University of BRISTOL
Centre for Academic Primary Care

NIHR | Applied Research Collaboration West

Personalised annual reviews for patients with multiple long-term conditions

How to do it

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The problem

- 15-20% of adults have multiple long-term conditions (MLTCs). About 1 in 20 of the adult population have at least 3 different major long-term conditions included in the Quality and Outcomes Framework (QOF)
- These individuals are often invited to multiple review appointments, at which they see different nurses who just focus on one single condition
- Much duplication of effort, inefficiencies. Inconvenient for patients
- Treats conditions in isolation, doesn't consider cumulative impact on patient, or how treatment of one condition might affect another, and trade-offs that may need to be made
- Most importantly, doesn't necessarily focus on the health problems that matter most to the patient. Not person-centred

> *"We've always had a massive frustration with how we manage patients with chronic conditions, you know, most of them have got more than one and we would have them come in one month for asthma, then in two months' time they'd be called in for a COPD review....We just felt like it was so fragmented, the care that we were delivering really."*
>
> *- Practice nurse*

[1] See acknowledgements for full list of the research team

Why replace multiple long-term condition reviews with a single annual review?

- More efficient and streamlined
- Doesn't take significantly more time. Replace lots of short consultations with one or two longer ones
- Review the whole patient, including mental health, not just one disease
- Addresses the real problems. Focus on the patient's needs and priorities. 'What matters to you'

> *"That question ('what matters to you').....I got answers from the patients that meant something to that patient...one particular patient who had pretty poorly controlled diabetes, and had some really bad depression...they said, I'm really isolated, I'm drinking loads of alcohol because my daughter died. They didn't really care about their diabetes ...being able to home in on that I was able to then slowly unpick it and feed them back into social prescribers.... If we'd have just done a diabetic review, we probably wouldn't have got that information."*
>
> *- Advanced nurse practitioner*

- Support self-management. Build sense of shared responsibility for the future
- Improve continuity of care
- More professionally satisfying for staff
- A whole person perspective creates opportunities to access other appropriate resources via social prescribing

> *"Yes, by doing it this way with three or more multiple conditions, means a condition is not going to get left out, whereas we were always leaving out conditions before, because the diabetic nurse... might do a bit of COPD actually, but wouldn't do the asthma as well. The asthma nurse wouldn't touch hypertension at all, but this means it's all getting done."*
>
> *- Practice manager*

What it will look like

- Patients recalled for review once a year
- Annual review includes:
    1. Initial consultation to collect information and do necessary tests
    2. A structured medication review
    3. Send patient their test results and a patient preparation document to encourage them to think about their priorities and questions they want to ask
    4. Annual review consultation – to discuss test results and information collected , and make a plan

> *"Yeah, I think it's really, well, it's very good for the patient – they don't have to keep coming for multiple blood tests; multiple trips, unnecessary blood tests as well and you know, it's all as one so that's good for the patient."*
>
> - *Practice nurse*

The annual review includes:

- A focus on 'what matters to you'. Patients are given an opportunity to discuss their values, priorities and goals
- Assessment of quality of life and well-being
- Brief assessment of mental health as well as physical health
- Optimising medical management of chronic conditions
- Medication review, with a focus on optimising treatment, simplifying treatment, and improving medication adherence
- Support for self-management
- Social prescribing where appropriate
- Review of carer's needs, where relevant
- Discussing effectiveness and goals of treatments; sharing decisions about future management (which might include stopping treatments)
- Agreeing an individualised management plan, which is printed off and shared with the patient

> *"So I think something like that is really useful... just printing it off I think is actually really effective because you walk away with something that is a reminder and it's really clear to you what's going on... but having that on a form is just useful in terms of keeping track of your own condition and having that as a point of reference."*
>
> - *Patient*

How to do it: 9 steps

1) Create a small planning group, to include the person responsible for running the recall system, an HCA, a nurse, a GP and a pharmacist
2) Identify a computerised template. We helped to develop the **Ardens multi-morbidity template for Emis**. Alternatives are available from other suppliers and some ICBs have developed their own, but many of these are QOF-focused and just address clinical needs rather than personalised care

> *"I think it's reassuring in that you know you're covering it all, so you're not missing anything. When someone's got like five or more conditions, you can quite easily miss one, whereas, obviously, on your multimorbidity template, they're all lined up. So you literally click from one to the other, so it's there. So you're not missing things and it's easier in that sense, definitely."*
>
> - *Practice nurse*

3) Identify patients with multiple long-term conditions and potentially complex needs e.g. with at least 3 different types of LTCs. Or people with multiple LTCs and who have had more than 12 consultations in the last 12 months.
   a) Download **our tool for Emis practices to identify people with 3+ types of LTCs** or
   b) Use the Ardens recall programme or
   c) Your ICB might have a risk stratification tool
4) Training:
   a. Clinical: Clinical staff doing whole person reviews need to be competent to do basic review of all the common major LTCs, particularly CVD, diabetes, respiratory disease, depression & anxiety, and dementia. They don't have to be able to do everything that a specialist nurse would do, but enough to be able to identify who needs more help. **See our suggested curriculum**
   b. Consultation skills: Clinical staff often need more training on shared decision making and how to create a personalised care and support plan. We worked with **Year of Care Partnerships**, and other opportunities are available from the **Personalised Care Institute**
   c. Operational: train clinical staff to use the template and train admin staff to run recall system, book appropriate appointments, and to send out patient preparation documents
5) Process mapping. The planning group should work together to map out in detail what happens currently in recall and review, and map out what will need to happen instead in the new system. See a recent **guide to process mapping** and an **example from one practice**
6) Make a plan.

a) Administration: Decide how to book the appointments, how long for, which member of staff, and how to send the patients their results and a patient preparation document after the initial assessment and before the annual review.
b) Maintenance: Plan how to stop patients being recalled for separate disease-focussed reviews, and how to ensure the register of patients needing annual review is kept up to date as new people acquire diagnoses and become eligible
c) Continuity and co-ordination: Discuss how to encourage continuity of care, and the roles and responsibilities of the different members of staff

7) Start small and plan to build up
8) Monitor the number of patients who have had a review, and the proportion who have received key elements of the review. Download an **example audit tool** (**NB: right click and save this xml file to your computer, then import it in Emis**) for use in Emis. This is designed to be used in conjunction with our search tool and the Ardens multi-morbidity template, and it shows whether some key elements of holistic care have been completed within the last 12 months. You could modify this tool to suit your own needs
9) Consider forming or joining a peer-to-peer community of practice – sharing ideas, problem solving, offering support

> *"She involves you in it. You know, she'll say, 'Have you got any concerns?', and she makes it clear if you want to ask questions about anything, then you're free to do so, you know. You're not held back in any way... You feel that you are being spoken to one-to-one, like, and it is second to none, I will say that."*
>
> *- Patient*

Issues you need to address

- Don't underestimate the difficulty of designing a template to support review of patients with MLTC, and keeping it up to date. It is more sensible to use a commercial product such as the Ardens multi-morbidity template unless you have a dedicated team of IT support staff.
- How to run your appointment system efficiently, including how to book sequential appointments for the initial consultation, medication review and annual review consultation.
- How to generate and send the patient preparation documents to patients. We used the Year of Care patient preparation documents which are also included in the Ardens multi-morbidity recall system.

- In our research study, many practices tried to do everything in one consultation rather than the two consultations (initial consultation and annual review) intended. But this meant that test results were not available at the time of the review and it was too much to cover in one consultation for both patients and staff. So they left things out, and tended to omit making a care and support plan, which many patients value.
- How to ensure appointments are long enough. These will need to be longer than conventional single-disease reviews, but remember they are instead of a series of separate reviews for each disease.
- Many staff are unclear what is meant by a care and support plan, and there is confusion with disease specific plans e.g. asthma action plans. If a patient has MLTCs they could end up with a confusing array of disease specific plans, which is why we think providing one holistic plan is important.
- Getting appropriate training for staff. This may take time, so you may need to initially a limited number of staff who have a wide range of skills, and make a plan to up-skill other staff over time.
- Some staff are comfortable having skills in a specific disease and unenthusiastic about reviewing other conditions as well. We need to make the case that most patients with one major disease (e.g. diabetes), have other major conditions as well. We need a more generalist perspective, both for good patient care and to be efficient.
- Some staff feel that the key priority is to fulfil QOF requirements and anything else is a luxury. But QOF is changing, and it was never intended to be a comprehensive guide to good practice. Focusing solely on QOF leads to poor care and is professionally unsatisfying.

The research that underpins this guidance

In the 3D trial, 1,546 patients from 33 general practices were randomly allocated to a personalised whole person review or usual care. The 3D intervention led to improvements in personalised care, but did not improve quality of life. Both patients and staff felt the new way of working was an improvement and it was no more expensive than usual care. However, many practices struggled to fully implement the new approach, and the fact that it was introduced in the context of a randomised trial made it even more difficult.

In the subsequent Personalised Primary Care for Patients with Multimorbidity (PP4M) study we addressed some of the implementation problems experienced in the 3D trial. We worked with Ardens to make their existing multi-morbidity template more patient-centred, and talked to Year of Care partnerships about the

needs for patient preparation and staff training. We supported 16 general practices to introduce the new approach (the 'implementation practices'), and compared them with 16 control practices that had access to the template but no other support.

We found that multimorbidity is common: 4% of adults patients, rising with age to 21% in patients aged 80+. Almost all the patients with MLTCs had at least one CVD diagnosis, and more than half had diabetes, respiratory disease and/or a mental health diagnosis. This shows that if we want to provide co-ordinated, personalised care for this group of patients, staff need to be confident to manage people with all these problems.

Implementation practices used the multi-morbidity template with 2,331 patients over a year (about half of all the patients with 3 or more conditions). They increased the extent to which they assessed a broad range of patient needs, for example mobility, memory, falls and pain. There was also a greater improvement in implementation practices in the percentage of people having reviews for diabetes, heart disease, stroke, atrial fibrillation, COPD and mental health problems.

Before implementation of the new approach, the target group of patients with multiple long-term conditions generated a large number of consultations in total – about 13 consultations per patient per year. Reassuringly, the new way of working did not generate any additional consultations in implementation practices compared with control practices.

Most practices and patients appreciated the new way of working. Patients particularly appreciated being asked about what matters most to them and having everything dealt with at once, while staff appreciated the efficiency gains, not having to swop between multiple different disease-specific templates, and feeling they identified important problems that might otherwise have been missed.

There was a lot of variation between practices in the extent to which they introduced the new patient-centred annual reviews. Implementation difficulties included difficulties scheduling the initial and annual reviews, and a lack of staff engagement with the concept of care planning. Some staff lacked the competence or confidence to manage problems outside their disease-specific expertise. Many practices felt overwhelmed by excessive demands and staff then tended to prioritise the disease-specific aspects of the review that they were familiar with, and the aspects of care incentivised by QOF. Successful implementation will rely on addressing these problems.

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