

British Heart Foundation House of Care Evaluation Report

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Executive Summary

The CCG in Gateshead recognised the need to work differently to improve the quality of care for people with long term conditions (LTCs) acknowledging the existing demand in practices and the projected increase in long term conditions. The British Heart Foundation (BHF) House of Care project launched in April 2015 and has focussed on implementing Care and Support Planning (CSP). An evaluation has been carried out providing a robust and neutral evaluation of care and support planning consultation in seven Gateshead practices.

The qualitative information collected through the interviews and focus group have been triangulated alongside the quantitative data collected (patient surveys) to ensure that the evidence presented is robust.

A literature review was carried out as part of the evaluation which supported evidence for CSP with of the key findings identified below:

- CSP enables self-management through shared decision making;
- Engagement in self-management is a cost effective approach;
- If self-management is implemented across the UK, 4 billion could be saved annually;
- Patients achieve better outcomes when engaged and empowered;
- Health improvements are most obvious when CSP is integrated into routine primary care;
- Personalised care helps patients become more able and confident in managing their own health;
- CARE Plus model in Glasgow highlights that patients welcome the idea of self-management and self-management supporting material;
- CSP has been shown to improve quality of life and shows a gain in quality adjusted life gained;
- Evidence has highlighted that a system shift is required in order for self-management and multi morbidity conditions to be better managed.

Patient feedback highlighted the following:

- Care Support Planning seemed to allow a patient – health care professional relationship to develop, encouraging patients to be more open and discuss issues that they might not have disclosed otherwise.
- Patient fed back on the whole that receiving the results in the post helped as:
 - as it gave them an idea of what was going to be discussed at the next appointment.
 - as it also provided prompts/reminders for the next PN or GP app.
 - Patients report being less worried and anxious as a result of the results coming through in weeks rather than months.
- Although it should be noted that some patients discussed not being able to understand the results that they did receive.
- Many patients enjoyed Action Planning as it helped them to make a lifestyle change.

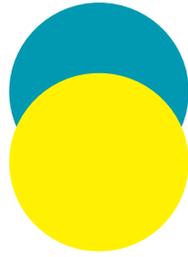
Health care professional feedback highlighted the following:

- The HCP's highlighted that patients are now taking more control of their own health, becoming more proactive rather than reactive as they are prepared for the review, by receiving their medical test results and prompts in the post, resulting in increased patient empowerment. This has also been highlighted in the patient feedback.
- This increased empowerment has been shown as valuable as staff highlight that with an aging population with increase LTC's enabling the clients to self-manage more effectively and therefore are less likely to be reliant on the medically led HCP interaction.
- HCP also indicate that this change from medically led HCP interaction is not universal and is challenging due to the nature of the population and confusion over who completes the action planning.
- Time saving seems to be a key theme, in that patients no longer need to attend multiple appointments and anecdotal feedback suggests a reduction in DNA's.
- It also seems key that, in order for the CSP to really be effective, each surgery really needs to 'buy in' at all levels from Admin to GP.
- It is also clear that flexible to appointment times is also vital for both the patients and staff benefits.
- Staff have reported an increased in personal skill set increased capability as they now deal with all conditions rather than specialise in one.
- Evidence suggests that the necessary skills to enable a successful HCP conversation.
- Social prescribing is highlighted as something that they find useful as loneliness is noted regularly by staff as a concern by patients.

In summary, CSP within seven Gateshead practices has shown some very positive results, as this becomes embedded and sustained over a longer period of time it is anticipated that these positive results will be magnified.

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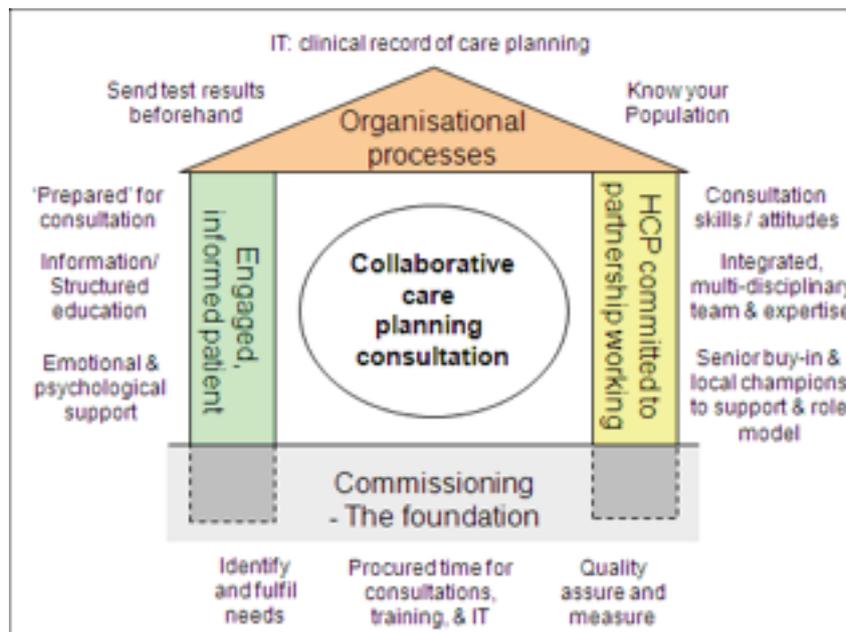
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Introduction and Project Summary

The CCG in Gateshead recognised the need to work differently to improve the quality of care for people with long term conditions (LTCs) acknowledging the existing demand in practices and the projected increase in long term conditions. The Newcastle Gateshead CCG LTC Strategy outlines a transformative approach to deliver collaborative, patient centred care that support self-management through care and support planning (CSP).

The CCG has taken a multi-layered approach to supporting self-management for people with LTCs. The Gateshead British Heart Foundation (BHF) House of Care project launched in April 2015 and has focussed on implementing CSP, aligning to and building on work already underway.

We have taken a developmental and supportive approach to enable practice teams to adopt the principles of care and support planning; using the ‘House of Care’ as a framework for implementing care and support planning. Our aim has been to deliver the ‘centre of the house’ – care and support planning for people with multiple long term conditions.



A project case study provides further information on the project implementation, approach and progress. This evaluation report outlines the evidence from seven practices in Gateshead, to assess the implementation and impact of care and support planning considering the patient and health care professional perspective, with the supporting context of a wider evidence base.

The research has been carried out by the North East Commissioning Support (NECS) Research and Evidence Team ensuring a robust and neutral evaluation of care and support planning.

What does the evidence say? How does Care and Support Planning support Patients and Practices?

Definitions

Self-management - Patients have a key role in protecting their own health, choosing appropriate treatments and managing long-term conditions. Self-management is a term used to include all the actions taken by people to recognise, treat and manage their own health. They may do this independently or in partnership with the healthcare system (NHS England 2016).

Self-care within NHS Enabling patients to resolve health issues themselves, and take control of managing their own symptoms is a critical aspect of health care delivery and the importance of enabling self-care is very significant to achieving this (NHS England 2015).

Personalised care and support plans should be developed in conjunction with other plans that the individual may have, for example where the person is receiving both Local Authority provided care and support and NHS health care (NHS England 2015).

Shared Decision making is a process by which a healthcare choice is made jointly by the health care professionals and the patient and is said to be the crux of patient centred care (NHS England 2017).

The Year of Care (YOC) Programme *'Working together for better healthcare and better self-care'*

The YOC Programme demonstrates how to deliver personalised care in routine practice for people with long term conditions (LTCs). This approach puts people with LTCs firmly in control of their care and supports them to self-manage.

It transforms the LTC annual review into a productive and meaningful conversation between the health care professionals and the person with LTC's. Care and support planning (CSP) (part of the Year of Care Program) aims to provide better patient experience, greater support for self-management/self-care, and greater engagement in and sense of control over health and healthcare for people living with one or more long term conditions (LTCs). The primary purpose of implementing care and support planning is to offer people with single and multiple long term conditions the opportunity to be more involved and get more out of their routine planned appointments with health care teams.

This process starts by identifying individuals via a single recall process which brings together information from all 'disease registers'. A trained health care assistant takes initial condition information at a first appointment. Test results and personalised information are shared with the individual one to two weeks prior to the CSP conversation itself, this ensures that the person and the health care professional have the same information and are not distracted by the completion of tasks and tests. The patient has the opportunity and time to reflect on what is important to them, with family and friends if necessary, ahead of the CSP conversation. The health care professional has the time and space to use their skills effectively. CSP is also a holistic and efficient way to support those with multi-morbidity by bringing together all a person's medical, social and behavioural issues into one conversation however many issues or conditions an individual may have.

Back in 2002, Derek Wanless called for an increased focus on moderating demand by investing in effective health promotion and disease management with the active involvement of individual patients and local communities. Wanless goes on to describe how a radical change in professional and public roles was needed to achieve this. By encouraging patients to adopt healthy behaviours and to diagnose and treat minor ailments, involving them in treatment decisions, and supporting them in active self-management of chronic conditions (Coulter and Rozansby, 2004).

Although this 'radical change' has not been fully integrated across the NHS, there is a growing body of evidence shows that patient engagement in treatment decisions and in managing their own health care can improve patients' experience and often results in more appropriate and cost effective utilisation of health services and better health outcomes (Coulter and Rozansby, 2004).

A key to improved patient engagement is building on health literacy ensuring clinicians help patients to help themselves. Encouraging patients to take more control when ill has been proven to be an effective tool for improving not only public health but personal health (Coulter and Rozansby, 2004). Paternalistic style of practice promotes dependency and does not allow for patients to create self-reliance (Coulter and Rozansby, 2004).

In addition to the benefits of the individual's engagement in managing their health conditions, there is extensive evidence that supports the hypothesis that self-management is a cost effective approach. Self-care is one of the best examples of how partnerships between the public and health service can work effectively - for every £100 spent on encouraging self-care/self-management, around £150 worth of benefits can be achieved in return (Wanless D (2002)).

More recently NESTA's People Powered Health Programme estimated that over 4 billion pounds could be saved annually if comprehensive support for self-management was implemented in England. Year of Care (via care and support planning and commissioning non-traditional services to support self-management) provides a systematic and practical approach to putting support for self-management into routine practice (NESTA's 2013). YOC and CSP have drawn on a number of models and approaches which describe a way of working supported by an evidence base. The chronic care model (Wagner, Austin, Von Korff (1996) organising Care for Patients with Chronic Illness describes

how better outcomes for people with LTCs can be achieved when there is partnership working between an 'engaged', 'empowered' or 'activated' patient and an organised, proactive healthcare system (Wagner, 1996)

A recent Cochrane review summarises the evidence for care and support planning (personalised care planning for adults with chronic or long term health conditions). This review highlights that improvements are most obvious when care and support planning is integrated into routine care, which includes goal setting and action planning and, importantly, ensures both health care professionals and patients receive appropriate training and support (Coulter, Entwistle, Eccles, et al 2015).

This report also highlights that people with long-term health conditions play an important part in managing their own health, as some of the tasks involved can be complicated, and require confidence and skill which can be obtained through undertaking effective training and support (Coulter et al, 2015). Such tasks include taking medicines properly, monitoring symptoms, adopting or maintaining healthy lifestyles, managing their emotions, solving practical problems, knowing when and how to seek medical advice or community support, and coping with the impact of the condition(s) on their daily lives (Coulter et al, 2015). This report also highlights that personalised care planning aims to provide support from a health professional that is tailored to the personal needs of individual patients. Such support recognises that patients' concerns cannot be approached with a "generalised" perspective, and helps patients to become more able and confident in managing their own health (Coulter et al, 2015).

Recent research was undertaken to review the CARE plus study in Glasgow. The CARE Plus study has been developed to enhance and optimise a primary care based complex intervention aiming to enhance the quality of life of patients with multi morbidity in the deprived areas of Glasgow (Mercer, O'Brien, Fitzpatrick, et al, 2016). This qualitative based study endorsed the need for longer health consultations, relational continuity and a holistic approach (Mercer et al 2016). This study also highlighted that most of the participants welcomed the idea of additional self-management support and the streamlining of written self-management support material for patients (Mercer, 2016).

A further study followed the CARE plus project which reviewed cost utility analysis (Mercer, Fitzpatrick, Guthrie, et al 2016). This study employs a RCT methodology to investigate quality of life and well-

being for the patients involved. The intervention comprised of structured longer consultations, relationship continuity, health care professional support and self-management support, the control practices continued as normal. Over the 12 month study, CARE Plus demonstrated a significant improvement in wellbeing (negative wellbeing), although did not show any benefit for positive wellbeing, energy or general wellbeing (Mercer et al 2016). This study also highlighted a gain in quality adjusted life in years, with a cost effectiveness ratio of £12, 224 per quality adjusted life year gained. Moreover, modelling suggested that cost effectiveness would continue (Mercer et al 2016). This study therefore demonstrates that enhancing primary care through a whole system approach may be a cost effective way to protect quality of life for multi morbidity patients in deprived areas (Mercer et al 2016).

Mercer (2016a) also highlights the shift required to create a system that will be better attuned to multi morbidity and its associated complexity. He highlights that the current system is geared to single conditions that are hospital centered, too doctor dependent, episodic and disjointed with passive patients that do not use self-care. Mercer sees a future system that is designed around people with multiple conditions that are embedded in the local community, supported by multi-professionals and team based care. Continuous care should be available when needed and is preventative rather than reactive. He also stresses that patients should be informed, empowered and self-directed with carers also feeling supported and valued and encouraged to access technology to provide greater choice and control (Mercer, 2016). As identified above, evidence has highlighted the need to create systems that fosters self-care to enable self-management and one of the key enablers to this is shared decision making. Shared decision is perceived as important as for policy makers and clinicians as it enhances the use of options for the patients, reduces unwanted healthcare practice variations, fosters the sustainability of the healthcare system and finally promotes the right of patients to be involved in decisions concerning their health (The Health Foundation, 2012).

From the patient perspective shared decision making can improve knowledge about their condition and treatment options, can improve involvement in their care, improve satisfaction with care provided, increase patients self confidence in their own knowledge and self-care skills and improve communication with professionals (The Health Foundation 2012).

From the health care professional perspective evidence has also highlighted that professionals report improved knowledge, skills and job satisfaction as well as reporting improved better organisation and team work. In addition staff also reported improved productivity during working hours (The Health Foundation 2012). There is also limited evidence that supports the idea that interventions supporting self-management and shared decision making work best when the professionals are fully supported, through education, skill building, and feedback through performance (Elwyn, Edwards, Hood et al 2004; Stacey, Graham and Pomey, 2005 and Elwyn, Edward, Kinnersley et al 2000).

In a locally based shared decision making study, the MAGIC study based in Newcastle highlights the key challenges that are faced during implementation of shared decision making across primary and secondary care. These factors include:

1. changing attitudes,
2. the belief from the clinicians that they do not have the right tools,
3. reports that patients do not want shared decision making,
4. a lack of recording the implementation of shared decision making
5. clinicians reporting too many other stresses and strains with the system (Joseph-Williams et al 2017). Joseph – Williams (2017) highlights that “shared decision making requires a shift in attitudes at all levels but can become part of routine practice with the right support”.

In summary, evidence has highlighted the following:

- CSP enables self-management through shared decision making;
- Engagement in self-management is a cost effective approach;
- If self-management is implemented across the UK, 4 billion could be saved annually;
- Patients achieve better outcomes when engaged and empowered;
- Health improvements are most obvious when CSP is integrated into routine primary care;
- Personalised care helps patients become more able and confident in managing their own health;
- CARE Plus model in Glasgow highlights that patients welcome the idea of self-management and self-management supporting material;
- CSP has been shown to improve quality of life and shows a gain in quality adjusted life gained;
- Evidence has highlighted that a system shift is required in order for self-management and multi morbidity conditions to be better managed;
- Staff have also reported a positive impact including improve knowledge, skills and job satisfaction.

3

What does Feedback from Gateshead Say?

Evaluation Methodology

National level data presented above has positively indicated that CSP highlights benefits for patients, staff and practices. In order to gain a greater understanding of the patient and health care professional experience and view of CSP locally, Newcastle Gateshead CCG commissioned an independent researcher to conduct a robust evaluation. All the evaluation data has been collected from seven Gateshead practices who agreed to participate in the evaluation.

The evaluation involved:

1

Ten one-to-one interviews with patients currently receiving CSP as part of their care. The information collected via the interviews was collated and analysed using the methodological approach of Grounded Theory and analytical method of Framework Analysis.

2

Analysis of a patient survey (CQI 2 survey) providing feedback on the care and support planning consultation. Further information on the patient survey methodology is included within appendix four and five.

3

One focus group with seven health care professionals (including administration staff, health care assistants, nurses and GPs) identified from the BHF evaluation practices within the Gateshead. The information collected via the focus group was collated and analysed using the methodological approach of grounded theory and analytical method of Framework Analysis.

4

Patient surveys (LTC6) at baseline and follow up (one year plus). This survey provides an overview of patient experience in respect to care of their LTC. Further information can be found in appendix four and six.

The qualitative information collected through the interviews and focus group have been triangulated alongside the quantitative data collected (patient surveys) to ensure that the evidence presented is robust. The evidence presented below gives a flavour of the positive benefits of CSP integration at regional local level presented from two perspectives: patients with long term conditions and health care professionals.



4

Patients with a Long Term Condition

Four higher order themes from patients with a long term condition have been identified and are detailed below:

- 1. Holistic and Individualised Care
- 2. Enabler (For better self-management)
- 3. Reassurance and Preparation Prompts
- 4. Motivational for most through preparation
- 5. Motivational for most through goal setting and action planning

4.1

Holistic / Individualised Care

Patients highlighted how the Care Support Planning way of working has allowed them to develop more personal relationships with the health care professionals, as they dealt with all parts of other physical and mental health and they discussed the advantages of more bespoke individualised care:

Patient 10

"Because I think it makes you more relaxed and more open to discuss things that you might not have wanted to discuss."

Patient 6

"She's very good, yeah she's very good (patient talking about nurse practitioner). And she talks about the whole of you, not just your condition, which is great because then, you know, you're not a condition, you know what I mean? I lost mi mam last year and I was her main carer so she was asking us about how I was coping with um, not having mam."

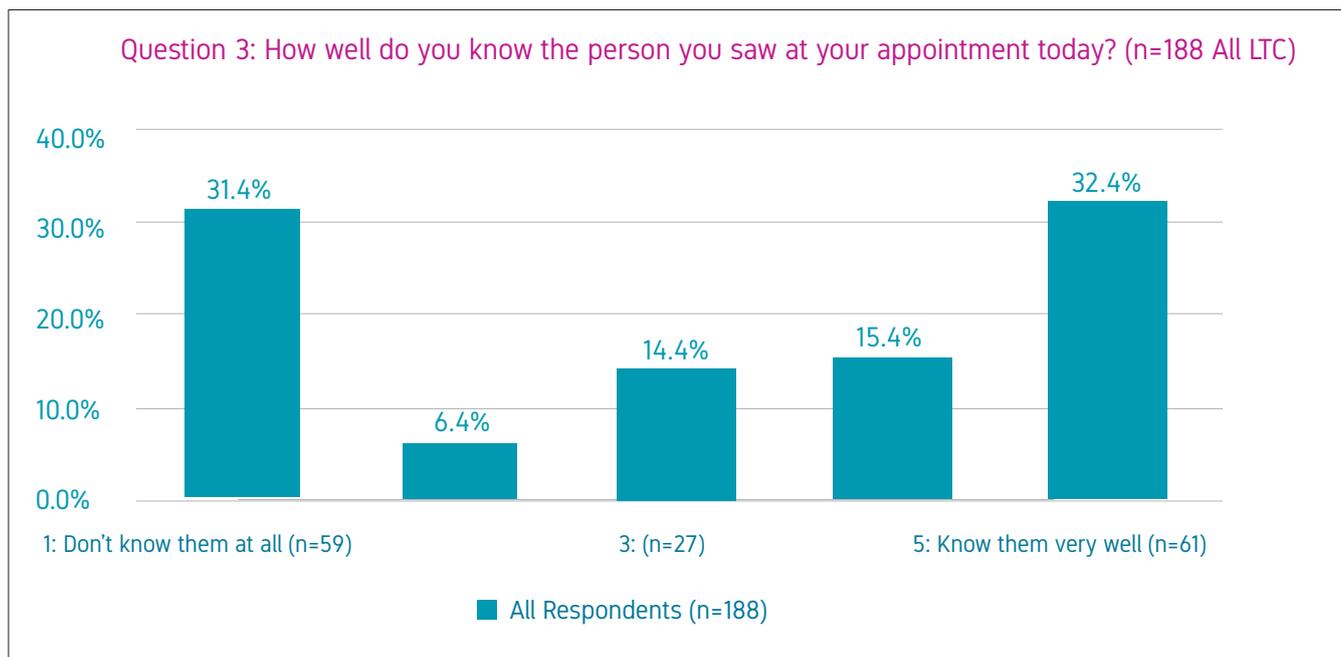
"Yes, I think it felt as if it was tailor-made to suit my health regime."

Patient 7

Patient 10

"And to me, that's everything. It's like getting your car serviced by a mechanic and you don't know nothing about cars, yeah?"

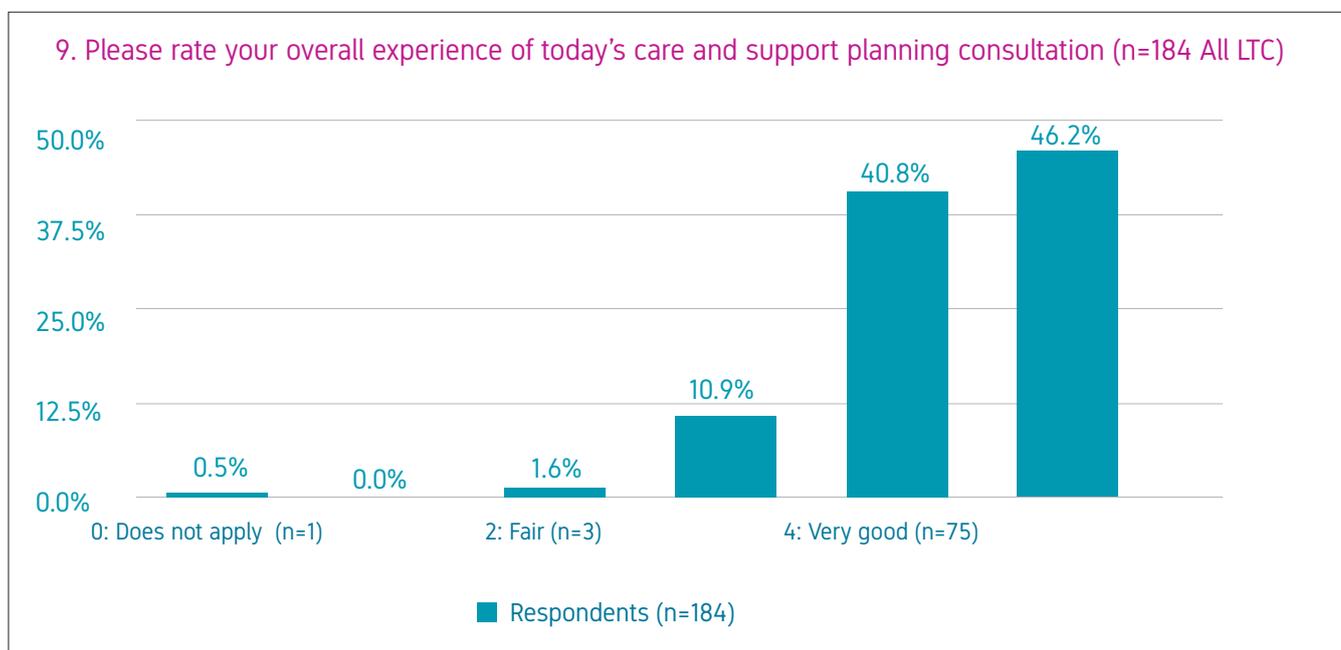
Quantitative data collected reviewed how well the patients know their HCP with 31% (n=59) responding that they did not know their clinician at all and 32% (n=61) responding that they know them very well.



This data seems to be at odds with each other, but what is clear to remember is that evidence suggests that positive relationships with health care professional's results in better health care for the patients. The attitude and skills of health care professionals can have a significant effect on the extent to which people feel engaged and supported (The Health Foundation, 2012). People who feel supported by their doctors and nurses may be more 'activated more satisfied and have better health outcomes (Lam and Lam, 2010).

Evidence from the patients interviewed highlighted that felt that the care they received was better when they developed a more personal relationship with their health care professionals as they were more likely to disclose more personal information that they might not have disclosed before.

The rated experience of the consultation shows that 87% n=160 rated their overall experience of the care and support planning consultation as very good or excellent.



4.2

Enabler (For better self-management)

Patients discussed that receiving the results in the post, combined with seeing the health care professional, was very useful and this enabled them to manage their personal health:

Patient 1

"Because she said 'whatever you get in the post, it won't be everything at all', but when you come down and see (Health Practitioner name), she puts the computer in front of you and she explains everything."

Patient 7

"(Practitioner name) got all of my test results up on the screen and as I read through the hard copy list, the yellow sheet, she was pointing out 'previous readings' 'present readings' and 'safe zones' as it were and where I was on those zones. And each point on the hard copy we went through on the screen and she's sort of flagged where I should be watching things a little bit more than perhaps I have been and it just went through quite sweetly."

"Well I thought it was quite interesting because when I went to see her a couple of weeks ago, she was, (I was asking her) to explain all the different things there. So she was telling me that I was in the right, where I should be, you know. And I was thrilled to bits, you know."

Patient 2

Although it should be pointed out that not all Health care professionals had a positive opinion or expressed that positive opinion to the patients:

Patient 1

"She said 'you'll get something in the post', 'some you might not understand' she said. But it was ok, the liver I think was a bit, not as it should be but it wasn't too bad. But everything else they said was spot-on."

Some of the patients also indicated some of them did not receive the results in the post (n= 2), highlighting some inconsistencies or potentially misunderstanding:

Patient 1

"I didn't get one of those (referring to feedback in the post)."

Patient 4

"No I didn't receive the results in the post."

Some of the patients (n=2) reported lack of understanding of the results that came out to them through the post:

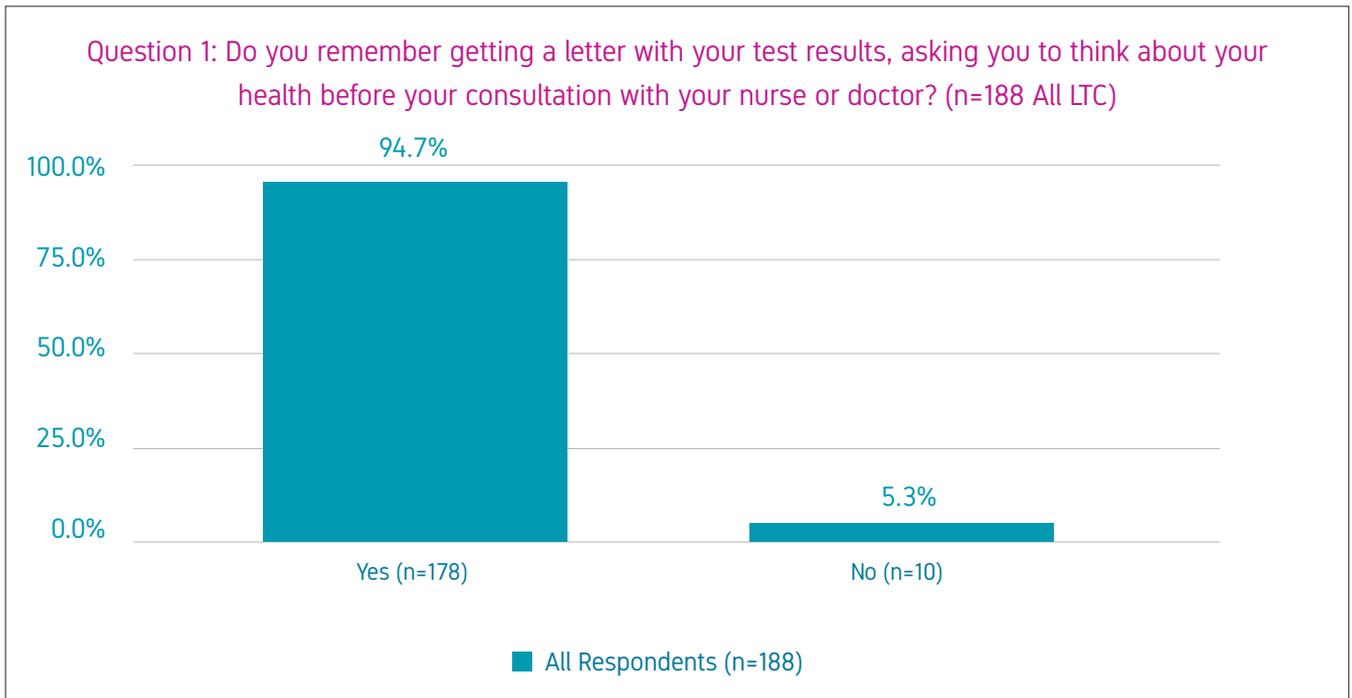
Patient 1

"Yes, so many, you don't get to them all (patient talking about appointments)"

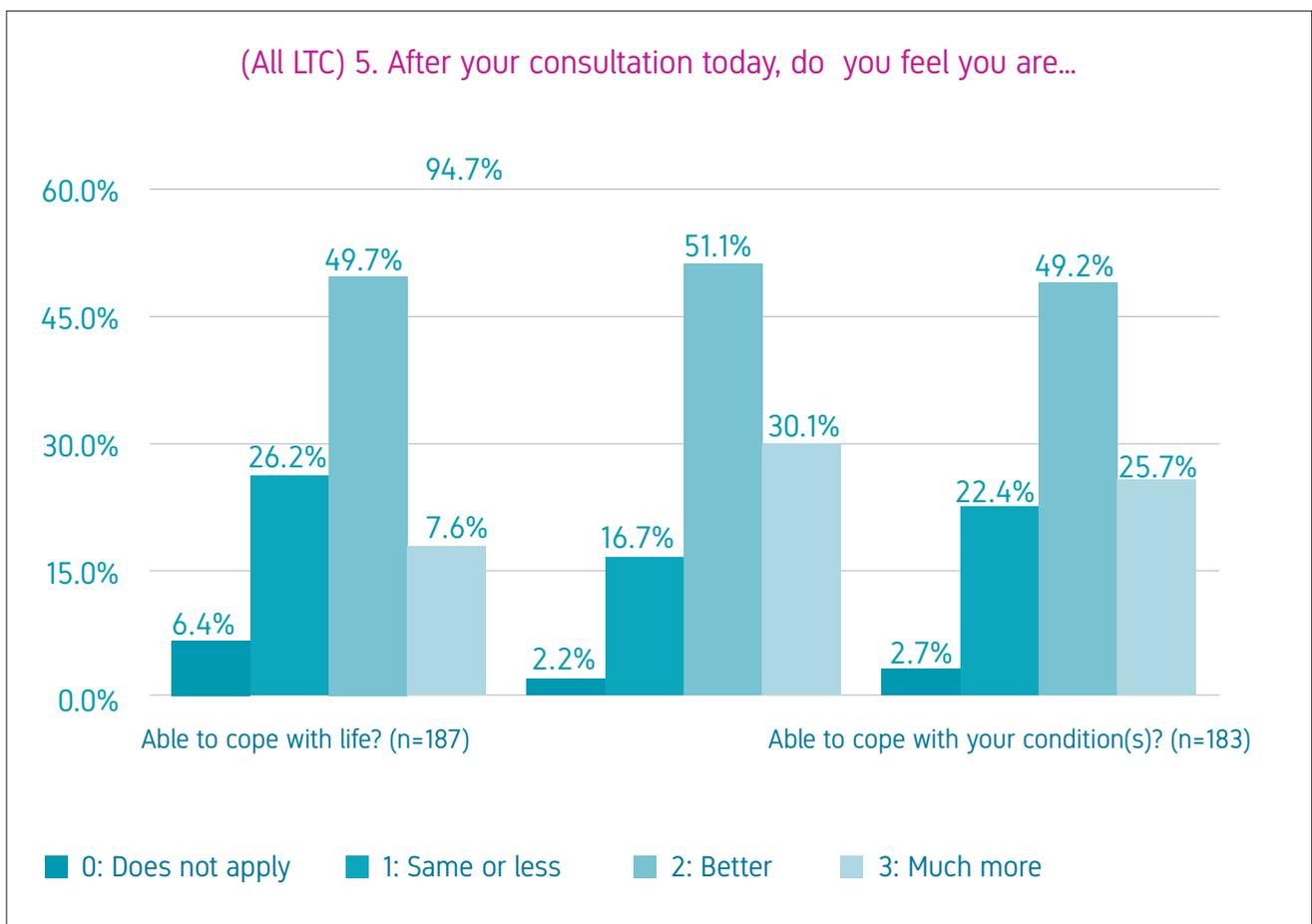
Patient 1

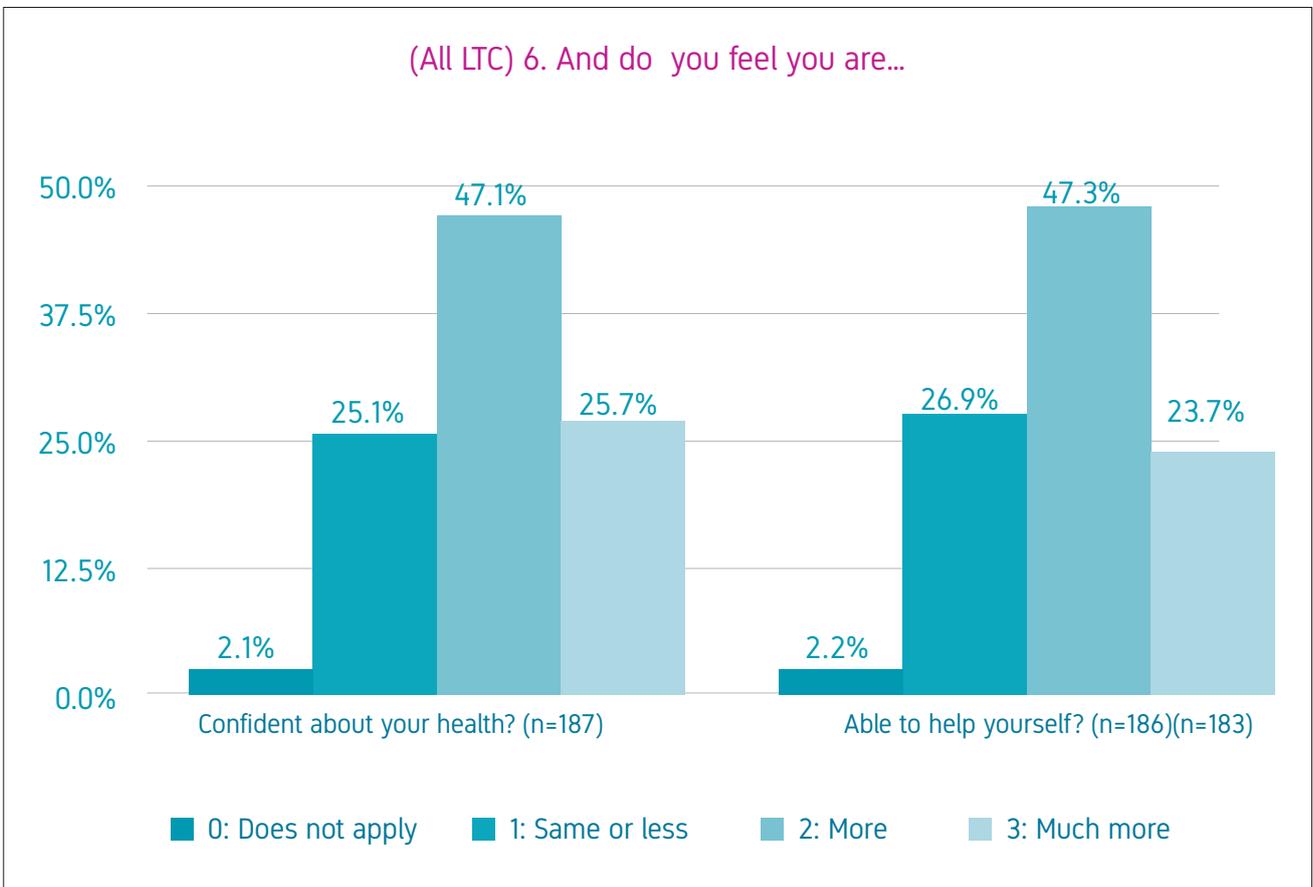
"Well I mean, my husband, you know, he was looking at it and 'what's that, what..?' And I said 'well 'renal' is kidney' and the bloods, I didn't much understand. But they were happy, you know, it had on that it was satisfactory."

The patient survey showed 95% (n=178) remembered getting a letter with test results, asking you to think about your health before your consultation with the nurse or doctor. This indicates the preparation step (results and agenda setting prompts) is routinely carried out in practice for the cohort of patients surveyed.



The patient survey focused on the impact of the consultation on the patient, although no base line data was available, the results highlighted that the majority of patients 67.3% (n=126) felt that they were better able to cope with life after the consultation. In addition 81.2% (n=151) were better able to understand your condition and 74.9% (n=137) were able to cope with their condition after the consultation.





Patients were also asked to rate how confident they felt about their own health 47% (n =88) answered they felt 'more' confident about their health following on from the consultation. Whereas 26% (n=46) stated they felt 'much more' confident. In addition 2% (n= 4) did not feel this question applied to them.

Alongside this patients were asked to rate how confident they felt about helping themselves 71% (n=132) of participants stated that they felt 'more' or 'much more' able to help themselves after the consultation.

4.3 Reassurance and Preparation Prompts

Many patients highlighted how they liked the results being forwarded in the post. They found that it provided them with reassurance and let them know in advance of any problems they may need to discuss with their practice nurse or GP:

Patient 1

"Yes, because I was sort of forewarned, if you like."

"Well I think if I hadn't got the results in the post, by the time I saw her - which was three, four weeks after - I probably would have been getting a bit anxious. But because I got that letter, well I knew coming down to see (practitioner name)."

Patient 4

"That was good. Because when I took this form out I could go through them with her, you know, what I wanted to talk about, so I thought it was good."

Patient 2

Patients indicated that the feedback form also provided a prompt to remind them to ask question during their next PN or GP appointment and this enabled them to concentrate on issues that might be important to them:

"Oh yes, because naturally you go somewhere, like say a doctor or anything, and things just slide your head. So that was very handy. So I could talk about what problems I had or anything."

Patient 2

Patient 3

"Yes because sometimes you have it all in your mind and then when you get to the surgery you forget half of it! ((both laugh)) So of course I had it all written down. And I was able to ask her what I feel were the more important things."

Patient 6

"And then I got a letter afterwards telling us the results. And I was very pleased with that because it puts everything in black and white and you can go through it and there's a place at the end of the letter to put questions and I thought that was great. Because by the time you get to see your review, get your review, you tend to forget what you were going to ask. So it was good that there was a place there to put them down."

Patients also highlighted how they enjoyed having a more instant feedback for the results which made them less worried or anxious:

"No it's better. It's definitely better because you're told straight away"

Patient 6

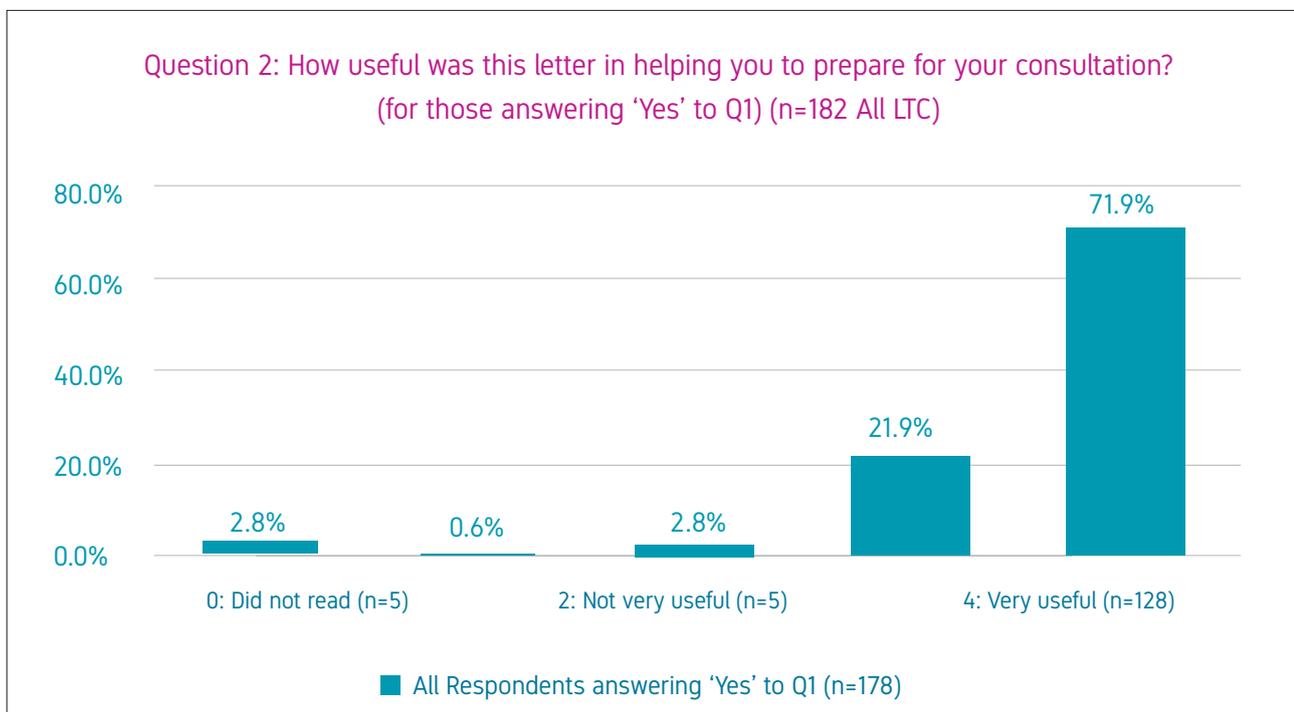
Patient 7

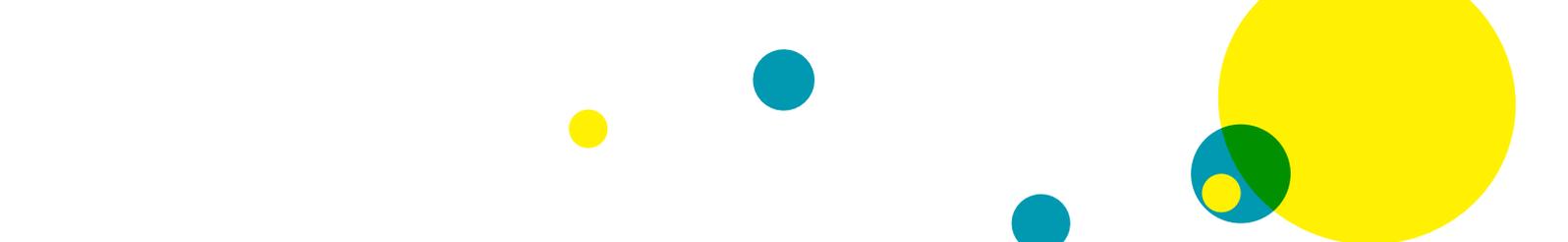
"I think it is yes because if someone gives things verbally it could come and go within ten minutes. Whereas if you have a data sheet - for want of a better expression, at least you have something to refer to...'what was my BP that time? Oh aye, that was it, that's a touch high' which it was but it came back down when I seen the nurse the second time. But as I say, to have it as a visual..."

Patient 10

"I think there is something on that form, I can't remember off the top of my head but it does say various things 'it should be between this, that and the other and it's good to be this' and it gives you- , what I like about it as well, it gives you the year prior to what your results are for this year, so you can make a comparison. And then you can say 'oh crikey, I better drink a bit less!' or something like that you know!"

The majority of the patients surveyed supported the qualitative theme of reassurance as 72% (n=128) responded that the preparation letter (include results and agenda setting prompts) was very useful.





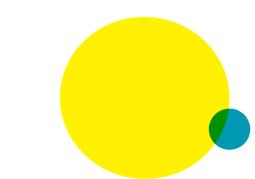
4.4

Motivational for most through preparation

Many of the patients discussed that they really enjoyed the feedback given through this way of working and this feedback allowed them to make healthy changes to their lifestyle:

"Yes it really hit me when I saw the weight I was. With not being able to get around, I never really give it a thought, you know. And then when they told me that I said -, I couldn't believe it! So I started the next day. And I don't call it 'a diet' anymore, it's just healthy eating... so it helped me 100%"

Patient 2



4.5

Motivational for most – through goal setting and action planning

Many of the patients highlighted that motivation to make changes to lifestyle came after the annual review appointment with the HCP.

"My goal was to just 'keep going' everything as it should be."

Patient 6

Patient 7

"Yes because when I went home I said to the wife 'we're going to have to completely ban chocolates and biscuits because my sugar levels are slightly high' and she said 'well I think we should anyway' because we do occasionally have a few choccy biscuits with a cup of tea. And I said 'I know that biscuits are a rubbish food' so it was on my mind to change little things to make the long term better."

"Not... 'plan' is perhaps too defined a word. Just more like a general watch on things. Try and keep the weight down especially, because of how weight and diabetes are linked closely. So just diet and weight really."

Patient 7

Patients also highlighted that they received their results in a matter of days and they thought this was really good service:

Patient 3

"Yes she did. Yes she said I would hear in a few days, which didn't take very long, I couldn't recall how many days but it wasn't very long."

Patient 5

"I think it was about a month from when I had the blood tests. But in the meantime I got the letter to say I had results. Which was a relief, that you've got the results, you didn't have to wait that month. Because I had the letter within a week, so that was quite good."

One patient also highlighted that she thought that the CSP was a waste of time for her and she would have highlighted any of these issues if she had them:

Patient 5

"No I didn't but I felt that that was a little bit of a waste because if I had a problem with any of those issues I would have been down to see the doctor in the meantime. So I didn't think that was actually necessary."

- Care Support Planning seemed to allow a patient – health care professional relationship to develop, encouraging patients to be more open and discuss issues that they might not have disclosed otherwise.
- Patient fed back on the whole that receiving the results in the post helped as:
 - as it gave them an idea of what was going to be discussed at the next appointment.
 - as it also provided prompts/reminders for the next PN or GP app.
 - patients report being less worried and anxious as a result of the results coming through in weeks rather than months.
- Although it should be noted that some patients discussed not being able to understand the results that they did receive.
- Many patients enjoyed Action Planning as it helped them to make a lifestyle change.

5

Health Care Professionals

Nine higher order themes have been identified from health care professional feedback and have been presented in three headings detailed below:

Process

1. Varying Surgery Processes
2. Aversion to change in process

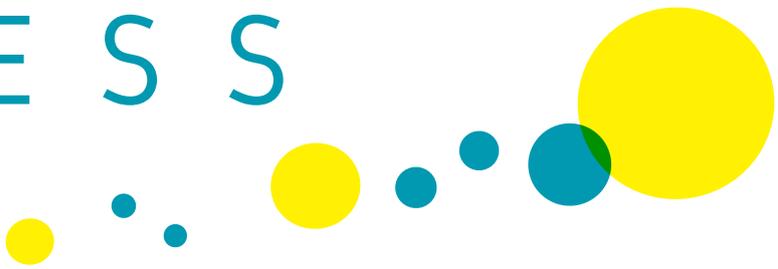
Outcome

3. Empowerment (for patients to control their own health)
4. Multi morbidity approach is time saving for practice and patients
5. Flexible service offer (to deliver social prescribing)

Best Practice

6. Whole Surgery Engagement
7. Vital Administration role
8. Education around CSP Process (understand CSP and moving away from medically led model)
9. Staff Enrichment

P R O C E S S



5.1

Varying Surgery Processes

An interesting theme that has emerged is in respect to surgery management: each surgery attending the focus group had different ways in which they managed appointment times with patients with long term conditions within the care support planning appointment process. Some surgeries allocated a generic 20 minute appointment which causes the practice nurse to run behind and potentially causing friction for both staff and patients:

"I think one of the problems I have is that no matter how many problems they have, I get 20 minutes. (Intake of breath from a participant). All I do is a long term condition, which is why I was employed. I get 20 minutes to see each patient for the second part of the Care Planning. So if they've got diabetes, hypotension, heart disease, atrial fibrillation and asthma, I get 20 minutes."

Practitioner 2

Practitioner 2

"So you know saying that all the patients get everything all together, yeah they do but I get no lunch break, I get no coffee break, I'm always late, I never finish on time."

Whilst other surgeries allocated a more bespoke time slot (allocated on an individual basis) which seemed to result in a more harmonious balance for the staff / practitioners:

Practitioner 5

"Our GPs, when they've got the blood results, they send a task to (admin staff) 'this patient will need a 20 minute appointment with me' 'this patient will need a 40 minute appointment with nurse practitioner' 'this patient will need a 30 minute appointment with me, nurse, Dr Blah Blah, Dr Blah Blah'. So the GP decides, from whatever long term condition they have and the results, how long that patient should be how long that appointment should be."

"Although the HealthCare's do get a bit stressed finding appointments but that's because we don't get 20 minutes per appointment! We get whatever we deem to be necessary. Our shortest appointment is 30 minutes. And then we get longer for each additional person"

Practitioner 3

Practitioner 6

"In our practice we've got primarily two, so we have a GP and we have a nurse practitioner who gets so many surgeries a week that are filled with just long term condition appointments. And if there's any, like, spill over, then they decide which GP can pick up and see the patient. But we have surgeries allocated for it, specifically."

5.2

Aversion to change

Health care professionals were also keen to highlight that the new way of working was initially hard to integrate and potentially changes the way of working for staff and patients:

Practitioner 3

"I think getting it off the ground has been a logistical nightmare, and I make no apologies for saying that. It has been a logistical nightmare because we all could see the logic behind it and the theory behind it. But as with a lot of things that are brought into nursing and medicine, the theories are always very sound but the practice is always much more difficult to actually bring forward."

Practitioner 3

"I think in some cases it has but not in all cases. Because patients, like staff, are resistant to change. And I've found, certainly with the older patients, they expect to come in and be told what to do. They don't expect to come in and be asked what they would like to do. And that different approach is kind of... I think some of them find it a little bit difficult initially to get on board with, because it's 'well, what do I need to do?' 'Well, let's see, which object are we going to work on and take it from there'. So some yes, it's made a big difference. Others, not so much."

Despite potential problems with integration at first all of the health care professionals interviewed highlighted the great benefit they see from this way of working:

Practitioner 3

"I've been nursing a long, long time - anything new that's brought in, you'll always get some resistance to. There's always going to be somebody who says ((adopts dull sceptical tone)) 'I don't know why we need to change it, it was the fine the way...we've always done it like this'. I mean how many times have we all heard that! I think a lot of people are resistant to change and it's actually trying to get people on board. Just sort of saying 'it is worth trying this' and I think almost without exception, once you actually get it running, everybody's found benefits from it - patients and staff."

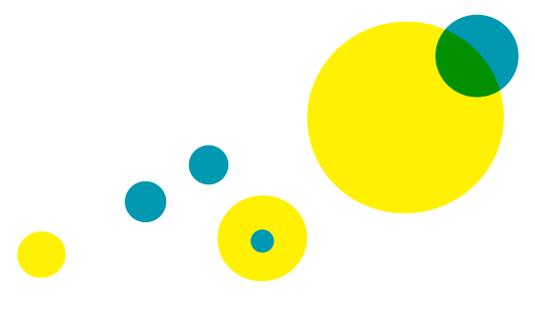
"Was bad (initially) I went 'right OK'. I was totally 'teaching granny to suck eggs' was kind of my attitude. I did go on the two day training and it was like 'oh you'll have a different opinion by the time you've left' and I have to say, my mind was changed, having understood why I was doing it, the logic behind it. Because it was kind of put to me as just a lumping together of the long term conditions, I thought ((adopts cynical tone)) 'aye right, fine, some of us have been trying to do that for a long time'. But actually, when I looked into it a bit further, I have to say, I was kind of sold, more than I expected to be."

Practitioner 3

Practitioner 5

"I just felt that the building-, you know the building blocks, and it just all made sense. And although different people had been trying to do it, over the years, to do it in different ways, it just seemed a more structured, sensible, logical way to progress."

OUTCOME



5.3 Empowerment (for patients to control their own health)

An interesting association has been noted between Care and Support Planning and how it has empowered patients to control their own health. Healthcare professionals highlighted a number of examples within their own practices:

“By sending them the results so they’ve got the results to think about before they come and asking them to think about what they want. So rather than them coming in and us just saying ‘yeah, you’ve got...you need to do something about it. It’s about giving them the information prior to that so they can be aware.”

Practitioner 2

We’ve had a couple of patients who’ve looked at their diet and lifestyle before they’ve come in. And ones that I think, seeing it in black and white, you know, previously when they’ve been told about these things they think (make shrugging uninterested noise). And I think the thing of seeing of it, particularly (in ones that are motivated) if they’ve seen last year’s results to this year’s it’s kind of gone ‘ooh’, ‘it made me realise what (all these times)’ so it has had a positive impact on some of them.”

Practitioner 2

The healthcare professionals interviewed also highlighted their understanding of how important the empowerment of patient is within the changing environment of health care, for example an ageing population with increased number of Long Term Condition's (LTCs):

Practitioner 3

"I mean as the population is getting older, we're having more and more people who have complex long term conditions. So it makes sense to have some kind of robust system in place to make sure that they're not slipping through the net, that they are being followed up, that they're being empowered to look after themselves. That they're not coming twice a week just because they want to see somebody. That there are options open to them just to...."

"Yes and I think, seeing last year's results as well, does give them a bit of (assurance)...particularly if there's been a jump in their results, a big change, then it does..."

Practitioner 3

The healthcare professionals also highlight how the patients are being empowered and how healthcare professionals are moving away from the medical led model to a more self-management model and opening the door for patients to talk about issues that matter to them and their health.

Practitioner 3

"Focussing on what concerns them rather than what concerns us. Because we're very much kind of 'we need to hit these targets' and what's important to us is very often not what's important to them."

"A primary example is bereavement. I had a gentleman come in recently for his review and, you know, you sort of say 'how are you?' and he burst into tears and went 'I'm dreadful' and I'm like 'OK'...But that was more important to him, at that time, than looking to see what his blood pressure was or what his cholesterol was or anything else."

Practitioner 3

Practitioner 2

"Well, sort of what the patient felt or what the patient needed would be at the bottom of the list where it's (CSP process)...kind of turned it round a bit."

5.4

Multi morbidity approach is time saving for practice and patients

Health care professionals highlighted that time saving for both the practitioners and the patients are significant. In respect to the patient the health care professionals highlight how they save time as the patient no longer needs to attend multiple appointments which in turn has reduced DNA's (anecdotally as we have no statistical evidence to support this) as reported by admin staff:

"Certainly for the patient it's saving them an awful lot of time, coming in. I mean beforehand, I looked after asthma patients, COPD patients, heart failure patients, diabetic patients, I was sometimes ringing the same person, you know, weekly, and they might have just been.... because at first we did wonder whether the (bulk) had been there for so long but we actually sold the fact that 'yes it's a longer appointment but it's saving you three others'. And I think nine out of ten people are more than happy now. ((Another participant agrees))."

Practitioner 5

Practitioner 6

"Yeah, yeah, so I do all the long term condition appointments. I do all the Care and Support Planning but I also do all the diabetic appointments as well. So I can see between the two, the difference that it saves in them."

Practitioner 5

"I think some of them might...you know if they had three or four different things, might have thought 'well I've been, I've been for that, I'm not going again'. So maybe they've thought 'well I'm not going for my asthma because I've just been for my heart check'. But now everything's done so.... (Group agreement)."

5.5

Flexible service offer (to deliver social prescribing)

Many of the health care professionals highlighted that social prescribing was something that they found useful especially with older patients many attended appointments and would disclose that they were lonely and making GP appointments because it was 'something else they could do':

"Most of them, because most people with long term conditions are older people, so when they come in for their appointment sometimes they will disclose, like from the front, that they're lonely. So if they've circled it on the front, the GP will discuss it with them. So with me being the social prescriber as well they'll just send us a message and say 'is there anything around the area where they live, or anything that they can go to?' so that's saving appointments as well. Because they're going out and they're going to a new group or they're going to have like lunch, or they're going on days out instead of coming back to the GP for something to do, because they're lonely."

Practitioner 6

"Yeah we've had exercise. People who wanted to do exercise. They've been told the exercise classes that are out and about, or what's on at the leisure centre and things like that. We've had."

Practitioner 6

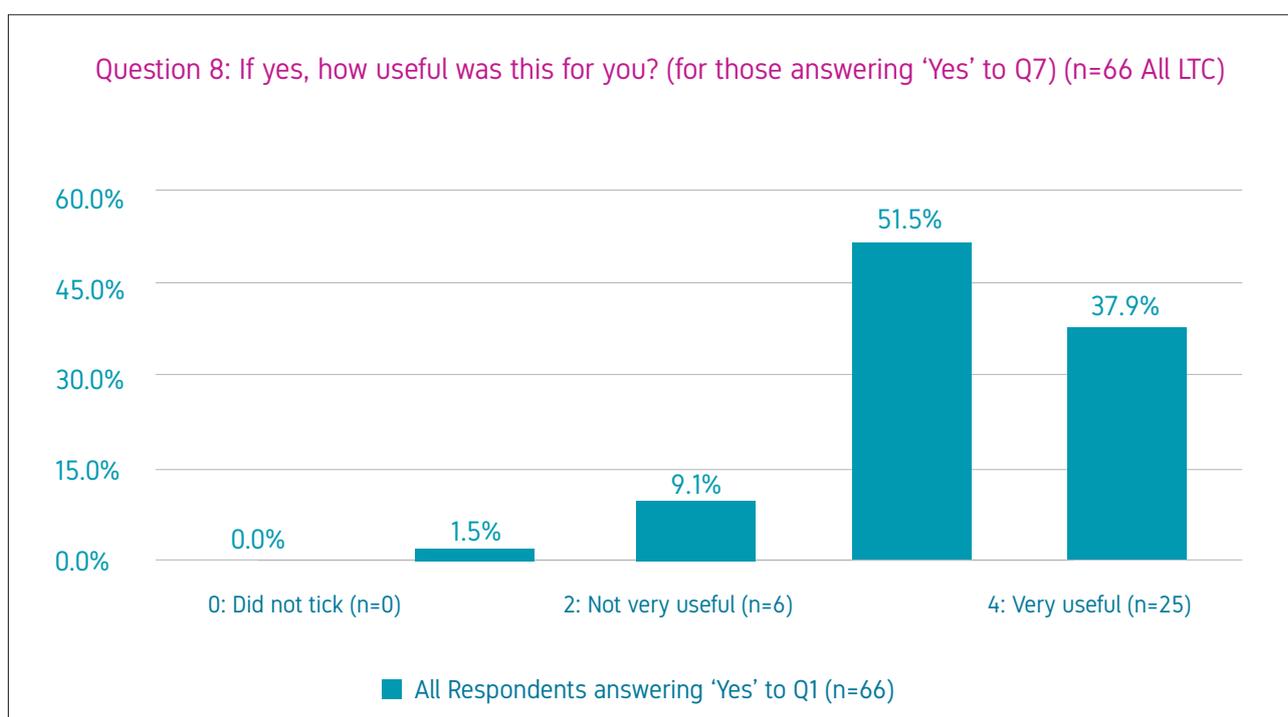
"Yeah, befriending's the biggest. I've even had people who need to learn how to read and write, I've referred them to place to go that they've identified."

Practitioner 6

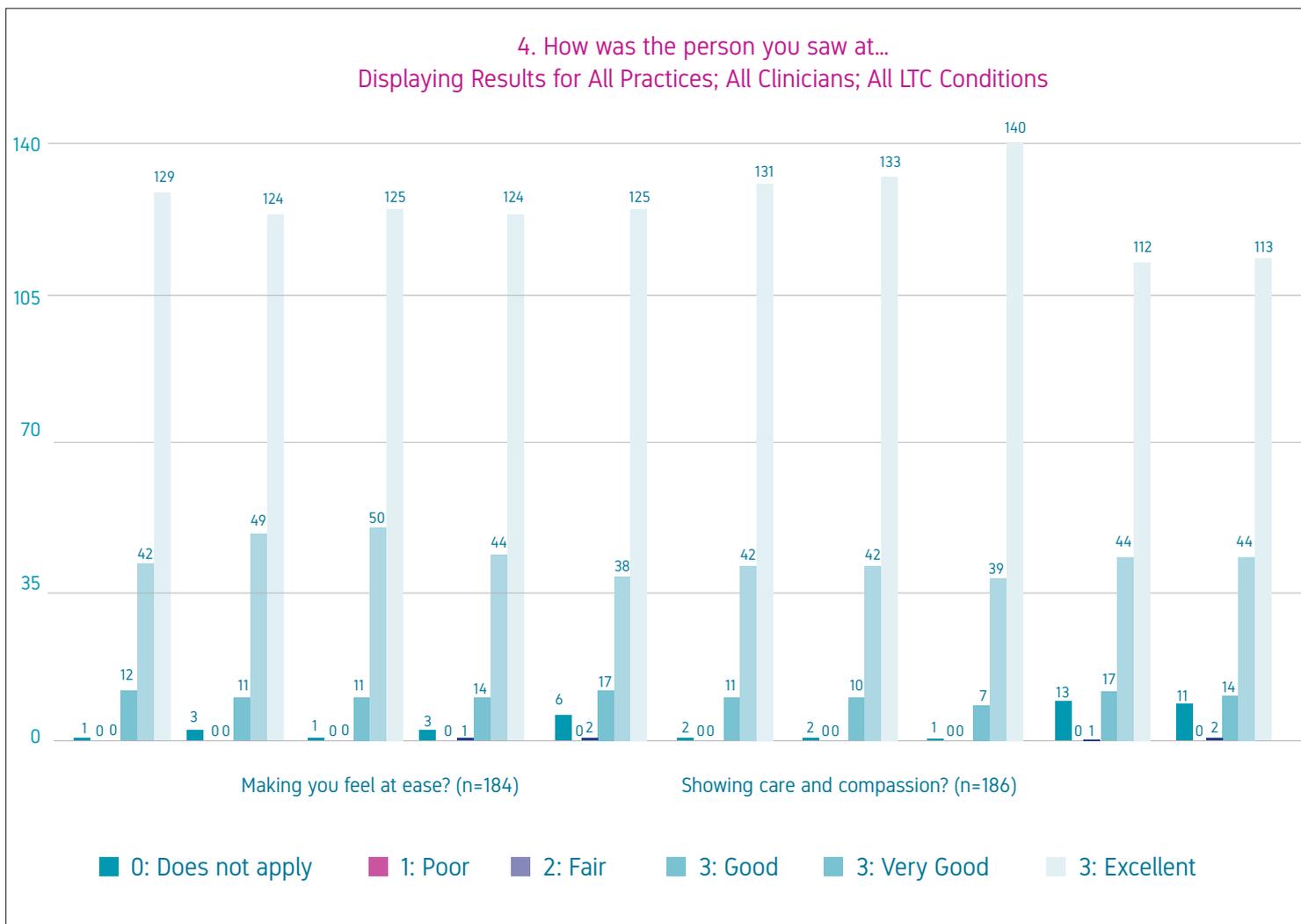
Additional quantitative evidence strengthens these findings by highlighting that during health care consultations 35% (n=66) of patients discussed services or activities in the local community. However it should also be noted no baseline was taken here and 65% (n=122) patients reported that they didn't discuss services or activities in the local community. This area is still to be developed further but we acknowledge not all patients would require discussion or sign posting to activities in the local community. We believe that this area has improved/increased since the initial report in December 2016.



From the 35% of the patients that indicated that they discussed services and activities 89.4% (n=59) found this 'somewhat useful' or 'very useful' supporting the qualitative findings.



Additional information collected on HCP consultation skills when patients were asked a set of 10 questions relating to their experience with the health care professionals who carried out the review.



From the 10 questions asked all showed a high level of positive feedback with 91% (n= 1690) of the responses being ‘very good’ or ‘excellent’. None of the responses were rated as ‘poor’ and 0.3% (n=6) responses were ‘fair’. It should be highlighted that 2.3% (n= 43) responded as ‘does not apply’ indicating that patients perception of needs varied and careful consideration should be given to ‘readiness’ of the patients to make a change, or changes are already underway.

5.6

Whole Surgery Engagement

The health care professionals were also keen to highlight that surgeries need to 'buy in' in order for this way of working to work and they stressed that the whole surgery needed to adapt:

"We had a GP that was involved with it, we had HealthCare's that were on board, and I came in and just got dumped in it - but that's neither here nor there. It's been-, I think - as I say - the theory behind it is fantastic. I like the planning that goes into it. I like the forward-thinking that they come back, they see somebody for their measurements, for want of another expression, get all their blood pressures, bloods etc. done."

5.7

Vital Administration role

It became clear that many of the health care professionals attending considered that how the service was received by admin support was a key influence in how new ways of working were integrated into the surgeries:

"We were quite lucky in that we had an admin person that was willing to take it on"

Practitioner 3

Administration staff were keen to highlight that it has improved the way they work and interact with patients:

Practitioner 6

"We don't have figures or anything but there's-, out of the people that I sent appointment letters to-, so in a month it could be between 70 and 80 patients, that I send blood results out. And I would say out of them, the most I've had is about six that haven't turned up..."

Practitioner 6
Administration Support

"Like even just the simplest thing of like -, because when we send the blood results out we give them an appointment. So if they can't make it, all they do is like just give us a ring, but I found that even patients now, I know their names. If you say their names I know exactly who it is, just from the conversations that I've had on the phone with them. And then it could be the simplest thing, like I need to rearrange, but then they could go into detail about like, their appointments and go 'oh, I found this really useful' or 'can you tell us the difference between these...' and even though I'm not medically trained, they're still asking me questions. Which they probably would never have asked before."

5.8

Education around CSP process (moving away from medically led model)

Healthcare professionals highlighted an issue with how some patients expect medically led treatment. Health care professionals discussed issues for patients (in the preparation phase) not understanding how to complete the action planning section of the form but also that patients are unwilling to complete as they feel it's the medical health practitioner's role:

Practitioner 2

"Because they don't know what to do with it. It's a piece of paper and 'I don't understand, what am I supposed to do with this?' or 'this is for you to fill in' 'well no, actually, it's for you to fill in!' ((group laughter))

"There are a couple of patients that come with them filled in and have made plans and are doing things. But the majority of them are 'and I had to bring this for you' 'have you wrote anything on it?' 'no.'"

Practitioner 1

However this varies from surgery to surgery, some surgeries highlighted how patients are keen to complete the action plan start of the care plan and find it very useful.

Practitioner 3

"I find the majority of ours actually write in it. Or they put down things that they would never have put down before at appointments."

"And they get the results sent out and they have a chance to look at them, which most of them do. They may come back and say 'I don't know what that is' but the majority of them will say 'well why does that say that?' Now it might be something simple as far as we're concerned, but if it's something that they've picked up on, it gives you a starting point to openand as you said, somebody writing something down saying 'I'd never have told you that face-to-face but because I can write it down...' I think it just encourages the patient to open up more to you, to actually be more forthcoming."

Practitioner 5

5.9

Staff enrichment

Once fully integrated as a new way of working the health care professionals highlighted the benefits of increasing their own personal skills-set and potentially improving how they care of patients:

"And it's also widened my horizons because I've had to learn the bits I wasn't so sure about, I've had to expand my knowledge because I've got to be able to deal with it. So you know, I've been and done a diabetic course because I didn't know a great deal about diabetes. So from that point of view it's been quite beneficial. From a personal point of view, because I've had to actually give myself a shake and say 'you don't know how to do this, you better learn'. Because at that particular time there was nobody else could do it so it was..."

Practitioner 3

Practitioner 2

"I think it keeps you up-to-date more with everything but I came from a practice where I was the only nurse. So I had to do it anyway so I...but it certainly keeps you on your toes. And you deal with more patients. And I suppose you do get the rapport with them and the relationships that I was used to in a small practice, because you're seeing the same ones. But even in a big one you get the -, particularly the patients that come more frequently. And they get to know you. And they come in the door and say 'I'm not speaking to you!' (all laugh) 'OK!'"

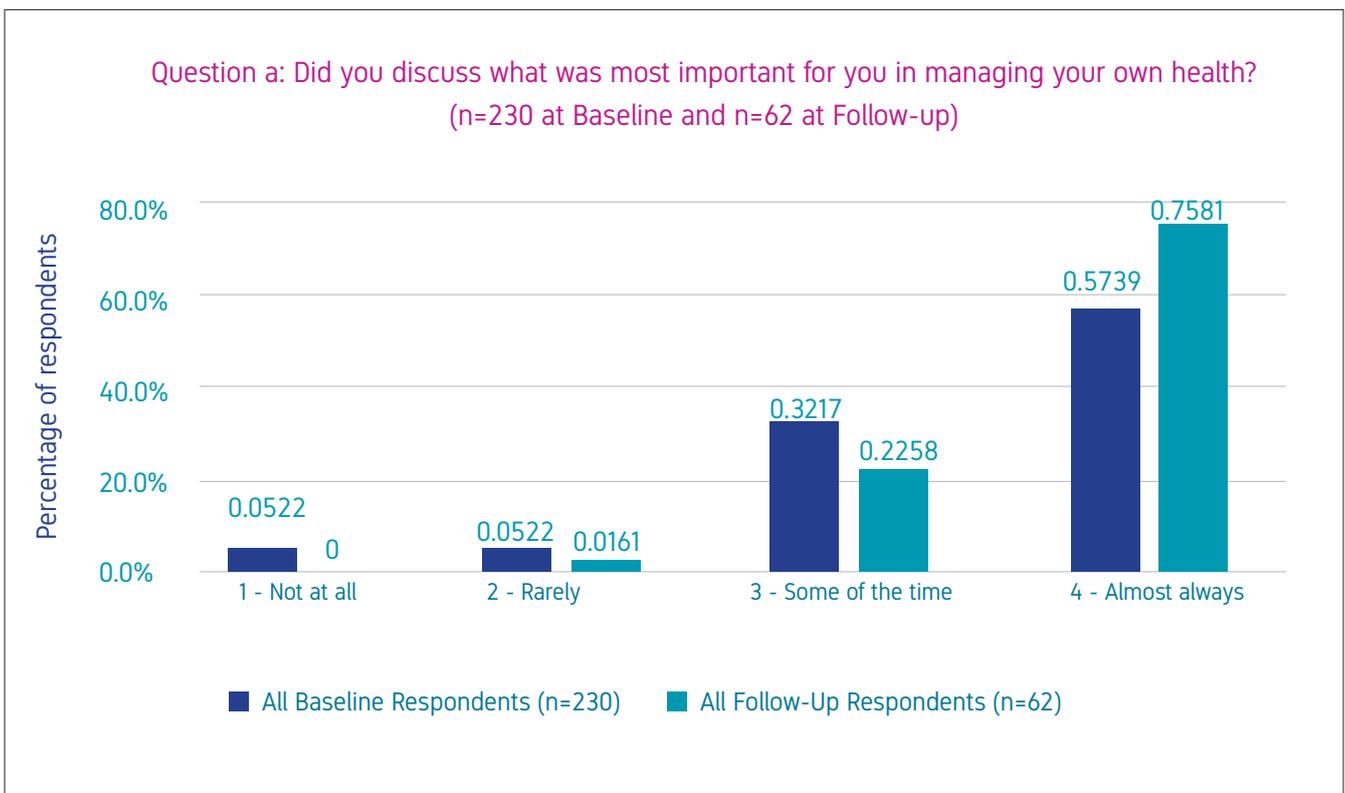
- The HCP's that attended highlighted that patients are now taking more control of their own health, becoming more proactive rather than reactive as they are prepared for the review, by receiving their medical test results and prompts in the post, resulting in increased patient empowerment. This has also been highlighted in the patient feedback.
- This increased of empowerment has been shown as valuable as staff highlight that with an aging population with increase LTC's enabling the clients to self-manage more effectively and therefore are less likely to be reliant on the medically led HCP interaction.
- HCP also indicate that this change from medically led HCP interaction is not universal and is challenging due to the nature of the population and confusion over who completes the action planning. – patient education
- Time saving seems to be a key theme in that patients no longer need to attend multiple appointments and this has caused a reduction in DNA's
- It also seem key that in order for the CSP to really be effective each surgery really needs to 'buy in' at all levels from Admin to GP
- It is also clear that flexible to appointment times is also vital for both the patients and staff benefits
- Staff have reported an increased in personal skill set increased capability as they now deal with all conditions rather than specialise in one.
- Evidence suggests that the necessary skills to enable a successful HCP conversation
- Social prescribing is highlighted as something that they find useful as loneliness is noted regularly by staff as a concern by patients



Baseline and Follow up Patient Survey

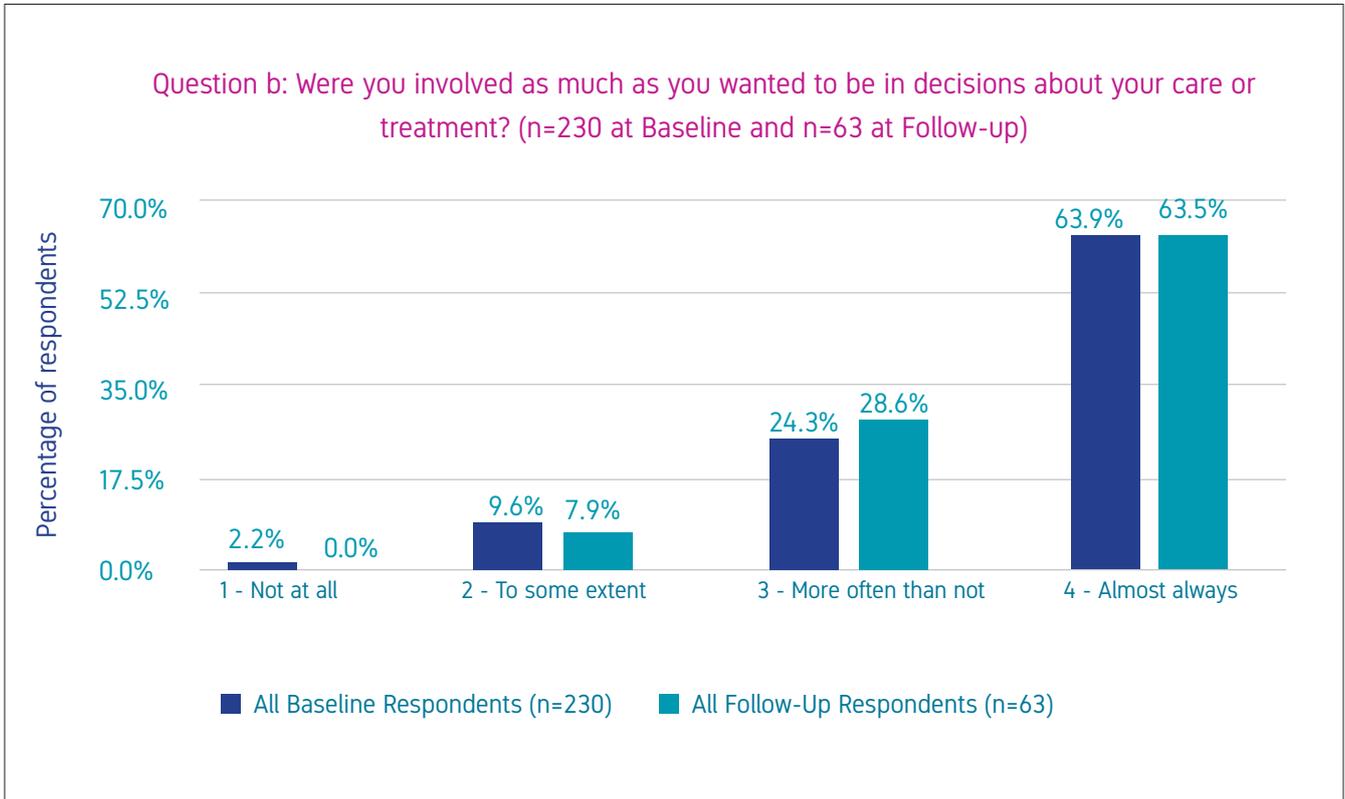
In order to assess the wider impact patients were asked to complete a survey prior to any Care and Support Planning consultation. The same survey was utilised by practices when they had fully embraced the CSP consultation for patients that had experienced the consultations one or more times. The idea of the survey is not specific to the consultation rather an overview of the care received for LTC over a 12 month period. It would be anticipated that over a longer period of time there could potentially be a more pronounced difference in percentages. We are aware that there is a difference in numbers from patients at baseline (n=234) and at follow up (n=63) we have used percentages in order to view the data so that it can be compared.

Patients were asked before and after at least on CSP appointment if they discussed what was most important for managing their own health.

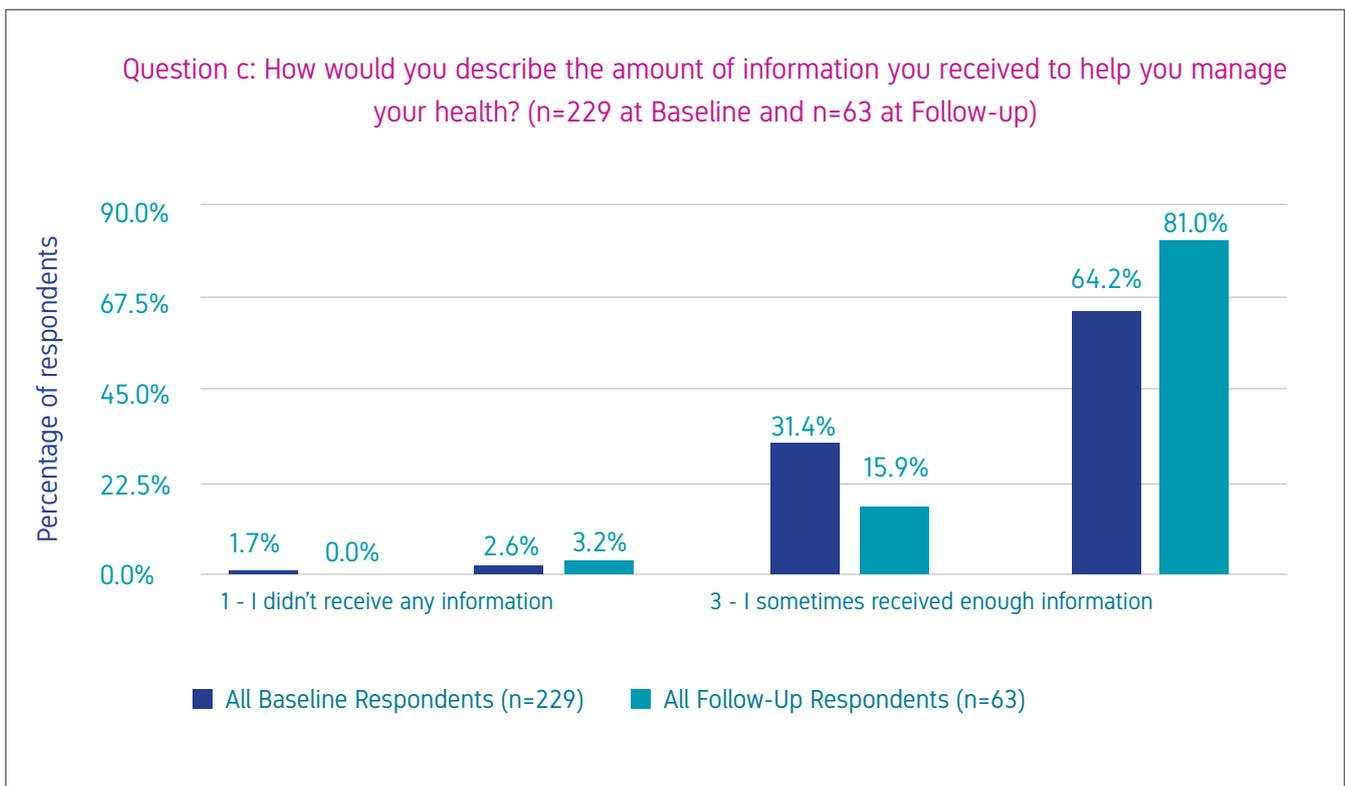


The graph identified above highlights an increase from 57.4% (n=132) baseline to 75.8% (n=47) follow up for 'almost always' discussed what was most important in managing their own health.

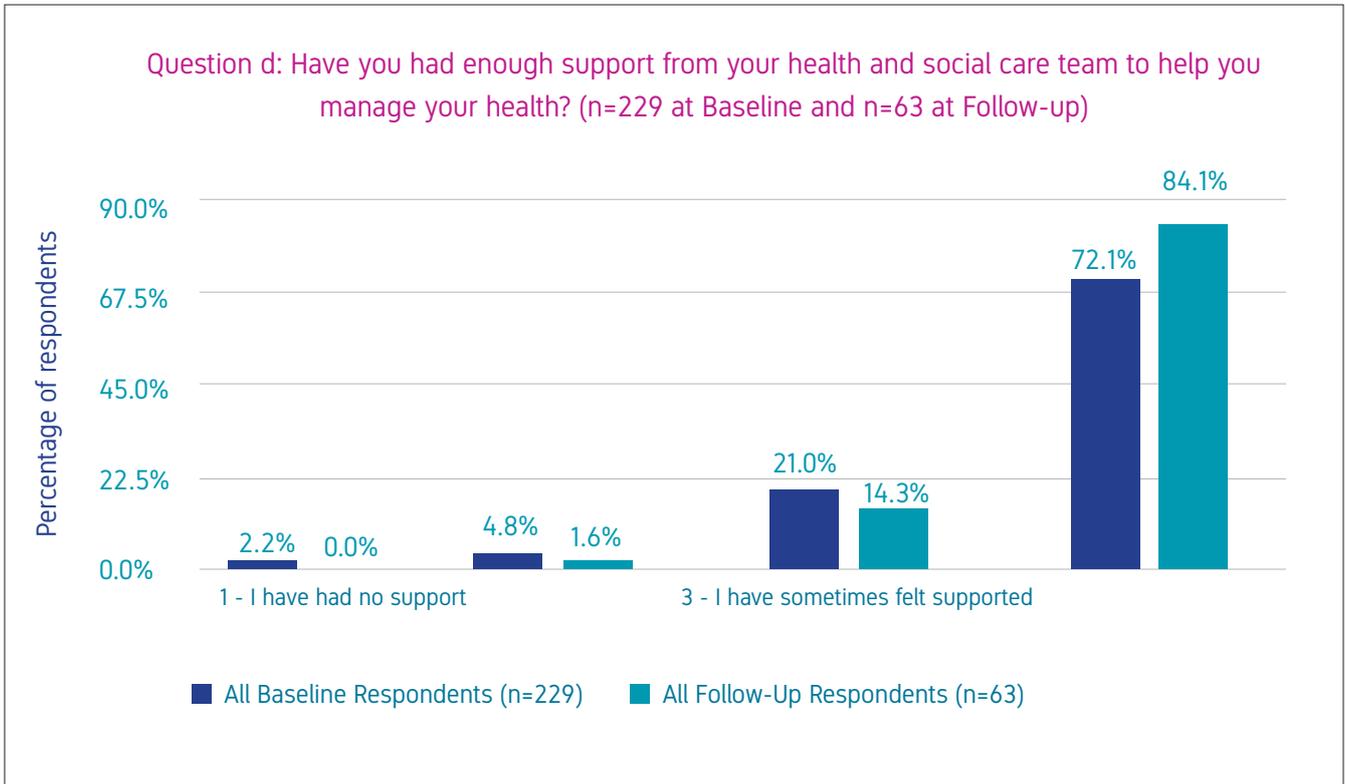
When triangulated with the qualitative based interview data and CQI data we believe that this supports the themes of 'Holistic and Individualised Care' and 'Motivational for Most-through goal setting and action planning' as patients discuss what matters to them.



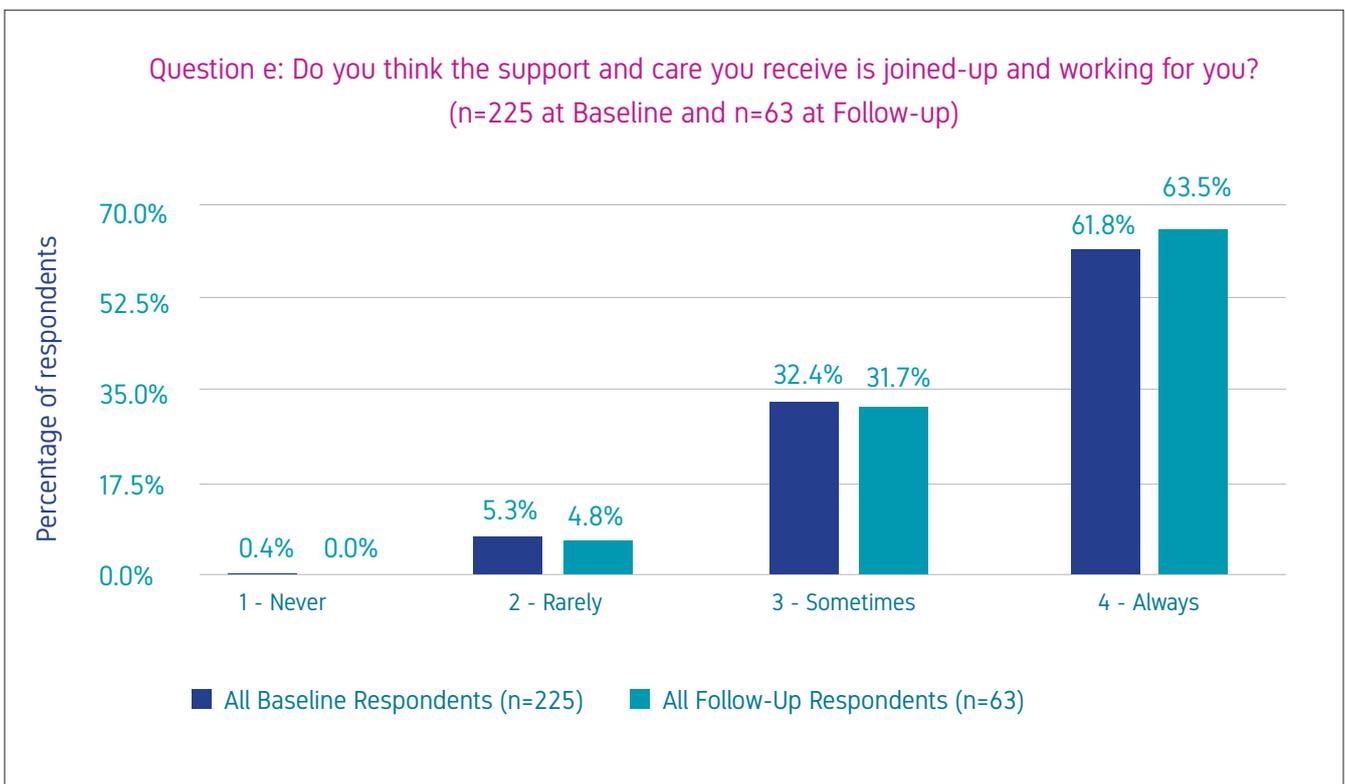
The graph above demonstrates a consistency in patient involvement in treatment with high percentages shown by 63.9% (n=147) at baseline and 63.5% (n=40) at follow up.



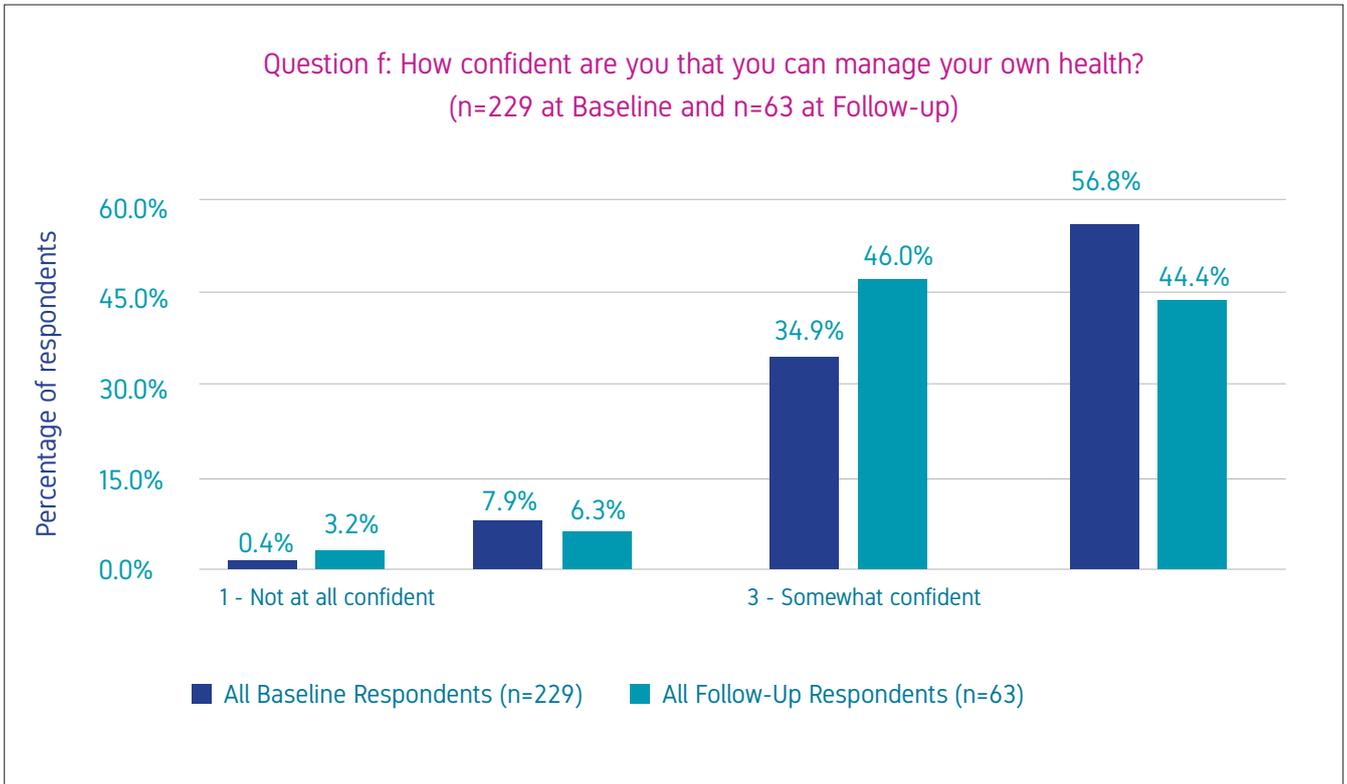
This graph indicates a positive shift of patients feeding back that they 'always' receive the right amount of information' 81% (n=51) compared to 'I sometimes receive enough information' 15.9% (n=10) at follow up. This question directly relates to the theme of 'reassurance and preparation prompt'.



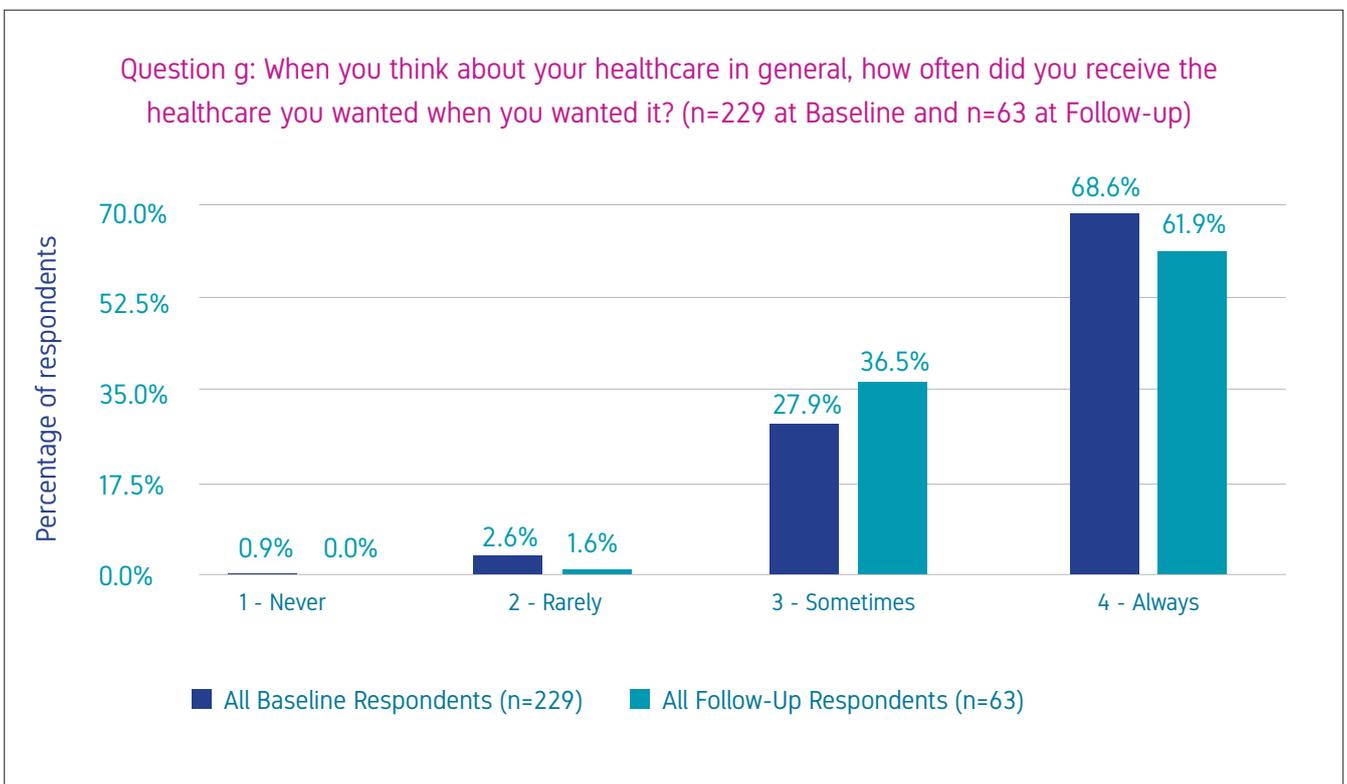
This graph indicates a large percentage of patients reported that they have 'always felt supported' 84.1% (n=53) follow up when compared to 72.1% (n = 165) at baseline.



This graph highlights limited change from baseline to follow up.



This graph shows that the percentage of patients responding with ‘somewhat confident’ has increased from 34.9% (n=80) baseline to 46% (n=29) at follow up. However the percentage of patients stating ‘very confident’ has decreased from 56.8% (n=130) baseline to 44.4% (n=28) follow up. On reflection we anticipated an increase in confidence levels as indicated within the ‘Enabler’ theme.



This graph indicates that a high percentage of patients ‘always receive the healthcare they wanted when they wanted it’ with 68.6% (n=157) at baseline when compared to 61.9% (n=39) at follow up.

7

Conclusion

- Evidence has highlighted the value of care and support planning. Locally health care professionals have highlighted that full integration within a practice is imperative for CSP to be successful.

- Health care professionals also reported patients felt more empowered, gained self-management skills and accessing more flexible services. Alongside this
- Health care professionals described the development and improvement of their own personal skills.

- Patients highlighted many benefits to their lives including improved understanding and skills to navigate self-care whilst encouraging a more individualised care approach, moving away from a paternalistic health care model.

CSP within seven Gateshead practices has shown some very positive results, as this becomes embedded and sustained over a longer period of time it is anticipated that these positive results will be magnified.

