

# Medication Awareness Pathway Support (MAPS)



**A SHARED CARE, CO-DESIGNED PATHWAY  
FOR HIGH-DOSE OPIOID PATIENTS IN  
FLEETWOOD PCN.**

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Evaluation report by  
Health Innovation North West Coast.

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# 1 EXECUTIVE SUMMARY

High-dose opioid prescribing has become a significant public health issue in England, contributing to addiction, overdose, and increased NHS costs. Despite limited evidence of effectiveness for ongoing chronic pain management, opioids continue to be prescribed at high doses, placing patients at risk of dependency and health complications.

In response, Lancashire and South Cumbria Integrated Care Board (ICB), Fleetwood Primary Care Network (PCN), Inspire Lancashire (specialist drug and alcohol services, provided by the organisation Change, Grow, Live), and Health Innovation North West Coast (HINWC) co-designed the Medication Awareness Pathway Support (MAPS) programme. This pathway aims to provide safer, patient-centred approaches to high-dose opioid reduction through multi-disciplinary collaboration, pharmacist-led reviews, and access to psychosocial and recovery support.

## EVALUATION AIMS

The evaluation assessed whether MAPS:

- Achieved safe opioid reduction in patients on high-dose or multiple opioids.
- Delivered a positive patient experience.
- Was acceptable and feasible for clinicians and stakeholders.

## EVALUATION METHODOLOGY

- Cohort: Patients on  $\geq 120$ mg oral morphine equivalent identified via EMIS patient record searches.
- Methods: Analysis of medication review outcomes and referral activity, patient experience questionnaires, clinician surveys (using the Theoretical Framework of Acceptability), and a multi-stakeholder focus group.
- Period under review: January to June 2025.

## KEY FINDINGS

- **Patient outcomes**
  - 51 patients identified and invited for a medication review; 29 engaged in the review and the MAPS pathway.
  - Overall, engaged participants reduced opioid use by 33%, with some becoming completely opioid-free.
  - Patients were offered patient-centred pain management alternatives and support beyond medication.
- **Patient experience**
  - 73% felt supported; 65% felt comfortable or very comfortable with reviews.
  - Patients valued clear explanations and the supportive role of pharmacists.
  - Some suggestions for more optimal follow-up communications were noted.

- **Clinician experience**
  - Clinicians rated the previous service extremely poorly (net promoter score of minus 100, indicating no one would recommend it as an approach to care).
  - Clinicians reported improved confidence, collaboration, and ability to safely manage opioid tapering with MAPS.
- **Stakeholder insights**
  - Benefits: Better collaboration, safer prescribing, patient-centred care, psychosocial support, and medication cost reduction.
  - Challenges: Variation in practice and patient engagement, time and resource pressures to deliver the model optimally, funding and resource sustainability, and the need for stronger policy alignment to increase the focus on primary care prescribed high-dose opioid patients.
  - Opportunities: Formalising multi-disciplinary team (MDT) models of medication review, enhancing training for primary care, improving patient involvement, and streamlining data sharing.

## CONCLUSION

The MAPS programme demonstrates that collaborative, biopsychosocial models can safely reduce opioid prescribing while improving patient and clinician experience. The approach supports NHS ambitions to reduce harm from opioids and provides a replicable model for wider rollout.

With leadership support and ongoing monitoring, MAPS has strong potential to transform high-dose opioid management across Lancashire and South Cumbria and beyond.

## RECOMMENDATIONS

- **Spread the pathway across the ICS to standardise safe opioid management.**
- **Formalise MDT meetings with clear roles and responsibilities.**
- **Strengthen patient voice through structured feedback and co-creation of care plans.**
- **Expand training for clinical and non-clinical staff on addiction, pain management, and trauma-informed care.**
- **Improve data sharing across primary care and specialist services to enhance continuity.**
- **Secure sustainable funding and strategic buy-in to embed the pathway in the long term.**

## 2 BACKGROUND

High-dose opioid prescribing in England has become a significant public health issue, contributing to multiple problems, including addiction, overdose, and increased healthcare costs.

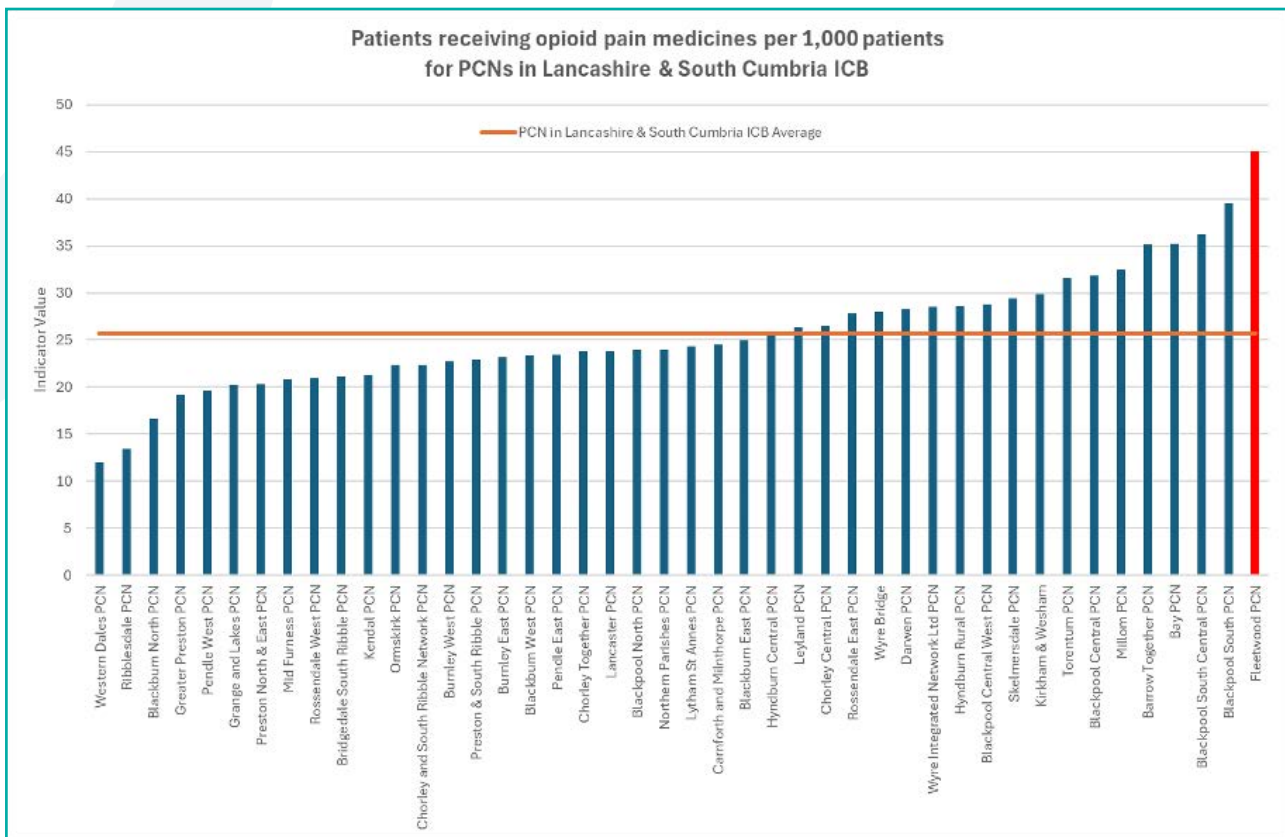
When prescribed at high doses or for long durations patients can develop tolerance, requiring higher doses to achieve the same pain relief, leading to dependency and addiction. It also significantly increases the risk of accidental overdose, which can be fatal.

NHS England have concerns about the over-prescribing of opioids for chronic pain, which frequently occurs despite limited evidence of their long-term effectiveness. This practice can fuel addiction among patients who may not have been properly informed about the risks.

Increased opioid prescribing can also lead to a strain on healthcare resources. Treating opioid addiction and its complications, such as overdose, hospital admissions, and mental health issues, places a significant financial burden on the NHS. This includes costs related to managing addiction (e.g., opioid substitution therapies) and treating patients with opioid-related complications.

In response to particularly acute, deprivation-linked challenges in the region, Lancashire and South Cumbria Integrated Care Board (ICB) have a programme of opioid management.

**Figure 1: shows prescribing for high-dose opioids, and the need for a particular focus on the Lancashire coastal areas.**



Working with Health Innovation North West Coast (HINWC), local teams at Fleetwood Primary Care Network (PCN) and Inspire Lancashire (the specialist drug and alcohol service) set out to collaborate to tackle the growing problem of patients on prescribed high-dose opioids or multiple opioid prescriptions.

HINWC work to bring together stakeholders from across the system to co-design and evaluate new care pathways and inform future policy making and funding streams.

The team co-ordinated the process of a high-dose opioid medication review pathway co-design, bringing together key local stakeholders with representatives with lived experience.

The new pathway aims to foster closer working and facilitate supported medication reviews for patients identified as being at risk of dependency. Bringing in psycho-social interventions and considering treatment with opioid substitution therapies, it provides more options to support patients following their medication review.

As a pharmacist and biopsychosocial-led model, it offers a new way of working, taking pressure off GPs to manage pain medication in isolation.



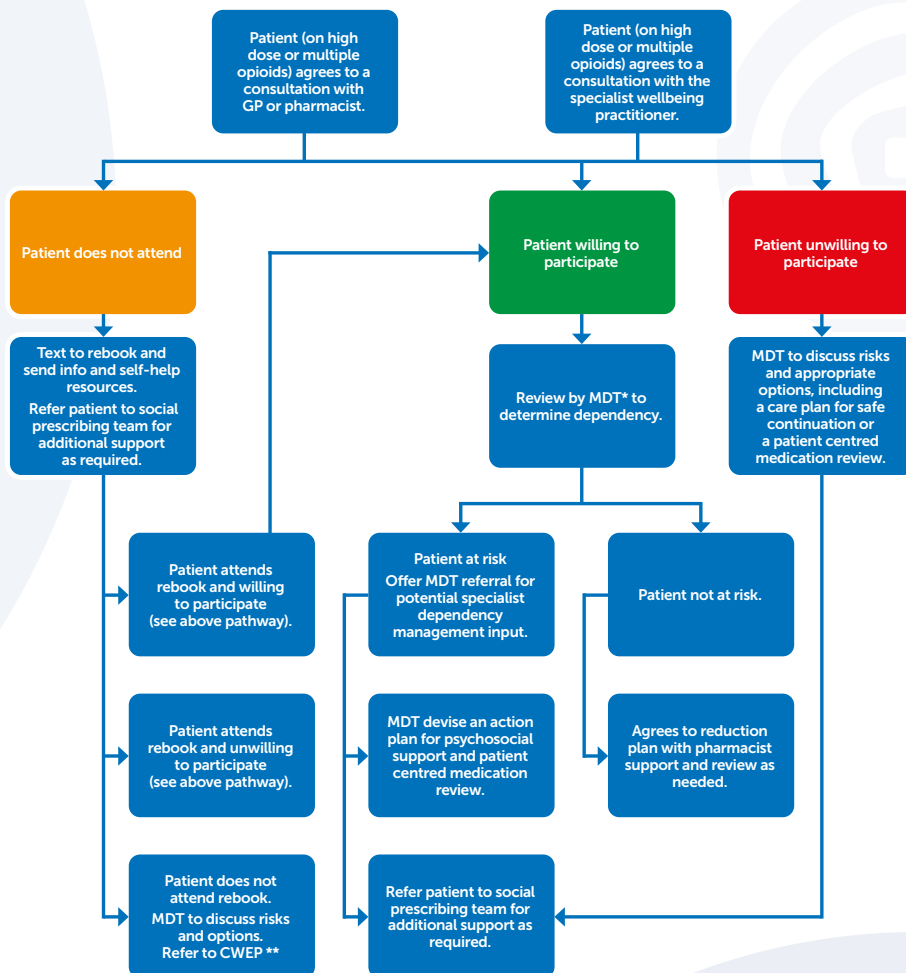
### 3 PATHWAY DESIGN AND IMPLEMENTATION

Following a series of co-design workshops a new medication review and patient support pathway was agreed and named the Medication Awareness Pathway Support (MAPS) programme.

**Figure 2: The MAPS Pathway:**

#### MAPS: MEDICATION AWARENESS PATHWAY SUPPORT (accessing supported opioid medication reviews)

The pathway has been codesigned by all partners including input from representatives with lived experience.



MAPS has been tested by Fleetwood PCN and Inspire with input from the ICB medicines management team and representatives with lived experience. Notable innovation in the pathway includes the formation of a multi-disciplinary team meeting and the outreach of specialist wellbeing practitioners from the local drug and alcohol service.

At the outset of the pathway implementation, a Theory of Change was developed in collaboration with key participants and stakeholders from all teams, outlining the change expected and outcomes and impact to be measured through evaluation (see appendix 1).

## 4 EVALUATION AIMS

### PRIMARY AIM

- Understand whether the new pathway leads to a safe reduction in opioid prescribing for patients currently on high doses.

### SECONDARY AIMS

- Evaluate if the pathway delivers a positive patient experience, including whether they stay stable during the medication reduction.
- Understand if the pathway is acceptable to healthcare professionals delivering it, and to identify any barriers to further spread.

### PATIENT COHORT

- The patient cohort eligible for invitation to medication review are patients on high dose (over 80mg) or multiple opioids.

### EVALUATION GOAL

- To improve outcomes for patients on high-dose opioid medication at risk of dependency, through testing the pathway and surfacing barriers and facilitators to further spread.



## 5 EVALUATION METHODOLOGY

Clinicians were surveyed at the start and end of the initial six-month pathway pilot period from January to June 2025. A validated implementation science methodology called the Theoretical Framework of Acceptability was used to structure questions across its seven domains: affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, opportunity costs, and self-efficacy. The clinicians also rated their previous service using the net promoter score (NPS). NPS asks respondents to rate the likelihood that they would recommend a service to a friend or colleague and is a widely used scale to gauge satisfaction with an approach or product.

Patients were asked about their experience of the pathway through a bespoke questionnaire. This questionnaire was designed with input from representatives with lived experience and provided to all patients one month after their initial consultation.

A focus group at the end of the pilot surfaced stakeholder opinion of the pathway benefits, drivers, challenges, opportunities for improvement, and barriers to further spread.

Quantitative data was collected and analysed on: Medication review referral rates, medication review uptake rates, rates of referral to social prescribers, uptake with social prescribers, rates of referral to the drug and alcohol (D&A) team, uptake with the D&A team as well as change in opioid medication dose.



## 6 RESULTS

### 6.1 QUANTITATIVE FINDINGS

#### MORPHINE EQUIVALENCE MEASURE

The opiates class of drugs includes many drugs of varying potency that needed to be converted to morphine equivalence to determine patient eligibility for the pathway. To measure the opioid equivalence of different or combined drugs, a measure is made against a dose of 10mg of oral morphine. The table below identifies some of the approximate equi-analgesic potencies of opioids for oral administration.

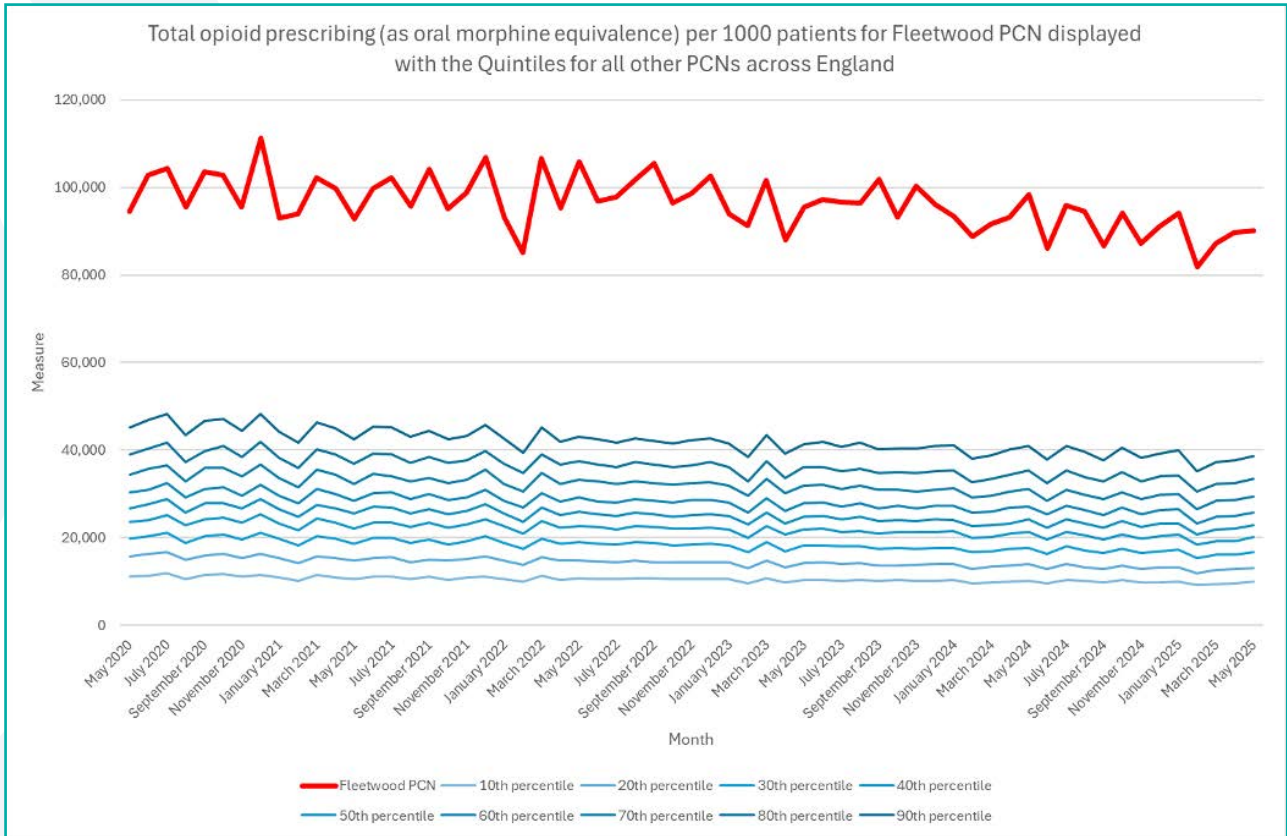
	Potency	Equivalent dose to 10mg oral morphine
Codeine phosphate	0.1	100mg
Dihydrocodeine	0.1	100mg
Hydromorphone	5	2mg
Morphine	1	10mg
Oxycodone	1.5	6.6mg
Tapentadol	0.4	25mg
Tramadol	0.1	100mg

Source: <https://fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/dose-equivalents-and-changing-opioids>

### WHY FLEETWOOD PCN

Fleetwood PCN is in the top (worst) quintile for the total opioid prescribing (as oral morphine equivalence) per 1,000 patients in England.

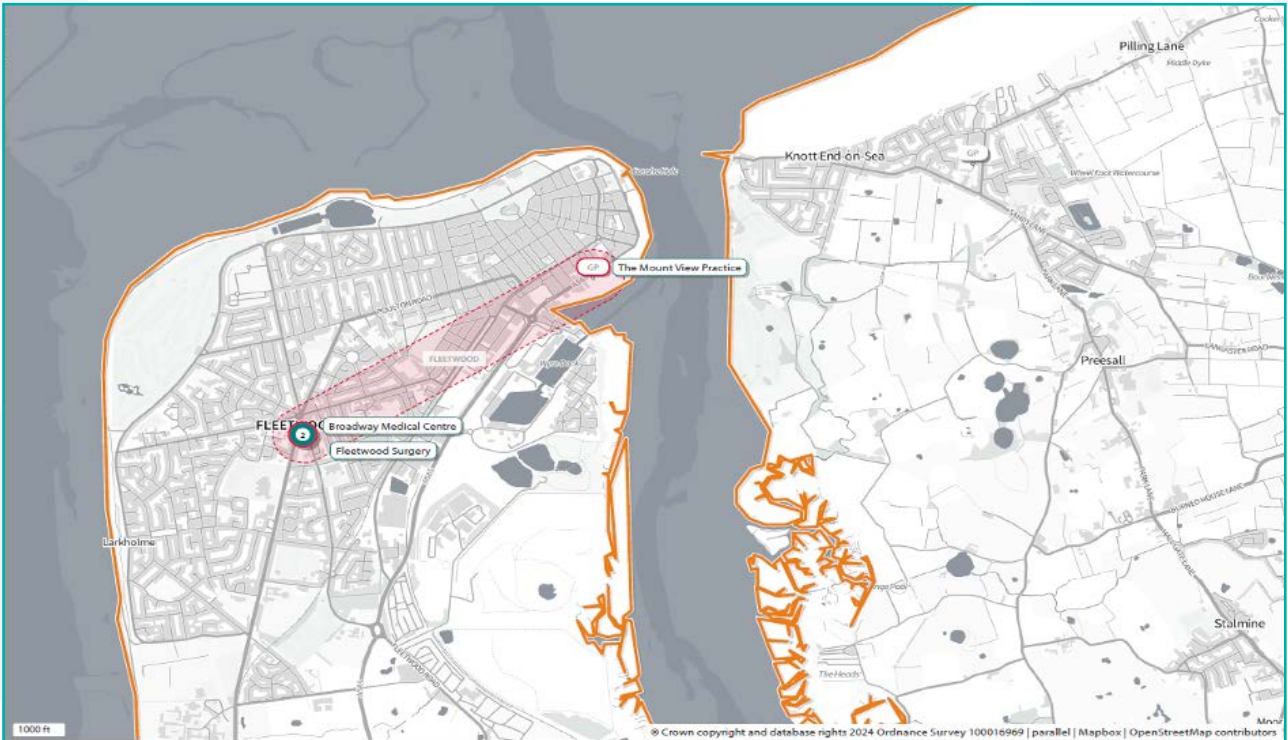
**Figure 3: Total opioid prescribing for Fleetwood PCN compared to other PCNs across England.**



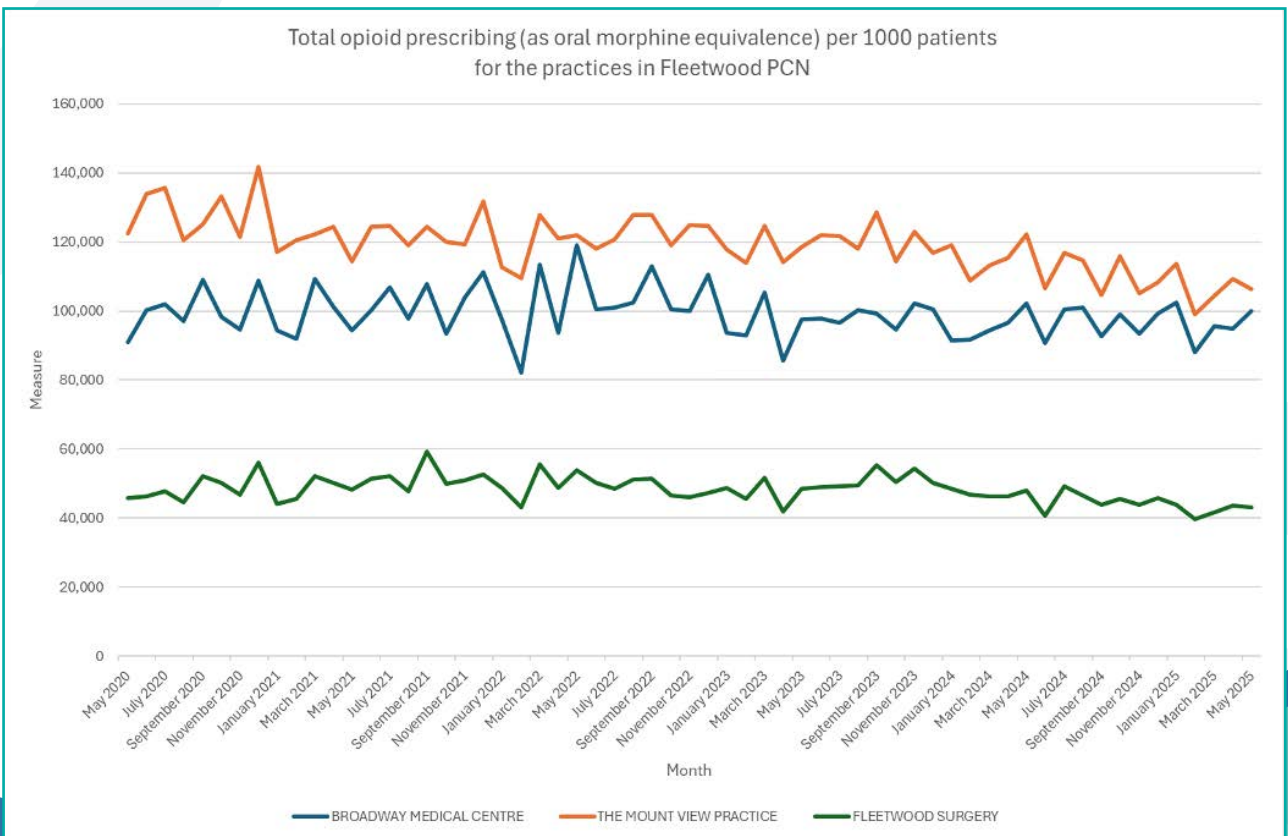
Fleetwood PCN is comprised of three GP practices, The Mount View Practice, Broadway Medical Centre and Fleetwood Surgery.

Surgery	Number of Patients Enrolled
<b>Broadway Medical Centre</b>	9,731
<b>Fleetwood Surgery</b>	6,358
<b>The Mount View Practice</b>	12,396

**Figure 4: Practice locations**



**Figure 5: Total opioid prescribing for the practices in Fleetwood PCN**



## HOW THE PATIENTS WERE SELECTED

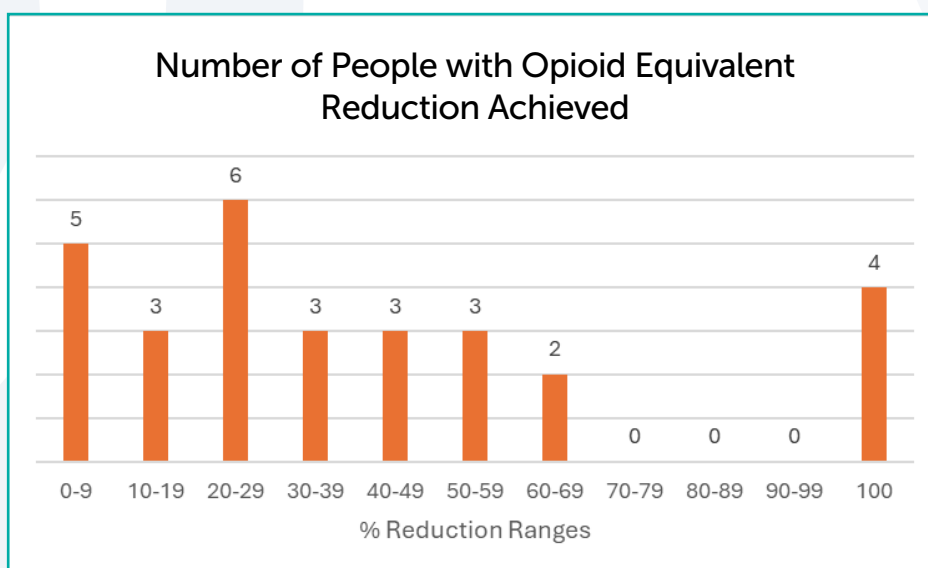
The practices all use EMIS as the electronic patient record (EPR). As the largest practice in the PCN, the search was carried out on The Mount View Practice. The pharmacist created a search and produced a report identifying patients who were prescribed 120mg of oral morphine equivalent or above. This search was independent to the length of time the patient had been prescribed the opioid medication. The longer a patient is on a medication, the more likely addiction will be, however, reducing the dosage would reduce the risk to the patient.

## MEDICATION REVIEW OUTCOMES

Fifty-one patients were invited for opioid reduction reviews. Of these, six people did not attend the appointment, 15 patients declined wanting to reduce their medication and one patient left the practice.

**Of the 29 remaining patients (57% of the total invited), the reduction of equivalent oral morphine ranged from no reduction to being completely opioid free (100% reduction). Overall, this cohort reduced the total oral equivalent dose by 33%.**

**Figure 6. Number of people with opioid equivalent reduction achieved.**



The highest number of patients (six) showed a reduction of 20-29% morphine equivalent. Four patients had a 100% reduction and were no longer on opioid medication.

All 29 patients were offered a patient-centred approach to pain management beyond opioids, which included access to pain-management resources.

Patients were asked what non-pharmacological or over-the-counter methods they used to manage pain. Twelve patients did not use any other pain relief methods; others used gels and creams and a number used or were going to try TENS (transcutaneous electrical nerve stimulation) machines.

Referral to a specialist wellbeing practitioner was an option for further support. Five patients were offered this support, four of them declined the support.

Social prescribing is another option for support. One of the 29 patients was already having social support; one further patient was referred to social prescribing.

## 6.2 FOCUS GROUP FINDINGS

All key stakeholders involved in the pathway development and testing participated in the end of project focus group.

The session incorporated a facilitated discussion of the pathway benefits and challenges, opportunities for improvement, and barriers to further spread.

Thematic analysis of the discussion provided the following insights:

### BENEFITS OF THE PATHWAY

#### Improved communication and collaboration

- Regular MDT meetings were highlighted as a major benefit, boosting collaboration and communication.
- Stronger relationships and communication across different professions improved understanding and care quality.
- Learning from each other, especially from representatives with lived experience and first-hand knowledge, was valuable and appreciated.

#### Patient-centred care

- The patient-centred model enabled the patient's voice to be heard.
- The pathway placed an emphasis on shared decision making and a holistic understanding of client needs.
- Better understanding of patients' perspectives led to more empathetic and informed care.

#### Clinical and safety improvements

- Opioid reduction was achieved safely, with specialist psychological and pharmacist support. This reduces levels of risk from opioids and polypharmacy prescribing and illicit drug use, and therefore reduces the risk of overdose, side effects and unnecessary specialist referrals.

#### Psychosocial support and recovery

- Psychosocial interventions and access to recovery workers were seen as significant improvements.
- Patients appreciated the range of options available to support them, even when not accessing all options at that point in time.

#### Improved patient awareness and empowerment

Engaged patients are activated and are more aware of:

- Long-term effects of opioid use (e.g., diminishing returns, tolerance, side effects).
- Risks of polypharmacy and high-dose medications.
- Available support options.

Patients also report increased wellbeing following medication reduction, with comments like:

*"The fog has started to lift."*

*"My libido has come back."*

When medication reviews are delivered holistically and sensitively, patients don't feel judged and know help is coordinated and compassionate.

### **System-level outcomes**

- Prescription costs have gone down.
- The pathway demonstrated the success of collaborative approaches and system thinking.
- A coordinated model of care is now available, which is replicable and sustainable.

## **CHALLENGES AND OPPORTUNITIES FOR IMPROVEMENT**

### **Variation in practice engagement**

- Some practices may be more aware of the need for reform and be more willing to engage than others. Implementation standards or toolkits could help overcome this.

### **Time and resource availability**

- Staff need protected time to attend MDTs, training, or reflective practice. Implementation will be challenging without this.

### **Policy alignment and strategic buy-in**

- Spread across the ICS would require ICB and commissioning bodies to formally recognise and back the approach.
- Formalising the MDT model and participant roles would address issues around variability.
- Consider co-located teams or virtual hubs to maintain momentum.
- Other PCNs should formally launch their pathways with robust training, communication, data integration and across organisation engagement from the outset.

### **Communication and culture**

- The lack of a shared use of language across all levels and organisations can be a barrier. A unified vocabulary around care (e.g., “person-centred”, “activation”, “recovery”), helps to avoid siloed language or misunderstandings and could be supported with: A quick-reference glossary, onboarding/briefing packs and staff development sessions.

### **Secure longer-term funding and sustainability**

- Ongoing funding is needed to ensure sustainability and continuity.

### **Training and support for wider staff**

- Ongoing training is required for:
  - GPs and prescribing clinicians on opioid management and tapering conversations
  - Non-clinical staff (e.g., reception) on trauma-informed and stigma-free approaches
- Provide supervision or reflective practice spaces for frontline staff, particularly those new to addiction or dependency work.
- Foundational training could be offered to all staff on: Substance misuse and addiction, trauma-informed care, chronic pain management, referral and escalation processes.

### **Enhance patient involvement**

- Bring patient feedback into the design and evaluation of services more systematically.
- Explore peer-led support groups or recovery champions to complement clinical services.
- Allow patients to co-create their own care plans with the MDT.

### **Improve data sharing and communication**

- Streamline communication and information sharing between teams and services.
- Initial joint meetings with both the pharmacist and wellbeing practitioner to create a cohesive care plan.
- Invest in shared care plans or digital platforms where relevant parties can view updates and progress.
- Reduce duplication and improve continuity of care by integrating systems.

### **Continue to improve the support offer for patients**

- Address challenges with limited prescribing of opioid substitution therapy (OST) due to budget limitations.
- Broaden prescribing options (e.g., Buprenorphine) to better support those with entrenched tablet dependence.

### **Tackle system gaps**

- Address wider system issues:
  - Long waits for specialist service
  - Limited funding for opioid substitution therapy.
  - Disconnected commissioning between mental health, primary care, and addiction support
- Create clearer pathways from initial GP contact through to long-term recovery support.

### **Pathway enhancements**

- Initial joint consultations with pharmacists and wellbeing practitioners.
- Integrated delivery of opioid reduction alongside psychosocial interventions.
- Broaden implementation groups to include social prescribers.
- Accelerate PCN engagement to avoid early delays.
- Introduce staff incentives and implementation pledges from prescribers.
- Create joint entry points with specialist outreach to improve patient engagement.



## RECOMMENDATIONS

### Spread the pathway across the ICS

The pathway has been shown to foster collaborative working that leads to better, more holistic patient care and a reduction in high-dose opioid use.

### Continue and formalise MDT meetings

- Regular, structured MDTs should remain central to the care approach.
- Include all relevant stakeholders, particularly those from Inspire, to maintain a multi-agency lens.

### Enhance patient voice mechanisms

- Introduce more structured ways for patient feedback and stories to inform care planning.
- Consider involving patients directly in relevant parts of MDT discussions (e.g., co-creation of care plans).

### Strengthen inter-professional learning

- Establish peer learning opportunities or joint training sessions between healthcare providers and third-sector partners.
- Leverage lived experience representatives' skills to run reflective or educational sessions.

### Consolidate and expand access to wellbeing practitioners

- Ensure easy, consistent access to wellbeing practitioners in primary care.
- Formalise this support through clear referral or communication pathways.

### Embed shared decision-making practices

- Promote training in shared decision-making tools and models.
- Empower both staff and patients with resources to make informed, collaborative decisions.

### Monitor and evaluate outcomes

- Implement a framework to track the impact of MDTs and collaborative work on patient outcomes (e.g., safety, recovery progress, satisfaction).

### Seek strong leadership buy-in to champion the pathway

Leadership should:

- Visibly support implementation
- Raise awareness
- Model the behaviours expected (e.g., trauma-informed care)

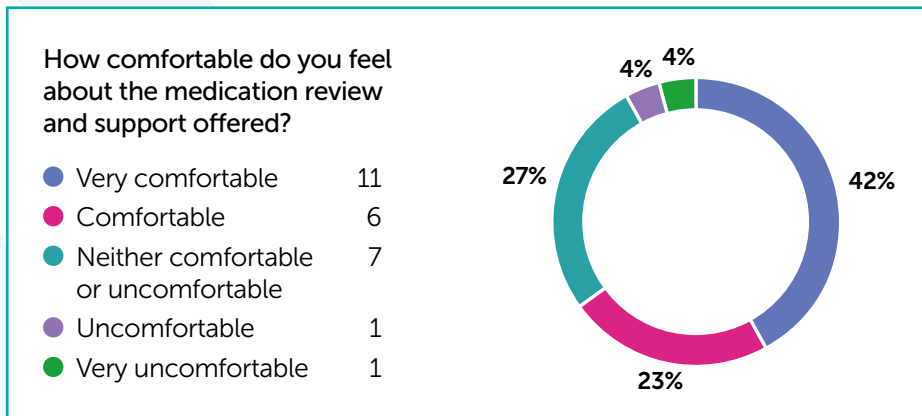
## SUMMARY

The focus group participants agreed that the pathway demonstrates clear benefits for patients, staff, and the wider system through improved collaboration, safety, and patient-centred care. Implementing the recommendations outlined here will help overcome existing barriers, enhance sustainability, and support wider rollout. Strong leadership, dedicated resources, and ongoing evaluation are critical to maintaining momentum and achieving lasting impact.

### 6.3 PATIENT SATISFACTION

Patients were asked about their experience of the pathway through a questionnaire one month after their initial medication review. There was a total of 26 respondents to the survey.

When asked how comfortable they were with the medication review and support offered, 65% responded either comfortable or very comfortable.



When asked the reasons for their answer, they gave these responses:

***"The pharmacist was very helpful; he helped me come off strong painkillers."***

***"The pharmacist makes me feel at ease and explains well about my medication."***

***"I was told I would be contacted after a month to see how I was getting on and 5 months on no phone call."***

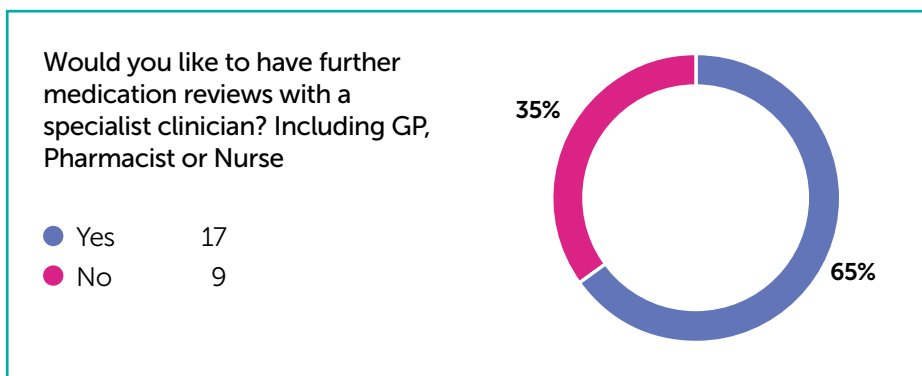
When asked how often they have medication reviews at their practice, they gave a range of different responses with patients being reviewed at different times due to their individual circumstances.

***"I think that the medical reviews are usually carried out by your doctor usually when medication needs increasing or changing."***

***"This is my second [medication review] in 6 years approximately."***

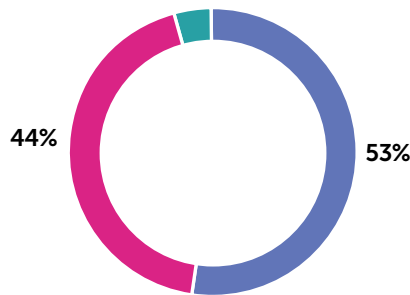
***"I am being asked more often at the moment."***

***"Never had [a medication review] before, usually had meds changed when I saw a doctor about past drugs and horrible side effects."***



Which specialised clinician would you prefer to have a review with?

● GP	17
● Pharmacist	14
● Nurse	1
● Community Well Being Engagement	0



These are some comments given when patients were asked to explain their answers to the previous two questions about specialist clinicians.

*"I think the pharmacist gave me more than enough information needed."*

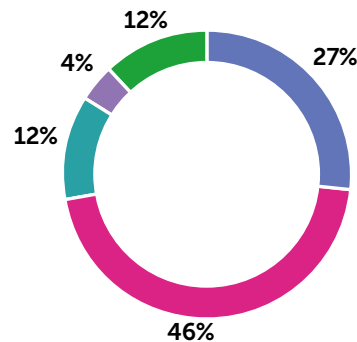
*"As long as they're qualified and experienced."*

*"I think being prescribed strong drugs should only be by a doctor."*

*"Personally, I'm not really bothered who I see as they are all professionally qualified to conduct a review."*

How supported do you feel with your medication?

● Very supported	7
● Supported	12
● Not sure	3
● Not supported	1
● Very unsupported	3



Out of a total of 26 respondents, 73% felt very supported/supported compared to 15% who felt not supported.

*"After speaking with the pharmacist, I feel they supported me and listened."*

*"In an ideal world I would like to be able to see a doctor when I needed to same day if possible but due to the workloads placed on our NHS that's not possible."*

*"Get consultations when required."*

*"I feel I'm being treated well, and the pharmacist and I understand the plan and are on the same page at present."*

Patients were asked what support they would find most useful, the top three things selected by the patients were

- **Structured medication reviews**
- **Relaxation**
- **Support from a Community Well Being Practitioner**

Which of the following would you find more useful?



When asked what the service could have done differently to help them more effectively:

***"I think annual medical reviews"***

***"Reacted a bit faster when required"***

***"Nothing as I am happy with services provided"***

***"Go through some of the exercises that I might try. I really want to lose at least 6 stone"***

***"Tell the receptionist staff to stay out of my medication business and speak to me like a human, also speak with other pharmacists out of their own practice"***

Nine patients responded that they have reduced their medication when asked what they have done differently since being involved with the service. Other comments included:

***"Behaviour change"***

***"Keeping active"***

***"Cannot reduce pain meds as its painful"***



## 6.4 BASELINE CLINICIAN SURVEY

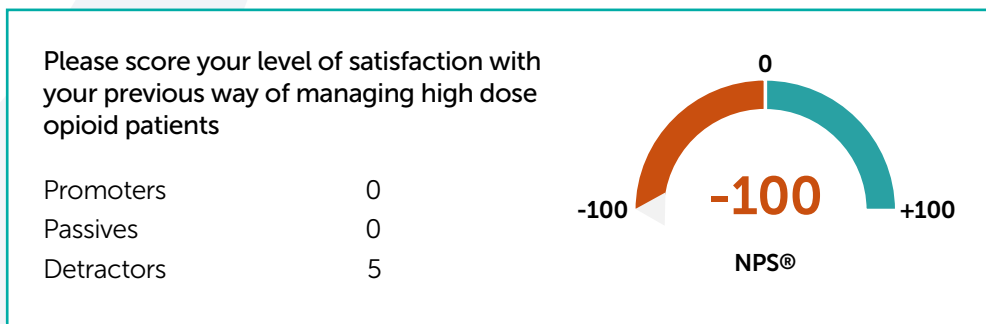
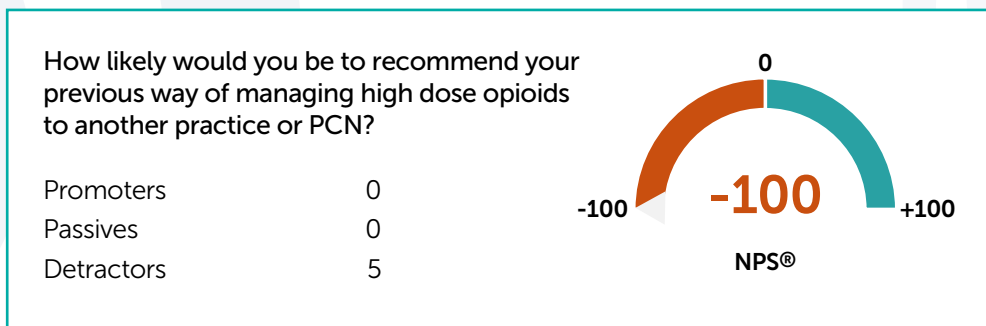
When asked about the issues and challenges with their previous way of managing high-dose opioid patients, clinicians responded:

***“Lack of time to effectively manage in GP consultations. Lack of awareness on regimes to safely reduce patient obstacles. Unwillingness to reduce due to perceived symptoms. Difficulties maintaining effective follow up of patients”***

***“Angry and reluctant patients”***

***“Difficult to keep up with and review opiate usage/reductions due to sheer volume of patients using them. time restraints. changing their beliefs”***

Clinicians were asked to rate their previous service using the NPS. The NPS rates the likelihood that they would recommend a service to a friend or colleague and is a widely-used scale to gauge satisfaction with an approach or product. The scale runs from minus 100 to positive 100.



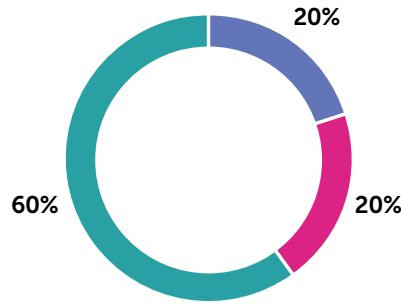
For both questions, the responders gave the previous service the lowest possible score of –100, indicating they would never endorse or recommend it as a good service.

The following questions were based on the theoretical framework of acceptability (TFA).

The TFA was developed to provide a structured approach to understanding and measuring acceptability in healthcare interventions. It consists of seven component constructs that help identify the characteristics influencing acceptability: Affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, opportunity cost and self-efficacy/ confidence.

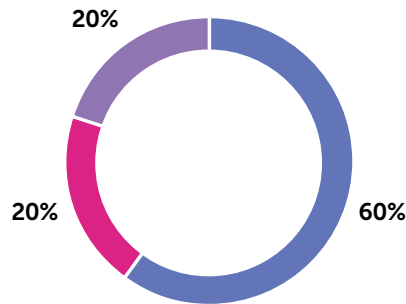
How comfortable do you feel about MAPS (Medication Awareness Pathway)?

● Very uncomfortable	1
● Uncomfortable	1
● No opinion	3
● Comfortable	0
● Very comfortable	0



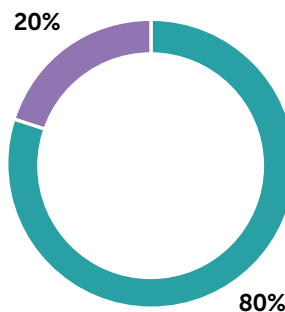
How much effort will it take you to carry out opioid reduction support?

● Huge effort	3
● A lot of effort	1
● No opinion	0
● A little effort	1
● No effort at all	0



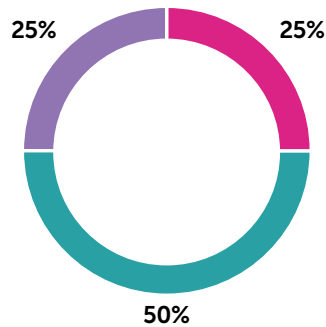
There are moral or ethical consequences to engage with MAPS (Medication Awareness Pathway)?

● Strongly disagree	3
● Disagree	0
● No opinion	4
● Agree	1
● Strongly agree	0



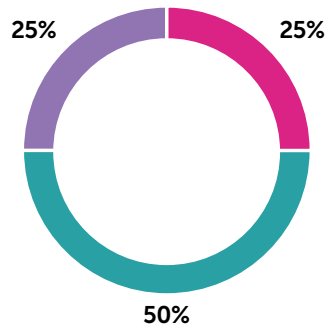
How fair is the current pathway for MAPS (Medication Awareness Pathway)?

● Very fair	0
● Unfair	1
● Neither fair or unfair	2
● Fair	1
● Very fair	0



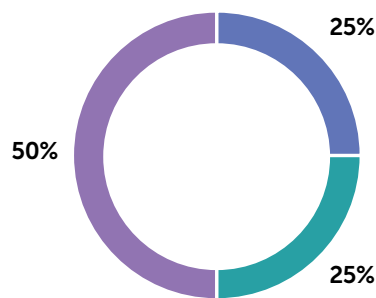
The pathway will support patients to reduce their opioid prescriptions?

● Strongly disagree	0
● Disagree	1
● No opinion	2
● Agree	1
● Strongly agree	0



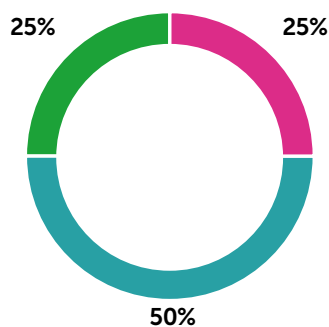
MAPS (Medication Awareness Pathway) will improve patient outcomes?

● Strongly disagree	1
● Disagree	0
● No opinion	1
● Agree	2
● Strongly agree	0



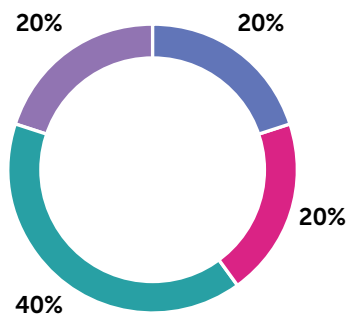
It is clear MAPS (Medication Awareness Pathway) will help improve my work behaviour?

● Strongly disagree	0
● Disagree	1
● No opinion	2
● Agree	0
● Strongly agree	1



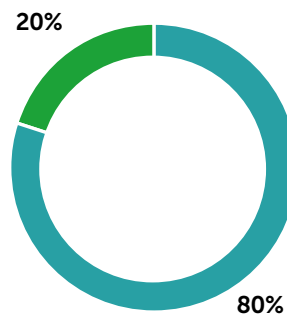
How confident do you feel about participating in MAPS (Medication Awareness Pathway)?

● Very unconfident	1
● Unconfident	1
● No opinion	2
● Confident	1
● Very confident	0



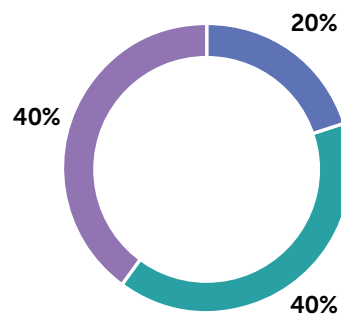
Engaging in MAPS (Medication Awareness Pathway) in primary care will interfere with my other priorities?

● Strongly disagree	0
● Disagree	0
● No opinion	4
● Agree	0
● Strongly agree	1



How acceptable is MAPS (Medication Awareness Pathway) to you?

● Completely unacceptable	1
● Unacceptable	0
● No opinion	2
● Acceptable	2
● Completely acceptable	0



## 7 DISCUSSION

**Although the link between high-dose opioid prescribing and unwanted side effects and dependency is well understood, the optimal way to support the healthcare system to prevent unwarranted prescribing is less clear. There is limited evidence for the long-term effectiveness of opioids for non-cancer pain and evidence that patients can develop tolerance, requiring higher doses to achieve the same pain relief.**

Many practices grapple with managing patients on high-dose opioids, not wanting to leave them without effective pain management or to drive them to use illicit substances. However, the clinician baseline data highlights the level of dissatisfaction with the existing model of care.

Patients on prescribed pain medication don't always identify dependency issues when they arise, and there is a significant stigma if they are labelled as drug dependent, with the use of specialist drug and alcohol support services.

This pathway, and the multi-disciplinary and collaborative working it supports, offers a model of care that facilitates well-managed medication reviews. It also offers reassurance to clinical staff, empowering them to deliver the patient-centred approach that is needed.

Bringing together primary care with specialist addiction knowledge and expertise in the practice setting goes some way to addressing the barriers and stigma associated with the service.

Whilst only piloted in one locality, the findings strongly suggest that this collaborative, patient-centred approach could be spread to other practices to standardise safe opioid management and help the ICB meet their objectives of improving patient care and reducing unwarranted high-dose opioid prescribing.

Before attempting to roll this model out across the region, there are several barriers to overcome and recommendations to consider.

The team designing and implementing the pathway were highly motivated and committed considerable time and effort to improving patient care. Significant pressures across primary care must be acknowledged.

Spreading this model of care will require both engaged staff and investment in their time for direct medication reviews and initial pathway set-up. It is recommended that training for both clinical and non-clinical staff is expanded to include addiction, pain management, and trauma-informed care. Formalising the MDT meetings with clear roles and responsibilities will help to make the model sustainable, as will improved data sharing and continuity across primary care and specialist services.

Securing long-term funding would be a significant enabler and aligning this work with strategic policy drivers to reduce patient risk due to prescribed opioids would help to make that possible.

Patient perceptions around medication and medication reduction must also be acknowledged. As shared through the patient survey, there is ongoing concern about medication reduction and uncontrolled pain. However, the combination of education, information, support and alternative options to pain management can alleviate some of these concerns. Using consistent and appropriate patient-centred language is critical, and action to strengthen the patient voice in any future implementation is strongly recommended.

## 8 LIMITATIONS

The six-month duration of the project limited the maximum number of feasible reviews and meant there were too few reductions to warrant comparison to historical opioid prescribing data trends for matched patients in the PCN. The patient cohort looked at patients exceeding the 120mg of morphine equivalent dose of opioids. There will be patients who are slightly below this range and were therefore just missed out on selection but may still need support.

Insight into the most effective combinations of psychological support and social prescribing is also lacking, due to the small number of patients taking up these offers during the project's duration. Longer term monitoring and evaluation is needed to produce a better understanding of optimal support packages for pain management when reducing opiates.

## 9 ACKNOWLEDGEMENTS

We would like to thank all stakeholders for their participation in this evaluation.

A particular thanks to:

**Jonathan Churchill MRPharmsS, Fleetwood PCN Pharmacist. Katie Egan, Change Grow Live - Inspire Lancashire ICS Lead, Faye Prescott, Medicines Optimisation lead for Morecambe Bay and NHS Lancashire and South Cumbria Integrated Care Board, Paul Hemsil, POMS – Prescription Only Medication Support, Derby City Substance Misuse Team, Rebecca Cartmel, Community Wellbeing Advanced Practitioner Change Grow Live/ Inspire.**

### EVALUATION TEAM

**Laura Boland, Head of Evaluation. Sarah Whittle, Project Support Officer.  
Paul Brain, Business Intelligence Programme Manager.**



# 10 APPENDICES

## APPENDIX 1: THEORY OF CHANGE

**Statements**

The identification and management of opioid analgesic dependency (OAD) is challenging, and relapse remains common. There are new Community Wellbeing and Engagement Practitioners in post which presents an opportunity for community-based medication reviews with integrated specialist's support.

As with Opioid Dependency more generally, Opioid Agonist Therapy (OAT) may be part of a comprehensive programme that includes medical, social, and psychological treatment. OAT replaces the opioid of dependence (illicit or prescribed) with one that provides stable dosing, affording an opportunity to engage with other aspects of recovery.

**Mission**

**Primary aim:**

- Supporting patients to safe and successfully reduce their Opioid medication.

**Secondary aims:**

- Improved patient experience
- Integrated pathway leading to less opioid dependency
- Understand the barriers and potential benefits of the pathway.

			OUTCOMES		
Inputs	Activities	Outputs	Short Term	Medium Term	Long Term
<ol style="list-style-type: none"> <li>Support from GP surgeries</li> <li>Engage with Clinical, psychosocial practitioners</li> <li>Set up Safeguarding links</li> <li>Ensure local consultants/pain team board with this pathway - present at COP</li> <li>Involve Patient advocates</li> <li>Reorganise workflow and communicate it well to all staff.</li> <li>IT resources to identify patients</li> <li>Consider MDT with pain team and +/- CGL rep for complex cases.</li> <li>Access to EMIS for Inspire</li> <li>Offer resources to use with patients not willing to engage.</li> </ol>	<ol style="list-style-type: none"> <li>Medication reviews with patient.</li> <li>Inspire will hold clinics for advisory purpose on PCN sites, to collaborate with GPs.</li> <li>Monitor effectiveness – data/ numbers of patients reduced or stopped.</li> <li>Gather patient experience/ stories.</li> <li>Signpost patients to get the appropriate support.</li> <li>Time of PCN pharmacists</li> <li>Support those who are on dependent opiates to build a trusting relationship with community wellbeing engagement practitioners.</li> </ol>	<ol style="list-style-type: none"> <li>Patient appointments with Clinical Pharmacist</li> <li>Patient appointments with wellbeing practitioners</li> <li>Patient referrals to social prescribing</li> <li>Medication review completed</li> <li>Staff training completed</li> <li>Opioid prescribing figures to improve</li> <li>Patients utilising other pain reduction methods such as graded activity</li> <li>Being open to non-clinical (medication) routes of therapy.</li> </ol> <p style="text-align: center;"><b>DATA SOURCES</b></p>	<p><b>PATIENTS</b></p> <ol style="list-style-type: none"> <li>Improve patient experience through patient centred holistic approach and reduce stigma.</li> <li>Patient empowered to make better decisions about dangerous doses of medications.</li> <li>Patient dose is lowered</li> </ol> <p><b>STAFF</b></p> <ol style="list-style-type: none"> <li>Staff satisfaction suggesting other ways to treat pain, so they don't initially prescribe high dose pain killers.</li> <li>Integrated working across PCN, Inspire &amp; LEROS</li> </ol>	<p><b>PATIENTS</b></p> <ol style="list-style-type: none"> <li>Patients hear through word-of-mouth they won't get high dose painkillers which increases engagement with other types of support</li> <li>Improved in physical and mental health.</li> </ol> <p><b>STAFF</b></p> <ol style="list-style-type: none"> <li>Confidence in managing these cohorts of patients.</li> <li>Practice prescribing spend to lower.</li> <li>Stronger relationship with partners to get them to engage with the service.</li> </ol>	<p><b>PATIENTS</b></p> <ol style="list-style-type: none"> <li>Improvement in quality of life.</li> <li>Reduction in opioid related deaths/harm</li> <li>More effective services due to reduction in stigma.</li> <li>Changing the culture of going to the GP and expecting to walk out with a prescription.</li> <li>Reduction of cost for prescribing</li> </ol> <p><b>STAFF</b></p> <ol style="list-style-type: none"> <li>Less crisis and acute admissions.</li> </ol>

Continued overleaf

			OUTCOMES		
Inputs	Activities	Outputs	Short Term	Medium Term	Long Term
11. Update pathway with communication mechanisms 12. Support those who are on dependent opiates to build a trusting relationship. 13. Expand the pathway to accommodate the different patient cohorts. 14. Formulary discussion. 15. Create Support Toolkit 17. Discuss setting up considering a shared care SLA. 18. Link in to LA reducing harm meeting.  <b>DATA SOURCES</b>	8. Social Prescribing activities 9. Representatives with lived experience to work with the teams who are reviewing this pathway and make sure patients are engaging so they are not labelled, give patients more of an understanding  <b>DATA SOURCES</b>			<b>Wider Health &amp; Care Networks.</b> 1. Better MDT working across sectors 2. Improved relationships between primary and secondary care.	

KEY ASSUMPTIONS	AREAS FOR DEVELOPMENT/ CONSIDERATION
	1. Patients feel judged, so they stop engaging with services. 2. it takes very little time to increase these doses but takes a lot of time to reduce it 3. Patients won't want to engage at all 4. Staff time to undertake this work 5. Patients could feel concerned about medication reduction 6. Hospital initiated prescribing is common 7. Use of correct language is important e.g., using the term "de-prescribing" would frighten patients 'addicted' so would be fearful to engage. "Medication awareness" would be a more helpful term. 8. Be wary of removal of choice in the pathway 9. A process of joint and inclusive decision making is required on reduction timescales 10. Increased illicit drug use is a risk

## APPENDIX 2: MAPS: MEDICATION AWARENESS PATHWAY SUPPORT (MEDICATION REVIEWS)

- 1 Do you consent for us to use your anonymous comments as part of the project?
  - Yes, I consent
  - No, I do not consent
- 2 Can you please share the last four digits of your phone number below
- 3 How comfortable do you feel about the medication review and support offered?
  - Very comfortable
  - Comfortable
  - Neither comfortable nor uncomfortable
  - Uncomfortable
  - Very uncomfortable
- 4 Please tell us more why you gave the answer
- 5 How often do you have medicine reviews at your practice?
- 6 Would you like to have further medication reviews with a specialist clinician? Including GP, pharmacist or nurse
  - Yes
  - No
- 7 Which specialist clinician would you prefer to have a review with?
  - GP
  - Pharmacist
  - Nurse
  - Community Wellbeing Engagement Practitioner
- 8 Please explain your answer to question number 6.
- 9 How supported do you feel with your medication?
  - Very supported
  - Supported
  - Not sure
  - No supported
  - Very unsupported
- 10 Please tell us more why you gave this answer?
- 11 Which of the following would you find most useful?
- 12 What could the service have done differently to help you more effectively?
- 13 What have you done differently since being involved with the service (behaviour change, medication reduction, healthier options or other successes)
14. Would you be happy for us to quote your feedback anonymously?
  - Yes
  - No

## APPENDIX 3

Baseline Clinician Questionnaire - MAPS: Medication Awareness Pathway (High-dose Opioids)

- 1 Do you consent for us to use your anonymous comments as part of the project?**
  - Yes
  - No
- 2 Please tell us about the issues and challenges with your previous way of managing high-dose opioid patients.**
- 3 Please score your level of satisfaction with your previous way of managing high-dose opioid patients**
- 4 How likely would you be to recommend your previous way of managing high-dose opioids to another practice or PCN?**
- 5 How comfortable do you feel about MAPS (Medication Awareness Pathway)?**
  - Very uncomfortable
  - Uncomfortable
  - No opinion
  - Comfortable
  - Very comfortable
- 6 How much effort will it take you to carry out opioid reduction support?**
  - Huge effort
  - A lot of effort
  - No opinion
  - A little effort
  - No effort at all
- 7 There are moral or ethical consequences to engage with MAPS (Medication Awareness Pathway)?**
  - Strongly disagree
  - Disagree
  - No opinion
  - Agree
  - Strongly agree
- 8 Please tell us more about your response to question 7**
- 9 How fair is the current pathway for MAPS (Medication Awareness Pathway)?**
  - Very unfair
  - Unfair
  - Neither fair or unfair
  - Fair
  - Very fair

**10 The pathway will support patients to reduce their opioid prescriptions**

- Strongly disagree
- Disagree
- No opinion
- Agree
- Strongly agree

**11 MAPS (Medication Awareness Pathway) will improve patient outcomes**

- Strongly disagree
- Disagree
- No opinion
- Agree
- Strongly agree

**12 Please explain your above answer**

**13 It is clear MAPS (Medication Awareness Pathway) will help improve my work behaviour**

- Strongly disagree
- Disagree
- No opinion
- Agree
- Strongly agree

**14 Please tell us more about your response to question 13**

**15 How confident do you feel about participating in MAPS (Medication Awareness Pathway) new pathway?**

- Very unconfident
- Unconfident
- No opinion
- Confident
- Very confident

**16 Please tell us more about your response to question 15**

**17 Engaging in MAPS (Medication Awareness Pathway) in primary care will interfere with my other priorities**

- Strongly disagree
- Disagree
- No opinion
- Agree
- Strongly agree

**18 How acceptable is MAPS (Medication Awareness Pathway) to you?**

- Completely unacceptable
- Unacceptable
- No opinion
- Acceptable
- Completely acceptable

## APPENDIX 4

### Learnings from previous PCN Communication with Patients

Patients at the practice local to our representative with lived experience who were on high-dose opioids were initially sent a letter. The letter caused concerns for many, as it led patients to believe their medication was being stopped. This was later replaced with an SMS with more sensitive language. The SMS was used by the team at Fleetwood PCN. Both are available below:

Surgery Address

Tel:

Dear ...,

Re: **Long-term opiate prescriptions**

I would like to draw your attention to a new service we are introducing into the practice. For some time, it has been recognised that chronic pain, lasting for longer than twelve weeks despite receiving medication or treatment can severely impact the quality of life of patients. However, NICE guidelines do not recommend the use of opioids in the management of chronic, non-malignant pain as the risks of doing so outweigh the benefits; the risks associated with the use of opioids for longer than twelve weeks include dependence, tolerance, and death. High-dose opiate prescriptions are defined as those that exceed doses of 120mg per day of morphine or equivalent.

Since you have been taking this level of medication for some time, as a practice we no longer feel able to prescribe this for you unless you see our drug dependency team to review your prescriptions and work with you to reduce the dose you are being prescribed.

Kind Regards ...

### SMS to patients:

Following a recent review of your notes, it has been identified that you are currently prescribed one or more medications for pain relief. These medications can lead to various side effects and risks when taken for a prolonged time and are no longer recommended to treat long term pain as per national guidelines. To discuss these medications further and answer any questions or concerns you may have about your pain relief medication, please contact the surgery to arrange for an appointment with X our Prescription Medication Practitioner.

Thank you,

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