Year of Care Gateshead: GP practices combining health reviews using care and support planning

Summary

Combined annual health reviews in general practice with care and support planning driven by what matters to the person involved, their concerns and questions. For people with multiple conditions a single care plan is developed with their health care professional which can include linking people into practical support and activities in the community.

Main points

- Started to re-think approach in 2013 and CCG published a new long-term conditions strategy
- Worked with Year of Care Partnerships which provided expertise and resources and then trained staff and directly supported practices to adopt the approach
- Project manager appointed, clinical lead identified and steering group set up including supporting a patient reference group
- Joint funding from the CCG and British Heart Foundation helped seven early adopter GP practices get started in in 2014
- Work now extended across Newcastle and Gateshead

Context

Gateshead is located on the southern bank of the River Tyne, directly opposite Newcastle. The borough stretches almost 13 miles along the south bank of the River Tyne and covers 55 square miles. Just over 200,000 people live in Gateshead.

It is the 73rd out of 326 most deprived local authorities in England. Deprivation is concentrated in the urban parts of central and east Gateshead. There is a small ethnic minority population, largely based in central Gateshead, but their age profile is young, with low reported levels of obesity and other risk factors for diabetes. Central Gateshead is also home to a large and long-established Jewish community.

In Gateshead, two in every three adults carries excess weight and one in four are obese. There are higher rates of cardiovascular disease, diabetes and respiratory illness than the national average.

Year of Care Partnerships

Year of Care Partnerships is an NHS organisation, based within Northumbria Healthcare NHS Foundation Trust.

It was set up to offer commissioners and providers expertise, practical support and training to embed care and support planning as a more personalised way to deliver care for people with living with long-term conditions.

Developed in a pilot programme using diabetes as an exemplar, Year of Care Partnerships has now worked with over 40 communities to introduce care and support planning for people with long-term conditions.

What is care and support planning?

Care and support planning (CSP) is a way of changing routine annual reviews in general practice to ensure that the discussion is based on what is important to each person in living their life with long-term conditions.

It moves away from a tick-box approach and replaces it with a genuinely patient centred conversation bringing together what matters to the person and the technical expertise of the professional. Routine test results and a prompt to identify topics to talk about are sent to patients ahead of the session so they can prepare.

It often ends up focusing on solutions that link to community support or better coordinated care for people who may be attending multiple medical appointments. Issues, previously discussed in separate visits, are brought together into a single review process no matter how many conditions the person may live with.

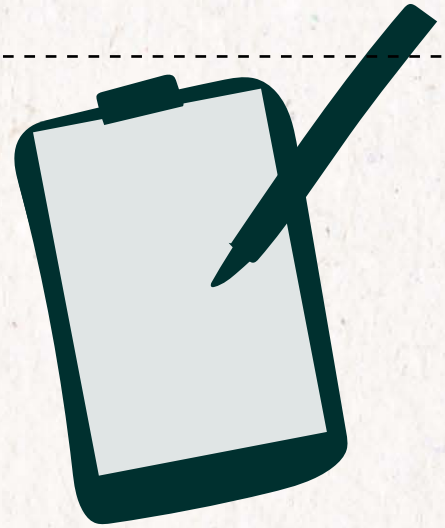
What was done?

Gateshead CCG started to rethink its approach back in 2013 with leadership from Dr Steve Kirk, Clinical Director for Delivery. A new long-term conditions strategy recognised that living with multiple conditions was becoming increasingly common and it wanted to place a greater emphasis on self-management and move away from treating people in disease silos.

In 2014 the CCG successfully applied to take part in the British Heart Foundation House of Care project. This three-year feasibility study aimed to transfer the learning about CSP in diabetes to people living with cardiovascular disease.

It was rapidly identified that many people had other long-term conditions and the concept of a combined annual review process for those living with multiple conditions was adopted.

A steering group was established with representatives from the CCG, Year of Care Partnerships, GP practices, voluntary sector representatives and public health. A patient reference group was also established to co-produce the project and a full time project manager appointed.



Year of Care Partnerships provided CSP training for practices. This involved an introductory day followed by a reflective half day some six weeks later.

Six practitioners were also trained as Year of Care trainers to champion the work and build local capacity and local clinicians developed disease-specific master classes for practice nurses and GPs to improve confidence in long-term conditions management.

Regular "Time Out" sessions involving all practice staff from the receptionists and admin assistants to GPs were used to ensure everyone was aware of the new approach and could answer any questions patients had.

What has been achieved?

As part of the evaluation of the feasibility study, 190 patients were surveyed. It showed:

94% found the preparation letter 'useful, 'or somewhat useful'

87% rated the care and support planning conversation as "very good" or "excellent"

81% were better able to understand their conditions

75% were better able to cope with their conditions

71% felt more able to self-care

It also found clinical processes such as blood pressure measurement were recorded more reliably and staff reported their skills and understanding of the challenges faced by those with multiple LTCs had improved.

Feedback from individual patients has been positive too. One said it helped them really understand their conditions whereas before they had felt "kept in the dark". Another said previously the reviews had seemed too focused on medicine whereas now there was "time to talk" and draw up strategies to improve their health and wellbeing.

Dr Rebecca Haines, the CCG's clinical lead for diabetes and GP partner at Glenpark Medical Practice, which was one of the early adopters, said: "The new approach has really made a difference to the way we work - it seems to have made it easier for patients to become more actively involved and talk about what matters to them.

"It is all about getting patients prepared for the annual review – we find it gets them thinking about what they want to discuss and that helps us make the most of the review."

Moving away from single disease reviews has also been important. Dr Haines said: "For example, there was one patient who had been coming for his diabetes review for years. It was only when we started doing care and support planning that he mentioned the thing he wanted to talk about was pain.

"He had come to see a doctor a few years ago and was told it was just wear and tear and nothing could be done. He had not bothered to mention this again despite worsening symptoms and by then had quite advanced osteoarthritis. We were able to help and support him much better from that point on."

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– LINDSAY OLIVER, YEAR OF CARE PARTNERSHIPS NATIONAL DIRECTOR

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What lessons have been learned?

The work of the early adopters has taught Gateshead several key lessons, particularly in terms of preparing for the care and support planning combined review.

People are invited for a review in their birthday month, making it far easier for everyone to remember when it is due. People initially attend an information gathering appointment where a healthcare assistant completes a range of tests and assessments at a single appointment for all the conditions the person lives with.

This then allows for the important step of preparation - people are sent a pack including their routine test results, which includes depression screening and asks people to identify issues that are impacting on their health, such as housing and loneliness.

The idea is that people can have a think about the things they wish to discuss and have the same information as the doctor or nurse. This gets sent to people one to two weeks before the care and support planning conversation.

In one of the practices the admin team thought it would be a good idea to send this preparation prompt on yellow paper so that it would be easy to distinguish from other pieces of information. This proved popular and people often now talk about their "yellow letter".

The care and support planning appointment allows a little more time for a discussion based on the concerns and questions that the patient has. It brings together traditional clinical issues with what is most important to the individual as well as creating an opportunity to think about the ways in which people can manage their own health and be supported to live well with their multiple conditions. The aim is to create a single care plan no matter how many conditions the person lives with - and this can include linking people to practical support and activities in the community through social prescribing link workers.

What is happening now?

The initial project lasted three years, running from 2014 to 2017. During this time Gateshead CCG merged with Newcastle CCG and work is under way to roll out the work across general practices in both areas using incentive payments. So far 59 out of 63 local GP practices are taking part.

Practices are also increasing the number of long-term conditions they include, extending it to involve people living with ageing and frailty and, in some places, people living with musculoskeletal conditions.

Year of Care Partnerships national director Lindsay Oliver says the work done in Newcastle and Gateshead has been "magnificent". "They're a real beacon. They have put the right structures in place in terms of support and training, which has made it much easier for practices to change the way they work and sustain it."

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