Evaluation of Dudley Quality Outcomes for Health: final report

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Executive summary

Executive summary– overview of the evaluation

- As part of its vision for transforming primary care, Dudley CCG has developed a new contractual framework for primary medical services – Dudley Quality Outcomes for Health, locally known (and henceforth in this report) as the Long Term Conditions Framework (LTCF).

- LTCF was devised as a revision to the Quality Outcomes Framework (QOF), and consolidates existing QOF indicators and includes indicators relating to Local Incentive Schemes (LIS) and Directed Enhanced Services (DES).

- The main aims of the framework are to: simplify and rationalise QOF; drive up standards and address unwarranted variation; facilitate holistic management of individuals with long term conditions, including an increased focus on care planning; focus measures and

incentive payments on actions seen as having a strong evidence base; and develop outcomes that could be shared between primary and secondary care.

- ICF, the Health Services Management Centre and the Strategy Unit were commissioned to evaluate the implementation and impact of LTCF. The methodology included: an online practice survey; observation of holistic reviews; interviews with staff and patients; a review of care plans, and analysis of routine data.

- The majority of the work was carried out with seven case study practices, purposively selected to ensure a diverse sample, ensuring variation across a range of important variables such as size of registered population, team size and composition, QOF performance, and socio-demographic characteristics.

The research was carried out between October 2016 and January 2017.

- The LTCF can be understood as three distinct but inter-linked elements: a streamlined template, multi-morbidity approach and the mainstreaming of care planning. These elements can be thought of as building blocks: successful implementation of the template will provide a firm foundation for the transition to a multi-morbidity approach, and so on. It is the combined implementation of all three elements that will bring about more efficient, holistic and person-centred care.

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Executive summary – key findings

- Practices understand the main purpose of the framework as its potential to save time and free up resources. There was much less emphasis on how the framework may help drive changes in the relationship between patients and healthcare professionals (HCPs) towards a more collaborative and enabling model of care. There is scope for the CCG to strengthen the focus on the role of the framework in facilitating new approaches to the organisation and delivery of care to support people to manage and live well with their long term condition(s) (LTCs).

- Staff welcomed the integration of all information and data inputting requirements into a single EMIS template, although there were some queries about the evidence-base underpinning particular questions within the template. Views about

whether the template was easier to use and saved time in comparison to arrangements under QOF were mixed. Staff reported that the new template was taking longer and was more burdensome than QOF, but this may be because practices are so familiar with QOF that it has become 'second nature'; time will tell if the new framework proves to be time saving in future.

- Operational changes made as a response to the new framework have been variable. Some practices have chosen to implement the template directly into their existing clinic structures, whereas others have made considerable changes to the organisation of their appointments. These changes included increasing appointment times for LTC reviews and introducing two-stage appointments with tests and template completion

carried out by a healthcare assistant (HCA), and a subsequent consultation focused on care planning and a more general discussion of the patient's health and wellbeing.

- Many of the practices which had implemented the framework into their existing ways of working reported difficulties with fitting everything in to their allocated time with fears of running over. Reasons given by practices for incorporating the LTCF into their existing ways of working included: a lack of time and resources to restructure care processes; concerns about wasting resources if patients DNA'd longer appointments; difficulties changing recall processes; and reluctance to change to a new way of working given that the framework was still only in pilot phase.

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Executive summary – key findings

- Some practices were changing their skill mix to facilitate the implementation of holistic reviews. This included increased recruitment of HCAs with HCAs taking on an enhanced role in the delivery of LTC care. Responsibility for conducting holistic reviews was largely being picked up by the nursing workforce, with some transfer of more straightforward data gathering tasks from practice nurses to HCAs.

- Practice staff praised the CCG for its collaborative approach to developing the framework, and for providing practical support with implementation, including training sessions. Staff also talked about additional and ongoing training needs, in particular opportunities to improve their knowledge and skills across the range of LTCs covered by the template. Many practice nurses have specialised in a particular disease area, and lacked

confidence to carry out holistic reviews which might cover a range of different conditions. This unfamiliarity with a new way of working might explain why only a third of staff responding to our online survey reported that the framework had improved their job satisfaction.

- There is a tension in the delivery of LTC care within general practices. The drive towards care being delivered outside of hospital settings, encouraged by policy, requires a degree of specialisation within the primary care workforce, who are seeing patients with increasingly complex conditions and health needs. But there is a potential conflict with the goals of the LTCF, because the move towards providing holistic and integrated care requires professionals with generalist skills.

- There was wide variation in care planning practices. We observed some consultations which were

exclusively focused on care planning, where patients played an equal role in conversations that addressed all aspects of their health and which included signposting to wider services and supports. Others we observed were template-driven; patient involvement was largely limited to answering questions and there was no care planning conversation. Most of the consultations we observed tended to fall somewhere between these two positions.

- An analysis of care plans provided by case study practices showed that goals were often passively phrased and lacked specificity ('think about losing weight') and were often focused on medical management tasks. The template provided by the CCG for care plans is likely to be a key factor here.

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Executive summary – key findings

- Staff had mixed views about the value of care planning; some spoke enthusiastically about putting patients at the centre of their LTC care, using an approach aimed to support and enable people to achieve their own goals. Others were more cautious or negative, in particular, questioning whether care planning would have an impact on patient behaviour and result in better self-management.

- One of the key changes for patients was being asked a wider range of questions about their health and wellbeing, prompted by the new EMIS template. Aside from the type of questions being asked them, patients generally hadn't noticed a difference between previous LTC consultations and the new holistic review.

- Asking patients a wider range of questions had encouraged them to share information that they previously may not have disclosed.

However, this sometimes raised difficulties for staff who felt unable or unwilling to respond to these new issues. This was particularly common in relation to mental health problems.

- The findings point to several factors that could improve the experience and impact of care planning: ensuring there is sufficient time to engage patients in a meaningful conversation about their health goals; preparing patients and professionals for a more collaborative conversation; and ensuring there is access and clear referral pathways to a co-ordinated set of services linked to general practice.

- Many supported an integrated approach to LTC care involving holistic, person centred reviews but also questioned whether all patients wanted or needed this. Several issues, in particular, were raised: a) if it is realistic to combine

appointments into a single review where a patient has multiple and/or complex conditions; b) whether patients can cope with longer (e.g. 45 or 60 minute) appointments and c) if care planning is necessary for those whose LTCs are stable and who are in good health. A good approach may be to target resources according to need and potential benefit.

- Utilisation of the template varied across practices as did performance against framework indicators. The utilisation rate for the template ranged from 0% in one practice to over 75% in others.

- For the poorest performing practice, performance on 70% of the LTCF indicators was significantly below average. The best performing practice performed significantly above average on nearly 60% of the LTCF indicators, achieving average performance on a further 27% of indicators.

Executive summary – key findings

We analysed CCG data to see whether performance was affected by the length of time since the framework was first implemented. We found no consistent difference in performance between the phase 1 pilot practices (which have been using the LTCF template since early 2016) and remaining practices who had begun implementation later in the year.

Our findings suggest three key factors influencing how successfully the framework was being implemented: resonance between the framework and the ethos of care in the practice; individuals taking on responsibility for leading implementation and supporting colleagues and, an understanding of how the framework is different from previous ways of working and what the core goals of the framework are.

While implementation of the framework is still at a relatively early stage, we were nonetheless able to identify some important early impacts. These included: upskilling of practice staff; a stronger focus on care planning and supporting self-management; moves towards a more holistic model of care; and more joint working across the primary/secondary care interface. One of our case study practices reported evidence of improved clinical outcomes, and another of a downward trend in admission rates to accident and emergency. However fewer than half of those responding to our online survey thought that the framework had improved the experience of care, suggesting that there is still some way to go for process changes to translate into direct improvements for patients.

The CCG should congratulate itself on progress made so far. It has played a significant role leading the implementation of an evidence based framework that is logical, practical and encourages an holistic approach to managing LTCs. This is no easy feat and the feedback shared by practices reflects that throughout, the CCG has been, and is, held in high regard.

The evaluation has provided insight and learning around implementation and early impacts of the LTCF. Nevertheless, the LTCF is still at a relatively early stage, and we have identified seven high level recommendations for consideration by the CCG and practices to further strengthen its implementation and impact. These are considered in turn below.
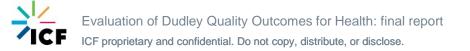
Executive summary – recommendations

1. **Developing a strong narrative, emphasising all desired outcomes for the framework**: evidence from across the NHS has consistently demonstrated that change programmes benefit from having a strong narrative and clear vision, in particular around desired goals and endpoints. We would encourage the CCG to review how it is communicating the LTCF to practices and wider stakeholders. Much of the emphasis so far has been centred around the implementation of new tools and processes, and our evaluation framework supports this approach (getting the technical 'building blocks' in place before moving on to the more challenging goal of culture change). But if the LTC framework is going to transform the experience and outcomes of LTC care, there now needs to be a stronger focus on how the framework will act as a vehicle for changing the model and relationship of care. Re-framing the narrative could help to ensure that this vision is shared and there is a consistent understanding of the framework across the CCG area.

2. **Working with practices to co-produce solutions to issues and challenges**: as our evaluation highlights, several issues have arisen as practices have started to implement LTCF which will need addressing if a new model of LTC care is going to be successfully embedded within general practice. Some of these challenges need to be better understood before solutions can be developed. We would encourage the CCG to continue to work closely with practices to further explore the challenges they are facing in delivering efficient, holistic and person-centred LTC care, and support them to co-produce and test out solutions to these. This could include the following areas: understanding the skills and workforce challenges related to a more holistic, multi-morbidity approach; exploring how practices could tailor support to people with LTCs, and what tools and processes might support this; and considering how practices can prepare and engage patients for care planning.

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Executive summary – recommendations

3. Establishing a formal programme of training and development to support implementation: we recommend that the CCG develops a structured programme of training and support to encourage the transformation of LTC care. This should include training on the following:

- *A multi-morbidity approach*: the CCG should continue to provide LTC condition specific training for HCPs to refresh and expand their knowledge in a full range of conditions covered by the framework.

- *Care planning*: in particular, to address what patient-led care planning is and how that might differ from what is currently being offered to patients.

- *Wider services*: to complement formal services such as Integrated Plus, the CCG could provide training (for clinical and non-clinical staff) to ensure that 'care navigation' is a core element of all patient contacts.

4. Fostering a culture of shared learning: we would encourage practices, with the support of the CCG, to consider how they might develop opportunities for peer-to-peer learning and support. There is much value in practices sharing with and learning from one another, and this approach can be embedded into the CCG's wider programme of primary care development. This might include using large-scale meetings and events to showcase work and examples of good practice, as well as 'buddying up' practices who are leading the way in implementation and/or performance acting as a source of inspiration and advice for those that are in need of support.

5. Maximising opportunities presented by the MCP to strengthen the delivery of LTC care: there would be value in the CCG ensuring that ongoing support to manage people with LTCs is provided to primary care upon entering into the MCP contract. Indeed, the MCP is well placed as a vehicle through which to collectively provide primary care with easier and systematic access to specialist expertise within secondary care. We would encourage the CCG and practices to explore these new opportunities as tendering of the MCP progresses. This is particularly important given that community-based services are seeing increasing chronicity and complexity in the patients they care for and treat. The MCP also provides a further means of encouraging locality based working. Through this there may be an opportunity to develop locality-based solutions to the workforce challenges we have identified, employing skill mix across (as well as within) practices.

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Executive summary – recommendations

Furthermore, as implementation of the new model of care for Dudley progresses, the CCG should also ensure that it continues to strengthen the links between general practice and wider support services, including those in the voluntary and community sector.

6. Using the framework to focus and incentivise improvement: the framework itself provides a means by which the CCG can give focus to and incentivise improvement. Performance data could be used to identify strong and weak performance, at both a practice and indicator level, in order to tailor strategies for driving improvement. As part of this process, we would encourage the CCG to work with practices to understand and seek solutions for any issues that may be holding back progress. Linked to this, we would encourage the CCG to use the LTCF indicators to incentivise improvements in LTC care and reduce variations in performance –

for example, by attaching larger payments to indicators where performance is most in need of improvement. It is also important that the CCG measures not just changes in the process of care, but dimensions of quality and experience too. In terms of care planning, for example, practice payments could be linked not only to the proportion of patients receiving a care plan, but the extent to which patients feel they are meaningfully involved in developing that plan. Current moves to embed routine collection of PREMs and PROMs into community-based services provides an opportunity to gather this kind of patient feedback.

7. Engaging patients in ongoing implementation: the framework is starting to drive changes in processes of care, but evidence for its role in improving patient experiences and outcomes is lacking. Of course this could – at least in part – reflect the timing of the evaluation, which was too early for major impacts

to be seen. But there is also considerable scope to more fully engage patients 'as partners' in the transformation of LTC care. The evaluation has identified several areas where such engagement would be of value. For example, in thinking through where the limits of combining appointments might be, and the feasibility of alternative models of delivering holistic reviews such as telephone appointments. Moreover, our findings suggest that the current care plan template can be a barrier to successful care planning, and should be re-worked. For example, the template should prompt and document action planning, and include information about when and how care plans should be reviewed. Involving patients in redesigning the care planning template would help to ensure that care plans are user-friendly and of practical value to those who are expected to use them.

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Background, methodology and evaluation framework

Dudley Quality Outcomes for Health Framework

Background

Dudley Clinical Commissioning Group (CCG) successfully bid to become a Multi-Specialty Community Provider (MCP) vanguard site in 2015, with the aim of bringing community services together as a single organisation. As part of its vision for transforming primary care, the CCG has developed a new contractual framework for primary medical services – Dudley Quality Outcomes for Health, locally known (and henceforth in this report) as the Long Term Conditions Framework (LTCF) or the framework.

LTCF was devised as a revision to the Quality Outcomes Framework (QOF). The founding idea was that QOF was no longer fulfilling its function of incentivising a focus on quality, and created administrative and measurement requirements that could be simplified in order to create efficiencies.

The framework consolidates existing QOF indicators and includes

indicators relating to Local Incentive Schemes (LIS) and Directed Enhanced Services (DES).

The development of the framework has involved multi-professional inputs. Advice has been taken from GPs, nurses, pharmacists, public health professionals, and commissioners. It has also been shared with member practices and sent for comment to external experts. By the time it went live, the framework had been revised over 40 times.

Person-centred care

The CCG intends the LTCF to drive a more holistic and integrated approach to the management of long-term conditions (LTCs). The EMIS template, which has been designed to support implementation of the framework, brings together the multiple reporting systems under QOF into a single template. It is expected that practices will offer patients a single 'holistic review' for

The new framework was developed with the key aims of:

- Simplifying and rationalising QOF, reducing the number of measures and reporting requirements

- Driving up standards and addressing unwarranted variation

- Facilitating holistic management of individuals with long term conditions, including an increased focus on care planning and person-centred care

- Focusing measures (and so incentive payments) on actions seen as having a strong evidence base

- Developing outcomes that could be shared between primary and secondary care.

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Dudley Quality Outcomes for Health Framework

all their LTCs, where this is feasible (for some patients who have several, complex conditions, for example, more than one appointment may still be needed).

It is also expected that all patients with LTCs will have a care plan, including personal goals, that are reviewed on at least an annual basis, and that collaborative care planning will form a key part of the holistic review process. The EMIS template includes a care plan template, which clinicians can complete during the consultation and print off for the patient to take away.

The new model of care being implemented in Dudley also includes mechanisms to link patients to wider services and supports within the community, to help them live well with and manage their LTCs and avoid unnecessary hospital admissions. This includes the Integrated Plus Service, delivered by Dudley Council for Voluntary Service and the roll out of an integrated multidisciplinary team (MDT) model within primary care.

Dudley's new model of care

The Five Year Forward View (FYFV) described a series of challenges facing health and social care services. It also set out a series of responses, the foremost of which was a proposed set of new care models. These proposals were subsequently developed into the New Care Models programme, which was established through 50 local 'Vanguard' sites.

One of the care models outlined in the FYFV was the Multi-speciality Community Provider (MCP) model. In essence, the MCP model seeks to enhance and integrate the range of services provided in community settings. In doing so, it recognises the centrality of primary care and general practice.

In broad terms, Dudley's MCP is being developed in two ways:

- Firstly, components of the model are being developed upon existing services, such as the MDTs in primary care, and schemes such as Dudley's primary care development programme. The LTCF can be seen as part of this.

- Secondly, the MCP is being commissioned. To date, this has involved the production of a contract (joint with NHS England, which has also issued multiple supporting documents), an outcomes framework, whole population budget, service scope and prospectus – supported by market engagement and a forthcoming procurement exercise. In combination, the thought here is that the MCP will provide a more long-term framework for the development of a new care model in Dudley.

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Implementation of the framework

Implementation

The framework was piloted in early 2016 in 12 GP practices. It was offered to all practices from April 2016 onwards, and 40 out of 47 practices have signed up to deliver it.

To facilitate implementation and uptake of the new framework, new EMIS templates have been developed and introduced within practices.

The CCG has used £1million of the Transformation Fund, provided by NHS England as part of the New Care Models programme, for primary care development. This will support the implementation of the framework and the wider system transformation to establish an MCP. The CCG has also offered care planning training sessions, as well as educational sessions on specific LTCs. It has recently undertaken a training needs assessment for practice nurses and healthcare assistants (HCAs). Further training and development support to help practices successfully implement and embed the framework is planned in 2017/18.

The framework as payment mechanism

Practice payments were not linked to the framework in 2016/17 (practices received block payments based on historic QOF scores). In 2017/18, practices will receive 50% block payment, with the other 50% linked to the achievement of specific indicators (see box to right).

It is expected that the new payment mechanism will be fully implemented in 2018/19.

In 2017/18, 50% of practice payments will be linked to six indicators from the previous QOF system (relating to blood pressure, atrial fibrillation, diabetes, asthma and COPD) plus the following:

- **ACC1-9: Access standards**
- **G1: Completion of holistic assessments**
- **G3: Completion of care plans**
- **LD1: Completion of holistic assessments for patients with learning difficulties**
- **Audits: completion of relevant audits including an audit of the end of life/palliative care register, an audit of appointment availability, participation in the National Diabetes audit and an annual audit of repeat prescribing practice. For advanced diabetes practices only, there is also an audit of insulin and GLP-1 starts.**

Overview of the evaluation aims and methodology

Aims of the evaluation

The evaluation of LTCF focused on four main areas:

1. Rationale and design

- Why was this change initiated?
- What problems or opportunities was it established to address?
- How was it designed?

2. Implementation

- What was the experience of the pilot practices and how was the roll-out introduced?
- What changes have been made and how have the changes made been experienced?
- What impact is LTCF having on the model and delivery of LTC care?

3. Outcomes

- Have the desired outcomes been realised?
- What difference has the scheme made for: staff, patients, commissioners, the wider system?
- What factors have influenced the outcomes achieved?

4. Development and lessons learned

- How should this scheme develop in Dudley?
- What lessons can be drawn from the experience in Dudley?
- To what extent are these lessons transferable to other local systems of care?

Methodology

Given the range and complexity of the questions the evaluation was seeking to explore, a multi-method approach, combining quantitative and qualitative methods and capturing data from a wide variety of sources and perspectives was chosen (see Figure 1).

The fieldwork included:

- **A practice survey**: an online survey was sent to all practices that had signed up to deliver LTCF. All practice staff were invited to complete the survey, while practice managers were asked to provide a response on behalf of the practice as a whole. There were 55 responses to the survey, from staff across 36 practices. In addition to the fixed response questions, the survey included opportunities for free text comments, which 25 respondents made use of.

Fig 1. Evaluation methodology

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Overview of the evaluation aims and methodology

- **Observation of holistic reviews**: seven practices were selected as in-depth case studies (see page 19 for details about how these were selected). In each case study practice we aimed to observe up to five holistic reviews, with the consent of the patient concerned. Observations were recorded using a structured template, a copy of which is available on request.

- **Staff interviews**: in each case study practice, we aimed to interview up to four staff across a range of different roles (including GPs, practice managers, practice nurses and HCAs). The interviews principally focused on implementation of the framework and the impact of changes made at the team and practice level.

- **Patient interviews**: all patients whose reviews had been observed were invited to take part in a follow up interview, to share their experiences of the consultation we had observed.

- **Care plan review**: each case study practice was asked to provide a random sample of 50 care plans which were then combined and their content reviewed. Our review focused on the language and content of the goals set, in particular the extent to which these appeared to be patient-centred.

- **Analysis of routine data**: a quantitative analysis of data from the EMIS system was undertaken to describe activity under the new framework. The analysis is based on data extracted in January 2017. The framework has only been in place for a relatively short period. As such it is unlikely to have resulted in significant clinical outcomes (such as reductions in hospital admissions) that would be detectable within routine datasets. No attempt therefore has been made, at this point, to evaluate whether any such outcomes have been achieved. Due to the way that the data are held, it has not been possible to look at changes in performance over time, with data only available at singular time points.

Ethical approval

Ethical approval for the study was granted by the University of Birmingham's Humanities and Social Sciences Ethics Committee.

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Case study research

A key element of the evaluation was an in-depth analysis of the implementation and outcomes of the LTCF at a practice level. This involved the purposive selection of seven case study practices.

Case study practices were selected to ensure a diverse sample, with variation across a range of key variables such as size of registered population, team size and composition, QOF performance, and socio-demographic characteristics such as deprivation. To ensure coverage across the area, at least one practice was chosen from each of the five Dudley localities. Practice characteristics are as follows:

1. Large practice, high QOF score, average deprivation score for area
2. Medium sized practice, high QOF score, lower deprivation score
3. Small practice, medium QOF score, higher deprivation score
4. Medium sized practice, high QOF score, lower deprivation score
5. Small practice, medium QOF score, average deprivation for area
6. Medium sized practice, lower QOF score, higher deprivation score
7. Small practice, high QOF score, higher deprivation score

Table 1 below summarises the research that was undertaken in each practice. As shown, the number of interviews and observations carried out varied, especially in relation to the patient research where observations and interviews ranged from 13 in one practice to three in another. All but one practice provided a sample of care plans for our review, although one practice provided only 21 plans.

Practice identifier	Number of patient observations and interviews	Number of staff interviewed	Care plans reviewed
1	13	5	50
2	4	4	50
3	9	6	50
4	9	4	50
5	4	4	50
6	3	4	0
7	4	2	21
Total	46	29	271

Table 1. Research activities undertaken at each of the case study practices

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A framework for understanding the LTCF

The LTCF can be understood as three distinct, but interlinked, components (illustrated by the diagram on the right):

- A new template of incentivised and evidence-based indicators, intended to simplify and rationalise previous reporting arrangements.

- A multi-morbidity approach to LTC care, with practices integrating routine appointments into a single (or fewer) holistic reviews.

- The mainstreaming of collaborative care planning, with professionals taking on a more facilitative role which is focused on supporting self-management.

Each component is linked to a particular outcome, although in practice it is the combined implementation of all three elements that will bring about more
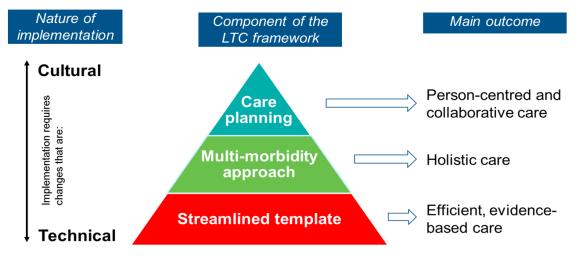

Fig 2. Evaluation framework

efficient, holistic and person-centred care.

Our findings, from this evaluation and wider work, suggest that the different levels of the triangle can be thought of as building blocks. In other words, implementation of the template will provide a firm foundation for the transition to a multi-morbidity approach, and so on. Higher up the triangle, implementation becomes progressively less technical and more 'cultural',

requiring changes in attitudes, behaviours and ways of working, not just the adoption of new processes and tools.

In what follows, we have used this framework to analyse and present our findings, offering insights and recommendations relating to each component described above in order to support a phased approach to ongoing implementation.

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A note on our methodology and its limitations

There are several key issues that should be borne in mind when reading our findings:

- The evaluation provides a snapshot of the framework at what is still a relatively early stage in its implementation. Indeed some practices had only been using the new template for a matter of weeks at the time of our fieldwork visits. It is possible that there will be further changes in how practices are organising and delivering LTC care, and key elements of the framework (eg. the payment mechanism) are yet to go live. Perhaps as a reflection of this, many interviewees focused on the new LTC template rather than the framework as a whole.

- We have sought in our fieldwork to capture early impacts, but some of the key goals that the framework has been designed to achieve (eg. more holistic care, a culture of collaborative care planning) are long-term processes that will take time to achieve. We have looked for evidence that care is moving towards these goals, but are not able to say concretely that they have yet been achieved.

- Case study practices were at different stages in terms of implementation, in part because some were involved in the initial pilot (which ran 18th January to 18th March 2016) and therefore had been working with the template for longer.

- Follow up work is planned for later in 2017, when we would expect there to be a clearer picture of whether and how the LTCF is impacting on the organisation, delivery and outcomes of LTC care.

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General views on the long term conditions framework

Practices identified several purposes of the framework, in particular time and resource savings

Practice staff largely felt that they understood the rationale behind the framework, identifying several different purposes behind its introduction.

When describing this rationale, there was a stronger emphasis placed on potential practical and resource benefits from using the framework, compared with how it might support and encourage more collaborative, person centred care and changes in the relationship between patients and healthcare professionals (HCPs). The most commonly reported function was the potential to create time savings, both for practices and patients.

Practice staff felt that patients would benefit where multiple appointments were combined into a single holistic review, both in terms of better patient experience and by reducing the number of times they needed to come into the practice. Most also highlighted the possible impact this could have in terms of freeing up practice resources

through the streamlining of multiple appointments.

"I think from patients' point of view rather than them coming to a COPD clinic and then an asthma clinic and then a diabetic clinic, because a lot of these patients have these LTCs two and three together so from a patient point of view, we have got positive feedback. From our point of view, I think it would nicely tie all of them together, make them more streamlined and organised. So I can totally see the rationale behind it and I think it is a good idea" [GP]
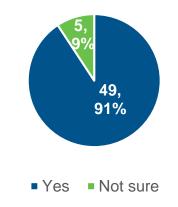
"Theoretically it's to reduce the number of times the patient needs to come to the surgery for long term disease management so theoretically reducing appointment need and therefore increasing resources at the practice hopefully." [GP]

"It's just about simplifying the systems and making it better for patients, not

keep calling them back in and getting them to do one thing here, one thing there when they've got -, and we've got payment structures that are all over the place and it's about simplifying the whole process." [Practice manager]

Our online survey confirms that practice staff feel they largely understand the LTCF, with 91% (49/54) of respondents reporting this to be the case.

I understand the new LTCF

- Yes
- Not sure

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Other purposes of the framework were also cited, but to a lesser extent

A number of further reasons for the introduction of the framework were also highlighted by staff:

- Supporting a more 'holistic' and 'whole person' approach to managing LTCs:

  "I see it as getting away from artificial divisions in patient care so it's about looking at the patient holistically.." [GP]

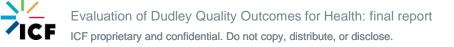 *"It's more like a holistic approach really, so you see the patient as a whole, you're dealing with the problems."* [GP]

- Achieving greater consistency across practices to ensure that all practices are providing the same high quality care to people with LTCs:

  "I think it was to make sure that there was probably more quality everywhere, because I know there's a wide range of practices in Dudley." [Practice manager]

- Encouraging a more patient-led approach to LTC care, including a stronger emphasis on lifestyle and self-management support:

  "I think they're trying to get patients to have a bit more control over their own health and futures I guess." [Practice manager]

  "[It's] about the outcomes that patients really want rather than fixed outcomes really that the QOF had…If you've got outcomes that are more person specific then patients will work more towards it and with us…So we might get better outcomes" [GP]

A shared understanding of the purpose and vision behind the LTCF is important to maintaining momentum and encouraging take up across the CCG. Our findings show that, so far, practices have principally understood the framework in terms of efficiency goals. Indeed this may be how the CCG originally 'sold' the framework to practices, given such goals are hugely important at a time when general practice is facing unprecedented demand. That said, if the framework is going to transform the experience and outcomes of LTC care, there needs to be a stronger focus on how the framework will act as a vehicle for changing the model and relationship of care.

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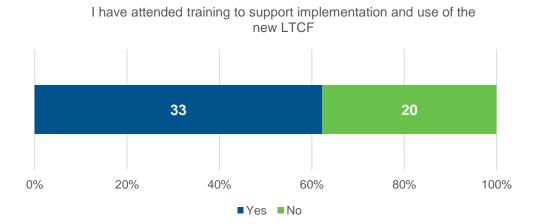
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Training provided was useful and support from the CCG was really valued

The role of the CCG in implementing the new framework was valued and well received. In particular, practice staff felt well supported by the CCG, who had been responsive to their requests for help:

"[The] CCG are very supportive and, you know, I think they want to make it work." [Practice manager]

"I know that I can pick up the phone to the CCG with any question, with any query and I will be given support up there and I just think that that's a tremendous resource." [Practice manager]

Almost two thirds of survey respondents (33/53, 62%) had attended training to support use of the new LTCF. Of all 53 respondents, 32 answered a question reflecting on the value of this. The majority (78%, 25/32) stated that the training offered by the CCG was useful to support implementation and use of the framework. Practice staff valued the chance to refresh their knowledge or learn about new conditions and find out more about wider services:

I have attended training to support implementation and use of the new LTCF

33	20	

0% 20% 40% 60% 80% 100%

■ Yes ■ No

"At a study day that we did a couple of weeks ago, I was made aware of the self-management team but until then I wasn't aware of what they actually did." [Practice nurse]

A few staff suggested that the training would have been more beneficial if it had been provided before 'going live' with the template:

"I think probably we should have had them before it was

implemented. I think we could have done with doing [the training] this time last year in preparation." [Practice nurse]

ICF

Further training needs were identified by practices

Some practice staff felt that further help/training in implementing the template would be useful. This view was also reflected in the survey, with one third of respondents (17/52, 33%) reporting that they/their practice would like more support around implementation.

Practice staff suggested areas in which this would be most valued:

- Help with the practical aspects of implementation, in particular with changing recall processes and running searches to identify patients with multiple LTCs:

"..more help with managing call and recall would be helpful." [GP]

"We need to have a breakdown of patients by how many LTCs they have and by month of birth as this is how we would like to call them in. We are struggling to do this ourselves." [Practice manager]

- Greater focus on the functionality of the template and how to navigate the different sections on-screen:
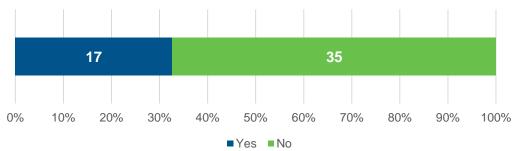
"Some other bits that I need to clarify, offering structured education, self-management, things that I'm not really quite sure what I'm doing with it." [Practice nurse]

"We were actually wanting [training] directly related to the template, which is a very time-consuming thing to use." [Practice nurse]

- Further LTC specific training to support a more holistic approach to care, particularly in areas that practice nurses and HCAs are traditionally less familiar with:

"[The CCG could do with] picking areas where they feel that maybe nurses need a bit more, because really these have always been diabetes, COPD and asthma. There hasn't been a lot put into palliative care, heart failure, mental health." [Practice nurse]

"More help with cancer care, admission avoidance, dementia and mental health areas not previously undertaken by nurses and HCAs." [Nurse specialist]

I / my practice would like more support on how to implement and use the new LTCF

17	35

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

■ Yes ■ No

Views on whether the framework is preferable to QOF were mixed

'Buy in' to the ethos of the framework is important to encourage spread to those who have not yet opted into the framework contract and to support sustainability for those who have. In our interviews, to further understand how the framework was perceived, we asked practice staff whether, given the choice, they would continue with the LTCF or go back to QOF. Broadly there were three types of answer given:

1. **Preference for QOF**: the QOF templates were easier to use and/or less time consuming.

   "I'd say I'd go back to QOF from a familiarity point of view because I knew where we were then. But I do think the long term conditions framework has the possibility to make things better so I would want to keep aspects of it, and certainly the holistic care aspect of it I'd want to keep…I'm not yet convinced that it is going to

   reduce workload." [GP]

2. **Reserving judgement**: there were two reasons given for this view. Firstly, that QOF will be changed in 2017 and it is impossible to say which system will be better until the new QOF arrangements are known. Secondly, that the new template is taking more time at the moment and is more burdensome than QOF, but this may be because practices were so familiar with QOF that it had become 'second nature'. More time is needed to see if the new framework proves to be time saving with greater familiarity.

   "I would say at the moment I wouldn't like to say one way or the other. Because I think it's something that we would have to see at the end of the year how it's turned out because I think a lot of

   people would probably say they would rather go back to QOF but I think that's because we've known it - we're familiar with how it works. I suppose the real test would be has it made a difference to patients. And I would say that if it hasn't then probably we'd go back to QOF!" [Practice manager]

3. **Preference for the LTCF**: because it supports holistic care and a focus on proactive LTC management.

   "I think the principle of the long term conditions framework is very good so I think after we've got over the teething difficulties and sorted times and things out I would go along with the long term conditions.'"[Practice nurse]
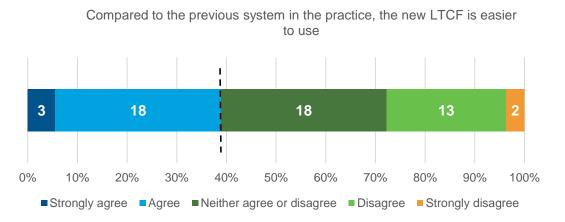
Streamlined template

Views about the new LTC template are mainly positive

In order to support the introduction of LTCF in general practice, the CCG designed and developed a streamlined EMIS template, which has been introduced within practices. The template incorporates condition specific pages with data gathering for all LTCs as well as a care planning template, which clinicians can complete and print off for the patient to take away. The template was designed to display only the specific, relevant pages for each patient, making it easier to populate.

This aim of the streamlined template is to facilitate the holistic management of people with LTCs, particularly those with multiple co-morbidities, and ultimately create efficiencies.

In general, practice staff shared positive views about the functionality and design of the new template. Almost 40% of survey respondents (21 out of 54) reported that the new LTCF is easier to use compared to previous ways of working:

"Easy to use and very useful that that essential parts of LTC care are in template." [GP]

Compared to the previous system in the practice, the new LTCF is easier to use

Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
3	18	18	13	2

"Because before, it was a case of having to stop and think for yourself, you know, when you look at what conditions they've got. But now, it's all in front of you, so it does make it easier in that sense." [Practice nurse]

One reported benefit of the template was the opportunity to have information about all LTCs in one place, reducing the need to alternate between different templates when reviewing a patient with multiple LTCs. Some interviewees felt that the template was intuitive and logically laid out to support the flow of a consultation:

"Whereas before, we'd have to go to various different templates, which was probably fiddlier, because you had to keep going out of one, and into another, so it's good that it's all in one." [Practice nurse]

One practice manager felt that the template could drive a move towards holistic care and a whole person approach:

> *"The templates are very good and enable the clinicians to provide complete holistic care for the patients." [Practice manager]*

The template has been developed and updated over time; several staff had provided feedback to the CCG, which had subsequently been used to refine and improve the template so that it better met their needs.

However, a few people questioned the appropriateness of some of the content. In particular, they identified certain types of information required by the template that – it was felt – was unnecessary or were unlikely to lead to better patient outcomes. Some questioned the evidence-base behind the scheme:

> *"How many years are we going to carry on asking [patients] if they eat oily fish, even if they do not like it/are vegetarians? Where is the evidence that this improves outcomes?" [GP]*

> *"So the nurses are spending a lot of their time doing all that stuff when actually, if they've got uncontrolled diabetes or some other issue that's a bit more pressing, whether they're eating five fruit and veg a day is not as bad as the fact that they're nailing the cakes, they can't take their tablets properly, it's that element of it actually we need to triage which bits are important and which bits are not as important." [GP]*

Staff held mixed views about whether template is more efficient than previous ways of working

Views were mixed on whether the new template was saving time. Only 15% of respondents (8 out of 53) reported that the new template took less time to complete than arrangements under QOF, despite having all information and data inputting in one place:

> *"It's not saving time at the moment. That's because we've got a lot more boxes to tick." [Practice nurse]*

> *"I find the layout difficult to navigate to find the data I want to enter. This can mean it takes longer than previous methods." [GP]*
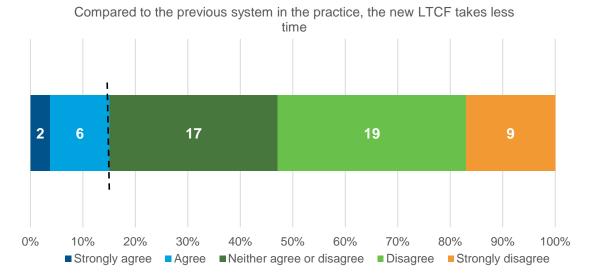
Furthermore, as a result, a few felt that this led to more time being spent focusing on the template itself, rather than concentrating on the patient.

> *"Template very cumbersome and feels like tick boxing --rather than spending time with patient to explore his/her concerns and enquiries" [GP]*

> *"There is extra stuff to put into [the template], without having any extra time on the appointments. So it can be a little, you sort of have to work around the template whilst the patient's talking or the BP machine's going. You have to keep ticking all sorts of little boxes to try and cut down the time." [Practice nurse].*

But some staff also acknowledged that there was a 'learning curve' with the new system, and that the time taken to complete the template would likely reduce as they become more familiar with it:

> *"Personally I like it. I mean the more consultations you do with the patients and the more au fait you are with the framework, you can whiz through." [Practice nurse]*

> *"I think as we become more experienced with filling in and completing the templates and knowing what to look for and what you should be doing and ticking and moving down to [time to complete will decrease]" [Practice manager]*

Compared to the previous system in the practice, the new LTCF takes less time

| 2 | 6 | 17 | 19 | 9 |

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

■Strongly agree ■Agree ■Neither agree or disagree ■Disagree ■Strongly disagree

Staff held mixed views about whether template is more efficient than previous ways of working (2)

Minor teething problems were still reported by some staff. Issues fell into two main categories:

- Condition specific information – some information still cannot be recorded on the template and requests for the inclusion of extra content were made:

    "*There are still things that need adding for example prostate injection and ear syringe template.*" *[Assistant practitioner]*

    "*Still needs refining, i.e. at risk diabetes within template plus cardiology page is not user friendly.*" *[GP]*

- Technical difficulties with using the template – knowing how to correctly code certain fields or exemptions and how to stop reminders frequently popping up:

"So within the practice that's where we've had problems because it's trying to get staff to uniformly code stuff so that the information is being picked up." [Administrator]

 "It is unclear if data is 'required' or optional. This was clear on previous templates." [GP]

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Multi-morbidity approach

Some practices have made significant changes to implement the LTCF, others have not
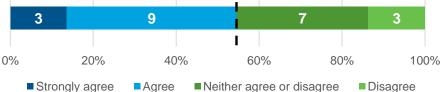
Implementation of the template will provide a firm foundation and the first building block towards the transition to a multi-morbidity approach to support people with LTCs. The aim is to facilitate more holistic management of LTC care through practices integrating routine, condition specific appointments into a single (or fewer) holistic reviews.

Our research has revealed a considerable degree of variability in the practical and operational changes made by practices to support the implementation of the framework. Practices broadly fell into one of two categories:
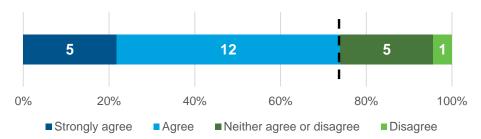
1. **Practices that have made little or no changes to the way that their care is organised**: in these practices the template has been introduced, and is being used, within their existing clinic structures and appointment times.

2. **Practices that have changed (or are planning to change) how they organise and deliver LTC care**: to support the holistic approach to care facilitated and encouraged by the template. Examples of changes include combining separate condition specific appointments into one, allocating set days for holistic review consultations, changes to recall processes and employing HCAs to provide further resource and support.

Our survey provided further insight into the extent of changes being made (see tables below). More practices had started to make multi-disease clinics available to patients (74%, 17 out of 23) than had made changes to the structure of appointments (55%, 12 out of 22).

We have changed the structure of appointments within our practice

Strongly agree	Agree	Neither agree or disagree	Disagree
3	9	7	3

We are making multi disease clinics available to patients

Strongly agree	Agree	Neither agree or disagree	Disagree
5	12	5	1

Practices reported several barriers to changing the organisation and delivery of LTC care

There were several reasons why practices had chosen to incorporate the LTCF into their existing ways of working:

Resource implications – practices identified that in order to change how they structure and deliver care, capacity would be needed and this could be resource intensive.

For example, having someone in place to lead the changes and support the administrative burden associated with changing appointment and clinic structures. Our survey found that changes had been predominantly led by practice managers, with 83% (19/23) reporting that they had the responsibility to introduce the LTCF within their practice.

In addition, some thought that the framework might pose particular challenges for certain practices: for example, those with smaller teams of staff may find it more difficult to cover staff absences and maintain consistency in care or lack the resources to make better use of skill mix.

> *"Dr A has been on maternity leave for a few months as well so, it just means there's a little bit of a delay." [GP]*

Potential for wasted appointments –some practice staff raised concerns about extending the length of appointments and combining clinics because, if patients did not attend, this could be a considerable waste of time and resources. In short, a DNA of a 10 minute appointment was less of a problem for the practice than a DNA of 30 minute one. Conversely, a number of people felt that combining appointments could reduce the likelihood of DNAs, because patients were being asked to visit the practice only once rather than multiple times.

Difficulties with changing recall processes – changing recall processes was considered an important step in enabling practices to restructure their appointments. Several practice staff were finding it difficult to restructure their appointments and needed support to introduce new systems (e.g. recall by birth month). Additionally, others reported struggling with an effective and accurate way of identifying people with multiple LTCs on different disease registers.

> *"I feel we have the skills in place to deliver the service but need assistance with the recall of patients." [Practice manager]*

View of LTCF as a pilot – because the LTCF is still in pilot phase, some questioned the value of making changes – which could be very resource intensive – which might subsequently be reversed.

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Some practices have increased the amount of time available for LTC consultations

Many of the practices which had implemented the framework into their existing ways of working reported difficulties with 'fitting everything in' to their allocated time and fears of running over.

For the other practices (those that had made changes) there were two main ways that they were trying to increase the amount of time available in the holistic reviews (summarised below, and explained in more detail on page 51):

a) *Extending the length of LTC appointments*

b) *Having a two stage appointment:* with tests and template completion carried out by a HCA, and a subsequent consultation focused on care planning and a more general discussion of the patient's health and wellbeing.

Having this extra time to focus on a more holistic approach appeared to be of benefit. For example, one practice manager told us:

> *"If I was to give them an appointment under the QOF way and call them in separately I would need to have 9,500 appointments in the diary. Just to see each one of them once for one of their things. Now I can do 4,500 appointments, make them longer appointments and actually give them better quality of care within that appointment."*
> [Practice manager]

However, practices also highlighted the resource intensive nature of combining reviews and protecting more time for each appointment. In particular, the impact longer reviews had on the number of appointments a practice could offer in a day, with longer appointments leading to a decrease in possible slots. Some administrators in practices that had introduced two stage appointments described the difficulty of arranging reviews with multiple HCPs and understanding the timing implications of each.

Some staff were positive that streamlining reviews would be of benefit to patients

Views on whether streamlining reviews into one (or simply, fewer) was better for patients were mixed. Some thought it was saving patients time and improving their experience:
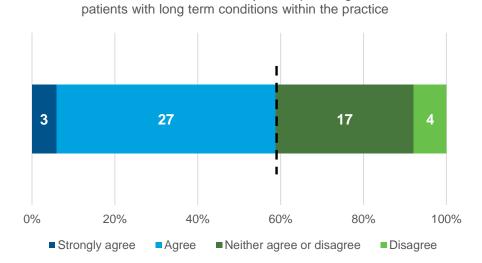
"But the difficulty with QOF was if a patient was on the diabetic register, plus the COPD register, plus say the heart failure register, sometimes if you couldn't quite coordinate all the appointments they had to come back in three times and they've [the patients] got to be cross about it." [Practice manager]

Additionally, 59% (30 out of 51) respondents to the survey felt that LTCF had led to more joined up management of people with LTCs within the practice. Slightly fewer (52%, 27 out of 52) also felt that it had led to more joined up management of people with LTCs within the wider system of care.
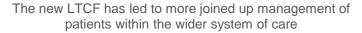
Others felt that streamlining reviews may have a negative impact, for example, that discussing multiple conditions in one appointment, and the timing implications of this, may be too much for some people with LTCs:
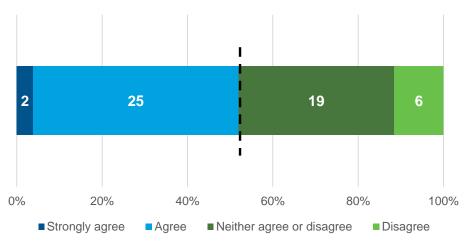
"Seeing a patient with 5 or 6 conditions can mean a long appointment for the patient who doesn't retain all info and very stressful for the clinician if their day comprises of patients like this all day" [Nurse specialist]

The impact of this for patients and their ability to take part in a more collaborative conversation is explored more in the next section.

The new LTCF has led to more joined up management of patients with long term conditions within the practice

3	27	17	4

■ Strongly agree ■ Agree ■ Neither agree or disagree ■ Disagree

The new LTCF has led to more joined up management of patients within the wider system of care

2	25	19	6

■ Strongly agree ■ Agree ■ Neither agree or disagree ■ Disagree

The move towards streamlining reviews has impacted on practice staff

The implementation of the LTCF has had various impacts on practice staff. Our research found that most practices are, or are planning to, making more efficient use of their skill mix to facilitate the introduction and embedding of holistic reviews.

In our practice survey, 32% (7/22) of practice managers reported making changes to skill mix within the practice to manage people with long term conditions (see figure on right).

In particular, this has involved recruiting more HCAs and/or HCAs taking on an enhanced role in the delivery of care. Across the case study practices, there had been an increase in the number of HCAs recruited and examples of how their roles had been extended included taking responsibility for patient tests and template completion.

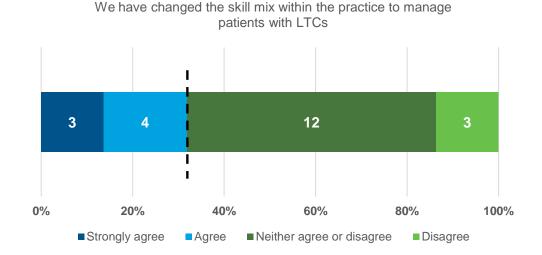*"We are using the HCA more with this framework" [Practice Manager]*

"The way we've streamlined it now is that we have the HCAs, patient sees

the HCA first then they see the nurses and we have three, sometimes four clinics running parallel." [GP]

Our research also shows that there is a wider shift in the delivery of LTC care; while this pre-dates the introduction of the LTCF, the new framework is nonetheless acting as a major driver.

Responsibility for conducting holistic reviews was largely being picked up by

the nursing workforce. In addition, practices were starting to move responsibility for more straightforward data gathering tasks from practice nurses to HCAs, encouraging a more efficient and better use of skills within a practice.

"Well it has changed the way the doctors are doing things, because they don't seem to be touching the template at all. They leave it – because there's so much more in it, I think they just leave it to me now!" [Practice nurse]

We have changed the skill mix within the practice to manage patients with LTCs

Strongly agree: 3	Agree: 4	Neither agree or disagree: 12	Disagree: 3

■ Strongly agree ■ Agree ■ Neither agree or disagree ■ Disagree

Confidence in working across conditions is an important enabler of this approach

An important enabler of a multi-morbidity approach is having a team of clinicians who feel comfortable and confident to conduct integrated, holistic reviews. As we noted above, the majority of LTC care is now being picked up by the nursing workforce. This is presenting some challenges in terms of the capabilities and skills available.

Above all, the single condition approach to LTC reviews under the QOF system encouraged a drive towards specialisation within the practice nurse workforce – in other words, nurses often specialised in, and were responsible for, managing patients with a particular condition.

The success of an holistic approach to care would depend upon staff having confidence across the range of LTCs that patients might have. Many nurses reported not yet feeling confident to take on this role, in particular because of a felt lack of knowledge and experience in conditions other than that in which they had specialised. The need for additional training to bring the nursing workforce 'up to speed' with the range of conditions covered by the template was raised by several interviewees:

"I wouldn't say I felt confident, no, you know, it's an area that it's going to have to be, you know, a bit more - learning for me I suppose." [Practice nurse]

"We are struggling with the concept of combining them all really it's becoming very difficult…when you're talking about alteration of medication whether it be insulin tablets to inhalers that kind of thing you really need people to know what they're doing" [GP]

Specialisation vs generalisation in LTC care

An interesting theme which has emerged from the research is the tension and balance to be struck between generalisation and specialisation of skills, predominantly among the nursing workforce.

"Some nurses don't do diabetes, some don't do asthma or don't do COPD. They've specialised in different areas and the LTC requires you really, to be a generalist across all conditions." [Practice manager]

The drive towards more LTC care being delivered outside of hospital settings, encouraged by policy, requires a degree of specialisation within the primary care workforce, who are seeing patents with even more complex conditions and health needs. But there is a potential conflict here, because the move towards providing holistic and integrated care requires professionals with generalist skills.

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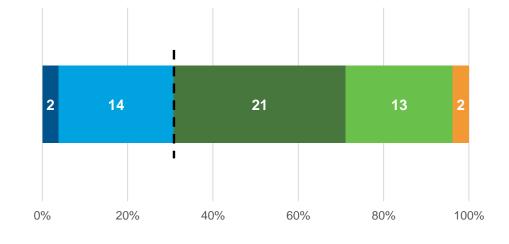ICF proprietary and confidential. Do not copy, distribute, or disclose.

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New ways of working are perhaps linked with reported levels of staff satisfaction

Training provided by the CCG had contributed to a degree of upskilling in the nursing and HCA workforce. However many called for further and ongoing training to increase confidence and knowledge around not just physical LTCs, but also mental health, cancer and palliative care:

"I used to do the asthma and then when we went to the old role of having separate clinics you tend to lose those skills a little bit. So from my point of view I feel I've had to re-brush up on quite a few things, which is good I mean that's a good you know good for us all to keep up to date." [Practice nurse]
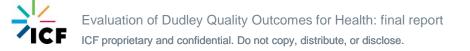
This unfamiliarity with a new way of working is perhaps reflected in the online survey, with only a third of respondents (31%, 16/52) agreeing that the framework had improved their job satisfaction, and almost the same proportion (29%, 15 out of 52) reporting that it hadn't.

The identification of need, development and training for clinicians is key to supporting this multi-morbidity model.

The new LTC framework has improved staff satisfaction

| Strongly agree | Agree | Neither agree or disagree | Disagree | Strongly disagree |

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Care planning

Care planning: variability in practice

A major aim of QOFH is that patients will be supported to identify personal goals and develop a care plan, to help them to take ownership of their condition and its management. Our case study research provided us with multiple sources of evidence with which to explore the nature and extent of care planning that was taking place.

We found that the format and content of holistic reviews varied considerably, particularly in relation to care planning. This ranged from/to:

- Consultations which were exclusively about care planning (template completion and any tests needed had been carried out at a separate appointment), with patients playing a equal role in conversations that addressed all aspects of their health (including social and mental health problems). This included signposting to wider services and supports, such as self-management programmes and voluntary sector resources and focus on actions to support goals.

- Consultations which were driven by the HCP and focused on medical monitoring tasks. Patient involvement was largely limited to answering questions relating to the template, and there was no care planning conversation. In some cases, care plans were being filled in "for the patient" after the consultation, but the patient wasn't made aware of this.
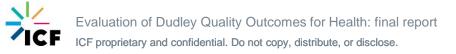
Most of the consultations we observed tended to fall somewhere between these extremes, where goals were not explicitly requested or explored as such but patient perspectives were listened and responded to.

There was variation both within as well as between practices. For example, in one practice we observed very different styles of care planning in a permanent and locum practice nurse, with the former offering a more patient-led approach to identifying and defining goals and the latter focused largely on template completion.

Person-centred care planning: the philosophy

- People with LTCs are in charge of their own lives and self-management of their conditions and are the primary decision makers about the actions they take to manage these.

- People with LTCs bring personal assets, strengths and abilities to develop solutions. The care and support planning process supports them to articulate their own needs and decide their own priorities.

- The care and support planning conversation is a meeting 'between experts' which brings together the lived experience of each person and the technical expertise of the practitioner.

- People are much more likely to take action from decisions they make themselves rather than decisions that are made for them.

Source: Year of Care Partnerships

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Variability in care plans

Good practice guidance emphasises that, for care plans to be valued and effective, they must be owned by the patient. Evidence shows that, if patients do not have ownership of their care plan, they are likely to see it as irrelevant and will rarely, if ever, consult it (Simpson et al 2016).
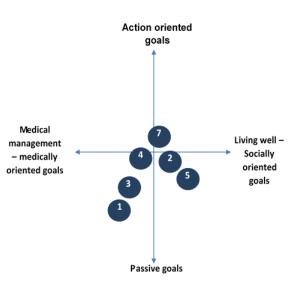
In practice this means:

- Plans must be produced *with* patients, not *for* them – the most important thing is the quality of the conversation, which the care plan should document.

- They must be based on what is important to the person, in their life and for their health.

- They should support people to take an active role in their health.

- They should be action-oriented – for example, goals should be SMART (specific, realistic, achievable etc.)

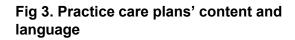- They should use everyday and person-centred language.

Each case study practice was asked to provide a random (anonymised) sample of 50 care plans for the evaluation team to review. We received plans for six practices (one practice provided 21 care plans) making a total of 271 plans reviewed. It was not our goal to 'read off' conclusions about care planning from these documents alone as the plan itself is a way of documenting this process. Rather, we focused our analysis principally on:

- the content of the goals – e.g. whether they were concerned with biomedical management or a person's wider life and wellbeing (socially oriented)

- the language used – e.g. action oriented or passive; person-centred or medicalised.

In particular, we sought to make an assessment about whether the care plans in our sample fulfilled a key function: namely that they supported people to take an active role in their health (see box on the left).

The diagram below is a visual representation of the care plan analysis. The practice identifier (PI) has been marked on the axis in accordance with the content of the care plans we reviewed.

Fig 3. Practice care plans' content and language

Supporting realistic and achievable goals

Generally care plans tended to contain more passively phrased goals – goals were often vague (for example, "think about losing weight and exercising more" or "make healthier life choices)" and plans did not typically include details about the actions that the person would take towards achieving their goal or when, how or by whom the goal would be reviewed.

The template provided by the CCG for care plans is likely to be a key factor here, as it provides only limited space for information to be recorded and does not include a section for patients and professionals to complete an action plan (breaking down the goal into manageable chunks). It is the combination of goal setting *and* action planning which is critical for encouraging successful self-management and behaviour change.

Moreover, the effectiveness of care planning is enhanced when patients are encouraged to reflect on both the importance of goals set and their confidence that these can be achieved. According to The Health Foundation, people have a good chance of achieving a goal where they rate their confidence as 7 (out of 10) or more (Health Foundation n.d.). This reflective process can lead to more relevant and realistic goals being set, and to patients identifying and addressing barriers to achieving their goals before they get underway.

Some templates for care planning, including one recommended by the Royal College of General Practitioners, includes prompts for patients to consider these issues (see example on right).

Fig 4. Excerpt from Year of Care Partnerships Care Plan template (Source: RCGP 2011)

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Care plan analysis: more detailed themes

The table below presents more detailed themes from our analysis of patient care plans, presenting both good practice examples, as well as areas where improvement is needed if patients are going to own and use their care plans to manage their condition(s) effectively.

Theme	Description	Examples
Person-focused goals	▪ Some care plans included goals that related to people's broader lives and wellbeing, not just to medical management ▪ In some cases, these were phrased in the first person, creating a sense that the care plan belonged to the patient	
Action oriented and motivational language	▪ A few care plans included very specific goals and targets – for example, *"reduce alcohol intake, aim for 1-2 alcohol free days"* ▪ Some employed motivational language, acknowledging achievements already made and encouraging further positive behaviour change	
Focus on medical management	▪ The majority of goals were medically orientated around managing specific conditions, such as diabetes and blood pressure ▪ Many included highly technical and medicalised language, such as *"reintroduce producer"* and *"reduce metformin due to renal function"*.	

Care plan analysis: more detailed themes

Theme	Description	Examples
Topic areas of focus	▪ The most common topic areas covered by the goals were: diet, weight, exercise, asthma, blood pressure, smoking and diabetes. ▪ There was less focus on mental health; where goals were related to mental health, they tended to be about medical management, such as *"see GP about mood"* and *"try antidepressants"*	**Goals** Goal 1: Lose weight Goal 2: N/A Goal 3: N/A Goal 4: N/A **Goals** Goal 1: To maintain good asthma control Goal 2: N/A Goal 3: N/A Goal 4: N/A
Some "goals" were not goals	▪ Some goals were just notes for the HCP or updates on the status of the patient. ▪ Some goals were centred around signposting to other services. It was unclear whether this was for the patient or professional to follow up on.	**Goals** Goal 1: Hbaic will be raised due to the effects of current long term steriods. Goal 2: Discussed monitoring at home Goal 3: Review 3 ths Goal 4: N/A **Goals** Goal 1: Diet Discussed Goal 2: refer to Podiatry Goal 3: N/A Goal 4: N/A
Lack of consistency of care plans within practices	▪ Within some practices, care plans differed between HCPs in terms of in terms of type and level of information inputted and language used. ▪ Some HCPs had repeated the same goals word for word for different patients.	**Goals** Goal 1: Has managed to lose over 3kg in the last 10days via his weightt loss efforts - healthy eating + increased physical activity and will continue these efforts. Goal 2: N/A Goal 3: N/A Goal 4: N/A **Goals** Goal 1: I'd like to improve diabetes control Goal 2: I'd like to improve my sleep Goal 3: I'd like to lose a little weight Goal 4: N/A

Staff views and patient experiences

Introduction

Our observations and interviews with members of practice teams offered insights into what staff care planning is, and what they think about it. As guidance from the Royal College of GPs (2011) emphasises, care planning consultations are about people "taking ownership of their problems and making informed, supported choices about their lives." They describe it as follows:

> "Just imagine one of your longstanding patients with diabetes, Mrs Smith, who has been coming to see you for years. However, instead of being the passive recipient of your 'worldly advice', she sets the agenda and with your guidance, decides what she is going to change, how she is going to do it and when she will come back and speak to you again." (RCGP, 2011, pg 5)

In the consultation, the professional's role is akin to that of a facilitator or enabler, in an approach that allows patients to set their own goals and make their own decisions.

Staff views

Some staff we spoke to shared this view of care planning; for example one told us:

> "Care planning is the tool for patients to nominate things to do to look after their health and what it means to them, in their terminology … its translation of the outcomes that are required but in a way that the patient understands and then the patient drives towards it." [Practice manager]

What we heard from others, though, suggests that many see care planning in more medicalised terms, as a more formalised approach to the providing and documenting of medical advice:

> "I think it gets easier as you get more senior and it's easy to say to patients well why haven't you done your exercises, why haven't you done this, why did we suggest you lost weight et cetera." [GP]

> "I think care planning works extremely well on patients where you've got a clear trajectory of illness…when you haven't got that clear trajectory and there is nothing further we can do medically, we cannot prolong your life and we can't predict exactly what's going to happen to you. We can't do care planning to me in those situations." [GP]

Staff views and patient experiences

Staff had mixed views about the value of care planning. Some spoke enthusiastically about putting patients at the centre of their LTC care, using an approach where the aim was to enable and support people to achieve their own goals. Those who expressed more cautious or negative views questioned whether i) patients wanted to engage in care planning and/or ii) that care planning would benefit patients and improve outcomes. Some held very strong views about this; for example, one GP told us:

> *"Care planning is pretty much pointless. It's a lot of work and a lot of time for very little gain." [GP]*

Recent evidence (see box on right) shows that care planning can be effective in improving dimensions of physical health and self-management outcomes, but only when it is carried out intensively and comprehensively.

There were also some concerns that care planning would identify new needs that general practices either did not have the capacity to deal with and/or might not be best placed to address (for example, social needs related to housing and isolation). We pick this issue up in again on page 54, where we discuss how general practice and care planning might link with wider services.

Care planning outcomes: what does the evidence say?

In 2015, a Cochrane systematic review was published, reporting the effects of personalised care planning for people with long term conditions (Coulter et al 2015). A total of 19 RCTs were included in the review, which showed that care planning was associated with small improvements in indicators of physical health (eg. blood glucose, blood pressure, asthma control), as well as improvements in mental health and in people's confidence and skills to manage their health. Effect sizes were greatest where care planning was more comprehensive, intensive and better integrated into routine care. In the more successful studies, the care planning process including included patient preparation, record sharing, care coordination and review.

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What is care planning: staff views and patient experiences

Patient experiences

For patients, one of the key changes seen so far was that they were being asked a wider range of questions about their health and wellbeing, prompted for in the new EMIS template:

"We do go into more depth. We ask how they're sleeping, we're asking about depression, so we're asking much more quite personal questions really." [Practice nurse]

We heard examples of where these new questions were prompting patients to raise issues that they previously hadn't thought or wanted to disclose:

"One lady came and she said "you know, my daughter's been telling me to say something for ages and ages" and she clearly hadn't and it's only because I asked that question." [Practice nurse]

However, we also saw or were told about examples where an issue had been raised by the patient, but the professional had either been unable or unwilling to respond to it – this was particularly common in relation to mental health problems.

For example, after their holistic review, one patient told us:

"I don't think [the practice nurse] was quite interested in that part of me (my depression)." [Patient]

A staff member we interviewed felt she lacked the skills and time to be able to respond to patients disclosing feelings of depression**:**

"I've had quite a lot of people really upset when I've asked them about feeling depressed in the last month. And so they've broken down in tears. It might be the first time they've said anything and really it's for me, I haven't got the time to go into that, I haven't necessarily got the skills to do it. But you're asking the question, so it's how do you go about asking that question so that they're patient isn't expecting too much from you but, at the same time, you don't want to put them off from telling you as well." [Practice nurse]

Aside from the kinds of questions being asked of them, generally patients hadn't noticed a difference between previous consultations for their LTC(s) and the new holistic review. This suggests that approaches to care planning have not, so far, been greatly influenced by the introduction of the LTCF.

Impact of care planning

In our interviews, several staff speculated about whether the care plan would have an impact on patient behaviour. Some gave specific examples where care planning had made a difference – for example, that patients seemed more knowledgeable about their conditions or medications and how to manage them. However, more common was the view that care planning would have limited impact, and there was scepticism about whether the majority of patients would do anything differently following the care planning consultation:

> *"I think that there will be a small cohort of patients who will alter their behaviour because of that but I don't think the vast majority of them will particularly not those with multiple different conditions I think." [GP]*

However, there is also considerable scope to amend the care planning process to enhance its impact. For example, as one interviewee commented, patients are more likely to act on goals that they have set themselves because they feel ownership of these. This links back to the point made earlier, that the goal setting process in many of the consultations we observed was being driven by the HCP rather than the patient.

Few consultations included a discussion with patients about what the purpose of care planning was or how they might use their plan to manage their conditions and improve their wellbeing. It was also not clear in most cases, when, or even if, goals set would be reviewed or updated at a later date. And, above all, almost no patients were given a printed copy of their plan to take away with them.

Delivering effective care planning

Our findings point to three factors that enhance both the experience and impact of care planning:

1. Structuring appointments to ensure there is sufficient time to engage patients in a meaningful conversation about their health goals and how they might progress these.
2. Preparing patients and professionals for the care planning conversation.
3. Ensuring access and clear referral pathways to a coordinated set of services, linked to general practice.

Each of these is addressed in turn below.

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1. Structuring appointments to allow time for a meaningful care planning conversation

Across the holistic reviews observed, a common theme within those in which patients were more actively involved was having sufficient time to engage in a conversation about the patient's health, how they manage their health problems and any services or supports they may need.

We observed two main ways of structuring appointments to protect the time to do this:

1. **Extending the length of appointments** to enable the HCP time to both complete the template and engage the patient in a care planning process. Where appointments times were short (e.g. 15 minutes or less) conversations were generally more template-driven and opportunities to deliver a more holistic model of LTC care were being lost. As staff told us:

   "I just find it's quite, you're doing a lot of work on the computer while the patient's actually in with you. Which isn't always a good thing. Whereas I'd rather be looking at and talking to the patient." [Practice nurse]

   "I could only deal with the patients with diabetes. I couldn't deal with all their long term conditions in one consultation, because it was too lengthy for me. And

really I thought the idea, one of the ideas of the long term conditions template is that we can see them, if they have got diabetes and CKD, we can deal with both in one consultation and not having the patient in for two consultations really. But that can't happen or I've never been able to allow that to happen with my time constraints." [Practice nurse]

2. **Having two stage appointments and utilising different skill mix within a practice.** One practice is delivering holistic reviews in a two stage process, similar to the 'House of Care' model of care planning that is promoted by the Royal College of GPs. Patients meet initially with a HCA who completes the template and carries out any tests that are required. This allows the practice nurse, in a subsequent appointment, to concentrate their time on having a conversation centred around what matters to the patient. As one staff member told us:

   "We've kind of combined [all that together now] and we're calling it an LTC clinic. And the way we've streamlined it now is that we have the HCAs, patient sees the HCA first then they see the nurses and we have three, sometimes four clinics running parallel." [GP]

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2. Preparing patients and professionals for a different kind of role and relationship

Preparing patients

We heard several times from practice staff about the need to prepare patients to have a different kind of conversation, that care planning is less effective and patients are less engaged in the process when they go into the consultation 'cold':

"Yes, the care plan side of things, the patients haven't got time to think about what they want to go on a care plan. And they're pretty much put on the spot, which is a bit, unfortunate really because if they did want to hone in on something they've got to think about it straightaway. Whereas if they've got time to prepare for it, they might have a better answer about what they want to actually go on the care plan." [Practice nurse]

"We say, 'Well, what do you want to improve?', they kind of look at you a bit like 'What on earth are you on about?' They're just not used to it…They're used to that kind of paternalistic thing where we just tell them what's good for them. And so, for us, then turning round and asking, 'What do you want to do?', a lot of them aren't prepared." [GP]

This view is echoed in wider debates about care planning, where the importance of preparing patients is increasingly acknowledged. A major review of 'what works' in implementing self-management support and care planning into mainstream NHS care found that:

"The value of patients being, and feeling, prepared for consultations was also emphasised. Preparatory activities recognise that collaborative care places demands on patients and therefore they must be properly equipped to participate; they also help to make the best of the (limited) time that patients and professionals spend together. (Ahmad, Ellins and Krelle 2014).

Providing patients with information in advance helps them to prepare for and get the most out of the consultation, and is a key element of some models of care planning now being implemented in general practice. For example, the House of Care model – promoted by the Royal College of GPs – involves a two-stage appointment like that being used in one of our case study practices. In between the two appointments, patients are sent their test results (with guidance about what these mean) as well as question prompts to help them think about what they'd like to discuss at their review. As we discussed on page 48, current evidence shows that approaches to care planning which include preparation of this kind are associated with greater improvements in patient outcomes.

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2. Preparing patients and professionals for a different kind of role and relationship

Training and support for professionals

Evidence also shows that the effects of care planning are greater where there is investment in training and skills development for HCPs (Coulter, Roberts and Dixon 2013). This might include opportunities for professionals to develop patient-centred consultation skills such as motivational interviewing and condition-specific training (Centre for Reviews and Dissemination 2015).

Some staff that we spoke to reflected on the culture change that is necessary to develop and embed person-centred approaches such as care planning into mainstream care. As one person told us, it required a fundamental shift in thinking and practice:

"If you've got outcomes that are actually person-specific, then hopefully the patients will actually work more towards it along with us, and so we might get some better outcomes that way, but, as well, we really should be doing what's important to people…It's a partnership, and, you know, we spent a long time saying, you know, 'If only they'd lose weight, if only they'd adjust their diet, if only they'd do some exercise.' It's getting people into that frame of mind. You know, the pills will only work so well, you've got to join in and help us. The trouble is, all of our professions – the whole of the NHS – has been telling people for the last

30 years that the pills will do the job. Aren't they marvellous? And nobody realised that, yeah, they're not that marvellous, and you'd better help us out, as well." [GP]

Evidence from the 'what works' review we mentioned above (Ahmad, Ellins and Krelle 2014), points to four characteristics of effective training for HCPs:

1. **Communicate the 'right' message**: training delivered in an open and non-judgemental way; peer-to-peer approaches were particularly well regarded.

2. **Adopt a holistic approach**: training teams rather than individuals fosters peer support and mutual learning, helping to embed a new operational culture and ways of working.

3. **Maintain a practical focus**: training appears to be most effective when focused on practical learning, giving professionals the opportunity to practice new skills and work through real-life examples.

4. **Challenge existing perceptions and traditions**: training needs to challenge assumptions about what constitutes 'care planning' and the extent to which this is already being practiced.

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3. Ensuring access and clear referral pathways to a coordinated set of support services

There was recognition that care for people with LTCs is increasingly being provided by MDTs, with wider (e.g. voluntary and community) services playing an important role in supporting people to live well and manage their health. Indeed, as we noted earlier, some professionals were concerned that care planning was identifying issues that general practice, and the NHS more generally, was not best placed to respond to:

> "And so I've found that the trickiest [question on the template] is the sleep one…You're asking if they sleep well and then what do I do with that information apart from saying "go and see the GP." [Practice Nurse]

> "It opens up queries about well is this really relevant to our consultation you know. We know that the social side of things forms such an important part of the medical side of things but I worry that the way the direction we're moving in health care is that we're trying to deal with things that really health care shouldn't be dealing with." [GP]

Some staff were more positive about how they could respond to issues of this kind arising during consultations, citing recent developments that are supporting practices to connect patients to wider services, such as link workers and MDTs. Prompts built into the new template were also making it easier for staff to make onward referrals:

> "Initially we talked about things like with this mentioned self-management referral and I didn't even know what that was…I don't want to be asking patients if they want an onward referral for that, what does that mean to them, what are they going to be offered? But we've got these inserts now as well which explains things so at least that way I can either give it them or run through with them what that explains. So it helps, because we knew about the diabetes structured education programmes, and things like Action Heart but I didn't know there were specific kind of self-management courses for patients with long term conditions." [GP]

But we also heard about difficulties. Several interviewees mentioned long waiting times to see link workers or to access services such as pulmonary rehab:

3. Ensuring access and clear referral pathways to a coordinated set of support services

"Our problem now is that, you know, we can say, 'Yeah, yeah, we can get the district nurses to come and see you', but I can't at the moment, because they're not responding to letters and phone calls… They haven't got enough, so they're kind of ignoring me and hoping I'll go away…I've had someone this morning say, I did a COPD review with her and referred her to pulmonary rehab, and she hasn't heard in nine weeks…I've referred lots of people to pulmonary rehab, it's really good, but unfortunately, there's a queue now…It's all very well promising things, but then, when you can't deliver…yeah, it's not so great." [GP]

We were also told that some patients don't follow up on referrals made to services such as self-management programmes. As one nurse suggested (see first quote below), one problem may be that many services are provided in a group-based format, which is not appealing to all patients:

"A lot of people just don't want to go groups, they don't know what to expect and they find it scary I think. And I haven't had anyone say "yes" to the self-management and I've been really pushing that in the last three/four weeks." [Practice nurse]

"I talk about with the diabetics, I talk about exercise as well and then I let them know about all the services. I mean they're really lucky in Dudley, there's loads of services available for that as well, again hardly any of them gets taken up." [Practice nurse]

This echoes wider evidence; learning from across the NHS has shown that, *"In self-management support, the group-based education and skills training model has become predominant across the health service…Evidence suggests that these can be effective approaches, but not for all groups, circumstances or outcomes. The message here is be flexible, and offer a suite of options wherever possible"* (Ahmad, Ellins and Krelle 2014).

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Tailoring LTC care to patient need and preference

Many interviews supported an integrated approach to LTC care involving holistic reviews and a single patient care plan. As one GP told us:

"I think to have one care plan for you know an overall number of conditions can be helpful, because you can just add on to that care plan and update which can be helpful for a patient, rather than just having the separate ones." [GP]

That aside, many practice staff questioned whether all patients wanted or needed to engage in care planning. In particular, the following issues were raised:

- Some people might not want to participate in care planning. For example, some staff suggested that older people might prefer a more paternalistic relationship with HCPs. But we would add a note of caution here: no group is

homogeneous in its preferences, and decisions about whether care planning is desirable should be made with – not for – patients. Patients ought to understand what care planning is before making a decision about whether they want to engage in it; our findings suggest that many do not know what it is.

- Is it realistic to combine appointments into a single review where a patient has multiple and/or complex conditions; can patients cope with longer (eg. 45 or 60 minute) appointments, do they want this? Having long appointments risks information overload.

- Is care planning necessary for patients whose LTCs are stable and who are in good health? It may not be feasible for practices to offer care planning to all patients with LTCs, especially if

more time was allocated to holistic reviews or a two-stage approach (as discussed above) was adopted. A better approach would be to target resources according to need and potential benefit. Patients with complex conditions and needs may require more frequent and intensive care planning. Longer recall periods and different types of consultation (such as telephone appointments) could be considered for people who are self-managing effectively. The question for the CCG and practices to consider is what tools or approach to use to target resources and tailor support to people with LTCs.

Implementation and variance

There is significant variation in utilisation of the template

One prominent theme has emerged across the evaluation as a whole – that of variance. We have already discussed this in terms of, for example, differences in how practices are structuring clinics and appointments to deliver holistic reviews, and in approaches to care planning. There is also variation in the extent to which practices are using the template. The chart to the right illustrates utilisation rates of the LTC template by practice. This has been calculated as the percentage of patients with a LTC who have had the template used during their appointment.

The template has been used for around 42% of 'eligible' patients who have at least LTC. The utilisation rate varies widely between practices: from 0% in one practice to over 75% in others. This suggests that the template is being used unevenly in LTC reviews across the CCG.
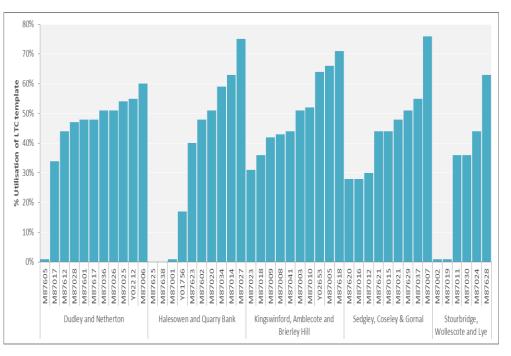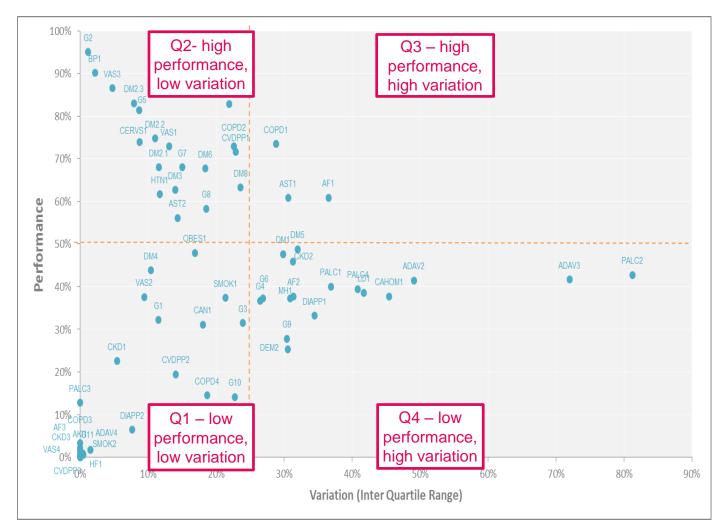

Fig 5. Chart showing variation in utilisation across the CCG

Analysis of quantitative data shows that some GP practices are also currently performing much better against the indicator measures within the framework. This mirrors the qualitative findings presented and those explored earlier in this report around differences in the way the LTCF has been introduced.

Variation in performance across the indicators themselves was another prominent finding, perhaps a reflection of the differences in practice observed through the case study work.

The implications of this variance and ways to make best use of this is explored in the following sections.

There is also significant variance in performance within indicators

Fig 6. Chart plotting performance against variation within each LTCF indicator

In order to provide a framework for thinking through the implications of variation, the chart to the left plots (for each indicator in the framework) overall performance across all practices against variation in performance between practices.

The chart highlights considerable differences in performance amongst the indicators contained within the framework.

The analysis broadly classifies the indicators within four quadrants, and implications associated with each quadrant are explored on the next page.

There are a series of different implications associated with this variance within indicators in the framework

Indicators in quadrant 1 – these indicators are characterised by low performance (i.e. practices are performing less well against these indicators, compared to others in the framework) and low levels of variation between practices (i.e. performance is relatively consistent across practices). This combination could be indicative of a systemic issue that requires a system response to understand and unblock any barriers to progress.
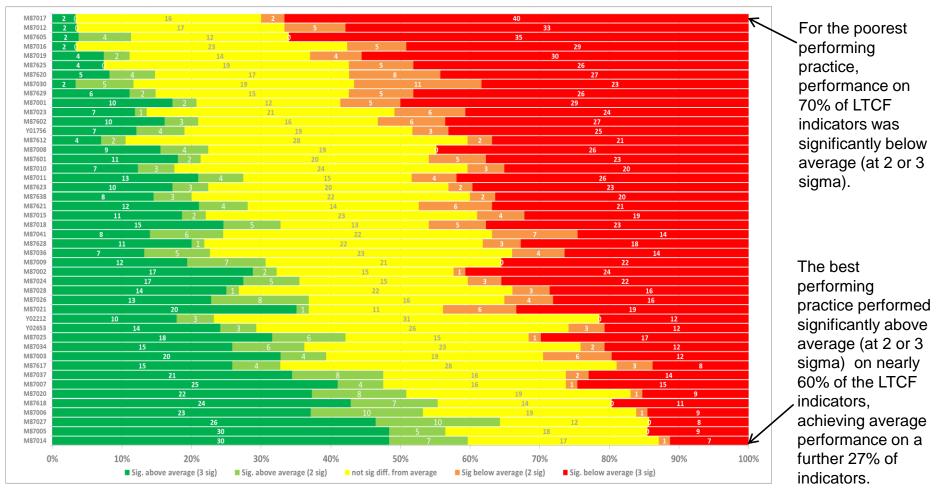
Indicators in quadrant 2 – these indicators are characterised by relatively high performance that is consistent across most practices. Indicators within this quadrant may warrant lower prioritisation within the framework and associated incentives.

Indicators in quadrant 3 - these indicators are characterised by high performance but with considerable variation amongst practices. This combination suggests that high performance should be achievable across all practices but additional support or encouragement may

be needed for some practices to fully achieve their potential. The highest performing practices are a potential source of learning and best practice that could be shared with other practices to close the variability gap.

Indicators in quadrant 4 – these indicators are characterised by relatively low performance but high levels of variation. This combination would suggest differences in approach amongst practices and, as such, there may be scope to support the lower performing practices to develop. In addition there may be other more systemic barriers to maximising performance across the system which may need to be addressed.

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High variance can also be seen in performance across practices within the CCG

The chart below shows, for each practice, the number (and percentage) of LTC indicators where practice performance was significantly above (green) or below (red) average performance. The data were extracted and analysed in January 2017. The chart reflects a huge variance between the highest and lowest performing practices.

For the poorest performing practice, performance on 70% of LTCF indicators was significantly below average (at 2 or 3 sigma).

The best performing practice performed significantly above average (at 2 or 3 sigma) on nearly 60% of the LTCF indicators, achieving average performance on a further 27% of indicators.

Fig 7. Chart plotting variation in indicator performance by practice

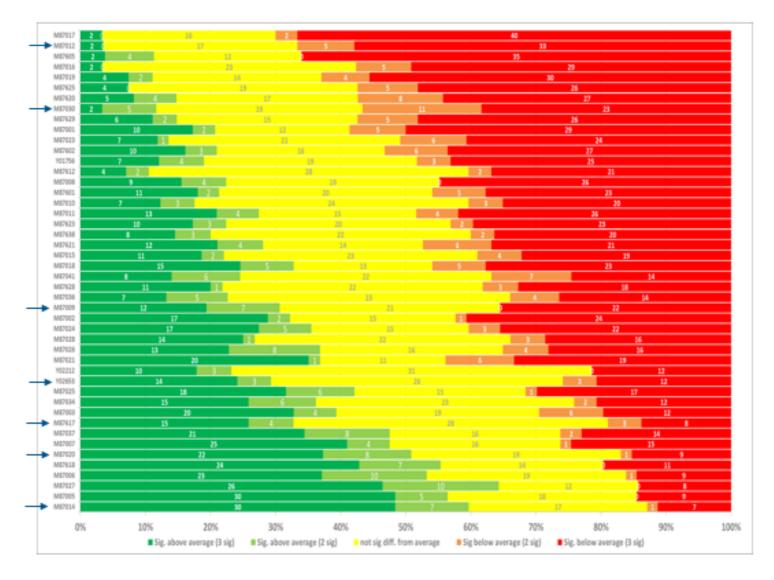# The case study practices display variance in performance

Fig 8. Chart plotting variation in indicator performance by practice with case study practices highlighted

Performance of the case study practices (indicated by arrows on the graph to the left) varied, with four achieving strong performance against the indicators, one achieving average performance and two performing less well.

We also analysed the data to examine whether performance was affected by the length of time since the framework was implemented. We found no consistent difference in performance between the phase 1 pilot practices (which have been using the LTCF template since early 2016) and remaining practices who had implemented later in the year.

The framework is being delivered more successfully in some practices than others – there may be several potential reasons for this

As the previous pages reflect, the framework is being delivered more successfully in some practices compared to others. Three possible reasons behind this have emerged from our research:

- **Resonance between the framework and ethos of care in the practice:** in some practices, the framework seems to have chimed with ongoing efforts to improve the quality of care provided to people with LTCs. In practices where the underlying ethos of the framework mirrored the ethos of the practice, the introduction of the framework created an opportunity to make changes to the way in which care was provided.

- **Leadership**: particular members of staff had taken strong ownership of the framework in certain practices. They were driving implementation and encouraging and supporting colleagues to make changes (e.g. in ways of working and structuring of appointments) to make the framework a success. Having leadership of this kind was particularly important given the magnitude of the changes that practices felt they were being asked to implement.

- **Understanding of how the framework is different**: practices displayed variable levels of understanding around how the LTCF differed from previous ways of working and what the goals underlying the framework were. Some practices, which appeared to focus more heavily on the template than on the framework's wider aims, had been slower to make other changes to support a more holistic approach to care.

It is less clear what impact size of practice and patient demographics may be having on delivery. Our case study research did not provide consistent evidence to suggest that there are links between practice size, patient demographics and ease of implementation/delivery.

That said, the framework might pose particular challenges for smaller practices: for example, they lack the resources to make better use of skill mix and offer flexibility around appointments.

"I think with people with practices that are bigger they've got to be doing it in another way or because they've got more staff they can have one that's based purely for kind of the administrative side of things whereas being a smaller practice we don't have lots of people doing specific roles. So those are things that we are kind of struggling with." [GP]

Outcomes and early impacts

Anecdotal feedback of early impacts is emerging

Throughout the fieldwork, we sought to capture evidence of early impacts. It is important to acknowledge that some of the key goals that the framework has been designed to achieve, including more holistic care for people with LTCs and a culture of collaborative care planning, are longer-term processes that will take time to reach. Nevertheless, the research has started to uncover signs that care is moving towards these goals, with anecdotal evidence of early impacts already coming to light.

1. Upskilling practice staff – a few practices reported that introducing holistic reviews for patients had provided them with an opportunity to upskill their staff and support them to play an enhanced role in the delivery of LTC care. The CCG has provided a series of condition specific training sessions allowing HCPs to expand and refresh their knowledge. For some practices, the introduction of the template had prompted them to think about ways in which they could use their workforce differently. To support this, there were examples of

sourcing external training for HCPs and protecting time for GPs to work closely with nurses and HCAs to encourage them to take on more responsibility, for example reviewing patients blood results:

> *"Nurses changed from individual specialities to being upskilled and retrained across all long term conditions." [Practice manager]*

> *"I did some tutorials with them, we also arranged for a podiatrist to come and talk to the HCAs to give them training. Then because it was mainly doctor led and nurses, they are trying to encourage them to become more independent in terms of the long term conditions because that is the way forward. So I think there is this issue of their personal development too, that is why we've introduced this long term condition meeting, which is usually happening once every month…We're also using that forum as a little bit of training." [GP]*

> *"We've turned around from being a*

teaching practice to being a learning practice." [Practice manager]

2. A stronger focus on supporting self-management – a small number of staff shared examples with us which suggest that the framework may be starting to have a positive impact in terms of patients' confidence and ability to self-manage:

> *"We've had some success, certainly, particularly with the asthmatics who kind of learn about what the brown inhalers do and, I've got to say, with some of the diabetics have been marvellous, to be honest with you. They have – there's been two or three that have been appalling in the past who have actually taken on board that it isn't just the tablets; it is diet and exercise, as well, and they've done fabulously well." [GP]*

Anecdotal feedback of early impacts is emerging

In addition, some practice staff reported that the template had encouraged them to discuss a wider range of issues than might previously have been discussed in annual reviews, including mental health and sleep problems.

3. A move towards providing more holistic care for people with LTCs – some interviewees felt that the new template, combining information for different conditions and an aim to streamline appointments, had encouraged a move towards a more whole person approach to supporting people with LTCs. An example of this was witnessed in an observation of a holistic review in which the person was encouraged and supported to talk about his multiple LTCs and mental health, focusing on the impact this had on him and his life.

4. Clinical outcomes – one practice reported improvements in clinical outcomes for their patients. Practice staff felt this to be an effect of both HCPs and patients focusing more on

the results of clinical tests – which are clearly laid out on the patient care plans –in holistic reviews:

> *"If I compare my diabetes figures outcome with last year, they are better than last year in terms of the HcA1c control, in terms of their blood pressure control, in terms of their lipid control. And I think this is because the nurses are thinking more into it, they're thinking more and they're looking more at the targets and they are trying to do more." [GP]*

5. Impact on secondary care – not long before our fieldwork visit, one practice had analysed their A&E admissions data for people with LTCs under 65 years of age. The analysis had shown a positive trend in terms of admission rates, which staff thought was related to the introduction of the new framework:

> *"Our diabetes patients that end up in hospital is below the national average and having just done a report on other things I can see that*

> *in the last 12 months we have had no patients admitted via A&E who have a LTC. I had to run the data a few times because I wasn't convinced. This is for the under 65 age group and there haven't been any admissions." [Practice manager]*

6. More joint working across the primary/secondary care interface – one practice highlighted that streamlining their appointments and structuring them to run on certain days of the week had opened up the opportunity to work more closely with secondary care specialists, including diabetic and geriatric consultants. Given that a key aim of the framework is to develop outcomes that can be shared across primary and secondary care, this development may be a particularly important one.

7. Use of skill mix and changes in workload – the framework is still at a relatively early stage in its implementation and, as such, it is difficult to determine whether it is time saving and/or will definitely lead to a better use of skill mix. Some interviewees did report that the new template had encouraged efficiency in their practice and were starting to see the benefits of this.

For example, a number reported that their practice had made progress with transferring an element of general practice workload from GPs to practice nurses, and practice nurse workload to HCAs. Ultimately the aim was to free up GP time (to focus on responsive care) and make better use of the range of skills within the practice team:

"So I think that's the benefit for me, that I'm using my team to the best capacity that I could possibly use it. Doctors are doing the day to day stuff that I need them to be doing whereas the nurses are doing the long term condition management." *[Practice manager]*
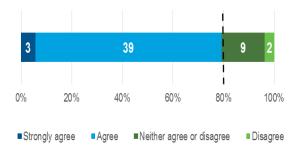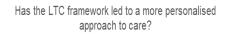
"Theoretically it's to reduce the

number of times the patient needs to come to the surgery for long term disease management so theoretically reducing appointment need and therefore increasing resources at the practice hopefully." *[GP]*
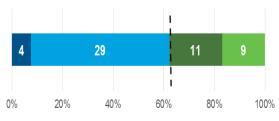
"In many patients cases this has resulted in them only attending once or twice per year rather than for the individual LTCs - up to 5 times, saving patient time and staff time." *[Practice manager]*

8. Improving dimensions of the patients experience – the staff survey provides insights into the early impact of the LTCF on patients' experiences of LTC care. The majority of survey respondents (79%, 42/53) reported that the framework had increased the focus on care planning for people with LTCs and 62% (33/53) felt that it was supporting a more personalised approach to care (see graph). But fewer than half (44%, 23/52) believed it had improved the patients' experience, suggesting that there is still some way to go for process changes to translate into direct improvements in the experience of care.

Has the LTC framework increased the focus on care planning with people who have LTCs?

■ Strongly agree ■ Agree ■ Neither agree or disagree ■ Disagree

Has the LTC framework led to a more personalised approach to care?

■ Strongly agree ■ Agree ■ Neither agree or disagree ■ Disagree
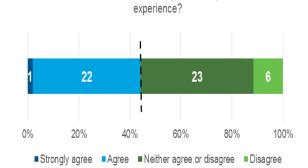
Has the LTC framework improved the patient's experience?

■ Strongly agree ■ Agree ■ Neither agree or disagree ■ Disagree

Summary of findings, recommendations and next steps

Summary of findings

The evaluation provides a snapshot of the framework at what is still a relatively early stage in its implementation. However, the research has uncovered a wealth of information that can be utilised by the CCG going forward. The findings of the evaluation, recommendations and next steps are summarised on the following pages.

- The LTCF can be understood as three distinct but inter-linked elements: a streamlined template, multi-morbidity approach and the mainstreaming of care planning. These elements can be thought of as building blocks: successful implementation of the template will provide a firm foundation for the transition to a multi-morbidity approach, and so on. It is the combined implementation of all three elements that will bring about more efficient, holistic and person-centred care.

- Practices understand the main purpose of the framework as its potential to save time and free up resources. There was much less emphasis on how the framework may help drive changes in the relationship between patients and HCPs towards a more collaborative and enabling model of care. There is scope for the CCG to strengthen the focus on the role of the framework in facilitating new approaches to the organisation and delivery of care to support people to manage and live well with their LTC(s).

- Staff welcomed the integration of all information and data inputting requirements into a single EMIS template, although there were some queries about the evidence-base underpinning particular questions within the template. Views about whether the template was easier to use and time saving in comparison to arrangements under QOF were mixed. Staff reported that the new template is taking more time at the moment and is more burdensome than QOF, but this may be because practices were so familiar with QOF that it had become 'second nature'; time will tell if the new framework is time saving.

- Operational changes made as a response to the new framework have been variable. Some practices have chosen to implement the template directly into their existing clinic structures, whereas others have made considerable changes to the organisation of their appointments. These changes included increasing appointment time for LTC reviews and introducing two-stage appointments with tests and template completion carried out by a HCA, and a subsequent consultation focused on care planning and a more general discussion of the patient's health and wellbeing.

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Summary of findings

- Many of the practices which had implemented the framework into their existing ways of working reported difficulties with fitting everything in to their allocated time and fears of running over. Reasons given by practices for incorporating the LTCF into their existing ways of working included a lack of time and resources to restructure care processes; concerns about the wasting of resources if patients DNA'd longer appointments; difficulties changing recall processes; and reluctance to change to a new way of working given that the framework was still only in pilot phase.

- Some practices were changing skill mix to facilitate the introduction and embedding of holistic reviews. This included increased recruitment of HCAs and HCAs taking on an enhanced role in the delivery of LTC care. Responsibility for conducting holistic reviews was largely being picked up by the nursing workforce, with some transfer of more straightforward data gathering tasks from practice nurses to HCAs.

- Practice staff praised the CCG for its collaborative approach to developing the framework, and for providing practical support for implementation, including training sessions. Staff also talked about additional and ongoing training needs, in particular opportunities to improve their knowledge and skills across the range of LTCs covered by the template. Many practice nurses have specialised in a particular disease area, and lacked confidence to carry out holistic reviews which might cover a range of different conditions. This unfamiliarity with a new way of working might explain why only a third of staff responding to our online survey reported that the framework had improved their job satisfaction.

- There is a tension in the delivery of LTC care within general practices. The drive towards care being delivered outside of hospital settings, encouraged by policy, requires a degree of specialisation within the primary care workforce, who are seeing patents with even more complex conditions and health needs. But there is a potential conflict with the goals of the LTCF, because the move towards providing holistic and integrated care requires professionals with generalist skills.

- There was wide variation in care planning practices. We observed some consultations that were exclusively focused on care planning, where patients played an equal role in conversations that addressed all aspects of their health and which included signposting to wider services and supports. Others we observed were template-driven;

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Summary of findings

patient involvement was largely limited to answering questions and there was no care planning conversation. Most of the consultations we observed tended to fall somewhere between these extremes.

- An analysis of care plans provided by case study practices showed that goals were often passively phased and lack specificity ('think about losing weight') and were often focused on medical management tasks. The template provided by the CCG for care plans is likely to be a key factor here.

- Staff had mixed views about the value of care planning; some spoke enthusiastically about putting patients at the centre of their LTC care, using an approach aiming to support and enable people to achieve their own goals. Others were more cautious or negative, in particular, questioning whether care planning would have an impact on patient behaviour and result in better

self-management.

- One of the key changes for patients was being asked a wider range of questions about their health and wellbeing, prompted by the new EMIS template. Aside from the type of questions being asked of them, generally patients hadn't noticed a difference between previous LTC consultations and the new holistic review.

- Asking patients a wider range of questions had encouraged them to share information that previously may not have been disclosed. However, this sometimes raised difficulties for staff who felt unable or unwilling to respond to these new issues. This was particularly common in relation to mental health problems.

- The findings point to several factors that could improve the experience and impact of care planning: ensuring there is sufficient time to engage patients in a meaningful

conversation about their health goals; preparing patients and professionals for a more collaborative conversation; and ensuring there is access and clear referral pathways to a co-ordinated set of services linked to general practice.

- Many supported an integrated approach to LTC care involving holistic, person centred reviews but also questioned whether all patients wanted or needed this. Several issues, in particular, were raised: a) if it is realistic to combine appointments into a single review where a patient has multiple and/or complex conditions; b) whether patients can cope with longer (e.g. 45 or 60 minute) appointments and c) if care planning is necessary for those whose LTCs are stable and who are in good health. A good approach may be to target resources according to need and potential benefit.

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Summary of findings

- Utilisation of the template varies across practices as does performance against framework indicators. The utilisation rate for the template ranged from 0% in one practice to over 75% in others.

- For the poorest performing practice, performance on 70% of the LTCF indicators was significantly below average. The best performing practice performed significantly above average on nearly 60% of the LTCF indicators, achieving average performance on a further 27% of indicators.

- We analysed CCG data to examine whether performance was affected by the length of time since the framework was implemented. We found no consistent difference in performance between the phase 1 pilot practices (which have been using the LTCF template since early 2016) and remaining practices who had implemented later in the year.

- Our findings suggest three key factors influencing how successfully the framework is being implemented: resonance between the framework and the ethos of care in the practice; individuals taking on responsibility for leading implementation and supporting colleagues and, an understanding of how the framework is different from previous ways of working and what the core goals of the framework are.

- While implementation of the framework is still at a relatively early stage, we were nonetheless able to identify some important early impacts. These included: upskilling of practice staff; a stronger focus on care planning and supporting self-management; moves towards a more holistic model of care; and more joint working across the primary/secondary care interface. One of our case study practices reported evidence of improved clinical outcomes, and another of a

downward trend in admission rates to accident and emergency. Although fewer than half of those responding to our online survey thought that the framework had improved the experience of care, suggesting that there is still some way to go for process changes to translate into direct improvements for patients.

- The CCG should congratulate themselves on the progress that has been made so far. It has played a significant role leading the implementation of an evidence based framework that is logical, practical and encourages an holistic approach to managing LTCs. This is no easy feat and the feedback shared by practices reflects that throughout, the CCG has been held in high regard.

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Recommendations

The evaluation has provided rich insight and learning around implementation and early impacts of the LTCF. The CCG has made great strides in leading the introduction of a new evidence based framework that is practical and strives to encourage more holistic care. Nevertheless, the LTCF is at what is still a relatively early stage, and so building on the learning from our research, we have identified a series of recommendations for consideration by the CCG and practices to further strengthen its implementation and impact.

1. **Developing a strong narrative, emphasising all desired outcomes for the framework**: evidence from across the NHS has consistently demonstrated that change programmes benefit from having a strong narrative and clear vision, in particular around desired goals and endpoints. We would encourage the CCG to review how it is communicating the LTCF to practices and wider stakeholders. Much of the emphasis so far has been centred around the implementation of new tools and processes, and our evaluation framework supports this approach (getting the technical 'building blocks' in place before moving on to the more challenging goal of culture change). But if the LTC framework is going to transform the experience and outcomes of LTC care, there now needs to be a stronger focus on how the framework will act as a vehicle for changing the model and relationship of care. Re-framing the narrative could help to ensure that this vision is shared and there is a consistent understanding of the framework across the CCG area.

2. **Working with practices to co-produce solutions to issues and challenges**: as our evaluation highlights, several issues have arisen as practices have started to implement LTCF which will need addressing if a new model of LTC care is going to be successfully embedded within general practice. Some of these challenges need to be better understood before solutions can be developed. We would encourage the CCG to continue to work closely with practices to further explore the challenges they are facing in delivering efficient, holistic and person-centred LTC care, and support them to co-produce and test out solutions to these. This could include the following areas: understanding the skills and workforce challenges related to a more holistic, multi-morbidity approach; exploring how practices could tailor support to people with LTCs, and what tools and processes might support this; and considering how practices can prepare and engage patients for care planning.

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Recommendations

3. Establishing a formal programme of training and development to support implementation: we recommend that the CCG develops a structured programme of training and support to encourage the transformation of LTC care. This should include training on the following:

- *A multi-morbidity approach*: the CCG should continue to provide LTC condition specific training for HCPs to refresh and expand their knowledge in a full range of conditions covered by the framework.

- *Care planning*: in particular, to address what patient-led care planning is and how that might differ from what is currently being offered to patients.

- *Wider services*: to complement formal services such as Integrated Plus, the CCG could provide training (for clinical and non-clinical staff) to ensure that 'care navigation' is a core element of all patient contacts.

4. Fostering a culture of shared learning: we would encourage practices, with the support of the CCG, to consider how they might develop opportunities for peer-to-peer learning and support. There is much value in practices sharing with and learning from one another, and this approach can be embedded into the CCG's wider programme of primary care development. This might include using large-scale meetings and events to showcase work and examples of good practice, as well as 'buddying up' practices who are leading the way in implementation and/or performance acting as a source of inspiration and advice for those that are in need of support.

5. Maximising opportunities presented by the MCP to strengthen the delivery of LTC care: there would be value in the CCG ensuring that ongoing support to manage people with LTCs is provided to primary care upon entering into the MCP contract. Indeed, the MCP is well placed as a vehicle through which to collectively provide primary care with easier and systematic access to specialist expertise within secondary care. We would encourage the CCG and practices to explore these new opportunities as tendering of the MCP progresses. This is particularly important given that community-based services are seeing increasing chronicity and complexity in the patients they care for and treat. The MCP also provides a further means of encouraging locality based working. Through this there may be an opportunity to develop locality-based solutions to the workforce challenges we have identified, employing skill mix across (as well as within) practices.

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Recommendations

Furthermore, as implementation of the new model of care for Dudley progresses, the CCG should also ensure that it continues to strengthen the links between general practice and wider support services, including those in the voluntary and community sector.

6. Using the framework to focus and incentivise improvement: the framework itself provides a means by which the CCG can give focus to and incentivise improvement. Performance data could be used to identify strong and weak performance, at both a practice and indicator level, in order to tailor strategies for driving improvement. As part of this process, we would encourage the CCG to work with practices to understand and seek solutions for any issues that may be holding back progress. Linked to this, we would encourage the CCG to use the LTCF indicators to incentivise improvements in LTC care and reduce variations in performance –

for example, attaching larger payments to indicators where performance is most in need of improvement. It is also important that the CCG measures not just changes in the process of care, but dimensions of quality and experience too. In terms of care planning, for example, practice payments could be linked not only to the proportion of patients receiving a care plan, but the extent to which patients feel they are meaningfully involved in developing that plan. Current moves to embed routine collection of PREMs and PROMs into community-based services provides an opportunity to gather this kind of patient feedback.

7. Engaging patients in ongoing implementation: the framework is starting to drive changes in processes of care, but evidence for its role in improving patient experiences and outcomes is lacking. Of course this could – at least in part – reflect the timing of the evaluation, which was too early for major impacts

to be seen. But there is also considerable scope to more fully engage patients 'as partners' in the transformation of LTC care. The evaluation has identified several areas where such engagement would be of value. For example, in thinking through where the limits of combining appointments might be, and the feasibility of alternative models of delivering holistic reviews such as telephone appointments. Moreover, our findings suggest that the current care plan template can be a barrier to successful care planning, and should be re-worked. For example, the template should prompt and document action planning, and include information about when and how care plans should be reviewed. Involving patients in redesigning the care planning template would help to ensure that care plans are user-friendly and of practical value to those who are expected to use them.

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