Appendix K

Long Term Condition Management – A Guide to Recovery (a marathon not a sprint!)

The General Practice Nurse Network at NES organised two webinars to consider the future of Long Term Condition Management, first broadcast on the 1st June and the 24th June 2021.

Dr Scott Jamieson GP, Dr Nico Grunenberg GP and Alison Fox, Practice Manager shared their thoughts with us at these Teams live events and to gain the most from this guidance, it is worth reviewing these two events to gain a better understanding of what re-design can look like and the evidence which underpins Long Term Condition Management. Copies of their presentations and recordings of the events are available.

Where are we at? (rest, refresh, recover)

Effective management of long-term conditions (LTC), at the best of times, has been challenging for the health and social care system. The global pandemic forced practices to re-design systems of care overnight, re-prioritising services to create additional capacity to deal with work related to Covid-19. Undoubtedly, this has resulted in a disruption in the provision of proactive care and LTC management. Even prior to March 2020, with the removal of the Quality and Outcomes Framework (QOF) for payment and auditing purposes, practices were at the beginning of a re-design process. Some practices will have already reviewed their clinical protocols and systems whereas others were perhaps at the beginning of this process when the pandemic hit.

Additionally, individuals may have chosen not to access care through fears they may contract or transmit COVID-19. Maintaining good health and avoiding deterioration requires pro-active monitoring and management to optimise treatment and as we progress through the pandemic, one of the many challenges is how we will continue to deliver routine care including follow up review and LTC management, whilst Covid-19 remains a risk.

Deep inequalities, exposed by the pandemic, show that those who have been worst affected by the virus, are largely those who had worst health outcomes pre Covid-19. Therefore, continuing to ensure that these patients receive appropriate treatment, review and management is still very important.

The removal of QOF for payment and auditing purposes and the establishment of GP clusters provided the opportunity to re-design long term condition management to ensure that services were appropriate to population need following the most up to date clinical evidence and the principles of realistic medicine. Pre COVID-19, many practices were moving away from condition specific annual reviews to person centred care and what was most

important to patients. Covid-19 disrupted this transition and re-design process and for some practices this has been “on hold” with questions now being raised about how you start that re-design process and prioritise patients for review.

Where are we heading? (recover, refresh and re-design)

Each practice will have their own individual challenges, whether it be building space, IT structure, engaging with people and communities, or recruitment and retention issues.

However, an opportunity now exists to help patients regain control over their lives by engaging in a meaningful and constructive way rather than merely collecting data for the sake of audit and payment purposes.
This means that services can be re-designed in a person-centred way, possibly differently to the way it was done before with strict annual reviews, allowing practices to co-ordinate complex care more effectively.

It will be important to recognise the role people play in improving their own health and to support them to do so by optimising self-management.

The initial step in addressing inequality is good two-way communication by working in partnership with the patient to identify their priorities and goals and to then develop an action or management plan with them. Helping people to find ways to identify what matters to them, then promoting self-management such as setting realistic goals and securing their support to achieve these.

This may mean a move away from traditional annual reviews where a set of data was collected and was perhaps more prominent than the management of the condition. Therefore, thinking about how you collect data and how you help the patient manage their condition may be two different strands or at least need to be thought about in different ways.

The question of how you re-prioritise patients utilising an annual recall procedure is somewhat now redundant particularly if a patient has now missed out on that annual review and a year has passed. What may be more prudent, is how do we design a system that works from this point onwards, how do we communicate that to our patients so that they understand and can buy into this revised service.

How do we get there? Where do we start?

Despite the challenges and barriers, COVID-19 has also brought opportunities to challenge the traditional ways of working. COVID-19 has already propelled changes to the way routine care is delivered. Teams are working very differently now to 18 months ago, and the use of digital technology particularly in relation to consultation with patients, has been rapid. At times far too rapid

and we now need to reflect on the best bits and how they are working and the bits that still need to either change or imbed.

There is always a risk that practices will try to return to previous ways of working which is a natural reaction to fast paced change which had little practice buy in or ownership at the beginning of the pandemic. Harking back to the familiar brings comfort and a feeling of control again but there is now the opportunity to learn from our everyday work and to question its value, its clinical appropriateness and its worth to the patients.

Learning from everyday work – Rethinking Long Term Condition Management

Before starting any re-design process ask yourself and the team the following:

- Why is your practice doing things the way you are? Is it best practice? Is it value added care? What does the evidence say? (refer to Dr Scott Jamieson's presentation above for an overview). Or is it – this is the way we have always done it?
- Look at the principles of realistic medicine and the evidence available. Do you have sufficient clinical input to the practice protocols for managing long term conditions? Are they clinically led from evidence or administratively led based on older QOF protocols? Do you need to re-write your protocols and re-train staff? Can you share this clinical input across clusters?
- What is the best method of data gathering for each individual – phone, video or face to face in a clinical setting or patient's home? If this the same process you'd use for management?
- Do you treat the person and not the condition? What is the Process (what information and data do you need, how is this shared, what conversation takes place, and how do you record the agreed action plan?). When does that person need to be reviewed again? Does it need to be annually? Is their review tied in with medication management, for example?
- Who is the best person? What is the role of local HSCP Community Centres in data gathering, Practice Nurse, Health Care Assistant, Practice Pharmacist, Link Worker, the GP? What is the role of the reception team – do you need data or information prior to review?
- Does your appointment and recall system need reviewed? Trial new and innovative approaches – try small tests of change to start with.
- How are you working with and communicating with patients about how and when they will be reviewed in the future, especially those who were reviewed/ recalled regularly prior to covid-19 and are anxious that they may have not been reviewed for some time

Technology is an enabler for some, but if we are to successfully manage LTCs - new systems and processes to enable high-quality person-centred care are essential. One bonus is that continuity of care may be more sustainable which can help build relationships of trust and shared understanding.

Other Considerations

- What education do you provide – do you signpost patients?
- What is your practices role in mitigating health inequalities?
- What matters to staff? Do they need updated training?
- How can you use the third sector?
- Social prescribing – is this something to consider?

Being overly ambitious, whilst amidst a global pandemic, is not wise. This is not a short sprint, but a marathon. Small steps of change – then evaluate – share. Small practical wins. Dr Nico Grunenberg describes his small tests of change and you can access the recording as above

Celebrate your successes and share good practice and innovation within your GP clusters. Sharing can cut down the workload and learning what works well somewhere else can save "re-inventing the wheel".

Remember that your patients are at the heart of any change process and people like choices so ensure that this is a shared journey. A small focus group to discuss your ideas with patients could save wasted time and effort if the planned outcome doesn't work for them. Think about your use of digital consulting methods – they may not work for everyone.

A Team Approach

Virtually everyone in the practice has a role in long term condition management from the reception staff signposting and making appointments, to the recall administration staff, through to the clinical and community staff. It is worth listing all those involved in the process and clarifying their roles, identifying who is going to take a lead in each area.

How do you prioritise patients?

Consider what components of care can be delivered by each member of the team and how you prioritise your patients – do you start with the high risk (often more complex cases)? Should these people be reviewed by GP/Nurse or AHP more immediately?

Those with greatest clinical risk (for risk factors modification) may include people with multi morbidity and at higher risk of adverse clinical outcomes, poor concordance, social complexity, and frailty. There may be an increase in mental health issues in this group which they may wish to discuss as part of any review.

Those at lower risk, such as people with stable hypertension could be monitored by HCAs (practice guidelines will be required locally). Florence can

be utilised for remote monitoring and self-care. Could patients' text in home BP readings?

General Principles

As QOF is no longer being used for payment or audit purposes, the general principles for practices to manage long term conditions has become somewhat lost.

Returning to local clinical and practice discussions to consider **current clinical evidence** will be important. Once this has been established**, processes, training and systems** can be developed with **appropriate people aligned to tasks**.

Establishment of **good clinical protocols** (at practice or GP cluster level) will guide **review/recalls periods** and help to **establish clinical priorities** (high risk scenarios may influence the areas that you focus on more immediately).

Considering **what is important to patients** will influence the **method of review** remembering that choice is important and not one size fits all.

The word VALUE springs to mind – the value of the clinical evidence, the value of the tests you are taking, the data you are collecting and recording and the frequency in managing the condition and the value to the patient of the review process, what they are getting out of it and what their long and short terms goals are in managing their own health.