Edinburgh Integration Joint Board

Minutes

Edinburgh Integration Joint Board
Futures Committee

10.00am Wednesday, 19 February 2020
Dean of Guild Waiting Room – City Chambers

Present: Peter Murray (Chair), Angus McCann, Councillor Ricky Henderson and Councillor Melanie Main.

In attendance: Eddie Balfour, Tony Duncan, Christine Farquhar, Bruce Guthrie, Natalie Le Couteur, Ian McKay, Ella Simpson, and Jay Sturgeon.

1. Multimorbidity

Bruce Guthrie presented on the topic of Multimorbidity, polypharmacy and later life care. Multimorbidity was the medical definition for people with two or more long term health conditions. Part of the challenge of focusing on multimorbidity was the population that multimorbidity care was targeted at. As medical conditions for the patient increased in complexity this was the stage where intervention of care was required. The National Institute of Clinical Excellence (NICE) guidelines suggested that the General Practitioner (GP) would be required to assess when this care intervention took place.

There was not an evidence base to draw recommendations from for multimorbidity care, therefore the patient with multimorbidity had to be at the centre of the care. An individual clinician had to focus on the person rather than the disease and the clinician would have to understand the condition, treatments and how these factors would impact the patient's quality of life.

A frailty map was presented which revealed that as a patient accumulated more diseases, the disease wasn't the sole contributor to death but rather the combination of diseases.

The presentation focussed on how health systems could respond to the treatment of multimorbidity, and this was summarised as follows:

- Strong generalism within health care system.

- Focus on holistic care and care co-ordination.
- Focus on high volume processes predominately used by people with multimorbidity.
- Focus on specific problems that were common and important to people with multimorbidity.

NICE recommendations had indicated that when treating multimorbidity, consideration should be given to the following factors:

- Could routine data be used as a robust measure to predict life expectancy which would be clinically useful?
- How should primary care be organised for people with multimorbidity?
- Does community holistic assessment and intervention for people living with high levels of multimorbidity improve outcomes?
- When (if ever) was it safe or effective to stop preventive medicines?

The presentation focussed on the merits of comprehensive geriatric care which took place by team assessment and lengthened lives and led to less time spent in hospitals or care homes for the patient population. The group suggested that it could be used for analysis by the Futures Committee and the IJB. It was acknowledged that there was uncertainty to how this methodology of care worked in the community and highlighted that complex team assessments were expensive, worked in hospital settings, but owing to the expense, were not universally possible.

The presentation then focussed on the results emerging from the 3D study, which focussed on how Primary Care was organised and was a study of people with at least three conditions. Traditionally patients with multiple chronic health conditions were managed in a disjointed fashion in primary care, with annual review clinic appointments taking place separately for each condition. The study aimed to determine the cost-effectiveness of the 3D intervention, which was developed to improve the system of care. The findings revealed that in the first year, quality of life for the patient did not significantly improve however for it was a more positive experience for patients, which did not cost any more than traditional methods of care delivery.

The medical practice where the 3D study was undertaken, ran both the 3D methodology trial and the traditional method of delivery of care concurrently and this cost the practice more to oversee both methods.

The presentation then focused on polypharmacy and acknowledged through the presentation of graphical information that, over time, people were taking more drugs. The positive reasons were that there was more medicines available to treat diseases however the negative aspect was that more drugs meant more side effects, which in turn had to be treated with more drugs to treat the side effects.

The focus on what members of the medical profession could do to prescribe safely was summarised as follows:

- Focus on people at particular risk.
- Focus on indicators of high-risk prescribing.
- Focus on prescribing systems.

Indicator interventions showed that a mix of education and supporting people helped to remove high risk prescribing.

Dr Guthrie pointed to an example and used graphical information from Forth Valley GP practice where a methodology to reduce prescribing was applied and led to a significant drop in prescribing compared with a graph detailing prescribing of antipsychotics in older people with dementia where the level of prescribing was not reduced, and the graph showed neither an upward or downward trend.

The 3D study recorded that there were no improvements in polypharmacy or quality of life after one year. It was rarely possible to secure funding to run a study for five or ten years, to determine the longer-term impact of the study.

A discussion followed where the following points were raised:

- That there were concerns about prescribing populations with learning disabilities, rather than placing patients into a care home setting which would cost more.
- That prescribing problems were for doctors and pharmacists to resolve.
- That the antipsychotics in dementia issue was a response to a medical system that was not considered to be responsive to patients with mental health issues, which led to GPs using drugs to treat the patient however the logical challenge was to address the mental health issues that lay at the centre.
- That consideration should be given to the social care component and the holistic community care be considered as part of addressing the challenges.
- That the IJB could use the Discovery system to identify trends, such as requests for feeding patients with liquid foods, categorised by age and number amongst other measures which would help to determine what matters should be the areas of priority for the IJB Futures Subgroup.
- To note that Transformation programme for the IJB, had not specifically taken multimorbidity into account, however this would be reviewed.
- That dementia and mental health were looked at in insolation, however it was acknowledged that both dementia and mental health should be considered in tandem.
- That repeat prescribing system had to be easy for the prescriber and there were lots of things to do to make it safe for example more pharmacy input into GP practices would be helpful to address polypharmacy.

- That as part of a trial in South West Edinburgh, geriatricians and pharmacists had worked together and looked at patients where greater than ten drugs were prescribed and started to assess whether the patient still required those drugs.
- That GP prescribing in Edinburgh was good, however there was further work to be undertaken.
- That there were concerns that new ways of working, which had produced positive benefits, were disregarded as they formed part of a pilot and therefore implementation of these projects in widespread practice did not occur.
- That many GP surgeries lacked the capacity to reorganise how care was delivered as they were already at breaking point.
- That a study was undertaken focusing on pilot projects in the NHS, with 200 projects considered and contained eight recommendations. The study did not garner widespread publicity however the results were considered a wealth of information and would be helpful to share with the Futures Sub Committee.

The presentation recommenced and discussed prescribing safely and polypharmacy which was regarded as a very complex problem. the GP or patient had to engage in difficult conversations regarding life, death and futility. That anticipatory care planning could potentially be used as a mechanism to respond to polypharmacy. The discussion then turned to clinical trials of effectiveness of drugs that are done within a narrow scope of eligible patients who qualify for taking part in the trial. For example half of trials excluded 71% of patients or more, so were not considered comprehensive

During discussions an example in Glasgow called the Ship was shared which was a pilot project funded for three years. Multidisciplinary teams were based within a GP practice, including social work and targeted longer conversations with those for whom a ten-minute GP appointment was not enough. It was not presently understood whether this methodology of care would work when scaled up across the NHS however, it was acknowledged that deprivation was expanding and Scotland performed poorly when compared with health inequalities in Europe. The inequality seen in Edinburgh was less severe that the inequality experienced elsewhere in Scotland therefore there was an opportunity if similar practices of care were adopted, to address inequality. The Scottish School of Primary Care had published a review on the Ship, and this would be shared with the Futures Sub Committee.

The group summarised that if prevention and early intervention were not joined up to target health issues associated with lifestyle and lack of choice, these issues would become amplified in due course.

The NICE Multimorbidity Guidance was considered which looked at prevention and early intervention.

Further discussions emerged which focussed on the following points:

1) That the independent nature of GP surgeries could be considered a burden to systemic change.
2) That the benefit of GP surgeries was the flexibility due to smaller size and ability to implement change more quickly.
3) That prevention approaches had to integrate with primary care.

The presentation then focused on the work which was underway by the Advanced Care Research Centre, which was in receipt of a £20M programme grant, with the focus being multidisciplinary, mainly on researching care in later life with a team of 15 researchers and 10 support staff. There were four key pieces of research underway:

1) Understanding the person in context;
2) Data driven insights and prediction;
3) New models of care;
4) New technologies of care.

It was highlighted that medical professionals were generally poor at gauging when people will die, to meaningfully determine who was at risk of admission into a care home and therefore to allow for future care home needs to be anticipated. Work underway by the research team was diverse and as an example included engineers who were using sensing to determine if a patient had an illness in their body, which would allow for preventative action and treatment to take place ahead of the patient receiving a diagnosis in later life.

Further funding was required, to progress with the research that was underway. Funding had recently been secured for a 36 PHDs with the precondition that these were used to fund technology PHDs.

There was work underway by the IJB and the Advanced Care Research Team that were considered complementary and scope for further joint exploration.

Peter Murray advised that the presentation would be of interest to Chairs and Vice Chairs of IJBs across Scotland and there was a forum to allow for this information to be shared with IJB Chairs and Vice Chairs and strengthen the links between academia and IJBs.

Decision

1) To agree that the IJB's transformation programme would consider multimorbidity.
2) To agree to share the study of 200 NHS pilot projects, with eight key recommendations with the Futures Sub-Committee.
3) To agree to share The Scottish School of Primary Care's review of the Ship with the Futures Sub Committee.
4) To agree that Tony Duncan would meet with Bruce Guthrie discuss mutual areas of interest between the IJB and the Research Team and areas for which further funding would be required to undertake research that would be bespoke to the EIJB

5) To agree that Peter Murray would facilitate an introduction to the Chairs and Vice Chairs of the IJBs across Scotland, to set up a dialogue with academia.

2. Minutes

The minutes of the meeting of 21 October 2019 were presented.

Decision

To approve the minutes as a correct record.

3. Terms of Reference

The Terms of Reference was presented.

Decision

To agree the terms of reference.

(Reference – report by the Head of Strategic Planning, Edinburgh Health and Social Care Partnership, submitted.)

4. Home Care Robots

Four videos showcasing the use of various robots were shared which demonstrated the sophistication and practical application of robots. The UK Government had recently issued funding of £34 Million for robotics.

A discussion ensued which focused on the following points:

- That the Amazon Alexa wasn't developed for people with disabilities, however its use by disability populations was considerable.
- Utilising robotic products that were available in the mainstream that could be adapted for use for care at home would be worthy of exploration.
- That there was a technology enabled care work stream within the IJB transformation and could form part of the longer-term strategy.
- In terms of practical applications for robots, there were many of potential uses, for example robots could work alongside human homecare workers or manage manual lifting tasks.
- Sensing technology could be used to determine when a patient has fallen, a robot could alert instantaneously, rather than a care worker discovering the person three hours after the fall had occurred.
- That consideration to how robots were person centred was important and that there would be inevitable reticence to having a robot deliver care instead of a human home care worker.
- As homecare budgets become pressured, due to increased demand on services from an aging population, those charged with care for the elderly and vulnerable would be faced with real conundrums such as whether to provide no care, 24-hour care with technology, or three hours of care.

- That robots could be used to provide medicine prompts which was often the principal reason for a homecare visit to take place and this could free up the care worker to use their skills to engage in a more meaningful human interaction and provide a better quality of care to the patient.
- That robots would be considered helpful for spinal injury rehabilitation patients. Where repeated exercises were required to stimulate and rehabilitate nerves which would allow for speedier nerve recovery.
- That physiotherapists would work from Monday to Friday on a nine to five working pattern, whereas there was not a limit to how many working hours or days a robot could provide.
- That physiotherapists could not be with somebody six times a day to repeat the activities required for rehabilitation, however if there was a robotic intervention that could produce better patient results.
- That Edinburgh was well placed to enjoy the knowledge transfer of innovations under development by the local universities and that engagement with this sector in advancing this area of work for the EIJB was key.
- That the technologies such as Amazon Alexa had become widespread due to commercial success and affordability and the robotic hoover and lawnmower had become mainstream items in households.
- That when the current young population became older and were dependent on home care, they would likely be less prejudicial about embracing and accepting these technologies in their homes, given the omnipresence of technology in society that they had grown accustomed to.
- That there were three areas of focus for the IJB which were:
    - How do we support our staff;
    - Homecare technology;
    - Robotics.
- That there was a requirement to refine what the focus would be for the Futures Committee for submission to the EIJB meeting on 5 March.

Decision

1) To note the discussion.
2) To refine the Futures Committee's focus for submission to the EIJB meeting on 5 March 2020.
3) To agree that Tony Duncan would engage with the university sector regarding Artificial Intelligence and robotics where the technologies could be applied to improve the offer of Health Care delivery.

5. Futures and The Environment

Decision

To agree to continue consideration of this item to the next Futures Committee on 27 May 2020.

6. Long Term Strategy Update - Tony Duncan.

Decision

To agree to continue consideration of this item to the next Futures Committee on 27 May 2020.

7. Annual Cycle of Business

The Committee's Annual Cycle of Business was presented.

Decision

To agree to note the Annual Cycle of Business.

(Reference, Annual Cycle of Business)

8. Date of Next Meeting

To note that the date and location of the next Futures Committee was Wednesday, 27 May 2020, 10am to 12pm, in the Diamond Jubilee Room, City Chambers.