Long Term Condition Management Resources

Contents

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.

St Triduana's
Medical Practice

The St. Triduana's Story

Implementing care and support planning for people with long term conditions

"It was as bit of a leap of faith at the start, but now we wouldn't go back to our old way of working"

St. Triduana's Medical Practice is a GP practice in Edinburgh with around 11,000 patients. Previously care for people with long term conditions was based on fulfilling QOF requirements with unconnected medicine reviews leaving little opportunity for addressing patient issues and concerns. People were seen for separate individual disease reviews which focused on completing tasks rather than on 'good conversations' and 'planning care with people'.

Time to change

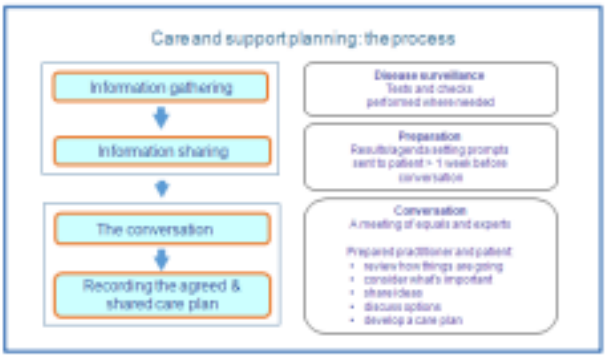
St Triduana's Medical Practice was already involved in NHS Lothian's 'Headroom' project when the team attended a session to hear about care and support planning using the House of Care, supported by the British Heart Foundation. The practice was keen to use care and support planning as a means to deliver the **Realistic Medicine** aspirations of more honest conversations, more pragmatic approaches to medical treatments and a focus on 'more than medicine', alongside a partnership approach to working with the people that they serve. In addition care and support planning was consistent with the new GMS contract and good way to deliver patient focused medical care in place of QoF.

Getting started

A few GPs and nurses attended Year of Care training and cascaded this to the rest of the practice team. The practice had a small leadership team who worked together to plan and deliver the necessary changes to implement care and support planning. This involved changing existing processes and roles of team members. The practice tested out the process with around 10 cardiovascular patients including people with diabetes. In May 2017, this was scaled up to include all people with multiple long term conditions.

"Even at the testing stage we always had an eye on what was realistic and what was scalable - in retrospect we should have spent less time on piloting with a few patients"

A process that balances good clinical care with what matters to people



"I originally thought I was already patient centred, but after getting involved in this programme, I had to admit I wasn't. Unless you are willing to admit you are not perfect, you won't get anywhere." ***GP***

"I was really worried that we would lose the biomedical agenda, but this really hasn't happened – both the clinical and the patient stuff are equally important and we seem to be getting the balance right." ***GP***

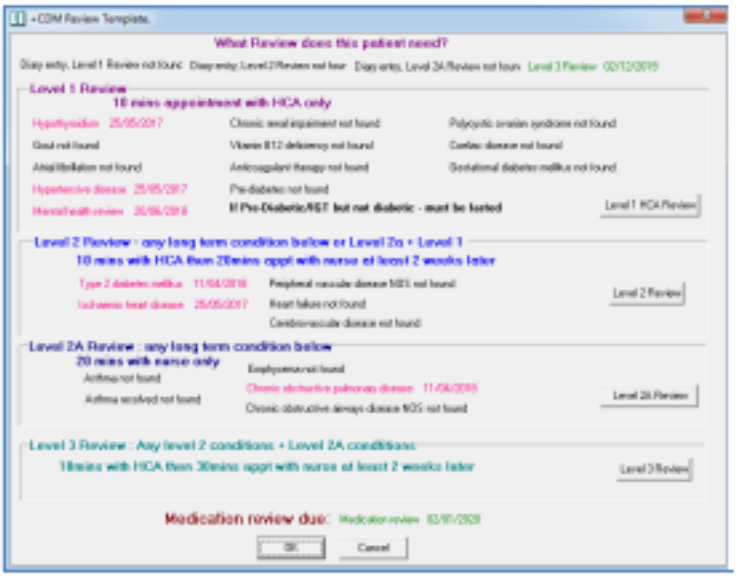
ALLIANCE

The Scottish Government

The process – how it works at St Triduana's

After initial piloting the practice moved to a single care and support planning (CSP) process for all long term conditions, held a month before the medicine review was due. This meant that not only could the practice ensure all tests and tasks for all conditions had been done, but also that relevant information from the CSP conversation and tests could be used to streamline the medicine review and make it more meaningful.

Information gathering is done by healthcare assistants (who also have a dual role working in reception). The practice calls patients to book appointments (and also sends text reminders). The practice set up EMIS PCS IT templates to help reception with appointments, sending out preparation materials, social prescribing and recording the care plan itself. This has taken time and requires a common understanding of the programme to ensure it works well for each member of the team, recognising the critical nature of each step in the process.



The timing of appointments is managed by flagging people as 'level 1, 2 or 3' depending on the number and complexity of their long term conditions. Each level has a defined appointment time and role allocated. This is built into the template so it's easy to remember and obvious to all involved. A person can also be 'moved up' a level if they have other more complex conditions e.g. frailty, dementia. By creating such a robust process not a single person has ended up being given the wrong appointment – the admin and reception team is key to this success.

Care and support planning conversations are mainly done by nurses, with GPs handing the most complex cases. The nurses are being supported by GPs to confidently manage care and support planning across a range of conditions and it is hoped that, with time, all nurses will be able to handle all but the most complex care and support planning conversations.

A real team effort

"Our team is what makes this work"

One of the most impressive things about the practice is not only how culturally 'in tune' with the ethos of CSP they are, but how that extends to the way the team works – they are all proud of each other and of what they have achieved. They recognise that this has been a huge change for the whole team, particularly for nurses. Everyone has been involved and the vision and implementation of CSP has been involving, strengthening and communicated well within the team.

The practice manager, Alison Fox, has worked closely with the clinical leadership team and developed regular sessions to review implementation of the process and a regular weekly MDT as an opportunity for peer support and supervision. This has helped the team understand each other's roles and now includes the full time link worker, community psychiatric nurse and pharmacist who support the approach. External facilitation has been useful to challenge and offer new ideas, as has having time set aside to do the work associated with set up of CSP and staff development.

Professional development

One of the team's key aims is to have staff trained, supported and working to the *"top of their licence"* as a means of promoting good quality clinical care with as few visits to the practice for the patient as possible.

Impact on roles

Redesigning the system of care has forced the team to review roles. Healthcare assistants now take on more of the tests and tasks during information gathering appointments. Many healthcare assistants also work in reception which gives the practice an extra benefit as they understand the system and the philosophy of the approach; they can explain this to people with long term conditions when they contact the practice or when making appointments.

The big change has been for practice nurses who used to be focused on single conditions and the completion of templates. Going from such a structured template-led approach to a CSP conversation where you don't know what the patient will bring up has been quite a challenge.

"It was a significant change from what we used to do, and we were worried about fitting it all in. Once you have tried it, it becomes clear that we're not being asked to just add more checklists in for all the conditions someone has, we need to change the whole way we handle our conversations around what really matters to the person. It's taken quite a while for the penny to drop and for me to get my head around the fact that I don't need to fix everything."

Supervision and support

GPs have a strong role in supporting and developing the nursing team. The practice is already seeing that acute appointments are less pressured so clinicians are able to concentrate more on the complex cases which need their expertise.

The practice has a range of 'bitesize' training sessions together with a regular calendar of learning cycles which are facilitated externally. They are particularly useful in helping to tease out and discuss ways of handling some of the challenges which the practice team face. They give an opportunity for peer support and informal supervision from GPs – sharing how people handle difficult conversations, as well as seeing how the rest of the team (pharmacy, mental health, links worker etc.) can contribute. This is all part of the practice's recognition that reviewing the detail and keeping the team thinking about this has helped evolve and refine things. The practice see this reflective time as important to the quality of what they deliver.

'More than medicine' and community support

Ensuring care and support planning feeds into the practice based link worker is really reaping rewards. Many people identify issues such as debt, housing or social isolation as the biggest issue impacting on their life and their long term condition. The practice involves the link worker in their meetings and benefits from hearing about what's going on in the local community; St Triduana's has the lowest DNA rate when making a referral. Patients have been supported practically with real life issues and this is already having an impact on individual patients and their self-care.

Looking to the future

The practice has a continual development programme for the team. Further training of healthcare assistants in spirometry and foot checks is planned, and clinical training around respiratory and ongoing sharing across social prescribing, pharmacy and the rest of the team will continue. The practice is also looking into frailty as well as people currently supported mainly in secondary care to see how they can provide CSP without calling them in unnecessarily, or crossing over with the support they are already getting. The practice has travelled a long way in three years but also recognises that there is still much to do.

So what difference is this making?

The practice was asked to consider the benefits of introducing CSP and using the House of Care framework including more than medicine. This is what they said:

Benefits for people with long term conditions

*"They (*people with LTCs*) like getting information beforehand. Because they can see results, it helps make the mental link – they see connection between lifestyle stuff and results, the penny drops, they can see the positive results of what they have done."* (Practice Nurse)

"Patients like the opportunity to discuss what matters to them. It's really the first time they've had this opportunity. They might want to talk about work, care package, respite, toe nails, lifestyle, and quite often unexpected things. Sometimes a bit surprised but there's always something." (Practice Nurse)

"Our IT templates also record the care plan itself, so at any time we can see what matters to the person and what goals they are working on so we can reinforce and support this through all our contacts with that person and understand the patient's preferences." (GP)

"In particular it's improved our use of more than medicine – so many cases we used to give people medicine when in fact the problem was with more social issues – having this approached and then being able to refer to Links Workers is a real benefit to patient care." (GP)

"Without a doubt it's better for patients." (Practice Nurse)

Staff benefits

Reception has found this process a lot less work than previous appointment systems for chronic diseases.

"It's clearer and simpler and the templates make it easier." (Administrator/HCSW)

"Previously there was quite a bit of duplication of effort – all gets done systematically now." (GP)

"We are constantly developing people, and I think this approach helps people be able to operate at top of their licence, and frees up time for GPs to focus on the right stuff." (GP)

"It's so much easier to do medicines reviews now – mostly it's already done." (GP)

"We have certainly seen links between staff groups improving." (Practice Manager)

Practice benefits

"Care and support planning is also something that helped with safety – combining appointments meant the chance of something getting missed was less – clearer, simplified, safer." (Practice Manager)

"We hoped the move would be more efficient in appointment use, and some of this does seem to be happening. We have one of the lowest DNA rates and the number of GP appointments is definitely going down." (Practice Manager)

"I believe we can run a successful business and be patient-centred by focusing on what matters to the person - we are now on the easiest path to make this happen. I am so proud when so much negative stuff is around that we have a system which is both positive and sustainable." (Practice Manager)

For further information contact Alison Fox alison.fox@nhslothian.scot.nhs.uk or Dr Louise Bailey Louise.Bailey2@nhslothian.scot.nhs.uk

ST TRIDUANA'S
MEDICAL PRACTICE
54 MOIRA PARK, EDINBURGH, EH7 6RU
TEL 0131 657 3341 WWW.STTRIDUANAS.CO.UK FAX 0131 669 6055

System Date Long

Name
Patient Address Stacked

Dear – *Title Surname*
Thank you for attending the surgery prior to your annual review. Your results are detailed in this letter. We hope this information will help you to decide what is important to you and support you in managing your long term health.
You may wish to consider what you want discuss with our practice nurse before the telephone appointment on:
Appointment Date at Appointment Time

Some things that people ask about include – circle any that are important to you:

LIFESTYLE	MENTAL HEALTH	HEALTH CONCERNS	SOCIAL
Giving up smoking	Feeling down or stressed	Medication	Work and employment
Alcohol	Sleep issues	Concern of new symptoms	Driving
Ithier eating or concerns a your weight	Loneliness or isolation	Risk of future health problems	Benefits
Keeping active			

Your recent results for discussion at your review include:

Blood Pressure
Read Code Fields - 2469 /Read Code Fields - 246A
In general we aim for blood pressure less than 140/ 90. The target for blood pressure control depends on the conditions you suffer from. Please discuss your individual target with the nurse at your appointment.

Cholesterol
Read Code Fields - 44PJ
Keeping cholesterol less than 5mmol, lowers your chances of having heart attacks or strokes. We recommend a diet low in salt and saturated fat and high in fruit, vegetables and oily fish.

Diabetes control
Read Code Fields - 42W5
Hba1c is an overall measure of the body's sugar levels over the past 8-10 weeks. Levels below 42 are normal. Levels of 42 and above are suggestive of higher blood sugar levels. If this is raised, we will discuss this at your appointment.

Smoking and Vaping
Read Code Fields - 137
Avoiding smoking has many health benefits. All sorts of tobacco can be harmful and stopping smoking has the most significant health benefit for you. Vaping is less harmful than smoking but not safe and not without risks.

Weight
Read Code Fields - 22K

The healthy weight for you depends on your height and this is assessed using Body Mass Index (BMI). Ideally being between 20-25 is a healthy weight.

Drinking alcohol in safe limits (<14 units/week) and exercising regularly, ideally >30 minutes 3 times per week may also help reduce blood pressure and lower your risk of developing heart disease or suffering from a stroke.

We look forward to speaking with you for review and discussing any issues of concern at that time.
This phone appointment will include looking at your current medication and health.

ST TRIDUANA'S
MEDICAL PRACTICE
54 MOIRA PARK, EDINBURGH, EH7 6RU
TEL 0131 657 3341 WWW.STTRIDUANAS.CO.UK FAX 0131 669 6055

System Date Long

Name
Patient Address Stacked

Dear – *Title Surname*
Thank you for attending the surgery prior to your annual review. Your results are detailed in this letter. We hope this information will help you to decide what is important to you and support you in managing your long term health.
You may wish to consider what you want discuss with our practice nurse before the telephone appointment on:
Appointment Date at Appointment Time

Some things that people ask about include – circle any that are important to you:

LIFESTYLE	MENTAL HEALTH	HEALTH CONCERNS	SOCIAL
Giving up smoking	eeling down or stressed	Medication	Work and employment
Alcohol	Sleep issues	Concern of new symptoms	Driving
thier eating or concerns about your weight	Loneliness or isolation	isk of future health problems	Benefits
Keeping active			

Your recent results for discussion at your review include:

Diabetes Control
Read Code Fields - 42W5
Hba1c is an overall measure of glucose control over the past 8-10 weeks. Good glucose control is between 48-58 mmol/mol, however you can discuss your individual target with the nurse at review.

Blood Pressure
Read Code Fields - 2469 /Read Code Fields - 246A
In diabetes, we aim for a blood pressure of135mmHg / 85mmHg but we also tailor this on an individual level depending on your age, medical conditions and other treatments.

Cholesterol
Read Code Fields - 44PJ
Keeping cholesterol less than 5mmol, lowers the chances of having heart attacks or strokes. We recommend a diet low in salt and saturated fat and high in fruit, vegetables and oily fish.

Smoking and Vaping
Read Code Fields - 137
Avoiding smoking has many health benefits. All sorts of tobacco can be harmful and stopping smoking has the most significant health benefit for you. Vaping is less harmful than smoking but not safe and not without risks.

Weight
Read Code Fields - 22K
The healthy weight for you depends on your height and this is assessed using Body Mass Index (BMI). Ideally being between 20-25 is a healthy weight.

Kidney function
We monitor your kidneys looking at the Albumin/Creatinine Ratio (ACR). ACR results are better if 2-5 in men, 3-5 in women. High levels may suggest the kidneys are working harder due to the diabetes. If high for the first time it is usually repeated on an early morning urine sample.

Date of last diabetic foot check: Read Code Fields - 66Ab
Your foot check detects if you have problems with circulation or the feeling (sensation) in your feet. We may suggest you attend a chiropodist depending on the results.

Date of last Diabetic eye check: Read Code Fields - 9N2f
Your annual eye check looks for any changes to tiny blood vessels at the back of your eye.

Drinking alcohol in safe limits (<14 units/week) and exercising regularly, ideally >30 minutes 3 times per week may also help reduce blood pressure and lower your risk of developing heart disease or suffering from a stroke.

We look forward to speaking to you for review and discussing any issues of concern at that time.
This phone appointment will include looking at your current medication and health.