Glenpark
MEDICAL PRACTICE

The Glenpark Story

Implementing care and support planning for people with long term conditions

Creating the space for better conversations

'I always felt I had good consultation skills but when you become more collaborative it changes your whole relationship with patients" – quote from GP at Glenpark

Glenpark Medical Centre is a GP Practice in Dunston, a deprived part of Gateshead with about 9300 patients.

For many years chronic disease management had been doctor led and managed in individual clinics. So a patient with both diabetes and asthma would be seen in diabetic clinic and in asthma clinic through the year and the conditions were managed separately.

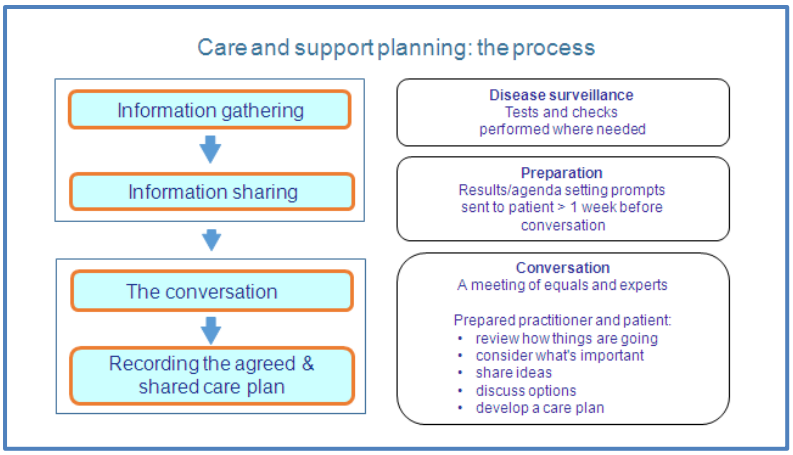
Motivation to change

The practice realised that their current systems of care were inefficient for both patients and the practice. For example, as the QoF year was ending they would find patients who hadn't had an asthma check despite having been in three times in the year for diabetes reviews, so had to bring them in again for another appointment. In June 2013 they decided to change the way they worked. The main aim was to provide more holistic care, create the space for a better conversation and combine their chronic disease monitoring to one annual review for all their long term conditions (LTCs) and to do this review in their birthday month – so they and the practice would always know when it was due.

Two of the partners had read a lot about Year of Care previously and this philosophy of chronic disease management, using a collaborative approach with patients, seemed to fit in with the changes we were keen to make.

Changing processes to enable better conversations

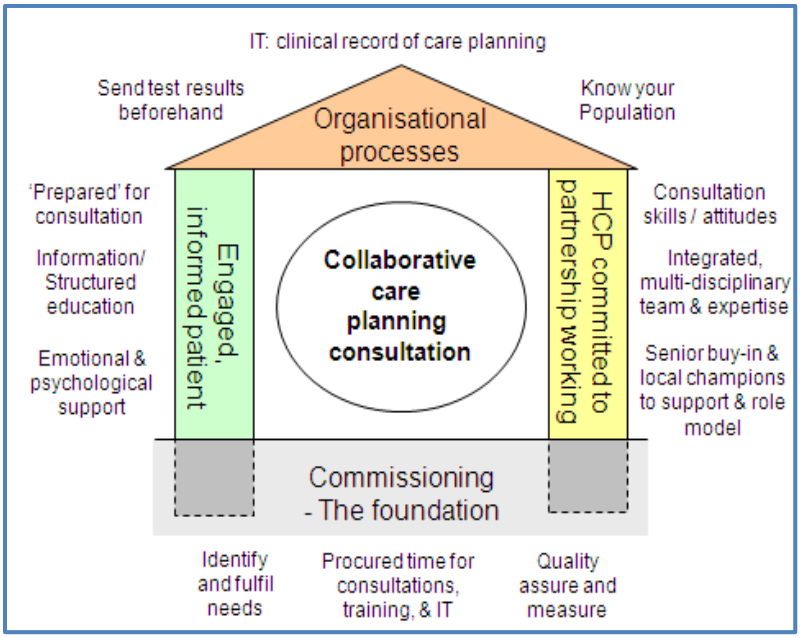
The main focus of the changes was about creating a single care planning process for people with long term conditions which was systematic and streamlined, allowing for "preparation" for a holistic care planning conversation. The practice used the care planning process and implemented changes which involved the whole practice team.



Conversations are different now - the agenda setting prompt has given patients permission to talk about things and has led to some more interesting conversations

Implementing Changes – a real team effort

Whilst the practice started work on their organisational processes and healthcare professional training, the Clinical Commissioning Group began to support the change to Year of Care multi morbidity clinics in Gateshead supported by a British Heart Foundation grant, which was a huge support for the process, as well as on-going local work on social prescribing and support for self-help.



In order to enable the changes team members have developed new skills and roles. The practice partners are very supportive of the changes and the practice administration team have been key to the success. Having a GP lead for IT in the practice has been a particular advantage.

The implementation of the process has valued the development of the staff as much as it has valued the expertise and lived experience of the patients.

The practice used the House as a framework to plan implementation of the changes.

To begin with the practice mapped out the patient journey through care and support planning (CSP) which helped them identify practical issues such as IT and appointment times.

Recall and Registers

The practice employed an administration apprentice and they set up a system for recall which she now manages and runs, freeing up time from other people in the admin team. Our current LTC recall register is done within EMIS using the Search and Recall feature. It searches for patients with a birthday in that month who have a READ code for diabetes and/or any vascular disease (e.g. IHD, CVA, PVD). The resulting list also recalls which other LTCs each patient has from a list of conditions that may affect what information may need to be gathered e.g. asthma, COPD, CKD, heart failure. This search is run monthly and the results can be exported to Excel for easier viewing.

Information Gathering

The admin team have simple instructions which mean they book the right length of appointment for information gathering with the healthcare assistant, depending on which conditions the patient has. The standard appointment is 20 minutes with a set number of "extra" minutes for other tests e.g. foot checks for diabetes, microspirometry for COPD. District nurses carry out tests for house bound patients and explain the new process to them.

The practice, in conjunction with Gateshead Community Based Care, have developed an "intelligent" information gathering template for all LTCs, so only the tests required for each individual are visible to the healthcare assistant, who has clear instructions about what needs to be done in terms of tasks and tests for each individual.

The healthcare assistants have received additional training and understand their role in both information gathering and signposting through the CSP process. They have a laminated copy of the yellow results letter to show people, so they can look out for it arriving in the post and recognise it as being part of the process and important to bring along to the next appointment. This gives patients the ability to "opt out" of results sharing although no one has done this so far. They also reassure patients that they would be contacted by telephone if there were any worrying or urgent results that needed acting on before their next appointment.

Information Sharing

The blood test results from the information gathering appointment are sent to a generic results box called "Dr Chronic Disease". This keeps them separate from other results to allow for triage. One GP and our nurse practitioner have time set aside each week at different times to go through these results. Any unexpected/urgent results are dealt with promptly as usual (e.g. unexpectedly low eGFR, new anaemic). The GP or nurse practitioner then looks at the patient's records and results to work out the most appropriate healthcare professional (HCP) to arrange the care planning consultation with. At this point we take into account whether the patient has a named HCP for cancer care or admission avoidance, or a regular doctor that they see, and the other conditions they have/medication they are on. The minimum appointment length for a care planning appointment is 20 minutes, but extra time is added according to the conditions, results, mental health issues, learning disabilities, interpreter needed etc.

For example, a patient with IHD who is otherwise well would get 20 minutes with our nurse. A patient with poorly controlled diabetes and COPD would get 30 minutes with the nurse practitioner or GP. A patient with well controlled diabetes who has recently been diagnosed with dementia and is on multiple pain relief medications would get 30 minutes with a GP. Most patients need 20 or 30 minutes, but for a very complex patient with multiple issues we would sometimes allow twice as long. We aim to review all the patient's conditions during this time not just those we have searched for because we often find other issues like arthritis and depression are a huge influence on chronic conditions such as diabetes so they cannot be managed alone.

Although this sounds time consuming it takes no more than an hour per week in total and we feel this is a vital step to ensure the patient is seen by the HCP with the best skill set and/or closest relationship with the patient, for the appropriate length of time.

A task is sent to admin who arrange the appointment for the stated length with the suggested person. They then print off a mail merged document on yellow paper which states the appointment, has an agenda setting page, the results inside, and a goal setting care plan on the back page. These letters are "intelligent" and print off results appropriate to each patient's LTCs. The yellow paper makes it stand out from the other information sent out by the practice and makes the document easier to refer to.

The LTC coordinator ensures that letters only go out 1-2 weeks before the care planning appointment so that the patient doesn't need to wait too long with their results before they are seen.

The system is the same for housebound patients, although currently the information gathering and preparation is not as comprehensive since the district nurses are not practice based. Patients still have a care planning consultation at home with the relevant doctor or nurse practitioner.

Better Conversation

The time spent in consultations is now much more effective, with what matters to the person as the starting point. The team feels strongly that by interacting with the patient and spending less time on the computer gathering information they are having better conversations. People like having their yellow letter with their results on and find the conversation more relaxed and patient centred.

"I feel like I can ask the questions rather than just being questioned" …. "They were interested in how I felt" … "I got a chance to ask things rather than being asked" … "I learned a lot"

Supporting and developing staff

- An apprentice was recruited and is now working full time as the LTC administrative coordinator; she has developed skills and confidence and is an essential member of the team.
- One of the healthcare assistants used to be a receptionist and she was been supported to develop her role and her skills in terms of performing routine tests and tasks.
- To enable the team to develop to be able to support people with a range of different conditions the nursing team have improved their skill mix. They have attended local master classes organised by the Gateshead clinical leads.
- The team attended Year of Care training locally, funded by the British Heart Foundation, which allowed them to develop their care planning consultation skills and share ideas and learning with other practices.
- The nurse practitioner, who is so passionate about this approach, has agreed to be trained up as a local trainer, despite not normally feeling confident at public speaking.

What difference has this made so far?

- Staff are enthusiastic and enjoy working in a different way, including developing new roles
- The whole practice has been involved and people seem clearer about their roles
- Even though patients have good relationships with the practice team, they seem more able to talk about things they used to be reluctant to discuss – people get more out of the time they have with the doctor or nurse
- The patients like the new system and they have not received any negative feedback
- The QoF data collection is done all in one go and so there is less chasing up at the end of year

Challenges and next steps

- Because we are quite a large practice not all of the staff have had CSP training. We are lucky because the lead GP for CSP is a Year of Care trainer, so we try to provide on-going in house training and encourage attendance at other relevant training where possible e.g. local Time Out meetings.
- We feel the service for housebound patients could be improved especially in preparing them more for the care planning consultation and we hope to work with the district nursing team on this in the coming year.

Conclusion

The practice started the new call and recall system with multi-morbidity clinics in June 2014, and then began sharing results and collaborative care planning consultations in June 2015. It works really well and this year, at the end of the QoF year, there was a lot less chasing up of people/tests etc. It feels more intuitive to review all a patient's problems together, and now we have gone through the Year of Care training we are starting to focus even more on consultation skills, goal setting and working in a partnership with the patients.

All practices are different, and not all of our methods will work elsewhere. Neither do we feel that we have got things perfectly right - it is still evolving and we hope to learn from other practices as they move towards a similar way of working. However we would not go back to our old way of managing LTCs now as we all feel so positive about the new system.

Pressures on practice time make it difficult to respond to individual enquiries so please contact Glenpark Medical Centre via enquiries@yearofcare.co.uk.