The HOUSE Journal

The newsletter for the Year of Care Community of Practice

Issue 23
South Tyneside

Welcome to The HOUSE Journal

Lindsay Oliver, YOC National Director

It's a pleasure to introduce this edition of The House Journal in which we feature the work that South Tyneside have been doing since 2018 to implement personalised care and support planning (PCSP) linked to social prescribing. This work has been thoughtfully planned, clinically led and supported by commissioning managers. It highlights the importance of embedding Year of Care training and facilitation alongside locally led implementation that goes well beyond 'box ticking'. The implementation aimed to truly embed personalised care for people with long-term conditions by simultaneously looking at care processes, practice culture and staff skills in personalised conversations.

The South Tyneside team describe the approach they took and how they have implemented a single PCSP process for people with single and multiple long-term conditions (LTC) as normal care in primary care. The approach has been an engine for change and has driven a whole host of improvements around the personalisation of core clinical care.

Spotlight on South Tyneside

What made you decide to implement PCSP with Year of Care?

We had been talking about personalised care for over 15 years but were not able to take any major steps until we came together as a team in Sept 2018. There was a sense that the system of providing LTC care had to change due to ever increasing demand and the impact of social deprivation. We realised we needed to move away from a system where everyone got the same experience regardless of need. We talked about how we take it forward and we considered our options – Year of Care certainly was the vehicle. It gave us a different perspective on how we could start to deliver PCSP beyond training staff. We liked the idea of moving away from a siloed system of working to a whole system approach to PCSP.

What part of the personalised care programme makes you most proud?

Everest Mthombeni
Commissioning manager South Tyneside CCG

The relationships that we've built not only with the practices, but our health and social care system, ensure we consider how the whole system interacts and the experience for patients. Together with Year of Care we've been flexible and adapted especially when we worried that the pandemic would derail practices. We found that the Year of Care process brought a lot of resilience to practices and they were able to start thinking outside the box. Practices found the training, facilitation and support that we've put in place really useful. I think as a project team we've worked well - Rak's GP expertise, Caroline's nursing expertise and my project management experience.

Rak Bhalla
GP at Colliery Court Medical Group and Associate Director for LTCs South Tyneside CCG

PCSP was a new concept to many of our colleagues and we had to shift the mindset of general practice to work in a proactive way, putting the person at the centre. We have also extended the personalised care system within primary care to the wider system including social care, mental health and VCSE.

When we talked about this concept called 'personalised care' I did not come across one individual who said they didn't think it was a good idea and didn't want to be involved.

Caroline Sykes
Nurse practitioner and lead nurse for YOC in South Tyneside CCG

We had 21 practices working very differently and recognised that a system wide approach was needed. We started small with 4 pathfinder practices and over the last 3 years with support and training from Year of Care and each other we now have all 21 practices up and running with PCSP - a great achievement especially as this was during the pandemic. Nurses needed to be involved with this change right from the beginning and I was keen to develop a single use template we all shared. We devised this together with support from practice IT teams and is something I am proud of. I also feel nurses and practices in general have much closer supportive relationships consequently.

What were the critical success factors for implementation?

Everest Mthombeni

Our ambition was to provide PCSP based on 'what matters to the person' for South Tyneside residents with long-term conditions, providing a service which is equitable, meets the clinical needs of the individual and builds their knowledge, skills and confidence to self-manage. To effectively deliver on our vision to move from a fragmented approach to a coordinated system of care, we required a reputable partner to deliver training, facilitation and support for our practices on their journey to implementing PCSP.

After extensive research we approached Year of Care Partnerships who provided us with a different perspective into how we could actually start to implement personalised care beyond staff training. Our initial approach was based on starting small and spreading the change, so we enlisted a group of early adopter practices to help us to co-design and test the new pathway and processes that would offer patients and clinicians in South Tyneside a better experience during and after their consultations.

We provided practices with taster sessions that gave them an overview of the Year of Care approach, their training programme and facilitation. This gave us the opportunity to reinforce that it was a whole practice change which required buy-in and commitment from all staff in order for it to be effectively implemented and for the change to be sustained. Year of Care's previous experience in delivering this work elsewhere and examples of it working well helped to get people on board. We also kept a learning log throughout the whole process and regularly met to reflect on what went well, what hadn't gone so well and what we could do to address that going forward.

> *"GP practices had to do a lot to reorganise their processes and shift mindsets and this should be celebrated."*

Rak Bhalla

Planning was key to successful implementation of personalised care. We were clear that we needed a project team which was able to support our practices both clinically and administratively. We spent a year planning before we started to implement Year of Care in practice. We spent the time bringing our team together, finding out a little bit about how we worked and which of our system partners we needed to build relationships with to really start building momentum. We also used our 'Time-In Time-Out' educational sessions to talk about personalised care and to continuously emphasise the principles. We explained why it was important to think about the person sitting in front of you and their story rather than just the medical condition they're living with. 'What Matters to You' became our strap line and we all wore badges with the words 'I'm actively collaborating'.

We explained our support offer and implementation plan to practices and asked for registrations of interest, rather than insisting that this was something they did. Our adage is 'start somewhere and go everywhere' so we started small because we believed people would naturally become interested as practices shared the benefits.

Identifying 'Pathfinder Practices'

Following initial meetings, we started to identify our early adopter practices that had expressed interest. We called these our 'Pathfinder Practices'. It was the four pathfinders who were going to test out our systems, build our learning and share their experience. As early adopters they were the ones who were going to be coming up against barriers and finding the solutions which we would then pass on to others. It was important for us to build relationships with them and agree what they could expect from us and what we expected from them. We continued to visit the pathfinder practices regularly to offer support and listen to their feedback. We were keen to have different size and shape practices with different philosophies so that when other practices started to come on board, we could buddy them up with a similar practice.

Following Year of Care training we went back to the four pathfinder practices and used the practice checklist in the Year of Care practice pack to understand the degree of implementation - it varied. This taught us that you couldn't just leave it to the practices to 'get on with it', it was important to make contact on a regular basis and help facilitate the change to processes.

IT infrastructure

We realised that we needed to develop a single IT template that was going to facilitate and deliver PCSP across all South Tyneside practices. Over the years practices had developed their own templates and there were multiple systems in use generally designed for entering data for QOF only. Additionally, there was no IT support team in South Tyneside at that time and so setting this up became one of our early enablers.

Caroline involved practice nurses in the development of the template to ensure they embraced and owned it. This was a real selling point to other practices. She was passionate about ensuring all the task-based activity was removed from the care planning consultation template to make time for the PCSP conversation. Caroline also recognised that the template needed to automatically update, meet QoF requirements and have links to useful resources such as asthma management plans. For nurses who had been using four or five different templates, the new template consolidated everything making it easier to navigate and to offer a personalised conversation.

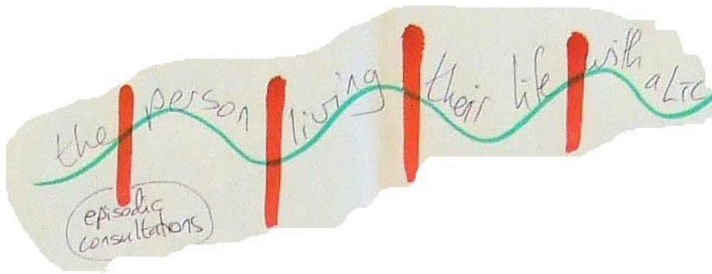
Caroline Sykes

Changing the conversation

The practice nurses have seen a huge change in their role. We were asking them to completely change the way that they had been consulting with patients with long-term conditions. Our nurses have a vast amount of medical knowledge and experience, built up over many years and as a nurse working alongside them I tried to encourage them to start to think differently about the conversations they were having with patients about their conditions.

I asked them to reflect upon their experiences of seeing the same patients coming back year after year with the same medical and social issues. Long-term condition management is linked to QOF targets so medications were often increased. Encouraging positive behaviour change is key to the improved long-term management of conditions and I encouraged nurses and GP colleagues to think about the impact that having a different conversation based on what matters to the patient may have on this.

I found that the Year of Care visual of the patient perspective (below) helped to demonstrate this. There are intermittent reviews with the GP and nurse but the rest of the time patients are managing the conditions on their own, and for most there are many challenges.



Training and professional development

After YOC training I found that shifting the focus to what matters to the patient, even those with complex needs and multiple conditions, gave the consultation more focus because it helped me understand what the patient's agenda was and how it often differed from my own.

You worry about a raised HbA1c and the associated risks but a shift in conversation can often highlight how overwhelmed some patients can feel - providing specific support and involving social prescribers for example can have a very positive impact, which in turn may improve numbers.

As part of the training it was really helpful to explore how we ensure clinical concerns are balanced against patient concerns and what matters to them. Actions and medications would still need to be addressed and we discussed ways of exploring with patients how positive behaviour changes can naturally improve blood results etc.

We were worried that the pandemic might throw us off track but we found the process changes supported us to keep going. During the pandemic the Year of Care team facilitated a focus group with the South Tyneside nurses about what a virtual training package would look like. The information and training package they provided was vitally important, because otherwise PCSP would have just stopped. We continued training throughout COVID.

Ongoing support for the whole team

Maintaining regular contact with staff has been critical to success both with new practices starting their training and with nurses from the initial pathfinder practices:

- A WhatsApp group for nurses and HCAs was set up by my colleague to provide a platform for support and queries.
- Regular personalised care updates at Time In Time Out sessions - being the lead means nurses have a named person to address issues with.
- Open dialogue with nurses with regards to the template and any changes they feel are needed.
- Reviewing the Year of Care process and sharing how it links to wider NHSE policies and future projects.

It has also been key to recognise the vital role that HCAs have in the process and the preparation of the patient. Year of Care delivered training specifically for HCAs and a helpful tool we now use is a laminated copy of the results letter and preparation prompt to discuss with patients at the information gathering appointment.

"Having worked as a GPN for many years and looking after patients with multiple LTC, it was exciting to try a new way of working, that put the patient and their hopes and expectations about their health at the centre of the consultation. This allowed them the chance to take a more active role in managing their long-term conditions.

As part of a pathfinder practice I have enjoyed gaining skills and knowledge over the last 4 years and passing my experience onto practices just starting out with this way of working." **Kirsty Morritt** Marsden Rd. Health Centre

Year of Care – working in partnership

Year of Care first met with South Tyneside in 2018 at a very early stage in their thinking about personalised care. We have been able to share our learning about set up support, what works and the importance of planning an implementation strategy alongside training and practice facilitation.

This included a substantial period of preparation and planning, including thinking through critical success factors (www.yearofcare.co.uk/critical-success-factors), being clear about what they wanted to achieve and placing emphasis on changing the systems of care to support a cultural shift towards personalised care which also offered good quality clinical care. They developed local solutions with practices and fostered relationships to achieve implementation in an incremental way, allowing practices to join up at a time that was right for them.

We feel this offers an exemplar of how to do it well and we are looking forward to continuing to work closely with the team to embed the approach further.

How Year of Care have supported this work:

- Advice and support to develop an initial plan, sharing expertise and resources
- Delivering taster events to ensure practices understood what the programme was about and what the work of implementation looked like
- Training for practice teams in YOC personalised care and support planning approaches
- Facilitation at practice level to look at processes of care and how they could make practical changes to support the approach
- Keeping in touch and feeding back challenges, identifying any support needs and positive stories from practices – working together on solutions
- Support sessions for practice nurses on remote care and support planning to maintain a person-centred ethos and share the reflection tool
- Training for health care assistants to support them to deliver the first step in the personalised care and support planning process
- Plans for ongoing training and use of the YOC Quality Mark - a self-assessment tool for practices

The importance of working at practice level – facilitation and support

Training focuses on helping practitioners understand how PCSP differs from current practice and supports the development of new person-centred communication skills. To help practices work out how to implement PCSP we offer a practice-based visit which includes the wider support team. At this session we spend time thinking through the benefits of the approach, considering how admin teams will describe the process to patients and we develop a detailed plan for implementation using a process mapping approach. This includes how it will work, which resources are needed, staff roles and further training or development needs. This seems to make a real difference in terms of getting this to happen at practice level.