Care and Support Planning and House of Care:

A key enabler of the new GMS Contract

Care and support planning provides a mechanism to achieve a collaborative way of working for 'people not conditions'. It provides a readymade solution to the aspirations outlined in **Realistic Medicine** and the new GMS contact. The approach has been tried and tested for over a decade in primary care across more than 40 regions across the UK, and has been implemented successfully by primary care teams across a number of areas in Scotland.

How does Care Support Planning fit with the ethos and vision within the GMS contract?

Care and support planning (CSP) fits with the vision and principles set out in the General Medical Services (GMS) contract which builds on the core values of general practice and promotes an approach to people which can be best delivered by expert generalists. The contract emphasises the importance of continuity, a strong therapeutic relationship with the patient, and the need to move to conversations which are focused on what matters to the person, in keeping with the principles of Realistic Medicine.

- *'The consultation remains the foundation of General Practice - it is where the values of compassion, empathy and kindness combine with expert scientific medical knowledge to the benefit of the patient care and mental and physical health'*
- *'Dealing with multi-morbidity; coordinating long term care and addressing the physical, social and psychological aspects of patients' wellbeing through their lives'*
- *'General practice nurses had a key role in the achievement of the QOF points as part of the old GMS contract. However many people felt that QOF greatly increased bureaucratic workload and had a negative impact on consultations supporting "box ticking" rather than facilitation holistic and person centred consultations'*
- *'The new GMS contract will allow general practice nurses to have more meaningful person centred conversations.'*

GMS Contract Offer 2017

What is Care and Support Planning?

CSP is a systematic process, which uses a range of skill mix across the practice, to ensure that people experience a single care and support planning consultation no matter however many conditions they live with – there is a strong focus on multi-morbidity.

CSP seeks to transform the current annual review into a meaningful and useful discussion, enabled by **preparation** and with a focus on looking forward and planning. These consultations identify what is important to the person, discuss and explore issues and develop priorities, goals and actions to support them to live well with their condition/s. CSP is ideal for people with single and multiple long term conditions, including frailty as it brings together physical, psychological and social health / care issues within a single care and support planning process which also:

- **links** traditional clinical care with support for self management
- **signposts** the person to activities within a supportive community (more than medicine)
- for people with complex care: **coordinates** across health and social care
- can be used to develop **anticipatory care plans.**

CSP was developed by primary care professionals and people living with long term conditions as a person centred replacement to the disease specific, "monitoring" focused Quality and Outcomes Framework (QOF) review system.

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How does Care and Support Planning using the House of Care Framework enable delivery of the new GMS contract?

Care and support planning is a tried and tested approach, which has been shown to improve outcomes, improve team working, skill mix and utilisation of resources within practice, and create improvement in both patient and staff experience of care delivery at a practice level. Implementing care and support planning within a GP cluster or IJB will create a systematic method of ensuring that people with long term conditions, multi-morbidity and frailty receive high quality patient centred care. In particular it will:

Separate out disease monitoring into a single coordinated treatment room visit no matter how many conditions an individual patient is living with, which is usually performed by a trained health care assistant (making better use of skill mix and streamlining/standardising care processes)

Ensure people with long term conditions receive results and agenda setting prompts to enable them to be prepared, more informed, involved and in a better position to make decisions about their care, including self management. There will be less time spent in the conversation giving people information, more time working on patient and professional concerns

A single care planning conversation no matter how many conditions a person may have, delivered usually by practice nurses with support and supervision from general practitioners, which facilitates a holistic person centred consultation and provides longer appointments for those with more need or complex issues. Develops the role and skills of practice nurses towards that of expert generalists moving away from a role around chronic disease management to one focussed on care planning

A single administrative process, involving the whole team and a recall system using the practice register rather than single disease registers, coordinated by practice administration team and led by practice managers

A focus on multi-morbidity which steps away from a disease focused approach. CSP is a generic approach which focuses on supporting people to live well and focuses on what matters to them. Implementing CSP for 'people not conditions' has been shown to be well received by patients, and to free up appointments and save time

An approach which focuses on more than medicine (i.e. community support and personal assets), and uses care navigation (often trained receptionists) and social prescribing (Links Workers) to seek support and solutions which are often community focused using existing community assets and activities.

Workforce development and the multidisciplinary team

Implementing CSP creates opportunities to move work and tasks to people with new or expanded roles within the team. For example, a HCA can do a significant number of tasks, freeing up nurses to support people in care planning consultations and enhancing job satisfaction. GPs take an oversight role and support the skills development of other team members. Everyone's role in the team is crucial.

Training, facilitation, tools and resources have been developed to support the implementation of the care and support planning process and development of the consultation skills. There are also case studies and practical toolkits to support organisations who wish to implement this approach in response to its exact fit with the GMS contract. For more information please contact enquiries@yearofcare.co.uk

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