Medicines Safety Improvement Programme

Pan-London Shared Learning Event

Presented by:
Sarah Dennison
Jessica Catone
Natasha Callender
Lucie Wellington

#MedSIPLondon
#opioids

NHS England

Welcome everyone

Housekeeping

Format for the afternoon

Setting the scene

Opioids are a highly effective class of analgesics and, when used judiciously, are of great benefit to many people living with pain. However, in the case of ‘chronic non-cancer pain’, when the source of long-term pain does not have a cause that can be treated, opioids can do more harm than good, particularly when used at higher doses.

Over 0.5 million people in England are prescribed opioid analgesia for longer than 3 months, the majority having chronic pain that is not associated with cancer

Inequalities – certain patient characteristics were identified as increasing the risk of harm. Either from increased risk of long-term use or susceptibility to dependence or harm

Case for change

Management of ‘chronic non-cancer pain’ requires personalised care and shared decision making its core with patients requiring a mixture biopsychosocial support so that they carne live well with pain

Opioids prescribing is a complex problem that requires a multifaceted approach across the system

It is estimated that for every 62 patients with chronic pain who can be supported with alternatives to long-term analgesia, one life can be saved, unchecked it is predicted that around 6000 people a year will be hospitalised with adverse events whilst taking opioids for extended periods

Join at

slido.com

#1040 810

Impromptu Networking

Jessica Catone

Impromptu Networking

When you hear the bell, find someone you don’t know, introduce yourself and discuss the following:

- What has brought you to the event
- One thing you hope to get out of the day
- Something you learned through your MedSIP work.

When you hear the bell again, find a new person to meet.

Two 5-minute rounds

Medicines Safety Improvement Programme (MedSIP) Overview

Jessica Catone

Natasha Callender

Lucie Wellington

National Medicines Safety Improvement Programme (MedSIP)

Aim: reduce prescribing of high dose opioids (> 120mg oral morphine) in non-cancer pain by 50% by March 2024

Chronic non-cancer pain management requires personalised care and shared decision-making, using a mixture of biopsychosocial support so patients can live well with pain.

NHSE estimate that **1 life can be saved for every 62 patients** with chronic pain who could manage their pain without opioids

~ 6000 people a year will be hospitalised with adverse events whilst taking opioids for extended periods

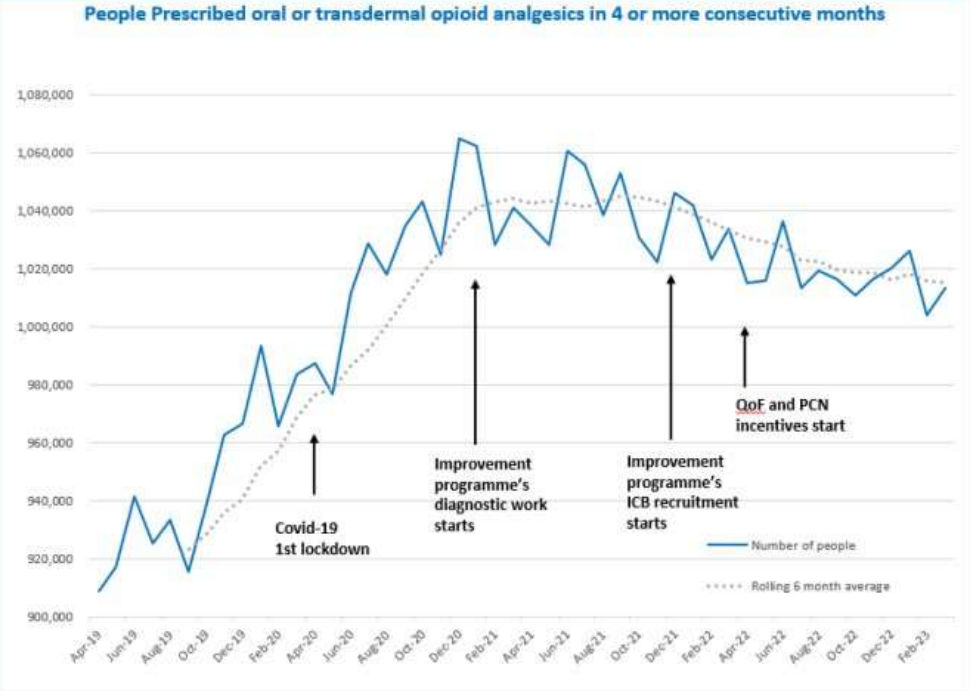
National Medicines Safety Improvement Programme (MedSIP)

Reducing opioid prescribing saves 414 lives

- Support for ICBs through the Academic Health Science Network Patient Safety Collaboratives to build confidence in general practice clinicians as we support ICBs to navigate access to neighbourhood providers of biopsychosocial support (the alternative to reliance on analgesics).
- NHS England commissioned support for ICBs is continuing throughout 2023/24.

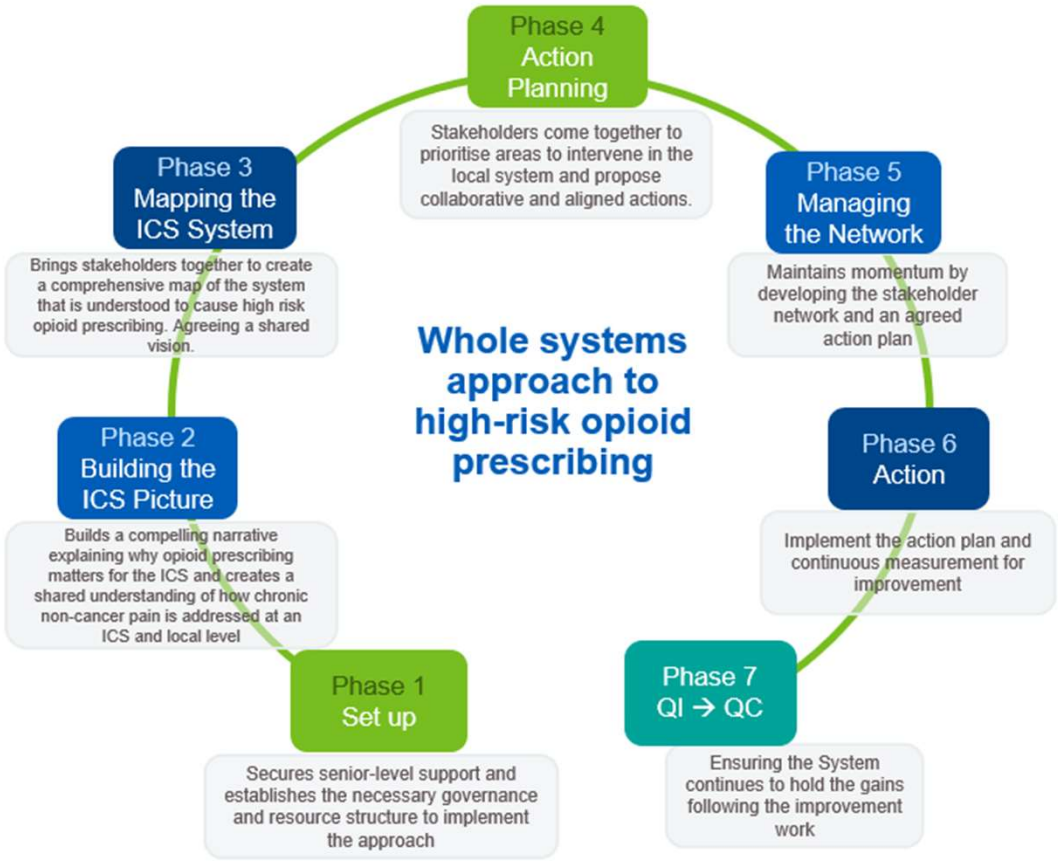
Saving 414 lives over 2 years and **2,570 fewer cases of moderate harm** each year as a result of fewer people with chronic pain being prescribed long-term opioid analgesics than in 2021

4,200 fewer people prescribed high dose opioids (>120mg OME per day)



Patients report **better quality of life**, **less pain** and **less disability** as a result of improved care

National Medicines Safety Improvement Programme (MedSIP)



National Patient Safety Improvement Programmes

Medicines

UCLPartners Opioids Programme

Jessica Catone – Implementation Manager

March 2024

@UCLPartners

www.uclparters.com

Delivered by:

UCLPartners
Patient Safety Collaborative
Health Innovation Network

Led by:

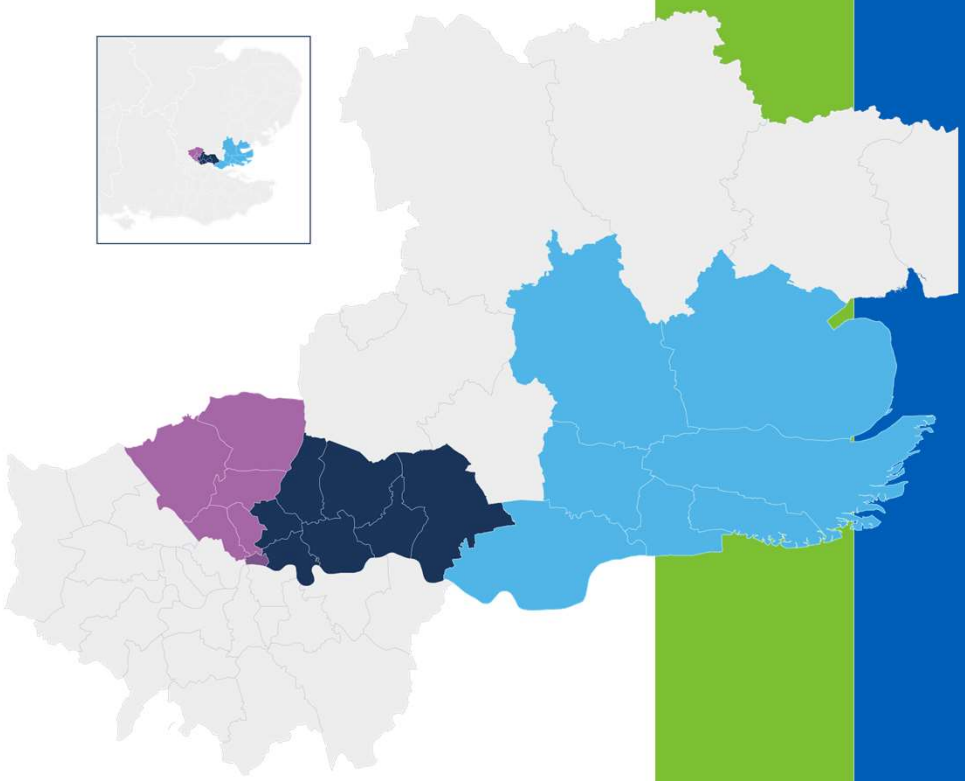
NHS England
NHS Improvement

Our communities

Our mission is to help five million people from North London to the Essex coast live longer, healthier lives.

The region we cover is home to some of the most diverse communities in Europe.

- North Central London
- North East London
- Mid and South Essex



MedSIP UCLPartners Work to Date

- NCL / NEL joint core working group
  - Meetings every 6-8 weeks
- Set up UCLPartners Opioids Network
  - Every 3 months
  - Completed 4 Network meetings
- Primary care clinicians survey
  - 169 responses over 2 weeks
- Group Education Sessions
- Discharge Letter Audits
  - QI session

MedSIP UCLPartners Plan for 2024/25

- Continue Core Working Group and Opioid Network meetings
- Discharge Letter Audits
  - Share learning
  - QI support
- Working up further support for primary care
- Embedding initiatives for sustainable improvement

National Patient Safety
Improvement Programmes

Medicines

Health Innovation Network Reducing harm from opioids in chronic (non-cancer) pain

Natasha Callender, Senior Project Manager (Medicines Workstream Lead)

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Health Innovation
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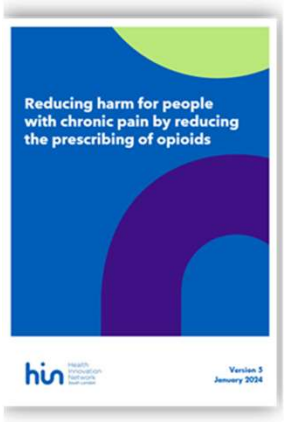
HIN local workstreams

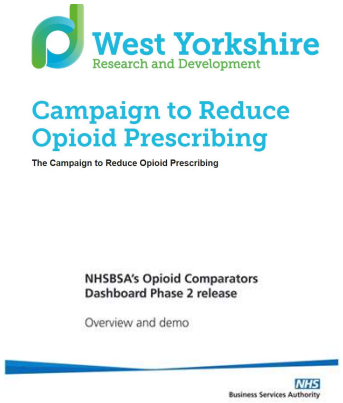
Working with people living with chronic pain

Using data for system audit and feedback

Working with staff to drive improvement

HIN opioid and chronic pain programme overview





Working with staff to drive improvement

- 2022/23 Opioid Stewardship Quality Improvement Collaborative
- 2023/24 Opioid Action Learning Set series
- HIN Reducing harm from opioids in chronic pain resource pack

Using data for system audit and feedback

- 2022 -24 Modified approach to Campaign to Reduce Opioid Prescribing using NHS BSA data for GP practices and primary care networks

Working with people living with chronic pain

- 2022/23 Chronic Pain Experience Based Co-Design Project producing a co-designed poster and recommendations for peer support and group education.
- 2023/24 Educational video series of patient stories on how they try to live well with chronic pain filmed during pain Awareness month

Find out more

- Check our website **Reducing harm for people with chronic pain by reducing the prescribing of opioids**
- You can read more about developments with our local programme in our blogs:
- **Medication Without Harm: Improving care for people living with chronic pain - Health Innovation Network**
- **Medication Safety: How patients and healthcare professionals make safety work - Health Innovation Network**
- **Working with patients as equal partners to improve chronic pain management - Health Innovation Network**
- **One year on: how can working in partnership with people living with chronic (persistent) pain improve care?**

Reducing harm for people with chronic pain by reducing the prescribing of opioids

Patient Experience | Patient Safety

August 7, 2023

National Patient Safety
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ICHP Opioid Programme: Pharmacist-led Opioid Reviews

Lucie Wellington, Senior Innovation Advisor, Imperial College Health Partners (Physiotherapist)

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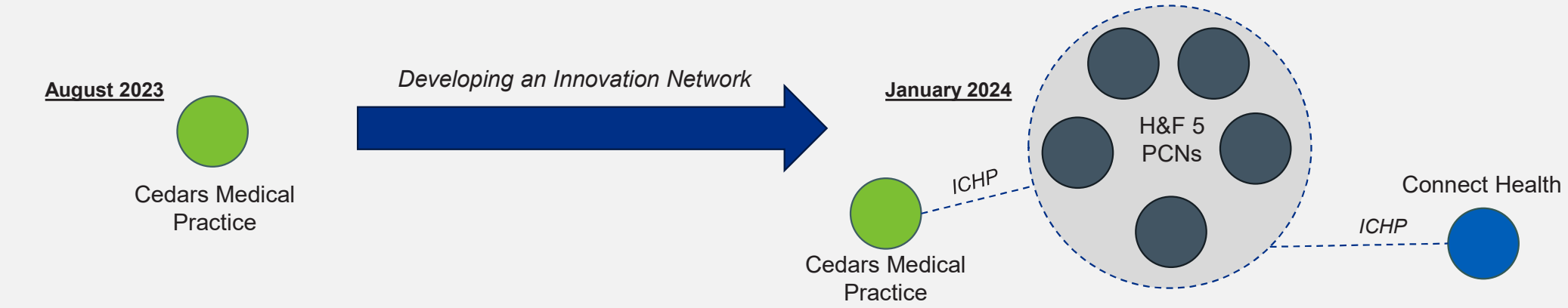
What we are doing in NW London

We piloted pharmacist led reviews in a Hillingdon GP Practice then scaled it in Hammersmith and Fulham, introducing an education programme and MDTs.

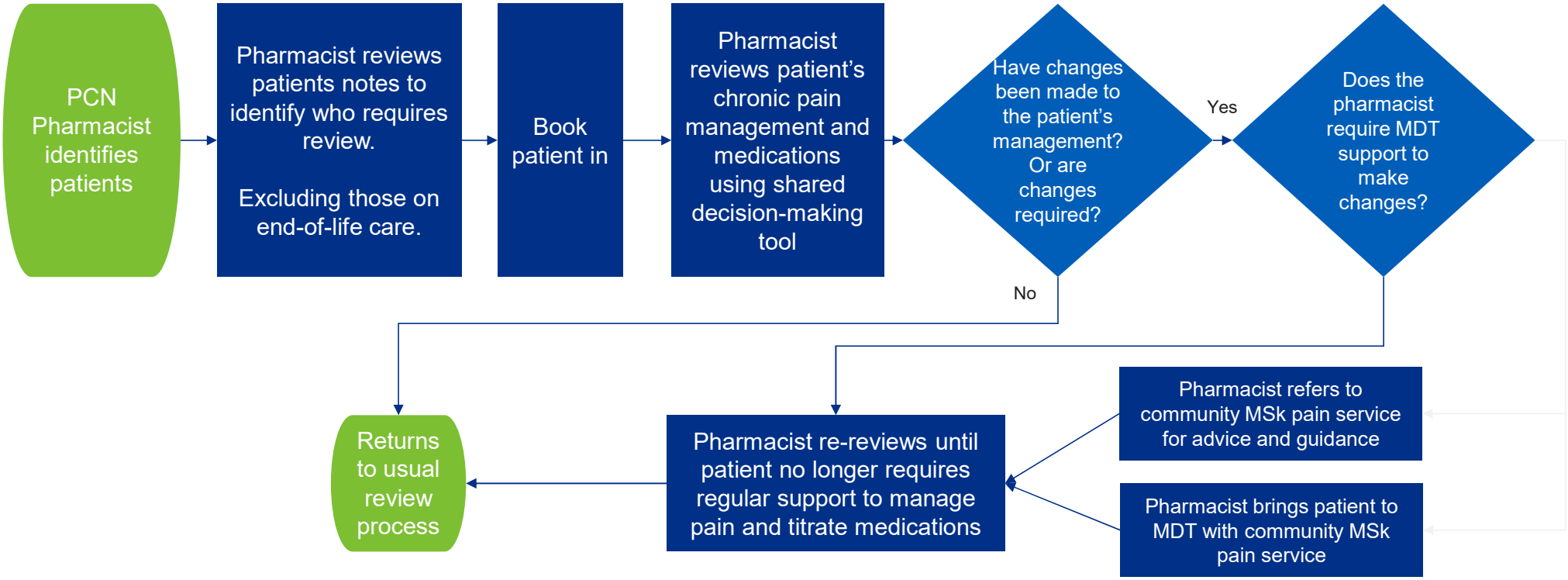
It involved upskilling the primary care pharmacy workforce to review patients on opioid medicines, using a personalised care approach and reducing patients' opioid use where possible. We utilised expertise from community MSK services to provide training, MDTs, and clinical advice and guidance.

A pilot was launched in Cedars Medical Practice in Hillingdon. Learning from Cedars was used to develop a larger model.

A pilot in 5 PCNs in Hammersmith and Fulham with additional features such as an MDT led by the Community Pain MSk Services was set up.



What our pathway looks like in practice



"GP pharmacist was calm, understanding and took the time to listen."

Person with Lived Experience of Chronic Pain

What we are hoping to achieve

For the patient…

- To be supported by primary care for chronic pain (reduce need for secondary care involvement)
- Improved experience, outcomes and quality of life.
- Increased access to primary care services and other clinical services and less inequalities in access
- Improve continuity of care via a single practitioner pathway

For the sector…

- The testing of a new model of care aligning to NWL ICB's long term condition mission
- Establishing a population health approach to risk stratify patients for medicines optimisation.
- Strengthening collaboration between primary care and community including upskilling
- Reduced spend from opioid medicines

Reduce harm from opioids for the population

Useful tools we created and can share

1. Chronic Pain Training Slides
2. Chronic Pain Webinar recordings
3. Primary Care Patient Invite SMS and Phone Script
4. Data Collection Template
5. Suggested Patient Survey Questions
6. Patient self-management and education tools and websites
7. Useful clinician resources
8. A worked example using the IHI's Model for Improvement in an Opioid Reduction Programme

This will be available on the ICHP website soon. In the meantime, please email me for resources: lucie.wellington@imperialcollegehealthpartners.com

Credit and thanks to Dr Ian Bernstein for supporting the pilot as clinical lead and the co-creation of many of these resources.

"You can feel like you're out in the ocean, and the pharmacist contacting me felt like being thrown a life-belt."

Person with Lived Experience of Chronic Pain

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Medicines

Thank you

@NatPatSIP / @MatNeoSIP

www.improvement.nhs.uk

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Living with Chronic Pain

David Paisley

Pain: Equality of Care and Support Within the Community

Dr Sarfraz Jeraj

Dr Feyisara Mendes

Mind & Body in chronic pain:

Pain: Equality of Care and Support in the Community

(PEACS)

Dr Sarfraz Jeraj, Clinical Psychologist

Dr Feyisara Mendes, GP

KING'S HEALTH PARTNERS

Context

THE NEED

- Chronic pain is a bio-psycho-social condition
- Unacceptably poor outcomes, in particular for Black people living with chronic pain
- 34% of Black women in Lambeth live with chronic pain, compared to 18.3% of the Black ethnicity male population and 19.8% of White females

OUR AIMS

- To co-develop a holistic approach which understands, identifies, and supports people's needs, working with people from Black communities in Lambeth
- To improve health outcomes for patients within a culturally appropriate framework
- To test the effectiveness of the approach, including in addressing inequalities

THE IMPACT

- PEACS supported a total of 597 people
- 296 (224 black women) of those were from the Black community
- Engagement and representation from Black women increased
- 87% of surveyed patients said they would recommend PEACS
- Patients reported to have felt 'seen', a sense of belonging, and a sense of empowerment

Impact on Urban Health

KING'S HEALTH PARTNERS

Co-design

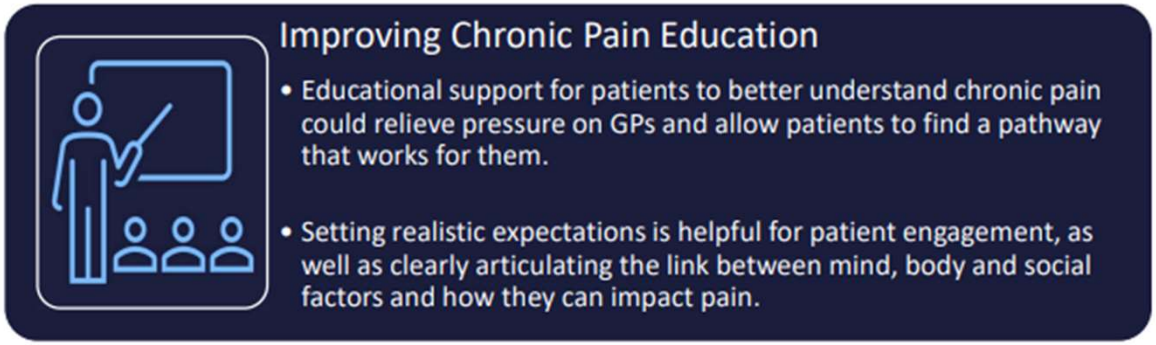
Why is co-design important?

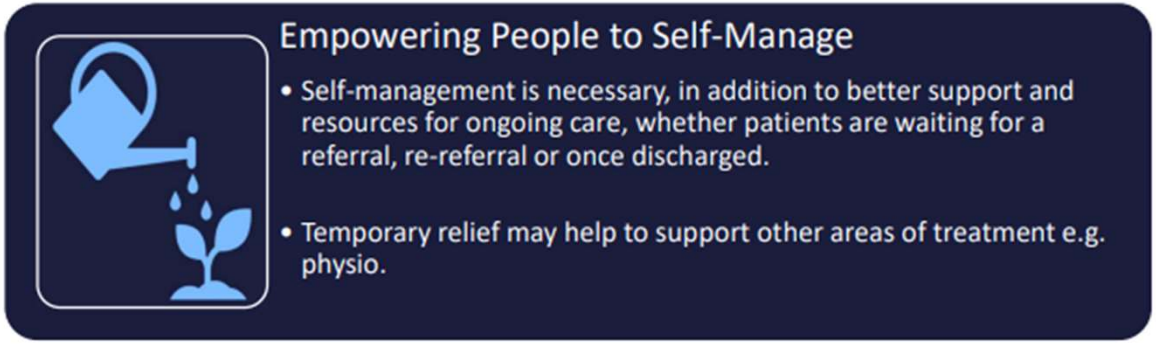
- To better meet patient needs and address existing challenges
- To mitigate for structural bias
- To increase buy-in from patients

What did we do?

- Led by Comuzi
- Engaged with:
  - 19 patients from Black backgrounds
  - 5 carers
  - 16 clinicians
- Continued engagement

- The evaluation concluded: “the codesign process had an immediate impact on the **relationships between community members and healthcare professionals** and has contributed to **better understanding** about chronic pain and how the healthcare system can support patients in managing their chronic pain”.





The PEACS intervention

AIMS OF THE PATHWAY

- Improved quality of life
- Reduced health inequalities through more accessible care
- Improved understanding of chronic pain
- Effective utilisation and coordination of care

KEY ELEMENTS

- Bio-psycho-social
- Lifestyle medicine
- Community approaches
- 1:1 assessment
- Specialist and integrated workshops

KING'S HEALTH PARTNERS

Follow-up

> *"My kids asking 'Why are you looking so happy today? Oh, you're going to your pain group, aren't you?"*

Why is follow-up important?

- Continued improvement journey
- Peer support
- Relapse prevention

What do we do?

- Peer support
- Focused sessions with clinicians
- Collaboration with VCSE

What have been the results?

IMPROVED UNDERSTANDING

- Improved chronic Pain knowledge (83%)
- Improved Self-Management (79%)

ACCESS AND CARE CO-ORDINATION

- Improved coping and awareness of Local Services (57%)
- Service compared favourably to other health services (63%)

IMPROVED QOL

- Improved Connectedness (63%)
- Reduction in Pain Catastrophising ($p<0.01$)
- Three Quality of Life domains improved ($p< 0.05$)

KING'S HEALTH PARTNERS

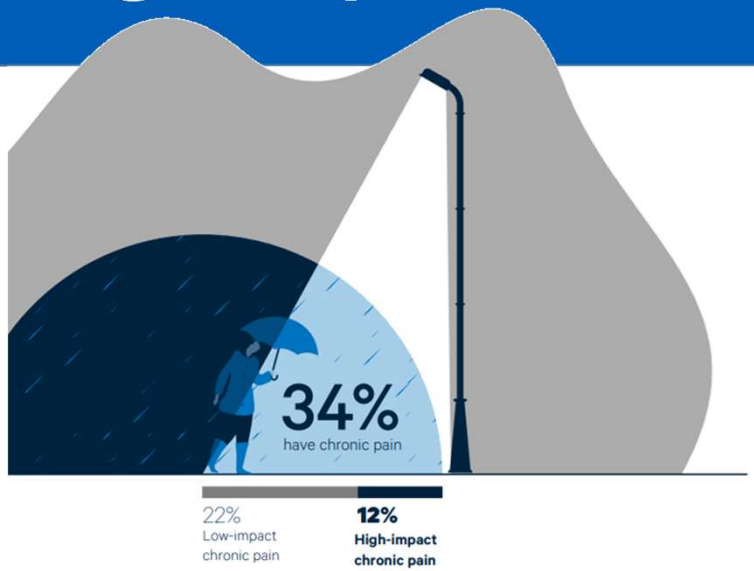
North West London Integrated Care System
Working together for better health and care

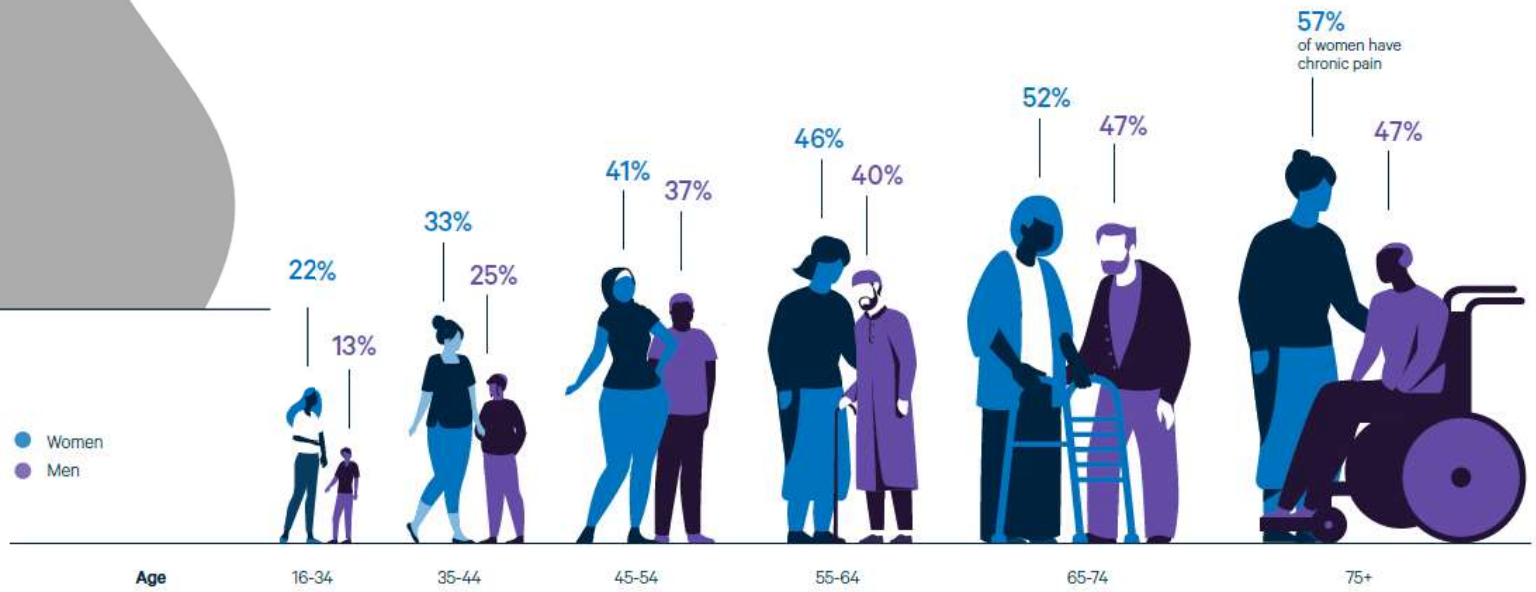
NHS North West London

A population health approach improving health and wellbeing for people with high-impact chronic musculoskeletal pain

Dr Benjamin Ellis
March 2024
benjamin.ellis@nhs.net

High-impact chronic pain





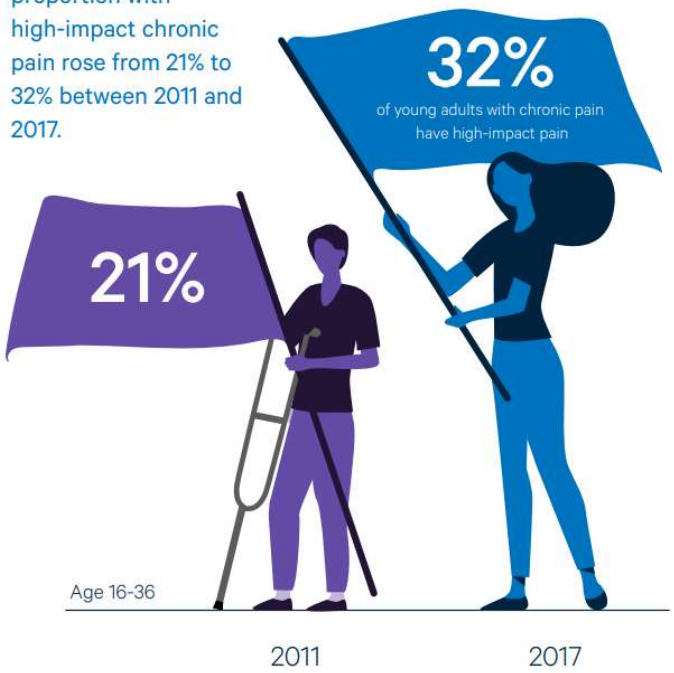
About 8 in every 10 people (84%) with chronic pain report that at least some of their chronic pain is in the neck or shoulder, back, limbs or extremities – all sites where pain is most likely to be musculoskeletal.

https://www.versusarthritis.org/about-arthritis/data-and-statistics/chronic-pain-in-england

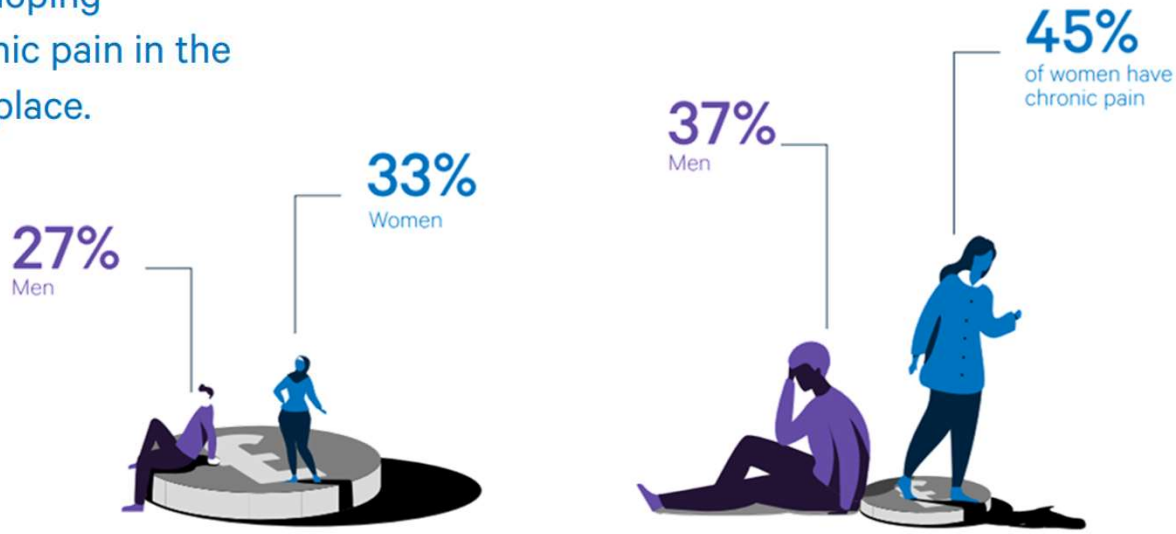
NHS
North West London

High-impact chronic pain

Among young adults with chronic pain, the proportion with high-impact chronic pain rose from 21% to 32% between 2011 and 2017.



Social disadvantage and psychological stress increase people's risk of developing chronic pain in the first place.



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https://www.versusarthritis.org/about-arthritis/data-and-statistics/chronic-pain-in-england

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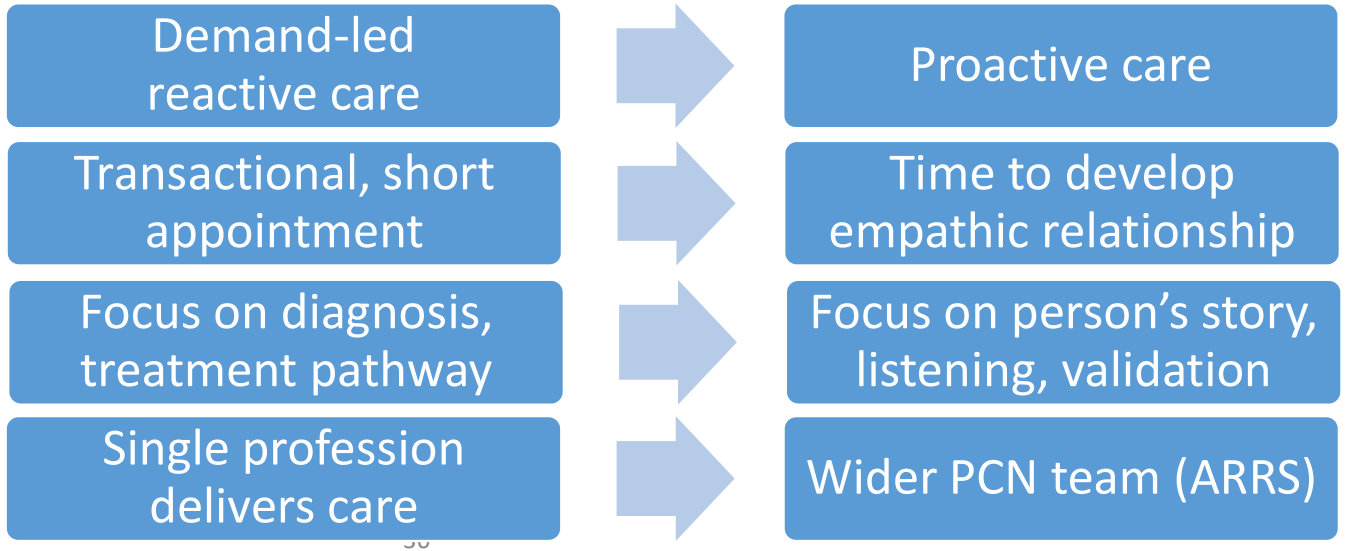
PCN-based population health management

Data-driven tool or methodology that refers to ways of bringing together health-related data to identify a specific population that health and care systems may then prioritise for particular services.



Improved understanding of chronic pain:

- Local extent and impact
- Local demographics, need and inequalities
- Psychological, social, economic drivers

Personalised care

Longer appointment with GP/other trained HCP
Listening to patient journey, exploring trauma

Supporting understanding of chronic pain
Help patients identify concerns, needs, preferences
- *What matters to me*

Six-weekly MDT to discuss complex patient
Primary care team, secondary care input

Review progress and need
Signposting, referrals; discharge to usual care

Engagement with neighbourhood, place, system

People's needs and preferences vary over time, and can benefit from a wide range of services; many of which already exist in some form locally

Shifting mindset of individuals, professionals and services from 'curing' pain to '**living well**' with and '**managing the impact**' of chronic pain

Leadership and co-production

Named clinical and patient leadership

Understanding the local impact of chronic pain

Steering group, community of practice

Alignment with wider strategies, Fuller

39

Co-production with people with pain

Including underserved and disadvantaged groups

Regular feedback from people with pain

39

Start small at neighbourhood level

Iterative, incremental improvement

Resource mapping at neighbourhood, place

Engagement with local community groups

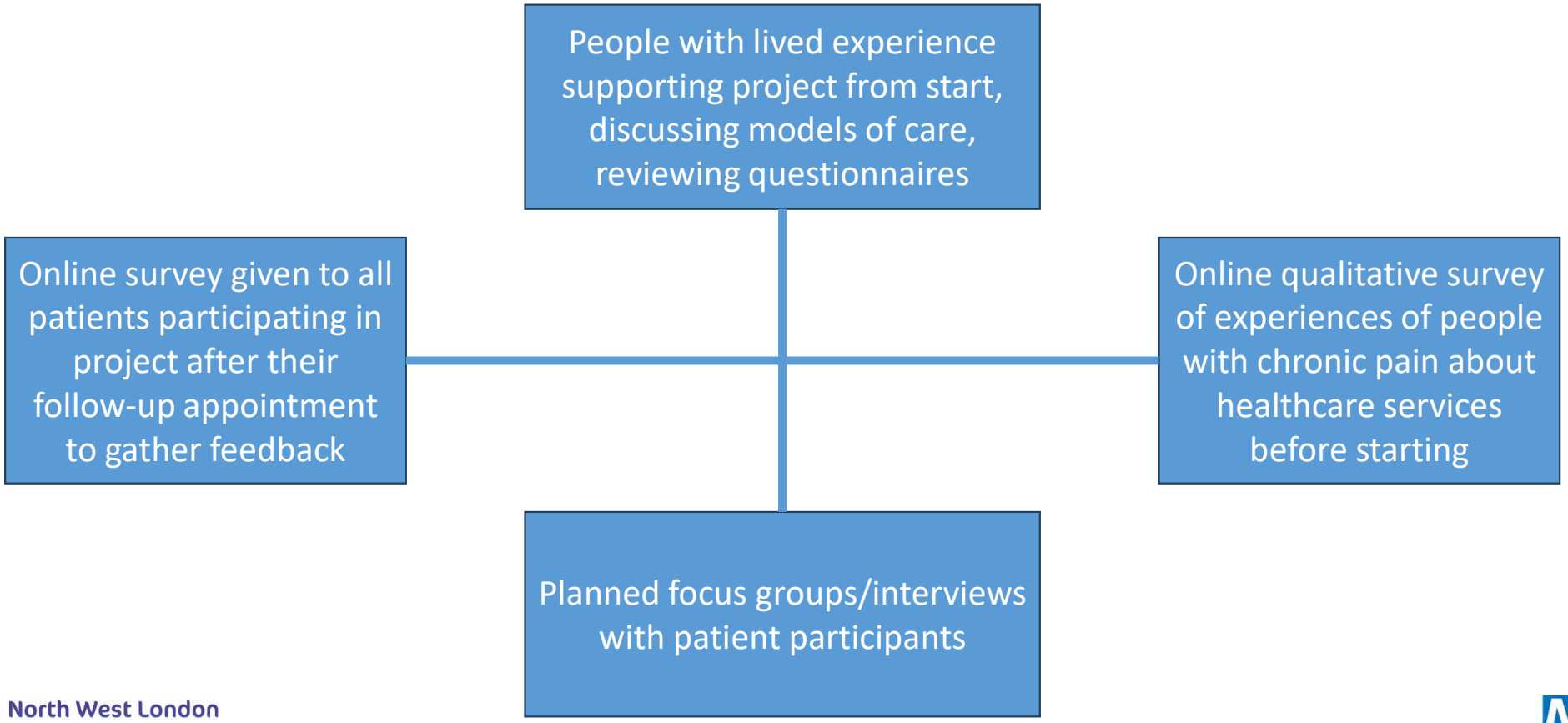
39

North West London project objectives

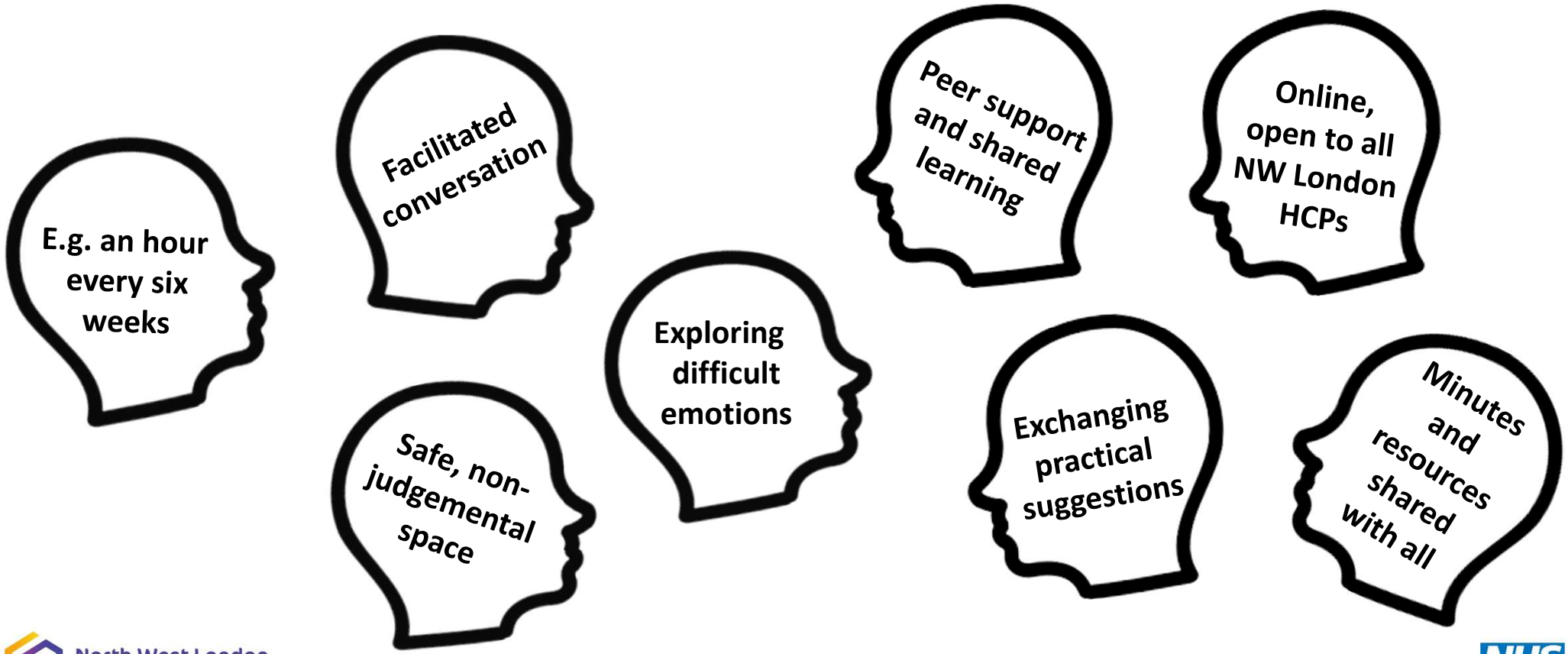
The project aims to sustainably **improve health and wellbeing** of people with chronic pain by **proactively increasing knowledge, skills, and confidence in self-management** of their symptoms, and **tackling inequalities** through supporting **engagement with local communities**.

The approach is to offer a **primary care-based, personalised care and support planning approach**, thought **multi-disciplinary working** within primary care with **support** from secondary care specialists.

Lay/public involvement



Reflective practice sessions



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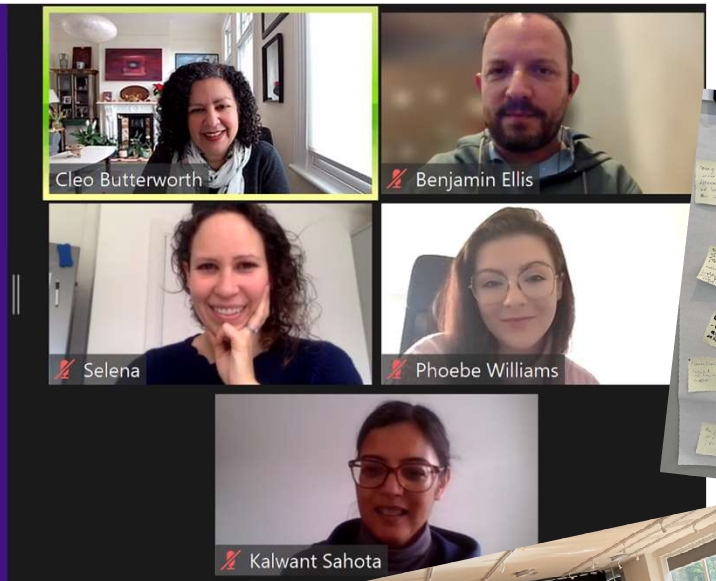
Establishing a community of practice

Our problem statement

"The problem is that chronic pain is a complex, multi-faceted, intangible condition which is being managed in a poorly integrated health and social care system within a culturally biased society"



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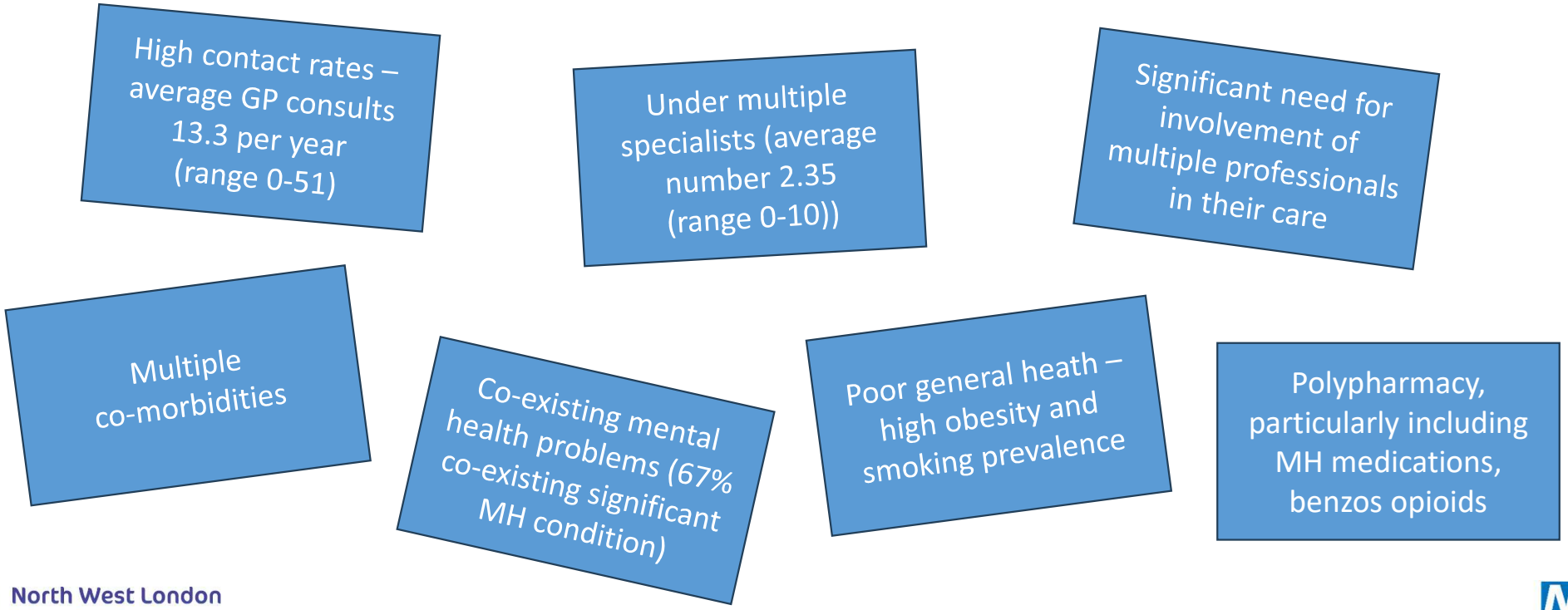
NW London – people with chronic pain

Records audit, 78 patients coded with Fibromyalgia in primary care



Clinical outcomes: MSK-HQ score

Pilot (Jan 21 – March 22)

- Pilot at large inner GP practice
- GP-led consults
- 46 patients through pathway
- 7 MDT meetings

Average age	51	
Male	8/46	17%
Female	38/46	83%
Pre-existing confirmed diagnosis of Fibromyalgia	28/46	61%
Diagosis suspected by GP	18/46	39%
Average number of repeat prescription medications	6.5	
Number of patients with significant comorbidities	31/46	67%
Number of patients with pre-existing coded mental health condition	30/46	65%

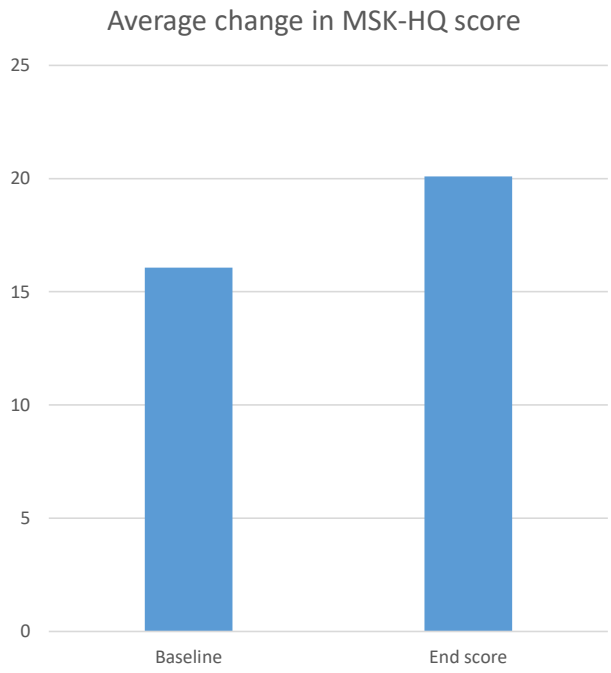
Growth (March 23 – present)

- 5 new PCNs so far
- Same aims, patient-centred focus
- Focus on principles, not fidelity
- Minor variations on delivery (e.g. who delivers appts, MDT composition)

Clinical outcomes: MSK-HQ score

Pilot site data:

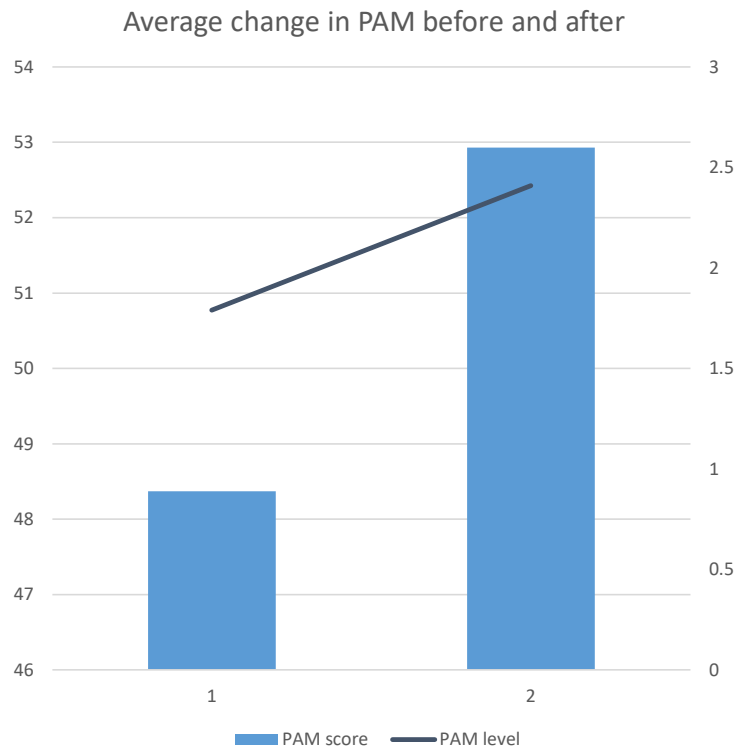
- MSK-HQ score
- 14 questions focusing on MSK symptoms, non-MSK symptoms, wellbeing, understanding of condition and confidence in managing symptoms
- Significant improvement in average MSK-HQ score:
  - **Average pre – 15.75**
  - **Average post – 19.875**



Clinical outcomes: Patient Activation Measure

Pilot site data:

- Average score increased from 48.37 → 52.93
- Average level increased from 1.79 → 2.41 (0.62)
- 7 patients increased from level 1 → 3 or 4
- **A 0.6 rise as seen in this initiative is linked to:**
  - **Reduction of 3 GP appointments per patient per year**
  - **Primary & secondary care demand savings of £345/patient/year**
- As activation rises, over time physical health improves & contacts fall



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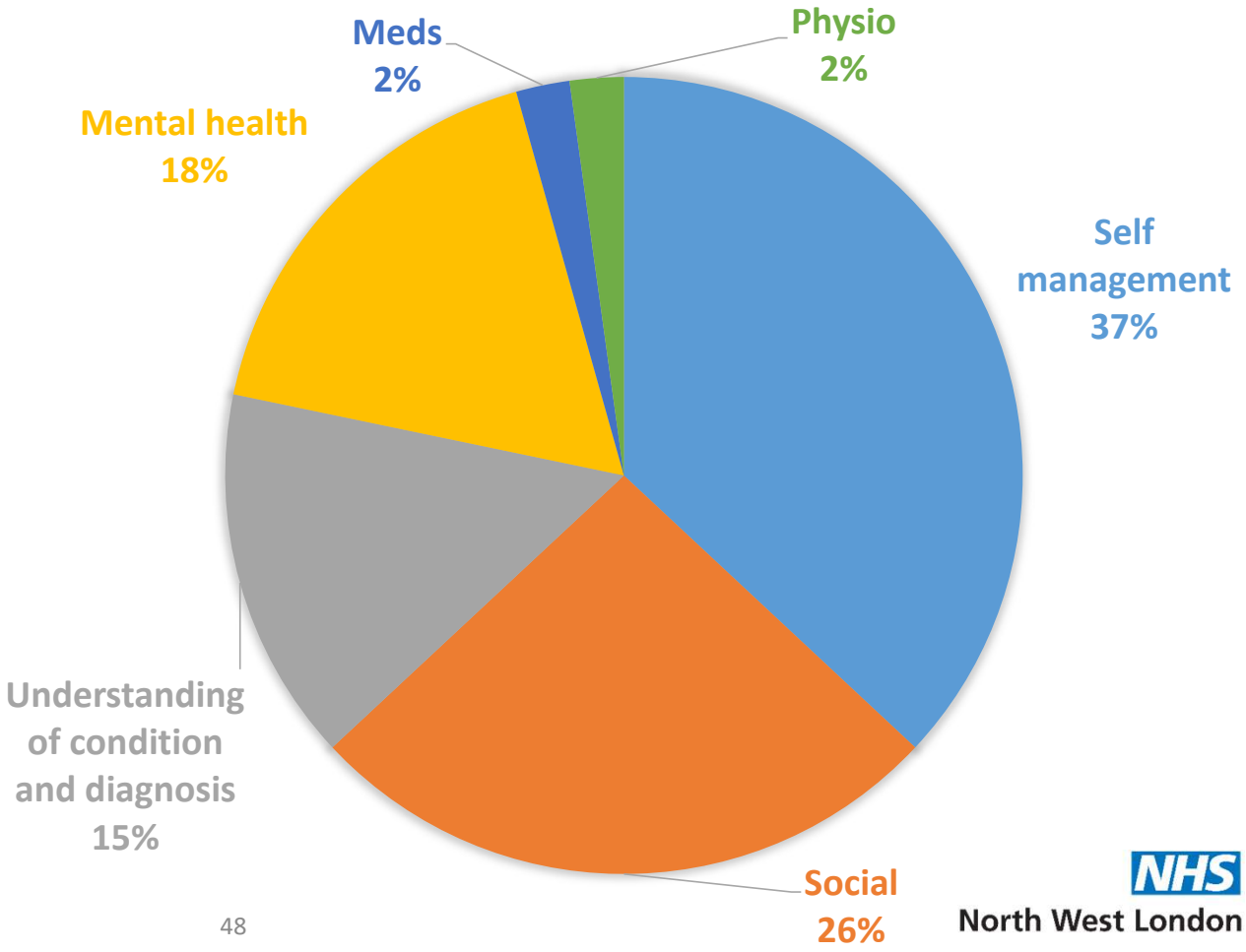
Social outcomes

Pilot site data:

- Most patients wanted support with self-management and social support
- Limited focus on medical aspects of pain (pilot and expansion)
- Onward referrals most commonly to social prescribers and psychological support



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Nadia's story – Personalised approach to pain

My name Nadia I was diagnosed with fibromyalgia, which had taken a while to get and I had suffered with pain for years. I also had a history of mental health issues and found it difficult to leave my house and often never spoke to a soul for days and days….

Outcomes – for patients, practitioners, and system

- Reduction in GP appointments
- Fewer hospital admissions
- Shift from reactive to more planned/ structured care
- Improved patient experience of care
- Improved health and wellbeing
- Reduced number and severity of reported exacerbations
- £ efficiencies

Nadia's PCN has defined pain and mental health as a local population health priority- they are supporting workforce development, including the additional roles within the practice. Nadia is proactively identified invited for a care planning conversation by her GP, looking at what is important to her- identifying walking and getting out of the house as a priority. By the 3rd session with a health coaching Nadia was walking outside with less pain and walking aids and improved mood. Over the summer Nadia was even able to try kayaking and canoeing. She felt strong and able to cope with life's challenges.

Nadia understanding of her condition and confidence in managing exacerbation and breathing techniques improves. She is introduced to local support groups, leisure centre and better understands her condition.

Social Prescribing Link Worker/health and Wellbeing Coach refers to goals in the digital personalised care and support plan and identifies online peer support and staged goals towards exercise and increasing wellbeing.

"Every step along the way I was wholly supported, my experiences, worries, concerns were validated and my progress, however small, praised. The support I got working towards my goals helped me in so many ways."

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In people's own words…

"**Understanding what [chronic pain] is** has been really helpful, being able to research and read about it because I know what it is"

"**Having time** to discuss my condition and symptoms thoroughly rather than feeling rushed to pick one or two bigger symptoms"

"**Being validated**, not having my worries dismissed, **being listened to** and feeling like the doctor really cared about me and my pain"

"Follow up appointments were really helpful as we would **pick up where we left off** and then talk about how the previous months went during the build up to the follow up appointment"

"Now I have **courage to live with the pain**"

"Not feeling alone, **feeling supported** by my GP, **being able to ask questions and have answers**, knowing I have a voice in my treatment"

"It went above and beyond, I wasn't sure what to expect especially after dealing with chronic pain on my own for so long/ my pain being dismissed. So it really was **an incredibly welcoming experience & very supportive**."

Views on the multidisciplinary approach

- Early data analysis from a researcher observing debrief meetings between project team and PCN project leads:

Value of the MDT model in primary care: The MDT's work is considered valuable, especially in addressing gaps in knowledge and understanding.

Shift from biomedical to social perspective: The MDT model allowed for a positive shift in mindset from a biomedical view to a more social perspective.

MDT approach and personalising patient care: The role of the MDT enables a better understanding of patients' needs and improves care delivery.

Concerns about MDT burnout: Concerns were expressed about the potential risk of overusing the MDT model in primary care.

Acknowledgements

Imperial Health Charity
Selena Stellman, GP lead
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Helen Dawson & Agnes Kocsis – clinical support for MDTs
National Association of Primary Care and Jag Mundra
Jen Pearson, University of the West of England
People with lived experience involved in the project
North End Medical Centre and Dr Sara Douglas for support of initial pilot project and bid

Break

Integrated and Multidisciplinary Support for Complex Pain at UCLH

Dr Kelley Corcoran

Dr Jackie Walumbe

University College London Hospitals NHS
NHS Foundation Trust

The Complex Pain Team

Dr Kelley Corcoran
Consultant Psychologist & Clinical Lead
Dr Jackie Walumbe
Advanced Practice Physiotherapist
7th March 2024

Safety | Kindness | Teamwork | Improving

Sue's Story

743

https://www.patientvoices.org.uk/flv/1089pv384.htm

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Referrals

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Referral Criteria

* **Complex to manage pain and/or**
* **>120 mg morphine equivalent/day or rapidly escalating opioid doses**
* **Has visited A&E more than twice or**
* **Been admitted to hospital more than once, for pain, in the last year**

Exclusion Criteria

* **Age < 18**
* **Acute pain**

Currently specialities accessing the service include

- Primary Care
- Emergency Dept.
- Gastroenterology
- Urology
- Rheumatology
- Hepatobiliary
- Orthopaedics
- Clinical pharmacology
- Haematology
- Neurosurgery
- Neurology
- Gynaecology
- Infectious diseases
- Acute medical unit
- ENT
- Care of the elderly
- Maxillofacial surgery

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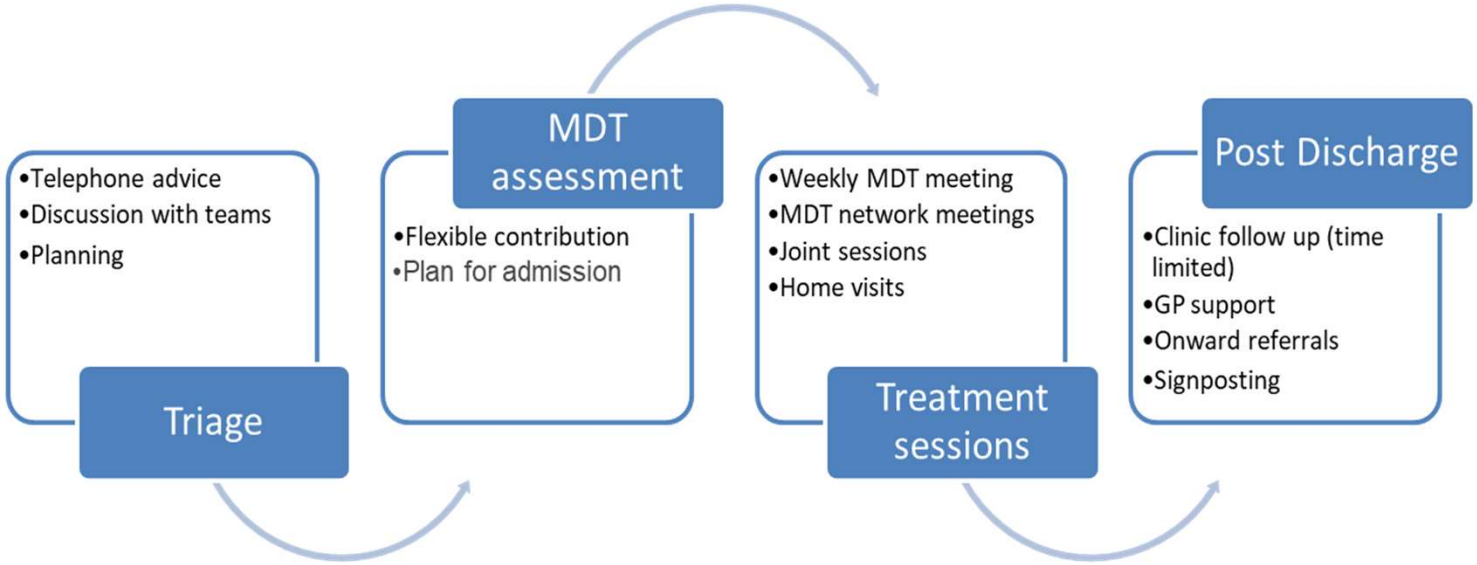
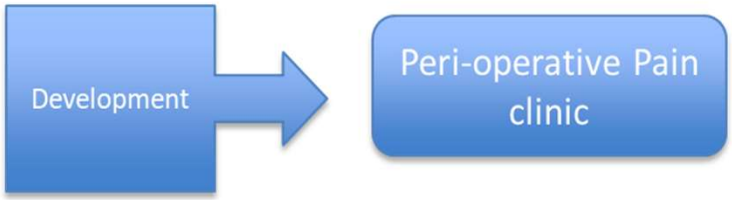
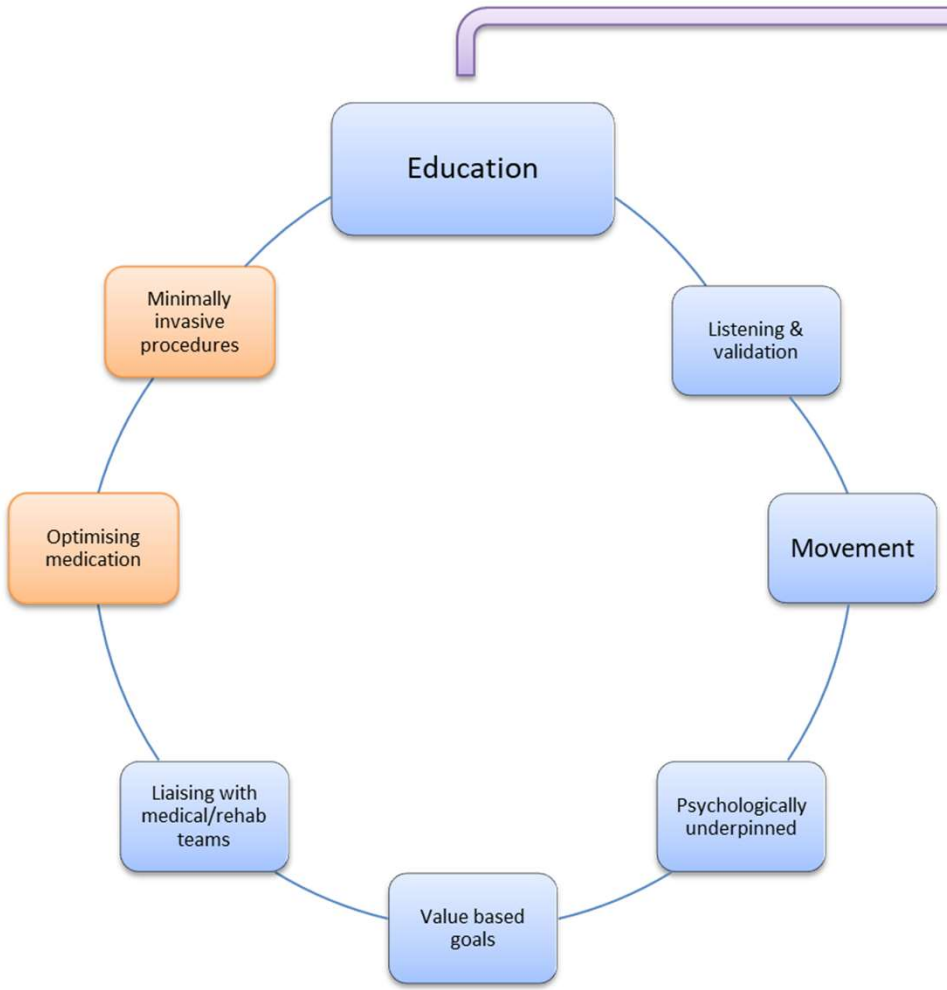




Empathy & Compassion



- Education on persistent pain and its neurobiology
- Exercise, activity and movement
- Biopsychosocial model.
- Lifestyle advice.
- Flare up management.
- Fear-avoidance.
- Graded exposure/pacing.
- Self-compassion.
- Build self esteem and resilience.
- Impact of thoughts, emotions, body sensations and behaviours on pain

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Impact

- Improved mental health, wellbeing and function.
- Reduced medication use.
- Now commissioned/substantive service following successful pilot.

- Avoid unproductive use of healthcare resources.
  - Reduce length of hospital stay.
  - Fewer investigations.
  - Fewer ED visits.
  - Fewer GP visits.
  - Fewer outpatient visits.

Estimated cost savings per annum based on reductions in health care use as a result of CPT intervention (n=130)

	Rate	Mean reduction per year per patient	Saving
GP consultation	£50	2.2	£14,300
A&E Visit	£400	2.6	£135,200
Specialist OPD	£120	1.6	£24,960
Hospital bed stay	£400	11.6	£603,200
			£777,660

- Dr Luke Mordecai preparing full evaluation as part of his MD

Qualitative – Staff experience

- "being able to share decisions with an experienced and expert team is incredibly helpful…. This, to me, is what integrated care is"

  -Hospital Consultant

- "in A&E there's a set plan and patients go back home as opposed to coming onto the ward"

  -Haematology Registrar

- "I have felt so supported and have learnt a great deal about reducing opioids, thank you!"

  -GP

Challenges

- Recruitment and retention
- Difficult succession planning
- Collaboration with other condition networks
  - Sickle Cell Disease
  - Gastroentorology
- Ongoing evaluation
- Sustainability and Spread
- Clinical ethics and moral injury
- Admission for “forced tapers”
- Who does the reduction?
  - Drug and alcohol
  - Admitting teams
  - General practice

With thanks to

Dr Brigitta Brandner

UCLH charity

uclh NHS

NHS
Camden
Clinical Commissioning Group

Safety | Kindness | Teamwork | Improving

Pan-London Fireside Chat

Lucie Wellington

Nita Sanghera

Shiva Dogohary

Dr Di Aitken

15% Solutions

Natasha Callender

A 15% Solution is something you can do right away <u>without</u> needing more of anything:

freedom,
resources,
permission,
authority,
control.

You can act right now.

What can you do over the next 12 months to support the London effort to sustain local improvements to chronic (non-cancer) pain management?

Instructions and Steps

On your own come up with your 15% Solutions. One idea per post-it note (3 – 4 mins)

With two other people, share your idea and talk about where you can do something now (5 mins)

Write your favourite solution on a sheet of paper…

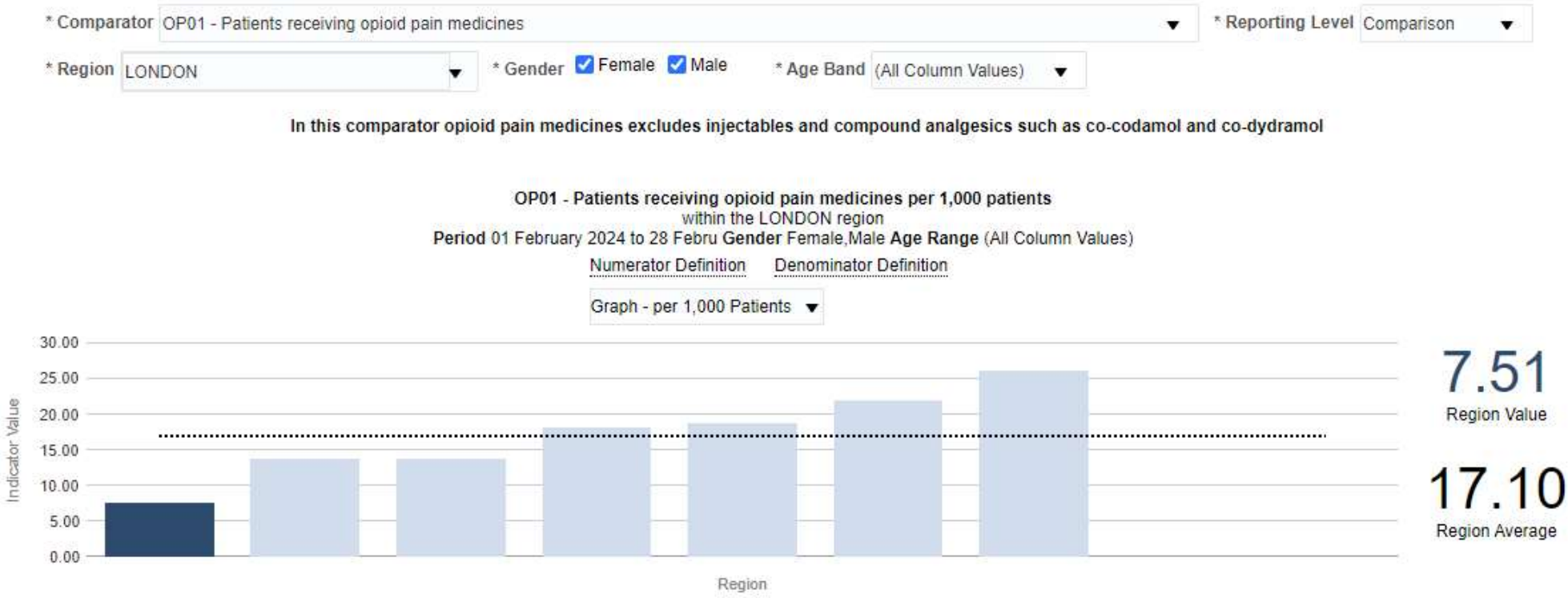
Closing remarks

Reflections

Housekeeping

Sarah Dennison
Controlled Drugs Accountable Officer & Medication Safety Officer
NHS England - London Region

London Opioids Use (over 4 weeks: 1st – 28th February 2024)



Thank you

To our speakers and fire side chat panel members

To everyone involved in organising this event

To our Expert by Experience

To all of you for joining us and being part of this event

Thank You

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