Chronic Condition Recall- routine invitation

The background (idea germinating pre-pandemic c 2019):

1. Inefficient and frustrating for patients to be booked into multiple appointments, or speaking with clinicians without all useful information available;
2. Default booking option is GP – significant demand on GP resource
3. New PCN/other staff, changing frequently, hard to embed new staff members who could potentially review patients.

Aims:

1. Move to "Year of Care" type model, where patients attend for 2 appointments, first with HCA to collect appropriate information (when needed), then with appropriate clinician to review all chronic conditions and set up further follow up if needed.
2. Automate invites for this as far as possible using batch messaging and coding
3. Book patients in for appropriate appointments for the chronic condition review needs. This would include: booked with appropriate clinicians, ensuring sufficient time for outstanding investigations and reviews. If not attended/coded as reviews done- review system to generate appropriate 2nd invites
4. NB – this does not do:
    a. follow up reviews for BP/HbA1c- need separate system for this
    b. deliberately does not invite housebound, care home, LD or dementia patients as these not appropriate for SMS invite (automatically excluded by Arden's)
    c. CKD, rheumatoid arthritis, epilepsy, PAD not included as QOF doesn't specify annual review

The pitch/results:

- Saved clinician QOF time/rush by 75-90%
- Saved c1 GP session/week (previous heavy use of GPs for chronic disease review)
- Save reception 3-5mins per booking of chronic disease reviews, improve booking accuracy, easy to use.
- HCAs mostly finding that appropriate patients booked in.
- Patient satisfaction improved due to appropriate length of appointment and proactive invites. More complex patients have sufficient time with GPs as default
- Better use of wider practice team. Asthma, COPD, Hypertension reviews booked with pharmacy team by default; Diabetes reviews with nurse by default. Previously all done by GPs.
- Minimal/no additional cost- uses resources we already have
- Have updated/changed based on feedback as wasn't perfect first time, but adapted (and continue to adapt) successfully.

Components:

1. Arden's recall- use Ardens Long Term Condition Recall system (no need to develop searches)
2. AccuRx batch invite/letters
3. EMIS batch coding
4. Arden's multi-morbidity templates (no need to develop/maintain templates)
5. EMIS appointment book set up to give space chronic disease, and time for doubles if needed
6. F12 protocol to allow reception staff to know which appointments v quickly

In practice:

1. Send out batch invites asking patients to call practice
2. Patient contacts practice, stating they have been invited to do so
3. Reception launches EMIS protocol, this looks at patient's conditions, reviews outstanding and (for certain conditions) whether bloods/other information needed. Takes 3 seconds per patient.
4. EMIS tells receptionist how long to book appointments for and with which clinician
5. Patients booked for these appointment(s) – 2 if bloods/BP etc needed, 1 if just need clinician review
6. Hopefully, patient attends.
7. If not, or not coded appropriately, manual review of notes, keep list of patients who need 2nd invite. Batch invite and code second invite.

Cautions/Drawbacks:

1. On inititation need someone relatively IT literate to tweak due to inevitable teething issues
2. Needs annual maintenance re searches
3. Have been errors with invites/coding with admin team needing to be careful with batch messages and batch coding.
4. Coding, coding, coding. Avoiding 2nd invite requires good coding in templates that all annual disease reviews carried out. Often not done. Need to train well whoever is reviewing who needs 2nd invite.

To develop something similar:

1. Agree:
    a. Agree this is how you would like chronic disease reviews done with year of care reveiew- check all on board across practice: reception, admin, HCAs, nurses, PAs, pharmacists, GPs- is a whole team approach.
    This is a system that aims to:
        i. Save time for clinicians/patients and fit in with holistic care planning
        ii. Reducing missed opportunities for information gathering and reviews when in surgery and giving adequate time length for this
        iii. Using appropriate clinicians trained in review of specific conditions
        iv. Worth reading Ardens info re system and multi-morbidity templates

        v. Save time for reception /admin
    b. Agree who will review what, how much time needed for each review. Overleaf for how we do this at LHGP.
    c. Identify who will lead- needs quite a bit of time/energy to have discussions, check progress and review.

2. Implement:
    a. Develop AccuRx and letter templates
    b. Tweak/develop F12 protocol and train reception team to use (with principles) – this is based on which clinician will see which patient and for how long. Need someone who understands EMIS concepts and protocols to do this.
    c. Once above agreed, ensure space in EMIS appointment book so that timely review can be done with appropriate clinician once initial data gathering done
    d. Train clinicians to use Arden's templates:
        i. Multi-morbidity initial consultation for data gathering
        ii. Multi-morbidity annual review for annual review

3. Review:
    a. With staff/patients, how getting on. ?further training needed, e.g. re coding, using protocol
    b. Annually- some of the F12 components need updating with beginning of QOF year.
    c. Audit- annual review appointments, especially if using new staff members to conduct these reviews.

Next steps for us

- Identify further integrations for making each appt count- e.g. diary recall bloods due
- Consider how fits in with invites for BP/Hba1c when have been above target

Lavender Hill – Chronic Disease Setup – who reviews which pt?

If PACT/LD/care home/dementia/housebound- diverted away, with note to discuss with regular clinician re when to review and for how long.

For information gathering:

- None if none needed, e.g. only has asthma
- 10min HCA if bloods OR physical measurements (but not both)
- 20min HCA if bloods AND physical measurement (but not full diabetes review due)
- 30min HCA if diabetes review

NB- Physical measurements:

- BP if SMI/LD or have cardiovascular or metabolic disease and not done this QOF year or last BP out of range (out of range defined in line with QOF guidelines for BP, diabetes, frailty etc)
- Bloods if SMI/LD or have cardiovascular or metabolic disease and not done this QOF year or last HbA1c out of range/due do CKD. HbA1c out of range defined by frailty target.
- Foot check if not yet done this QOF year

For chronic disease review appointment- aim 2 weeks after info gathering:

Nurse lead for diabetes:	See any patient with diabetes (with or without hypertension) but with no other chronic diseases. 30mins for annual review. See any patient with non-diabetes hyperglycaemia (with or without hypertension) but with no other chronic diseases. 15 min for annual review.
Pharmacists:	See any patient with any combination of asthma, COPD and/or cardiovascular disease (including AF, CCF, CAD, Hypertension, Stroke, TIA) 15 mins if respiratory conditions only 15 mins if cardiovascular conditions only 30 mins if both respiratory condition and cardiovascular condition
GP:	See everyone else. 10 mins if one condition and not LD/SMI/dementia (NB cardiovascular conditions lumped together as if “one” condition as annual review so similar) 20 mins if >1 condition and not LD/SMI/dementia (NB cardiovascular conditions lumped together as if “one” condition as annual review so similar) Treat LD/SMI/dementia separately- if only one of these and no other chronic condition, 20 min GP appointment. If LD/SMI/dementia and another condition- 30min GP appointment.

Next steps

- Consider including Primary Care Plus so that they review SMI if no other chronic conditions
- How to fit in other additional roles, e.g. PA, paramedic

IT Heavy lifting- the part practices not sure about/need in house expertise: F12 protocol

Is key otherwise reception spend too long/find too hard to work out who to book for what. When tried without this (year 1 c 2020, didn't work).

Simple terms- black box. Reception launch protocol, this checks what conditions patient has, reviews had this QOF year and information gathering outstanding. Gives 1 answer c 3 seconds later that states which appointments needed.

Essentially identifies one of c. 48 scenarios (4 potential HCA appointment lengths, 12 potential different follow up options after).

This is based on multiple concepts built from ground up (c10h work, already saved this QOF year).

1. E.g. 1 concept would be "last systolic BP", another would be "does this patient have diabetes", etc.
2. Then a concept can be based on other concepts and built for a patient to identify target systolic blood pressure. This would be built up from any recent coded target in EMIS, frailty, chronic conditions they have.
3. You then build a concept that tests whether the latest blood pressure concept value was above or below the target systolic blood pressure concept value.
4. You then do the same for diastolic blood pressure and build a concept to check that both systolic and diastolic blood pressures are recent and below target blood pressure.
5. You then repeat this for all other measurements and potential chronic disease annual reviews that are needed (!)
6. You then work can build concepts based on annual reviews needed and measurements outstanding that matches the way of working you want in practice (probably 30-50 concepts total, lots of them already built into EMIS for the protocols EMIS already uses).
7. Doesn't take as long as you'd think, just quite tedious initially.

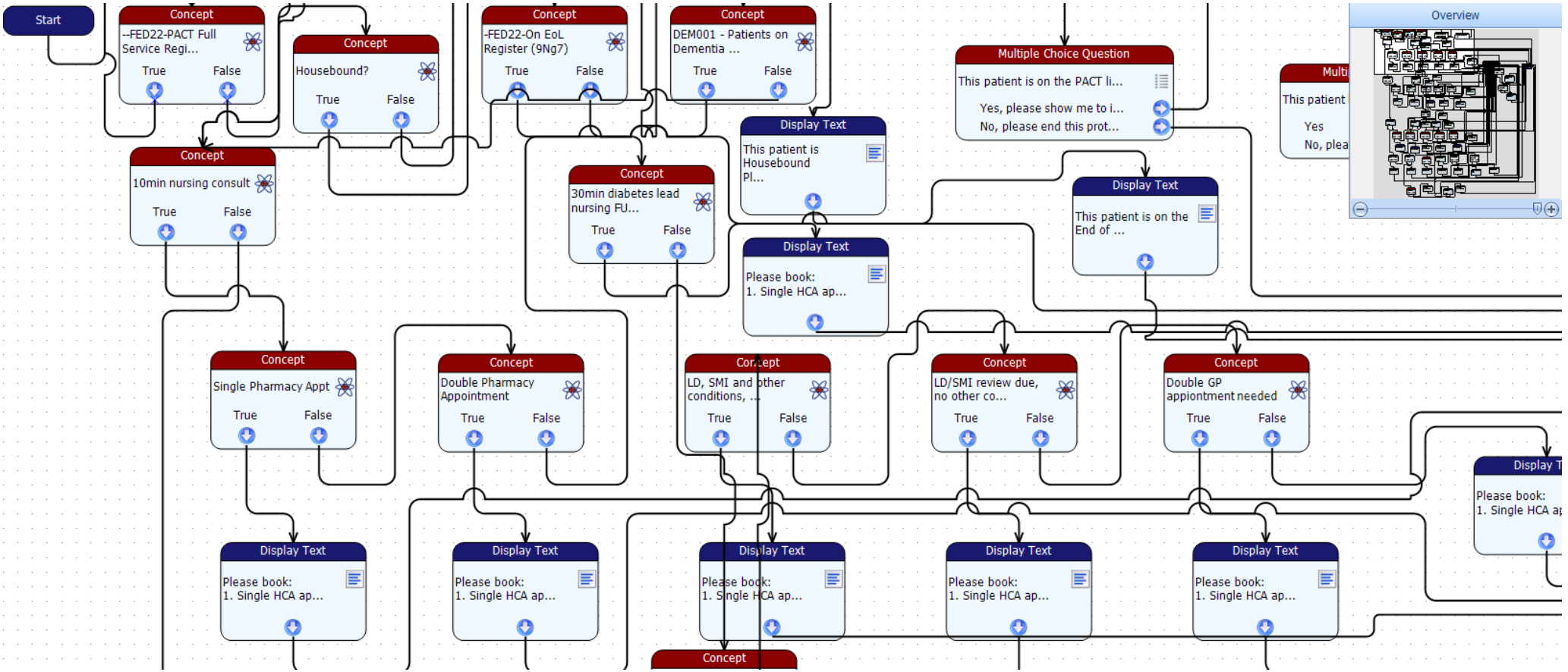
Once concepts built, you build the flow diagram in the protocol. This is a decision tree that basically says – check this concept first, then this one, etc.

E.g. the first thing the protocol I've built checks is the "housebound" concept, that looks to check whether the latest housebound code in the patient notes is corresponds to housebound. If this is true, then it shows up a text box saying this and asking the user to discuss with regular GP. If false, then it continues checking other concepts.

This gives (eventually) the c 48 different options that I mentioned before. These each ping a text box corresponding to those concepts- e.g. "10 min HCA appt, 2w later 30min pharmacy appt".

How to develop this? Don't bother unless you sold on the idea. The politics behind who does what takes time and is important. But if enough will to get it done, start identifying early who could build these concepts (happy to share mine so not entirely from scratch), who could build and edit the protocol.

The protocol in some of it's glory:



This patient is on the PACT list, please don't book their appointments but ask Sahar to do so (or liaise with their usual GP if it is more urgent).

Would you like to see which chronic disease appointments they need?

- Yes, please show me to inform what appointments they might need
- No, please end this protocol

Display Text

Please book:
1. Single HCA appointment (the patient is either due a BP check, foot check or blood check but not more than 1 of these). If patient declines HCA, please book single nursing appointment.
2. Single appointment with GP at least 1 week later (so results available). Face to face or telephone, as the patient prefers. Please book longer if there are known communication difficulties.

OK

Display Text

Please book:
1. 30 minute (triple) HCA appointment (this patient either needs their annual diabetes review, annual learning disability review or annual mental health review including bloods). If they decline a HCA, please book a 30min (double) nursing appointment.

2. 30minute appointment with Nurse Sam Norton at least 1 week later as this patient has diabetes. Preferably face to face. If they would prefer, please book a single appointment with a GP, face to face or phone as the patient prefers. Please give more time if there is a known communication issue.

OK