

**The Holmside story**  
**Person centred primary care**  
**Care and support planning**



What team work, organisation and training can achieve  
for people with long term conditions

***'It's what we do now – we have never looked back'***



Two important things came together in the summer of 2012 at Holmside, a 9000 person, inner city practice in the West end of Newcastle. Now 18 months and a great deal of hard work later 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. Patient and staff satisfaction and engagement has increased, there are less unplanned attendances at the practice, and no deterioration in QOF measures or increase in practice costs.

***'..thank you so much, without you....my life and lifestyle would be very different to the one I now enjoy.'*** (Person with LTCs)

***'You build relationships ...and then see results!'*** (ANP)

***'In primary care you always feel you are chasing your tail and fire firing - this makes you feel you have achieved something—like a proper job'*** (HCA)

***'.....undeniably better to start with all LTCs'*** (ANP)

***'It's just the right thing to do!'*** (GP)

People with LTCs are a big challenge for primary care. They want more say in their care, more help to live well day by day and a more coordinated but personal approach. As numbers and individual complexity increases and incentives remain focused on tick box activities and targets, it often feels impossible to provide that for everyone, however desirable. The Holmside team are showing it can be done. Tackling the processes for all people with LTCs, including those with multimorbidity leads

to economies of scale that impact across the practice, in a way that care and support planning for a single condition like diabetes or COPD cannot do alone.

By 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*<sup>1</sup> (YOC) programme was providing training in care and support planning as part of the local *People Powered Health Programme*<sup>2</sup>. 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. They invited the YOC team to a whole practice meeting to look together at the case for change and the implications for the practice if everyone on their 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. They found it was possible to train the nurses to be confident about working in a generalist way to provide career progression within the team. Receptionists trained as phlebotomists and then as healthcare assistants and health care assistants moved to administer and coordinate the day to day programme. Everyone feels valued.

18 months later, with solutions found to the early challenges, the practice are reviewing their first 'QOF year' and looking at outstanding issues around documentation, embedding evaluation in routine care, developing clinical skills further, involving GPs more routinely with patients with complex issues and thinking about those who are housebound or part of the national enhanced service. They are finding that year 2 is even better. 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. They have been able to make and embed these changes at the same time as taking over and introducing care planning to another local practice.

Every general practice is different. Each practice will need to work through the details, adapting the core YOC philosophy, approach and principles of care and support planning to their own population and circumstances. The following paragraphs describe how Holmside went about it.

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<sup>1</sup> [www.yearofcare.co.uk](http://www.yearofcare.co.uk)

<sup>2</sup> [www.nesta.org.uk/project/people-powered-health](http://www.nesta.org.uk/project/people-powered-health)

## Holmside: Care and Support Planning- putting it into practice

### Critical Success Factors

The nurse practitioner (NP) has identified some critical success factors. These include

- Training in care planning to get the right ethos and consultation style
- Regular team meetings to improve the service as quickly as possible
- Robust templates for both the health care assistant (HCA) and practice nurse (PN)
- Regular training sessions for HCA/PN
- Having a dedicated admin team for support and systems development
- Having a dedicated lead nurse to go to with all issues whether clinical/admin.
- A whole team approach

### Administration

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 (see box). These are reviewed by the lead GP for each group to ensure that the care and support planning process is right for them and the right people are involved, often at the team's regular breakfast meetings.

For instance those where mental health issues, cancer or dementia is recorded as one of the issues are reviewed by the respective practice leads for each of these conditions, and might be seen outside this process. This defines small groups of people each month to be invited to take part. Each is sent one of a standard set of 'personalised' letters tailored to their needs (new to care planning, regular care planning, the condition or groups of conditions etc) with information from their records, and an invitation to attend a first (20 minute) appointment with the healthcare assistant if tests or examinations are needed as part of the preparation step. Results or reflective prompts if no tests are needed are then sent out, merged into letters with explanations, encouraging reflection prior to the care planning consultation itself. This is usually with a nurse two to four weeks later. Appointments are made by the person as a double appointment of 30 minutes (2 x 15mins) with a nurse or 20 minutes (2 x 10 mins with a doctor), avoiding the rigidity of a 'clinic based' system.

Review appointments are agreed as part of the care planning process, although everyone with diabetes is seen twice a year. Everyone can request an appointment at any time with the person they made the original plan with and will then be booked into a 'care planning review' single slot (10 or 15 minutes) with the relevant doctor or nurse.

All the administrative staff, including receptionists has been trained in this approach and everyone is able to guide patients and enquirers about the system, make the appointments in the right way at the right time and make sure that it works for each person.

As the practice has developed its systems, in the light of feedback and learning , the approach and the letters used are adapted and these changes are built into practice systems – laminated instructions on the front of PCs, detailed scripts for HCAs ( to ensure the process is consistent during holidays or with new staff ), and repeated rounds of in house training.

All of these changes required new IT and practice systems to be developed, but these are now available. Their systematic usage and ongoing development relies on highly developed team work and an individual with responsibility for managing month by month. Because processes are now streamlined and everyone knows and understands their roles this takes between 2 and 3 days of administrative work a week.

## The administration processes

### Over view of process

- 'Patient chase' is synched with EMIS to be up to date
- Search for people with one or more LTCs by birth month
- Conditions included in this care planning process are; AF, Asthma ,BP, cancer, CHD,CKD, COPD ,Dementia, Diabetes, Epilepsy, Heart Failure, Mental Health, peripheral Arterial Disease, Learning Disabilities, Rheumatoid Arthritis, Stroke)
- Search for 'seen in last three months' – so not to duplicate care in first year
- Second search for people with diabetes – under hospital supervision
- **Special actions : when certain diagnoses are highlighted (excludes 30-40 people)**
  - Epilepsy – seen by the GP for drug review before HCA appointment
  - Rheumatoid arthritis (following treatment plan set by Specialist) : Currently reviewed by GP and ANP – aim to develop training for practice nurses to build confidence to include people with RA in a holistic care planning review
  - People with Learning disabilities – seen by GP
  - Children – GP makes individual decision except for asthma – which is routine
  - Cancer, mental health and dementia: reviewed by practice lead for suitability for care planning process
- Housebound – the aim is to introduce an approach to the same standard in the near future - dependant on the role of District Nurses. Currently the house bound are added to the GP visit list.
- **First Letter to patients**
  - o Each person gets either a routine letter to start the process or one tailored to the following groups
    - Diabetes
    - Epilepsy
    - Rheumatoid arthritis
    - Asthma and COPD alone
    - Asthma and COPD plus other conditions
- **Letters following investigations – with prompts 'how are you'**
  - o Under ongoing development in the light of feedback

### Clerical workload in a typical month – figures approx.

<b>Practice population = 9000 over 2 sites</b>			
<b>Patients in birth month</b> identified with one or more LTCs from <i>'Patient chase'</i>			<b>240</b>
Those where one or more of the specific conditions identified requiring specific review or separate letter : Total			<b>99</b>
Diabetes	18	Cancer	13
Asthma <16 yrs	1	Mental health	7
Learning disabilities	0	Dementia	5
Rheumatoid Arthritis	6	COPD only	10
Asthma only	28	COPD with other LTCs	7
Asthma with other LTCs	3		
Routine letter to offer HCA appointment to start the care planning process			<b>128</b>

#### **Start-up challenges:**

A number of issues occurred at the start such as 'shared care issues'; *'I go to the hospital'*. These have all now been addressed.

The commonest 'complaint' is now that results and letters haven't arrived when expected ....*i.e.* *'where are my tests and letters'!!*

**An opportunity for improvement:** When the two step approach to care and support planning is described to clinical teams they often raise concerns that sending test results to people will provoke anxiety and potentially generate telephone calls and more work. This rarely proves to be the case. People are keen to have their own information and value the recognition that gives about their involvement. However when Holmside started to send out letters to people from multi condition registers this included people with chronic kidney disease, a common co morbidity with vascular disease and diabetes. This produced a flood of calls from people stating they had no idea they had anything wrong with their kidneys and naturally expressing surprise and concern. The NP rang each person. This provided an opportunity to explain the significance of abnormal kidney function tests in a way people could understand. Subsequently this has not proved to be an issue. Staff have been trained in how to talk routinely about kidney tests and their significance, a topic which is often as anxiety provoking for primary care teams as it is for patients. The Holmside approach demonstrates that commitment to involving and engaging people in their health is not only a way to gain their interest but may be the first step in taking action to prevent deterioration.

## New roles

**Healthcare assistants (HCAs)** were trained in new roles. This involved specific clinical tasks such as examining the feet for people with diabetes and spirometry for those with COPD. Special templates were produced so that the HCA could quickly identify which tests were needed for each person, including QOF checks, and ensure that request forms were generated automatically.

Just as important was the expectation that they would start the engagement process with the person, both explaining the new system and their role in it, how they would be contacted, how they could make a second appointment, and also encouraging them to ask questions about things they didn't understand and valuing their input to their own health. An initial 'script' was provided by the advanced nurse practitioner to enable each HCA to carry out these functions and also begin to sign post individuals to supportive community activities. Any issues identified were then flagged to the practice nurse.

One of the three practice sites has a large population of non English speakers. The HCA has an important role in discussing translation needs and flagging these up to ensure everything is in place well in advance of the care and support planning conversation itself.

### Practice nurses

Having **nurse practitioner** leadership for the nursing team was important from the outset. She brought specialist knowledge in respiratory disease to complement the diabetes expertise into the practice but was able to try out the new consultation herself, and role model the way of working including a generalist approach. This including recognising that the core care planning skills of building empathy, listening and gently challenging and supporting the person to find solutions and practical actions, are as important as disease expertise. However each nurse has to feel confident in understanding the main issues for the conditions that patients may raise and this was ensured by repeated rounds of training on specific topics and a recognition that knowing who to go to for further information was as important as having all the answers. As new issues arise new in house training is arranged, so everyone feels confident and supported. For instance the issue of rheumatoid arthritis has recently been identified and new training is planned.

The nurse practitioner also reviews all the returning test results to identify if urgent action is needed outside the routine care and support planning process. The person is contacted directly by the administration team to ensure that an appointment is made with the right person.

### GPs

The GPs were initially sceptical with concerns about workload, deskilling, sending patients their results and other practical issues. They now support the programme wholeheartedly and provide ongoing support and supervision to the nursing team as well as doing care planning with special groups of individuals and people with complex issues. They are also well placed to realise when people have not attended, describe what care planning is about and encourage them to do so.



## Training

Recognising the importance of continuous learning and investing in time within the practice as well as more formal 'training' is seen as critical to success.

In - house training for nursing and administrative staff is essential to ensure everyone is confident in what they have to do, and enables the incremental changes that accompany 'learning by doing' to be introduced smoothly across the whole team. Backed up by aide memoirs attached to monitors and 'scripts' for HCAs', this has been an important part of the team building process.

Training was initially intensive and has covered key condition specific issues as well as the care planning process itself, delivered in half hour and hour slots as part of the normal working week. It includes induction of new staff, refreshers and focuses on specific queries and issues as they arise.

Outside the practice all the nurses and the GPs involved in diabetes attended Year of Care core care and support planning training. This introduces participants to the 'philosophy' and skills involved in supporting people with LTCs to live good lives and increase well being, as well as the principles and practice of goals setting and action planning to support self management on a daily basis. The NP has completed the Training the Trainers programme. There is regular contact with the Year of Care facilitator for ongoing queries, support and exchange of learning. The Year of Care team are attending the practice 'protected time' meeting annually.

## Team work and ongoing improvement

With nine part time GP partners the NP is the only full time member of staff and is supported and mentored by one of the senior partners. Everyone is kept involved and decisions can be made quickly in the minuted, well attended, breakfast meetings held on different days to each week.

The core care planning team meet regularly with the lead GP, and issues are discussed at the monthly practice 'time in' meetings. For the first year most of the discussion focussed on making the systems work and ironing out problems. An evaluation form has been added asking '*How did we do?*' and there is an opportunity to include additional questions which could be changed from time to time and give feedback on specific issues including staff skills in patient centred support. The team are gradually working through a list of issues from how to support the reduced number of non responders, whether those with chest disease should all be seen in the summer months, to the language used and range of patient information on offer.

## Making the most of IT

While it is the human skills of good systematic team work including training which are at the heart of the success of this transformational change at Holmside, it could not have happened without IT systems and the skills of the administrative staff in using these effectively and imaginatively. However the limitations of the systems mean a key challenge has been trying to ensure that patient tests and results are merged into explanatory letters and can be produced in ways which meet modern standards of presentation for information and communication.

## Measurement for improvement and resource use

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 of working. Experience from elsewhere would suggest that it take 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.

The number of letters sent out has decreased significantly with no increase in costs of postage despite a large increase in price of stamps during the first year.

### Sustaining improvement and culture change – moving into year 2 and beyond

As patients and staff settle into the new process further modifications are being made. Patients have come to expect to be seen in this way and look out for the letters and any test results. When these come back in a healthy range they ask if they need to be seen again, altering the nature of the conversation about the best way to maintain health long term and the role of wider community support. The NP has begun to include booked care planning telephone conversations, firstly ringing to agree a convenient time and prompt the person to think about what they want to discuss and ensure that they will have their results or prompt sheet in front of them for the second call. This extension of her role will have further training issues for less experienced staff if it is to be included systematically in the care planning process. Others no longer need double appointments slots to review their goals and plans, particularly when these have been successfully achieved.

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. The NP describes the satisfaction of supporting people to identify their own priorities and develop their own solutions to issues, rather than concentrating on blood test results and giving advice up front. The person who made life style changes for the first time 'because she wanted to do it' is just one example. Having the 30 minute appointment to work in this new way is extremely valuable.

Inevitably staff leave or retire, clinical skills may get rusty and everyone needs professional development. The team recognise that this will mean the need for ongoing leadership and review to ensure that the opportunities provided both by a more engaged population and better trained workforce can be grasped.

**August 2014:** 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. Pressures on practice time make it difficult to respond to individual enquiries so for the time being please contact them via [enquiries@yearofcare.co.uk](mailto:enquiries@yearofcare.co.uk)