Health Innovation West of England

West of England Patient Safety Collaborative

Medicines Safety Improvement Programme:

Reducing Harm from Opioids in Chronic (Non-Cancer) Pain

2022-2025 Programme Summary Report

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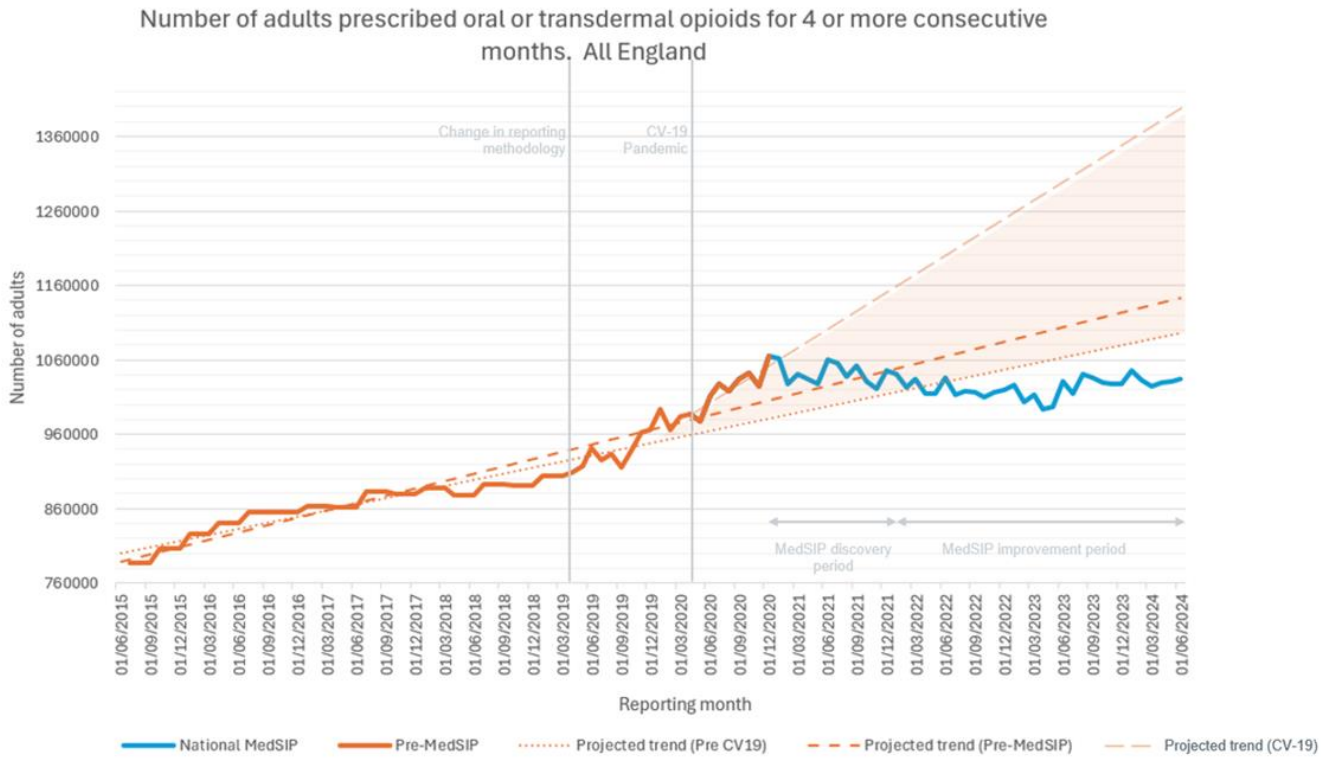
Executive Summary

The Medicines Safety Improvement Programme (MedSIP) 'Reducing Harm from Opioids in Chronic (Non-Cancer) Pain' workstream was developed and launched in April 2022 following the publication of the Prescribed medicines review: report (2019).

This review covered adults and 5 classes of medicines. Analysis of prescribing data for 2017-2018 demonstrated that 26% of the adult population of England received, and had dispensed, one or more of the medications within the scope of the review.

Opioid medicines totalled 5.6million (13%) of these prescriptions.

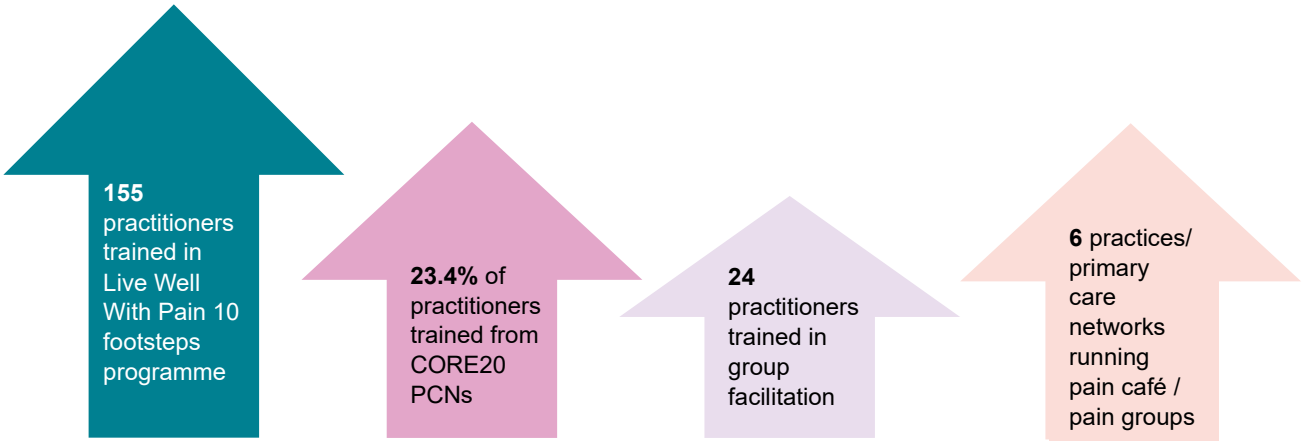


The above chart demonstrates opioid prescribing trends with trajectory projections of the anticipated prescribing rates using the mean values pre-COVID-19, post COVID-19 and following the implementation of the national MedSIP programme.

The ambition was to reduce harm from opioid medicines (by reducing high-risk opioid prescribing) by 50% by March 2025.

Opioids increase the risk of mortality, for every 62 people who stop opioids (any dose) or do not start, 1 death is prevented. (Medications Safety Improvement Programme Methodology Report, December 2022)

Through a neighbourhood health and biopsychosocial approach to self-management of chronic (non-cancer) pain in the West of England locality, **17 lives have been saved** by reduction in chronic opioid use, and **487 people have had the risk of opioid related death halved** (through the reduction of high dose opioids).



Health Innovation West of England (HIWE) supported a community event for Black and Brown women with chronic pain facilitated by the Bristol Health Partners Chronic Pain Health Integration Team (HIT) and Diverse Research Engagement Network. Participation in this event promoted the programme to local health providers, voluntary, community, faith and social enterprise (VCFSE) members and the wider community, to ensure that they were aware of current and planned pain café locations. Attendance and sharing opportunities at this event facilitated connections which led to a webinar in February 2025 sharing a small-scale enquiry into the experiences of Caribbean and South Asian women living with persistent/chronic pain.

Key learning from the enquiry shared within the webinar included:

- The influence of ethnicity and gender on interactions in medical appointments.
- Scant awareness/accessible information of local NHS pain management offers.
- Very little/no advice or signposting to non-pharmaceutical support, or services, e.g., local low cost or free movement classes.

There have been reflections (since the event) regarding some of the pilot pain groups, with practitioners recognising that attendance at groups is predominantly female, with a heavy bias towards white women – which is not representative of local demographics.

Skills developed through this programme are being utilised to develop groups and wider service improvements related to other chronic health conditions, observations of local clinical practice through reflection have supported surfacing of potential unconscious bias and encouraged focus on equitable health and wellbeing services.

Practice teams are engaging with patients and patient experience groups to assess how they can provide services that are more accessible, taking into account the timing of the groups, locations being used, prioritising locations such a community hubs that are frequently accessed in the neighbourhood, and addressing unconscious practitioner biases at a practice level, which may be widening the gap in referrals/services being offered.

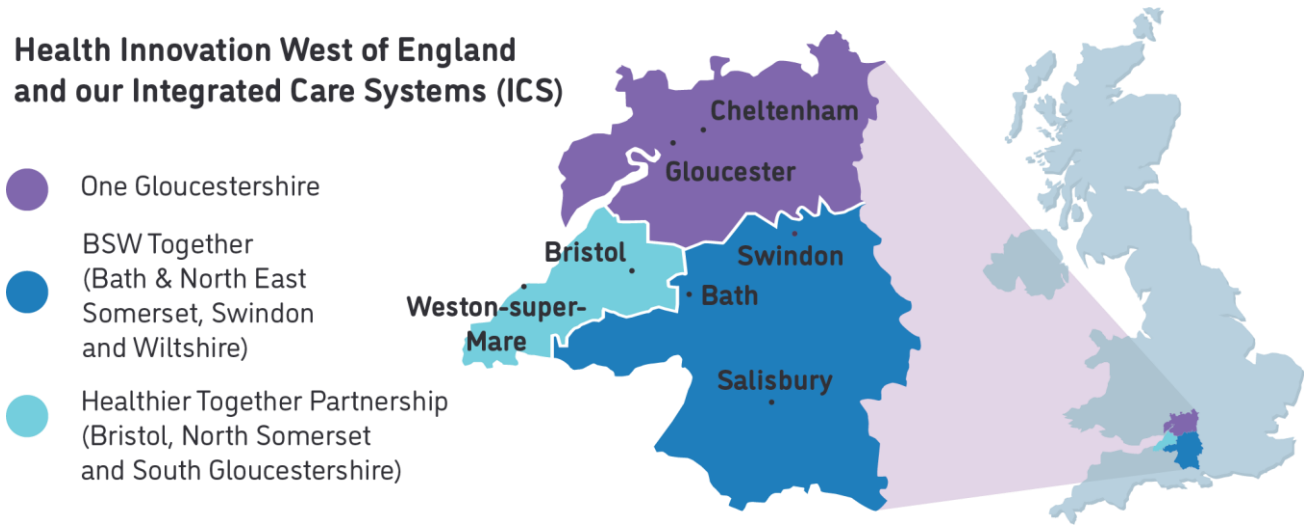
There have been wider positive impacts to communities and accessibility of services through some local initiatives by advocating for improved local infrastructure, such as the installation of more dropped curbs to make the area more accessible for those with mobility issues, and installation of ‘elephant feet’ on chairs in reception areas contributing to a more supportive and inclusive environment.

Health Innovation West of England

We are one of 15 health innovation networks across England. Formerly called ‘academic health science networks’, we were first licensed by NHS England in 2013 to operate as the key innovation arm of the NHS.

With core funding from NHS England and the government’s Office for Life Sciences, our collective aim is to spread health innovation at pace and scale – improving health, transforming lives and generating economic growth.

Our regional focus:



We enable collaborating and connecting by bringing together all the key players who play a role in innovating health and care, including:

- NHS providers and commissioners
- Social care providers
- Patients, carers and the wider public
- Industry
- Universities and research bodies
- Local authorities
- The voluntary, community and social enterprise sector

Central to our work in healthcare service and system transformation is our award-winning support for improving patient safety.

Our patient safety work programme is informed by the NHS Patient Safety Strategy, and the National Patient Safety Improvement Programme (known as NatPatSIP). Our goal is to ensure that patients in the West of England can be confident that care is safe for patients based on a culture of openness, collaboration, continuous learning and quality improvement.

Patient Safety Collaborative

Our patient safety work is delivered by the West of England Patient Safety Collaborative (PSC). We host and coordinate the PSC. Our PSC is made up of all the NHS providers and commissioners across the region, including hospitals, mental health and community organisations, the ambulance service, primary care and integrated care boards. It brings together local patients and healthcare staff, all driven by a shared vision to bring about system-wide improvements to ensure the safety and wellbeing of people in the care of our health services.

Programme Aim / Ambition

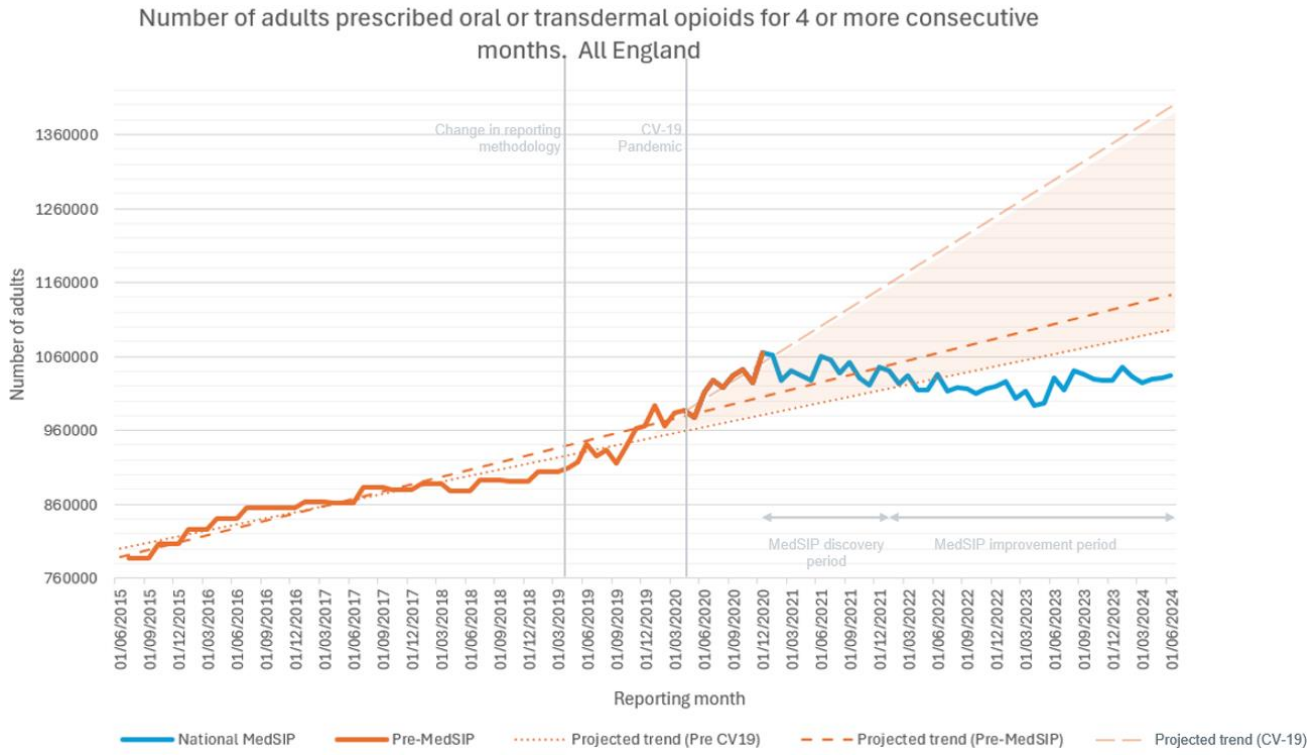
The Medicines Safety Improvement Programme (MedSIP) 'Reducing Harm from Opioids in Chronic (Non-Cancer) Pain' workstream was developed following the publication of the Prescribed medicines review: report (2019).

This review covered adults and 5 classes of medicines:

- benzodiazepines (mostly prescribed for anxiety)
- z-drugs (sleeping tablets with effects similar to benzodiazepines)
- gabapentin and pregabalin (together called gabapentinoids and used to treat epilepsy, neuropathic pain and, in the case of pregabalin, anxiety)
- opioids for chronic non-cancer pain
- antidepressants

Analysis of prescribing data for 2017-2018 demonstrated that 26% of the adult population of England received, and had dispensed, one or more of the medications within the scope of the review.

Opioid medicines totalled 5.6million (13%) of these prescriptions.



The above chart demonstrates opioid prescribing trends with trajectory projections of the anticipated prescribing rates using the mean values pre-COVID-19, post COVID-19 and following the implementation of the national MedSIP programme.

The ambition was to reduce harm from opioid medicines by reducing high-risk opioid prescribing by 50% by March 2025.

- There are over 1 million people in England with high-risk opioid prescribing. Management requires personalised care and shared decision making with patients requiring biopsychosocial support so they can live well with their pain.

- There is no evidence for efficacy of high dose opioids (≥120mg/day oral morphine equivalent (OME)) in long term pain.
- The Faculty of Pain Medicine has advised that increasing opioid load above this dose is unlikely to yield further benefits but exposes the patient to increased harm.
- The effects of COVID-19 are anticipated to have exacerbated the use of opioids for chronic pain which is linked to both deprivation and the prevalence of mental health conditions such as anxiety.

A **whole system approach** to reducing harm from opioids has been developed to support local approaches to helping people live well with chronic non-cancer pain

- By March 2025 – 25,000 fewer people prescribed oral or transdermal opioids from more than 3 months – preventing around 400 deaths.
- By March 2025 – 4,500 fewer people prescribed high dose opioids (120mg OME/day), halving their risk of opioid related death.
- People with chronic non-cancer pain reporting better quality of life.

Project Approach and Engagement Activities

Activities were planned in response to survey results; this survey explored the barriers to de-prescribing opioids and was sent to Primary Care clinicians in September 2022.

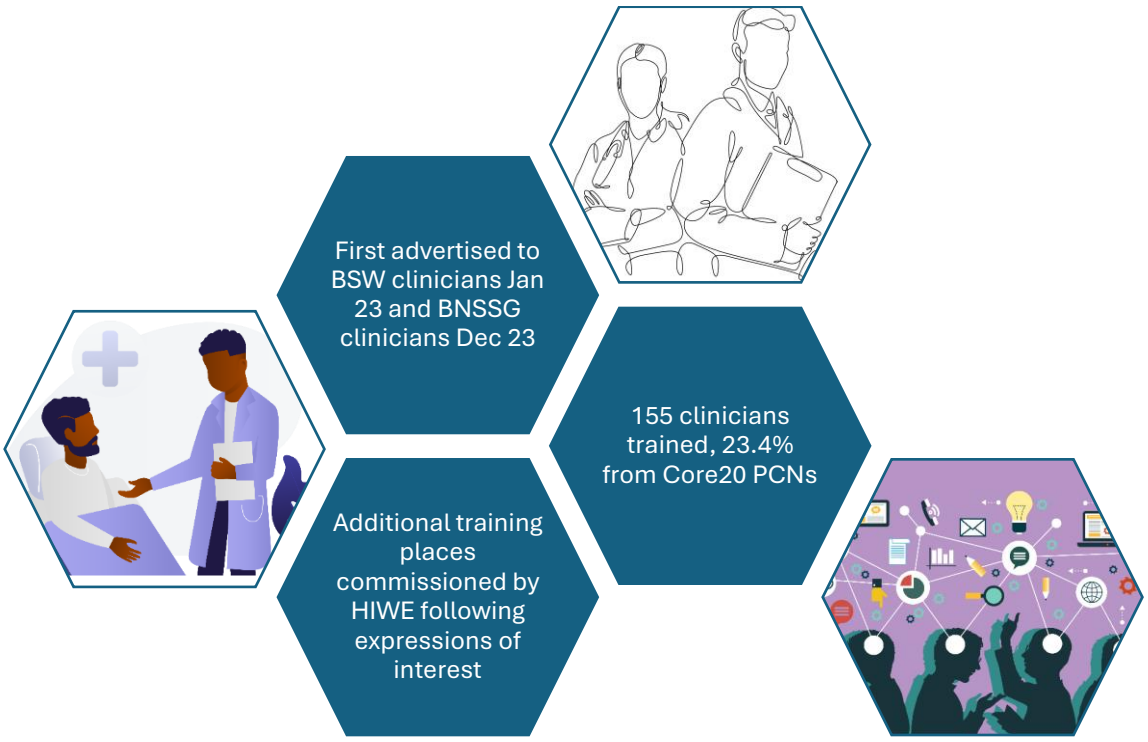
50% of the survey respondents felt they needed additional training to support de-prescribing of opioids, citing the following barriers:

- 70% of responding clinicians had low to average confidence in explaining pain mechanisms.
- 72% had little to average understanding of when opioids should be tapered/stopped and the principles for dose reduction.
- 69% stated they had little to average confidence in explaining non-medicinal self-management techniques for managing pain.
- Only 55% of respondents felt confident in explaining risks associated with long-term use of opioids.
- Majority of respondents described themselves as having “average” confidence in discussing mechanisms of pain and self-management options.
- Almost 60% of respondents were unaware of PrescQIPP e-learning available; 75% unaware of ‘Flippin’ Pain’ resource.
- Large majority of respondents were unaware of support for clinicians in local area.

We facilitated two launch webinars to give insight into the programme and the programme aims, with attendance and presentations from people with lived experience of chronic pain with/without opioid management. Additionally, we supported a quarterly steering group with one of our Integrated Care Systems that did not have an existing workstream for reducing harm from opioids.

In 2022/23 the Quality and Outcomes Framework (QOF) had a module on quality improvement which provided additional support for engagement in the programme.

Due to the feedback from the clinicians, we initially commissioned 100 training places for the Live Well With Pain (LWWP) 10 Footsteps Programme, increasing this to 155 training places as local interest in utilising biopsychosocial approaches to self-manage chronic pain conditions developed.



We received overwhelmingly positive feedback from LWWP training delegates, including:

- "I use it (LWWP training) almost every day and sometimes multiple times a day. I explain the resources available and suggest small changes e.g. pacing to help get them started. I have also arranged for our social prescriber to attend the courses, and we are due to run a pain management course for our patients who cannot access the online resources due to not having internet access/ dyslexia/ illiteracy. I have also given a 10 footsteps presentation to my other colleagues (nurses. GPs, pharmacists) so we are all saying the same message at the practice."
- "I use it almost every day and adapt my sessions (clinical pharmacist) based on the patients' needs. I often print out leaflets so they can look through the information in their own time. It helps me justify why the strong pain killers (opioids/ gabapentinoids) are not helpful for chronic pain and we need to find the minimal effective dose and keep reviewing."
- " I always mention the ten steps, signposting to the website (amongst others). I have reached out to other professionals in my area that share the same ethos. Recently facilitating a GP education session on this topic. “
- “I want to set up a Pain Cafe in the health centre where our GP practice is in Weston-Super-Mare...I feel equipped now to go to the PCN with this.”
- “Very informative and thought provoking. Good and honest discussions with feedback and answering of questions. From today I will take back the idea of a pain clinic and how they may link in with our work on frequent attenders to the surgery.”
- “From today I will take back to my practice the importance of community and community engagement in treating pain and the wide range of interventions/activities that can be helpful in treating pain, beyond medication.”

Building on the success of the training uptake for Live Well With Pain, we responded to the reflections of practitioners to enable development of further skills, with a focus on a coaching approach to conversations for deprescribing and group facilitation training.

As practices/Primary Care Networks (PCNs) embrace group consultations/support to maximise impact, this training has not only supported practitioners developing pain cafes/groups but also supported a biopsychosocial approach for person centred care for other health conditions, including chronic obstructive pulmonary disease (COPD).

To deliver this training, we collaborated with experienced group facilitator and trainer Kevin Feaviour from ImagineIF. Practitioners reflected on the training stating:

- “Facilitating is not about controlling and working a room, it’s about reading a room and creating a safe space for people to have the best experience they can or an experience they’d like by providing relevant resources and information.”
- Main takeaway from the session “how to implement different ways to engage participants with the resources provided and the discussions we had.”
- “This was one of the best trainings I have ever attended. From the organisation, trainer and trainee things went smoothly, engagement was fantastic and had the best experience possible. Thank you!”
- “I enjoyed it much more than previous training I have done, it was very engaging and thought provoking.”
- “The training was excellent and some of the best I have attended.”

Anecdotal evidence from practitioners has demonstrated that this training and approach is being utilised more widely across practices and PCN health and wellbeing programmes to utilise biopsychosocial approaches for other chronic health conditions, maximise patient reach and improve service efficiencies.

Following the group facilitation training event in October 2024, there were requests to support the initial development of a community of practice (CoP) across the West of England for those that are currently running/piloting or in the set-up phase of a pilot pain café.

The first CoP for practitioners developing or currently providing pain cafes within the West of England locality took place at the beginning December 2024.

During this event, practitioners shared their experience of setting up pilot programmes, discussed sustainability of existing groups and shared resources to support system colleagues to create their own proposals for submission to their practice/PCN management teams.

At the end of the session a volunteer was sought to organise and facilitate the next occurrence – with subsequent CoPs led by practitioners being held in January and March 2025, creating a framework for a sustainable peer network for on-going support.

Health Innovation West of England

Medicines Safety Improvement Programme: Reducing Harm from Chronic (Non-Cancer) Pain Timeline

*Hyperlinks to all recorded sessions are found in the **Resources** section.*

Equity

HIWE supported a community event for women racialised as Black and Brown with persistent/chronic pain, facilitated by the Bristol Health Partners Chronic Pain HIT and Diverse Research Engagement Network. Participation in this event promoted the programme to local people living with persistent/chronic pain, health providers, voluntary, community, faith and social enterprise (VCFSE) members and the wider community to ensure they were aware of current and planned pain group/café locations.

100 resource postcards were distributed to community members and health professionals present to share through their networks and/or services during the event.

We were also able to develop connections which led to a webinar in February 2025 sharing a small-scale enquiry into the experiences of Caribbean and South Asian women living with persistent/chronic pain.

Sharing this small-scale was particularly important to the HIWE team as there is a lack of research in the UK which explores the experiences of Global Majority Ethnicity men and women accessing NHS care for support/management of persistent pain conditions.

Equal Lives states *"it has been discovered that women feel pain more intensely, more often, for longer periods and in more areas of the body than men. 70% of people with chronic pain are women. Yet 80% of pain medication has only ever been tested on men!"* With further narrative describing *"Black people experience significantly higher rates of chronic pain than any other racial-ethnic group in the UK. 44% of Black people have chronic pain, compared with 35% Asian, 34% of white, 34% mixed/multiple ethnicities, and 26% any other ethnic background. Research has shown that compared to white patients, Black patients are less likely to be given pain medication, and if they are given pain medication, they're given less."*

This gap in pain management has previously been reflected and explored (specifically relating to perinatal care pathways with historical context) in the Black Maternity Matters collaborative programme, developed by Health Innovation West of England in partnership with Black Mothers Matter, BCohCo and Representation Matters.

Key learning from the enquiry shared within the webinar included:

- The influence of ethnicity and gender on interactions in medical appointments.
- Scant awareness/accessible information of local NHS pain management offers.
- Very little/no advice or signposting to non-pharmaceutical support, or services, e.g., local low cost or free movement classes.

The report and webinar discuss the racial and gender bias's experienced by the women interviewed when accessing health and care services to try to address their persistent pain.

Participants cited during the interviews that they were asked "how their pain was stopping them from carrying out activities in the home", whereas reflections from other studies and medical practitioners demonstrate that men are predominantly asked how their pain is affecting their ability to perform their job; the women interviewed stated that their home life was their priority and that they weren't making sacrifices in this environment, but many had changed job roles to something less active, had reduced their working hours or had stopped working completely because of their pain.

There was a significant lack of awareness of available resources and referral pathways which limited how in control (the women interviewed) felt regarding management of their pain condition – this was

a key influencer in ensuring that we had sufficient postcards for the community event, so the resources could be taken and shared more widely with community members unable to attend the event.

The report and discussion demonstrated a clear difference between Caribbean and South Asian women's experience of being able to share openly with peers and family – many women felt that they could not talk about their pain or difficulty within their family/network due to cultural expectations to appear 'strong' to their family/communities, or there was a feeling that they were exaggerating their experience.

With the pilot pain groups that were being developed, HIWE were able to invite one of the pilot leads for the local area to the community event to outline what the pain group was going to look like and how to access it when it launched the following month.

Practitioners that attended the webinar and provided feedback reflected that the event was *"very insightful education around clinician bias and signposting needs"* and how it had *"increased awareness of how women may be treated differently in pain consultation, how 'pallor' could be misinterpreted and what is important to Caribbean/ South Asian women may differ to those of different ethnicities".*

When asked in the survey what the practitioners would take back to their practice areas, some of the attendees provided the below feedback:

- "Share learning from today with practice teams, and look at identifying our patients in this group, explore what additional support we can offer and how we can do better."
- "To remember the inequalities that women face and also the impact of menopause."
- "Reinforces my aspiration to offer more local support and signposting in chronic pain."
- "Movement and holistic options are most requested."
- "Asking women about impact of pain on job - not just home stuff, and how important signposting is."

There have been further reflections since the event regarding some of the pilot pain groups, with practitioners recognising that attendance at groups is predominantly female, with a heavy bias towards white women – which is not representative of local demographics.

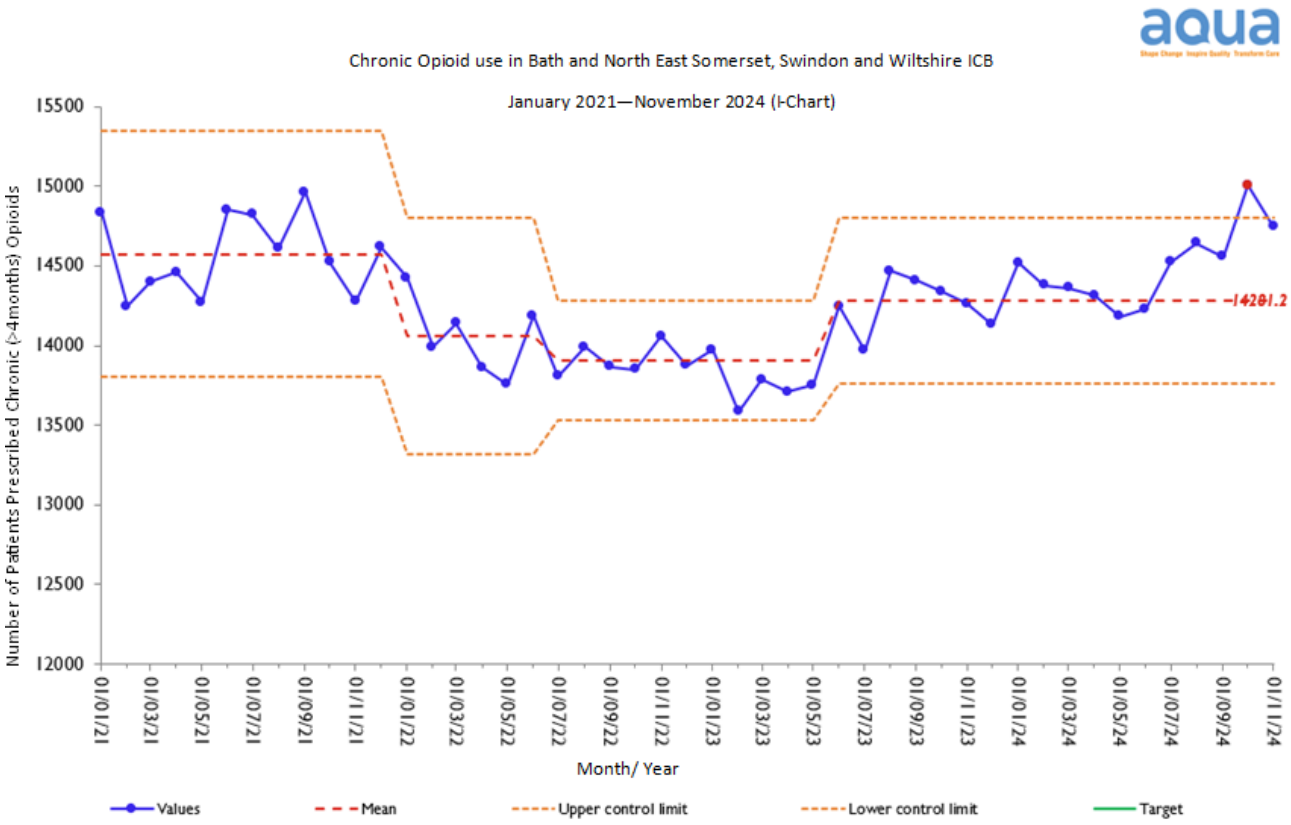
Practice teams are engaging with patients and patient experience groups to assess how they can provide services that are more accessible, taking into account the timing of the groups, locations being used (prioritising locations such a community hubs that are frequently accessed in the neighbourhood), and addressing unconscious practitioner biases at a practice level which may be widening the gap in referrals/services being offered.

Data

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB)

Engagement commenced in collaboration with BSW ICB in 2022 to support development of a system-led working group with a focus on opioid prescribing practices. This working group had a core membership of practitioners from both primary and secondary care providers.

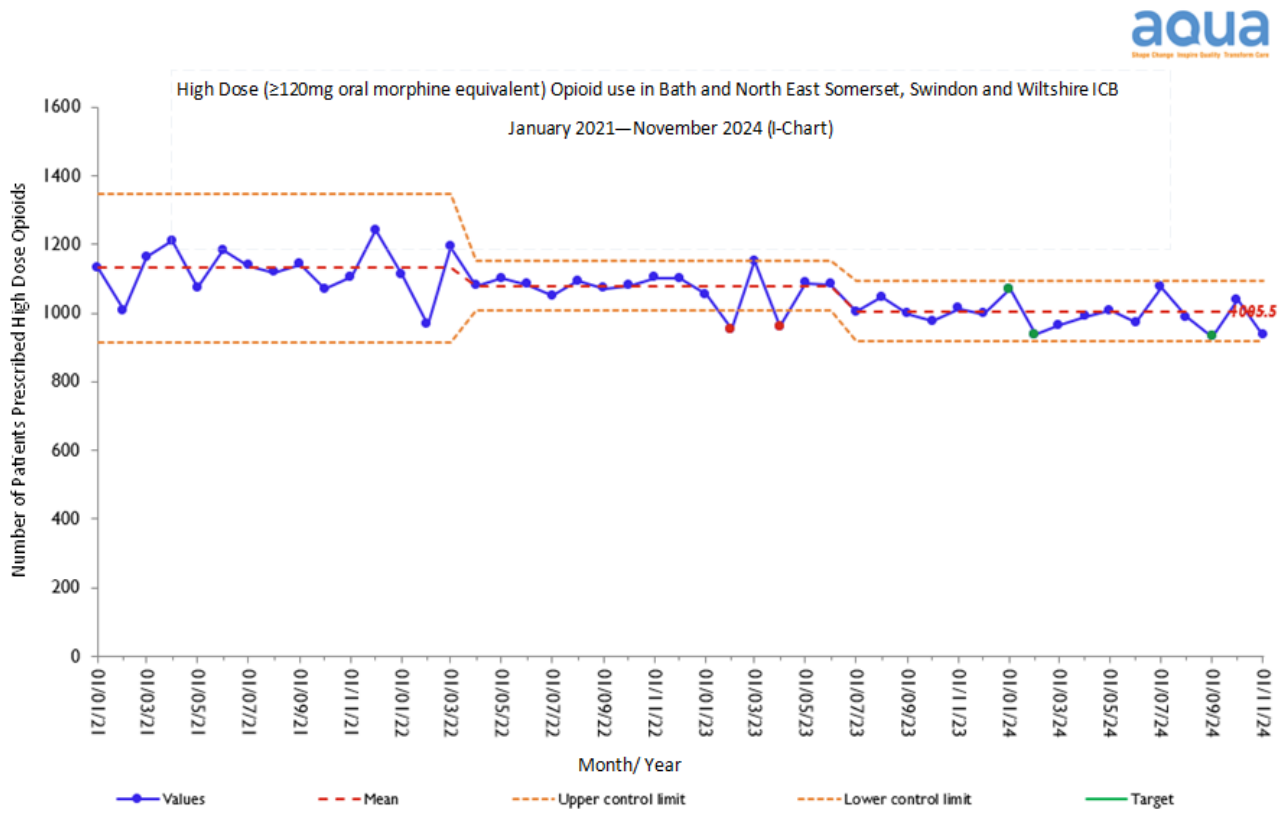
Local clinical audits identified that approximately 80-85% of opioid prescribing practices were initiated in primary care services for acute onset pain conditions, or to support people waiting for surgical or specialist referral outcomes. Many people seeking support for management of pain were offered referrals to other health and care services, including physiotherapy and mental health services, but less than a third of patients were offered non-pharmacological management options.



The above chart demonstrates that prior to the programme launching in 2022 the mean prescribing rate for opioids for 4 months or more was 14,572, with a downward shift to a mean prescribing rate of 13,908 in the 2022/23 financial year.

Although the mean rate has increased slightly since June 2023, the mean rate of prescribing has remained stable at 14, 281. This reduction in mean prescribing rate of 291 prescriptions, equates to **5 lives saved**.

There has been a more substantial shift in trend for high dose (≥120mg OME) opioid use (demonstrated in the chart below). The mean prescribing rate in January 2021 was 1132 patients, with the first reduction in mean demonstrated in April 2022 down to 1079 patient and further reducing in July 2023 to 1006. **This reduction equates to 126 people having their risk of opioid-related death halved.**



BSW ICB had an existing pain group prior to the programme commencing. In 2018 Rachel Dolman, Senior PCN Clinical Pharmacist at North Wilts Border PCN trailblazed an innovative approach to supporting patients diagnosed with Fibromyalgia.

Fibromyalgia affects up to 1 in 20 patients in primary care, more likely to be diagnosed in women than men and defined by chronic widespread pain, often accompanied by fatigue and sleep disturbance.

The North Wilts clinical team recognised that appropriately supporting patients with chronic pain can be challenging due to the personalised nature of their conditions, often requiring multiple appointments with complex solutions/management plans; the range of effective medication is limited, and patients therefore often end up with chronic high dose opioid use.

The PCN planned, developed and founded a community pain group led by their Senior PCN Clinical Pharmacist (with a specialist interest in pain management). This group was supported by the wider clinical team, utilising an approach rooted within the rapidly developing evidence base of using biopsychosocial self-management methodologies for chronic pain management.

Group participants were invited directly via the General Practitioner (GP) or another clinician, either verbally during consultation or using the local messaging system. Initially the invites were for Fibromyalgia patients however, due to the success and feedback received from participants, the group increased its capacity to include all types of chronic pain including those diagnosed with Long COVID.

This local innovation was enabled by a practice management team that facilitated an opportunity for experimentation to try something that wasn't in use elsewhere, supporting the request from the clinical team to ensure that this service would be available across the PCN and not limited to a single practice.

Patient satisfaction questionnaires from people that regularly attend the group identified the top benefits of attendance:

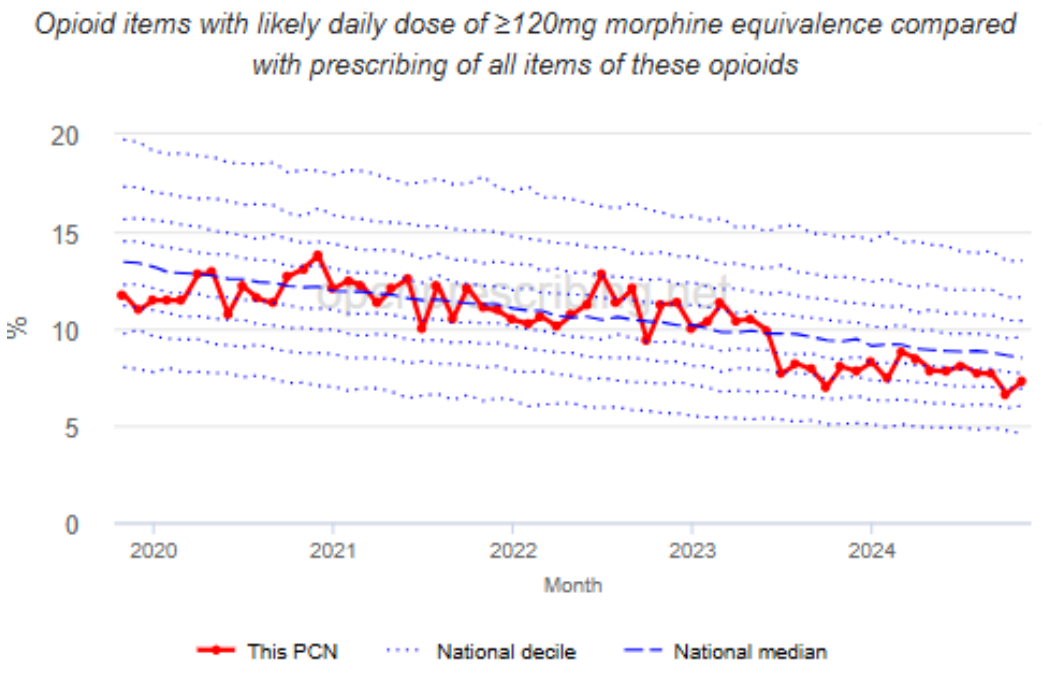
- Information sharing
- Presenter sessions well organised
- Sharing ideas and experiences

70% of respondents stated that they leave (the group) feeling happy and likely to recommend to a friend, and 60% connecting outside of the organised group – ensuring that the social support for flare ups is available outside of the monthly group.

As the group has been run solely by Rachel (up to January 2025), a high level of trust has been developed between her and the patients, which has enabled and encouraged individuals to attend structured medication reviews to discuss their pain management. This process has been mirrored through the patients that first meet Rachel during a pain medication review, who subsequently commence attendance at the community pain group.

There have been challenges experienced by the team; despite a number of patients actively engaging in the group there has been some difficulty around patient buy-in – as not everyone feels that "talking therapies" is the solution. Similarly, the demographics of the group typically favours females aged over 40, which is exacerbated as the prevalence of Fibromyalgia in men is significantly lower and it has therefore been difficult to establish the attendance of men within the setting.

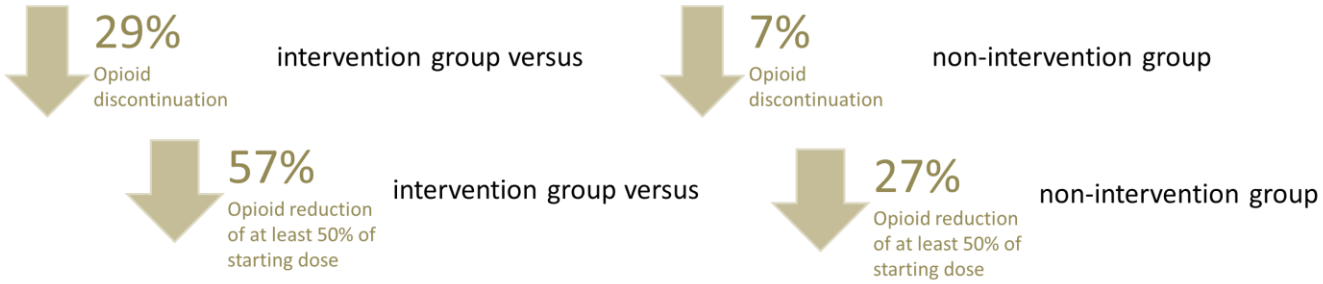
Implementation and sustaining this community pain group for the last 6 years has resulted in demonstrated reduce high dose opioid use within the PCN, as evidenced by the Open Prescribing Data:



The PCN has established a system for regularly monitoring opioid use and has been able to maintain this as a focused area for improvement as the reduction in high dose opioids motivates the team through this visible improvement outcome.

Since the group was established in 2018, the evidence supporting biopsychosocial approaches to chronic pain self-management has substantially increased.

Sandhu, Booth & Furlan *et al.,* (2023) study found that in people with chronic pain due to non-malignant causes, compared with usual care, a group-based educational intervention that included group and individual support and skill-based learning significantly reduced patient-reported use of opioids, but had no effect on perceived pain interference with daily life activities:



Similar results have been replicated through the Cornwall Connected by Pain project, supported by ImagineIF.

Hope House Surgery (within BSW) have been supported by Rachel in setting up and developing their own Pain Café pilot, (which is currently in evaluation phase) as the practice explores funding opportunities to sustain the initiative.

To increase resilience of the community pain group (and promote future sustainability), one of the PCN Health and Wellbeing Coaches has completed the Live Well With Pain Course (funded by HIWE) and has begun supporting sessions.

North Wilts Border PCN are exemplary both regionally and nationally, as the group continues to be directly funded by the PCN (covering the running costs of village hall hire, administration to prepare for the monthly groups, funding external speakers/trail activity sessions and providing backfill for the team to facilitate the group).

The PCN practitioners have shared their experience as one the longest running pain groups with others at a practitioner-led community of practice, which commenced in December 2024 to provide peer support opportunities, as well as collaborating with the BSW Medicines Optimisation team to ensure that reducing opioid use remains a safety priority, by being a core member organisation on a system level steering group established during the programme.

Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)

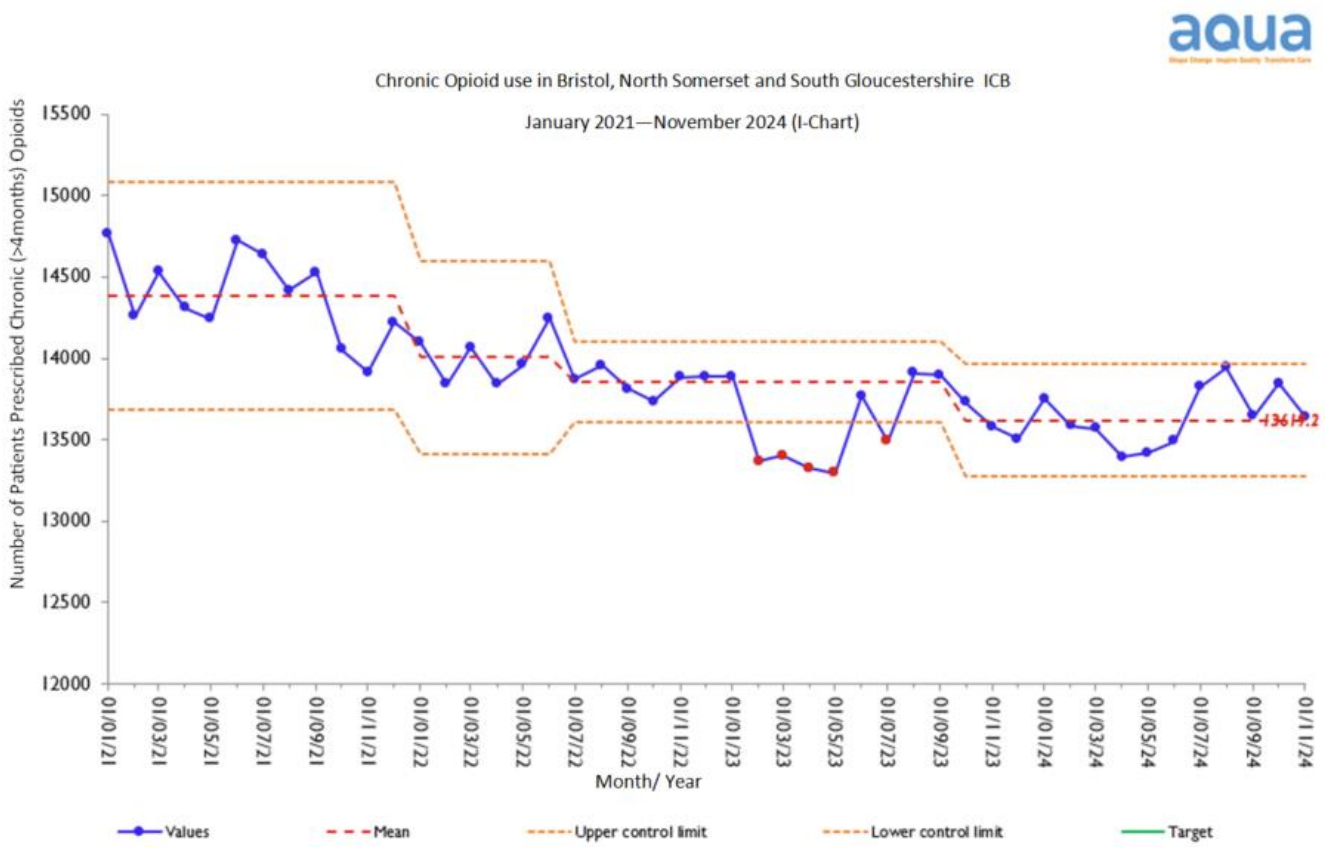
BNSSG had an existing Dependence Forming Medicines working group and workstreams through partnership with Bristol Health Partners Chronic Pain Health Integration Team (BHP Chronic Pain HIT), so the MedSIP Opioids programme commenced with the focused work in BSW to support system-led change processes.

With interest in the programme growing from both system leads and practitioners in 2023 the programme support offer was extended into BNSSG, with an extension of the offer for training in the LWWP 10 Footsteps programme. Due to the level of interest, an additional 55 places were commissioned in 2024 to fulfil the demand from the systems, resulting in 155 practitioners across the BSW and BNSSG localities receiving training in biopsychosocial pain self-management techniques.

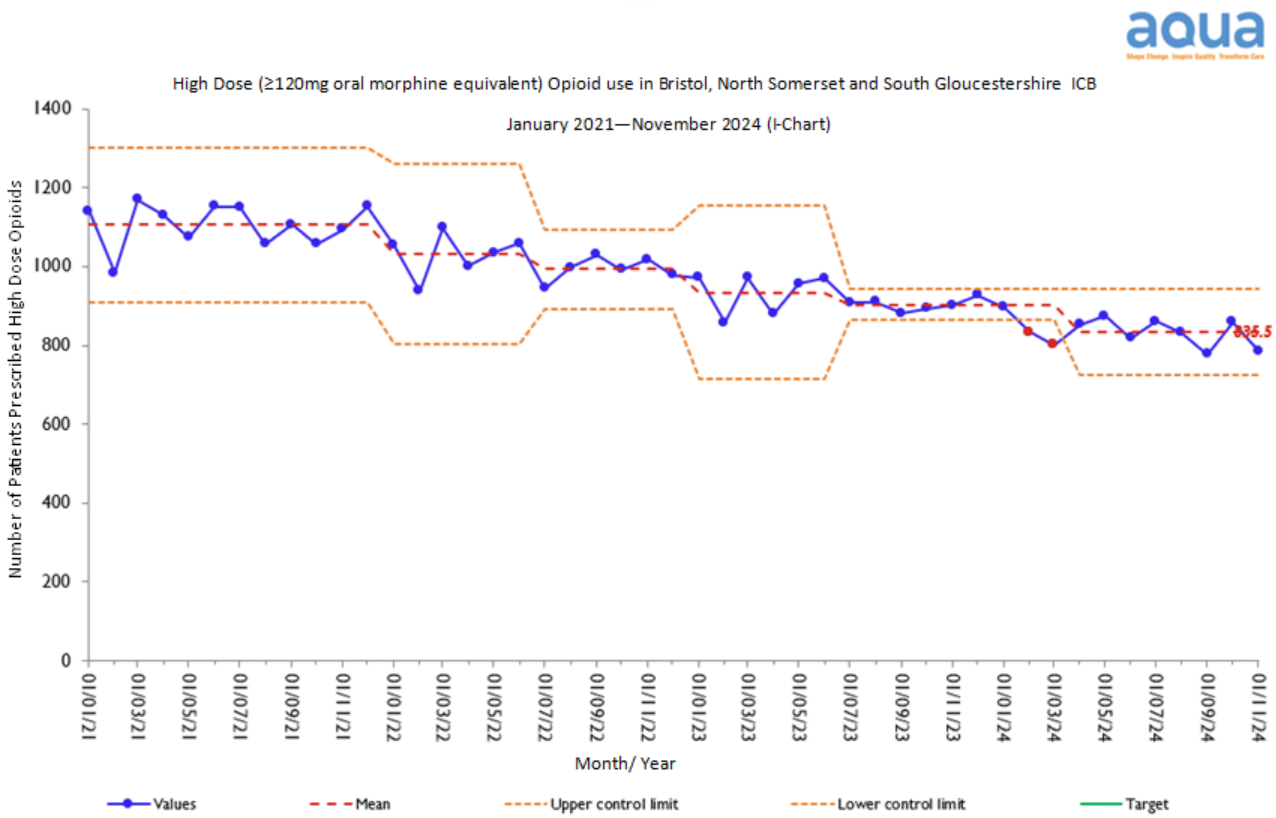
Chronic pain is a named health priority for BNSSG ICB and Weston, Worle and Villages have the highest rates of chronic pain in the Bristol, North Somerset and South Gloucestershire region as identified by the recent Burden of Chronic Pain in BNSSG Report (April 2024).

Horfield Health Centre/ Phoenix PCN were the first practice to develop a pain group in BNSSG; further developing their programme to set up a pain group specifically for younger patients (<29) as well as groups supporting people living with other long-term health conditions – for full details please see BNSSG – Horfield Health Centre full case study.

BNSSG was on a downward trajectory for chronic opioid use with mean prescribing rate for opioids for 4 months or more, prior to the programme commencing in April 2022, being 14,382. This value had a gradual decline over the following 3 years, dropping to its lowest mean value in October 2023, to a mean prescribing rate of 13,619 – a reduction of 763 prescriptions, which equates to **12 lives saved.**



Similarly, the rate of high dose opioid prescribing was slightly lower, with a starting mean rate in January 2021 of 1105 patients, this has reduced over the last 3 years to 836 in April 2024; this downward trend has been sustained across that time frame, despite some isolated increases in individual months. **This continuing downward trend has halved the risk of opioid related death for 269 patients.**



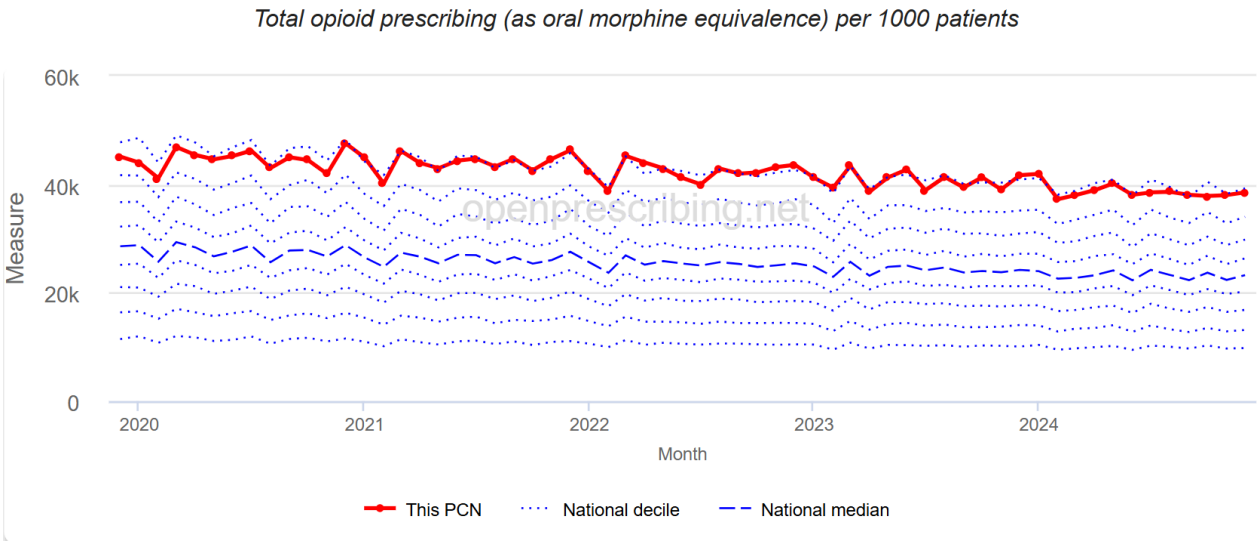
Despite the trends for BNSSG ICB overall demonstrating reducing prescribing patterns for both chronic and high dose opioids, there are areas where there are pockets of higher prescribing trends, which may be related to patient demographics and indices of multiple deprivation.

It is recognised that chronic pain is disproportionately greater amongst those from lower socially economic regions. Higher chronic pain rates in the Weston locality are associated with higher levels of deprivation indicative of greater health inequalities within this region. Chronic pain is a major health and societal burden in terms of years lived with disability and the economic impact due to health resources used and work absenteeism.

Graham Road Surgery and Horizon Health Centre (Pier Health Group Ltd.) are Deep End Practices (where the Indices of Multiple Deprivation are used to rank practices with the highest proportion of patients living in 15% most deprived data zones.) Compared to the most affluent populations, deprived populations in the UK have increased levels of multimorbidity, with disease onset 10–15 years earlier, significantly higher mortality rate, and an increased association with chronic pain and mental health morbidity.

GPs working in areas of deprivation experience increased demand for GP appointments and are under increased stress, with more patients registered per GP.

Open Prescribing data demonstrates that Pier Health PCN have exceptionally high rate of opioid prescribing:



The clinical team at Pier Health Group decided to pilot the pain café model as it is one of self-management, aiming to help people feel more empowered to manage their pain, experience improved well-being through reduced isolation and psychological distress and greater social engagement.

The team have adopted a multi-disciplinary approach, a chronic pain lead GP was identified and the role promoted at practice level, alongside a further co-lead GP to cover both the Graham Road and Horizon Health Centre GP practice sites. Both GPs attended the LWWP Ten Footsteps Training organised and funded by Health Innovation West of England. A mental health (MH) lead nurse with specialist knowledge of addictions had already written a 'PHGL Gabapentinoid Prescribing Policy.' Both GPs and the MH Lead Nurse worked together to raise awareness of chronic pain within the practice and at PCN level, arranging teaching sessions around deprescribing and sharing the LWWP approach and resources to all clinicians, alongside deprescribing activity at a practice level.

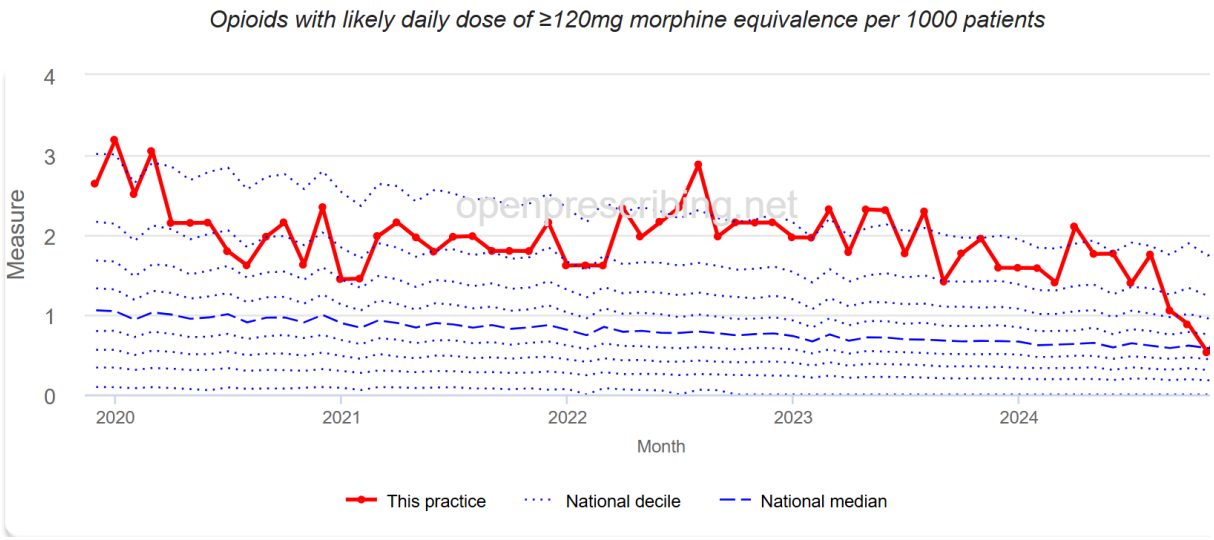
Social Prescribers working at PCN level for Pier Health and serving Weston, Worle and Villages were identified as being in a key position to support a Pain Café Pilot Project.

Unfortunately, the Pier Health practitioners were unable to attend the initial group facilitation training, so this was included in the proposal for funding support for the pilot programme.

The chronic pain lead GP arranged this training using funding allocated through Kevin Feaviour (ImagineIF). This facilitator training was made available to other members of the practice team, and included all six social prescribers for the PCN, three Mental Health Support Workers from the practice-based MH team and one Prescriptions Clerk who works closely with both GPs around opiate and gabapentenoid deprescribing.

The pilot pain café for Pier Health Group launched in April 2025.

Following engagement of practices within the PCN in the MedSIP Opioids programme through Health Innovation West of England in mid-2024, prescribing rates for high dose opioids began to significantly reduce in practices with practitioners that had attended the funded LWWP training (chart below demonstrates data from Horizon Health Centre):



Further pilot work in BNSSG is explored in the Case Studies section.

Gloucestershire ICB

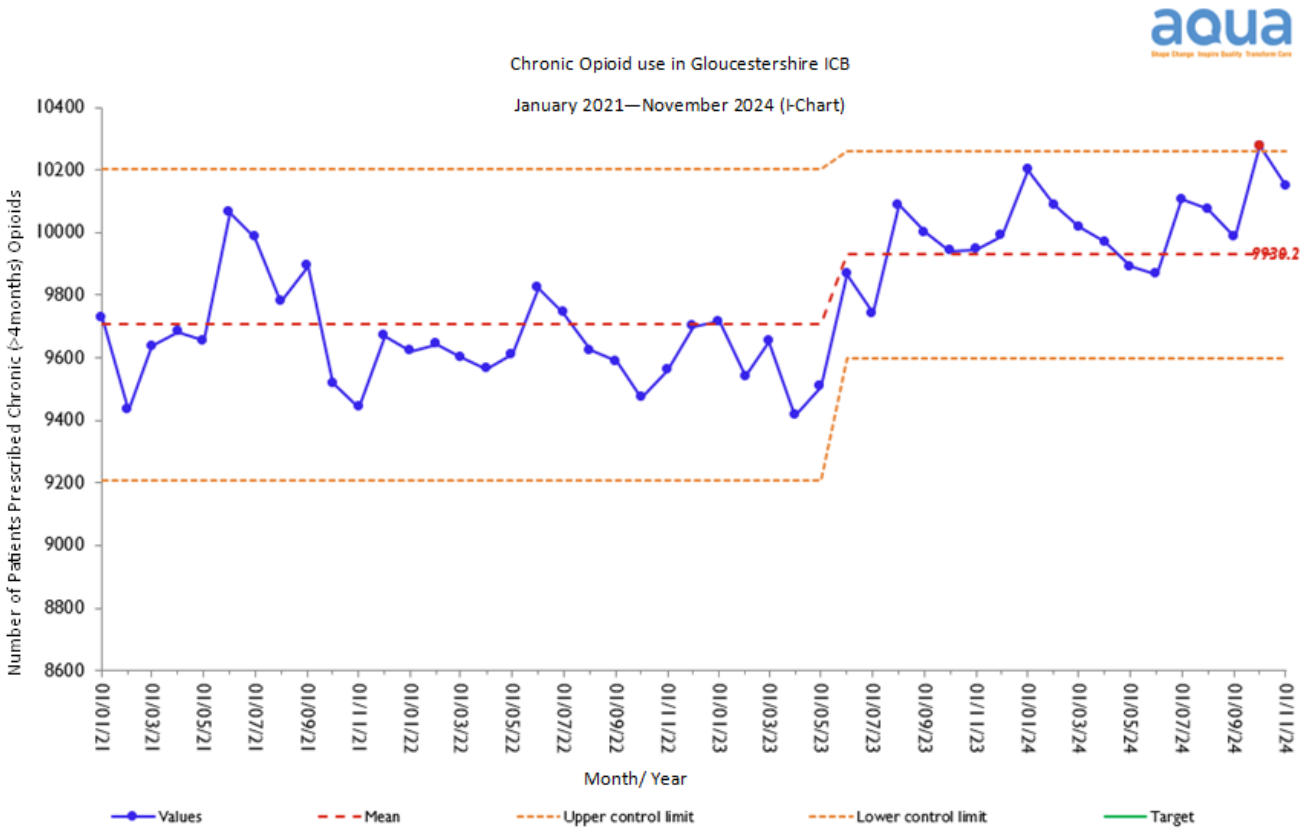
Project work with Gloucestershire ICB was predominantly to share information and education opportunities as the system already had a successful Chronic Pain workstream.

A series of workshops were held by the Living Well with Pain Clinical Programme Group, alongside the GL11 insights project, to gain a broader understanding of how individuals felt they could better support individuals living with chronic pain.

A full report of the work achieved through a collaboration between the ICB and the GL11 Community Hub can be read here: 'Living Well With Pain' 2023 Full Project Report

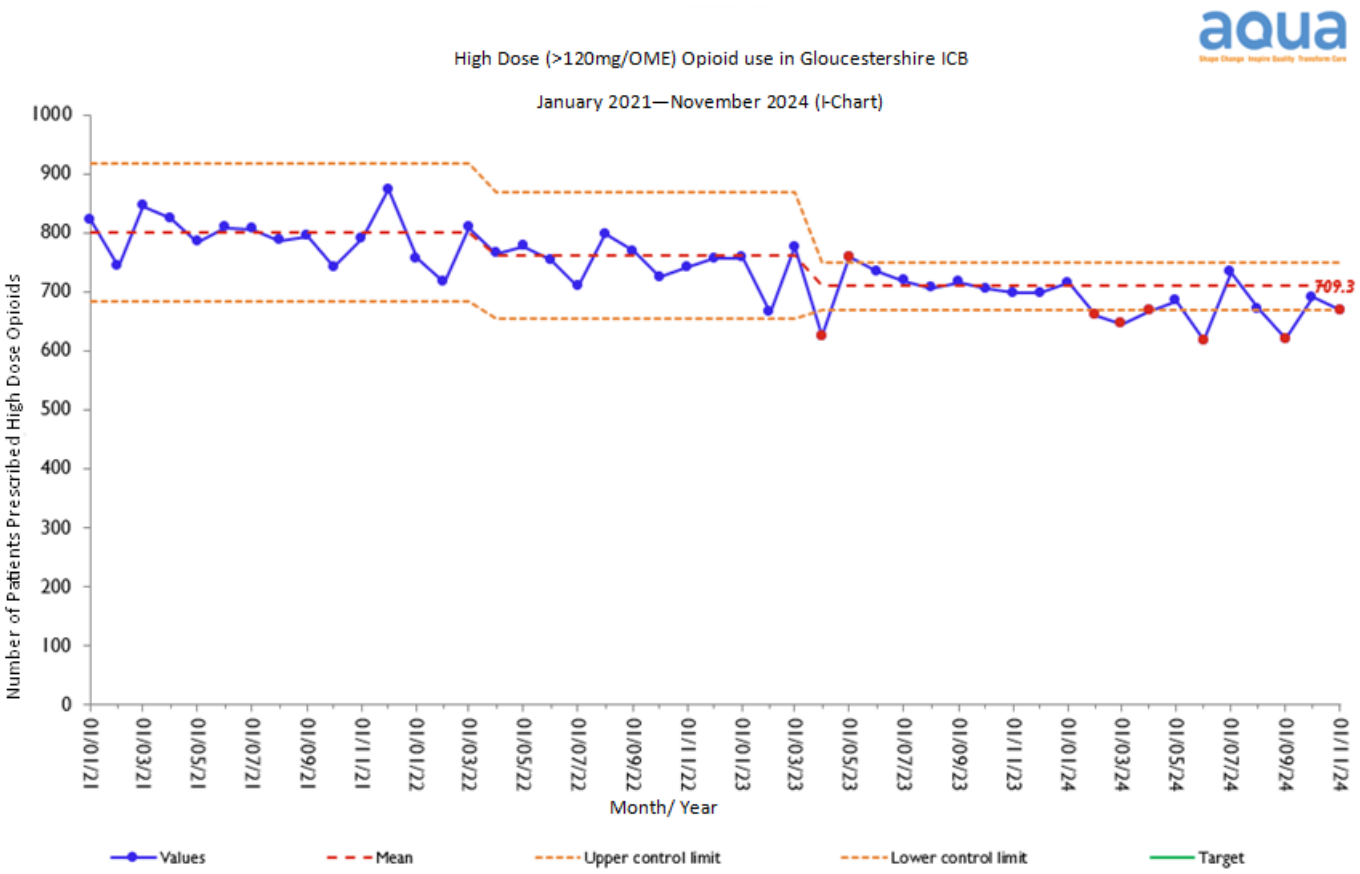
Themes that arose from the project work reflect those demonstrated more widely through patient surveys for chronic pain, the survey focused on the impact in three distinct areas: how chronic pain has impacted on peoples' lives, how others respond to the people with chronic pain, and the peoples' experience of the health and community systems.

Isolation, lack of understanding, communicating/linking between NHS services, peer support, medications and requests for education about chronic pain and its management were reflected across the focus groups.



Gloucestershire was one of the lowest opioid prescribing localities nationally, however, prescribing mean data began to trend up in June 2023, when the mean prescription volume for chronic opioids shifted from 9,707 to 9,930.

Despite the rising trend in chronic opioid prescribing, the data for high dose opioids continues to trend down, in-line with national data:



Although not as dramatic as the other ICBs in the locality, Gloucestershire have reduced hide dose prescribing from a mean rate of 801 prescriptions down to 709; **this continuing downward trend has halved the risk of opioid related death for 92 patients**.

Unfortunately, funding for the Gloucestershire Chronic Pain workstream was withdrawn in 2024. As the team were aware of and linked in to the work happening in collaboration between HIWE, BSW and BNSSG (as part of the Patient Safety Commission), the project team were contacted to support development of a funding application for grants to pilot pain groups in an area with both high rates of chronic and high dose prescribing.

Representatives from the Gloucestershire team also joined the community of practice to learn from network peers what was working well within their pain groups, and their plans to improve the pilot groups.

Project on a Page - Case Studies

The following pages share approaches, impact and learning from the pilot groups or set-up process for pilot groups from practitioners that have been supported by HIWE to initiate or sustain their pain café/groups.

These project on a page case study are aimed at giving quick insights/overviews of achievements or work in progress.

Full case studies from each of the project teams can be found in the 'Full Case Studies' section.

Case studies were submitted by:

BSW – North Wilts PCN

BSW – Hope House Practice

BNSSG – Bridge View Practice

BNSSG – Horfield Health Centre

BNSSG – Horizon Health Centre/ Pier Health Group

BNSSG – Northern ARC PCN

Laminated, A3 poster versions of the project on a page case studies have been shared with project leads to enable them to display and share the quality improvement work that they have undertaken locally to improve patient experience and wellbeing.

Health Innovation West of England

BSW – North Wilts Border PCN

Medicines

Improvement Project: **North Wilts Border PCN Pain Group**

Project Team: **Rachel Dolman Senior PCN Clinical Pharmacist,** Bath and North East Somerset, Swindon and Wiltshire (BSW) ICB

Date: **Feb 2025**

North Wilts Border

in association with Health Innovation West of England

There are over 1 million people in England with high-risk opioid prescribing. Management requires personalised care and shared decision making with patients requiring biopsychosocial support so they can live well with their pain.
There is no evidence for efficacy of high dose opioids (>120mg/day oral morphine equivalent (OME)) in long term pain.
Nationally, utilising a whole system approach to reducing harm from opioids has been developed to support local approaches to helping people live well with chronic non-cancer pain – this approach was already being initiated in BSW through the pain group innovatively developed at North Wilts Border PCN in 2018, which has since been adapted/adopted more widely.

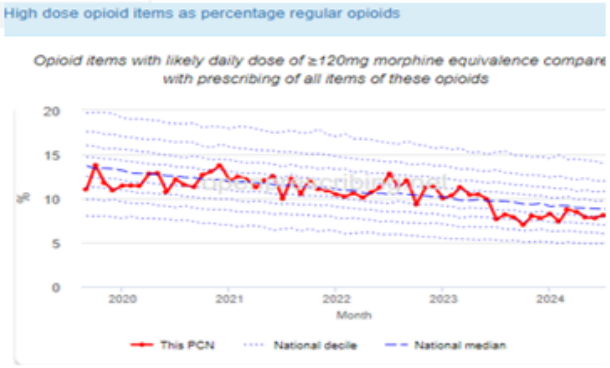
The Medicines Safety Improvement Programme (MedSIP) aims by March 2025 – 25,000 fewer people prescribed oral or transdermal opioids from more than 3 months – preventing around 400 deaths.
4,500 fewer people prescribed high dose opioids (120mg OME/day), halving their risk of opioid related death.
People with chronic non-cancer pain reporting better quality of life.

Reductions in prescribing data trends are tracked through the NHS Business Service Authority ePACT2 system.
The below chart is from the national opioids tableau dashboard, demonstrating a national downwards trend in high-dose opioid prescribing, this is replicated in the BSW data chart.

The approach of the *MedSIP: Reducing Harm from Opioids in Chronic (Non-Cancer) Pain* is to utilise biopsychosocial approaches to pain management, meaning that patients are supported through social groups/networks to adopt non-pharmacological methods of managing their daily pain and flare ups. Evidence to support this approach has been emerging for over 10 years, although there has been an increased focus in studies the last 3-4 years, with outcomes demonstrating that this approach can:

- Reduce opioid use of participants by up to 64%
- Reduce visits to the GP by up to 50%
- Reduce lost work hours due to absence by up to 21%
- increase quality of life by up to 64%

To support this approach, Health Innovation West of England (HIWE) hosted educational webinars which are available to watch back online and funded 155 training places with provider Live Well With Pain – a programme developed by a GP to train practitioners in self-management techniques so that they can offer their patients alternatives to pharmacological management. This was identified as a need when 69% of Primary Care practitioners in BSW responded to a survey in 2022 stating that *'they had little to average confidence in explaining non-medicinal self-management techniques for managing pain'*.
Practitioners from North Wilts Border PCN attended this training offer and have continued to work with HIWE to support other practitioners across the ICB and wider locality in developing pain groups/café's and offering peer support.
Their innovative approach to implementation of a pain group in 2018 has resulted in clear benefits to their patient groups, as demonstrated in the downward trend of the practice prescribing data below.



What we learned and next steps:

- Open Prescribing Data (left) demonstrates a reduced number of high dose opioids prescribed across the PCN where this initiative has been successfully implemented and sustained for six years.
- Positive patient feedback from the group has highlighted that *70% leave feeling happy and likely to recommend to a friend, with 60% connecting outside of the organised group.*
- Support for other pilots across the locality continue to be provided by HIWE.
- A practitioner led community of practice commenced in December 2024 to provide peer support opportunities, with contributions from the North Wilts Border PCN team.
- Collaboration with the BSW Medicines Optimisation team has ensured that reducing opioid use remains a safety priority with a steering group established during the programme.
- Resources for both practitioners and patients will continue to be hosted by HIWE.

Health Innovation West of England

BSW – Hope House Practice

Medicines

Improvement Project: **Pain Café**
Project Lead: **Safia Latif, Clinical Pharmacist - Hope House Surgery**, BSW ICB
Date: March 2025

Hope House Surgery

in association with Health Innovation West of England

The Pain Cafe was established to support patients living with chronic pain in an area with high opioid prescribing rates. It aims to provide resources, reduce isolation, and enhance patient engagement with well-being services. The Pain Cafe has effectively supported patients living with chronic pain, fostering community engagement, increasing awareness of resources, and enhancing psychological wellbeing whilst also contributing to improvements in the broader community, and health service interactions. Due to the pilot nature of this project, patients diagnosed with fibromyalgia were the primary target patient group.

Aims & Objectives

- Provide support and resources to patients living with chronic pain.
- Empower patients to 'live well' with pain by increasing knowledge and confidence.
- Decrease reliance on general practice and surgery interactions.
- Optimise pain treatments, including deprescribing inappropriate medications.
- Increase engagement with well-being services.
- Decrease patient isolation.

How it started…

We realised that the programme we created had to revolve around finding a way for patients to tell their story. After considering 1:1 appointments, we realised group consultations (monthly pain cafes) would be the most efficient way to do this. There we other practitioners within the local geography providing this model who inspired us to pursue this idea. We recognised that we needed to focus on support, provide minimal education during the sessions so that attendees could direct the conversation to what was important to them and offer resources as needed.
The team were trained in the Live Well With Pain model and initially obtained funding for a 6month pilot through Health Innovation West of England. We were subsequently able to achieve an extension to a full 12-month pilot due to the success of the initial programme and feedback being received from the attendees.

Co-Producing Pain Café Content

Attendees were asked to fill out a feedback form at the first pain café occurrence, this identified key priorities for the patient group linked to: sleep, movement and pain management. This ensured that the content and guests invited to support the café were relevant to the needs of the attendees and would support engagement and on-going attendance. This process of co-production has continued throughout the programme, with patients frequently asking questions about pain management strategies, showing a keen interest in learning and sharing experiences and contributed to planning topics for the café.

Outcomes & Impact from Pilot Evaluation

The Pain Café has already demonstrated significant benefits to both the surgery and the local community:

1. **Patient Feedback**
   - **Satisfaction**: Attendees reported positive experiences, with many highlighting the supportive environment decreased isolation
   - **Perceived Benefits**: Participants noted a better understanding of available resources.
   - **Suggestions for Improvement**: Requests for additional topics and guest speakers were made.
2. **Social and Psychological Impact**
   - **Reduced Isolation**: Participants reported feeling less isolated and more connected to peers, with many forming support groups outside of the cafe.
   - **Psychological Wellbeing**: Many attendees reported improvements in mood attributed to peer support and shared experiences.
3. **Changes in Pain Management**
   - **Adoption of Strategies**: Patients began to adopt new pain management strategies learned during sessions, including mindfulness, breathing techniques and movement exercises.
4. **Uptake of External Resources**
   - **Engagement with Local Services**: A significant number of patients signed up for activities like seated exercise classes and other programs offered by The Active Way and local organisations (e.g., dance classes, breathing workshops).
   - **Increased Familiarity**: Patients became more familiar with and trusting of local services, enhancing their willingness to engage with additional resources.

Challenges and Lessons Learned

Challenges:

Attendance Variability: Fluctuations in attendance posed challenges for session planning. Reasons included half-term and illnesses. Additionally, the time of the session was noted to be difficult for many participants as it was too early (10am).
Data tracking: very difficult to get quantitative information. Appointment history was only available for the last year so couldn't compare to the year before. Variability of patients at each café make it difficult to see impact on prescription/medications.

Lessons Learned:

Tailored Themes: Future sessions should focus on themes that cater to specific interests of attendees.
Alternative Scheduling: Offering sessions at different times may increase participation.

Next Steps

- 6-week Live Well With Pain 10-Footsteps course for pain café attendees starts in May 2025.
- Local grant funding was secured in March 2025 by the practice team to allow the group to continue.

Health Innovation West of England

BNSSG – Bridge View Practice

Medicines

Improvement Project: **Living Well With Pain**
Project Leads: **Viv Mundy, Catherine Jones, Lucy Gillett and Aimee Speakman, Bridge View Medical, BNSSG ICB**
Date: April 2025

BRIDGE VIEW MEDICAL

in association with Health Innovation West of England

Identification of needs and change idea
Bridge View Medical (BVM) is a single practice PCN operating across 5 sites in south Bristol. Serving a patient population of 39,000. 26% of patients live in the 20% most deprived areas of BNSSG.
7.8% of the BVM Population over 18 are recorded as living with painful conditions; this is the second most impactful condition in BVM. It was identified that many of the individuals suffering with chronic pain would benefit from a more holistic approach to help self-manage the pain. Following attendance at several pain management webinars and discussions with other agencies who have introduced variations on pain clinics, pain courses and pain cafés in collaboration with Health Innovation West of England. BVM decided to trial a series of Living Well with Pain Courses to bring together cohorts of those living with chronic pain. The 6-week Living Well With Pain programme is designed to share information, with topics including – 'what is pain', manageable techniques and activities to help feel more in control, more confident and better equipped to live with the pain and improve wellbeing. The course is being run in a community setting to help de-medicalise the programme, but the Health and Wellbeing Coach facilitating the course is supported by a GP, Pharmacist, Physiotherapist and Social Prescribing team who have input into the course at various stages.

Solution: 6-week Living Well With Pain programme
BVM plan to deliver 3 or 4 6-week Living Well with Pain courses in a community setting over 12 months to act as a launch pad for attracting clients to peer support led community pain café.

Stage 1:
- Investigation, training and gaining buy–in from staff and patients.
- HIWE and local initiatives in Cornwall and Somerset supported with training.
- Survey to patients to understand level of support.
- Identifying suitable cohort who would most benefit .
- We decided to target patients who are at the start of their pain journey, aged 18 – 40 and co-prescribed a strong and weak opioid or with Fibromyalgia diagnosis.

Course 1:
Commenced with 12 people signed up to 6-week programme, delivered in a community setting.
Courses 2/3/4 are planned to take place throughout the 2025-year, varying day and time of delivery to support attendance.

Costs/Resources:
Staffing: 1 x Health and Wellbeing Coach (HWC) facilitates course; 1 x admin support; attendance by appropriate members of MDT for different sessions; Management support/ data analysis
We experienced a delay to the launch as the HWC identified to facilitate the course went on maternity lead, meaning a new facilitator needed inducting and training.

Room Hire: Quaker Meeting House, Bedminster.

Resources: Client Workbooks, materials for activities.

Impact (to date)
We are still very much in the early days of the project as we have recently completed the first cohort, however, the first course feedback has demonstrated the value to the service users. Including:
- the ability to interact with others and sharing their experiences.
- the patient group benefited from hearing about different techniques to try, however, felt that they needed more time as there are a lot of topics to cover in 6 sessions in any reasonable depth.
- they valued the attendance of the social prescriber outlining what post course opportunities were available in the community, however, they felt like the end of the course 'was a bit of a cliff edge' – having developed social connections they would have liked ability to continue these.

As a result of this feedback, with consent from the participants, the HWC facilitator set up a self-managed WhatsApp group so group members could stay in touch with each other. The Social Prescribers and facilitator are also setting up an introduction to a community group, where attendees can meet regularly and also sign up to gentle exercise class.

Due to the change in team, the HWC Facilitator was thrown in at the deep end - so this was very much a pilot of the materials and format which will be adapted in response to the feedback for future courses.

This was a collaborative project involving GP, Pharmacist, Physio, Social Prescribers as well as the Health and Wellbeing Coaches. The opportunity to bring this multi-disciplinary team together was very powerful in sharing learning and different skills/ knowledge to provide a holistic approach and build communication. A volunteer from the community was also brought in the help with set up and support attendees; 2 of the attendees had learning difficulties.

The ability to understand more about other community assets was valued and the staff involved found the power of hearing the stories of lived experience very moving.
104 patients were originally sent invitations for the first course, of these, 13 accepted. Average attendance was 4 sessions. (Others deferred until the next course).

Learning and Next Steps
- Having the right facilitator is key, with the ability to set a positive tone 'focus on what you can do not what you can't'.
- Choosing time and day for course is challenging as many in this group working and may have also have mobility issues which affects choice of location.
- Flexibility to adapt resources to meet needs of the cohort.
- Important to have post–course support plan, this is required as the feedback demonstrated that the most valuable aspect of the course for individuals was not feeling alone and sharing with others.

There are 3 more course planned in the next 9 months; each course targeting different cohorts of those living with pain. The plan is to offer these on different days and times of the week, so that everyone has an opportunity to access the course at a time that suits them around work and family commitments. Options are also being explored in how to develop more peer support post-course.

Health Innovation West of England

BNSSG – Horfield Health Centre

Medicines

Improvement Project: **Live Well with Pain Group**
Project Lead: **Saba James, Health and Wellbeing Lead**
Horfield Health Centre, BNSSG ICB
Date: March 2025

Horfield Health Centre | Phoenix Primary Care Network | in association with Health Innovation West of England

The Health & Wellbeing Lead, Saba James, and the Wellbeing team at Horfield Health Centre worked alongside their lead Pharmacist, Sandra Whitehouse, to create a supportive group for patients who had limitations accessing the online '10 Footsteps' programme. These limitations included dyslexia and poor literacy, social anxiety and/or other difficulties accessing community services. All staff involved completed the '10 Footsteps' training. The list of possible participants were selected by the pharmacists at their medication reviews after discussing how they were self-managing their conditions. We decided to invite people regardless of their diagnosis, based on their experience of living with chronic pain.

Need

Chronic pain is a named health priority for Bristol, North Somerset and South Gloucestershire (BNSSG) ICB.
The group was established to help people:

- Discover ways to help self-management of chronic pain to reduce pressure on GP and pharmacist appointments.
- To be less reliant on medication and medical services.
- To increase social contact and access to the community (reducing isolation).
- To share skills (alongside pills) as a way of living well with pain.
- Explore what a bio-psycho-social model of health creation feels like in practice.
- Share their experiences and feel heard and supported.

Our Approach

Once we decided to create a group to meet the need we followed these steps:

- Regular contact between Lead Pharmacist and Health & Wellbeing Lead to discuss aims/planning.
- All staff involved trained through Health Innovation West of England (HIWE) funded places in the 10 Footsteps programme to increase knowledge, skills and confidence.
- Group Lead booked on the HIWE Facilitator Training to learn about the Pain Café model with 'Imagine If' for tips and tools.
- Created a list of participants (35 people) to call with input from Pharmacists.
- Booked in dates with venue and confirmed practitioners.
- Created session plans with the wellbeing team's input.
- Reviewed resources and content we could print and share.
- Purchased a work phone for this and future groups for WhatsApp comms.
- Booked 6 sessions and 2 taster sessions over 7 months
- Completed risk assessments/consent forms/equality assessments.
- We created a safe space by establishing a group agreement and identifying what people needed to feel comfortable to attend – remind everyone at the beginning of each session.
- Asked participants which were their favourite topics from the 10 Footsteps programme they'd find most interesting. Top three: Sleep, Nutrition, Acceptance.
- We decided to use the Health & Wellbeing Check Tool as the evaluation (participants given a copy of theirs and will follow up at the end)
- We provided blue envelope wallets to collate handouts and a bound notebook for people to take notes from the session if they like writing.
- We have one lead and at least one support per session
- The sessions run monthly with key themes and a WhatsApp group to share info and links
- The Facilitators review the content the week before in a short meeting to discuss content.

Challenges

- The biggest challenge was encouraging people who were nervous about groups or had social anxiety to attend. It took time to build rapport and consistent communication to maintain attendance. To help build social connections initially: we included quizzes, ice breakers around the topics we were exploring and asking people how they genuinely are feeling today.
- We felt it was important to run the pilot group outside of the GP Practice, in the community. This space was non-medical and demonstrated that our health and wellbeing is not just a medical matter – how we live, socialise and understand ourselves is essential to our 'health creation' (our health wealth).
- Careful use of language was discussed as a team. We wanted to validate peoples' experience and not present ourselves as experts – our role is to facilitate the flow of the session and encourage 'spiralling up' conversations with open questions. Saba James and Matt Mulligan ran sessions in their specialist areas on sleep and nutrition – inviting people to relate the information to their lives and what they wanted to follow up and action.

Key Learning Points

1. **Gender representation:** despite male patients expressing positive interest during contact phone calls, attendance at the group has been 100% female; we have also recognised that a significant number of referrals into social prescribing and health coaching are for females (nearly double the number of males).
2. **Group numbers:** Don't be concerned if the numbers drop every now and again. We had a very small group of 3 and it proved to be beneficial for the participants. Next time we start a group, we will invite a higher number of people – we started with 35 people and now have a core group of 9 (15 on the list). We share resources and information from the group via WhatsApp, so it has a wider reach for those unable to attend.
3. **Be mindful of people's physical needs**: one participant attended who hadn't left the house for years and required a lot of support, due to the stress experienced by this individual we offered support through referral to our social prescribing team instead – personalising our offer to meet this individuals needs. We invite people to bring cushions/hot water bottles/heated pads and things they can easily bring to help them feel more physically comfortable. We also have the Community Centre turn the heating up to high, especially in winter.

Impact to date

- Participants are enjoying the group – they are opening up more about their experiences and supporting each other in the sessions with guidance and empathy (topics from sleep to sex have had us all laughing and listening).
- One person said she already feels different – commenting that her rheumatology nurse noticed a change and commented on it. She is also considering if she can start volunteering as a way to get back to work.
- The success of the early stages of the pilot means we will roll-out Live Well with Pain groups across both practices of our PCN, including a Young Person's group (19-29). We're also extending the Live Well With series to launch a COPD group.
- There is a more joined up approach between the GP practice, pain management clinics and the community support group.
- We have been in touch with the Pain management team and attended some of their online sessions to see how they work with people to complement what they do. We have one of their practitioners running a session on Acceptance with the group.
- We can have a greater outreach by having two members of staff supporting 10-15 people in the afternoon, rather than 2-3 1:1 sessions.

Health Innovation West of England

BNSSG – Horizon Health Centre/ Pier Health Group

Medicines

Improvement Project: **Pain Café Pilot**
Project Lead: **Dr Eleanor Holmes, Chronic Pain Lead GP**
Horizon Health Centre, BNSSG ICB
Date: March 2025

Horizon Health Centre · Graham Road Surgery · Pier Health Group

in association with Health Innovation West of England

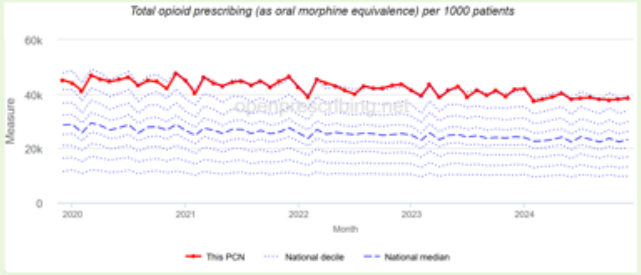
Chronic pain is a named health priority for Bristol, North Somerset and South Gloucestershire (BNSSG) ICB and Weston, Worle and Villages Primary Care Network (PCN) have the highest rates of chronic pain in the BNSSG region as identified by the recent Burden of Chronic Pain in BNSSG Report (April 2024).

Background

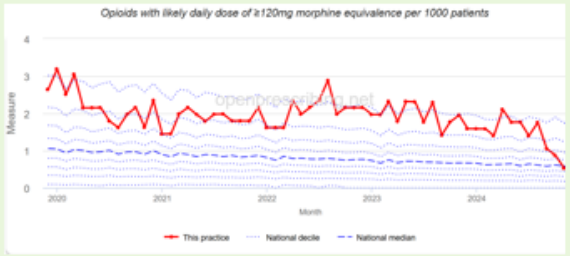
Latest figures from BNSSG systemwide dataset show that there are 6,377 people in Weston, Worle and Villages PCN who have chronic pain and (a) anxiety/depression, or (b) are high-intensity users of ED, or (c) are on both opioids and gabapentinoids.

Graham Road Surgery and Horizon Health Centre (Pier Health Group Ltd.) are Deep End Practices (where the Indices of Multiple Deprivation are used to rank practices with the highest proportion of patients living in 15% most deprived data zones.) Compared to the most affluent populations, deprived populations in the UK have increased levels of multimorbidity, with disease onset 10–15 years earlier, significantly higher mortality rate, and an increased association with chronic pain and mental health morbidity.

OpenPrescribing data demonstrates that Pier Health PCN have exceptionally high rate of opioid prescribing:



There is little evidence that opioids are helpful in long term pain, and the risk of harm increases significantly above 120mg morphine (or equivalent) per day, without much increase in benefit. Following engagement of practices within the PCN in the Reducing Harm from Opioids in Chronic (non-cancer) Pain Medicines Safety Improvement Programme through Health Innovation West of England in mid-2024, prescribing rates for high dose opioids began to significantly reduce in practices with practitioners that had attended the funded Live Well With Pain training (chart below demonstrates Horizon Health Centre data):



Why Pain Cafes?

The aim of the Pain Café model is one of self-management: to help people feel more empowered to manage their pain, experience improved well-being through reduced isolation and psychological distress and greater social engagement.

Our Approach

In order to set up a Pain Cafe Pilot Project, a team needed to be assembled within our Deep End Practices to support this work; raise awareness of the background and need for a different approach to chronic pain management; highlight the work already done in this area in Cornwall and Devon; identify members of staff who could refer into and facilitate the Pain Cafes; develop a way of identifying patients who might be suitable for a Pain Cafe approach to self-management.

Team Building and Training Within Practice A chronic pain Lead GP was identified and the role promoted at practice level, alongside a further co-lead GP to cover both the Graham Road and Horizon Health Centre GP practice sites. Both GPs attended the Live Well With Pain (LWWP) Ten Footsteps Training organised and funded by Health Innovation West of England. A Mental Health Lead Nurse with specialist knowledge of addictions had already written our 'PHGL Gabapentinoid Prescribing Policy.' Both GPs and the MH Lead Nurse worked together to raise awareness of Chronic Pain within the practice and at PCN level, arranging teaching sessions around deprescribing and sharing the LWWP approach and resources to all clinicians, alongside deprescribing activity at a practice level.

Collaboration at PCN Level Social Prescribers working at PCN level for Pier Health and serving Weston, Worle and Villages were identified as being in a key position to support a Pain Café Pilot Project.

Facilitator Training Pain café focused Facilitator Training was identified as a need for the Social Prescribers early on. The chronic pain Lead GP arranged this training using funding allocated through Community Psychologist and experienced Pain Café Facilitator and trainer Kevin Feaviour. This facilitator training was made available to other members of our practice team, and in included all six social prescribers for the PCN, three Mental Health Support Workers from our practice-based MH team and one Prescriptions Clerk who works closely with both GPs around opiate and gabapentenoid deprescribing.

Key Learning Points

1. Team working is key to creating momentum and buy in from community partners.
2. Chronic Pain Leadership is important at GP practice level.
3. The wider practice team is important, both clinical and non-clinical.
4. Patients want to engage with Pain Cafes.
5. Conversations about chronic pain are about building trust and relationships in care.
6. If someone has done it well, don't reinvent the wheel, ask to collaborate!

Next Steps

- The Pain Café Pilot Project is set to launch on Tuesday 29th April 2025, running monthly on the last Tuesday of every month 13.00 – 15.00, for one year.
- Expansion of LWWP Training to Clinical Staff.
- Building a Collaborative Chronic Pain Community in Weston-Super-Mare.
- Securing Further Funding to Sustain Pain Cafe Development.

Health Innovation West of England

BNSSG – Northern ARC PCN

Medicines

Improvement Project: **Pain Café Pilot, Part 1** (in set-up phase)
Project Leads: **Evie Day & Roxi Beville, Pioneer Medical Group - Northern ARC PCN**, **BNSSG ICB**
Date: March 2025

PIONEER MEDICAL GROUP ACCESSIBLE - RESPONSIVE - CARING

in association with Health Innovation West of England

Identification of needs and planning

As a wellbeing hub of personalised care professionals (Health and Wellbeing Coach, Social Prescribers and Care Coordinators), we recognised that many patients are referred to us with chronic pain conditions. We support these individuals in 1-1 sessions and can signpost them to the online 'Ten Steps to Living with Pain' programme as well as other resources. However, a significant proportion of support offered is online and we have found that this cohort can struggle to make changes.

Initial Steps to Change

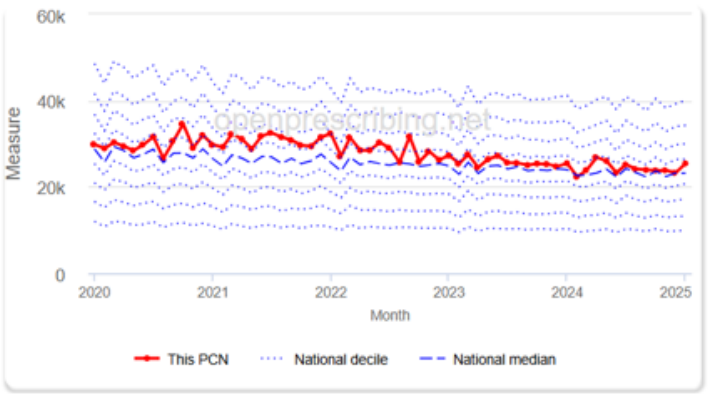
It was identified that Pain Management training would be beneficial for members of the Social Prescribing and Health and Wellbeing Coaching team, so that we are better able to support this cohort of individuals. Through Health Innovation West of England (HIWE) we were able to access funded training in the Ten Footsteps to Living Well with Pain (through Live Well With Pain) and Group Facilitation (through ImagineIF).

This was beneficial to understand multiple levels of supporting this cohort, including but not limited to:

- How individuals with chronic pain can feel day-to-day
- Different experiences that have impacted them and/or caused their pain initially
- Different tools that might be helpful
- Approaches that can be unhelpful
- How to support individuals in a group setting
- Evidence for how and what is most effective to support this cohort overall

We felt strongly that this group programme could benefit our patients, aligning with the need (and current work) to reduce opiate prescription in our practice.

Total opioid prescribing (as oral morphine equivalence) per 1000 patients



This OpenPrescribing data chart measures the total Oral Morphine Equivalence (OME) in ALL opioid prescribing (excluding prescribing for addiction) including low-dose opioids in drugs such as co-codamol and co-dydramol for Northern ARC PCN.

Community of Practice

We were invited to join a West of England Pain Café Community of Practice (CoP), to discuss running a group for individuals with chronic pain. This was such a helpful experience to learn from other healthcare professionals, both medical and non-medical coming together – coaches, pharmacists etc.

We were able to discuss how we can support a struggling cohort to effectively manage their pain and make steps forward for their physical and mental health. We were able to learn how to set up a Pain Café for our patients.

This was such a beneficial experience for us, we facilitated the next CoP to continue connecting with like minded peers and supporting others through the proposal and set-up processes.

The Pain Café – Current progress: Funding approved!

We were so grateful to receive the funding from Health Innovation West of England for this pilot programme. This will allow us to run 8 sessions with patients, including an evaluation session at the beginning and at the end to understand what has helped individuals with chronic pain and what they might need moving forward.

It is hoped that we will be able to carry on providing this approach for patients beyond this pilot, however, at the least we will be able to offer an evidence-based programme for up to 20 patients. This holistic self-management support will give patients tools to support themselves, as well as connections to others going through similar experiences, and access to specialists who we will invite to sessions.

Who?
We have selected patients from our current wellbeing hub referrals and called them to assess their interest and needs. This includes adults with chronic pain who can attend to a group face-face-face, wanting to access holistic support for pain management.

Where?
We have identified a few community spaces that would be accessible to patients and met with providers to discuss availability. We are waiting for final patient number confirmations to ensure that the correct sized space is utilised,

When?
We will offer 2-hour sessions, monthly, due to evidence that this may be most beneficial. We will review this with patients in the initial taster session, and midway through (Session 4).

How?
Social Prescriber (Roxi) and Health and Wellbeing Coach (Evie) will facilitate the Pain Café using the Ten Steps Programme resources: Ten Footsteps to Living Well with Pain. We have also invited specialists to support in some sessions, including but limited to: Pharmacist, Music and movement specialist, Sleep specialist, and Nutritionist.

Resources Created During the Programme

Resource postcard

This resource library has been created to provide support materials in one location for people living with pain and professionals supporting people living with pain.

People that do not use English as a first language can amend their browser settings to the language of their choice to translate the web page; resources with YouTube videos can utilise closed captions in a preferred language.

Lived experience and local pain group videos

Horfield Live Well with Pain Group & Community Support for Living with Chronic Pain Information from attendees and the team running the Horfield (Bristol) Live Well with Pain Group, including information on the approach and impact from utilising a biopsychosocial approach to management of chronic/ long-term health conditions.	
Living with Chronic Pain - Biopsychosocial Approach - Lynn's Story Lynn describes her experience of being diagnosed with psoriatic arthritis and fibromyalgia; Lynn discusses the reassuring factor of knowing that she is not alone in her pain journey, accepting her diagnosis and finding activities that are helpful (for her) to avoid pain relieving medications.	
Living with Chronic Pain - Alice's Story Alice discusses how an acute episode of back pain progressed into a chronic pain condition in relation to the value of being able to attend a pain group to feel seen and supported, enabling her to stop high dose opioids.	
North Wilts Pain Group - Patient Experiences Group attendees explain how attending a pain group has enabled them to explore opportunities to feel in control of their chronic/persistent pain condition; the value of being heard by peers and how that encourages them to seek reduction in pain medications – supported by the relationship with the clinical pharmacist that developed and runs the group.	
Chronic Pain & Deprescribing - Ali's Story Ali shares her experience of being diagnosed with osteoarthritis and her journey from being started on opioids, continuing the medications without seeing any improvement and her scepticism as being referred to a pain group. Following referral to the pain group Ali began the process of tapering (reducing) the opioids and found alternative, non-medicinal, management options.	

Resources for Professionals

General information on medicines optimisation and medications

Improving Chronic Pain Management by Reducing Harm from Opioids	
North Wiltshire Pain Group case study	
Hope House Pain Café consultation poster	
Medication optimisation – Live Well With Pain website	
Information on individual medicines and possible procedures for patients – Faculty of Pain Medicine website	
Opioid prescribing for chronic pain – NHS England	
Group consultations: how can they improve clinical outcomes and reduce waiting lists webinar – Digitally Enabled Outpatients (Please note you will need to login to FutureNHS Collaboration Platform to view)	
Health Innovation West of England – Improving chronic pain management: reducing harm from opioids video	
Health Innovation West of England – exploring alternative approaches to supporting patients to live well with pain video. This one-hour webinar focusing on supporting people to live well with pain, where you'll gain an understanding about patient engagement and empowerment strategies and resources developed to help you immediately in your practice.	

Health Innovation West of England – Pain Cafe Webinar – recorded 16 October 2024. Here, Kevin Shares the outcomes of the pain café on wellbeing, managing pain and lives and reduction on use of opioids through a biopsychosocial approach.	
Health Innovation West of England – Experiences of Caribbean and South Asian women living with chronic pain webinar – recorded 27 February 2025. A webinar co-hosted by Nilaari and NCIM, Subitha shares her finding on the Experiences of Caribbean and South Asian women living with chronic pain.	
Recipe for a Successful Pain Cafe – excerpt from Health Innovation West of England and webinar recorded 16th October 2024. Here, Kevin shares valuable tips on how to successfully start and maintain Pain groups over time.	
ImagineIF Pain Cafes – Cornwall Connected by Pain Early Impact Report	
Pain Café webinar event report with additional resource links: This is an event report with useful links from the Pain Café webinar co-hosted with ImagineIF.	
Putting 'Live Well With Pain' learning – excerpt from Community of Practice, 20th November 2024. In this Community of Practice hosted by Health Innovation West of England, Safia Latif, a Clinical Pharmacist at Hope House Surgery, shares insights on applying Living Well learning in practical settings.	
BSW Opioids leaflet	
How to use the Live Well with Pain Health and Well Being Check tool – Live Well with Pain	

Rethinking Pain Service and Health Innovation Yorkshire and Humber videos

Developing Good Practice – In this session, Dr. Shahzad Jamil discusses what constitutes good clinical practice in respect to long-term opioid prescribing and why we need to give focus to this topic.	

The Language of Pain – In this session, Mark I. Johnson, Professor of Pain and Analgesia at Leeds Beckett University, outlines the language of pain and how we engage and communicate with people through their pain journey.	
Identifying Patients and Local Prescribing Data – In this session, Nicola Chicken, Project Manager at Health Innovation Yorkshire and Humber, looks at how we identify patients who are at potential risk of harm from opioid use.	
Pragmatic Approach to De-Prescribing Opioid Based Medication – In this session, Dr. Asim Suleman, Clinical Lead at Rethinking Pain Service, highlights the risks involved with opioid-based medication and considerations to make when prescribing opioid/opiate medication.	
Building the Infrastructure of Community Pain Support – In this session, Kerry Page, Programme Manager at Rethinking Pain, discusses how Rethinking Pain aims to transform pain management across the region.	
Framework of Opioid Stewardship in Primary Care – In this session, Dr Shahzad Jamil and Dr Yasir Abbasi explore what needs to be done to enable us to move forward in creating a framework for opiate prescribing in Primary Care.	

Chronic pain and fibromyalgia

Fibromyalgia Action UK – Link goes directly to health professional information and education pack.	
Flippin Pain – Resources including links to MSc courses focussed on pain; podcasts; key message posters and a blog written by a health professional living with Fibromyalgia.	
Living Life to the Full – Free resources for supporting people doing living life to the full course, including living life to the full with pain.	
NHS Scotland – Pain Association – Library of webinars and academic papers on chronic pain.	

Sheffield Persistent Pain – YouTube video *'Assessing persistent pain for GPs',* information on pain medication and use of opioids for persistent pain.	
TEDx Talks – TEDx Adelaide – Lorimer Moseley – Why Things Hurt, 15minute video covering some basic neurophysiology, pain theory and understanding pain perception.	
Versus Arthritis – Chronic pain in England: Unseen, unequal, unfair Report (2017).	

Chronic pain due to hypermobility disorders

Hypermobility Syndromes Association – A clinician's guide to hypermobility disorders, including most common diagnoses, investigation and management and 10 things to try in clinic.	

Musculoskeletal pain

movingmedicine.ac.uk – Consultation guides, with guidance for conversations lasting 1 minute, 5 minutes or longer; infographics that can be utilised during these conversations with people living with musculoskeletal pain.	

Pain service information/education

Bath Centre for Pain Services – Information on referral criteria for Bath Centre for Pain Services.	
Bristol Pain Clinic – Information on pain clinic referral for University Hospitals Bristol Trust with contact details, as well as self-management information.	
Health Education England – e-Learning for Health module on pain management, created in partnership with the Faculty for Pain Medicine and The British Pain Society.	
North Bristol Pain Clinic – Information on pain clinic referral for North Bristol Trust with contact details, as well as self-management and pain management programme information.	
Somerset Community Pain Management Service – Information for GPs in the referral area for Somerset Community Pain Management Service – linked to Musgrove Park Hospital.	

Resources for people living with pain

Arthritic pain

ESCAPE-pain – Group rehabilitation programme for people with chronic joint pain; links to face-to-face classes via a location map or you can access YouTube videos for exercises you can do from home. There is also an app available on both Android and iOS devices.	
Versus Arthritis – Direct link to the 'Let's move with Leon' resources, a 12-week programme of 30-minute movement sessions to support improvement of strength, flexibility and cardiovascular fitness for people living with pain associated with arthritis or other joint conditions.	

Back pain

Back Care – Library of resources, each leaflet is available as a pdf document.	

Chronic pain

Action on pain! – Charity website with support and advice information and further information links.	
Bath, Swindon and Wiltshire ICB Reducing and Stopping Opioids Patient Information Leaflet – A pdf document with information on reducing opioid medications and additional links to self-help resources.	
Body Reprogramming – Resources include videos and a free patient guide – this has translations available: Spanish, German, Italian and Arabic. This website has built in translations for French and German, but most of the content should also translate through your browser.	
Brain and Spine Foundation – UK based charity; pdf patient information leaflet and website that provides information on chronic pain.	
Bristol, North Somerset and South Gloucestershire Self Help – A pdf document with links to self-help resources and YouTube videos.	

Bristol Pain Clinic – University Hospital Bristol pain clinic website – this link will take you directly to the 'What can you do to help yourself?' page, this has a built-in translation to view in Polish.	
British Pain Society – Understanding and Managing Long-Term Pain pdf leaflet – please note that this is heavily watermarked, which may make it difficult for people with visual impairments or reading difficulties.	
Chartered Society of Physiotherapists – Strengthening exercises published via YouTube to support accessibility through closed captions; exercises vary in impact levels to support gradually building strength and getting joints moving to reduce chronic pain through movement.	
Chronic Pain Support Group – Support group based in East Anglia, but all publications and newsletters with supporting information published to website.	
Control Your Pain – Information on chronic pain and different treatment options available. Website has built in translations for Spanish, German and French.	
Flippin' Pain – A selection of resources co-created by people with persistent pain, healthcare professionals, pain scientists and communications experts to help make sense of the science behind pain.	
italk – Living well with chronic pain resources, initially designed to support people in Hampshire attending a Live Well with Chronic Pain class. This website has Recite© built in to translate the information, it also provides audio description in multiple languages for those that have visual impairments or difficulty reading.	
Live Well With Pain – Collection of resources that are designed to help patients learn the skills they need to effectively self-manage their pain; full of tried and tested ideas and methods – many suggested by people who are themselves living well despite their pain.	
Living Life to the Full – Free online courses with one course focusing on living with chronic pain.	

My Joint Health Hub – Chronic pain section of the website with direct links to YouTube videos, has additional resources linked and resources for people living in Bristol, North Somerset and South Gloucestershire to self-refer for additional support. Built in website translations available in Albanian, Somali, Polish, Arabic, Bengali, Chinese (simplified), Gujarati, Pashto, Turkish, Urdu and Romanian.	
NHS England: Decision Support Tool – An interactive tool to help you when making choices about options to consider when managing your chronic pain. This tool could be completed prior to an appointment with a member of your healthcare team, or during an appointment. This is a pdf document and is only currently available in English.	
NHS England: Ways to Manage Chronic Pain – General information about living with chronic pain, links to physiotherapy self-referral pathways; information on over-the-counter pain relief and alternative treatments such as low impact exercise. Links to additional resources on the page.	
NHS England: Fitness Studio Exercises – Direct link to the video resources for low impact exercises, additional link on page for strength and flexibility exercise plan. The videos include a transcript for those with hearing difficulties and audio description for people with vision impairment; there are no language translations built in, and the transcript is built into the video so is unlikely to translate with browser language settings.	
NHS Scotland: Chronic Pain – Information about chronic pain, its causes and how you can manage it. Embedded YouTube videos from Pain Association Scotland about pacing and managing pain flare ups.	
North Bristol Pain Clinic – Information for people living with pain that may benefit from a local specialist pain management service. The website includes information on gaining a referral (if appropriate), what to expect during your appointment, patient information leaflets and information on the use of Transcutaneous Electrical Nerve Stimulator (TENS) as an alternative to or alongside medication to manage pain.	
Pain Association – Although two of these YouTube videos are specifically for people based in Scotland (attending a meeting/attending a course), there are an additional eleven videos which have good accessibility as they utilise the built-in closed captions feature.	
Pain Concern – Support information, phone line, forum and radio programme to support people living with pain or family members or carers of people living with pain.	

Pain Concern: Airing Pain Podcast – Direct link to the Airing Pain podcast. Over 140 episodes with each discussing different topics/ areas of concern or support opportunities for people living with pain. These podcasts have transcripts for each episode that can be translated through the browser, or alternatively the episodes have direct links to the YouTube videos with closed captions.	
Pain Toolkit – These resources require payment and have been included in this list as it holds a library of audiobooks, webinars, workshops, and an online support café/forum which may be of beneficial to some people living with pain.	
Pain CD – Direct link to 'Living With Chronic Pain' by Neil Berry, this can be accessed for free online or downloaded from the website; alternatively, it is possible to purchase a physical copy of the CD.	
Pain UK – Direct link to the Pain UK YouTube channel; bite sized videos lasting 2-6minutes to support pain management.	
Physiotherapy Pain Association – Culturally-specific support information (via downloadable pdf) for people living with pain written in collaboration with a Muslim Chaplain and Imam.	
Sheffield Persistent Pain – Resources for people living with pain to support understanding about why we feel pain and how that can become a chronic/persistent pain cycle. YouTube videos embedded from The Royal Holloway University faculty.	
The Pain Clinic Bristol, North Somerset and South Gloucestershire – Patient information pdf leaflet about the pain clinic service in the region.	

Joint Pain

My Joint Health Hub – Eight sections to the website for specific regions of pain: foot and ankle pain; back pain; elbow pain; hand and wrist pain; hip pain; knee pain; shoulder pain and an area for pelvic health.	
Nuffield Joint Pain Programme – free course provided by Nuffield Health for anyone living with joint pain. You can search if you have access to a local Nuffield gym offering the programme at the bottom of the page via the postcode checker.	

Musculoskeletal Pain

One You South Gloucestershire – Information leaflet for the One You initiative to support reduction of joint pain in people with a body mass index of 30 or more or who are smokers via weight management and smoking cessation programmes. The document is a pdf and therefore has limited accessibility.	
Yoga with Adriene – Low impact, chair yoga with other videos available to build strength and flexibility – YouTube so built in closed captions with translation options.	

Pain Scale

British Pain Society – pain scales in multiple languages to support improved assessment by healthcare professionals and patients; available in: Albanian, Arabic, Bengali, Chinese (simplified), Chinese (traditional), Greek, Gujurati, Hindi, Polish, Punjabi, Somali, Swahili, Turkish, Urdu. Vietnamese and Welsh.	

Pilot Group Full Case Studies

BSW North Wilts Border PCN Community Pain Group Innovation

In 2018 Rachel Dolman, Senior PCN Clinical Pharmacist at North Wilts Border PCN trailblazed an innovative approach to supporting patients diagnosed with Fibromyalgia.

There are over 1 million people in England with high-risk opioid prescribing. Reducing from high dose to low dose opioids (or not escalating) reduces risk of opioid related mortality by 50%.

The Faculty of Pain Medicine Opioids Aware resource demonstrates that the risk of harm increases substantially at doses above an OME of 120mg/day, but there is no increased benefit. Despite widespread use, there is little evidence that opioids are helpful for long term pain and only a small proportion of people may obtain good pain relief with opioids in the long-term if the dose can be kept low and especially if their use is intermittent.

Fibromyalgia affects up to 1 in 20 patients in primary care, more likely to be diagnosed in women than men and defined by chronic widespread pain, often accompanied by fatigue and sleep disturbance.

The North Wilts clinical team recognised that appropriately supporting patients with chronic pain can be challenging due to the personalised nature of their conditions, often requiring multiple appointments with complex solutions/management plans; the range of effective medication is limited, and patients therefore often end up with chronic high dose opioid use (with likely daily dose of ≥ 120mg oral morphine equivalence (OME)).

The PCN planned, developed and founded a community pain group led by their Senior PCN Clinical Pharmacist (with a specialist interest in pain management). This group was supported by the wider clinical team, utilising an approach rooted within the rapidly developing evidence base of using biopsychosocial self-management methodologies for chronic pain management.

Group participants were invited directly via the General Practitioner or another clinician, either verbally during consultation or using the local messaging system. Initially the invites were for Fibromyalgia patients, however, due to the success and feedback received from participants, the group increased its capacity to include all types of chronic pin including those diagnosed with Long COVID.

This local innovation was enabled by a practice management team that facilitated an opportunity for experimentation to try something that wasn't in use elsewhere, supporting the request from the clinical team that this service would be available across the PCN and not limited to a single practice.

Patient satisfaction questionnaires from patients that regularly attend the group identified the top benefits of attendance:

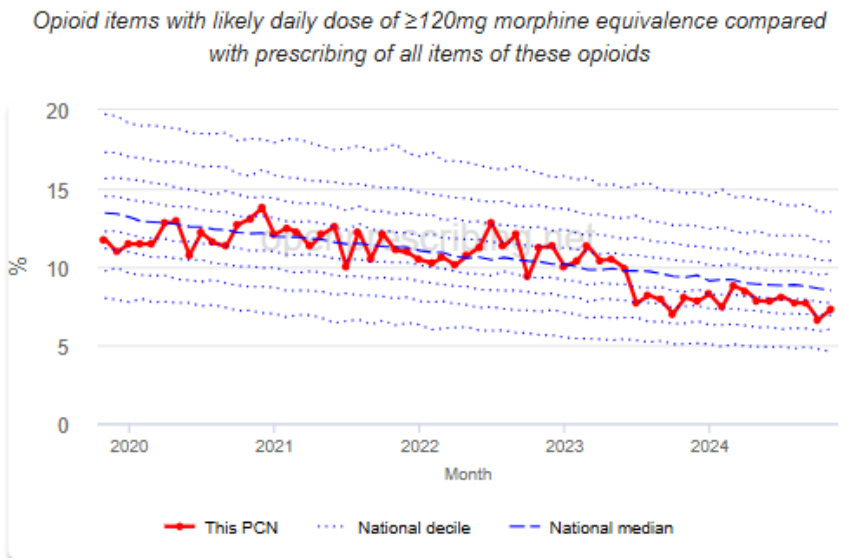
- Information sharing
- Presenter sessions well organised
- Sharing ideas and experiences

With 70% of respondents stating that they leave feeling happy and likely to recommend to a friend, and 60% connecting outside of the organised group – ensuring that the social support for flare ups is available outside of the monthly group.

As the group has been run solely by Rachel (to date), a high level of trust has been developed between her and the patients, which has enabled and encouraged individuals to attend structured medication reviews to discuss their pain management. This process has been mirrored through the patients that first meet Rachel during a pain medication review, who subsequently commence attendance at the community pain group.

There have been challenges experienced by the team; despite a number of patients actively engaging in the group there has been some difficulty around patient buy-in – as not everyone feels that "talking therapies" is the solution. Similarly, the demographics of the group typically favours females aged over 40, which is exacerbated as the prevalence of Fibromyalgia in men being significantly lower and therefore it has been difficult to establish the attendance of men within the setting.

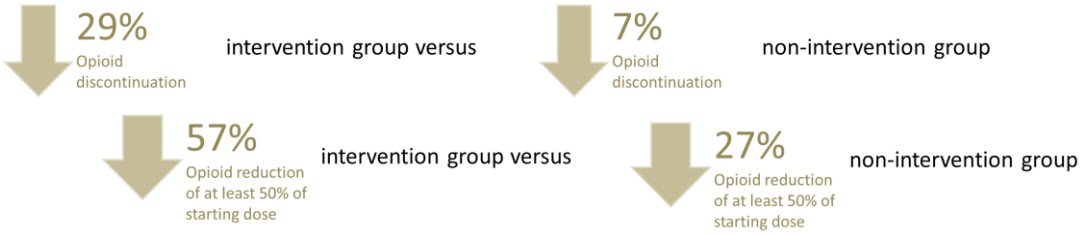
Implementation and sustaining this community pain group for the last 6 years has resulted in demonstrated reduce high dose opioid use within the PCN, demonstrated by the Open Prescribing Data:



The PCN has established a system for regularly monitoring opioid use and has been able to maintain this as a focused area for improvement as the reduction in high dose opioids motivates the team through this visible improvement outcome.

Since the group was established in 2018, the evidence supporting biopsychosocial approaches to chronic pain self-management has substantially increased.

Sandhu, Booth & Furlan *et al.*, (2023) study found that in people with chronic pain due to non-malignant causes, compared with usual care, a group-based educational intervention that included group and individual support and skill-based learning significantly reduced patient-reported use of opioids, but had no effect on perceived pain interference with daily life activities:



Similar results have been replicated through the Cornwall Connected by Pain project, supported by ImagineIF.

In 2022, the Medicines Safety Improvement Programme (MedSIP) launched the *Reducing Harm from Opioids in Chronic (Non-Cancer) Pain* workstream, utilising a whole system approach to reducing harm from opioids developed to support local approaches to helping people live well with chronic non-cancer pain – this approach was already being utilised in BSW through the pain group innovatively developed at North Wilts Border PCN in 2018, which has since been adapted/adopted more widely.

To support this approach, Health Innovation West of England (HIWE) hosted educational webinars which are available to watch back online and funded 155 training places with provider Live Well With Pain – a programme developed by a GP to train practitioners in self-management techniques so that they can offer their patients alternatives to pharmacological management. This was identified as a need when 69% of Primary Care practitioners in BSW responded to a survey at the start of the workstream, stating that *'they had little to average confidence in explaining non-medicinal self-management techniques for managing pain'.*

Practitioners from North Wilts Border PCN attended this training offer, as well as a subsequent event exploring the use of coaching conversations to support patients in reducing or stopping opioids, utilising the skills and techniques that these opportunities have provided to develop the group discussions/content. They have continued to work with HIWE to support other practitioners across the ICB and wider locality in developing pain groups/café's and offering peer support.

Additionally, the PCN have been supported through the development of a resource library for both practitioners and patients, which will continue to be hosted by HIWE.

Hope House Surgery (within BSW) have been actively supported by Rachel in setting up and developing their own Pain Café pilot, (which is currently in evaluation phase) as the practice explores funding opportunities to sustain the initiative.

To increase resilience of the community pain group and promote future sustainability one of the PCN Health and Wellbeing Coaches has completed the Live Well With Pain Course (funded by HIWE) and has begun supporting sessions throughout the year.

North Wilts Border PCN are exemplary both regionally and nationally, as the group continues to be directly funded by the PCN (covering the running costs of village hall hire, administration to prepare for the monthly groups, funding external speakers/trail activity sessions and providing backfill for the team to facilitate the group).

The PCN practitioners have shared their experience as one the longest running pain groups with others at a practitioner-led community of practice, which commenced in December 2024 to provide peer support opportunities, as well as collaborating with the BSW Medicines Optimisation team to

ensure that reducing opioid use remains a safety priority, by being a core member organisation on a system level steering group established during the programme.

Health Innovation West of England

North Wilts Border

in association with Health Innovation West of England

North Wilts Pain Group

Project lead: Rachel Dolman
Senior PCN Clinical Pharmacist

Background:
Community pain group founded in 2018 to support general practice with patients diagnosed with Fibromyalgia, due to its success the group increased its capacity to include all types of chronic pain including Long Covid.

- ❑ Wide demographic of patients; typically female, 40yrs +

Need:

- ❑ GP's understand chronic pain patients are challenging due to the personalised nature of their conditions
- ❑ Requirement of multiple appointments
- ❑ Complex solutions / management
- ❑ Effective medication is limited
- ❑ GPs requested this service to be initiated across the PCN

Next Steps: To increase resilience, PCN Health and Wellbeing Coach has completed the LWWP Course (funded by Health Innovation West of England) and has begun supporting sessions throughout the year. The maximum number of attendees able to attend the village hall setting is 60

https://www.malmesburypcc.nhs.uk/chronic-pain-support/

Solution:

- ❑ Direct invite via the GP or other clinician either verbally or using the local messaging system
- ❑ Patients requiring an (SMR) with a pain management pharmacist are tasked directly to Rachel Dolman
- ❑ Opioid reduction plan discussed and implemented where appropriate

Costs/Resources:
Running costs include:
village hall hire, preparing and organising sessions, funds for "speakers" and TIME

Challenges:

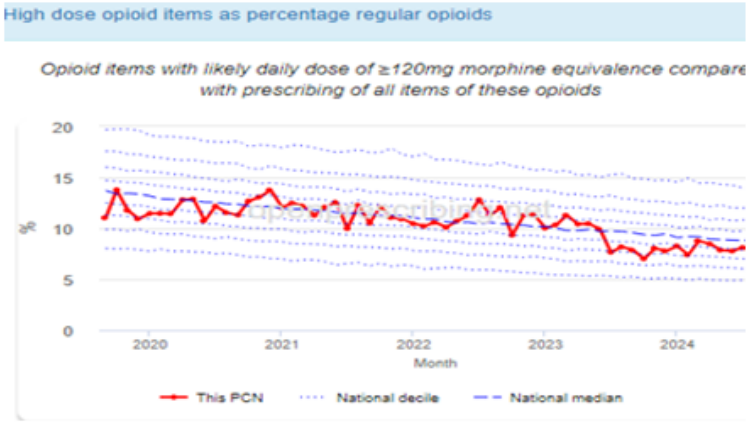
- ❑ Patients buy in - Not everyone feels "talking therapies" is the solution
- ❑ Patient expectations - Medication to manage their conditions
- ❑ FBM prevalence in men is 20%, therefore difficult to establish men within the setting

Lessons:
Conditions for success:

- ❑ Project lead with enthusiasm & drive
- ❑ Supportive practice management team providing the opportunity to experiment

Recommendations & advice:

- ❑ Positive energy to drive the project and influence others
- ❑ Patient involvement – what are their expectations and needs from the group



Impact:

- ❑ Open Prescribing Data – reduced number of opioids prescribed across PCN
- ❑ Positive PSQ feedback:

Top benefits highlighted: *"Information sharing, "Presenter sessions well organised" & "Sharing ideas and experiences"*
70% leave feeling happy and likely to recommend to a friend
60% connecting outside of the organised group

- ❑ High opioid prescribing reduced, regular monitoring and focus area across the PCN
- ❑ Focusing de-prescribing opioids in areas most needed, addressing health inequalities
- ❑ GP's happy with referral pathway and the ability to signpost patients for additional clinical and holistic support
- ❑ Informed using resources Chronic Pain Support - Malmesbury Primary Care Centre

BSW Hope House Practice – Pain Café

The Hope House Practice team were the first to initiate a pilot pain group within the West of England MedSIP programme. A conference-style poster of the initiation of their pilot is shared on the following page, with the full poster available online.

The team have shared their learning at throughout their pilot at West of England Polypharmacy Community of Practice (CoP), supporting alignment of the MedSIP programme and Polypharmacy programme through structured medication reviews alongside the biopsychosocial approach that initiation of the pain café has promoted.

Safia Latif, Clinical Pharmacist presented in the first 20mins of the CoP titled 'Initiating Change' in March 2024, with an update shared in the 'Delivering Change' follow up session in December 2024.

Safia has also provided the below evaluation summary.

Hope House Surgery Pain Café Evaluation

Executive Summary

The Pain Cafe was established to support patients living with chronic pain in an area with high opioid prescribing rates. It aims to provide resources, reduce isolation, and enhance patient engagement with well-being services. This evaluation assesses the impact of The Pain Cafe on patients, the broader community, and health service interactions.

Program Objectives

- Provide support and resources to patients living with chronic pain.
- Empower patients to 'live well' with pain by increasing knowledge and confidence.
- Decrease reliance on general practice and surgery interactions.
- Optimise pain treatments, including deprescribing inappropriate medications.
- Increase engagement with well-being services.
- Decrease patient isolation.

Evaluation Methodology

- **Participants**: Patients diagnosed with fibromyalgia, ages 34-82 (average age: 61).
- **Data Collection**: Patient feedback (testimonials, questionnaires), attendance records, informal discussions, third-sector input, and engagement metrics.
- **Time Frame**: Evaluation conducted over one year with monthly sessions (February 2024 – 2025)

Patient Engagement

- **Participation**: High levels of engagement observed during sessions, with active participation in discussions and enthusiastic responses to topics. Patients created their own WhatsApp group to meet outside of the café, including planning their own Christmas meal.
- **Questions Raised**: Patients frequently asked questions about pain management strategies, showing a keen interest in learning and sharing experiences and contributed to planning topics for the café.

Outcomes and Impact

The Pain Café has already demonstrated significant benefits to both the surgery and the local community:

- **Immediate Patient Engagement and Service Collaboration**
  The café has attracted consistent attendance, with 13 patients attending regularly. These participants have gained a better understanding of different non-clinical ways to manage their condition. This engagement has fostered stronger relationships with a variety of local services, creating a network of support for those in need.

- **Support for Isolation and Movement**
  One of the most significant impacts has been the reduction in patient isolation. Regular attendees have benefited from group activities, such as the seated dance class, which was attended by 12 patients. This focus on movement with the Active Way helps to improve physical health, while also providing a social space where patients can share experiences and support each other. In addition, a variety of well-being services, including group walks, bike rides, and 1:1 consultations, have further enriched the program.

- **Collaboration with Local Services**
  The café has led to the participation of multiple different local services, fostering a sense of community and mutual support. A strong partnership with ActiveWay has opened opportunities for patients to engage in different movement-based activities, while also helping organisations meet their contact goals.

- **Accessibility and Staff Well-being**
  The café has enhanced accessibility to services for patients through the surgery. It has also increased engagement with the Patient Participation Group (PPG), helping to build confidence in the surgery and improving staff job satisfaction. Furthermore, the café has prompted changes, such as the introduction of "elephant feet" in the upstairs waiting room, which has contributed to a more supportive and inclusive environment.

- **Impact on Local Infrastructure**
  The café has played a role in advocating for improved local infrastructure, such as the installation of more dropped curbs to make the area more accessible for those with mobility issues.

- **Sustainability and Broader Impact**
  The café has allowed patients to form their own self-sustaining groups, further extending the support network beyond the monthly sessions, including planning their own Christmas meals and meet ups. Resources created through the café will be shared across the surgery and clinical services, helping to reach a broader patient base and enhance the overall impact of the initiative.

Outcomes and Impact

1. **Patient Feedback**
   - **Satisfaction**: Attendees reported positive experiences, with many highlighting the supportive environment decreased isolation
   - **Perceived Benefits**: Participants noted a better understanding of available resources.
   - **Suggestions for Improvement**: Requests for additional topics and guest speakers were made.

2. **Social and Psychological Impact**
   - **Reduced Isolation**: Participants reported feeling less isolated and more connected to peers, with many forming support groups outside of the cafe.
   - **Psychological Wellbeing**: Many attendees reported improvements in mood attributed to peer support and shared experiences.

3. **Changes in Pain Management**
   - **Adoption of Strategies**: Patients began to adopt new pain management strategies learned during sessions, including mindfulness, breathing techniques and movement exercises.

4. **Uptake of External Resources**
   - **Engagement with Local Services**: A significant number of patients signed up for activities like seated exercise classes and other programs offered by The Active Way and local organisations (e.g., dance classes, breathing workshops).
   - **Increased Familiarity**: Patients became more familiar with and trusting of local services, enhancing their willingness to engage with additional resources.

Challenges and Lessons Learned

Challenges Faced
- **Attendance Variability**: Fluctuations in attendance posed challenges for session planning. Reasons included half-term and illnesses. Additionally, the time of the session was noted to be difficult for many participants as it was too early (10am).
- **Data tracking**: very difficult to get quantitative information. Appointment history was only available for the last year so couldn't compare to the year before. Variability of patients at each café make it difficult to see impact on prescription/medications.

Lessons Learned
- **Tailored Themes**: Future sessions should focus on themes that cater to specific interests of attendees.
- **Alternative Scheduling**: Offering sessions at different times may increase participation.

Recommendations

1. **Future Pain Cafe Sessions**
   - Introduce new themes based on participant feedback and interests.
   - Encourage greater patient involvement in selecting topics and formats.
   - Consider alternate times/dates
   - Consider different cohort of patients as this cohort seems well-connected and could be self-sustaining.
   - Discuss with current patients how to move forward and create their own meet ups.

2. **Sustainability and Scaling**
   - Consider expanding to include other chronic pain conditions and/or targeting different patients
   - Develop a framework for ongoing funding and resource allocation.
   - Allow patients to progress from pain café to 6-week LWWP course starting in May 2025.

3. **Further Collaboration**
    - Explore partnerships with mental health charities, dietary experts, and additional community organisations to enrich the program and provide holistic support.

Conclusion

The Pain Cafe has effectively supported patients living with chronic pain, fostering community engagement, increasing awareness of resources, and enhancing psychological wellbeing. Continued adaptation and collaboration will be vital for sustaining and expanding the program's impact.

Health Innovation West of England

Turning Down the Volume: supporting patients with chronic pain

A Pilot Programme

Emma Clarke & Safia Latif

Hope House Surgery

Introduction

The Chronic Pain Consultation: limited time to address patient needs/frustrations, limited options, long wait time with referrals, increasing medications and side effects.

What We Know:

Chronic Pain is an area of need: It has been estimated that chronic pain accounts for 4.6 million general practice appointments in the United Kingdom each year.[1]

Affects overall well-being: See the Pain Cycle[2] (below) Pain treatment should be multidisciplinary and include nonpharmacologic treatment.[3] Several trials looking at therapies such as physical therapy, CBT, massage, acupuncture, and mind-body practices (yoga, tai chi) for treatment of chronic pain show sustained improvements in pain and function that persist after the therapies were delivered.[3]

The Pain Story: patients need to feel acknowledged and heard. This is difficult to do in a short consultation, however it is an integral part of creating change. It is the platform from which their journey can start.

Aims

Empower patients to turn down the volume on their pain: increase patient's knowledge, confidence and support. To understand how to 'live well with pain' and improve their quality of life.

We hope that this will lead to:

-optimisation of pain treatment/medications
-decrease in GP surgery interactions
-deprescribing of any inappropriate meds/opioids
-increase engagement in community well-being services
-less reliance on GP – patient control

Hope House Surgery

How it Started...

Live Well With Pain (LWWP): organisation created by healthcare professionals working in pain management to promote self-management approach. Made up of many patients with lived experience as well.[2]

Ten Footsteps: training for practitioners and access to resources to provide a patient education course.

Getting Started:

Need: as a social prescriber and pharmacist it was clear this programme would be beneficial in our area (health inequalities, access, increased opioid use/misuse). The surgery is located in an area with a high rate of deprivation.

Support: GP Partnership/surgery was already looking to find ways to address chronic pain, including the hiring of ARRS staff like first-contact physiotherapist. Received good support/encouragement from partnership/management. ICB/HIN offered to support us to plan a way to offer this. As we researched other models of implementation across the country – Sue Crisfield offered a lot of valuable knowledge and experience.

Obstacles: funding, use of staff time, patient participation and commitment

'Final Product':

Pain Cafes: Realised that the programme we created had to revolve around finding a way for patients to tell their story. After considering 1:1 appointments, we realised group consultations (monthly pain cafes) would be the most efficient way to do this. Sue Crisfield already doing this model and really helped us for this idea. Focus on support, minimal education, offer resources as needed.

LWWP Patient Education Course: after attending monthly pain cafes, patients who express interest offered to attend six-week course learning about the 'Ten Footsteps'.

Funding: We applied for funding for 1 year of monthly pain cafes and 1 six-week course including backfill for social prescriber hours and 1 additional admin. Received funding for 6 months from the RUH/HIN as a pilot programme. Additional applications sent to the Sperring Trust, the co-op, Dragon's Den and Radstock council

Patient Cohort: fibromyalgia patients (185 pts) who were able to attend the surgery. Excluded patients with cancer pain; Due to limited space and availability, this was a good size cohort to start with.

...How it's Going

First Pain Clinic: 15th Feb 2023.

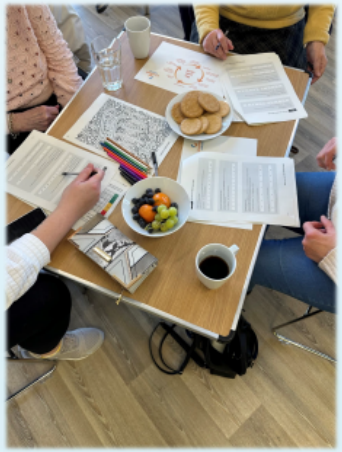
What went well:

Attendance: 23 patients attended. Using the Accurx florey system we were able to text patients a link to RSVP. We had responses from ~25 patients who couldn't attend with reasons why they couldn't come. These reasons mostly centred around not being available at that time.

Engagement: patients were immediately engaged and shared that they were very grateful for this space and opportunity to chat to others– isolation is a key issue. Some things that helped this: inviting patients from one cohort (fibromyalgia) helped patients engage as well and setting appropriate patient expectations by sending them information before.

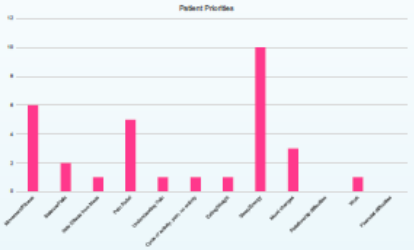
Set up/timing: small tables set up in a café format, tea/coffee/refreshments provided. Two hours (30 mins set up/pack up, 1 hr for café) was sufficient time. Hosting event at the surgery made it easy for patients to access and they felt comfortable approaching us to ask questions.

Future Considerations: moving forward we can consider alternate timings, online meetings, reaching out to patients in other ways (phone/letter), consider volunteer from our Patient Participation Group to help with refreshments, addressing topics raised in feedback forms



Proposed Evaluation

Feedback Forms: patients asked to fill out feedback forms at their first pain café attendance. These forms ask patients to describe their pain, knowledge/confidence on managing pain, and prioritising the issues they feel are most important to them. After our first café the following priorities were identified based on feedback forms – sleep, pain relief and movement being the top three



Metrics: additional evaluation will include (but not limited to) GP surgery interactions before, during and after the pain café; engagements with community wellbeing services; medication usage.

Moving Forward

We look forward to continuing our pain cafés and making improvements and adjustments along the way. We hope that we will have 6-12 committed patients to host our 6-week LWWP education course this year. Additionally, we would like to be able to continue and expand this initiative. We hope that this pilot will make clear the need for programmes such as these and inspire others to consider it in their areas.

Acknowledgements

We would like to thank Gill Travers and Health Innovation West of England; Hope House partnership, management and staff; Sue Crisfield, and Lucy Lightfoot and the BSW ICB for all their support.

References: 1. Belsey J. 2002: Primary care workload in the management of chronic pain: a retrospective cohort study using a GP database to identify resource implications for UK primary care. Journal of Medical Economics 8, 39–50. [Google Scholar] 2. Live Well With Pain. 2024. Ten Footsteps programme – Live Well with Pain 3. Dowell D, Ragan KR, Jones CM, et al. CDC clinical practice guideline for prescribing opioids for pain—United States, 2022. MMWR Recomm Rep

BNSSG - Northern Arc PCN Pain Café Reporting (Evie Day and Roxi Beville)

Case Study Part 1: March 2025

Pain Cafe Set Up

Identification of needs and planning

What was happening?

In-person group support was identified as something that could be helpful. Patients have been able to express that they struggle with motivation and capacity to do things at home, to use online resources, and to go out alone. Individuals can be scared to make physical changes and/or may not know how, but they do not want to carry on living the way they are living. There is a holistic ME/Fibromyalgia group in our locality, with content that overlaps with chronic pain management, but this is not suitable for all patients.

Initial steps to change

We discussed this need in our hub meetings and identified that Pain management training would be beneficial for my colleague Roxi (Social Prescriber) and I so that we are better able to support this cohort.

We were able to get this training through Health Innovation West of England, including three online sessions with others, and a full day in person Group Facilitation training. This was very beneficial to understand multiple levels of supporting this cohort, including but not limited to:

- How individuals with chronic pain can feel day-to-day
- Different experiences that have impacted them and/or caused their pain initially
- Different tools that might be helpful
- Approaches that can be unhelpful
- How to support individuals in a group setting
- Evidence for how and what is most effective to support this cohort overall

We felt strongly that this group programme could benefit our patients and started to discuss with the relevant professionals within our practice. We identified that this aligned with the need and current work to reduced opiate prescription in our practice.

Community of Practice

We were invited to a Pain Café Community of Practice, to discuss running a group for individuals with chronic pain. This was such a helpful experience to learn from other Healthcare professionals, both medical and non-medical coming together – coaches, pharmacists etc. We were able to discuss how we can support a struggling cohort to effectively manage their pain and make steps forward for their physical and mental health. We were able to learn how to set up a Pain Café for our patients.

The Pain Café – current progress

Funding approved!

We are very grateful to have been approved funding from Health Innovation West of England.

This funding will allow us to run 8 sessions, including an evaluation session at the beginning and at the end to understand what has helped patients and what they might need moving forward.

It is hoped that we will be able to carry on providing the support for patients beyond this pilot, however at the least we will be able to offer an Evidence based programme for up to 20 patients. This holistic self-management support will give patients tools to support themselves, as well as connections to others going through similar experiences, and access to specialists who we will invite to sessions.

Who?

We have selected patients from our current wellbeing hub referrals and called them to assess their interest and needs. This includes adults with chronic pain who can come to a group face-face-face, wanting to access holistic support for pain management.

Where?

We have identified a few community spaces that would be accessible to patients and met their providers to discuss availability. We are waiting for final patient confirmations.

When?

We will offer 2-hour sessions, monthly, due to evidence this may be most beneficial. We will review this with patients in the initial taster session, and midway through (S4).

How?

Roxi and I will facilitate the Pain Café using the Tens Steps Programme resources: Ten Footsteps to Living Well with Pain - Live Well with Pain

We have also invited specialists to support in some sessions, including but limited to: Pharmacist, Music and movement specialist, Sleep specialist, and Nutritionist.

8-session Plan:

Session 1 (Taster and evaluation):

- Meet and greet – name, favourite food
- HWBC check in – Evaluation of needs
- Explanation of group and options for sessions moving forward – 10 steps
- What do you want from this group? Talk to person to left and write post its with option to share
- Activity/game - ice cream cards (3-5 scoops that make up a good day!)
- Next time we will…look at 1 of 10 steps and have a specialist supporting

Session 2-7:

- What's gone well since last time? What's been challenging?
- Activity – pick 6 most important of the 10 steps to people in the group and do 1 each week
- Specialist input – info or activity
- Feedback one thing you are going to take away /do for self
- Next time we will…

Session 8 (Summary and evaluation):

- What's gone well this well about group? What's been challenging?
- HWBC check in – Evaluation of needs
- What do you want moving forward?
- Activity/game - ice cream cards (3-5 scoops that make up a good day!)

BNSSG – Horfield Health Centre/ Phoenix PCN

Project proposal:

We plan to run a Living Well with Pain group to support people find ways to:

- self-manage their pain with evidenced based tools
- improve their feelings of wellbeing and confidence
- begin the process of reducing reliance on medication
- share and learn from people who also experience pain

We will do this by:

- Running and facilitating a monthly meet up group at a local community organisation (currently Lockleaze Neighbourhood Hub space): we will discuss frequency at out taster session to assess if people would prefer a more frequent meet up time
- Asking what's important to participants to help co-author agendas: this will be part of the taster session and Session 1 (including in the review process of every session)
- Adapting the 10 footsteps programme resources to suit the needs of the group
- Inviting specialist practitioners to share ways to help manage pain from movement to food and green spaces
- Making it fun, open, friendly, inclusive and adapting for a range of physical and mental health needs

The aim is to run the group for 6 months: running 8 sessions (1xtaster session, 6 Living Well with Pain, 1xevaluation/what's next session). Our research shows from 2 evaluated projects that monthly meetings were more manageable for participants and had greater attendance than more frequent meetings. We are open to changing frequency should our group prefer it. We may also run two groups if we have large numbers wanting to sign up. We may also split groups based on demographics if appropriate.

Project Timeline

1. October: Sandra Whitehouse shares list of patients and Saba and Grace reach out to GPs with patients to refer to create a list of 30-40 invitees
2. October: Health & Wellbeing Lead calls everyone and finds out who may be able to attend a taster session, share more information
3. November: w/c 4th November: Taster session with evaluation to help co-author topics/themes. Coaching questions about importance and confidence. Discuss days/times best for grp
4. November/December: First session picking up themes
5. Sessions 2-6: January to May: same day/time every month may shorten frequency depending on feedback. Specialist practitioners to be invited (movement coach, CBT practitioner, forest therapy & green spaces, art therapy, mindfulness, pharmacist session, music therapy)

6. June: Final evaluation session: repeat evaluation and ask about what's next. Could be a peer led group in discussion with LNH for funding.

Benefits for the PCN

Support the Pharmacy Hub's goal of reducing reliance on opiates and to offer an adapted 10 footsteps programme for those who cannot access resources online and/or need face-to-face support.

Extend the pain management offer to include evidence-based personalised, psycho-social-bio approach to improve patients' self-management of their pain to increase levels of confidence and feelings of wellbeing (this includes adapting resources to meet need, co-authored agenda-setting, coaching tools, inviting external practitioners)

To connect patients with community services, practitioners and resources. Improve engagement with already existing services.

Addressing Health Inequalities

We are offering a personalised approach to help address those needs of patients living with chronic pain that have barriers to accessing the current 10 Footsteps programme that is delivered online. In our taster and first sessions we will listen and respond to the patients' experiences and draft a plan that addresses their needs. This will include adapting tools and resources proved by the 10 footsteps programme to meet literacy and access requirements.

Part of the group's sessions will include inviting specialist practitioners to offer access to shared information not currently offered in the NHS or this area. For most of our patients, accessing this type of practitioner and session would not be affordable. We will also offer trips to visit venues that offer therapeutic support specifically for pain management to help extend people's comfort zone and ability to be more independent. This can be followed up with assisted public transport support if the main barrier is fear and lack of experience.

Online and geographical access to services is a major difficulty, so providing high quality care locally to them, in a location they are familiar with would benefit them greatly. It also means their transport costs are minimised.

Health Innovation West of England

Live Well with Pain Group Phoenix PCN: North Bristol

Case Study

Background
The Health & Wellbeing Lead, Saba James, and the Wellbeing team at Horfield Health Centre worked alongside their lead Pharmacist, Sandra Whitehouse, to create a supportive group for patients who had limitations accessing the online '10 Footsteps' programme. These limitations included dyslexia and poor literacy, social anxiety and/or other difficulties accessing community services.

All staff involved completed the '10 Footsteps' training. The list of possible participants were selected by the pharmacists at their medication reviews after discussing how they were self-managing their conditions. We decided to invite people regardless of their diagnosis, based on their experience of living with chronic pain.

The Group
After pre-group phone calls and taster sessions, the established group is now 9 women who consistently attend the sessions living with a range of conditions from Fibromyalgia, peripheral neuropathy, Psoriatic and Rheumatoid arthritis – all the women have lived with chronic pain for at least 12 months. The group are all local to North Bristol with an ethnic mix of three women of colour and six White British women.

Our Partners
The local community centre 'The Hub' provide their space at the community rate for our group. They also have staff on-hand to support and offer signposting to events at The Hub. Health Innovations West of England funded the cost of the group being run in the community alongside the cost of staff, resources and visiting practitioners.

The Population
Horfield Health Centre's catchment area includes pockets of deprivation alongside more affluent communities. Our target group was those people who do not have easy access to services alongside a range of wider social issues impacting their ability to self-manage. The purpose of the group is to raise awareness of the Bio-Psycho-Social model of health creation to support people to live better with their conditions. None of the three men who were invited attended and were followed up by our male health coach. We discuss this in the Lessons section.

Health Innovation West of England

Live Well with Pain Group

Need

The group was established to help people:

- discover ways to help self-management of chronic pain to reduce pressure on GP and pharmacist appointments.
- to be less reliant on medication and medical services.
- to increase social contact and access to the community (reducing isolation).
- to share skills (alongside pills) as a way of living well with pain.
- explore what a bio-psycho-social model of health creation feels like in practice.
- share their experiences and feel heard and supported.

Solution

Once we decided to create a group to meet the need we followed these steps:

PLANNING: three months before launch

Oct-Dec 2024

- Regular contact between Lead Pharmacist and Health & Wellbeing Lead to discuss aims/planning.
- All staff involved trained in the 10 Footsteps programme to increase knowledge, skills and confidence.
- Group Lead booked on the Facilitator training to learn about the Pain café model with 'Imagine If' for tips and tools.
- Created a list of participants (35 people) to call with input from Pharmacists.
- Applied for funding for venue and practitioners.
- Contacted community practitioners to ask if they would like to be involved and their fees – discussed dates/timings.
- Booked in dates with venue and confirmed practitioners.
- Created session plans with the wellbeing team's input.
- Reviewed resources and content we could print and share.
- Purchased a work phone for this and future groups for WhatsApp comms.
- Booked 6 sessions and 2 taster sessions over 7 months
- Completed risk assessments/consent forms/equality assessments.

Implementation

Once we had the group and the venue booked with an outline of session plans and resources, we then focused on the following actions.

- We phoned all participants to discuss the group and invited to a taster session (informal style chat).
- We created lists of resources required for each session (mainly used flipchart paper, some videos, birdsong as the background noise, tea & coffee).
- We created a safe space by establishing a group agreement and identifying what people needed to feel comfortable to attend – remind everyone at the beginning of each session.
- Asked participants which were their favourite topics from the 10 Footsteps programme they'd find most interesting. Top three: Sleep, Nutrition, Acceptance.
- We decided to use the Health & Wellbeing Check Tool as the evaluation (participants given a copy of theirs and will follow up at the end)
- We provided blue envelope wallets to collate handouts and a bound notebook for people to take notes from the session if they like writing.
- We have one lead and at least one support per session
- The sessions run monthly with key themes and a WhatsApp group to share info and links
- The Facilitators review the content the week before in a short meeting to discuss content.

Health Innovation West of England

Live Well with Pain Group

Challenges

The biggest challenge was encouraging people who were nervous about groups or had social anxiety to attend. It took time to build rapport and consistent communication to maintain attendance.

We felt it was important to run the pilot group outside of the GP Practice, in the community. This space was non-medical and demonstrated that our health and wellbeing is not just a medical matter – how we live, socialise and understand ourselves is essential to our 'health creation' (our health wealth).

We also discussed careful use of language as a team. We wanted to validate people's experience and not present ourselves as experts – we were there to facilitate the flow of the session and encourage 'spiralling up' conversations with open questions. Saba James and Matt Mulligan ran sessions in their specialist areas on sleep and nutrition – inviting people to relate the information to their lives and what they wanted to follow up and action.

We felt it was important to help build social connections initially: we included quizzes, ice breakers around the topics we were exploring and asking people how they genuinely are feeling today.

Lessons 1

Gender: None of the three men attended despite saying they were interested on the phone. In addition, we also notice that a significant number of referrals into social prescribing and health coaching are for females (nearly double the number of males). We are following this up as a research project to dig a little deeper into (1) men living with chronic pain and if a men's group might be suitable and (2) referral trends by clinical staff (who is referring in, for what reasons and how unconscious bias and social norms alongside other factors might influence this).

Planning/spontaneity balance: Although planning is essential and the pre-project set-up does require focus and time, it is also important to listen to the group and let go of any plans in the moment to follow where the groups is going. Asking people: I'm noticing we're talking about X now, is this something you want to spend some time on or shall we return to Y.

Appropriate participants: one of our participant's early-on in the taster sessions struggled to listen and would dominate the conversation without following the group agreement, even with careful facilitation. We decided to invite them to our Connect café instead to meet their needs and those of the group.

Lessons 2

Small turnout: Don't be concerned if the numbers drop every now and again. We had a very small group of 3 and it proved to be beneficial for the participants. We shared the information on WhatsApp, so it had a wider reach.

Numbers: Next time we start a group, we will invite a higher number of people – we started with 35 people and now have a core group of 9 (15 on the list). Some of the people who didn't attend this time have said they'd like to attend the new group from September.

Mindful of people's physical needs: we had someone attend who hadn't left the house for years and required a lot of support. She decided she didn't want to continue as she found it very stressful – we referred her to our social prescribing team instead. We also invited people to bring cushions, hot water bottles, heated pads and things they can easily bring to help them feel more physically comfortable. We also have the Community Centre turn the heating up to high, especially in winter.

Regular communication: We introduced the optional WhatsApp group to maintain contact with the participants. With busy lives we found people can forgot sessions even though they want to attend.

Health Innovation West of England

Live Well with Pain Group

Impact

Our group is in its infancy – we have had 2 taster sessions and 3 groups. We do not have any final evaluative data to provide about the user outcomes and experience. What we do know:

Participants

1. Participants are enjoying the group – they are opening up more about their experiences and supporting each other in the sessions with guidance and empathy (topics from sleep to sex have had us all laughing and listening).
2. Participants are following up the signposting in the sessions – one person is now attending the Good Boost water exercise classes locally with another attending the diabetes management programme and attending community centre events.
3. Participants are in touch with each other between sessions socially to offer support and meet up.
4. Participants are curious about non-medical approaches – taking down tips and tricks from each other and the 10 Footsteps.
5. One person said she already feels different – she said her rheumatology nurse noticed a change and commented on it. She is smiling in our sessions and feeling more confident. She is also considering if she can start volunteering as a way to get back to work. We didn't realise the impact of being able to signpost as well as run the groups. There is potential to develop this further.

Staff / service

1. The success of the early stages of the pilot means we will roll-out Live Well with Pain groups across both practices of our PCN, including a Young Person's group (19-29). We're also extending the Live Well With series to launch a COPD group.
2. There is a more joined up approach between the GP practice, pain management clinics and the community support group.
3. We have been in touch with the Pain management team and attended some of their online sessions to see how they work with people to complement what they do. We have one of their practitioners running a session on Acceptance with the group.
4. Long-term we can offer patients more holistic, person-centred care for pain management working alongside the pharmacists and complementing pain clinics.
5. We can have a greater outreach by having two members of staff supporting 10-15 people in the afternoon, rather than 2-3 1:1 sessions.

Health Innovation West of England

Live Well with Pain Group

COSTS *(see next page for the breakdown of the costs)*

We wanted to trial a funded group to assess how the community venue, additional resources, invited specialist practitioners and additional staff attendance were integral to the success of the group.

Our assessment thus far is that we could create a community feel in the GP practice with some of the sessions in the GP practice's space and other at community spaces. Rather than paying for people to run sessions, we could ask already existing leaders from funded social prescribing groups to run 'taster' sessions as a feeder into their groups. We would need to speak to our PCN to find out if there are any funds for a small investment in a community space alongside the GP Practice. It has been beneficial to have colour printed copies of handout with additional stationery. Long-term we wouldn't be able to provide that without funding.

Next steps

Our focus is on:

1. Completing the cycle of the 6 group sessions with the last one in July and reviewing the Health Check data and qualitative feedback forms. We will introduce a before and after evaluation at our next group around knowledge, skills and confidence in self-managing chronic pain.
2. We have additional funds from a recent film project with Health Innovations West of England and will put that into a summer event with the group – there is a Forest Therapy session at Leigh Woods which we will ask if people want to attend. Leigh Woods also runs seasonal women's health projects. Introducing the group to a green space outside of the immediate area may increase confidence to travel further a field. It also reinforces the value of green spaces for our health wealth signposting to local events.
3. We are starting a Live Well with Pain for young people after Easter. We received feedback from people under 29 that some of the events they have attended had not be targeted at their age group. We will also assess if a one-off combined group in June with the current group and the young person's group may be beneficial for inter-generational support.
4. We are assessing how much of our Health & Wellbeing Service (made up of health coaches and social prescribers) should aim for 1:1 support and groups sessions. We are reviewing with the clinical teams across our PCN practices.

Health Innovation West of England

Live Well with Pain Group

COSTS			
Input(s)	**Unit(s)**	**Cost (£)**	**Notes**
5 specialist practitioners – 1 hour @ £100 for 60/90 mins	5	500.00	
Room hire 8 bookings for 2 hours (1 taster, 1 evaluation, 6 sessions)	8	400.00	
Cost per session **Including 2 x staff @ 2 hours (rate 1: 314.20 ph/rate 2: 17.95ph)** **On-costs @ 30%** **Refreshments**	8	 507.00 152.00 20.00	
IT equipment in room	8	160.00	
Admin time to engage patients before and follow up issues/queries (rate: £12 ph) **16 hours includes pre-course engagement with phone calls, evaluation collation, support during the month, following up patients who may require additional support, evaluation and final report, newsletter updates**	16	192.00	
Total Grant Value		**£1931.00**	

Health Innovation West of England

BNSSG – Horizon Health Centre/ Pier Health Group

Pain Cafe Pilot Project

Graham Road Surgery and Horizon Health Centre, Weston-Super-Mare

What was the problem?

Background

Chronic pain is a named health priority for BNSSG ICB and Weston, Worle and Villages have the highest rates of chronic pain in the Bristol, North Somerset and South Gloucestershire region as identified by the recent Burden of Chronic Pain in BNSSG Report (April 2024).

Chronic pain is disproportionately greater amongst those from lower socially economic regions. Higher chronic pain rates in the Weston locality are associated with higher levels of deprivation indicative of greater health inequalities within this region. Chronic pain is a major health and societal burden in terms of years lived with disability and the economic impact due to health resources used and work absenteeism.

There has been a longstanding lack of secondary care pain service provision in Weston-Super-Mare. Until 2022, the nearest Pain Clinic Service was in Bristol. Consequently, accessing appropriate treatment via local pain services for the Weston-Super-Mare population has been a significant barrier. Local chronic pain patients have often been unable to travel to Bristol for pain clinic appointments. In addition, historically a high number of locum GPs at local practices has led to increased prescribing for chronic pain.

Consequently, the Weston population has suffered from a lack of access to secondary care pain services and community-based support causing a considerable health inequality. Progressive pain-related functional impairments and overreliance on dependence forming medications have created further health inequalities, long-term physical and mental health disabilities and co-morbidities.

Placing the immense impact of chronic pain within the local context, latest figures from BNSSG systemwide dataset show that there are 6,377 people in Weston, Worle and Villages PCN who have chronic pain and (a) anxiety/depression, or (b) are high-intensity users of ED, or (c) are on both opioids and gabapentinoids.

These disproportionately high rates of chronic pain and opioid use are reflected in clinical practice. Since January 2022 Dr Krisztina Kenesey, Consultant in Pain Medicine UHBW, has led a Pain Clinic service (2 days a month) at Weston General Hospital. Dr Kenesey and colleagues have identified high levels of opioid prescribing in this region. Analysis performed by Helping Health in 2024 shows that opioid prescribing has increased over the last nine years in all practices within the Weston locality. Opioid prescribing rates are in the fifth (highest) quintile compared to the rest of the BNSSG ICB and across England.

High levels of polypharmacy are a particular issue, as 30% of those with chronic pain in Weston, Worle and Villages PCN have 10 or more repeat pain medication prescriptions, compared to only 2.1% in the BNSSG population as a whole. Other highly prescribed medications often used for pain are gabapentinoids, antidepressants, benzodiazepines which, like opioids, are dependence forming despite providing limited analgesic benefit.

Therefore, the challenge is to reduce the progression of disabling chronic pain and high levels of opioid poly-prescribing within the Weston locality.

Need

Graham Road Surgery and Horizon Health Centre (Pier Health Group Ltd.) are Deep End Practices (where the Indices of Multiple Deprivation are used to rank practices with the highest proportion of patients living in 15% most deprived data zones.) Compared to the most affluent populations, deprived populations in the UK have increased levels of multimorbidity, with disease onset 10–15 years earlier, significantly higher mortality rate, and an increased association with chronic pain and mental health morbidity.

GPs working in areas of deprivation experience increased demand for GP appointments and are under increased stress, with more patients registered per GP. This is not a new problem, as explained in 1971 by the late Julian Tudor Hart, in his seminal ‘inverse care law’ article proposing: ‘those in most need of good health care, are least likely to be able to access it.’ Despite significant efforts to address health inequities and inequalities within general practice, progress has been slow.

What was the solution?

Why Pain Cafes?

Pain Cafes have been in development and delivery in Cornwall since 2020, starting during the COVID 19 pandemic. The aim of the Pain Café model is one of self-management: to help people feel more empowered to manage their pain, experience improved well-being through reduced isolation and psychological distress and greater social engagement.

Previous research states that more understanding is needed to design the most effective pain management strategies and that ‘lived experience’ is central to shaping research. There is a societal and humanitarian need for pain management to support those in pain and distress (Faculty of Pain Management 2020).

What did we do?

In order to set up a Pain Cafe Pilot Project, a team needed to be assembled within our Deep End Practices to support this work; raise awareness of the background and need for a different approach to chronic pain management; highlight the work already done in this area in Cornwall and Devon; identify members of staff who could refer into and facilitate the Pain Cafes; develop a way of identifying patients who might be suitable for a Pain Cafe approach to self-management.

Team Building and Training Within Practice

A chronic pain Lead GP was identified and the role promoted at practice level, alongside a further co-lead GP to cover both the Graham Road and Horizon Health Centre GP practice sites. Both GPs attended the Live Well With Pain (LWWP) Ten Footsteps Training organized and funded by Health Innovation West of England.

A Mental Health Lead Nurse with specialist knowledge of addictions had already written our ‘PHGL Gabapentinoid Prescribing Policy.’ Both GPs and the MH Lead Nurse worked together to raise

awareness of Chronic Pain within the practice and at PCN level, arranging teaching sessions around deprescribing and sharing the LWWP approach and resources to all clinicians, alongside deprescribing activity at a practice level.

Collaboration at PCN level

Social Prescribers working at PCN level for Pier Health and serving Weston, Worle and Villages were identified as being in a key position to support a Pain Café Pilot Project. The Chronic Pain Lead GP approached the PCN to ask to meet with and identify interested social prescribers with experience of group facilitation.

Facilitator Training

Pain café focused Facilitator Training was identified as a need for the Social Prescribers early on. The chronic pain Lead GP arranged this training using funding allocated, making contact with Community Psychologist Kevin Feaviour and ImagineIF, who had been instrumental in the set-up and ongoing running of the Pain Cafe model in Cornwall and Devon, and in building and expanding the Communities of Practice around Pain Cafes and ongoing research and development of this approach to self-management of chronic pain.

This facilitator training was made available to other members of our practice team, and included all six social prescribers for the PCN, three Mental Health Support Workers from our practice-based MH team and one Prescriptions Clerk who works closely with both GPs around opiate and gabapentenoid deprescribing.

What were the results?

Pain Cafe Launch Date

The Pain Café Pilot Project is set to launch on Tuesday 29th April 2025, running monthly on the last Tuesday of every month 13.00 – 15.00, for one year with the aim to invite twenty participants from across both practices.

The For All Healthy Living Centre (CIC) has been identified as the best venue for the Pain Café Pilot Project and a room booked for all the Pain Cafes over the year that is accessible and can support the grassroots community and socio-psycho-bio approach that a Pain Café needs to be successful from funding allocated.

Facilitator training completed with positive feedback:

The PCN Social Prescribing Team have all attended the LWWP Ten Footsteps training as well as Pain Cafe Facilitator Training arranged with Kevin Feaviour (see attached report and collaborative poem output.)

“I hope that the scheme works well, and we get to eventually get to signpost more of our Mental Health patents to the Pain Cafes.”

“It was good to get an understanding about how the Pain Cafe will run so that hopefully when we can signpost, we can "sell" it well.”

"Kevin was absolutely wonderful, how he delivered the session and his knowledge on the pain cafes was brilliant."

Relationships have been built and strengthened between/within our practice teams and between our practice team and the PCN social prescribers.

"It was lovely to meet and get to know the social prescribing team, understanding each other's roles better to support patients in chronic pain."

Pain Café Pilot Referral Pathway

A Pain Cafe Referral Pathway has been developed using existing 'Elemental' software for social prescribing referrals, linked to our EMIS medical record, as a secure way for the Lead and Co-Lead GPs to refer patients.

Social Prescribers are arranging first contact with patients and confirmation of attendance has started ahead of the Pain Cafe launch.

An expert patient with lived experience of chronic pain and a background in healthcare and community support group set up has been identified by the lead GP who is keen to attend the Pain Cafe Pilot and provide key feedback to the facilitators.

Next steps

Expansion of LWWP Training to Clinical Staff

Funding is earmarked to train ten clinical members of staff within Graham Road Surgery and Horizon Health Centre on the LWWP 'More Skills, Fewer Pills': this included GPs, ANPs and Clinical Pharmacists and aims to strengthen the existing team and offer cascade teaching and training to all clinical staff within PHGL and wider across the PCN.

Building a Collaborative Chronic Pain Community in Weston

The Chronic Pain Lead GP was a co-applicant along with Pier Health PCN Associate Clinical Director on a successful Type 1 RCF funding bid, with Dr Jenny Lewis who is Director of the Chronic Pain Health Integration Team (HIT) and Associate Professor in Clinical Research UWE (See attached.)

The aim of this funding application is to understand:

1) the experiences of those living with chronic pain particularly from under-represented communities and identify issues that inform meaningful health inequality research priorities for the community.

2) key challenges faced by local healthcare providers in treating chronic pain, particularly around the approach to safe and successful deprescribing.

Securing Further Funding to Sustain Pain Cafe Development

Our Deep End Practices within the above bid have secured a further £1,632 for expansion of associated chronic pain clinical staff training in preparation of an expected Pain Cafe rollout wider

across Pier Health PCN and linking with a further funding bid to pilot a Community Pain Clinic for Weston that will link with the Pain Cafes work.

The Chronic Pain Lead GP is in discussions with Dr Jenny Lewis to be a co-applicant on any Type 2 Application that follows on from the above.

What were the learning points?

i. Teamwork is key to creating momentum and buy-in from community partners.

ii. Chronic Pain Leadership is important at GP practice level.

iii. The wider practice team is important, both clinical and non-clinical.

iv. Patients want to engage with Pain Cafes.

v. Conversations about chronic pain are about building trust and relationships in care.

vi. If someone has done it well, don't reinvent the wheel, ask to collaborate!

Group Facilitation Training - Pain Poem

(Created from statements people in the group hear from people living with chronic pain)

Pain, pain - go away don't come back another day

Pain is taking over my life

A distraction from life. All encompassing

I cannot cope… it is getting me down

It stops me doing other things

Preventing me from doing what I loved

The loss of things I used to do

A type of grief

Pain can be irritating

I can't commit – I never know what I will feel when I wake up

My family don't understand

Affects my motivation and makes me feel so isolated

Isolating and embarrassing

I don't want to bump into people that knew me before the pain

Because I am embarrassed with how I am (appear)

I don't know what I can do to improve my pain

Pain is unique

Appendix 1 – ImagineIF Group Facilitation Training Pain Poem

Pain Personified: a co-produced 'what pain is to me' poem

Group Facilitation Training Participants
24th October 2024

I can't live my life as I used to
It's like a dementor sucking the life and joy out of me
A constant battle with myself
I wish someone could, for 1 minute, experience my pain
(I'm) unable to explain my pain (to others)
My pain is trapping me in a life I didn't choose.

It's really lonely and unbearable
I'm not in control
Exhaustion is my life
Constant discomfort
Isolated and uninterested
(Having to) Overcome scepticism
It's confusing and no one really understands me and what I'm trying to explain as to how I feel
A constant companion
Limiting
I'm frightened but I will try to manage.
One day at a time.
A quiet and steady determination
It's in the little things.

Health Innovation West of England

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