The HOUSE Journal
The newsletter for the Year of Care Community of Practice
Issue 26
Round up from the Network Event

Welcome to The HOUSE Journal – Lindsay Oliver, Year of Care National Director

Energising, fun, thought-provoking and practical were some words participants used as they left the Year of Care Network Event last month.

The focus of this year's event was on using personalised care and support planning (PCSP) in primary care to support people with multiple long-term conditions, health inequalities and frailty.

It was heartening to hear the reinvigorated commitment to delivering high quality PCSP.

In this edition of The House Journal, we share the key learning and reflections from the presentations, groupwork and workshops that we delivered on the day. We look forward to seeing you at next year's event!

'It's just not PCSP' if it doesn't include...

We began the day by revisiting PCSP and the underpinning philosophy that acknowledges the role of the individual in managing their health and their life. We recognised that PCSP is an ongoing process of planned care which requires certain things to be in place to mark it out as being different to other forms of planned care and that it should be delivered by health and care professionals who have been trained to have PCSP conversations.

We all agreed that 'it's just not PCSP' if it doesn't include the following elements:

- Tests, tasks and assessments separated from the PCSP conversation
- Information/preparation (agenda setting prompt/routine results) shared at least one week before the PCSP conversation
- A conversation that is relational rather than transactional
- Patient and professional agendas both considered
- Forward looking, solution focused conversation based on the patient's own goals
- A 'plan' that summarises the decisions made together (determined by the patient and what will make a difference to them) including follow-up and support

Sharing lessons learned from the pandemic about PCSP

The CASPER study (Care and Support Planning Experienced Remotely)

During the COVID-19 pandemic general practice was forced to switch from face-to-face to remote contact, almost exclusively over the telephone. The CASPER study explored the experiences of practice staff delivering PCSP around this time and we presented the findings during the event.

The study found that disruption in practice systems during the pandemic made it more difficult for people to be prepared for PCSP and this impacted on the quality of conversations. The loss of face-to-face contact reduced the relational dimensions for both people and professionals which frequently resulted in more transactional and biomedically focussed conversations. It was much harder for health care professionals to deliver an 'equivalent' conversation by telephone, including maintaining the ethos of PCSP (equals and experts) and key elements of the conversation such as goal setting and action planning.

We learned that remote consulting works for a few people who are managing well, have an established relationship with the health professional and who find telephone consultations easy and convenient. However for most, especially those with multiple long-term conditions, complexity, psychosocial or practical needs, face to face conversations were more effective and more satisfying for staff.

For more details scan the QR code or visit: **CASPER publication**

Have we lost sight of long-term conditions?

We presented a blog written by Dr Becky Haines and Lindsay Oliver which curates the national policy, data and core messages about the status of long-term conditions in the NHS in England. We highlighted the focus on access and elective recovery which has been at the forefront of incentives and policy over the last 2 years and presented a strong case for proactive care for the 28 million people living in the UK with single and multiple long-term conditions.

We highlighted the plight of deprived populations who are more likely to develop single and multiple long-term conditions and associated complications earlier. We emphasised the treatment burden and costs associated with treating and managing multiple long-term conditions in disease silos and made the case for a primary care system that focuses on using PCSP to deliver personalised, coordinated, high quality clinical care focused on what will make a difference to individuals.


Have we lost sight of long-term conditions?

Becky Haines, GP at Glenpark Medical Centre and GP Advisor for NHS Year of Care Partnerships

Lindsay Oliver, National Director of NHS Year

July 2024

What gets in the way of delivering PCSP conversations for people with multiple long-term conditions?

As a group we recognised that we may not always be using the term 'multiple long-term conditions' to mean the same thing, and that within primary care QOF conditions are usually prioritised over other long-term conditions. We **heard from Kathleen**, a patient with multiple LTCs, who explained the many benefits of having combined condition reviews.

PCSP streamlines care processes by combining 'disease' reviews into a single process, saving time and money for both patients and practices. The event attendees acknowledged that staff who deliver PCSP conversations sometimes struggle with the idea of moving to this approach, however. To address this, participants stressed the importance of staff receiving communication skills training to build confidence so they could handle both the complex clinical and psychosocial aspects of patients' lives within a single PCSP conversation.

"Medicine decisions should be made hand in hand with patients"

Moving to a multiple long term condition PCSP approach	
Perceived challenges	**Enablers**
• Creating coherence within wider community and organisations • Getting everyone on board • Time to get together to reflect • Feeling the need to be an expert in everything (and understanding this is not necessary) • Practices think patients wouldn't like it • Nurse confidence and expectations • Out of nurse comfort and regulatory zone • Listening vs. intervention	• Policy and drivers • Educating and engaging the wider team • Single IT systems that are flexible/accessible to everyone • HCA role – identifying early issues at information gathering • Triage and supervision/support • Preparation for patients and professionals (saves time and helps prioritise) • Training in PCSP consultation skills • Evaluation to understand benefits for people and professionals

Using the Year of Care approach to PCSP to deliver proactive care – learning from a regional project

This session detailed learning from our project in North Cumbria focusing on the delivery of proactive care using the Year of Care approach to PCSP.

We outlined the proactive care process (focusing on frailty), that was developed and tested during the project along with key learning and recommendations that were also shared in our **previous newsletter**.

A practitioner perspective: moving to multiple LTC conversations

Frances Ashcroft, Primary Care Practitioner at Glenpark Medical Practice, **shared her reflections** on how she has developed confidence and competence to move from single "disease focused" condition reviews to having PCSP conversations with people with multiple long-term conditions.

Workshops

The team delivered three interactive workshops which were identified in feedback as the *"standout sessions"* of the event. Key learning from the workshops is below.

Workshop 1 – Creating the conditions to deliver personalised proactive care for people with frailty

This workshop focused on frailty as a risk factor of living with multiple long-term conditions and the value of considering this within PCSP.

We explored the benefits of screening for signs of frailty as part of information gathering using tools including the Clinical Frailty Scale and questions about falls. Patient preparation tools for those living with frailty were also shared, with groups exploring how to include frailty within the conversation at different stages of later life. There was emphasis on future planning, highlighting the value of written plans that include goals for living well, managing exacerbations and making decisions about future care.

"Biography over biology"

Some of the key learning included:

- Increased awareness of the risk factors for developing frailty, such as polypharmacy, obesity, low levels of physical activity and social deprivation
- Importance of recognising early signs of frailty during face-to-face appointments. This may include slowed walking speed, exhaustion and unintentional weight loss
- The value of having personalised conversations that focus on the things that are most important and will make the most difference
- Awareness of preventative interventions that can support those with frailty to live better for longer
- Evidence suggests that medicines optimisation, regular physical activity, and environmental modification can all help; staying socially connected is also important
- The value of having a written plan that details decisions about self-management and future health and care

"I had a real light bulb moment…about frailty and what we need to add to our PCSP"

Workshop 2 – Building practitioner confidence in having multiple long term conditions

This workshop considered how we use the PCSP process to deliver high quality clinical care and distil down a manageable agenda for the PCSP conversation. Some of this is enabled by the process and some by ensuring that practitioners receive adequate training in PCSP conversations, including feeling confident to prioritise patient and professional agendas, alongside training in a range of long-term conditions, psychological wellness and social issues.

Completing lengthy IT template were seen as a potential barrier to PCSP conversation. Making sure most of the data entry happens at information gathering was seen to be very important as was consultation skills training to help structure the conversation and keep it patient focused.

The PCSP process supports the patient and ensures they get to the right practitioner for the issues they wish to discuss at their PCSP conversation in the following ways:

- Ensuring most of the disease monitoring/QOF and all task-based work is completed ahead of the PCSP conversation
- The HCA at the information gathering visit identifying early patient issues and ensuring these are known to the clinician at triage
- Triage by a senior clinician is an important step for those with multiple LTCs, not only does it help to review results and patient concerns, but urgent issues like the need to repeat an eGFR or organise a lying and standing BP can be arranged ahead of the PCSP conversation
- Triage can support learning and development and ensures people see the right professional, with enough time to discuss and plan for issues that concern the patient and professional
- Patient preparation saves time in sharing information during appointments, and this helps patients prioritise issues they want to discuss
- During the PCSP conversation having the skills to link common issues together and focus on one or two priorities is a critical skill for health care professionals
- Recognising PCSP in an ongoing process with review - you can't do everything every time - and it's best to focus on a few things and do those well

Workshop 3 – The role of PCSP in supporting people with health inequalities

Health inequalities, health inequity, health literacy and the social determinants of health are interrelated descriptions of both avoidable and unfair differences in the experiences and outcomes of distinct groups, and the characteristics (geography, gender, ethnicity, education, wealth etc.) that give rise to these.

People who live with health inequalities often have worse experience of care, develop multiple long-term conditions earlier and have poorer health outcomes. The impact of non-health related factors is often underestimated by health care professionals and can be difficult to address through conventional health system approaches.

The PCSP approach with its focus on a more holistic view of people can be an opportunity to identify and support people who live with health inequities:

- Administrative staff can support access, liaise with people individually and make appropriate adjustments to appointments enhancing engagement with the PCSP process
- The health care assistant can help people understand the process and signpost to social prescribing where relevant or/and encourage people to raise issues within their PCSP conversation
- Preparation for PCSP (the agenda setting prompt) can help people to identify non-medical issues that might be affecting their health
- PCSP conversations take a biopsychosocial approach exploring the patient's story and can help people to make plans that work for their situation
- Using 'More than Medicine' through social prescribing or non-traditional approaches can support people with long term conditions to flourish

For more details scan the QR code or click here.

What are the key things that make personalised care and support planning different to disease specific annual reviews?