The HOUSE Journal

Issue 20

The newsletter for the Year of Care Community of Practice

Welcome to The HOUSE Journal

Lindsay Oliver, National Director

In this edition of The House Journal we focus on how care and support planning (CSP) can be developed to offer a single process and conversation which works not only for people who have a single condition, but also those who live with multiple long-term conditions. This has many advantages to both the practice and patients who all benefit from a more focused and streamlined approach to care.

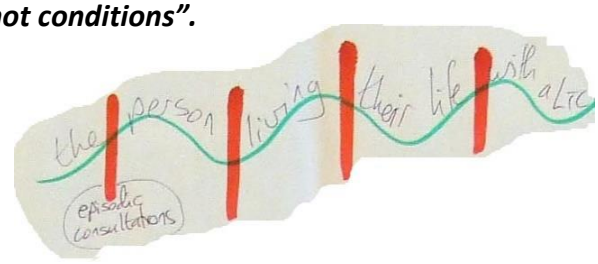
There are now many practices who have implemented this as part of introducing CSP into the practice, and many more who are seeking to move to this way of working. As we slowly (hopefully) emerge from the pandemic and begin to get to grips with a backlog of routine care for people living with long term conditions, this is perhaps something to consider.

CSP for people with single and multiple conditions – Lesley Thompson

I have worked as a national Year of Care trainer and facilitator for 10 years. Initially we developed the approach using diabetes as an exemplar and then tested it in other single conditions such as COPD. We've now extended it to be an approach that includes all of the long-term conditions and issues a person lives with, emphasising the importance of '*what matters to you?*" within the CSP conversation.

No matter what the scope of CSP is in practice the core philosophy, principles and systematic processes can ensure consistent delivery of person-centred care across a person's lifetime from prevention and single/multiple long-term conditions through to frailty and end of life.

In many practices this has been achieved by taking an incremental approach to implementation, adding in more conditions to the core recall list. Initially focus is often on QOF conditions but increasingly recognising that other conditions that people live with and aren't included in QOF, such as chronic pain, can have a huge impact on their day to day lives – our focus is now on ***"people not conditions".***



YOC Moving On Workshop for practices who wish to increase the scope of CSP

The Year of Care team has developed a half day **'Moving on Workshop.'** This supports practices already offering CSP to people with single long-term conditions to develop an action plan to extend the approach so that people experience a single CSP process no matter how many conditions they live with.

The session involves:

- Revisiting the core principles of CSP
- Identifying the groups of people that the practice would like to extend CSP to
- Working through the process changes involved including recall, information gathering and preparation
- Revisiting the role of the HCP and the impact of including more issues within a single CSP conversation
- Identifying any training needs for professionals and how they can be supported to develop their skills.
- Working out how medicines review and social prescribing fit in and around the process

Those attending this session should have attended YOC core CSP training and their practice should have established CSP processes in place.

For further information and details on how to book a remote or face to face 'Moving On Workshop' please contact us at enquiries@yearofcare.co.uk.

"I could ask the questions instead of being asked the questions…"
"You may not have all the answers but you've helped me work things out"

The role of care and support planning for people with multiple long-term conditions - Andrea Elsbury

What do we mean by multimorbidity?

More than 1 in 4 people have two or more long term conditions[1] (often described as multimorbidity) and this increases with age to almost 2/3 of people over the age of 65. Worryingly, multimorbidity affects people living in deprived areas 15 years earlier than elsewhere[2].

'Multimorbidity is the presence of 2 or more long term health conditions which can include defined physical and mental health conditions, ongoing conditions such as a learning disability, symptom complexes such as frailty or pain, a sensory impairment, and alcohol and substance misuse.' (Multimorbidity: clinical assessment and management (2016) NICE

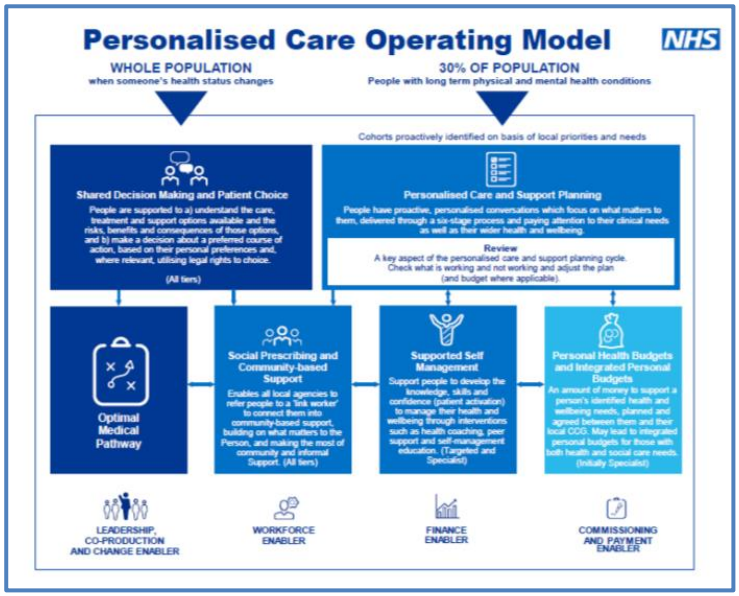
Healthcare for people with multiple long-term conditions (LTCs) is often complex. Guidance is generally produced for single conditions and doesn't look at how conditions and their treatments interact with each other. This can result in people attending multiple appointments which are single disease focused, retelling their story to different clinicians and having to carry the continuity between clinics – sometimes referred to as 'treatment burden'.

"People living with several conditions not only have to manage each one, but also the consequences of the ways in which they interact" **'Just one thing after another' Living with Multiple Conditions (2018) The Richmond Group Taskforce**

CSP policy

In 2016 NICE[3] and the RCGP[4] developed recommendations focused on working with people with multiple LTCs. A very clear purpose was to reduce the treatment burden for patients, address issues of polypharmacy and frailty, and include a focus on risk factors of future disease, through a more tailored and better coordinated approach to care. It encouraged a shift in emphasis to supporting people to manage their LTCs (including use of non-medical approaches) and to thinking about day to day living, as well as incorporating the person's own priorities and goals.

More recently the NHS Long Term Plan sees personalised care as core to how we work with people to 'have choice and control over the way their care is planned and delivered, based on what matters to them and their individual strengths, needs and preferences'[5]. The comprehensive model for personalised care has CSP at the heart of how we work with people with LTCs, with a focus on care being holistic and person-centred. A single-review approach for multiple LTCs offers a practical way to deliver this.



Universal Personalised Care (UPC): Implementing the Comprehensive Model

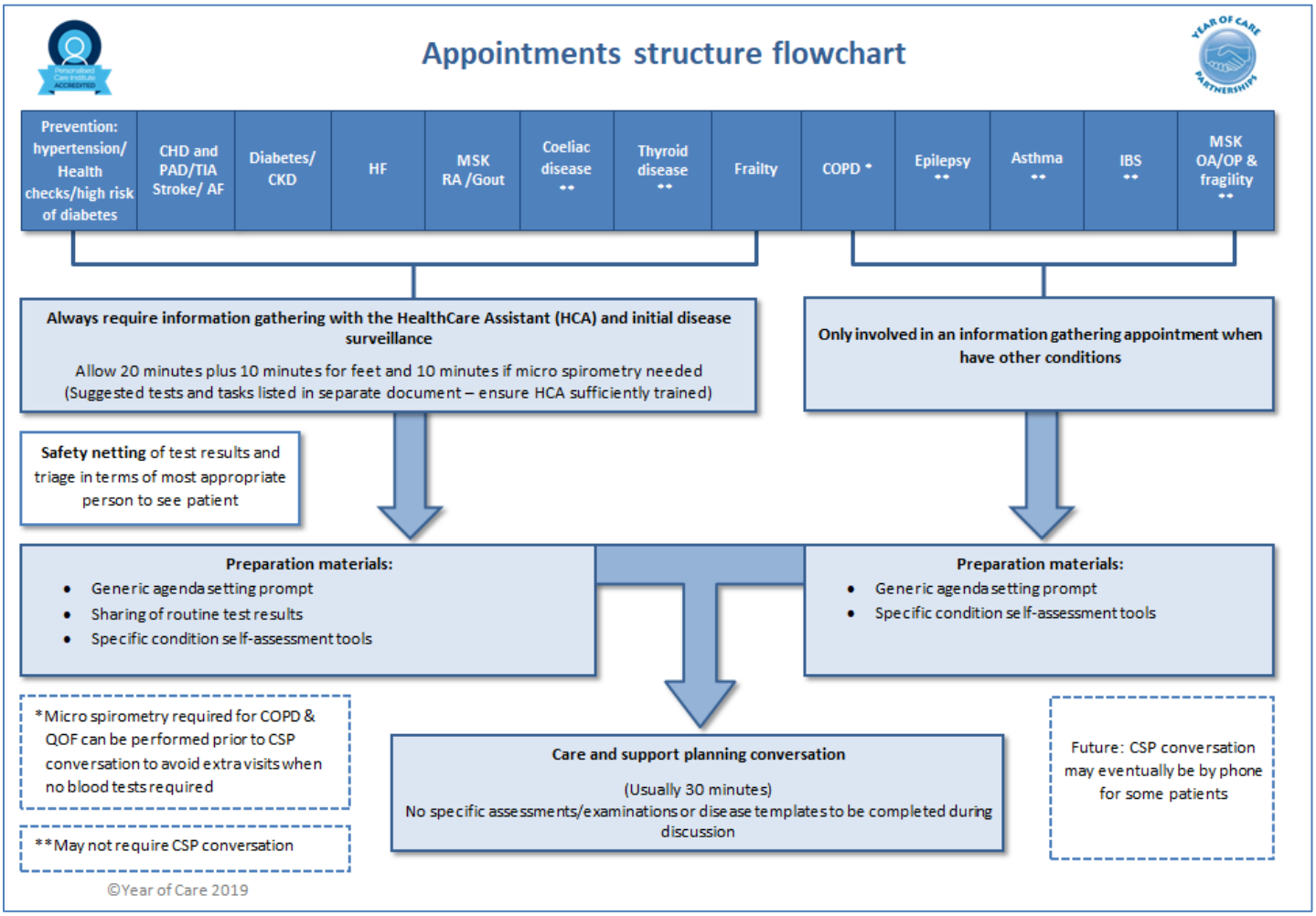
Year of Care and multimorbidity

The Year of Care approach to CSP brings together the aspirations of the NICE multimorbidity approach to working with people with LTCs, with the principles of the UPC Operating Model, in a single robust CSP process. It is underpinned by a strong philosophical approach with the person at its heart, supporting practices to embrace a person-centred approach to their patients with multiple LTCs.

Developing the capacity for a single information gathering appointment that includes tests and measurements for all the LTCs a person has, reduces duplication of tests and enables the person and health care professional to prepare for a single review appointment which can look holistically at what matters to the person and how they can manage / live well with all their conditions.

From principles to practice

Use the flowchart to explore where your process could be adapted to enable people with more than one long term condition to have a single review for all their conditions. Contact us if you want a copy of this flowchart.



Care and support planning at Glenpark – how it works for Beryl

Becky Haines, GP at Glenpark Medical Practice and Gateshead Clinical Lead for Diabetes

"Beryl is 82 years old; she is widowed and lives alone. She has type 2 diabetes, hypertension, osteoarthritis, diverticular disease, hypothyroidism, bronchiectasis, COPD, chronic kidney disease, hiatus hernia and moderate frailty. Within our old system she would have attended the surgery for diabetes clinic 2 or 3 times a year, a COPD nurse appointment once or twice a year, a separate GP appointment for a medication review and also a plethora of appointments if she had problems with her arthritis or pain. Now Beryl is recalled in her birthday month for a single PCSP process focused on what matters to her."

Find out about the changes Glenpark Medical Practice made to their long term condition reviews and how CSP works for Beryl here.

"As a healthcare professional, this feels like a much better, more satisfying way of working. In my opinion, once this process is embedded, it can change the whole ethos of a practice and significantly improve patient experience, and certainly we would never go back to our old way of working" **– Becky Haines**

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Meet Isobel

Isobel is 74 and has a number of long-term conditions which historically have all been managed in separate pathways, within her GP practice.

She has moderately severe COPD, type 2 diabetes managed via a care and support planning process, a long history of osteoarthritis with significant pain and recently diagnosed osteoporosis. A typical year in the life of Isobel looked like this.

Implementing a 'multimorbidity' care and support planning approach in the practice enables Isobel to have a single long-term condition review, incorporating shared decision making and more than medicine options for her self-care. Not only did Isobel attend the surgery on fewer occasions, but she made different decisions about how she wanted to manage her long-term conditions.

You can find out more about how care and support planning worked for Isobel by attending our 'Moving on Workshop'.

Patient comments following CSP

"Well organised, accessible, fantastic staff. Each time I've visited the practice staff have been really accommodating, friendly and professional. I was really impressed with the way information re: results of diabetes testing is presented. It was in a way that actually makes sense for the first time and made me take stock of the results rather than just seeming like numbers on a page. Things like this make such a difference! I feel like they have some very good systems in place and it is well organised even in difficult times like now!"

★★★★★★★★★★

"Getting the letter before helped me to think about what had led me to gain weight. I thought about what would help me lose weight and keep it off this time and was able to get the help I need to do that."

★★★★★★★★★★

"This is the first time anyone has sat and listened to my story. I can really talk to you; you haven't dismissed me or told me what to do."

★★★★★★★★★★

Professional thoughts on CSP

'It's much more enjoyable to do [reviews] now compared to what it was like previously."

★★★★★★★★★★

"One person surprised me because I did not expect her to engage, she came prepared with ideas, I was able to narrow what she wanted down to finding an exercise class with other larger people."

★★★★★★★★★★

"We describe this work as the best thing ever, we are talking less and giving the person more control. We are using the tools and focusing on people's strengths, and we are noticing the changes people are making."

★★★★★★★★★★

"More rewarding, patients are helping themselves. When you just give people advice, they do nothing, and it gets worse. Working in this way will get easier, it is no longer about a 'fix-it' approach, we are now changing, learning".

★★★★★★★★★★

References

[1] NIHR Collection: Multiple long-term conditions (multimorbidity: making sense of the evidence (March 2021) doi:10.3310/collection 45881 (accessed 04/05/2021)

[2] https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf (accessed 04/05/21)

[3] Overview | Multimorbidity: clinical assessment and management | Guidance | NICE (accessed 04/05/21)

[4] RCGP-Responding-to-needs-of-Multimorbitiy-2016.ashx (accessed 04/05/21)

[5] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf (accessed 04/05/21)