



SMMGP 4th National Conference

Partnerships in Progress - What Works and What Doesn't

9th October 2009, Barnsley

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Partnerships: Primary Care Perspective

- Looking back 10 years: “Orange Book” 1999 (1)
- Secondary care services had long waiting lists
- Isolation of GPs offering primary care drugs services
- GPs regarded as “mavericks” by colleagues
- Pioneering individuals, lack of clinical governance structure
- No wraparound services or “keyworking”
- Shared care was a new idea
- GPSIs were a new idea
- Research framework: did treatment of drug users really belong in primary care?

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Developments Since 1999 - Partnerships

Key feature: development of primary care services away from isolated GP prescribing towards partnership working

- Development of clinical governance frameworks with RCGP and other professional organisations, National Guidelines development, PCTs
- Partnership working with psychiatrists, keyworkers, voluntary agencies, within shared care schemes, pharmacists
- Development of “specialised” primary care clinics and GPSIs in partnership with commissioning bodies
- Participation in overall framework of drug treatment provision, regulation and funding via DATs, PCTs and NTA (eg Models of Care (2))
- Primary Care at all levels now a key element in service provision

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Is this a good thing?

Little research into outcomes of partnership working per se
BUT...

- Positive outcomes (especially reductions in deaths) related to increased numbers in treatment (3,4,5)
- Wraparound treatments known to enhance clinical outcomes (4)
- Underpinned by robust clinical governance- end of the “mavericks”
- NTA/government partnerships have led to increased funding
- National guidance and protocols developed in partnership have improved consistency
- Joined-up approach developed between primary care and other agencies e.g.hospitals, specialist nursing interventions, pharmacies

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How it can sometimes go wrong:

- Potential lack of understanding between clinicians and non-clinicians regarding health services and clinical interventions
- Differing organisational ethos in partnerships
- Funding issues may obscure good practice issues
- High visibility schemes may predominate over evidence-based but boring ones
- Inadvertent organisational drift may lead to loss of primary care focus

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The clinical evidence base- we ignore it at our peril!

The best evidence for improved outcomes for drug users is still for long-term prescribed maintenance interventions which reduce deaths, morbidity, drug use and crime (3).

These interventions:

- Reduce mortality and drug-related morbidity very significantly (4,5)
- Reduce crime (6,7)
- Reduce risk taking behaviour and spread of blood borne viruses (6,7)
- Can be enhanced by wraparound services (6)
- Can be done safely without increasing methadone-related mortality (8,9)
- 4 recent NICE evaluations endorsed methadone, buprenorphine, naltrexone and some cognitive interventions

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Joint commissioning of primary care drugs services: challenge or opportunity?

NB the best evidence base is for prescribed treatments, BUT

- Clinical services for drug users are often commissioned by joint commissioning groups, unlike other NHS services
- JCGs may have very good understanding of broader non-medical aspects of service, less good grasp of medical aspects
- May be a lack of mutual understanding especially of how the NHS works
- May lead to costly medical services which may then underperform
- May favour high profile initiatives, politically driven developments at the cost of clinical services
- Bidding systems for services within the NHS may not be user friendly to long-term GP/primary care services

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Potential Ethical Pitfalls in Partnerships

- GP/GPSIs may become too closely identified with the criminal justice system
 - e.g. “breaching” patients for failing to attend appointments
 - e.g. stopping scripts for non-clinical reasons
- Encroachment on Dr – patient relationships via agreements to waive confidentiality etc
- GPs perceived as part of the punishment system rather than working for the individual patient
- Confusion within GP role: part of the machine?
- At worst: potential 2nd rate standards of clinical governance

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Growth in partnerships with non-statutory agencies and organisations

- Huge growth in not for profit non-statutory organisations offering drugs services- especially wraparound and keyworking
- Many positive partnerships but NB potential risks of “bidding wars”
- May be uncomfortable environment for primary care/other clinical organisations
- Potential problems in addressing clinical issues in non-clinical organisations :
 - ❖ May not be plugged in to NHS clinical governance
 - ❖ Complexities of employing clinical staff especially Drs
 - ❖ Can involve non- standard clinical regimens
 - ❖ Treatment of drug problems in isolation from overall medical picture

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Nuts and bolts of general practice/primary care: a mystery to non-medical partners?

- Funding/financial structures of GPs
- Time pressures (e.g. NDTMS, TOPS)
- Primary care/GP care planning structures
- Role of prescribed drug treatment as part of holistic clinical health care of the patient by GP
- Role of complementary interventions including non-medical prescribing
- Cost of medical care as opposed to other interventions

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GPs Do Not Always Make Good Partners

- Secretive, hard to get hold of, never available
- Don't like attending meetings
- Insist on being paid for everything on an itemised basis
- May prefer to reach for the prescription pad and ignore other interventions
- Do not always have required levels of specialist training
- May not recognise other people's skills
- Are very busy with lots of other patients not just drug users
- Are irritable about excessive paperwork, box ticking and protocols

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So What Works?

Partnerships that have improved clinical care

1. Development of specialist nurses

- ❖ Nurse prescribers
- ❖ Specialist partnerships e.g. midwives, hepatitis C nurses, DVT nurses, links into hospitals
- ❖ Practice nurses becoming involved in the needs of drug users e.g. wound management, family planning

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So What Works?

Partnerships that have improved clinical care

2. Partnerships with Pharmacists

- ❖ Development in pharmacy services, needle exchange, supervised consumption, OTC preparations etc on a widespread basis
- ❖ Pharmacy prescribing schemes
- ❖ Clinical governance and standardising process highly successful
- ❖ Close working and feedback from pharmacists a key safety intervention
- ❖ Trust and confidence between pharmacist and prescriber to work in the patient's best interests e.g. holidays, missed pick ups
- ❖ Pharmaceutical Society involvement in clinical governance issues around prescribing

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So What Works?

Partnerships that have improved clinical care

3. Ground level partnerships with local agencies

- ❖ Depends on relationships between individuals in agencies and in DAATs
- ❖ Not necessarily expensive
- ❖ Can be facilitated by responsive commissioning
- ❖ Is the opposite of the “written protocol for every situation” approach
- ❖ Is the type of partnerships that GPs/primary care are familiar with
- ❖ Builds up gradually but is easily rapidly destroyed
- ❖ May involve psychiatrists ,keyworkers, hospital staff, social workers, shared care workers and other professionals
- ❖ Also may involve local or national user groups/organisations

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Successful primary care partnerships: early research outcomes of 2 schemes

- **Barnsley:** DAT/primary care/voluntary agency partnership – GP outreach to offer lower threshold prescribing to needle exchange attenders in 2 voluntary agencies, drug worker and specialised nurse support
- **Derby:** Targeted clinic for heroin-using street sex workers-partnership DAT/street agency/primary care clinic with keyworking and specialised medical interventions

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Barnsley rapid access low threshold prescribing pilot

- Partnership project primary care clinic/voluntary agencies– funded and supported by DAT
- Aim to bring untreated patients into treatment (meet DAT target and patient needs)
- GP outreach located in needle exchange at 2 local voluntary agencies one afternoon a week, patients seen subsequently by specialised nurse and counsellor at primary care clinic for ongoing prescribing
- See drug users for substitute prescribing or other health interventions and start script same day where indicated
- Supported by drugs workers at the 2 voluntary agencies and by specialised nurse at primary care clinic

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Low threshold prescribing pilot: early outcomes

- 125 patients recruited to date (10 months)
- 91 (73%) retained in maintenance treatment
- 2 did not require script
- 32 (26%) DNA/self discharged to date
- 37 (30%) never previously treated

- No adverse incidents or double scripting to date
- Outcomes to be analysed at 1 year for all patients

- Patients commented that they hadn't realised it could be so easy to enter treatment
- Some had previously dropped out from services before ever getting into treatment due to waiting times, missed letters, failed appointments etc

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Targeted clinic for heroin-using street sex workers, Derby

- Partnership between primary care drugs clinic, local street agency and DAT
- Heroin- using drug users sign-posted and supported from street agency into targeted drug treatment
- High level support and specialised medical interventions e.g. sexual health

Studied by local medical school research project:

- 34 patients studied who entered the service 2006-7
- Christo inventory used to measure status at entry and at 1 year
- Paired t-test to compare mean Christo score at entry and at 1 year
- Statistically significant improvements in drug use, physical/mental health, social stability ($p=0.002$)

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• 34 involved in sex work at entry, only 11 involved at 1 year

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Conclusions

- Primary Care based interventions have a robust evidence base (8,10)
- There is also evidence that wraparound services improve outcomes (6)
- Partnership working is therefore needed but it has its pitfalls
- The best outcomes are achieved by supported maintenance based interventions for the majority of patients (3,6)
- “The most effective programmes are those that provide higher doses of methadone as part of a comprehensive treatment programme with maintenance rather than abstinence as the treatment goal” (3)
i.e. good evidence-based partnership working

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References

1. Drug Misuse and Dependence: guidelines on clinical management. London: HMSO, 2007.
2. Models of Care for the treatment of adult drug misusers, NTA 2002, DOH
3. Ward J, Hall W, Mattick RP. Role of Maintenance Treatment in Opioid Dependence. *Lancet* 1999; 353: 221-6.
4. Reducing Drug Related Deaths: a report by the Advisory Council on the Misuse of Drugs. HMSO 2000 Chapter 1.
5. Gronbladh L, Ohland M.S, Gunne L. Mortality in heroin addiction: impact of methadone treatment. *Acta Psychiatrica Scandinavica* 1990; 82: 223-227.
6. Ward J, Mattick RP, Hall W, eds. Methadone maintenance treatment and other opioid replacement therapies. Amsterdam: Harwood Academic, 1998.
7. Marsch LA. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behaviour and criminality: a meta-analysis. *Addiction* 1998; 93: 515-532.
8. Keen J, Oliver P, Mathers N. Methadone maintenance treatment can be provided in a primary care setting without increasing methadone - related mortality: The Sheffield Experience. 1997-2002. *BJGP* 2002; 52 (478) 387-389.
9. Neeleman J, Farrell M. Fatal methadone and heroin overdoses: Time trends in England and Wales. *Journal of Epidemiology and community health*. 1997;51:435-437.
10. Keen J, Oliver P, Rowse G, Mathers N. Does methadone maintenance treatment based on the new National Guidelines work in a primary care setting? *BJGP*, (2003) ; 53:461-467.

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