Primary Care Resilience WebEx

Managing Long-Term Conditions in Primary Care

WebEx #4 Summary | Wednesday 23 September 2020

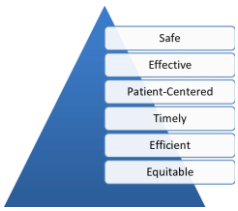
Summary of WebEx Topic: A General Practice Perspective and Multidisciplinary Teams

General Practice perspective

- Nico Grunenberg, GP, Cluster Quality Lead, NHS Tayside and Primary Care Quality Improvement Faculty Member, HIS

Long-term remobilisation in the current context creates opportunities to go back to basics to:

- reconsider what healthcare quality and value means
- reconnect with the 'why' of your caring vocation, and
- deliver personalised care whilst ensuring safety.



There are significant **workload implications** of catching up with care reviews, risk stratifying and working differently. But it is possible to **identify priority groups** and **run tests of change** to **redesign** as services remobilise. Practices can learn from each other. **Recall systems**, **monitoring**, and **management**, all provide fertile opportunities for testing. However, IT systems must begin to facilitate these new ways of working.

It's also important to **empower patients** to ask questions to inform decision making, and engage with **seldom heard groups** to personalise their care.

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Roles of the multidisciplinary team

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

- The multidisciplinary team can play a key role in helping people with long-term conditions to live longer, healthier and happier lives by delivering quality care through collaborative working.
- An integrated workforce can enable people to grow community connections and support their self management.
- Co-design and partnership working, and considering what matters to the person, will allow the right care to be delivered at the right time.

The Links Approach in Supporting People with Long-Term Conditions

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

Links workers deliver **1:1 solution-focussed interventions** focusing on what matters to the person. Links workers:

- **provide a flexible** level of support (no fixed limit to number of appointments)
- **support self management**
- **link individuals to** services and community assets that will benefit them, and
- **support attendance** where required (for example, where an individual is lacking in confidence).

<u>Other features of a links approach:</u>

- **Practice development** – supporting practices to understand the social aspect of health.
- **Resource mapping** is integral in implementing a links approach.
- **Community network building** with statutory and third sector services and community-based groups.
- **Can be complementary to other primary care initiatives** (such as the 'more than medicine' aspect of House of Care).

"Feedback from General Practice is that the links worker programme has been a fantastic resource… that GPs can rely on… in order to help people."

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Summary of WebEx Topic: The House of Care Approach

Care and Support Planning: Scotland's House of Care Programme
- Graham Kramer, Clinical Lead for Scotland's House of Care, Community Pharmacy Scotland

Overview of the House of Care approach

- Upskilling healthcare assistants in the medical processes of care
- Sending results to the person prior to their appointment
- Conversation by phone, video or face-to-face
- Principles can be adapted for group settings.

Resulting in:

- People who are much more engaged and curious.
- Healthcare professionals enabled to change their approach to facilitate patient-led goal-setting.
- Greater satisfaction and confidence in self management.
- Less medical prescribing, more social prescribing ('more than medicine').

"We find people are much more prepared, engaged and curious, and full of their own suggestions and recommendations. It's a much more productive conversation"

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NHS Grampian's experience of House of Care
- Alison Hannan, Advanced Public Health Practitioner and House of Care Project Lead, NHS Grampian

NHS Grampian have delivered training to nearly four cohorts of practices so far, with a fifth planned. There are significant changes necessary to the administration process to enable a two-step appointment system.

Interim evaluation report of practices that have fully embedded care and support planning found **positive results**:

- Healthcare professionals have increased confidence to have a care and support planning conversations with their patients and report greater job satisfaction.
- Positive feedback received on appointment system changes, which have resulted in more time with patients to have deeper conversations.
- Increased number of patients engaged with their annual review and due to increased skills a wider range of diseases were reviewed.

However it also identified **challenges** with:

- buy-in from staff to the House of Care concept
- mixed opinion on whether chronic disease management should be nurse- or GP-led
- managing staff shortages whilst up-skilling staff
- Limited physical space within practices.

Patient Feedback

99% felt care and support planning helped them take control

77% felt better able to keep themselves healthy

Staff Feedback

"Looking back… it was a really good thing to have happened to the practice introducing care and support planning… and it's making a difference when talking to the patients "

- Practice Nurse

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Summary of WebEx Topic: Group Consultations, Telehealth and Remote Monitoring

Group Consultations
- Dr Jo Smail, GP Partner, NHS Lothian

Overview

- Consultations with between **6-15 people** with a similar condition or set of clinical problems (for example, diabetes, heart disease, asthma).
- Clinical consultations **delivered face-to-face or virtually in a supportive peer group setting.**
- **Sessions last 60-90 minutes,** with the clinician present for around half the time.
- Supported by a group consultations **facilitator.**

Benefits

- **Alternative** way of consulting that enables patients to be connected with their healthcare teams and each other leading to a deeper understanding of their condition.
- Healthcare professionals have **increased confidence** to have a care and support planning conversation with their patients and greater job satisfaction.
- **Efficient** way for clinicians to deliver advice.
- **Peer support** allows patients to learn from each other different approaches to self manage.

Flow of a typical 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 ….

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Telehealth and Remote Monitoring
- Dr Brian McKinstry, GP and Emeritus Professor of Primary Care eHealth, University of Edinburgh

Evidence in support of telemonitoring for:

- **High blood pressure** – improves outcomes, decreases workload, and is well liked to patients and clinicians. (Scale-up BP, supported by Scottish Government's Technology Enabled Care team, allows clinicians to receive regular detailed reports via Docman, showing if action is required. *(Further information in Q & A document)*.
- **Diabetes** – shows promise, but has proven to be more difficult to scale up so far. It is ready for implementation (in an evaluative framework to learn from its scale-up).
- **Congestive cardiac failure** – works really well for the short-term (up to 180 days) compared to normal care and can be used post-discharge.
- **Asthma** – might be useful for those at high-risk of hospitalisation and can aid reviews.
- **Chronic Obstructive Pulmonary Disease** – promise in light-touch approach with Patient Reported Outcome Measure to aid reviews.

Telemonitoring in COVID

- COVID-19 has prompted re-evaluation as evidence to date compares telemonitoring with normal care, and normal care has been disrupted.
- Opportunities to use telemonitoring to conduct reviews rather than day-to-day monitoring.

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Resources and Questions raised during the WebEx

House of Care

- Care and Support Planning in MacDuff (Video)
- From fixer to facilitator (Evaluation report)

Links Worker Programme:

- Participant Stories: Denis, Liz

Telehealth webinars

- Telemonitoring in COVID-19
- BP Scale Up

WebEx Resources

- WebEx #4 Slides
- **Questions and Answers Summary** – document produced post-WebEx to respond to the questions posted on the chatbox.

- Primary Care Resilience WebEx Series

Themes from the chatbox

Redesign of care delivery

"Great opportunity just now to design chronic disease management support that suits patients and practices better."

"Realistic Medicine principles need to thread through everything we do."

"Opportunities to redesign not just relocate historical work via Community Treatment and Care Services."

Person-centred/ person-led care

"In Holland their policy aim is that everyone is the CEO of their own health ... perhaps this is something we could aspire to replicate?"

"If we get personalisation (what matters to you) and shared decision making really flourishing so that patient decisions decide treatment we should get much more Realistic Medicine, reduced variance, risks balanced, etc."

"MDT needs to include the patient."

"House of Care is about a relentless focus on preparation and engagement."

Engaging with seldom heard groups

"How do we ensure people with the lower volume long term conditions are engaged with and supported through primary care? Multiple sclerosis, Ehlers Danlos Syndrome, Epilepsy, Fibromyalgia, recovering post-Stroke, to name but a few. We are talking more about long COVID, but there is already a significant cohort of patients who currently feel under-supported."

"Hard to reach" or "easy to ignore"? Real challenge engaging with 'unworried unwell', for whom self-management is a destination not a starting point - takes time to build relationships, trust, confidence... Community Links Practitioners can help with this."

Service Directories

"https://www.aliss.org/ is a useful site type in postcode to see what support groups are available in your local area."
"NHS24 through NHS Inform platform are also developing a national service directory, and have connected in with ALISS."

IT Systems / Platforms

"Structured education for people with diabetes also been held for years with success, need to decide the appropriate platform to continue currently."

"Agree with all said so far. `been on previous webinars and meetings re what is House of Care and why it is best. BUT

1. What tech / IT is available, what have practices used?
2. How do we get from here to there practically?"

"We need a smart and flexible IT interface solution that empowers patients, not just gathers data."

"IT systems are behind the game; still based on Quality Outcomes Framework-thinking.

"If systems like MedLink evaluate well, should we roll out on a "once for Scotland" approach, or should we support local variation?"

"Any system/ needs to be tweakable by a Practice or Cluster. Patients are individual so the response/care needs to be equally individual."

"Now information gathering doesn't need to be done in a visit... could input in other ways if patients are able."

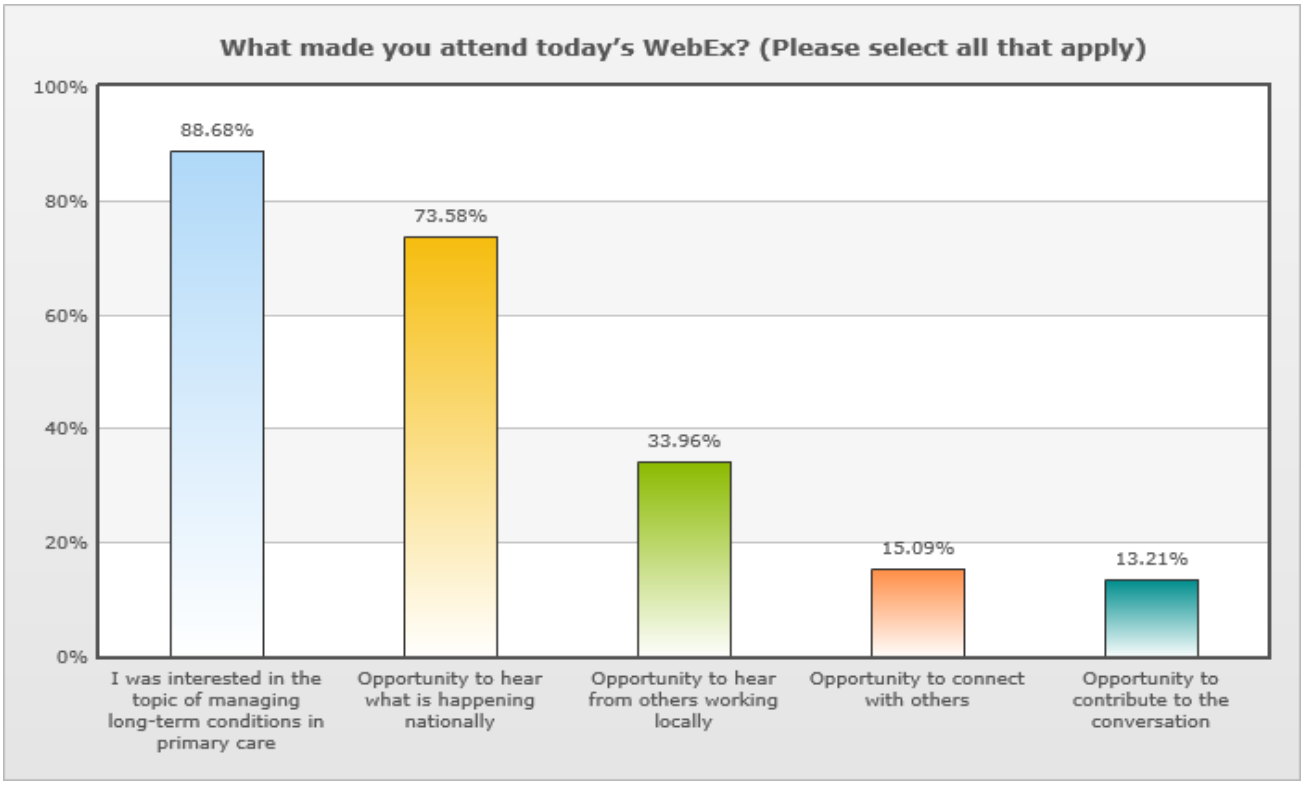
Survey Feedback

How likely would you be to attend a future Primary Care Resilience Series WebEx?

- There were 53 respondents to the feedback survey. Over **90% of respondents said it was *likely* or *very likely* they would attend** a future Primary Care Resilience Series WebEx.

Top Reasons for Attending

- Respondents' main reasons for attending the WebEx were an interest in the topic of managing long-term conditions in primary care and hearing what is happening at a national level.
- **18** people said they would be interested in being involved in a Long-Term Conditions Network.



General feedback

- "Enjoyed the session today with the short presentations. Good pace and very interesting. Helpful session."
- "Great webinar - short and snappy presentations, gave enough information to trigger discussion and interest."
- "I find theses sessions very useful and great to hear about the work going on but also that others are finding navigation difficult."
- "Much work taking place across Scotland, it would be good of course to get some data on patients and types of consultations and outcomes."
- "Chronic disease management is moving away from the rigidity of the contract, becoming more tailored to the individual. Maybe there is hope of all practices being allocated a links worker."

- "Sorry - but I feel that there is a disconnect between the Primary Care coalface and HIS aspirations. The audience is self-selected (as I know that many of my GP colleagues do not have an hour at lunchtime - even for food!), and those not attending are fire fighting rather than planning long-term conditions management."
- Wonderful though Link Workers are (and I loved working with our link worker) and group consultations are, I heard no discussion of the risks of medicalising things that are not medical and an acknowledgment that they don't help with the crisis in GP recruitment and retention."
- "Perhaps a different platform it is annoying having to dial in on my phone and use my computer."

What will you take away from today's WebEx and apply at to your own work?

Increased understanding

House of Care Approach

"An understanding of how House of Care works in Scotland, as I have come from working in London as a Practice Nurse for 9 years using Year of Care."

"Interested to hear about House of Care approach."

Local projects

"Link in with projects that are happening locally that I was unaware of."

Telehealth and remote monitoring

"The acceptance of Near Me consultations by patients and how all health professionals are moving to this way of consulting."

"I will find out more about Medlink - hadn't heard of that previously - it was mentioned in the chat."

Reassurance

"Most information was known to me but very helpful update particularly in context of remobilisation of services."

"Confirms our concerns about distant review of some conditions, need joined up thinking to minimise patient f2f interactions."

Encouraged to explore adoption or sharing of new practices

Person-Centred Care

"Encouraging our practice nurses to develop our recall systems to be more patient specific. And that interactions with patients need to focus on 'what matters to you'

Patient Centred, right person right time."

"Continuing the change of focus "what matters to me" person-centred care. How to change our long-term disease monitoring to fit this."

House of Care Approach

"Look at House of Care options."

"Going to look in to training/roll out of House of Care."

"This has helped us to find useful resources in planning chronic disease monitoring following the House of Care model."

Telehealth and remote monitoring

"Find up about scale-up BP provision locally. We have been encouraging patients to access BP monitoring at home, this would make it so much easier to apply widely. Insight in use of remote consultations especially Near Me for chronic disease monitoring."

"Florence may be worth a second look. We should probably be doing more Near Me."

"The fact Near Me is being used in the treatment of long-term conditions in many areas and also the encouragement to use Florence."

Redesigning care delivery

"Will look at changing the practice in the future with regards to disease management."

"Share the type and scale of change that is happening in chronic disease management."

"Need to start looking at re-mobilising chronic disease management but in a realistic way - need help from HSCP / Board to move away from default Quality Outcomes Framework list and to person-centred care."

"Consideration of how we manage and follow up our patients with Long Term Conditions."

"Felt I was aware of most things that are going on, need to work on convincing colleagues on how the contribution of a wider range of professions can help them."