

Facilitating the management of long term conditions

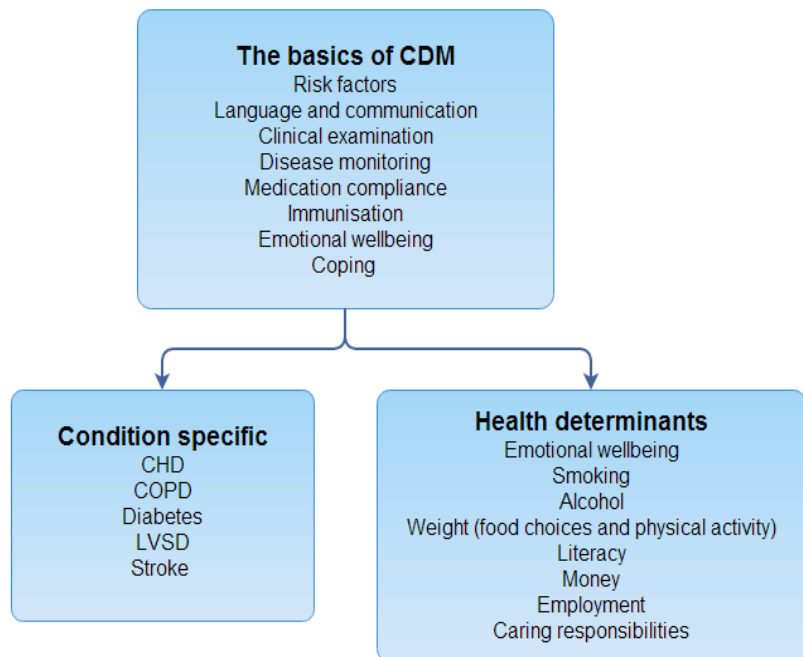
A practitioner's guide to
NHS Greater Glasgow and Clyde Chronic Disease
Management (CDM) 2021

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Introduction

This guide provides supports to Practice Nurses for the management of long term conditions (LTC). You may already have a detailed knowledge of many of the components to LTC consultations. The information included here aims to help you feel confident about delivering the consultation process as a whole.



Three approaches underpin the consultation:

- Proactive, structured clinical care
- Addressing individual risk factors
- Person centered consultations

There is clear evidence that a structured approach to Long Term Condition management:

- Improves the processes of clinical care.
- Ensures that evidence-based interventions are delivered, in keeping with guidelines and best practice.

When LTC consultations are systematic and based on the most up to date evidence within a system of coordinated care, patient outcomes are improved and risk of recurrence or progression of the original condition is substantially reduced.

Electronic templates for LTC management consultations are effective tools for delivering these clinical benefits; they give easy access to accurate, quality assured information, help clinicians with decision making and provide supportive tools to assist clinical care.

ADDRESSING INDIVIDUAL RISK FACTORS

Almost 60% of our disease burden is generated by seven leading risk factors: high blood pressure (12.8%); tobacco (12.3%); alcohol (10.1%); high blood cholesterol (8.7%); overweight (7.8%); low fruit and vegetable intake (4.4%) and physical inactivity (3.5%). An important aspect of caring for people with Long Term Conditions is to support them to address these specific risks factors (NHSGGC 2015).

PERSON CENTRED AND SUPPORTING SELF MANAGEMENT CONSULTATIONS

Person-centred care means providing care that supports people to achieve the level of health that gives them the best opportunity to lead the life that they want. It involves supporting self-management, sharing decision making and taking a collaborative approach to care and support planning.

Supporting self-management helps people to develop the knowledge, confidence and skills they need to make the best decisions and actions for them. Studies have shown that supporting someone to self-manage their conditions, including lifestyle changes, have clinical benefit in a wide range of conditions such as diabetes, coronary heart disease, heart failure, and rheumatoid arthritis (Rochfort et al 2018)

Person centred consultations are a major determinant of the outcomes of interactions between clinicians and patients. A person centred consultation:

- fits with a patient's expectation of the consultation and information needs.
- establishes what matters to the patient
- facilitates an agreed care and support plan.

There is evidence to show that person centred consultations:

- improve patient satisfaction
- improve professional fulfillment
- save time
- increase compliance with therapy.
- improve goal setting and action planning

LINKS

[Health Foundation's Person Centred Care Resource Centre](#)

It's Okay to Ask is a tool which can help people take some simple steps to get the most of their appointments. It can be downloaded from [NHSinform](#)

Information on inequalities sensitive practice as part of person centered care can be found [here](#).

[Anticipatory Care Plan information](#)

USING TEMPLATES TO ENHANCE THE PRACTITIONER-PATIENT RELATIONSHIP

Building a good relationship is considered by both patients and practitioners to be one of the most important aspects of care. Using computer-based templates ineffectively during a consultation can potentially interrupt the conversation. There is, however, emerging evidence to show how computers can be used to enhance the patient/practitioner relationship.

Computers allow you to share information with patients in a way that has not been possible in the past. Patients may signal how they prefer the computer to be used. For example, those who look at the computer while a practitioner is using it may be interested in seeing more. A response to this is to turn the screen to involve them in recording data and seeing the consultation process. Some patients will ignore the screen completely and focus on the practitioner. Don't attempt to involve a patient with the screen if they don't tend to look at it. What

INTRODUCTION

is important is to include your patient in the decision as to whether they wish to use the computer.

Another way of maintaining the relationship whilst inputting data is to think aloud, i.e. describe to the patient what you are doing while you are doing it. Some patients will introduce a new topic of discussion or ask questions while you are inputting data to the computer. Recognise this as an opportunity for them to do so and be aware they may introduce important information. Electronic templates are therefore a vital element of effective LTC care planning. They have been designed to support you to deliver a high quality, person centred LTC consultation.

Templates can help you make decisions in conjunction with your patient and take the right actions in improving their care. They are not intended simply as a way of recording information, although sometimes structured information is helpful to you in supporting the patient to manage their LTC.

Overall templates should be used as a guide for your consultation. It will be your communication skills that ensure an equal conversation between you and the patient takes place and that the consultation is truly person centered (Mann et al 2018)

The basics of Long Term Condition Consultation

Structured LTC consultations significantly improves care for chronically ill populations. These benefits are derived from two main sets of active ingredients:

1. Evidence-based delivery of biomedical care interventions e.g. statin therapy in patients with coronary heart disease for prevention of future cardiovascular events.
2. The right types of LTC delivery systems, care models and organisational approach.

Important components of these delivery systems include:

- Structured multidisciplinary team care
- Integrated decision support
- Use of electronic templates and other supportive information technology
- Provider expertise and skill
- Education and support to patients
- Planned LTC care of the population
- Use of registers

The content of each electronic template has been designed in conjunction with NHSGGC's Managed Clinical Networks, to ensure they contain the right information and high quality evidence to inform care of your patient in accordance with local guidelines. They can help you deliver consistent, clear and appropriate clinical care by providing a framework to enable flexibility to respond to each individual patient's needs.

Pre-consultation

LANGUAGE, COMMUNICATION AND ACCESS SUPPORT

INTENTION

Identify any additional communication and/or access support needs to facilitate the consultation.

WHY

- In NHSGGC there are 41,400 people who have severe sight loss. One in eight over-75s and one in three over-90s have serious sight loss. Around 80% of people with a learning disability have some form of sight loss.
- In NHSGGC approximately 13,000 people have severe to profound deafness. Within this group at least 1400 people use British Sign Language, however it may be as high as 3000. There is thought to be approximately 1000 Deafblind people.
- There are over 80 different languages spoken in Glasgow and NHSGGC has an interpreting service which provides interpreters to NHS patients on request at any time day or night, 7 days a week.
- Compared to other Scottish cities, Glasgow has the highest level of reported disability among working age adults (24%). Recent research has shown that difficulty getting into surgery buildings was more likely among physically disabled patients, with a stronger association among disabled patients aged 65-84 years. Therefore ensuring accessibility is an important part of pre-consultation preparation (Popplewell et al 2014)

GOOD PRACTICE

- Meeting people's access needs can include physical access, communication support and accessible information. Meeting people's access needs contributes to meeting legal requirements for equalities legislation and improving person centered care.

LINKS

- How to Book An Interpreter [How to book an interpreter](#)
- Accessible Information [Communication information resource including clear to all](#)
- Equalities in health [Information and resources](#)

SHARED DECISION MAKING AND CONSENT

“Shared decision-making and informed consent are fundamental to good practice. Serious harm can result if we don’t listen to the people we care for, and if they are not given the information and support they need to make informed decisions about their care” (GMC 2020).

The above extract has been taken from the GMC guidance document ‘Decision Making and Consent’ It focuses on delivering personalised care and firmly aligns with the principles of Realistic Medicine, including:

- finding out what matters to people, so we can share relevant information in the most effective way.
- the importance of taking a proportionate approach – good decision making needn’t always be formal, or time consuming

LINKS

[Chief medical officers report - 2020 -2021](#)

Shared Decision making [TURAS](#)

Patients also have the right to know how their information is being used for the purposes of their clinical care and, when relevant, for secondary uses such as service planning, evaluation or research. If patients wish to opt out of data sharing, the template allows this to be recorded. (Our experience suggests that very few patients choose to opt out).

LINKS

- [Patient information: Your health, your rights.](#)

PATIENT PREPARATION

Providing people with an opportunity to prepare can help to ensure they get as much as they can from their LTC consultation. It means that they are in a much better position to contribute fully to the discussions and decisions made. The below links will take you to useful resources to support the preparation of patients.

LINKS

[Its ok to ask](#)

[Alliance Scotland](#)

[NHSGGC Practice Nurse Support and Development Team - Care and Support planning tools](#)

Remote LTC consultations

Over the last couple of years the use of remote consultations has increased in General Practice, and this is likely to continue in the future.

NES states that ‘There are two key types of remote consulting: **telephone** and **video**. Telephone consulting is widespread and is the first-line remote consulting method. However, there are some situations where video calling can offer additional clinical information and a greater presence in a call. In NHS Scotland, video consultations should be offered by **Near Me**, which can be accessed by all NHS clinicians’ (NES 2021).

NES has developed a package of resources to support PN’s with their remote consultations. Click [HERE](#) to access the resources.

Risk factors

INTENTION

To identify characteristics or other conditions that place people in a different risk category for developing other long term conditions and/or complications.

TEMPLATE CONTENT

Ethnicity

Comorbidities (rheumatoid arthritis, hypertension, mental health and chronic kidney disease)

WHY

- Most ethnic groups in Scotland reported better health than the 'White: Scottish' ethnic group. However, ethnic health inequalities vary by gender, with women's health poorer than men's, and are significantly greater in older age-groups. Poor health is caused by a wide range of factors, including biological determinants (age, sex, hereditary factors), and wider social determinants such as education, social position, income, local environment, and experiences of racism and racial discrimination. The social determinants of health are unequally distributed across ethnic groups, leading to unjust and preventable health inequalities. A recent study in Glasgow indicated that self-reported health was worse for people who didn't speak English well, people who have lived in the UK for more than 10 years and for Pakistani people. See report [here. Further Information](#)
- Type 2 diabetes is more common in people from some [ethnic groups](#) including people with African, Asian and Caribbean backgrounds, compared with European populations. Due to the higher risk of diabetes and other health conditions NICE have recommended that practitioners are made aware, and make their patients aware, that members of black, Asian and other minority ethnic groups face an increased risk of chronic health conditions at a lower BMI than the white population (below BMI 25 kg/m²). [Further Information](#)
- The relationship between COPD and ethnicity is complex. Poorer access to primary care in ethnic minorities might lead to later presentation with respiratory symptoms and later diagnosis with more severe disease. [Further Information](#)
- Rheumatoid arthritis is a chronic disabling disease associated with an increased risk of cardiovascular disease, low mood and depression. It may also worsen the effect of other long term conditions. Finally, it is a powerful independent risk factor for increased mortality from cardiovascular disease.
- Hypertension is an important risk factor for disease progression. Blood pressure control (delivered via drug therapy and promotion of physical activity) achieves real world reductions in both development of complications of diabetes and recurrent vascular events in stroke and coronary heart disease.

- Around 30% of all people with a long term condition also have a mental health problem, especially those who have multiple long term conditions. The combination of mental health problems with other long term conditions has serious implications, including:
 - poorer clinical outcomes
 - lower quality of life
 - reduced ability to manage their condition effectively

In both coronary heart disease and diabetes, there is also evidence of earlier death in patients with co-morbid mental health conditions. It is important to detect (and even more important to manage effectively) mental health problems as part of the chronic disease management process.

- Chronic kidney disease often co-exists with diabetes and hypertension. Co-morbidities require good coordination of all aspects of care, to help manage often complex comorbidities, optimise medication, monitor and respond to laboratory parameters to minimise the risk of disease progression.

GOOD PRACTICE

- Clinicians should review this section in advance of their consultation and consider modifying their approach in the light of these characteristics.
- Book interpreters well in advance of consultation.
- Understanding of Cultural issues which may impact on self -management

3. Clinical examination

INTENTION

To identify complications or risk factors for progression of an existing disease which you can discuss with your patient and thereby improve their outcomes.

TEMPLATE CONTENT

Height/weight/BMI

Pulse rate and regularity

Blood pressure

WHY

- Obesity worsens the clinical impact of existing chronic diseases.
- A simple manual pulse check is cheap, quick, simple and around 90% sensitive in detecting atrial fibrillation (AF). Patients with other vascular disease have a substantially increased risk of AF. AF is also a major risk factor for stroke.
- Proactive management of blood pressure substantially reduces the risk of recurrent vascular events. Blood pressure control reduces both macrovascular and microvascular complications of diabetes. It is also a key element of effective management of patients with heart failure (Heart MCN 2021).

GOOD PRACTICE

- For accurate height measurement: use a wall-mounted measuring device, consisting of a vertical ruler with a sliding horizontal rod adjusted to sit on top of the head. The patient should be standing upright on a firm surface,

looking straight ahead, arms at their sides with shoes removed and feet together. The shoulders, buttocks and heels should be touching the wall. Height should be recorded in centimetres.

- Weight measurement: Scales need to be calibrated twice a year according to the manufacturer's recommendations. Patients should remove shoes, heavy outer clothing and items from their pockets. Weight should be measured and recorded in kilograms.
- BMI is calculated with the formula: $\text{Weight (kilograms)}/\text{height (metres}^2\text{)}$.
- If an irregular or abnormally fast pulse rate is found, this requires urgent diagnostic investigation if the cause is not already known. Clinical action may be required even when the cause is known, especially when the patient is symptomatic.
- Hypertension guidelines are available to follow when recording BPs
- If patient has a BMI <18.5 and/or experiencing unexplained weight loss, regardless of BMI, carry out nutritional screening using MUST tool.

LINKS

- MUST tool: a five-step screening tool to identify adults, who are malnourished or at risk of malnutrition. The tool includes management guidelines which can be used to develop a care plan [MUST Tool and patient information and pathways](#)

4. Disease monitoring

INTENTION

Annual disease monitoring is a vital component of effective long term condition consultation

TEMPLATE CONTENT

Condition specific monitoring

WHY

- When done well, annual consultations significantly reduces the risk of mortality, disease progression and recurrent vascular events.

GOOD PRACTICE

- Review recent trends in measurements and risk factors with the patient.
- Discuss potential explanations for the findings of routine monitoring (either favourable or not) from both the patient's perspective and from your own.
- Consider options for change/ improvement in partnership with the patient.

5. Medication compliance

INTENTION

To discuss the importance of medication adherence in order to reduce the risk of disease progression, improve the patient's wellbeing and help them to live independently.

TEMPLATE CONTENT

Prescription

Compliance

Recommended medication

WHY

- Around 50% of patients treated for long term conditions are not adherent to their long term therapy.
- Rates of medication adherence in patients treated for long term conditions drop after the first few months of therapy.
- Non adherence to medication causes between a third and a half of treatment failures and a substantial number of deaths in patients with long term conditions e.g. non adherence to statins increases the relative risk for mortality by around 25% (NHSGGC 2015)

GOOD PRACTICE

- Is the patient education up to date?
- Is the patient education material sufficiently clear to them and available in accessible formats? See [Clear to All](#)
- Is there a polypharmacy issue we can address?
- Is the patient receiving support to manage side effects?
- Can prescribing changes be made to minimise these problems?

6. Immunisation

INTENTION

To protect patients with long term conditions who are most at risk of developing serious complications should they develop influenza or pneumococcal infection.

TEMPLATE CONTENT

Flu immunisation

Pneumococcal immunisation

WHY

- Patients with LTC's, after adjustment for age, are at 6 to 19 fold increased risk of dying following influenza infection, dependent on their underlying condition.
- Influenza is a simple and cost effective preventive intervention. It should be offered to all patients in clinical risk groups at higher risk of influenza associated morbidity and mortality. This applies to all conditions in our LTC consultation programme. [Greenbook chapter 19](#)
- Pneumococcal infection can be more common and serious in patients with chronic disease, particularly patients with chronic respiratory disease (NHSGGC 2015)

GOOD PRACTICE

- Adults in clinical risk groups, other than those who are severely immunocompromised, should receive a single dose of pneumococcal vaccine in accordance with the latest Green Book guidelines. [Greenbook chapter 25](#)
- To raise the topic of immunisation with patients, discuss any fears, issues they

may have regarding immunisation and signpost to local immunisation hubs

7. Emotional wellbeing

INTENTION

To identify the presence and severity of mental health issues.

TEMPLATE CONTENT

Wellbeing score
Depression screening
Anxiety screening

WHY

- The risk of mental health problems increases substantially for those living with long term physical conditions.
- Rates of mental health problems increase with the number of long term physical conditions and with levels of socioeconomic deprivation.
- A period of a month is a useful indicator as it shows changes in general feelings.

GOOD PRACTICE

- There are recognised and recommended tools for assessing mental wellbeing which can be explained to the patient.
- If the patient is showing mild anxiety and/or depression, ask if they would like to be referred to another service and agree who will make this appointment. Goal planning and an agreed action plan should be undertaken which includes a means of follow up and timescale for doing this.
- If your patient is showing significant anxiety and/or depression, refer to GP.

LINK

[Health and Wellbeing Directory](#)

8. Coping with condition(s)

INTENTION

To encourage discussion as to whether your patient would benefit from accessing wider support provided beyond the GP practice.

TEMPLATE CONTENT

Coping/management of conditions

Family/carers coping

Extra support required

WHY

- Self-efficacy (a patient's belief in their own ability to manage their condition) is an independent predictor of survival.
- People who manage their own condition confidently and make daily decisions to improve their health and wellbeing have improved clinical, emotional and social outcomes.
- The health and wellbeing of carers should be safeguarded through the provision of the support they need to continue in their caring role.
- Community resources can support people to manage their long term condition more effectively.
- Changes to the patient's family life and their support mechanisms may be necessary following diagnosis or deterioration.

GOOD PRACTICE

- This section links to the health determinants section; it starts the process of supporting the patient to consider and if appropriate prioritise topics for further discussion.

LINKS

- The Health & Wellbeing Directory ([Public Health Service Directory - Home](#)) lists community services to support patients to manage their long term condition, including peer support services and patient education programmes.

Stroke

BACKGROUND

The effects of a stroke can make it difficult for the person to perform activities of daily living (e.g. dressing, feeding, bathing, tying shoes etc.). Mobility can vary widely, depending on the severity of the stroke and its location, along with the person's general level of health. Within a few days or weeks after a stroke some people develop spasticity in the part of the body affected by the stroke. This can impact on their functional recovery.

After a stroke, some people experience language deficits (aphasia and dysarthria) which significantly impair their ability to communicate. At least 40 per cent of stroke survivors will initially experience some difficulty swallowing, although for many people it improves quite quickly (NHSGGC 2015).

WHAT'S INCLUDED

New stroke or transient ischaemic attack (TIA)

Gain an understanding of any additional strokes/TIAs that have occurred since last consultation. If the person has had a further stroke they may have new or exacerbated problems.

- View diagnosis.
- Check if a carotid endarterectomy has been performed

Diagnostic investigations

- Record MRI results.
- Record CT scan results.
- Record referral to stroke/TIA clinic.

Functional assessment

The following functional assessment of symptoms is included to identify any new or worsening problems since hospital discharge or their last consultation:

Education and resources

Support people to access courses/services that give them the tools, techniques and confidence to manage their condition better on a daily basis.

- Record attendance at day hospital care/stroke group.
- Record support from Occupational Therapist, Physiotherapy, Speech and Language Therapist, Psychologist and Dietician.
- Signpost patients to stroke support groups, helplines and websites run by voluntary organisations such as CHSS (www.chss.org.uk), Stroke Association (www.stroke.org.uk) and Different Strokes (www.differentstrokes.co.uk).

STROKE

Symptoms: functional assessment	Template
Mobility	Walking problems
	Stairs problem
	Problems transferring
	Problems with balance
Spasticity/tone	New spasticity
	New situation flaccidity
	Shoulder or stroke-related pain
Activities of daily living	Problems preparing food
	Problems eating
	Difficulties dressing
	Toilet difficulties
Continence issues	Bladder problems
	Referral to continence team
	Bowel problems
Communication issues	Communication difficulties
	Referral to Stroke Team
Swallowing issues	Naso-gastric/PEG feeding
	Difficulties swallowing solids and liquids
Wheelchair status	Wheelchair user
	Wheelchair request
	Wheelchair adjustment
	Wheelchair condition
Community Stroke Team referral	Referral

COMMUNITY STROKE TEAM

- Glasgow and Clyde CST is a rehabilitation team consisting of Specialist Nurses, Physiotherapists, Occupational Therapists, Speech and Language Therapists and generic Support Workers, providing therapy to patients with stroke specific rehabilitation goals.
- Referrals to the CST can now be made via SCI gateway.
- The team will liaise with Stroke Consultants, Hospital Stroke Nurses and patient's GP as required. CST can also forward referrals to the Stroke Psychology service as necessary.
- Treatment plans and reviews will take place within a patient's own home.
- Patients' progress will be under ongoing review. If progress is continuing, rehabilitation will continue for up to 8 weeks. In certain circumstances, this can be extended to a maximum of 12 weeks.

STROKE

GOOD PRACTICE

- Issues can sometimes become apparent only when the person is home.
- If possible, avoid referring for expected static problems such as hemiplegic weakness unless there has been a clear deterioration on the stroke affected side.
- If your patient is experiencing any new or worsening problems in relation to the functional assessment questions, please refer on to the Community Stroke Team for assessment.
- If there is any mechanical problem, the patient should contact WESTMARC repair services. If they own the wheelchair, the NHS does not carry out repair (phone: 0844 811 3001 or 0141 201 2624).

Link:

[Information, guidance and tools](#)

Diabetes

BACKGROUND

A structured, holistic approach to preventing diabetic complications transforms clinical outcomes. Key elements are the optimisation of glycaemic control; prevention, detection and management of hypertension, microalbuminuria and dyslipidaemia; and supporting the patient with reducing lifestyle risk factors in ways which fit their individual needs and circumstances.

WHAT'S INCLUDED

Clinical information

Diabetes is associated with a range of micro and macrovascular complications. These should be asked about at each annual consultation. Screening services are also available to identify these early, before the patient becomes symptomatic. It's important to check that patients take up the offer of annual screening and to explore barriers to attendance if they haven't.

Diagnostic investigations

A systematic approach to the diagnosis of diabetes is vital, to ensure that the appropriate patients are managed with the right interventions. Please click [HERE](#) for NHSGG&C diagnostic guidelines.

Clinical examination

Hypertension is a recognised risk factor for progression of diabetic retinopathy and nephropathy. Lowering blood pressure reduces the risk of macrovascular and microvascular disease. Annual screening of the feet is vital. In patients who are classified as low risk, this simple screening procedure can be undertaken by generalist staff with basic training. Patients whose foot risk has been assessed as at moderate or high risk require specialist podiatric management, with early and appropriate surgical referral, and treatment of associated risk factors. Foot risk stratification should be recorded using SCI-diabetes.

Disease monitoring

Achieving optimal glycaemic control has proven benefits in reducing the development and progression of microvascular complications of Type 2 diabetes by around 50-60%.

DIABETES

Area of examination	Further information
Dietary review	Adopting a healthy eating plan will help to control blood glucose levels. A healthy eating plan includes regular meals, eating starchy food at each meal and eating at least 5 portions of fruit and vegetables. It is advisable to cut down on sugary foods as these raise the blood glucose levels too quickly and foods high in fat as these promote weight gain which will make diabetes harder to control.
Erectile dysfunction	Men with diabetes tend to develop erectile dysfunction 10 to 15 years earlier than men without diabetes. As men with diabetes age, erectile dysfunction becomes even more common. This can have a significant impact on quality of life and affect relationships.
Pulse and blood Pressure	A person with diabetes does not experience the same symptoms of a heart attack due to damaged nerve endings so it is important to check pulse and blood pressure regularly. Having high blood pressure is one of several risk factors that can increase the chance of developing heart disease, a stroke and some other complications. Many people with diabetes need to take medication to lower their blood pressure.
Injection sites	Correct management of injection sites can help to avoid complications. Injection rotation makes it less likely to result in the development fat deposits that can make a patient's skin look lumpy and delay the absorption of insulin.
Podiatry	As diabetes can cause nerve damage and affect circulation, patients should have their feet checked regularly. Using the foot risk stratification tool can also help predict the development of diabetic foot ulcers.

GOOD PRACTICE

- For those who fail to achieve glycaemic targets, intensive dietary advice and support may be required to encourage appropriate self management.
- Please refer to the dietetic prioritisation tool to identify those patients who require specific dietetic input. These include individuals with chronic diseases, the elderly, those recently discharged from hospital, and those who are poor or socially isolated.
- All patients should be offered access to patient education or re-referral for initial structured group education if they have not engaged with this previously.
- You have a responsibility to inform patients that specific DVLA requirements may apply. Current requirements are outlined here: <https://www.gov.uk/diabetes-driving>.
- Foot screening details should be inputted on SCI –diabetes.

LINK [Information, guidelines and tools](#)

Chronic obstructive pulmonary disease (COPD)

BACKGROUND

The overall aim of the COPD consultation is to deliver population based care to patients with stable COPD, thus maximising the uptake of therapies (such as smoking cessation, pulmonary rehabilitation and pharmacotherapy for symptomatic control). All of these interventions are individually tailored to the patient's personal priorities and needs, social circumstances and co-morbidities.

Stopping smoking is the single most effective way of preventing COPD from getting worse. Co-existing asthma changes the treatment pathway. Practitioners should:

- Review diagnosis.
- Check smoking status.
- Review recent admissions and/or outpatient appointments.

WHAT'S INCLUDED

Diagnostic investigations

- Diagnostic spirometry.
- Chest X-ray.

Diagnostic spirometry is used to plan appropriate use of medication, particularly inhaled steroids. Chest X-ray aids diagnosis of co-existing pathology.

Symptom management

These items have high impact for assessing health status, irrespective of spirometry results. Worsening of any of these signs or symptoms indicate a red flag and the patient should be referred to the GP where further treatment should be considered.

Symptoms	Further information
MRC Grade	MRC is a validated measure of disease severity (irrespective of patient's FEV1). It is also used to determine eligibility for Pulmonary Rehab service.
Frequent exacerbations	There will be impact on treatment if patient is experiencing 2 or more exacerbations in a 12 month period. (An exacerbation is classed as an acute onset of increase in breathlessness, cough or sputum production or change in sputum colour, sustained for at least a day.
Unintentional weight loss	A low BMI can impact on lung function, may indicate underlying cancer, and is an independent predictor of mortality. Patients should be nutritionally screened using MUST. Patients with COPD sometimes find it difficult to eat due to breathing difficulties and/or choking on some food.

Symptoms	Further information
Worsening oedema	May indicate chronic hypoxia and heart failure
Haemoptysis	COPD patients are at high risk of developing lung cancer.
Hypoxia	Occurs in advanced disease. Consider referral for consideration of oxygen in non smokers and ex smokers of six months or more.
Sleep disturbance	Medication, sleep position and sleep-related breathing changes can cause COPD patients to have disturbed sleep. Identifying sleep disturbance may result in medication changes (including prescribing oxygen or changing the dosage of bronchodilator therapy).
Oedema or ankle swelling	Swelling of legs, feet and ankles may indicate the development of pulmonary hypertension.

Recommended medication/compliance

Review how the patient is coping with current treatment.

- Inhaler technique.
- Oxygen therapy.

Incorrect inhaler technique will prevent patients receiving the maximum benefit from medication.

Education and resources

Support people to access courses/services that give them the tools, techniques and confidence to manage their condition better on a daily basis.

- Attendance/referral to pulmonary rehabilitation (those with an MRC Grade of 3, 4 or 5 can be referred).

GOOD PRACTICE/TIPS

- COPD patients can access the Pulmonary Rehabilitation service more than once (although it should be more than 2 years since last referral).
- Referrals to Pulmonary Rehabilitation can now be made via SCI Gateway.
- NHSGGC guidelines advise against conducting yearly spirometry. If a COPD patient's symptoms are worsening, they should be referred back to the GP prior to further spirometry tests and/or referral.
- Be aware that the risk of poor inhaler technique is higher in older and more debilitated patients.

LINK [Information, guidelines and tools](#)

Coronary heart disease (CHD)

BACKGROUND

The overall strategic aim of the CHD consultation is to deliver systematic population based care to patients with stable CHD, maximising the uptake of effective secondary prevention therapies (such as smoking cessation, programmed cardiac rehabilitation, lipid management, blood pressure control and individualised brief interventions for behavioural risk reduction). All of these biomedical interventions are individually tailored to the patient's personal priorities and needs, social circumstances and relevant co-morbidities (NHSGGC 2015).

WHAT'S INCLUDED

Clinical information

The clinical information and diagnostic investigations fields will auto-populate from the clinical system. They provide information about the dates and types of clinical CHD presentation/s in your patient. You should confirm that these are correct and that nothing is missing.

Diagnostic investigations

Baseline coronary angiography provides a definitive diagnosis of CHD and allows assessment of its anatomical severity and complexity. It also guides decisions on its therapeutic management of CHD in addition to other relevant clinical factors and comorbidities.

Lipid management

Patients with CHD should be taking statins for secondary prevention. There is some evidence (supported by NICE) that patients whose plasma cholesterol exceeds 5 mmol/L should be offered a higher intensity statin to enable treating to target. Any decisions on intensification of statin therapy should take into account the patient's informed preferences, co-morbidities, multiple drug therapy and the benefits and risks of treatment. This value is intended to guide treatment rather than be a threshold patients are expected to achieve. Lifestyle modification should be considered as an adjunct or alternative to cholesterol lowering medication in patients whose dietary habits would benefit from improvement

Symptom management

An increase in GTN consumption and/or angina at lower levels of physical activity are suggestive of worsening myocardial ischaemia. This should prompt further investigation. New or worsening breathlessness may occur as a result of progressive myocardial ischaemia or heart failure. Both require urgent investigation.

CORONARY HEART DISEASE

Area of examination	Template
Clinical information	Angina diagnosis
	Acute Coronary Syndrome diagnosis
	Angioplasty/CABG diagnosis
Diagnostic investigations	Angiogram results
Symptoms	Record chest pain status
	Record how often using GTN spray
	Record breathlessness
	Cholesterol

Education and Resources

Click [HERE](#) for more information regarding Cardiac Rehabilitation.

GOOD PRACTICE

- If angiography has never been undertaken in a patient with poorly controlled angina symptoms, refer to GP for review and consideration of cardiological referral / possible angiography.
- Ask about restriction to usual activities of daily living because of angina/breathlessness.
- Ask the patient whether the frequency and severity of their angina symptoms over the past 4 weeks is the same, slightly worse or much worse than previously.
- New symptoms of significant breathlessness always require a definitive diagnosis, even in a patient with longstanding CHD.

LINK [Information, guidelines and tools](#)

Left ventricular systolic dysfunction (LVSD)

BACKGROUND

The overall strategic aim of the LVSD consultation is to deliver systematic population based care to patients with LVSD, thus maximising the uptake of effective therapies (such as ACEI/ARBs, programmed cardiac rehabilitation and early detection of deterioration in order to provide multidisciplinary care at the right stage). All of these biomedical interventions are individually tailored to the patient's personal priorities and needs, social circumstances and relevant co-morbidities.

WHAT'S INCLUDED

Clinical information

The diagnostic investigations and disease monitoring fields auto-populate from the clinical system, providing the date/s and results of any recent admission/s and investigations in your patient. You should confirm these are correct.

Recommended medication/compliance

There is strong clinical and cost-effectiveness evidence to support the use of ACE inhibitors in all patients with heart failure with LVSD. ACE inhibitors improve symptoms, reduce hospitalisation rates and improve survival in all age groups. ARBs are also effective in LVSD, but should only be used in patients intolerant of ACE inhibitors.

Area of examination	Template
Clinical information	Access to heart failure liaison nurse service
	Echocardiogram status (abnormal or declined/OP referral)
	Underlying cause
Symptoms	NYHA Score ¹
	Paroxysmal nocturnal dyspnoea
	Oedema or ankle swelling status

¹ The New York Heart Association (NYHA) Functional Classification of the extent of heart failure. NYHA places patients in one of four categories based on how much they are limited during physical activity; the limitations/symptoms are in regards to normal breathing and varying degrees in shortness of breath and/or angina pain.

Area of examination	Further information
Clinical examination	Height/Weight/BMI (record if not weight bearing, record if declined weight measurement, record clinical status, MUST tool status/remind patients to weigh themselves every day)
	Pulse rate and regularity (record pulse rate, check rhythm, confirm AF diagnosis)
	Blood pressure (record measure, record hypertensive disease, previous record of Microalbuminuria/Proteinuria)
Disease monitoring	Urea and electrolytes

GOOD PRACTICE

- Discuss with the patient whether they require more help with understanding and managing their condition. Consider referral to Heart Failure Liaison Nursing Team or specialist pharmacist.
- Echocardiography is important in making a definitive diagnosis of LVSD. Normally, an echocardiogram is undertaken at diagnosis. The symptoms and signs can be non-specific. Echocardiography also provides a measurement of left ventricular ejection fraction, which guides therapy, as only patients with impaired ejection fraction benefit from the therapies encouraged within the CDM consultation for LVSD.
- NYHA classification of heart failure is vital in guiding therapy.
- Monitoring renal function is vital: You should review U&E results, check that they are within the expected range for that patient and do not require action. Drug therapy for LVSD can adversely affect renal function and cause hypo or hyperkalaemia. Patients on combinations of different diuretics and ACEI/ARB drugs should have their U&Es measured regularly, especially in the initial stages of therapy.
- Monitoring symptom progression is also vital: Assessing symptoms can determine whether the patient's LVSD is worsening and requires review by GP/Heart Failure Liaison Nursing team/Cardiologist.
- Daily weights (at the same time each day) are a simple way to monitor fluid balance. If the patient's weight increases by more than 1 Kg (2 lbs), and sustained over 3 days (as per guideline) the patient should be reminded to contact the practice.
- Pulse: abnormal tachycardia or bradycardia requires investigation and action, as may have numerous underlying causes, including decompensated heart failure, a new cardiac conduction defect or drug induced.

LEFT VENTRICULAR SYSTOLIC DYSFUNCTION

- Blood pressure: abnormally low and high values require investigation and action. Underlying causes include hypovolaemia which may require modification of diuretic therapy or uncontrolled hypertension, which may be worsening the patient's heart failure.
- Ask about restriction to usual activities of daily living because of breathlessness/fatigue. Ask the patient whether the frequency and severity of their breathlessness/fatigue over the past 4 weeks is the same, slightly worse or much worse than previously. New symptoms of significant breathlessness/fatigue/palpitations always require a definitive diagnosis, even in a patient with longstanding heart failure.
- Consider impact of co-morbidities as a cause for their symptoms.

LINK [Information, guidelines and links](#)

Health determinants

Having a conversation with patients about their lifestyle and life circumstances is core to supporting the management of long term conditions successfully. The health determinants (HD) section is designed to help facilitate this conversation by identifying issues potentially affecting the patient's health and wellbeing.

By assessing status, you can identify health behaviours and wider issues which may be impacting on or affecting the patient's ability to manage their long term condition.

By setting an agenda, you will have the time to find common ground between what you consider to be important issues and what your patient would like to discuss further.

[Health Determinants - agenda setting](#)

HEALTH LITERACY

Health literacy is the term used to describe the ability to engage with health information and services (WHO definition).

Health literacy is about people having enough knowledge, understanding, skills and confidence to use health information, to be active partners in their care, and to navigate health and social care systems (Scottish Gov definition)

People remember and understand less than half of the information that we discuss with them. Improving people's understanding is crucial for improving patient safety, communication, effectiveness, self-management and health literacy.

Adapting how you communicate with people can help everyone, not only those with low health literacy.

[The Health Literacy Place](#) is the main source of health literacy information and resources in Scotland. The website has a range of tools and techniques which can support your patient conversations:

- **Use of simple language** Avoid jargon and use language that is easy for the patient to understand, both when you speak to them and in any written information you provide.
- **Teach Back** Check that you have explained everything in ways people understand, by asking them to explain in their own words the information you have given. For example, you might say 'I want to make sure that I have explained your medicine clearly. Can you tell me how you will take your medicine?'
- **Chunk and check** can be used alongside teach back and requires you to break down information into smaller chunks throughout consultations and check for understanding along the way rather than providing all information that is to be remembered at the end of the session.

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- **Use pictures** Some concepts can be difficult to explain, both for patients explaining what is wrong with them and for professionals explaining what they would like people to do. Graphics and pictures can sometimes help communication.
- **Routinely offer help with paperwork** It is not possible to tell by looking at someone whether they might have problems with paperwork or understanding health information. Staff should routinely offer help with paperwork and other tasks that are asked of people during interactions with healthcare.
- Check confidence for following agreed treatment/activities. For example you might say 'On a scale of one to ten, how confident do you feel about doing what we have discussed?'
- Provide written or other forms of information covered in consultations. **NHS Inform** has a whole range of patient information which can be accessed to support consultations

National Clinical Director, Professor Jason Leitch explains more about these techniques in [this video about good communication](#)

Clear to All

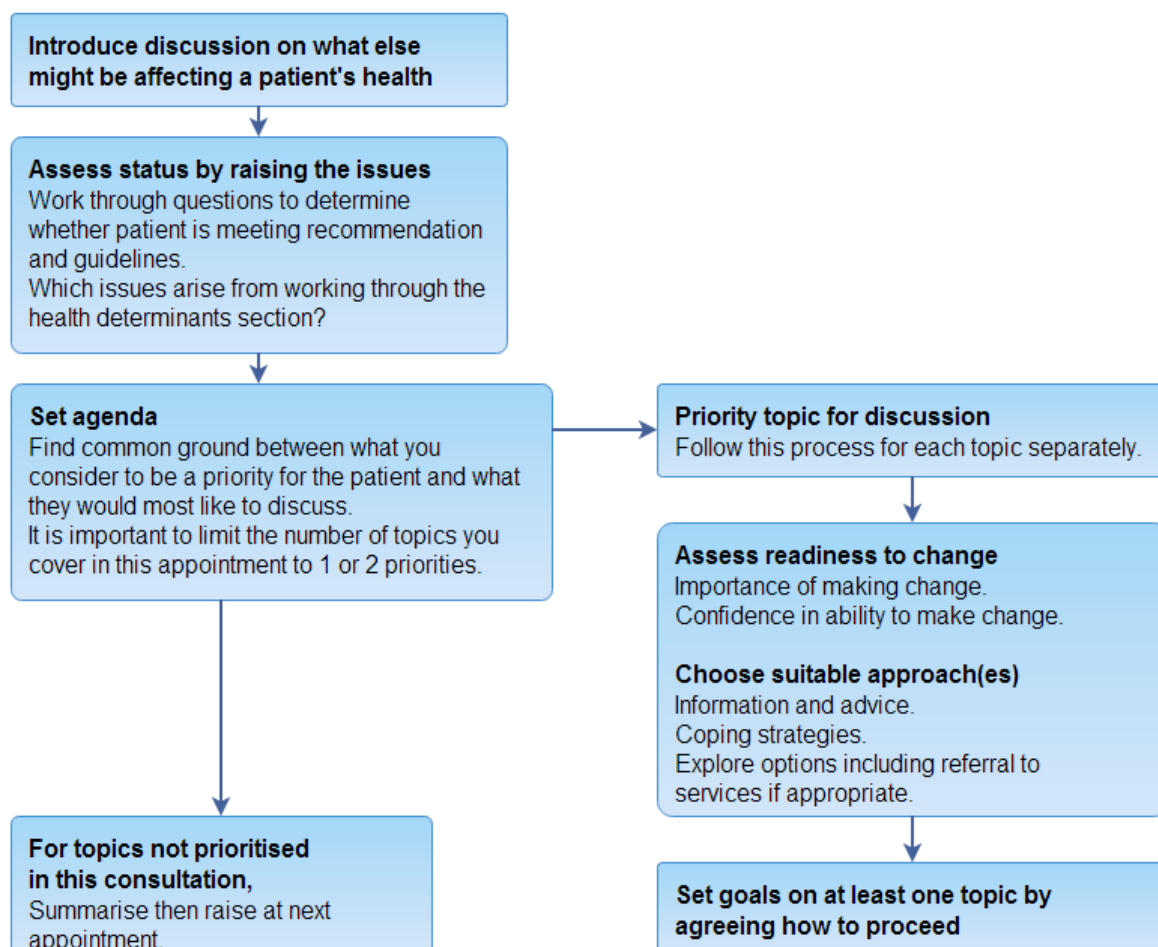
Clear information and communication is vital for providing high quality service and care.

NHSGGC believes providing clear information benefits those who use our services and those who deliver them.

Clear information helps us to improve access to services, promotes social inclusion and enables people to make informed choices.

The guidelines in [the Clear to All portal](#) ensure there is a consistent, accurate approach to the provision of information for patients and the public.

THE BRIEF INTERVENTION APPROACH



Making a brief intervention means adopting an evidence-based approach to addressing lifestyle issues. It provides you with alternative and sensitive strategies to support your patients to make changes. Practice nurses are recognised as being skilled in supporting self-management. The brief intervention involves patients as partners in managing their own health. We know patients respond well to ‘supported’ self management.

HEALTH & WELLBEING SERVICE DIRECTORY

The Health & Wellbeing Service Directory ([Public Health Service Directory - Home](#)) lists community services to support patients to tackle issues arising from this discussion.

Information on this topic is contained in The Basics of CDM (see page 11).

NOTE ON EMOTIONAL WELLBEING

The following pages list the topics in the HD section. Emotional wellbeing can be addressed as part of agenda setting.

Assess Status Section

By working your way through the questions in this section of the template you can determine issues which may be having an impact on the person's ability to manage their condition.

How to start the conversation

It is helpful if you consider in advance how to move from the clinical to the non-clinical part of the consultation.

Here are some examples of ways to start the conversation: "I have a few questions to ask about different things which can affect your health/condition. Are you happy to spend the next X minutes discussing these a bit further?"

"We have found that many people who have condition X have benefited from making small changes to their lifestyle. Would you be willing to look at these issues in a bit more detail?"

Setting the Agenda

Based on the responses your patient has given in the "Assess Status" part of the consultation you will have an overview of the issues which may be affecting their health and well-being.

Find common ground between what you consider to be a priority and what your patient would most like to discuss. This allows you to acknowledge your clinical responsibility while still maintaining a person-centred approach.

- It is important in this section to be open and honest about your position in relation to the issues highlighted.
- You may wish to consider offering the patient an opportunity to highlight areas of concern first before you discuss any other relevant issues

Highlight the areas for potential discussion.

Ask permission to give your patient feedback on how any of the issues identified relate to their individual circumstances

A degree of sensitivity is required and the practitioner must endeavour to be supportive and non-judgemental.

Invite the patient to identify other potential issues which may be more pressing

Here is an example of a way to start this section of the consultation:

"Following a heart attack, we know that there are lots of different things that can impact on your recovery and reduce the chances of another incident. These include the tablets you take, smoking, weight, physical activity, healthy eating and alcohol. From a health perspective we know that quitting smoking is one of the most important things to do following a heart attack but I wonder if there is anything on this list which you might like to talk about today – anything you might like to talk

about changing or getting more information about?"

Plan how to use the remaining time to explore the issue further

Emphasise personal responsibility

Goal Setting

OUTCOMES OF THE CONVERSATION

Remember this part of the consultation is not all about referring to services it is about working with the patient to identify relevant goals:

"I will stop smoking by next June" or "I will think about stopping smoking by next June" or "I will try my best to smoke less" etc.

Patient not ready to change

Conversations to support change may last for many years. It is perfectly reasonable to suggest to the patient that they may not be ready to make changes, but they may wish to consider doing something, and perhaps they might want to talk about it next year

The practitioners key role is to ensure this decision is informed and thoughtful

A useful final question could be:

"What would need to happen for you to reconsider change?"

Reflecting the answer can help the patient to really hear what it is they are saying and to check they are comfortable with the decision.

Agreeing to discuss this issue further at another time is an acceptable goal.

Patient still unsure

The practitioner's role is to support the patient to reflect on the issues discussed

The decisional balance tool can help to distil the issues surrounding change and taking it home may generate more clarity.

Offering the patient information may also help

Patient ready to change

Support the patient to generate ideas.

If they need help offer a menu of options

Please consult the [Health and Wellbeing Directory](#) for local service details.

Exchange information on the process of making change e.g. experiences of others making changes, realistic expectations

Considerations for setting goals

- Complexity of need
- Number of behaviours that patient may need to address
- Prioritisation
- Making a SMART plan

If the patient is already meeting the recommendations or has no issues reinforcing maintenance is an important aspect of supporting long term change and preventing relapse.

Further Information - [Inequalities Sensitive Practice](#)
[Health Determinants agenda setting](#)
[Patient information resources](#)

Smoking

INTENTION

To motivate a quit attempt.

TEMPLATE CONTENT

Ask patient if they smoke

Record status

Number of cigarettes per day

Advise them to stop - provide information on the best way to stop smoking; with support from Quit Your Way stop smoking service.

WHY

- Smoking substantially increases the risk of developing heart disease, lung cancer, COPD, strokes, stomach ulcers, stomach cancer, bladder cancer, oral cancer among many others.
- Stopping smoking is the only proven way to reduce the rate of decline in lung function in people with COPD.
- A person smoking 20 cigarettes a day has six times the risk of stroke compared to a non-smoker.
- Giving up smoking dramatically reduces the risk of a heart attack and is particularly important for those who have other risk factors such as high blood pressure, raised blood cholesterol levels, and are diabetic or overweight and physically inactive.
- Light smokers are also at increased risk of CHD.
- If smokers are referred to specialist stop services by a GP practice, they are more likely to attend and to stop smoking

GOOD PRACTICE

- Explore what the patient understands about smoking and their condition.

- Regularly raising the topic of smoking and engaging in brief interventions is effective in triggering quit attempts and encouraging smokers to use the smoking cessation services.
- Some patients believe they may gain weight if they stop smoking. Concerns about weight gain should be addressed by health care providers whilst emphasising the fact that the health benefits of smoking cessation far outweigh post cessation weight gain, even in people who are focused on weight management.
- If the patient is motivated to stop smoking refer to NHS Greater Glasgow and Clyde Quit Your Way stop smoking service. Where possible SCI Gateway should be used to directly refer clients to their local service, where this is not possible you can refer via telephone by calling 0800 916 8858.

Alcohol

INTENTION

To reduce harmful drinking.

TEMPLATE CONTENT

Ask patient if they drink

Record status

Number of weekly units

WHY

- Brief interventions reduce alcohol consumption amongst hazardous drinkers in the order of 15-30% for up to one year.
- Alcohol-specific deaths are at their highest level since 2008. Over the latest five years, 55-59 was the age-group with the largest number of alcohol-specific deaths. Alcohol-specific death rates in the most deprived areas were 4.1 times more than those in the least deprived areas.
- Harmful consequences of drinking are not confined to dependent drinkers. The wider population of people drinking at hazardous and harmful levels experience harm from their alcohol consumption; it is for this group whom brief interventions are most effective.

GOOD PRACTICE

- Using the FAST (Fast Alcohol Screening Tool) screening tool at the assess status stage can help patient to identify the impact of their drinking and support them to prioritise it for further discussion.

LINKS

- [FAST screening tool guidance.](#)
- [Topic guidance for alcohol.](#)

Weight

INTENTION

To attain a healthy BMI through diet and physical activity.

TEMPLATE CONTENT

Wants to lose weight

Patient initiated diet

Exercise grading

WHY

- Someone who is overweight is twice as likely to die prematurely as a person within a healthy weight range.
- 47% of type 2 diabetes can be attributed to obesity, 36% of hypertension, 18% of myocardial infarction, 15% of angina and 12% of osteoarthritis.
- Malnutrition affects 10% of adults at GP practice and 33% of patients admitted to hospitals and care homes.
- Increased physical activity can modify cardiovascular risk factors including blood lipids and resting blood pressure.

GOOD PRACTICE

- If BMI >25 ask patient what aspects of their lifestyle they think are contributing to their weight.
- If patient has a BMI <18.5 and/or experiencing unintentional weight loss within the last 3-6 months, carry out nutritional screening using MUST.
- Increasing their activity levels as a means of losing weight, discuss what activities they have enjoyed in the past or new ones that might interest them. Provide physical activity information or signpost to local services.

LINKS

- Topic guidance for both healthy eating and physical activity.

Literacy

INTENTION

To facilitate access to adult education service where appropriate.

TEMPLATE CONTENT

Identify literacy and/or numeracy issues

WHY

- People with literacy difficulties have poorer health status, are less likely to understand their long term condition, and are also less likely to adhere to prescribed courses of treatment.
- One person in 28 in Scotland faces serious challenges with literacy and/or numeracy.
- Older people are more likely than younger people to have literacy difficulties.
- People who live in the 15% most deprived areas in Scotland tend to have lower literacy scores.

GOOD PRACTICE

- To identify if a patient is experiencing difficulties with literacy, ask: “How often do you need to have someone help you with understanding forms, letters, or medicine labels?”
- If person responds either “sometimes” or more often than sometimes, this is an indicator of some degree of difficulty with literacy and/or numeracy.

LINKS

- [Health Literacy Place](#)

Money

INTENTION

To facilitate access to money advice service where appropriate.

TEMPLATE CONTENT

Identify money worries

WHY

- The COVID-19 pandemic has negatively impacted the income of many households as a result of job losses, furlough, reductions in working hours, and an increase in caring responsibilities. The impacts of the pandemic on physical and mental health has negatively affected the ability of many people to manage their finances.
- Many people are experiencing changes to their welfare benefits which impact on their ability to manage their finances. People in low paid work are also affected by benefit changes.
- The tax and benefits system is complex and there is a lack of awareness of entitlement.
- Money advice services have a prevention role.
- Healthier Wealthier Children found an average of £3,000 per annum per family from raising the issue of finance.

GOOD PRACTICE

- Advise patient that any change in their circumstances, such as a diagnosis of a long term health condition, may mean that they are entitled to benefits to help with household costs.
- Ask patient if they would like to speak to someone about what additional sources of income they may be entitled to.

LINKS

- [Long Term Conditions and Macmillan Service](#)
- [NHS Greater Glasgow and Clyde Support and Information Service](#)
- [The Royal Hospital for Children Families Money and Debt Advice Support Service](#)
- [Citizens Advice](#)

Employment

INTENTION

To facilitate access to employment service where appropriate.

TEMPLATE CONTENT

Employment status
Difficulties in workplace

WHY

- For those with ongoing health conditions, remaining in work is shown to be beneficial to their health as it can help them recover from sickness and decrease the risk of long-term incapacity.

GOOD PRACTICE

- In addition to helping those looking for jobs, the employment services are able to support someone who is unhappy at work and would like support to consider other options.
- Employment services can support people to access volunteering opportunities or further education courses.

LINKS

- Topic guidance.

Caring Responsibilities

INTENTION

To facilitate early identification of carers and access to carer support.

TEMPLATE CONTENT

Carer status

WHY

- At any point in time, 1 in 8 people in Scotland are caring for someone.
- Compared with non-caregivers, caregivers have poorer mental and physical health. They often have substantial unmet support needs.
- The carer's wellbeing is affected by the situation of the person(s) they care for including lack of responsive and joined-up services.
- The largest proportion of households with a carer (28%) are in the 20% most deprived areas.
- Under the Carers (Scotland) Act 2016, all staff have a legal duty to inform carers of their right to support.

GOOD PRACTICE

- A care is defined as someone of any age who provides unpaid support to family or friends who could not manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has a mental health or substance misuse problems.
- Early intervention and support is vital in minimising the risk of carer fatigue and breakdown. Caring responsibilities can change in nature and intensity over time, therefore it is important to

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- continually monitor the impact of this and encourage carers to seek support.
- It is important to consider the range of care and support someone may be receiving or giving. Often people with LTCs will have some form of informal care, however they may also be providing support to others alongside this.
 - All carers have the right to individual support to meet their own needs. Staff should encourage carers to contact their local Carer Support Services or offer to make a referral on their behalf.

- Staff can refer carers through SCI Gateway. Alternatively they can call the Carers Information Link on 0141 353 6504.

LINKS

- [NHSGGC webpages for carer information](#)
- [Local Carer Support Services Contact Information](#)
- [Flyers, posters \(A4 or A3\) and business cards with Carer Support contact information available to order, free of charge, from the Public Health Resource Directory](#)

Further information and support

1. TRAINING OPTIONS

Learning tables have been developed to support the learning needs of practice nurses to deliver safe and effective care. The education opportunities that we are recommending are not only designed to underpin and support clinical excellence for your patients but will also provide active learning opportunities for professional regulation and NMC revalidation.

Further resources/information:

[NHSGGC MCNs - Guidelines and protocols](#)

[NHSGGC PNSDT learning tables and resources](#)

[PNSDT WebPages](#)

2. PRACTICE NURSE Support and Development Team

The Practice Nurse Support and Development Team support workforce planning and development. As part of this, they can provide practice nurses with 1:1 mentoring, small group learning and telephone support. They also maintain the locum list.

- Phone: 0141 211 3632
- Email: PNATeam@ggc.scot.nhs.uk

Primary Care Support Services, Ground Floor JBR House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0X

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NHS Greater Glasgow and Clyde

