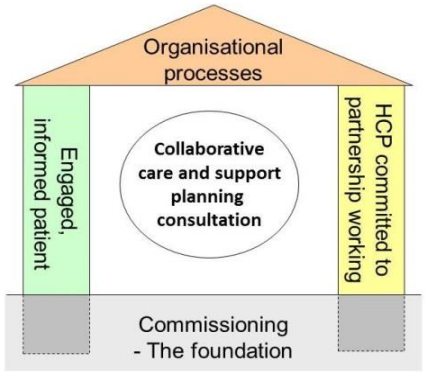


A better way to work in general practice

Personalised care and support planning

Improving quality of care, job satisfaction and morale, cost and productivity

Care and support planning general practice impact of PCSP V2 Aug 24

Introduction to personalised care and support planning

Personalised care and support planning (PCSP) aims to provide better patient experience, greater support for self-management, and greater engagement in and sense of control over health and healthcare for people living with one or more long term conditions (LTCs).

In our experience this leads to increased job satisfaction and improved morale for practice staff, better team work and increased practice efficiency.

Building on the core attributes and flexibility of general practice, it reduces day to day pressures and has been described as ‘a better way to work’ in tough times.

Introduction to the tool

This document is based on experience from general practice teams taking part in the Year of Care (YOC) programme. It contains 3 linked components.

Part 1

An overview of care and support planning, summarising the benefits for patients and practices in their own words

Part 2

Worked examples of 'before and after' implementation of systematic care and support planning including process and workflow changes and staff utilisation from practices implementing the approach in a range of conditions using a common framework but varied starting points.

Part 3

An interactive practice activity and cost profiling tool to check out the impact of implementing care and support planning processes within a single practice, with a focus on providing a single care and support planning process for individuals no matter how many conditions or issues they may live with.

Part 1

Overview of personalised care and support planning

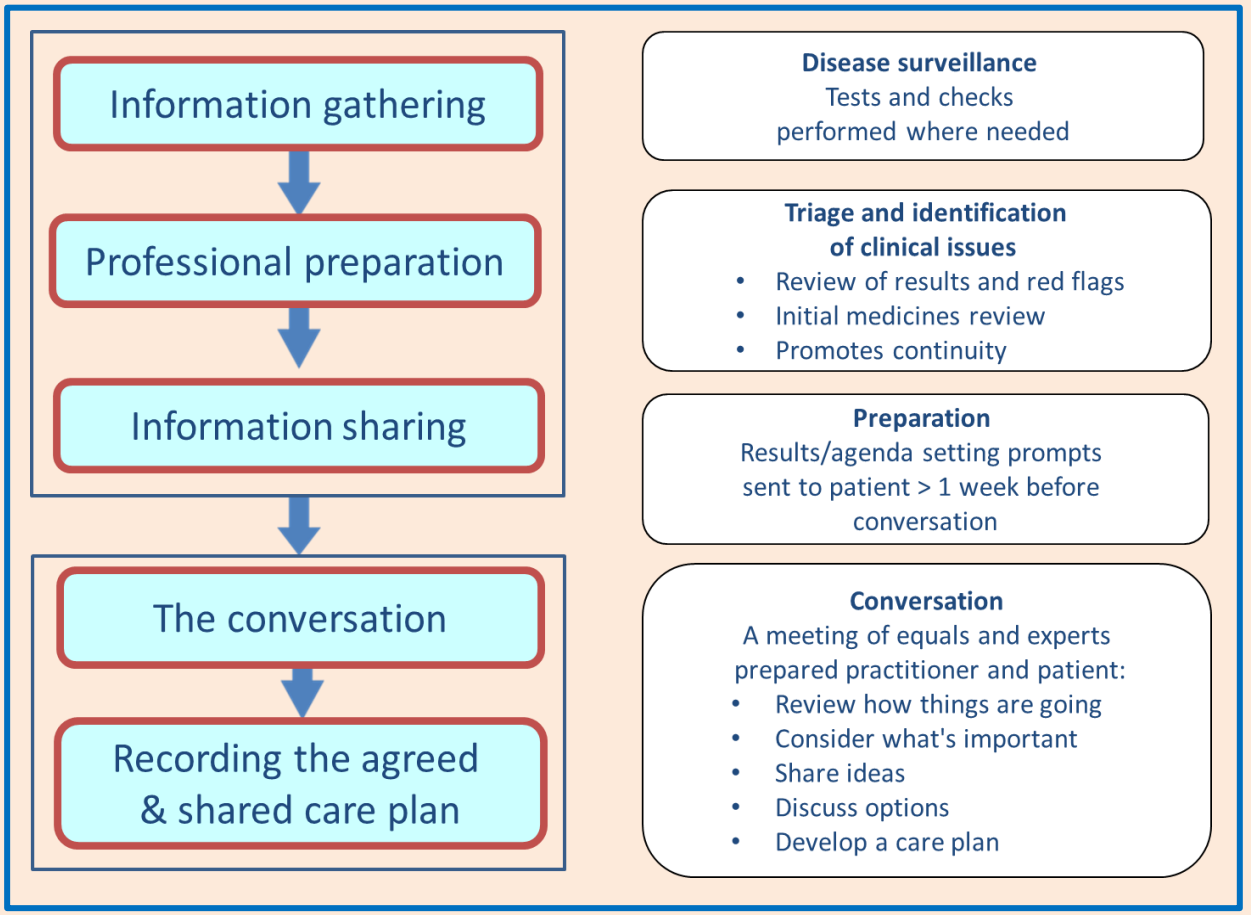
Personalised care and support planning (PCSP) is a systematic process which replaces current approaches to routine care and is designed to ensure that each person has a personalised conversation/consultation with a health care professional that is focused on what matters to them.

It is forward looking and solution focussed to enable them to live their life to the fullest.

It brings together traditional clinical care with support for self-management, helps to sign post to activities in a supportive community (social prescribing) and coordinates with social care.

Back to introduction

Overview of personalised care and support planning



This approach separates tasks for disease surveillance from the care and support planning conversation.

Preparation (sharing of results and agenda setting prompts) enhances the conversation and makes maximum use of time available.

In particular the person has the same information as the health care professional and has time to reflect and think about issues.

This is achieved via a single CSP process with defined steps, delivered by a team with clear roles and a changed skill mix making best use of talents and training.

Back to introduction

How it works in practice

The primary purpose of implementing personalised care and support planning (PCSP) 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 starts by identifying individuals via a single recall process which brings together information from all 'disease registers'. A trained health care assistant completes activities for disease surveillance at a first appointment. Test results and personalised information, together with reflective prompts, is shared with the individual one to two weeks prior to the PCSP conversation, ensuring that the person and the practitioner have the same information and are not distracted by the completion of tasks and tests.

The person has the opportunity and time to reflect on what is important to them, with family and friends if necessary, ahead of the PCSP conversation. The practitioner has the time and space to use their skills effectively.

PCSP 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 to introduction

Part 1

Personalised care and support planning - improving quality and creating efficiency

This new way of working depends on changes to skill mix as well as practice infrastructure including appointment number and length, IT and overall administration. These changes are an opportunity for clinical and non-clinical staff to reflect upon and change routine practice processes into a more streamlined approach to planned long term condition care as well as improving overall practice efficiency.

A better engaged and motivated workforce supports practice resilience. PCSP is cost neutral once it's set up, with savings for some, particularly those with multi-morbidity. Overall practice productivity is increased. Long term there are savings across the wider health care community as a greater number of people are engaged in their own health and self-care.

"While the improvement in quality of care was the prime aim of the Year of Care programme it is important to understand the costs involved. Within the practice the biggest cost is staff time and the longer consultation. The natural assumption would be that this would lead to increased costs. However this proved not to be the case."

Part 1

How personalised care and support planning helps

Streamlined administration

Setting up a single PCSP process brings clinical and administrative teams together

Planned systems and processes understood by patients and staff replace unplanned and ad hoc contacts and appointments scattered across the year

- Single call and recall system
- More efficient task allocation, and role clarity for whole team

Reduced numbers of appointments

- Patients with multiple conditions have single PCSP process instead of multiple separate reviews
- Routine reviews reduced as follow up plans are individualised
- Cost of patient contacts reduced especially for those with multiple long term conditions

Patients are positive about the opportunity it affords them

- it feels like 'common sense'
- it engages them as a person not a set of conditions

Part 1

Streamlined administration

Practice feedback

"Before Year of Care we hadn't thought much about what needs to go on behind the scenes to make a clinical encounter effective and the practice nurse was struggling to do it all herself. The Year of Care house helped to clarify all the steps needed and gave us a framework to stand back and look at the service and to clarify roles and responsibilities so we now have far more robust organisational structures, better skill mix and better teamwork and communication." **GP**

"The new pathway is not only more patient centred but more efficient in time for both patients and health care professionals. The MDT meeting … useful learning experience and an opportunity to discuss the hard to reach, the housebound and those with the most complex needs. It maximises the use of individuals' skills and competencies within the practice." **Practice Manager**

"We have identified clear roles for everyone involved in CSP for patients with LTCs. The HCAs and Practice Nurses work from separate 'smart' templates. This prevents duplication of work and helps to ensure that all aspects of care are addressed." **GP**

How personalised care and support planning helps

Information gathering/disease surveillance appointments

Most practices are training a health care assistant (HCA) to do core disease surveillance/ assessments for all conditions at a first appointment. Coordinated via a single template this ensures a consistent approach to the range of tests that are performed. This achieves:

- Fewer separate visits across the year for the patient
- Efficient use of staff time
  - HCA perform tasks and tests previously carried out by practice nurses
  - Expensive professional time freed up by better administrative support.
- All QoF measures completed with no chasing up at the end of year
- Improvement in data completeness and process measures

Part 1

Information gathering/disease surveillance appointments

Patient and practice feedback

Patient feedback

"It's very reassuring to know that everything is getting done and nothing is getting missed"

"My son was always saying "you are never away from the doctors dad" – now I just go once a year for everything and I know what's what"

Practice feedback

"Before they come in, I look to see what they've had done, …..and it is clearly documented in the notes…So when they come in, they sit down, and I am turned away from the computer and I am just focused on them."

"We suspended QoF and were worried that we might see some decline in measurement, in fact it's actually improved a little bit - by putting in systematic care and support planning"

How personalised care and support planning helps

Preparation

Preparation is an important step in the PCSP process which creates much of the benefit for the person living with long term conditions.

- It gives the person an opportunity to review test results and agenda setting prompts and think about what they want to get out of the consultation.
- Preparation saves time in the consultation as information has already been shared with the person
- This reduces the likelihood of need for further reviews by ensuring people can focus on what is important to them

Part 1

Preparation

Patient and practice feedback

Patient feedback

"You can't take it in when they are telling you the information – having it written down means you can take your time"

"I am more in control. I have my results and information so I am not so reliant on the system. I can share the information with my own family and use it to encourage them to be more healthy"

"Having the results in writing is definitely helpful and definitely made me feel more pro-active about my diabetes as opposed to just finding out the results and then forgetting about it'"

"The results were a wakeup call"

"This way you are talking about something you know about and not something you are kept in the dark about"

Practice feedback

"An informed patient coming in the door, that's the biggest difference" GP

" …not only patient centred – also creates a sense of ownership having her results beforehand. Definitely helps people think about their diabetes and more efficient use of time" Practice nurse

"It's actually more rewarding. We don't spend so much time doing heights, weights etc. We spend more time engaging with patients and finding out about their problems at home rather than ticking boxes" Nurse practitioner

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

How personalised care and support planning helps

The conversation

The personalised care and support planning conversation supported by preparation focuses on the important issues for both the individual and the professional. It is a chance to take stock, share ideas and develop an individualised plan which looks forward and anticipates issues.

Our experience would suggest that personalised care and support planning creates opportunities for

- efficient use of consultation time:
  - Tasks, tests and disease checklists completed ahead of time
  - Patients come prepared and informed with the same information as the professional
  - Booked consultation time is less than other approaches to multi morbidity
  - Professional and patient agenda handled together
- time and ‘space’ to use core professional skills with renewed job satisfaction
- practice nurses to work more flexibly, becoming confident in handling a range of conditions and issues

Part 1

The conversation

Patient and practice feedback

Patient feedback

"It was good – I liked the way she explained the results. She said there was a number of ways of doing things. She listened to me. She respects that I have my own way of doing things"

"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"

"It was nice she was talking to me and not just fiddling with my feet"

"This …. helps me to control what's wrong with me now – I get a lot of benefit from it"

"He's communicating more information than he did a couple of years ago. Last two occasions Dr… has been more open and able to communicate. Before he was more severe"

Practice feedback

"I enjoy doing the clinic a lot more now... working with them rather than at them"
Practice nurse

"I always felt I had good consultation skills but when you become more collaborative its changes your whole relationship with patients"
GP

"My consultation technique has changed. The patient takes the lead. I always thought this was the best way of doing things but this has formalised the approach"
GP

''I used to say the same type of thing in consultations but now every consultation is different'' Practice nurse

Part 1

How personalised care and support planning helps

Routine appointments and practice culture

Staff report PCSP reduces multiple pressures across the practice, because more consolidated appointments achieve more for both the person and the professional. The impact on routine appointments and staff morale are particularly positive once the systems are in place and embedded and when the approach is applied universally.

- Routine practice appointments:
  - Practitioners can concentrate on the presenting issue, confident that routine care of LTCs is being well managed
  - Patients are better informed about LTCs with a current 'plan'
  - Perception among GPs that 'frequent attenders' use less regular appointments
- Across the practice:
  - Patients report they know how to use the practice better
  - A systematic approach to social prescribing and ongoing community support, understood by whole team
- Staff motivation:
  - Clinical staff enjoy PCSP consultations
  - Admin staff report greater clarity and understanding of role
  - HCA's report improved job satisfaction
  - Career progression amongst and between admin staff and HCAs supports retention

Routine appointments and practice culture

Practice feedback

"My impression is we aren't swamped as we used to be. The workload has eased because the number of interim reviews has gone down. It's more manageable but we've needed strong admin to make it work"

"Because I am now confident that we have a functional call and recall system, it is much easier to focus more on the presenting complaint during other consultations, whilst being mindful of LTCs, but not having to worry about organising LTC review appointments- which more often than not, have already taken place"

''People are more involved in the care and support planning process as well as with their own health, with some shorter consultation lengths and greater systematic use of the phone''

"It's been met positively by everybody in the team. HCAs because it gives them a bit more responsibility and an opportunity to do more than they do at the moment…The nurses are keen on some of the training that's been offered…And GPs in terms of the potential impact on self-management''

Part 2

Worked examples before and after implementation

General practice teams are inherently flexible and committed to make change, support one another and distribute tasks depending on the experience, seniority, availability of staff and innovations in technology, as well as changes in clinical practice and activities in the wider community around them.

PCSP is a complex intervention requiring changes to culture, new skills and changed infrastructure. Ensuring this becomes 'normal business' depends on this 'local wisdom' in each practice team; embedding the essential principles of CSP while 'making it work around here'.

> *"In general practice, you can move resources around in all sorts of ways to make things work across the team".* GP

Even at times of extraordinary pressure, GP teams are able to use the help and support available to introduce PCSP and find it becomes an important part of 'bringing the joy back to general practice'.

The following examples show some of the options available to practices as they begin to think about and implement PCSP.

Part 2

Personalised care and support planning – using practice resources differently

Each practice will know the best way to deploy their staff and their best starting point. The following examples show the range of options for PCSP in single conditions and multi morbidity, including an overview and data from real practices.

A. Overview: personalised care and support planning: a range of options

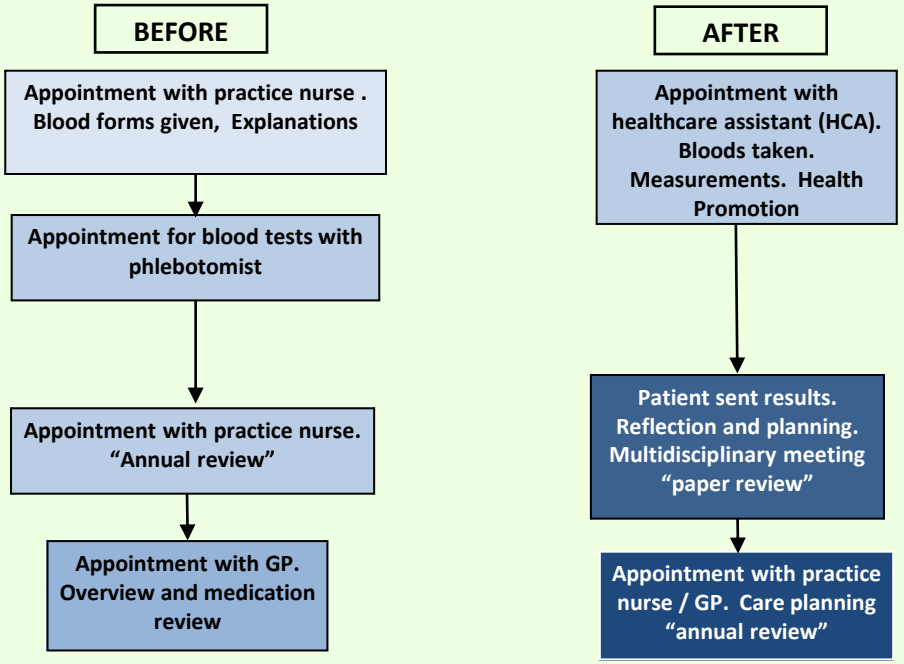
B. Bringing together three different conditions (diabetes, CHD and COPD) in a single PCSP approach: direct practice costs

C/D. Introducing a single PCSP approach (D before/E after) for all people living with any long term condition on the practice register: the 'bottom line'

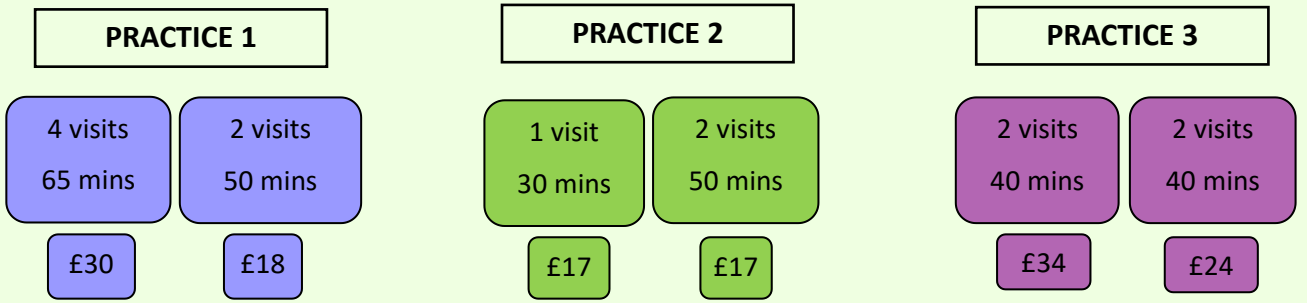
Part 2

A. Overview: personalised care and support planning - range of options

One of the important findings from the Year of Care Pilot project (2008) in 3 diverse primary care communities was that not only was the experience better for patients, staff and practices but overall PCSP was cost neutral. This masked the large variation between practices both before and after introducing PCSP shown below.



Different practices had different working arrangements involving different members of staff. Each pair of coloured boxes below represents one practice and records the number of visits a person with diabetes had to make, the time they spent with a healthcare professional and the cost per individual before and after introducing care planning.



Part 2

B. Effect on GP practice contact time, number of visits and costs of introducing PCSP for people with multiple long term conditions

PRE-IMPLEMENTATION OF PERSONALISED CARE AND SUPPORT PLANNING

Diabetes		CHD		COPD	
Admin and recall: Recall lists, appointments and invitation 7 mins - administrator	£1.33	**Admin and recall**: Recall lists, appointments and invitation 7 mins - administrator	£1.33	**Admin and recall**: Recall lists, appointments and invitation 7 mins - administrator	£1.33
Test taking: BP, weight, bloods 25 mins - HCA	£5.00	**Test taking:** BP, weight, bloods 10 mins - HCA	£2.00	**Test taking:** 10 mins - practice nurse	£3.10
Clinical review of tests: 2 mins - nurse practitioner	£0.90	**Clinical review of tests**: 2 mins - nurse practitioner	£0.90		
Routine review: 20 mins - practice nurse	£6.20	**Routine review/consultation:** 15 mins - practice nurse	£4.65	**Routine review/consultation:** 15 mins - practice nurse	£4.65
Total cost per patient	£13.43	**Total cost per patient**	£8.88	**Total cost per patient**	£9.08
Total contact time per patient	2 visits 45 mins	**Total contact time per patient**	2 visits 25 mins	**Total contact time per patient**	1 visit 25 mins

Total cost per patient for individual condition review approach	**£31.39**
Total contact time for individual condition review approach	5 visits 95 mins

POST-IMPLEMENTATION

Combined diabetes + CHD + COPD

Admin and recall: Recall lists, appointments and invitation 7 mins - administrator	£1.33
Information Gathering: All tests 30 mins - HCA	£6.00
Clinical review of tests: 2 mins - nurse practitioner	£0.90
Information Sharing: letter production (plus stamp) 1 min – administrator	£0.19 £1.04 with stamp
Personalised care and support planning conversation: 30 mins - practice nurse	£9.30
Total cost per patient	**£17.72** £18.57 with stamp
Total contact time per patient	2 visits 70 mins

Moving to a personalised care and support planning approach for people with multiple long term conditions results in a reduction from **5 to 2 visits** and from **95 minutes to 70 minutes** contact time. It also leads to a **reduction in costs** for the practice of up to **£13.67 per patient**.

C. and D. Experience and costs for a real life cohort of LTC patients in one month (2017)

In the following examples:

BEFORE PCSP, people living with long term conditions in this practice experienced a range of separate types of review and depending on the condition(s), appointment times ranged from 10 to 40 minutes, with either GP or a practice nurse.

AFTER PCSP
The practice moved to a multi-morbidity single CSP approach with the majority of the care and support planning appointments being held with a practice nurse with support from a GP. Specific details of each combination of conditions can be seen in the next slide.

In these scenarios, using a total practice population of 9,699 patients, **AFTER PCSP resulted in a reduction in direct costs for this cohort of patients from £2582.55 to £2035.12 across one month.** This has been achieved through the introduction of a more systematic process across all conditions, changes in skill mix and consolidation of appointments.

C. Experience and costs for a real life cohort of LTC patients in one month (2017), BEFORE the introduction of CSP

Condition	Number of Patients	Administration: Recall lists, appointment booking, letter production and postage		Triage/exceptions: Screen out those not needing recall e.g. palliative		Test taking: BP, weight, bloods		Clinical review of tests		Routine Review/consultation	
		Time/Who	Cost per pat	Time/Who	Cost per pat	Time/Who	Cost per pat	Time/Who	Cost per pat	Time/Who	Cost per pat
Asthma	38	10 mins band 3 administrator, 1 stamp	£2.16	1 min band 3 administrator	£0.16	0		0		20 mins, band 6 practice nurse	£7.20
COPD	12	10 mins band 3 administrator, 1 stamp	£2.16	1 min band 3 administrator	£0.16	0		0		40 mins band 6 pracitce nurse	£14.40
DM +/- CVD +/- Stroke +/- PAD	23	10 mins band 3 administrator, 1 stamp	£2.16	1 min band 3 administrator	£0.16	20 mins band 3 HCA	£3.20	2 mins GP	£1.88	30 mins band 6 practice nurse	£10.80
CHD	9	10 mins band 3 administrator, 1 stamp	£2.16	1 min band 3 administrator	£0.16	15 mins band 3 HCA	£2.40	2 mins GP	£1.88	15mins band 6 practice nurse	£5.40
Stroke	13	10 mins band 3 administrator, 1 stamp	£2.16	1 min band 3 administrator	£0.16	15 mins band 3 HCA	£2.40	2 mins GP	£1.88	15mins band 6 practice nurse	£5.40
HF	5	10 mins band 3 administrator, 1 stamp	£2.16	1 min band 3 administrator	£0.16	15 mins band 3 HCA	£2.40	2 mins GP	£1.88	15mins band 6 practice nurse	£5.40
PAD	3	10 mins band 3 administrator, 1 stamp	£2.16	1 min band 3 administrator	£0.16	15 mins band 3 HCA	£2.40	2 mins GP	£1.88	15mins band 6 practice nurse	£5.40
AF	5	10 mins band 3 administrator, 1 stamp	£2.16	1 min band 3 administrator	£0.16	15 mins band 3 HCA	£2.40	2 mins GP	£1.88	10mins GP	£9.40
Thyroid	19	10 mins band 3 administrator, 1 stamp	£2.16	1 min band 3 administrator	£0.16	0		0		10mins GP	£9.40
Epilepsy	5	10 mins band 3 administrator, 1 stamp	£2.16	1 min band 3 administrator	£0.16	0		0		10mins GP	£9.40
MH	17	10 mins band 3 administrator, 1 stamp	£2.16	1 min band 3 administrator	£0.16	15 mins band 3 HCA	£2.40	2 mins GP	£1.88	20mins GP	£18.80
LD	7	10 mins band 3 administrator, 1 stamp	£2.16	2 mins GP	£1.88	15 mins band 3 HCA	£2.40	2 mins GP	£1.88	20mins GP	£18.80
Rheumatoid Arthritis	3	10 mins band 3 administrator, 1 stamp	£2.16	1 min band 3 administrator	£0.16	0		0		15mins GP	£14.10
Dementia	5	10 mins band 3 administrator, 1 stamp	£2.16	2 mins GP	£1.88	0		0		20mins GP	£18.80
Osteoporosis	1	10 mins band 3 administrator, 1 stamp	£2.16	1 min band 3 administrator	£0.16	0		0		10mins GP	£9.40
CKD	23	10 mins band 3 administrator, 1 stamp	£2.16	1 min band 3 administrator	£0.16	0		0		15mins band 6 practice nurse	£4.65
Cancer	6	10 mins band 3 administrator, 1 stamp	£2.16	2 mins GP	£1.88	0		0		15mins GP	£14.10
										Grand Total, All pats "Pre" CSP costs	**£2,785.50**

Conclusion: In these scenarios, using a total practice population of 9,699 patients, moving to a multi-morbidity CSP approach resulted in a reduction in direct costs for this cohort of patients from £2785.50 to £2108.47 across one month. This has been achieved through the introduction of a more systematic process across all conditions, changes in skill mix and consolidation of appointments.

D. Experience and costs for a real life cohort of LTC patients in one month (2017), AFTER the introduction of CSP

Condition	Number of Patients	Administration: Recall lists, appointment booking and letter production		Triage/exceptions: Screen out those not needing recall e.g. palliative,		Information Gathering: all tests including foot checks,		Clinical review of tests		Information Sharing		Care and Support Planning Conversation	
		Time/Who	Cost per pat	Time/Who	Cost per pat	Time/Who	Cost per pat	Time/Who	Cost per pat	Time/Who	Cost per pat	Time/Who	Cost per pat
Diabetes +co-morbidities: CKD, all CHD, stroke PAD, +/- other LTC e.g. thyroid, dementia (not COPD)	23	10mins band 3 admin.	£2.16	1 min band 3 admin. plus 1 min band 8 nurse practitioner	£0.37	30mins band 3 HCA	£4.80	2 mins band 8 nurse practitioner	£0.74	Postage	£0.56	20mins band 7 practice nurse	£7.20
CHD - all types (stroke, AF, HF, PAD) +/- other LTC e.g. thyroid (Not COPD)	22	10mins band 3 admin.	£2.16	1 min band 3 admin. plus 1 min band 8 nurse practitioner	£0.37	15mins band 3 HCA	£2.40	2 mins band 8 nurse practitioner	£0.74	Postage	£0.56	20mins band 7 practice nurse	£7.20
COPD (+ any other single LTC including CVD/MH)	10	10mins band 3 admin.	£2.16	1 min band 3 admin. plus 1 min band 8 nurse practitioner	£0.37	30mins band 3 HCA	£4.80	2 mins band 8 nurse practitioner	£0.74	Postage	£0.56	30mins band 7 practice nurse	£10.80
COPD + Diabetes	2	10mins band 3 admin.	£2.16	1 min band 3 admin. plus 1 min band 8 nurse practitioner	£0.37	40mins band 3 HCA	£6.40	2 mins band 8 nurse practitioner	£0.74	Postage	£0.56	40mins band 7 practice nurse	£14.40
Asthma (no info gathering)	20	10mins band 3 admin.	£2.16	1 min band 3 admin.	£0.16	0			£0.00	Postage	£0.56	20mins band 7 practice nurse	£7.20
Asthma +/- single LTC e.g. CKD / MH (info gathering needed)	8	10mins band 3 admin.	£2.16	1 min band 3 admin.	£0.16	15mins band 3 HCA	£2.40	2 mins band 8 nurse practitioner	£0.74	Postage	£0.56	20mins band 7 practice nurse	£7.20
Dementia (no info gathering)	2	10mins band 3 admin.	£2.16	1 min band 3 admin. plus 1 min band 8 nurse practitioner	£0.37	0			£0.00	Postage	£0.56	20mins GP	£18.80
Dementia (includes all other LTC) info gathering needed	5	10mins band 3 admin.	£2.16	1 min band 3 admin. plus 1 min band 8 nurse practitioner	£0.37	15mins band 3 HCA	£2.40	2 mins band 8 nurse practitioner	£0.74	Postage	£0.56	20mins GP	£18.80
Mental Health / LD (includes all other LTC)	14	10mins band 3 admin.	£2.16	1 min band 3 admin. plus 1 min band 8 nurse practitioner	£0.37	15mins band 3 HCA	£2.40	2 mins band 8 nurse practitioner	£0.74	Postage	£0.56	20mins GP	£18.80
All other single or multiple LTCs (e.g. epilepsy, RA, Thyroid)	25	10mins band 3 admin.	£2.16	1 min band 3 admin.	£0.16	10mins band 3 HCA	£1.60	2 mins band 8 nurse practitioner	£0.74	Postage	£0.56	15mins band 7 practice nurse	£4.65
Cancer	5	10mins band 3 admin.	£2.16	1 min band 3 admin. plus 1 min band 8 nurse practitioner	£0.37	0		2 mins band 8 nurse practitioner	£0.00	Postage	£0.56	20mins GP	£18.80
								Grand Total All Patient "Post" CSP costs				**£2,108.47**	

Conclusion: In these scenarios, using a total practice population of 9,699 patients moving to a multi-morbidity CSP approach resulted in a reduction in direct costs for this cohort of patients from £2785.50 to £2108.47 across one month. This has been achieved through the introduction of a more systematic process across all conditions, changes in skill mix and consolidation of appointments.

Practice activity and cost profiling tool

This interactive practice activity and cost profiling tool is designed to

1. compare time and resource use 'pre' and 'post' implementation of personalised care and support planning across varying patient numbers for either single conditions, or multi-morbidity across a practice
2. model/predict impact on time and resources by altering salaries, roles, postage and time allocation across each stage of the process.

The examples in Part 2 were produced using this tool.

To access this tool or gain more information please contact enquiries@yearofcare.co.uk