



Newcastle Practices

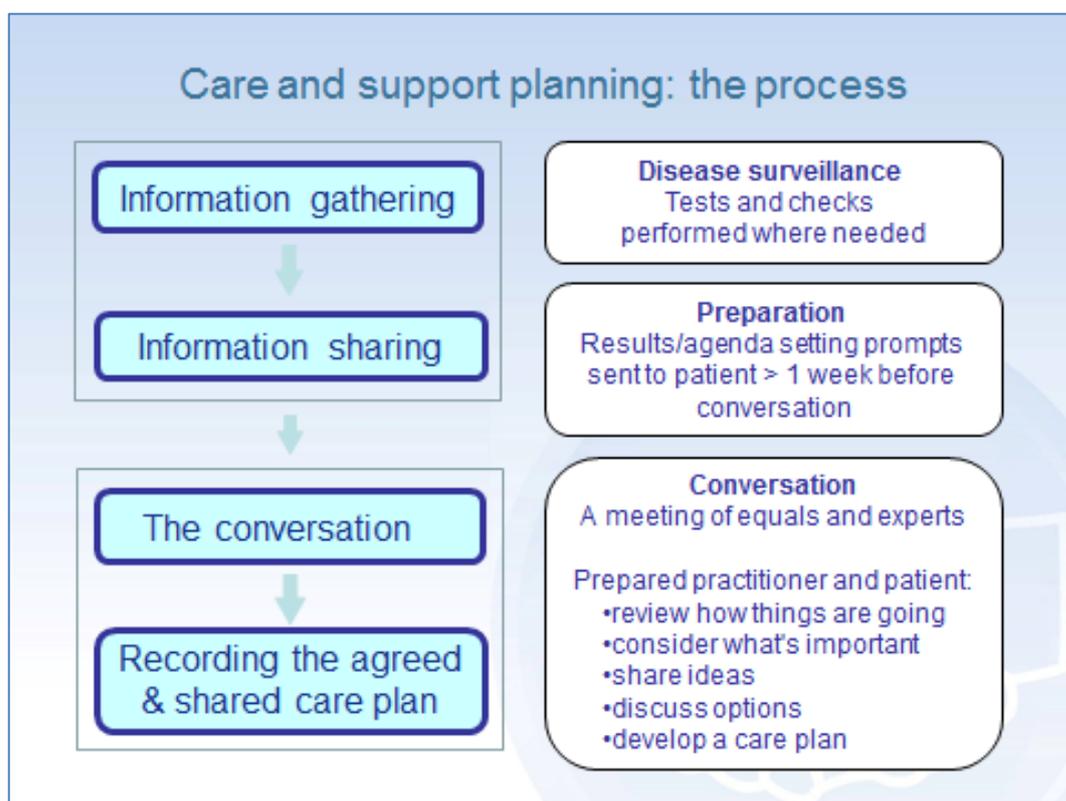
*Care and support planning stories from the
frontline*

What is care and support planning?

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 long term conditions (LTCs) 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 no matter how many conditions the person lives with. Organisational processes, practice care pathways, staff/team roles and support are redesigned to achieve this.



The following interviews are the early experiences of implementing CSP from a range of primary care staff, both clinical and administrative.

Practice Manager and Administrator Stories

Michael Foster - *Practice manager*
Holmside Medical Group

Brian Doyle - *Practice manager*
Walker Medical Group

Ben Hannan - *Practice manager / pharmacist*
Heaton Road Surgery

Lucy Chambers - *Administrator and patient care co-ordinator*
Saville Medical Group

Dee Richardson – *Receptionist*
Walker Medical Group

The Holmside Medical Group Story

A practice manager's perspective of care and support planning

At Holmside everyone with one or more long term conditions (LTCs) has a coordinated personalised approach to their routine care based on a care and support planning (CSP) process. This focuses on what matters to each person in their daily lives, what they would like to achieve and what support is needed; all brought together in a single process and plan, however many 'conditions' the person may have.

"Previously at Holmside we had quite a fragmented approach to our LTC management. We had multiple recalls for multiple conditions and also a recall for medication review for patients".

Back in the summer of 2012 the practice management team were actively thinking about ways to reduce the number of letters they sent out to the same person, for multiple reviews and medicines management. The nursing team felt most comfortable with seeing people in separate condition clinics but they wanted to do more to support them. At the same time the *Year of Care Partnership*¹ (YOC) programme was providing training in CPS as part of the local *People Powered Health Programme*². The practice nurse who attended was enthused about how this could make a difference in diabetes and the management team suggested the bigger and bolder step of including everyone with any number or combination of LTCs into a single recall system. The newly appointed nurse practitioner had expertise in respiratory disease and she recognised that a single consultation for each person, with however many conditions they had, could be achieved. Nursing and administrative teams began to work together on practical details.

Working initially with the YOC team they mapped out what would be needed to administer the new way of working and the training needs of staff.

"We had a few time in sessions where the whole team got together to discuss the end to end process. From the outset we realised the importance of everyone knowing their particular role.

As a practice we have seen real benefits around adopting this approach for our patients with LTC's in that we have one single system, one process for inviting patients in, that everyone understands and understands their role in it. We have cut down massively on the number of encounters patients have, quite often needless, and we have a process now that everyone understands.

Now that we have adopted this new system for the past 2-3 years it has become very well embedded in our patient population. All the feedback that we have had has been that patients really do value this single encounter relationship we have with them, and almost exclusively all the feedback is positive".

The Holmside team are collating their experience, templates and resources and working with the YOCP team to find ways to make them available for others who would like to reap similar benefits. Patient and staff satisfaction and engagement has increased, there are less unplanned attendances at the practice, and there has been no deterioration in quality and outcomes framework (QOF) measures or increase in practice costs.

¹ www.yearofcare.co.uk

² www.nesta.org.uk/project/people-powered-health

The Walker Medical Group Story

A practice manager's perspective of care and support planning

We became involved in care and support planning (CSP) as part of the Clinical Commissioning Group (CCG) initiative and attended a taster event to find out more about CSP. We cover all the 6 conditions in the CCG service specification and also hypertension.

We have a large practice population of approx. 11,000, so we started off initially with people with diabetes plus the other specified long term conditions (LTCs). We thought it would be a good way of dipping our toe in the water and trying it out, working out how it would work best for us and then spreading it across other LTCs.

I think it is important that you have a local champion who really engages with the whole thing. I was fortunate in that one of our health care assistants (HCAs) recognised the benefits for patients and for ourselves, right from the initial training, so she really took hold of it and became a champion for CSP. We also have a GP lead, all the nursing team have got to be involved because they are the ones who will be seeing most of the patients, and we also had an IT coordinator. He was a great help sorting all the computer side of things. It is also important that the reception team are on board due to the complexity of it. Initially there were just a couple of the reception staff involved, but as it expands, we are going to involve the whole of the admin team from the new quality and outcomes framework (QOF) year. We have had a lot of ad hoc meetings, as and when problems have arisen.

We decided to introduce a birth month recall system, so there was quite a lot of work to identify all the different LTCs a person had. The birth month recall has worked well; it needed a bit of tweaking initially as some people had just been seen a few weeks prior to their birthday. It gets better the longer you run it. We also started with our diabetic population and then introduced other conditions so we found we lost time, and if I was starting again, I would go for all conditions from the start. Despite losing some time due to this it has made it easier to achieve QOF. I am hoping that next year when everything is running more smoothly, we will not be doing as much of a catch up. I think this will be a benefit of the system going forward.

There is almost the same number of patients in each month; we don't have big variations between months. Each one of those patients has been categorised as being in YOC 1 to 13, depending on the conditions that person has. For example, YOC 1 might be diabetic, YOC 2 might be diabetic and chronic obstructive pulmonary disease (COPD). So, every possible combination of LTC is taken care of. Then we agreed with our practice nurses (PN) and HCA how long the appointment needed to be for each category. This information is put onto a waiting list so reception can go into that list and see how long the initial appointment with a HCA or PN needs to be. It can be anything from 10 minutes to 40 minutes depending on the number and combination of LTCs they have. The person comes into their initial appointment and has all their tests done, and the HCA books their second appointment at a time to suit the person. A task is sent to admin so that when the results come back, they know to send out the results and prompt along with a reminder of the review date. At the second appointment we discuss the results and plan their care for the following year.

We find it works well as the receptionists know how long an appointment to give so it takes away all the clashes with nurses feeling they haven't been given a long enough appointment, and it takes away from reception having to make the second appointment as it is done when the person comes for their first (information gathering) appointment.

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I have an excellent nursing team and they have adjusted to the more generic way of working. The main anxiety from the nurses was about the length of appointments, and whether it's appropriate to see someone for 40 minutes even if they have lots of conditions. There was also a worry about the amount of time lost if people did not attend (DNA), but I don't think the DNA rate is too bad with YOC whereas before it was horrendous.

My concern is for the people who have their first appointment, have their results shared with them and they think that's fine and then don't bother to come back for their second appointment. What do we do with them, do we offer telephone appointments, and only bring back those who really need to come back?

I haven't had any direct feedback from patients. Personally, I am a person with a LTC and I would love for my surgery to be implementing CSP.

Our population is a typical inner city mix, with varying levels of affluence, and multi-cultural with a large Eastern European population. We prepared patients for the change in process via posters, verbally in the run up to the launch, and using our website and Facebook. I still feel that only scratches the surface and that the first initial invite letter that explains the change, why we are doing it, and what it looks like going forward, is really important.

The main challenge at the beginning was inertia from some staff who questioned why do we need to change as our standard of care is good. Some GPs were concerned that the standard of care might actually drop. A lot of systems have grown up and people have a vested interest in those systems, then something new comes along and provokes anxiety. Any change is challenging for some people.

We were lucky as we were incentivised, so that helped win staff over. It's difficult to sell the intangible, particularly as you have to turn the systems around, it is not painless.

If I was to give advice to other practice managers starting out it would be just to go for it all from the start, otherwise you are left with a lot of catching up to do. Start at the beginning of the QOF year.

One major outcome for the practice is that it has helped us achieve our QOF targets earlier, and I think the impact will be even bigger next year.

Another benefit is that the two receptionists who have been part of the team have loved being part of it. They have learned a lot about how general practice works, how different conditions affect people and the impact on the nursing staff as well. They feel they are a lot more knowledgeable. Now that all the admin team are to be involved hopefully they will also feel more empowered when dealing with patients.

CSP has really focussed us on how we work with the housebound population and how their care might be better. We have an HCA who goes out and does the first part and then their information is posted out, this is followed up with a GP appointment. It's better than ever, much more structured.

Plans going forward are to include those patients with frailty in CSP.



The Heaton Road Surgery Story

A practice manager/pharmacist's perspective of care and support planning

We started initially with Year of Care (YOC) and care and support planning (CSP) at the beginning of 2016. We spent the 2016 to 2017 financial year getting the process right, and getting the staffing right.

When we started we did not have any recall systems, we had adhoc care. So firstly we designed a recall system based on prescribed medication that people took, and then inviting them in. That way we were picking up everything that was included in our quality and outcomes framework (QOF) registers, but also people who might not necessarily be picked up from a traditional chronic disease review, people with epilepsy for example. In that way we identified 200 people a month needed a review. Our biggest intervention areas were chronic obstructive pulmonary disease (COPD), hypertension, and cardiovascular disease. We have definitely seen an improvement in control in people who have hypertension, who are coming in with something else.

We've now got 'patient chase' (an EMIS partner product) instead of doing our own manual recall, we've automated our mailing list, so actually the administrative side of it is going to be minutes as opposed to hours but that's all through learning about what did and didn't work for us.

Staff involved in CSP include a lead pharmacist and a lead GP. We had a dedicated administrator to send out the result letters and book appointments, and we had 2 nurses trained in CSP and a health care assistant (HCA). Our lead GP comes from a practice in North Tyneside that had been doing it for a while and she had seen it working well, so she had that drive and enthusiasm to get it right here.

One of the lessons learned was that we need to be clearer and more consistent in the terminology used. What we need is a more sustainable system regardless of staff turnover. The admin staff had varying levels of understanding of the process, so it caused a bit of confusion. I think we need to be very specific and a bit more visual for some of the members of staff, using process maps and flowcharts. We still have a dedicated administrator for the results etc. but we have included more staff from the admin team in the meetings about YOC and the processes, so they have a better understanding about the appointments, which member of staff, and how long they need to be.

Another issue we had was our HCA got confused with the different terminology. You would get a different result from the HCA whether you called it an 'annual check' or 'YOC'. The instructions need to be very specific about the individual blood tests and tasks that the patient requires, so the staff has something to refer to.

The advantage of CSP is that it's a lot more organised, the numbers of appointments needed were definitely reduced and that's a huge selling point, although it may be a longer appointment. For the people that came in it was a one stop shop, instead of their care being fragmented. One of the benefits we found was that patients were coming in for planned reviews and I feel that our care is a bit safer.

I think it's that holistic element that was more enjoyable for the clinician, as you got to look at everything together, and you aren't just ticking boxes for QOF. You were able to have a more real conversation with your patients about what is important for them, so it shifted the focus from achieving QOF, or whatever targets you usually do, into having better consultations with patients.



I think that can be both a positive and a negative. Ultimately you've got a professional agenda, if you've got someone with a chronic disease in front of you, and you talk about what's important to them, and there are actually no overlaps, it can feel time pressured. When it's worked well, you feel as though you have done a really good job, and that's really gratifying.

Generally over the last year of integrating this alongside primary care navigation, and also prescribing, we have more honest conversations with patients about what they need. We've had the care navigator since the 1st August and she's spending time sorting out financial, social or isolation issues. It's been a huge benefit having all this.

I think we've had a mixed response from patients, some of them really embraced it and loved getting the letter with their results on, and they were really motivated which is great. Other responses have been "*I don't really know why I got these*". I think that sometimes the processes let us down and the patients don't bring the results for reasons x, y and z. Patients were prepared for the change in process via an explanatory letter, we spoke at the patient's participation group, and we put it in our practice newsletter. The change in the consultation should have been explained at the HCA appointment and in the first invite letter.

The HCA role is really important; I think they are almost like a front door to the CSP process. It was all well me giving them a sheet for them to read out, but actually that's not their style, that's something we need to look at. It's important to get the HCA on the training, because if she's really enthusiastic and owns it, the whole process runs more smoothly.

One of the challenges has been the change in role for some staff. One of our nurses struggled with it because she was used to doing the diabetes clinic and doing the asthma clinic and was unsure about how to combine conditions.

It wasn't the culture change that was the main thing for us, it was more the processes that were different. The biggest challenge with YOC is not the CSP conversation, it's changing all the systems to get it in, and that's the hardest part.

We have invested a lot in technology and I think that has partly been driven by YOC. We have released more administration time by getting in digital dictation, and out sourcing some typing. YOC have sort of set that off with the mailing and the patient chase system, so if you had told me the benefits of it, I wouldn't have said that, but actually it's had that effect.

The change in practice was mainly driven by me and the lead GP, we occasionally met with others. I think a lesson learned is about getting the whole team on board, and I think going forward again we have been a bit more inclusive on how we are doing things.

So I think we've had a lot of work to do and I think the culture is right, it's just we haven't had the right systems. QOF data is a lot better and that was because of planned recalls. Especially respiratory and blood pressures have been well targeted earlier on in the year.

The Saville Medical Group Story

An administrator and patient care co-ordinator perspective of care and support planning

I work in a large practice as chronic disease administrator. I first became involved in Care and Support Planning (CSP) in 2017, when I attended training offered by Year of Care Partnerships (YOCP).

Patients are recalled in their birth month for all 6 conditions identified in the service specification; diabetes, cardiovascular disease (CVD), peripheral arterial disease (PAD), ischemic heart disease (IHD), asthma, chronic obstructive pulmonary disease (COPD) plus atrial fibrillation (AF). We didn't used to include AF, but we have new IT software (patient chase) which enables us to include them and it made sense for us to do so.

I send out a first invite letter for them to come in for their information gathering appointment and a second letter with all their results and the preparation prompt prior to their CSP appointment. We included in the second letter that all the results have been checked by a GP.

Coding was an issue, getting the nurse to click the codes for information gathering, and long term condition (LTC) summary sent to patient. I created a search within EMIS, based on the 'LTC summary sent to patient' code. This identifies which patients have been seen, and once the results have been checked I code 'patient informed of test result' and this takes them off the list.

The results come back to any doctor, and urgent results are dealt with by them in the usual way. Some people would prefer to see a GP for their second appointment and if they need a medication review, they would see the doctor, as nurses cannot do that as they are not prescribers. So blood results come back into the patients notes and then I run a search for the CSP cohort.

The main challenges have been the logistics of getting the system up and running in a large practice that is split between two sites, particularly as not all staff work across both sites, and using a new template from the Clinical Commissioning Group (CCG). It has been a challenge to get everyone to do the same thing. The practice established a CSP steering group, consisting of both administrative and clinical staff. Initially it seemed quite daunting until we worked out how it would work for us in our practice.

We prepared people for the changes by putting information, including posters, on our website. We have only had a couple of phone calls from patients. It wasn't that they didn't like it; it was just that they were confused about the changes; they just needed clarification on what it was. I was expecting a lot more as it was something new. I don't sit in on the consultations, but I haven't had any negative feedback from our nurses. I haven't personally had any negative feedback from patients, they seem to like it. I am aware of one patient who came back to see the GP, and he wasn't at all concerned about his LTC, it was all social stuff, he was worried about losing his house which he would probably never had mentioned if there hadn't been a prompt for it. We do have access to a primary care navigator but I'm not sure if referral rates to them have gone up.

The new system has increased my workload, but it has also given me more responsibility and has elevated my role. My role has expanded to be both chronic disease administrator and patient care co-ordinator.

I don't know whether we are further ahead with quality and outcomes framework (QOF) this year, it feels as if we might be, but I'm not sure if this is due to having more stable staffing, new IT system or CSP. We probably have a larger number of people coming back; possibly sending the results has given people the incentive to come back.

The Walker Medical Group Story

A receptionist perspective on implementing care and support planning

My colleague and I were selected to be involved in care and support planning (CSP). My role was to start with a combined list of patients from a birth month register who needed to be in the quality and outcomes framework (QOF) before the beginning of April. My job was to code them, see what chronic illnesses they had, and then send letters out. That was probably the most challenging time because we were trying to catch up.

We were constantly looking at the spreadsheet we had created – constantly back in, out, changing and updating, getting appointments, but I think moving forward beyond April it works.

It's possible that patients didn't get the concept of it at first. Personally, I think it's the right thing to do because you're not getting people in 3, 4, 5 times a year. So we started it and then the other girls stepped in doing the initial letters, but I don't think they realised just how much you have to look into it. It's not just 'I'll look on there, I'll click it, and I'll send the first letter'. You've got to look in patient's notes, see whether they've been in recently, and if they've been in the last 2-3 weeks do we need to get them in again? Then we need to ask clinical staff "do we?" or "don't we?". There's a lot of checking that goes behind that letter because we don't want to annoy patients sending the 1st, 2nd, 3rd letter. So you have to be very careful.

The letters are coded; we have YOC1, YOC2 etc. We have a sheet with all the codes on. At the beginning it was 'do we have another code for that?' but you don't want to end up with loads of codes. The letter that goes out has a code on it, so when a patient phones, if we put the code in for example YOC1, a template will automatically drop down. This indicates who to book them with and how long for. The patients sometimes ask "am I seeing them both together?", so we have to explain the new system, that they will have the first appointment to gather information, and then another 2 weeks later to discuss the results.

We send letter 1 at the beginning of the previous month. The second letter is sent 10-14 days later, and the last letter gets sent out before the start of the birthday month. After that if they haven't booked we do phone calls, it gets good results. The patients are more likely to make an appointment if they get a call. Each month there aren't that many that haven't made appointments. I am hoping that next year there won't be as much catching up, we won't have that massive combined list.

If they've got other appointments we try to combine them with the health care assistant (HCA). It's forward thinking; it reduces the amount of times they're coming in. There are no negatives. It was bit of headache to start, but once the systems are up and running it's easy.

I've not had much feedback from patients about CSP.

Personally I think it is better, particularly for older people, not having to keep coming back, it's cost efficient for them.

We include housebound people too. The nurse does the information gathering bit for the housebound, the GP does the second bit (review appointment). The GP does the medication review at the same time, while they are with the patient.

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We highlight the spreadsheets - when completed we highlight them in yellow, if we need to task one of the GPs, we'll use red so we know the GP has to have a look at it, queries for the nurses we highlight in green.

We had tried to get November's patients in November, but we started too late and my advice is to start earlier. We are doing training for the rest of the reception team, so we are going to do a flowchart. Our aim is to turn the spreadsheets yellow!

My top tip is to make sure you look at the notes, check if they've been in, and check with the clinical staff to see if they need to come back.

I think it's a good role, I love doing it.

Nurse Stories

Michelle Corkhill - *Practice nurse*

Cruddas Park Surgery

Bridget O'Sullivan - *Practice nurse*

Biddlestone Health Group

Karen Hammond - *Practice nurse*

Walker Medical Group

The Cruddas Park Surgery Story

A practice nurse perspective on their first year of care and support planning

Care and support planning (CSP) was already happening when I arrived at Cruddas Park, so when I attended the training it made sense to me straight away, I could see it was what we were doing. It is about giving patients more ownership of their condition, focusing on their priorities. I might think that their diabetes isn't very well controlled, but the patient might be more concerned about their heart disease.

It is good to be bringing their conditions together in a single review appointment, because it means we can think about them all at the same time. Some patients have a lot of long term conditions (LTCs) and to come 3, 4, 5 times is difficult for them, but also the issues, like diet and exercise, are often relevant to them all.

Being prepared for their appointment helps patients take control of their health. Instead of thinking *"What is she going to tell me to do today?"*, I can support patients by asking *"What do you think, you've had your results and a bit of time to think, what is most important to you?"*. Some patients may still expect to be 'told what to do' and I don't worry if people haven't filled out their prompt. I explain what it is for, and encourage them to put down their thoughts if they want.

A lot of people come in now with things jotted down. Of the 5 people I have seen today, 3 were keen to talk about their results, offer an explanation for high readings, and tell me what they wanted to do about it. I think that's great because then they have already described their action plan. It is so much better, when we are setting goals, we can talk about the specific problems they have identified, and ways they might tackle them. For example weight loss, preparation might help people start thinking about what they could do and come in with ideas already in their mind. It gives people the chance to make their own decisions.

Patients who are involved in developing their own action plan are more likely to have stable conditions that they can maintain themselves and better long term health. They can take charge of their own lifestyles without having to come in to the surgery. If someone has had hypertension for 12 years they can tell me what works, what they have tried, how they get on with their medications, what makes a difference to them. They know their condition better than I do, they know their exercise limitations, and they know what they eat at home. My role is to support them in educating themselves about their condition, thinking through ideas around lifestyle and pointing them towards national organisations if they would find that helpful.

It also gives people the choice - this morning, a patient told me that her results were high because she had just lost her husband. That was her priority and her diabetes and hypertension didn't mean much to her at the minute. So our conversation was about recognising the other things that were going on and what was important to her. People can be prevented from living well by many things, including social factors so talking about these is as important as much as the medical issues. And if their LTC isn't the greatest priority, it is about us keeping an eye on it while supporting them with their own decisions.

Services such as Ways to Wellness and the Healthy Lung Service are great for patients who will engage. Sometimes it can be challenging encouraging people to take up the opportunity, just getting them to try something once before deciding. It is good if services like that can be visible, information in waiting rooms and to give patients, even being available to introduce to patients.

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Engagement of the practice team is important to make CSP successful, here it is accepted as just what we do, not something different. CSP benefits patients by allowing them to contribute to their own health, encouraging them to think about how to stay well, how to look after their lifestyle and identify changes that are possible. It is about trying ideas and different strategies and providing on-going support through motivational interviewing, guiding patients and finding out what is important to them.



The Biddlestone Health Group Story

A practice nurse perspective on their first year of care and support planning

I first came across care and support planning (CSP) when I worked in North Tyneside and the Year of Care (YOC) pilot was introduced for diabetes care. It initially felt a bit overwhelming and complicated, there were changes to the admin systems and templates we used, but what I took from it was the different way of carrying out the review, asking patients about how they feel about things. It was good to get that type of rapport, instead of just giving information and telling people what to do, not really engaging them. That was the part I really liked, all I really wanted from it was to change the way I consult.

After moving to Newcastle, our practice weren't initially using CSP, but I was still trying to use the approach that I had learned during my consultations. So when YOC was introduced here, I understood the process and was less worried by all the admin. It's important that the whole team, including the admin team and the health care assistants (HCAs), understand how it works so that they know what patients are coming for at each stage.

Our HCA now books the CSP appointment for 2 weeks' time whilst she has the patient with her for their tests. She completes the template, there is quite a bit more for her to cover such as smoking, blood pressure, bloods, height, weight, body mass index (BMI), physical activity, cardiovascular risk where necessary, and depression scores are still useful. During the review I talk to the patient about their goals, look at action planning, and record a summary of the conversation. I ask people *"What are your main issues?"* *"What would you like to discuss today?"* they may tell me *"I'm not sleeping well"* or *"I'm feeling down"*.

We talk about their issues, then I bring in my clinical observations, it might be their HbA1c or something else, as the things that I would like to talk about. When asking about goals I ask if there is anything in particular that the person is keen to do. They might want to lose half a stone, get their blood glucose down and might have ideas about how they are going to do it, perhaps by cutting down on portion size, or doing a bit more exercise. Sometimes I ask patients to reflect on how realistic their goals are, for example for weight loss, I might try to renegotiate if I feel they want to set too difficult a goal - nobody likes to feel they have failed or not reached their target.

Involving patients is important. Before YOC, I don't think I involved patients as much; I would be focused on clinical targets and what the patient needed to do to reach them. I would say to patients *"You need to"* offering less individualised patient care. Now I think about the clinical issues and the patient issues, which might be nothing like mine, and how we can bring them together. I make suggestions by saying *"What about..."*, and they could say *"I'm not interested..."* I record this and note it as something to explore again next time. If I set a target that a patient is not interested in, they are 100% not going to do it. When we agree a goal I can ask the person how they might achieve it, what will it look like, how they are going to feel when it happens. We can talk through ideas such as about portion size, glycaemic index (GI) foods, trying a range of different things. When a patient starts taking responsibility, you know that they are going to do it. Something like monitoring their own blood glucose is a good example, they can see the effects of food choices and suddenly it becomes a bit of a challenge for them, seeing the difference that certain changes can make.

If patients are well controlled and happy with the way their conditions are, their aim might be just to maintain this. Sometimes scoring their confidence and importance seems trickier when patients are

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well, they may feel their conditions are not that important to them because they are not causing them problems. So I try to encourage them to think about how important is it to them to stay this well controlled. If patients don't understand the use of the numbers of the scaling questions I might show them the scale and ask how important is this if this end is not important and that end is very important, where would you put yourself, and patients point and say "...about there". Initially there was a lot to think about during CSP consultations, then making sure it's recorded, but I'm getting used to it now.

We have always done multi-morbidity appointments, for example for people with diabetes and ischemic heart disease (IHD), but now we are sending results beforehand, and looking at a wider range of conditions. With additional training we will have the right skill mix, but that can take a while. Our next steps will be to bring in other conditions such as atrial fibrillation (AF), heart failure and peripheral arterial disease (PAD), and as a team we need to agree a way of doing this, how we modify prompts and results sharing documents, and which clinician is best suited to see those patients. Everyone has had varied training and is confident in different areas, we can support each other.

When I ask what they thought of getting their results, quite a few patients say it is a good idea and people ring things on the prompt, sleep, mood etc. It helps them to say "*I've got a couple of things here I want to ask – I've not been sleeping very well*", or "*I am not walking as well*", so I am then able to signpost them and provide links to relevant support services. Some people still come in without their letter; it's still new to them. We are hoping to send the same colour coded results sheet at a 6 month interim as the annual review, and we are adding to the letters, tweaking things as we develop and learn.

Our aspirations for moving forward with CSP are firstly to have a sleeker system that incorporates 6 month recall, then including other conditions, working out what needs gathering and sharing for each and identifying the training needs of staff. For patients we want this to be a one stop shop, where they feel comfortable to talk about anything that they want to discuss. When patients are engaged you can see them thinking, linking their goals to all of their conditions. We can consider their worst fears and look at ways to prevent them. It's a chance to think about the implications, to support and enable informed choice.

The Walker Medical Group Story

A practice nurse perspective on their first year of care and support planning

After attending the Year of Care (YOC) training, our team started to get going with care and support planning (CSP). There were initial challenges, it was important that other practice staff understood the benefits of both CSP and the idea of single reviews for patients with multiple long term conditions (LTCs). Some staff were concerned about not having enough time for consultations where patients had a number of conditions, and worried that the relevant results for each condition would not all be available at the review. In fact, what we have found is that the health care assistant (HCA) appointment enables all the information to be ready and there, everything is done and in one place.

I had no reservations about CSP from a patients' perspective, it is an opportunity to encourage patients to be more proactive, get involved and take more responsibility for their own health. We have found that birthday month recall works well; it's an easy way for patients to remember their review date. Before we implemented CSP, care provision felt a bit disjointed, patients would come in for separate reviews for each of their conditions. Nothing ran together or flowed correctly and to me it felt jumbled up. For example a patient would attend for their hypertension review, and their medication would be checked, but not those taken for any of their other conditions. And for people with comorbidities, it might be that only one of their conditions is troubling them. If a patient attending for a heart review was having more problems with their chronic obstructive pulmonary disease (COPD) or asthma, there wasn't always enough time to address both; if you did the clinic would run over and if you didn't the person would often need another appointment.

This way everything is looked at together and we can treat people more holistically. It allows you to consider what is important to the patient; if their breathing is more of a problem than their heart; it provides a fuller clinical picture. It is better for older patients too; it means we are not bringing them back several times a year. It's a one stop shop – an opportunity to look at everything in one go and to encourage patients to think about their lifestyles.

One of our admin team and a HCA go through birthday month list, and send letters inviting patients to come in for a pre-review check. Patients see one of the HCAs or practice nurses to have bloods, weight, blood pressure and foot screening done. The HCA talks to them about the aim of the CSP appointment and books the appointment for 2 weeks. Patients are reminded to look out for a letter containing their results, and encouraged to read it, think about them and bring the results with them to discuss when they come back in.

One of the keys to success was getting everybody on board from the start, and telling patients about how their care was going to change. Every patient is given an information leaflet that explains what is happening, letting them know what CSP is about. The benefits of CSP to me as a clinician are that it feels like I am offering a more holistic care package. We have two weeks to prepare for the appointment, the patient has been seen for all their tests, and because their CSP appointment has been made at their visit to the HCA, they are more likely to attend. When they do attend, they know what it is about, and getting their results can encourage them to think more about their health.

Patients like receiving their results, although some bring their letters back with them and haven't yet done much with them. But others have really studied their results and the information. We had a short-lived technical glitch recently, during which we were unable to send results letters, and during that time patients complained about not receiving them!

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Some patients come into their appointment saying *“Yes I got it and I want to go through it”*, others are not as sure; people need time to adjust to the change. One patient showed her husband and he was really interested too. And because they have something written down, developing an action plan is easier, it needs practice to get the structure of the conversation right to encourage patients to take the lead a bit more. Some patients still expect to be ‘told what they’ve done wrong’. Some people comment on their results compared to the previous years, they see that it’s better or worse than last years, but they often then talk about why and might say *“Oh it’s because I’ve been to a wedding”* or *“I’ve been on holiday”* etc. Having results beforehand provides a bit of structure and an opportunity for them to think about changes they might make, it has got to be their plan. If the patient doesn’t bring up something that is important clinically I might say *“Can we have a closer look at this aspect of your results”* or *“Is this causing you any concern or worries?”* to try to tease something out.

We started by introducing CSP for people with diabetes and other co-morbidities, and by next year, once we have birth month recall well established, we aim to be including people with respiratory disease. We want everybody to get comfortable with how CSP is working and then we will begin to introduce the other LTCs. Eventually we will start to look at how we could incorporate medication reviews into CSP appointments for some people. It might mean that some patients who are stable, happy and not on medication may not need to come back every 6 months, but know that if they do have any problems they have that option.

GP Stories

Richard Croft – GP

Cruddas Park Surgery

(Plus his person reflection as a local GP experienced in care and support planning)

Rachel Cooper – GP

Holmside Medical Group

The Cruddas Park Surgery Story

A GP perspective of care and support planning

My name is Richard Croft; I am a GP trainer at Cruddas Park practice. We have two sites, stretching across the western city, one in Cruddas Park and one in Kenton, that each have about 5,000 patients so 10,000 in total. We cover an economically and socially diverse population.

We decided to go for care and support planning (CSP) properly 2 years ago, so 2016 into 2017. We still have work to do, but CSP now covers diabetes, chronic obstructive pulmonary disease (COPD), heart disease and hypertension.

The start was the Year of Care (YOC) training and that was hugely important. It had to be an on-going thing to make sure everybody understood the concept. To complement that, I ran a session in one of our time in sessions, where I covered a small part of the core training; to spread the message to a wider number of the practice team and to win over those within the team that had doubts about the changes.

We developed a steering group, consisting of GP, nurse, health care assistant (HCA), member of the admin team, and our assistant manager, plus a key member of the admin team for recall systems. We started to meet regularly. We had some nurses and HCAs who we rotated through the group, so it wasn't the same person, so everyone felt part of the process.

The first step was to identify roles and work out what people were actually doing, and the skill mix within the team. We found that there was a lot of overlap, so you have to develop a very clear flow chart for your systems. There were some issues around protection of roles, but once we got a team who were enthusiastic it was fine.

The first thing is having that protected time to sit down as a group and look at the practice systems; understand what's happening now and what might be different in terms of appointment length, covering the appointments, and how we get our recall systems running smoothly. We very rarely have time to do that especially as a clinician.

CSP consultations are done mostly by the practice nurses, but in order to understand the benefits you've got to experience it yourself. That is a huge part of the training that everybody in the team needs to have that experience so they can grasp the concept. Otherwise you don't really know what you are doing, and you don't see the value in it, you just see it as another recall system. It's a lot more than that, it just happens to fit in really nicely as an excellent recall system but patients get a much better, higher quality consultation. The good thing is that when I do see patients because I've had that experience about goal setting and action planning, then I know what they have been talking about, and it's hugely important that everyone understands it.

If the nurse sees someone that they feel needs to see a GP she will slot them in that day. We have stand by slots through the day, so the patients don't have to come back. Usually that's more about the clinical side of the medication changes. We've got really good links with voluntary sector services, and 'Ways to Wellness', and now we've got the care navigator for all our social prescribing. The nurses can sign post to these organisations so people rarely have to see a GP as it's all contained in the consultation. We just pick up all the boring medical bits, so it works really well. The medication review is more difficult to do and something that we need to look at.

There was some anxiety following the training that patients would start getting letters and would be ringing up, asking questions and be anxious about their results, and the doctors would be overloaded

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with screen messages. So we prepared for the worst. We had a script for our receptionist so that she could deal with these queries and it just didn't happen. Patients started getting the letters and coming for the reviews and we didn't get any phone calls from patients.

We had the YOC video running on the practice screen advising people about the changes. Our key admin person sent a covering letter with the first appointment explaining things were going to be different, so it was a very clear change. Actually patients seemed to be ready for it and we even had a patient come in saying *"my husband gets the letter with his results, but I don't get one, can I have a letter like that?"* So my experience is that patients really embrace it and come for their appointments.

The whole thing is just much more efficient, to have that confidence that there is a system running in the back ground and if somebody falls out of that system they will get picked up further down the line. In the quality and outcomes framework (QOF) areas we are definitely not doing any worse than before we brought in YOC no doubt about that. It's hard to know how much YOC would be responsible for improving diabetes control but the fact that we are getting people through the door for a review on a regular basis has got to be a good start.

Moving to multi morbidity clinics, staff training is something to factor in. All staff have been trained up to the right level of knowledge, so they are able to deliver the right level of support. That's why the roll out for each condition had to be slow. The HCAs have had some basic consultation skills training as well for their bit, because their bit is just as important as the nurses. We've done some training in our time in sessions, when we meet once a month and at a session run by the Clinical Commissioning Group (CCG) for nurses and HCA's.

We've been quite lucky with our HCAs; we've been able to train them to a higher level than some other practices have. They are both ex admin team members first of all, so they know that side, then they were trained as phlebotomists and they were also trained in Spirometry and then trained to do ECG's, so they are actually quite skilled.

CSP gives a different slant to the consultations and just gives the patients a chance to talk about something else, and here it's normally housing benefits or carers duties and that's a good thing to keep people in contact with the surgery. To be honest I've not really had any feedback on people feeling overwhelmed with results.

I think the biggest challenge was getting everyone into a room and saying right we're going to introduce a new system, and change always increases people's anxiety. What we have learnt along the way is that we have had access to YOC trainers when we needed. It's just been pretty straight forward most of the time. I suppose the danger with that is you might lose track of what's going on, is the quality still there? Are people just getting into the routine and going through the motions rather than actually having good conversations?

I had a meeting recently about bringing CSP into GP training; we are very keen on that. It is very interesting because we do that already by default. Because of our long term condition recall system, they automatically get trained in CSP.

It would be interesting to have a sit down and a bit of a reflection on where we are at now, and how we move forward. Unfortunately you have to start with your QOF, but is it time to bring in other conditions, now we have got comfortable in what we are doing? We have 3 big projects on the way that feed into CSP. Firstly we are designing a frailty team to work across 3 practices, we are developing a medicine management function, and the third is mental health.

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A Personal Reflection

A local GP experienced in care and support planning

I look at my dad when he was alive; he had a stroke and used to moan that *“every time I come in they’re asking the same questions. I’m bored sick of it, I don’t want to go in, I know what to eat and I know what I’ve got to do, what’s the point?”* he would say.

I could see his point of view because all that would happen was he would get called in for his blood tests, go get his results then go home again. He never experienced this care and support planning (CSP) kind of approach and maybe he would have liked to be given the opportunity to look at other aspects of his life, the social side. Not looking at the cholesterol because it would have just bored him to death, still taking the statin, still doing what he should do most of the time.

CSP does give a different slant to the consultations and gives patients the chance to talk about something else. Here it’s normally housing benefits or carers duties and that’s a good thing to keep people in contact with the surgery. To be honest I’ve not really had any feedback on people being overwhelmed with their results.

The Holmside Medical Group Story

A GP perspective of care and support planning

At Holmside everyone with one or more long term conditions (LTCs) has a coordinated personalised approach to their routine care based on a care and support planning process. This focuses on what matters to each person in their daily lives, what they would like to achieve and what support is needed; all brought together in a single process and plan, however many 'conditions' the person may have.

"Initially we heard about the Year of Care (YOC) project around diabetes but we have a huge number of older patients with multiple LTCs and we decided to take the opportunity then to try to bring them all together and actually to use the model not just in diabetes but for all other conditions the patient was coming in with. We felt it would reduce the number of appointments the patient needed and also there was a lot of overlap between conditions. For example a patient coming in with diabetes would often be talking about vascular risk, and there would be education that would apply to all".

The YOC team was invited to a whole practice meeting to look together at the case for change and the implications for the practice if everyone on their quality and outcomes framework (QOF) registers was included. With GP support and joint leadership from nursing and administration they worked as an entire practice team to reorganise systems, develop resources, identify new roles, develop staff and provide training.

"I think the first main lesson for anybody thinking of implementing the process would be to ensure it is a whole team process and not a single process led by one interested champion".

The nursing team felt most comfortable with seeing people in separate condition clinics but they wanted to do more to support them. The newly appointed nurse practitioner recognised that a single consultation for each person, with however many conditions they had could be achieved.

"The GP's have provided the support, specifically around mentorship and clinical support to nursing staff. Providing support for the more difficult patients so that if a member of nursing staff is seeing someone who is more complex or who has clinical problems they don't feel able to deal with then the GP can step in and see them or provide support and mentorship for those cases.

I think the first benefit for the practice has been bringing the whole team together to develop the new process. Certainly that has been very strengthening for the team by involving everyone in developing it".

Patients are contacted in their birth month. Holmside are an EMIS practice and use 'Patient Chase' to create a birth month register of LTC combined patients, which are divided into practice agreed groups according to the conditions and number of conditions each person has. These are reviewed by the lead GP for each group to ensure that the CSP process is right for them and the right people are involved, often at the team's regular breakfast meetings.

"Bringing all their LTC together into one annual recall has been more efficient both for the practice and the patients themselves. It has provided a much more consistent approach to the way that we are managing their conditions".

Recording changes in resource use within a practice is difficult. It is not routine and the practice has plans to address this. The good news is that QOF figures have not deteriorated despite this new way

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of working. Experience from elsewhere would suggest that it takes two or three years to make a difference to clinical outcomes as habits of both patients and professionals die hard and engagement increases over a number of care planning cycles.

There have been some savings for those with respiratory conditions and the definite impression that those who used to make unplanned GP appointments on a frequent basis do so less often.

“Two or three things that we have noticed, certainly patients who come for care planning appointments seem to be better at taking their medication. There certainly seems to be some slight as yet not necessarily measurable drop in cholesterol and an improvement in HbA1c results for patients with diabetes. The other thing we have seen looking on a Clinical Commissioning Group (CCG) wide level at our individual practice is that against the trend of emergency admissions with chronic obstructive pulmonary disease (COPD) we’ve had a reduced rate over the last 12 months. We think that this is due at least in part to these patients attending a care planning appointment, understanding their disease and having a care plan for their COPD”.

The positive outcomes that individuals achieve are highly motivating for staff. Seeing the benefits in practice from this new way of working is the best way to embed it.

“No we definitely would not go back to the old system of working. It was much more inefficient both for the patients and the practice, and this has definitely been a positive step for the practice”.



Health Care Assistant Stories

Janice Spence – *Health care assistant*

Walker Medical Group

The Walker Medical Group Story

A health care assistant perspective on implementing care and support planning

I first became involved with care and support planning (CSP) when I went on the training course along with other members of the practice team; a practice nurse (PN), practice manager (PM), and one of the GPs. I thought it sounded really good and it could help with both staff and patients.

My involvement was initially organising how we would categorise people to call them in. We came up with a list of Year of Care (YOC) codes; we had to work out who they would see based on the skill set of the staff. The IT manager sent through a list of all patients and I coded them. I also keep an eye on waiting lists and on patients whose condition might have changed so they need their codes altering. I also had input into forming the templates. My job now is to see patients for their first appointment, doing all the tests depending on what conditions they have.

We started in diabetes and then we found out we had to include all 6 conditions by March, so it was a nightmare, with a lot of catch up to do.

Part of my role is to explain to each patient attending for CSP what will happen next and that they must attend for their second appointment. I think it helps the overall process because patients don't understand why they've got to come in and that we are combining 3 or 4 appointments they would have had through the year. Most of them are actually very happy, and will probably only have 2 appointments per year, so that's good. Some people might think that they don't need to come back for the second appointment because they've got their results, so it's explaining why it is important.

The biggest challenge has been the admin side of things, how we were going to identify them, who they needed to see and for how long. We have roughly 260-300 patients per month, so that was a lot of work. The second appointment tends to be a similar length of time even if people have more than 1 condition. We need to look at everything and make sure the patient has enough time to discuss what they want to.

The benefit for me as a health care assistant (HCA) is that in the past people would come in to see me but maybe also have an appointment the next week with someone else for a few more tests, I would try to do as much as I could but now we are more structured and I know what I've got to do. I think it's more beneficial for patients and for us. We know that we're not missing things.

We're hoping that we will be chasing less quality and outcomes framework (QOF) data at the end of the year, there will always be some people who don't come in but last year we had 1000 patients to catch up.

I think the benefit to the patient is not having to come back for multiple appointments and all the medication is reviewed at one time.

All our chronic disease management is run by our nurse practitioners (NPs) and nursing team. The doctors have a smaller number of people to see. We knew that the NPs would not have enough time so we enhanced the HCA and nursing role where we could.

As an HCA we get anywhere from 6-11 YOC appointments/day, so does my colleague, so they all have to have an appointment with a nurse or NP in a couple of weeks, so it can be quite tricky fitting in that number of longer appointments. We have regular nurse meetings every fortnight where we can discuss issues.

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If we were starting again, we would not just do diabetes first we would have done all the 6 conditions from the start. I think it would also have been better to have more people trained initially so everyone understands the system.

Initially just two of the reception team were involved but now it's been rolled out to all reception staff being involved in sending the letters out. We have a template for which letter needs to go, depending on what conditions they have, but sometimes the wrong letter gets sent. It falls down when the patient has been in for the first appointment but misses the second, and then they might be sent the wrong letter. So there is some learning around that but it's a new way of working.