



**SERVICE**

**EVALUATION:**

**OPIOID IMPROVEMENT**

**COLLABORATIVE**

**PROGRAMME**

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## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

## Acronym list

Acronym	Full term
ACOPS	Adult Community Older Peoples Services
BHSCT	Belfast Health and Social Care Trust
DH	Department of Health
HSC	Health and Social Care
HSCQI	Health and Social Care Quality Improvement
IHI	Institute for Healthcare Improvement
MOIC	Medicines Optimisation Innovation Centre
NHSCT	Northern Health and Social Care Trust
OICP	Opioid Improvement Collaborative Programme
PDSA	Plan-Do-Study-Act
PHA	Public Health Agency
QI	Quality Improvement
SHSCT	Southern Health and Social Care Trust
TMSNI	Transforming Medication Safety in Northern Ireland
WHO	World Health Organization
WHSCT	Western Health and Social Care Trust

## Contents

Executive summary .....	5
1. Introduction .....	6
1.1 Background.....	6
1.2 Opioid Improvement Collaborative Programme (OICP) .....	7
1.3 Aims.....	10
2. Project summaries .....	10
2.1 BHSCT ACOPS and West Belfast GP Federation .....	10
2.2 BHSCT Musgrave Park Hospital Primary Knees .....	11
2.3 BHSCT Royal Victoria Hospital Ward 5A Thoracic Surgery.....	12
2.4 Carryduff Surgery .....	12
2.5 Mourne Family Surgery .....	13
2.6 NHSCT Antrim Surgical Pharmacy Team .....	14
2.7 Scotch Quarter Practice.....	15
2.8 SHSCT Orthopaedics and Trauma .....	15
2.9 WHSCT Orthopaedics and Trauma .....	16
3. Evaluation methodology .....	17
4. Evaluation results .....	18
4.1 Engagement.....	19
Participant engagement with the programme: .....	19
Mentor engagement with the programme: .....	20
Programme delivery team programme engagement:.....	20
4.2 Networks: .....	21
4.3 Outcomes.....	21
Engagement: .....	22
Workload: .....	22
Primary care factors:.....	22

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

Technology: .....	23
Programme factors: .....	23
Service users: .....	24
Data and governance: .....	25
4.4 Impact .....	25
Sustainability:.....	25
Scale and spread:.....	27
4.5 Programme observations .....	28
Positive feedback.....	28
Suggested improvements .....	29
5. Lessons learned .....	30
6. Recommendations.....	31
6.1 Scale and spread .....	31
6.2 Network.....	32
6.3 QI capacity .....	32
7. Conclusion.....	32
8. References .....	34
Appendix 1: Focus group Participant Information Sheet .....	36
Appendix 2: Focus Group Participant Consent Form .....	39
Appendix 3: Focus Group MOIC Staff Interview Guide .....	41
Appendix 4: Project team online survey .....	44
Appendix 5: Mentor online survey .....	47
Appendix 6: HSCQI programme delivery team online survey .....	49

## Executive summary

The Opioid Improvement Collaborative Programme (OICP), mandated by Health and Social Care Quality Improvement (HSCQI) Leadership Alliance, was established to fulfil the Department of Health (DH), Northern Ireland (NI) Transforming Medication Safety for Northern Ireland (TMSNI) strategy to ‘reduce the burden of avoidable harm from high-risk medicines’. During 2023-24 the collaborative committed to undertaking a targeted medicine safety improvement programme with the aim of reducing preventable harm associated with opioids. This improvement programme was a joint partnership between the Health and Social Care Quality Improvement (HSCQI) Hub and Network and the TMSNI programme team. The Medicines Optimisation Innovation Centre (MOIC) conducted an evaluation of the programme which is presented in this report.

OICP aimed to foster collaboration between primary and secondary care teams, focusing on improving opioid prescribing for non-malignant pain. The specific objectives of the evaluation were to explore healthcare practitioners’ views on engaging with the programme, practice with regards to opioid use in non-malignant pain and the impact of the quality improvement (QI) projects.

Forty participants were enrolled in 9 project teams, including primary, secondary and cross-sector teams, 30 participants successfully attained their Level 2 QI. Each team successfully designed and conducted an improvement project within their scope of practice.

Feedback from programme participants, HSCQI programme delivery team and HSCQI mentors was achieved through a mixed method approach and confirmed:

- Collaboration was achieved; OICP successfully created an environment for learning and improvement in prescribing practices.
- Short to medium term benefits were achieved; projects were completed with positive outcomes, indicating better opioid management.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

While long-term effects are yet to be fully established, continuing efforts to scale and spread these innovations are necessary for lasting change in Northern Ireland's health landscape. It is essential to leverage established networks, programme momentum and policy motivation to achieve long-lasting improvements in opioid prescribing across Northern Ireland.

### 1. Introduction

#### 1.1 Background

The Transforming Medication Safety in Northern Ireland (TMSNI) strategy was launched in September 2020 (1) and it aligns medication safety priorities in Northern Ireland with the World Health Organization (WHO) third Global Patient Safety Challenge 'Medication Without Harm' (2). The TMSNI strategy identified opioids as one of four high risk medicines (anticoagulants, insulin, opioids and non-steroidal anti-inflammatories) in which to undertake a targeted improvement programme with the aim of reducing preventable harm. The Opioid Improvement Collaborative Programme (OICP) was established to meet this commitment. This improvement programme was a joint partnership between the Health and Social Care Quality Improvement (HSCQI) Hub and Network and the TMSNI programme team.

A regional opioid improvement stakeholder engagement workshop took place in August 2023 involving representatives from a range of organisations, including staff from all Health and Social Care (HSC) Trusts, GP Practices, GP Federations, Community Pharmacy, NI Hospice, Medicines Optimisation Innovation Centre (MOIC), Strategic Planning and Performance Group (SPPG), Public Health Agency (PHA), Department of Health (DH) and the community and voluntary sector from all regions of NI. The purpose of the workshop was to:

- Facilitate HSC stakeholder engagement and networking;
- Set out the strategic context and share learning from best practice;
- Facilitate discussions in breakout sessions to identify influencing factors and consequences of high risk opioid prescribing and explore priorities for safer opioid prescribing in the management of non-malignant pain;
- Seek to establish a high level programme aim statement;

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

- Identify project teams to enrol in the opioid improvement collaborative programme.

The workshop identified influencing factors and consequences of high risk opioid prescribing for non-malignant pain management from a wealth of different perspectives. The workshop enabled the sharing of knowledge to understand opioid use in NI, highlighted potential barriers to engaging project teams in the programme and helped inform the final design of the OICP model.

Participants at the stakeholder engagement workshop were provided with an invitation to nominate project teams from their organisations to participate in a regional OICP commencing in October 2023. Project teams registered to participate via an online registration form, closing 14<sup>th</sup> September 2023 which was extended to early October 2023 at the request of interested project teams.

### 1.2 Opioid Improvement Collaborative Programme (OICP)

The high level programme aim was:

By June 2024 the HSCQI opioid improvement collaborative programme will have supported a number of project teams from primary and secondary care to focus on opioid prescribing for the management of non-malignant pain.

Secondary to this, the programme aimed to train participants in quality improvement aligned to the Q2020 Attributes Framework for Health and Social Care Level 2 (3).

The programme output was designed to be the development of a suite of interventions to improve prescribing in primary and secondary care. This would be achieved by:

- (i) creating collaborative conditions for project teams from primary and secondary care;
- (ii) project teams shared learning and making improvements focused on opioid prescribing for non-malignant pain management;
- (iii) the delivery of taught Level 2 QI theory and methodology.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

The OICP was initially planned to engage participants over a 7 month period which included four face-to-face learning sets and three remote project surgeries. This was later extended to 11 months with four face-to-face learning sets and 5 remote project surgeries. The learning sets were opportunities for the participants to learn aspects of Level 2 Quality Improvement (QI) methodology, network, collaborate, learn from lived experience and subject matter experts and share knowledge. The project surgeries were a forum for all participants and focused more on providing project team updates, feedback and troubleshooting. In between these joint working sessions the teams were encouraged to progress their project and carry out cycles of Plan-Do-Study-Act (PDSA). The Q2020 Attributes Framework for Health and Social Care (3) was used to guide the content for this programme and the structure of the programme was an adaptation of the Institute for Healthcare Improvement (IHI) Breakthrough Series model (4) represented in Figure 1.

### Opioid Improvement Collaborative Programme Model

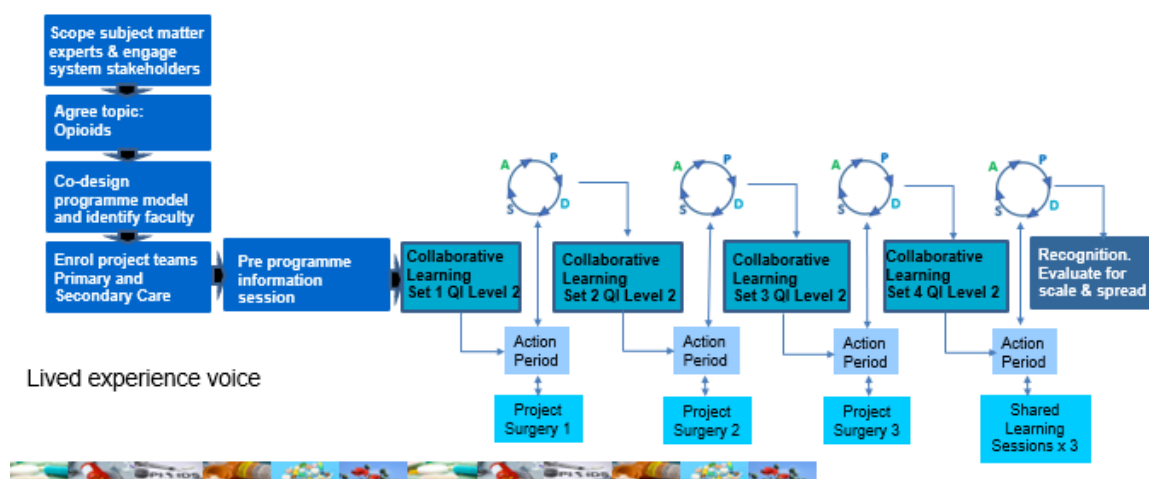


Figure 1. Opioid Improvement collaborative Programme Model

In addition to these frameworks, project participants were enrolled in UCLPartners 'Introduction to Quality Improvement' online training modules (5). The modules included; an overview of QI, where to start your QI project, understanding measurement and improvement, making changes and PDSA cycles.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

The programme recruited 40 participants who formed 9 project teams: three teams were within GP practices in the primary care setting; four teams were in the secondary care, hospital setting; and two teams worked cross-organisationally in primary, secondary and community-based care settings. Thirty participants successfully completed and attained their Level 2 QI Training, aligned to the standards of the Q2020 Attributes Framework for Health and Social Care.

The programme was extended until September 2024 to provide project teams more time to apply their QI learning and evidence changes made to opioid prescribing. All project participants and stakeholders were invited to a celebration event in September 2024 to present their QI projects and share their learning with invited stakeholders. A timeline illustrating the key components of programme delivery is provided in Figure 2.

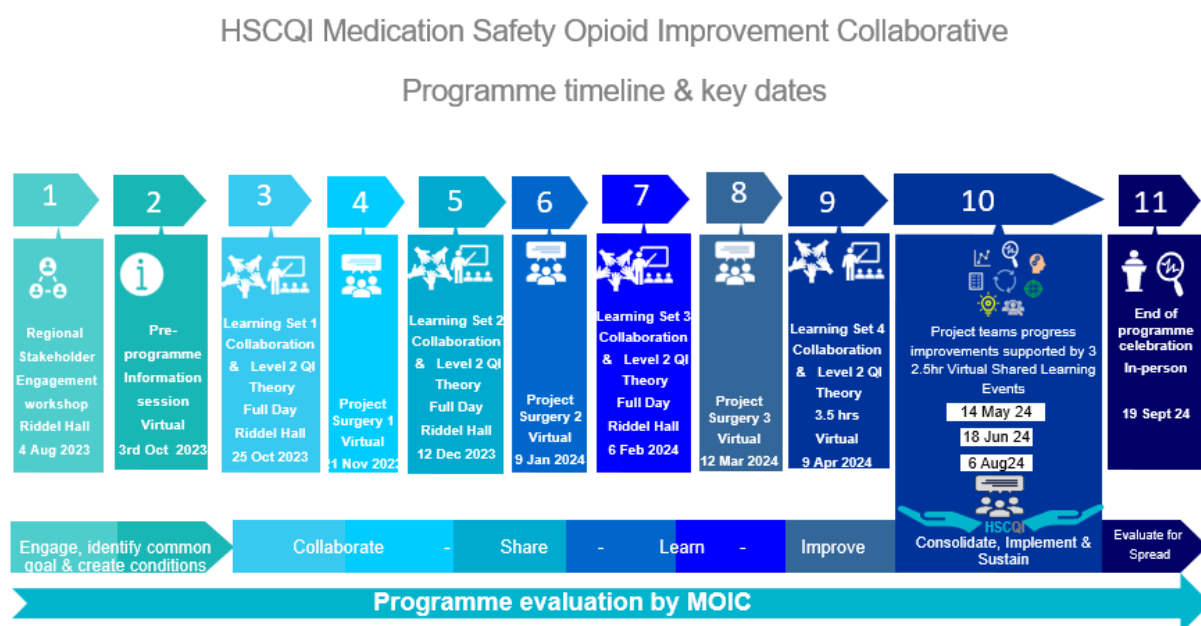


Figure 2. Programme delivery timeline

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

### 1.3 Aims

The DH commissioned MOIC to evaluate the OICP programme. The main aim of the evaluation was to investigate whether the programme worked as expected:

- How well staff engaged with the programme and what benefit is this having **short term?**
- Has practice improved with regards to opioid use in non-malignant pain- **medium term?**
- Does the programme have the potential to impact on the quality of care received by service users- **long term?**

The specific objectives of this evaluation were to explore healthcare practitioners' views on engaging with the programme, practice with regards to opioid use in non-malignant pain and the impact of their QI project.

## 2. Project summaries

Summaries of each of the 9 opioid improvement projects are presented below to provide context for the evaluation report.

### 2.1 BHSCT ACOPS and West Belfast GP Federation

Project team name:	BHSCT ACOPS and West Belfast GP Federation
Setting:	Secondary care; BHSCT Home Care Service Primary care; GP federation
Population:	Service users over 65 in receipt of BHSCT Homecare services and needing assistance with medication administration.
Problem:	To improve medication safety regarding opioid prescriptions for BHSCT Homecare service users who are in receipt of assistance with medication.
Aim:	To reduce the number of opioid prescriptions in West Belfast GP Federation practices for patients in receipt of BHSCT Home Care medication assistance and to improve the quality of opioid medication information sharing to facilitate management of associated risks by 40% by September 2024.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

Change ideas:	<ol style="list-style-type: none"> <li>1. GPs practices within the West Belfast GP Federation completed opioid medication reviews.</li> <li>2. Development and roll out of INFORM checklist shared with community social work teams.</li> </ol>
Outcomes:	<ol style="list-style-type: none"> <li>1. 56% (n=20) of patients reviewed by GP Practice Pharmacists received a reduction in their opioid prescription.</li> <li>2. INFORM Medication Checklist developed and embedded within West Belfast GP Federation GP Practices and West Belfast BHSCT Community Social Work team.</li> </ol>
Aim achieved?	Yes

## 2.2 BHSCT Musgrave Park Hospital Primary Knees

Project team name:	BHSCT Musgrave Park Hospital Primary Knees
Setting:	Secondary care; Musgrave Park Hospital
Population:	Opioid naïve patients undergoing a total knee replacement
Problem:	Reduce persistent opioid use post primary knee replacement in opioid naïve patients.
Aim:	Reduce the number of opioid naïve patients, who have had primary knee replacement surgery in Musgrave Park Hospital, still on opioids three months post-op, by 20% between 31 <sup>st</sup> January and 31 <sup>st</sup> August 2024.
Change ideas:	<ol style="list-style-type: none"> <li>1. Non-pharmacological approach to pain: use of ice packs.</li> <li>2. Patient education leaflet on pain management.</li> <li>3. Consistent key messages from the pain nurse, reinforced by the ward staff.</li> </ol>
Outcomes:	A 66% reduction in the number of all opioid naïve patients using opioids after 3 months was achieved when compared to baseline data.
Aim achieved?	Yes

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

## 2.3 BHSCT Royal Victoria Hospital Ward 5A Thoracic Surgery

Project team name:	BHSCT Royal Victoria Hospital Ward 5A Thoracic Surgery
Setting:	Secondary care; Royal Victoria Hospital
Population:	Opioid naïve Patients undergoing surgery for lung cancer
Problem:	Following lung cancer surgery patients were frequently discharged solely on strong opioid medication but were not being prescribed simple analgesia such as paracetamol.
Aim:	To reduce the number of opioid naïve patients, who had lung cancer surgery, being discharged home from the Royal Victoria Hospital Thoracic surgery ward on high strength opioid analgesics without simple analgesics by 20% from beginning of October 2023 to end of June 2024.
Change ideas:	<ol style="list-style-type: none"> <li>1. Education sessions with ward staff.</li> <li>2. Development and implementation of guidelines for prescribing discharge analgesia following best evidence.</li> </ol>
Outcomes:	A reduction from a median of 31% of patients being discharged home on strong opioids with no simple analgesics to zero patients being discharged on opioids alone.
Aim achieved?	Yes

## 2.4 Carryduff Surgery

Project team name:	Carryduff Surgery
Setting:	Primary care; GP practice
Population:	Patients living with non-cancerous chronic pain
Problem:	Patients on more than one long-term opioid medication for the management of non-cancerous chronic pain.
Aim:	To reduce the percentage of patients who are on more than one opioid for non-cancerous chronic pain by 30% by April 2024.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

Change ideas:	<ol style="list-style-type: none"> <li>1. Keeping chronic pain on the agenda.</li> <li>2. Educational resources developed for patients, careers and clinicians.</li> <li>3. Chronic Pain Review Template developed and tested.</li> <li>4. New course developed and deployed in Carryduff in collaboration with Versus Arthritis.</li> <li>5. Teaching day for all prescribers and medical students.</li> <li>6. Practice website as signpost to resources.</li> </ol>
Outcomes:	<ol style="list-style-type: none"> <li>1. 69% had a personalised chronic pain review with a clinician.</li> <li>2. 58% completed the pain management course with Versus Arthritis.</li> <li>3. 40% have reduced to only one opioid.</li> <li>4. 3% are now not taking any opioid medication.</li> <li>5. No increase in prescription of 'z' drugs for this cohort.</li> <li>6. Sustained reduction in prescribing of total opioids.</li> </ol>
Aim achieved?	Yes

## 2.5 Mourne Family Surgery

Project team name:	Mourne 20by24
Setting:	Primary care; GP surgery
Population:	Patients who had previously been prescribed co-codamol 30/500 for non-malignant pain but had not requested a repeat prescription recently.
Problem:	Monthly prescribing data indicated that the practice had a higher than average rate of codeine prescribing within the locality.
Aim:	To reduce co-codamol 30/500 prescribing by 20% by 1 <sup>st</sup> May 2024.
Change ideas:	<ol style="list-style-type: none"> <li>1. New practice policy developed and implemented: GP assessment required if co-codamol 30/500 had not</li> </ol>

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

	<p>been requested in previous 12 weeks (later reduced to 8 weeks).</p> <ol style="list-style-type: none"> <li>2. Team awareness/education was provided about new policy and new NICE guidelines.</li> <li>3. A patient information leaflet was developed.</li> </ol>
Outcomes:	<ol style="list-style-type: none"> <li>1. Between April 2023 and April 2024 the rate of co-codamol 30/500 prescribing fell by 32%.</li> <li>2. Prescribing of total opioids reduced.</li> <li>3. The patient information leaflet was not effective.</li> </ol>
Aim achieved?	Yes

## 2.6 NHSCT Antrim Surgical Pharmacy Team

Project team name:	NHSCT Antrim Surgical Pharmacy Team
Setting:	Secondary care; Antrim Area Hospital
Population:	Opioid naïve patients on the elective surgical ward
Problem:	The use of codeine in surgical patients was a concern, potentially leading to long-term use and on-going demand from primary care.
Aim:	To reduce inpatient use and discharge supply of codeine in opioid naïve patients by 20% in Antrim Hospital Surgical Elective Unit by the end of August 2024.
Change ideas:	<ol style="list-style-type: none"> <li>1. Treatment plan on discharge communication.</li> <li>2. Treatment algorithm tool.</li> <li>3. Patient information leaflet.</li> </ol>
Outcomes:	<ol style="list-style-type: none"> <li>1. Immediate Discharge Summaries showed that standards of information shared with primary care had improved.</li> <li>2. Healthcare professionals reported that the algorithm had a positive influence on their prescribing.</li> <li>3. Surgical discharge prescriptions: Pain Plan and quantity of opioids dispensed is now embedded</li> </ol>

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

	<p>practice for all surgical patient discharges in Antrim Hospital.</p> <p>4. A greater than 20% reduction in codeine supplied to the surgical elective unit was achieved.</p>
Aim achieved?	Yes

## 2.7 Scotch Quarter Practice

Project team name:	Scotch Quarter Practice
Setting:	Primary care; GP practice
Population:	Twenty nine patients prescribed the highest strength-400mg daily of long-acting tramadol and not on any other opiates.
Problem:	Highest prescribers of tramadol in East Antrim GP Federation
Aim:	To reduce the number of patients prescribed a daily dose of 400mg long-acting tramadol, by 50% between January 2024 and the end of July 2024.
Change ideas:	<ol style="list-style-type: none"> <li>1. Face-to-face chronic pain review GP appointments.</li> <li>2. Use of a patient information leaflet.</li> <li>3. Developing and implementing a practice opioid policy.</li> </ol>
Outcomes:	<ol style="list-style-type: none"> <li>1. There was an 83% reduction in number of patients prescribed the highest dose of long-acting tramadol 400mg daily.</li> <li>2. No patients were started on the 400mg daily dose of tramadol during the project.</li> <li>3. Practice opioid policy is in daily use.</li> </ol>
Aim achieved?	Yes

## 2.8 SHSCT Orthopaedics and Trauma

Project team name:	SHSCT Orthopaedics and Trauma
Setting:	Secondary care; trauma ward Craigavon Area Hospital

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

Population:	All post-operative ankle fracture patients being treated in SHSCT.
Problem:	In the Southern Trust, the trauma and orthopaedic wards generate the largest number of prescriptions for opioids. Ankle fractures are associated with high levels of pain and therefore ankle fracture patients are prescribed an opioid to help with pain management and can generate a high number of requests for repeat prescriptions of opioids post ankle surgery.
Aim:	To reduce the number of patients requesting a repeat prescription for an opioid from their GP, within 8 weeks post-surgery for ankle fracture in Craigavon Area Hospital, by 25% between April and July 2024
Change ideas:	<ol style="list-style-type: none"> <li>1. Development of an information leaflet for patients undergoing surgery for ankle fracture.</li> <li>2. Staff education sessions among physiotherapists and pharmacists of non-pharmacological pain management strategies.</li> <li>3. Primary care resource pack developed on Page Tiger hosting the patient information leaflet, guide to suggested pain management and signposting.</li> </ol>
Outcomes:	<ol style="list-style-type: none"> <li>1. A 25% reduction was achieved in the number of patients requesting repeat prescriptions for an opioid from their GP.</li> </ol>
Aim achieved?	Yes

## 2.9 WHSCT Orthopaedics and Trauma

Project team name:	WHSCT Orthopaedics and Trauma
Setting:	Secondary care; WHSCT Altnagelvin Hospital Primary care; GP Federation
Population:	Opioid naïve, lower limb trauma patients

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

Problem:	Opioid medication should be prescribed for 5-7 days post-operatively. There was a risk that patients were remaining on opioids longer than necessary after discharge.
Aim:	To reduce the percentage of patients who remain on opioid medication at eight weeks post discharge from the orthopaedic trauma wards, Altnagelvin Hospital by 50% by 31 <sup>st</sup> August 2024.
Change ideas:	<ol style="list-style-type: none"> <li>1. Implemented discharge pain medication flow diagram and doctor education.</li> <li>2. Patient information leaflet and patient education.</li> <li>3. General practice pharmacist education.</li> </ol>
Outcomes:	The percentage of patients receiving opioids $\geq 8$ weeks post discharge was reduced by more than 50%.
Aim achieved?	Yes

### 3. Evaluation methodology

In order to evaluate the programme the views of 3 key stakeholder groups were sought: the programme participants; HSCQI programme delivery team; and the HSCQI mentors. A mixed methods approach was employed. Feedback was obtained from in-person focus groups conducted with programme participants at the September 2024 celebration event and online using surveys (Microsoft Forms) which were circulated via email in September 2024.

All potential participants of the focus groups were provided with an information sheet (Appendix 1) and given the opportunity to ask questions about the evaluation. All participants provided informed, voluntary, written consent (Appendix 2) to take part in the focus groups. Each focus group was hosted by two members of staff from MOIC, one to facilitate discussion and one to make notes, check recording and encourage involvement. The focus groups were conducted with an interview guide (Appendix 3) to ensure consistency between groups and provide a framework for discussion. The discussions were audio recorded and transcribed in full using Microsoft Teams.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

Transcripts were then checked for accuracy and amended by a MOIC Programme Manager. All directly identifiable information was removed from the transcripts and the contents verified by a second MOIC Programme Manager. Once the transcripts were verified, the audio recordings were deleted.

Key themes from each focus group were identified by a Programme Manager. These themes were cross checked against the recording by a second Programme Manager. Any differences in coding were discussed and agreed by consensus.

The online surveys were open for a minimum of 10 days to collect responses from programme participants (Appendix 4), HSCQI mentor (Appendix 5) and the HSCQI programme delivery team (Appendix 6). Again, key themes were identified from the written responses and verified by a second Programme Manager. Any differences in coding were discussed and agreed by consensus.

Illustrative quotes are highlighted below, these are not directly attributable to individual participants. Responses from project participants were denoted by 'PP'; those from mentors 'M'; and programme delivery team were coded as 'PDT'.

### 4. Evaluation results

Three focus groups were conducted with 18 participants, each focus group had between 5-7 participants. Representation from all 9 project teams was achieved.

Anonymous, written survey responses were received from HSCQI programme delivery team (n=4), HSCQI mentors (n=4) and programme participants (n=1).

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

### 4.1 Engagement

Getting stakeholder engagement and buy-in to a new programme is difficult especially with current known workforce pressures. While representation from the Northern Ireland Ambulance Service and South Eastern Health and Social Care Trust was not possible due to the pressures on the service at the time 40 participants were enrolled from four HSC Trust areas in Northern Ireland across both primary and secondary care settings. This highlights the widespread nature of challenges associated with opioid prescribing and that it is not a problem specific to one particular illness, population or care setting. Active participation and retention of participants throughout the programme was maintained. Factors that both supported and inhibited this engagement are presented below.

#### Participant engagement with the programme:

Workforce barriers to engaging with the QI programme were common to most teams specifically in regards to resourcing members of staff to participate in the programme. This meant participants maintaining current workloads while taking on an additional workload in the form of participating in the OICP, in some cases this time was taken from clinical practice, there was no protected time to participate and general staffing pressures applied. Local staff factors such as seeking approval from colleagues to participate was viewed as a hurdle as participation would impact on the wider clinical team. Similarly, no local recognition, low staff enthusiasm, coordination of availability (different shift patterns, staff turnover, different sites, holiday periods) and lack of mentor in one team at the start were barriers to engagement. Technical issues including getting access to the programme's SharePoint and the Encompass roll-out were noted as barriers to engaging with the programme.

'...taking the 'I' out of audit'

PP1, Focus group 1\_2

In contrast to these barriers, enablers to participation in the OICP included intrinsic motivation to improve patient care, agency to influence change, previous experience

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

with improvement projects and an interest in the topic. The programme was also seen as an opportunity to improve the sustainability of primary care by improving capacity by reducing demand for potentially inappropriately prescribed medications. Extrinsic factors such as senior management drivers, improving networks, a supportive wider clinical team, a supportive mentor and the involvement of key champions were key to project team participation. Factors around the design of the programme itself contributed to participation in particular; fee-free contribution to continuing professional development, team working, attaining QI certification and a joint regional initiative across primary and secondary care to facilitate Northern Ireland-wide change at a policy level. Additionally, the fact that opioid prescribing was recognised as an issue locally and regionally was a motivating factor to participate and the 'HSCQI label' with the connection to the TMSNI programme attracted support from the project teams.

### Mentor engagement with the programme:

Engagement from mentors echoed similar themes in terms of barriers and included workload, time pressures and additionally a mis-match of availability between mentor and mentees. Factors that enabled mentor participation included intrinsic motivation, goodwill, good communication including clear guidance and both remote and face-to-face meetings.

### Programme delivery team programme engagement:

From the programme delivery team perspective, engagement in the programme benefitted from a real world problem with compelling evidence and being aligned to the TMSNI strategic priority. Again the involvement of key people, the early stakeholder workshop, and established peer relationships facilitated engagement. Budget restrictions for in-person events, competing priorities and uncertainty around which stakeholders to engage were highlighted as challenges to overcome to achieve good engagement.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

### 4.2 Networks:

Collaborative conditions were established to facilitate the formation of project teams, some of which were cross-organisational, including staff from primary and secondary care or staff from different services within the one HSC Trust. New networks were created and existing relationships were strengthened across many different settings: within the project teams themselves; across different project teams; within wider clinical teams through implementation of change ideas; across primary and secondary care; across different geographic locations within primary care; across different services within HSC Trusts; HSC Trust and GP Federation collaboration; improved relationships with pharmacists; links were made with community based organisations including the Healthy Living Centres Alliance and service user groups including Versus Arthritis; and, perhaps most importantly collaboration with service users themselves.

Improved visibility of the HSCQI organisation and of the project participants involved in the programme was noted as a benefit of this networking. The networking itself was facilitated by the use of electronic resources, including SharePoint.

‘... collaboration, people in different areas  
bring a different perspective.’

PP4, Focus Group 4

### 4.3 Outcomes

Each project group identified an opioid prescribing issue relevant to their setting and population. Using QI methodology they developed and deployed change ideas to address the issues as summarised in section 2 above. Nine projects were completed, each aiming to improve the appropriateness of opioid prescribing. All projects achieved their stated aim. During the programme various challenges and facilitators to achieving those aims were experienced and are detailed below.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

### Engagement:

Engaged staff had a strong influence on realising the aims of the projects, whether this was supportive senior management, engaged ward staff, primary care receptionists, HSCQI support, practice-based pharmacists, junior doctors, determined project team members and mentors all ultimately resulting in effective team work. Similarly, engaged service users and expert patients were highlighted as enablers to the success of the projects.

'...it's that reiteration of you're not doing it on your own'  
PP3, Focus Group 1\_2

I know the power that expert patients and peer support for that kind of biopsychosocial model to get them involved. It's been very positive'  
PP3, Focus Group 1\_2

Likewise, poor engagement from key stakeholders (specifically no engagement from surgeons), attrition of project team members, in-person team meetings when working across primary and secondary care settings, low staff confidence and staffing pressures were cited as barriers to achieving the project aims. Medical staff rotation was also challenging to manage due to the continual training required.

### Workload:

Work and time pressures were a common theme across all participant groups as barriers to achieving the project participants' aims. Related to this was the cost of overtime for staff participating in the programme in their own time.

### Primary care factors:

A number of factors specifically affected primary care, with enablers including: involving other members of the practice to achieve consensus when developing new policies; previous experience of social prescribing; being associated with a QI aware GP Federation; and autonomy to act as a practice to make changes to processes were factors that were believed to facilitate primary care-based projects achieve their aims.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

However, this flexibility and autonomy was carefully balanced around the risk of a potential “patient flood” caused by changes to policies and procedures.

### Technology:

Technology was identified as a factor to improve accessibility of information for service users by using QR codes, websites, online patient information sheets and hyperlinked signposting of further information. Compliance with change ideas was also aided by creating a template on Encompass.

It was noted that the Encompass roll out put additional pressure on those programme participants affected as it diverted focus from the project to focus on training for the IT system change making it difficult to prioritise time to spend on the QI project.

### Programme factors:

Aspects of the programme that the project participants perceived as having positively influenced outcomes included; supportive HSCQI personnel and QI mentor, setting realistic aims, being held accountable at regular project updates, having open and realistic communication, the flexibility of remote meetings, opening communication channels between primary and secondary care settings. Similarly the programme delivery team stated that regular contact with participants; having dedicated resource including funding for in-person sessions; a specific focus on opioid use underpinned by a good understanding of opioid prescribing; subject matter experts; alignment with the TMSNI strategy; and the skill mix provided by the teams in HSCQI and TMSNI were key to delivering the improvement projects.

Programme factors identified as being detrimental to achieving the project aims included not having a mentor at the start of the programme or having a negative experience with a mentor and being provided with an overwhelming amount of information and resources.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

While opioid prescribing was a common, cross-sectoral issue which engaged the participants it was also a multi-causal issue in which many different potential methods could be employed to advance practice. This can be both beneficial as there are many different ways to achieve the aim of improved opioid prescribing and it is particularly suited to a wide ranging multi-stakeholder programme such as the OICP but it can also add difficulty because there is no one 'right' answer.

'It's one of those wicked problems that there is not just one cause or one perspective of it'

PP3, Focus Group 1\_2

#### Service users:

There was a perception that service users held the belief that there was a hierarchy within the medical profession with hospital doctors being viewed as superior to their primary care colleagues. This led to difficulties when GPs considered making changes to opioids previously prescribed in hospital. Reducing or changing opioid pain medication typically led to time consuming, challenging consultations for clinicians especially when the prescribing power lay with the doctor thus creating "...very ugly, unbalanced communication" [PP3, focus group 1\_2].

Positive feedback from service users was a motivator for programme participants achieving their project outcomes.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

### Data and governance:

Data collection and information governance were particularly problematic for a number of project groups. Firstly, getting approval to access appropriate data was an issue for staff working in GP Federations due to issues with the data ownership of patient data held within GP Practices. This proved a significant challenge to overcome, involved multiple submissions to information governance and was specific to teams working across primary and secondary care settings. Another challenging and time consuming issue lay in retrieving consistent, patient-specific data reports in both primary and secondary care.

‘...we were still having a tennis match  
with the data people.’  
PP2, Focus Group 1\_2

### 4.4 Impact

Many teams reported seeing a positive change not only in a reduction of the specific opioids prescribed to the target population of each project but also a wider reduction in general opioid prescribing within their care setting. Participation in the OICP impacted a wide range of stakeholders but arguably most benefit was experienced by programme participants and service users. One participant noted that despite being amongst the lower prescribers of opioids, improvement was still important to prioritise as ‘...if you have somebody inappropriately on medication that is still very significant to that individual and their families...’ [PP3, Focus group 1\_2]. However, for the changes made to HSC service provision in respect of opioid prescribing to persist and become widespread standard practice they should be sustainable and scalable, factors identified in this regard are discussed below.

### Sustainability:

Factors supporting sustainability of change for more appropriate opioid use included a broad desire for change and for that change to be embedded in the culture. There is also a legal obligation to ensure the changes are embraced to comply with control drugs legislation for the appropriate prescribing of opioids. Many of the changes

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

implemented by the project teams have been adopted as standard care in their sphere of practice. These changes included; patient information leaflets, ice packs, flow diagrams, an opiate practice policy and a medication checklist.

When implementing these change ideas beneficial factors identified for sustaining change included; understanding the patient experience, managing service user pain and medication expectation, consistent messaging across teams, engaged staff and keeping the topic on the agenda. There was a belief that top down change supported by senior staff was key, while also noting that junior doctor engagement was also essential as they are the 'seniors of the future' [PP1, Focus Group 1\_2]. Outside of HSC staff, partnering with expert patients was seen as important to understand the patient experience and educate HSC staff and support service users about pain management.

For this to be a sustainable change, you need to involve everybody and, and also you need to keep it on the agenda.

PP3, Focus Group 1\_2

The OICP positively impacted at an individual level by expanding staff training and development but also at an HSC level by increasing regional QI capacity. The thirty participants who achieved the Level 2 QI qualification now have the tools and contacts to identify and complete new self-directed QI projects. It was also reported to have had a positive impact within the wider clinical groups motivating others to make positive changes to their clinical practice.

I think seeing the impact of your project on the patients, the benefit of it, it gives you a real encouragement to keep going, or to think, maybe not just yet, but to think "What other QI project could we take part in?"

PP1, Focus Group 3

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

In terms of resources required to sustain changes there was a clear ask for funding and the need to support project team staff to set aside time specifically for QI work, equally for mentors to support QI work and senior HSCQI staff to deliver the programme. Similarly there was a request for additional staff resource to support the changes implemented, for example, practice based pharmacist sessions, reception

‘...setting up a system that makes it easier to do the better thing’

PP3, Focus Group 1\_2

staff, physiotherapists and counsellors. From the HSCQI programme delivery team, additional resources required to ensure the sustainability of a QI programme included; subject matter expertise, funding for in-person learning sessions, administrative support and a dedicated SharePoint site for secure document sharing.

#### Scale and spread:

As with all improvements the findings should be disseminated to all appropriate stakeholder groups. This dissemination began with the HSCQI celebration event in September 2024 which was attended by a range of stakeholders including policy and commissioning leads. Initial evidence indicated ad hoc sharing and uptake of the change ideas generated through the OICP between programme participants, in different wards within a hospital and across an HSC Trust. Links with regional groups and services to facilitate region-wide change should also be considered. This programme has led to an awareness of how QI can support the strategic objectives for HSC and there is potential for it to inform a future potential public health campaign to raise public awareness about the risks of opioid use. Additional suggestions to facilitate the scale and spread of the QI innovations included the development of a pain management strategy for NI, improve service user access to pain management programmes, improve links with addiction services and to put in place opioid prescribing guidance.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

There was a divergence of opinion whereby project team members working in secondary care championed simple change ideas that were universally applicable and therefore could be easily replicated in other wards and hospital settings across Northern Ireland. Contrastingly, those who worked in primary care stressed that each GP Practice is different and faced different issues with opioid prescribing, different relationships with their staff and different needs. Therefore it was viewed as much more difficult to scale and spread the innovations tested within the primary care setting. Despite this view, continued joint working across primary and secondary care was considered essential as was the need to evidence sustained improvements and maintaining the QI network to influence scale and spread.

On a practical level it was noted that there was potential for Encompass to facilitate spread due to the ability to embed checklists, generate reports and link key prescribing data in one place.

### 4.5 Programme observations

#### Positive feedback

Focus group participants praised the support and leadership of the HSCQI programme lead. They also described the programme as an open forum with no blame which was an important basis on which to build trust for collaboration and the design of improvement projects.

Face-to-face meetings were positively received and resulted in unintentional learning about primary and secondary care settings and networks.

The programme was flexible and adapted to the needs of the participants. The flexibility of the QI training around deadlines, repetition of training due to illness and acceptance of the limited capacity to release staff to attend meetings was appreciated.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

### Suggested improvements

The main change requested was regarding meetings, primarily to either reduce number of check-ins and/or to increase the efficiency of the project surgery meetings. It was suggested that the format of project surgery meetings could be altered to include less presentations and include more functional work or learning. It was also suggested that rather than having all nine projects on one call, similar projects could be grouped together. There was a wish for more collaborative working between project teams with common goals and a proposal to design regional or multi-HSC Trust projects.

Regarding the programme content there were requests to simplify the level of training and reduce the information provided including more of a focus on data use and analysis. This simplification could accommodate a proposal to allow more junior HSCQI staff to deliver the QI training, however, it was also noted that the content was delivered to meet the requirements of Level 2 Q2020 Attributes Framework for Health and Social Care (3). In contrast, the UCLPartners modules were considered to be straightforward, easy to navigate and the fact that they could be revisited and completed at any time or pace was appreciated. However, one person mentioned not finding the modules particularly beneficial.

An unplanned extension to the programme was rolled out to provide project teams with more time to test their change ideas and gather results. Nevertheless, this also resulted in programme fatigue and some projects ran out of capacity to release staff for the additional meetings.

Encouraging wider engagement across the project teams and with mentor colleagues were areas highlighted for improvement. Greater multi-disciplinary representation on the project teams was thought to be important and it was specifically noted that no surgeons took part in the programme. A number of suggestions were made to improve the participation of mentors in the programme including; providing more information and support from HSCQI team, mentor networking, mentor breakout sessions,

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

creating a buddy system for new mentors, having a specific mentor email or WhatsApp group and more active participation at the learning sets.

On a practical level, assistance with poster printing for primary care colleagues who did not have access to HSC Trust printing services would be welcomed.

### 5. Lessons learned

Stakeholders involved in the OICP provided some insights into the lessons learned in the delivery and participation in the programme, these are summarised below:

- Engaged staff with a will to improve patient care are central to driving change and innovation throughout HSC. Despite the significant, common barriers of workload, staffing pressures and time shortages these were overcome by determination, team work and a common goal to learn, develop and deploy improvements to better patient care.
- The importance of partnering with expert patient groups both to understand the patient experience and educate HSC staff but also to support and educate service users about pain management was highlighted as an essential component.
- The use of technology was subtly weaved throughout the focus group discussions and there was a sense of growing need and anticipation for technology to deliver an ease of access to data and reporting, create reminders and templates and provide data continuity. However, in partnership with technology there needs to be the skills to understand the data received to achieve accurate, consistent reporting. More of a focus on data extraction and reporting was requested by programme participants. While discussion was largely focused on Encompass there was also similar pertinent issues applying to primary care information systems and websites to be considered. Despite Encompass being a barrier to teams engaging with the programme during this unique time of technology adoption across secondary care it was also viewed as a potential enabler for future scale and spread of quality improvement innovations.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

- An information governance issue arose that was both unexpected from programme participants' perspective and significant in terms of working across primary and secondary care settings. This resulted in limiting access to GP records by GP Federation-employed General Practice Pharmacists due to each GP practice being their own data controller. This may prove to be a hindrance to innovation and the role of Practice Based Pharmacists in the future.
- The contents and format of the programme could be refined based on the feedback received to potentially reduce the level of information provided and increase the efficiency of the project surgery meetings.
- The end point of the OICP was attainment of Level 2 QI for the programme participants and dissemination at a celebration event. However, to maximise the impact of the programme it may be beneficial to have a meeting or series of meetings with participants to brainstorm scale and spread, create a targeted dissemination strategy and a plan to maintain the QI networks created. This would enable exemplar aspects to be taken forward to inform key policy and commissioning leads with the aim of building these into regional guidelines.
- This programme created QI capacity and capability across HSC. Maintaining these networks and building on the success of the OICP will benefit future QI programmes.

## 6. Recommendations

### 6.1 Scale and spread

Good practice with regards to opioid prescribing has been identified and implemented locally. The TMSNI team should consolidate the learning from the specific change ideas and outcomes into recommendations for implementation to be considered by primary care commissioners and Trusts for scale and spread on a regional basis to improve the long term quality of care across Northern Ireland.

## 6.2 Network

One of the key challenges and successes of this programme was to establish a broad network of interested clinicians from different practice areas and different geographies that shared an ambition to improve opioid prescribing. During regional scale and spread this network could be utilised to facilitate improvements in opioid prescribing.

## 6.3 QI capacity

Regional QI capacity was increased as a result of participants being trained to Level 2 QI. HSC does not have a regional QI capacity database. HSCQI should inform respective QI Leads in Trusts/primary care about staff who achieved Level 2. HSCQI should follow-up with these participants to monitor QI activity at 6 months and 12 months following attainment of Level 2 QI to examine whether achieving this level of training increased ongoing QI activity.

## 7. Conclusion

In terms of the OICP's objectives of creating collaborative conditions for project teams from primary and secondary care and for those teams to share, learn and make improvements focused on opioid prescribing for non-malignant pain management, these have clearly been met. Despite HSC staff having heavy workloads and being time-poor, improvement is possible with motivated, enthusiastic staff committed to improving the patient experience.

A key benefit of using QI methodology is the flexibility and the speed with which specific changes can be implemented but lasting success will lie in harnessing these examples of good practice and spreading them through regional initiatives to convert this exemplar good practice to standard practice.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

This evaluation clearly demonstrated that staff were engaged with the OICP and this has delivered benefits relating to opioid prescribing in teams' spheres of practice over the short term, year-long programme. The enthusiasm of the participants and the fact that all projects were followed through to completion having met their stated aims provides evidence that this programme has improved opioid prescribing in the medium term. However, the longer term impact of this programme is less clear. Positive steps to ensure scale and spread of successful innovations will be required for this collaborative to demonstrate long term impacts on opioid prescribing. It is essential to capitalise on the networks that have been established, the momentum that the programme created and the motivation of the policy and commissioning leads to deliver long term, positive changes in opioid prescribing across Northern Ireland to improve the health and wellbeing of the entire population.

## 8. References

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Appendices

Appendix 1: Focus group Participant Information Sheet ..... 36

Appendix 2: Focus Group Participant Consent Form ..... 39

Appendix 3: Focus Group MOIC Staff Interview Guide ..... 41

Appendix 4: Project team online survey ..... 44

Appendix 5: Mentor online survey ..... 47

Appendix 6: HSCQI programme delivery team online survey ..... 49

## Appendix 1: Focus group Participant Information Sheet

**HEALTHCARE PROFESSIONAL INFORMATION SHEET**

**Study title:** HSCQI Opioid Improvement Collaborative Programme service evaluation

**Invitation to participate in a service evaluation**

This service evaluation will examine the HSCQI Opioid Collaborative Programme. You have been invited to participate in a focus group or questionnaire because of your participation in this programme.

This information sheet describes the evaluation and your role in it. Before you decide, it is important that you understand why the evaluation is being carried out and what it will involve for you. Please take time to read this information and discuss it with others if you wish. If anything is not clear, or if you would like more information, please ask the person responsible for this study. After that we will ask you to sign a consent form in order to participate in the study.

**Voluntary nature of participation**

Participation in this evaluation is voluntary. You can withdraw from the evaluation at any time without giving any reason and without there being any negative consequences. If you withdraw from the study or withdraw your consent, your personal data collected for the purposes of the evaluation will be removed.

**Purpose and aims of the evaluation**

The main goal of this evaluation is to investigate whether the programme worked as expected.

The specific aims of this interview are to explore healthcare practitioners' views on engaging with the programme, practice with regards to opioid use in non-malignant pain and the impact of their QI project.

**Who is organising and funding the evaluation?**

The Opioid Improvement Collaborative Programme is organised by the HSCQI and the Medicines Optimisation Innovation Centre are conducting an evaluation.

**What will the participation involve?**Providing consent

- After you have had time to read and understand this information sheet you will be asked to sign a consent form.

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

### During the focus group

- During the focus group you and your project team will be asked some questions regarding your participation in the programme.
- We are looking for your honest opinions.
- The researcher(s) may need to take notes during the call and will be audio recording the conversation so that we can listen back to it and make more detailed notes.
- The call should not last longer than 60 mins. We will work at a pace that is set by you and you may take a break at any time during the call.

### Collection and processing of information after the video call

- Other than the recording obtained during the interview, no other personal data will be collected.
- All recordings collected during the interview will be transferred to a password-protected computer that only the staff at MOIC will have access to.
- We will transcribe the recordings and anonymise any identifiable information in the process. Recordings will then be destroyed after use.
- Anonymised findings may be used in further publications or dissemination activities (e.g., in journal articles, workshops and conferences).

### **Possible benefits of taking part**

The evaluation will investigate what worked well in the programme and what could be improved in the future. The findings of this evaluation may influence policy regarding opioid use in Northern Ireland.

### **Possible disadvantages and risks of taking part**

There is no foreseeable risk or disadvantage to you by taking part in this focus group.

### **Incidental findings**

There are no foreseeable incidental findings of taking part in this focus group.

### **Financial information**

Participation in this study will involve no cost to you, other than your time. You will receive no payment for your participation.

### **Informing about the evaluation results**

A written summary of the evaluation will be made available to all participants once completed. Results, including direct quotations may also be published in a report to the funding body, journals, publications and conferences. No participants will be able to be identified from these reports.

### **Further information**

Further information related to the study can be requested from the research team.

### **Contact details of the researchers / person in charge**

Research Team:

Dr Glenda Fleming [Glenda.Fleming@northerntrust.hscni.net](mailto:Glenda.Fleming@northerntrust.hscni.net)

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

Dr Nicola Goodfellow [Nicola.Goodfellow@northerntrust.hscni.net](mailto:Nicola.Goodfellow@northerntrust.hscni.net)

Telephone: 028 9442 4942

## Appendix 2: Focus Group Participant Consent Form

**PARTICIPANT CONSENT FORM**

**Study title:** HSCQI Opioid Improvement Collaborative Programme service evaluation

**Participant declaration**

- I have been invited to participate in the above study. The purpose of the study is evaluate the Opioid Improvement Collaborative Programme.
- I have read and understand the participant information sheet. The participant information sheet has provided me sufficient information about the above evaluation, its purpose and execution of the study, about my rights, and about the possible advantages and disadvantages of taking part.
- I have had the opportunity to ask questions about the evaluation and have had these questions answered satisfactorily.
- I have been given sufficient information about the collection, processing, transfer/disclosure and deletion of my responses during the study. I understand that other than voice recordings obtained during the study by staff from MOIC, no other personal data will be processed during this study.
- By signing this form, I confirm that I voluntarily consent to participate in this evaluation and that I also grant consent to the processing of my responses for the purposes described in this document.
- I have not been pressurised or persuaded into participation and I have had enough time to consider my participation in the study. I understand that my participation is entirely voluntary and that I am free to withdraw my consent at any time, without providing any reason.
- I also have the right to request the removal of my identifiable personal data in accordance with data protection legislation.

**To be completed by the participant**

Agreement (please complete the details below to confirm your consent)

Name:	
Date:	
Signature:	

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

**To be completed by MOIC personnel**

Please complete the details below to confirm receipt of signed consent

Name:	
Date:	
Signature:	

The original consent signed by the participant will be kept by the research team.

**Contact**

Dr Nicola Goodfellow (MOIC programme manager)

Email: [Nicola.Goodfellow@northerntrust.hscni.net](mailto:Nicola.Goodfellow@northerntrust.hscni.net)

Telephone: 028 9442 4942

## Appendix 3: Focus Group MOIC Staff Interview Guide

**MOIC STAFF INTERVIEW GUIDE**

**STUDY TITLE:** HSCQI Opioid Improvement Collaborative Programme service evaluation

**DATE:** \_\_\_\_\_

**INTERVIEWER NAME:** \_\_\_\_\_

**PROJECT TEAM NAME(S):** \_\_\_\_\_

The aim of this focus group interview is to inform a service evaluation of the HSCQI opioid improvement collaborative programme.

- How well have staff engaged with the programme and what benefit is this having **short term**
- Has practice improved with regards to opioid use in non-malignant pain- **medium term**
- What impact will this programme have on the quality of care received by service users- **long term**

The programme challenged project teams to develop change ideas to improve opioid use for non-malignant pain and implement these in practice using QI methodology.

The interview will cover the broad themes below and example questions are provided to guide the discussion.

**PLEASE AUDIO RECORD (TURN OFF CAMERA) AND USE THE MS TEAMS MEETING LINKS PROVIDED**

**Enable transcription**

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

## Interview questions

Focus of questions	Example interview questions
Engagement	<ul style="list-style-type: none"> <li>• What <b>motivated</b> you to participate in this programme?</li> <li>• <del>Describe how you engaged with the programme?</del></li> <li>• What <b>barriers</b> did you experience in engaging with the programme?</li> <li>• Describe how your project team has engaged with               <ul style="list-style-type: none"> <li>○ Other project teams</li> <li>○ Service users</li> <li>○ Extended clinical team</li> <li>○ HSCQI Hub and Network</li> </ul> </li> <li>• What factors affected your engagement with the project stakeholders? (What barriers and enablers were experienced when seeking engagement?)</li> <li>• How have your peer networks changed as a result of participating in this programme? (What networks were created/maintained/strengthened as a result of this programme?)</li> </ul>
Outcomes	<ul style="list-style-type: none"> <li>• Describe how your project has reduced preventable harm associated with opioids?</li> <li>• How did you select your <b>target population</b>?</li> <li>• What <b>outcomes</b> (intended and unintended) has your project delivered?</li> <li>• What factors <b>enabled</b> the delivery of your project?</li> <li>• What <b>barriers</b> were encountered in delivering your project and how were they overcome?</li> <li>• If you were to repeat your project what would you do differently?</li> <li>• Have any <b>additional</b> or <b>avoidable</b> costs been identified in your project?</li> <li>• Describe any <b>resources required</b> to support your change ideas that were not previously in place?</li> <li>• What benefits did you experience as a result of your participation in the programme?</li> </ul>
Impact	<ul style="list-style-type: none"> <li>• Which change idea(s) had the <b>greatest impact</b> on the use of opioids?</li> <li>• How could your change idea(s) be <b>scaled and spread</b>?</li> <li>• Have your change idea(s) been <b>adopted</b> into standard practice?               <ul style="list-style-type: none"> <li>○ If so, which changes?</li> <li>○ Is there capacity to sustain the improvements made?</li> </ul> </li> </ul>

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

	<ul style="list-style-type: none"><li>• How will you use the skills you developed due to your participation in this programme to implement future improvement projects?</li><li>• Thinking about the programme as a whole what did you like and what could be improved?</li></ul>
	<ul style="list-style-type: none"><li>• Anything else you would like to add?</li></ul>

**THANK YOU!!**

## Appendix 4: Project team online survey

### HSCQI opioid improvement collaborative programme evaluation- project team

#### Invitation to participate in a service evaluation

This survey is part of a service evaluation to examine the HSCQI Opioid Improvement Collaborative Programme.

You have been invited to participate in this survey because of your involvement in this programme.

The main goal of this evaluation is to investigate whether the programme worked as expected.

The specific aims of this survey are to explore healthcare practitioners' views on engaging with the programme, practice with regards to opioid use in non-malignant pain and the impact of their QI project.

A written summary of the evaluation will be made available to all participants once completed. Results, including direct quotations may also be published in a report to the funding body, journals, publications and conferences.

By completing this survey, **I confirm that I voluntarily consent to participate in this evaluation** and that I also grant consent to the processing of my responses for the purpose of evaluation and dissemination of the HSCQI Opioid Improvement Collaborative Programme.

Please do not provide any identifiable information in your responses below. All responses are anonymous. If you would like any further information on the evaluation please contact [Nicola.Goodfellow@northerntrust.hscni.net](mailto:Nicola.Goodfellow@northerntrust.hscni.net). Please submit your response by 30 September 2024. Thank you!

\* Required

1. Today's date \*
2. What **motivated** you to participate in this programme?
3. What **barriers** to participation did you experience?
4. Describe how your project team has engaged with **other project groups**?
5. Describe how your project team has engaged with the **extended clinical team**?

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

6. Describe how your project team has engaged with **service users**?
7. Describe how your project team has engaged with the **HSCQI Hub and Network**?
8. What **factors** affected your engagement with the project stakeholders?(What barriers and enablers were experienced when seeking engagement?)
9. How have your peer **networks** changed as a result of participating in this programme? (What networks were created/maintained/strengthened as a result of this programme?)
10. **How** has your project reduced preventable harm associated with opioids?
11. How did you select your **target population**?
12. What **outcomes** (intended and unintended) has your project delivered?
13. What factors **enabled** the delivery of your project?
14. What **barriers** were encountered in delivering your project and how were they overcome?
15. If you were to repeat your project what would you do **differently**?
16. What **additional** or **avoidable** costs have been identified in your project?
17. Have you identified any **resources** required to support your change ideas that were not previously in place?
18. What **benefits** did you experience as a result of your participation in the programme?
19. Which change idea(s) had the **greatest impact** on the use of opioids?

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

20. How could your change idea(s) be **scaled and spread**?

21. Have your change idea(s) been **adopted** into standard practice, if so which changes?

22. How will you use the skills you developed due to your participation in this programme to implement future improvement projects?

23. Thinking about the programme as a whole what did you like and what could be improved?

24. Is there anything else you would like to add?

This content is neither created nor endorsed by Microsoft. The data you submit will be sent to the form owner.

Microsoft Forms

## Appendix 5: Mentor online survey

### HSCQI Opioid Improvement Collaborative Programme evaluation - mentors

#### Invitation to participate in a service evaluation

This survey is part of a service evaluation to examine the HSCQI Opioid Improvement Collaborative Programme.

You have been invited to participate in this survey because of your involvement in this programme.

The main goal of this evaluation is to investigate whether the programme worked as expected.

The specific aims of this survey are to explore the programme delivery team's views on engagement, delivery and impact of the programme.

A written summary of the evaluation will be made available to all participants once completed. Results, including direct quotations may also be published in a report to the funding body, journals, publications and conferences.

By completing this survey, **I confirm that I voluntarily consent to participate in this evaluation** and that I also grant consent to the processing of my responses for the purpose of evaluation and dissemination of the HSCQI Opioid Improvement Collaborative Programme.

Please do not provide any identifiable information in your responses below. All responses are anonymous. If you would like any further information on the evaluation please contact **Nicola.Goodfellow@northerntrust.hscni.net** Please submit your response by **30 September 2024. Thank you!**

\* Required

1. Today's date \*

2. As a mentor to the programme were your **roles and responsibilities** clear?

Yes

No

3. How could your **role and responsibilities** be further clarified?

4. How did the project team **engage** with you?

5. How did you **engage** with your project team?

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

6. To what extent did you **engage** with the HSCQI Hub and Network?

7. What factors **enabled** engagement with the programme?

8. What **barriers** did you experience when engaging with the programme?

9. Did you feel **supported** in your role as a mentor?

Yes

No

10. What **support** for mentors should be included in future improvement programmes?

11. How much **time** (hours per month) did you use to provide support to the project team?

12. Was this time sufficient to provide effective mentoring?

13. Would you agree to be a mentor in future improvement programmes?

Yes

No

14. Is there anything else you would like to add?

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## Appendix 6: HSCQI programme delivery team online survey

### HSCQI Opioid Improvement Collaborative Programme evaluation - programme delivery team

#### Invitation to participate in a service evaluation

This survey is part of a service evaluation to examine the HSCQI Opioid Improvement Collaborative Programme.

You have been invited to participate in this survey because of your involvement in this programme.

The main goal of this evaluation is to investigate whether the programme worked as expected.

The specific aims of this survey are to explore the programme delivery team's views on engagement, delivery and impact of the programme.

A written summary of the evaluation will be made available to all participants once completed. Results, including direct quotations may also be published in a report to the funding body, journals, publications and conferences.

By completing this survey, **I confirm that I voluntarily consent to participate in this evaluation** and that I also grant consent to the processing of my responses for the purpose of evaluation and dissemination of the HSCQI Opioid Improvement Collaborative Programme.

Please do not provide any identifiable information in your responses below. All responses are anonymous. If you would like any further information on the evaluation please contact **Nicola.Goodfellow@northerntrust.hscni.net** Please submit your response by **30 September 2024. Thank you!**

\* Required

1. Today's date \*
2. Describe how the programme has **engaged** with the project teams?
3. Describe how the programme has **engaged** with service users?
4. Describe how the programme has **engaged** with the with wider stakeholders e.g. policy leads?
5. Describe how the programme has **engaged** with the HSCQI Hub and Network?
6. What **barriers** affected engagement with the programme stakeholders?

## OPIOID IMPROVEMENT COLLABORATIVE PROGRAMME EVALUATION

7. What **enabled** your engagement with the programme stakeholders?
8. How have your peer **networks** changed as a result of delivering this programme?
9. What **outcomes** (intended and unintended) has the programme delivered?
10. Describe how the programme **changed practice** with respect to opioid use?
11. What factors **enabled** delivery of the programme?
12. What **barriers** were experienced in the delivery of the programme and how were these overcome?
13. What **adaptions** were made during the programme and why?
14. What would you **differently** in the future and why?
15. What **resources** were required to deliver the programme?
16. How **sustainable** is the delivery of this type of programme in the future?
17. What needs to happen in the **longer term** to influence opioid use in non-malignant pain?
18. What is needed to achieve **scale and spread** of good practice identified by the programme with respect to opioid use in non-malignant pain?
19. What **knowledge sharing** has occurred or will occur in the future as a result of this programme?
20. Is there anything else you would like to add?

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