Summary of Primary Care Resilience WebEx #2

Friday 26 June 2020, 1-2pm.

This document summarises the **presentations and discussions** during the Primary Care Resilience WebEx #2, held on Friday 26 June and attended by **315 participants**.

You can find the **recording** of the WebEx and a copy of the **slides** on our 'Primary Care Resilience WebEx Series' page on Improving Together interactive, our one-stop-shop library of resources for primary care. If you are interested on **watching specific presentations** please click on the graphic (see example next) under each presentation summary. 

Below is the **table of content** of this summary:

Summary of Primary Care Resilience WebEx #2

Friday 26 June 2020, 1-2pm.

Summary of discussion topic 1: How to build relationships and collaborations between primary care services and care homes in Scotland

The interface between primary and Social Care - Dr Donald Macaskill, CEO, Scottish Care

Care Home population

- Care homes employ 53,500 staff.
- 1/10 nurses are employed in the social care in Scotland. The vast majority of that care provision is for older people.

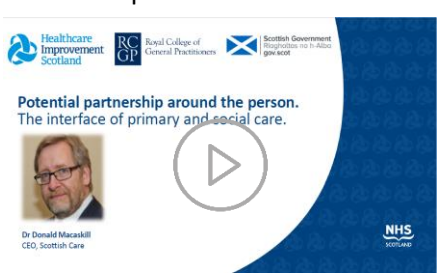
Interface during the pandemic

- Tough beginnings - at the start of the pandemic, many of those in social care, felt a degree of abandonment by primary care services and confusions about transfers into acute care.
- Great potential for technology- NHS Near Me is great but it is "not the panacea".
- Relationships are essential. They have got better and there have been some *"astonishing professional interrelationships, respect and working between our palliative/ end of life communities including general practice, the acute sector and our pharmacy colleagues."*
- The care sector's main issues are perceived to be lack of staffing, resource and integrated relationships.

> "It's not all broken but it is fractured"

The new care normal – potential for greater collaboration. Suggestions for how to get there:

- Stronger and clearer primary care in-reach into residential and nursing homes.
- More integrated work for Anticipatory Care Plans.
- Increased use of Near Me for secondary and primary care and use of diagnostic on-line tools.
- Use of 'Hospital in care home' models of intensive support and ensure equity of care.
- Mutual learning/education for multidisciplinary teams and mutual respect for roles.
- Re-build public confidence.



Click image to play this session in YouTube.

Building collaborations between primary care services and care homes – RCGP perspective - Dr Alasdair Forbes, Deputy Chair (Policy),RCGP

- During Donald's presentation relationships between primary care and care homes were described as "Patchy at best". Alasdair suggested that this was perhaps a reflector of GP workload and system stress.

Project 8 years ago – looking at completing Anticipatory Care Planning (ACP) and end of life care planning in a 30 bed residential care home. This was ran by a trainee over the course of a year.

- Trainee ensured that everyone in the care home had their ACP completed, up to date, and discussed with the patient and/or their families. .
- This was provide families with time to think about what they would want for their loved one. Families responded well to this.

Alasdair's learning points from ACP:

- Good relationships with the care home staff are essential. This is particularly important as general practice are relying increasingly on the nursing staff in the care homes to be our eyes and ears.
- Care home staff alerting GPs to when they feel someone may be reaching end of life
- One nursing home/ care home allocated to one practice. This can be problematic in some areas if you have very big care homes as it takes a lot of resource.

Next steps: more involvement from secondary care.

> "Building on relationships has had a huge advantage because when COVID-19 hit we were not caught out"

Click image to play this session in YouTube.

CHART: Care Home Assessment & Response Team

- Dr Paul Baughan, GP, Clinical Lead (HIS)

In mid April dedicated Care Home Assessment and Response Team formed in response to the pandemic to support the 2000 residents in care homes across Forth Valley.

Background

- Early in pandemic there was a significant outbreak of the virus in a local care home during a weekend.
- There were challenges finding clinical staff to assess all the residents, and care home staff to provide care and medication.
- Care homes were receiving multiple daily phone calls from public health, Care Inspectorate, social care and GP practices all asking similar questions.

Benefits with CHART:

- Now **one daily phone call** is made by social care and information is shared amongst all agencies.
- **Care homes have a single central number to call for any clinical advice** for COVID-19, and the CHART team can respond promptly, with access to medication and oxygen when required.

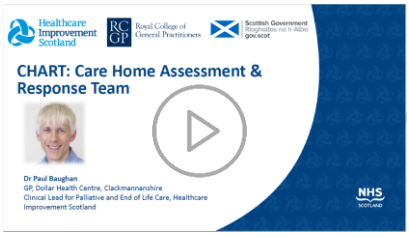
Core CHART Team:
- GP
- Advanced Nurse Practitioner
- Social Work
- Palliative care nurse specialist
- Care Home Liaison nurses

Support from:
- Elderly Care
- Enhanced Community Team
- Pharmacy
- Infection control
- District nurses
- Dietetics

Key learning points

- **Dedication resilience and care from care home staff-** infection control is extremely challenging in a care home setting. For example, patients with dementia often do not understand the personal protective equipment (PPE) and can pull at masks.
- **Benefits of good Anticipatory Care Planning**- details of priorities of care, who resident would want to be involved in decisions about their care. It is essential that this information is included in the summary and also that the KIS is shared with all the care home.
- **Partnership working between social care and with external agencies-** The clinical team and the social care team are collocated in the same building and have daily strategic meetings, with other partners such as public health. This allows them to focus on the care homes that need the most support.

"I would encourage GP practices to continue to check ACP and KIS are shared…Sensitive conversations with the residents care home staff and families are more important now than ever"



Click image to play this session in YouTube.

Summary discussion topic 2: Primary Care Recovery –refocusing and adapting to the current context

Primary Care Recovery- refocusing and adapting to the current context

- Dr Michelle Watts, Medical Adviser, SG

- What do we want to keep, stop and develop going forward?
- Re-mobilise, Recover, Re-design: the framework for NHS Scotland
- The framework out how health boards will safely and incrementally prioritise the resumption of some paused services, while maintaining COVID-19 capacity and resilience
- Primary care and the multidisciplinary team have never been more important.

"How to we ensure we have a shared purpose, and genuinely work together to make things better for our local population?"

- New ways of working- teams and teaming very important. (Bruce Tuckman's stages of team development)

Click image to play this session in YouTube.

Primary Care Recovery
- Dr Andrew Buist, Chair, Scottish GP Committee, BMA

"General practice really stepped up to the plate with the COVID crisis"
Overnight we moved and adapted to:

- New ways of consulting – such as more telephone consultations, Near Me, photographs.
- Wearing Personal Protective Equipment (PPE) in consultations.
- Adapted to shielding patients and also staff who are shielding
- Digesting new guidance on weekly basis
- New COVID Hubs and assessment centres.

Resurgence of core demand and restarting paused services

- GP workforce shortages, evident before the pandemic, will impact on this.
- Procedures will take longer due to PPE and infection control (e.g. cleaning requirements)
- For all services that were paused such as disease management, immunisation or screening, need to consider the ask, capacity and resource.
- Remote and video consultation means less face-to-face appointments but may take longer.
- Mixed model approach needed for smears testing and the influenza programme, if these are going to take longer.
- Patient pathways need to be redesigned jointly at the interface with both primary, secondary and social care.
- Restart the Primary Care Improvement Plans and start delivering on the Memorandum of Understanding e.g. pharmacotherapy, Community Treatment and Care Services.
- Vaccination transformation- *"now is an excellent time to progress this improvement programme".*
- Move to paperless prescribing – currently time-intensive for GPs
- Need better broadband, software and investment in premises.

Click image to play this session in YouTube.

How NHS D&G is supporting GP practices
- Dr Grecy Bell, Deputy Medical Director for Dumfries and Galloway HSCP

- **Building connections and fostering relationships.** NHS D&G have been meeting with the whole primary care team including dentistry, pharmacy, optometry and community and social care.
- Weekly meetings with secondary care through the interface group and the clinical directors group,
- Supporting practice managers to implement changes. Some of these are complex, others are more focused on support with public messaging.
- It's important to pause and reflect on GMS contract and learn from pandemic/ ways of working.

"It's really important that boards and partnerships invest the time to try and build on these relationships…it's the only way forward."

Click image to play this session in YouTube.

Risk Assessment Resource for General Practice
- Dr Duncan McNab, GP Assistant Director Patient Safety and Quality Improvement, NES

These resources can help practices move forward, assess risk in their new environment and, where appropriate, redesign services to comply with current health protection and best practice guidelines.

The Risk Assessment Resource includes:

- Frequently Asked Questions
- Safety Checklist (C-MoRISS)
- 5-Step Guide to Risk Assessment in General Practice
- Essential Steps to Design Work Better

Find out more or download the full resource pack on Improving Together interactive.

Click image to play this session in YouTube.

Themes from the chatbox

Technology / IT enabled

"A psychiatrist in the Highlands used **video consultations to work with dementia patients i**n care homes with a lot of success."

"I have **remote access to vision on my laptop** which I access using the care home internet connection during visits. GPs need the IT to support this."

Sharing data

"The ACP/KIS is a 'live' document - so **CHs need access online to the live document** not an outdated printed copy held in the patient record."

"We have access to one of our care homes systems **so can see BP weight/ stool charts etc.** by logging on which is very helpful."

System issues and engagement

"I have found communication issues with care homes **due to lack of staff, support and technology.** Some areas don't have access to emails and don't have the staffing levels to allow integration into Enhanced Community Support teams. It **could be very valuable having their input** and support at these weekly meetings and would allow us to keep in touch with patients who live in a care setting."

The phrase "**overwhelmed system is so accurate** - too many demands on a stressed workforce for often same data and information - lack of consistency across country is shameful and NHSFV have led the field in modelling partnership working and mutuality of respect"

Building relationships

"We have spent many years working with our Care Homes - developing excellent relationships - again **amazing dedicated nursing and care staff who we know** - great relationships and team working has led to joint meetings / QIP in ACP working etc."

"Good to hear the **pharmacy profession being recognised** by Donald."

"We need to **build on the secondary geriatrician experience** into the community as we have done in some of mental health approaches - but all this needs a properly resourced working"

"**Community respiratory Team to help manage O2 and COPD** in care homes was extremely helpful and much quicker than usual way of accessing O2. "

"Supporting the GP as the expert medical generalist **working in partnership** with our secondary care colleagues and care networks in the community **should be the legacy of COVID**."

Equality

"Care Homes are the homes of the residents and **care home residents should have exactly the same health care as others** in the population".

Remobilising primary care

"One of the difficulties we have is trying to move forward into a new normal whilst being ready to **move quickly again if a second wave**."

"Edinburgh HSCP has developed amazingly ambitious **'new ways of working' for vaccinating 80-90000 patients for Flu** - drive through in shopping malls / football stadiums - COVID has created a paradigm shift opportunity for all services in Primary Care "

"Re-mobilisation is the **golden opportunity to re-shape pathways and embed realistic medicine** but this needs time and pump priming resource. We also need time to engage with secondary care colleagues to improve pathways. **Without national support and public messaging this opportunity will be lost**."

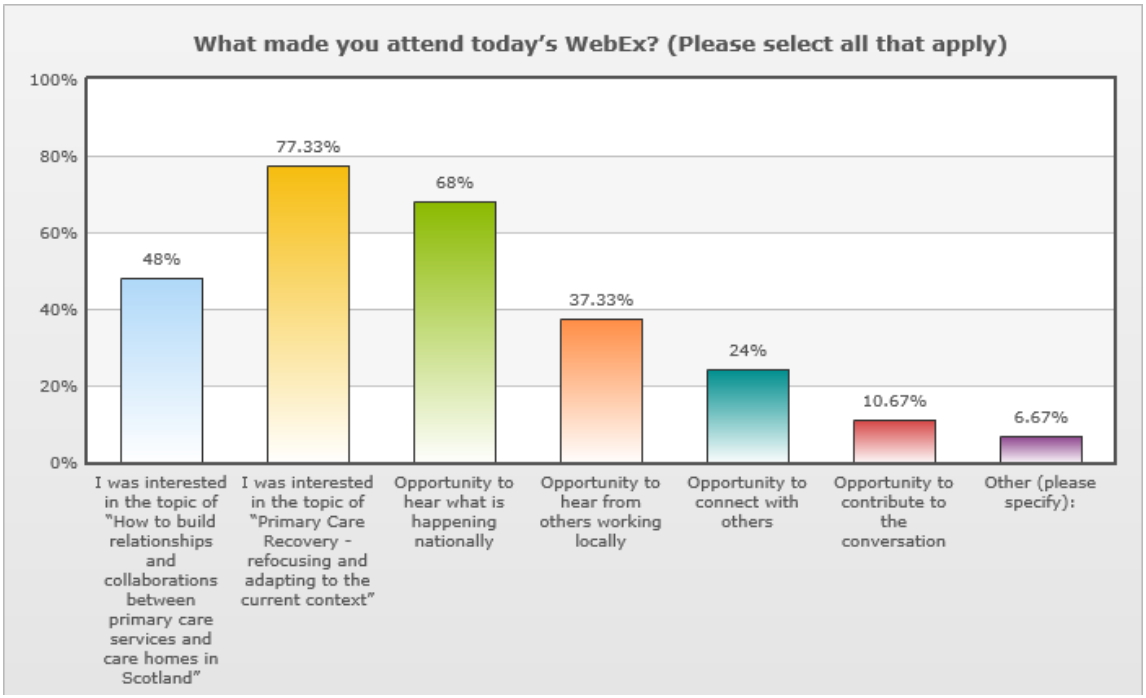
"Absolutely everything - consults, phlebotomy, phone calls, video - **everything takes twice as long.** I cannot see how we will manage at scale"

"We had **good support from infection control virtual walkthrough** of premises, to inform investment in the future. "

Evaluation Feedback

Top Reasons for Attending

- Respondents main reasons for attending were either an interest in the specific topics and/or hearing what is happening at a national and local level



Future WebEx Topic Preferences

- Primary care recovery
- Use of technology
- Long-term conditions
- Working across interfaces
- Multidisciplinary team working

Specific Areas of Interest

- Rurality – challenges and opportunities
- Multidisciplinary management of LTCs in current context
- Care coordination at the primary-secondary care interface
- Public health impacts of COVID (e.g. effects on inequalities, self management, access, shared decision making)