University of BRISTOL
Centre for Academic Primary Care

Centre for Academic Primary Care Lunch-time Webinar Series
INNOVATION AND IMPACT IN PRIMARY CARE RESEARCH

Looking after people with multiple long-term conditions in primary care

What needs to change?

Contributors: Professor Chris Salisbury, Dr Rachel Johnson and Dr Cindy Mann, University of Bristol
Dr Claire Lake, NHS Greater Manchester Integrated Care (Manchester Locality)
Professor Richard Byng, University of Plymouth

NIHR | School for Primary Care Research

Wednesday, 9 November, 2022 • 12-1pm • Via Zoom
Register at www.bristol.ac.uk/capc/events

University of BRISTOL
Centre for Academic Primary Care

NIHR | Applied Research Collaboration West

NIHR | School for Primary Care Research

Looking after people with multiple long-term conditions in primary care – what needs to change? (title slide)

- Professor Chris Salisbury.
- Dr Rachel Johnson.
- Dr Cindy Mann.
- Dr Claire Lake.
- Professor Richard Byng.

#capcwebinar
www.bristol.ac.uk/capc
@capcbristol

Introduction

Professor Chris Salisbury

Long term conditions

e.g.

- Diabetes.
- Asthma.
- Heart disease.
- High blood pressure.
- Depression.

Multiple long term conditions aka ‘multimorbidity’

- Poor quality of life.
- Poor mental health.

Multiple long term conditions aka ‘multimorbidity’

- Poor quality of life.
- Poor mental health.

- Problems with the health care ***system.***

A serious problem

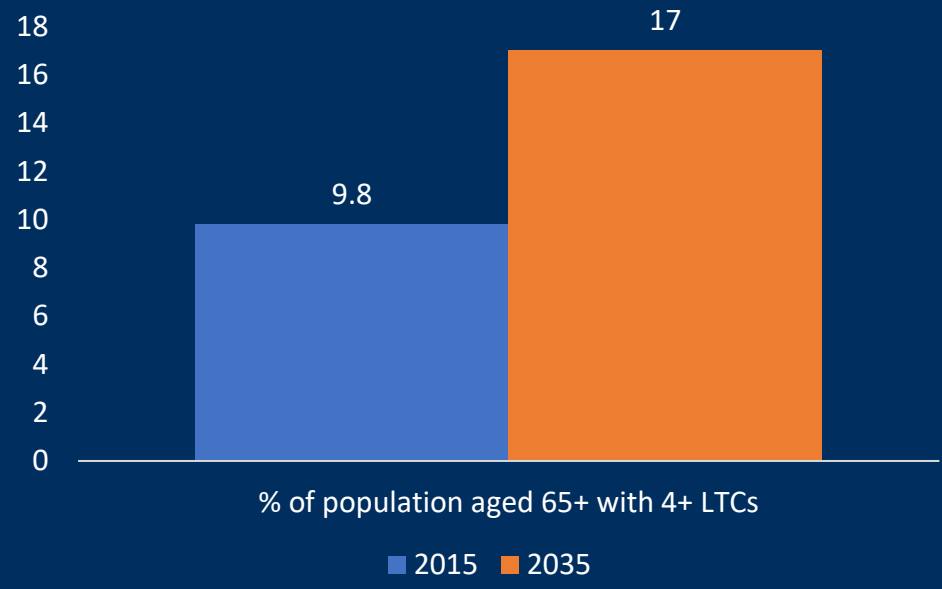
I remember one time I went [to the GP] and I had three different problems and they said no sorry, you need to go and make another appointment and come back I was really annoyed … they could at least hear me out because I'm not pretending, I've gone there with a serious problem.

(Woman, 49 years: arthritis, hypertension, asthma).

Cowie L, Morgan M, White P, Gulliford M. Experience of continuity of care of patients with multiple long-term conditions in England. Journal of Health Services Research & Policy. 2009;14(2):82-87.

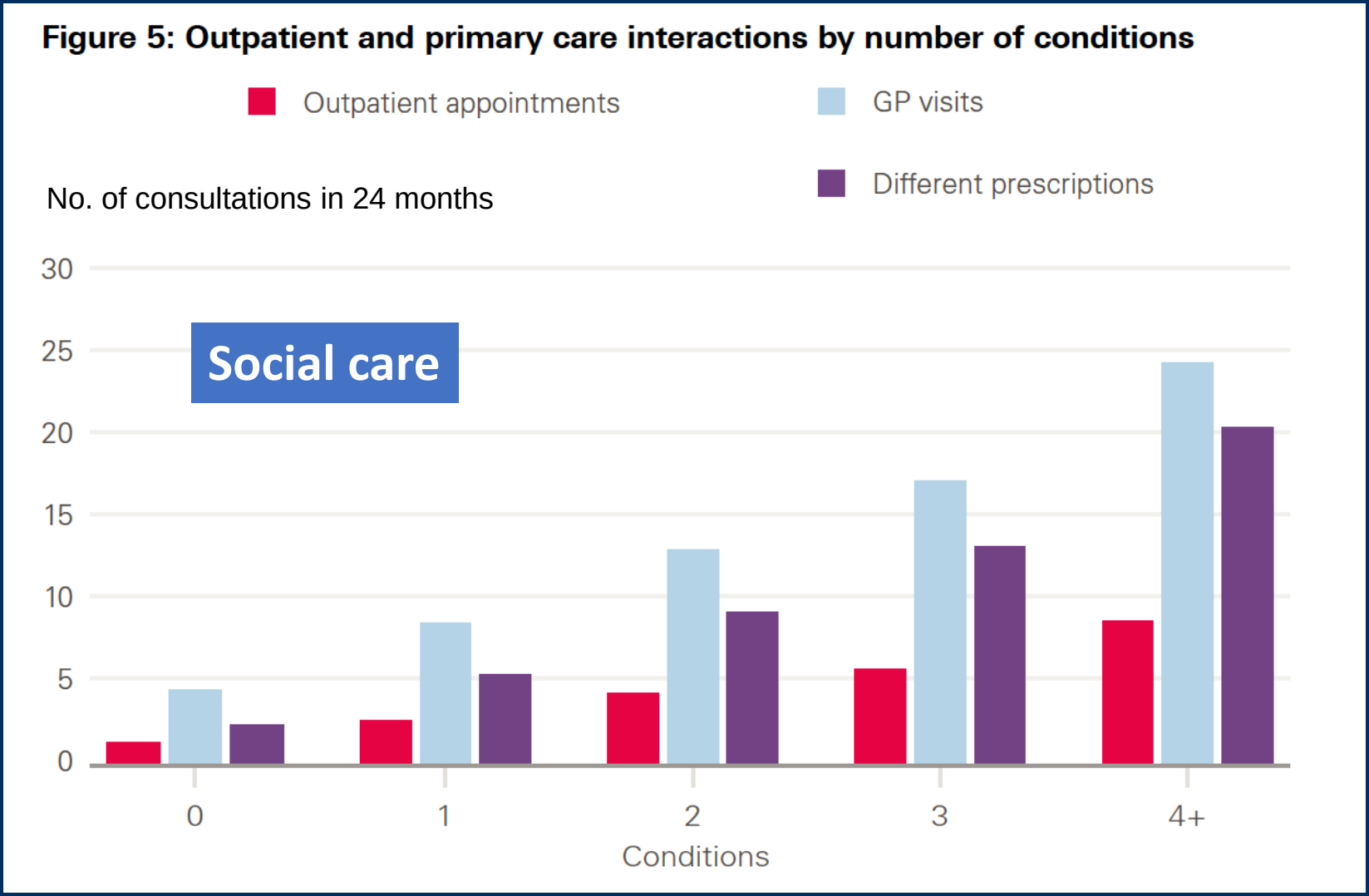
Prevalence of multiple long term conditions

- About a quarter of adults in England have two or more long-term conditions.
- Prevalence of multiple long term conditions rises with age.
- More than half of those aged 65+ have two or more long term conditions, 1 in 10 have 4+ conditions.
- Number of older people in population increasing.
- By 2035:
  - % of population aged 65+ with **4+ conditions** will almost double.
  - 34.1% of those with 4+ conditions will have mental health problems or dementia.



Kingston A et al *Age and Ageing*, Volume 47, Issue 3, May 2018, Pages 374–380

Outpatient and primary care interactions by number of conditions (chart)



Understanding the health care needs of people with multiple health conditions. © The Health Foundation

Tension: patients have multiple diseases but primary care designed to treat one disease at a time.

Patients have multiple diseases

Primary care designed to treat one disease at a time

Trends in primary care

- care segmented by disease;
- conditions are reviewed in isolation;
- by nurses who specialise in that condition;
- using disease-specific checklists based on disease-specific guidelines; multiple consultations;
- one problem at a time but not what bothers them.

Patient experience

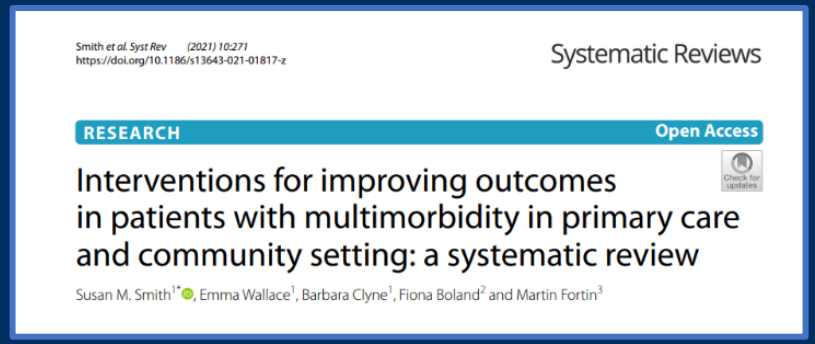
- inconvenient;
- poorly co-ordinated;
- inefficient;
- not patient-centred.

Designing patients to fit the system rather than the system to fit the patient.

What needs to change

- Whole person review.
- Person centred.
- Support for self-management.
- Care co-ordination.
- A trusted, responsible clinician.
- Simplify medication.
- Mental alongside physical health.
- Research?

Systematic Review of interventions – what's the problem?



Smith et al. Syst Rev (2021) 10:271
https://doi.org/10.1186/s13643-021-01817-z

Systematic Reviews

RESEARCH Open Access

Interventions for improving outcomes in patients with multimorbidity in primary care and community setting: a systematic review

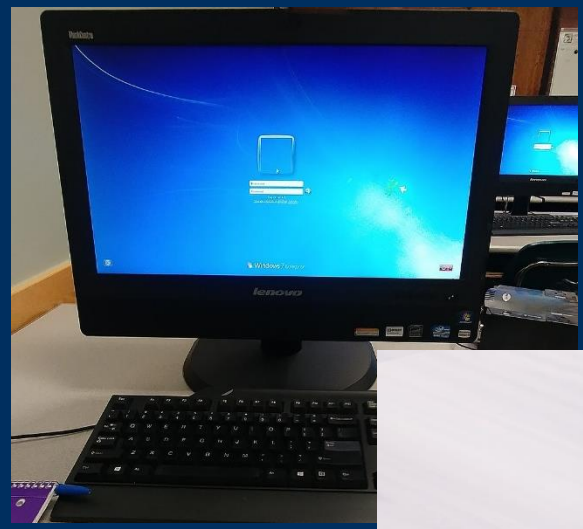
Susan M. Smith[1*], Emma Wallace[1], Barbara Clyne[1], Fiona Boland[2] and Martin Fortin[3]

16 RCTs:

- Little/no evidence of effect on primary outcomes of health related QoL or mental health.
- Little effect, or mixed results, on most other outcomes.
- care coordination may improve patient experience of care.
- self-management support may improve patient health behaviours.
- Overall, certainty of evidence low due to significant variation in study participants and interventions.

Why doesn’t it seem to work as planned?

- Research not like real life
- New skills and attitudes
- New software
- New appointment systems



Kenziehunter17, CC BY-SA 4.0

Wilfred Iven CC1.0

Improving primary care for patients with multiple long term conditions

- How can we help practices implement?
- What makes it difficult?
- What would make it easier?
- What are motivating factors that we can build on?
- How do ‘successful’ practices do it?
- Implementation research.

The PP4M study

Personalised Primary care for People with Multimorbidity - PP4M

Dr Rachel Johnson

ARC West	Professor Chris Salisbury	
ARC West Midlands	Professor Krysia Dziedzic	Professor Clare Jinks
ARC Wessex	Professor Mari Carmen Portillo	
PenARC	Professor Richard Byng	

Template-supported holistic person-centred annual reviews

Template-supported holistic person-centred annual reviews

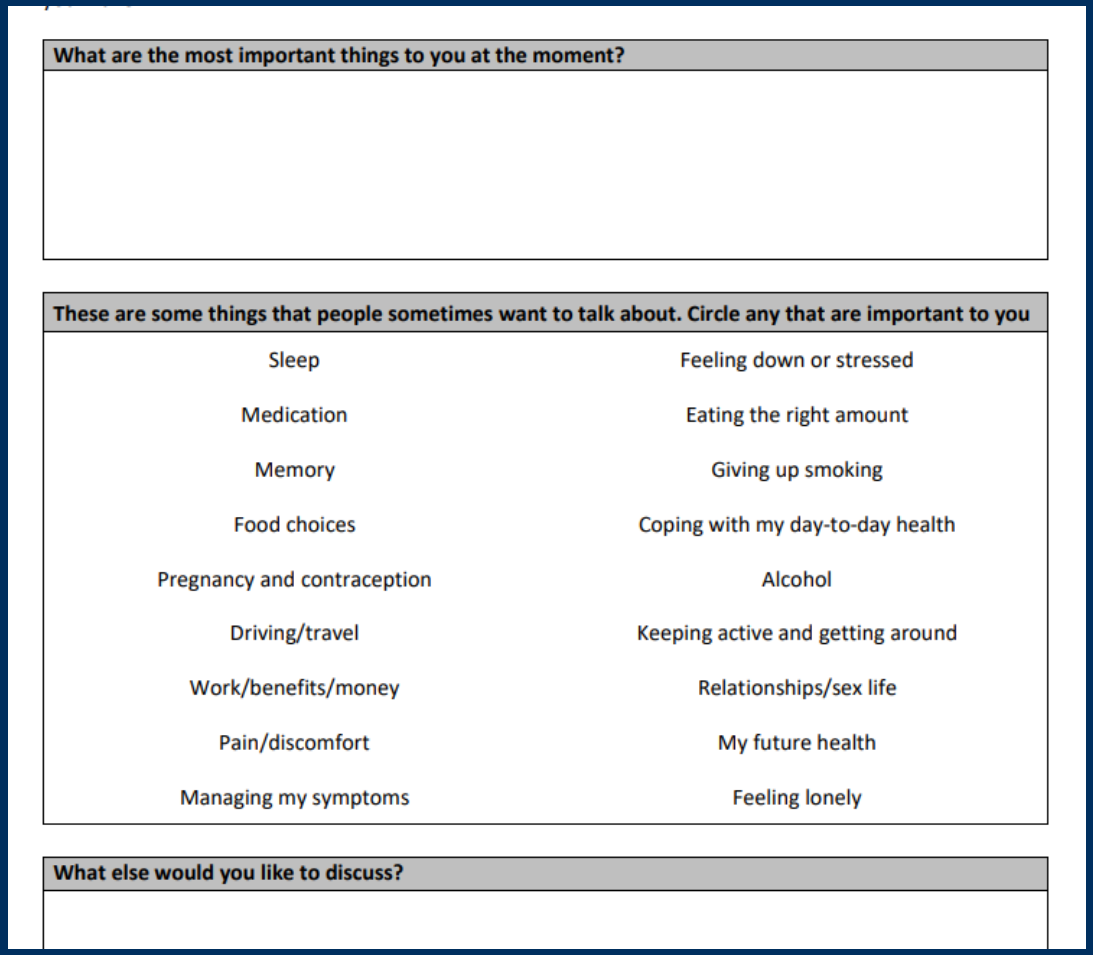
- Combined review of all person's long-term conditions.
- Fulfils the Quality and Outcomes Framework (QOF) requirements.
- Focuses on what matters to the person.
- Includes quality of life, function, well-being, mental health, memory, falls, medication concerns.
- Supports social prescribing and shared decision making.
- Records priorities and agreed goals, and care plan.

Two-stage review process: Stage 1

Stage 1: initial consultation:

- Healthcare assistant led.
- Information gathering and sharing.
- Disease surveillance checks.

Patient preparation materials



What are the most important things to you at the moment?

These are some things that people sometimes want to talk about. Circle any that are important to you

Sleep	Feeling down or stressed
Medication	Eating the right amount
Memory	Giving up smoking
Food choices	Coping with my day-to-day health
Pregnancy and contraception	Alcohol
Driving/travel	Keeping active and getting around
Work/benefits/money	Relationships/sex life
Pain/discomfort	My future health
Managing my symptoms	Feeling lonely

What else would you like to discuss?

- Prompts to consider health and wellbeing.
- Prompts to consider what is important to the person/ what they would like to discuss.
- Results of tests with explanation to aid understanding.

YEAR OF CARE PARTNERSHIPS

Two-stage review process: Stage 2

- Prepared practitioner and patient.
- Review how things are going.
- Consider what’s important.
- Develop a care plan.

Implementation strategies

- Resources explaining:
  - benefits of the intervention.
  - what is required of practices.
- Ardens training webinar.
- IT Tools to support implementation.
- Identify practice teams to drive implementation.
- Process mapping of how the intervention will work in practice.
- Liaise regularly with practice team to troubleshoot.

Engaging practice teams

Aim:

To identify practice teams to drive implementation.

Reality:

Small core delivery teams with limited power and capacity.

Enthusiasm for person-centred care.

Workload pressures.

Mapping practice processes

A complex change affecting many interlinked processes:

- Who and how to invite.
- Patient preparation materials.
- Need for / timing of first and second appointments.

Healthcare professional skills.

Wide variation in practice processes and in how they decide to implement the intervention.

Staff roles

Nurses and healthcare assistants are pivotal to the provision of long-term condition reviews.

Who is capable of doing holistic, long-term condition reviews and developing a care plan?

Challenge of researching service change

- Simple interventions are complex in practice.
- Research processes can add complexity.
- Less ownership? Seen as temporary?
- Intervention is adapted in practice.
- Difficult to measure impact.

Evaluation

Questions:

- What makes implementation easier / more difficult?
- What are the benefits for patients, healthcare staff and the practice?
- How do ‘successful’ practices do it?
- What are motivating factors that we can build on?

Methods:

- Interviews with patients and staff.
- Videos of consultations.
- Questionnaires for patients.
- Questionnaires for staff.
- Routinely-collected medical record data.

The MaxWELL pilot study

Maximising Wellbeing in Everyday Life with Long-term conditions.

University of BRISTOL
Centre for Academic Primary Care

NIHR | School for Primary Care Research

Core principle: partnering with patients

© University of Bristol

Holistic person-centred reviews

- Quality of life, not just diseases.
- Test results and prompts so patient can prepare.
- Patients choose health priorities and goals and make a plan.
- Proactive self-management encouraged and supported.
- Recognises patient agency and role.

MaxWELL additions

Pixabay License Free for commercial use No attribution required

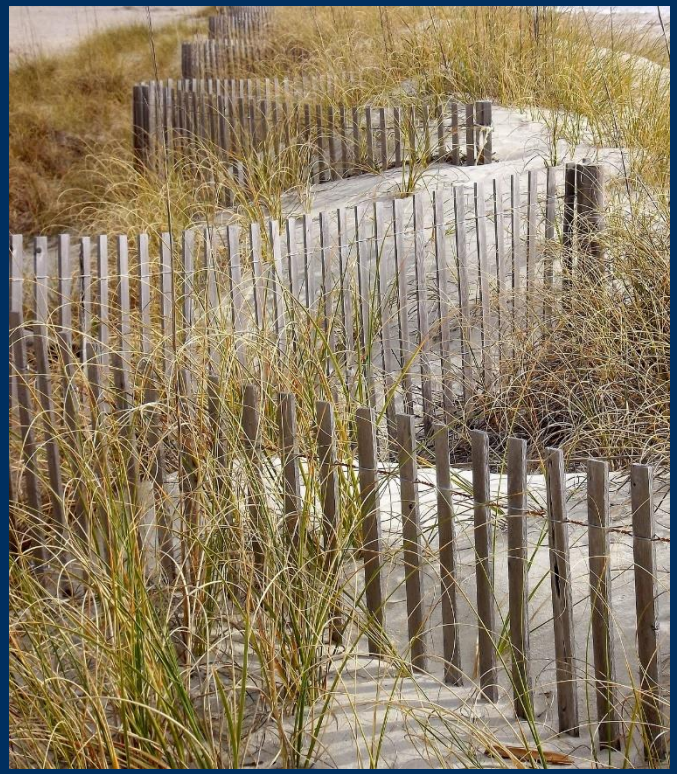
- Extensive staff training in care and support planning.
- A facilitated process mapping session.
- Community consultation around set-up in their practice.

Partnering with patients in their care – what patients would like.

Person first:

- Time to discuss everything they want on one occasion.
- To be listened to.
- Timely, convenient access to appointments.
- More information about their health.
- Better continuity of care.

Partnering with patients in their care – barriers patients may face



Pixabay LicenseFree for commercial use No attribution required

- What does the change mean?
- Will they be left to manage alone?
- Health literacy.
- Ability to constructively advocate for themselves in the health system.
- Traditional expectations of health professionals.

Partnering with patients in their care – staff motivations


© University of Bristol

Staff motivations:

- More rewarding.
- More efficient.
- ‘how I would like to practice’.
- Improved care.
- Would like patients to self-manage better.

Staff concerns:

- Professional responsibility – safety and accountability.
- Skills.
- Quality Outcomes Framework.
- How willing are patients to take responsibility themselves? How much information can individual patients handle?

Systems Training Expectations Preparation Support (STEPS)

- S - System – whole team planning, IT and appointments, nursing team.
- T - Training – and time to develop expertise.
- E – Expectations – it will take time to change traditional ways.

Systems Training Expectations Preparation Support (STEPS) continued

- P – Preparation – for patients – before service change and before reviews.
- S – Support – from colleagues. Mentoring and more training. Use all skills.

Funders

This research is funded by the National Institute for Health and Care Research (NIHR) Applied Research Collaboration (ARC) Multiple Long-Term Conditions Implementation Programme and by the NIHR School for Primary Care Research. This research was supported by NIHR ARC West, NIHR ARC Wessex, NIHR ARC West Midlands, NIHR ARC South West Peninsula and BNSSG Integrated Care Board. The views expressed in this article are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

FUNDED BY

NIHR | National Institute for Health and Care Research

NHS
Greater Manchester
Integrated Care

Sharing Manchester's Approach to Long Term Condition Management

Dr Claire Lake

GP and Interim Medical Director, Manchester Locality

Part of Greater Manchester Integrated Care Partnership

NHS
Greater Manchester
Integrated Care

Context

Manchester Locality

is one of 10 localities within NHS Greater Manchester Integrated Care

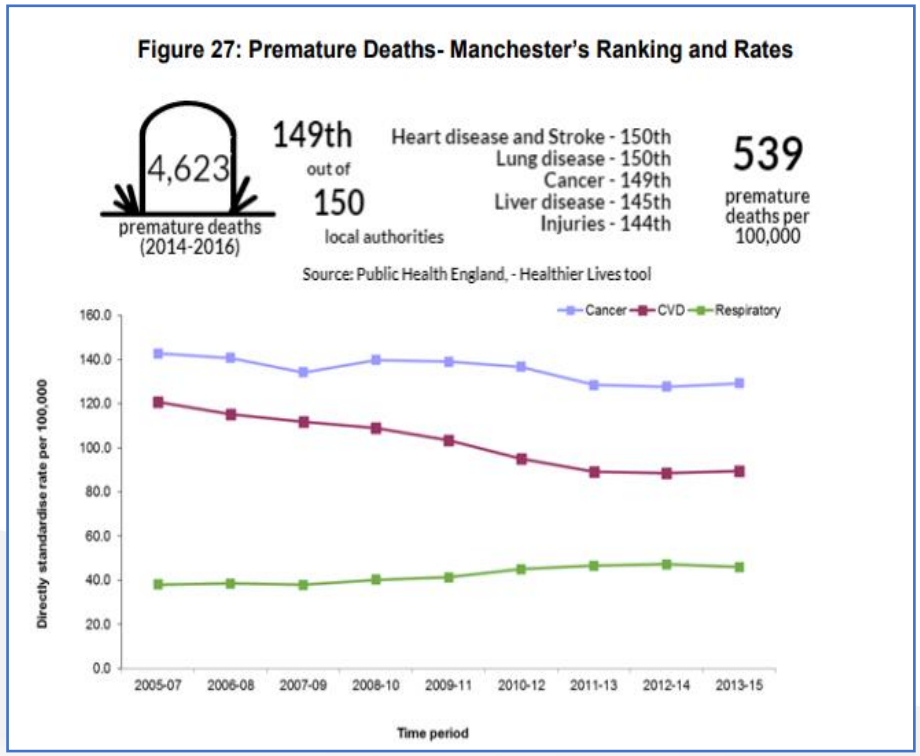
- Population circa 600,000
- 83 GP Practices
- 14 Primary Care Networks (PCNs)
- Diverse city with over 200 languages spoken

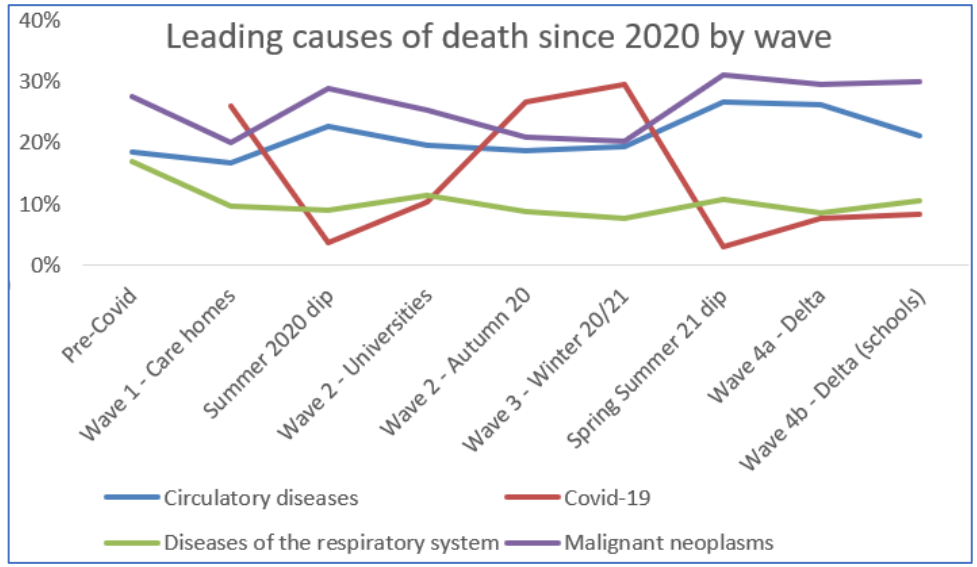
Long standing deprivation and inequality

- Manchester is ranked 6th on the national IMD (Index Multiple Deprivation)
- Proud to be a Marmot City Region

Our Health Challenges – charts showing premature deaths; leading causes of death since 2020 by wave; and change in numbers of patients with diabetes from 2020 to 2021 who have poor disease control or who haven't been seen for 24 months.

NHS Greater Manchester Integrated Care



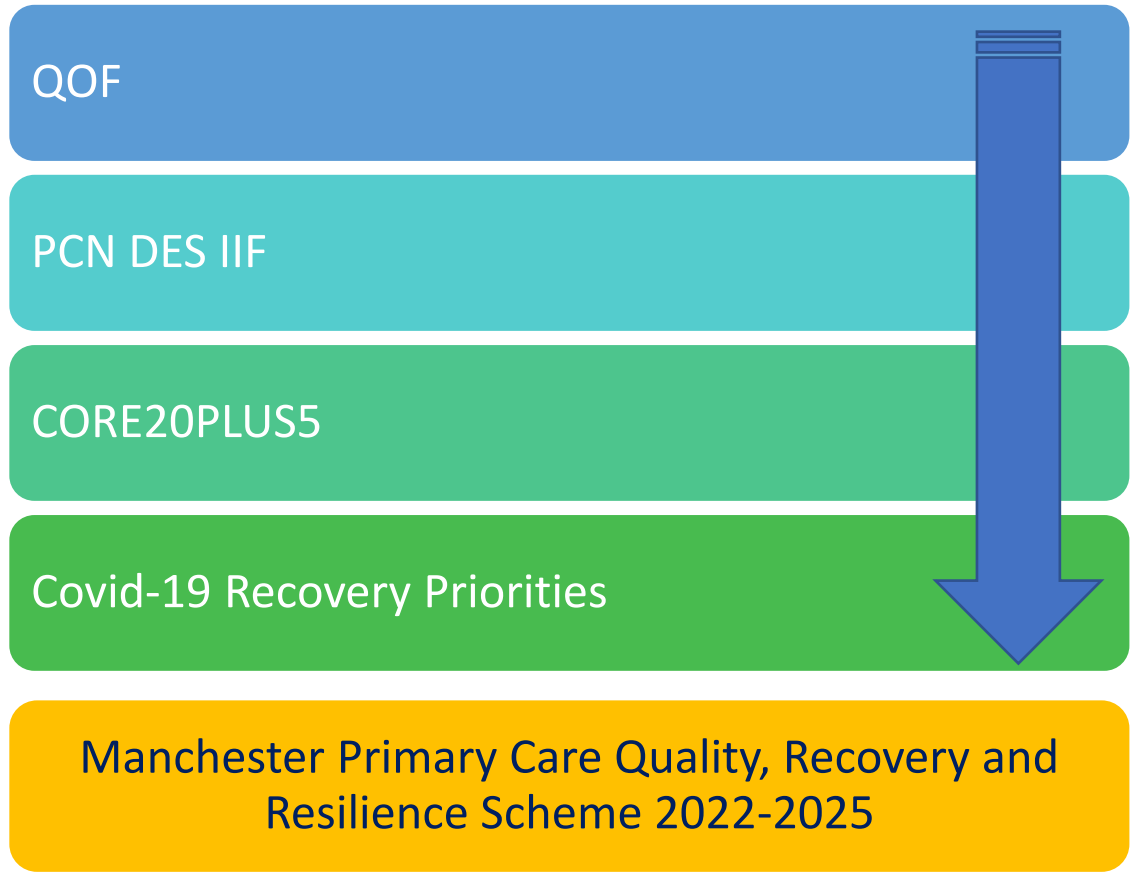


Change in numbers of patients with Diabetes from 2020 to 2021 who have poor disease control* or who haven't been seen for 24 months

Manchester CCG	Number of Patients with Poor Control
December 2020	9408
December 2021	13185

*as defined by GM Diabetes SCN

Finding a new approach



- A Funded scheme for Manchester General Practice
- Aims to reduce unwarranted variation, tackle inequalities in health outcomes and support general practice in recovery

Quality Section: Embedding Multimorbidity reviews

NHS Greater Manchester Integrated Care

Aim:

To provide proactive, holistic care for people with diabetes and cardiovascular disease, focusing on those who have not had a recent review and those at most risk

The ask:

1. **Defined population for each practice**
   - 2022-23 Diabetes; 2023-25 Diabetes + Cardiovascular disease
   - Patients who have poorest disease control OR who haven't been seen in practice >18months
2. **Each GP practice to plan and implement multimorbidity reviews for the defined population**
   - Encourage proactive and holistic care
   - Make every contact count and improve patient experience
   - Optimise efficiency in primary care LTC management
3. **Use a data-driven Population Health Management approach**
   - Working with Manchester Local Care Organisation at a neighbourhood level to support targeted work within communities to improve uptake of reviews, and reduce inequalities in health access and health outcomes for this defined group

Key Enablers

- **Building on the foundation of collaborative working**
- A team approach of Clinical leadership, Primary care team, Business intelligence, Quality leads and Comms and engagement to drive innovation and quality forward
- **Emis Resources**
- Data searches, template for multimorbidity reviews (bespoke local template), achievement dashboard and monthly data drop in sessions
- **Long term condition dashboards**
- Diabetes dashboard, to be followed by CV disease dashboard
- Interrogate data geographically, by protected characteristic and by disease parameter
- **Funding**
- To embed quality approach to Long Term Condition management recovery and to encourage new ways of working and innovation such as multimorbidity reviews

Snapshot of Diabetes Dashboard

Diabetes Dashboard - Monitoring Summary

Monitoring Trend | Home Page | Show Filters

Split By Ethnicity

Latest Data as of: 30 September 2022

	African	Any other Asian background	Any other Black / African / Carib..	Any other ethnic group	Any other Mixed / multiple ethnic ..	Any other White background	Arab	Bangla..	Caribb..	Chinese	Declined to provide	English / Welsh / Scottish / North..	Gypsy or Irish Traveller	Indian	Irish	No record of ethnicity	Pakist..	Roma	White and Asian	White and Black African	White and Black Caribbean	Grand Total
BMI Monitoring, Last 12 Months	73.6%	71.1%	68.1%	68.3%	64.0%	69.6%	70.4%	74.6%	72.8%	64.9%	70.6%	72.3%	59.3%	73.3%	71.7%	54.2%	73.0%	66.7%	76.3%	71.0%	70.7%	71.8%
Blood Pressure Monitoring, Last 12 Months	82.7%	82.3%	82.8%	77.6%	71.5%	78.5%	79.7%	87.6%	87.5%	81.5%	82.0%	84.1%	59.3%	81.9%	88.6%	64.4%	83.1%	66.7%	78.0%	79.9%	81.6%	83.0%
HbA1c Monitoring, Last 12 Months	82.5%	84.9%	82.8%	80.5%	72.7%	78.7%	81.3%	88.0%	86.6%	81.2%	80.5%	84.5%	66.7%	84.3%	87.0%	63.5%	85.2%	66.7%	80.5%	81.8%	85.1%	83.8%
Cholesterol Monitoring, Last 12 Months	78.3%	80.1%	75.8%	73.7%	68.2%	75.2%	75.5%	82.6%	80.1%	76.0%	74.2%	78.1%	66.7%	79.2%	80.7%	56.2%	80.6%	66.7%	74.6%	75.7%	78.7%	78.1%
Urinary Albumin Monitoring, Last 12 Months	50.8%	49.8%	49.5%	44.2%	45.5%	45.4%	50.4%	55.5%	49.1%	48.5%	47.1%	47.3%	29.6%	52.4%	48.6%	27.2%	47.4%	33.3%	44.9%	42.5%	47.7%	47.6%
Serum Creatinine Monitoring, Last 12 Months	82.1%	83.6%	80.7%	79.0%	74.8%	79.5%	79.7%	86.8%	87.2%	81.9%	80.8%	84.7%	66.7%	83.6%	88.6%	64.6%	84.6%	66.7%	75.4%	78.0%	85.6%	83.6%
Foot Check, Last 12 Months	62.3%	63.4%	56.8%	57.5%	52.9%	56.0%	63.1%	70.3%	67.4%	57.9%	64.0%	62.6%	29.6%	63.6%	65.3%	42.9%	65.2%	33.3%	61.9%	55.1%	61.5%	62.6%
Smoking Status, Last 12 Months	94.9%	93.0%	92.3%	90.2%	88.0%	85.5%	92.6%	94.8%	90.8%	88.8%	89.8%	87.1%	77.8%	94.6%	85.4%	76.2%	94.6%	100.0%	90.7%	92.5%	86.8%	90.0%
8 Care Processes, Last 12 Months	40.1%	38.8%	34.7%	34.9%	34.7%	32.1%	38.0%	43.3%	38.1%	37.1%	36.3%	35.9%	14.8%	41.1%	35.9%	17.7%	37.4%	33.3%	37.3%	34.6%	38.5%	36.6%
Eye Checks, Last 12 Months	52.2%	52.6%	52.6%	48.5%	49.6%	46.9%	47.2%	46.6%	53.4%	51.2%	49.2%	49.8%	22.2%	51.8%	47.6%	39.6%	46.3%	33.3%	45.8%	50.9%	56.9%	49.1%
9 Care Processes, Last 12 Months	26.0%	26.3%	21.1%	22.7%	23.6%	19.5%	22.2%	26.3%	24.5%	22.3%	23.4%	22.5%	7.4%	26.8%	21.8%	11.7%	23.3%	33.3%	22.0%	24.3%	26.4%	23.1%

NHS
Greater Manchester
Integrated Care

Next steps:

- Mid-way through year 1 of the scheme
  - Focus on supporting practices to implement and deliver multimorbidity reviews
  - Year 1 = doing more reviews and seeing people who haven't been seen for the longest
  - Actually means our parameters for disease control are worsening
  - Year 2-3 expect to start to demonstrate clinical improvements
- Evaluation of approach – learning and impact
  - Feedback from practices/patients of using multimorbidity reviews
  - Benchmark data for comparison
  - Does this multimorbidity and targeted approach to LTC management start to tackle health inequalities?
- Ambition to share and spread work across our ICS/beyond

Keep in touch

- Email: phc-info@bristol.ac.uk
- Visit our website: www.bristol.ac.uk/capc
- Follow us on Twitter: @capcbristol
- Sign up for our newsletter: www.bristol.ac.uk/capc

Information about future webinars in the series and other CAPC events are available on the Events page of our website: www.bristol.ac.uk/capc/events

Thank you