



Improving chronic pain management by reducing harm from opioids

Report on an analysis of published literature and real-world case studies from across England.

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Executive Summary

Over 0.5 million people in England are prescribed opioid analgesia for longer than 3 months, the majority having chronic pain that is not associated with cancer. National Institute for Health and Care Excellence (NICE) guidance states that opioids should not be offered to manage chronic non-cancer pain as harm out-weighs the benefit.

A systematic analysis was conducted of literature and real-world examples of interventions to reduce opioid prescribing for chronic pain management that is not associated with cancer. The analysis identified the benefits of whole-system approaches to improving chronic pain management, with shared decision making at their centre and extending along the pathway from prevention, through timely de-escalation and into treatment; all treatment underpinned by effective mobilisation of community-based biopsychosocial support.

The aim of this report is to help leaders in Integrated Care Systems to identify learning from other areas and to find helpful resources as they design and deliver improvement programmes for people living with chronic pain.

The report should be used in conjunction with the resources on the Medicines Safety Improvement Programme collaboration zone which can be found here:

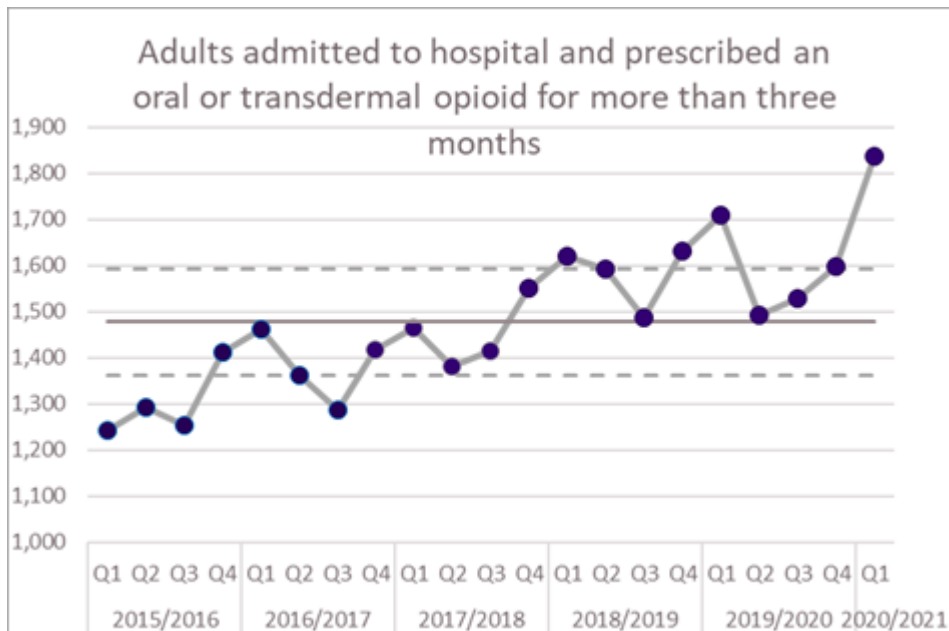
future.nhs.uk/MedicinesSafetyImprovement

Introduction

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

The harm associated with the prescribing of opioids for chronic non-cancer pain is [well understood](#) when we consider the whole population. [Data](#) linking primary care prescribing of opioids and hospital admissions for the adverse events associated with opioids shows an increasing level of harm (Figure 1). Unchecked, it is predicted that around 6000 people a year will be hospitalised with adverse events whilst taking opioids for extended periods.

NHS practitioners, along with the communities they serve, have risen to this challenge.



1. Number of adult patients in England on opioid treatment for more than 3 months who have been admitted to hospital with respiratory depression, accidental overdose or confusion. Source NHSBSA [ePACT2](#).

As a result of concerns that the COVID-19 pandemic may exacerbate the problems of managing chronic pain due to the backlog of elective care procedures, at the end of 2021/22, a “real world” intelligence gathering exercise was undertaken by the Patient Safety Collaboratives ([PSCs delivered by the AHSN network](#)) on behalf of the [National Patient Safety](#) Team’s Medicines Safety Improvement Programme. This exercise identified 112 separate endeavours across England where services were being provided with the specific aim of reducing the prescribing of opioids and thereby protecting people from their harmful effects. These 112 case studies were analysed for the purpose of describing an improvement programme that has the potential to be delivered by [Integrated Care Systems](#) to reduce avoidable harm associated with opioids which have been prescribed by the NHS. Integrated Care Systems have [responsibility to lead improvements in the quality and safety](#) of care provided to their populations.

Not all the interventions that were reviewed could be included in this report due to the constraints of space. The examples included are not an exhaustive list of the beneficial work that has been done.

Research

A rapid evidence review was commissioned by the South West Academic Health Science Network to identify interventions designed to reduce high-dose opiate prescribing for non-cancer pain ([February 2020](#)).

Nine reviews were identified, containing 110 individual primary papers. However, a majority had significant methodological limitations. The interventions identified were complex with single and multicomponent parts, targeted at patients, healthcare professionals and organisations and were conducted in a range of care settings (primary, secondary, inpatient and outpatient).

The review concluded that published research is of poor quality with a mixed picture in terms of effectiveness. There is also limited indication of what types of intervention or intervention components are most effective. Very little research has been conducted in the UK. The rapid review identified ongoing UK trials which may provide more robust data on interventions that could be effective.

The analysis team invited Dr Debi Bhattacharya (University of East Anglia (UEA)) and Dr Harbinder Sandhu (I-WOTCH, University of Warwick) to provide expert input based on their research activities. These two programmes bring, or seek to bring, when complete, the evidence to underpin practitioner behaviour change and patient behaviour change, respectively.

The UEA research team have undertaken a structured review to capture details of local and national activities, with the aim of learning from existing research literature and the practice environment. This 'realist review' aims to understand which elements of an opioid reduction programme are effective, for whom, under which circumstances, and how. Some examples cited include the relationships and attitudes of individuals providing the service, and the environment in which the service is delivered. The research team have identified key service elements and conducive circumstances to design an opioid deprescribing intervention with effective components that best fits the circumstances that can be feasibly replicated.

The UEA team identified [seven main features](#) that should be included in all opioid tapering, or deprescribing, interventions.

The need for a clear expectation that opioid deprescribing is the responsibility of prescribers is the first and overarching feature of the toolkit. The remaining elements of the toolkit include:

- Information about the consequences of excess opioid use,
- Information about how to taper (guidelines),
- Prescribers with appropriate knowledge and skills to initiate tapering discussions and navigate the patient pathway,
- A consistent approach by all members of the of the healthcare team,
- Comprehensive education for patients,

- A pathway for patient management including access to appropriate levels of psychological and physical support.

[The I-WOTCH study](#) (a definitive multi-centre randomised controlled trial) aims to evaluate the effectiveness and cost effectiveness of a patient-centred multicomponent self-management intervention for people living with chronic non-malignant pain. Those I-WOTCH intervention includes a three-day group facilitated course led by a trained nurse and a lay person with chronic pain and experience of opioid withdrawal/tapering. Additionally, participants will also receive a copy of 'My Opioid Manager (anglicised); a self-help guide for people using opioid drugs for chronic pain'. This study is due to publish later this year.

Method – System Engagement

The 15 Patient Safety Collaboratives were able to utilise their deeply embedded relationships within their local systems to identify current, past or paused (due to the COVID-19 pandemic) activity aimed at reducing the use of high dose opiates for chronic non-cancer pain. Teams employed a range of techniques to engage with stakeholders during what was an exceptionally busy period for the NHS, with pharmacy and pharmacists deeply involved with the developing pandemic and subsequent vaccination programme.

In order to obtain a real-world picture, the PSC's engaged a variety of stakeholders, from medicines optimisation teams to chief pharmacists, acute and primary care pain teams, drug and alcohol teams, medicine safety officers, third sector organisations and academia to gain insights. Each intervention was examined using a structured interview template to ensure parity of information. This analysis reports the results of over 112 structured stakeholder interviews to paint a real word picture of interventions past, present and future covering the NHS in England.

Method - Analysis

The purpose of the analysis was to identify one or more interventions that could form the basis of a national opioids safety improvement programme focussing on chronic non-cancer pain.

To inform the analysis a Rapid Research Synthesis was conducted by SW AHSN on behalf of the PSCs. The following steps were then taken by the programme's leadership team with input from subject matter experts (Annex A).

- Evidence provided by the PSCs was collated and summarised by the analytics team at Kent, Surrey and Sussex AHSN
- Using the summaries, effectiveness was assessed using a low-threshold and wide definition of effectiveness.

- Evidence of effectiveness was cross checked with the submitted supporting documentation.
- Cluster analysis was performed to identify themes within the interventions.
 - Stage one: Settings/sector clusters
 - Stage two: Pathway clusters
- Cluster analysis was performed on the “tools” (supporting documentation) supplied with the interventions.
- Subset analysis was undertaken to identify targeting (population segmentation) to address inequity of harm.
- First ‘test and challenge’ session – guidance from academia.
- Second ‘test and challenge’ session – guidance from Health Inequalities experts.
- Third ‘test and challenge’ session – expertise from NICE & NHS E Personalised Care Programme.
- Interventions were analysed for Scale & Spread considerations – guidance provided by SW AHSN Spread Academy.

Results

The pathway that emerged from the analysis identified 5 stages



Prevent initiation refers to strategies and practices that divert treatment away from the prescribing of strong opioids whilst still effectively managing pain.

De-escalation refers to activity that prevents increasing doses of opioids or minimises the duration of treatment whilst still meeting the patient’s clinical needs. Preferencing oral therapy over injectable therapy also falls into this stage.

Find Chronic Use are the methods used to identify patients who are at risk of dependence and/or harm from continuing use of opioids, usually strong opioids.

Treat refers to the interventions aimed at reducing opioid prescribing, lowering the dose or weaning off strong opioids. It typically involved dose tapering, often in combination with biopsychosocial interventions.

Sustain was the stage at which interventions were designed to maintain the lowest possible opioid use by optimising patient's ability to manage their pain without medication.

Prevent

A paper identifying 'Factors Associated with high dose opioids' made the key recommendation to tap into real-time live data where patients on opioids can be followed over time and if they get to a high dose then the GP should be alerted and reminded to check the five factors to prevent harm.

A series of interventions were found which addressed the need to prevent opioid prescribing occurring. These interventions included a wide variety of educational resources for both patients and prescribing clinicians, including video presentations and signposting to alternatives such as social prescribing

A variety of patient information leaflets were discovered.

There were examples of PrescQIPP Education and Training e-learning courses being used, which included assessment and certification for clinicians. This follows a two-module approach of reducing opioid use in chronic pain and information on dependence forming medicines, focused on Public Health England (now called the UK Health Security Agency) prescribed medicines review 2019. The target audience was predominantly primary care, although it could also be used for secondary care clinicians. There was some evidence to suggest this corresponded to an initial reduction in prescribing rates, although the licenses require funding with currently no indication of longer-term impact.

An intervention found in primary care included a patient contract with details stating that benzodiazepines would not be routinely prescribed.

It was interesting to note that this intervention found that some GPs failed to engage with the initiative, with a recommendation to equip clinicians with the skills and confidence in having difficult conversations and that time was a limiting factor on appointments.

Script Switch was set up with an opioid risk assessment tool in GP Practice which initiated a message to the prescriber when prescribing >100mg to complete the risk assessment, prompting a conversation with the patient about potential side effects and risk/benefits. A second message was instigated with the reauthorisation of high dose opioids with tapering considerations and suggesting alternative options.

A memorandum between the pain clinic and Clinical Commissioning Group (CCG) was found with agreement to not prescribe >100mg but this was found to be difficult to manage. There were multiple examples of medicines optimisation learning events being held for GPs. Two research initiatives are currently underway in Oxford, which are in the development stage and have obtained funding to expand and grow their resource and test their effectiveness. These initiatives are: a catalogue of opioid drugs to centralise and disseminate information that could assist researchers, prescribers and the public to improve the safe use of opioids; and a preventable deaths tracker - a database and tool to collect,

evaluate and report preventable opioid-related deaths in England and Wales. These tools would both provide a feedback loop to improve learning.

A number of secondary care specific interventions have been identified. University College London Hospitals NHS Foundation Trust (UCLH) has established an Opioids Stewardship Committee to provide the drive and governance that is needed to implement improvements in practice. This is comparable to antimicrobial stewardship.

There was an example of a bundle of elements run through an acute trust which included:

- 1) Pre-operative opioid reduction and patient education (working with pre-op assessment team to deliver this. Patient opioid leaflet complete).
- 2) Pre-operative risk assessment for severe pain: in place via 4 questions.
- 3) Pre-operative assessment for opioid use problems: in production.
- 4) Intra-operative opioid minimisation techniques: part of departmental ethos in anaesthesia, with multiple guidelines in place.
- 5) Education of junior doctors around opioid stewardship and safe prescribing at discharge – in place for F1 and F2 doctors.
- 6) Electronic prescribing identification of patients taking high-dose opioids – Electronic Prescribing and Medicines Authorisation (EMPA) now in place, reports being developed.
- 7) EMPA identification of inappropriate discharge prescription of opioids and gabapentinoids – currently via teaching of junior doctors.
- 8) Plans made for complex opioid-use patients on discharge and communicated to surgical teams via CPL (electronic ward round info).
- 9) Involvement of clinical psychologist in opioid management in complex cases – informal discussions at present. Business case completed.
- 10) After discharge, a number of interventions are in development. These include: SMS messaging patients to assess pain and opioid use. We have funding for the messaging system and are developing a question set. We also intend to institute a subacute follow up clinic at 2 weeks post-discharge (initially via telephone / zoom / teams), this is in the discussion phase.
- 11) Involvement of GP educators to inform primary care trainees of the problems of long-term and inappropriate post-operative opioid prescribing.

[De-escalate](#)

Examples of letters to patients regarding reviewing opioids were observed, these included a review of side effects, trials of reducing opioids and signposting resources.

Implementing NHS Trust-wide clinical guidelines for the management of acute pain in adults including choice of opioid, guidance on de-escalating dosage and transfer from modified release to immediate release opioid prior to discharge, maximum quantity of seven days' supply at discharge, a weaning plan and communication to GPs if required.

Patients were also provided with a local opioid information leaflet on discharge.

The toolkit from University of East Anglia tells us that there must be a clear expectation of the responsibility of the prescriber. This involves clinicians across all areas of the system, from primary through to secondary and community care settings. Education is paramount and this is being driven across all aspects of the system by opioid deprescribing champions, covering numerous healthcare professionals and specialities.

Educational resources include webinars for F1 doctors on opioid prescribing, conducting surveys of nurses to identify learning needs and the creation of targeted e-learning, opioid stewardship and audit days,

Patient information leaflets for patients undergoing surgery include information about managing pain at home and include non-pharmaceutical options.

A number of secondary care specific interventions have been identified, including the implementation of a transitional pain service to minimise opioid use at all stages of the secondary care patient pathway and which was cited as part of the hospital ethos.

Interventions included organisational policies on Opioids for Acute Pain Management which included introduction of IV morphine restriction measures to disrupt the cycle of repeat patient admissions which might result in opioid dependence developing. IV morphine boluses beyond 48 hours have been banned within the acute trust, with data indicating a reduction in the number of patients developing dependence on opioids and reduction in the number and duration of admissions of patients that report to hospital regularly for the acquisition of morphine.

[Find](#)

25 case studies encouraged GPs to improve the care of people on opioids by offering a financial incentive or providing audit data with associated feedback on comparative performance. In some cases, both techniques were used. In most cases the information provided to GPs included treatment guidance and some signposting to online resources for practitioners and patients.

The most frequently recorded outcome of these interventions was to count the number of patients that had had their medication reviewed. For example, 15 GP practices in Bromley were incentivised and reported reviewing 336 patients and 27 practices participated in the Brighton & Hove CCG Scheme with 210 patients (93%) reviewed.

Cost and volume of prescribing was the primary end-point of some of the programmes:

- Great Yarmouth & Waveney CCG reported monthly savings of £45K as a result of their programme.
- In Yorkshire, the Campaign to Reduce Opioid Prescribing, an audit and feedback scheme, reduced prescribing by 5.14%.

- East Sussex CCG supported the clinical work in the practices that were encouraged by an incentive scheme and achieved a 21- 28% average reduction in prescribing volume, saving £272,000 in unnecessary prescribing costs.
- Kernow CCG, as part of their system wide programme achieved 18% reduction in total oral morphine equivalent prescribing over 3 years, 28% reduction in high dose patients over 3 years and saw 18% reduction on £3.3m annual spend = £594,000 annual saving.

Importing standardised and clinically prioritised searches into GP Clinical Systems has been identified as being beneficial. Both Wandsworth CCG and the 'Bridging the Gap' study in Swindon developed in-system searches. The Eclipse system was used across Gloucestershire and in Barking, Havering and Redbridge CCGs. PrescQIPP also offers benchmarking as part of a suite of support.

Risk stratification protocols were also of benefit in the Gloucestershire Programme in which 308 patients were supported to reduce or stop their analgesia.

Patient activation, encouraging self-care or patient initiated consultations, was also a component of the successful programmes in Ipswich, Gloucestershire, West Hampshire, Cornwall ('Skills not Pills' campaign) and County Durham ('Painkillers Don't Exist' campaign) used in combination with direct mailing to patients.

A different approach was taken in Nottingham where an out-of-hours GP service identified patients by their attempts to over-order opioid medication, which instigated case-note and clinical review.

Treat

We had over 50 promising interventions which fell into the "TREAT" theme. What was clear in reviewing these submissions was *treatment* of the "opioid problem" is difficult, complex and multifaceted. Supporting patients to reduce and stop taking opioids takes time, resources and, for some, a specialist skill set, including compassion focused therapies, motivational interviewing, and an understanding of chronic pain.

Supporting patients to understand that they can live well with managed pain, and that their lives would be better without opioid medication relies upon a therapeutic trust-based relationship, where tapering plans can be individualised and flexed to suit patients' life circumstances and additional help can be provided through support groups and coping mechanisms. The Faculty of Pain medicine recommend a 10% dose reduction every 2 weeks, however it has been reported that the pace of reduction is most successful if set by the patient and agreed, in an individualised tapering plan, which is widely communicated within the practice team, supported by EMIS coding, on-screen messaging and communicated to the community pharmacy.

A number of examples were reported using pharmacists in this role, some pharmacists took overall responsibility for all prescribing and development of individualised tapering plans and others worked directly with the patient and deferred prescribing to the GP post-consultation

for issue of the prescription. A recorded limitation was where independent prescribers with a specialist knowledge were not available. All recognised the time commitment and support required, citing 1-1.5 hour for initial consultation followed by 15-30 mins every 1-2 weeks, a preference for face-to-face consultations, and spoke enthusiastically about the challenges and rewards of working in this area. However, the COVID-19 pandemic has demonstrated that support can be meaningful when delivered virtually or by telephone. Patient information leaflets and online support materials are required, [and https://livewellwithpain.co.uk/](https://livewellwithpain.co.uk/) was commonly referenced. Pharmacists in these roles also provide practice /Primary Care Network (PCN)-based prescribing education, facilitate Multidisciplinary Team (MDT) case discussions and give feedback on prescribing data and trends, which is used as an improvement indicator. The Specialist Pain Pharmacist (SPP) referral service described a bespoke GP referral service delivered by a SPP in the form of a shared decision making SMR appointment using a structured conversation.

East Sussex dependence forming medications (FDM) recovery worker service and East Lancashire's INSPIRe both described partnerships with Change, Grow, Live a national health and social care charity to support improvements in quality of life, reduce anxiety to achieve, and maintain a life without opiates. This is a commissioned service, costing £100-150k per CCG.

Central Lancashire 'Moving Well' service, West Midlands 'Back to life' programme and the south west 'Skills not Pills' all describe an holistic approach to pain management delivered virtually (as a result of COVID-19) in a variety of scenarios, one-to-one, self-directed learning (videos) and support groups focusing on the biopsychosocial model.

Examples of multi-disciplinary working were numerous:

- From " Stuck to Success"
- "Pathway persistent systems service (PSSS)"
- "Opioid detox programme for chronic pain patients"
- "Bridging the Gap" Providing a specialist pain service at a GP Practice – a pilot study
- Wandsworth review of patients with chronic non -cancer pain

Research and innovation were also evident:

- "Opioids within an MDT setting" to be evaluated as Masters Dissertation
- Pain check
- Community pharmacy and prescribed opioids
- PROMPPT Study (NIHR)

Regional guidelines to support opioid prescribing for chronic pain exist and were cited, many of which reference “Faye’s Story” as the case for change. Faye’s story puts the potential dangers into reality, from Faye’s parent’s perspective, describing the sequence of events which sadly lead to her untimely death from respiratory depression. There was also an example of CCG vision and strategy for patients on opioid medication.

We did not find any interventions that utilised Quality Improvement methodology to improve the “treatment” of opioid prescribing, often prescribing data was the measure of success.

Sustain

Several cases evidenced the importance of social prescribing, either by appropriate signposting or direct referral pathways. One PCN had a social prescriber attached to the GP practice and had been evidenced through qualitative feedback rather than clinical outcomes. The term ‘Skills not Pills’ used in reference to a social prescribing and community development approach to managing pain better by reducing opioids prescriptions and setting up a self-support patient virtual group.

There were two specific social prescribing groups:

A local walking group set up specifically for people living with pain who use the walking group as a way of managing their health condition and getting recovery support, instigated by a patient with lived experience. The Footsteps Festival is an example of a COVID-19 response; this is an interactive online festival to guide managing pain to support all people living with pain, their families, friends and carers. It includes pre-recorded content and links accessed through mylivewellwithpain.co.uk.

Soundscape was an example of a community produced asset. It recorded sounds that can be used in managing pain and providing relaxation. It was developed by a local artist/sound technician who recorded local sounds.

There were references in the examples of a move from face-to-face consultations or social prescribing solutions as a direct result of the COVID-19 pandemic.

Complex patients

The analysis found very small-scale examples of improving prescribing at GP practices for patients with an addiction profile and with unstable substance use. The examples identified that treatment plans need to be personalised and holistic. These high intensity services run in general practice were not sustained due to the resources required.

There were examples of effective specialist multidisciplinary services (both from addiction services and pain clinics) for complex patients, however none of the examples managed large case-loads.

System-wide working

There were examples of system-wide working from across the country. One area took a consistent approach in information dissemination to patients such as patient information leaflets distributed through all acute trusts within an ICS and through the Local Area Prescribing Committee.



Sustainability and Transformation Partnerships (STPs) in East Midlands used nationally available data to identify variation in prescribing and the related deaths to instigate a systemwide approach to improvement.

In East Sussex a successful pilot in Hastings backed by data from across the CCG was used to inspire the whole system to support practices to offer improved care using a cross sector prescribing guideline that ensured consistent messaging about chronic pain. 21-28% reductions in the volume of prescribing of strong opioids was achieved.

In East Kent a collaborative approach brought organisations together to better meet the needs of patients with a focus on patients requiring knee surgery creating a cross sector implementation plan.



Collaboration within the Sunderland care system led to a “position statement” and the public facing campaign “Painkillers Don’t Exist”. This was made the cornerstone of consultations for chronic pain and drove a monthly reduction in prescribing of 0.7%

In recognition of the complexity of care for patients with chronic pain North Central London established a MDT 'Opioid Stewardship Committee' to review and learn from complex cases, amending guidance and protocols as a result.

Cornwall and the Isles of Scilly have operated multiple interventions which form a system-wide approach. A Patient Safety Quality Improvement (PiSQuI) project supported general practice to set an ambition to reduce opioid prescribing and test ideas to support improved care. At the same time the acute trust implemented new protocols to prevent initiation and escalation of opioid doses. Perranporth, one locality in Cornwall, introduced "Skills Not Pills" via Facebook to offer a virtual self-support patient group. Bringing together organisations from across Cornwall achieved a 28% reduction in high dose patients over 3 years.

The 11 CCGs that formerly made up the West Yorkshire and Harrogate STP collectively undertook an National Institute for Health Research (NIHR) funded study across 311 practices. The Campaign to Reduce Opioid Prescribing reduced prescribing by 5.14%, reversing a previously increasing trend and delivered consistent messages across a population of around 2.5m people.

A trust-led initiative in Nottinghamshire led to a 3.8% reduction in new invitations of opioids at discharge. This was achieved using revised protocols and generating a consistent message for patients by offering education to general practice and a patient information leaflet that was agreed for the county.

In Lancashire, the CCG, the Local Authority and the Addiction Services worked collaboratively to improve care for patients in the Pennines. This linked management of dependence with psycho-social interventions and support for housing, education, training and employment.

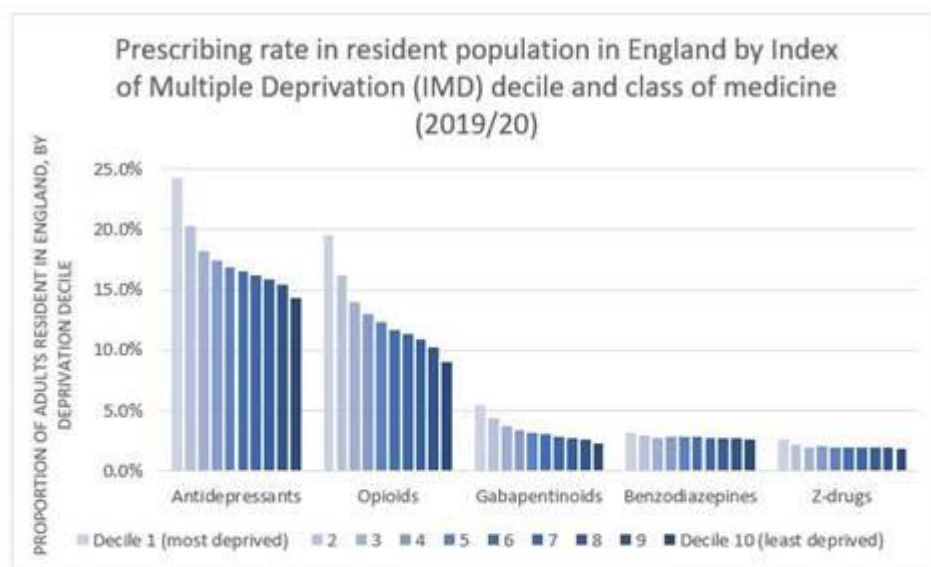
Gloucestershire operated a system wide "Living Well with Pain" programme which included a primary care 'risk mitigation programme'. 308 out of 762 high risk patients (40%) were supported to reduce or stop their pain medication. Practices found that the programme built confidence, offered improved support and generated better liaison with the pain clinic and musculoskeletal (MSK) services.

Process mapping by the Somerset system identified that providers did not fully understand the services available across their system often leading to duplication and inefficiency in the patient journey. The system deployed guidelines, GP audits and improvement measures and offered educational opportunities in primary care whilst developing a wider MDT approach to pain management.

'I reduced my oxycodone high doses. I was scared initially but came off oxycodone eventually and feel amazing. I now believe all the tablets I took affected my mental health and changed my whole personality. Now I am getting back to myself, with thanks to my doctors' support' Patient in East Sussex

Inequalities

In the reviewed case studies and associated resources there were no patient information leaflets which had been translated into languages other than English and therefore no cultural awareness of language use.



Indices of Multiple Deprivation (IMD) was used for the analysis of deprivation, taken from the ONS and assigning each patient based on their most recent known address (not necessarily patient address at the time of prescribing). The figures show variation in annual prescribing for the most recent full financial year 2019/20. Antidepressants and opioids have noticeably increased rates of prescribing in the most deprived decile compared to the least deprived decile.

The ONS England population by IMD was used as the denominator for this analysis, whereas the PHE report used registered population which would lead to slightly different proportions.

These patient characteristics were identified as increasing the risk of harm in the examples that were analysed. Risk arose either from increased risk of long-term use or susceptibility to dependence or harm.

- >Men
- >Older age
- >Prescribed benzodiazepines
- >Unemployed
- >A&E attendance
- >Family History of Drug or Alcohol or prescribed medicine dependence
- >PMH of substance misuse or alcohol dependence
- >Women with PH of pre-adolescent sexual abuse

- >Depression
- >Other psychological disease
- >Prescribed >120mg Oral Morphine Equivalent

Conclusion & Recommendations

The AHSNs hold a unique position within the health and care landscape. AHSNs hold deep local relationships with health and care systems via their 'on the ground' presence in every region. This allows AHSNs to have insights about how innovation can be spread in practice in a real-world setting, with the ability to implement innovations at scale across all areas of the country. Complex problems, such as opioid prescribing show that a multifaceted approach is required across the system. Patient Safety Collaboratives are well placed to bring information together to translate the evidence into real-world practice, utilising specific quality improvement skills to ensure that change is sustained and embedded.

This report is the first step in understanding real-world evidence and impact and provides insight on whether innovations are ready to scale and systems are ready to adopt.

Through their unique position, AHSNs can connect local, regional and national networks to share best practice approaches and knowledge-share, unifying innovators and offering real world evaluation.

The analysis identified that improvements in care were most effectively facilitated if clinicians were supported to adopt new practices at the same time as people on opioids were supported to adopt alternatives to medication.

A stratified approach to offering support to people on opioids has been identified by the analysis as a pragmatic approach (figure 4).



4 Stratified support for people prescribed opioids

Some people on opioids appear to respond to simple advice & guidance, this might be given in the form of a letter signposting them to resources such as [My Live Well with Pain](#). Brief interventions by the GP, during a consultation can also contribute to improvement. Localised services, delivered over the scale of a [Primary Care Network](#), offering support for tapering along with signposting to biopsychosocial interventions may support many patients to reduce their doses or stop taking opioids. For patients with the most complex needs the analysis shows the benefit of services, delivered at place, by a multidisciplinary team with specialist knowledge of both managing dependence and managing chronic pain.

The analysis recognised the benefits of a whole system approach to continuous improvement in opioid safety. Smaller scale support remains valuable, particularly to the patients that benefit. However, in these situations patients experience discord from the mixed messages they receive from different parts of the system or even different practitioners. The effort to reduce doses of opioids, which is often achieved slowly over months, is easily undone in a single prescribing episode by another service.

A whole system continuous improvement approach also increases the opportunity to target resources towards the patient groups that are most in need because of inequitable distribution of harm associated with opioids. A whole system approach delivered over a number of years appears to be necessary to improve care at sufficient scale and in a way that sustains the beneficial changes.

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