocrine insufficiency management flowchart. Pain Clinic & Endocrine team, Aberdeen Royal Infirmary, NHS Grampian. (please see diagram below)



- Department of Health and Social Care. Controlled Drugs (Supervision of Management and Use) Regulations. 2013. https://www.gov.uk/government/publications/information-about-controlled-drugs-regulations
- Department of Transport. Guidance for healthcare professionals on drug driving. 2014. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/325275/healthcare-profs-drug-driving.pdf
- National Institute for Healthcare Excellence. *Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults. NICE guideline [NG215]*. 2022. https://www.nice.org.uk/guidance/ng215
- NHS England. *Optimising personalised care for adults prescribed medicines associated with dependence or withdrawal symptoms: Framework for action for ICBs and primary care*. 2023. https://www.england.nhs.uk/long-read/optimising-personalised-care-for-adults-prescribed-medicines-associated-with-dependence-or-withdrawal-symptoms/
- NHS Greater Manchester. *NHS Greater Manchester Integrated Care - Opioid Prescribing for Chronic Pain: Resource Pack.* https://gmmmg.nhs.uk/wp-content/uploads/2023/12/Opioid-resource-pack-2023-final-for-web.pdf
- NHS Derby and Derbyshire. *JAPC Opioid Prescribing for Chronic Pain: Resource Pack.* https://www.derbyshiremedicinesmanagement.nhs.uk/assets/Clinical_Guidelines/opioid/JAPC_opioid_resource_pack.pdf
- Health Innovation Network. *Reducing harm for people with chronic pain by reducing the prescribing of opioids*. 2024. https://healthinnovationnetwork.com/wp-content/uploads/2023/11/Opioids-resource-pack-rebranded-January-2024-1.pdf
- NECS Medicines Optimisations. https://medicines.necsu.nhs.uk/opioidresources/
- Frimley Health and Care Integrated Health System. *Opioid tapering guidance and resources for Primary Care*. https://www.frimley.icb.nhs.uk/policies-and-documents/medicines-optimisation/prescribing-guidelines-1/central-nervous-system/1997-opioid-tapering-toolkit-and-resources-for-primary-care/file

References

1. Faculty of Pain Medicine of the Royal College of Anaesthetists. The Good Pain Medicine Specialist: Standards for Revalidation of Pain Medicine Specialists in the UK 2021. https://fpm.ac.uk/media/831
2. Faculty of Pain Medicine of the Royal College of Anaesthetists. *Core Standards for Pain Management Services in the UK edition 2*. 2021. https://fpm.ac.uk/media/3231
3. Faculty of Pain Medicine of the Royal College of Anaesthetists. *Opioids Aware*. https://fpm.ac.uk/opioids-aware
4. Faculty of Pain Medicine of the Royal College of Anaesthetists. *Taking opioids for pain*. https://fpm.ac.uk/opioids-aware-information-patients/taking-opioids-pain
5. Faculty of Pain Medicine of the Royal College of Anaesthetists. *Writing opioid prescriptions.* https://fpm.ac.uk/opioids-aware-best-professional-practice/writing-opioid-prescriptions
6. Faculty of Pain Medicine of the Royal College of Anaesthetists. *Tapering and stopping.* https://fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/tapering-and-stopping
7. General Medical Council. *Good Practice in Prescribing and managing medicines and Devices 2021.* https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices
8. Faculty of Pain Medicine of the Royal College of Anaesthetists. *Briefing Statement to Health Professionals on the Management of Opioid Medications.* https://fpm.ac.uk/sites/fpm/files/documents/2019-07/FPM%20Opioid%20letter%202018.pdf
9. Faculty of Pain Medicine of the Royal College of Anaesthetists. *Surgery and Opioids: Best Practice Guidelines.* https://fpm.ac.uk/media/2721
10. Faculty of Pain Medicine of the Royal College of Anaesthetists. *Patient Information Leaflets.* https://fpm.ac.uk/patients/patient-info
11. East Kent Prescribing Formulary. *Opioid Tapering Resource Pack*. 2020. https://eastkentformulary.nhs.uk/media/1572/opioid-tapering-resource-ekpg-jan-2020.pdf
12. Oxford University Hospitals NHS Foundation Trust. *Guidance for an opioid reduction in primary care.* 2023 https://www.ouh.nhs.uk/services/referrals/pain/documents/gp-guidance-opioid-reduction.pdf
13. NHS Greater Manchester Integrated Care. *Opioid Prescribing for Chronic Pain: Resource Pack - GMMMG Opioid Prescribing for Chronic Pain: Resource Pack*. https://gmmmg.nhs.uk/wp-content/uploads/2023/12/Opioid-resource-pack-2023-final-for-web.pdf
14. South & West Devon Formulary and Referral. *Management of Opioids.* https://southwest.devonformularyguidance.nhs.uk/formulary/chapters/4-central-nervous-system/management-of-opioids
15. Nichols VP, Abraham C, Eldabe S, Sandhu HK, Underwood M, Seers K. Process evaluation protocol for the I-WOTCH study: an opioid tapering support programme for people with chronic non-malignant pain, *BMJ Open*, Vol 9, Issue 10, 2019. https://bmjopen.bmj.com/content/9/10/e028998
16. Tordoff, S.G., Ganty, P. Chronic pain and prescription opioid misuse, *Continuing Education in Anaesthesia Critical Care & Pain*, 2010. 10: 5, 158-161. https://www.bjaed.org/article/S1743-1816(17)30345-1/fulltext
17. National Institute for Health and Care Excellence. *Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults: NICE Guideline [NG215].* 2022. https://www.nice.org.uk/guidance/ng215
18. National Institute for Health and Care Excellence. *Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes: NICE Guideline [NG5].* 2015. https://www.nice.org.uk/guidance/ng5
19. Eccleston C, Fisher E, Thomas KH, Hearn L, Derry S, Stannard C, Knaggs R, Moore RA. Interventions for the reduction of prescribed opioid use in chronic non-cancer pain. *Cochrane Database Syst Rev*. 2017 Nov 13;11(11) https://doi.org/10.1002/14651858.CD010323.pub3
20. Frank JW, Lovejoy TI, Becker WC, Morasco BJ, Koenig CJ, Hoffecker L, Dischinger HR, Dobscha SK, Krebs EE. Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy: A Systematic Review. *Ann Intern Med*. 2017 Aug 1;167(3):181-191. doi: 10.7326/M17-0598
21. Chou, R., Turner, J.A., Devine, E.B., Hansen, R.N., Sullivan, S.D., Blazina, I., Dana, T., Bougatsos, C. and Deyo, R.A., 2015. The effectiveness and risks of long-term opioid therapy for chronic pain: a systematic review for a National Institutes of Health Pathways to Prevention Workshop. *Annals of internal medicine,* 162(4), pp.276-286. doi: 10.7326/M14-2559
22. Els, C., Jackson, T.D., Kunyk, D., Lappi, V.G., Sonnenberg, B., Hagtvedt, R., Sharma, S., Kolahdooz, F. and Straube, S., 2017. Adverse events associated with medium-and long-term use of opioids for chronic non-cancer pain: an overview of Cochrane Reviews. *Cochrane Database of Systematic Reviews* 2017 Oct 30;10(10):CD012509. https://pubmed.ncbi.nlm.nih.gov/29084357/

23. Lawrence, R., Mogford, D., Colvin, L. Systematic review to determine which validates measurement tools can be used to assess risk of problematic analgesic use in patients with chronic pain, *BJA, 2017 - 119(6), 1092-1109.* https://www.bjanaesthesia.org/article/S0007-0912(17)54137-9/fulltext

24. Butler, S.F., Budman, S.H., Fernandez, K., Jamison, S.N. 2004. Validation of a screener and opioid assessment measure for patients with chronic pain (4) *Pain*, 112, 65-75. DOI: 10.1016/j.pain.2004.07.026

25. Butler, S.F., Budman, S.H., Fanciullo, G.J., Jamison, R.N. 2010. Cross Validation of the Current Opioid Misuse Measure to Monitor Chronic Pain Patients on Opioid Therapy, *The Clinical Journal of Pain, 26(9), 770-776.* doi: 10.1097/AJP.0b013e3181f195ba

26. National Institute on Drug Abuse. *Opioid Risk Tool.* https://nida.nih.gov/sites/default/files/opioidrisktool.pdf

27. Chou, R., Turner, J.A., Devine, E.B., Hansen, R.N., Sullivan, S.D., Blazina, I. et al. The effectiveness and risks of long-term opioid therapy for chronic pain: a systematic review for a National Institutes of Health Pathways to Prevention Workshop. *Ann Intern Med.* 2015. 162 (4): 276-86. DOI: 10.7326/M14-2559

28. National Institute for Health Care Excellence. *Health topics: Opioid Dependence. 2022*. https://cks.nice.org.uk/topics/opioid-dependence/

29. National Institute for Health and Care Excellence. *Controlled drugs: safe use and management: NICE Guideline [NG46]. 2016.* https://www.nice.org.uk/guidance/ng46

30. World Health Organization. *Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings.* 2009. https://iris.who.int/handle/10665/207032

31. National Institute for Health Care and Excellence. *Drug misuse in over 16s: opioid detoxification: NICE Clinical guideline [CG52]* 2007. https://www.nice.org.uk/guidance/cg52

32. Sandhu H, Underwood M, Furlan A, Noyes J, Eldabe S. What interventions are effective to taper opioids in patients with chronic pain? *BMJ* 2018; 362:k2990. doi:10.1136/bmj.k2990.

33. US Department of Health and Human Services – Centers for Disease Control and Prevention. *CDC Clinical Practice Guideline for prescribing opioids for pain.* 2022. https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm

34. Eccleston, C., Fisher, E., Thomas, KH., Hearn, L., Derry, S., Stannard, C. et al. Interventions for the reduction of prescribed opioid use in chronic non-cancer pain. *Cochrane Database Syst Rev*, 2017; 11(11). doi.org/10.1136/bmj.k2990

35. Derby and Derbyshire Integrated Care Board. *Opioid Management Plan: Treatment agreement.* https://www.derbyshiremedicinesmanagement.nhs.uk/assets/Clinical_Guidelines/opioid/Appendix_7_Opioid_Management_Plan.pdf

36. The U.S. Department of Health and Human Services. *Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics*. 2019. https://www.hhs.gov/system/files/Dosage_Reduction_Discontinuation.pdf

37. Addiction Professionals. *The management of pain in people with a past or current history of addiction.* 2018. https://www.addictionprofessionals.org.uk/the-management-of-pain-in-people-with-a-past-or-current-history-of-addiction

38. Davoli M, Amato L. Large evidence base, small effects: motivational interviewing for alcohol misuse in young adults. *Database of Systematic Reviews*, 2014, Issue 9. doi: 10.1002/14651858.ED000088

39. NHS England. *Medicines Optimisation*. https://www.england.nhs.uk/medicines-2/medicines-optimisation/

40. Faculty of Pain Medicine. *Diagnosis, identification and risk populations.* https://fpm.ac.uk/opioids-aware-opioids-addiction/diagnosis-identification-and-risk-populations

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