The St. Triduana's Story

Implementing care and support planning for people with long term conditions

"It was as bit of a leap of faith at the start, but now we wouldn't go back to our old way of working"

St. Triduana's Medical Practice is a GP practice in Edinburgh with around 11,000 patients. Previously care for people with long term conditions was based on fulfilling QOF requirements with unconnected medicine reviews leaving little opportunity for addressing patient issues and concerns. People were seen for separate individual disease reviews which focused on completing tasks rather than on 'good conversations' and 'planning care with people'.

Time to change

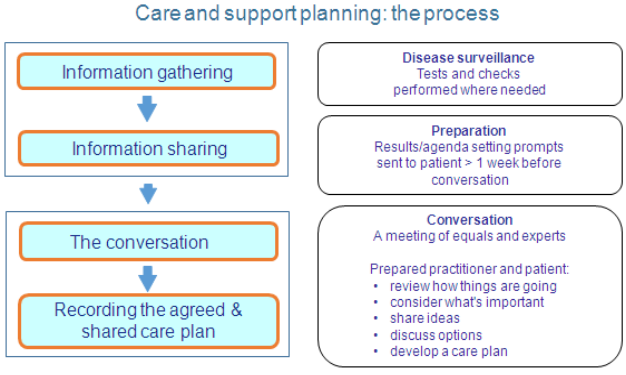
St Triduana's Medical Practice was already involved in NHS Lothian's 'Headroom' project when the team attended a session to hear about care and support planning using the House of Care, supported by the British Heart Foundation. The practice was keen to use care and support planning as a means to deliver the **Realistic Medicine** aspirations of more honest conversations, more pragmatic approaches to medical treatments and a focus on 'more than medicine', alongside a partnership approach to working with the people that they serve. In addition care and support planning was consistent with the new GMS contract and good way to deliver patient focused medical care in place of QoF.

Getting started

A few GPs and nurses attended Year of Care training and cascaded this to the rest of the practice team. The practice had a small leadership team who worked together to plan and deliver the necessary changes to implement care and support planning. This involved changing existing processes and roles of team members. The practice tested out the process with around 10 cardiovascular patients including people with diabetes. In May 2017, this was scaled up to include all people with multiple long term conditions.

"Even at the testing stage we always had an eye on what was realistic and what was scalable - in retrospect we should have spent less time on piloting with a few patients"

A process that balances good clinical care with what matters to people



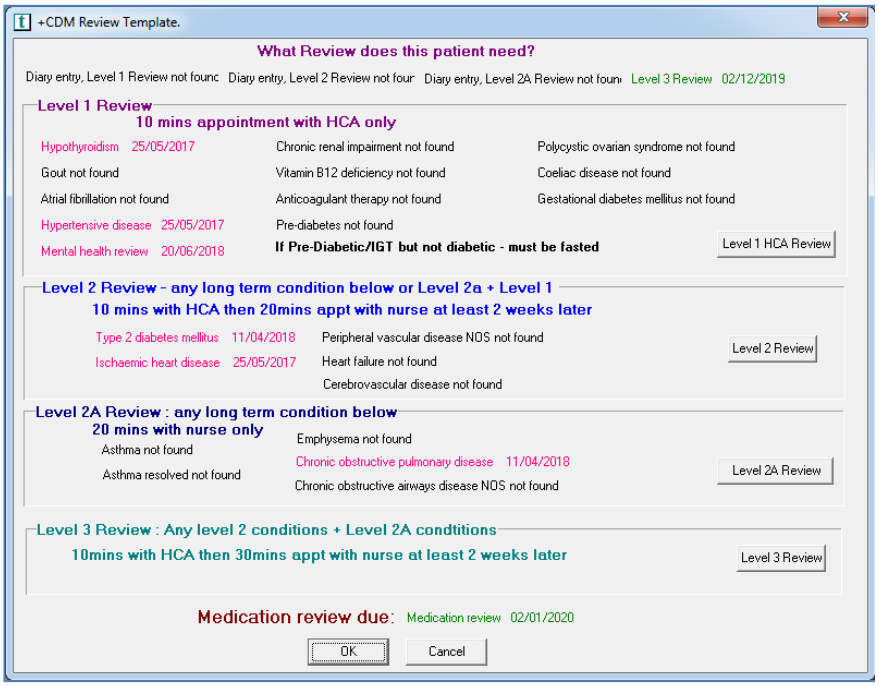
"I originally thought I was already patient centred, but after getting involved in this programme, I had to admit I wasn't. Unless you are willing to admit you are not perfect, you won't get anywhere." ***GP***

"I was really worried that we would lose the biomedical agenda, but this really hasn't happened – both the clinical and the patient stuff are equally important and we seem to be getting the balance right." ***GP***

The process – how it works at St Triduana's

After initial piloting the practice moved to a single care and support planning (CSP) process for all long term conditions, held a month before the medicine review was due. This meant that not only could the practice ensure all tests and tasks for all conditions had been done, but also that relevant information from the CSP conversation and tests could be used to streamline the medicine review and make it more meaningful.

Information gathering is done by healthcare assistants (who also have a dual role working in reception). The practice calls patients to book appointments (and also sends text reminders). The practice set up EMIS PCS IT templates to help reception with appointments, sending out preparation materials, social prescribing and recording the care plan itself. This has taken time and requires a common understanding of the programme to ensure it works well for each member of the team, recognising the critical nature of each step in the process.



The timing of appointments is managed by flagging people as 'level 1, 2 or 3' depending on the number and complexity of their long term conditions. Each level has a defined appointment time and role allocated. This is built into the template so it's easy to remember and obvious to all involved. A person can also be 'moved up' a level if they have other more complex conditions e.g. frailty, dementia. By creating such a robust process not a single person has ended up being given the wrong appointment – the admin and reception team is key to this success.

Care and support planning conversations are mainly done by nurses, with GPs handing the most complex cases. The nurses are being supported by GPs to confidently manage care and support planning across a range of conditions and it is hoped that, with time, all nurses will be able to handle all but the most complex care and support planning conversations.

A real team effort

"Our team is what makes this work"

One of the most impressive things about the practice is not only how culturally 'in tune' with the ethos of CSP they are, but how that extends to the way the team works – they are all proud of each other and of what they have achieved. They recognise that this has been a huge change for the whole team, particularly for nurses. Everyone has been involved and the vision and implementation of CSP has been involving, strengthening and communicated well within the team.

The practice manager, Alison Fox, has worked closely with the clinical leadership team and developed regular sessions to review implementation of the process and a regular weekly MDT as an opportunity for peer support and supervision. This has helped the team understand each other's roles and now includes the full time link worker, community psychiatric nurse and pharmacist who support the approach. External facilitation has been useful to challenge and offer new ideas, as has having time set aside to do the work associated with set up of CSP and staff development.

Professional development

One of the team's key aims is to have staff trained, supported and working to the *"top of their licence"* as a means of promoting good quality clinical care with as few visits to the practice for the patient as possible.

Impact on roles

Redesigning the system of care has forced the team to review roles. Healthcare assistants now take on more of the tests and tasks during information gathering appointments. Many healthcare assistants also work in reception which gives the practice an extra benefit as they understand the system and the philosophy of the approach; they can explain this to people with long term conditions when they contact the practice or when making appointments.

The big change has been for practice nurses who used to be focused on single conditions and the completion of templates. Going from such a structured template-led approach to a CSP conversation where you don't know what the patient will bring up has been quite a challenge.

"It was a significant change from what we used to do, and we were worried about fitting it all in. Once you have tried it, it becomes clear that we're not being asked to just add more checklists in for all the conditions someone has, we need to change the whole way we handle our conversations around what really matters to the person. It's taken quite a while for the penny to drop and for me to get my head around the fact that I don't need to fix everything."

Supervision and support

GPs have a strong role in supporting and developing the nursing team. The practice is already seeing that acute appointments are less pressured so clinicians are able to concentrate more on the complex cases which need their expertise.

The practice has a range of 'bitesize' training sessions together with a regular calendar of learning cycles which are facilitated externally. They are particularly useful in helping to tease out and discuss ways of handling some of the challenges which the practice team face. They give an opportunity for peer support and informal supervision from GPs – sharing how people handle difficult conversations, as well as seeing how the rest of the team (pharmacy, mental health, links worker etc.) can contribute. This is all part of the practice's recognition that reviewing the detail and keeping the team thinking about this has helped evolve and refine things. The practice see this reflective time as important to the quality of what they deliver.

'More than medicine' and community support

Ensuring care and support planning feeds into the practice based link worker is really reaping rewards. Many people identify issues such as debt, housing or social isolation as the biggest issue impacting on their life and their long term condition. The practice involves the link worker in their meetings and benefits from hearing about what's going on in the local community; St Triduana's has the lowest DNA rate when making a referral. Patients have been supported practically with real life issues and this is already having an impact on individual patients and their self-care.

Looking to the future

The practice has a continual development programme for the team. Further training of healthcare assistants in spirometry and foot checks is planned, and clinical training around respiratory and ongoing sharing across social prescribing, pharmacy and the rest of the team will continue. The practice is also looking into frailty as well as people currently supported mainly in secondary care to see how they can provide CSP without calling them in unnecessarily, or crossing over with the support they are already getting. The practice has travelled a long way in three years but also recognises that there is still much to do.

So what difference is this making?

The practice was asked to consider the benefits of introducing CSP and using the House of Care framework including more than medicine. This is what they said:

Benefits for people with long term conditions

*"They (*people with LTCs*) like getting information beforehand. Because they can see results, it helps make the mental link – they see connection between lifestyle stuff and results, the penny drops, they can see the positive results of what they have done."* (Practice Nurse)

"Patients like the opportunity to discuss what matters to them. It's really the first time they've had this opportunity. They might want to talk about work, care package, respite, toe nails, lifestyle, and quite often unexpected things. Sometimes a bit surprised but there's always something." (Practice Nurse)

"Our IT templates also record the care plan itself, so at any time we can see what matters to the person and what goals they are working on so we can reinforce and support this through all our contacts with that person and understand the patient's preferences." (GP)

"In particular it's improved our use of more than medicine – so many cases we used to give people medicine when in fact the problem was with more social issues – having this approached and then being able to refer to Links Workers is a real benefit to patient care." (GP)

"Without a doubt it's better for patients." (Practice Nurse)

Staff benefits

Reception has found this process a lot less work than previous appointment systems for chronic diseases.

"*It's clearer and simpler and the templates make it easier."* (Administrator/HCSW)

"Previously there was quite a bit of duplication of effort – all gets done systematically now." (GP)

"We are constantly developing people, and I think this approach helps people be able to operate at top of their licence, and frees up time for GPs to focus on the right stuff." (GP)

"It's so much easier to do medicines reviews now – mostly it's already done." (GP)

"We have certainly seen links between staff groups improving." (Practice Manager)

Practice benefits

"Care and support planning is also something that helped with safety – combining appointments meant the chance of something getting missed was less – clearer, simplified, safer." (Practice Manager)

"We hoped the move would be more efficient in appointment use, and some of this does seem to be happening. We have one of the lowest DNA rates and the number of GP appointments is definitely going down." (Practice Manager)

"I believe we can run a successful business and be patient-centred by focusing on what matters to the person - we are now on the easiest path to make this happen. I am so proud when so much negative stuff is around that we have a system which is both positive and sustainable." (Practice Manager)

For further information contact Alison Fox alison.fox@nhslothian.scot.nhs.uk or Dr Louise Bailey Louise.Bailey2@nhslothian.scot.nhs.uk