



In this issue:
Page 1:
Round up from the Year of Care network event
Page 2/3:
Care and Support planning: a 'multi-morbidity' approach
Page 4:
The IMPACT tool and a 'moving on workshop'

Welcome to The HOUSE Journal Lindsay Oliver, National Director YOCP
In this edition we turn our attention to some of the outputs and messages from the network event held in September. I would like to express my thanks to all of the speakers and participants at this year's event who made it such a success. In particular we focus on the challenges and potential solutions when moving away from a 'single disease' approach to a single care and support planning (CSP) process for 'people not conditions' taking into account all long term conditions. Future newsletters will focus on how this might work for people who are frail or unable to access the practice and for conditions not usually included in routine recall systems, such as musculo-skeletal conditions.

Alf Collins - Clinical Director Personalised Care Group, NHS England *'Personalised Care and Support Planning'*

We were delighted to welcome Alf Collins to give an overview of the importance of CSP as a central component of person centred care. Alf's presentation reminded us that:

- the number of people living with a long term condition continues to rise and for many people living with *multiple* long term conditions is the norm.
- There is a clear link between lower confidence levels to manage conditions and how many conditions people live with, disease silo'd approaches may be compounding this.
- Proactive approaches to supporting people to build knowledge, skills and confidence to better manage their health conditions are a central component of policy.
- This can be delivered by introducing CSP through general practice which addresses the current imbalance between the professional and patient agendas.
- The work of the Year of Care community is important in supporting personalised CSP to be the default clinical care model.



Dr Sue Arnott – Lead Clinician NHS Lanarkshire *'The Lanarkshire Story'*

Sue is a GP and local clinical lead for the 'House of Care' programme in Lanarkshire and we were delighted to hear her first-hand experience of both supporting a local programme and implementing the approach in her practice. Sue told us:

- there is a compelling case for change in Scotland around workforce and the sustainability of existing ways of working. CSP is an excellent fit with policy including Realistic Medicine¹ especially when it is applied using a whole register approach.
- It's important for practices and teams to see CSP as the norm and not 'just another project'.
- Developing local IT solutions and involving the whole practice team was critical.
- Data from practices that have implemented the approach clearly demonstrates how much people living with long term conditions value '**preparation**' and feel more able to understand their health and cope with health problems.



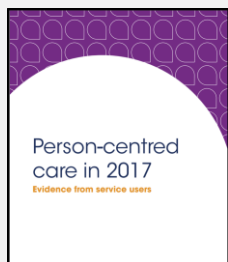
1. Realistic Medicine <http://www.gov.scot/Resource/0049/00492520.pdf>

The HOUSE Journal

National Voices report – Person Centred Care in 2017

This new report from National Voices demonstrates ‘little evidence of personalised CSP’ despite it being central to person-centred care. You can access the report via the following link:

https://www.nationalvoices.org.uk/sites/default/files/public/publications/person-centred_care_in_2017_-_national_voices.pdf



The challenges of a multi-morbidity approach

Introducing CSP involves hard work and a whole team approach but also has many rewards. When practice teams begin to look at a more integrated approach to CSP in long term conditions they often find a number of common issues arise including practice IT systems (registers and recall) and workforce/skill mix. The Holmside story (www.yearofcare.co.uk/examples-and-case-studies) gives one practice’s experiences of doing this and how they managed the process changes. In this edition of The House Journal we touch on some of the professional issues as practice teams move towards a single CSP process for people across disease registers.

Integrating respiratory conditions

In general practice, reviews for people with COPD often have a medical or monitoring focus. People living with this condition (as with any other LTC) often have a range of other concerns (e.g. sleep, mood etc.) which can be better supported using a CSP approach. Increased understanding and confidence around using rescue medication has also been seen in people undergoing CSP. However COPD is one of the most common conditions that practices worry about integrating into a general CSP approach. The issues that usually need to be considered are:

| Issues | Potential actions |
|---|---|
| Micro-spirometry versus full reversible spirometry | Many clinicians agree that it is not clinically necessary to do full reversible spirometry at annual review but this needs to be agreed in local guidelines. In a practice with 300 patients with COPD, moving from full spirometry to micro-spirometry would save 15 minutes per test i.e. 75 hours per annum which equals 2 full weeks of treatment room time. |
| The role of the health care assistant (HCA) | In many practices HCA’s have had additional training to enable them to do the assessments and tests associated with COPD specifically this includes checking inhaler technique and performing micro-spirometry. Many areas are now developing training for HCA to be able to do this. |
| How to include a preparation step for people with COPD only | For people with COPD only and where no additional bloods tests are needed, CSP may not need a 2 appointment approach. If the practice sends the person a reflective prompt with a CAT and MRC questionnaire ahead of their appointment this would be regarded as “preparation for the person”. These resources are available from Year of Care Partnerships (YOCP). |

YOCP has existing resources for COPD and very recently has developed a preparation tool for people with asthma. This tool would replace an information gathering appointment and could be used to generate the patient agenda as part of asthma reviews.

Workforce issues for practice nurses

In many areas practice nurses have become specialised in certain conditions and so delivering consultations which are more ‘expert generalist’ can feel a little daunting. Solutions that support the change to a multi-morbidity approach in practice have included:

- for new staff, allowing them to start CSP in conditions they feel more confident with to allow them to get used to the different style of consultation before they take on ‘new conditions’.
- Triage of patients so that people who have more complex issues see the GP for the CSP appointment
- Weekly supervision by the lead GP at a regular meeting or as part of triage.
- Nurses running clinics alongside each other so that informal supervision can happen before, during and after CSP clinics.
- Delivery of condition ‘master classes’ for multiple practices as part of a broader workforce strategy which include some of the less traditional topics such as benefits/work, sleep and pain.

Year of Care Partnerships has developed a competency questionnaire to enable CCGs and Health Boards to identify additional training needs following YOC CSP training. Please contact us if you would like to pilot this tool.

The HOUSE Journal

Keeping the balance – professional issues in the CSP conversation and process

Professional story

One of the concerns frequently cited by professionals around the CSP approach is about how to strike a balance between the patient’s agenda and the professional’s responsibility. The Year of Care approach has always been about valuing the expertise and experience of both parties and ensuring each have the opportunity to tell their stories and voice their concerns. The Year of Care team have recently begun to look at the disease specific knowledge required for different conditions and any red flags that might need action before or during the CSP process. This also serves as a useful reminder that a strategic workforce development plan that supports the clinical content of CSP would enhance the delivery of the programme across an organisation.

Medicines reviews

Ensuring that people get the maximum benefit from drugs and medicines requires both the knowledge and skills of the practitioner and understanding and engagement by the person. Currently people living with single long-term conditions (LTCs) take less than 50% of prescribed medication and there are greater challenges for those with more than one condition and multiple medications. Most drug trials have not included people with multi-morbidity and there is potential for adverse effects and interactions which are potentially serious in the frail and elderly. This means that as we move towards a multi-morbidity and frailty agenda this element of CSP will need specific attention.

How each practice incorporates the details of the medicines review into their own CSP pathway will vary and be influenced by the skill mix and workforce available. Some ideas generated at our community of practice network event included:

- a reflective tool on medication for self or supported completion as part of the preparation step which provides the person with an opportunity to reflect, identify questions and provide comments. This gives important insights into the person’s views on purpose, side effects and ‘adherence’.
- Practice pharmacists or GPs reviewing medicines prior to the conversation and providing pointers to the practitioner for the CSP conversation so that discussion about drugs is seamlessly included within options for management and self-management.
- If unexpected/complex issues about drugs and medicines arise during the CSP conversation patients could be signposted to a separate pharmacist review.

The community of practice felt it was important that we worked out ways for medicines management to be included in the CSP process to avoid separate and unlinked medicines reviews. Year of Care have developed a preparation tool specific to medicines and medicines management.

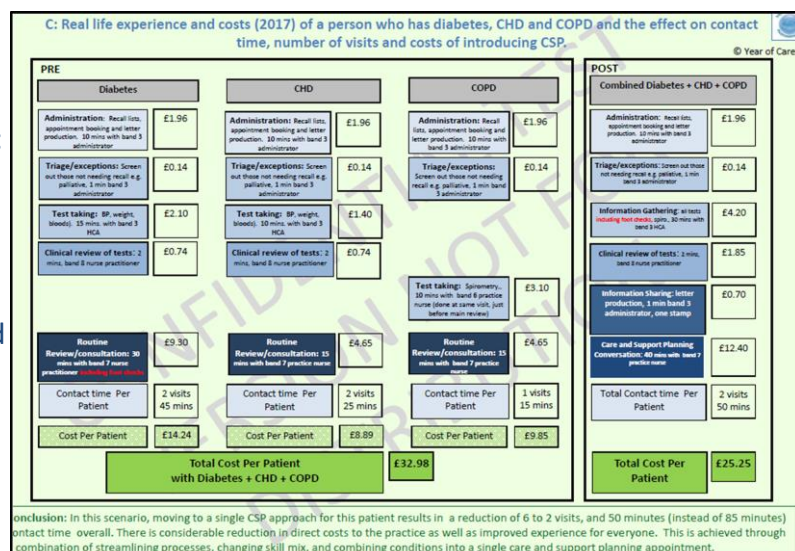
The IMPACT tool

YOCP have developed a tool which brings together a summary of the benefits of CSP. Designed to be used by facilitators and practices to help understand the impact CSP can have, the tool is made up of three parts:

Part 1 An overview of CSP, summarising the benefits for patients and practices in their own words

Part 2 Worked examples of ‘before and after’ implementation of systematic CSP from practices implementing the approach in a range of conditions and varied starting points.

Part 3 An interactive practice activity and cost profiling tool to check out the impact of implementing CSP processes within a single practice, with a focus on providing a single CSP process for individuals no matter how many conditions or issues they may live with.



The HOUSE Journal

David Paynton visit to North East

In August, David Paynton, National RCGP Clinical Lead for Commissioning travelled to the North East to visit two practices in Newcastle and Gateshead CCG to see at first-hand how the teams had embraced and embedded CSP in their practice as usual care. He was hugely impressed by the work at Cruddas Park and Glenpark surgeries and we would like to thank Amelia Kerr (nurse practitioner at Glenpark) who demonstrated amazing one to one CSP skills. David wrote:

"I was very impressed by the progress they had made and the impact this was having on both patient and staff morale as personalised care became embedded into the weekly practice routine and applied for up to 10% of the practice population.

Three critical success factors appeared to have enabled an idea to translate into reality;

- *The training, preparation and process mapping that took place at the start facilitated by Year of Care and the support of the CCG.*
- *The key role for administration and HCA staff with standardised operational processes designed "bottom up" by committed practice teams.*
- *The role of social prescribing, in Newcastle supported by Ways to Wellness² with signposting embedded into the surgery*

It was clear to me that once the initial investment had been made, no one in the surgeries wanted to go back to the old model of long term condition management."

2. Ways to Wellness <http://waystowellness.org.uk/>

Supporting you to 'move on'!

Year of Care Partnerships is developing a 'Moving On' workshop that will be designed for teams who have implemented CSP and are now ready to 'move on' to other conditions or multi-morbidity and address medicines management.

To find out more about the course, duration and costs please express interest at enquiries@yearofcare.co.uk

Year of Care Partnerships is on social media

Please like us on Facebook and follow us on Twitter for the latest Year of Care news and events.

