

Delivering Healthy Ambitions Better for Less



Overview.

Personalised care planning can ensure better outcomes for patients, reduced exacerbations of long term conditions, increased patient satisfaction and financial savings.

Why personalised care planning?

We currently have over one million people registered with a long term condition across Yorkshire and the Humber. This figure is projected to rise significantly over the coming years as a result of lifestyle factors and the ageing population.

In 2008-09 in Yorkshire and the Humber there were just over 500,000 emergency admissions, with a total cost of approximately £750m – this is close to 10% of an average PCT's budget. The large majority of these relate to patients with long term conditions, of which a significant proportion can be avoided through proper management in primary care.

There are significant variations with the region, emergency admissions due to exacerbations of long term conditions are more than twice as high in some practices in Y&H compared with others. This presents a huge quality and efficiency challenge to our local health services.

Healthy Ambitions pledged to help people in Yorkshire and the Humber “live with, not suffer from” their long term conditions.

What is the challenge?

The management of LTC in the NHS is usually not proactive, is semi planned in many cases and often only deals with one condition per consultation (for example asthma clinics). This means that patients with more than one LTC will need to go to several appointments through the year. Patients are inconvenienced and the NHS wastes resources.

We describe a more proactive and planned approach to the management of LTCs in primary care that can realise clear patient benefits and cost savings.

How could we provide better care for less?

Personalised care planning involves recording, in the patient's own words, the issues important to that individual and how they impact on self caring for their conditions so goals can be set by the patient to improve their own care.

Department of Health research and local evidence indicates the benefits of care planning include: reduced emergency attendances and inpatient days, quality-of-life improvements, greater patient knowledge and confidence in being able to cope with their condition(s), better use of medication, reduced costs and overall improved quality of care.

An approach to personalised care planning

- Patients living with long-term condition(s) are identified by their practice. They can be separated in patients with one or more LTC. Appointments are arranged for patients to have a care planning consultation
- Care planning with patient centred goals agreed between patient and clinician
- Clinician and patient able to monitor progress towards goals
- Clinician and patient identify a named contact within the practice
- All info is gathered on a template guiding the clinician through the process

Benefits of care planning

The care planning approach involves changing the way general practice is conducted currently – making patient management more proactive than ever before. We do have call and recall systems for diabetes and other long term conditions but the comprehensive care planning approach is more proactive, patient centred and motivates patients to actively self care.

Patient benefits

Patients on the whole like personalised care planning and setting their own goals. Clinicians using this approach identified that many patients had a reluctance to accept responsibility for their care as their care has been 'medicalised' over the years.

Personalised care planning for LTCs can mean fewer trips to the GP and a reduced risk of emergency hospital admission for patients. The care planning process has helped to identify gaps in patient education and misunderstandings which once filled enable better engagement and active self care. The time spent care planning with the patient has led in many instances to the patient having their 'eureka moment' which has transformed their whole approach to self care.

Quality benefits

Care planning uses standardised documentation to ensure the correct information is collected every time. During this process all parameters relating to QoF (quality outcomes framework) for that condition or conditions can be recorded on the template.

The data collected for the LTCs can help to improve the QOF figures in primary care as much of the data also populates the QOF templates. This process can also help to address shortcomings in underperforming practices in primary care. Doing this at one time rather than in a haphazard way in different consultations enable primary care to be more efficient in data collection and saves the patient from having to attend on several occasions for different LTCs.

Efficiency benefits

Savings are significant, driven by the reduction in emergency admissions resulting from long term conditions. Last year there were just over 500,000 emergency admissions in our region. The rate varies dramatically by PBC consortia, and bringing all practices up to the upper quartile would generate savings in the region of £200m.

A named individual from the practice, for example a practice nurse, can be assigned to the patient so that the patient can contact this individual to clarify or speak about concerns or problems relating to care. Evidence indicates that this opportunity for the patient to contact a named person can lead to greater personal satisfaction with care and helps to lower out of hours A&E attendances and reduced admissions.

Example of personalised care planning in action in Bradford

The proactive and planned approach to the management of LTCs in primary care has been piloted in general practice in Bradford.

All patients with one or more LTCs were identified in the practice and then segregated into groups of one, two, or three or more LTCs. This amounted to about 25% of the overall practice population. These patients were then given appointments to attend the surgery to have a care planning consultation for all their LTCs. This involved the process of care planning with the patient, collection of relevant data needed for the management of the condition/s and providing a clinical link in the practice as liaison for the patient.

Each of the LTCs can be considered as the patients wishes to enable a 'true picture' to be built of the patients concerns and issues. This process can be followed for each of the LTCs that the patient may have and enables all the information to be collected in one appointment rather than several appointments through the year.

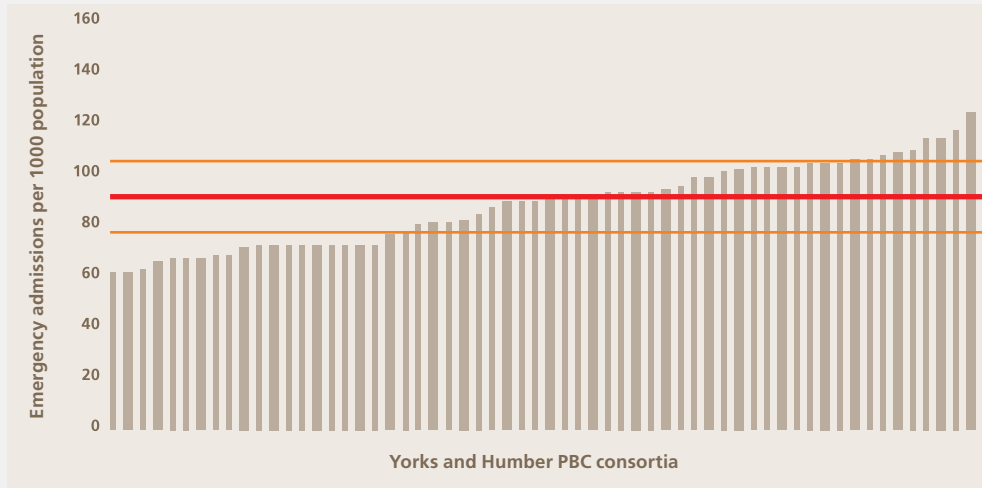
The patient may wish to set goals to address some of the issues highlighted e.g. weight loss or stopping smoking. These can be recorded on the care planning template as well together with the chosen method to be used to work towards this goal. The template has a facility to record whether this is a well being goal, or to reduce complications and has several categories to capture key information. The chosen method can also be added so that the goal is driven entirely by the patient methods. Whether the required service is available at present in the locality or if there is an unmet need can also be recorded so that commissioning at a micro and macro level for that LTC can be properly informed.

Analysis of recent data using this approach with diabetes has shown that the majority of the goals relate to immediate concerns i.e improving wellbeing. "Traditional" diabetes care focuses more on avoidance of long term complications, perhaps suggesting a mismatch with patient priorities. These data can be used to refine training for staff providing diabetes care and by commissioners for macro commissioning purposes.

Bradford and Airedale piloted the Diabetes care planning templates as part of a personalized care planning approach. The pilot concluded earlier this year. The PCT is now recruiting two dedicated posts to train and support 40+ practices working towards Level 2 accreditation in implementing care planning with their patients.

The pilot was mainly conducted in primary care, centring on 6 general practices. The practices received training on the care planning approach and the use of templates developed in SystemOne before using them in patient consultations. Secondary care activity was limited to providing consultants with a view of the patient record created and maintained in primary care. Extensive learning was captured from each of the 6 practices about the use of the templates by clinicians. A review of the pilot found that practitioners and patients demonstrated 'substantial enthusiasm for the personalised care planning approach and the concept of shared electronic health records'.

Emergency admissions by PBC



Source: YHPHO 2008-9

Financial benefits

As well as the quality benefits, there are also potentially significant financial benefits to be generated from keeping people out of hospital outpatients for diabetes and managing them through e-consultations.

The 2008/09 GP patient survey around care planning and financial savings found that 61% of people with a discussion or a care plan say they have better care as a result.

The typical practice that is in the best quartile for care planning will typically have (compared to the poorest quartile) 30 fewer emergency admissions per 1000 population (see graph). This means that moving an average list size practice from the bottom quartile to the top could save approximately 210 emergency admissions pre year. This is better for the patient and translates into efficiency savings in the region of £290,000 for an average practice.

This saving will increase as long term conditions prevalence increases, as predicted, over coming years.

Further savings will be made across the health system as care planning will result in reduced emergency attendances and inpatient days, quality-of-life, greater patient knowledge and confidence in being able to cope with their condition, better use of medication and an overall improved quality of care.

Implementation

Care planning supports patients and GPs working together, it supports moves towards self care and personalisation of care.

What needs to happen?

- Standard documentation is required to support care planning with a clear explanation and management of the impact on working processes.
- Integrated training that covers the care planning consultation and use of the template from a clinician's point of view, including how a clinician would work through some of the situations and barriers a clinician might face in practice with patients. Ideally this should be delivered by someone with a clinical background and understanding.

Key contacts

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