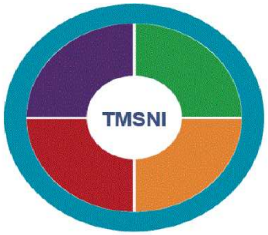
Opioid Improvement Collaborative
Stakeholder Engagement Workshop

4th August 2023

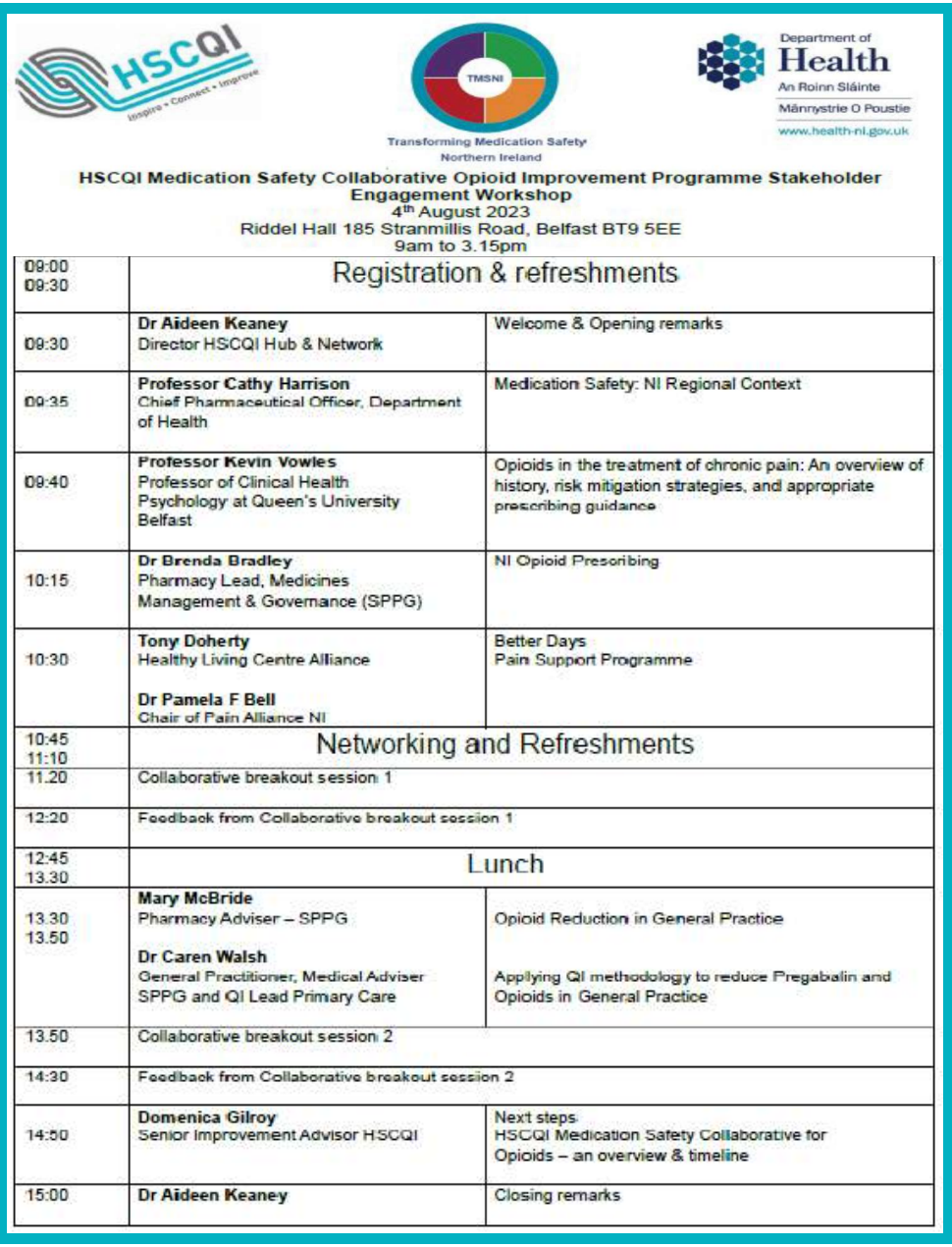


Transforming Medication Safety
Northern Ireland



Welcome everyone

Housekeeping



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TMSNI
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Department of Health
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Mànrystrie O Poustie
www.health-ni.gov.uk

HSCQI Medication Safety Collaborative Opioid Improvement Programme Stakeholder Engagement Workshop
4th August 2023
Riddel Hall 185 Stranmillis Road, Belfast BT9 5EE
9am to 3.15pm

09:00 09:30	Registration & refreshments	
09:30	**Dr Aideen Keaney** Director HSCQI Hub & Network	Welcome & Opening remarks
09:35	**Professor Cathy Harrison** Chief Pharmaceutical Officer, Department of Health	Medication Safety: NI Regional Context
09:40	**Professor Kevin Vowles** Professor of Clinical Health Psychology at Queen's University Belfast	Opioids in the treatment of chronic pain: An overview of history, risk mitigation strategies, and appropriate prescribing guidance
10:15	**Dr Brenda Bradley** Pharmacy Lead, Medicines Management & Governance (SPPG)	NI Opioid Prescribing
10:30	**Tony Doherty** Healthy Living Centre Alliance **Dr Pamela F Bell** Chair of Pain Alliance NI	Better Days Pain Support Programme
10:45 11:10	Networking and Refreshments	
11.20	Collaborative breakout session 1	
12:20	Feedback from Collaborative breakout session 1	
12:45 13.30	Lunch	
13.30 13.50	**Mary McBride** Pharmacy Adviser – SPPG **Dr Caren Walsh** General Practitioner, Medical Adviser SPPG and QI Lead Primary Care	Opioid Reduction in General Practice Applying QI methodology to reduce Pregabalin and Opioids in General Practice
13.50	Collaborative breakout session 2	
14:30	Feedback from Collaborative breakout session 2	
14:50	**Domenica Gilroy** Senior Improvement Advisor HSCQI	Next steps HSCQI Medication Safety Collaborative for Opioids – an overview & timeline
15:00	**Dr Aideen Keaney**	Closing remarks

Welcome

Dr Aideen Keaney
Director HSCQI

Professor Cathy Harrison
Chief Pharmaceutical Officer





Professor Kevin Vowles

Professor of Clinical Health Psychology

Queen's University Belfast

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Opioids in the treatment of chronic pain: An overview of history, risk mitigation strategies, and appropriate prescribing guidance

Kevin E. Vowles, PhD
School of Psychology

HSCQI Medication Safety Collaborative
Opioid Improvement Programme Stakeholder Engagement Workshop

4th August 2023

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Overview

- An abbreviated history of opioid use in healthcare.
- What is the scope of the problem in chronic pain?
- The clinically significant *minority*.
- Data on ways of moving forward for both minority and majority.

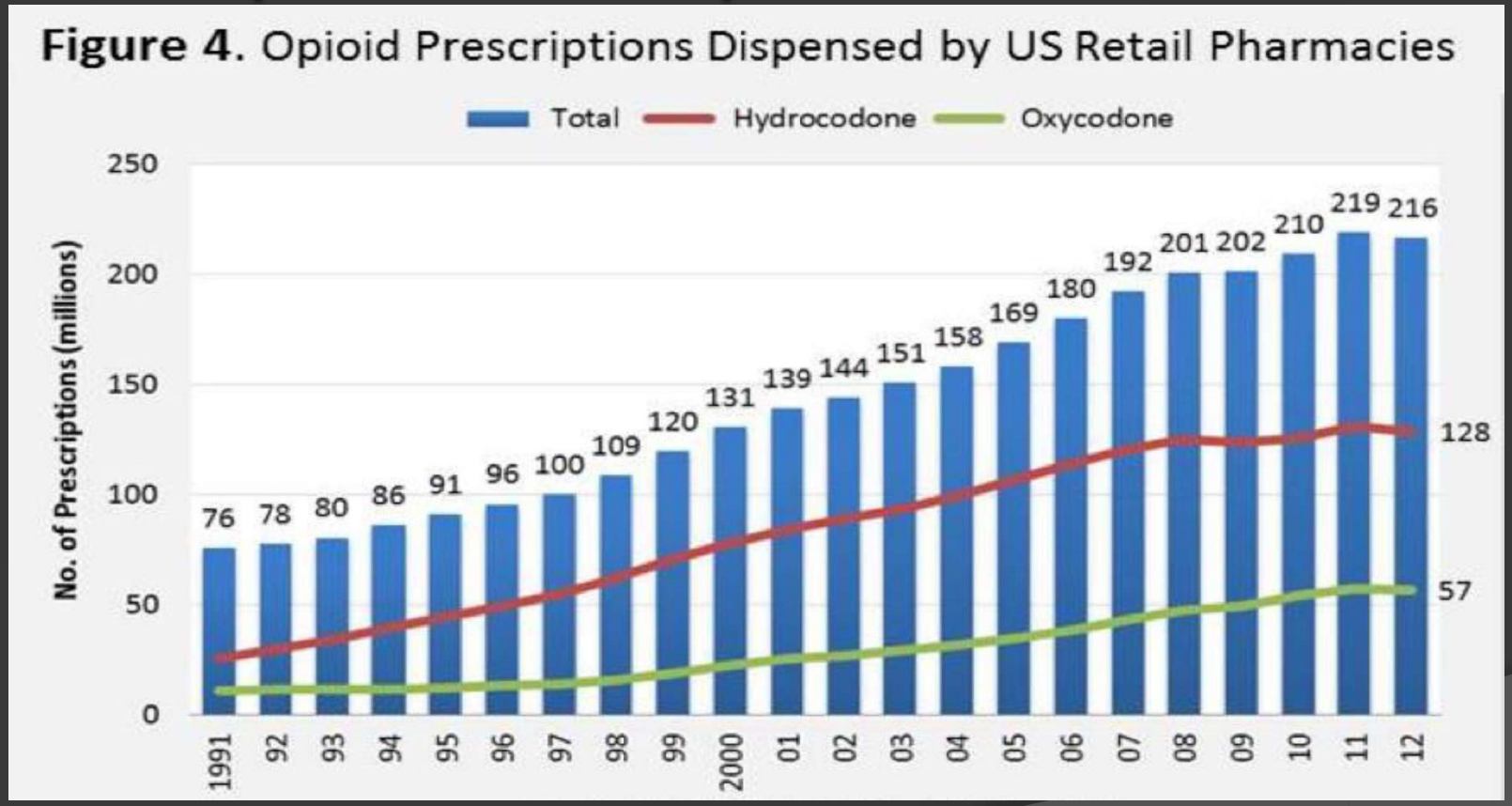
History of Opioid Prescription

- Prior to mid 1980's, restricted for surgery, recovery from severe injury, or end of life.

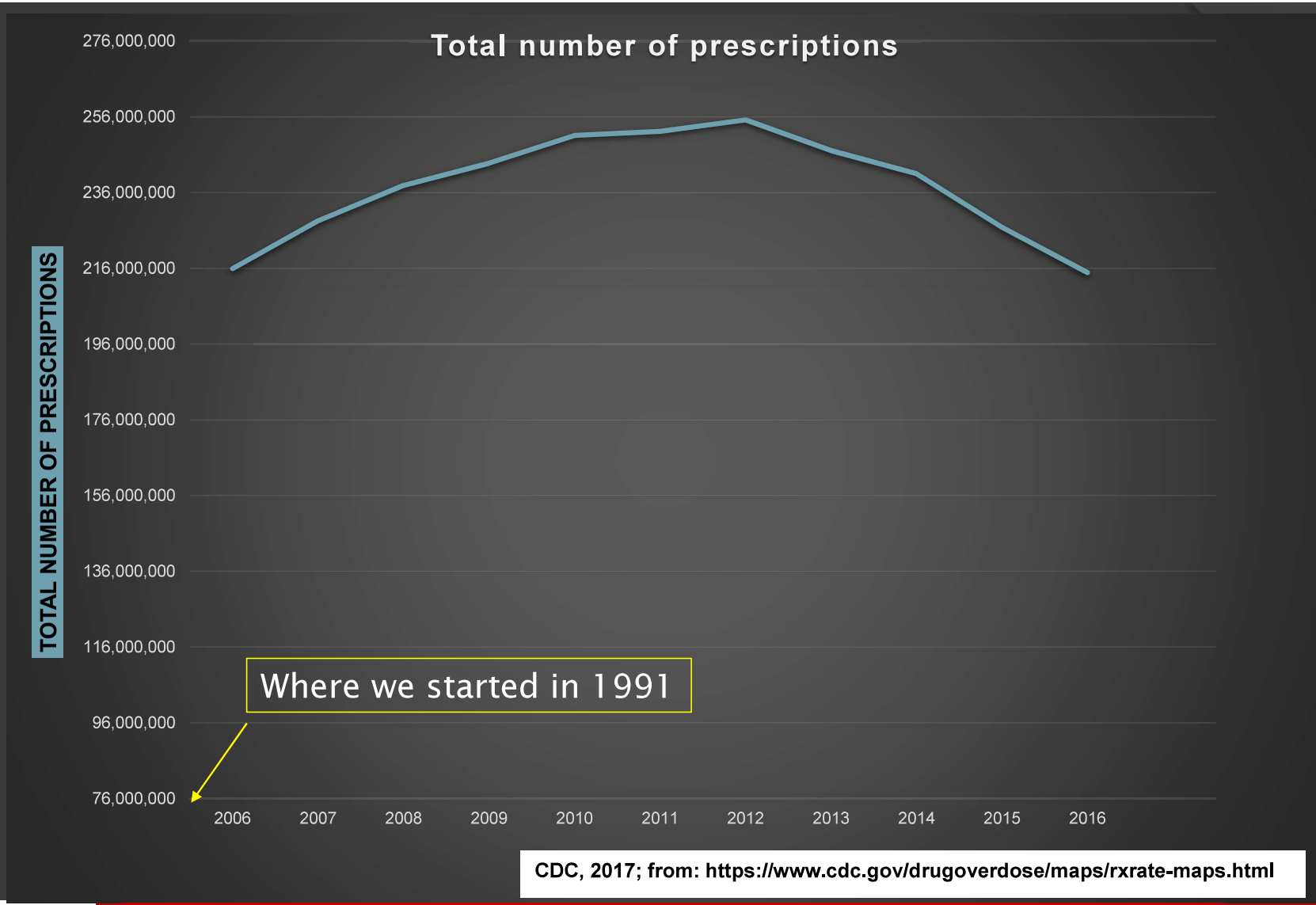
- Poor quality evidence mid-1980's describing low risk of "addiction" in chronic pain and "adequate pain relief"
  - e.g., Porter & Jick, 1980; Portenoy & Foley, 1986

- Evidence taken as gospel (i.e., meta-analytic) truth.

Net Result 1:
Explosion of Opioid Use

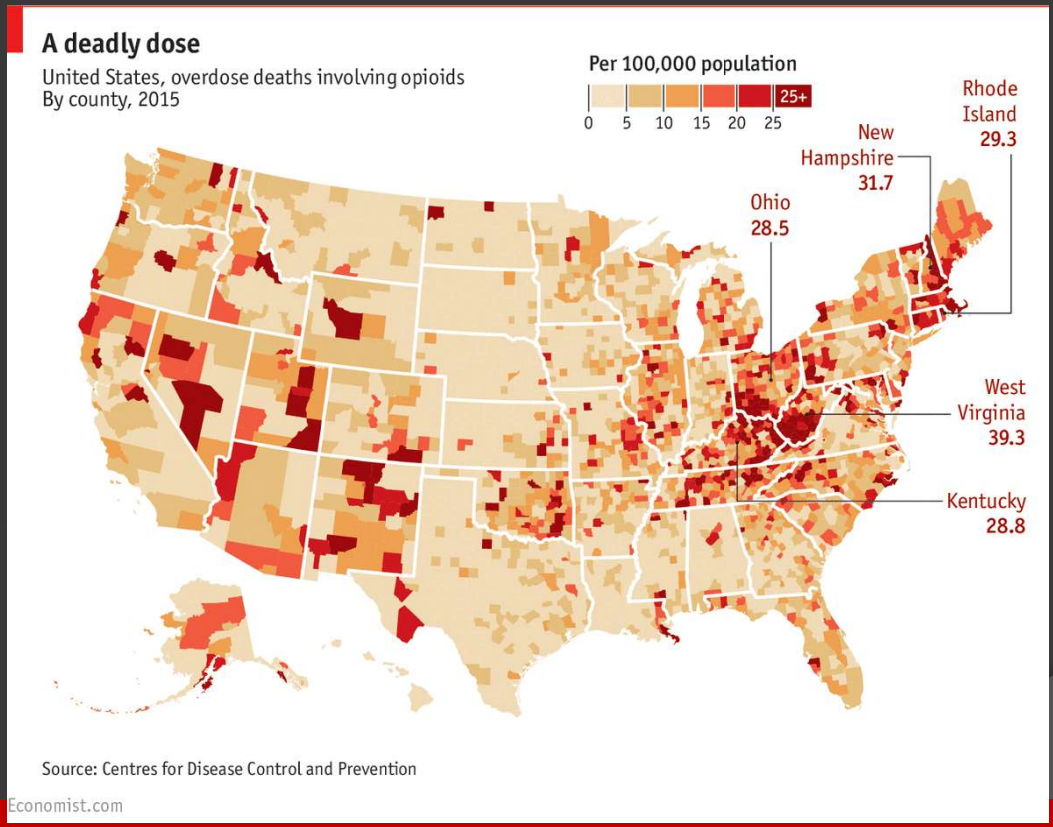


From: Volkow, 29 April 2014 – Presentation to Congress. IMS Health, National Prescription Audit, Years 1997-2013. www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2015/prescription-opioid-heroin-abuse

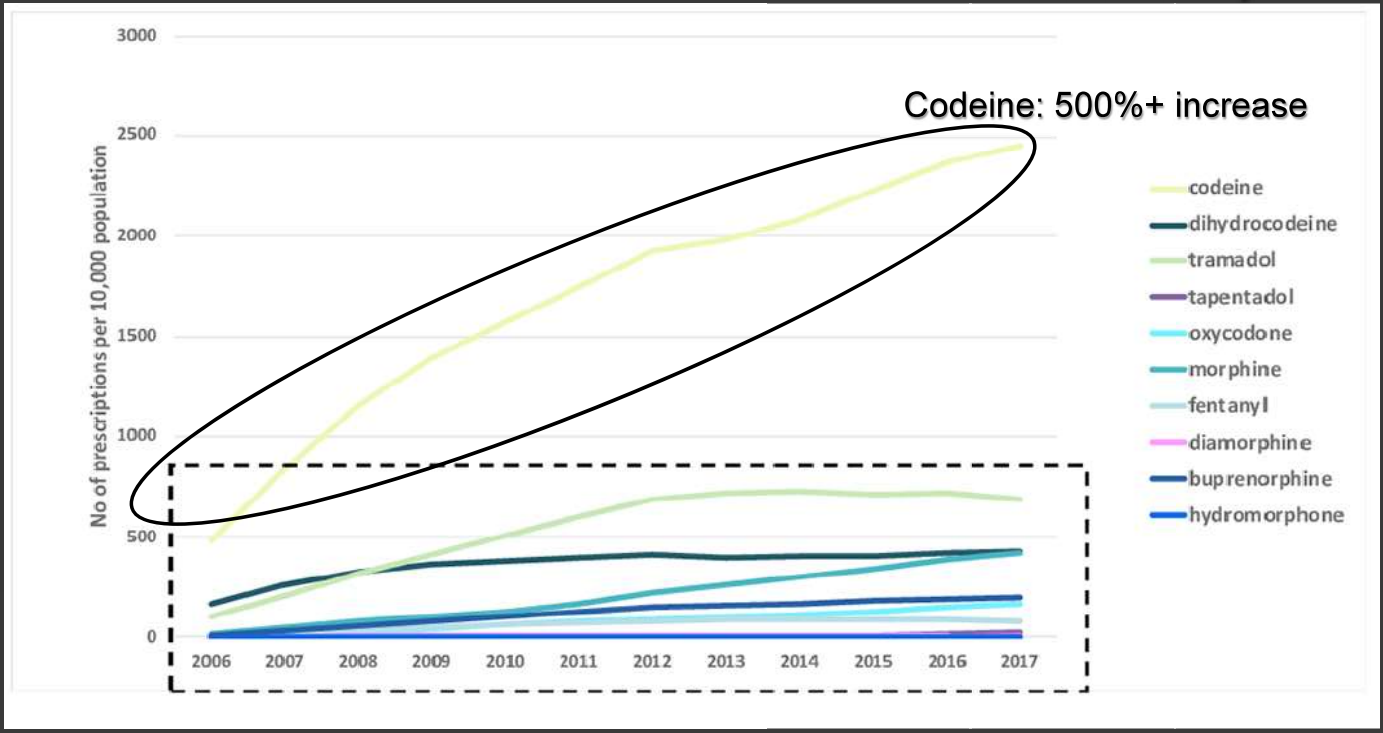


CDC, 2017; from: https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html

Is this just a US problem?

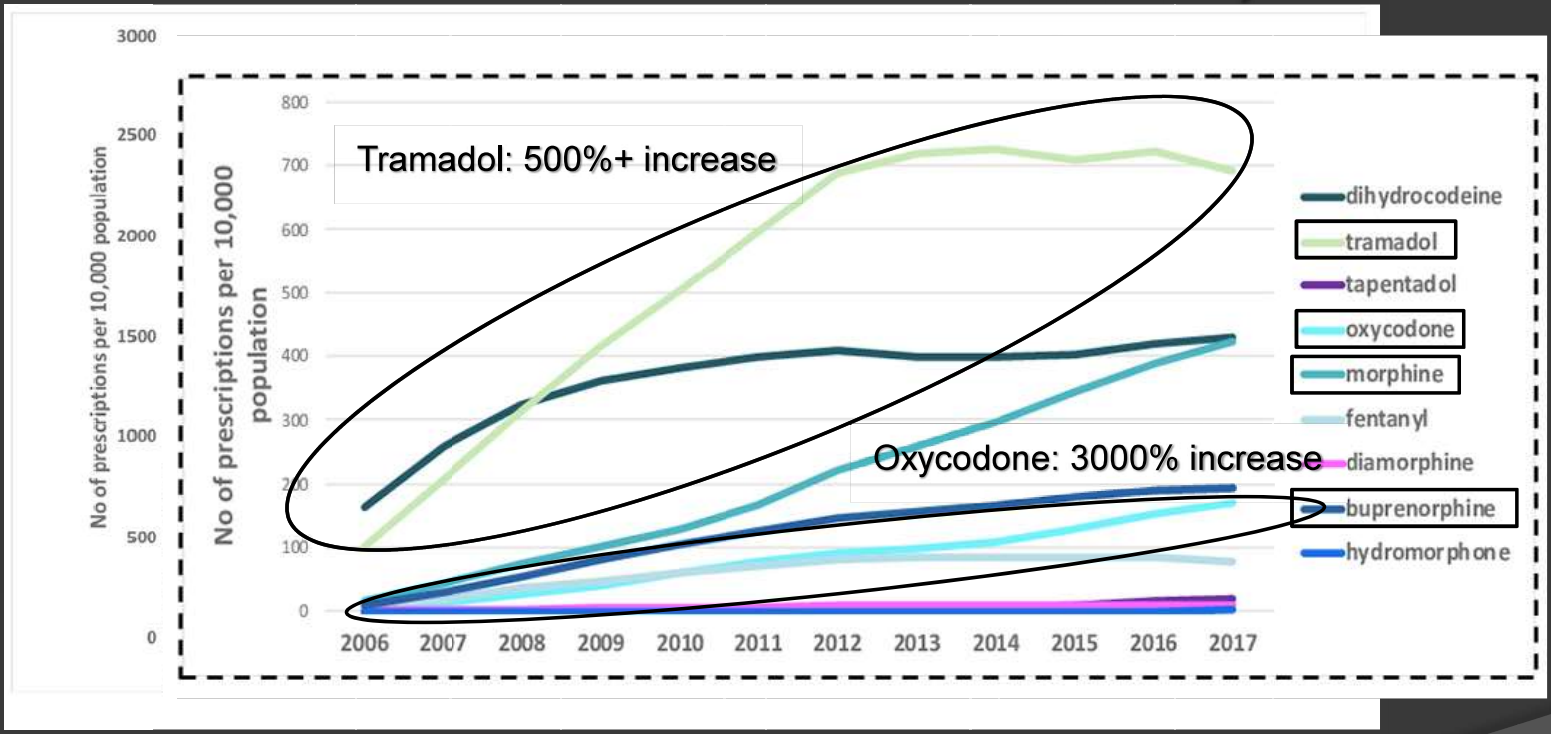


UK Prescribing: New Opioid Prescriptions, Non-Cancer Pain, Primary Care (2006 – 2017)



Jani M et al., 2020, *PLOS Medicine*

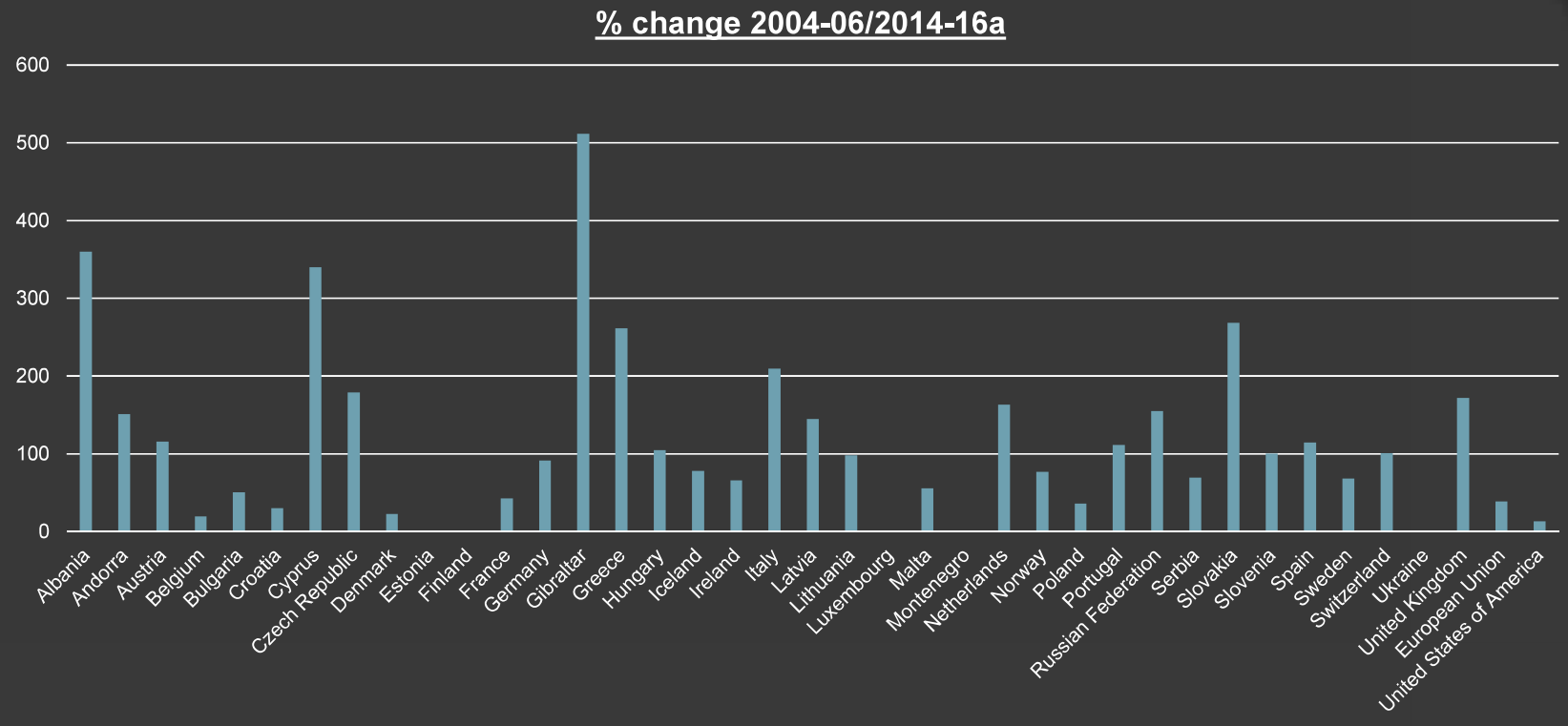
UK Prescribing: New Opioid Prescriptions, Non-Cancer Pain, Primary Care (2006 – 2017)



~15% of new users became long-time users (3+ prescriptions in 90 days)

Jani M et al., 2020, *PLOS Medicine*

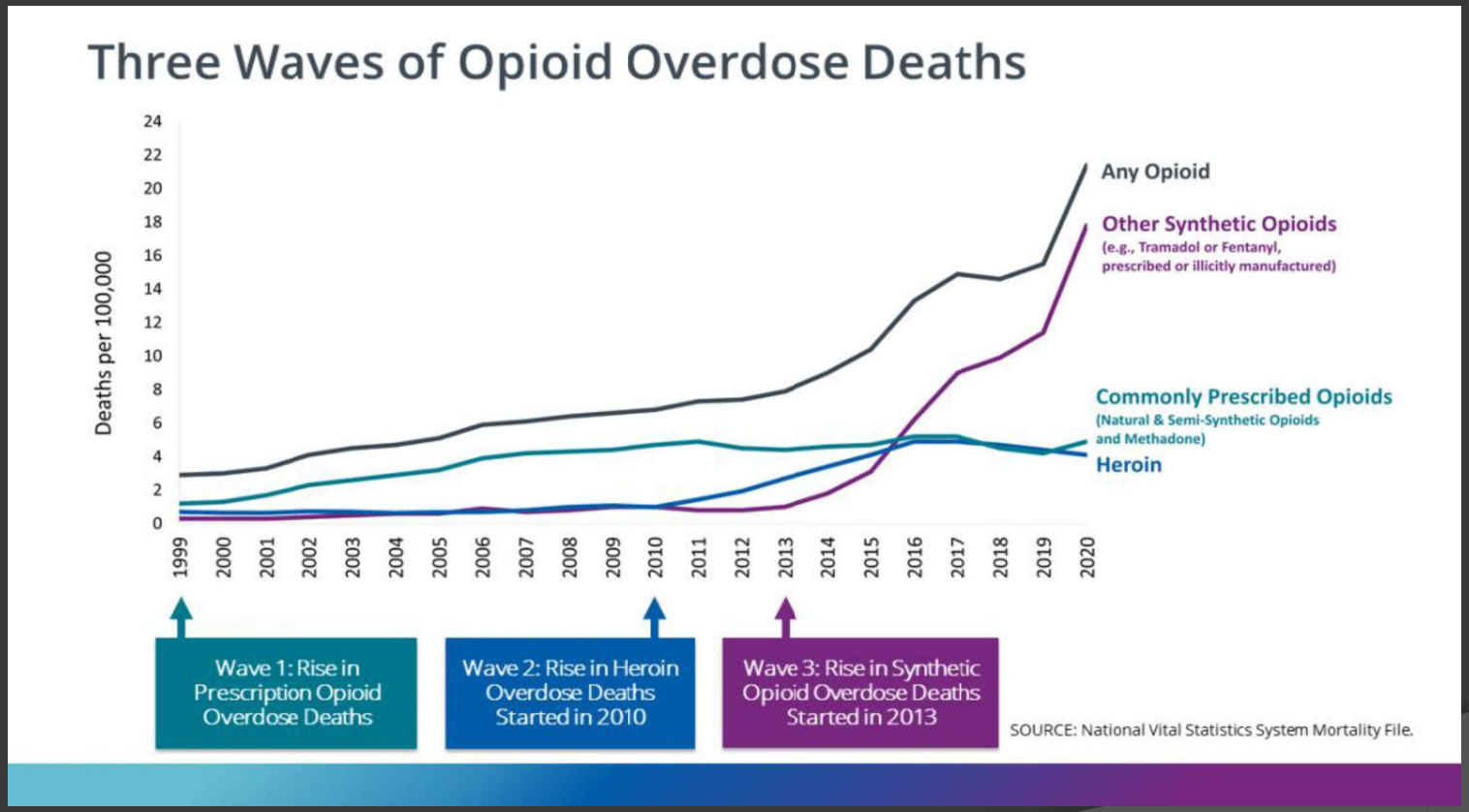
European Opioid Prescribing, 2004-2016



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Häuser et al., 2021, *Eur J Pain*

Net Result 2:
Explosion of Opioid-Related Problems



Comprehensive Review

PAIN

April 2015 • Volume 156 • Number 4

Rates of opioid misuse, abuse, and addiction in chronic pain: a systematic review and data synthesis

Kevin E. Vowles[a,*], Mindy L. McEntee[a], Peter Siyahhan Julnes[a], Tessa Frohe[a], John P. Ney[b], David N. van der Goes[c]

Vowles et al. (2015)	Adults with chronic non-cancer pain (≥3 months) using oral opioids	38	Rate of problematic use	<1%–81%
		29	Rate of misuse	21%–29% (95% CI: 13%–38%)
		1	Rate of abuse	8%
		12	Rate of addiction	8%–12% (95% CI: 3%–17%)

Voon *et al. Substance Abuse Treatment, Prevention, and Policy* (2017) 12:36
DOI 10.1186/s13011-017-0120-7

Substance Abuse Treatment, Prevention, and Policy

Conclusion: Hazardous opioid use appears to occur in a *clinically significant minority.*

Utility of opioids in chronic pain?

- Evidence does:
  - *Not support*
    - long term pain relief (in fact, non-opioids have better evidence)
    - long term improvement in functioning (no better than non-opioids)
  - *Support*
    - more frequent experience of iatrogenic effects (in comparison to non-opioids)
    - ***Supports* potential for harm

e.g., Krebs et al., (2018). Effects of opioid vs nonopioid medications on pain-related function in patients with chronic back pain or hip or knee Osteoarthritis pain. *JAMA, 6, 872-882*

Are opioids bad?

- Understanding what is meant by “addiction”:
  - It is reflective of a pattern of behavior.
- Shorthand:
  - Sustained Use + Negative Impact = “Addiction”
    - Formally referred to as *Substance Use Disorder*

Bottom Line in Chronic Pain:

Sustained Opioid Use + Negative Impact =

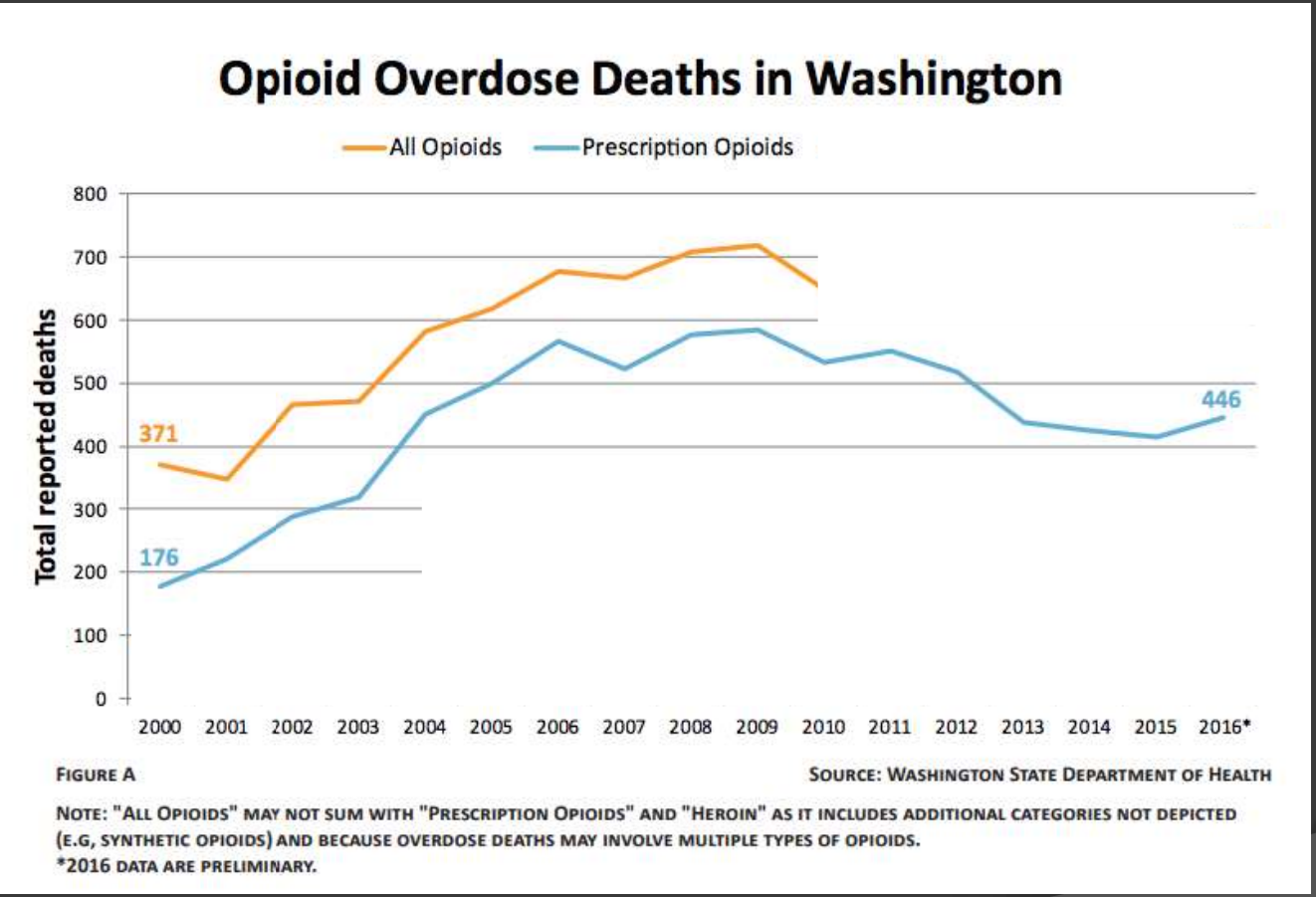
- Greater treatment drop-out
- Poorer treatment outcomes
- Higher dose = higher distress and disability
- Resumption of opioid use following a mandatory wean

Opioid use alone is not necessarily a problem;
Opioid Use Disorder most certainly is a problem.

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Vowles & Ashworth. (2011). Is opioid withdrawal necessary within comprehensive pain rehabilitation programs? *Pain, 152,* 10-12.

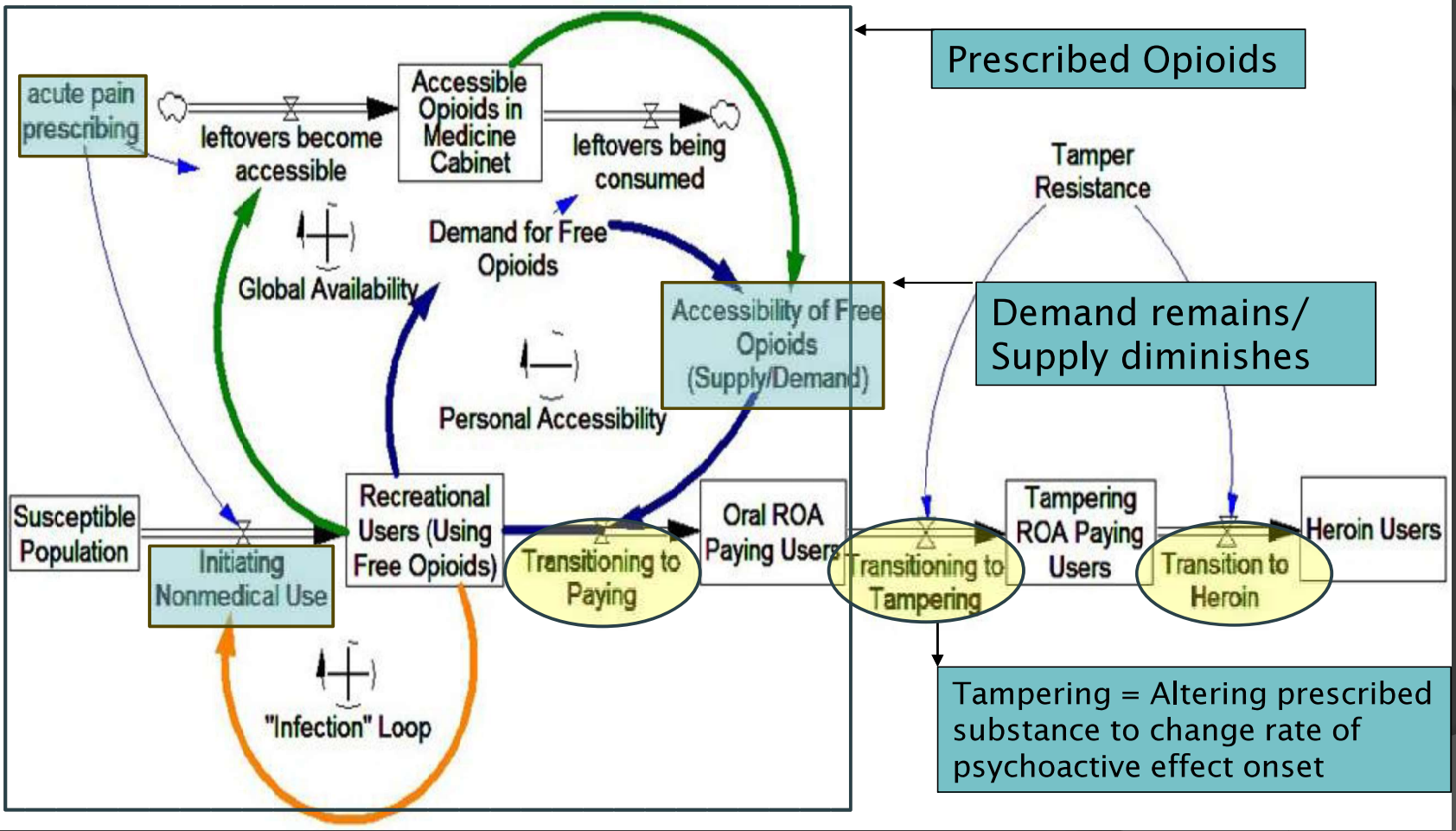
Can’t we just reduce the supply?



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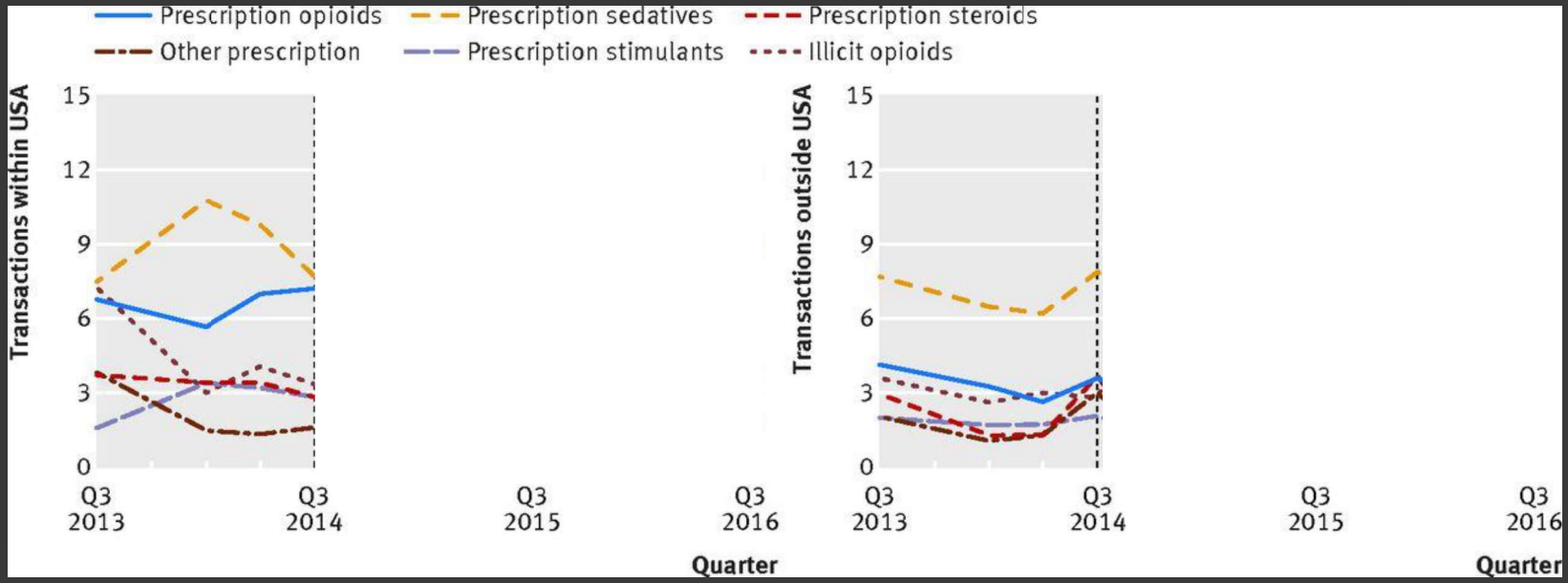
State of Washington’s Attorney General. (2017).''Reducing the Supply of Illegal Opioids in Washington State“ report.

Two ways into harmful use



Wakeland et al., (2015). Dynamic model of nonmedical opioid use trajectories and potential policy interventions. *Am J Drug Alcohol Abuse,* 41, 508–518.

Basic economics matter:
Supply and Demand



2014 US Federal Drug Administration (FDA) restricts access to Fentanyl.

Prescription of opioids *increased*; Illegal sales of opioids *increased*

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Martin et al., (2018). Effect of restricting the legal supply of prescription opioids on buying through online illicit marketplaces: Interrupted time series analysis. *BMJ, 361:* k2270

Pragmatic issues for providers

- Chronic pain remains prevalent.
- Hazardous opioid use is an established problem and restricting supply alone may ignore basic principles of *both* human behaviour and economics.
- Guidelines needed to help guide practice.
- Integrated treatments are needed that reduce *BOTH* *h*azardous opioid use AND chronic pain interference.

There are ‘off the shelf’ solutions available to guide us and decrease our workload here in NI.

Pragmatic issues for providers

- Chronic pain remains prevalent.
- Hazardous opioid use is an established problem and restricting supply alone may ignore basic principles of *both* human behaviour and economics.
- Guidelines needed to help guide practice.
- Integrated treatments are needed that reduce *BOTH* *h*azardous opioid use AND chronic pain interference.



DOI: 10.1002/ejp.1736

POSITION PAPER

EJP

European* clinical practice recommendations on opioids for chronic noncancer pain – Part 1: Role of opioids in the management of chronic noncancer pain

Winfried Häuser[1,2] | Bart Morlion[3] | Kevin E. Vowles[4] | Kirsty Bannister[5] | Eric Buchser[6] | Roberto Casale[7] | Asbjørn Mohr Drewes[10] | Geert D… | Esther Pogatzki-Zahn[14] | Martin R… | Thomas Tölle[17] | Nevenka Krčevsk…

DOI: 10.1002/ejp.1744

POSITION PAPER

EJP

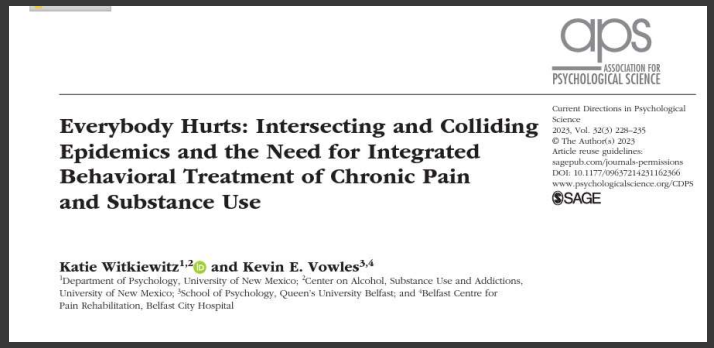
European clinical practice recommendations on opioids for chronic noncancer pain – Part 2: Special situations*

Nevenka Krčevski Škvarč[1] | Bart Morlion[2] | Kevin E. Vowles[3] | Kirsty Bannister[4] | Eric Buchsner[5] | Roberto Casale[6] | Jean-François Chenot[7] | Gillian Chumbley[8] | Asbjørn Mohr Drewes[9] | Geert Dom[10] | Liisa Jutila[11] | Tony O'Brien[12] | Esther Pogatzki-Zahn[13] | Martin Rakusa[14] | Carmen Suarez–Serrano[15] | Thomas Tölle[16] | Winfried Häuser[17,18]

- Guidelines developed by European Pain Forum (EFIC) task force (nine countries) and Pain Alliance Europe (Service user organization)
  - Endorsed by 11 other associations spanning Chronic Pain conditions, Mental Health, Addictions, Physical Health, and Rehabilitation.
  - *Caveat: Limited published evidence; thus reliance on consensus across members, external reviewers, and public commenters.*

Pragmatic issues for providers

- Chronic pain remains prevalent.
- Hazardous opioid use is an established problem and restricting supply alone may ignore basic principles of *both* human behaviour and economics.
- Guidelines needed to help guide practice.
- Integrated treatments are needed that reduce *BOTH h*azardous opioid use AND chronic pain interference.



aps
ASSOCIATION FOR PSYCHOLOGICAL SCIENCE

Everybody Hurts: Intersecting and Colliding Epidemics and the Need for Integrated Behavioral Treatment of Chronic Pain and Substance Use

Current Directions in Psychological Science
2023, Vol. 32(3) 228–235
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DOI: 10.1177/09637214231162366
www.psychologicalscience.org/CDPS
SAGE

Katie Witkiewitz[1,2] and Kevin E. Vowles[3,4]
[1]Department of Psychology, University of New Mexico; [2]Center on Alcohol, Substance Use and Addictions, University of New Mexico; [3]School of Psychology, Queen's University Belfast; and [4]Belfast Centre for Pain Rehabilitation, Belfast City Hospital



JAMA Intern Med. 2022;182(4):407-417. doi:10.1001/jamainternmed.2022.0033
Published online February 28, 2022.

Research

JAMA Internal Medicine | Original Investigation

Mindfulness-Oriented Recovery Enhancement vs Supportive Group Therapy for Co-occurring Opioid Misuse and Chronic Pain in Primary Care
A Randomized Clinical Trial

Eric L. Garland, PhD; Adam W. Hanley, PhD; Yoshio Nakamura, PhD; John W. Barrett, MD; Anne K. Baker, PhD; Sarah E. Reese, PhD; Michael R. Riquino, PhD; Brett Froeliger, PhD; Gary W. Donaldson, PhD



USASP
US ASSOCIATION FOR THE STUDY OF PAIN

PUBLISHED BY ELSEVIER

The Journal of Pain, Vol 21, No 7-8 (July/August), 2020: pp 798–807
Available online at www.jpain.org and www.sciencedirect.com

Integrated Behavioral Treatment for Veterans With Co-Morbid Chronic Pain and Hazardous Opioid Use: A Randomized Controlled Pilot Trial

Kevin E. Vowles,* Katie Witkiewitz,† Karen J. Cusack,‡ Wesley P. Gilliam,§ Karen E. Cardon,‖ Sarah Bowen,¶ Karlyn A. Edwards,* Mindy L. McEntee,‖ and Robert W. Bailey**

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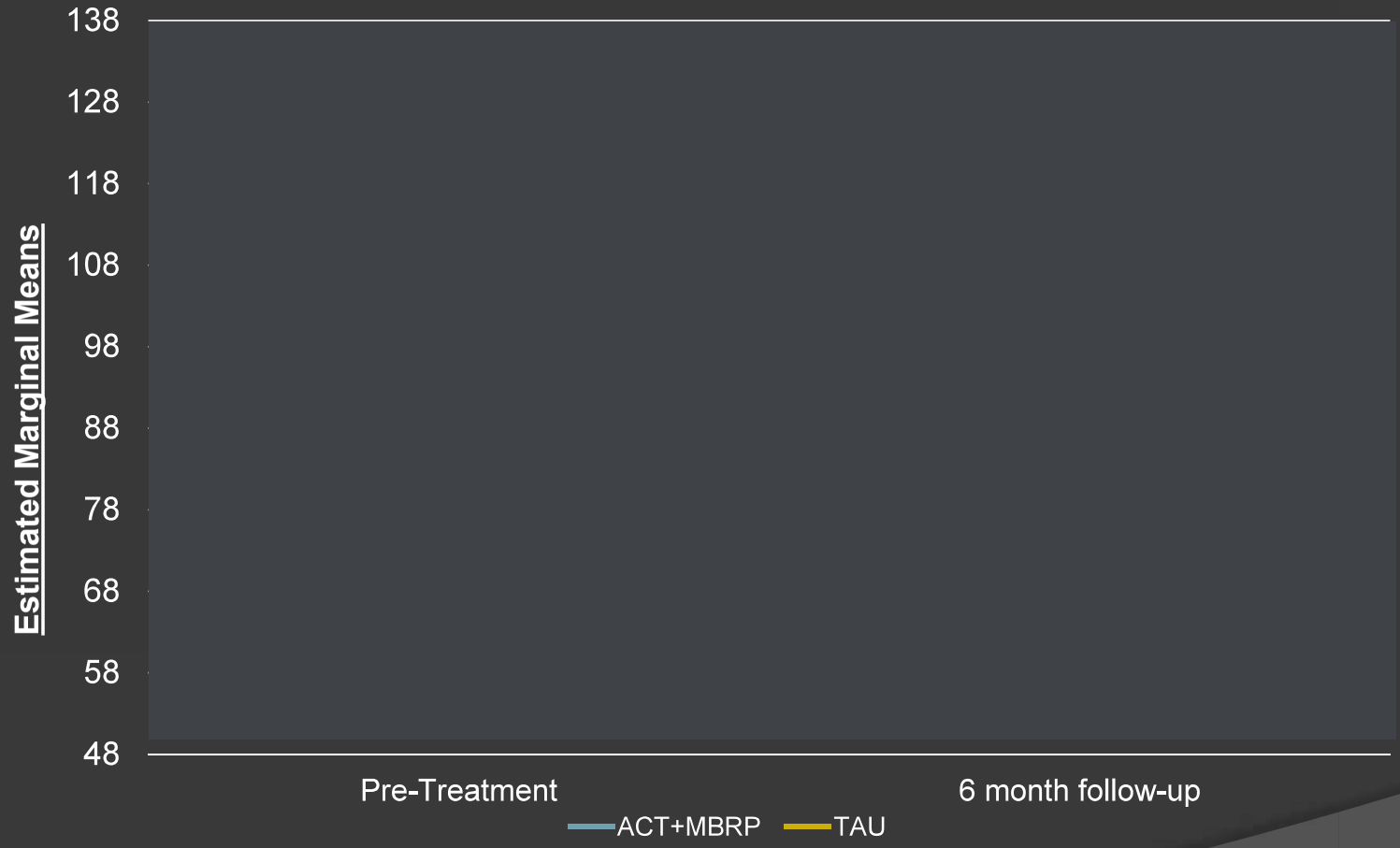
Participant characteristics

- 86% male
- Age: 51.8 yrs ± 10.1
- Ethnicity:
  - 50% Non-Hispanic white
  - 25% Latinx
  - 18% Native American
- Education: Ave 14.5 (*SD:* 2.1)
  - 11% High school
  - 54% some college
  - 14% tech/trade; 18% college
  - 4% post-grad
- Relationship Status
  - 39% married
  - 32% single
  - 29% divorced/separated
- Pain duration:
  - Ave: 17.2 yrs ± *8.7 yrs*
  - Median: 15.3 yrs (5 – 34)
- Pain Location:
  - 64% Low back,
  - 18% whole body
  - 7% Leg/hip
  - 11% Neck/upper back
- Compensation
  - 61% SS disability
  - 54% service connect
  - 4% other

Feasibility outcomes

- Randomized:
  - 41% of referrals (phone screen)
  - 83% of those formally assessed (in person screen)
- Started treatment: 80%
- Retained: 79% of those who started
  - Lost to follow-up *n* = 6 (3 per arm)
- Intervention arm details (*n* = 15 who started)
  - Session Attendance: 77%
  - 13 (87%) “completed” treatment (i.e., 75%+ attendance)

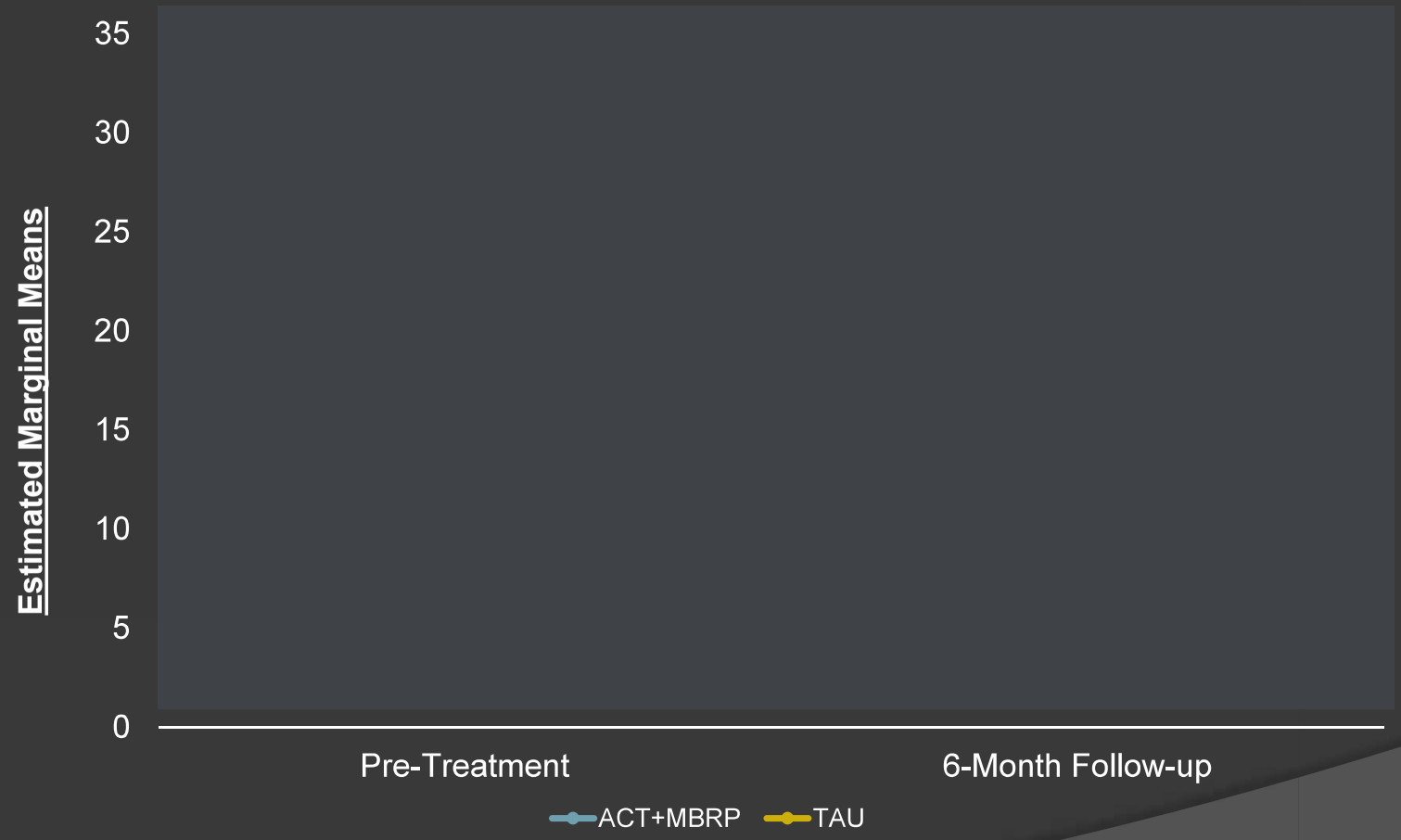
Pain Interference
(PROMIS v1.1 – 41 item version)



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Group*Time Interaction: F = 8.7, p = .009, η_p^2 = .35

Current Opioid Misuse (COMM)



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Group*Time Interaction: F = 5.7, p = .027, η_p^2 = .23



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Time: F = 8.7, p = .008, η_p^2 = .30
Group*Time Interaction: F = 0.98, p = .35

Pain and Opioids: Integrated Treatment In Veterans (POSITIVE) UH3 Study Design

- 160 participants to be randomized to integrated treatment or active control and followed for 1 year.
  - Weekly ACT+MBRP 90 min group sessions for 12 weeks
  - Weekly Education Control 60 min group sessions for 12 weeks, opioid and pain education
- Entering year 5 with follow-ups continuing through year 6 (Aug 2024).

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POSITIVE
Integrated Treatment for Veterans with Co-Occurring Chronic Pain and Opioid Use Disorder

Take home messages...

- Opioids are neither good nor bad.
  - They carry a risk profile that is clinically significant.
  - There is no dose that is risk free, but greater dose/longer duration increases risk significantly.
  - Their increased supply has had *unintended consequences*.
- The demand has been created.
  - In isolation, limiting the supply may have *unintended consequences*.

- We do not need to start from the beginning in NI.
  - The guidelines have been written; the data are available.
- This is not an opioid problem; this is a chronic pain problem.
  - Adequate treatment requires adequate resources.

Acknowledgements

- PhD Students:
  - Laurie Steffen
  - Mindy McEntee
  - Rob Bailey
  - Melissa Pielech
  - Graham Ford
  - Eric Kruger
  - Karly Edwards
  - Maura McCarron
- Main Collaborators:
  - Katie Witkiewitz
  - Lance McCracken
  - Mark Sullivan
  - Julie Ashworth
  - Gail Sowden
- Clinical teams
  - Belfast Centre for Pain Rehabilitation, City Hospital
  - Center for Spine Health, University of New Mexico
  - Interdisciplinary Pain Assessment and Musculoskeletal Treatment Service, Staffordshire NHS Trust
  - Bath Centre for Pain Services, Bath & NE Somerset NHS Trust
- Funding sources (2012 -):
  - PHA Northern Ireland
  - National Institutes of Health: R34AT008398, R21AT007939, UH3DA051241, R01DK114085
  - US Department of Health: 1i01Rx00304-08A1
  - Arthritis Research UK (now Versus Arthritis)
  - Pfizer Independent Grants for Learning and Change
  - Robert Wood Johnson, Center for Health Research
  - Life Sciences Discovery Fund

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Thanks for your attention.



Questions?

k.vowles@qub.ac.uk

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Dr Brenda Bradley

Pharmacy Lead,

Medicines Management & Governance SPPG





NI Opioid Prescribing

Dr Brenda Bradley

Pharmacy Lead, Medicines Management & Governance (SPPG)

Background

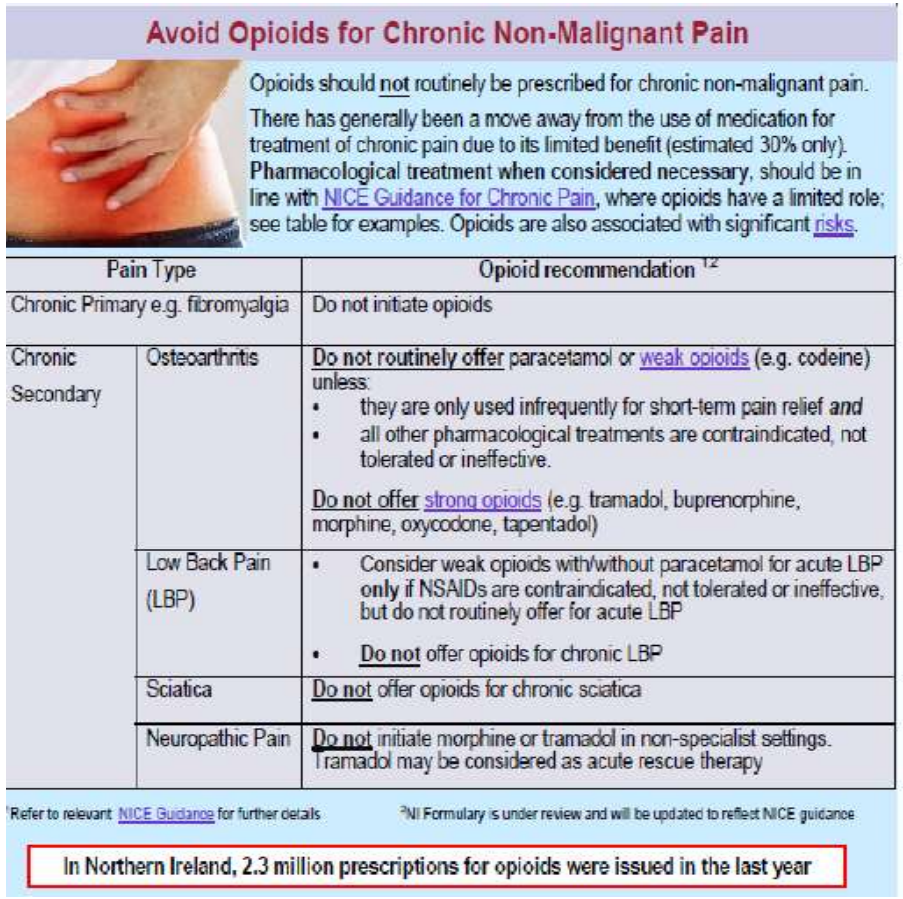
- Opioids: Controlled Drugs (CD) and high risk medicines
- Risks for both primary and secondary care
  - Inappropriate prescribing/use
  - High doses/risky combinations
  - Legislative Requirements
- Significant proportion primary care prescribing started by secondary care
- NI - 5% of the population prescribed opioids
- Concerning due to limited place in therapy

Avoid Opioids for Chronic Non-Malignant Pain

- Follow NICE Guidance - https://www.nice.org.uk/guidance/NG193
- Strong opioids not recommended
- Buprenorphine patches and tramadol recently removed from NI formulary (other strong opioids removed previously)
- Explain reasons if prescribing outside guidance

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Avoid Opioids for Chronic Non-Malignant Pain

Opioids should not routinely be prescribed for chronic non-malignant pain.

There has generally been a move away from the use of medication for treatment of chronic pain due to its limited benefit (estimated 30% only). **Pharmacological treatment when considered necessary**, should be in line with NICE Guidance for Chronic Pain, where opioids have a limited role; see table for examples. Opioids are also associated with significant risks.

Pain Type		Opioid recommendation [1,2]
Chronic Primary e.g. fibromyalgia		Do not initiate opioids
Chronic Secondary	Osteoarthritis	Do not routinely offer paracetamol or weak opioids (e.g. codeine) unless: • they are only used infrequently for short-term pain relief *and* • all other pharmacological treatments are contraindicated, not tolerated or ineffective. Do not offer strong opioids (e.g. tramadol, buprenorphine, morphine, oxycodone, tapentadol)
	Low Back Pain (LBP)	• Consider weak opioids with/without paracetamol for acute LBP only if NSAIDs are contraindicated, not tolerated or ineffective, but do not routinely offer for acute LBP • Do not offer opioids for chronic LBP
	Sciatica	Do not offer opioids for chronic sciatica
	Neuropathic Pain	Do not initiate morphine or tramadol in non-specialist settings. Tramadol may be considered as acute rescue therapy

[1] Refer to relevant NICE Guidance for further details [2] NI Formulary is under review and will be updated to reflect NICE guidance

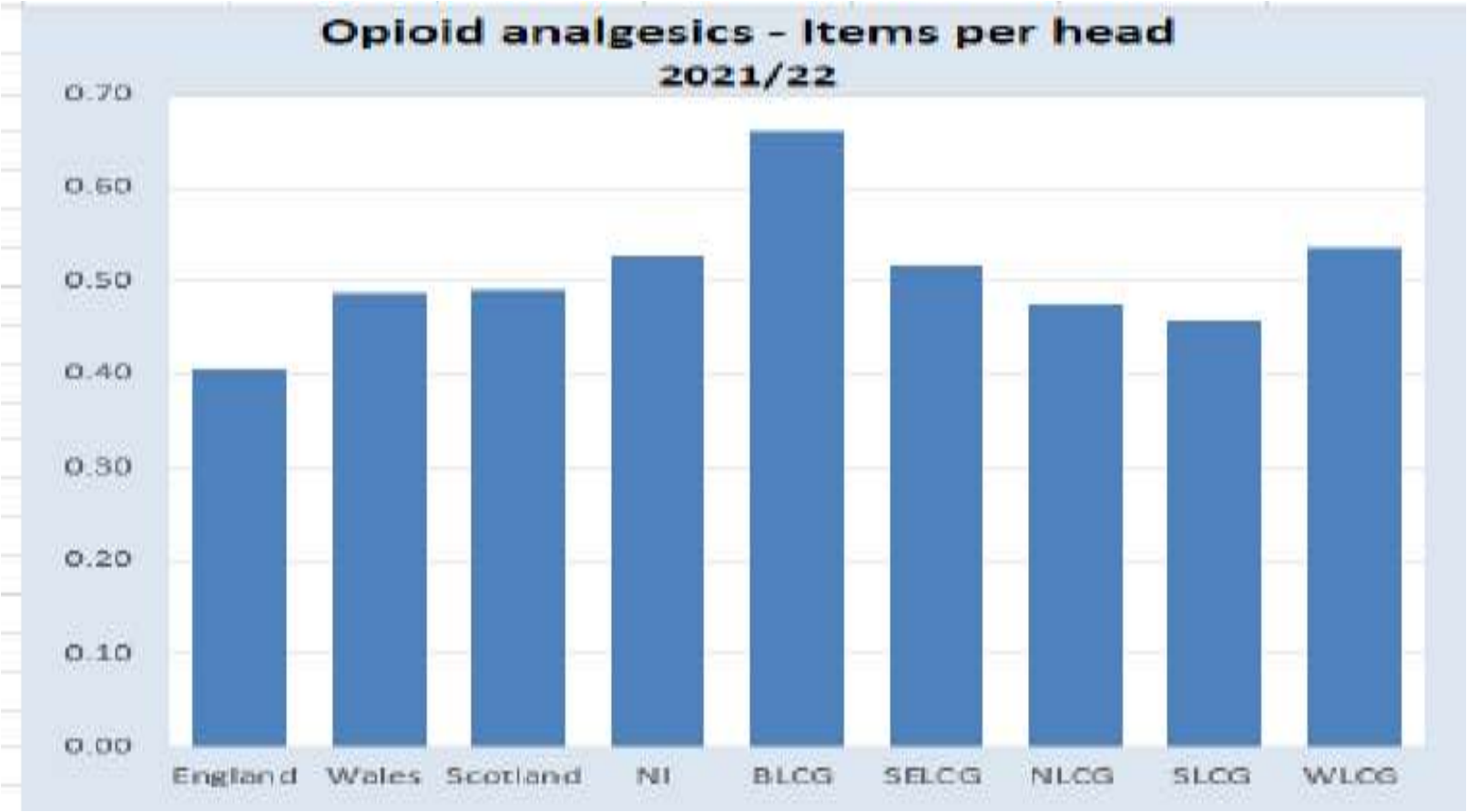
In Northern Ireland, 2.3 million prescriptions for opioids were issued in the last year

https://niformulary.hscni.net/prescribing-newsletters/medicines-management-newsletters/volume-14-2023/

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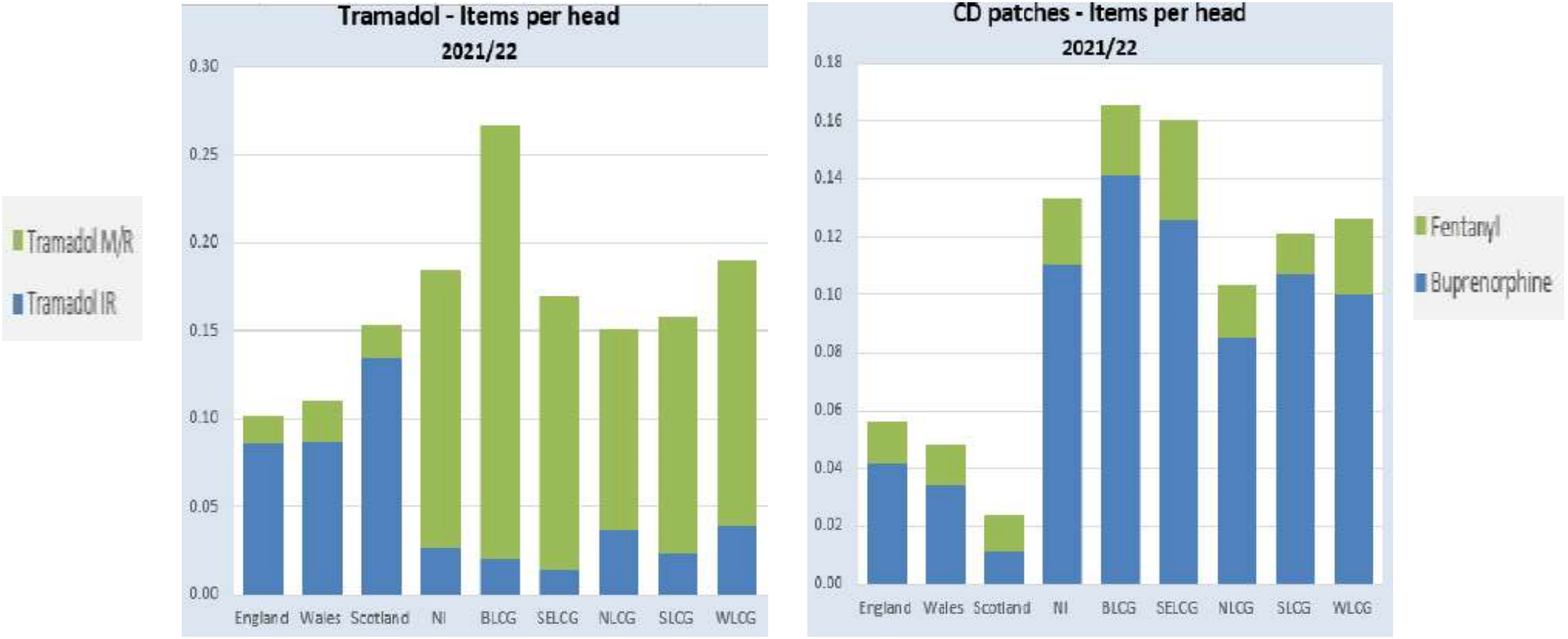
UK Comparison – Total Opioids



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Tramadol and CD patches

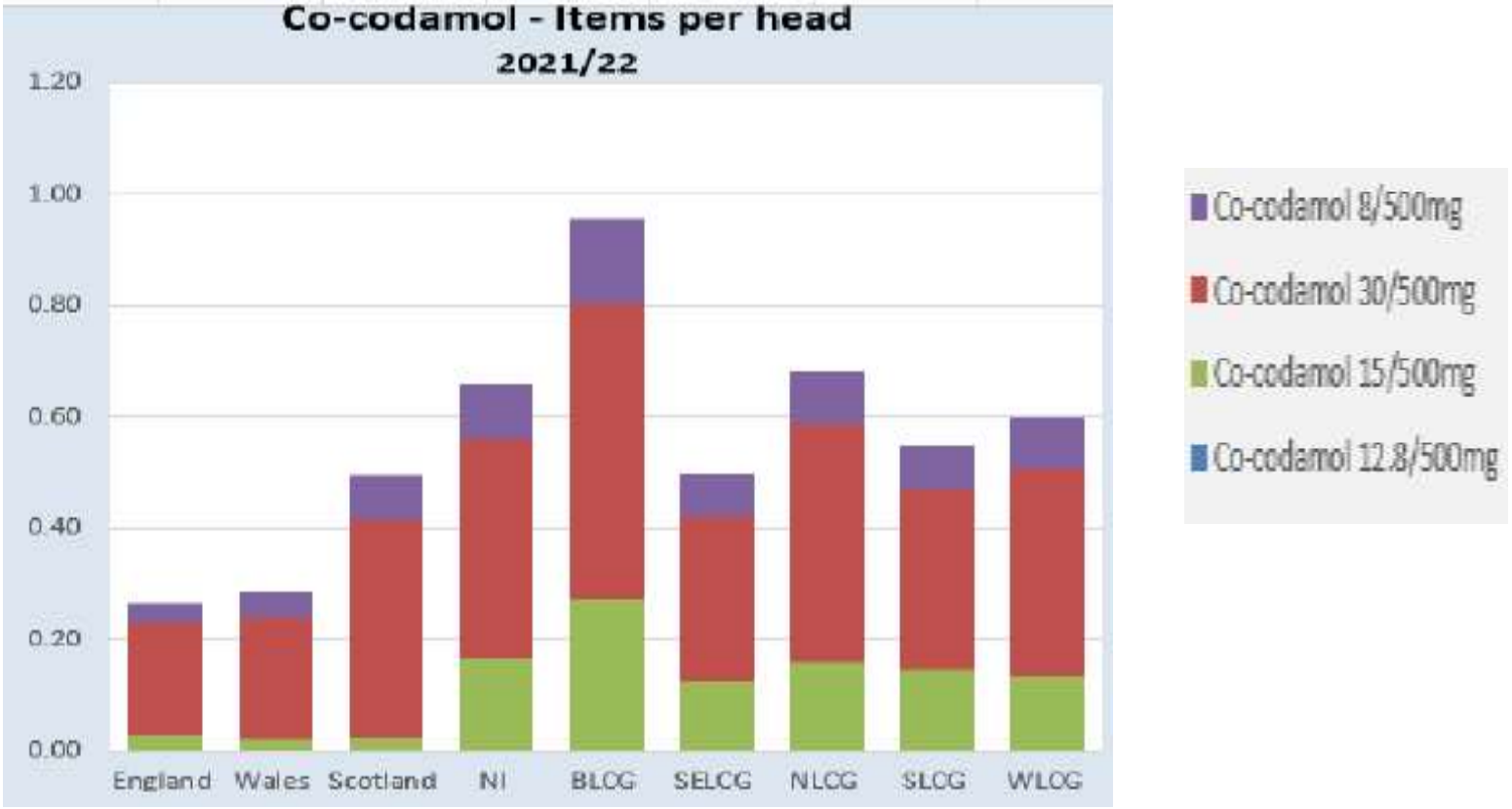


NI higher than other parts of the UK

Co-codamol

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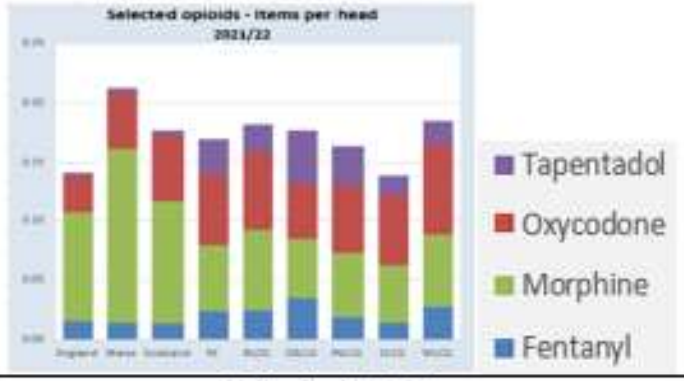
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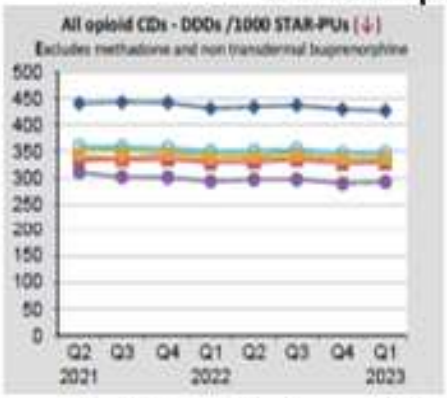
NI higher than other parts of the UK

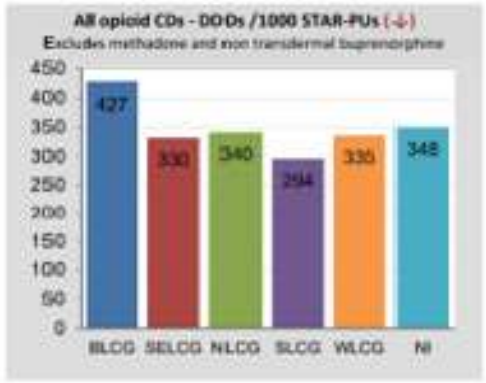
Additional Northern Ireland Opioid Data

Schedule 2 Opioids – UK comparison

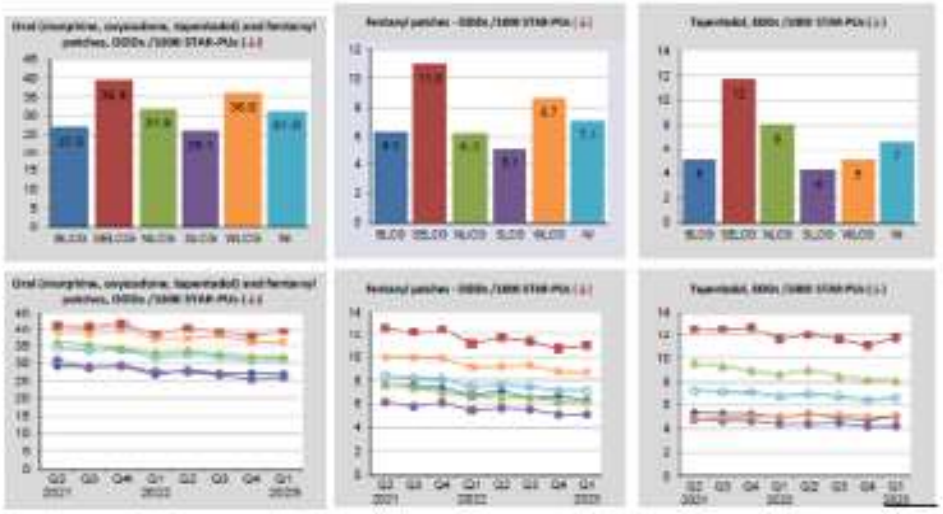


NI Total Opioid Prescribing

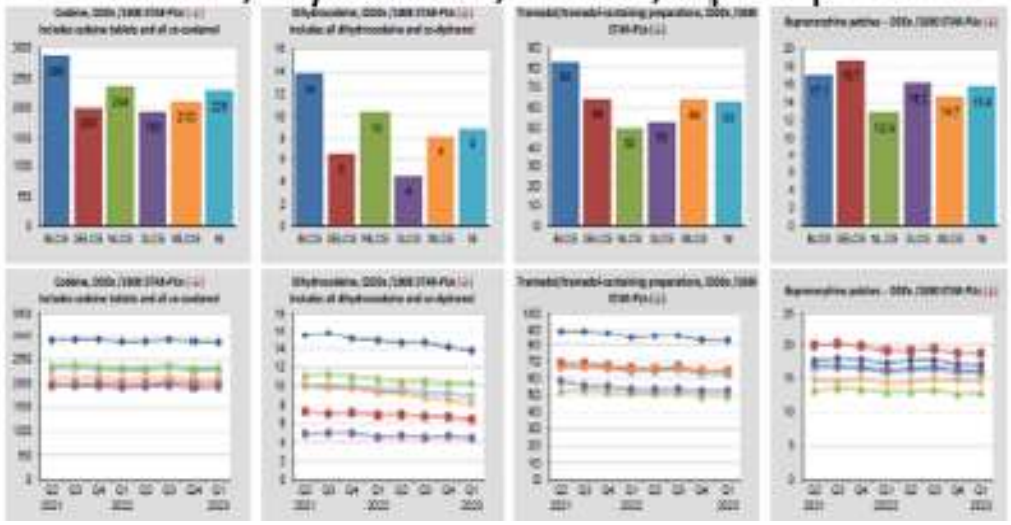




Schedule 2 CDs



Codeine, dihydrocodeine, tramadol, buprenorphine



Percentage of population receiving opioid analgesics by age and sex, 2022/23

Age Group	% Male	% Female	% Overall
Under 18	0.1%	0.1%	0.1%
18 – 24	0.4%	0.7%	0.6%
25 – 34	1.3%	2.2%	1.8%
35 – 44	3.1%	4.3%	3.7%
45 – 64	7.0%	9.4%	8.2%
65 – 74	9.9%	12.8%	11.4%
75 – 84	11.4%	16.7%	14.3%
85+	15.7%	25.3%	21.8%
All Ages	**4.2%**	**6.3%**	**5.3%**

Number of individuals receiving opioid analgesics by deprivation quintile, 2022/23

Deprivation Quintile	Number of Individuals	% of total Population
1 (most)	24,043	6.8
2	22,702	5.9
3	20,508	5.1
4	18,406	4.7
5 (least)	15,377	4.3
Unassignable	110	N/A
Northern Ireland	**101,146**	**5.3**

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Opioid prescribing a UK priority



- **England: NHS England's Patient Safety Strategy 2023**

  'Improving non-cancer pain management by reducing harm from high-risk opioid prescribing –Medication Safety Improvement Programme'

  Opioid prescribing indicators -national medication safety indicators

- **Wales: All Wales Analgesic Stewardship Guidance**

  Opioid Burden and tramadol prioritised within National Prescribing Indicators for 2022-2025

- **Scotland**: **Opioid prescribing for chronic pain guide (Draft)**

  Opioid prescribing - National therapeutic and polypharmacy indicators

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Northern Ireland

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www.health-ni.gov.uk

How do we reduce opioid risks in NI?

- Whole system approach
- Stakeholder collaboration – primary and secondary care
- Share best practice
- Learn from others/experts – local, UK, world-wide
- New ideas/ways of working
- Opportunities in breakout sessions to discuss focus areas

We need your help – starting today

Useful resources

Transforming Medication Safety Northern Ireland

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

NICE National Institute for Health and Care Excellence

NORTHERN IRELAND Formulary

LiveWell with pain

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists



Faye's Story



Sean's Story



Guideline summary

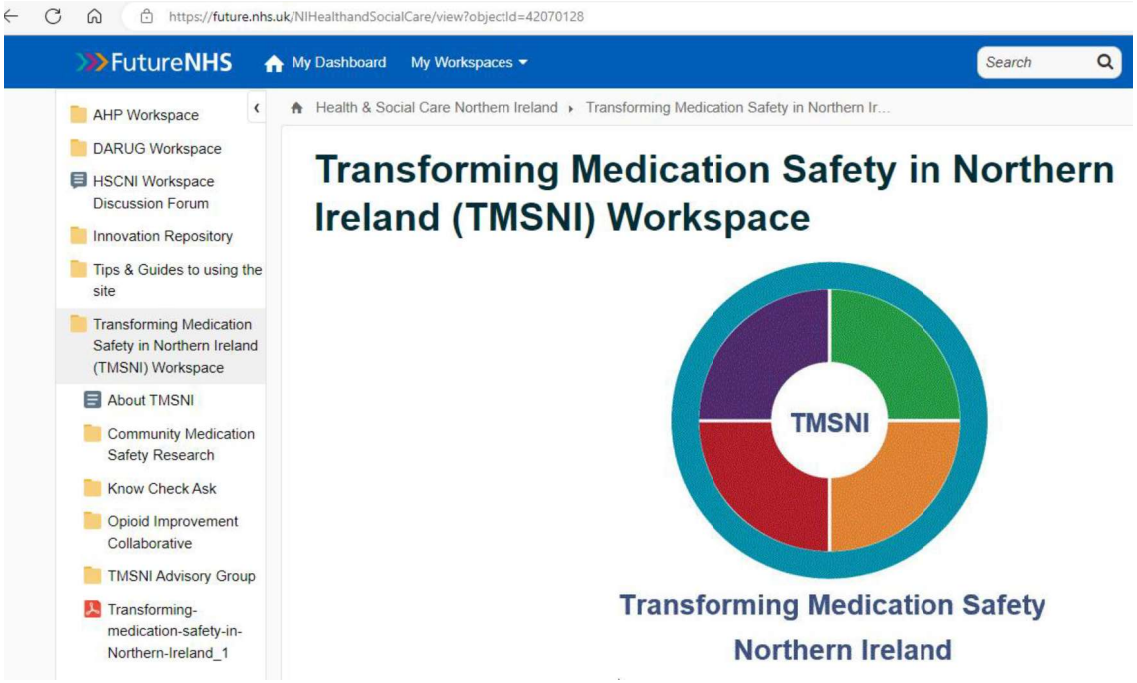
Clinical practice guideline for deprescribing opioid analgesics: summary of recommendations

Aili V Langford[1,2], Christine CW Lin[3], Lisa Bero[4], Fiona M Blyth[2], Jason Doctor[5], Simon Holliday[6], Yun-Hee Jeon[2], Joanna Moullin[7], Bridin Murnion[2,8], Suzanne Nielsen[9], Rawa Osman[10], Jonathan Penm[2,11], Emily Reeve[1,12], Sharon Reid[2], Janet Wale[13], Carl R Schneider[2,*], Danijela Gnjidic[2,*]

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NHS futures workspace - **Transforming Medication Safety in Northern Ireland (TMSNI) Workspace**

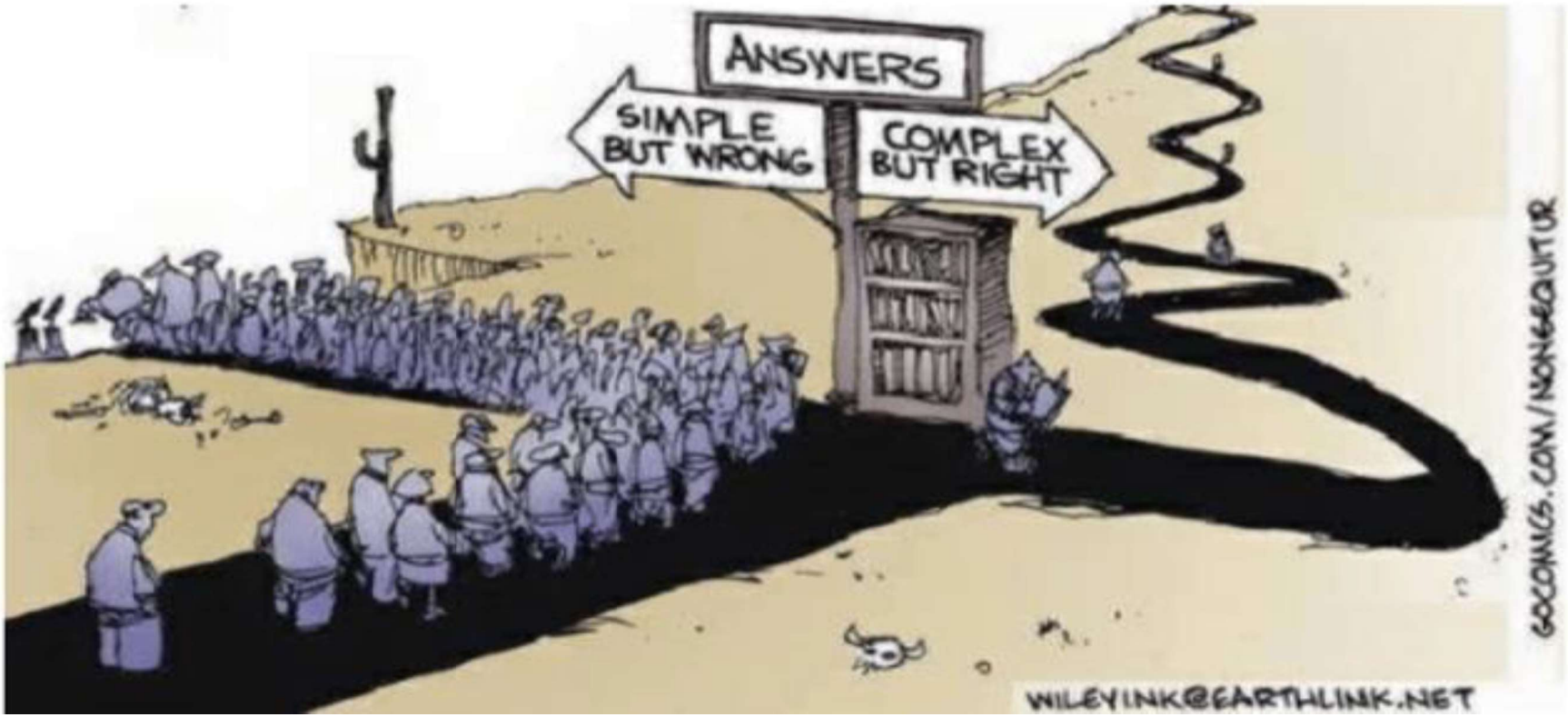


https://future.nhs.uk/NIHealthandSocialCare/view?objectId=42070128

Next steps…

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Q & A

Transforming Medication Safety
Northern Ireland

HSCQI
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Tony Doherty

Regional Co-Ordinator, Healthy Living Centres

Dr Pamela Bell

Chair of Pain Alliance NI

TMSNI

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Northern Ireland

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Better Days

Pain Support Programme

A CO-DESIGNED COMMUNITY DEVELOPMENT APPROACH TO LIVING WELL WITH LONG-TERM PAIN

HSC Health and Social Care

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

Healthy Living Centre Alliance

HSC Public Health Agency
Project supported by the PHA

Better Days Pain Support Programme

- A co-designed community development approach to living well with long-term pain
- Collaborative cross-sectoral project aimed at improving health and wellbeing for people experiencing chronic pain in NI.
- Partners include the Healthy Living Centre Alliance (HLCA), Public Health Agency (PHA), Strategic Planning & Partnership Group (SPPG), Queens University Department of Psychology & Mental Health Foundation NI
- Launched in 2017 and has evolved into a regional programme supporting a self-management approach to pain using a community development model.
- Flexible programme involving pharmacists, physiotherapists, artists and community development workers

Better Days is delivered in 28 centres across all 5 Trust areas

Healthy Living Centres By Location

- Western HLC
- Belfast HLC
- Northern HLC
- South Eastern HLC
- Southern HLC



Healthy Living Centre Alliance
E: info@hlcalliance.org T: 079 2181 0642

1. THE OLD LIBRARY TRUST
Healthy Living Centre, Central Drive, Creggan, Derry, BT48 9QG. Tel: 028 7137 3871 Email: george@olt.ie
2. WATERSIDE NEIGHBOURHOOD PARTNERSHIP
Shared Future Centre, City Park View, 61 Irish Street, Waterside, Derry/Londonderry BT47 2DB. Tel: 02871 342959 Email: watersidenp@hotmail.com
3. OAK HLC
LITE House, Cross Street, Lisnaskea, Fermanagh, BT92 0JE. Tel: 028 6772 3843 Email: Michael.Mowen@oakhlc.com
4. STRABANE HEALTH IMPROVEMENT PROJECT
15b Ballycolman Estate, Strabane, BT82 9AQ Tel: 028 7138 3557 Email: strabanehealthimprovement@gmail.com
5. DERC VALLEY HLC
5 Parkview Rd, Castlederg, BT81 7BN Tel: 028 8167 0764 Email: martin@dergvalleycare.com
6. OMAGH FORUM FOR RURAL ASSOCIATIONS
Omagh Community House, 2 Drumragh Avenue, Omagh, BT78 1DP. Tel: 028 82 251559 Email: maryt.conway@omaghforum.org

7. THE MAUREEN SHEEHAN CENTRE
106 Albert Street, Belfast, BT12 4HL. Tel: 028 9031 0346 Email: heartproject@btconnect.com
8. TOP OF THE ROCK HLC
689 Springfield Road, Belfast, BT12 7FP. Tel: 028 9244 5748 Email: r.mccorley@usdt.co.uk
9. ARDOYNE/SHANKILL HEALTH PARTNERSHIP
The Houben Centre, 432 Crumlin Road, Belfast, BT14 7TF. Tel: 02890 756638 Email: una@ashic.com
10. EAST BELFAST COMMUNITY DEVELOPMENT AGENCY (EBCDA)
65 Templemore Avenue, Belfast, BT5 4FP. Tel: 028 9045 1512 E: linda@ebcda.org
11. SHAFTSBURY COMMUNITY AND RECREATION CENTRE
97 Balfour Avenue, Belfast, BT7 2EW T: 028 9031 2377 Email: nbrennan@lorag.org
12. NEWLODGE DUNCAIRN COMMUNITY HEALTH PARTNERSHIP
206 Duncairn Gardens, Belfast, BT15 2GN Tel: 028 9074 5588 Email: julie@communityhealthpartnership.co.uk
13. LIGONIEL HEALTHY LIVING CENTRE
Wolfhill Centre, 148 Ligoniel Road, Belfast, BT14 8DE Tel: 028 90 391 225 Email: health@ligonielvillage.com
14. NEW LIFE COUNSELLING
25 Ardoyne Road, Belfast, BT14 1HX Tel: 028 9039 1630 Email:normapatterson@newlifecounselling.net

15. NORTHERN AREA COMMUNITY NETWORK
Old School House, Mill Street, Cushendall, BT44 0RB Tel: 028 2177 2100 Email: info@nacn.org
16. LOUGHGIEL COMMUNITY ASSOCIATION
The Millennium Centre, Lough Road, Loughgiel, Ballymena, BT44 9JN Tel: 028 2764 1389 Email: loughgiel@btconnect.com
17. COOKSTOWN WESTERN SHORES AREA NETWORK
2 Hillhead, Stewartstown, Dungannon, BT71 5HY. Tel: 028 8773 8845 Email:info@cwsan.org
18. CAUSEWAY RURAL AND URBAN NETWORK
1 Brook Street, Coleraine, BT52 1PW Tel: 028 7034 4934 Email: ann@crun.org
19. TIDAL
Toome House, 55 Main Street, Toome, County Antrim, BT41 3TF. Tel: 028 7965 9199 Email: tidal_toome@hotmail.com

20. THE RESURGAM TRUST
Lagan View Enterprise Centre, 69 Drumbeg Drive, Lisburn, BT28 1NY Tel: 028 9252 8233 Email: gillian.lewis@resurgamtrust.co.uk
21. PENINSULA HEALTHY LIVING PARTNERSHIP
4 Church Grove, Kircubbin, Newtownards, BT22 2SU. Tel: 028 4273 9020 Email: sheila.balle@setrust.hscni.net
22. COUNTY DOWN RURAL COMMUNITY NETWORK
Ballymote Centre, 40 Killough Road, Downpatrick, BT30 6PY Tel: 028 4461 2311 Email: nicholas@countydownrcn.com
23. POLECLASS COMMUNITY ASSOCIATION
Sally Gardens Lane, Belt Steele Road, Dunmurry, Belfast, BT17 0UJ. Tel: 028 9062 7250 Email: martin@sallygard 22ens.org

24. THE VERVE PROJECT
Rowallane HSC, Ulsterbury Centre, Brownlow, Craigavon, BT65 5BE Tel: 028 3756 2952 Email: lisamcaliskey@southerntrust.hscni.net
25. THE CLANRYE GROUP
Drumalane Mill, The Quays, Newry, County Down, BT35 8QS. Tel: 078 6674 6423 Email: liam.devine@clanryegroup.com
26. WEST ARMAGH CONSORTIUM
20 Cathedral Road, Armagh City, BT61 7QX Tel: 028 3752 2759 Email: smccleary@btinternet.com
27. SOUTH LOUGH NEAGH REGENERATION INITIATIVE
1 Maghery Road, Dungannon, BT71 6PA. Tel: 028 3885 2550 Email: mcallindenmary@yahoo.co.uk
28. RURAL HEALTH PARTNERSHIP IN SOUTH ARMAGH WALD CENTRE
Tullynavall Road, Cullyhanna, Newry, BT35 0PU. Tel: 028 3086 1220 Email: ruralhealthpartnership@hotmail.co.uk
29. KILKEEL DEVELOPMENT ASSOCIATION
The Nautilus Centre, Rooney Road, Newry, BT34 4AG. Tel: 028 4176 2525 Email: kda.chiefexecutive@gmail.com

Better Days
Pain Support Programme

Topics include:

- Mental Health
- Sleep
- Pain Toolkit
- Self Care
- Understanding Pain
- Pharmacist Session
- Relaxation & Breathing
- Gentle Movement & Exercise
- Nutrition
- Peer Led Session



Programmes are mostly delivered face to face (some offer hybrid)



Minimum of 8 participants per programme



2 facilitators are present at each session



Participants complete surveys at start and end of programme



8-12 sessions per programme



Each session includes Chi Me or gentle movement

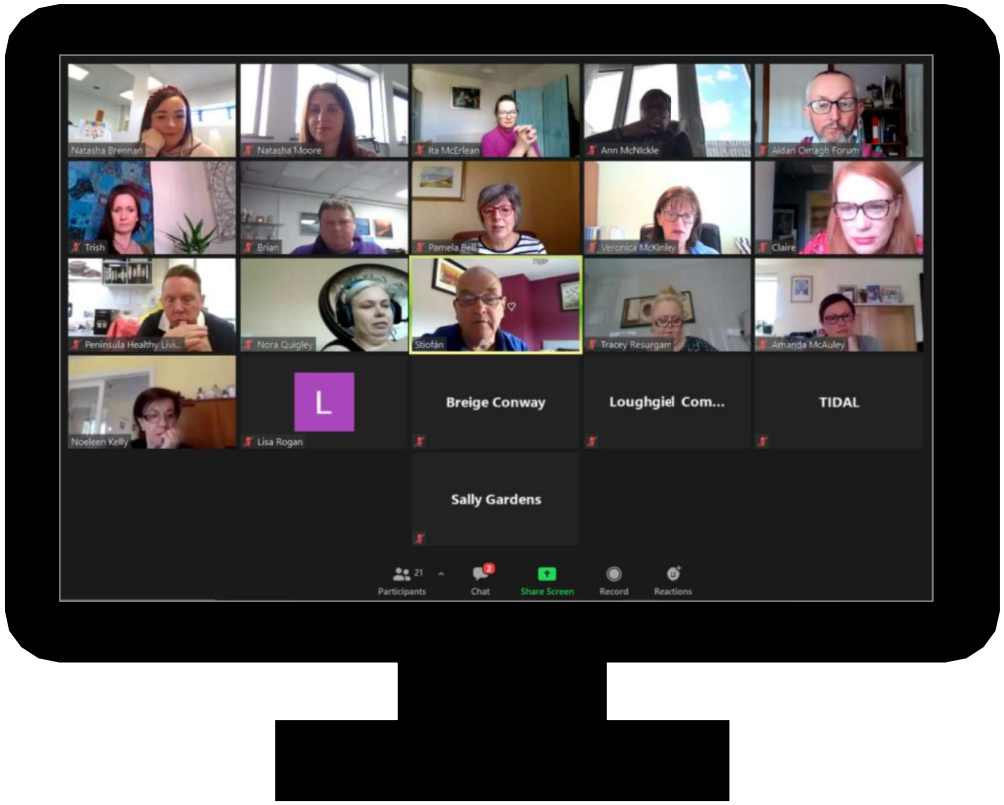
Pain Support Facilitators

Better Days
Pain Support Programme

Our Facilitators generally have a background in health development roles

<u>Training includes:</u>

- Support meetings
- Bi-annual and ongoing training programme
- Chi Me
- Pain management / Pain Toolkit
- Pharmacy and physio support
- Psychology
- Sleep
- Nutrition
- Mental Health



Better Days
Pain Support Programme

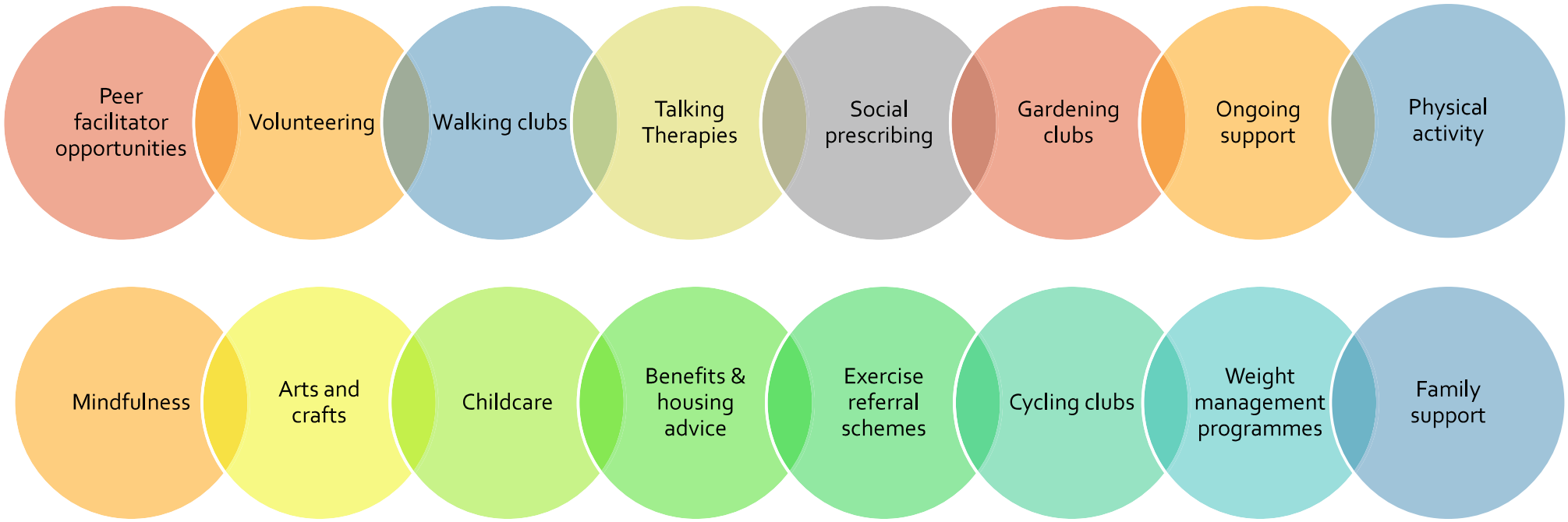
Cost

- £1700 per programme
- Approximately £150 per person

Post Programme

Healthy Living Centre Alliance

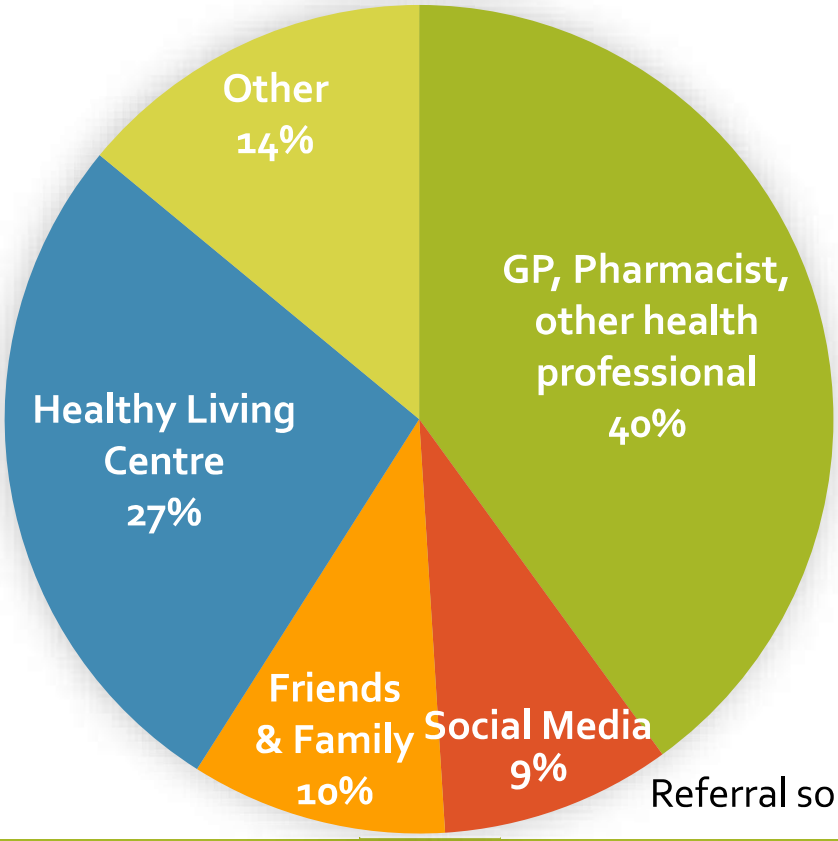
The Better Days Programme is only the beginning of the participants journey



Better Days Pain Support Programmes 2022-23

- 44 programmes
- 486 participants

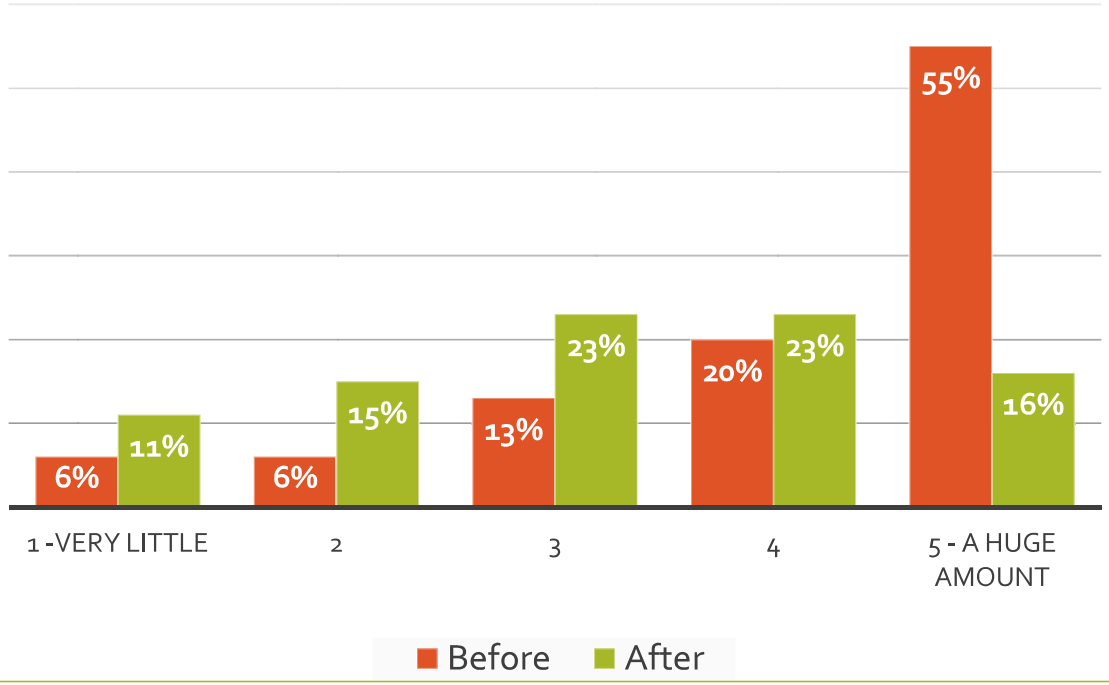
- Majority of participants were female (83%)
- Over 45's made up for 86% of participants
- 69% participants report having pain for 10+ yrs



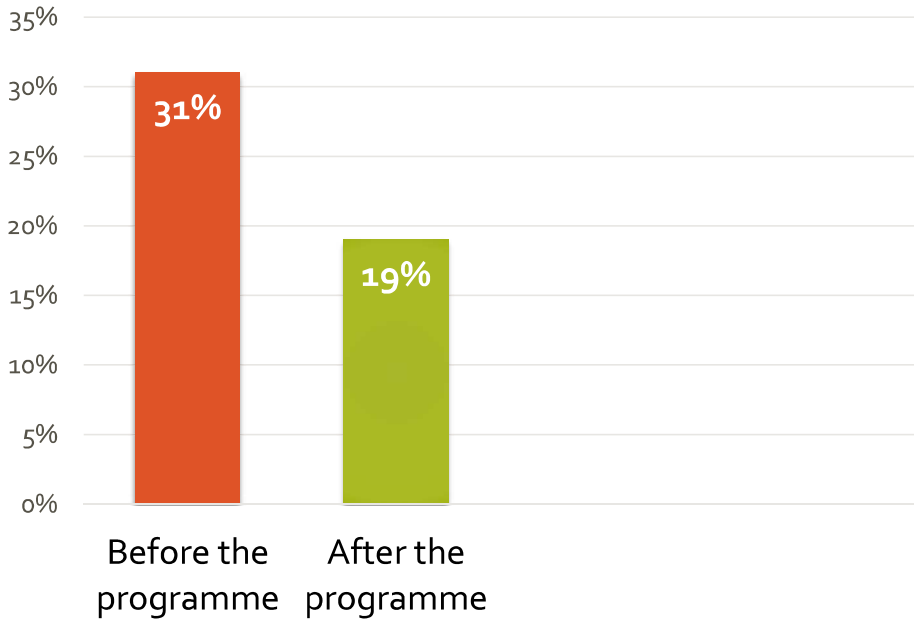
Referral sources/ signposting

2022 – 2023

On a scale of 1 – 5 how much do you rely on medicines to help your pain



I am severely / extremely anxious or depressed



126 participants completed programmes between January and March 2023

Better Days
Pain Support Programme

Since starting the programme:

I understand my pain medicines better	74%
I understand that medicines play only one part in helping pain	73%
I have discussed my pain medicines with my GP practice	27%
I have discussed my pain medicines with my local pharmacist	23%
The amount of pain medicines I take has changed	17%

Examples of self-reported medication changes:

-Amitriptyline down 75mg to 50mg

-Some meds were unhelpful. I am trying a new variant at present

-Taking less painkillers and use my toolkit from my pain class

-I have cut back on pain relief

-Reduced pain relief needed for nerve pain

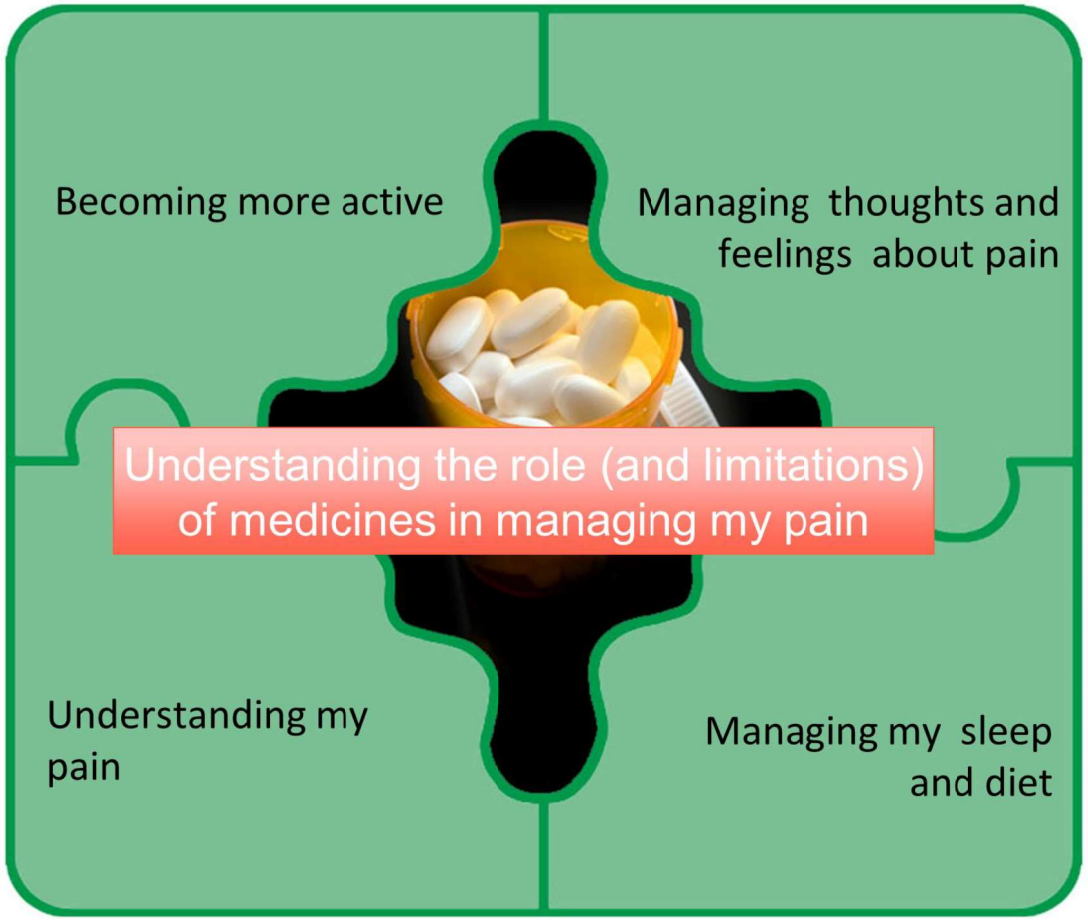
-I have reduced the amount of brufen I take with a determination to stop taking them completely

-I went to pharmacist and reduced my medication due to advice from the pharmacist at one of the sessions

100% of completers would recommend the Better Days Programme to others living with pain

- *I feel that the programme has helped me tremendously and am feeling a lot more positive about life and more understanding of how to help with my pain*
- *Excellent programme, more GPs and health professionals should be referring to this - so valuable*
- *It's been great going to the pain support programme, it's been very helpful and encouraged me to get out and meet people and I don't feel I'm on my own with all my health issues. It's a non judgemental environment.*
- *I found the course very beneficial with understanding and coping with my pain, and sharing with other sufferers. The facilitators were excellent giving helpful techniques to deal with coping with pain. The chi mi classes enabled me to exercise gently and the breathing techniques helped to reduce my frustration living with pain 24/7*
- *I would find discussing my problems difficult but the course has helped me recognise that they are not a weakness*
- *It is good to be with other people challenged by a life of pain. It is good to share problems and learn of possible solutions. It is good to be able to discuss your pain and its problems and not be judged. It is good to share!*

Holistic pain management




Acceptance
Support
Better understanding
More in control
No judgement
Socialise
Better Days
Pain Support Programme
Make changes
Less alone
Improved quality of life
Routine
Helping myself
Balance
Feel more positive

Q & A

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Northern Ireland

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Breakout sessions



Rooms:

- A (main room)
- B (up the stairs towards reception)

Room allocation:

- Refer to sticker on pack for room allocation

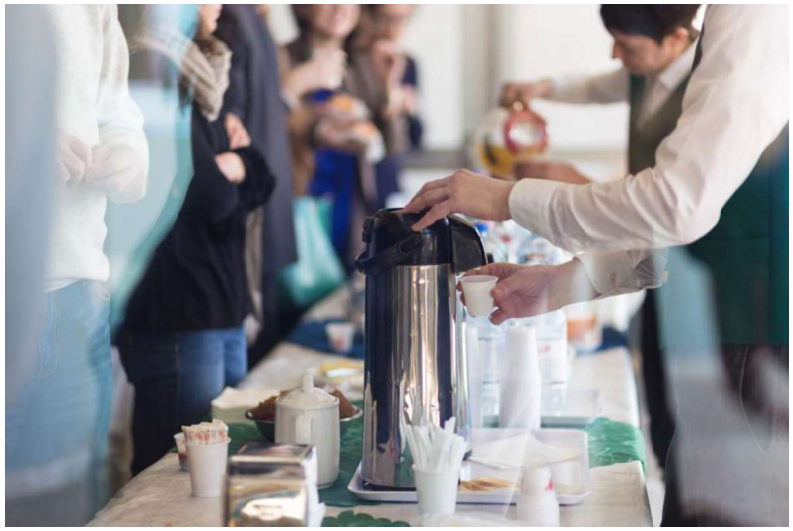
Breakout session 1: 11:20am to 12:20pm
Breakout session 2: 1:50pm to 2:30 pm

Feedback from both sessions in main room

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Time for networking and refreshments



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Breakout session 1

Focus: Consider and discuss in huddles (a**) INFLUENCING FACTORS** and **(b) CONSEQUENCES** of **high-risk opioid prescribing** for **non-malignant pain management.**

Consider (a) **INFLUENCING FACTORS** and (b) **CONSEQUENCES** from perspective of:

- The person living with non-malignant pain and prescribed high risk opioids.
- The carer of a person living with non-malignant pain and prescribed high risk opioids.
- The health care professional working in Primary or Secondary Care who is dispensing, initiating, reviewing, prescribing, reducing or stopping opioid prescribing
- The health care professional involved in delivering interventions to patients with non-malignant pain in Primary or Secondary care settings who are prescribed high risk opioids
- Etc…..



INFLUENCING FACTORS



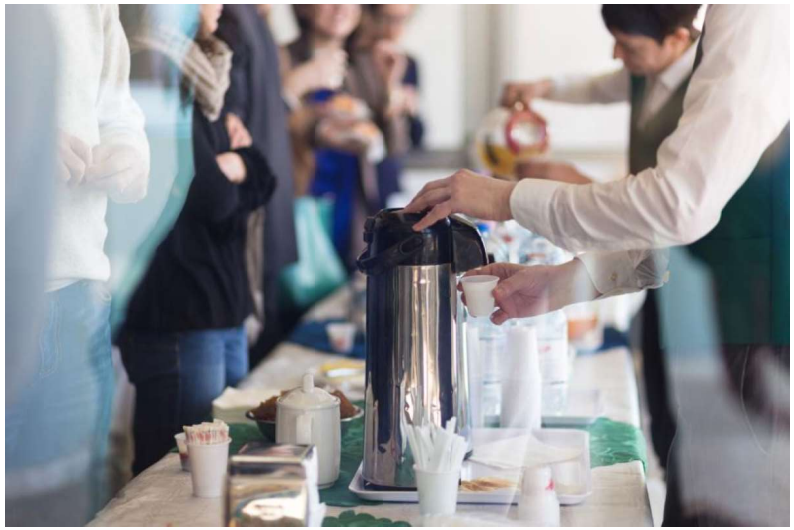
CONSEQUENCES

- Group Yellow and Pink post its into themes on 2 separate flip chart sheets
- Feedback from each huddle to room

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Time for lunch



Transforming Medication Safety
Northern Ireland

Welcome back





Mary McBride

Pharmacy Adviser, SPPG

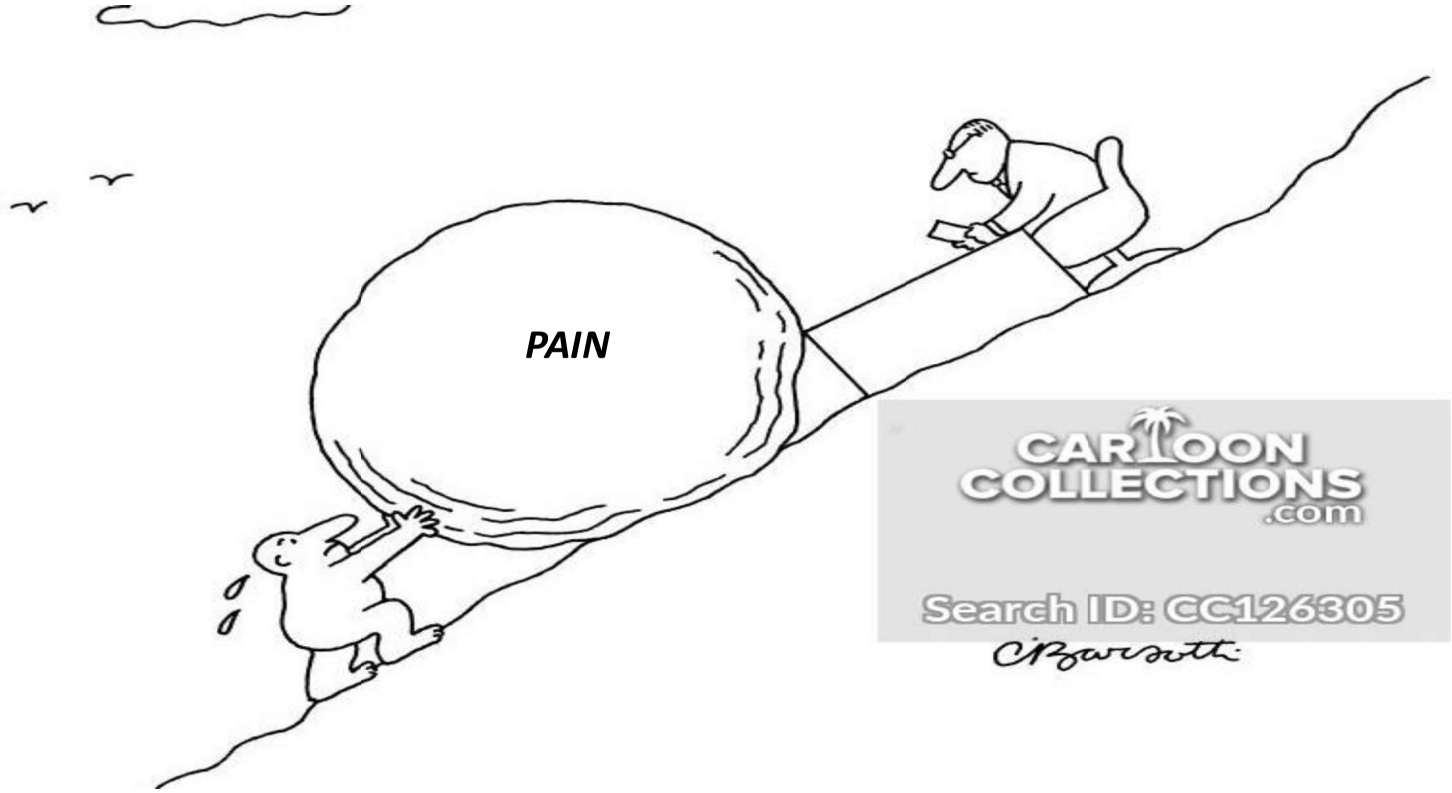
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Health and Social Care

Learning from Reducing Opioid Prescribing in General Practice

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

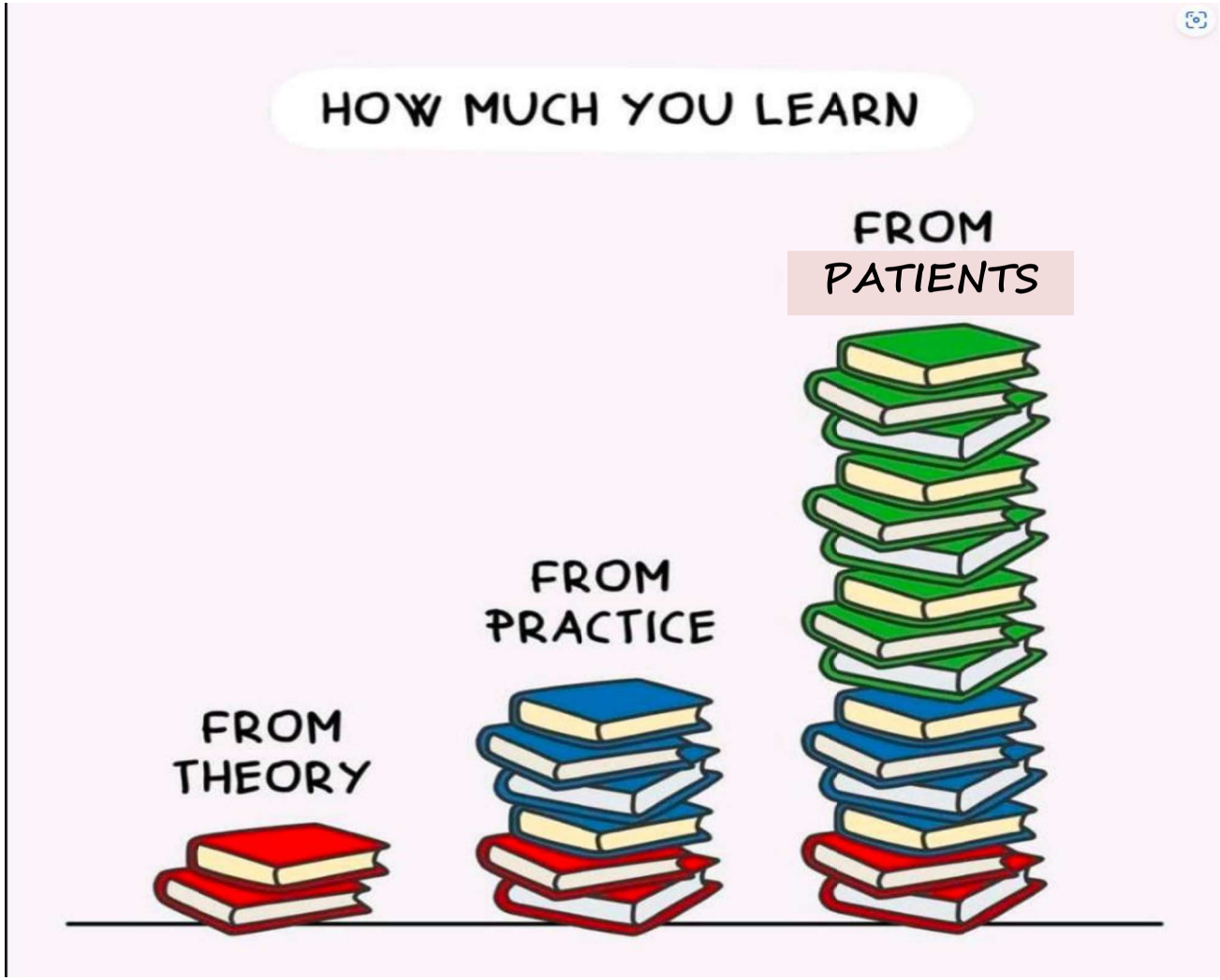


Mary McBride
Pharmacy Adviser
SPPG

Strategic Planning and Performance Group

Health and Social Care

Department of Health
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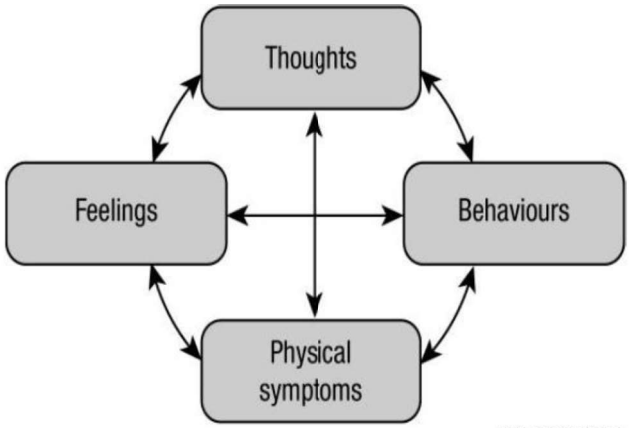
- **If a patient has pain that remains severe despite opioid treatment it means they are not working and should be stopped, even if no other treatment is available.** Opioids Aware | Faculty of Pain Medicine (fpm.ac.uk)
- A tolerable level of pain that facilitates optimal physical and emotional function and avoidance of complications
- **Medication has to support daily functioning-unrealistic for patient to expect to be pain free.**
- Chronic pain is very complex. Patients with severe or debilitating symptoms, particularly if on high dose opiates should have assessment of their emotional influences on pain experience.

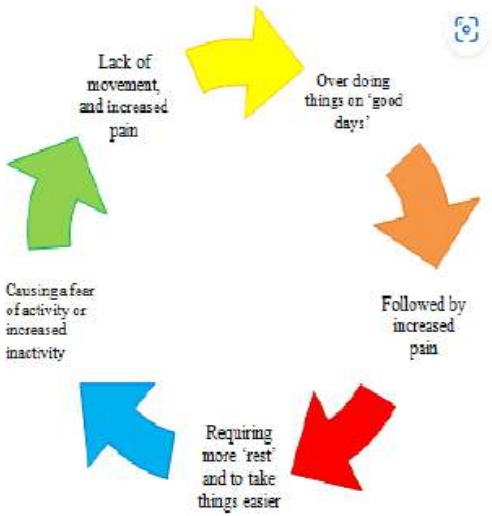
1. Review indication
2. Discuss side-effects
3. Look out for red flags
    - Taking medication for other problems e.g. the medication helps me feel better about myself.
    - I feel the medication helps me to relax-even if the pain does not go away

Health and Social Care

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Patient Centred Care



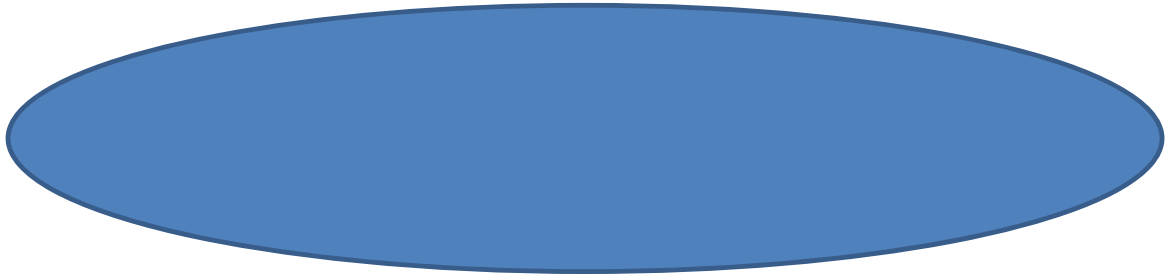


Health and Social Care

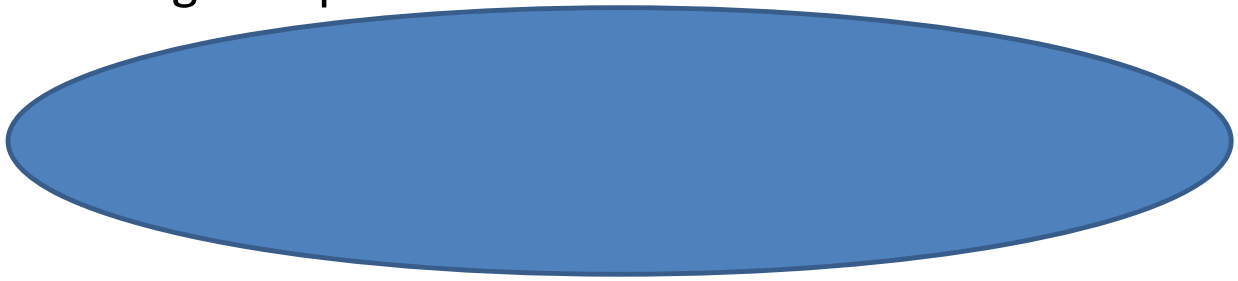
Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Patient Exercise

- Get patient to list all activities they managed prior to onset of pain



- Get patient to list all activities they are currently able to manage despite medication



Health and Social Care

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TOP TIPS BEFORE STARTING REDUCTIONS

1. Review COMPASS report, seek advice from pharmacy adviser. Start with highest area of opioid prescribing and risk stratify-patients on >90mg OME.
2. Have a practice team meeting to discuss strategy and ensure everyone is content with procedure.
3. Detail how reductions will be flagged on patient notes so that all staff are aware person is on opiate reduction plan.
4. Discuss as a practice how you will deal with setbacks. Involve MDT if available.
5. Involve local community pharmacies and advise them on reduction plan.
6. Know what resources are available in your area to refer patients to for further non-pharmacological support e.g. Better Days program, PMP etc.

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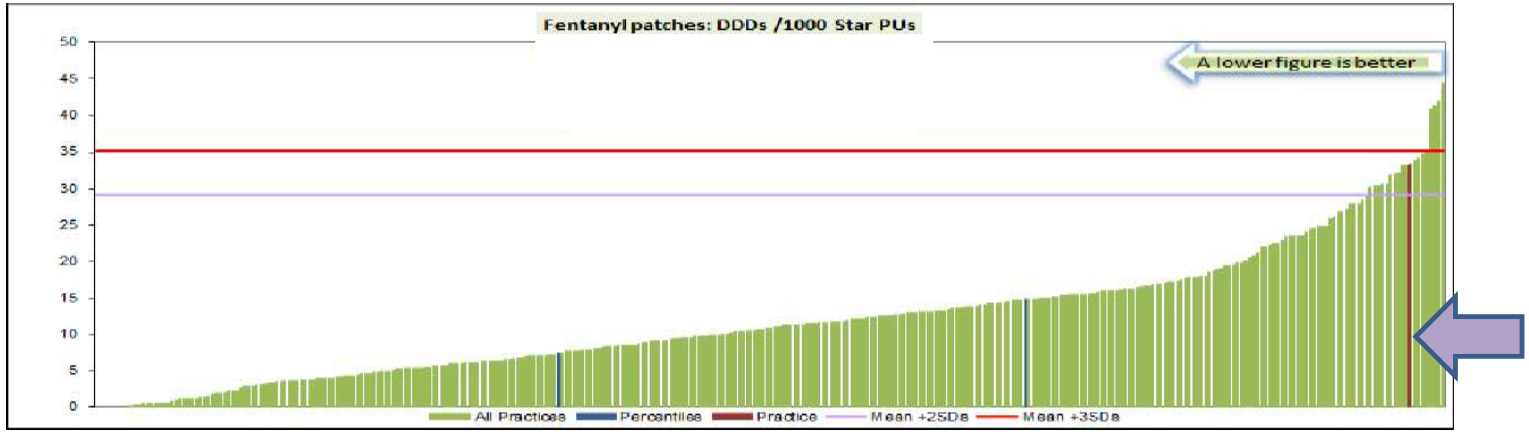
TOP TIPS WHEN STARTING REDUCTIONS

1. Listen to the person's pain story.
2. Identify and explain the different types of pain (nociceptive, neuropathic, chronic secondary and/or primary). Acute vs Chronic
3. Explain sensitisation-faulty car alarm.
4. Discuss limitations of opioids and side-effects.
5. Be honest about possibility of never controlling pain fully.
6. Provide information leaflets, signpost to videos-Tame the Beast, Brainman quits his opioids. Allow person to digest and discuss information.
7. Arrange follow up appointment to begin reductions. Go Slow. Prepare person for possibility of increased pain when beginning reduction.
8. Human factors/Life events may lead to setbacks.

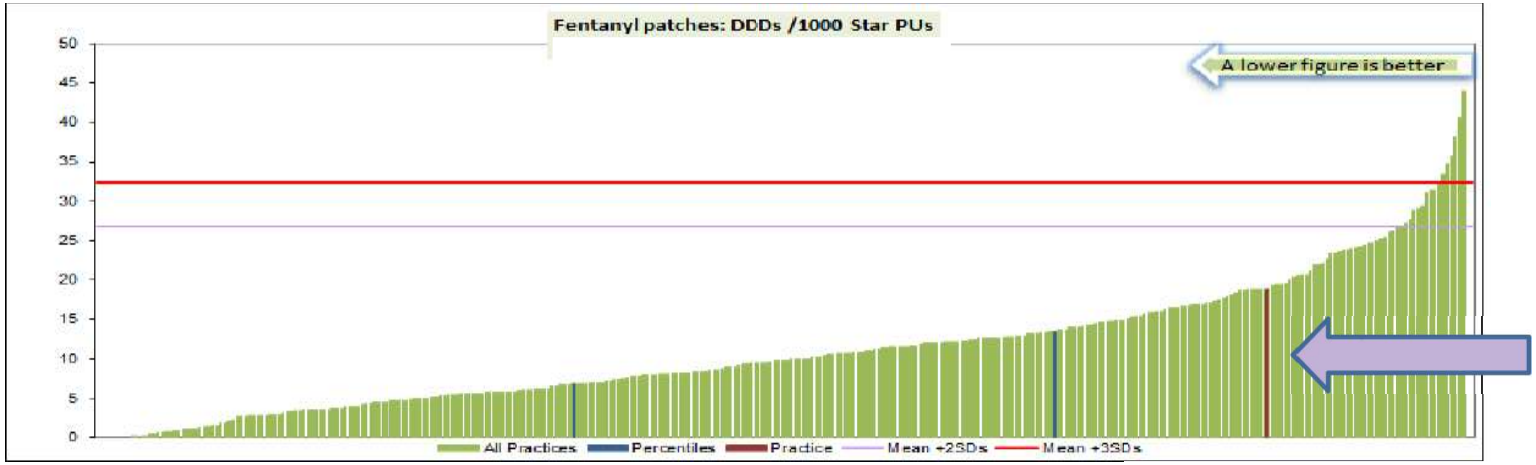
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OUTCOMES



2017: Practice was 10th highest in N.Ireland for Fentanyl prescribing.



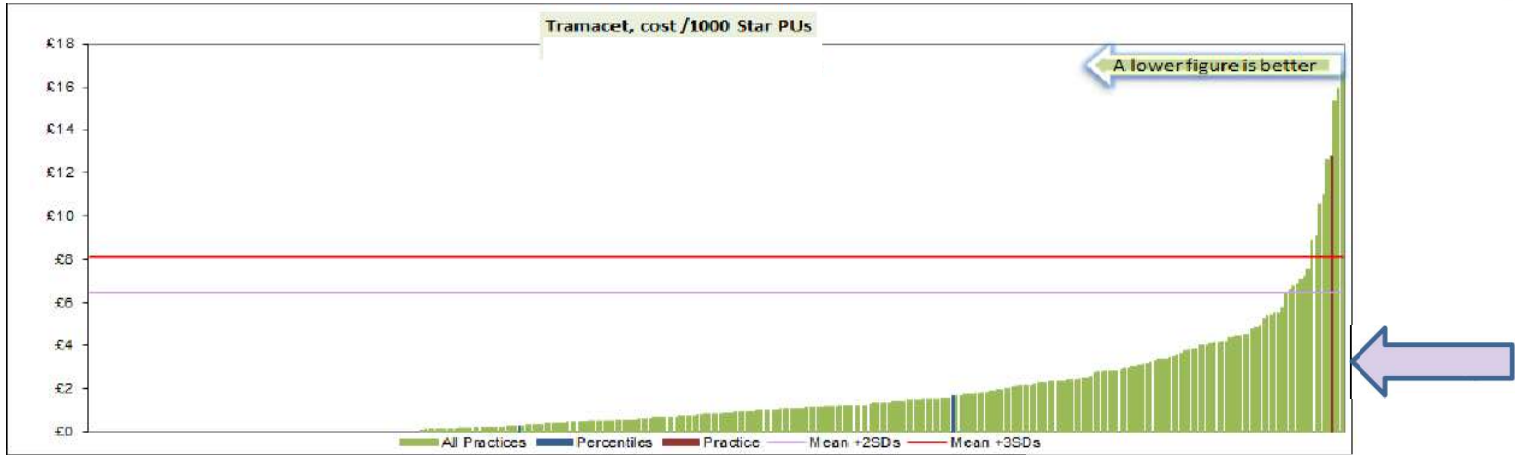
43% reduction.

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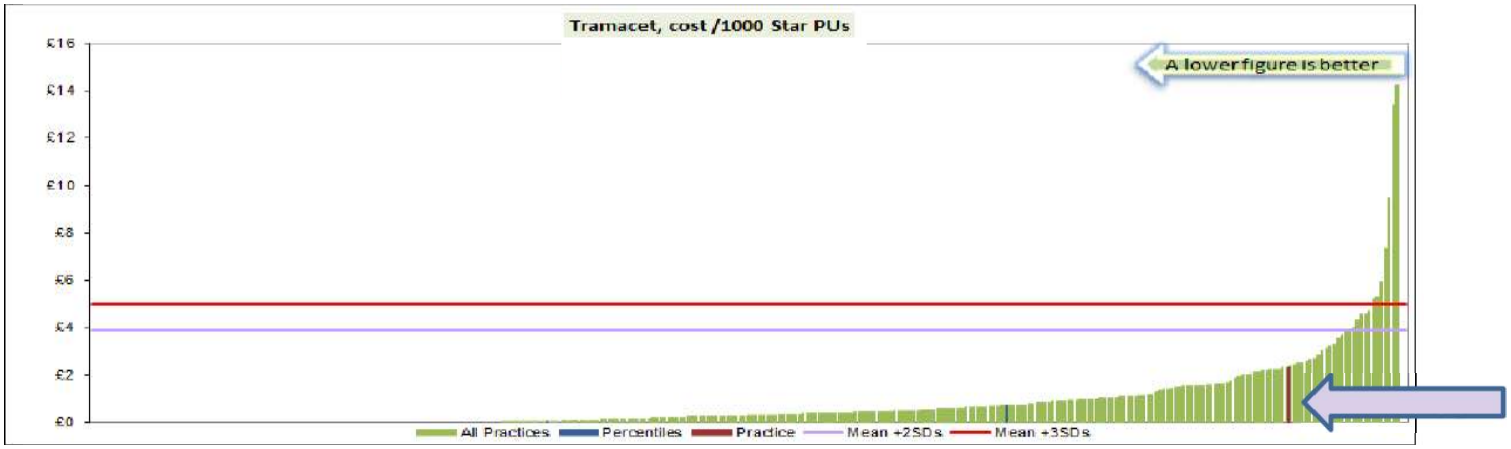
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OUTCOMES



Practice was 4th highest practice in N.Ireland for prescribing of Tramacet.



82% reduction Tramacet

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Resources

Pain – Primary Care Intranet (hscni.net)

Newsletters & Publications | NI Formulary (hscni.net)

RED WHALE: Chronic-pain-and-dependence-forming-medication_March2023_finaledit.pdf (gp-update.co.uk)

Chronic-pain-communication-skills-and-self-management_March-2023_finaledit.pdf (gp-update.co.uk)

Home - Live Well with Pain

OPIOIDS AWARE: Opioids Aware | Faculty of Pain Medicine (fpm.ac.uk)

PRESCQIPP: Pain | PrescQIPP C.I.C

COMPASS REPORT

You Tube: BRAINMAN: https://youtu.be/MI1myFQPdCE https://youtu.be/DEPK_b2p0JU

YouTube: TAME THE BEAST: https://youtu.be/ikUzvSph7Z4

Versus Arthritis: Northern Ireland | Versus Arthritis

Pain Medication review

1. Is there a pain related diagnosis?

- When did pain start?
- What triggered it?
- Has it got worse/ better over time?

2. Has the pain relief reduced over time – even if the dose has increased?

3. What drugs have been taken for pain in the last month? Assess effectiveness

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Pain Medication Review

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	Score 0 – 10 (0 = no improvement, 10 = 100% improvement)
Analgesia score	
Functional improvement(ability to do daily activities)	
Sleep improvement /Change in mood	
Overall quality of life improvement	
Able to return to work or stay in work	

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Does the patient ever experience the following

Shaking/ Tremors	*Nausea Vomiting*
Diarrhoea	*Itching*
Aching muscles	*Severe anxiety /paranoia*

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Do the medicines help the patient

Deal with setbacks and high pain levels	*Feel good about themselves*
Feel more relaxed even if the pain doesn't go away	Get a good night's sleep because pain is relieved
Keep doing the things that are important to them	*Forget about other problems they have-that may not be pain related*
Help them to remain in work	Helps patient undertake regular exercise/stretching etc

Strategic Planning and Performance Group

Dr Caren Walsh

General Practitioner, Medical Adviser SPPG and QI Lead Primary Care





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Applying QI methodology to reduce Pregabalin and Opioid prescribing in General Practice

Dr Caren Walsh
Medical Adviser
Directorate of Integrated Care

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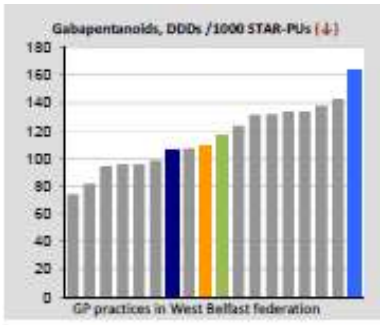
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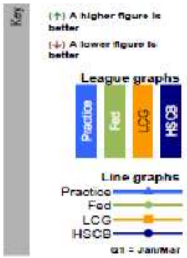
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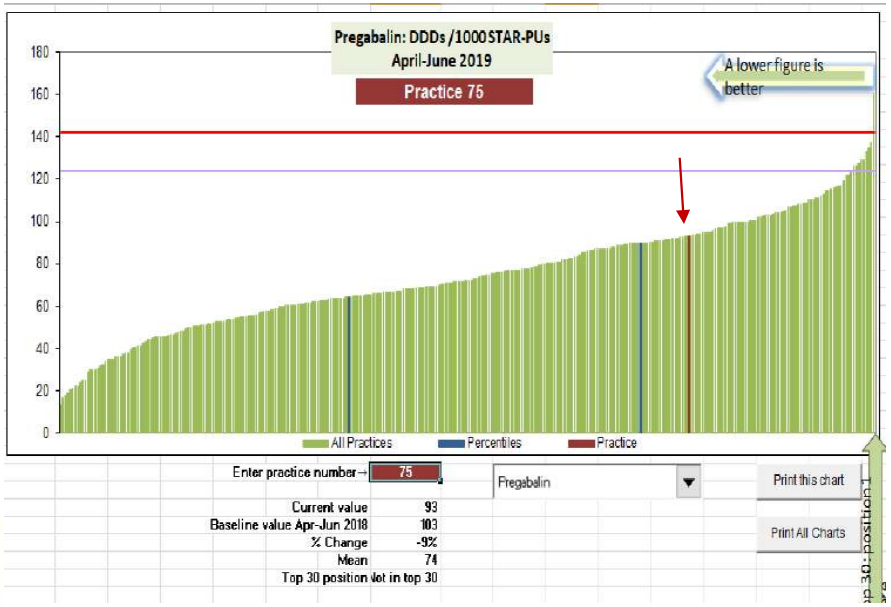
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Is there room for improvement?

June 2019







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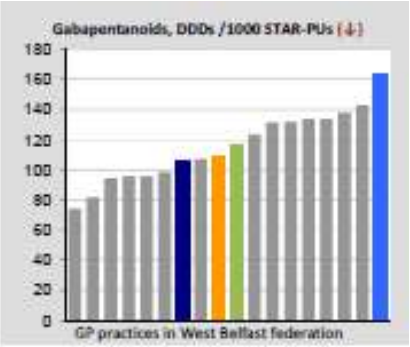
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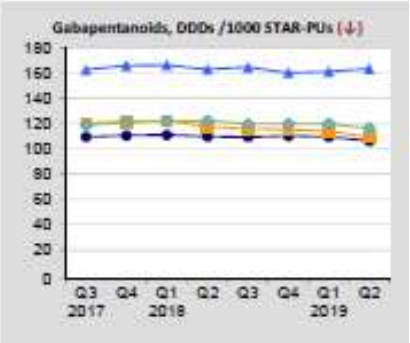
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Why?
Reducing Pregabalin prescribing

Harm
Mortality- 33 pregabalin related deaths in NI 2017
Physical dependencies
CNS depressant- effects additive with opioids, alcohol, antidepressants, antipsychotics and anxiolytics

Prescribing trends
In UK increased by 350% in 5 years
NI highest prescribing rate in UK
In Belfast number of prescriptions increased by 46% between 2011 and 2015
In NI pregabalin prescriptions cost £17m each year

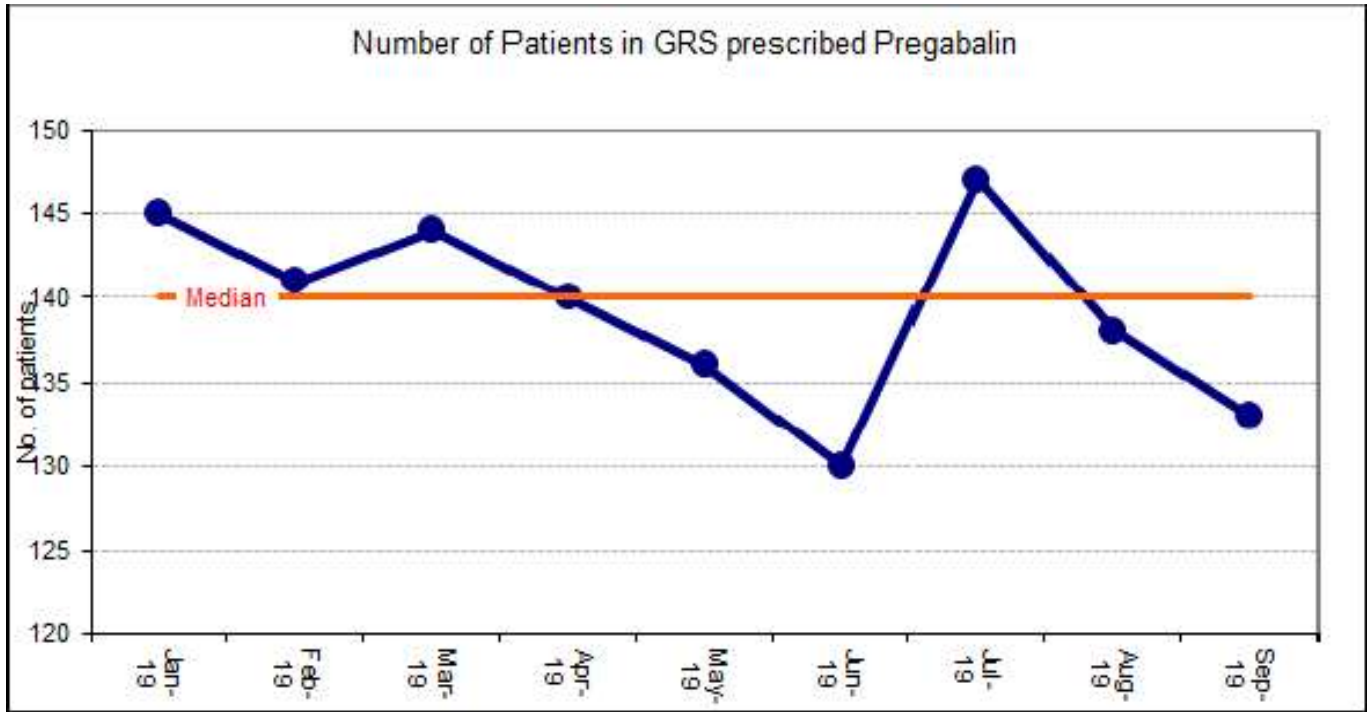




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Gathering information- Baseline data

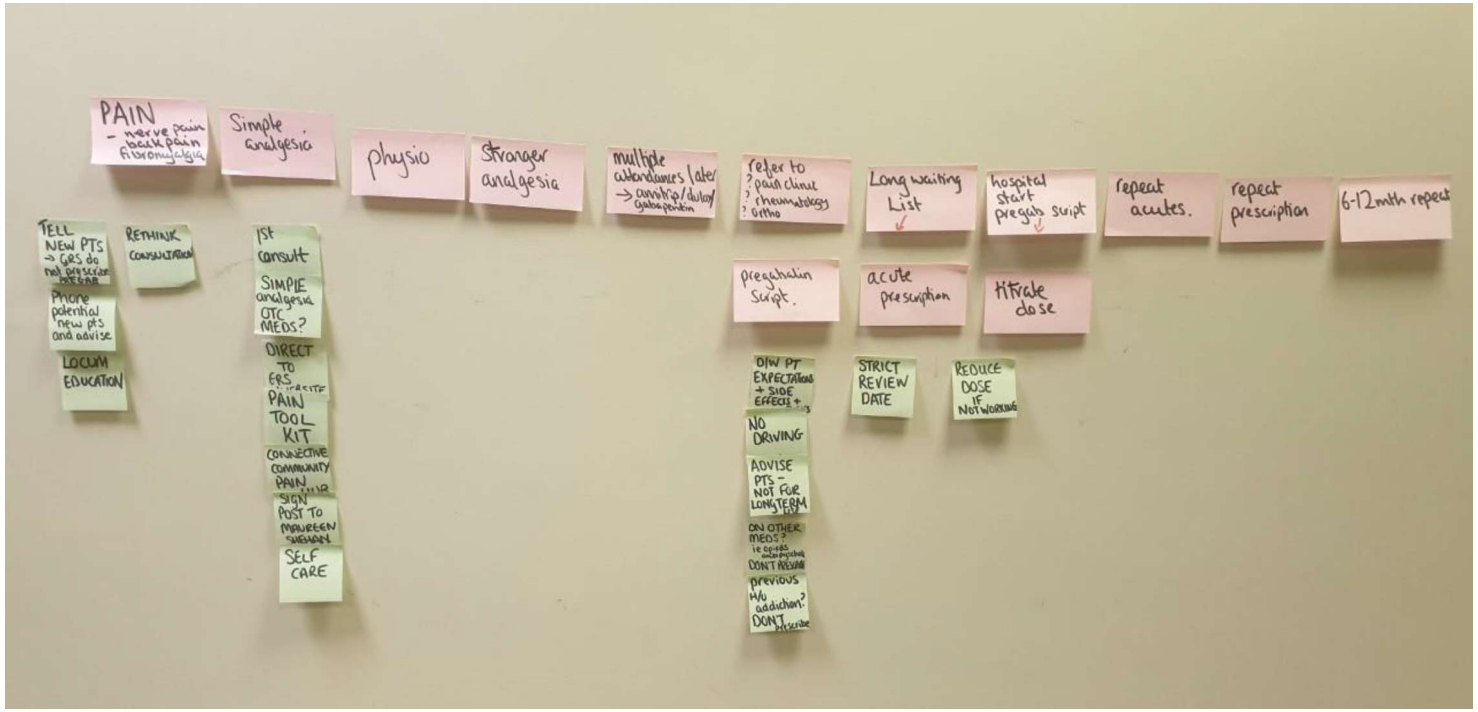


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Systems thinking- Process Mapping



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What are we trying to accomplish?

Aim: To reduce the number of patients prescribed Pregabalin per Month in Grosvenor Road Surgery from 139 to 97 (30%reduction) by May 2020

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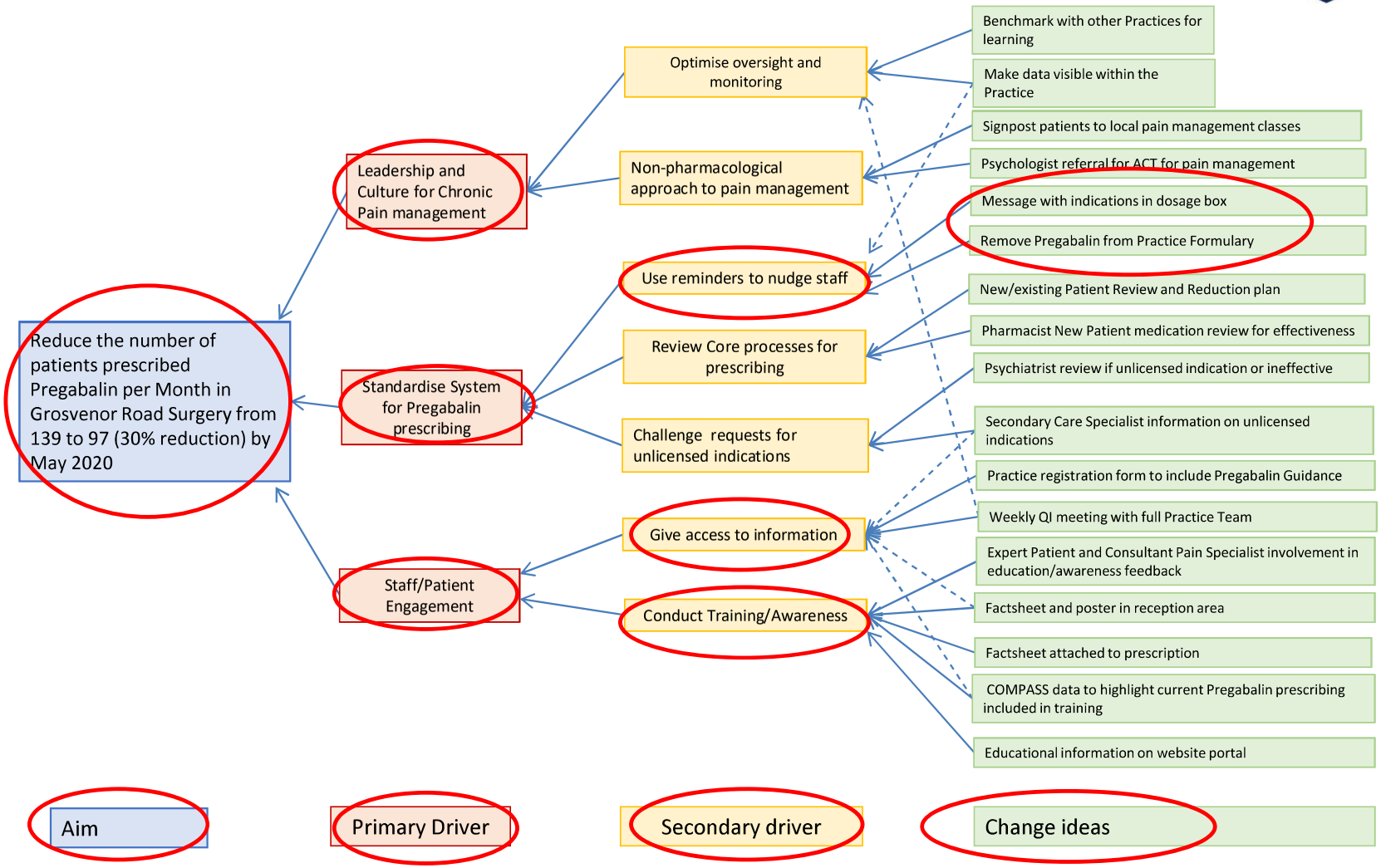
How will we know that change is an improvement?

- Outcome measure:
  - Number of patients prescribed Pregabalin per month
- Process measure:
  - Number of patients per week who have undergone a pregabalin medication review
- Balancing measure:
  - Number of patients prescribed Gabapentin per month

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What changes can we make that will result in improvement?

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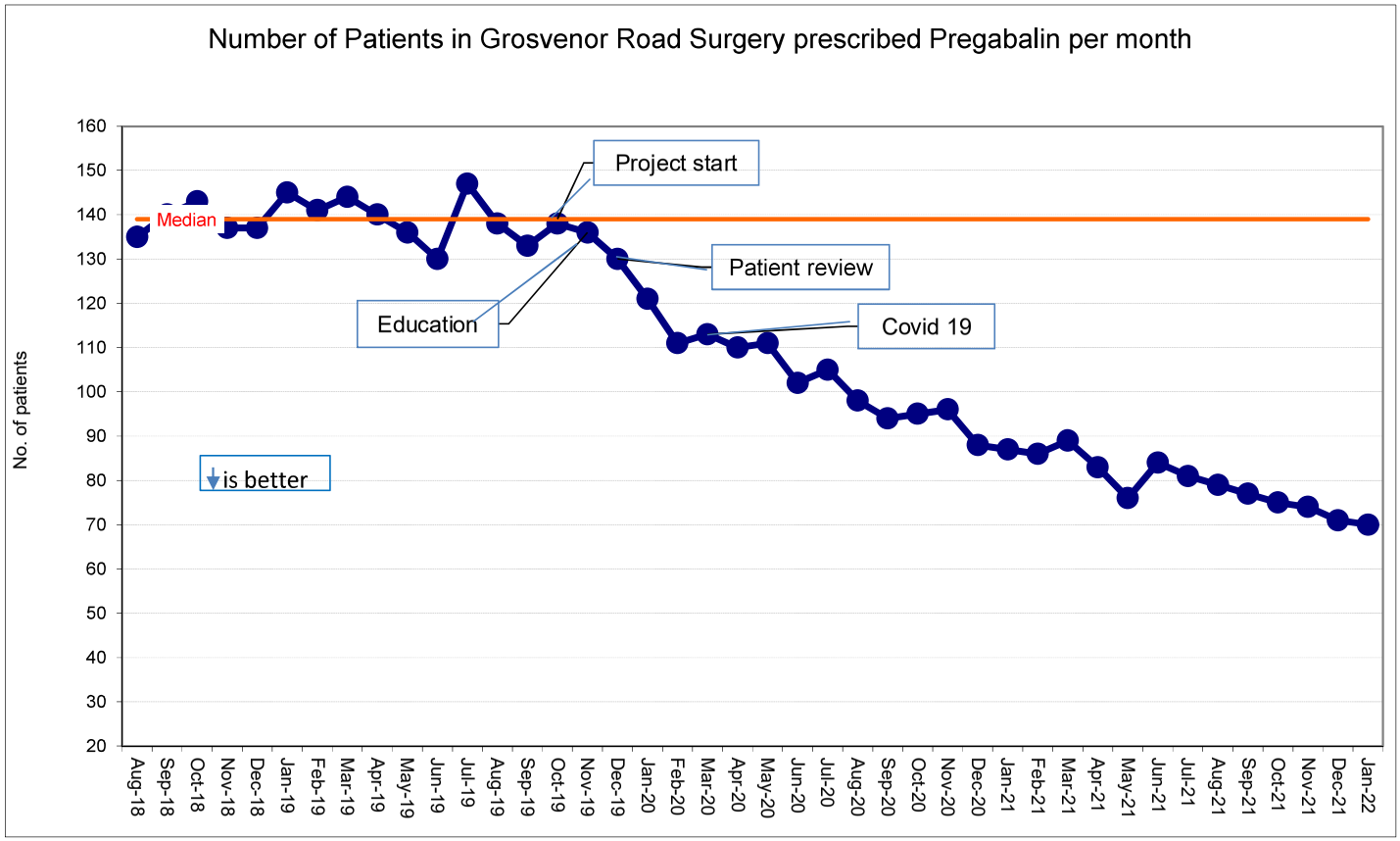


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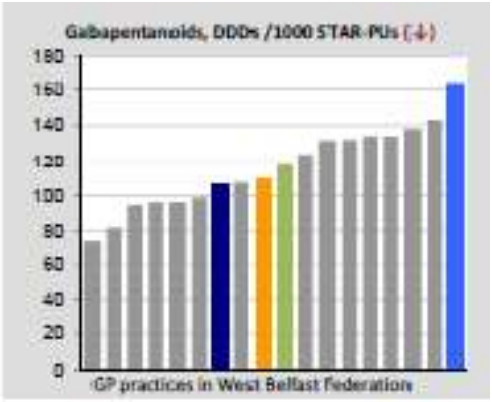
Has improvement been sustained?

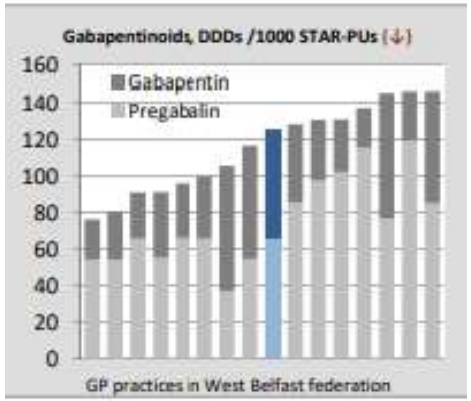


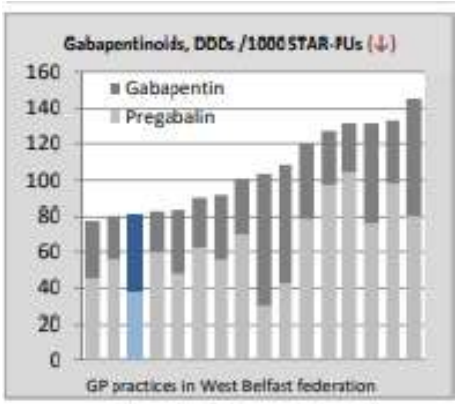
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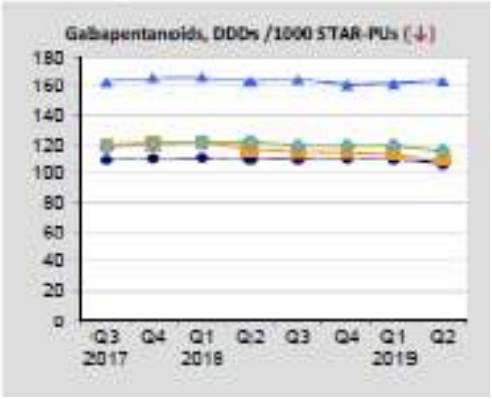
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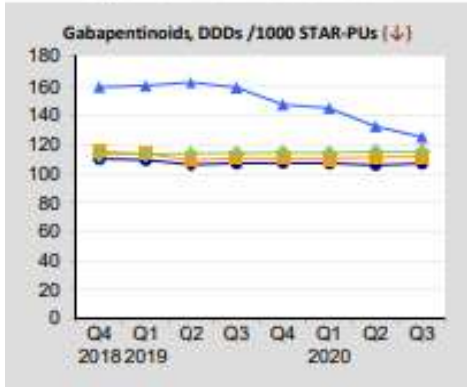
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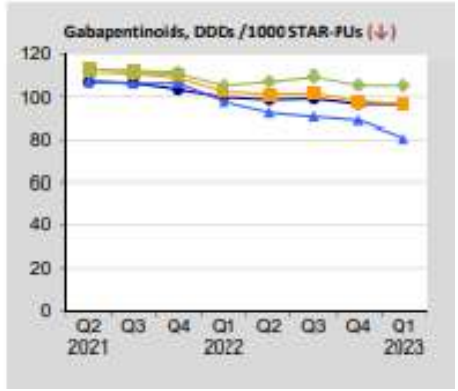










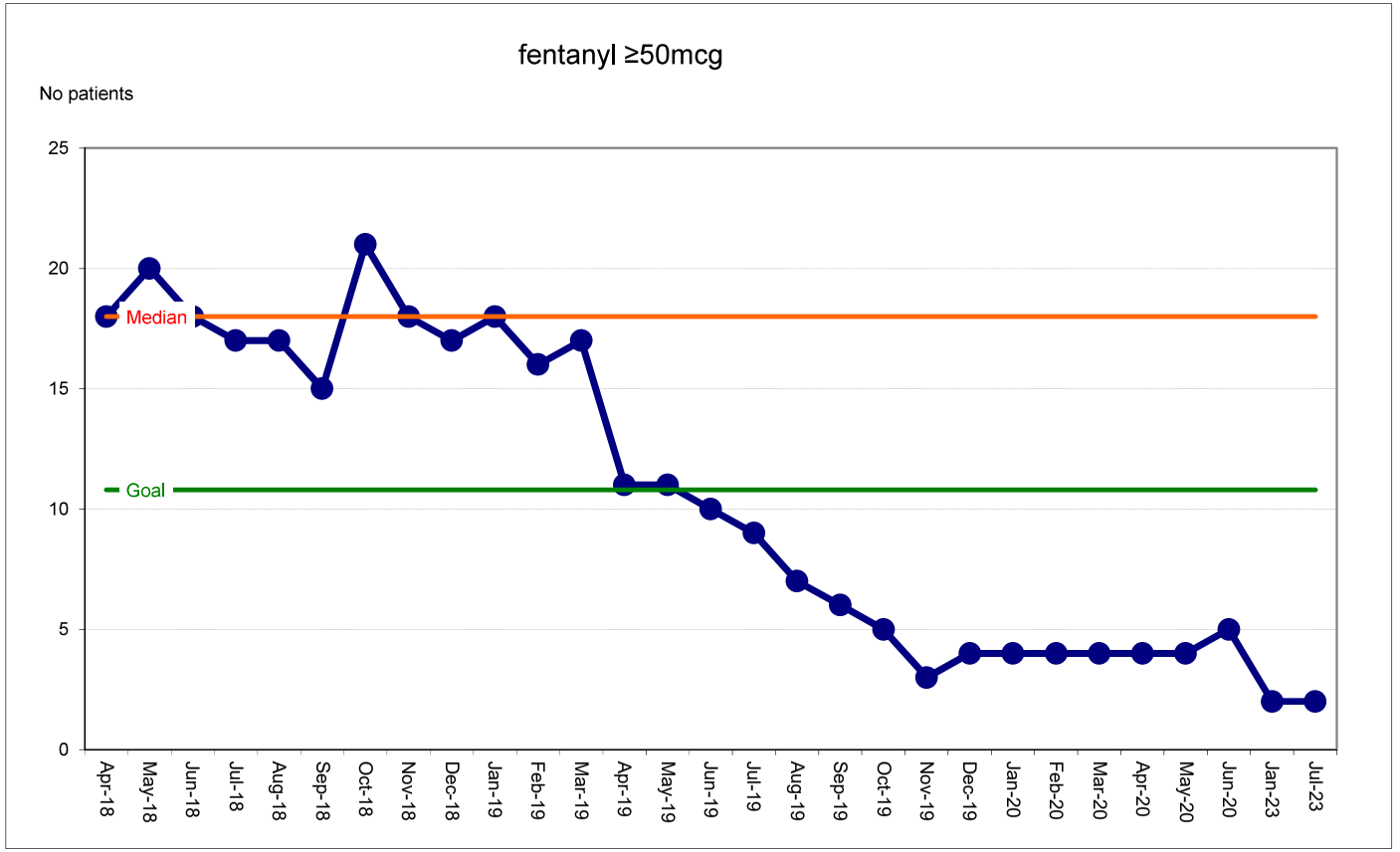


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Number of patients prescribed ≥50mcg Fentanyl patch

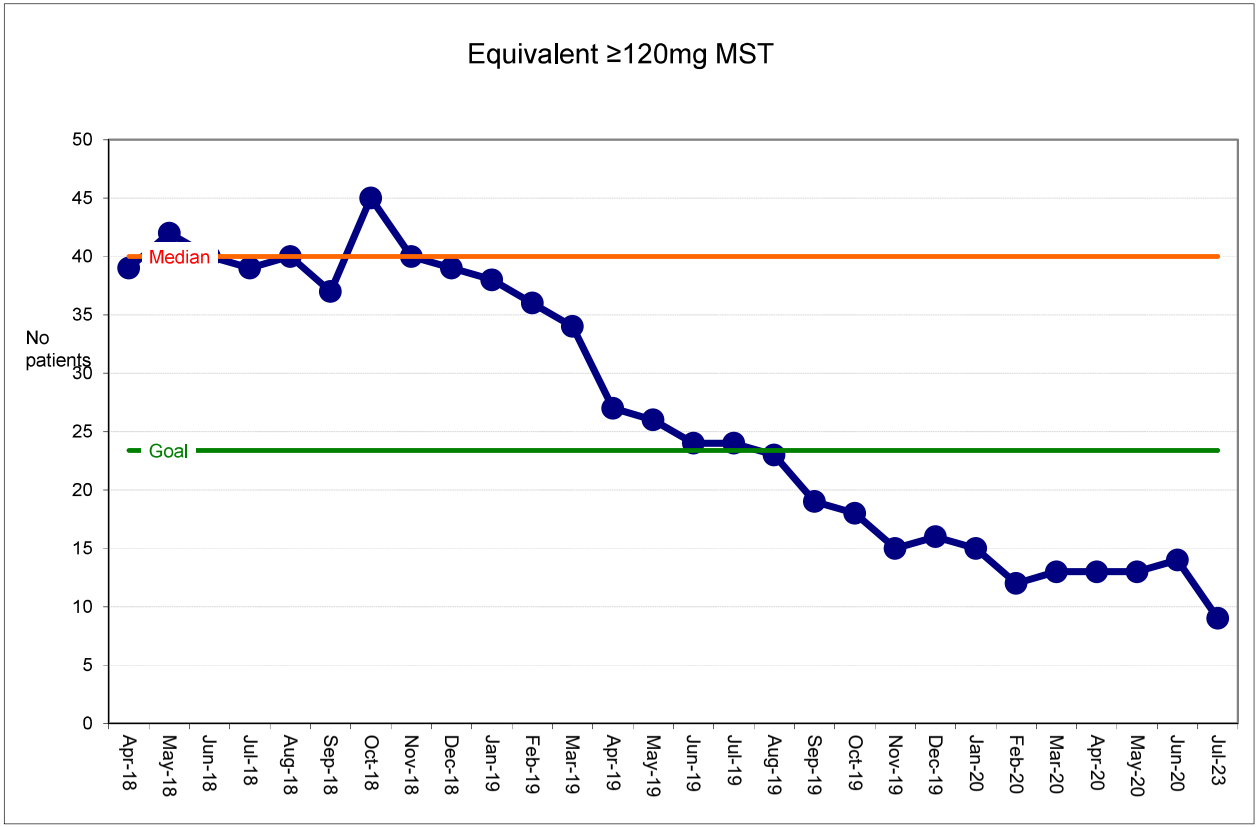


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Number of patients prescribed ≥120mg equivalent Morphine Sulphate



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Q & A

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Breakout sessions



Rooms:

- A (main room)
- B (up the stairs towards reception)

Room allocation:

- Refer to sticker on pack for room allocation

Breakout session 1: 11:20am to 12:20pm
Breakout session 2: 1:50pm to 2:30 pm

Feedback from both sessions in main room

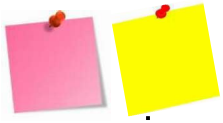
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Breakout session 2

Focus: Your reflections from the day and an improvement you have identified for your team/clinical setting in relation to **high-risk opioid prescribing** for **non-malignant pain management.**

Take 5 mins, reflecting about what you already knew before today and what you heard from speakers or discussion in 1st breakout session or when you were chatting with colleagues over lunch.

Use post its 

Note down an improvement you are considering in relation to the subject area.

- What is it you want to improve? What might good or better look like?
- Who might you need to involve?
- What might you need to find out more about when you return to your organisation?

- Discuss in your huddles
- Place post its on flip chart sheet, group any similar improvements identified.
- Feedback to room

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Domenica Gilroy

HSCQI Senior Improvement Advisor
Aligned to TMSNI Programme Hub

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Next steps and how you can help

- Learning from workshop
- Invitation to register project teams
- Your feedback matters

Evaluation of opioid improvement: stakeholder engagement workshop, 4th August, 2023



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Closing remarks

Dr Aideen Keaney
Director HSCQI

&

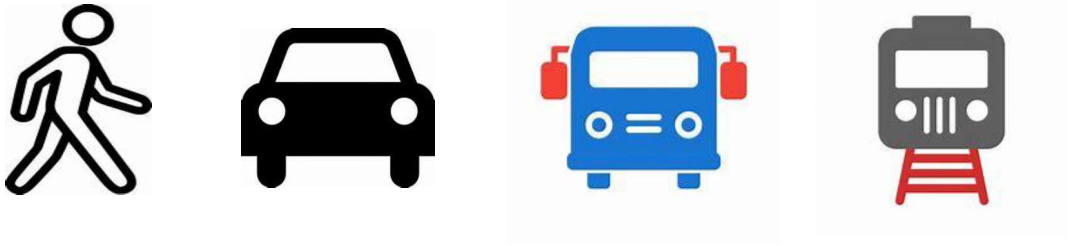
Professor Cathy Harrison
Chief Pharmaceutical Officer

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Thank you for your time today

Safe travels home



Feedback welcome

Evaluation of opioid improvement: stakeholder engagement works
hop, 4th August, 2023

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