Responding to queries from Primary Care Resilience WebEx 4 – 23 September 2020

The fourth WebEx of our Primary Care Resilience Series took place on Wednesday 23 September 2020. This series aims to share the learning from the rapid change in how general practice operates that has occurred in response to COVID-19, whilst also looking at primary care recovery and renewal.

Discussions on each WebEx are led by colleagues from Scottish Government, Royal College of General Practitioners and Healthcare Improvement Scotland.

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.

This WebEx was focused on **managing long-term conditions in primary care**, and covered person-centred care planning approaches, making best use of the multidisciplinary team (such as Community Links Practitioners), offering group consultations, and using telehealth and remote monitoring.

This document aims to respond to queries raised by participants during the third WebEx. Presenters, GPs, and colleagues in Scottish Government, NHS National Services Scotland, NHS National Education for Scotland and University of Edinburgh have provided answers to these queries.

Questions and Answers

Responses to queries in relation to person-led care

1. Does the patient ever get a say/choice on who they think would be the best person to support them in review?
2. In Holland their policy aim is that everyone is the CEO of their own health ... perhaps this is something we could aspire to replicate? *(The CEO of own health is in the context of the citizen having good access / owning their own health and social care data)*
3. How do people deal explicitly with value conflicts and constraints in this? Sometimes what the patient asks for is not good for them?
4. How does this all align with Realistic Medicine? – managing expectations will be a massive aspect of all of this.

Responses to queries in relation to co-design

5. What does “design with” mean? Does it mean bringing everyone into a room, or is it showing stuff to people and taking their feedback to the change agents?
6. Should we incentivise and/or pay patient partners for their time and contribution?

Responses to queries in relation to Care and Support Planning, using the House of Care model

7. How do we get from here to there practically?
8. What tech/IT is available and what have practices used?
9. Is there central funding for roll out of House of Care in Scotland? *(I know there have been challenges around funding for training)*

Responses to queries in relation to group consultations

10. What platform is being used for virtual groups?

Responses to queries in relation to telehealth and remote monitoring

11. Would it be an idea for having BP machines available in public area's for self-monitoring?
12. How can Docman and Florence be used for blood pressure monitoring?
13. Has anyone used other patient-led review technology such as 'MedLink', etc.? Particularly for 'green' path patients with mild / well controlled asthma – are there other options for this in use anywhere?

Response to a query in relation to link workers

14. Not all practices have a links worker, is it time that they did?

Response to a query in relation to the multidisciplinary team

15. There are a range of clinicians supporting people manage their long term conditions - how do we ensure they are all working collectively/collaboratively?

Responses to queries in relation to person-led care

1. **Does the patient ever get a say/choice on who they think would be the best person to support them in review?**

   Patients have some choice in who they seek out but this is from a limited pool of available professionals. Within primary care, patients will register with a practice they choose and see a set of preferred clinicians and other professionals..

2. **In Holland their policy aim is that everyone is the CEO of their own health ... perhaps this is something we could aspire to replicate? *(The CEO of own health is in the context of the citizen having good access / owning their own health and social care data)***

   We need to aim for and move towards patients owning their health data as well as patients accessing and feeding into their health records.

   This will involve a considerable change in how clinicians use the medical record tool and give patients more transparent ownership as well as responsibilities.

3. **How do people deal explicitly with value conflicts and constraints in this? Sometimes what the patient asks for is not good for them?**

   Patient centred delivery of care has still continued during COVID-19 time, especially if there was a strong culture and experience of this before COVID-19. From our local experience, in primary care settings the delivery of person-centred care has adapted and perhaps even more rapidly adapted in what works for patients.

   Value conflicts are interesting and challenging at the same time. It is more often about doing less and understanding what drives certain behaviours. Primary care and ongoing care settings are perhaps better enabled to explore this over time.

4. **How does this all align with Realistic Medicine? – managing expectations will be a massive aspect of all of this.**

   Support for care at home, or as close to home as possible, remains central to care provision in Scotland, and is closely aligned to Realistic Medicine: Shared decision making, person-centred care planning and consideration of harms and benefits of treatment options are all connected closely to how we can support people with long term conditions to manage their own health and wellbeing.

Responses to queries in relation to co-design

5. What does "design with" mean? Does it mean bringing everyone into a room, or is it showing stuff to people and taking their feedback to the change agents?

Real co-design is discover-define-develop and deliver together; involving equal patient partners from the start of this process.

Healthcare Improvement Scotland's Community Engagement Directorate's micro-site also has resources to enable better engagement with people in relation to health and social care services.

You can find more information about public services engaging with individuals on an equal basis at the Scottish Co-Production Network.

6. Should we incentivise and/or pay patient partners for their time and contribution?

There are some examples in Canada (Canadian Institutes of Health Research and CEPPP in Montreal) where co-design with patient partners works very well. Patient partners are recruited, trained and selected for their expertise. They are not financially incentivised but recompensed for their time and expenses.

Responses to queries in relation to Care and Support Planning, using the House of Care model

7. How do we get from here to there practically?

Local sites wanting to embed the care and support planning approach should put in place the processes and arrangements that will enable this. The approach taken will depend on your NHS board and local support available.

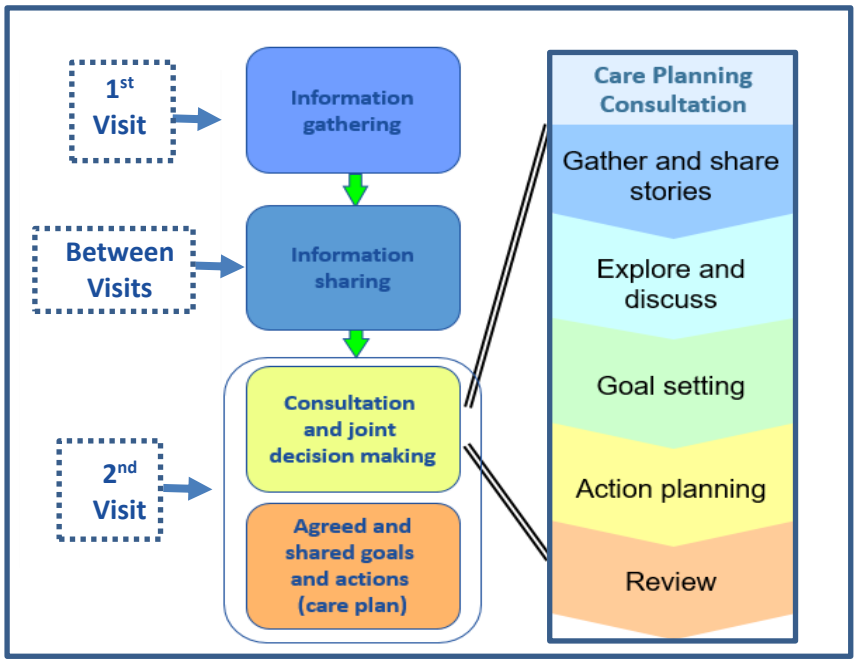
Practically, this can include:

- Developing a 2-step consultation process (*see Figure 1*)
- Customising template letters (including care and support planning results letters), posters and leaflets
- Raising awareness and supporting the development of consultation skills amongst clinicians and administrative staff
- Locally adapting IT systems such as Vision and EMIS
    - There are Year of Care templates available for adapting that can be installed on Vision and EMIS, however there can be some glitches locally depending on the type of EMIS being used.

You can find out more information about local experiences of using the model and support available in the following documentation:

- From fixer to facilitator: evaluation of the House of Care programme in Scotland

Figure 1: Care and support planning 2-step consultation process



8. What tech/IT is available and what have practices used?

IT is still an issue; some practices have worked with their local NHS IT to develop templates. NHS Grampian worked with Vision and adapted Year of Care patient results letters.

9. Is there central funding for roll out of House of Care in Scotland? *(I know there have been challenges around funding for training)*

There has been funding for training but no central roll out. Scotland's House of Care Programme is looking to develop national support for local training and facilitation, and perhaps funding could be made available through Integration Authorities and Primary Care Transformation Funds.

Responses to queries in relation to group consultations

10. What platform is being used for virtual groups?

The Scottish Government Technology Enabled Care team are currently exploring the most suitable platform(s) to be used for group consultations. There is ongoing user testing and information governance activity with various platforms to identify the most appropriate one(s).

At present each board is to risk assess the platform they are confident in using.

- NHS Near Me is not particularly suitable for group consultations, due to the participant limits. The Attend Anywhere platform which NHS Near Me uses is not designed for groups of more than 5 participants, so this is not recommended, as the quality of the video call will deteriorate.
- Microsoft Teams is being trialled by some areas, for example, for virtual pulmonary rehab.

Responses to queries in relation to telehealth and remote monitoring

11. Would it be an idea for having BP machines available in public area's for self-monitoring?

This is reasonable in normal times but poses a problem in terms of infection control at the moment. As far as we're aware, there is nothing in the literature evidencing the effectiveness of providing such a service, but it does seem sensible.

12. How can Docman and Florence be used for blood pressure monitoring?

For an overview of the BP Scale Up programme, please view the video below:

- BP Scale-Up Webinar 23/07/20

The extraction of data from the Florence website is carried out by NHS National Services Scotland and this is collated into the report below (Blood Pressure Report Example). The report is then sent to health boards from where it is disseminated via Docman. The clinician decides in advance how frequently the document is sent out.

There is additional documentation below:

- Blood Pressure Report Example
- Blood Pressure Monitoring Dataflow
- System Overview (NHS Lothian Example)

The project is currently being rolled out across Scotland (paused for a few months due to COVID-19). Health Boards wishing to implement this solution should go through their Technology Enabled Care Scotland Leads in the first instance.

The scale-up solution is essentially the same as the approach in NHS Lothian but the patient CHI number is now added to Florence as opposed to at the NHS board.

13. Has anyone used other patient-led review technology such as 'MedLink', etc.? Particularly for 'green' path patients with mild / well controlled asthma – are there other options for this in use anywhere?

MedLink is within use in various practices across Scotland.

Scottish Government has recently established a primary care digital board, and a data and intelligence group (led by Sir Lewis Ritchie) and this will support and enable closer connections with the wider system. This will also enable national support and management of procuring and evaluating systems which operate within the wider technical infrastructure.

Response to a query in relation to link workers

14. Not all practices have a link worker, is it time that they did?

In many areas, monies for link workers comes from funding to support the implementation of the GMS contract via Primary Care Improvement Plans. How this money is allocated is dependent on how health and social care partnerships choose to allocate the funding within their area.

You can find more information about link workers on Improving Together interactive.

Response to a query in relation to the multidisciplinary team

15. There are a range of clinicians supporting people manage their long term conditions - how do we ensure they are all working collectively/collaboratively?

All clinicians involved require an equal presence at ‘the table’ when supporting people with long-term conditions management, through strong communication and collaboration, and sharing good practice using quality improvement methodology.

There is also the importance of ensuring we utilise supporting self-management strategies, engage with communities and third sector organisations, such as the Health and Social Care Alliance Scotland.

The solutions to this approach don't all lie with health and social care services and clinicians need to embrace all involved and lead from love.