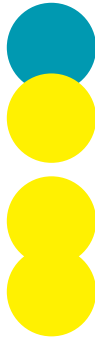
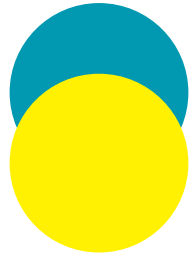


Our Experience of the Gateshead House of Care Project

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Introduction

This case study outlines the activities, progress and learning from the Gateshead British Heart Foundation (BHF) House of Care Project, which ran from April 2015 to March 2018.

For each element we have summarised how we've approach this, outlined the benefits, challenges and learning from our experience with some top tips to consider.

We hope this provides a useful insight into the Gateshead House of Care Project.

The contents of the case study are:

- Background and Context
- Activities: Building the House of Care in Gateshead
- Roof Organisational processes: Summary of approach, benefits, challenges and Learning from our experience
- Health Care Professional Committed to Partnership working: Summary of approach, benefits, challenges and Learning from our experience
- Left Wall Engaged and Informed Patient: Summary of approach, benefits, challenges and Learning from our experience
 - Patient feedback on CSP consultation
 - Patient Case study
 - Gateshead Patient Reference Group Case study
- Foundations: Commissioning Summary of approach, benefits, challenges and Learning from our experience
- Practice Implementation Progress
 - Year of Care Quality Marker
 - Practice Feedback
 - Multi Morbidity Clinic Data
- Next Steps

Much of our learning supports the established evaluation and learning from Year of Care Partnerships and further information can be found on: www.yearofcare.co.uk

The Clinical Commissioning Group (CCG) in Gateshead were successful in an application to participate in the BHF House of Care national project where five sites across the UK were selected to implement care and support planning for people with cardiovascular (CVD) within a multi morbidity context using the House of Care Framework.

The health of people in Gateshead is generally worse than the England average, with life expectancy for both men and women lower than the England average. In Gateshead life expectancy is 9.2 years lower for men and 7.3 years lower for women in the most deprived areas than in the least deprived areas.

Lifestyle factors have a significant impact on the prevalence of long-term conditions. Smoking prevalence is slightly higher, but statistically similar to the national rate. Significantly fewer adults are physically active and significantly more adults are overweight or obese than the national average.

The population is ageing and it is projected that by 2039 there will be an additional 14,400 people aged 65 or older, an increase of 38% from 37,800 in 2014 to 52,200 in 2039, 9,700 of these people will be aged over 85+. There are more than 60,000 people currently on disease registers in scope of the Newcastle Gateshead Long Term Condition (LTC) strategy. As at 30th June 2016 the Primary Care Data for the whole Gateshead population 7.2% of patients have two or more LTCs and 3.8% of patients have three or more LTCs.

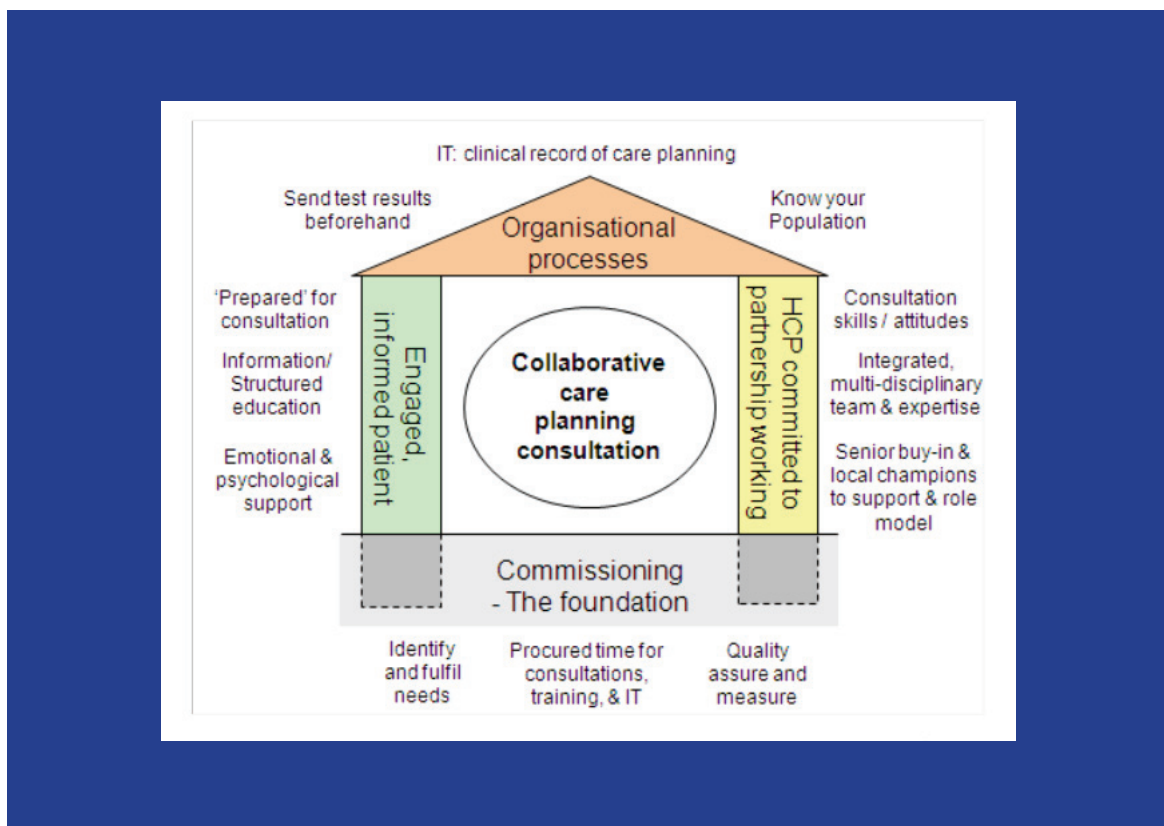
Newcastle and Gateshead CCG's Long Terms Conditions Strategy recognises the multi morbidity burden in its population and aims to enable innovations in the delivery of proactive care to this patient group, as opposed to the disease area silo's that have dominated in the past.

The Newcastle Gateshead CCG LTC Strategy outlines a transformative approach to deliver collaborative, patient centred care that supports self-management through care and support planning (CSP). The CCG has taken a multi-layered approach to supporting self-management for people with LTCs and the Gateshead House of Care project has been a central element to this.

The three year House of Care project has focussed on implementing care and support planning using the year of care approach, aligning to and building on work already underway within the CCG to transform the way General Practices routinely manage their patients with multiple LTCs. Alongside the resource from the CCG, funding from the BHF enabled the establishment of a project team to manage the delivery and evaluation of the project; this consisted of a full time project manager, part time administration officer, part time LTC involvement officer and evaluation support.

Activities: Building the House of Care in Gateshead

The CCG took a developmental and supportive approach to enable General Practice teams to adopt the principles of care and support planning; using the 'House of Care' as a framework for implementing C&SP. The approach was incremental over a period of two to three years to enable practices to implement as and when the time was right for their practice.



A group of partners and stakeholders in Gateshead formed the local steering group which has led the development, implementation and evaluation of the House of Care project, with membership made up of representatives from the CCG, GPs, Practice Nursing, Local Authority, third sector, Year of Care Partnership (YOCP) and the British Heart Foundation.

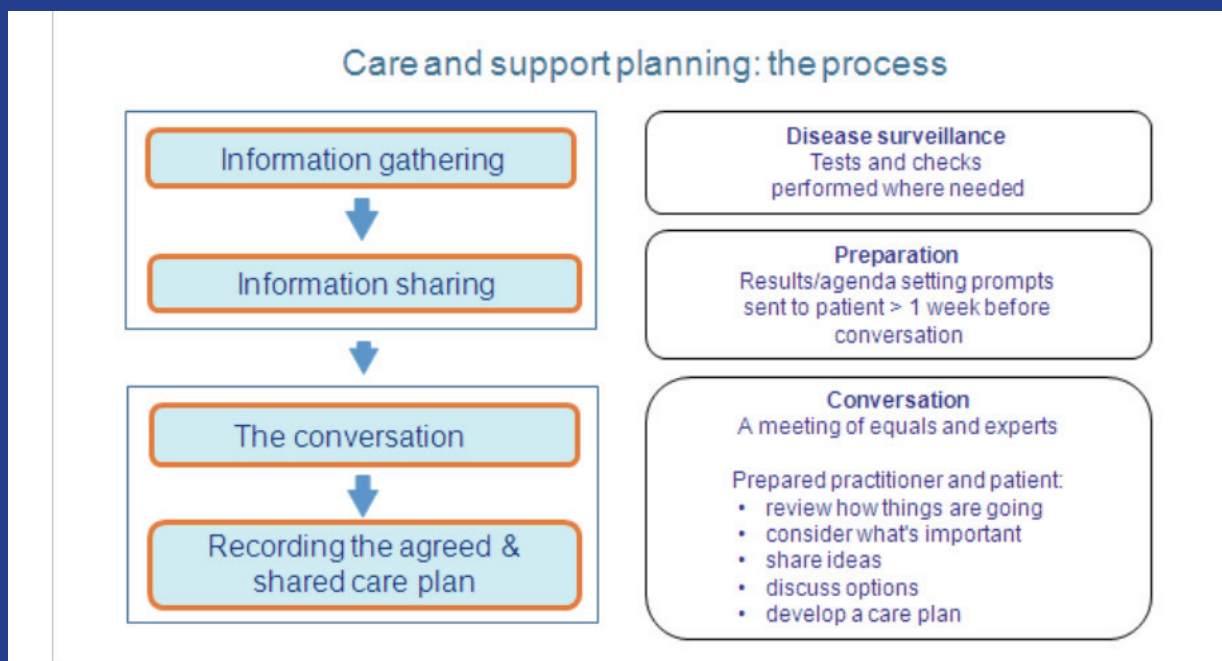
The group developed an action plan and utilising the house of care framework, identified the outcomes to be delivered by the project and the activity required to deliver it. This project case study outlines the detail under the roof, right wall, left wall and foundations. CSP is a 'new way of working' for general practice and involves changes to attitudes, skills and day to day organisation of work, which all need to be introduced at the same time to be effective.

The overall aim of the project was to implement patient centred care and support planning (the centre of the house) as routine care in all Gateshead General Practices, for patients with a defined set of multiple LTCs. There is an accompanying evaluation report that outlines the evidence and impact of care and support planning in Gateshead.

3.1

Roof Organisational processes

Care and support planning (CSP) is a systematic process to ensure that people living with one or more LTCs have better, solution orientated conversations with health care practitioners focused on what matters to them. The care and support planning process and steps is detailed below:



This includes General Practices establishing:

- An integrated recall system for patients with multiple LTCs e.g. birth month recall
- an information gathering appointment for relevant disease surveillance (if required);
- sharing the relevant information (e.g. test results) and preparation prompts with the patients in advance of their review appointment
- a review appointment which involves a care and support planning conversation between the Patient and Health care professional.

These processes support the General Practice QoF (Quality outcomes framework) requirements for long term condition tests and an annual review, however there are organisational and process changes required to implement a CSP approach.

The Outcome the CCG aimed to deliver for the roofs 'organisational processes' was:

Develop the local infrastructure and provide support to implement and embed care and support planning as routine in general practice

To enable this outcome, where possible more generic 'enablers' were developed for all practices in Gateshead to reduce the complexity and avoid duplication. This was particularly relevant for the IT developments and these were driven by the local Gateshead GP Federation (CBC Health) and CCG clinical leads, these included:

- A central call and recall system for patients with multiple long term conditions which is available for practices to purchase from the GP Federation. This has helped practices with the challenge of moving from a single condition to multiple condition recall system although some practices have also done this in house by developing their own searches.
- Development of a 'Master Template' for EMISWeb available to all local practices to aid information gathering and coding.
- The YOCP resources to present the results and agenda setting prompts were combined for people with different multiple LTCs and support was provided to practices to set this up on their practice systems to auto populate the results and generate relevant information to share with patients in advance of their CSP appointment.

As individual practices have their own ways of working, processes and staff dynamics; specific organisational set up needed to be determined and agreed by each practice team. Although all practices are delivering CSP conversations, their internal processes differ, for example practices have different processes for allocating appointments. Learning

from the project identified that the practices most successful in embedding CSP for their patients with LTCs, all have a year of care working group which meets to see how things are going, work through any issues and any new ideas. Such groups benefited from having a membership drawn from across the practice team including both clinicians and administrative staff.

The CCG included the development of long term condition care (steps for implementing CSP) as part of their Practice Engagement Project (PEP) in both 2015/16 and 2016/17; this is a CCG mechanism to incentivise change and development within general practice. The PEP set out the vision and expectations from the CCG, for its member practices LTC management and this includes quarterly facilitator visits and support. The 2015/16 PEP included awareness raising sessions for practice staff on CSP, and the requirement for practices to prepare for CSP with a focus on the practice organisation systems and training. The year two (2016/17) PEP involved practices completing the year of care self-assessment and delivering an action plan to fully implement care and support planning using year of care approach.

Learning and tools from the early adopter practices in Gateshead were shared alongside practice learning and sharing events focused on CS&P to encourage and support practice managers to share ideas, challenges and solutions for implementation. The table below provides an insight into the learning gained from implementing CSP.

Practice Staff Feedback – Tips for Others (from CSP Training Session)

- For admin team to arrange appointments instead of sending a letter stating the patient has to make their own appointment
- Results on yellow paper/ coloured paper to print patient information onto (to help the information stand out to patients)
- Get all members of staff involved in YoC understanding their role and how the process works
- Regular meetings for team to share information and pass on any problems
- More admin involvement re appointment reminders
- Involve HCAs more re home visit preparation
- Focus on good/positive points initially then lead into problem areas in CSP appointment
- Emphasise it's not an opportunity to tell patients off
- Conditions advice leaflets given out at first information gathering appointment
- If patient forgets ask receptionist at booking time have you brought yellow paper – print out again on yellow paper to reinforce idea

Reflections on the approach to the *Organisational Processes*

The benefits:

- Working at a bigger scale to develop the IT and enabling infrastructure has worked well and reduced the burden on individual practices.
- Anecdotally patients have fed back they like having their review in their birthday month as they know when they should expect it.
- The LTC master template supports the separation of information gathering and conversation with the review appointment.

The challenges:

- Defining the patient cohort for multi morbidity and developing the practice searches that relate to this can be challenging.
- The process to deliver CSP contains a number of steps; if there is an issue with one part it impacts on the whole process and potentially impact the outcomes for the patient. Embedding and sustaining system change can be a challenge and particularly influenced by staff changes.
- CSP requires process changes within General practice and understandably the practicalities are often the initial focus. It is important the philosophy and ethos behind the different conversation is not lost.

Learning from our experience:

- All practices have different starting points and their journey will reflect this. It is important to be flexible to account for this.
- To make C&SP work well all elements need to be in place with everyone fulfilling their role; a whole practice team approach works best
- It takes time for practice teams and patients to adapt to this new way of working
- The administration process to develop one multi morbidity call and recall system takes time as the transition takes place
- Within the first information gathering appointment, preparing the patient for the process and results letter is vital. One practice has this on yellow paper to differentiate this from other paperwork and patient feedback has been positive as it helps differentiate it from other paperwork.



Top Tips

- A practice team approach really helps with the set up and ongoing organisation and a regular team meeting with representatives from admin, HCA, Nurse and GP is really valuable.
- A dedicated admin officer to have overview of this process in practice helps the organisation process
- A process of triaging results to identify the most appropriate length of appointment and health care professional can work well.

3.2

Right Wall: Health Care Professionals committed to partnership working

Care and support planning is a proactive approach to LTC management that encourages patients to talk about what really matters to them, to identify goals and agree an action plan. A change in the consultation is fundamental to care and support planning and to enable links with activities in a supportive community. The 'health care professional committed to partnership working' is key to this approach and forms the right wall of the house.

The outcome the CCG aimed to achieve for the right wall 'HCP committed to partnership working' was:

HCPs have the knowledge, skills and confidence to deliver care and supporting planning and support self-management



In order to engage, train and support health care professionals in the year of care approach it was felt clinical leadership and local clinical expertise would best support engagement from practice and the subsequent roll out of CSP. The CCG LTC Clinical Director (who is also a GP) and CCG Lead nurse have played a significant role in developing the strategic and operational approach; utilising their knowledge, experience and understanding of LTC management in practices. Alongside this, six Gateshead clinicians (two GPs and four nurse practitioners) were recruited and trained as local 'Year of Care trainers' and formed the basis for the training and support strategy.

- At the beginning CSP taster sessions (designed by YOCP) were delivered to staff groups at the General Practice 'time out' training session; the taster session aimed to share the philosophy and overall aim of CSP. Practice teams mapped the current patient pathway and used the YOCP 'Elsbeth Game' to help experience LTC care from a patient perspective.
- Practice staff were offered 1.5 day Year of Care Partnership training and since January 2015, eight rounds of training have been delivered. Six were delivered by local trainers and this local model has evaluated very well. The trainers were carrying out

CSP consultations in their own practice and could relate with the experiences and challenges by practice staff as well as having an awareness of the local information and support available. This added great value to the training delivery and aided a sustainable HCP led approach across Gateshead practices.

- In September 2017, a one day training course (designed by YOCP) was introduced and will be established as an ongoing training offer. The table below outlines the number of staff (and staff groups) who have attended the YOCP training.
- Relevant additional training sessions were provided in the bi monthly practice 'time out' training events and this included more engagement/introductory sessions, HCA workshops and consultation training.
- There are regular diabetes and respiratory masterclasses available to practice staff locally to enable them to develop their knowledge in managing long term conditions.
- Following on from the YOCP training, the rate of implementation within practice varied and one to one support from the trainers was offered to support practices with implementation.

Total number of Gateshead practices trained (January 2018)	31/31
Total number of practice staff trained	153
Including:	
GP	36
Nurse Practitioner	17
Practice Nurse	56
Health Care Assistant	25
Admin/Manager	15
Other	3

Alongside a focus on skills for CSP, the CCG has supported training programmes to address any skills gaps in the current workforce due to the previous disease specific model of LTC management in general practice; enabling a more patient centred approach. To support a 'more than medicine' approach and awareness of community activities HCPs have been kept up to date with the development of social prescribing and the local directory of services 'OurGateshead'.

Reflections on our approach to Health Care Professionals Committed to Partnership working

The benefits:

- Gateshead based YOC trainers (clinicians in general practice) provided consistent messages and support to practices and were able to feedback intelligence and learning to the implementation group.
- YOC training and delivery has identified training needs and local TITOs (Training sessions) have provided a good mechanism to address wider training needs.
- YOCP have developed a training course and suite of supporting materials specifically designed to achieve the culture shift required for care and support planning.

The challenges:

- The introduction of multi morbidity clinics (in place of single conditions) and CSP can be challenging for health care professionals – taking HCPs out of their preferred specialism and changing the nature of the conversation is a big shift.
- Overall engagement with the year of care approach has been mostly positive but an area that practices/ HCP feel unsure about is sending results and agenda setting prompts. The training and sharing patient/ HCP stories can help to shift this perception.
- We offered Gateshead wide training where possible but some elements (particularly the administration process) are determined at a practice level and can't be offered across all practices.
- The time from training to full implementation has varied across practices and direct facilitation support may have been beneficial for some practices; in some cases it has been challenging to get YOC trainers into practice.

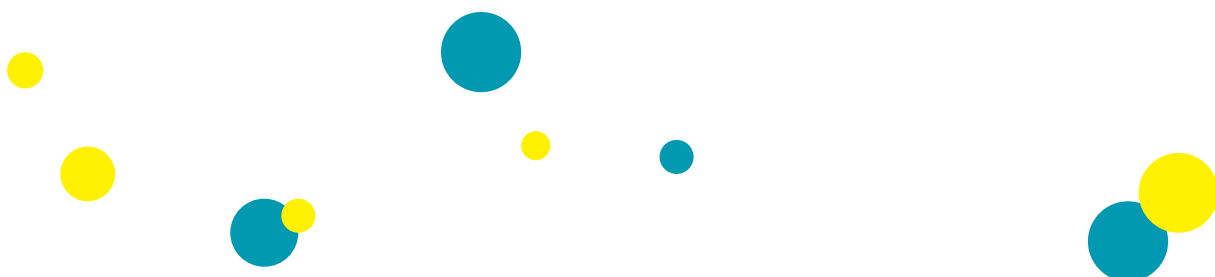
Learning from our experience:

- Clinical leadership and clinical champions are key to engaging HCP and practices. We have built in clinical leadership and have developed the role of Gateshead Year of Care trainers to support practices. Within each practice, clinical leadership and engagement is vital and it is dependent on individuals and situation within the practice.
- Process works best when all staff groups in a practice have an understanding of CSP and knowledge of the process

- Supporting HCPs to realise the approach is more person centred but the HCP story is still as important.
- Changing this way of working is a long term strategy. It is not a failure if a patient doesn't engage in year one, use time to listen to concerns and explain and they may engage in year two. It is a cultural change for patients too and don't be disheartened if patients don't return the results form.
- Care navigators and/or community link workers very important as part of the wider offer and link to community activities.
- On-going training offer is required; this includes the one day course with the 'philosophy' and also addressing 'other' training needs.

Top Tips

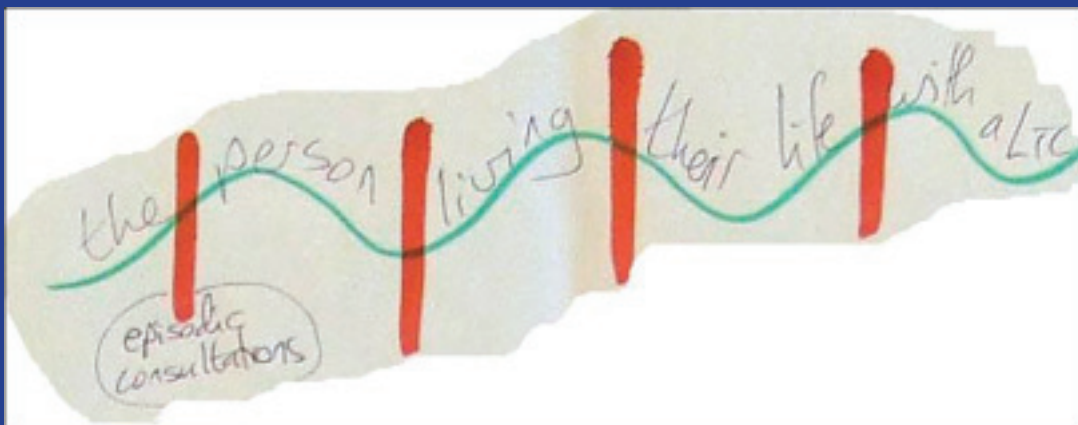
- Each practice needs champions to drive CSP forward.
- Carrying out training needs analysis to inform wider training needs can help prepare the team. The topics identified on the Year of Care results template can be used as a template.
- Consider local training days to up-skill HCPs in different LTCs early in the process



3.3

Left Wall Engaged and Informed patients

The Year of Care (YOC) programme recognises that people who live with long term conditions (LTCs) make the majority of the decisions that affect their lives day by day (green line in the figure below), spending only a few hours each year with a health care practitioner (orange bars in the figure below). The YOC approach seeks to transform this brief contact into a meaningful and useful discussion via systematic care and support planning and enable links with activities in a supportive community.



The underpinning philosophy is:

- People with LTCs are in charge of their own lives and self-management of their conditions and are the primary decision makers about the actions they take to manage these.
- People with LTCs bring personal assets, strengths and abilities to develop solutions. The CSP process supports them to articulate their own needs and decide their own priorities.
- The care and support planning conversation is a meeting 'between experts' which brings together the lived experience of each person and the technical expertise of the practitioner.
- People are much more likely to take action from decisions they make themselves rather than decisions that are made for them.

The outcome the CCG aimed to deliver for left wall – ‘engaged and informed patients’ was:

People with more than one long term condition have care and support planning as routine care and gain the knowledge, skills and confidence to self-manage



The central approach to support the ‘left’ wall has been the development of the Gateshead long term condition patient reference group, established and led by the part time LTC Patient Involvement Officer. The group meet regularly and is made up of people from Gateshead with LTCs and over the three year project their role and remit has evolved. Group members have developed a good overview of the aims of care and support planning and are in a great position to challenge and develop solutions together.

The activities of the LTC Patient reference group included;

- Developing a leaflet and poster to explain the care and support planning process to help practices communicate CSP to their patients.
- Patient experience of care and support planning has informed the monitoring and guidance issued to practices from the CCG. Acting as a live feedback loop.
- Informing changes on OurGateshead; encouraging an emphasis on activities rather than groups. As well as a simpler way of searching information and signposting to health information were made to help the content meet the needs of residents.
- Providing feedback about the issues people with LTC face trying to obtain repeat medication and working with medicines wastage group.

The members of the group have continually provided insights into living with LTCs and reiterated the desire to be informed and empowered; reaffirming the value in care and support planning for people with long term conditions.

Patient Feedback on care and support planning consultation

"The nurse was very helpful and understanding about my concerns making me feel more positive about my health control. She was also very good in assisting with the setting of goals."

"I came from the appointment informed and more motivated than when I first went in. The nurse gave me useful information in an informative way."

"Answered all my concerns and very caring, felt a lot better after consultation."

"Nurses had explained that appointments for reviews were changing. I liked having results in advance. I liked being able to say what was important to me at the beginning. I liked having a record of what we decided to do to help me stick to a plan. I know the nurses at the practice well, felt we both had more time today which was nice."

"Very knowledgeable, empathetic and able to put my mind at rest with my current conditions. I now have a plan to carry out exercise and diet needs, to keep my condition at bay and avoid any deterioration. Well pleased, in fact it was brilliant!"

"After discussing things it gave me a better perspective of where I wanted to be and do."

"Made me think about accepting help at home which might make my health better in the long run. Had time to talk and answers to my problems are not more medicine. Been referred to a community worker who may be able to help me sort out my home."

"Liked seeing the results on paper didn't feel rushed like it sometimes does in the surgery."

"Nurse is sort of person who is friendly and easy to talk to. She listened and did not rush through things, if unsure, explained you didn't need to be concerned and went through your concerns again, all in all a pleasant person and very approachable."

"Talked about some very personal problems - have been referred to some people who might be able to help me deal with the personal problems. Felt someone is taking notice."

Reflections on our approach to engaged and informed Patients

The benefits:

- The LTC Patient Reference Group have grounded our approach to care and support planning with Gateshead patients and connected the philosophy into reality; providing a patient perspective.
- Patient input on the proposed wording when we co-produced leaflets and patient information on CSP.
- Members of the patient group have presented at meetings and events; sharing their experience of living with LTCs and aspiration to be more informed is a powerful part of the case for change.

The challenges:

- Practices are responsible for communicating to their patients (e.g. inviting patients to appointments and explaining the new three stage process) and they all have slightly different styles and systems. Where possible the CCG has provided best practice materials. There is an opportunity for practice patient groups to get involved in the operational elements at a practice level.
- If the CSP approach wasn't shared or understood by patients (especially during the first year) it led to some confusion and uncertainty about expectations of the appointments.
- Employing LTC Involvement Officer has given the focus and capacity to develop LTC patient reference group, however this isn't a sustainable model in the long term.

Learning from our experience:

- It takes time for patients adapt to this new working (as well as HCPs) and practices have anecdotally fed back that patients get more benefit in the second year when they've been through and understood the process.
- Getting patients involved in developing CSP is really valuable and worth the time in setting up. Being open on issues and challenges has developed our relationship and provided the opportunity to coproduce.



Top Tips

- Involve local patient groups early on in the process to help with implementation.
- Use the information gathering (preparation) appointment to inform patients about the new system, explain and show examples of the results letter to reduce anxiety and acceptance
- Patient experience and feedback can help ongoing improvement

/ Patient Case Study – Mrs B /

Mrs B is a patient in a surgery that has implemented the Year of Care annual reviews including care and support planning for patients with long term conditions. Mrs B was interviewed to gain the patient perspectives on the Year of Care implementation.

I had a heart attack quite a few years ago. I started to get some pains which I thought were related to my gastric problem, so I ignored them. Two days later I woke up in the middle of the night, with pain in my arm. The pains continued for several days but I kept saying 'oh I'm fine, I'm all right now'. After a few days when I was out shopping but felt terrible. By the time I got home I was fighting for my life. An ambulance was called and with the blue light sirens blaring, I was taken to the hospital. The staff were all in a line waiting for me outside the Freeman Hospital, They were fabulous. I had a couple of stents fitted and immediately felt better. '

A few years later I had another illness and was very unwell for many months. My illness meant that I was very inactive and I put on a lot of weight. I reached 12 stone 6, which is a lot as I am only 5'1". Also I can't get around as I should, because of arthritis in my hip. I have just had my annual review. My surgery offers a 2 stage appointment and I really like it. You have all the rigmarole with the health care assistant, getting weighed, blood pressure and blood tests. You have the results sent to your home and then come back to see the nurse a week or so later. My nurse is fabulous she puts you through everything and she asks you what you want to change in the next year. This is the second time I have had this type of appointment.

Last year, the nurse asked me what I would like to happen in the next year and how would I like to change things. I said I wanted to lose some weight as I was shocked when I saw what my weight was. Being so ill before and not being able to get around, I had piled on the weight. So I started the next day. I don't call it 'a diet' anymore, it's just healthy eating. Because I can't really exercise, I bought one of those little pedal bikes that you can sit on the sofa. And just started pedalling.

And it worked. Sometimes it was a pound a week or sometimes I went three weeks without losing anything. But I plodded on. At my appointment this year, I have lost three stone. I was a size 24 and I am now a size 14. So that appointment helped me a hundred percent.

Again this year I saw the health care assistant first, who weighed me, took my blood pressure and other tests. I had my results sent through the post. I knew to expect them and I was keen to know what my results were as I am 'dead nebbby'. It explained all the different things, what all the different scores mean, which is great. The front had things that I might talk to my nurse about. I put rings around what I wanted to discuss. This was good because when I got the form out at the surgery, I could go through with the nurse the things that I wanted to talk about. I thought it was good. Naturally when you go to see a doctor or nurse things slide right out of your head. This this was very handy. It meant I could talk about what problems I had.

My nurse is lovely; I was pleased that it was her when I went back for my second appointment. She is really supportive and listens to me. She went through everything on the form and asked how I was. I couldn't fault her. I never really understand about blood pressure but she talked me through all my results and what they meant. I was able to discuss all the things that I felt I needed to know, including all the things that I had circled. Like last year, she asked me what I want for the year ahead. I said I want to get to nine stone. It so annoying to have these arthritis pains in my hip and lower back that reduce my activity. But I am determined.

My annual review has been a good experience from start to finish. I would be very disappointed if it the style changed because I like it like this. When you get the letter with your results you can look at it and take it in. I still have the one from last year, so that I can check over how I am doing. That's why I asked about my blood pressure because it was different from the time before. My nurse told me that it had probably come down with my weight.

Gateshead Patient Reference Group

By Maggie Woodward, LTC Involvement Officer

THE AIM

In November 2015, Gateshead established a Long Term Condition Patient Reference Group to support the development of the Year of Care programme. This was established as part of Gateshead's desire to build a strong left wall of the HOC framework and the value of engaged and informed patients.

The Gateshead team, particularly the CCG LTC Portfolio Manager, wanted to find out from patients what it might mean in practice for patients to be encouraged to play an active role in their care and treatment. Also to discover from patients how primary care staff can enable patients to become activated in their care. From the outset, the idea was for this group to work co-productively with members of the CCG to identify important issues and bring about workable solutions. People with long term conditions such as heart problems, stroke, diabetes, hypertension and COPD were recruited to join in a variety of ways.

Although co-production was the aim, the starting point was informing and engaging the group so that they had an understanding of the ambition for the YOC programme. Gradually the function and expectations of the group formed as understanding and trust grew. The approach to the group was very open and flexible, acknowledging the group needed to develop their purpose together and this could not be imposed. It has taken time to develop but together we have grown into a partnership. This is different from individual issue based work with patients. We have found that the relationship is key – this is not a one off but an enduring relationship that becomes a force for action and doing.

THE PRACTICALITIES

Over the last 2 years membership has grown to approximately 20 people. The group meets about every 4-6 weeks for 2 hours. In addition members meet outside of these meetings to focus on a particular issue or to attend/speak at events such as Time In Time Out.

The group chair and vice chair are patients and there is a strong sense of team spirit and collaboration. The meeting agenda is filled with items from developing a patient leaflet to providing the patient perspective on plans for medicines management. The work plan is currently being finalised for the focus for the next 6 to 12 months.

The Patient involvement officer works two days a week and has been funded from BHF House of Care project to support the development of this group. This has been beneficial as it has enabled:

- Time to recruit patients
- Time to communicate with individuals/the group outside of meetings and build patients' understanding and confidence, so that they are willing to join in. Once people are involved they feel sufficiently connected to take on additional work/responsibilities.
- Strong links between patients, CCG and the BHF House of Care project.
- Developing the agenda and ensuring the patient perspective is included and driven forward.
- Streamlined facilitation and information flow acting on discussions from the group and feedback of impact
- Connection to the CCG but not seen as a part of the CCG; able to take on board and direct/act on feedback.

3.4

Foundations: Commissioning

Care and Support planning brings together physical, mental and social health / care issues in a single care and support plan however many conditions or issues the person may live with.

This includes :

- linking traditional clinical care with support for self-management
- signposting the person to activities within a supportive community
- coordinating across health and social care

In order to deliver CSP the appropriate foundations/ commissioning needs to be in place. This is 'system wide' and includes a number of dependencies.

The outcome the CCG aimed to deliver for foundations – 'commissioning' was:

People's holistic needs are addressed and they are supported to access voluntary and community support if they would like.
The CCG and partners commission services which meet the needs of people with CVD and LTCs.



The CCG has funded practices to set up and deliver multi morbidity care and support planning clinics over and a three and a half year timeline; enabling the development of staff roles, training and system changes in recognition of this shift in focus.

Alongside this, the social prescribing strategy has been developed (available on <http://www.newcastlegatesheadccg.nhs.uk/wp-content/uploads/2016/10/Social-Prescribing-Strategy-1.pdf>) and the social prescribing model across Newcastle and Gateshead is being developed further with the emergence of care navigators/ social prescribers.

An area of clear overlap for social prescribing and CSP is access to a menu of services; to support people to sign post to activities in the community. OurGateshead (accessed via www.ourgateshead.org) is a community website sharing information on local activities and events. The CCG and Public Health collaborated on a development work including locality area pages, practice pages and function to run a print list of activities and training has been provided for practice staff.

Reflections on our approach to the commissioning foundation

The benefits:

- There is a synergy between practices fully engaged with the philosophy of CSP and social prescribing – enabling the ‘full’ pathway to be in place.
- Taking a full system approach through a multi-disciplinary steering group with representatives from the CCG, BHF, practices, voluntary sector, Public Health and YOCP has enabled a joined up approach.
- OurGateshead is available to provide information about local services and this was established prior to project and a brilliant platform to build on.

The challenges:

- The Local Authority decommissioned Live Well Gateshead in April 2017, a service providing lifestyle support and this was an important referral route for HCPs.
- Financial incentive can encourage practices to raise awareness and adopt care and support planning, but there is a risk practices disengage if/when the funding stops.
- Balancing the fidelity to the care and support planning approach and practice autonomy and flexibility has been a challenge.
- CSP is a long term approach which doesn’t necessarily fit with current short term QIPP savings and pressures. The case for change needs to be realistic.

Learning from our experience:

- Having an understanding of what is available in the community can be a concern for HCP and clinicians need support with social prescribing. Community link work or navigators can be central to this.
- ‘Monitoring’ the fidelity of CSP is challenging and a balance of quantitative and qualitative information helps develop a clearer picture.



Top Tips

- Work collaboratively across your local geography as the whole house of care framework needs to be in place to support patients to self-care and this can’t be delivered by one organisation.
- Continual training is necessary to embed and sustain CSP – a training offer should be considered alongside any commissioning decisions

4

Practice Implementation Progress

The case study has considered the 'house of care' as a framework and largely provided a CCG system perspective however CSP is actively delivered by a practice and the success is dependent on the practice. As part of the House of Care project, seven practices have participated in the evaluation and this has included a focus on the practical implementation and delivery of CSP. The seven practices volunteered to be early adopters and also represent different geographical areas, levels of deprivation, and size of practice.

The table below provides further contextual information on the list size of the practice, how long term condition annual reviews were previously delivered and when they started implementing CSP.

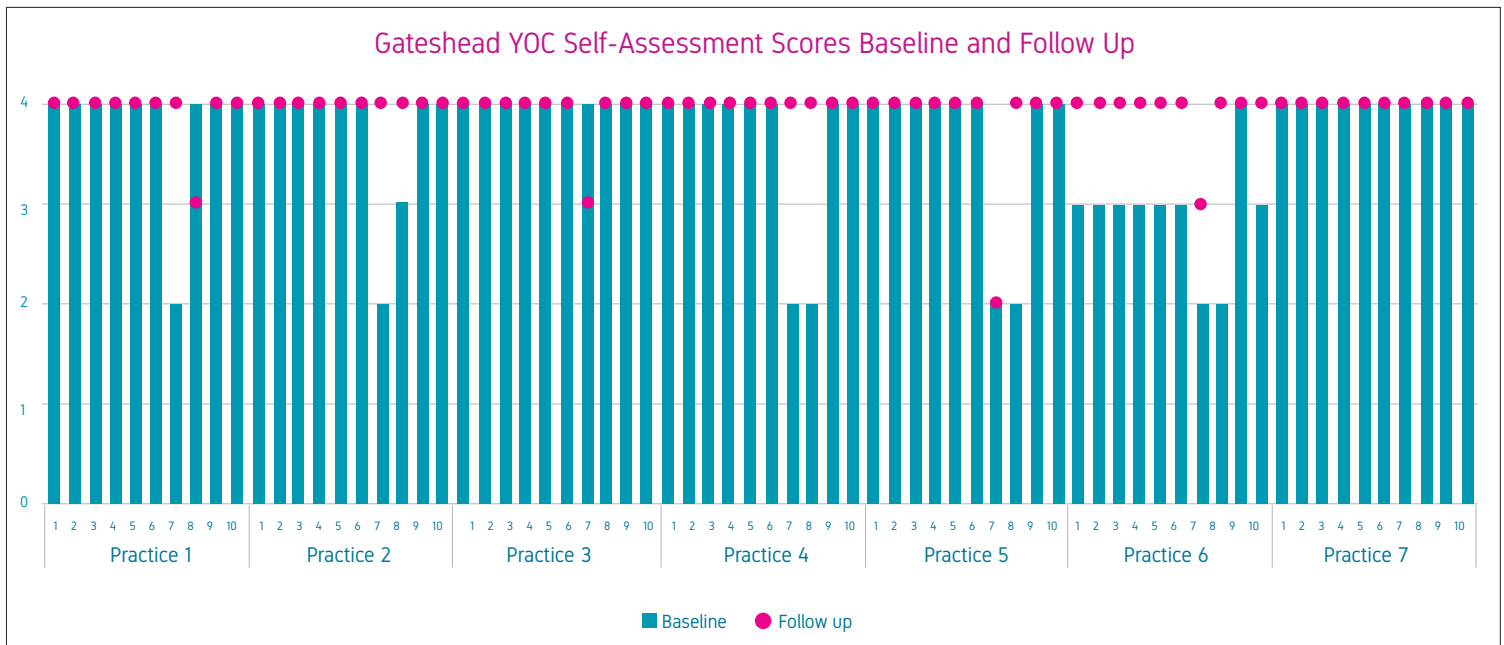
Practice Number	Practice Size (small is up to 4000 registered patients, medium is 4000 to 10000 registered patients and large is 10000 plus registered patients)	Prior to CSP in multi morbidity clinic – practices delivered:	Care & Support Planning Go Live Date
1	Medium practice	Single long term condition clinics	September 2015
2	Medium practice	Single long term condition clinics	June 2015
3	Large practice	Single long term condition clinics	July 2015
4	Large practice	Multi morbidity clinics but did not prepare the patient for the review	April 2015
5	Small practice	Single long term condition clinics	January 2015
6	Large practice	Single long term condition clinics	March 2016
7	Small practice	Single long term condition clinics	September 2015

The practices have different patient cohorts for the multi morbidity clinics; all practices were asked to incorporate as a minimum patients with two or more long term conditions including Ischemic heart disease (IHD), Diabetes mellitus (DM), Cardiovascular disease (defined as patients on Stroke or TIA registers), Peripheral artery disease (PAD), Asthma or Chronic obstructive pulmonary disease (COPD) however some have taken a more extensive approach with a broader patient cohort.

4.1 Year of Care Quality Marker

The evaluation practices completed the Year of Care quality marker in summer 2016 (baseline) and in autumn 2017 (follow up). This includes 10 questions on the key areas for CSP and acts as a tool for practice teams to review where they are currently and where they'd like to be in the future by marking themselves on a scale of 1 to 4.

The graph below demonstrates their current baseline position (in summer 2016) and 12 to 18 months later their current follow up position (autumn 2017).

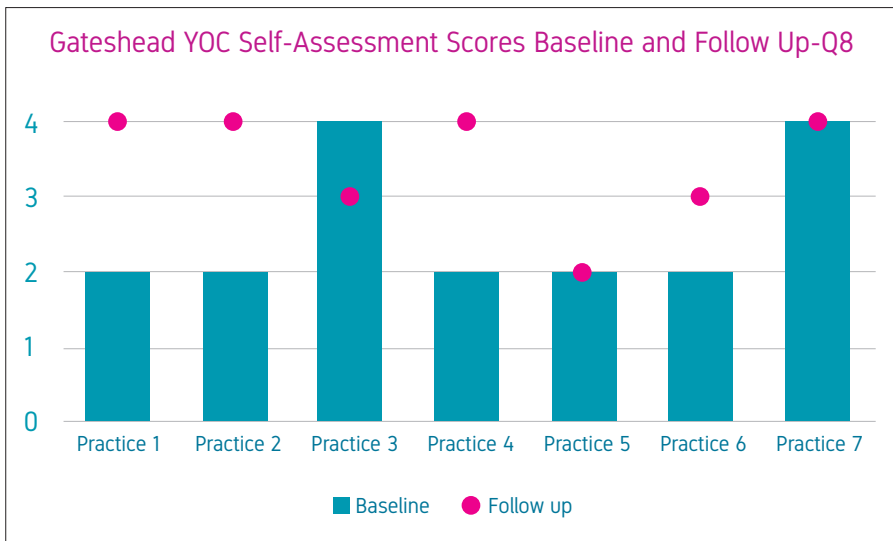


The evaluation practices rated their follow up current position as a '4 -cracked it' for questions one to six and nine to ten; indicating that the practices felt they had achieved these elements. The majority of the practices scored 4 in the summer 2016 baseline as practice set up have been underway prior to the baseline measures. Nonetheless, this demonstrates significant achievement from the practices.

As outlined within the graph below question 7 and 8 shows a bigger variation.

Question Seven Consultation skills - within the LTC Review Appointment

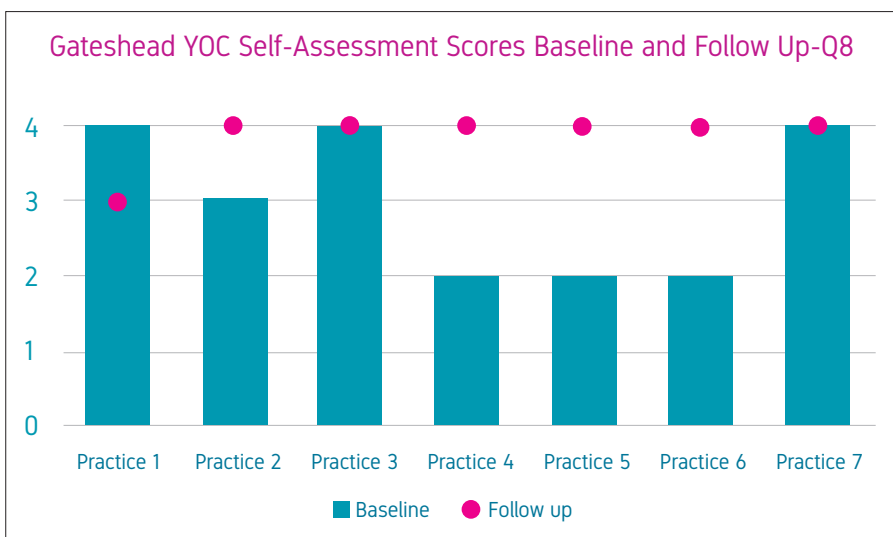
Evidence is available to demonstrate that consultations are patient centred and truly collaborative. Questionnaires and self- assessment tools are available and used for a predetermined number of consultations / patient visits.



A number of practices feel their consultation skills have improved since the baseline suggesting the consultation skills takes longer than the set up than the organisational elements. In order for a practice to achieve a '4' they need to have patient questionnaires as evidence which may affect the scoring level. The consultation is a significant part of CSP and there needs to be ongoing training and support for the health care professionals carrying out the consultation.

Question Eight Goals and Action planning:

The clinical record shows that where appropriate a goal has been identified together with a specific action plan. If this was not appropriate in the conversation, evidence of the person's main issues or concerns and the options / solutions discussed for addressing this is documented. Plans also include condition specific self-management planning where appropriate



Similarly question eight relating to goal and action planning have increased since the baseline. This reiterates the importance of the training and support relating to consultation skills. The practice teams have provided some feedback on the successes and challenges of CSP during an Action Learning Set in July 2017.

Some of the successes include:

"Has changed the conversation we are having with every patient not just LTC – new way of consulting."

"Successfully embedded a culture in the practice that supports CSP among all disciplines."

"Has made us more aware of social prescribing."

"Opportunity to structure the recall system in the practice birthday month review working well."

"Nice to hear feedback from patients thanking you for being so thorough and treating as a whole person not a condition."

"Streamlines care for patients with multiple conditions and allows them to talk about what's important for them ."



Some of the challenges include:

"Having enough available appointments."

"Changes in staff and retraining."

"Maintaining list of DNAs/
chase ups for appointments "

"Admin leaving – huge shoes to fill. Raft of knowledge lost and re training needed."

"Re-educating patients and staff on YOC process."

"Time constraints for multi morbidity clinics due to practice population."

The evaluation practices have demonstrated it is possible to deliver CSP within multi morbidity clinics, and once the clinics are set up this can benefit the practice systems alongside HCP and patient experience. However, once implemented CSP still requires on-going development, with team meetings to refine systems and adapt the changes within practice to successfully sustain CSP.

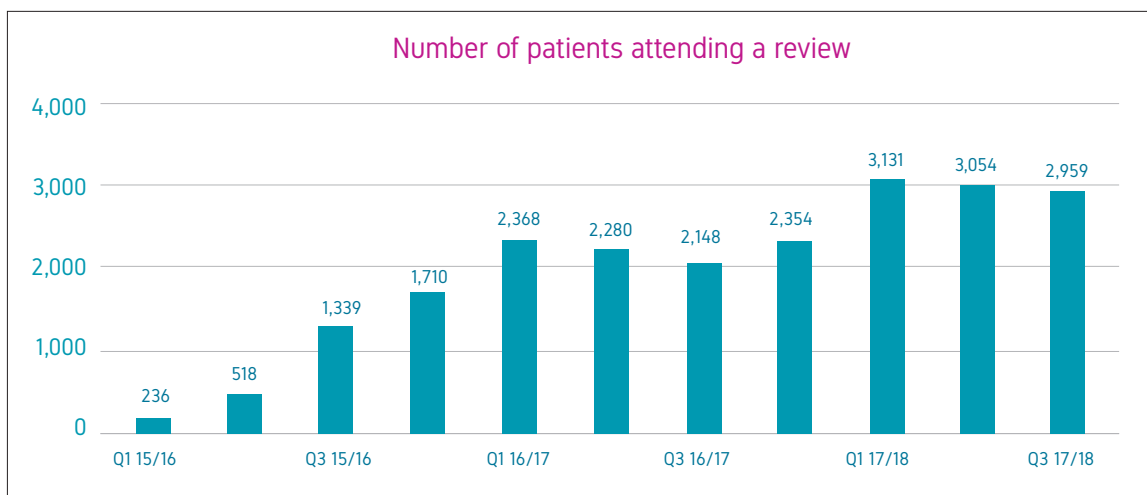
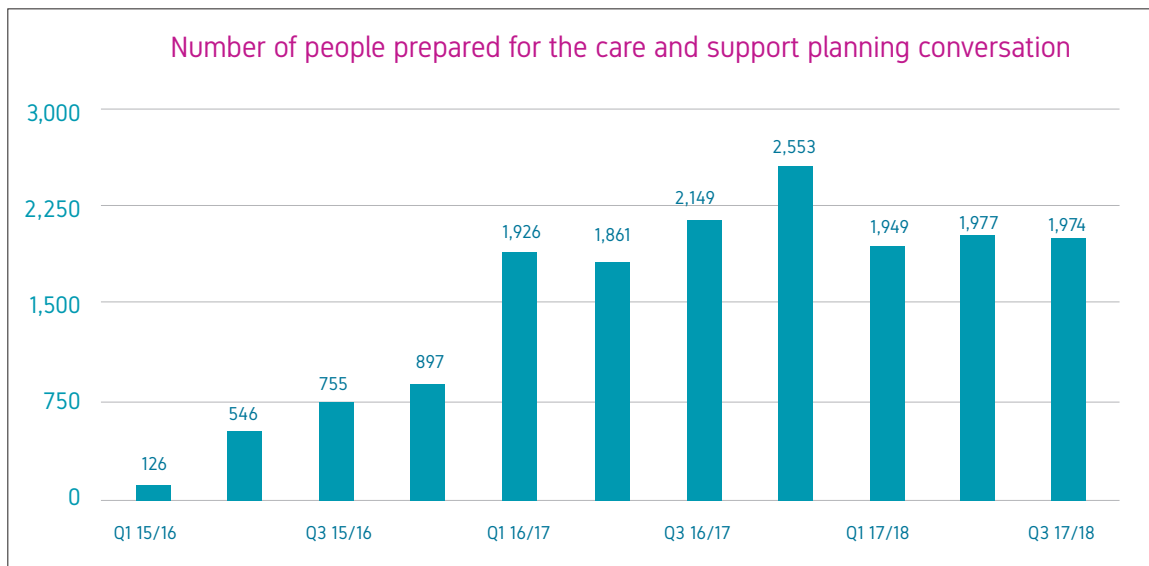
4.2

Multi Morbidity Clinic Data

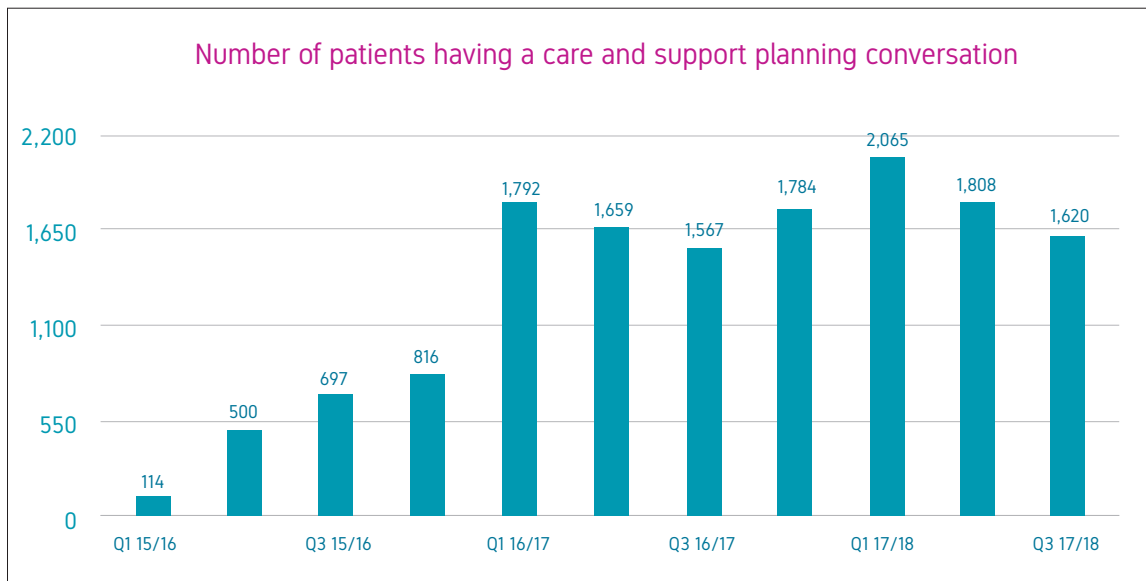
In order to help track the process and steps of care and support planning, practices were asked to code on their practice system each step of the care and support planning process within the multi morbidity clinics.

This process has been challenging within itself and it has taken a long time for coding to be reliable, and it highlights the complexity and interdependency of each element. Data can be a helpful tool, but cannot be solely relied upon to tell the full CSP process.

The graphs below are based on the aggregate data for the seven evaluation practices, from coding of each stage of the process (NB the information gathering data collection started in year two and not been included). The data is currently provisional, however outline positive information with an increase in care and support planning consultations within multi morbidity clinics from 2015 to 2018.



The above information has been correlated and combined to create the figure for the 'number of patients having a care and support planning conversation. This has been calculated based on each patient: receiving their results to prepare and having a review appointment.



The data shows that over the lifespan of the project (2015/17 to quarter 3 2017/18) 14,422 care and support planning consultation have taken place with long term condition patients. The full multi morbidity clinic data set can found in appendix two. The full evaluation report includes more robust HCP and patient feedback.



Next steps

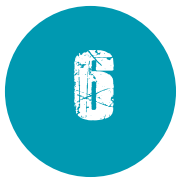


The BHF House of Care project has supported a long term strategy to transform care for people with long term conditions to enable support for self-management; making a difference to the individual, practice and system.



We hope this case study has provided an interesting insight into the implementation of care and support planning, and the practical information allows you to benefit from our learning. Our journey continues as we work to embed care and support planning as the new normal within general practice, enabling every patient with a long term condition to have the opportunity to be engaged and informed, and live their life to the fullest.





Acknowledgements



This work has been funded by the British Heart Foundation in their national House of Care programme and supported by Year of Care Partnerships. It has been a partnership approach across Gateshead with support from local stakeholders. We are grateful to all involved for their continuing hard work and support.

Appendix

1. Year of Care Quality Mark - Key Methodology Points

- The CCG made minor amendments to the YOC Quality Marker to make the questions specific to the Gateshead context and we named this the YOC Self-Assessment (insert copy below)
- Although the baseline was completed in summer 2016 practices had been working on the introducing care and support planning to varying degrees since January 2015 (18 months) and practices were delivering care and support planning so this was not an accurate baseline.
- Practices marked themselves on a scale of 1 to 4 highlighting the number which applies to the practice present position (in the table this is marked as P) and then highlighted the number they would like to achieve in the future over the next 6 to 12 months (in the table this is marked as F).

Table showing the Gateshead YOC Self-Assessment Scores summer 2016 (baseline) and Autumn 2017 (follow up)

Quality Mark Scores	1		2		3		4		5		6		7		8		9		10	
	Baseline Summer 2016																			
Practice	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F
1	4	4	3	4	3	4	3	4	3	4	3	4	2	3	4	4	3	4	3	4
2	4	4	4	4	3	4	3	4	4	4	4	4	2	4	3	4	2	4	3	4
3	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
4	4	4	3	4	3	4	3	4	4	4	3	4	2	3	2	3	1	2	3	4
5	4	4	3	4	2	4	3	4	3	4	3	4	2	4	2	4	1	4	3	4
6	4	4	4	4	3	4	3	4	4	4	3	3	2	4	2	4	2	4	2	4
7	4	4	3	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4

Quality Mark Scores	1	2	3	4	5	6	7	8	9	10										
Follow Up Autumn 2017																				
Practice	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F		
1	4	4	3	4	3	4	3	4	3	4	3	4	4	4	3	3	4	4	3	4
2	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
3	4	4	4	4	4	4	4	4	4	4	4	4	3	4	4	4	3	4	4	4
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	2	4	4	4
5	4	4	4	4	3	4	3	4	4	4	3	4	2	3	4	4	3	4	4	4
6	4	4	4	4	4	4	4	4	4	4	4	4	3	3	4	4	3	3	4	4
7	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4

2. Multi Morbidity Data Set

<i>Draft January 2018</i>	<i>Evaluation Practices Aggregate Data on Multi Morbidity Clinics</i>					
<i>Metric</i>	<i>15/16</i>	<i>16/17</i>	<i>Q1 17/18</i>	<i>Q2 17/18</i>	<i>Q3 17/18</i>	<i>17/18 YTD</i>
Number of people attending an information gathering appointment	NA	2,107	1,917	2,366	2,298	6,581
Number of people prepared for the care and support planning conversation (sent their results)	2,324	8,489	1,949	1,977	1,974	5,900
Number of people who attended a multi-morbidity clinic review	3,803	9,150	3,131	3,054	2,959	9,144
Number of patients having a care and support planning conversation	2,127	6,802	2,065	1,808	1,620	5,493
Number of patients referred to social prescribing	NA	NA	94	142	107	343

