REDESIGNING GENERAL PRACTICE AROUND CARE FOR LONG TERM CONDITIONS AND MULTIMORBIDITY

Better experience, better outcomes, better value

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Personalised care and support planning (CSP) was developed by grass roots general practice teams[1] working with the Year of Care (YOC) programme to replace fragmented, 'tick box' approaches to planned care for people living with one or more long term conditions (LTCs). The benefits achieved for patients were matched by a positive experience for practices and improved job satisfaction for staff. The House of Care described what was needed for spread across health care communities [2].

CSP has now been used to stimulate redesign of general practice care for people living with LTCs and multimorbidity across a whole CCG, with positive impact on practice costs, infrastructure, skill mix, staff satisfaction and team work.

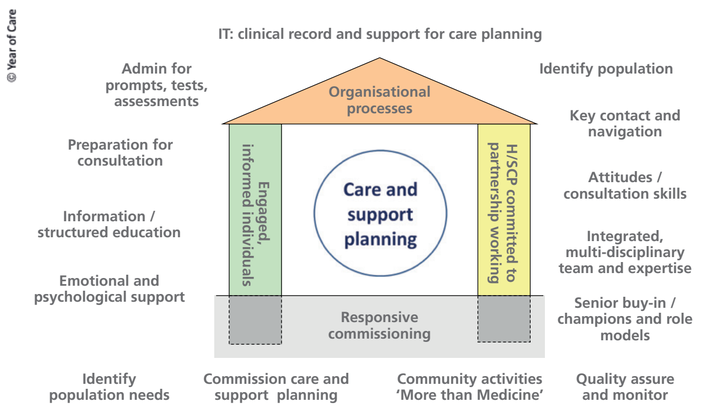
CSP enables GPs to review the relationship between clinician and patient, to recognise that the medical model is not the answer to every question and to value the patient coming prepared for a different conversation.

CSP has proved to be a method to engage practices in a difficult change project despite stress, workload, recruitment challenges and different starting points. It made it easier for practices to 'do the right thing'.

What is care and support planning?

CSP is a planned systematic process, which replaces current planned reviews, and is focussed on a 'better conversation' between the person with LTC/s and a healthcare professional, enabled by preparation. The results of any tasks or tests collected at an information gathering appointment, together with reflective prompts, are sent to the person 1-2 weeks before the CSP conversation. The discussion which is solution focussed and forward looking brings together traditional clinical issues with what is most important to the individual, supporting self-management, coordinating complex care and signposting to social prescribing. CSP is a single process and care plan however many conditions the person lives with. Organisational processes, practice care pathways, staff/team roles and support are redesigned to achieve this.

The House of Care: Supporting implementation of CSP

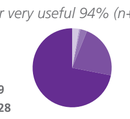


The HOC acts as a **check list** for what needs to be in place to deliver CSP. It is a **metaphor** for the interdependence of each part and provides a **flexible framework** to enable communities to get started and design the sort of house that suits their population

Impact for patients

HOW USEFUL WAS THE PREPARATION LETTER IN HELPING YOU PREPARE FOR YOUR CONSULTATION

Preparation letter somewhat or very useful 94% (n+167)

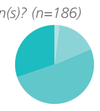


BENEFITS OF A BETTER CONVERSATION

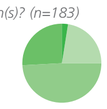
After your consultation today do you feel you are:

Able to cope with life? (n=187)

Able to understand your condition(s)? (n=186)



Able to cope with your condition(s)? (n=183)



Following their consultations:

PATIENT SURVEY **81%** (n=151) understood their condition 'better' or 'much more'

PATIENT SURVEY **75%** (n=137) were able to cope with their condition 'better' or 'much more'

PATIENT SURVEY **71%** (n=132) felt 'more' or 'much more' able to help themselves

PATIENT SURVEY **87%** (n=160) rated their overall experience of CSP as 'very good' or 'excellent'

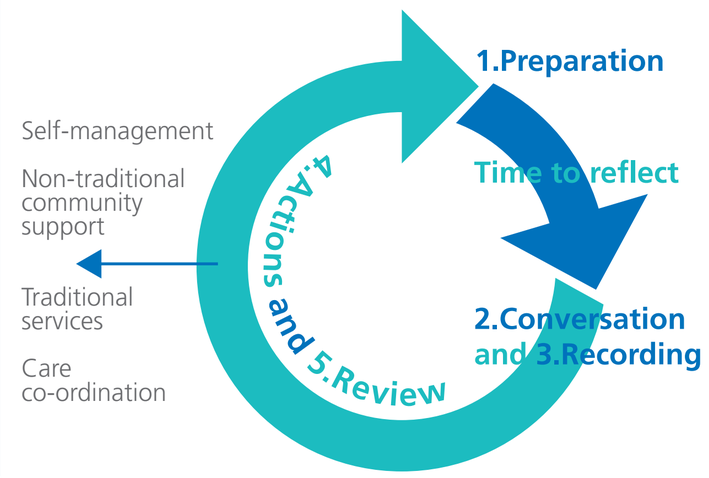
'discussed services in local community' **33%**

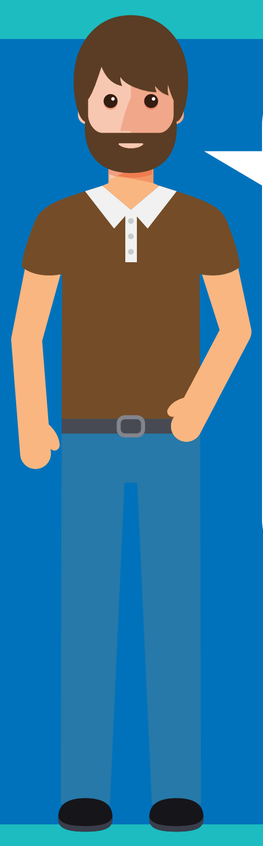
clinical metrics:

11% INCREASE...in patients who had BP recorded in the previous 12 months

10.9% INCREASE... in CHD patients BP of 150/90 or less **vs** **0.4%** INCREASE... across the CCG as a whole

Care and support planning overview





STAFF QUOTES

GP stories

"Improves job satisfaction - more time to spend with the patient ...and a conversation based on what's important for them …. so much more worthwhile than ticking boxes."

"they often come with their own plan ... This makes the job very easy!'

"…very strengthening for the team by involving everyone in developing it".

"it makes sense to have …a robust system in place. … they are not coming twice a week just because they want to see someone"

"…we definitely would not go back to the old system of working. It was much more inefficient for the patients and the practice."

Nurse stories

"You build relationships and then see results"

"It widened my horizons because I've had to learn the bits I wasn't sure about ...had to expand my knowledge...its been quite beneficial. I've had to give myself a shake and say 'you don't know how to do this, you better learn".

Healthcare assistant Stories (HCA)

"This makes you feel you have achieved something – like a proper job!"

"The skills training for HCAs...has increased their confidence ...has increased their interest in patient care and involved them taking on more and varied roles within the practice."

"The HCA role is really important; I think they are almost like a front door to the CSP process."

Admin /practice manager stories

"As a practice we have seen real benefits …for our people with LTCs...we have one single system, one process for inviting patients in, that everyone understands and ….their role in it. We have cut down massively on the number of encounters patients have …"

"The admin clerk has developed her skills and role and is now a key member of the team (also) acting as the first point of call for social prescribing."

"if you compared this years and last ...we had a lot less work to do in the last 3 months of the year. Our QOF data is a lot better, especially respiratory, and BP… for people with a range of conditions."

PATIENT QUOTES

About preparation

"…I had it all written down...was able to ask her what I feel were the more important things"

"it prompts you to think about all aspects of your health … encourages you to talk to the doctor or nurse …"

"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!"

About the conversation

"…they were interested in how I felt...I got a chance to ask things rather than being asked. I learnt a lot."

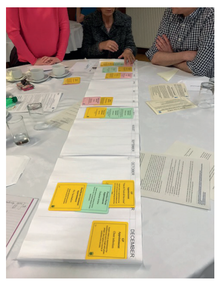
"after discussing things it gave me a better perspective of where I wanted to be and do."

"Had time to talk… answers to my problems are not more medicine"

"I said I wanted to lose weight...I've gone from 12st6 to 9st6 and I've done it all myself"

Mapping the care for Elspeth – a person with 5 long term conditions

Total annual appointments for Elspeth before CSP



Total annual appointments for Elspeth after CSP

OVERCOMING CHALLENGES

Common understanding of purpose and practicalities
Clinicians, managers and YOCP working alongside each other

Initial engagement
'Case for change', interactive activities with practice teams, targeting early adopters and case studies

"We do this already"
Experiential learning to highlight the difference

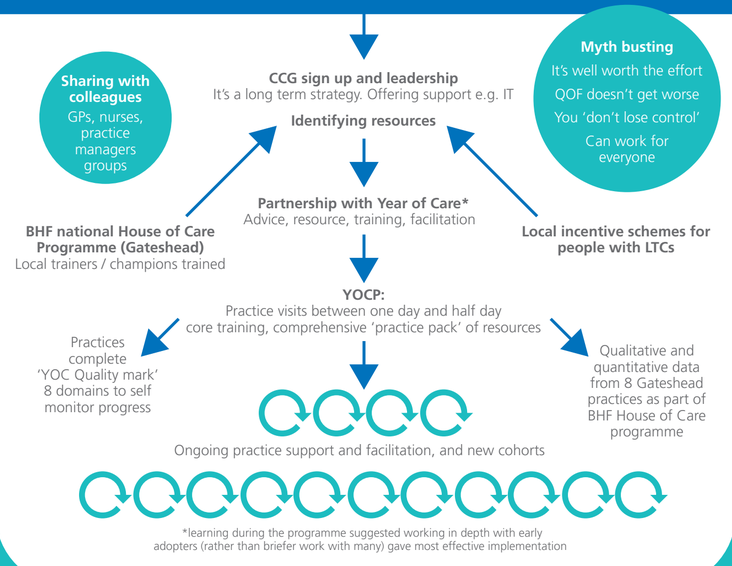
IT
Templates and support available **at the right time**

Nurses lack confidence in talking about new topics
CCG masterclasses and in house mentorship and clinical supervision

"Takes time" – practices work at different paces
On going support /practice facilitation

The 2 'starter' practices

Spreading the word: Peer confidence – this works!



What will it cost?

Practices introducing CSP make better use of resources and increase patient contact time by

- Changes in skill mix
- Consolidating appointments
- Streamlining processes

The YOCP activity and cost profiling tool[3]

This interactive tool enables a practice to compare resource use before and after implementation of CSP by

- Varying numbers of patients with single or multiple conditions (up to 100 different combinations available)
- Altering roles, salaries, postage and contact time across each stage of the CSP process

Example: modelling data using the tool from Cruddas Park Medical Group (practice size 9,699)

Patients with any QOF condition(s) are now part of a single CSP process however many conditions they live with.

Total cost for one month pre CSP	Total cost for one month post CSP
£2582.55	£2035.12

Freeing up £6569.16 per annum for other practice activities (reduction 21%)

59/63 practices now introducing CSP for multi morbidity as 'business as usual'.

1. www.yearofcare.co.uk
2. Coulter A, Roberts S, Dixon A. Delivering better services for people with long term conditions: building the House of Care: Kings Fund. 2013 http://www.kingsfund.org.uk/publications/delivering-better-services-people-long-term-conditions
3. enquiries@yearofcare.co.uk

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