Experiences of reducing opioid prescribing in UK primary care using enhanced feedback

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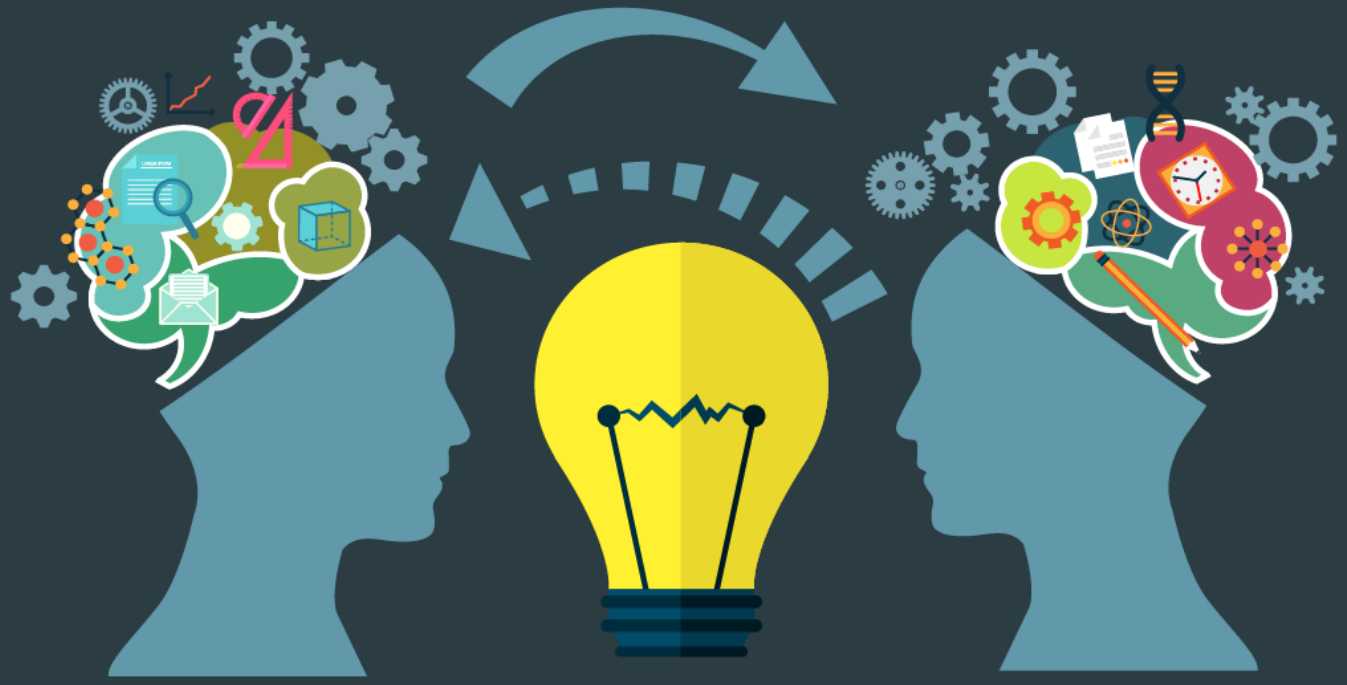
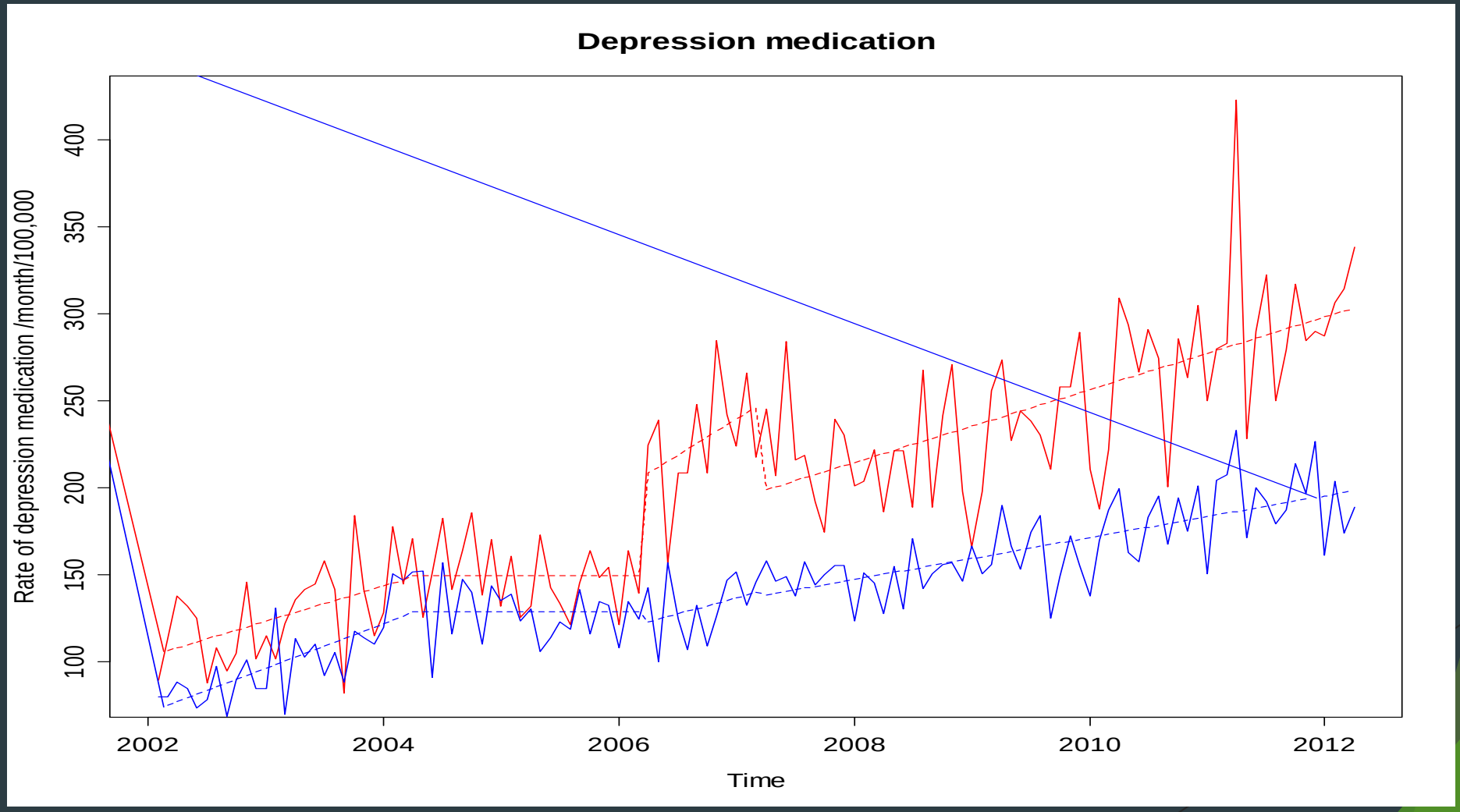
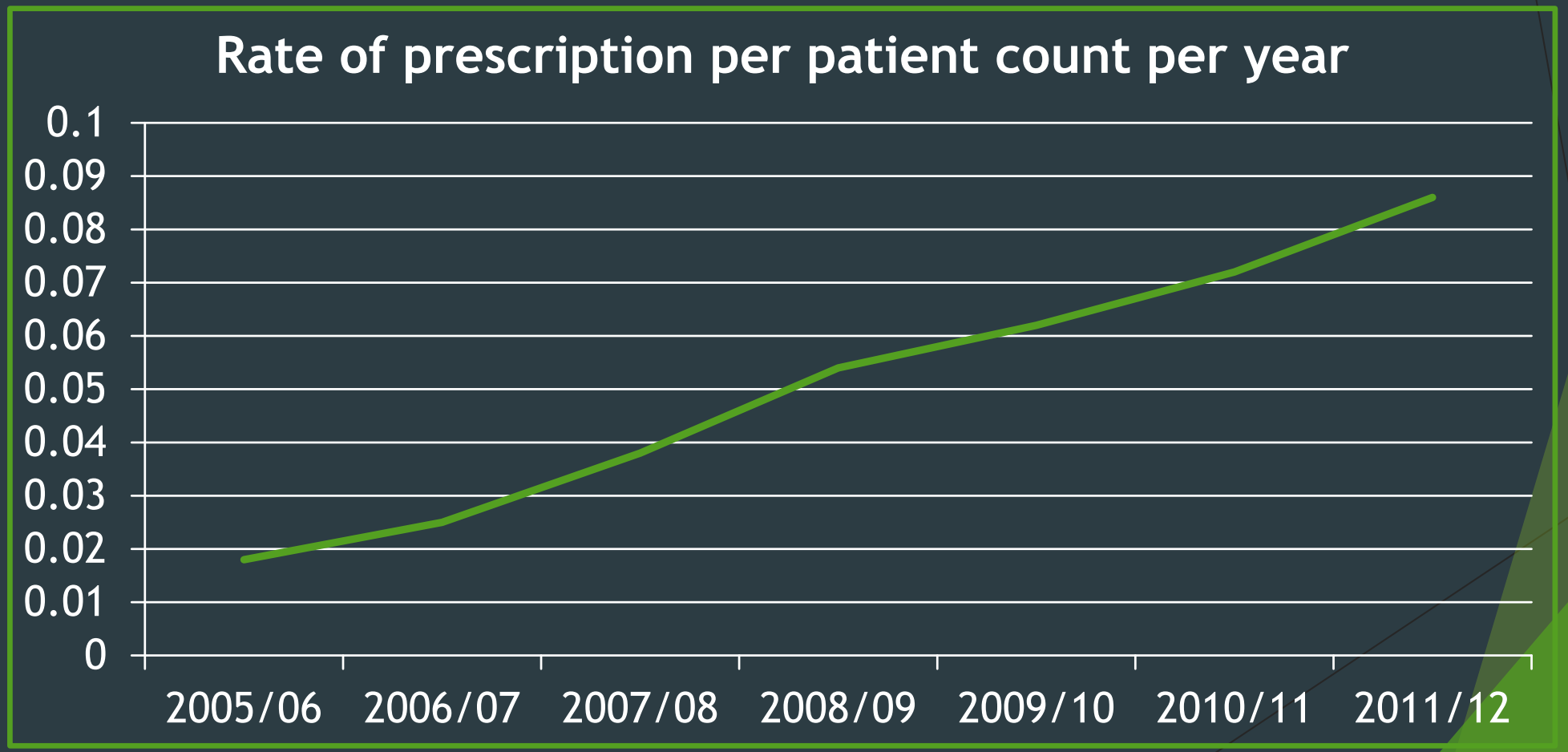
What do you need to have in place to deliver an A&F intervention in primary care?



Depression in chronic disease



OPIOIDS


Rate of prescription per patient count per year
0.1
0.09
0.08
0.07
0.06
0.05
0.04
0.03
0.02
0.01
0
2005/06
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12

ASPIRE

Action to Support Practices Implementing Research Evidence

Diabetes control

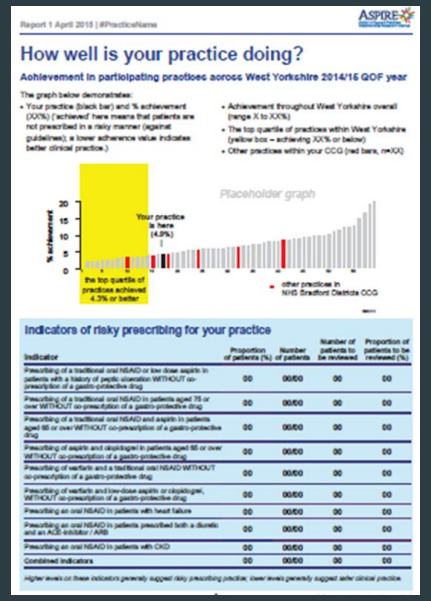
Blood pressure control

Anticoagulation for irregular heartbeats

Risky Prescribing

ASPIRE

Action to Support Practices Implementing Research Evidence



Report 1 April 2015 | #PracticeName

How well is your practice doing?

Achievement in participating practices across West Yorkshire 2014/15 QOF year

The graph below demonstrates:

- Your practice (black bar) and % achievement (XX%) ('achieved' here means that patients are not prescribed in a risky manner (against guidelines); a lower adherence value indicates better clinical practice.)
- Achievement throughout West Yorkshire overall (range X to XX%)
- The top quartile of practices within West Yorkshire (yellow box – achieving XX% or below)
- Other practices within your CCG (red bars, n=XX)

Placeholder graph

% achievement

Your practice is here (4.3%)

the top quartile of practices achieved 4.3% or better

other practices in NHS Bradford Districts CCG

Indicators of risky prescribing for your practice

Indicator	Proportion of patients (%)	Number of patients	Number of patients to be reviewed	Proportion of patients to be reviewed (%)
Prescribing of a traditional oral NSAID or low dose aspirin in patients with a history of peptic ulceration WITHOUT co-prescription of a gastro-protective drug	00	00/00	00	00
Prescribing of a traditional oral NSAID in patients aged 75 or over WITHOUT co-prescription of a gastro-protective drug	00	00/00	00	00
Prescribing of a traditional oral NSAID and aspirin in patients aged 65 or over WITHOUT co-prescription of a gastro-protective drug	00	00/00	00	00
Prescribing of aspirin and clopidogrel in patients aged 65 or over WITHOUT co-prescription of a gastro-protective drug	00	00/00	00	00
Prescribing of warfarin and a traditional oral NSAID WITHOUT co-prescription of a gastro-protective drug	00	00/00	00	00
Prescribing of warfarin and low-dose aspirin or clopidogrel, WITHOUT co-prescription of a gastro-protective drug	00	00/00	00	00
Prescribing an oral NSAID in patients with heart failure	00	00/00	00	00
Prescribing an oral NSAID in patients prescribed both a diuretic and an ACE-inhibitor / ARB	00	00/00	00	00
Prescribing an oral NSAID in patients with CKD	00	00/00	00	00
Combined indicators	00	00/00	00	00

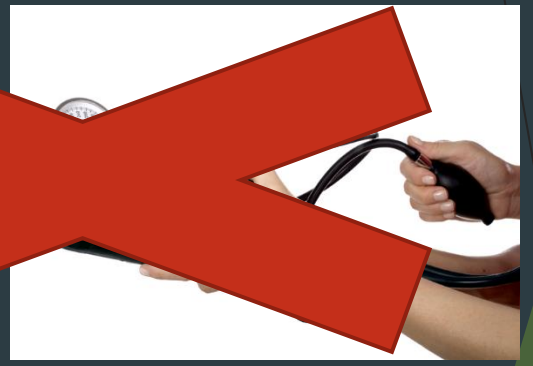
Higher levels on these indicators generally suggest risky prescribing practice; lower levels generally suggest safer clinical practice.

ASPIRE

Action to Support Practices Implementing Research Evidence

Diabetes cont

Blood pr
control



Anticoag
for irregular
heartbe

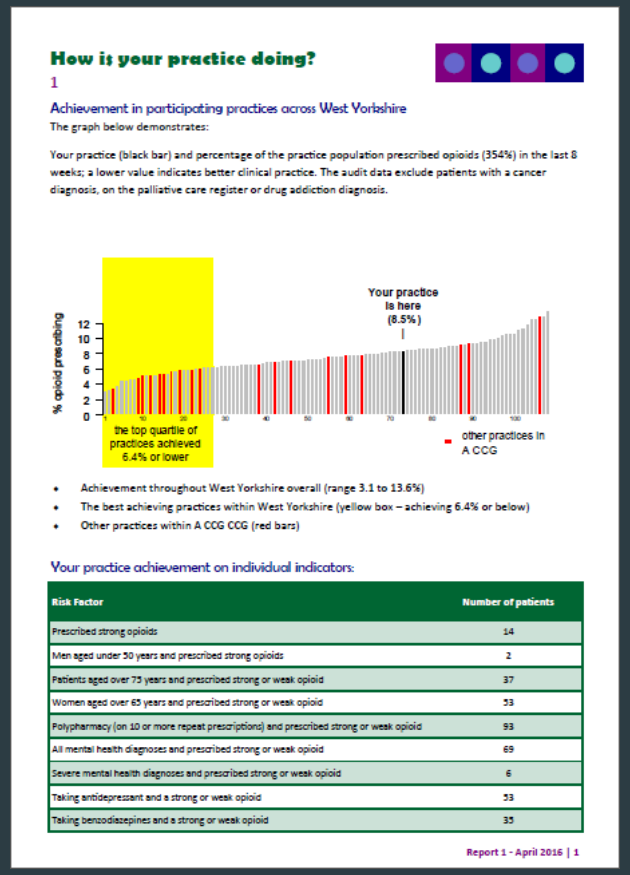
Risky Prescribing

What had we learnt?

- Recruitment
- Trust
- Scaling up
- Detailed EHR searches
- Connections

CROP

Campaign to Reduce Opioid Prescribing



How is your practice doing?

1

Achievement in participating practices across West Yorkshire

The graph below demonstrates:

Your practice (black bar) and percentage of the practice population prescribed opioids (354%) in the last 8 weeks; a lower value indicates better clinical practice. The audit data exclude patients with a cancer diagnosis, on the palliative care register or drug addiction diagnosis.

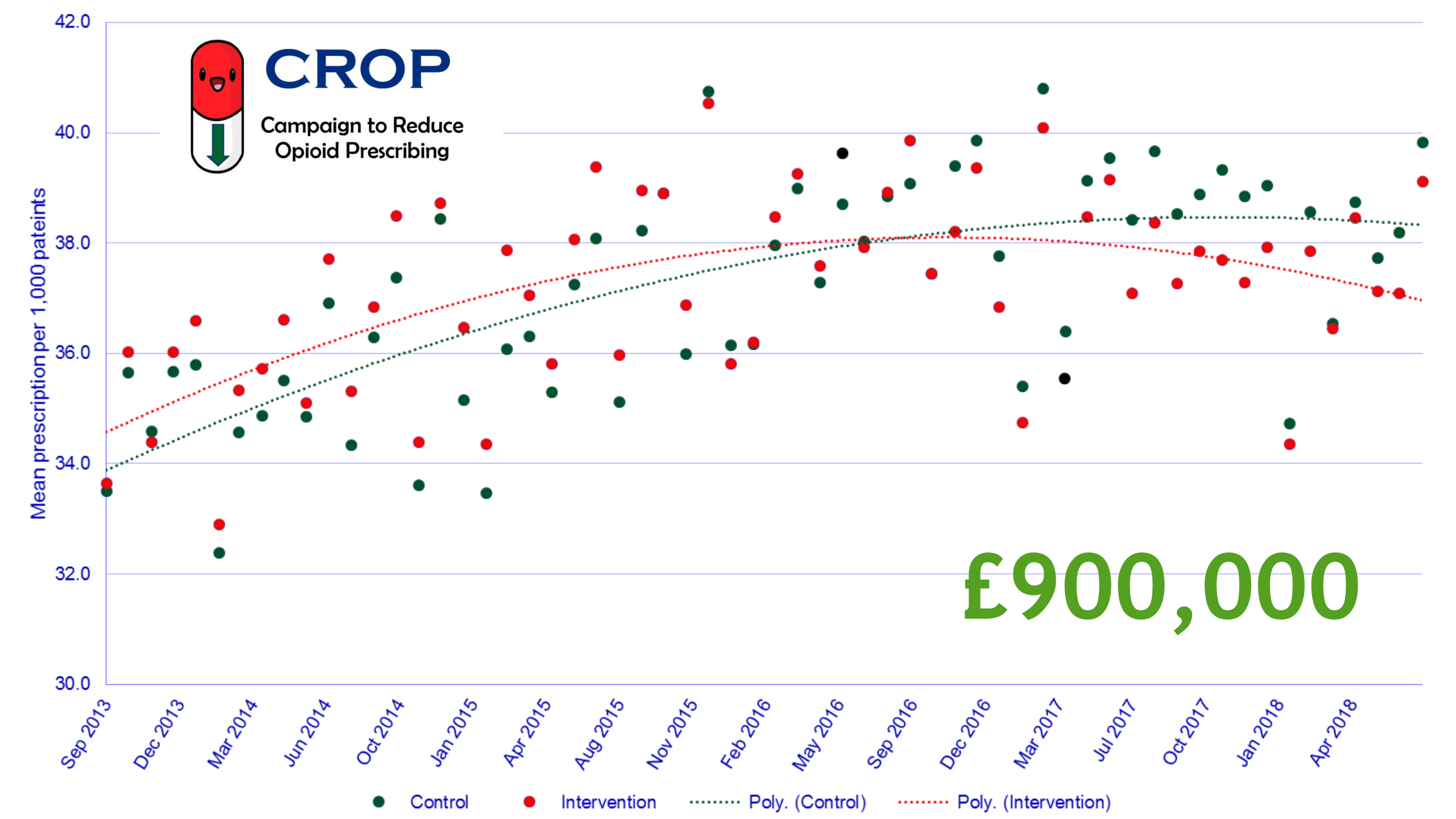
- Achievement throughout West Yorkshire overall (range 3.1 to 13.6%)
- The best achieving practices within West Yorkshire (yellow box – achieving 6.4% or below)
- Other practices within A CCG CCG (red bars)

Your practice achievement on individual indicators:

Risk Factor	Number of patients
Prescribed strong opioids	14
Men aged under 50 years and prescribed strong opioids	2
Patients aged over 75 years and prescribed strong or weak opioid	37
Women aged over 65 years and prescribed strong or weak opioid	53
Polypharmacy (on 10 or more repeat prescriptions) and prescribed strong or weak opioid	93
All mental health diagnoses and prescribed strong or weak opioid	69
Severe mental health diagnoses and prescribed strong or weak opioid	6
Taking antidepressant and a strong or weak opioid	53
Taking benzodiazepines and a strong or weak opioid	35

Report 1 - April 2016 | 1

- Clinical priority
- Locally collected data extracted at scale
- All practices in West Yorkshire (except one!)
- Bimonthly (ASPIRE format) reports for 1 year


CROP
Campaign to Reduce Opioid Prescribing
Mean prescription per 1,000 pateints
42.0
40.0
38.0
36.0
34.0
32.0
30.0
Sep 2013
Dec 2013
Mar 2014
Jun 2014
Oct 2014
Jan 2015
Apr 2015
Aug 2015
Nov 2015
Feb 2016
May 2016
Sep 2016
Dec 2016
Mar 2017
Jul 2017
Oct 2017
Jan 2018
Apr 2018
£900,000
Control
Intervention
Poly. (Control)
Poly. (Intervention)

Connections

UNIVERSITY OF LEEDS

West Yorkshire
Research and Development

NHS
North Kirklees
Clinical Commissioning Group

NHS
Greater Huddersfield
Clinical Commissioning Group

NHS
Calderdale
Clinical Commissioning Group

NHS
Leeds South and East
Clinical Commissioning Group

NHS
Leeds North
Clinical Commissioning Group

NHS
Airedale Wharfedale and Craven
Clinical Commissioning Group

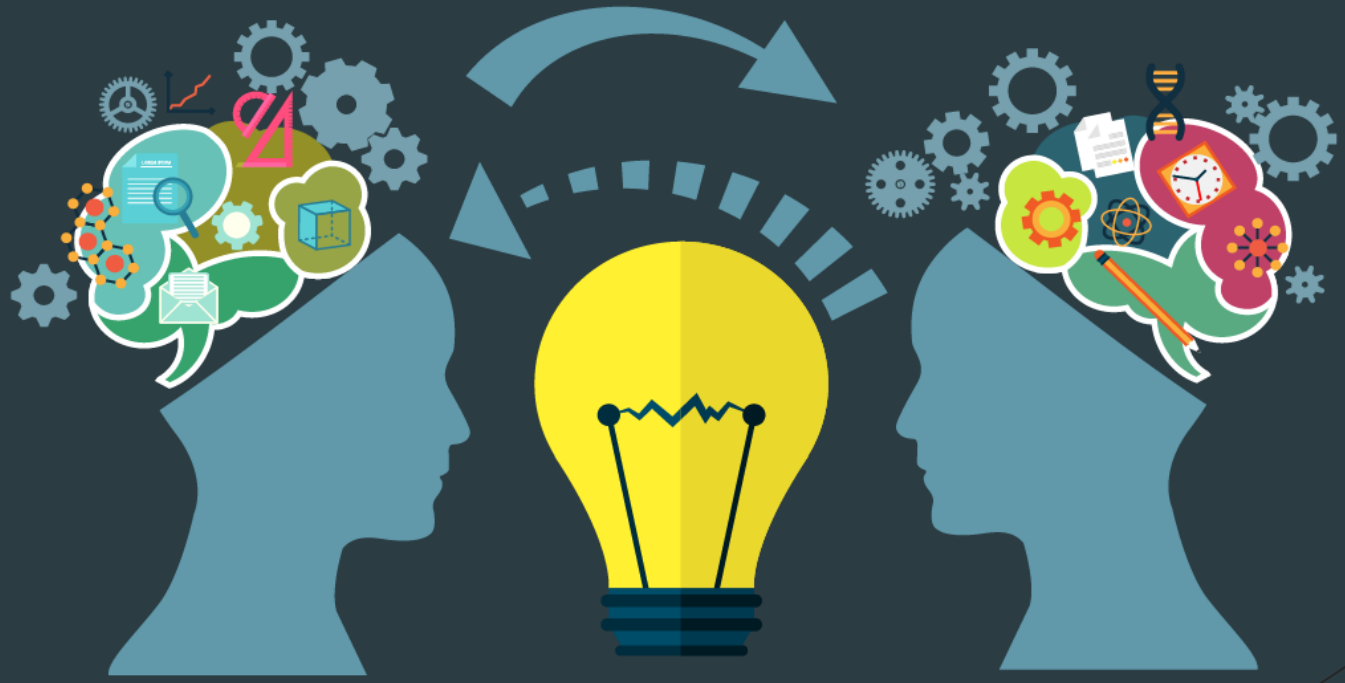
NHS
Bradford Districts
Clinical Commissioning Group

NHS
Wakefield
Clinical Commissioning Group

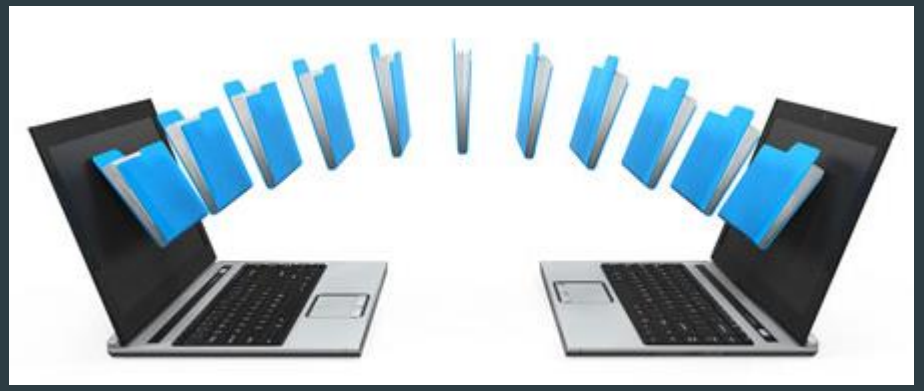
NHS
Leeds West
Clinical Commissioning Group

NHS
Bradford City
Clinical Commissioning Group

Who do you need to connect with and build trust with to deliver an A&F intervention in primary care?



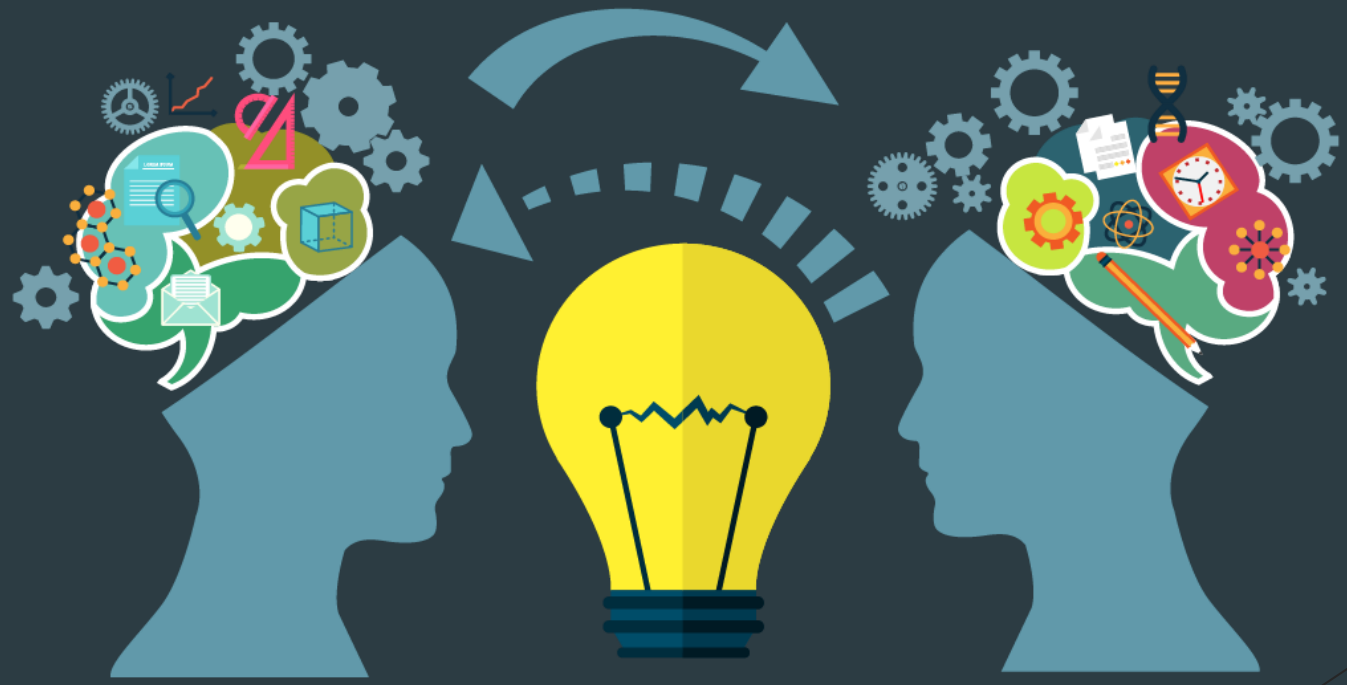
Obtaining data



- National prescribing data available – but includes opioids prescribed in palliative care

- Practices used to sharing data with CCGs and researchers
- Not all GPs use the same EHR system
- Consent to share EHR data added to annual data sharing agreement
- EHR data able to tailor searches to exclude palliative care patients and identify high risk groups

What data do you have access to and what consent is needed to deliver an A&F intervention in primary care?



What did practices say about the opioid feedback intervention?

"Actually I opened a can of worms because there was actually disgruntlement across a couple of prescribers that they thought even the bottom quartile was far too high!"

"I think there's barriers about … patient … satisfaction levels and what patients want. Particularly since we are moving politically from … clinical excellence being recognised as a key driver to GP practice, to patient satisfaction."

"Who wants to be opioid champ? But it needs somebody to encourage, to bully, to run the audit. To … educate the team to continue the downward pressure on reducing it and not initiating it and looking at alternatives and making everybody opioid aware"

"Everybody's … yes it's the right thing to do. Everybody recognises the prescription of opioids for non-cancer pain… is going out of fashion. It doesn't work and risk of all the other side effects and everybody's had hassles with patients"

"Well I, I mean I'm sure everybody in general practice will tell you the same thing. I've been a GP for 20 years and … the … wealth of information we're supposed to digest at the moment is beyond anybody's ability! So to be… the completely honest answer to your question is I don't think there's any way [to make the reports recognisable as something to prioritise]!

What did practices do to reduce their opioid prescribing?

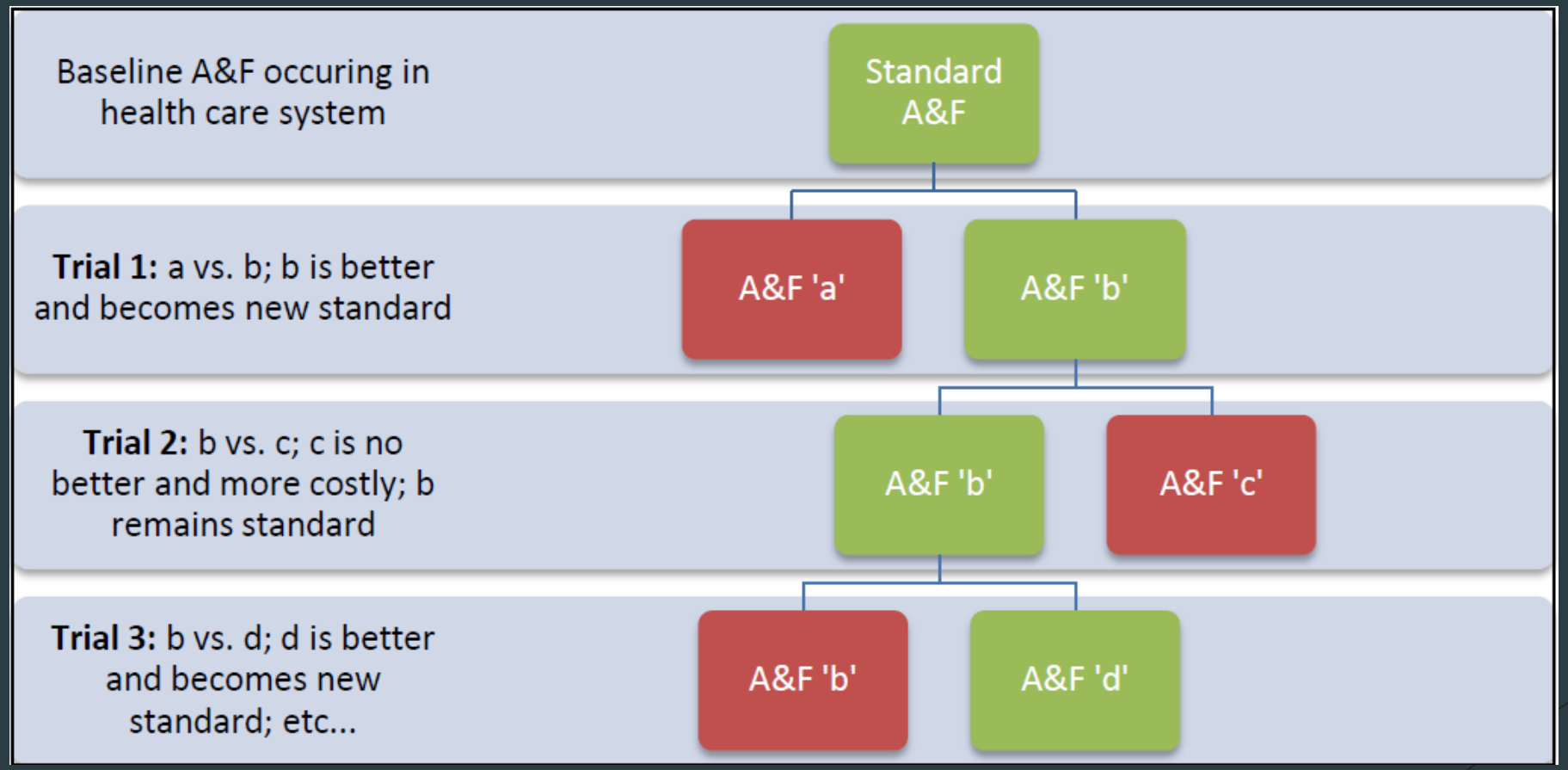
- Searches and alerts
- No more repeat prescriptions
- Sent ‘opioid aware’ leaflets to patients
- Practice protocol for starting opioids
- Consistent message from all GPs

What did we find?

- Practices that reduced prescribing the most had clear structures for quality improvement
- Non-prescriptive feedback allowed practices to identify strategies that fit with their way of working
- Some highlighted that implementation took time and effort, with risks of damage to patient relationships, appointment shortage and competing priorities
- Getting reports seen by the practice is difficult

What did we do next?

Future Implementation Laboratory

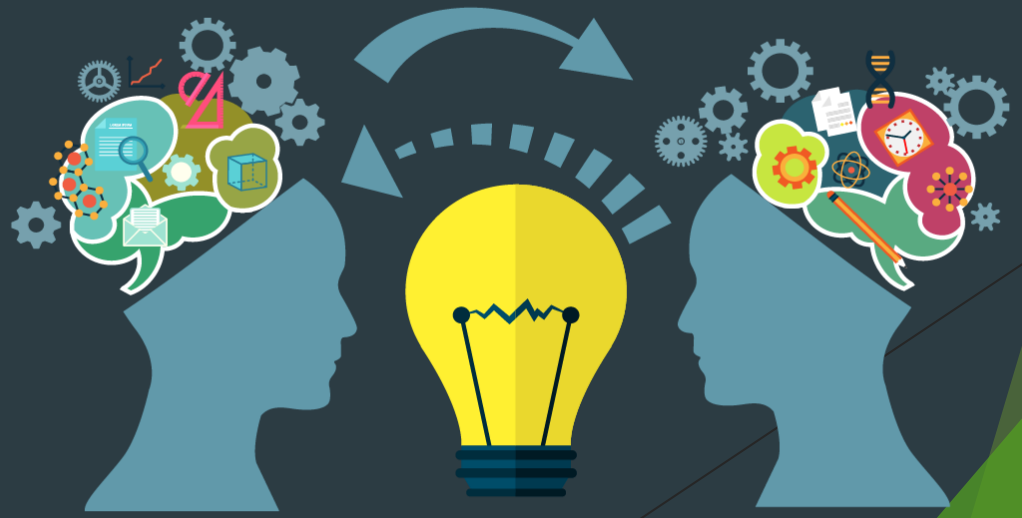


Audit & Feedback

MetaLab

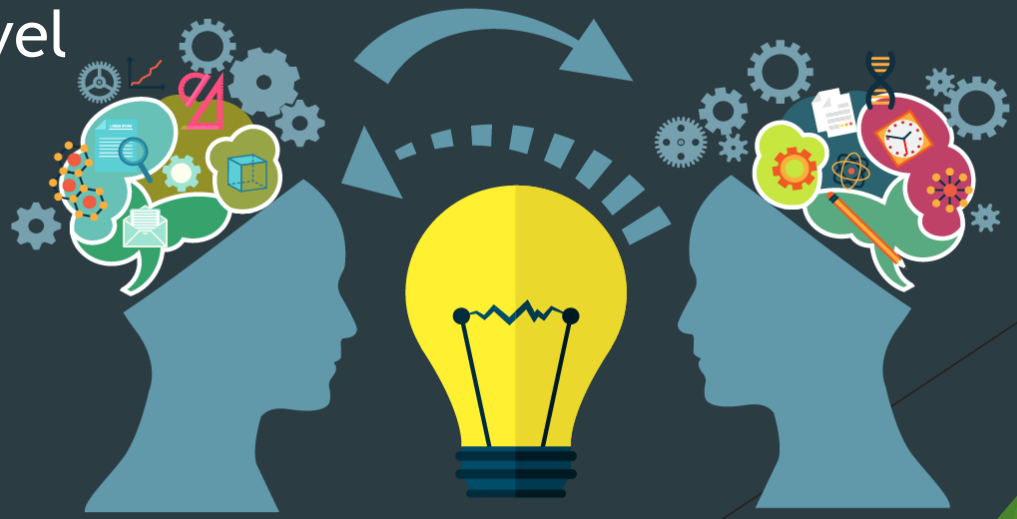
Issues with scaling up - ethics

- Consent?
  - Consent practices to take part and be randomised
  - Consent at commissioner level
  - Opt-out consent
  - Waive consent



Issues with scaling up – level of randomisation

- Increasing networking between practices and commissioning level
  - Randomise at practice level
  - Randomise at commissioner level
  - Randomise at high level



Issues with scaling up – data sources

- Different data sources with different levels of detail and issues
  - Nationally available prescribing data
  - General practice research databases
  - Extract directly from EHRs

Six learning points from our experience

- 1. Build relationships
- 2. Sort data sharing agreements
- 3. Build trust
- 4. Consider ethical issues e.g. consent
- 5. Identify appropriate data sources
- 6. Have a long-term trajectory

Lunchtime!