Issue 19

The HOUSE Journal

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 the inclusion of frailty topics within the care and support planning (CSP) process. This work was completed ahead of the pandemic and it demonstrates how the CSP process can encourage a focus not only on the 'diseases' that people live with but rather on the issues that people face, particularly for older people who are already (or are becoming) frail.

The two programmes of work we feature on pages 2-4 focused on adding new components to the care and support planning process to enable people to identify dementia or falls as a concern. They created opportunities for training of healthcare professionals to become more confident in discussing these topics and knowing how to support people or/and reduce their risk.

News and Updates

Personalised Care Institute (PCI)

In 2020 NHSE set up the Personalised Care Institute (PCI) at the RCGP with a view to setting standards for workforce training to support the delivery of the NHS Long-Term Plan and its ambitions around personalised care. As part of this role the PCI accredit and approve providers of personalised care training.

We are delighted to announce that Year of Care has achieved this status and anyone wishing to receive CPD points following our training can now receive 12 points on completion of an online PCI evaluation (this applies to England only). We will provide details of this to clinicians who attend training in the future.

NICE, SDM and Consent

CSP will often include a component of shared decision making (SDM). The GMC have recently strengthened guidance on decision making and consent (www.gmc-uk.org) and NICE have drafted a SDM Guideline which is currently out for consultation (https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making).

The GMC document emphasises patients' right to be involved in decisions and given the information they want or need in a way that they can understand to be able to reach decisions with professionals about their treatment and care. The NICE Guideline supports the same ethos of collaboration with patients as CSP and encourages organisations to think of ways to embed SDM into normal ways of working.

SNOMED codes

There are two new codes for personalised care and support planning (PCSP) that were introduced into the SNOMED-CT directory on 1 April 2020. They may be helpful for practices or organisations who are considering ways of tracking PCSP and these will be monitored in England by NHSE.

- **1187911000000105 Personalised care and support plan agreed** (finding) - the number of personalised care and support plans agreed in the reporting period.
- **1187921000000104 Review of personalised care and support plan** (procedure) - the number of patients who have received a review of their personalised care and support plan in the reporting period.

Including identification of falls risk and prevention within the care and support planning (CSP) process

CSP has proven to be a flexible framework to deliver personalised proactive care to people with LTCs, including people with multiple conditions, increasing complexity and frailty. It also provides an opportunity to focus on both the detection of new conditions or issues and focus on a preventative approach. With this in mind a small team of researchers and implementors (supported by the AHSN) worked with 8 practices in the North East of England to work out how falls, as an element of frailty, could be formally introduced within the CSP approach. This included bringing falls experts together with the YOC team to consider how the process could be modified and what additional training and resources were needed by practice teams.

Modifying the process

All practices were up and running with CSP prior to the pilot and were also recording frailty status as part of routine care in people aged 65 or older, usually using the Clinical Frailty Scale to validate the Electronic Frailty Index. This also meant that in those practices where a wide range of conditions were included in their CSP recall system 67% of people over 65 years, with LTCs and a verified frailty score (mostly mild or moderate), were already involved in CSP.

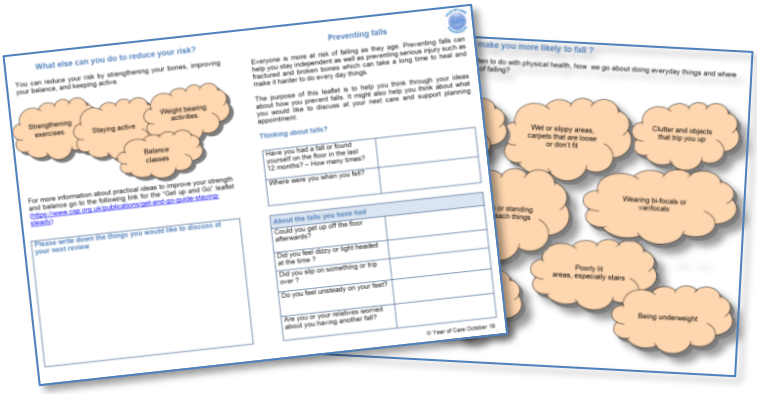
Practices were asked to:

Ask 3 questions at the information gathering appointment:

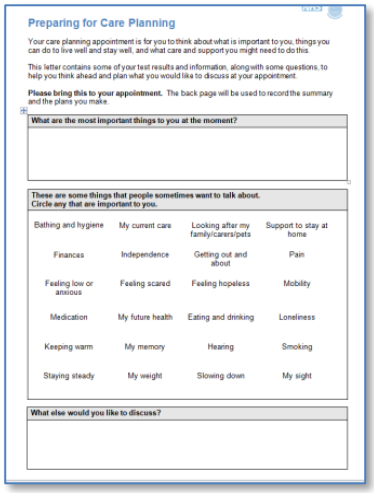
In the last 12 months:

1. *Have you had a fall including a slip or trip?*
2. *Have you had a blackout or found yourself on the floor?*
3. *Have you noticed any problems with your balance (e.g. whilst walking, standing up from a chair or dressing?)*

Those giving a positive answer to any question had their lying and standing blood pressure measured and were given a falls self-assessment leaflet by the Healthcare Assistant to prompt them to think about relevant self-management issues to discuss at the CSP conversation.



Preparation and CSP conversation



For everyone with mild, moderate or severe frailty a generic prompt sheet for frailty was used in place of the usual multiple LTC version sent out prior to the CSP conversation. This enabled the issue of falls to be discussed in the context of either new findings e.g. hypotension/postural drop or general concerns around falls risk and frailty.

Training and implementation

Practices were supported with implementation of the pilot by in-house facilitation and the provision of materials such as patient leaflets. Modifications were made to the IT templates to accommodate the additional activities/recording requirements. Specific training in falls and frailty proved essential to ensure that staff making the changes understood the rationale for the inclusion of the extra questions and that they were able to frame the questions in a way most likely to elicit a meaningful response.

A checklist based on the SPLATT acronym (Tideiksaar, 1998) was offered to clinicians as a framework to identify potential underlying causes of falls. The teams were also made aware of local resources such as strength and balance classes and other interventions to support healthy ageing/prevention.

The training included:

1. What is frailty and how it is identified?
2. Falls risk factors
3. Undertaking and interpreting lying/standing blood pressure
4. Having meaningful conversations about falls and frailty
5. Interventions to support healthy ageing/prevention
6. How to incorporate the new process into care and support planning

Learning and impact

- It proved possible to include falls and falls prevention work in the existing CSP process with benefits for patients and staff. The study involved over 2000 people in 8 diverse practices. The qualitative arm described success factors to support training and implementation.
- Practitioners acknowledged that including falls in the CSP process enabled them to broaden the content of discussion to include frailty as a general issue within what had traditionally been seen as 'LTCs review clinics'. They became more confident in discussing frailty topics within all their clinical practice.
- Asking questions about falls including slips and trips identified a previously unidentified cohort who were either at risk of falls or reported falling, with 50 to 74% of this group having new postural hypotension.
- Practitioners reported modifying medicines, self-management and formal strength and balance classes as outputs of a falls discussion within the conversation.

Please contact YOC for further information (enquiries@yearofcare.co.uk) and you can see the final project report here.

Dementia Care and Support Planning Toolkit

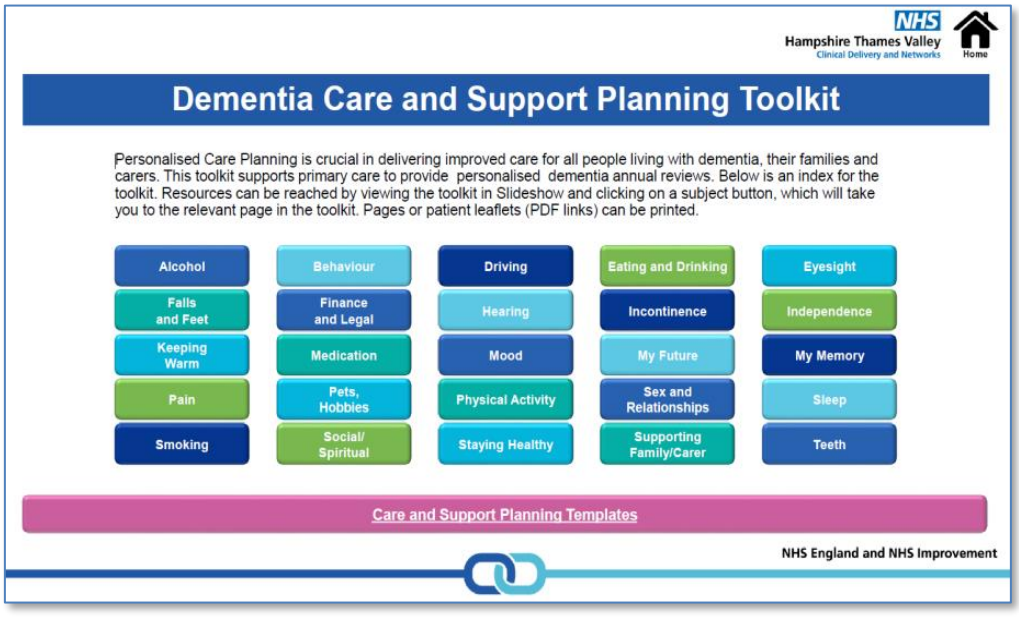
Supporting a personalised approach to dementia annual reviews

In Thames Valley the Year of Care approach to care and support planning (CSP) has been widely implemented in primary care for a range of long-term conditions including diabetes, respiratory disease and heart disease. However, few practices have offered this approach to people with dementia. Healthcare professionals lacked confidence to deal with topics raised during CSP conversations and were not sure how to signpost to the relevant support, and so CSP was commonly perceived as 'too difficult' for those with dementia.

Following discussions with practitioners, carers and people with dementia, Hampshire Thames Valley Clinical Network (HTVCN) has developed a digital toolkit to support meaningful consultations between practitioners and individuals with dementia as part of the CSP review and to enable the development of personalised plans.

All resources are within a single PDF toolkit that can be downloaded to any desktop, clinical intranet etc. and can support any practitioner e.g. GP, practice nurse or dementia advisor.

The Dementia Care and Support Planning Toolkit has also been adapted for use virtually. The material within the toolkit can be used by the patient and practitioner to prepare for the consultation and the consultation can then be held by telephone or video call.



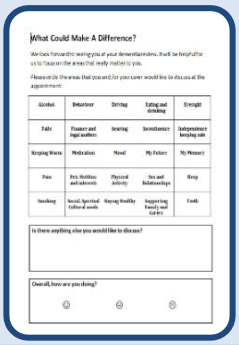
The **HOUSE** Journal

Personalised Dementia Annual Review Process

The Dementia Care and Support Planning Toolkit supports the dementia review and care and support planning process in several ways.

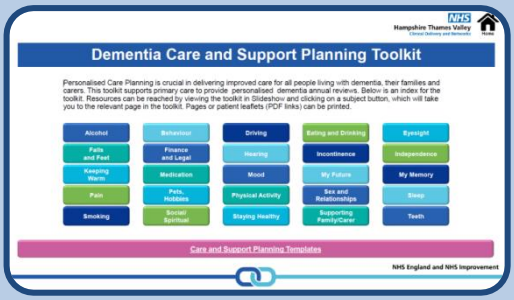
Preparation

The toolkit includes an appointment letter and an agenda-setting prompt *'What Could Make a Difference'* to be shared ahead of the CSP consultation, both developed by and adapted for people with dementia.



The consultation

The practitioner focuses the consultation around the concerns highlighted by the patient. The Dementia C&SP Toolkit has been designed to correlate with the topics on the agenda setting prompt and the practitioner can use it to identify information, advice and support relevant to the patient's concerns.



Development of a personalised care and support plan

The toolkit provides two types of care planning templates that can be used to record and share the person's care and support plan.

Patient and practitioner experience of using the Dementia C&SP Toolkit

Personalised dementia reviews using a care and support planning approach will empower and support people to live well with dementia. The HTVCN Dementia Care and Support Planning Toolkit supports practitioners to adopt this approach.

"Thank you for taking the time with my mother last week at her annual review. She was very anxious about coming to see the doctor, but you put her at ease and made her the centre of attention. She even said she enjoyed it!" ***Carer***

"I used to dread doing dementia reviews; I was really under confident, as I wasn't sure what I could do to help patients or their carers. Using the care and support approach has changed all this - the toolkit is easy to use, and patients choose what they want to discuss. It's now one of the most satisfying reviews that I do!" ***Practice Nurse***

For more information about the HTV Dementia CSP Toolkit please visit: https://www.southeastclinicalnetworks.nhs.uk/dementia-csplanning-toolkit/

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