# PERTH AND KINROSS INTEGRATION JOINT BOARD

Council Building
2 High Street
Perth
PH1 5PH

23 March 2017

With reference to the meeting of the **Perth and Kinross Integration Joint Board** being held in the **Council Chambers, Ground Floor, Council Building, 2 High Street, Perth, PH1 5PH** on **Friday 24 March 2017** at **10.30am,** I now enclose papers relative to **additional item 12** on the agenda.

If you have any queries, please contact Scott Hendry on 01738 475126 or e-mail committee@pkc.gov.uk.

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**Chief Officer**

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Councillor P Barrett, Perth and Kinross Council
Councillor I Campbell, Perth and Kinross Council
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**Additional Members**
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Dr A Noble, External Advisor to Board

**Stakeholder Members**
G Mackie, Staff Representative, Perth and Kinross Council
A Drummond, Staff Representative, NHS Tayside
H MacKinnon, PKAVS (Third Sector Interface)
B Campbell, Carer Public Partner
A Gourlay, Service User Public Partner

**Perth and Kinross Integration Joint Board**

**24 MARCH 2017**

**AGENDA**

12. General Practitioner Prescribing and Locality Engagement – Report by Clinical Director (copy herewith G/17/65) ***(Pages 1-10)***

**PERTH & KINROSS INTEGRATION JOINT BOARD**

**24 MARCH 2017**

# GENERAL PRACTITIONER PRESCRIBING AND LOCALITY ENGAGEMENT

**REPORT BY CLINICAL DIRECTOR**

**PURPOSE OF REPORT**
The purpose of this report is to seek approval from Perth and Kinross Integrated Joint Board to invest in a three year GP engagement plan focused on sustainable prescribing and the wider transformation of care.

## 1. RECOMMENDATIONS

It is recommended that the IJB:

1.1 Approve investment of £312k per annum from Partnership Development funding for three years in the GP Prescribing and Locality Engagement Programme for change.

1.2 Ask the Clinical Director to provide quarterly reports to the Integrated Joint Board (IJB) meeting to provide a further update for the June 2017 IJB meeting on progress on implementation linked to three year Prescribing Improvement Plan.

## 2. BACKGROUND

At the meeting on 3 February 2017, the IJB were provided with an update on Prescribing Management in Perth and Kinross and the significant challenge facing all three IJB's in Tayside on delivering a sustainable GP prescribing position.

The Budget Setting 2017/18 paper being presented in parallel to this report sets out the increasing gap between the resources available to the Partnership and the forecast level of expenditure on GP prescribing in 2017/18.

A fundamental shift is now required in the way in which GPs work with us as partners in the delivery of a sustainable prescribing position and in the wider transformation of care.

## 3. PROPOSAL

Appendix 1 sets out a proposal to invest in GP time for an initial three year period, to work with Perth and Kinross Health and Social Care Partnership (P&K HSCP) to strongly support the Strategic Delivery Plan priorities.

As a first priority, GPs would be committed to working in partnership with P&K HSCP along side locality pharmacists to address the Quality Prescribing agenda. A set of prescribing participation requirements would be agreed aimed at ensuring GPs are actively engaged in a range of activities aimed at improved quality and efficiency.

GPs would also be expected to actively engage in the new model of locality working and to participate in the Enhanced Community Support programme becoming an integral component of the wider programme to look at reducing unplanned hospital admissions.

## 4. FINANCIAL IMPLICATIONS

The proposal seeks investment of £312k per annum for three years. This ‘invest to save’ proposal is predicated on the principle that ongoing recurring funding will be dependant on delivery of recurring efficiency savings and this investment being the first call on such savings.

The funding requested is based on an average sized GP practice being funded for a half-day session of GP time per week at £250/session per week. A sliding scale will be developed to ensure that the different size of practice is taken into account.

A roll out plan is being developed which is considering taking on a new locality every four months in the first year. Funding required for 2017/18 in the first instance will be approx £150k.

## 5. CONCLUSION

The Strategic Plan has a clear aspiration to ensure sustainable future services. Delivery of our aims relies heavily on significant engagement from key professional groups including GPs. This proposal seeks to create the conditions to address key priorities.


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|---|---|---|
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## General Practice Prescribing and Locality Engagement

The current strategic plan for the development of the Health & Social Care Partnership in Perth & Kinross is based around its 5 priority areas:

1. Prevention and early intervention
2. Person-centered health, care and support
3. Work together with communities
4. Inequality, unequal health outcomes and healthy living
5. Making the best use of available facilities, people and resource.

The Scottish Government has designed a number of prerequisites for localities in consultation with local professionals and local communities:

- Localities should relate to natural communities and take account of GP clusters
- Localities must support collaborative working principles.
- Localities must support a proactive approach to capacity building in communities.
- Localities must cultivate better integrated working between primary and secondary care.

Many of the above objectives of the P&K IJB require significant engagement from key professional groups, including GP's. General practice however is perceived by many at the current time as being in crisis. Workload has increased substantially in recent years and has not been matched by growth in either funding or workforce. Consultation rates have escalated greatly over the past decade. Pressures on general practice are compounded by the fact that the work is becoming more complex and more intense. This is mainly because of the ageing population, increasing numbers of people with complex conditions, initiatives to move care from hospitals to the community, and rising public expectations. In the short to medium term at least it will not be possible for most GP's to put aside current clinical demands to spend time working in partnership with the IJB to deliver its objectives.

As independent contractors, GP's are not employed by the IJB and therefore cannot be 'required' to participate in the current redesign and IJB priorities. GP's are also not personally financially responsible for the medication spending they initiate with their prescriptions and whilst they are almost universally caring, hard-working and devoted physicians they are currently operating under very significant and growing pressures which allow very little time to pro-actively engage in the type of work required by the IJB.

We may therefore struggle to move the agenda of locality working, quality prescribing and reducing unplanned admission issues forward without recognising the current general practice environment and looking for ways in which the IJB can support their engagement in partnering the transformation process.

## Locality Working and ECS

The Chronic Care Model, which has influenced health policy around the world, stresses the need to transform health care for people with long-term conditions from a system that is **largely reactive** – responding mainly when a person is sick – to one that is much **more proactive**, and focuses on supporting patients to self-manage. This assumes an active role for patients, who are encouraged to become both more knowledgeable about factors affecting their condition and more actively involved in decisions about their care. It is also based on a conviction that local communities have multiple resources that can be mobilised to help people live healthier and more fulfilled lives [*1].

The current P&K Plan for Integrated Locality Working is a reflection of the IJB Strategic plan. The plan emphasises the importance of an integrated care approach through joint working of local partners including:

- GP's and primary Health Care
- Acute Hospitals and Community Health
- Social Care Providers
- Third and Independent Sector Providers
- Health and Social Work Professionals
- Housing Providers
- Ambulance Service
- Community Safety Partners

The current issues in the community and primary care include:

- Insufficient GP appointments to meet patient demand timeously and insufficient time in GP appointments to deal with complex medical, social and lifestyle factors
- GP generally "gate-keeper" / "bottleneck" that often limits throughput in a primary care clinic. In traditional models, the doctor holds consultations with almost everybody who contacts the clinic.
- Ongoing specialist referrals require GP administration / referrals
- Lack of integration of specialists in supporting primary care teams which leads to perpetuation of the traditional 'specialist referral' system.
- There is not an ethos of 'people being sent directly to the right person' which leads to unnecessary consultations, delay, extra testing and prolonged periods of concern for patients.
- Direct and prompt access to AHP's is generally poor
- Utilisation of community pharmacists is poor and is partly limited by the funding structure within Scotland.
- Utilisation of community optician services is limited
- Access to prompt dental assessment for acute problems is restricted and adds extra burden on GP services who are poorly trained to deal with such issues.
- There is a funding, leadership and clinical disconnect between the key professions and organisations responsible for delivery of health and wellbeing services eg General Practice / HSCP / Secondary Care / Community & Locality Pharmacy / Optometry / Mental health
- Limited / restricted use of minor injury / illness specialist nurses

Through employment or constitution most of the above 'local partners' can be expected to become highly engaged in a transformation program. Currently engagement with primary care and GP's is more difficult. It has become evident through the piloting of the Enhanced Community Support (ECS) model of care that, without resourcing this process, the GP input into this may be lost.

## Prescribing

There is currently significant pressure on prescribing budgets within each of the Tayside IJB's. Traditionally in general practice there is wide variation in the approach to prescribing and the value placed on this activity by individual prescribers, practices and the parent health boards. As modern medicine has become more complicated, and the pharmacological treatments applied more complex, the activity of quality prescribing has simply been absorbed into daily activity with variable pro-active engagement.
The overarching principals that should govern prescribing are to:

1. **Maximise effectiveness**: many patients with treatable long-term conditions are currently sub-optimally treated. "The evidence also suggests that care quality is currently sub- optimal and highly variable, and could be significantly improved through a better understanding of long-term conditions among primary care professionals and a more proactive approach to care management." [*2]
2. **Minimise risks:** Adverse drug reactions are said to account for around 6.5% of all hospital admissions and over 70% of the adverse drug reactions (ADRs) are avoidable. A systematic review on medicines related admissions to hospital in 2006 found a median percentage of preventable drug-related admissions to hospital was 3.7% (range 1.4–15.4). The majority (51%) of preventable drug- related admissions involved either antiplatelets (16%), diuretics (16%), NSAIDs (11%) or anticoagulants (8%). The median proportion of preventable drug- related admissions associated with prescribing problems was 30.6% (range 11.1–41.8), with adherence problems 33.3% (range 20.9–41.7) and with monitoring problems 22.2% (range 0–31.3). Four groups of drugs account for more than 50% of the drug groups associated with preventable drug-related hospital admissions.[*3] Perth and Kinross has a population of 147,740 across 25 GP practices. There is a significant increase projected in the population of people aged 65-74 (+26%), 75-84 (+48%) and 85 plus (+80%) over the next fifteen years. This will likely lead to a increase in the number of prescribed items of medication and therefore the poly-pharmacy issue with many patients received an ever more complex combination of medications.
3. **Minimise costs:** There is a clear need in the current financial environment to control costs. The unnecessary over-running of prescribing costs jeopardises the delivery of care across all areas of the P&K IJB. Some of the cost issues are under the following broad headings:

- **Generic prescribing** – currently adopting generic prescribing across the board could save the P&K IJB around £145K/annum
- **High cost: low benefit items** with prescribing patterns at variance with wider prescribing community – these issues have been highlighted extensively eg lidocaine patches, pregabalin etc
- **Non-formulary, higher cost items** eg rosuvstatin
- **Unnecessary prescribing**: "A culture of "more is better," where the onus is on doctors to "do something" at each consultation has bred unbalanced decision making. This has resulted in patients sometimes being offered treatments that have only minor benefit and minimal evidence despite the potential for substantial harm and expense" [*4]. This comment is entirety consistent with the CMO Realistic Medicine publication which states: "Waste in healthcare should be assessed not in terms of what might be thrown away, but in interventions that don't add value for patients. This includes avoiding unwarranted variation in clinical practice and resultant outcomes."
- **Cost incurred in managing adverse drug reactions** in primary care; hospital admission resulting from ADR's; hidden costs to patients and their families / carers as a result of ADR's
- **Waste**
- **Inefficient Repeat prescribing systems**

4. **Respect the patient's choices:** "Many doctors aspire to excellence in diagnosing disease. Far fewer, unfortunately, aspire to the same standards of excellence in diagnosing what patients want." [*5]. There may be complex reasons for this but a change in culture is clearly required to equip clinicians to move this agenda forward.

In Tayside, significant investment has been made with the introduction of Locality Pharmacists who have now become a crucial part of the primary care practice team, however a similar investment in GP time has not followed. The recently disbanded Quality & Outcomes Framework (QoF) was a driver to encourage prescribing in relative isolation based on different diseases with patients being regarded as being part of a numerator or denominator rather than on the whole person-centred approach.

## Unplanned Admissions

Emergency admission to hospital is inevitably unplanned and can be a time of stress and anxiety to both the patient and to relatives and friends. Some admissions cannot be avoided. But the more comprehensive our approach to improving health and wellbeing, and the co-ordinated provision of alternatives to hospital care, the less likely we make the need for hospital admissions. Older people admitted regularly to hospital as an emergency are more likely to be delayed there once their treatment is complete. This, in turn, is particularly bad for their health and independence. To move forward with initiatives to tackle this issue engagement with primary care colleagues will be essential.

Table 1- PRI 2016 top 25 admissions by bed-days occupied (account for 50.2% of all unscheduled admissions)

| | |
|---|---|
| PNEUMONIA & LRTI | 4,241 |
| CEREBRAL INFARCTION, UNSPECIFIED & OTHER CEREBRAL INFARCTION & CEREBRAL INFARCTION DUE TO THROMBOSIS OF CEREBRAL ARTERIES | 3,581 |
| URINARY TRACT INFECTION, SITE NOT SPECIFIED | 2,575 |
| CLOSED FRACTURE OF NECK OF FEMUR | 2,127 |
| CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH ACUTE LOWER RESP INFECTION /ACUTE EXACERBATION | 1,769 |
| TENDENCY TO FALL NEC | 1,733 |
| CONGESTIVE HEART FAILURE | 1,377 |
| INTRACEREBRAL HAEMORRHAGE, UNSPECIFIED | 1,284 |
| DELIRIUM, UNSPECIFIED | 1,113 |
| MALIGNANT NEOPLASM, BRONCHUS OR LUNG, UNSPECIFIED | 1,023 |
| PNEUMONITIS DUE TO FOOD AND VOMIT | 904 |
| STROKE, NOT SPECIFIED AS HAEMORRHAGE OR INFARCTION | 826 |
| SEPSIS, UNSPECIFIED | 691 |
| ACUTE RENAL FAILURE, UNSPECIFIED | 631 |
| CLOSED FRACTURE OF UPPER END OF HUMERUS | 585 |
| CLOSED FRACTURE OF PUBIS | 567 |
| CLOSED PERTROCHANTERIC FRACTURE | 555 |
| CHEST PAIN, UNSPECIFIED & ANGINA PECTORIS, UNSPECIFIED | 514 |
| CELLULITIS OF OTHER PARTS OF LIMB | 499 |
| BIPOLAR AFFECTIVE DISORDER, UNSPECIFIED | 435 |
| ACUTE MYOCARDIAL INFARCTION, UNSPECIFIED / (NSTEMI) | 422 |
| UNSPECIFIED INJURY OF HEAD | 420 |
| ATRIAL FIBRILLATION AND ATRIAL FLUTTER, UNSPECIFIED | 408 |
| FRACTURE OF BONE AFTER INSERT OF ORTHOPAED IMPLANT/JOINT PROSTH/BONE PLATE | 384 |
| CONSTIPATION | 362 |

“The evidence base in terms of robustly evaluated examples of redesign of care to reduced bed use and costs is relatively limited. However, this may be more a lack of evidence than evidence of no impact. There is a sound rationale and theoretical evidence base for many initiatives, usually involving moving care from acute services to the community, which could result in savings from reducing bed use. However, without reducing the number of beds in a facility (and the staffing to care for patients using these beds) savings will not be cash releasing. Furthermore, many of the examples we collected from IJBs required investment to implement the service redesign.” [*6]

A high-risk approach can be a good place to start; frail older people in particular and those approaching the end of their lives have an important need for special support in their own right. But since these groups comprise a relatively small proportion of the local population, targeting a much wider group with preventive care and self-management support is probably a better way to achieve benefits that are measurable across a local health economy [*7].

In order to tackle the issue of unplanned admissions a whole system approach is required involving the significant engagement of key professionals and carers along the current whole patient journey. Important in this will be getting primary and secondary care colleagues working together with a shared unified purpose.

**Proposal**

**The P&K IJB are asked to consider significant ongoing funding (£312K/annum across P&K) to support GP time, for an initial 3 year period, to work with the P&K HSCP to tackle the key issues outlined above. The funding would not be to 'reward' activity within current workforce time but to generate new capacity within the general practice community to genuinely work in partnership with P&K IJB.**

GP's would be committed to working in partnership with the HSCP and alongside locality pharmacists to address the Quality Prescribing agenda. This would be a mix of education; shared learning of effective systems; patient review; optimising cost effective prescribing; cascade of culture to permeate all GP's working in practice.

Suggested prescribing participation requirements might include as a starting point for discussion:

(a) Attendance and contribute to quarterly P&K Prescribing forum learning event
(b) QIP-2 participation: The Data-Driven Quality Improvement in Primary Care (DQIP) program
(c) Agreed cost optimisation programs
(d) Working with local community & locality pharmacists to develop systematic methods of reducing waste
(e) Quality Improvement Initiatives
(f) Information cascading
(g) Evidence of robust systems for repeat prescribing (with annual review of system) and appropriate medication reviews.
(h) Clearly documented systems to ensure appropriate laboratory test monitoring for relevant medication.
(i) Evidence of systems in place for medicines reconciliations after patient discharge from hospital.
(j) Regular structured report
(k) Evidence of systems in place for close co-operation between GP practice and local community pharmacies where prescribing and dispensing errors are discussed and lessons learned appropriately cascaded to other relevant clinicians.
(l) Work with other GP's to spread good practice and learn from significant events
(m) Feedback to lead GP / pharmacist where secondary care communication or system changes required
(n) Minimum of 2/1,000 patient population desktop poly-pharmacy reviews each week
(o) Minimum of 0.5/1,000 patient population face-to-face poly-pharmacy reviews each week
(p) Evidence of, and commitment to, change in terms of both quality markers and agreed cost optimisation targets
(q) Significant Events relating to medication error should be investigated and lessons learned. Where relevant this learning should be shared beyond the individual practice. Evidence of 3 such SEA per annum.
(r) Regular 6-monthly / annual reviews of all patients on 6 or more medications
(s) Practices should, where clinically appropriate, restrict prescribing to agreed preferential drugs that they become familiar with (Tayside Formulary) and demonstrate adherence to. This is important for safety, consistency, supply and cost-effectiveness.
(t) Generic prescribing rates should be reviewed annually and appropriate plans put in place to optimise this to ensure value for money.
(u) Annual review of ScriptSwitch audit
(v) Review practice performance in relation to agreed quality indicators and develop and enact a plan to address areas of variance.

GP's would be expected to actively engage in the new model of locality working and to participate in the ECS program helping identify and manage more pro-actively patients who require extra support and who might otherwise end up as unplanned admissions to secondary care.

Lastly, GP's would be expected to become an integral component in the program to look at reducing unplanned hospital admissions.

***References:***

1. *Delivering better services for people with long-term conditions: Building the house of care. The Kings Fund, Oct 2013 [https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf](https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf)*

2. *Managing people with long-term conditions", The Kings Fund, 2010*

3. *Howard RL et al. "Which drugs cause preventable admissions to hospital? A systematic review." Br J Clin Pharmacol. 2006; 63: 136 147.*

4. *BMJ 2015; 350: h2308*

5. *"Patients' preferences matter. Stop the silent misdiagnosis", The Kings Fund, 2012*

6. *Potential high impact redesign opportunities: survey of Integration Joint Boards and literature review, Feb 2017*

7. Roland M, Abel G (2012). 'Reducing emergency admissions: are we on the right track?'. *British Medical Journal*, vol 345, e6017