PACESETTER SCHEMES 2018-19

Health Board	Cardiff & Vale UHB
Pacesetter Title	Expansion of Medicines Management Resource – Pain clinics utilising independent prescriber qualifications
Context: what is the current evidence and how does this project add value?	Prescribing of painkillers in Wales is higher than in England, with increases in the prescribing of painkillers such as pregabalin, gabapentin, opioid patches and combinations of these products. These medications can be particularly harmful if taken with alcohol. The aim of treatment for chronic pain is to reduce pain sufficiently to enable the patient to remain active, however doses may be escalated in an attempt to eradicate pain. Waiting lists at pain clinic are long, and some of these opiate patients actually may be dependent upon their medicines whilst they are having little impact on their pain. This is a time consuming area to tackle in primary care, and difficult in times of increased pressure on GPs. Utilisation of a pharmacist's independent prescribing (IP) qualification, in the community, is a new approach to improve quality and reduce waste and unwarranted variation. There are a number of painkiller measures included in the National Prescribing Indicators highlighting that this area remains a priority for NHS Wales.
Aims of project	The aim of the project is to trial and develop a pharmacist led clinic, in primary care, to review pain medication. It is intended that through this project: • A pharmacist led clinic will be piloted in a cluster to review patients on pain medication • Links will be developed to enable the pharmacist to take a holistic view and refer patients where appropriate to other services e.g. addiction services, third sector support, community pharmacy, secondary care • Relationships will be developed to ensure that cluster pharmacists, community pharmacy and secondary care pharmacy are also linked into this work so that a consistent approach and understanding is developed • The practice will be engaged to agree to and develop practice policies to ensure a consistent

	approach to prescribing • The work will be rolled out to other clusters as appropriate and as refined. • Prescribing advisors (pharmacists) will be up skilled to expand their IP scope of practice into the area of pain. For example, o Therapeutics of pain o Motivational interviewing o Knowledge of and links with appropriate avenues for referral e.g. 3rd sector, expert patient programme o Expectation that scope will expand with experience
Allocation	£170,000
Start date of project	01/04/18
Alignment with Emerging Model	Stabilise primary care, motivated professionals. Alternative pathways.
Potential to demonstrate financial redesign / resource shift	Stopping of inappropriate painkillers would reduce costs to the NHS and may increase social productivity of patients reviewed. Through the delivery of clinics, this is another way to influence prescribers in a GP practice and improve their prescribing prospectively. This work would improve quality and take work away from GP practices, and potentially reduce waiting lists for secondary care pain clinics, ensuring that the system works in a prudent fashion, so that only complex patients are referred to secondary care.
Dates for submission of Business Plan and Delivery agreements	28/02/18
Status within: **HB strategy**	This work fits with the prudent prescribing agenda. The plan is to pilot it in 2 clusters at first and refine and roll out. It is an example of testing a new multidisciplinary team way of working in primary care. There could be a reduction in referrals to pain clinic and more patients would be seen closer to home,

IMTP process **Cluster Action Plans**	thereby improving accessibility to some patients. Medicines Management quality improvement work is part of the IMTP.
Timescales for each stage of project, with rationale	Feb – Mar 18: first PDSA cycle will be developed – to plan therapeutic scope of initial clinic to fit with practice prescribing profile, gain agreement of GP practice, engage with stakeholders, baseline measures developed and recorded. April 18: plan to see first patients; review after 3/12; revise PDSA cycle 3/12.
Evaluation methodology and measures to be used	Prescribing data will show the change in prescribing in the practices in which the clinics are held. As this data is available 2 months in arrears other measures will also need to be captured in order to report in the initial stages of the project. The following are considered: • Patient numbers reviewed • Number and type of intervention undertaken e.g. number of doses reduced/medicines stopped/started • Patient experience evaluation – pain control before and after, experience of clinic It would be expected that referrals to pain clinic should reduce however this could not be expected to be measurable in the timescales of this project (and may actually increase as patients are proactively reviewed).
Project support available	• Clinical Board Pharmacist • Locality Lead Pharmacists • Senior Management Team • Prescribing Advisors (IP Qualified)
Describe anticipated impact on health inequalities	Treatment will be provided closer to home in a patients GP surgery. Patients in chronic pain could find accessing secondary care clinics difficult, due to travelling or waiting times. Often pain killer use is higher in more deprived communities who may find attending appointments more difficult.

Potential for rollout at scale, with indication of costs and workforce implications	There is potential to roll out to other clusters, this would require engagement of the prescribing advisors and support in their development to expand their scope of practice to work safely and confidently e.g. allowing access to training (time and cost). Engagement with practices would be required in order to support the clinics administratively and invite patients to clinic. Re-prioritisation of the work plan would be required to align capacity with this work. There may be potential to expand this work to other areas in the community e.g. prison healthcare.

NATIONALLY AGREED CRITERIA FOR PACESETTER PROGRAMME – 2018/19

1. The schemes should be aligned to the work of the Implementing the Emerging Model Group in terms of building on:

    - Outcomes of previous Pacesetter projects
    - The whole system emerging model for primary care
    - Outcomes of the Pacesetter Critical Appraisal
    - Outcomes of the Parliamentary Review into Health and Social Care

2. Projects should actively explore the potential for whole system financial redesign and resource shift between sectors

3. Each project to be underpinned by a clear business plan and delivery agreement that has been agreed by the Health Board executive team, PC Directorate, cluster leads, the relevant cluster and the professionals responsible for delivering project outcomes.

4. A clear and realistic approach to timescales for project outcomes that takes account of bedding in, transforming care and reporting arrangements.

5. Robust measures for evaluation to be defined at the outset and using an appropriate range of methodologies to give a clear understanding of outcomes and benefits, including costing

6. The programme of work to be an integral part of the relevant cluster action plan, the health board strategy and the IMTP process

7. Evidence that the project team will be supported through appropriate backfill arrangements; dedicated project management; access to expertise in research analysis, IT systems usage and data analysis.

8. Consideration should be made of the specific challenges faced by professionals working with deprived communities in relation to innovation and redesign. Primary care teams in these areas often need more support and/or resource to initiate new ways of working and a proactive approach is required to promote innovation.