Primary Care Resilience WebEx series

Connect, rebuild and move forward together

Healthcare Improvement Scotland | ihub

Scottish Government
Riaghaltas na h-Alba
gov.scot

RCGP Royal College of General Practitioners

Introduction

Jill Gillies
Primary Care Improvement Portfolio Lead
Healthcare Improvement Scotland

Aims of the WebEx Series

1. **Reflect on what we have learnt from the response to COVID-19**
2. **Explore what changes we have made and what we need as we move forward**
3. **Connect and learn from each other**

TODAY – Managing Long-term Conditions in Primary Care
Discussion on Different Ways of Supporting People with Long-term Conditions

Primary Care Learning System

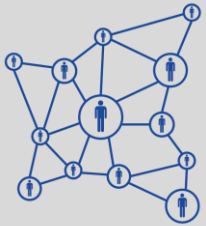
The **Primary Care Learning System** will continue being a key element of our work and underpins all our activities. It aims to accelerate sharing of learning and improvement work through a range of engagement and learning opportunities.

Hosting webinars

Producing evidence summaries

Producing case studies

Supporting networks



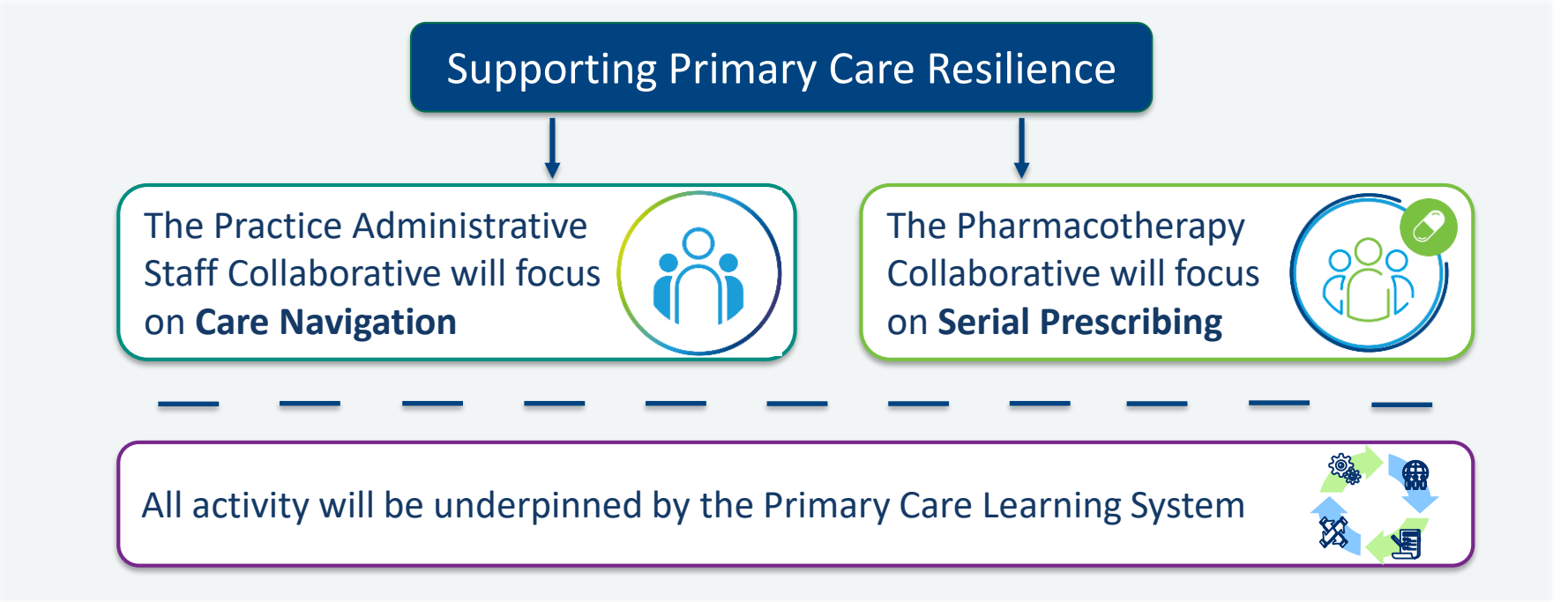
Responsive offers via Primary Care Quality Improvement Faculty

Addressing inequalities through capturing data and sharing learning

Developing **Improving Together interactive** – the one-stop-shop for these resources

Our offer

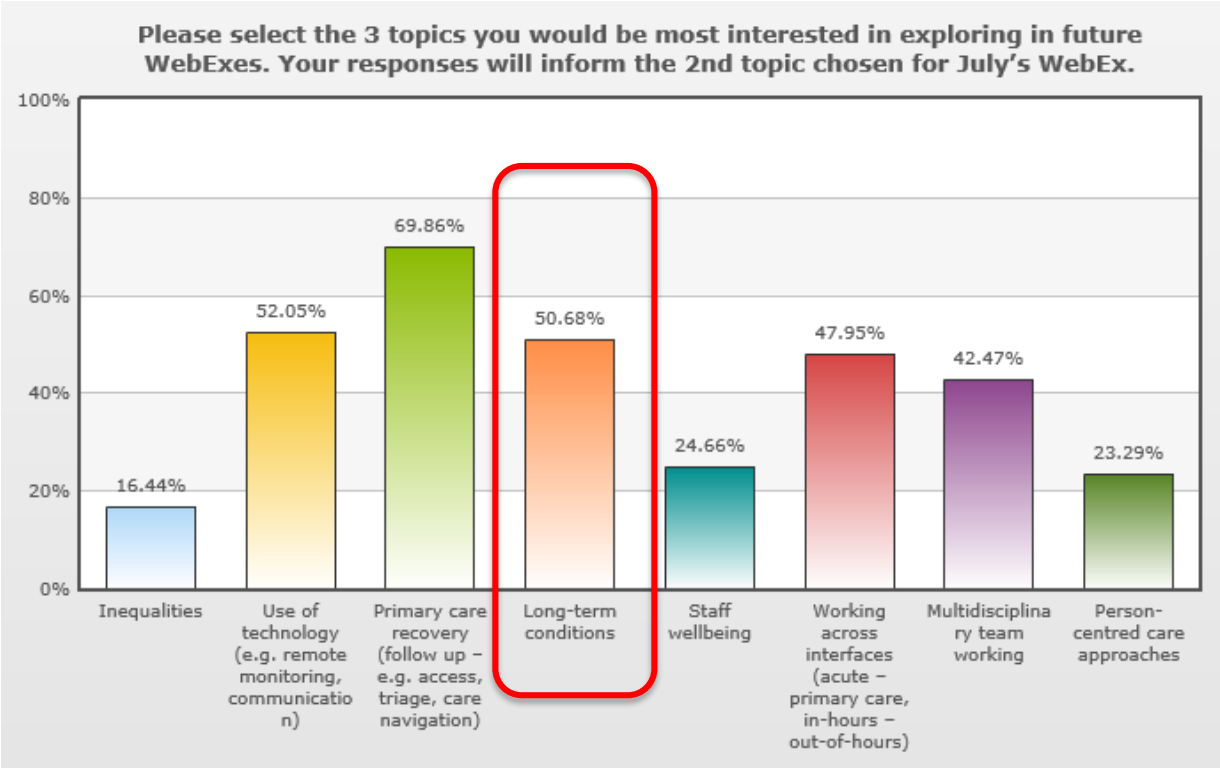
To support **resilience in primary care services** during COVID-19. We will work across the whole system and provide specific **improvement and service redesign support**.



Feedback from previous WebEx

Summary of further comments received	
Very interesting and useful	"Great presentations and some very useful and hopefully be able to apply in practice." "I am finding the WebEx's very helpful and provide good information on what is happening around Scotland. Good to share." "Really interesting topics and a lot covered in a very short space of time!" "Very useful concept and stimulating discussion - I was encouraged to dig out and read thro both WebEx 1 & 2!"
Mix of presenters	"It was good to have a mix of levels and disciplines involved" "It was a good web Ex, but did not really provide any new information! I am a GP and was already aware of work done towards Pharmacy First, and push towards CMS prescribing. It also was a very "pharmacy heavy" WebEx - not enough input from the "users" (GPs/ ANPs)."
Too much information, rushed	"Very interesting contributions, but maybe too much in an hour!" "It was very quick paces and difficult to retain all info given" "There was a lot of content in this webinar and it felt rushed. It felt a little unfair to the presenters."
More time to answer questions	"Would be better if the speakers could address some of the pertinent questions / themes from the chat box during the WebEx." "I found today very useful if not a little rushed - maybe one less speaker would have allowed a response to some of the questions ?" "The updates and FAQs post-WebEx/webinars are great as it's difficult to keep up with the comments during the session whilst focusing on what the speaker is saying."

Content of Today – Why Long-term Conditions?



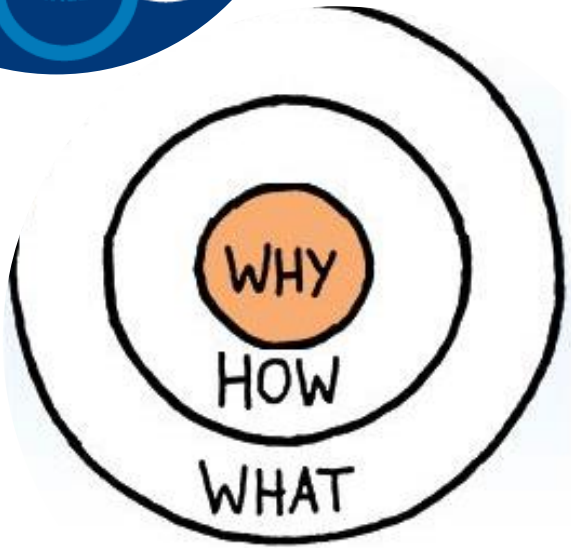
A General Practice perspective on managing long-term conditions

Dr Nico Grunenberg,
GP, Cluster Quality Lead,
NHS Tayside and Primary Care Quality Improvement Faculty Member, Healthcare Improvement Scotland

Remobilising elective care: LTC

VALUE

1. Allocative value
2. Technical value
3. Personalised value:
   - best current evidence
   - individual's clinical condition
   - individual's values.



Clinical examples

- **Asthma**: patient driven review: self assessment – patient entries
- **Diabetes**: individualised approach: what is essential? – practice attendance required?
- **Complex multimorbidity:** COPD, HF, CKD, polypharmacy: what is needed, what is wanted, what makes a difference?

LTC Remobilisation- Risk stratification

Priority Groups:

- Respiratory Shielding
- Diabetes
- CKD
- Heart failure
- Dementia
- Other frail or priority patients

Can we apply some of the previous principles to this high risk group and learn from this?

What can we change - what can we test?

- **RECALL:**
  - Patient driven – triggered recall
  - Patient centred – flexible
- **MONITORING:**
  - Where: Remote, telemonitoring, CTAC or practice
  - Realistic? Post QOF – evidence
  - Variance
- **MANAGEMENT:**
  - Value – patient specific
  - Shared Decision Making
  - Equitable – hard to reach groups

Data, data and more data

- **Unfamiliar territory**: Opportunity but need to ensure safe
- **Share** - Collaborate
- **Need IT** to facilitate – support – improve safety
  - Registers
  - Variation
  - Shared access – SDM

What are the roles that the multidisciplinary team play in supporting people to manage their long-term condition?

Lynne Innes
GPN and National Coordinator for General Practice Nursing, NHS Education for Scotland

@NHS_Education
@GpnNes

MDT collaborative working

Right person at the right time

Integrated partnership workforce

Growing community connections and relationships

A person-centred approach within an MDT

- Evidence based and best practice
- Accurate and appropriate care
- Specialist support

What Matters to You

Shared purpose

Seamless working

Complex care

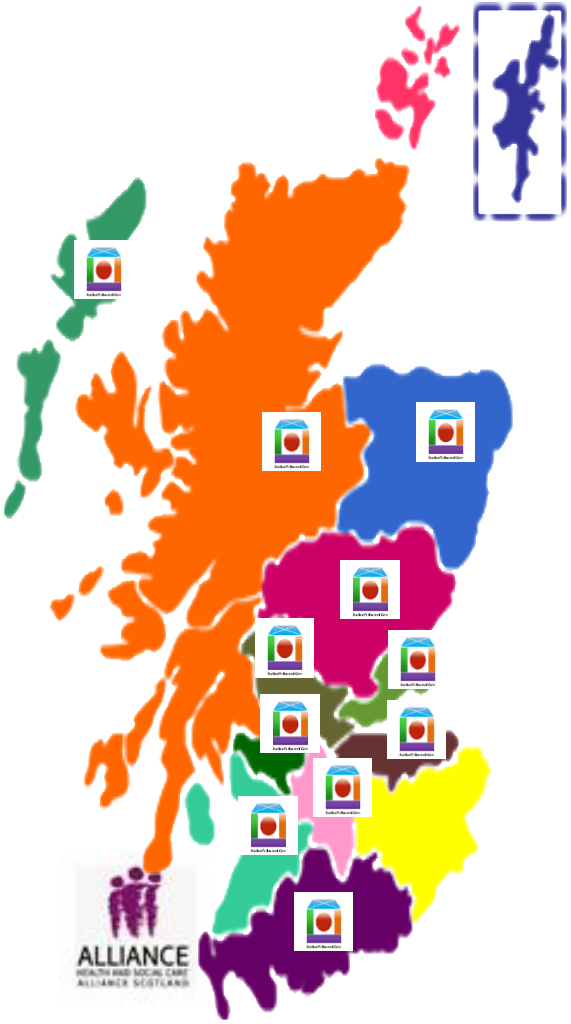
Improving healthcare outcomes

Person-centred care, health literacy and putting the person at the centre of collaborative care planning – House of Care approach

Graham Kramer

GP, steering group member of Health Literacy UK and Clinical Lead for Scotland's House of Care

Care & Support Planning:
Scotland's House of Care Programme



Over 400 HCPs

1st visit

Between visits

2nd visit

Information gathering

Information sharing

Consultation and joint decision making

Agreed and shared goals and actions (care plan)

Care Planning Consultation

Gather and share stories

Explore and discuss

Goal setting

Action planning

Review

Healthier Scotland
Scottish Government

ALLIANCE

Diabetes Care Planning Results

Diabetes planning appointment

Name: .....

Your appointment: .....

Please bring this to your appointment
We will use it to record the plan we make together about your diabetes.

Here are some things which people ask about.
Circle any which are important to you?

Medical check-ups	Your mood
Medication	Eating the right amount
Avoiding sugary foods	Giving up smoking
Monitoring glucose levels	Alcohol
Healthier eating	Foot care
Pregnancy and contraception	Physical activity
Driving	Sexual Health

What's important to you?
What aspects of your diabetes would you like to talk about?

Your Diabetes Results

The purpose of this leaflet is to help you know what your results mean, and to help you consider your options to reduce the future chances of complications.

Diabetes Control/HbA1c: Glucose (sugar) travels around your body in your blood. The levels of blood glucose in your blood over the last few weeks can be measured and can show your future risk of developing complications. This test is called HbA1c. The higher the number, the higher the risk. (This is not the same as your blood glucose finger prick level.)

48 53 58 61 64 67 69 72 73 80 Mmol/mol or more

Best levels: Between 48-58 mmol/mol is associated with your lowest risks of complications for the future.

You can help reduce your HbA1c by:

taking or adjusting insulin
being active
eating smaller portions
eating less fat (especially saturated fat)
taking medication
losing weight
having less sugar

NHS

HEART TESTS & CHECKS

KIDNEY TEST: Blood Test (eGFR)

Previous	Latest	Low Risk	More Risk	High Risk
		Above 60	45 - 60	Below 45

A blood test (eGFR) checks how well your kidneys are working. Ideally your eGFR should be above 60 and be stable.

Your questions, thoughts or ideas

DIABETES SCREENING TEST: HbA1c

Previous	Latest	Low Risk	More Risk	High Risk
		Less Than 59	59 - 69	Above 69

Diabetes is more common in people with heart disease. A blood test called HbA1c can detect people with diabetes. A level above 42 would suggest you are at risk of developing diabetes in the future and over 48 that you may have diabetes.

Your questions, thoughts or ideas

How does your heart problem affect you?

Are symptoms such as angina, chest pain or breathlessness stopping you doing everyday things?

Your questions, thoughts or ideas

LUNG & BREATHING TESTS & CHECKS

Forced Expiratory Volume (FEV1)

FEV1 as a % predicted is:	Mild Risk	Moderate Risk	Severe Risk
	50 - 80%	30 – 49%	Below 30%

This test checks for narrowing of the air tubes in your lungs. Your result is compared to predicted values from people of the same sex, age and height.

Your questions, thoughts or ideas

OXYGEN SATURATION LEVELS

Oxygen Saturation Levels are:	Normal	Increased Risk	Severe Risk
	95-100%	90-95%	Below 90%

Lung problems can reduce the amount of oxygen in your blood. The healthy range is usually between 95 and 100%

Your questions, thoughts or ideas

NHS

Name:

GENERAL HEALTH & WELLBEING ISSUES

Body Mass Index (BMI)

Previous	Latest	Low Risk	More Risk	High Risk
		20 - 25	25 - 30	Above 30

WEIGHT

Previous	Latest

Being overweight can make your condition more difficult to control and can increase risks of other health problems. Being underweight can also increase your risk of health problems.

Your questions, thoughts or ideas

SMOKING

Current Smoking Status	Low Risk	More Risk	High Risk
Cigarette smoker:	Non-Smoker	Ex/Passive	Tobacco User

Smoking causes problems with your health in many ways. Stopping smoking is one of the best things you can do to stay healthy.

Your questions, thoughts or ideas

MOOD

How you feel can make a big difference to your health. During the last month, have you been bothered by feeling down, depressed or hopeless, or had little interest or pleasure in doing things?

Your questions, thoughts or ideas

HEART TESTS & CHECKS

BLOOD PRESSURE

Previous	Latest	Low Risk	More Risk	High Risk
		Less than 130/80	130/80–140/90	140/90 or above

Keeping your blood pressure below 130/80 reduces your risk of health problems.

Your questions, thoughts or ideas

CHOLESTEROL & BLOOD FATS

Previous	Latest	Low Risk	More Risk	High Risk
		Less Than 4	4 - 5	Above 5

Lowering cholesterol can reduce the risk of heart attacks and strokes. Cholesterol lowering treatment is recommended for all people with diabetes aged over 40. The safest level of cholesterol is less than 4.

Your questions, thoughts or ideas

Upcoming dates:

Matter of Focus House of Care Evaluation

6th October 3.30 5pm

https://www.matter-of-focus.com/evaluating-health-and-social-care-transformation-learning-from-the-house-of-care-programme/

Taster Webinar Save the date.

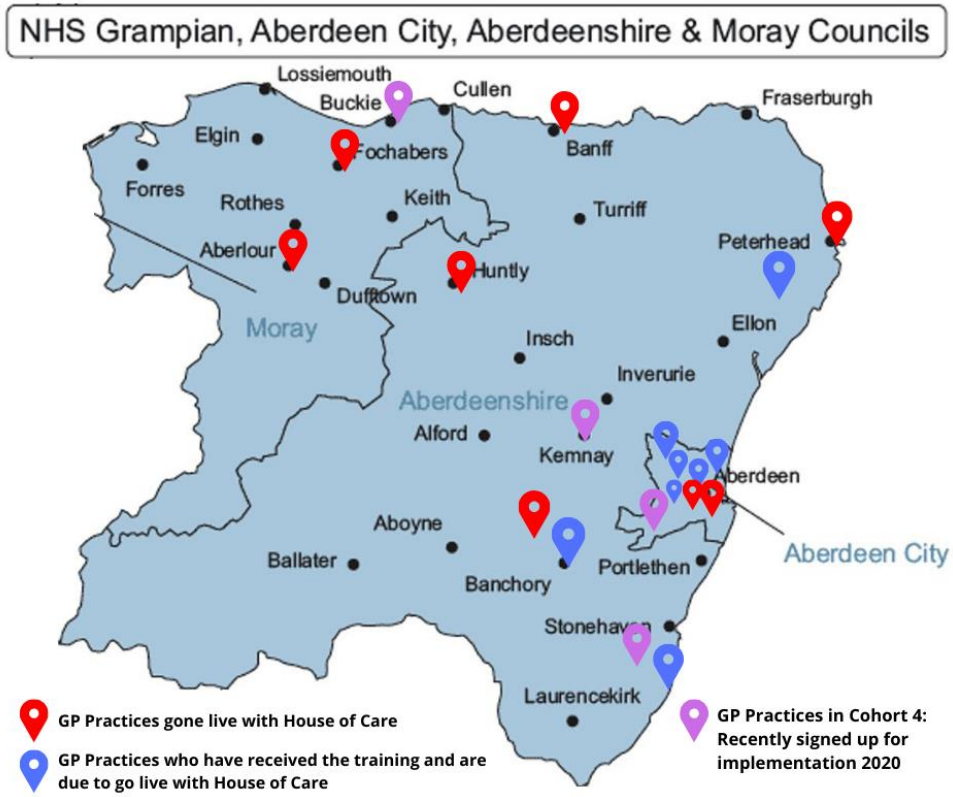
Wednesday October 14th TBA

@HoCScot gkramer@nhs.net

Our experience of using House of Care for person-centred care planning

Alison Hannan
Advanced Public Health Practitioner and
House of Care Project Lead, NHS Grampian

Grampian HoC Implementation 2019/20



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helping health happen

NHS Grampian

NHS Grampian House of Care
Six Month Interim Review

Positives

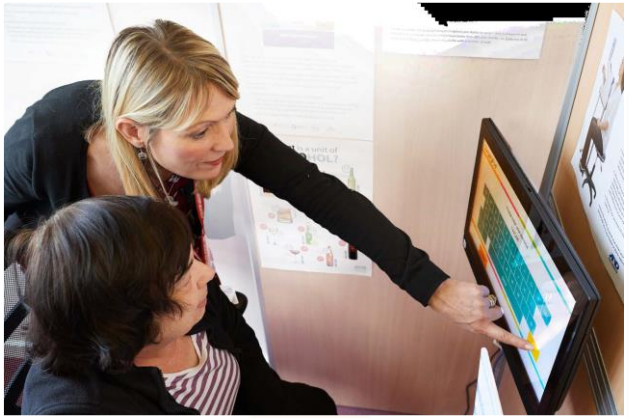
- Healthcare professionals have increased confidence to have a care and support planning conversation with their patients.
- Positive feedback on appointment system changes, longer time to have a deeper conversation with the patient.
- Increase number of patients engaged with their annual review.
- Greater job satisfaction, making a difference.
- Increase skills to review wider number of chronic diseases.

NHS Grampian House of Care
Six Month Interim Review

Challenges

- Buy in from all staff levels on the House of Care Concept.
- Mixed opinion Nurse Led/GP Led on for Chronic Disease Management.
- Practice staff complement e.g. shortage of staff within practice.
- Up-skilling staff to review multiple chronic diseases.
- Physical space within the practice.

The Success of Care and Support Planning in Grampian



Empowered

95% patients felt care and support planning helped them to take control

77% patients felt better able to keep themselves healthy

Informed & Prepared

I particularly like the simple and easy to understand “traffic light” system adopted as this gives a clear understanding of the test result figures. In the past these figures sometimes meant little as they were simply discussed and didn’t have any real meaning.

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NHS Grampian

Health Care Professional Stories

'I am really enjoying House of Care appointments and the majority of patients are also preferring the new approach. Getting the results before the appointment has taken away the shock factor and they have had time to process the results before they see me. The patients feel more empowered and leave the appointment feeling really positive and keen to make changes to their current lifestyle and health.'

Debbie Foreman Lead Practice Nurse, Cove Bay Health Centre/Kincorth Medical Centre

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NHS Grampian

Discussion

Pop in the chat box if you have questions or comments

The Links Approach in Supporting People with Long-Term Conditions

Chris Flynn
Senior Community Links Practitioner,
Health and Social Care Alliance Scotland







GPs at the Deep End

Glasgow City HSCP
Health and Social Care Partnership

Links Worker Programme

ALLIANCE
HEALTH AND SOCIAL CARE ALLIANCE SCOTLAND
people at the centre

The Links Approach in Supporting People with Long Term Conditions

Chris Flynn, Senior Community Links Practitioner
The ALLIANCE

"Our vision is for a Scotland where people who are disabled or living with long term conditions and unpaid carers have a strong voice and enjoy their right to live well."

Background and Role of the CLP

- Currently 31 Practices with Glasgow
- One-to-one solution focussed interactions
- Practice development
- Community network building

Links Worker Approach in Supporting Self Management

- Led by individual
- Flexible level of support
- Local
- Complementary in collaboration with other Primary Care Initiatives – House of Care

Implementing a Links Approach

- Resource Mapping – knowing the 3rd Sector
- Building Relationships
- Community Networks

Learning to Date

- Feedback from General Practice
- Feedback from Participants
- Impact of/Learning from Covid19
- 2017 Evaluation Report

Group consultations for supporting people with long-term conditions

Dr Joanna Smail
GP Partner, NHS Lothian

Group Consultations

Joanna Smail GP
joanna.smail@nhslothian.scot.nhs.uk

Alison Manson
alison@groupconsultations.com

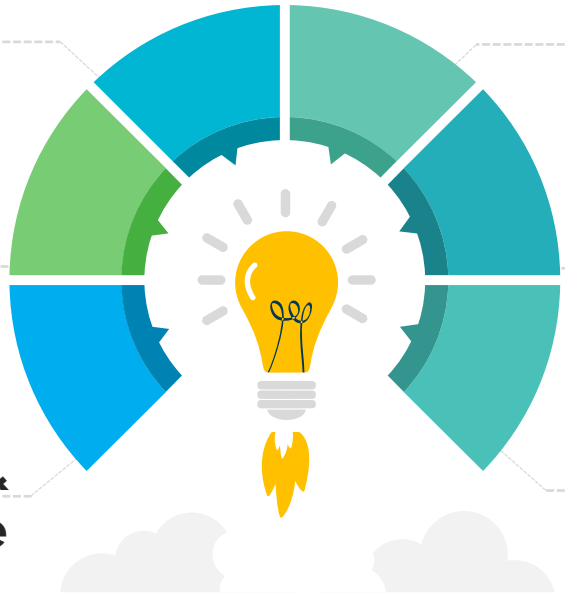
Tranent Medical Practice East Lothian

Why we need Group Consultations

Improve outcomes

Improve staff wellbeing

Create more time to care



Better experience for patients

Innovation & new efficient models of care

Workforce development & retention

Virtual Group Consultations can support re-mobilisation of care throughout Covid and beyond

group consultations

Group Consultations

Virtual or Face to Face

– Overview -

1:1 clinical consultations
delivered virtually on your platform of choice in a **supportive** peer group setting

Consultation with around 6-15 people
with a **similar** condition or set of clinical problems

Clinician
Doctor; nurse; pharmacist or other health care professional

60 - 90 mins
with the clinician present for around **half** the time

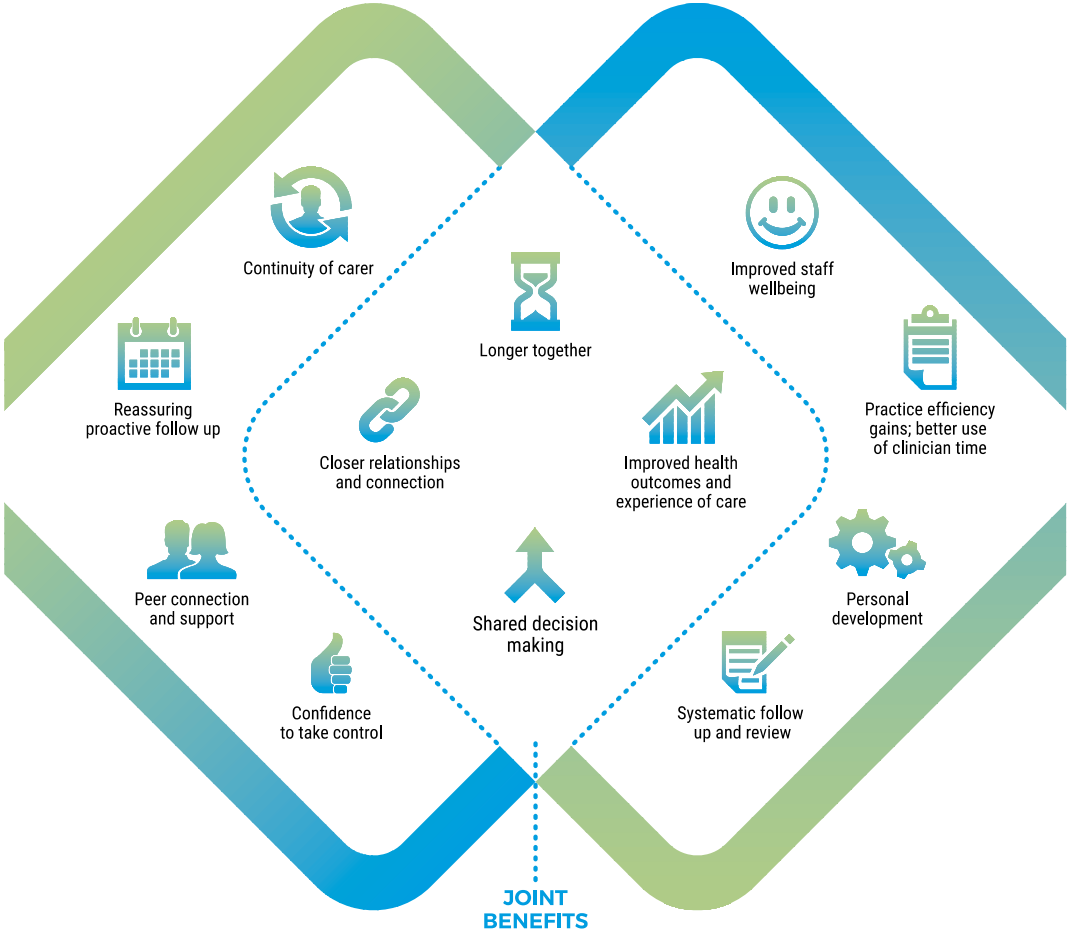
Supported by
a Group Consultations facilitator

Alternative way of consulting
that enables patients to be connected with their healthcare teams & each other either face to face or virtually

Allowing us to use virtual platforms and continue to deliver routine & planned care

group consultations

Benefits of Group Consultations



group consultations®

Group Consultations
FLOW OF SESSION

- Set session up and introductions
- Quick look at discussion/results board
- Your questions for clinician
- Clinician session
- Reflect and set goals
- Agree next steps /close session ....

group consultations

group consultations

OUR RESULTS / DISCUSSION BOARD

NAME	QUESTION	PREVENTER COMPLIANCE	INHALER TECHNIQUE	PEAK FLOW / PREDICTED	SMOKING STATUS
Jo		Daily			Y
Jack		? No script since 12/12/18			N
Sam		?			Y
Jenny		As needed			N
David		Daily			N
Beth		As needed			N

THANK YOU

For more information

www.groupconsultations.com
alison@groupconsultations.com

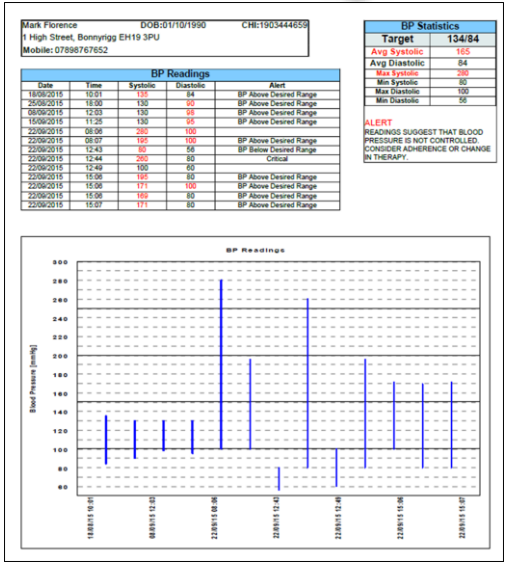
Telemedicine and remote monitoring to support the self management of long-term conditions

Brian McKinstry
GP and Professor of Primary Care eHealth,
University of Edinburgh

BP

- Strong evidence that telemonitoring of high blood pressure:
  - Improves outcomes (in higher intensity intervention)
  - No increase and probably a decrease in workload
  - Reduces need for F2F contacts
  - Liked by patients and clinicians
- Scale-UP BP
  - Sends regular reports via docman, no need to log on
  - Supported by SG Technology Enabled Care (TEC) programme
  - Supplies BP machines and software
  - 11 Health Boards, over 10,000 patients using

No Brainer!


Mark Florence DOB:01/10/1990 CHI:1903444659
1 High Street, Bonnyrigg EH19 3PU
Mobile: 07898767652

BP Readings

Date	Time	Systolic	Diastolic	Alert
16/08/2015	10:01	135	84	BP Above Desired Range
25/08/2015	18:00	130	90	BP Above Desired Range
08/08/2015	12:03	130	95	BP Above Desired Range
15/09/2015	11:25	130	95	BP Above Desired Range
22/09/2015	08:06	260	100	
22/09/2015	08:07	195	100	BP Above Desired Range
22/09/2015	12:43	80	56	BP Below Desired Range
22/09/2015	12:44	260	80	Critical
22/09/2015	12:49	100	60	
22/09/2015	15:06	195	80	BP Above Desired Range
22/09/2015	15:06	171	100	BP Above Desired Range
22/09/2015	15:06	169	80	BP Above Desired Range
22/09/2015	15:07	171	80	BP Above Desired Range

BP Statistics

Target	134/84
Avg Systolic	165
Avg Diastolic	84
Max Systolic	260
Min Systolic	80
Max Diastolic	100
Min Diastolic	56

ALERT
READINGS SUGGEST THAT BLOOD PRESSURE IS NOT CONTROLLED. CONSIDER ADHERENCE OR CHANGE IN THERAPY.

Diabetes

- Evidence from RCTs (38 trials, 6855 patients) suggest telemonitoring lowers HBA1C
- 1.8 times as many people in the intervention group achieving improved glycaemic control (HBA1C < 7%) than in the control group.
- Some evidence of reduced complications in smaller trials

However

- Scaling up appears to be more troublesome
- A slightly more unstable condition than BP
- Still need for physical assessment (eyes, feet, HBA1C home testing expensive)
- Need for observational implementation studies at scale

SHOWS PROMISE, implementation in an evaluative framework

CCF

- Multiple studies with varying results
- Latest meta-analysis (26 trials, 4923 patients) suggests
  - Reduced all cause mortality up to 180 days
  - No reduction in all cause hospital admissions and small increase in emergency room admissions
  - May be useful post discharge for short term use

Worth considering

Asthma

- Multiple trials with conflicting results
- Meta-analysis of 27 trials showed
  - No improvement in emergency room attendances
  - NO benefit in symptom control

However

- Subgroup of four smaller trials suggest reduction in hospitalisation
- Concluded may be of value in those at higher risk of hospitalisation

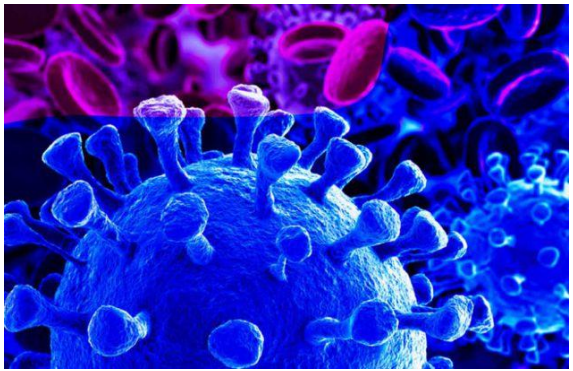
Use as a PROM for review or unstable asthma

COPD

- Multiple trials mainly negative
- Meta-analysis of 29 studies. The bigger and better the trial the more likely to be negative
- Work in Lothians showed increased workload with no improvement in outcomes
- VERY POPULAR with patients
- Observational studies of light touch approach more promising
- Use as a PROM?

Possibly light touch for review

Telemonitoring in COVID



- COVID necessitates re-evaluation
- Use of telemonitoring to conduct reviews rather than day to day monitoring
- BP a no-brainer
- Diabetes ready for implementation (but in an evaluative framework)
- Asthma/COPD consider as PROMS and aids to review
- CCF for post discharge

Discussion

Pop in the chat box if you have questions or comments

Closing remarks

Jill Gillies
Primary Care Improvement Portfolio Lead
Healthcare Improvement Scotland

Key resources from today's WebEx

- Links Participant Stories

Humans of Scotland

- Telemonitoring Webinar

- House of Care Video

- House of Care Evaluation Report

From fixer to facilitator
Evaluation of the House of Care Programme in Scotland

WebEx Resources on Improving Together interactive

Dedicated WebEx Page:

- Slides and Recordings
- Summaries
- Q & A Documents
- Upcoming dates
- Links to additional resources

Next steps

- Evaluation survey ➔ **link in the chatbox**
  - Interested in further support?
- Follow up email including the recording, slides, and summary
- Next WebEx in November

Keep in touch

Twitter: @SPSP_PC #PCImprove

Email: hcis.pcpteam@nhs.net


Thank
you