NAME

Katie Coleman

POSITION

GP Partner

ORGANISATION

City Road Medical Centre, Islington

SUMMARY

City Road Medical Centre in Islington embedded the Year of Care approach to diabetes through a locally commissioned service from **Islington Clinical Commissioning Group**. This involved a two-stage process with an initial appointment with a health care assistant after which patients would see a GP or practice nurse for a collaborative care and support planning consultation. Subsequently, the practice team explored how this approach could be extended to other long-term conditions. There were small improvements in 12 of the 19 QOF domains.

OVERVIEW AND REASON FOR CHANGE

City Road Medical Centre, the only GP practice located in the Bunhill ward, has one of the highest levels of deprivation within Islington and with this comes high levels of long term conditions (LTCs). In addition to high levels of severe enduring mental health problems, the prevalence of chronic depression is recorded as one of the highest in Islington. This has a direct impact on levels of health literacy and activation, which in turn impacts on people's ability to self-care and to take a more collaborative approach to the management of their health.

The practice therefore embraced a new opportunity to provide a more proactive approach to managing people with LTCs in the form of a new locally commissioned service (LCS) from Islington CCG.

WHAT DID YOU DO?

The new service looked to embed the Year of Care approach for people with diabetes, whereby people are offered a two-stage approach to care. The first stage involves an appointment with a health care assistant, where all essential health checks are carried out. This is followed by the collation of results that are then sent to the patient prior to the second stage with the practice nurse or usual GP for a collaborative care and support planning consultation. The second stage is completely guided by the individual and what matters to them. If a referral is necessary to achieve the individual's goal, this this would be undertaken as part of the second stage. The second stage should also have a clear review date agreed to ensure ongoing support and goals are achieved.

Over two years the practice team worked to embed the approach outlined for this patient group. This included developing **new organisational systems and processes**, identifying methods that would support people to self-care such as **referral to local health navigators** and the expert patient programme, as well as **supporting the practice team to attend training** that developed skills in health coaching, motivational interviewing and solution-based approaches to care.

Over time it became clear that this approach could be of benefit, not only in patients with diabetes, but for all patients with LTCs. The management team identified and implemented several actions. This included **identifying new software** that would enable the practice to hold a multi-morbidity register, the lead GP for LTCs carrying out a **practice diagnostic** to identify what was working well and what activities may require development, a **co-production event with the whole practice team** to consider what the new service would look like and **consultation with the practice patient participation group** on their thoughts.

WHAT HAPPENED?

To understand how effective this new process was, the practice compared how many patients with LTCs received the intervention prior to initiation of the new approach and then one year after the start. This number was based on the numbers of patients who had received the intervention based on achievement against QoF and did not look at patient experience. The data was taken from annual QoF data that is available in the October after the close of the QoF year. The baseline data for activity in QoF year 2015/16 (prior to the start of the intervention) was compared to data for the QoF year 2016/17. There were small improvements in 12 of the 19 QoF domains such as: percentage of patients with diabetes whose BP was 150/90 or less, or percentage of patients with diabetes who had had a foot check (these were significant). There was also an increase in number of diabetic patients whose Hba1c was 64mmol or less, who had a Hx of TIA whose BP was 150/90 or less – but these were not significant.

NEXT STEPS: SUSTAINABILITY AND SCALABILITY

It is difficult to say if the improvements were caused by the new approach implemented by the practice. However, since this was the first year that the practice has offered a holistic approach to LTC care it is important to allow this new way of working to continue for a further year to see if the improvements continue.