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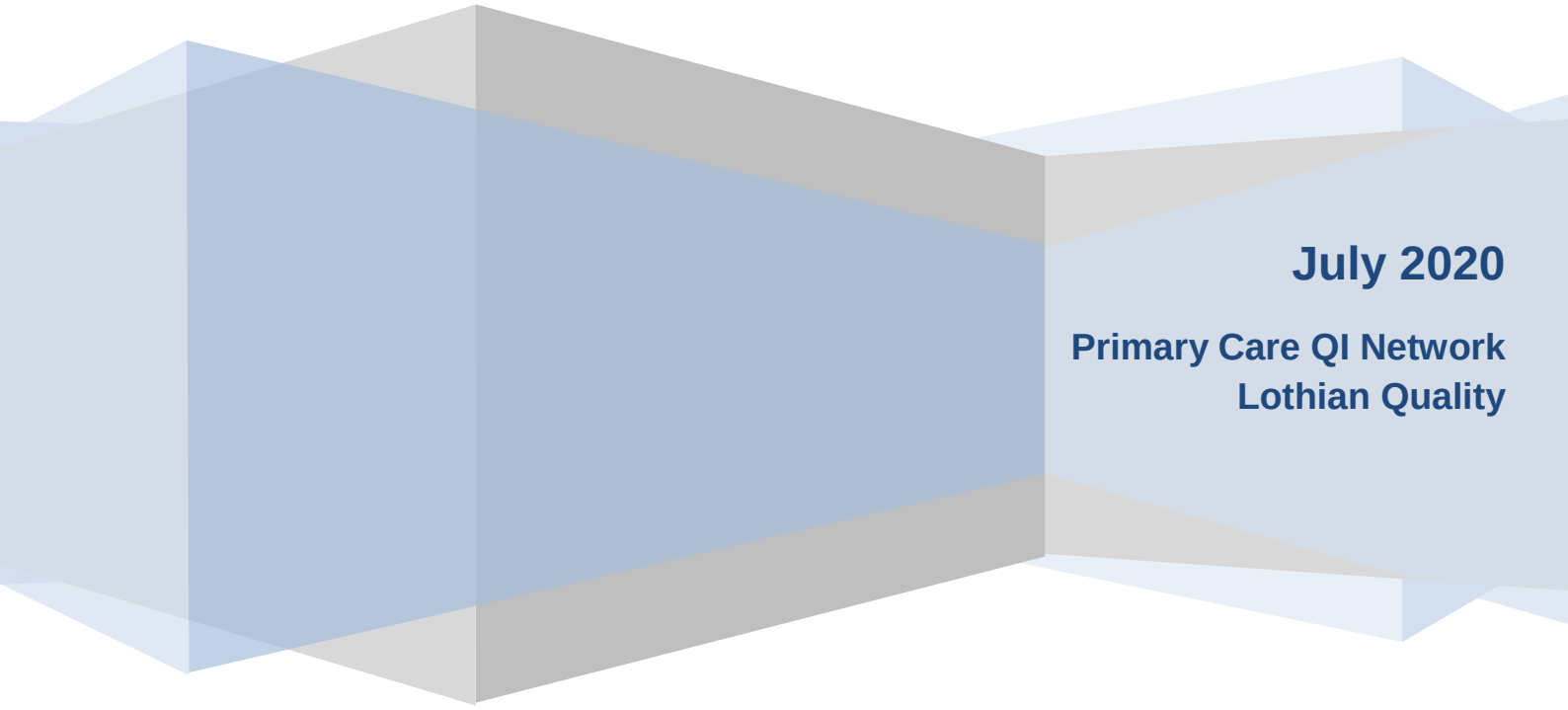
NHS Lothian

Rethinking Primary Care Chronic Disease Management in NHS Lothian after the COVID-19 Pandemic

The Quality Planning Perspective

EXECUTIVE SUMMARY



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Primary Care QI Network
Lothian Quality

1. Remit

"The Chairs Group were hoping....that this is a piece of work that CQLs could take forward in terms of devising and sharing plans, backed by robust clinical evidence and guidelines, on how we take CDM forward." [Lothian GP sub-committee member]

The GP sub-committee has requested guidance around 'Realistic Chronic Disease Management that is proportionate and pragmatic during the COVID era'. There is a very real sense of urgency about wider Chronic Disease Management (CDM) remobilisation and pathway re-design which requires a detailed Quality Planning perspective.

Core objectives:

- A pan Lothian approach to avoid individual practices needing to 're-invent the wheel'
- Development of a proportional and pragmatic approach to match current capacity
- Acknowledgement of the need for collaborative interface working
- Alignment with parallel work streams such as Community Treatment and Care (CTAC) clinics
- Facilitation of early tests of change to get some changes implemented before a potential Autumn second wave

1.1. The need for a quality planning approach

Developing changes that result in positive improvement and impact require careful planning. This needs to be supported by:

- data which helps us understand normal and abnormal variation
- understanding and appreciation of current systems and processes which might be amenable to improvements
- evidence and expert knowledge which can inform the adaptation of known good ideas
- creative thinking to generate new ideas, and
- acknowledging and using human psychology to overcome barriers and optimise our change efforts.

Careful quality planning facilitates a broad understanding of the issue which needs improvement or re-design, as well as its context, to allow us to develop improvement aims and a 'theory of change'. This needs to be underpinned by co-production and co-design with both staff and patients. Once change ideas are identified they should be explored further and tested iteratively (quality improvement), and success confirmed/monitored by measurement (quality assurance).

"Each practice has the greatest insight into their own local circumstances and practice recourses, but ... how [could] those resources could be deployed and where it may be best to focus those resources that each practice has? Our hope would be that... a consistent message coming from all practices could make a change in how we work of higher quality, safer and more readily accepted by our patients." [HSCP GP Lead]

1.2. Scope and exclusions

This quality planning report will examine the data, available evidence and disease guidelines, current systems and patient, staff and other stakeholder experience and opinion, to seek opportunities for change and improvement.

It will draw conclusions and make generic recommendations on directions of travel, identifying areas that will need further exploration, consensus agreement and further testing.

The report will not, however, make specific detailed disease-related monitoring and management change recommendations as these require detailed discussion and agreement with local experts. But it will bring together useful resources and potential protocols that have been used elsewhere for consideration.

1.3. Risks

There are risks when change (expert novel 'guidance' or pragmatic suggestions for new processes and clinical pathways) has not been agreed with relevant stakeholders and is implemented without adequate or robust testing in context. This may result in ineffective, or even harmful, change or widening of health inequalities.

Cluster Quality Leads (CQL) need to be empowered to lead and coordinate testing, and share their learning across Lothian to ensure consistency and prevent duplication of efforts in developing new ways of working for chronic disease management.

Inadequate further planning and securement of necessary financial, staffing and IT infrastructure resource, as well lack of project management or improvement advisor support, will create further strain on primary care services, and potentially lead to failure.

The Primary Care QI Network team does not have the capacity to lead or manage CDM improvement work, but will endeavour to provide improvement support to Practices and Clusters where needed as per current arrangements.

1.4. Further support

An Improvement breakthrough series collaborative approach[1] may be a suitable way to coordinate learning in a focussed and consistent way, and provide Clusters with QI support.

[1] *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement.* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org)

5. Conclusions and recommendations

5.1 The locally implemented COVID-19 'pause' has presented a unique opportunity to re-evaluate the delivery of Chronic Disease Management (CDM) in NHS Lothian, and prepare us for remobilisation.

5.2 Social distancing requirements for the ongoing control of COVID-19 are likely to be in place for the foreseeable future with consequent restricted capacity, and which necessitates new remote ways of working and CDM delivery.

5.3 In April 2020, immediately after the COVID-19 'pause' was initiated, approximately 75% fewer CDM monitoring tests were performed in primary care. There is world-wide evidence that such disruption of care can potentially contribute to adverse health outcomes, so remobilisation of CDM is urgent.

5.4 There is risk that practices will revert to pre-COVID CDM arrangements following the outdated QOF format. Such generic 'one size fits all' recall and management is no longer fit for purpose as it does not always deliver person-centred or value-added care.

5.5 Across the four HSCPs in NHS Lothian 80% of chronic disease is due to, in decreasing order, Hypertension (HTN), Asthma, Diabetes, Coronary Heart Disease (CHD) and Chronic Kidney Disease (CKD). Chronic Obstructive Pulmonary Disease (COPD) and Stroke both fall just outside the critical 80% where improvements will have most impact.

5.6 There are key opportunities across all disease areas including:

- Remote self-measurement where appropriate
- Telemonitoring
- CTAC for essential face-to-face physiological measurements & investigations, only where remote alternative is not available or accessible
- On-line self-management materials & education as the default
- Telemedicine apps
- Use of the New Contract primary care improvement plan HSCP-employed multidisciplinary professionals

5.7 In addition, review of national Guidelines and the established evidence-base also provides a plethora of individual potential change ideas (see full report) with the objectives of:

a) Maintaining stable or improving disease outcomes

b) Reducing unnecessary face to face (F2F) contacts for monitoring investigations or CDM reviews to minimise risk of virus spread

c) Reducing primary care 'amber' workload for chronic conditions because of capacity restrictions due to social distancing and physical environment, and to maintain capacity for acute response to further surges in the ongoing pandemic.

5.8 However, it is critical to acknowledge that most of these approaches are based on expert consensus opinion only, or limited local tests of change, and may have not been formally evaluated. Patient outcomes and balancing measures are not yet known due to the emerging nature of the pandemic.

5.9 In particular, there is very limited outcome data anywhere for local tests of change already happening around pragmatic attempts at disease-specific risk stratification and prioritisation of recall, with consequent considerable risk of unknown potential harms and widening health inequalities if scaled and spread without further testing.

5.10 Any new change in patient monitoring should all be considered in the context of multi-morbidity and as a broader opportunity of co-ordinating care to reduce duplication and unnecessary patient F2F interactions.

5.11 Multi-morbidity is the norm for the majority of patients and can present significant clinical challenges as guidelines are focused on specific individual conditions and may not be applicable to people with multiple chronic conditions. The recommended approach to care for this population specifically focuses on shared decision making and prioritisation of goals.

5.12 Increasing frailty also compounds the challenge of multi-morbidity and requires a Realistic Medicine approach to ensure both person-centred and value-added care.

5.13 Wider organisational transformation, such as Modernising Out-Patients, also present opportunities to reconsider how we optimise re-design CDM delivery using new models of care across the wider system.

5.14 CDM **recall** is a complex task which needs to be undertaken at Practice level by clinicians who know patients best:

- Recall previously run by admin staff will now need clinical input to ensure it is:
  - Individualised (considering risk, polypharmacy, disease control, capacity for self-management)
  - Coordinated in a single multi-morbid annual review (rather than multiple disease-specific appointments)
  - Person-centred (what matters most to people, with a shared understanding of what healthcare might realistically contribute to this)
  - Realistic (value-based)
  - Potentially prioritised to where subsequent monitoring and management are likely to have greatest impact (‘middle of the curve’), although this remains highly controversial amongst experts and patient groups.
- There are various disease-specific models for risk stratification (e.g. ABCD diabetes, NICE CKD, NICE Asthma questionnaire) based on expert consensus opinion which could be utilised to identify priority groups for recall & catch-up, but any approach risks missing certain groups with consequent potential harm, and therefore if considered for local adoption would need to agreed with Lothian MCNs and interface groups.
- Similarly, any local adoption of reduced blood test monitoring would need to be debated and agreed with the Laboratories Interface Group (PLIG).
- Detailed discussion & agreement with these Stakeholder groups has been out with the remit and timescale of this planning report.

5.15 CDM **monitoring** is a technical data collection task which could be delegated to HSCP-resourced Community Treatment and Care (CTAC) hubs:

- Will be dependent on clear specific individualised monitoring plans being in place for each patient, documented in a structured and consistent format which is compatible with the IT system being used, to ensure only/all appropriate tests and measurements are undertaken (a local template/process will need to be developed).
- Should be replaced by home monitoring systems for those patients with access to the necessary equipment e.g. automated BP machines for home-monitoring of hypertension
- The use of Telemonitoring (e.g. Florence BP) is an exciting and transformational approach, but it is vital to consider the patient population. This should be provided as an option rather than as the only choice, as although digital options tend to save time for both patients and practices, they can widen health inequalities due to poor access to the internet.
- Hypertension-based remote interventions have the greatest potential to reduce workload impact across all of primary care because of high disease prevalence.
- There may be some disease-specific opportunities for reduced or blood monitoring which need further exploration (see full report).
- Where a blood test is not required, or wanted after discussion of risks and benefits, then arrangements should be made where appropriate to minimise the need for F2F appointments, e.g. urine ACR by post, self-reported weight, home peak flows.
- There may be some opportunities for increased skill mix of Healthcare Assistants (HCAs) and reallocation of traditional Nursing tasks after appropriate training (e.g. diabetic foot checks).
- Where secondary care require chronic disease monitoring needs to be performed remotely then proportionate and realistic transfer of out-patient redesign resources will need to be transferred to HSCP budgets to create necessary capacity. This approach will also be dependent on the implementation of necessary laboratory order-comms so that secondary care colleagues receive their own results for their own patients, under their own governance arrangements.
- Due consideration also needs to be given to the engagement of patients who are clinically deemed to be high priority but who default because of ongoing COVID fears and shielding requirements.

5.16 CDM **management** is a clinical task; content & need will be dictated by the results of monitoring tests and previous engagement:

- Lifestyle and self-management advice & education, delivered through written and on-line audiovisual materials, should be the default with interactive clinician-patient reviews reserved for those with greatest potential gain from intervention.
- While social distancing measures remain in place, the default arrangement for any necessary management review or intervention discussions should be remote (via telephone or video NHSNearMe). Adequate supply of IT hardware (webcams, ear phones, 2nd screens) for practices needs to be prioritised as this may currently be a limiting factor.
- However, patients should be allowed reasonable choice, and F2F appointments (including home visits) still offered to those patients who need them or cannot access digital equivalents. Longer appointments will be required for PPE change and cleaning, and this will impact on capacity.
- Multiple disease-specific evidenced-based improvements may also be able to be made to improve clinical outcomes (see full report).

- Professional skill mix should optimised, particularly the use of practice-based Pharmacists where patients only require medication reviews or interventions (e.g. BP optimisation), but may also offer the opportunity for level 3 pharmacotherapy and specialist clinics (e.g. diabetes, heart failure); this may need HSCP resource prioritisation.
- Patients could be given access to their medical data (including test results & treatment advice) through appropriate NHSScotland-approved interactive self-management support and education sites/apps such as MyDiabetesMyWay, or commercial apps such as inhealthcare®. Any such new modalities will need recurring resource, infrastructure and governance secured by HSCPs or NHS Lothian.

5.17. With new proposals to move towards digital modalities, there is a real risk that the health inequalities gap between those who are connected and those who are not, will continue to widen. Alternative non-digital alternatives therefore need to built into new pathways for those that need them.

5.18. COVID-19 disproportionately affects BAME people, and co-existent obesity and T2 diabetes increases this risk further. Inadvertently reducing the frequency or accessibility of their chronic disease monitoring and management may further exacerbate their risk. We need to pay attention, acknowledge, and plan to mitigate these inequalities and associated risks as much as possible, by designing inclusive new CDM pathways and using an Integrated Impact Assessments.

5.19. Patients with chronic diseases are likely to have concerns about their health, their disease and their care. Patients with chronic diseases are not a homogenous group, with variation in their responses. A patient co-production approach to any re-design is strongly advocated.

5.20. There are also a large number of stakeholder groups likely to be impacted by changes in CDM who need to be consulted regarding any new proposed changes to CDM pathways.

5.21. COVID-19 was seen by the stakeholders as an opportunity for improvement that needed to be best utilised, with the idea of a “reboot” resonating with many of our participants. Disadvantages need to be considered and mitigated rather than stop change from occurring. The appetite for, and the potential benefits from change, indicate a ready environment to begin making changes.

5.22. The quality planning approach to CDM re-design has brought together a wealth of evidence, data, stakeholder opinion, patient experience and change ideas, but this is really only the tip of a very complex iceberg. Further analysis and prioritisation will be required by the primary care organisations who decide to move forward with this work.

5.23. Accountability for any decisions made regarding new recall pathways, monitoring requirements or care management models belongs to the primary care organisations or HSCPs leading this work.

5.24. Individual change ideas and new pathways will need to be rigorously tested at Cluster level before spread and scale to the whole of Lothian, and supported by measurement plans which include attention to balancing measures and patient experience, to mitigate potential risks.

5.25. CQL leadership and coordination will be pivotal to success, and an Improvement breakthrough series collaborative approach is suitable way to coordinate learning in a focussed way.

6. Driver Diagram