Opioids Collaborative

Participant stories

Once upon a time, there was a busy GP practice serving 7500 patients in Chessington. The approach to prescribing and monitoring patients prescribed opioids varied widely. Despite the clinical team working hard to adopt a patient-centred approach to long term condition management, the approach for patients living with chronic pain prescribed opioids was adhoc and sporadic.

Every day the clinical team were met with increasing demands across many clinical areas, the Group A Streptococcus outbreak, COVID-19 management and vaccination. The clinical team also had to prioritise patient groups in the Quality Outcomes Framework (QOF) and Investment and Impact Fund (IIF). This left little time for expansion of any other areas and medicines for chronic pain seemed to be forgotten about. However, an opportunity presented to undertake an Opioid Stewardship QI Collaborative at the Health Innovation Network (HIN) to support us to make improvements locally.

Because of that, a meeting was set up with the Practice Prescribing Lead and the Practice Pharmacist. A search was run to identify registered patients who were on greater than or equal to 120mg oral morphine equivalent. The patients identified were invited for a review with the Practice Pharmacist to explore ideas, concerns, and expectations of both the clinical side and the patients' point of view.

The issue of opioid prescribing was discussed at a practice meeting, and subsequently a pathway was laid out incorporating the following points:

Dr Caterina Avellini, GP Partner
Chessington Park Surgery

Health Innovation Network South London

Opioids Collaborative

Participant stories

- the aim was to focus on not initiating / being mindful of using opioids especially for chronic pain considering opioids have been found to have very little role/benefit in this area;
- if we are using opioids in an acute pain / flare up situation then the patient again must be advised that the prescription is for short term use only;
- patients must be made aware of the addictive potential and be involved in shared decision-making of a plan, with agreed follow up ideally with the clinician who initiated the prescription;
- the prescription should not automatically be put on repeat and thus remain on the acute medications list on the computer system;
- all prescribers were made aware that acute pain becoming chronic pain is a chance to explore alternative pain management via musculoskeletal/non-pharmacological support and interventions or to consider pain clinic referral as appropriate. Early implementation of supportive services is strongly recommended.

A practice wide email was sent out to all clinicians re-iterating all the five points discussed at the meeting. This included attachments of reference to non-pharmacological support recommended by NICE and a flyer on top 10 tips regarding Dependence Forming Medications (DFMs).

Finally, Chessington Park Surgery felt that they were working towards best practice, aligned with patients' best interests alongside reducing harm, as a unified team with a shared view that led to a clearer pathway for all to follow. Outcomes varied from patients resisting change, to agreed review and reduction plans and re-referrals to pain clinics for expertise, as well as advice and the support of non-pharmacological platforms e.g. social prescribing. They were also happy with more regular audits being undertaken to monitor impact of the changes in the future.

Dr Caterina Avellini, GP Partner
Chessington Park Surgery

Health Innovation Network South London

Opioids Collaborative

Reflections

What went well?

- The Quality Improvement (QI) project supported our local delivery on the national priority to have structured medication reviews for patients using potentially addictive medicines, e.g. opioids for the Impact Investment Fund (IIF) and local QI opioid projects for the Quality Outcomes Framework (QoF).
- The review of opioid prescribing for chronic (non-cancer) pain across practices in the PCN enhanced patient care in line with current guidelines.
- There was better collaborative working between individual GP practices within our PCN.

What didn't go as well?

- Due to competing priorities, it was challenging to get full involvement in the QI project at my practice.
- Despite national incentive schemes to drive our local opioid QI project, there were other competing incentive programmes which made it challenging to prioritise opioids at times.

What took you by surprise?

- At my GP practice, there were no protocols or local policies promoting safe prescribing of opioids.
- There were very low numbers of patients prescribed high dose opioids e.g., greater than or equal to 120mg oral morphine equivalent.
- Some clinicians were hesitant to follow the proposed protocol developed as part of the QI project.

Sukhjeet Kahai
PCN Pharmacist, Cross Deep Surgery

What did you find challenging?

- As a generalist working in GP practice, I felt I did not have sufficient clinical knowledge to support patients with complex pain.
- I had to change the initial driver for my QI project, I initially wanted to focus on reducing the number of patients prescribed high dose opioids but due to small numbers I decided to focus on preventing inappropriate prescribing in chronic pain.

What didn't you understand?

- The hesitancy from some clinicians to follow the protocol developed as part of the QI project to ensure opioids are initiated safely and appropriately.
- The need to have involvement from organisations outside the GP practice who attend the multidisciplinary team (MDT) meetings for complex and vulnerable patients, some of which were prescribed opioids for chronic pain management.

What was your biggest takeaway from the programme?

- I have an enhanced appreciation for collaborative working with clinical and non-clinical staff to improve opioid prescribing. Safer prescribing of opioids must be collaborative across the whole team in a practice and within a PCN to ensure consistency in opioid prescribing.

Sukhjeet Kahai
PCN Pharmacist, Cross Deep Surgery

Health Innovation Network South London

Opioids Collaborative

Reflections

What went well?

The need to focus on improving chronic pain by reducing harm from high-risk opioid prescribing was received well by practice colleagues. It became a standing agenda item at regular clinical meetings. We focused on three cohorts of patients:

- Patients on ≥120mg oral morphine equivalent (OME)
- Care home residents on opioids
- Patients ≥18 years on opioids for greater than three months and up to one year

To raise awareness of safer opioid prescribing we maximised use of accessible patient information e.g. opioids aware leaflets, shared via text messages.

What didn't go as well?

- For the three patient cohorts, none of the 12 patients identified on ≥120mg OME were willing to consider other strategies to support chronic (non-cancer) pain management, however, the subject was broached. There was some initial inertia exhibited by the care home supervising team in reducing or stopping opioids in instances where risk of harm outweighed intended benefit. The options for engaging clinicians and patients were limited after mapping out several strategies and approaches.

What took you by surprise?

- The clinical and non-clinical staff in the practice were enthused, motivated and willing to change practice to ensure there was safer opioid prescribing. This applied to all patients ranging from, newly initiated patients to those who have been prescribed opioids for greater than three months an up to one year.

Ramat Popoola
PCN Pharmacist, Northumberland Health Medical Centre

What did you find challenging?

- Overall, time constraints were a limiting factor to achieving our outcomes. There were several competing priorities from the Quality Outcomes Framework (QoF), Investment and Impact Fund (IIF) metrics, winter pressures, group A streptococcus and COVID-19. We also had a practice refurbishment programme which impacted appointment schedules.

What didn't you understand?

- I struggled to understand how we got to a place where patients were on ≥120mg OME, why there were so many patients initiated on opioids and the rationale for keeping them on their current doses where the clinical indication was unclear.

What was your biggest takeaway from the programme?

- I have a better appreciation for the impact of high-risk opioid prescribing and dependence forming medicines in general on our practice population. I have better awareness of the guidelines and resources available to guide safer opioid prescribing in chronic pain. As such, I learnt about the various ways clinicians can support patients with reducing high risk opioid medication regimes.

Ramat Popoola
PCN Pharmacist, Northumberland Health Medical Centre

Health Innovation Network South London

Opioids Collaborative

Reflections

Background

- There has been great concern regarding prescribing rates of opioids in the England and lack of awareness about the risks of dependence and addiction among healthcare professionals and patients. There is a national aim to reduce harm of opioid medicines by reducing high risk prescribing, e.g. ≥120mg oral morphine equivalent (OME). NHS England have also set an ambition of halving the number of opioids prescribed for chronic (non-cancer) pain by 2024.

Aim

- Within this project I decided to focus on the high dose opioids prescribed and set an aim to review patients currently prescribed high dose opioids (≥120mg OME) at The Albion Surgery. The aim was to review and reduce the number of patients prescribed high dose opioids by 50% by the end of March 2023.

Results

- At the beginning of the project there were 14 patients prescribed high dose opioids (≥120mg OME). The search was re-run in February 2023 and nine patients were identified. There were no new patients on the list, showing the increased awareness among clinicians had helped prevent new patients being initiated on opioids. Structured medication reviews were arranged, and five of these patients were prescribed oxycodone, one buprenorphine, two fentanyl patches and one morphine. Six were prescribed on repeat and three on acute. (Continued)

Claire Dampier
PCN Pharmacist, The Albion Surgery

Results cont.

- On completion of the structured medication reviews it became apparent that three of the nine patients were not taking medication at the doses recorded on their repeat list. Repeat lists were then amended. After completing structured medication reviews with the willing participants, the search was re-run and it again showed a downward trend; now only 6 patients were prescribed high-dose opioids. It is important to note we also arranged reviews for many patients on dependence forming medication who were on a lower dose of OME.

Outcomes

- As you can see from the results documented the aim was met for this QI project. We hope the improvements made will continue within the practice as the search is re-run every 3 months and the review dates are adhered to.

Lessons Learnt

- Moving forward, I would like to work towards implementing an opioid prescribing protocol within the surgery that all clinicians are aware of and consider when prescribing any form of opioid.

Claire Dampier
PCN Pharmacist, The Albion Surgery

Health Innovation Network South London