

How to support patient-centred care:

roof of the House of Care framework

Previous articles have described the differing aspects of the House of Care framework and how it can describe a system for delivering patient-centred care (PCC).¹⁻³ This article focuses on the roof of the house. These are the tools and organisational processes that protect and facilitate this new type of patient-professional relationship. This article tells the story of two clinical commissioning groups (CCGs), and their experience of those factors that have helped PCC to happen.

CARE PLANNING IN PRIMARY CARE

Sheffield CCG is in the second year of an evolving programme (planned for 5 years) to support PCC in primary care. Over 80 GP practices have signed up to a locally commissioned service. It was designed to add value to the 'avoiding unplanned admission' directed enhanced services (DES)⁴ by encouraging a more in-depth focus on the highest-risk patients. It initially started with an incentivised care planning programme. GP practices were paid per care plan, with a purpose-built computer template designed to assist the process. However, there was large variation in the quality of the care plans. Feedback from the first year from patients and clinicians highlighted a significant learning need around how to design and deliver a collaborative care plan that supported self-management.

Year 2 has focused on education of primary care teams around process and delivery. It also sought to introduce the patient activation measure (PAM)⁵ as a facilitating tool to assist the care planning process. Practices were given some freedom to choose the most relevant cohort of patients to work with. A multidisciplinary support team continues to provide ongoing support, tailored to individual practice needs. The intention is for future years to build on experience and introduce new

skills and systems for supporting self-management and shared decision making. Practices will be encouraged to capture changing activation levels and report on what they think they are doing that influences these changes.

TAILORED HEALTH COACHING

In Horsham and Mid Sussex CCG, in May 2015, we launched our newest service, 'tailored health coaching'.⁶ Its aim was to enhance our PCC offer to our population. This is a telephone-based opportunity for a patient living with any long-term condition to work with a coach. To empower them to take control, the patient identifies what it is that is important to them rather than what we think may be important.

Patients are proactively identified using the risk stratification tool, Docobo.⁷ This identifies those of medium risk of admission (range 45–65%) using both primary and secondary care data. They are then invited to take part in the service by way of an opt-out consent letter, to improve the likelihood of inclusion for those who are less motivated.

The approach that the coach takes with that patient is tailored according to their PAM, which has been demonstrated to improve outcomes.⁸ The PAM represents a measure of that patient's knowledge, skills, and confidence to self-manage.

Patients with higher levels of activation may just need 'signposting' to a local directory of services (menu of care IT platform)⁹ that covers a range of medical and non-medical self-help resources. These include self-referral to psychological support, e-learning opportunities about various conditions, social care information, housing and financial support, and third-sector support groups.

The coach, however, may need to spend longer with people who have lower levels of activation, building confidence, and co-generating smaller and more manageable goals that nourish success in self-management.

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Provenance

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The wellbeing goals and plans are captured for the patient, coach, and GP to see and interact with. The service is being evaluated by capturing pre- and post-PAM, Warwick-Edinburgh Mental Wellbeing Scores (WEMWBS),¹⁰ Docobo risk scores, and healthcare utilisation spend.

Our coaches come from a variety of backgrounds including working in the fields of mental health, learning difficulties, and chronic disease management, as well as health psychology. They are non-clinicians as we specifically wanted a holistic rather than health-centric offer. They provide the service both in and out of core hours.

The initial 6-month review has shown an improvement in WEMWBS and PAM scores. We await further qualitative and quantitative analysis of the data.

LEARNING POINTS

These examples illustrate the evolving learning journey of system change. We recognise that the tools and organisational processes that support PCC need to evolve alongside a stepwise progression in ways of thinking and doing. We suggest some key features of a good 'roof'.

Ownership. You have the best chance of success if the people working at the 'coal face' own the vision of what you are trying to achieve. This is best achieved by co-producing the programme of support and allowing all involved some degree of autonomy in how they deliver or receive services.

Measurement. We need good measures of how the system (professionals, patients, and structures) supports PCC. Quality improvement methodologies highlight the need to capture meaningful measures, including evidence of unintended consequences, and to react to what these measures tell us. This iterative learning process is often described as a plan-do-study-act cycle. In our experience we observe that the NHS often does plan-do, but often does not complete the study-act part, which is usually the most valuable and insightful.

Tailoring your support according to need.

Whenever you are trying to introduce new ways of doing things, you need to know where those involved are starting from. You can then tailor your training and support to match the need. This applies both to developing new systems of care or interacting with patients. In this context GPs

are probably best placed to support patients with highly complex multiple conditions. However, great care should be taken to avoid a very 'medical approach' with patients who are generally overwhelmed with life (low activation level). In this situation a peer support or voluntary sector worker might be better able to support the patient until they are more ready to focus on their medical needs.

New skills. PCC is different, with much more focus on patients leading their own problem solving, even if this involves very small steps. Skills such as motivational interviewing, goal setting, and coaching support this different approach. However, these are often not core skills in healthcare training, where the model of training is still very disease focused.

Faith in the longevity of commitment. PCC is a new paradigm of delivering care. It takes time to embed the ideas, generate the necessary skills and confidence, and appreciate the benefits. It helps to have contracts and programmes that commit to medium-/long-term consistency.

Good IT. This can be a great facilitator when it works well. Templates that promote the use of consistent codes, and prompt goal setting and coaching approaches, can be useful tools. They can also facilitate the auto-population of summaries for patients and clinicians. Ultimately encouraging patients to access their own NHS notes, with guidance on how to use them effectively, can empower them to own and interact with the records kept about them.

Contract and culture change. Contracts that incentivise changes can be very useful in supporting the adoption of a PCC approach. They often underpin financial incentives to deliver specific outcomes and key performance indicators. However, this alone is not enough. As Don Berwick observed, 'Culture trumps rules',¹¹ and real change only happens when the culture of the system evolves to adopt that new way of working as the normal way of working.

In summary, moving to a PCC approach is difficult and takes consistent and persistent effort. This article highlights some tools and behaviours that can facilitate this challenging transition. We welcome the ongoing debate, and hope collective experience will feed into continuous learning for the PCC approach.