Health Innovation East Midlands

Joined Up Care Derbyshire

Opioid Prescribing Quality Improvement Toolkit For Primary Care

VERSION 2 (NOV 2023)

Opioid Prescribing Quality Improvement Toolkit For Primary Care (version 2)

Contents

Introduction

This toolkit is a resource for general practices wishing to implement small changes that can reduce inappropriate opioid prescribing for chronic non-cancer pain. There is very little evidence for the use of opioids in chronic non-cancer pain and we estimate that for every 62 patients with chronic pain who can be supported with alternatives to long-term opioid analgesia, 1 life can be saved.

This toolkit is an accumulation of work that has either been tested or is planned to be tested locally and many of the resources included have been shared by general practices. We thank these practices for sharing their learning with us and the wider healthcare system and hope to add to this toolkit with further ideas.

Quality improvement is an established methodology, and this toolkit will use the Institute for Healthcare Improvement (IHI) model (see diagram 1).

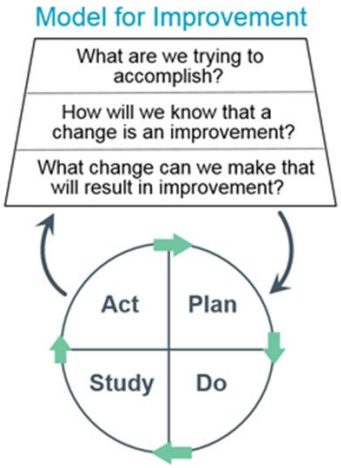

Diagram 1: IHI Model for Improvement

This model uses a Plan-Do-Study-Act (PDSA) cycle to test small changes. By using these cycles general practices can implement small changes with current capacity, quickly testing and adapting, and hopefully celebrating successes. The PDSA cycle is an iterative process that helps implement and refine interventions effectively (diagram 2).

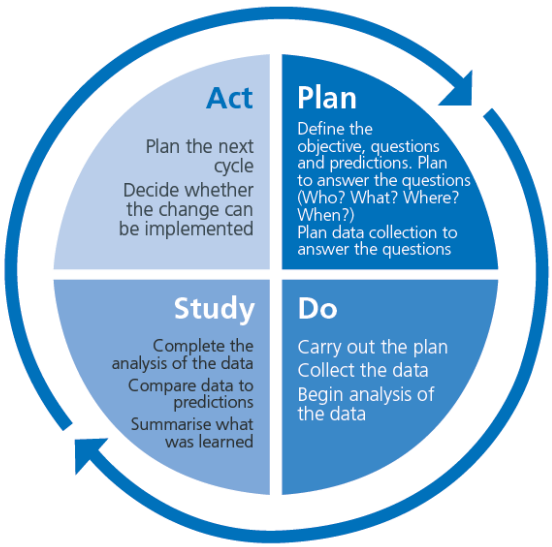

Diagram 2: PDSA cycle

How to use the toolkit

General practices should adapt the tools provided to suit their own ways of working and local populations. The toolkit aims to provide ideas and a structure for implementation but is not intended to provide exhaustive resources or overarching clinical governance. It is recommended that practices locally agree the work and consider clinical governance.

Suggested process:

- View your prescribing data for opioids and discuss as a practice possible opioid related areas of prescribing that you would like to improve.
- The toolkit can suggest ideas that can create changes in prescribing data and practice. Some of these are interlinked.
- Consider the size of the project that you can manage as a team and plan accordingly. It is better to start slowly and do something, than become overwhelmed and stop.
- A PDSA cycle template is provided for each item on the toolkit. This has questions that will help you plan each step of the cycle and suggestions for measurement. Agree and adapt these criteria to suit your needs.
- Remember to measure and share the results across the practice frequently. Sharing results helps to keep everyone focussed and engaged.
- If you are not seeing the results you hoped for on the data, do not be disheartened. It is very important learning and will help inform you on what you can improve for your next PDSA cycle.
- If you do see improvement, make sure you celebrate your success!

1. Repeat prescribing housekeeping

Aim	**Option 1:** To ensure all opioid medication that has not been issued in the last two months is safely removed from repeat on the clinical system if no longer clinically indicated. **Option 2:** To ensure that all schedule 2 and 3 opioid medication that has not been issued in the last two months is safely removed from repeat on the clinical system if no longer clinically indicated. (*Note: the time scale can be adapted as needed e.g., to three months)*
What are we trying to accomplish? (The why)	• To ensure that opioids that are no longer currently required by the patient are removed from repeat. • To ensure patients are using opioids appropriately and for the indication intended by the prescriber. • To avoid inappropriate use of opioids for chronic non-cancer pain. • To support good opioid stewardship.
How will we know that there has been an improvement (measures)	• The change in the number of patients who have opioids on repeat but have not been issued the medication within a specified time. (See resources available section)

What change can we make? (The how)	A suggested approach:
	• Import and run the relevant clinical system search to identify the patients who have not had opioid medication issued in the last 2 months. (The ICB Medicines Optimisation team (ddicb.meds.man@nhs.net) can help you do this if needed.)
	• Review the patients and consider:
	  ○ Removing the item from repeat and communicating the change to the patient. (Suggested Accurx wording is available in resources.)
	  ○ Speaking to the patient to review whether prescribing on repeat is appropriate or whether issuing as an acute when needed is a more appropriate option.
	  ○ If long-term opioids are required but the patient is needing less per month than prescribed. Amend the dose and quantity to reflect the current usage.
	• Re-run the search every two months and review the prescribing.

Resources available	Clinical system searches: SystmOne search; (EMIS searches can be supplied on request.)  Opiate housekeeping searches.rpt Accurx message wording: We are pleased to notice that you have not requested opioid analgesia, such as tramadol, recently. Opioids are no longer routinely recommended for chronic, long-term pain and can be harmful. We have removed this medication from your repeat prescription. It will still be available to request for acute flare-ups of pain. Please contact me at the surgery if you would like to discuss this further https://www.fpm.ac.uk/opioids-aware-information-patients/taking-opioids-pain

Repeat prescribing housekeeping (suggested PDSA cycle worksheet)	
Plan	Choose the search to use (all opioids/just schedule 2 and 3) Choose the time frame for non-collection (2 months/ 3 months/ other) How will communication to the patient happen if medicines are stopped (and agree the template to be used): • Accurx • Letter • Phone • Other Who will: • import and run the search? • review the patients and make the changes to the repeat? • communicate the change to the patient? When will the work start and be completed? How often will you re-run the search: monthly/bi-monthly/other

Do (suggested data to collect)	Searches imported and run (yes/no)
	Date started.
	First run: number of patients:
	• Identified
	• Reviewed
	• Where opioids are removed from repeat
	  ○ Communication sent (and by which route)
	  ○ Who contacted surgery to query the change. (Make a note of the query and outcome)
	Date completed.
	Number of patients who remain with opioids on repeat at the end of the review.

Study	Analyse the results: What worked well: What could be done better or differently:
Act	What changes would you make to the process ahead of the next run of the search? Then plan your next PDSA cycle. *If you have only used the search for schedule 2 or 3 opioids you could consider using the "all opioid" search.*

2. Brief interventions (making every contact count)

Aim	For all healthcare professionals (HCP) in a practice or PCN to use brief intervention techniques to increase the number of people accessing support to optimise pain management and reduce the use of inappropriate opioids. *(Note: Adding in the number of patients aimed for and a timescale will ensure the aim is a SMART aim)*
What are we trying to accomplish? (The why)	Brief interventions have been used successfully in many areas of healthcare to support changes in behaviour and thinking e.g. smoking, and can be transferred to opioids that are being taken for chronic non-cancer pain. This toolkit option aims: • For all healthcare professionals that are seeing a patient who is taking an opioid for on-going pain to perform a brief intervention, provide links to patient information, or refer to a clinician for a pain management review. • To increase patient awareness of the possible harms and lack of effectiveness of opioids in chronic non-cancer pain. • To increase the number of patients accessing support to attempt safe tapering of opioids and explore other options for pain management.
How will we know that there has been an improvement (measures)	• There will be an increase in the recorded use of brief interventions to patients on long-term opioids. • There will be an increase in the referrals made by HCPs to an appropriate clinician for support with pain management and opioid tapering. • There will be a reduction in the number of people taking long-term opioids (NHSBSA ePACT indicator OP2).
What change can we make? (The how)	• Agree a brief intervention process for opioids that is adopted by all HCP in the practice/PCN (consider the wider range of HCP including physiotherapist, social prescribers, health and well-being coaches, community pharmacist) • Ensure all staff are informed and confident with making the intervention.

Resources available	1. A webinar recording aimed at social prescribers and health and well-being coaches on chronic non-cancer pain can be found here.
	
	2. Possible questions/information to use as part of a brief intervention:
	
	• I can see that you are taking (*insert opioid*) for your pain.
	  ○ What benefit do you think it is providing?
	  ○ What side-effects do you think it causes?
	  ○ Have you noticed any other issues or concerns whilst taking your opioid medication?
	• Evidence suggests that for many people opioids are not very effective in chronic (or on-going) pain that is not related to cancer. In many cases they can be harmful and have many side-effects.
	• Would you like to talk to someone at the practice about your pain, other ways of managing your pain, or perhaps reducing your opioids a little?
	• There are some useful sites to help you with information about chronic (on-going) pain. (These can be shared via Accurx or email.)
	  ○ We have our own local one https://joinedupcarederbyshire.co.uk/stay-well/pain-management/self-management/ which also directs to https://livewellwithpain.co.uk/

	○ Brainman stops his opioids https://www.youtube.com/watch?v=MI1myFQPdCE ○ Brainman understanding pain https://www.youtube.com/watch?v=jIwn9rC3rOI • **Reducing your opioids must be done slowly to avoid withdrawal effects. Please do not stop your opioids suddenly and seek medical advice and support when you are ready to reduce. *(Note: A version of this advice wording should be included)*** **3.** If you believe a patient may be dependent on their opioids but unaware, this short video that shares lived experience can be shared electronically to allow the patient to reflect and re-engage with the clinician.

Brief interventions (suggested PDSA cycle worksheet)	

Plan	• Choose the brief intervention questions and information that will be used.
	• Decide who will be included in the HCP group that will implement the intervention.
	• If a person says they would like support, who should the HCP refer to and how?
	• How will the data be collected for:
	  ○ Number of brief interventions undertaken.
	  ○ Number of patients that have been referred for pain management support because of the intervention.
	  ○ Outcome of intervention
	• Who will collect the information?
	• Who will train the HCPs and when (including who will organise the training).
	• What resources are required e.g., list of questions, Accurx messages, links to websites and how will the HCP access them?
	• When will the process be reviewed (the end of the "do" phase of the PDSA cycle.

Do (suggested data to collect)	• Date started. • Number of brief interventions (consider using a read code such as XaOiE - Pain Management or XabTy – Brief Intervention) • Number of patients referred for support to optimise their pain management as a result of the brief intervention. • Number of patients tapering/stopped opioids. Consider collecting: • Information on the drug, starting dose and end dose. • Clinician feedback • Patient experience
Study	Analyse the results: What worked well: What could be done better or differently:
Act	What changes would you make to the process ahead of the next run of the search? Then plan your next PDSA cycle.

3. Opioid tapering clinics or appointments

Aim	To support patients to safely taper opioid medication and optimise their pain management. *(Note: consider adding in the number of patients that are aimed to be reviewed and setting timescale to ensure the aim is a SMART aim)*
What are we trying to accomplish? (The why)	• To safely reduce the number of patients who are unnecessarily taking opioid medication for their pain management. • Support non-pharmacological methods of pain management. • Referral for specialist pain management advice and support if necessary.
How will we know that there has been an improvement (measures)	• The number of patients taking long-term opioids or dose will reduce. • The clinic appointments are full and well attended • Patient and patient feedback on the clinic is positive patient feedback on the clinics is positive.
What change can we make? (The how)	• Schedule clinic sessions or appointments that are dedicated to supporting pain management and opioid tapering with an appropriately trained health care professional. • Identify patients that should be invited to the appointments.
Resources available	• Derbyshire wide pain management guidelines . A tapering guideline can be found on the opioid resources page (Opioid Resources (derbyshiremedicinesmanagement.nhs.uk)). • Opioids aware https://www.fpm.ac.uk/opioids-aware • Opioid calculator - ANZCA http://www.opioidcalculator.com.au/ (Also available as an app on the Google play or Apple store.) • Opioid template in Ardens • *JUCD pain management plan (work in progress)* • **Consider using an invitation letter – see toolkit option four** • If you believe a patient may be dependent on their opioids but unaware, this short video that shares lived experience can be shared electronically to allow the patient to reflect and re-engage with the clinician.

Opioid tapering clinics or appointments (suggested PDSA cycle worksheet)	
Plan	Set up the appointments: • How long will they be (initial appointments are likely to need a longer time). • How many appointments are to be allocated per week. • So you scheduled as a clinic or as individual and dedicated appointments across the week e.g., one per day per clinician. • Who will be the clinician for the appointments (Note: Where pharmacy technicians are available, they may be able to do follow-up appointments if a management plan is in place.) Who will the clinician debrief with/escalate for support as needed? Which patient group is appropriate for the clinics (based on the experience and competence of the clinician). How will patients be identified and invited to the clinic? There may be more than one method. Options include: • Referrals from other HCP e.g., nurses doing LTC reviews for respiratory conditions. • Referrals from brief interventions (see option three in the toolkit). • Clinical system searches or request NHS numbers for NHSBSA ePACT indicators. • Using invitation letters (see option four in the toolkit). What other support is available: • Physiotherapy. • Social prescribers and health and well-being coaches. • Pain management programme. • On-line resources.
Do (suggested data to collect)	Number of: • Appointments used. • Appointments available • Length of appointments • Total time allocated. • Patients seen in the appointments. • Tapers/opioids stopped. • Non-pharmacological support provided and type (e.g., pain management group, online resources.) • Referrals to secondary care Opioid medication tapered (drug, starting dose and finish dose) Clinician feedback Patient feedback on clinic and their own functionality and quality of life.
Study	Analyse the results: What worked well: What could be done better or differently:
Act	What changes would you make to the process ahead of the next run of the search? Then plan your next PDSA cycle.

4. Invitation letters

Aim	To provide patient information regarding chronic pain management to appropriate patients and invite them to the GP practice to review their pain management and to safely taper opioid medication if appropriate. *(Note: consider adding in the number of patients invited and the timescale to ensure the aim is a SMART aim)*

What are we trying to accomplish? (The why)	• To provide patients taking opioids for chronic non-cancer pain:
	  ○ Information on the evidence and harms for long term opioids.
	  ○ Information on non-pharmacological methods of pain management.
	  ○ Opportunity to attend a pain management review with a clinician and to be informed about opioids before attending.

How will we know that there has been an improvement (measures)	• The number of patients attending to discuss their chronic pain management because of a letter will increase and the number of patients taking long term opioids will reduce. • Patients attending the appointment will be better informed due to the information in the letter and more open to discussing reducing opioid medication.
What change can we make? (The how)	Identify patients who are appropriate to receive an invitation with supporting information about opioids. Provide appointments with an appropriate clinician as patients respond to the letter.
Resources available	This intervention may be used alongside toolkit item number 3 (tapering clinics and appointments) or toolkit item number 5 (codeine prescribing) Possible letter wording for the invitation: We are writing to you because you are currently taking opioid medication. Opioid medication includes medicines such as codeine, tramadol, morphine, fentanyl, buprenorphine, and oxycodone. Opioids are pain relieving medications which should only be used for short term relief of pain from injury, surgery, or cancer. They are effective over a short period of time to relieve moderate to severe pain. Evidence shows us that: • Opioids should not be routinely used for long term pain and that they often cause more side-effects than benefits. • The longer opioids are used and the higher the dose, the more your brain becomes sensitive to pain and your levels of pain may increase. (This is called increased pain perception). • Tolerance develops and means you need higher doses to get the same effect, which increases the risk of side-effects and can make the pain worse. • Some people become addicted to opioids. Recent medical research suggests that if you take opioid drugs for many months or years it can affect your body in a number of ways that increases your risks to your health.

Short-term effects include	Long-term effects include	Signs of addiction
Constipation	Constipation	Craving for medication
Vomiting	Weight gain	Feeling you need to take more medicine than prescribed – even if bad for your health
Nausea	Difficulty breathing at night	Feeling you need to take more medication for the same effect
Itching	Itching	Experiencing withdrawal when you stop
Drowsiness	Reduced ability to fight infection	Taking opioids for reasons other than pain relief
	Opioid induced pain sensitivity	
	Increased levels of pain	
	Reduced sex drive	
	Irregular periods	
	Fertility issues	
	Erectile dysfunction	
	Early death	

Taking opioids can affect your driving ability by reducing your concentration and reaction times even if you feel well.

Unfortunately, it may not be possible to take all of your pain away and you may have to accept that you may always have some level of pain. We recommend livewellwithpain.co.uk - this website has lots of information and resources for people who are living with on-going pain.

Everyone prescribed opioid medicines in the long-term should have them reviewed at regular intervals. We would like to offer you a review, and to discuss if you want to try reducing your dose. Many people find that they can reduce their opioid dose without the pain increasing. As fewer side-effects are experienced, quality and enjoyment of life can improve. All of this contributes to greater physical fitness.

Please do not stop taking your opioid suddenly, you may experience withdrawal symptoms (shivers, body aches, widespread pain, sweating, diarrhoea, increased pain, difficulty sleeping, nausea and vomiting, irritability, and agitation). Instead, we would recommend a gradual reduction, and will be able to give you personalised advice.

Please contact the surgery on xxxxx or bring this letter to the reception desk and ask for an appointment with xxxxxx to discuss your opioid dose.

Thank you for your help.

Yours sincerely

Invitation letters (suggested PDSA cycle worksheet)	
Plan	• Agree how the patients will be identified and what level of clinical review is needed before sending a letter. (Clinical system searches, NHS number request for NHSBSA ePACT indicators) • Agree the wording for the letter. • Agree who will send the letters. • How many letters should be sent and how frequently (to prevent a surge in appointment requests). (Note: local testing achieved a response rate of a third of people requesting appointments) • Which clinician(s) will see the patients' requesting appointments. (Consider how long you wish the appointment to be) • Who will inform the reception team of this project so that they can manage the requests appropriately and annotate the appointments correctly?
Do (suggested data to collect)	• Number of invitations sent. • Number of patients attending for an appointment because of the invitation. • Number of patients tapering (or have stopped) opioids. • Non-pharmacological support provided and type (e.g. pain management group, online resources. • Consider collecting: Drug, starting dose and finish dose
Study	Analyse the results: What worked well: What could be done better or differently:
Act	What changes would you make to the process ahead of the next run of the search? Then plan your next PDSA cycle

5. Codeine prescribing on repeat

Aim	To reduce the number of patients prescribed long-term codeine for chronic non-cancer pain as a repeat prescription. *(Note: consider adding in the number of patients and the timescale will ensure the aim is a SMART aim)*
What are we trying to accomplish? (The why)	The majority of opioid prescribing in GP practice is for codeine tablets. This is often on repeat and is prescribed long-term. Codeine 60mg four times a day is the equivalent of 30mg morphine per day, and therefore carries similar risks and should be discussed with the patient and stopped if not clinically appropriate. (Note: This toolkit option only covers repeat prescribing of codeine and therefore acute prescribing, that is potentially short-term and appropriate, is not included.)
How will we know that there has been an improvement (measures)	There will be a reduction in the number of patients with a repeat prescription for codeine tablets.

What change can we make? (The how)	**Option A – reduce the number of repeats**
	• Run a clinical system searched to identify patients with a repeat for codeine who have:
	  ○ Option 1 – issued opioid mmedication in the last two months.
	  ○ Option 2 – not issued opioid medication in the last two months.
	  ○ Option 3 – both option 1 and option 2
	• Implement a change:
	  ○ Option 1 – Review the clinical record and if prescribing is potentially inappropriate, contact the patient to request a medication review. (See toolkit item option 3 and 4)
	  ○ Option 2 – Review the clinical record and consider stopping the repeat and sending an Accurx message (see toolkit item 1) or manage as in option 1.
	Option B – Provide patients with information following the presentation of acute injury, to manage patient expectations.
	When a new acute injury is presented, consider providing supplementary guidance via Accurx that explains the expected timeline of the injury and where codeine has been prescribed acutely, the risks. Messaging can be in written form (see examples in resources) but may also be a short 30 second video done by a practice clinician that can also be sent via Accurx.

Resources available	**Option A** • Clinical system searches are available locally. Searches are also available from Ardens (if you have access) SystmOne searches; (EMIS web searches can be supplied on request.)  Codeine issued in last 12m.rpt • Toolkit item 1 – housekeeping • Toolkit item 2 – tapering clinics

- Toolkit item 3 - Invitation letters

Option B

Accurx messages to support the management of acute soft tissue injuries.

For an acute prescription for codeine (or other opioid) here are suggested wording for Accurx:

You have been given a short course of opioids (strong pain relief) for your acute pain. If this is a soft tissue injury it should resolve in four to six weeks.
Opioids are only useful in the short-term after injury or surgery.
If used for over six weeks, they do not work for 90% of people and they can cause harmful side-effects (see this link) including:

- Dry mouth (50%)
- Constipation (40%)
- Reduced sex drive/erectile dysfunction (25%)
- Sleep problems (26%)
- Weight gain (29%)
- **Increased pain**
- Mood changes
- Increased risk of falls and fractures

Taking opioids in the long term can lead to **tolerance, dependence, and misuse.**

Codeine prescribing on repeat (suggested PDSA cycle worksheet)	
Plan	Agree: • Who will import and run the clinical system searches? • Who will review the patients identified by the searches? • Which clinical search is going to be reviewed (regular codeine, irregular codeine, or both). • The wording for any invitation letters/messages (see toolkit items 1 and 4 for resources). • Who will review patients that require appointments, when and how long is needed (see toolkit item number 3). • When the work will start. • The target date for completion and review.
Do (suggested data to collect)	At the start and the end of the cycle: • Number of patients prescribed codeine tablets on repeat that are being issued regularly (every two months). • Number of patients prescribed codeine tablets that have not been issued in the last two months. • Total number of patients prescribed codeine on repeat. Number of patients contacted (telephone, Accurx message, letter) Outcome (tapering, stopped, on-going) for each method of contact
Study	Analyse the results: What worked well: What could be done better or differently:
Act	What changes would you make to the process ahead of the next run of the search? Then plan your next PDSA cycle.

6. Opioid repeat prescribing processes

Aim	To ensure a safe, efficient, consistent, and embedded procedure for managing requests for opioids received through the GP practice prescription service.
What are we trying to accomplish? (The why)	To embed the ICS agreed minimum standards for repeat opioid prescribing within the GP practice procedure for managing request for opioids. This is important because: • Opioids are high-risk medicines. • Completing this work will support the safe and appropriate prescribing of opioids to provide effectively and timely pain management to patients, using a process that is time-efficient, consistent, and robust for the practice. • It will create clear roles and responsibilities for all involved in the process including patients. • It will Increase the level of assurance both within the practice and to external bodies.
How will we know that there has been an improvement (Measures)	Use of clinical system searches to monitor the effect of the procedures. Suggested searches include: • Number of patients with an opioid medication on repeat (all schedules). Inappropriate repeat prescribing should decrease. • Number and percentage of patients with opioid medication on repeat and an appropriate medication review read coded within the last six months. The higher the percentage the better the result. • Number of patients issued opioid medication more than three working days early. The number of patients should be low and there should be a documented reason. • Number of patients who have not had their opioid medication issued from repeat in the last three months (and may benefit from review and discontinuation from repeat). This review can be supported by tool 1 – repeat prescribing housekeeping. Numbers should be kept low so that opioids that do not have a current clinical indication are not left on repeat. • Staff may report a reduced number of queries relating to opioids once the process has embedded.
What change can we make? (The how)	• Creating a practice specific procedure for the management of requests for opioids on repeat through the prescription order service at the practice. Ensure that the procedure: o is co-created with all relevant members of the practice team (this would ideally include local community pharmacist) o denotes clear roles and responsibilities • Is embedded into practice, monitored to ensure adherence, and reviewed/improved as needed. Incorporating regular reviews and assessments of prescribed opioids to ensure appropriateness for patients' pain management needs.
Resources available	• Minimum standards for repeat prescribing of opioids in general practice • Adaptable flow chart to support the implementation of the minimum standards for repeat prescribing of opioids in general practice

Opioid repeat prescribing processes (suggested PDSA cycle worksheet)	

Plan	• Bring staff together from all parts of the process to a workshop. Ensure to include staff that are undertaking the work not only managers. If possible include lived experience representation. During the workshop:
	  ○ Review the ICS agreed Minimum standards document for repeat opioids prescribing
	  ○ Reflect on whether you currently meet them, or exceed the standards
	  ○ Decide on the changes to the practice process that you wish to test, how you will measure if they are working, when how frequently you will run the measures, and when you would like the changes to start
	  ○ Review the roles and responsibilities suggested and reflect on how they will work in your situation
	• Capture the outcomes from the workshop, draft and then agree the procedure you want to try along with a review date. Flow charts are useful as an easy to review document and there is an adaptable flowchart provided in the resources.
	• Ensure that all staff are aware of and understand the new process and are easily able to refer to the process.
	• Decide how and when you will review how it is working as a practice to allow staff to feedback concerns whilst you are testing the new procedure.
	• If you have not got a clear communication process with your local community pharmacy, then consider creating one with them to enable time-efficient and reliable communication to them when the supply of opioids is either urgent or has been restricted, and also so that they can highlight concerns to the practice.
	•

Do (suggested data to collect)	• Number of patients with an opioid on repeat (all schedules)
	• Number and percentage of patients with an appropriate medication review within the last six months.
	• Number of patients collecting more than three working days early
	• Number of patients who have not collected opioids in the last three months (and may benefit from review and discontinuation from repeat).
	• Feedback on the process:
	  ○ Staff feedback on the process. Consider including administration team members that may not process prescriptions but do manage queries from patients, and community pharmacy colleagues.
	  ○ Patient complaints

Study	Analyse the results. What worked well? What could be done better or differently?
Act	What changes would you make to the process? Then plan your next PDSA cycle or if it is working well when you next review the process.

7. Pain management programme for chronic non-cancer pain

Aim	To provide a local, evidence based pain management support that focusses on supports people living with ongoing pain to use self-management techniques that others have found useful and to improve their quality of life despite the pain they are experiencing. This toolkit describes a programme based on the '*Ten Footsteps to living well with pain'* developed by **Live Well with Pain.**
What are we trying to accomplish? (The why)	Chronic non-cancer pain requires a biopsychosocial approach and research tells us that whilst medicines are not helpful, peer support and non-pharmacological approaches to management can be very successful and improve quality of life for the patient. Opioids have historically been used for chronic pain but are high-risk medicines that can cause significant patient harm for little benefit. Providing non-pharmacological support via this pain management programme provides clinicians and patients with an effective alternative to medicines as a treatment. Providing support locally allows patients to access the support easily without the transport challenges of secondary care and to build a local peer support network.
How will we know that there has been an improvement (Measures)	• There will be a local pain management programme offered (number, type/sessions) • The number of patients attending the courses/sessions. The better the attendance and whether patients stay on the course or attend the cafés will indicate how beneficial the support is to them. • Change in patient self-reported scores on how confident they are to self-manage their pain before and after the support offer. There is a health and well-being check tool in the resources to support this. • Patient feedback on the support. • Other support accessed as a result of the sessions e.g. via social prescribers that indicate other health needs are also being met. • Change in medication usage before and after the support (or the medication review after completing the course). • Positive clinician feedback on patient response to the course offer, any change in pain management or appointment demand as a result of the support.
What change can we make? (The how)	• Create a local chronic pain management support programme that you can offer to your patients locally. This can be designed and offered as a single practice or a range of practices.
Resources available	• An implementation guide, facilitators guide and adaptable practice leaflet is provided https://healthinnovation-em.org.uk/our-work/innovations/improving-the-management-of-non-cancer-pain-reducing-harm-from-opioids/691-lets-live-well-with-pain • https://livewellwithpain.co.uk/. A full suite of pain management resources can be found on the Live Well with Pain website.

Six-week pain management programme (suggested PDSA cycle worksheet)	
Plan	Review the implementation guide in the resources. This guide will provide step-by step support for you to create your own programme. The Facilitators guide also provided will provide the content that a facilitator trained in the ten footsteps approach can use to provide support. The course structure is adaptable to your local resources and capability. It is crucial to ensure that the whole healthcare team are engages with the plan, knows the process for referral, and who they can refer to for support.
Do (suggested data to collect)	• The type and number of pain management support offered (number, type/sessions) • The number of patients attending the courses/sessions. • Change in patient self-reported scores on how confident they are to self-manage their pain before and after the support offer. There is a health and well-being check tool in the resources to support this. • Patient feedback on the support via other routes e.g. end of course survey. • Other support accessed as a result of the sessions e.g. via social prescribers • Change in medication usage before and after the support (or the medication review after completing the course). • Healthcare team feedback e.g. patient response to the course offer, any change in pain management or appointment demand as a result of the support. • Number of staff trained to support the sessions. • Case studies
Study	Analyse the results: What worked well: What could be done better or differently:
Act	What changes would you make to the process ahead of the next run of the search? Then plan your next PDSA cycle.