



### Welcome to The HOUSE Journal - Lindsay Oliver, National Director

In this edition we have collected some good news stories from around our community of practice. We know that many areas are getting on with this work quietly and if you have any local evaluation, stories or contributions to future newsletters we would love to hear from you. We would also like to thank the British Heart Foundation for the opportunity to work with them to explore the feasibility and benefits of using this approach in people with, and at risk of, cardiovascular disease. It's clear that care and support planning as part of a systematic approach to long term condition (LTC) support helps to improve completion of clinical processes, staff job satisfaction and individual involvement in care. In particular people with LTCs find preparation and a different type of consultation helps them understand their condition better.

A new community based service was introduced in North East Essex contracted to increase education and confidence to self-manage in patients and move services from hospital into the community. Through investment in general practice, staff empowerment and integrated working, Year of Care training and the implementation of care and support planning, patient outcomes have significantly improved.

The latest National Diabetes Audit data shows

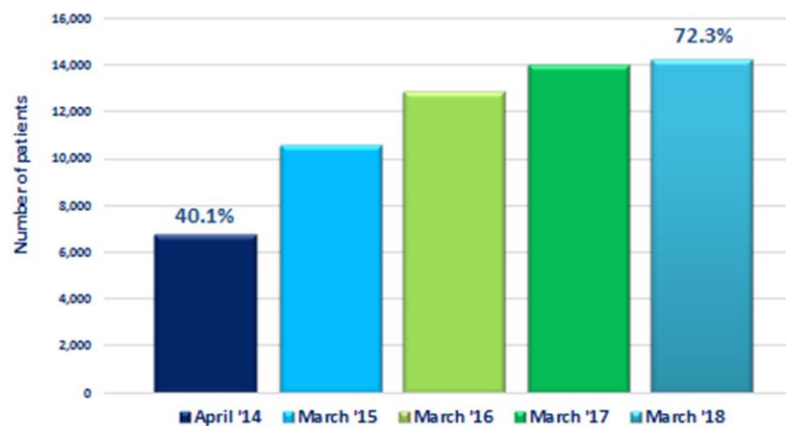
- 72.3% of people with diabetes received all 8 care processes (previously 40.1% in 2014)
- North East Essex is now 5th best performing area for patients receiving all 8 care processes (previously 119th in 2014)
- Vastly improved rates of foot screening and a reduction in the rate of amputation despite growing numbers of people with diabetes
- Following on from Year of Care training 78% of people receive a Year of Care preparation prompt which has contributed to the increase in people receiving all 8 care processes
- Clinical targets are improving too with year on year improvement in measures such as HbA1c, cholesterol and blood pressure (see graph).

**Teresa Hart – Project Support Officer,  
Suffolk GP Federation CIC  
North East Essex Diabetes Service (NEEDS)**

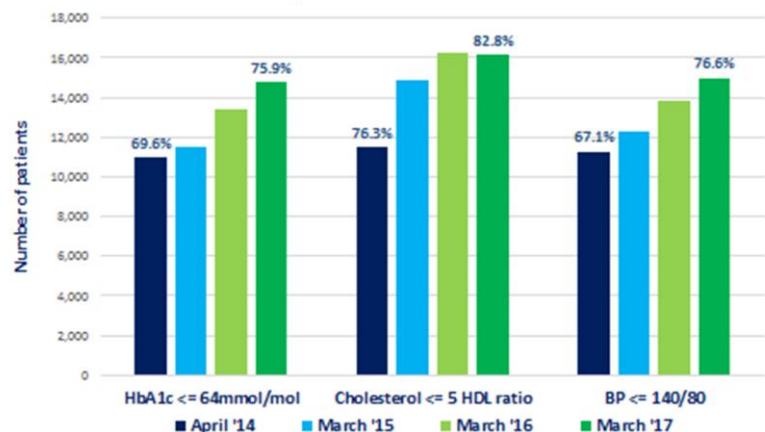
### North East Essex – Improving systems, clinical processes and treatment targets

#### Patients Receiving All 8 Clinical Processes

SOURCE: NDA



#### HbA1c, Cholesterol & BP



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# The HOUSE Journal

## Tower Hamlets – A decade of improvement - *using the whole house*

It's almost ten years since the initial Year of Care diabetes pilot in Tower Hamlets when local evaluation demonstrated huge improvements both in engagement and involvement of people with type 2 diabetes as well as biomedical measures and care processes. Implementation of care and support planning was an early part of a whole system approach using the House of Care framework including grass roots community engagement alongside training and practice support, use of dashboards with real time feedback and specialist diabetes support. The table below shows an update of local National Diabetes Audit data demonstrating how improvements have been sustained.

### Data for Tower Hamlets CCG, National Diabetes Audit (T2) (95% of practices)

	2009 (QOF with exemptions)	2012 ( Dashboard – no exemptions)	NDA 2015-16 (data from T2 DM)	NDA 2016-17 (data from T2 DM)
HbA1c <7.5%/58mmol/mol	37%	55%	62%	62%
BP ≤145/85	70%	90%	81% (new target 140/80)	83% (new target 140/80)
Cholesterol <5mol/l	65%	83%	85%	85%
3 combined		35% (national 19%)	45% (national 40.2%)	46%(national 40.8%)

## The British Heart Foundation - 'House of Care project'

Year of Care has been working with the British Heart Foundation and the Health and Social Care Alliance Scotland over the last 3 years to test the implementation of care and support planning for people living with cardiovascular disease and multi-morbidity across five sites (Hardwick, Gateshead, Glasgow, Lothian and Tayside). The programme was evaluated using a combination of qualitative and quantitative analysis across project teams, healthcare practitioners and people living with long term conditions. The main programme level analysis concluded:

- Patients report a good level of involvement in their own care, particularly in relation to discussing what is important for them to manage their own health.
- Patients feel their care and support is more joined up at follow-up compared to baseline.
- At follow-up patients feel more positive (compared to baseline) about the amount of information and support received to help them manage their health but don't always feel confident about doing so.
- At follow-up patients feel more positive (compared to baseline) about the way HCPs explain things, make them feel at ease and let them tell their own story (based on two sites).
- Practices are showing good progress with implementation and embedding of care and support planning and patients are enjoying the new approach to their care.

In addition the programme has showed that many practices prefer to implement a multi-morbidity approach and include cardiovascular disease as part of this approach in order to improve quality without increasing cost.

***The final report will be available in Autumn 2018***

# The HOUSE Journal

## Lanarkshire - Preparation and conversation: what do people think?

In NHS Lanarkshire Sue Arnott, a local GP, surveyed 56 patients who had received care and support planning. The locally produced survey showed that:

- 83% found it useful to receive their results beforehand
- 98% of patients felt listened to
- 96% had sufficient opportunity to say what they wanted to say
- 89% understood their LTC “very well”
- 82% felt able to cope with their LTC “very well”

*“I have appreciated both visits, it is good to see how we are doing in black and white, I have left feeling helped and encouraged”  
(Female, 75)*

## Newcastle and Gateshead - The impact of implementing care and support planning – better experience, better outcomes, better value

In Newcastle and Gateshead Care and support planning has been used to stimulate redesign of general practice care for people living with long term conditions and multimorbidity across the whole CCG with positive impact on practice costs, infrastructure, skill mix, staff satisfaction and team work as well as benefits for patients.

**59/63 practices are now introducing CSP for multimorbidity as ‘business as usual’.**

### Data from the local evaluation showed:

- 94% of patients found the preparation letter somewhat or very useful
- 81% of patients understood their condition “better” or “much more”
- 75% were able to cope with their condition “better” or “much more”
- 87% rated their overall experience of CSP as “very good” or “excellent”
- 71% felt more or much more able to help themselves

### Blood pressure improved:

- 11% increase in patients who had BP recorded in the previous 12 months
- 10.9% increase in CHD patients with BP of 150/90 or less

### Quotes from staff include:

- *“They (the patient) often come with their own plan ... this makes the job very easy....improves job satisfaction - more time to spend with the patient ...and a conversation based on what's important for them .... so much more worthwhile than ticking boxes...”(GP)*
- *“You build relationships then see the results... It widened my horizons because I’ve had to learn the bits I wasn’t sure about” (nurse)*

### Quotes from patients:

- *“It prompts you to think about all aspects of your health”*
- *“They were interested in how I felt...I got a chance to ask things rather than being asked”*

*In June 2018 Year of Care jointly presented a poster with Newcastle Gateshead CCG at the Kings Fund event 'Reimagining General Practice' on the fantastic work that the CCG has supported and is continuing to support for people living with long term conditions and multimorbidity.*

**You can see the poster here <https://bit.ly/2liUf1l>**

The Year of Care Quality Mark was developed to use with practice teams to allow them to self-reflect on their progress with all areas of implementation of care and support planning. It has now been used across a wide range of practices over a number of years, proving to be a valuable tool to help practices and local facilitators work together to continuously improve and review local delivery. We have listened to feedback on the use and content of this tool, and together with reflections from Year of Care Partnerships, we have updated the Quality Mark. It is hoped that practices new to using the Quality Mark will now use this updated version. Practices who have previously used the original version will find that their scores may change, and therefore local consideration needs to be given around where and when to move onto this new version. A copy of the updated tool can be obtained by contacting us at [enquiries@yearofcare.co.uk](mailto:enquiries@yearofcare.co.uk). The main improvements that have been made include:

1. Recognising the importance of team working across the whole practice,
2. Clarifying activities around whole practice populations /health literacy
3. Emphasising involvement of people with long term conditions Updating preparation to reflect that 2 appointments are not always necessary.
4. Highlighting different approaches to consultation skills development.

## Year of Care Train the Trainers

The next round of **Train the Trainers** is planned for

**13, 14, 15th November 2018**

**Hexham General Hospital, Northumberland**

The **Train the Trainers** programme enables organisations to deliver pre-prepared high quality local training themselves which is tried and tested and comes with a suite of resources to support practitioners.

Year of Care trainers are trained and supported to deliver the day and a half core training in order to support a local programme of implementation. Usually groups of three trainers are identified in an area. Trainers should have:

- attended Year of Care, care and support planning (CSP) training
- credibility with their training audience
- experience of care and support planning consultations
- worked within the clinical setting or have knowledge of the setting where CSP is being implemented
- experience of training health care professionals
- an interest in personalisation, communication & consultation skills
- engaged with the philosophy of the Year of Care programme
- the support of a local team e.g. CCG, health board
- dedicated time allocated and agreement from line manager to attend a 3 day train the trainers course, prepare for delivery of training and undergo YOC peer review and quality assurance
- dedicated time to deliver training on a regular basis

**Book your place on 01670 529268 or [enquiries@yearofcare.co.uk](mailto:enquiries@yearofcare.co.uk)**

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