

Opioid Prescribing Quality Improvement Toolkit for Primary Care

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London and North East London for their valuable contributions.



Introduction

This toolkit is a resource for general practices wishing to implement small changes that can reduce inappropriate opioid prescribing for chronic non-cancer pain. There is very little evidence for the use of opioids in chronic non-cancer pain and [we estimate](#)¹ that for every 62 patients with chronic pain who can be supported with alternatives to long-term opioid analgesia, 1 life can be saved.

This toolkit is an accumulation of work that has either been tested or is planned to be tested locally and many of the resources included have been shared by general practices. We thank these practices for sharing their learning with us and the wider healthcare system and hope to add to this toolkit with further ideas.

Quality improvement is an established methodology, and this toolkit will use the [Institute for Healthcare Improvement \(IHI\) model](#) (see diagram 1).

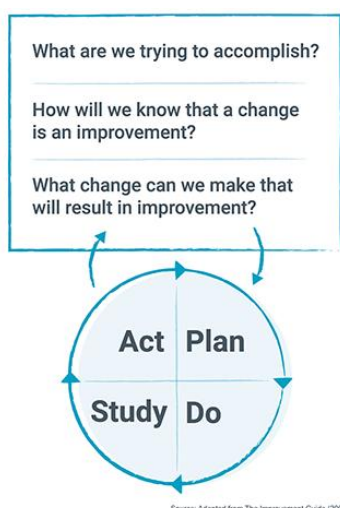


Diagram 1: IHI Model for Improvement

This model uses a Plan-Do-Study-Act (PDSA) cycle to test small changes. By using these cycles general practices can implement small changes with current capacity, quickly testing and adapting, and hopefully celebrating successes. The [PDSA cycle](#) is an iterative process that helps implement and refine interventions effectively (diagram 2).

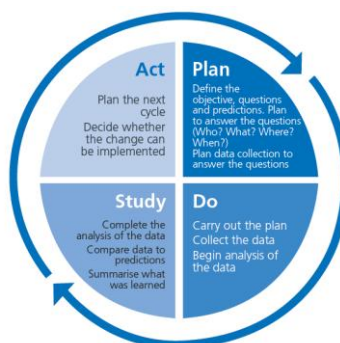


Diagram 2: PDSA cycle

¹ Access via NHS Futures login; access can be requested via link.

How to use the toolkit

General practices should adapt the tools provided to suit their own ways of working and local populations. The toolkit aims to provide ideas and a structure for implementation but is not intended to provide exhaustive resources or overarching clinical governance. It is recommended that practices locally agree the work and consider clinical governance.

Suggested process:

- View your prescribing data for opioids and discuss as a practice possible opioid related areas of prescribing that you would like to improve.
- The toolkit can suggest ideas that can create changes in prescribing data and practice. Some of these are interlinked.
- Consider the size of the project that you can manage as a team and plan accordingly. It is better to start slowly and do something, than become overwhelmed and stop.
- A PDSA cycle template is provided for each option in the toolkit. This has questions that will help you plan each step of the cycle and suggestions for measurement. Agree and adapt these criteria to suit your needs.
- Remember to measure and share the results across the practice frequently. Sharing results helps to keep everyone focussed and engaged.
- If you are not seeing the results you hoped for in the data, do not be disheartened. It is very important learning and will help inform you on what you can improve for your next PDSA cycle.
- If you do see improvement, make sure you celebrate your success!

1. Repeat prescribing housekeeping

Aim	<p>Option 1: To ensure all opioid medication that has not been issued in the last two months is safely removed from repeat on the clinical system if no longer clinically indicated.</p> <p>Option 2: To ensure that all schedule 2 and 3 opioid medication that has not been issued in the last two months is safely removed from repeat on the clinical system if no longer clinically indicated.</p> <p>(Note: the time scale can be adapted as needed e.g., to three months)</p>
What are we trying to accomplish? (The why)	<ul style="list-style-type: none"> • To ensure that opioids that are no longer currently required by the patient are removed from repeat. • To ensure patients are using opioids appropriately and for the indication intended by the prescriber. • To avoid inappropriate use of opioids for chronic non-cancer pain. • To support good opioid stewardship.
How will we know that there has been an improvement? (Measures)	<p>The change in the number of patients who have opioids on repeat but have not been issued the medication within a specified time. (See Resources Available section on the next page.)</p>
What change can we make? (The how)	<p>A suggested approach:</p> <ul style="list-style-type: none"> • Import and run the relevant clinical system search to identify the patients who have not had opioid medication issued in the last 2 months. • Review the patients and consider: <ul style="list-style-type: none"> ○ Removing the item from repeat and communicating the change to the patient. (Suggested Accurx wording is available in resources.) ○ Speaking to the patient to review whether prescribing on repeat is appropriate or whether issuing as an acute when needed is a more appropriate option. ○ If long-term opioids are required but the patient is needing less per month than prescribed. Amend the dose and quantity to reflect the current usage. • Re-run the search every two months and review the prescribing.

1. Repeat prescribing housekeeping

Resources available

Clinical system searches:

- SystmOne search:



Opiate housekeeping
searches.rpt

***NB:** *EMIS searches are not currently available. If you are willing to create and share EMIS searches for this toolkit option, please contact Jessica.Catone@uclpartners.com.*

- Accurx message wording:

We are pleased to notice that you have not requested opioid pain medication, such as codeine, morphine, oxycodone, or tramadol, recently. Opioids are no longer routinely recommended for chronic pain (lasting 3+ months) because they can provide less pain relief but cause more harm when used for long periods of time. We have removed this medication from your repeat prescription. It will still be available to request for sudden, short-term flare-ups of pain.

Please contact me at the surgery [[ADD SURGERY CONTACT DETAILS](#)] if you would like to discuss this further.

Find out more about opioids by clicking this link (printable version at the bottom of the page): <https://www.fpm.ac.uk/opioids-aware-information-patients/taking-opioids-pain>

Repeat prescribing housekeeping (suggested PDSA cycle worksheet)

Plan	<ul style="list-style-type: none"> • Choose the search to use (all opioids/just schedule 2 and 3) • Choose the time frame for non-collection (2 months/ 3 months/ other) • How will communication to the patient happen if medicines are stopped (and agree the template to be used)?: <ul style="list-style-type: none"> ○ Accurx ○ Letter ○ Phone ○ Other • Who will: <ul style="list-style-type: none"> ○ import and run the search? ○ review the patients and make the changes to the repeat? ○ communicate the change to the patient? • When will the work start and be completed? • How often will you re-run the search: monthly/bi-monthly/other?
Do (suggested data to collect)	<ul style="list-style-type: none"> • Searches imported and run (yes/no) • Date started • First run - number of patients: <ul style="list-style-type: none"> ○ Identified ○ Reviewed • Where opioids are removed from repeat <ul style="list-style-type: none"> ○ Communication sent (and by which route) ○ Who contacted surgery to query the change. (Make a note of the query and outcome) • Date completed. • Number of patients who remain with opioids on repeat at the end of the review.
Study	<p>Analyse the results:</p> <p>What worked well:</p> <p>What could be done better or differently:</p>
Act	<p>What changes would you make to the process ahead of the next run of the search? Then plan your next PDSA cycle.</p> <p><i>If you have only used the search for schedule 2 or 3 opioids you could consider using the "all opioid" search.</i></p>

2. Brief interventions (making every contact count)

Aim	<p>For all healthcare professionals (HCP) in a practice or PCN to use brief intervention techniques to increase the number of people accessing support to optimise pain management and reduce the use of inappropriate opioids.</p> <p><i>(Note: Adding in the number of patients aimed for and a timescale will ensure the aim is a SMART aim)</i></p>
What are we trying to accomplish? (The why)	<p>Brief interventions have been used successfully in many areas of healthcare to support changes in behaviour and thinking, e.g. smoking, and can be transferred to opioids that are being taken for chronic non-cancer pain. This toolkit option aims:</p> <ul style="list-style-type: none"> • For all healthcare professionals that are seeing a patient who is taking an opioid for ongoing pain to perform a brief intervention, provide links to patient information, or refer to a clinician for a pain management review. • To increase patient awareness of the possible harms and lack of effectiveness of opioids in chronic non-cancer pain. • To increase the number of patients accessing support to attempt safe tapering of opioids and explore other options for pain management.
How will we know that there has been an improvement? (Measures)	<ul style="list-style-type: none"> • There will be an increase in the recorded use of brief interventions to patients on long-term opioids. • There will be an increase in the referrals made by HCPs to an appropriate clinician for support with pain management and opioid tapering. • There will be a reduction in the number of people taking long-term opioids (NHSBSA ePACT indicator OP2).
What change can we make? (The how)	<ul style="list-style-type: none"> • Agree a brief intervention process for opioids that is adopted by all HCP in the practice/PCN (consider the wider range of HCP including physiotherapist, social prescribers, health and well-being coaches, community pharmacist) • Ensure all staff are informed and confident with making the intervention.

2. Brief interventions (making every contact count)

Resources available

1. A webinar recording aimed at social prescribers and health and well-being coaches on chronic non-cancer pain can be found [here](#).
2. Possible questions/information to use as part of a brief intervention:
 - I can see that you are taking [INSERT OPIOID] for your pain.
 - What benefit do you think it is providing?
 - What side-effects do you think it causes?
 - Do you know how to take your medicine as prescribed (e.g., at what time, how often, with food or not, what to do if they miss a dose, etc.)? Are you able to take it as prescribed?
 - (If applicable:) Are you aware of the possible interactions [INSERT OPIOID] can have with [INSERT OTHER MEDICATION(S)] which you are taking?
 - Have you noticed any other issues or concerns whilst taking your opioid medication?
 - Evidence suggests that for many people opioids are not very effective in chronic (or ongoing) pain that is not related to cancer. In many cases they can be harmful and have many side-effects, such as constipation, nausea, vomiting and drowsiness in the short term. Over time, they can also cause long-term constipation, problems with sex and fertility, and increased pain and sensitivity to pain.
 - Would you like to talk to someone at the practice about your pain, other ways of managing your pain, or perhaps reducing your opioids a little?
 - There are some useful sites to help you with information about chronic (ongoing) pain. (These can be shared via Accurx or email, or via QR codes or printouts for an in-person appointment.)
 - BHRUT Use of Opioids
<https://www.youtube.com/watch?v=EJNDBPiAgY0>
 - BHRUT Opioid Reduction
https://www.youtube.com/watch?v=6bFQL_jTSIg
 - BHRUT YouTube channel Living Better with Pain
<https://www.youtube.com/@livingbetterwithpain495>
 - Live Well with Pain
<https://livewellwithpain.co.uk/>
 - Brainman stops his opioids
<https://www.youtube.com/watch?v=MI1myFQPdCE>
 - Brainman understanding pain
<https://www.youtube.com/watch?v=jlwn9rC3rOI>
 - **Reducing your opioids must be done slowly to avoid withdrawal effects. Please do not stop your opioids suddenly and seek medical advice and support when you are ready to reduce. (Note: A version of this advice wording should be included.)**
3. If you believe a patient may be dependent on their opioids but unaware, this [short video](#) that shares lived experience can be shared electronically to allow the patient to reflect and re-engage with the clinician.

3. Opioid tapering clinics or appointments

Aim	<p>To support patients to safely taper opioid medication and optimise their pain management.</p> <p><i>(Note: consider adding in the number of patients that are aimed to be reviewed and setting timescale to ensure the aim is a SMART aim)</i></p>
What are we trying to accomplish? (The why)	<ul style="list-style-type: none"> • To safely reduce the number of patients who are unnecessarily taking opioid medication for their pain management. • Support non-pharmacological methods of pain management. • Referral for specialist pain management advice and support if necessary.
How will we know that there has been an improvement? (Measures)	<ul style="list-style-type: none"> • The number of patients taking long-term opioids or dose will reduce. • The clinics are full and well attended / patients attend appointments. • Patient feedback on the clinic(s) or appointment(s) is positive.
What change can we make? (The how)	<ul style="list-style-type: none"> • Schedule clinic sessions or appointments that are dedicated to supporting pain management and opioid tapering with an appropriately trained health care professional. • Identify patients that should be invited to the appointments.
Resources available	<ul style="list-style-type: none"> • Opioids Aware • Faculty of Pain Medicine FPM Learning resources • Opioid calculator - ANZCA (Also available as an app on the Google play or Apple store.) • Opioid switching calculator - West of Scotland Chronic Pain Education Group Opioid Switching Calculator • Consider using an invitation letter – see toolkit option 4. Invitation letters • UCLPartners Group Education Session resources (plus links to further resources at the end of the Implementation Guide) • If you believe a patient may be dependent on their opioids but unaware, this short video that shares lived experience can be shared electronically to allow the patient to reflect and re-engage with the clinician.

Opioid tapering clinics or appointments (suggested PDSA cycle worksheet)

Plan	<ul style="list-style-type: none"> • Set up the appointments: <ul style="list-style-type: none"> ○ How long will they be (initial appointments are likely to need a longer time)? ○ How many appointments are to be allocated per week? ○ Will they be scheduled as a clinic, or as individual and dedicated appointments across the week e.g., one per day per clinician? ○ Who will be the clinician for the appointments? (Note: Where pharmacy technicians are available, they may be able to do follow-up appointments if a management plan is in place.) ○ Who will the clinician debrief with/escalate for support as needed? ○ Which patient group is appropriate for the clinics (based on the experience and competence of the clinician)? ○ How will patients be identified and invited to the clinic? There may be more than one method. Options include: <ul style="list-style-type: none"> ▪ Referrals from other HCP e.g., nurses doing LTC reviews for respiratory conditions ▪ Referrals from brief interventions (see toolkit option 3. Opioid tapering clinics or appointments) ▪ Clinical system searches or request NHS numbers for NHSBSA ePACT indicators ▪ Using invitation letters (see toolkit option 4. Invitation letters). • What other support is available: <ul style="list-style-type: none"> ○ Physiotherapy ○ Social prescribers and health and well-being coaches ○ Pain management programme ○ Online resources.
Do (suggested data to collect)	<ul style="list-style-type: none"> • Number of: <ul style="list-style-type: none"> ○ Appointments used ○ Appointments available ○ Length of appointments ○ Total time allocated ○ Patients seen in the appointments ○ Tapers/opioids stopped ○ Non-pharmacological support provided and type (e.g., pain management group, online resources) ○ Referrals to secondary care • Opioid medication tapered (drug, starting dose and finish dose) • Clinician feedback • Patient feedback on the clinic, and their own functionality and quality of life.

Study	Analyse the results: What worked well: What could be done better or differently:
Act	What changes would you make to the process ahead of the next run of the search? Then plan your next PDSA cycle.

4. Invitation letters

Aim	<p>To provide patient information regarding chronic pain management to appropriate patients and invite them to the GP practice to review their pain management and to safely taper opioid medication if appropriate.</p> <p><i>(Note: consider adding in the number of patients invited and the timescale to ensure the aim is a SMART aim)</i></p>
What are we trying to accomplish? (The why)	<ul style="list-style-type: none"> • To provide patients taking opioids for chronic non-cancer pain: <ul style="list-style-type: none"> ○ Information on the evidence and harms for long term opioids. ○ Information on non-pharmacological methods of pain management. ○ Opportunity to attend a pain management review with a clinician and to be informed about opioids before attending.
How will we know that there has been an improvement? (Measures)	<ul style="list-style-type: none"> • The number of patients attending to discuss their chronic pain management because of a letter will increase and the number of patients taking long term opioids will reduce. • Patients attending the appointment will be better informed due to the information in the letter and more open to discussing reducing opioid medication.
What change can we make? (The how)	<p>Identify patients who are appropriate to receive an invitation with supporting information about opioids. Provide appointments with an appropriate clinician as patients respond to the letter.</p>

**Resources
available**

This intervention may be used alongside toolkit option [3. Opioid tapering clinics or appointments](#) or toolkit option [5. Codeine prescribing on repeat](#).

Possible letter wording for the invitation:

We are writing to you because you are currently taking opioid medication. Opioid medication includes medicines such as codeine, tramadol, morphine, fentanyl, buprenorphine, and oxycodone.

Opioids are pain relieving medications which should only be used for short term relief of pain from injury, surgery, or cancer. They are effective over a short period of time to relieve moderate to severe pain.

Evidence shows us that:

- Opioids should not be routinely used for long term pain and that they often cause more side-effects than benefits.
- The longer opioids are used and the higher the dose, the more your brain becomes sensitive to pain and your levels of pain may increase. (This is called increased pain perception).
- Tolerance develops and means you need higher doses to get the same effect, which increases the risk of side-effects and can make the pain worse.
- Some people become addicted to opioids.

Recent medical research suggests that if you take opioid drugs for many months or years it can affect your body in a number of ways that increases your risks to your health.

Short-term effects include	Long-term effects include	Signs of addiction
Constipation	Constipation	Craving for medication
Vomiting	Weight gain	Feeling you need to take more medicine than prescribed – even if bad for your health
Nausea	Difficulty breathing at night	Feeling you need to take more medication for the same effect
Itching	Itching	Experiencing withdrawal when you stop
Drowsiness	Reduced ability to fight infection	Taking opioids for reasons other than pain relief
	Opioid induced pain sensitivity	
	Increased levels of pain	
	Reduced sex drive	
	Irregular periods	
	Fertility issues	
	Erectile dysfunction	
	Early death	

Taking opioids can affect your driving ability by reducing your concentration and reaction times, even if you feel well.

Unfortunately, it may not be possible to take away all of your pain, and you may have to accept that you may always have some level of pain. We recommend livewellwithpain.co.uk - this website has lots of information and resources for people who are living with ongoing pain.

Everyone prescribed long-term opioid medicines should have them reviewed at regular intervals. We would like to offer you a review, and to discuss if you want to try reducing your dose. Many people find that they can reduce their opioid dose without the pain increasing. As fewer side-effects are experienced, quality and enjoyment of life can improve. All of this contributes to greater physical fitness.

Please do not stop taking your opioid suddenly. If you do, you may experience withdrawal symptoms (shivers, body aches, widespread pain, sweating, diarrhoea, increased pain, difficulty sleeping, nausea and vomiting, irritability, and agitation). Instead, we would recommend a gradual reduction and will be able to give you personalised advice.

Please contact the surgery on [INSERT PHONE NUMBER] or bring this letter to the reception desk and ask for an appointment with [INSERT CLINICIAN NAME] to discuss your opioid dose.

Thank you for your help.

Yours sincerely,

5. Codeine prescribing on repeat

Aim	<p>To reduce the number of patients prescribed long-term codeine for chronic non-cancer pain as a repeat prescription. This can include codeine in the form of co- drugs, dihydrocodeine, etc.)</p> <p><i>(Note: consider adding in the number of patients and the timescale will ensure the aim is a SMART aim)</i></p>
What are we trying to accomplish? (The why)	<p>The majority of opioid prescribing in GP practice is for codeine tablets. This is often on repeat and is prescribed long-term. Codeine 60mg four times a day is the equivalent of 30mg morphine per day, and therefore carries similar risks and should be discussed with the patient and stopped if not clinically appropriate. (Note: This toolkit option only covers repeat prescribing of codeine and therefore acute prescribing, i.e., potentially short-term and appropriate, is not included.)</p>
How will we know that there has been an improvement? (Measures)	<p>There will be a reduction in the number of patients with a repeat prescription for codeine tablets.</p>
What change can we make? (The how)	<p>Option A – reduce the number of repeats</p> <ul style="list-style-type: none"> Run a clinical system searched to identify patients with a repeat for codeine who have: <ul style="list-style-type: none"> Option 1 – issued opioid medication in the last two months Option 2 – not issued opioid medication in the last two months Option 3 – both option 1 and option 2. Implement a change: <ul style="list-style-type: none"> Option 1 – Review the clinical record and if prescribing is potentially inappropriate, contact the patient to request a medication review. (See toolkit options 3. Opioid tapering clinics or appointments and 4. Invitation letters) Option 2 – Review the clinical record and consider stopping the repeat and sending an Accurx message (see toolkit option 1. Repeat prescribing housekeeping) or manage as in option 1. <p>Option B – Provide patients with information following the presentation of acute injury, to manage patient expectations.</p> <p>When a new acute injury is presented, consider providing supplementary guidance via Accurx that explains the expected timeline of the injury and where codeine has been prescribed acutely, the risks. Messaging can be in written form (see examples in resources) but may also be a short 30 second video done by a practice clinician that can also be sent via Accurx.</p>

5. Codeine prescribing on repeat

Resources available

Option A

- SystmOne searches:



Codeine issued in
last 12m.rpt

***NB:** EMIS searches are not currently available. If you are willing to create and share EMIS searches for this toolkit option, please contact Jessica.Catone@uclpartners.com.

- Links to relevant options in the toolkit:
 - 1. Repeat prescribing housekeeping
 - 3. Opioid tapering clinics or appointments
 - 4. Invitation letters

Option B

Accurx messages to support the management of acute soft tissue injuries.

For an acute prescription for codeine (or other opioid) here are suggested wording for Accurx:

You have been given a short course of opioids (strong pain relief) for your acute pain. If this is a soft tissue injury it should resolve in four to six weeks. Opioids are only useful in the short-term after injury or surgery. If used for over six weeks, they do not work for 90% of people and they can cause harmful side-effects (see this [link](#)) including:

- Dry mouth (50%)
- Constipation (40%)
- Reduced sex drive/erectile dysfunction (25%)
- Sleep problems (26%)
- Weight gain (29%)
- **Increased pain**
- Mood changes
- Increased risk of falls and fractures



Taking opioids in the long term can lead to **tolerance, dependence, and misuse**.

6. Opioid repeat prescribing processes

Aim	To ensure a safe, efficient, consistent, and embedded procedure for managing requests for opioids received through the GP practice prescription service.
What are we trying to accomplish? (The why)	<p>To agree and embed minimum standards for repeat opioid prescribing within the GP practice procedure for managing request for opioids. This is important because:</p> <ul style="list-style-type: none"> • Opioids are high-risk medicines. • Completing this work will support the safe and appropriate prescribing of opioids to provide effectively and timely pain management to patients, using a process that is time-efficient, consistent, and robust for the practice. • It will create clear roles and responsibilities for all involved in the process including patients. • It will Increase the level of assurance both within the practice and to external bodies.
How will we know that there has been an improvement (Measures)	<p>Use of clinical system searches to monitor the effect of the procedures. Suggested searches include:</p> <ul style="list-style-type: none"> • Number of patients with an opioid medication on repeat (all schedules). Inappropriate repeat prescribing should decrease. • Number and percentage of patients with opioid medication on repeat and an appropriate medication review read coded within the last six months. The higher the percentage the better the result. • Number of patients issued opioid medication more than three working days early. The number of patients should be low and there should be a documented reason. • Number of patients who have not had their opioid medication issued from repeat in the last three months (and may benefit from review and discontinuation from repeat). This review can be supported by toolkit option 1. Repeat prescribing housekeeping. Numbers should be kept low so that opioids that do not have a current clinical indication are not left on repeat. • Staff may report a reduced number of queries relating to opioids once the process has embedded.
What change can we make? (The how)	<ul style="list-style-type: none"> • Creating a practice specific procedure for the management of requests for opioids on repeat through the prescription order service at the practice. Ensure that the procedure: <ul style="list-style-type: none"> ○ is co-created with all relevant members of the practice team (this would ideally include local community pharmacist) ○ denotes clear roles and responsibilities. • Is embedded into practice, monitored to ensure adherence, and reviewed/improved as needed. Incorporating regular reviews and assessments of prescribed opioids to ensure appropriateness for patients' pain management needs.

6. Opioid repeat prescribing processes

Resources available

- [Faculty of Pain Medicine Opioid Long Term Prescribing](#)
- [General Medical Council Guidance on Repeat Prescribing and Prescribing with Repeats](#)
- Example: [JUD minimum standards for repeat prescribing of opioids in general practice](#)
- Example: [JUD adaptable flow chart to support the implementation of the minimum standards for repeat prescribing of opioids in general practice](#)

Opioid repeat prescribing processes (suggested PDSA cycle worksheet)

Plan

- Bring staff together from all parts of the process to a workshop. Ensure to include staff that are undertaking the work, not only managers. If possible, include lived experience representation. During the workshop:
 - Discuss and agree minimum standards for repeat opioids prescribing in your ICS.
 - Reflect on whether you currently meet, or exceed, the standards.
 - Decide on the changes to the practice process that you wish to test, how you will measure if they are working, when how frequently you will run the measures, and when you would like the changes to start.
 - Agree roles and responsibilities and reflect on how they will work in your situation.
- Capture the outcomes from the workshop, draft and then agree the procedure you want to try along with a review date. Flow charts are useful as an easy to review document and there is an adaptable flowchart provided in the resources.
- Ensure that all staff are aware of and understand the new standards and/or process and are easily able to refer to the standards and/or process.
- Decide how and when you will review how it is working as a practice to allow staff to feedback concerns whilst you are testing the new procedure.
- If you have not got a clear communication process with your local community pharmacy, then consider creating one with them to enable time-efficient and reliable communication to them when the supply of opioids is either urgent or has been restricted, and also so that they can highlight concerns to the practice.

Opioid repeat prescribing processes (suggested PDSA cycle worksheet)	
Do (suggested data to collect)	<ul style="list-style-type: none"> • Number of patients with an opioid on repeat (all schedules) • Number and percentage of patients with an appropriate medication review within the last six months • Number of patients collecting more than three working days early • Number of patients who have not collected opioids in the last three months (and may benefit from review and discontinuation from repeat). • Feedback on the process: <ul style="list-style-type: none"> ○ Staff feedback on the process. Consider including administration team members that may not process prescriptions but do manage queries from patients, and community pharmacy colleagues. ○ Patient complaints.
Study	<p>Analyse the results.</p> <p>What worked well?</p> <p>What could be done better or differently?</p>
Act	<p>What changes would you make to the process? Then plan your next PDSA cycle or if it is working well when you next review the process.</p>

7. Pain management education for chronic non-cancer pain

Aim	To provide a local, evidence-based pain management support that supports people living with ongoing pain to use self-management techniques that others have found useful and to improve their quality of life despite the pain they are experiencing. This toolkit describes a programme based on the ' <i>Ten Footsteps to living well with pain</i> ' developed by Live Well with Pain .
What are we trying to accomplish? (The why)	<p>Chronic non-cancer pain requires a biopsychosocial approach, and research tells us that whilst medicines are not helpful, peer support and non-pharmacological approaches to pain management can be very successful and improve quality of life for the patient. Opioids have historically been used for chronic pain but are high-risk medicines that can cause significant patient harm for little benefit.</p> <p>Providing non-pharmacological support via this pain management education programme provides clinicians and patients with an effective alternative to medicines as a treatment. Providing support locally allows patients to access the support easily without the transport challenges of secondary care and to build a local peer support network.</p>
How will we know that there has been an improvement (Measures)	<ul style="list-style-type: none"> • Offer of a local pain management education or group programme (number, type/sessions) • Number of patients attending the courses/sessions. The better the attendance and whether patients stay on the course or attend the cafés will indicate how beneficial the support is to them. • Change in patient self-reported scores on how confident they are to self-manage their pain before and after the support offer. There is a health and well-being check tool in the resources to support this. • Patient feedback on the support. • Other support accessed as a result of the sessions e.g. via social prescribers that indicate other health needs are also being met. • Change in medication usage before and after the support (or the medication review after completing the course). • Positive clinician feedback on patient response to the course offer, any change in pain management or appointment demand as a result of the support.
What change can we make? (The how)	<ul style="list-style-type: none"> • Create a local chronic pain management education or group programme that you can offer to your patients locally. This can be designed and offered as a single practice or a range of practices.
Resources available	<ul style="list-style-type: none"> • An implementation guide and resources for Group Education Sessions (GES) are available on UCLPartners' website. • Local branches of Change Grow Live to support with opioid misuse and addiction. • Pain Cafés have been successful in the West and South West of England. More information can be found on the Health Innovation South West's website. • A full suite of pain management resources can be found on the Live Well with Pain website.

