



Medicines: never the full picture

Dr Cathy Stannard, the UK's leading expert in opioids in persistent pain and Clinical Lead for the NICE guidelines on Chronic Pain Management (due 2020), recently published a paper in the Drug and Therapeutics Bulletin titled "Where now for opioids in chronic pain?"

In it, she sets out where the UK currently 'sits' in terms of opioid prescribing in persistent pain and explains some likely reasons for using medicines rather than other methods for pain management.

It is clear from recent studies that evidence is still lacking to support the long-term use of opioids for people living with pain. However, Cathy does not suggest that opioids are never used for people with persistent pain; more that we need to adjust our thinking around their use, accept the limitations of their effectiveness, regularly review and taper them slowly when people report lack of benefit or demonstrate harm from their use. Dr Stannard ends with a future view:

"Effective drug therapies for long-term pain are unlikely to emerge and a shared recognition by healthcare professionals and people with pain that medicines play only a small role in pain management will help to reduce harms. The goal of long-term pain management is to support the patient in living as full a life as possible despite ongoing pain symptoms and to ensure that optimum attention is given to emotional and social difficulties..."

Dr Stannard's conclusions are reflected in the concerns of many of the contributors to our newsletter - see box, opposite.

Inside this issue

Taking on tapering

In this edition, we interview Dr Sarah Parsons, whose experience of dealing with the issue of high dose opioid prescribing in her practice has much to teach us about the challenges – and the rewards – of tackling the problem head on.

Introducing an appropriate model

Psychologist Patrick Hill, in the third of his series on supporting pain self-management, looks at the importance of understanding people's existing beliefs and fears about their pain in order to support them effectively.

Outcome measures

Dr Johanna Theron reminds us that your organisation's ability to demonstrate effectiveness is only ever as strong as the outcome measure you choose.

It's a goal!

Regular contributor Eve Jenner offers her advice on supporting people to set activity and lifestyle goals.

Degrees of difference

For those considering developing a multidimensional understanding of pain and its management we ask students from Cardiff's post graduate programmes what difference it has made to their practice.

Dr Sarah Parsons is a General Practitioner working in Ipswich. She recently contacted livewellwithpain.co.uk to share her experience of addressing high dose opioid prescribing in her practice and to offer some tips for undertaking this work in time-limited appointments.

Taking on tapering

Why did you decide to take on the problem of high-dose opioid prescribing?

It was something I had wanted to do for some time. The added press coverage that opioids have received this year, as well as local and national initiatives supported my feeling that it was a good time to work on a project to introduce opioid tapering.

Lots of practitioners tell us that they know something needs to be done to tackle opioid prescribing, but it can feel overwhelming. Where did you start?

First of all, I thought I needed to educate myself and in particular, I wanted to become very familiar with the local pain clinic guidelines (West Suffolk). I use the service's opioid tapering pack and their guidelines for pain management. I was also fortunate to spend time with Chris Waters* and she was really helpful in explaining how to approach the work and in answering any queries I had about the guidelines and pain management in general.

So, once you felt your knowledge and skills were at the level you needed, was there anything else you thought needed to be addressed in practice?

The staff working as prescription clerks (issuing prescriptions) in the practice also work on reception or cover document workflow. Obviously, they are not medically trained, and their knowledge of opioid prescribing is understandably, not the same as a healthcare practitioner. I realised patients could request oramorph, for example, and as long as it was on repeat prescription, it would be issued by the prescribing clerks without question. There was an occasion when I highlighted one particular

'I realised patients could request oramorph, for example, and as long as it was on repeat prescription, it would be issued by the prescribing clerks without question'

patient could effectively have double their daily dose of opioids using the oramorph just issued in this way. The staff were quite shocked about that and it made me realise that educating all the staff in the practice would be essential for the success for the project.

Practices might have lots of people receiving prescriptions for opioid medicines; how did you decide which people to target for your support?

The PrescQipp opioid audit was useful to identify people on high doses. A list of those people was provided to the head prescription clerk and shared with all staff issuing prescriptions. This was to ensure that any early prescriptions or requests for additional opioid prescriptions were flagged and highlighted to me. This meant that we all gained an insight into where problems may be.

Initially, as I was still learning the ropes, I concentrated on people who chose to see me to discuss their pain. As time has progressed and my confidence grew, I then wrote letters to some of the people on high dose opioids. Our local opioid tapering resource pack had a template letter and information leaflets that we sent out together. The leaflets cover opioids and pain and there's also one about driving whilst taking prescribed opioids.

Most people who received a letter came in to see me and this was done in a usual 10 minute consultation. During the initial appointment, we discussed the risks and benefits of opioids, self-management techniques that can be useful for pain management as well as tapering.

No-one has declined to try tapering, but they usually want to do it under their own terms, not necessarily as per the guidelines.

* Senior Clinical Nurse Specialist, Professional Development, West Suffolk Community Pain Service

Once you have agreed that a person will start tapering their opioid dose, how do you support them through the process?

I use the opioid monitoring templates that are within our practice software (Systemone and Ardens). I add an alert to the home page of any patient who is reducing their opioid prescription. This states they are on a tapering regimen and all requests for opioids are to be sent to me. Initially, I'll follow them up weekly for 2 weeks or so, then extend it to every 2 weeks for a month, then every month. I do this using 5 minute telephone consultations, although they can take 10 minutes. I make the next appointment during that conversation, rather than asking the patient to make the appointment at another time. I aim for a 10% reduction at each follow up, so if they are tapering quicker, I will do a 2 week follow up. Some patients will want to taper by 10% a month, eg patients with a dosset box or those that are particularly anxious about tapering. I issue acute prescriptions throughout the taper, ensuring there is sufficient supply until the next follow up appointment.

Are there any other resources you recommend or techniques that work well for you and the people you support?

I use links to pain management websites (including my.livewellwithpain.co.uk) and focus on self-management and non-pharmacological techniques. I incorporate motivational Cognitive Behavioural Therapy methods, remain encouraging and am always very careful with the language I use.

Time is such a major factor in Primary Care and there is never any more of it. How much time do you have for this project and have you had to stop doing other things in order to concentrate on it?

I work 6 sessions a week, Monday, Thursday and Friday. I normally use Fridays for opioid tapering appointments, because I am on call each Thursday and Mondays are usually really busy. I don't set aside a specific time which is dedicated to opiate tapering but fit it in to my regular surgery using 10-minute slots. In the last year, the number of people in my practice having prescriptions for high dose opioids has reduced

'One person had doubled their morphine intake by contacting the Community Matron who then prescribed oramorph whilst they were tapering with me'

from 25 to 15. I am pleased with this outcome and am hopeful positive changes will continue.

It appears your work has been well received, which must be satisfying? Have you had any problems or difficulties to overcome?

There have been some issues. I was hoping our practice pharmacist would support the work by taking on some of the telephone follow-ups. Time for us to meet and discuss the programme or undertake training and education proved more difficult than we imagined, so currently I'm doing this on my own.

My GP colleagues do attempt to taper opioids but practice isn't always consistent, for example; differences in the percentage reduction recommended or prescribing oramorph for 'breakthrough' pain whilst reducing modified-release preparations. I've realised that regular education and meetings are vital to keep things on track.

I hadn't realised that people can and will access opioid prescriptions from other services, for example Community Matrons. One person had doubled their morphine intake by contacting the Community Matron who then prescribed oramorph whilst they were tapering with me. There was no communication between the community service and the practice and I only found out when the patient mentioned it during a consultation. I've addressed this now and agreement has been reached about information sharing.

We also had a run of paper prescriptions go missing between the pharmacy collection service and two pharmacies. I had a word with the driver and the pharmacies involved. I also brought this to the attention of the CDAO who sent information to all pharmacies in the area and we haven't had a missing prescription since.

You've mentioned accessing support from your local Community Pain Service particularly when you started the project. Are you aware of other colleagues doing similar work locally that you can share your experience with?

I have given talks to the GP trainees and our local First 5 group. I have now been invited by another local practice to share what we do. I am part of a

Suffolk WhatsApp group that has 19 participants, all with an interest in pain management and which includes pain consultants, nurse specialists and GPs. We share useful links, advice and information. We created the group at the British Pain Society Annual Scientific Meeting that was held in Brighton last year.

I am also in an active First5 WhatsApp group within Suffolk and am constantly posting useful links regarding pain management.

As you're reflecting on your experience over the last year or so, is there any advice you would share with colleagues thinking of replicating this work in their own practices?

Undertaking this kind of work on your own is hard. I have confined the project to a small group of patients that I can manage on my own. I don't aim to taper every patient who is on over 120mg morphine equivalent a day but have focussed on those that are prepared to engage. I also don't always intend to stop opioids completely, although some have. I refer people who may benefit from a dedicated opioid tapering clinic to the local Community Pain Service, where they can also access to a Pain Management Programme when they're ready.

Sarah's top tips for opioid tapering and monitoring in Primary Care

- **Adopt a whole team approach - chose a lead for opioid monitoring and high dose tapering**
- **Educate all staff about opioids including prescription clerks and keep doing it.**
- **Identify those patients prescribed morphine 120mg oral morphine equivalent or more and target these patients first**
- **Invite people in for a 10 minute GP appointment – send a letter explaining the purpose of the appointment and include information leaflets that reinforce the messages**
- **Keep a list of all patients on a tapering programme**
- **Follow up closely - every 1-2 weeks initially, this doesn't always need to be face-to-face**
- **If you have opioid monitoring templates available e.g. Ardens, SystemOne, use them**
- **Develop a file of self-management resources to share with patients. Links to resources can be sent via e-mail or text message**
- **Reinforce self-management at every consultation.**
- **The rate of taper should be guided by the patient. A 10% reduction of the total dose every 1 – 2 weeks is a guide**
- **Inform the patient of symptoms of acute withdrawal and reassure frequently**
- **Never increase the dose when tapering**
- **Use acute prescriptions for the tapering dose and issue only the amount needed until the next follow up appointment.**
- **Use motivational CBT and be aware of the 'language' you use e.g. 'trapped nerve' that could reinforce misunderstandings**
- **If required, consider the use of opioid agreements**
- **Have a system for all CD prescription collection i.e. patient signature, digital documentation or pharmacy signature in the practice**
- **Report all CD incidents to your local Controlled Drugs Accountable Officer**

In the penultimate article in our four part series about supporting self management, Clinical Psychologist **Patrick Hill** explains how to introduce a new understanding of persistent pain.

Introducing and agreeing an appropriate model

In the previous articles, we looked at the importance of understanding people's existing beliefs and fears about their pain and how to manage them. We also looked at the importance of establishing a different kind of relationship with the people we support in practice – one that's more collaborative and will help them feel more confident about self-management.

At this point, we usually have established *what their pain is not* – rather than what it is. We can't leave it there, however. The human mind needs to make sense of what's happening before any action is taken.

One really practical thing we can do to support people with pain, is to learn how to explain that long-term pain is perfectly possible, in the absence of ongoing disease or damage.

Practical tip: Try using this metaphor to explain pain in 2 minutes

“Your nervous system is designed to protect you and normally produces sensations like pain as an alarm to tell you when something is wrong. It's your nervous system that does this, not the part of the body that hurts!

For reasons we don't fully understand yet, some people have nervous systems that become a bit like a car alarm that goes off all the time – in other words they become over sensitive and easily triggered, even when no-one is trying to steal the car.

People in that situation get pain, even when there's nothing 'wrong'.

We don't know how to disconnect the alarm, like you would in the car, but good self-management has the effect of reducing the sensitivity or calming it down.

People say that self-management doesn't take their pain away but makes it much easier to live with.”

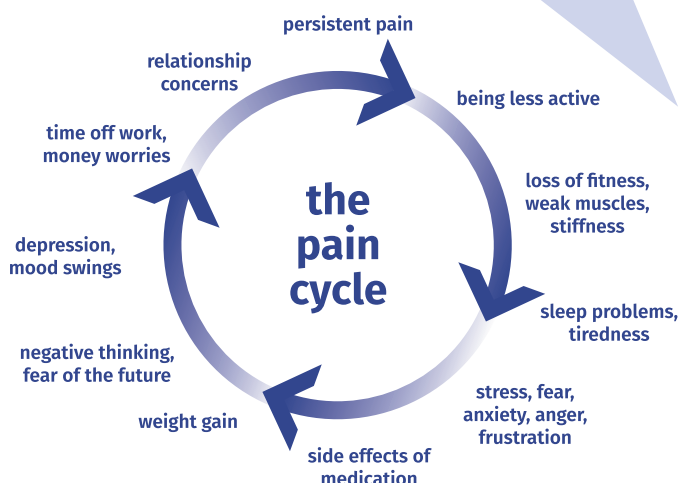
Taking the trouble to provide a different explanation helps people with long term pain to feel:

- They are being listened to and taken seriously
- That they are not imagining it or going mad
- That you want to work with them and help them to live a better life with pain

The Pain Cycle

The Pain Cycle is very useful to show how pain affects many other aspects of life and activity; creating a vicious circle, which makes it more difficult to deal with.

Most people recognise this when you put it in front of them and it can be a useful focus for discussion.



Rule of thumb

There's a rule of thumb in advertising that you have to get a new product in front of someone seven times before they will notice it. This applies to most new ideas – so don't expect people to change their ideas about pain the first time you try and do this. These are quite complex ideas after all and can initially appear to the opposite of everything we think 'pain' is.

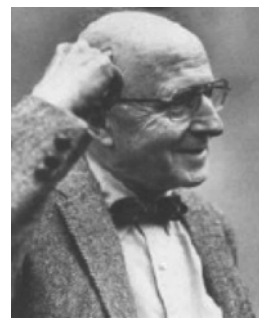
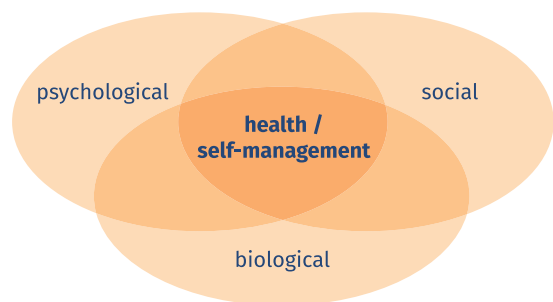
Resources

You will probably have to go over the same conversation more than once. This is why having resources available that reiterate the messages are so helpful, particularly in-between appointments.

Family's role

Families are often the driving force behind someone seeking more tests or treatment. So it may be helpful to have a family member come and talk about this as well and they can then positively reinforce the messages at home.

The biopsychosocial model



The biopsychosocial model of medicine, pioneered by George Engel in the 1970s, is an important component in our understanding of long term pain. As Engel said: **‘To understand disease we must take into account the patient, the social context in which he lives and the systems devised by society to deal with illness, that is the physician and the healthcare system. This requires a biopsychosocial model.’**

What can you do?

- Look up the biopsychosocial model if you don't know it already.
- Learn how to explain pain in 2 minutes.
- Help your patient identify some of the problems they have told you about – such as disrupted sleep, stiff joints, increased worries and so on – using the *Pain Cycle* tool. Support them to understand how it all fits together in their current experience.
- Have copies of simple information such as *The Pain Toolkit* or *Ten Footsteps* available that reinforce the information you have given but also give a way forward.
- Give them the links to You Tube clips such as “Explain Pain in 5 minutes” – these can be especially helpful for people who have difficulty with written information.
- Check their understanding and do your best to answer any questions they have.

Get the resources...

You can download and print the resources mentioned in Patrick's article at www.livewellwithpain.co.uk/resources/resources-for-patients

Patrick's previous articles on supporting self-management from Newsletters 2 and 3 are also still available via the website at www.livewellwithpain.co.uk/news/newsletters



Healthcare Outcome Measure:

Measures the end result of what happens to patients as a consequence of their encounter(s) with the healthcare system. When end results are assessed for groups of patients, patterns emerge allowing trends to be identified in clinical outcomes and the effectiveness of medical interventions (Krousel-Wood 1999)

Dr Johanna Theron is Clinical Lead for the Community Chronic Pain Service at Kent Community Health NHS Foundation Trust. Here, she discusses how and why the service chose the Pain Self-efficacy Questionnaire to measure their service outcomes.

Using an outcome measure for a Chronic Pain Service

When trying to review the quality of pain services up and down the land, there is often the lament that there are no outcome measures for these services. In east Kent, our large, comprehensive multidisciplinary community-based service was facing the same issue about 5 to 6 years ago. By that stage, the service had been running for more than 5 years and commissioners were asking for “proof” that we were effective. Although we were measuring Key Performance Indices (KPIs), auditing our various therapies and measuring different patient outcomes in these therapies, there was nothing that was clearly giving us an overview that we were an achieving service.

We started by looking at the IMMPACT (Initiative on Methods, Measurement and Pain Assessment in Clinical Trials) recommendations for studying patients with pain (Dworkin 2012). There were four key domains they felt should be measured: pain intensity, physical functioning, emotional functioning and patient rating of overall improvement. We then looked at all the various questionnaires that would suit these categories. Over many team meetings, we remained dissatisfied that these were exactly what we wanted. Whichever method we chose, needed to be relatively fast to do for patients and clinicians to enter (so doing multiple questionnaires would

not be ideal), free to use and importantly be able to be built easily into our informatics system.

There are many ideas as to what the focus of a pain service should or could be apart from pain reduction: return to work? self-management? less unplanned A+E visits? or reducing drug costs? We serve four different CCGs in this geographical area and the game changer was to ask them directly what exactly it was that they wanted to know. “Show us patients can manage their condition better when they are done with you” was the best answer. This absolutely resonated with our service’s core goal, which is to lead patients to supported long term self-management.

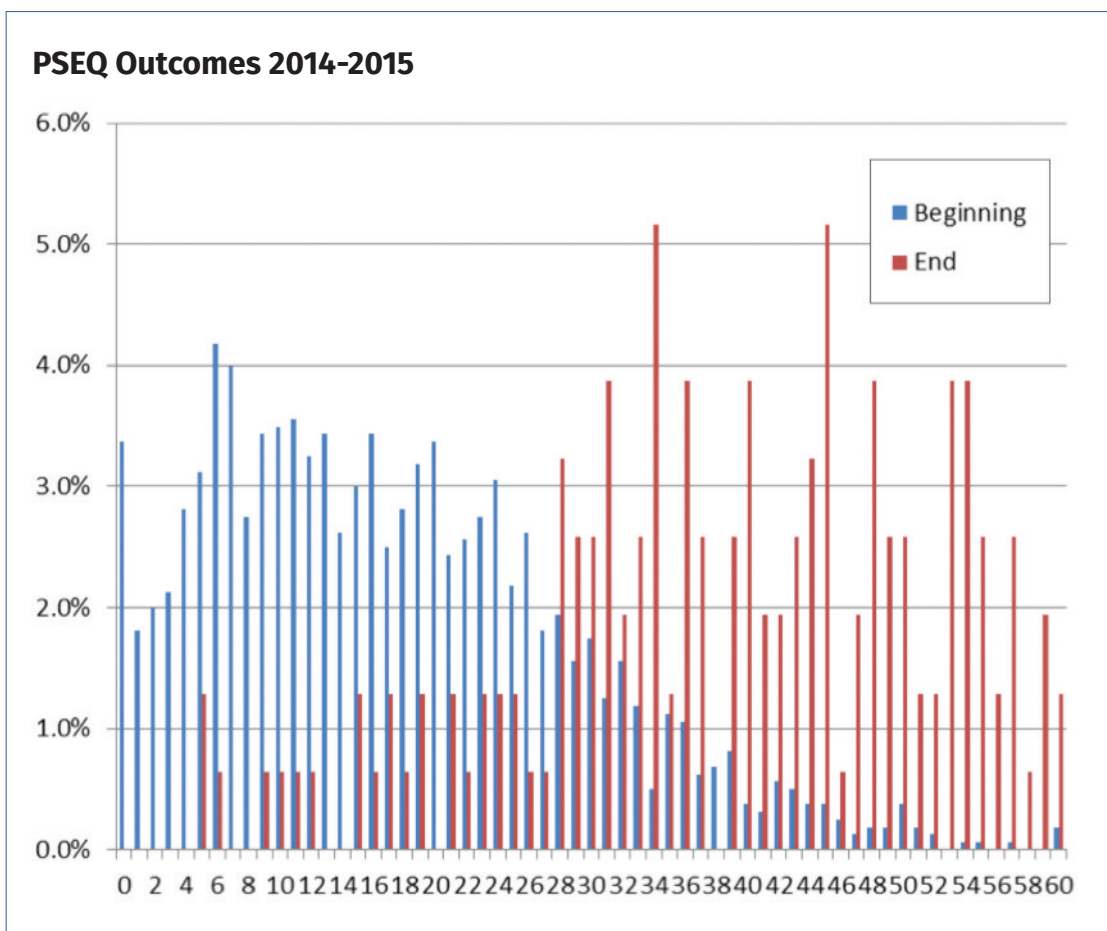
From there it was an easy jump to the Pain Self-Efficacy Questionnaire (PSEQ - Nicholas 1989), which measures a patient’s level of confidence (self-efficacy belief) on a rating scale in various areas of their lives, despite the fact that they are still in pain. The maximum score is 60/60.

After initially doing pilots in specific sites, we having been using this questionnaire as a service outcome measure since 2014. It is done on all patients on entry to and exit from the service, and on ad hoc episodes in between; for instance, when progress seems stuck or on completing a specific treatment modality. It also helps us to

‘We serve four different CCGs in our area and the game changer was to ask them directly what exactly it was that they wanted to know’

direct very low scoring patients to the more senior clinicians on entering the service. We have not only found it a useful measure of the service itself but also a good measure of how well an individual patient is progressing. Patients generally love seeing how their confidence is changing over time. Two audits done 2.5 years apart have shown almost identical outcomes: 86 % of patients score less than

30/60 on entering the service and 75% score more than 30/60 on exiting the service, demonstrating a clear shift in level of confidence. Higher self-efficacy belief could be assumed to lead to a higher chance of managing better. Both ourselves and our commissioners are happy that the PSEQ is an adequate demonstration of the change we facilitate in patients. We now include the rolling entry and exit scores each month with our KPI's.



Adopting into practice

The questions included in the pain self-efficacy questionnaire can be useful, even used informally, in framing discussions around potential barriers to self-management in practice. Many people living with pain lose confidence in their ability to take control of their condition and it can be helpful for practitioners to better understand what barriers might exist in that regard. Practitioners might want to consider using a couple of the questions,

perhaps if they link well with goals for change the person has chosen to work on (See Eve Jenner’s article on goal setting). A record of progress in terms of self-efficacy score over time can be kept and can be used to monitor progress for the patient and the practitioner.

Brief versions of the PSEQ have also been developed and validated, in order to reduce the burden on patients and those supporting them, whether through practice or research.

Notes

Dworkin RH, et al (2010). Research design considerations for confirmatory chronic pain clinical trials: IMMPACT recommendations. *Pain*; 149(2):177-93.

Krousel-Wood MA (1999). Practical Considerations in the Measurement of Outcomes in Healthcare. *The Ochsner Journal*;1(4) :187-194

Nicholas MK (1989). Self-efficacy and chronic pain. Paper presented at the annual conference of the British Psychological Society, St. Andrews

Nicholas MK (2007).The pain self-efficacy questionnaire: Taking pain into account. *European Journal of Pain*; 11(2):153-163

Briet, J.P. et al., 2014. The Pain Self-Efficacy Questionnaire_ Validation of an Abbreviated Two-Item Questionnaire. *Psychosomatics*, 55(6), pp.578-585.

Eve Jenner, Specialist Physiotherapist in Pain Management and *Live Well with Pain* collaborator offers her advice on supporting people to set activity and lifestyle goals.

It's a goal!

Goal setting is a key component of successful self management. Goals should represent a move forward from where the person is now and be centred on the person's (not the healthcare practitioner's) valued wishes and activities in the three areas of activity, relaxation and fun.

Goals are best broken down into manageable steps (targets). The *Health Needs Assessment* can form a basis for identifying topics for goal setting. In the group goal setting is best done in pairs or small groups with practitioner support.

When supporting people to set goals, it is important to ensure they are aiming for outcomes which are:

Realistic

An objective toward which the person is both willing and able to work and which represents substantial progress. The level of the goal should be high enough to exert some motivation and achievable in a number of steps or targets. Given the opportunity, individuals will begin to work out how to achieve their goals and develop the attitudes, abilities, skills, and financial capacity to reach them.

Example: The person with pain wants to walk up a mountain in Scotland, however, currently their walking distance is limited. The practitioner can support them to have the long-term goal of the mountain but in the short to mid-term, goals of increased walking distance / time / terrain can be set which allow them to achieve whilst still maintaining the motivation to reach their ultimate goal.

Enjoyable

Goals should be important to the individual and offer some enjoyment. Undertaking unpleasant activities is unlikely to be sustainable.

Example: The person with pain may feel that they 'ought' to go swimming however the discussion reveals that due to weight gain they don't have a swimsuit that fits and they feel embarrassed at being in the pool in front of people. In addition the nearest pool requires a journey of 45 minutes and 2 buses.

Specific

A specific goal has a much greater chance of being accomplished than a general goal. A specific goal answers the six 'W' questions:

- **Who** **who is involved?**
- **What** **what do I want to accomplish?**
- **Where** **identify a location**
- **When** **establish a time frame**
- **Which** **identify requirements and constraints**
- **Why** **specific reasons, purpose or benefits of accomplishing the goal.**

Example: A general goal would be, 'to become more active – stretch and exercise', but a specific goal would say, 'Find out more about becoming active via the GP exercise on referral scheme or joining a gym/health club or walking group – Yoga/Tai Chi classes.'

Timed

A goal should be grounded within a time frame. Almost any goal can be achieved by planning steps wisely and establishing a time frame that allows those steps to be carried out. Goals that seemed far away and out of reach eventually move closer and become attainable, not because the goals shrink, but because the steps grow and expand to match them.

Finally... confidence

It is often very helpful to ask how confident a person is that they will achieve their goal or target on a scale of 1 (no confidence) to 10 (completely confident). Low scores may indicate that the target is too ambitious, there are some undisclosed barriers or that the activity is not a high priority. Encouraging the person to review and if necessary revise their goal to increase their confidence can contribute to a successful outcome.

It is important to ask for feedback on goals at every session.

Your Journey with Pain is a leaflet that support people with pain to work through this approach to goal setting. It is available to download and share from www.livewellwithpain.co.uk/resources/resources-for-patients



MSc Pain Courses and Stand Alone Modules

Study entirely online

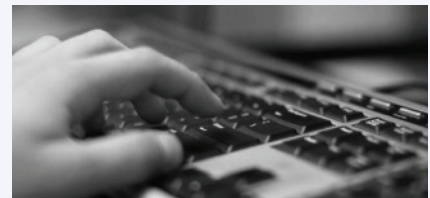
Cardiff University's Centre for Medical Education run a number of **interprofessional** MSc courses and stand alone modules for any healthcare professional wishing to further their knowledge of pain at MSc level. As online courses, they enable flexibility in studying and learning. The content comprises of on demand lectures, podcasts and interactive modules, with use of discussion boards and online assessments, to provide student support. Assessments are designed to enable students to apply their learning to clinical practice.

MSc Courses

- MSc in Pain Management;
- Cert/Dip and MSc in Pain Management (Primary & Community Care)

14 week Stand Alone Modules

- Foundation in Primary Care Pain Management;
- Foundation in Evidence Based Pain Management



The MSc in Pain Management starts in September (2 year course). The Cert/Dip and MSc in Pain Management (Primary & Community Care) runs as 3 separate stages (9 months each) and starts in October. The Stand Alone modules start in January / March each year. Access to a computer with a good broadband service is a requirement. There are **some bursaries available** for NHS staff in the UK. For more information on these, please email mscpainm@cf.ac.uk or primarycarepain@cf.ac.uk

Further details for each course can be found at: www.cardiff.ac.uk/medicine/courses/postgraduate-taught/e-learning

Degrees of difference

The part-time, e-learning MSc in Pain Management and the PgCert/Dip/MSc in Pain Management (Primary and Community Care) at Cardiff University, enable any qualified healthcare professional to develop their multidimensional understanding of pain and its management. So what difference does it make in practice? Here are some testimonials from recent students who are now applying their evidence-based learning to practice.

"I was able to pursue topics of interest to myself and my role as a physiotherapist within pain management. It has spurred me on to a position of "expert" in areas such as Painful Bladder Syndrome and Fibromyalgia. I have shared the knowledge I have gained in these modules with a variety of audiences,

physiotherapy training days, pain management multi-disciplinary planning days, rheumatology, urology consultant meetings and pain clinic teams. This learning directly resulted in the fibromyalgia pathway review in our Trust and creation of Therapies Clinical Practice Guideline for Fibromyalgia for equitable care across the county."
Physiotherapist

"I was interested in self management of chronic pain, relevant to my working field as a GP. With enormous financial pressures on NHS and limited resources in community, self-management of pain sounded an attractive option. I was able to find some robust evidence, to show clinical effectiveness and cost-effectiveness of self management programmes. This will be something

that I might discuss at the local CCG (clinical commissioning group) to implement in my practice."
GP Partner

"For my dissertation, I chose to assess the role of mindfulness in the management of low back pain. This was probably the biggest project I have ever done in my whole career in medicine. I was fascinated by the evidence that I found about mindfulness and how it could improve not only low back pain but also general physical and mental well-being. Currently, I am waiting to have a meeting with the local pain service to discuss the possibility of implementing mindfulness as an alternative to CBT (cognitive behavioural therapy) for patients with low back pain."
GP Partner

Get connected, stay connected

... with us and other clinicians

Get connected to share thinking and ideas on chronic pain and its management. In response to several clinicians' request in primary care *Live Well with Pain* has set up a Google Group for clinicians to connect and share. If you'd like to join this closed group, email us at *Live Well with Pain*.

Send us your contact information, including your name, professional group and current registration number and you will be invited to join.

Send your request to info@livewellwithpain.co.uk

Get the *Live Well with Pain* newsletter straight to your inbox

For the latest and best in clinical expertise on all things persistent pain-related, make sure you sign up for this quarterly newsletter, at:

www.livewellwithpain.co.uk/news/sign-up-for-our-newsletter

About *Live Well with Pain*

Live Well with Pain is a collaborative project, led by Dr Frances Cole, Emma Davies and Eve Jenner, with support from other clinicians. It is for clinicians who want to develop their patients' self confidence to live well with pain through better knowledge, skills and resources to guide them.

Developed and maintained by clinicians, for clinicians, *Live Well with Pain* has an online presence at www.livewellwithpain.co.uk where clinicians can access a wealth of resources for free, to use with their patients who are experiencing persistent pain.

The MSK and Chronic Pain Update Course

Did you know that 30% of repeat visits are MSK problems? That's a BIG chunk of your practice time.

On the course, we'll cover the latest on common **MSK conditions, diagnostic pitfalls** and **management tips**, and you'll take away a tool box of strategies to make those tricky consultations easier.

2019 COURSE DATES

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Manchester - Friday 28 June

Leeds - Thursday 10 October

Nottingham - Friday 11 October

London - Wednesday 13 November

Manchester - Thursday 14 November

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