C&SP Care and Support Planning for Multi-morbidity; *Making it Routine in General Practice*

Authors: Elizabeth Bryant, Sarah Chapman, Deborah Dews, Dr Rebecca Haines, Samantha Hood, Dr Stephen Kirk

WHY?

Why use Care and Support Planning (C&SP) for multi-morbidity?

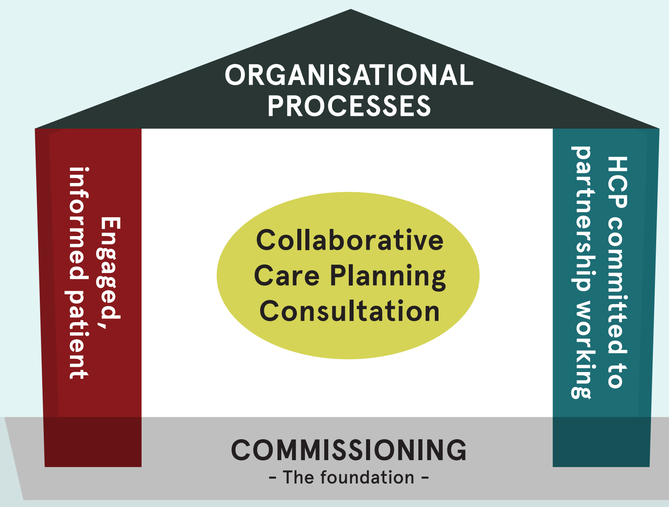
- Gateshead CCG recognised the need to work differently to improve the quality of care for people with long term conditions (LTCs).
- This C&SP (developed by the Year of Care Programme, YOC) is a systematic process which enables conversations to be focused on what matters to the person rather than the individual conditions.
- It involves an integrated conversation however many conditions and issues the person has.
- Preparation (sharing information and prompting reflection) enables a conversation between equals and experts and efficient use of time and resources.

HOW?

How did we approach this?

- We took a developmental and supportive approach to enable practice teams to adopt the principles of care and support planning.
- We used the 'House of Care' as a framework.
- We formed a Gateshead Operational Group with local partners to oversee and direct implementation of the Year of Care model of C&SP.

Building the House of Care in Gateshead:



Engaged and informed patient:

Established a LTC Patient reference group who have co-produced C&SP materials for patients.

Organisational processes:

Worked with our GP federation to support call and recall, and develop a Master Template for EMISWeb available to all practices to aid information gathering and coding.

Healthcare professionals committed to partnership working:

Trained local clinicians as YOC trainers who have delivered training and support to Gateshead practices.

Commissioning:

Funded practices to set up and deliver C&SP multi-morbidity clinics and invested in local link worker roles to enable social prescribing

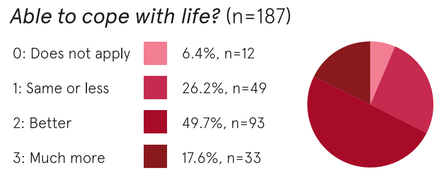
Evaluation Findings:

- CSP is being rolled out across all Gateshead practices
- 6 practices have participated in the evaluation and have collected patient feedback from surveys
  - *95% (n=178) remember getting a letter with test results and prompts asking patients to think about their heath before the review consultation with the nurse or GP*
  - *72% (n= 128) found the letter 'very helpful' to help them prepare.*
  - *35% (n=66) discussed services and activities in the local community*

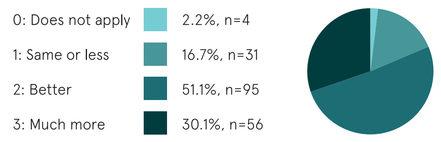
The surveys also demonstrated:

After your consultation today, do you feel you are...

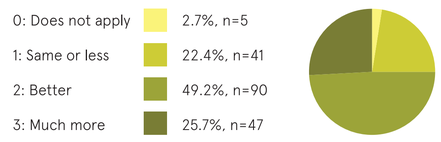
Able to cope with life? (n=187)



Able to understand your condition(s)? (n=186)



Able to cope with your conditions(s)? (n=183)



Following their consultations...

PATIENT SURVEY **81%** (n=151) *...understood their condition 'better' or 'much more'*

PATIENT SURVEY **75%** (n=137) *...were able to cope with their condition 'better' or 'much more'*

PATIENT SURVEY **71%** (n=132) *...felt 'more' or 'much more' able to help themselves*

PATIENT SURVEY **87%** (n=160) *...rated their overall experience of CSP as 'very good' or 'excellent'*

'I said I wanted to lose some weight...
I've gone from 12st6 to 9st6 and I've done it all myself'
Patient Feedback

'The patient is prepared for the consultation, having seen their results and thought about them in advance – this changes the whole conversation'
Health Care Professional Feedback

Two early adopter practices reviewed clinical metrics and found that:

CLINICAL METRICS **11%** INCREASE *...in patients who had BP recorded in the previous 12 months*

CLINICAL METRICS **10.9%** INCREASE *...in CHD patients BP of 150/90 or less*

VS

CLINICAL METRICS **0.4%** INCREASE *...accross the CCG as a whole.*

= +2098
CHD patients with a BP of 150/90 or less
** if replicated across the CCG*

Learning from our Experience:

- All practices have different starting points
- There may need to be a cultural and philosophical shift
- Preparing the patient is key
- A whole practice team approach works best
- Clinicians need support with social prescribing
  – *community link workers / navigators are key to this*
- It takes time to adapt to this new way of working

NHS Newcastle Gateshead Clinical Commissioning Group

Year of Care Partnerships

British Heart Foundation

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.