Transforming Scottish Primary Care: Quality after QOF

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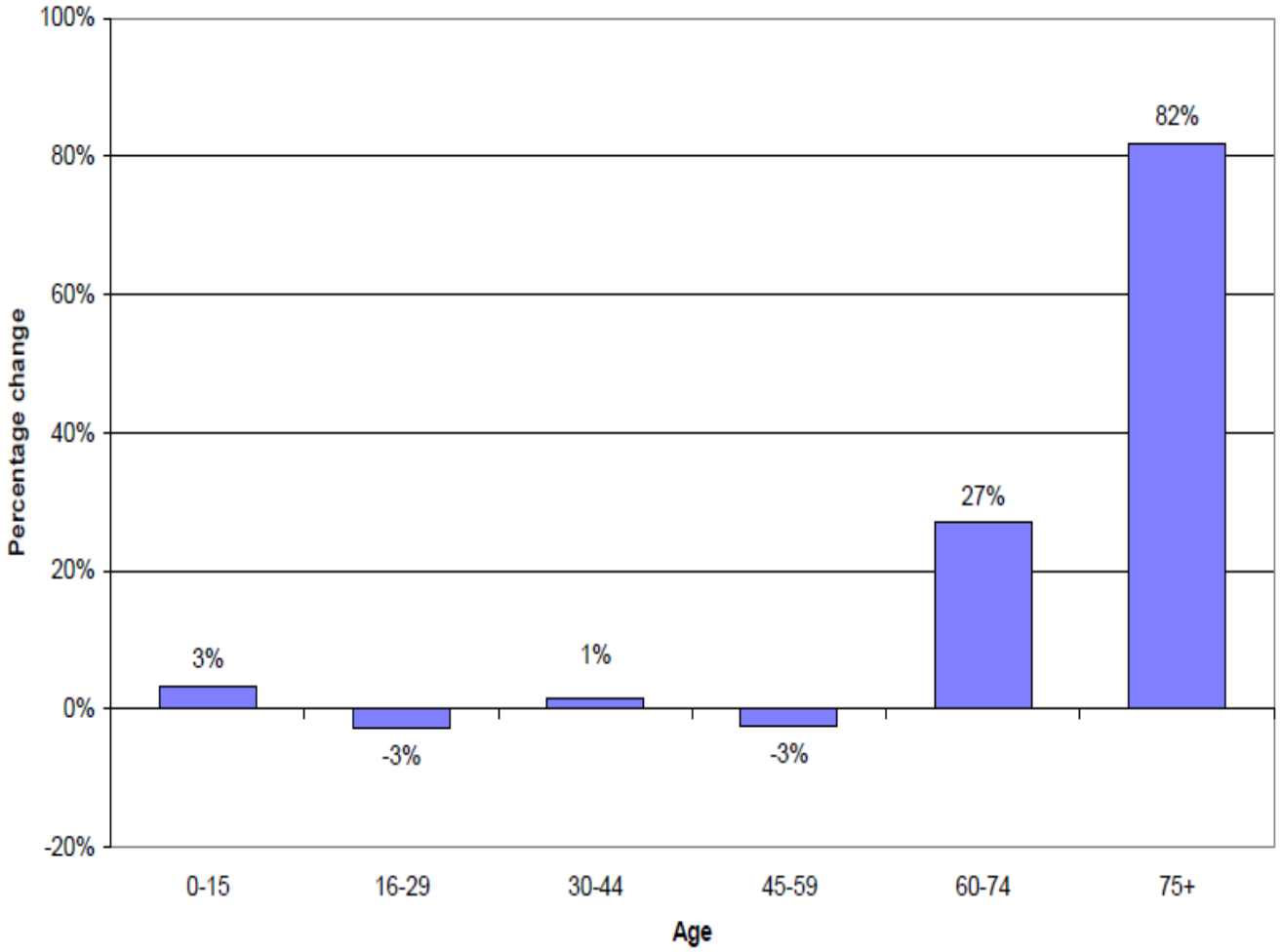
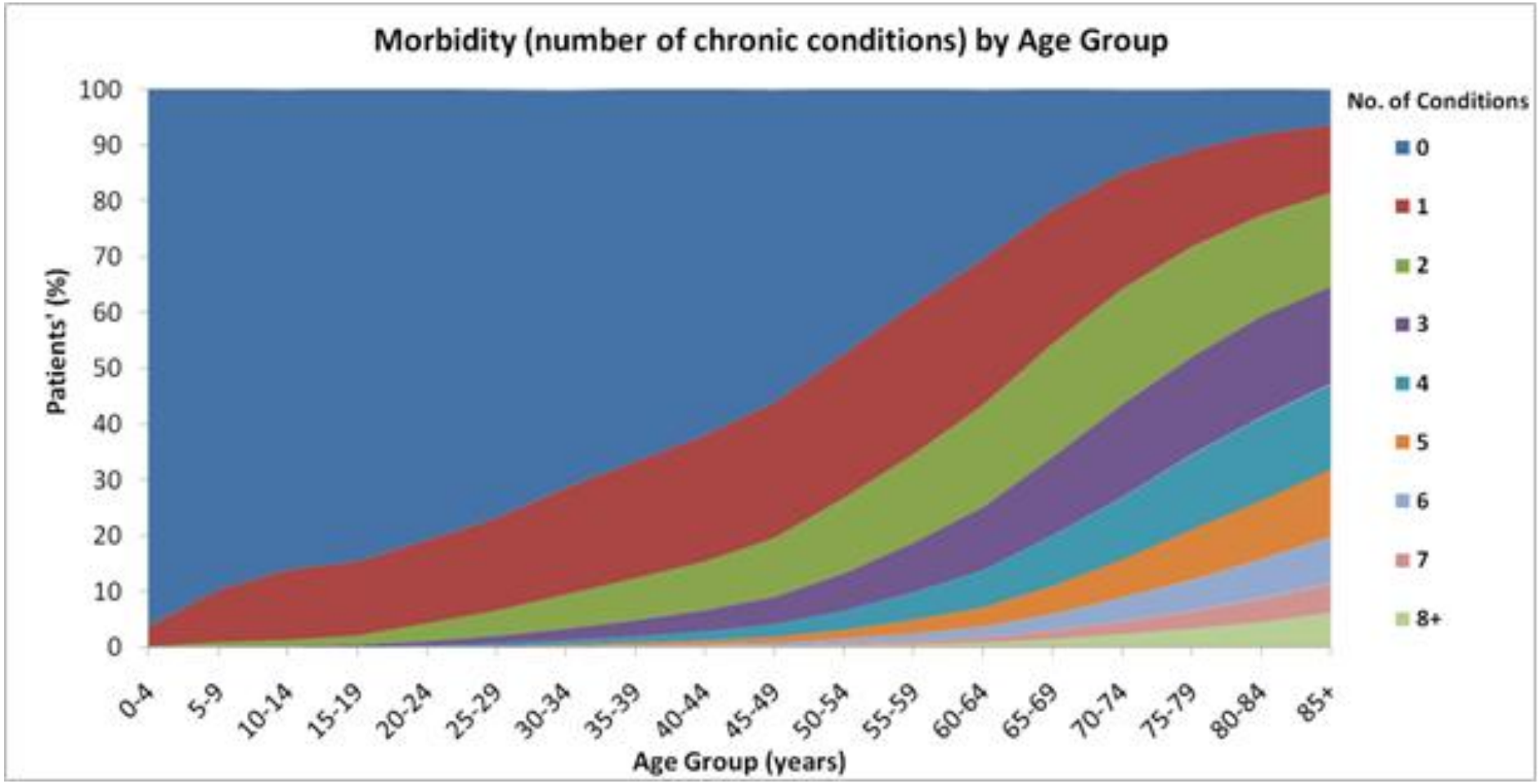
National Clinical Strategy: a business case for change

- **the world is changing**
  - Increasing demand – persisting inequality, ageing population, more complexity
  - Changing supply - health and social care integration - localities
- **keeping people in the community is right thing to do**
  - Staying at home or homely setting is what people want
  - Investment in primary care is cost effective
- **the status quo is not sustainable**
  - The system is under growing pressure Not all about doctors. Right professional, right place, right time.
  - Health inequalities demand creative responses

Projected % change in Scotland's population by age group, 2010 - 2035



Multimorbidity in Scotland

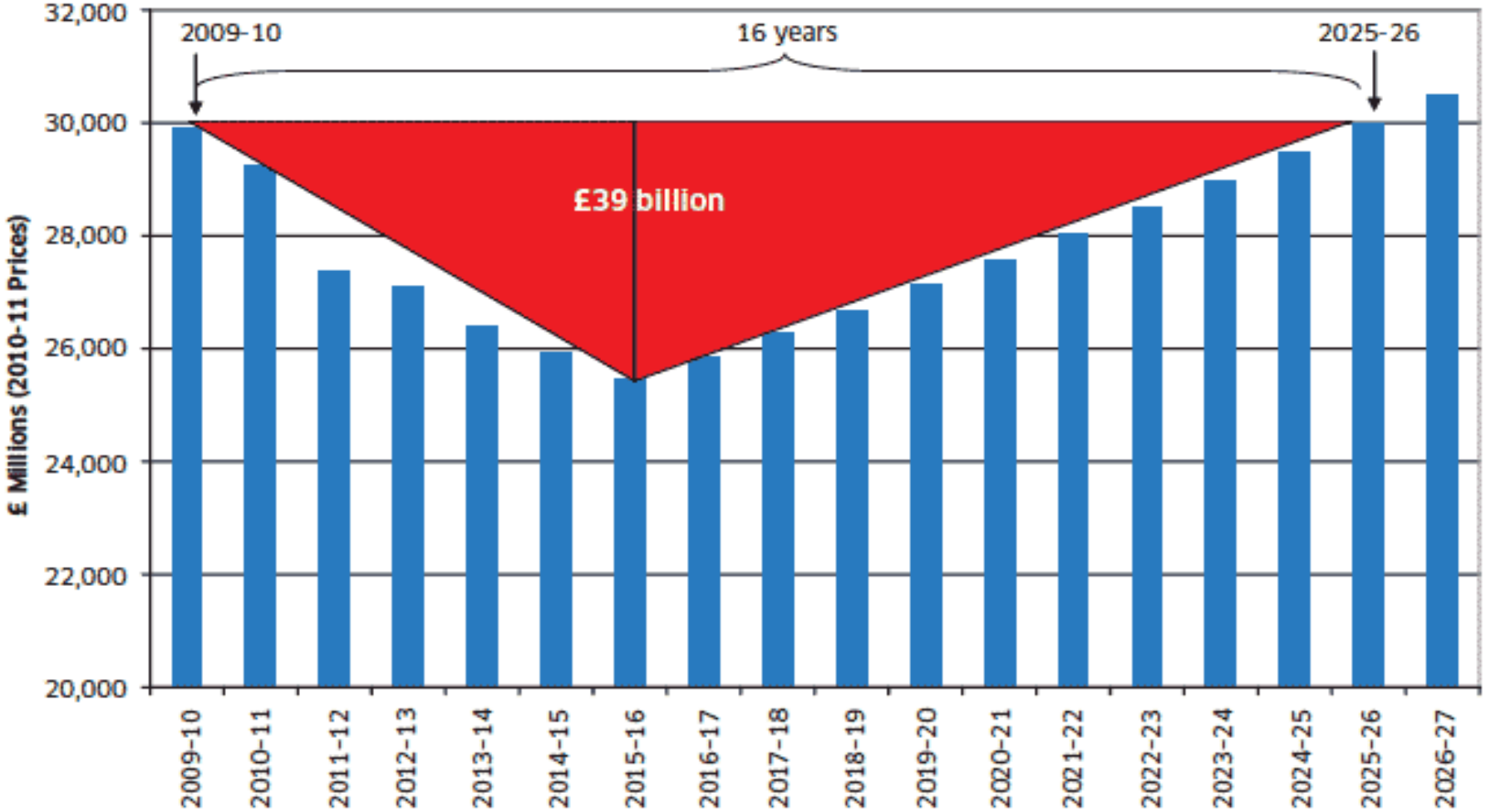


Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie

***Lancet* 2012; 380: 37–43**

Public Finances – Fall in Government Expenditure



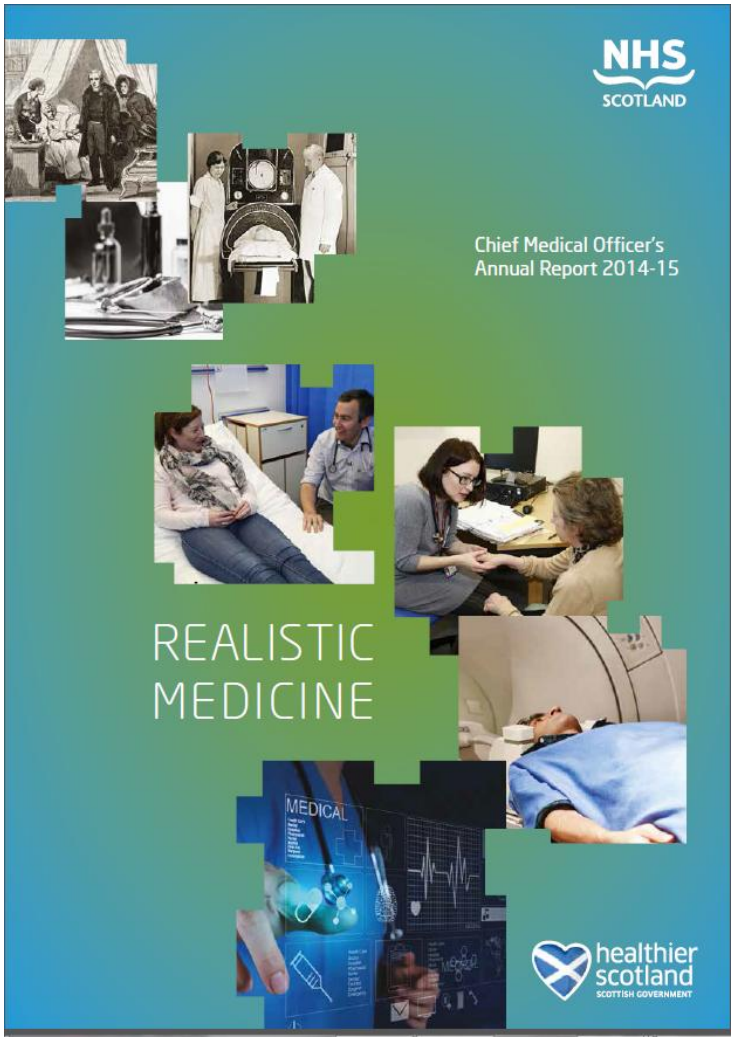
The Choluteca Bridge

Transforming Primary Care

"My vision puts **primary and community care at the heart** of the healthcare system, with highly skilled **multidisciplinary teams** delivering care both **in and out of hours**, and a wide **range of services** that are tailored to each local area. That care will take place in **locality clusters**, and our primary care **professionals will be involved in the strategic planning** of our health services. The people who need healthcare will be more **empowered and informed** than ever, and will **take control of their own health**. They will be able to directly access the **right professional care at the right time**, and remain **at or near home** wherever possible."

Shona Robison, Scottish Parliament, 15 December 2015

"We will transform primary care, delivering a new Community Health Service with a new GP contract, increased GP numbers and new multi-disciplinary community hubs." SNP Manifesto, May 2016



REALISTIC MEDICINE

CAN WE:

CHANGE OUR STYLE TO **SHARED DECISION-MAKING?**

BUILD A **PERSONALISED** APPROACH TO CARE?

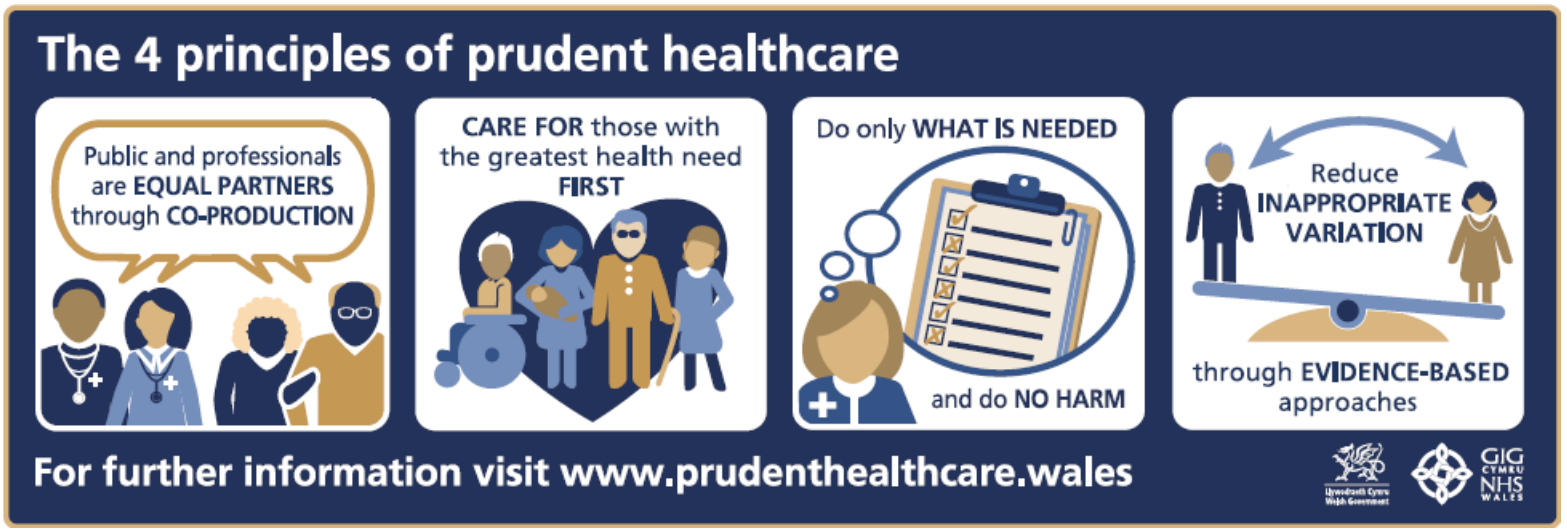
REDUCE HARM AND WASTE?

REDUCE **UNNECESSARY VARIATION** IN PRACTICE AND OUTCOMES?

MANAGE RISK BETTER?

BECOME IMPROVERS AND INNOVATORS?

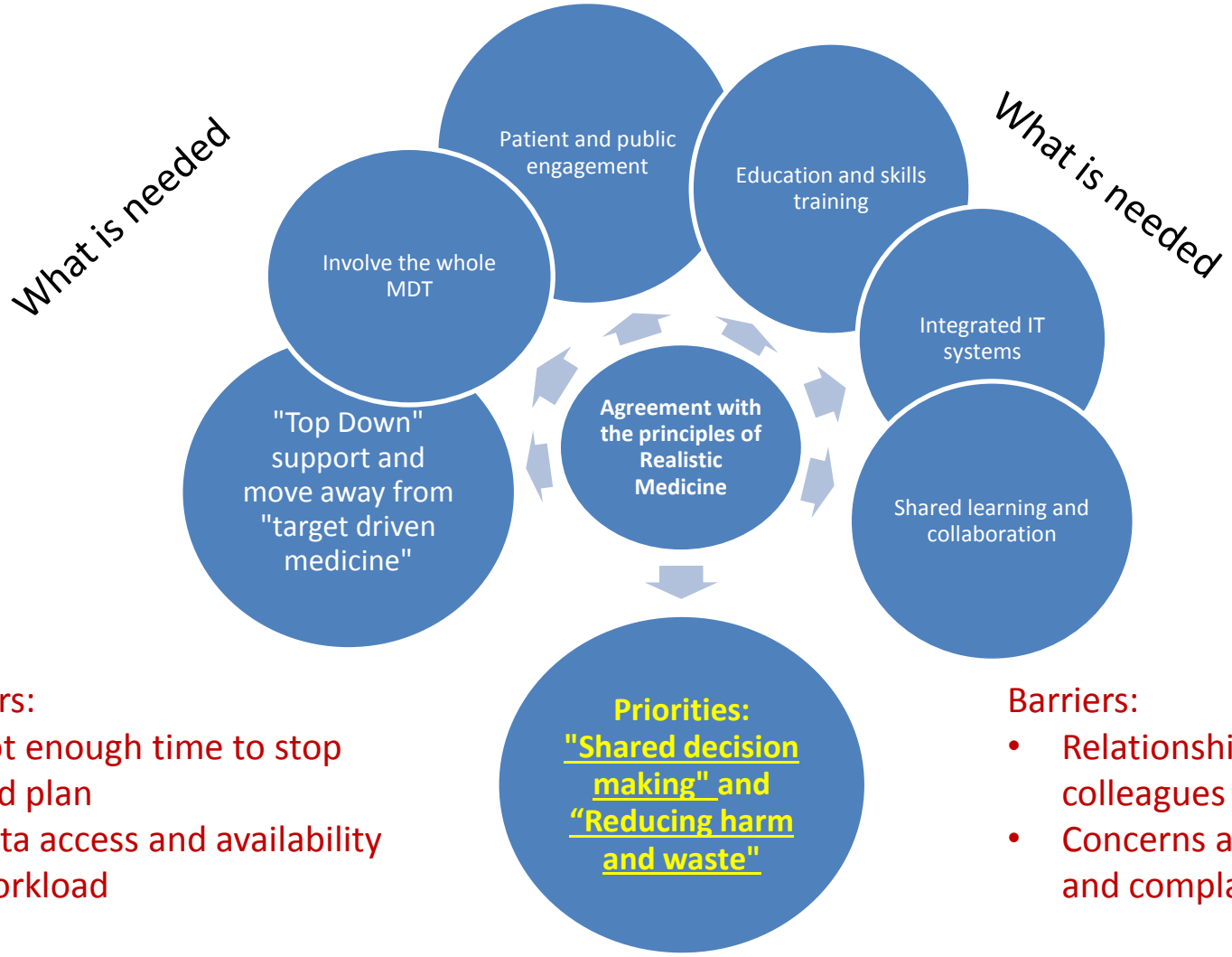
Realism in Healthcare



Doctors generally choose less treatment for themselves than for patients
Striving to provide relief from disability, illness and death, modern medicine may have overreached itself – is it now causing hidden harm?
Focus on patient – unwarranted variation in clinical practice and outcomes?
Multiple conditions – management leading to over-complex medical regimes?
Clinicians have duty to acknowledge powerlessness at times – difficulty on our part should not affect patient's experience of end of life.

Realistic Medicine: Feedback

Feedback was received via letters, emails, an online survey and social media. Thematic analysis was undertaken identifying overall conclusions



Barriers:

- Not enough time to stop and plan
- Data access and availability
- Workload

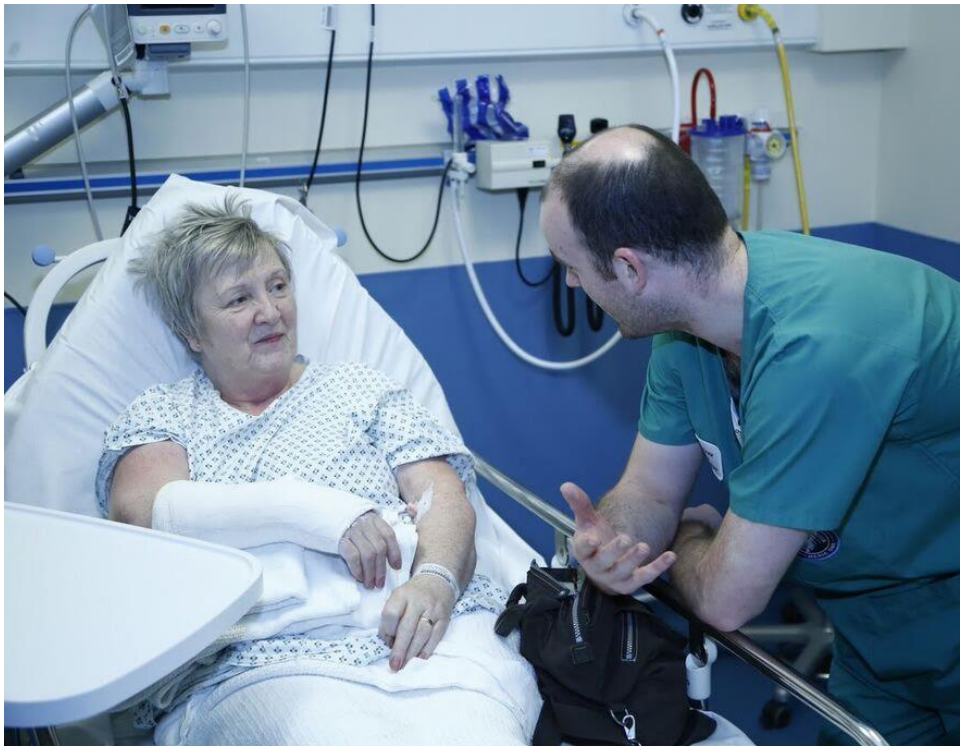
Barriers:

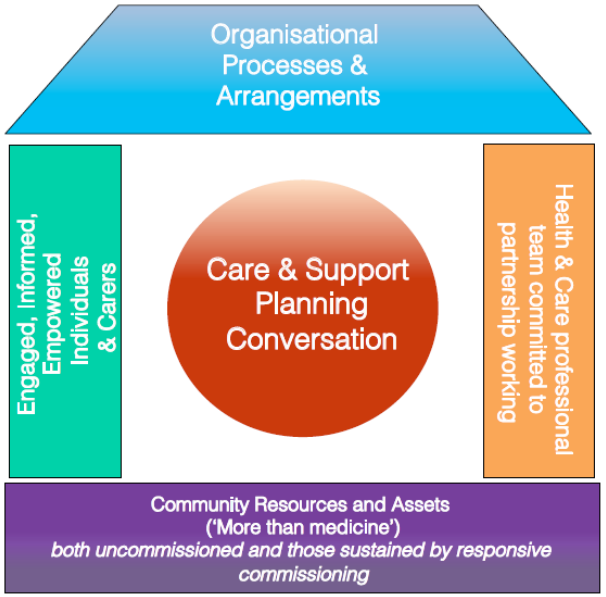
- Relationships with colleagues
- Concerns about litigation and complaints


CMO OFFICE
THERE'S SOME WISEGUY DOCTOR ON THE PHONE ASKING FOR THE S.I.G.N. GUIDELINE FOR REALISTIC MEDICINE....
Boyd

Sharing Decision-making and Informing Consent: People and Professionals Combining their Expertise

- Leave behind “doctor knows best”
- Shared power and responsibility of decision-making
- Requires system and organisational change to promote required attitude, roles and skills
- House of care is useful representation:





Scotland’s House of Care

The Kings Fund: Patient Preferences Matter

- Doctors generally chose less treatment for themselves than they suggest for patients
- Influenced by attitude to risk, litigation, peer pressure, incentives, industry promotion
- Patients who are fully informed choose less treatment AND have less regret

Variation in Healthcare

#Strongly evidence based interventions.

Predictable benefit: shouldn't be much variation

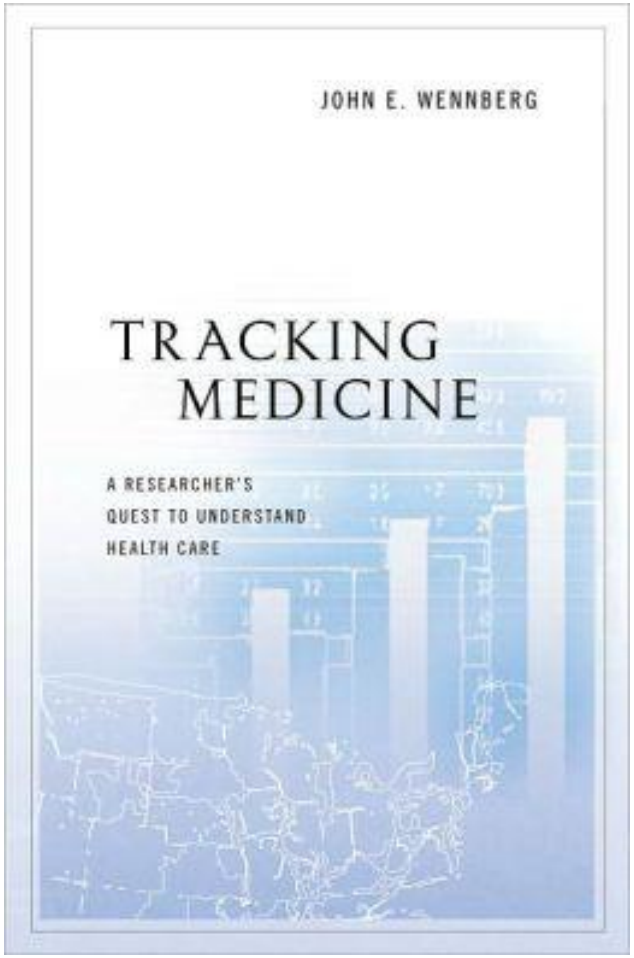
#Preference Sensitive Care.

Uptake driven by patient preference: Individual variation, but likely to be similar across populations

#Supply Sensitive Care.

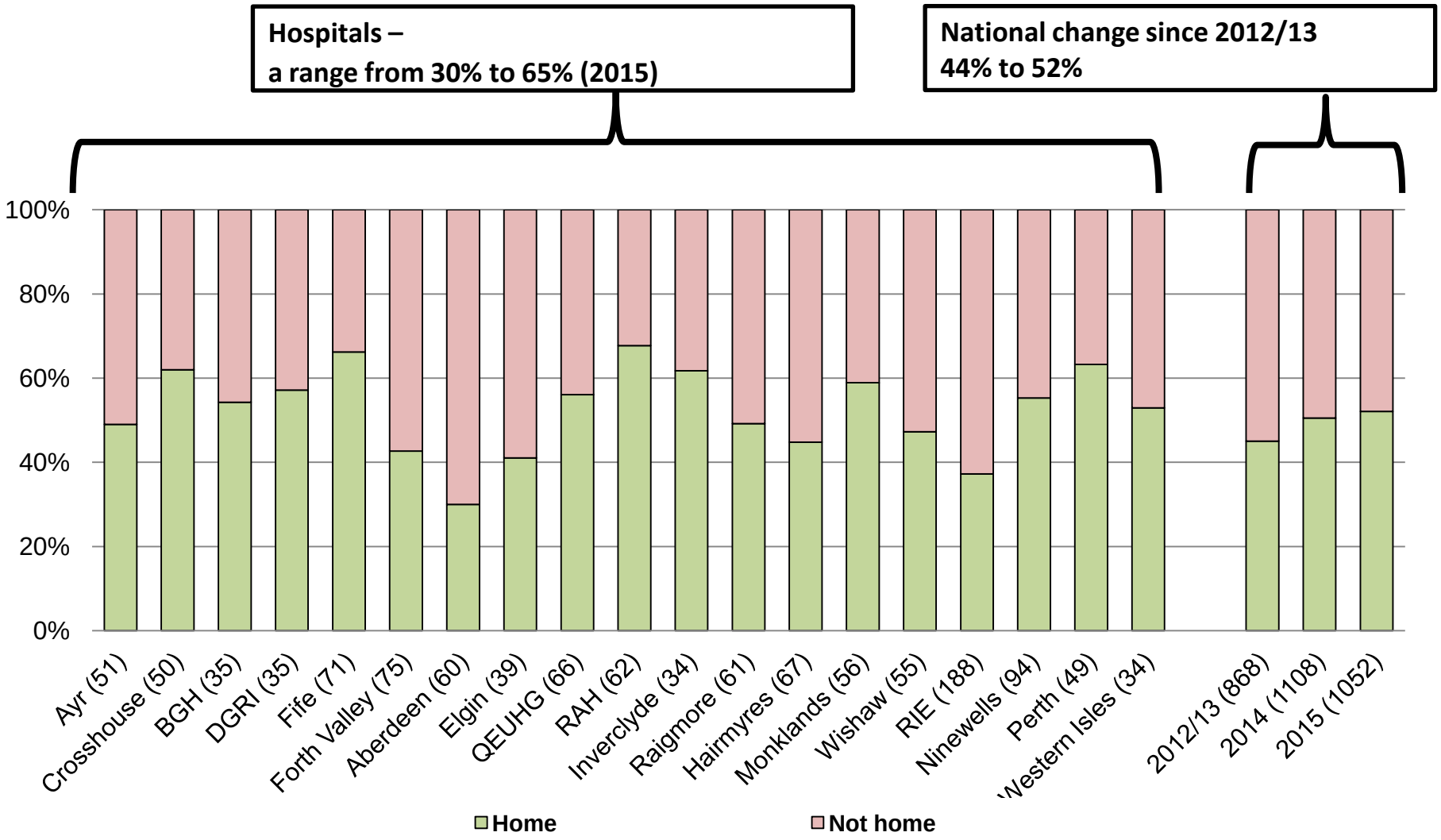
Supplier induced: High levels do not relate to better outcomes: Potentially high source of over-treatment and generally unwarranted variation.

Variation in Healthcare

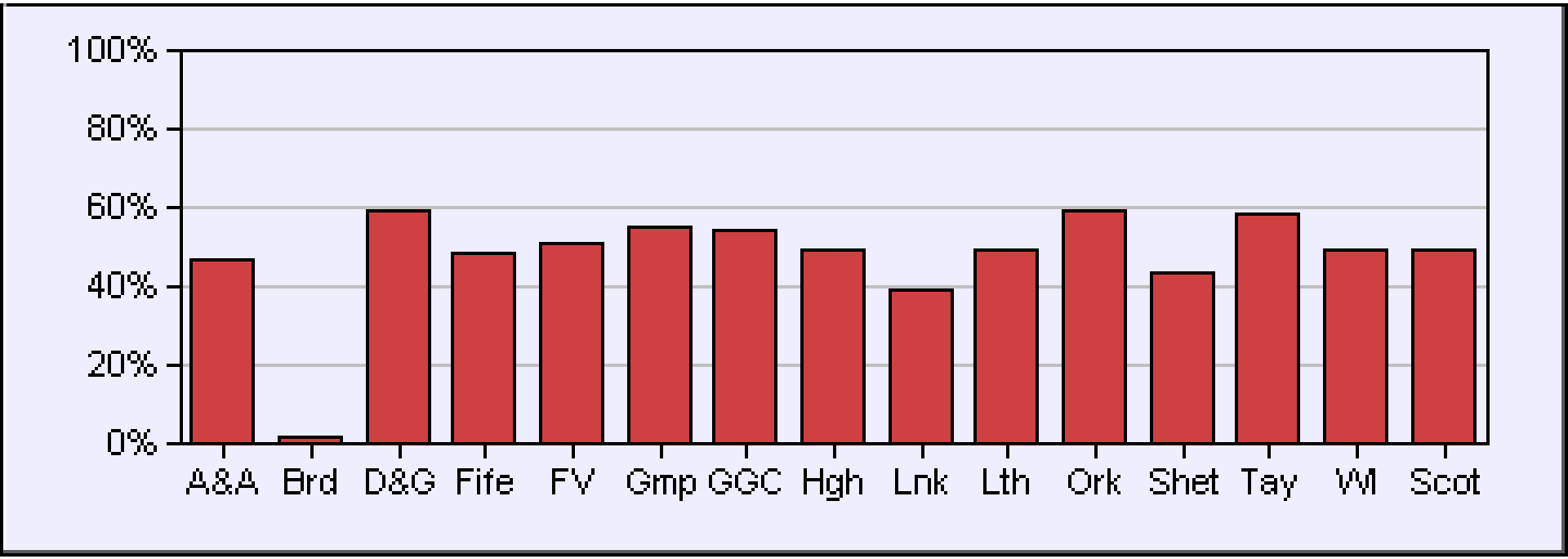


- Organised systems of healthcare delivery
- Establish informed patient choice as ethical & legal standard
- Improve the science of health care delivery
- Constrain undisciplined growth in health care capacity and spending

Variation in Outcomes: Getting back home after hip fracture



Scottish Diabetes Survey 2015: Care Process 1 Type 2 DM Age 18 plus



1. HbA1c **2.** Weight (BMI) **3.** Blood Pressure **4.** Smoking Status **5.** Retinopathy Screening* **6.** Urinary Albumin Test** **7.** Creatinine **8.** Total Cholesterol **9.** Foot risk

Atlas of Variation: New Zealand

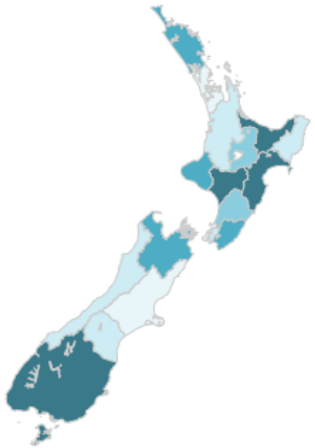
HQSC Atlas of Healthcare Variation | Opioid use by DHB

Method | Help

Select indicators

- 2014
- 2015
- By ethnicity (2015), rate per 1,000
- By age group (2015), rate per 1,000
- By gender (2015), rate per 1,000
- 2. People dispensed a strong opioid for 6 or more weeks
  - Total by year, rate per 1,000
    - 2012
    - 2013
    - 2014
    - **2015**
- 3. Weak opioid dispensing rates
- 4. People dispensed morphine

2. People dispensed a strong opioid for 6 or more weeks : Total by year, rate per 1,000 (2015)



Sector feedback

DHB	Rate per 1,000	Count
Auckland	1.2	592
Bay of Plenty	3.2	710
Canterbury	1.8	965
Capital and Coast	1.7	497
Counties Manukau	1.7	877
Hawke's Bay	2.9	457
Hutt	2.3	334
Lakes	2.4	244
MidCentral	2.4	417
Nelson Marlborough	2.8	403
Northland	2.8	467
South Canterbury	2.3	137
Southern	2.9	895

Bar chart: Total by year, rate per 1,000 (2015)

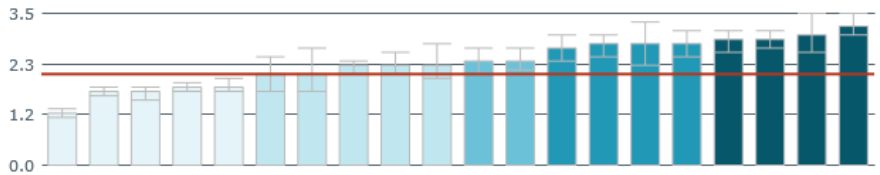
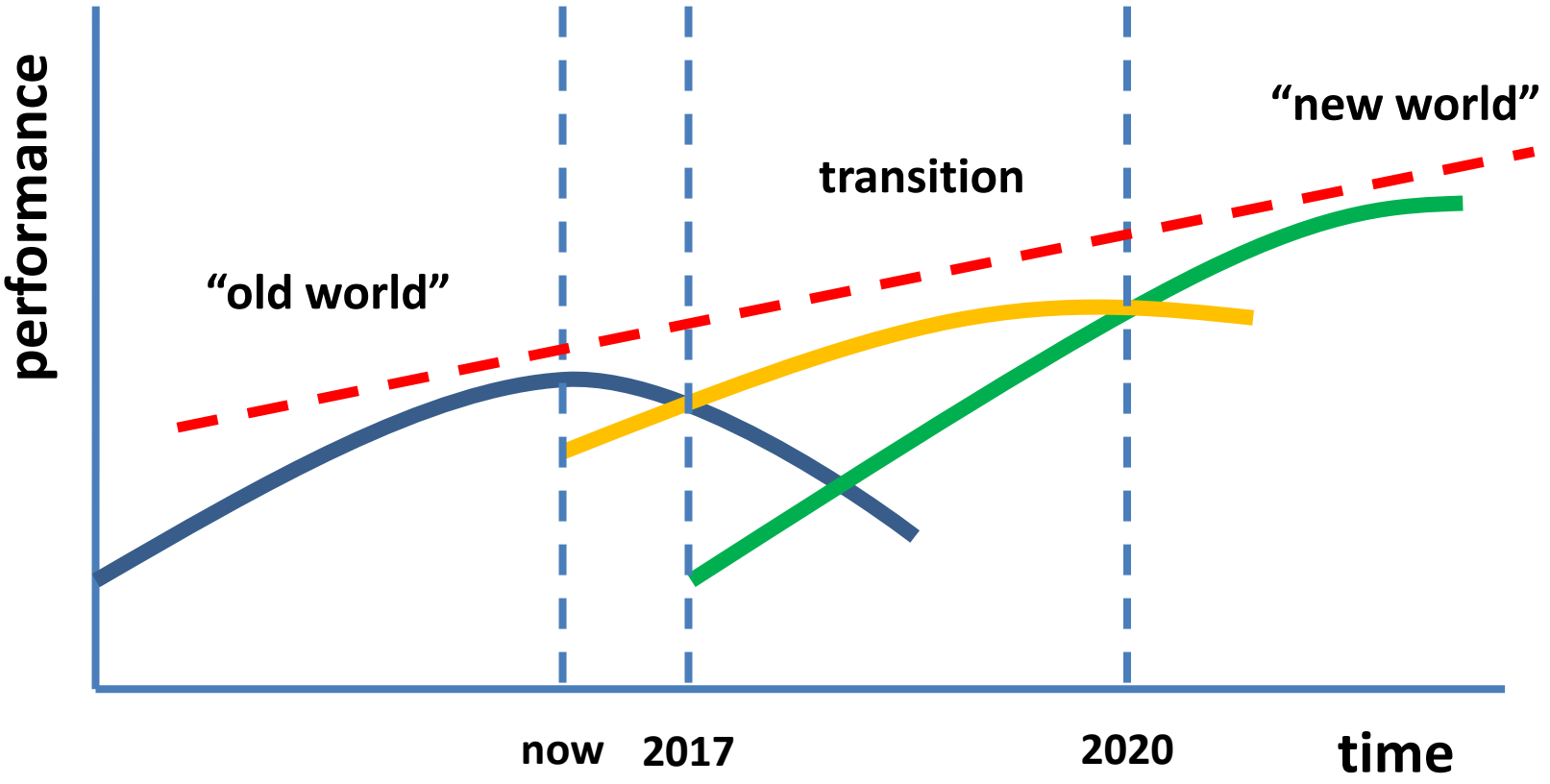


Chart series / | Find my Patients | Polypharmacy

Chart series: 2. People dispensed a strong opioid for 6 or more weeks : Total by year, rate per 1,000 (2015)

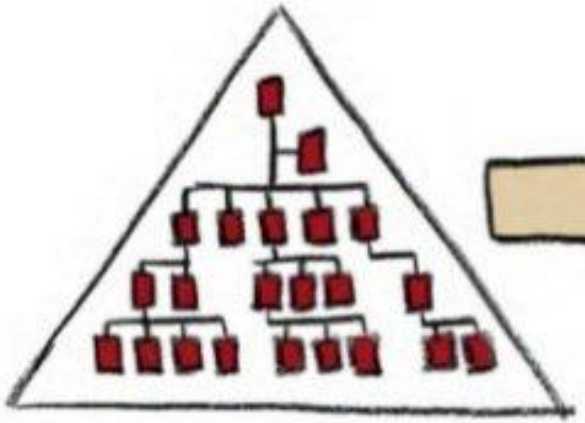
Transforming primary care



From a prescriptive contract to an enabling contract

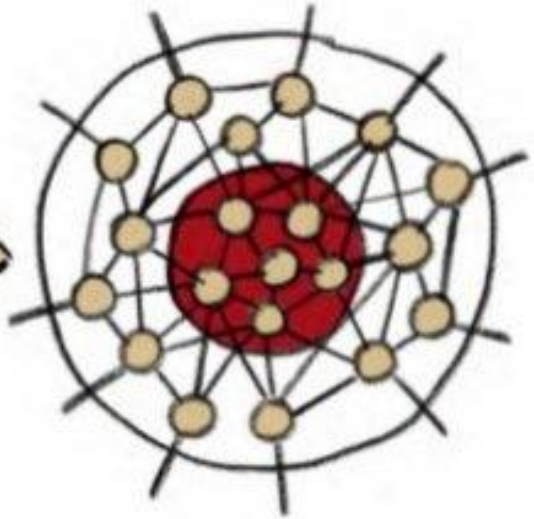
GP Clusters?

Industrial Age



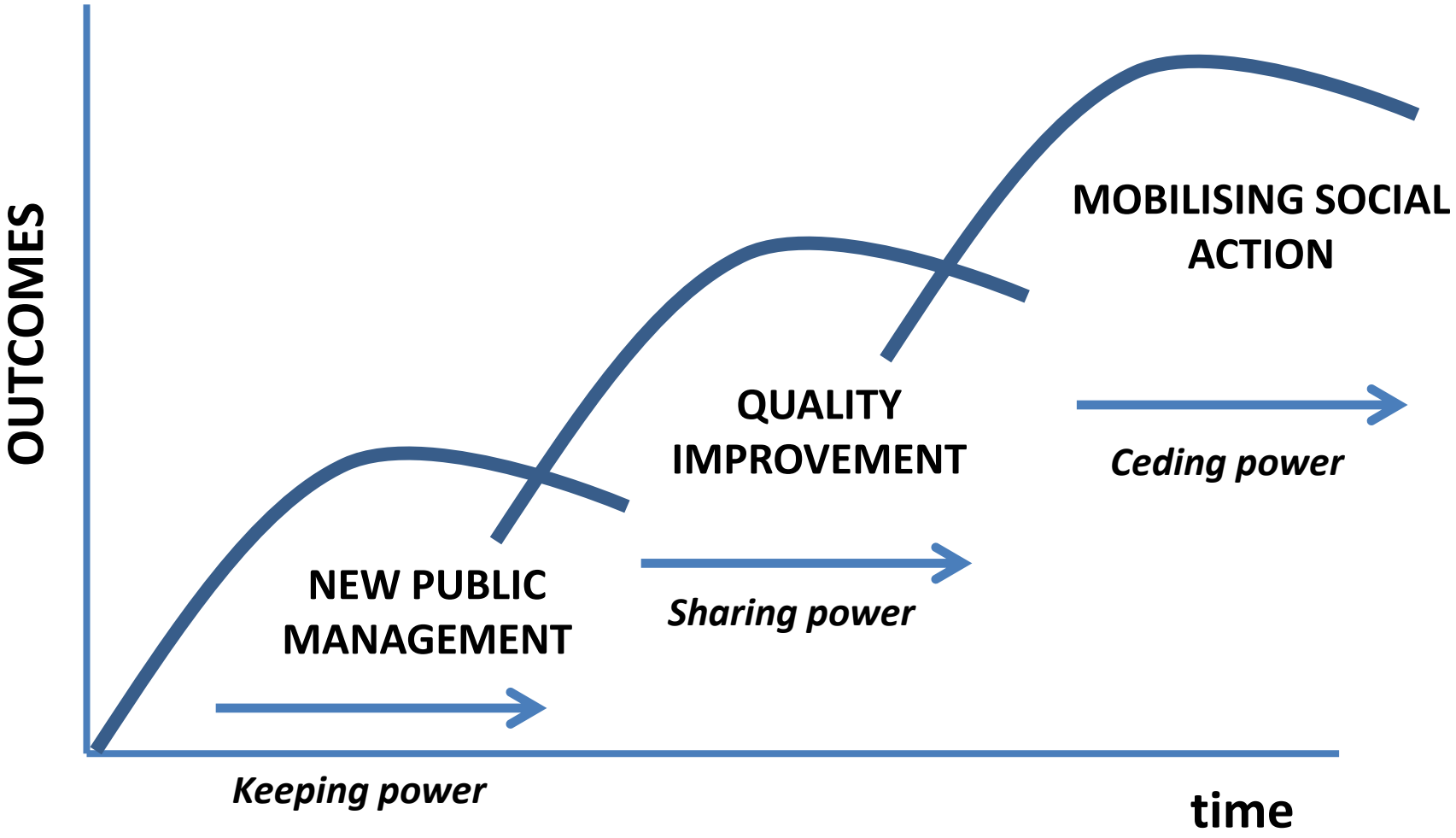
Mechanistic, dead
Differentiated, individualizing
Work the people
Top-down, managed
In parallel, in line
Efficiency-oriented

Knowledge Age



Systemic, alive
Integrated, team-based
Work the work
Outside-in, led
With-each-other-for-each-other
Complexity-robust

Quality after QOF



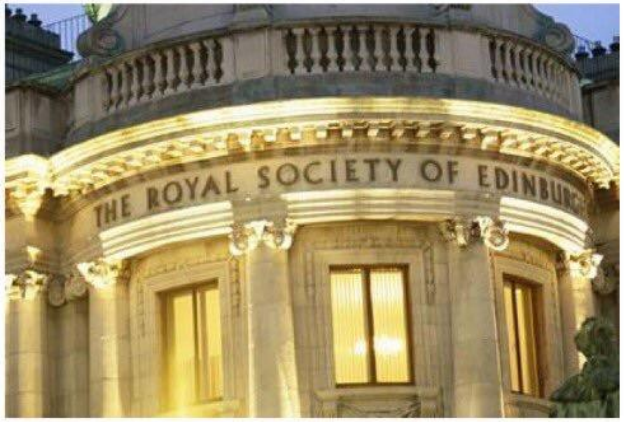
Scottish School of Primary Care

"Quality after QOF"

A workshop hosted by the Scottish School of Primary Care

on 23rd March 2016

in the Royal Society of Edinburgh



Quality after QOF

- **Principles and Values**
- Data
- Analysis
- Facilitation
- Improvement
- Network

Quality after QOF

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Quality after QOF

- Principles and Values
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I BEGAN TO REALIZE HOW IMPORTANT IT WAS TO BE AN ENTHUSIAST IN LIFE. IF YOU ARE INTERESTED IN SOMETHING, NO MATTER WHAT IT IS, GO AT IT FULL SPEED. EMBRACE IT WITH BOTH ARMS, HUG IT, LOVE IT AND ABOVE ALL BECOME PASSIONATE ABOUT IT. LUKEWARM IS NO GOOD.

-Roald Dahl

Continue the conversation.....

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Additional slides

Principles and Values

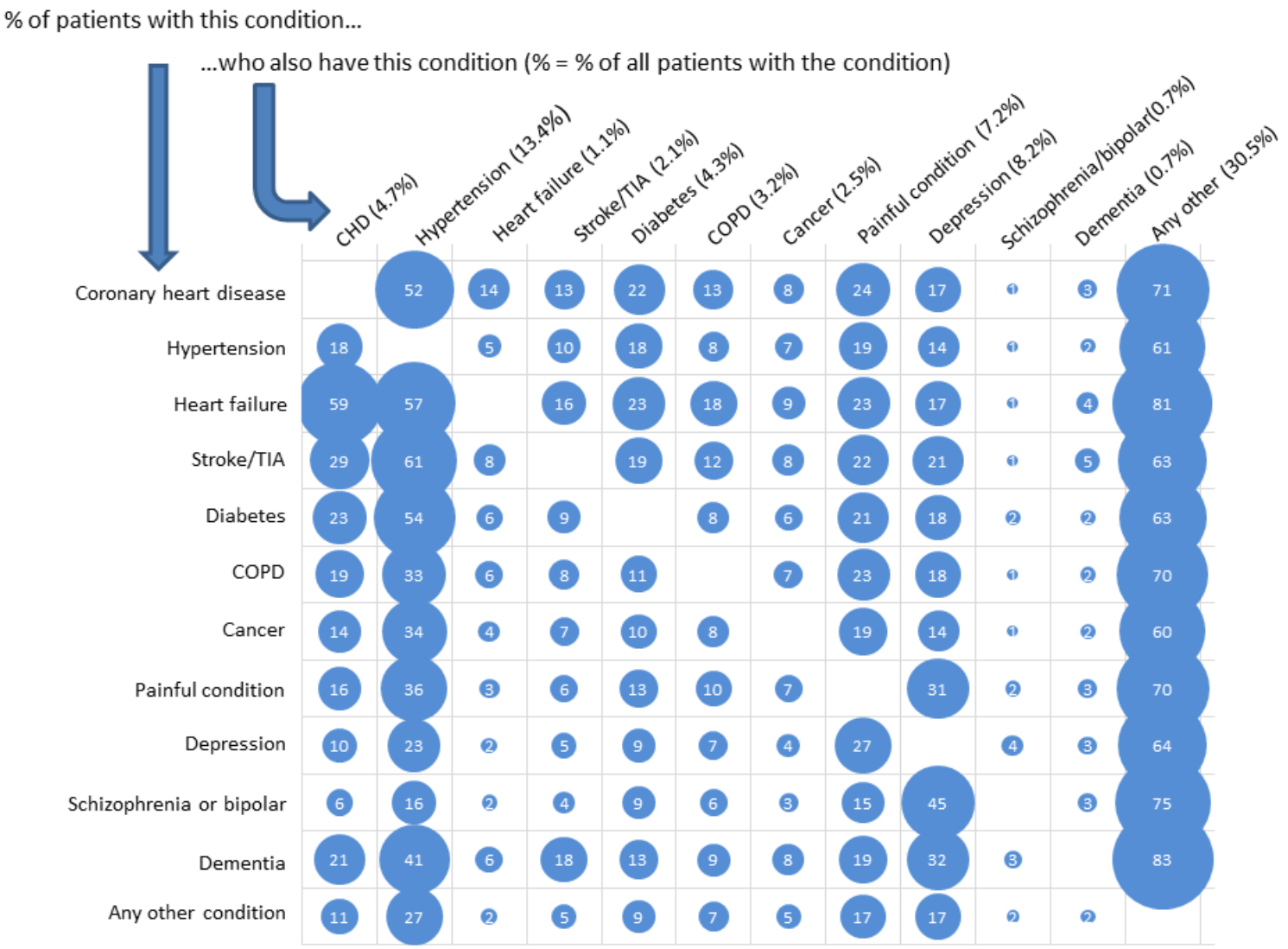
- **Respect the professionalism and clinical ambition of GPs and practice staff in their pursuit of continuously improving the quality care that they provide.**
- **Recognise this by a proportionate and an appropriate use of data and/or indicators with greater focus on system-wide care and outcomes where this is possible.**
- **Utilise GP Clusters as the means of establishing peer-led, values driven quality improvement activity with both focus on practice based (intrinsic) quality and contribution to system based (extrinsic) quality.**
- **Provide for local flexibility; enabling use of evidence to identify local clinical priorities and also proper engagement with local communities about what matters to them in the interactions that they have and services that they receive from their GP practice.**
- **Promote a more equal partnership with patients in decisions relating to their care, encouraging shared decision making and a stronger emphasis on conversations that establish what is important to individuals, their families and their carers.**
- **Be complementary to the new ways of working within health and social care partnerships and facilitate the key leadership role of GPs in shaping and monitoring the quality of services provided by those partnerships, in both primary and secondary care settings**
- **Recognise that continuing and developing the generalist approach, which encompasses both biotechnical and biographical aspects of care, is essential for the future of high quality care in GP clusters.**

Principles and Values

- **To provide open, consistent, high quality and accountable public services.**
- **To encourage mutual respect between all stakeholders, encompassing health care and staff governance.**
- **To ensure openness in appropriate and proportionate disclosure of necessary information.**
- **To encourage partnership in local needs assessment, and strategic planning.**
- **The provision of best value, joint approaches to common problems, and best use of available resources.**
- **The provision of best value and best use of available finite resources, recognising the need for choices to be made in how resources are used in primary healthcare**
- **To promote continuous improvement in the quality of care and transparency and candour in our interactions with other professionals and the public.**
- **To ensure that the GP cluster supports the sustainable delivery of high quality healthcare in a community setting, based upon identified local community needs, and contributes towards addressing the NHS Board/ Health & Social Care Partnership priorities**

Parity of Mental Health Services

- More mental health assessment and treatment at primary care level involving third sector.
- Specialist services used for specialist assessment and treatment.
- Better total health optimisation for chronic mental and physical disease.
- Better equipped public to self manage health.
- Delivers quality dimensions - timely, equitable, safe, effective, person-centred, efficient.



Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie