The HOUSE Journal

Issue 17
July 2020

The newsletter for the Year of Care Community of Practice

Welcome to The HOUSE Journal

Lindsay Oliver, Year of Care National Director

COVID-19 has had a huge impact on people living with long term conditions. Whilst being considered at high risk they have simultaneously been cut off from healthcare and support networks. This has been challenging for everyone however great innovation and adaptability has surfaced.

What can we learn from this so we can better meet the needs of people living with long term conditions as we move into the post-pandemic 'new normal' and beyond? And how do we ensure that we don't lose the values and aims of care and support planning as we rush to embrace new approaches?

In this edition three frontline practitioners share their thoughts and ideas about kick starting routine care for people with long term conditions using the care and support planning approach with modifications to processes, resources and how we have the 'involving conversation'.

We held a webinar on the 28th of July on this topic. If you didn't join live please use this link to access the recording https://bit.ly/3hOQnAp.

Also take a look at our new resources on page 4 or access them at http://www.yearofcare.co.uk/remote-care-and-support-planning.

Graham Kramer - GP and Clinical Lead Scotland's House of Care Programme

The current model for providing care for people with long term conditions in UK general practice focuses on the Quality and Outcomes Framework. This is a chronic disease surveillance model, providing systematic checks and data collection to ensure adequate treatment of biomedical parameters and screening for complications of conditions/treatments. The model also has a health promotion function around lifestyle and risk factors.

- On the one hand this model puts practices in a good position to identify and respond to the pandemic 'at risk' groups in their practice population.
- On the other hand, it is a model that has fostered a passive role for patients and not necessarily equipped them with sufficient resources and resilience.

Care and support planning seeks to address this and so as we move forward perhaps the key requirements for any adaptations are that they are more enabling, and identify and respond to the priorities of individuals in a way that facilitates their solutions for self- management.

We need to ensure that elements of the process can be delivered remotely without diluting these aims, sacrificing relational care or leaving behind those that have less skills or access to technologies.

How can we deliver this type of care more remotely?
We can certainly empower people to embrace self-monitoring, self-reported functional status and some biometric measures. The preparation step will need to include an easy way to communicate home monitoring to healthcare professionals and perhaps it's also time to ask ourselves how many tests we really need. This is currently determined by clinical and financial incentives and more research is needed into the clinical and cost effectiveness of wider self-monitoring against practice-based monitoring.

The pandemic has allowed us to discover the acceptability of telephone or video consulting. However, we need to focus on how both the person and the clinician prepare for these encounters so they are as productive as possible and not a cold-calling experience. We must be mindful that these encounters are prone to communication pitfalls and that checking two-way understanding will be especially important. We must also be careful that conversations aren't more clinician-led, and that hidden or additional personal agendas are not suppressed. Developing and teaching remote consultation models and skills will need to gain prominence on GP and nurse training curricula.

Being 'hands-off' and enabling people to have more control can sometimes worry clinicians. They fear that relaxing surveillance and "taking their eye off the ball" may lead to deteriorating outcomes. We don't have evidence of this and, in contrast, people who are 'allowed' to be more engaged are better able to look after themselves and safeguard their own clinical outcomes. However, now is an opportunity not just to enable patients and their carers to be part of their own team, but also to maximise our strong collaboration and communication with the wider teams who also support them. Strengthening interfaces between community care, secondary care and third sector has never been more important.

Finally, to ensure we reach those most at risk of exclusion we need a relentless focus on addressing health and digital literacies whilst broadening access to technologies. This must not be a one-way mechanism for professionals to turn people into expert managers of the technical aspects of conditions and communication. Rather it must make it easier for our patients to communicate their needs to us. We will be moving into a changed and unknown socio-economic landscape. It will be us healthcare professionals who will need to listen to the stories of our patients so that we learn and understand what matters to them. This will be the most meaningful 'data' that we need to gather.

Care and support planning for people with long term conditions during COVID-19 at Glenpark Medical Practice

Glenpark Medical Practice has been delivering care and support planning (CSP) for people with long term conditions for 5-6 years. During the first chaotic weeks of the pandemic, we phoned everyone who was due to have CSP imminently to check they were happy to postpone, and to reinforce that they could contact us with any problems. This brought home how many people attend each month for CSP and how hard it would be to try and catch up later in the year.

So, we decided to begin planned remote CSP in April and worked with Year of Care to adapt our existing processes and paperwork. Our principle aims were to reduce face to face appointments and only defer patients who would be getting another planned appointment in 4-6 months anyway to avoid a pile up of deferred work.

Triage, prioritisation and preparation

Our nurse practitioner, Amelia Kerr, started triaging by looking at conditions, previous results, medication etc. to decide who needed face to face information gathering. Once this was decided we sent a letter explaining that we were not offering face to face information gathering to the majority of people but instead shared an agenda setting prompt with a place for reflection about what was important to the person and things they may wish to talk about.

CSP conversations

We decided that all CSP conversations would be offered via telephone or video, except for people who had hearing difficulties, or had dementia or learning disabilities, where individual decisions were made.

Some people declined a face to face information gathering appointment and some people asked if they could still come so we were flexible about this. The majority of CSP conversations were with our nurse practitioner. The appointments were for a minimum of 20 minutes and were pre-booked rather than a 'cold call'.

Most conversations were by telephone but could be converted to video on request or to support practical help with inhaler or injection technique. We used text messaging to send action plans and information leaflets. If anyone felt uncomfortable using the telephone we saw people face to face using PPE either in the surgery or in their homes to avoid disadvantaging those who struggle with or don't have access to technology.

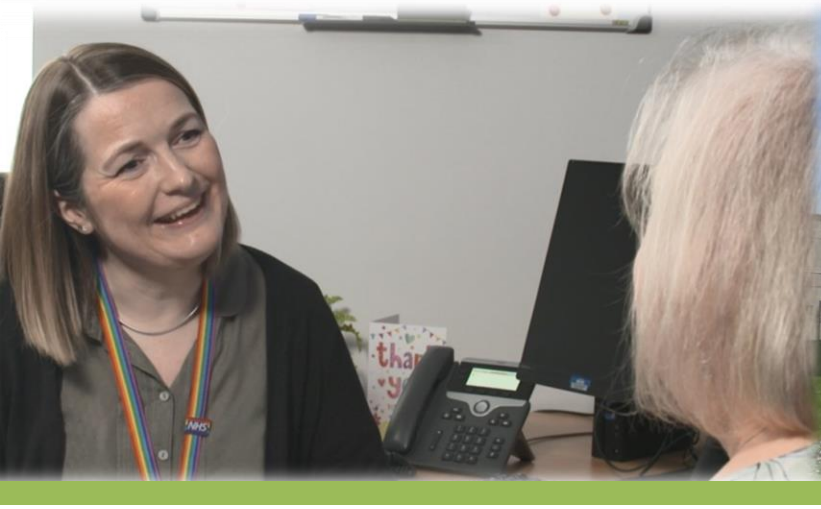
Consulting using the telephone feels very different. We've found it really important to check that the person is aware we have at least 20 minutes to talk and check that they have their preparation paperwork and a pen to hand. We feel that as health care professionals we have worked harder to ensure we are being person centred and really listening and focusing on what is important to the person. In the first few weeks, there were lots of concerns and questions about COVID-19 which made the conversations longer, but often this lead to discussions about advance care planning.

Looking to the future

We are still learning and adapting, and our triage process is changing as lockdown eases and more staff become available for face to face appointments. I asked our nurse practitioner, Amelia Kerr, for her thoughts on remote CSP:

"Be flexible, willing to adapt and respectful of what the patients feel comfortable with, not just what WE want to happen with reviews. Remember many people feel afraid at the moment. It's tiring work but very worthwhile - patients appreciate the contact, feel that we care about them and have continued to reach out despite the crisis".

Becky Haines
GP, Gateshead Clinical Lead for Diabetes, GP Clinical Lead and Advisor Year of Care Partnerships, RCGP Champion for Person Centred Care



Care and Support Planning for people with long term conditions during COVID-19 at Burnbrae Medical Practice

Care and support planning (CSP) before lockdown

I've been delivering the Scottish House of Care version of care and support planning for around 3 years and most recently introduced this at Burnbrae Medical Practice. At first recall was organised around birthday month and the patient phoned to arrange the information gathering appointment with the nurse. Following this the test results were checked by a clinician and preparation materials including results sent out to the person with long term conditions prior to the CSP conversation.

House of Care CSP review process April and May 2020

All long term condition face to face reviews were suspended in April and May 20. Following online and in-house training in telephone consultations the nurse practitioner (NP) and practice nurse (PN) contacted patients to do telephone reviews which included anticipatory care planning for those at very high risk from COVID-19 (including understanding of shielding guidance, preferred place of care, wishes around resuscitation and education around sick day rules).

June 2020 onwards

A new invitation letter was developed with prompts to provide basic information and questionnaires to complete and return to the practice. The NP did information gathering over the phone and arranged for clinically relevant tests in the practice. A clinician checked results, the preparation prompt was sent one week later and the NP phoned to have the CSP conversation. Burnbrae did encounter some issues such as letters being delayed and people not answering the call from a withheld number. There was also an increase in visits to the health centre as people returned documents making social distancing challenging.

Mid-June 2020 onwards

To enhance the process we added the step of a member of the admin team phoning patients a week after the invitation letter was sent, to remind them that the nurse would be ringing in 2-3 days for information gathering, and advise if a face to face appointment was needed.

Following this the CSP conversation with the NP was done by telephone or video dependant on patient preference. There was 75% engagement with this process at the end of June with no patient requests for video consultation.

Additional enhancements for the care and support planning review process moving forwards

Preparing for the change in process

Patients are prepared for the adapted process now using the administration team who can offer more detail about the process, along with notices on our website and Facebook page. Engagement following this change has been better at 75% - it was usually around 60-65% pre COVID-19. The invitation letter has been re-designed to include appropriate use of questionnaires, including exploring frailty, medication, mood and general health. The letter also includes a note about the CSP call coming from a withheld number to ensure people answer and a request not to hand data in at the surgery.

Data gathering

We encourage self-reporting of weight and blood pressure. This is not ideal but it encourages people to take ownership of their own measurements. Some use their own blood pressure monitors in conjunction with telemedicine and there is support to do this via our local pharmacist. Most people are happy to complete relevant questionnaires remotely, or with support from our nurses.

Conversations

The practice team is building up their confidence in telephone consultations as it becomes the new 'normal'. Having a clear plan for the CSP process has helped the patients but it's still important to 'set the scene' at the beginning of each conversation. We use Near Me and have found that patients don't seem to be keen on video consultations although often like sharing photographs. Moving forward we plan to leave it up to patients to choose which option they prefer.

The future

We are planning on continuing with 'remote' CSP for the rest of the year given the uncertainty over winter pressures, capacity and possible second wave of COVID-19. Hopefully we can work with the NHS Treatment Room service for support with phlebotomy, urine testing, foot screening and blood pressure where needed so that information to aid decision making is available for both the patient and practitioner.

Sue Arnott

GP Principal, Burnbrae Medical Practice, Shotts Lead Clinician NHS Lanarkshire LTC Hub

The **HOUSE** Journal

New remote CSP resource pack

Section 1 - Introduction to remote CSP options
In this section we have a summary that details Year of Care's learning from around the community of practice during the COVID-19 pandemic. We have a flowchart that walks through the CSP process from triage to the conversation, and suggests adaptations for remote options.

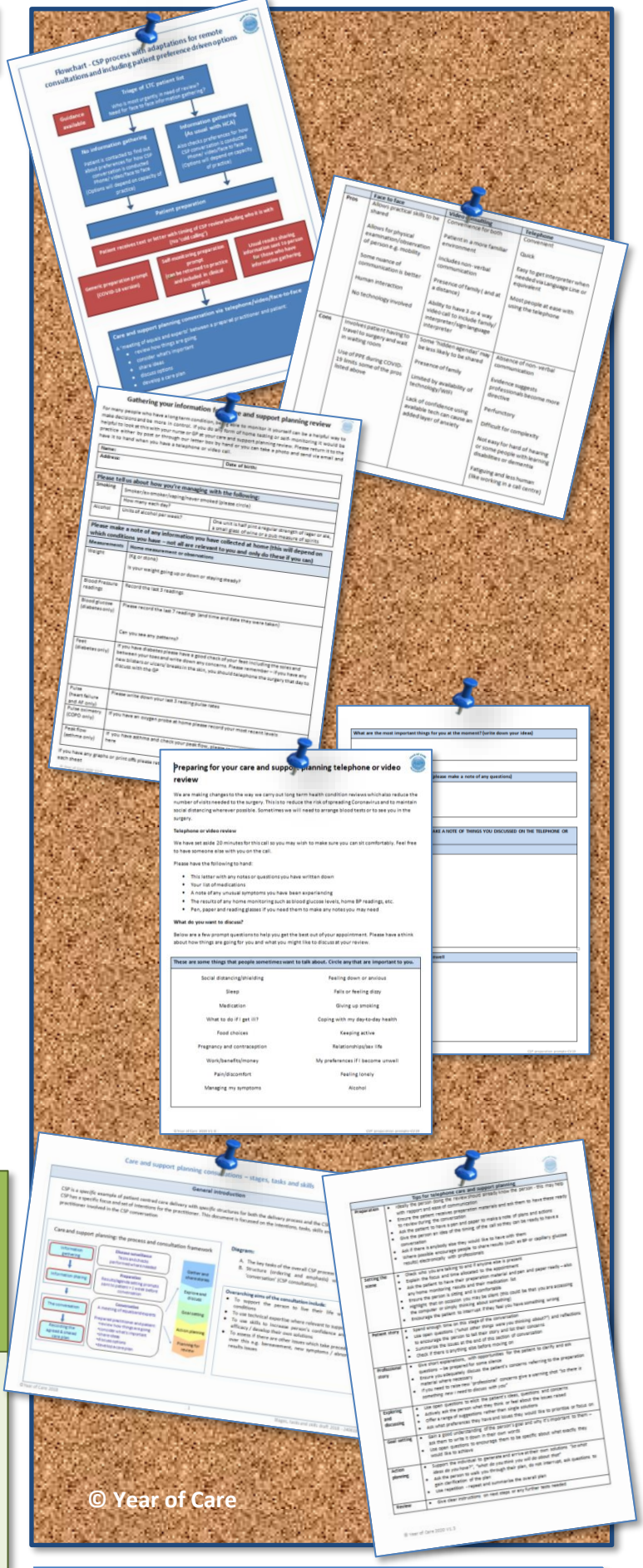
Section 2 - Prioritisation and recall options
This section contains a suggested guide for practices when triaging for multimorbidity reviews during the COVID-19 pandemic. It also lists the various pros and cons to consider for remote and face to face CSP.

Section 3 - Information gathering
We suggest some considerations for practices when planning information gathering appointments with an alternative to face to face reviews for those who still need to shield. We also developed a resource to allow people to collate their own self-monitoring results to have to hand for their CSP conversation.

Section 4 - Patient preparation for remote CSP
Some people may not need to have a formal information gathering appointment however preparation for their conversation is still just as important. We have included a resource to help people consider what's most important to them and things they'd most like to discuss which has been updated following feedback from the community of practice.

Section 5 - CSP conversations
This section has resources for healthcare professionals to support thinking through CSP conversations either over the phone or via video. There's a new document on stages, tasks and skills of the CSP conversation and some top tips documents for conversations held over the telephone or video.

Access the resources here:
www.yearofcare.co.uk/remote-care-and-support-planning



How has your practice adapted to offer remote care and support planning?

It has been incredible to hear about the hard work and determination from general practice to continue to support their population and also the speed at which new solutions have been successfully introduced.

It would be great to hear about adaptations practices delivering CSP have made to continue to support people during the coronavirus pandemic and how practices are planning to support people using remote technology.

Please contact us at enquiries@yearofcare.co.uk to share your story.

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