Managing multi-morbidity in practice… what lessons can be learnt from the care of people with COPD and co-morbidities?
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Introduction

The case for managing multi-morbidity

With an increasingly ageing population comes the challenge of how to deal with people with multi-morbidity (i.e. the presence of two or more long term conditions in one person). Although the prevalence of multimorbidity rises with age, a study of 314 Scottish general practices showed absolute numbers to be higher in the under 65 age group. Furthermore, a Canadian study suggested that multimorbidity is the norm rather than the exception with 69% patients aged 18-44 having multimorbidity and 93% patients aged 45-64.

People with multimorbidity are more likely to die at an earlier age, more likely to be admitted to hospital, have a poorer quality of life and are more likely to be prescribed multiple drugs with consequent poor adherence. This suggests that there is scope to improve management and outcomes for these patients. Traditionally, disease management guidelines and patient pathways have been devised around single disease entities. This has been encouraged by the demise of the generalist in secondary care and the development of super-specialties. However, this disease-centred approach tends to underestimate the effect of psychosocial factors influencing the patient’s health and encourages the development of multiple treatment regimes with increased potential for adverse drug interaction and poor adherence.

COPD and co-morbidity as an exemplar

Chronic obstructive pulmonary disease (COPD) is a long-term condition with a high prevalence (an estimated three million people in England) and with a high number of co-morbidities. Table 1 shows the prevalence of co-morbidities of significant long-term conditions in the Scottish general practice multi-morbidity study, and shows that people with COPD over the age of 65 had a mean of 4.5 co-morbid conditions shown in the table. As such, the organisation of care for people with COPD and its co-morbidities has the potential to be an exemplar for the organisation of care for people with multi-morbidities in general.

Table 1: Co-morbidity of 10 common primary care conditions in 314 Scottish general practices

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage of patients with the row condition who also have the column condition</th>
<th>Percentage of patients who only have the row condition</th>
<th>Mean No. of conditions in people aged 30 years with row condition</th>
<th>Mean No. of conditions in people aged 60 years with row condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroesophageal reflux disease</td>
<td>4.8</td>
<td>8.8</td>
<td>3.4</td>
<td>4.4</td>
</tr>
<tr>
<td>Hypertension</td>
<td>31.9</td>
<td>2.5</td>
<td>6.5</td>
<td></td>
</tr>
<tr>
<td>Heart failure</td>
<td>2.8</td>
<td>3.9</td>
<td>5.6</td>
<td></td>
</tr>
<tr>
<td>Stroke/transient ischaemic attack</td>
<td>6.0</td>
<td>3.6</td>
<td>5.6</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>6.5</td>
<td>3.3</td>
<td>5.0</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>17.6</td>
<td>2.9</td>
<td>4.8</td>
<td></td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>14.3</td>
<td>2.8</td>
<td>4.5</td>
<td></td>
</tr>
<tr>
<td>Painful condition</td>
<td>12.7</td>
<td>3.1</td>
<td>4.5</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>23.4</td>
<td>2.6</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>5.3</td>
<td>4.1</td>
<td>4.6</td>
<td></td>
</tr>
</tbody>
</table>

* Percentage who do not have one of 59 other conditions in the full count.
The Wagner chronic care model of structured care\(^6\) has identified four key elements which are likely to have a major impact on the quality and effectiveness of care. These elements are:

- the promotion of self-management,
- a comprehensive system to support clinical management,
- evidence-based support for decision making, and
- the use of clinical guidelines.

The 2010 NICE COPD Guidelines\(^5\) and international GOLD COPD Guidelines\(^7\) have increasingly recognised the need to assess co-morbidities when carrying out routine assessment of the patient with COPD. The Primary Care Respiratory Society-UK (PCRS-UK) have adapted the NICE COPD Guidelines for primary care and advocate a patient-centred approach to COPD assessment and management\(^8\) including the assessment of co-morbidities. Figure 1 shows an algorithm summarising this patient-centered assessment. However the guidelines fall short of how to organise care for these patients.

This document summarises the learning from a project to find out how general practices in the United Kingdom have risen to the challenge of organizing chronic care of patients with multimorbidity in practice, using the exemplar of COPD and its co-morbidities. It provides practical examples of approaches that have been tried, key learning points about what works and why, and suggestions for the way forward.

**Figure 1: Patient centred management of stable COPD in primary care\(^8\)**

[![Algorithm for patient centered management of stable COPD in primary care](image)](image)

This includes learning about planning ahead, organisational issues, identifying the right patients and evaluating the impact of change. As such, it will be of help to all those interested in improving the way care is organised in their own area for patients with multi-morbidity.

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Findings from sites

**Survey method**
A simple seven item questionnaire was developed by the multidisciplinary project committee which included questions about practice demographics, how and why systems for managing COPD patients with co-morbidities were developed, the impact and any lessons learnt.

The questionnaire was uploaded to Survey Monkey and publicised amongst the networks of the Royal College of General Practitioners, NHS Improvement, the Primary Care Respiratory Society UK and Education for Health. The survey was open from the 29 November 2012 to 8 February 2013.

Over thirty sites responded to the call for examples of effective management of multi-morbidity in COPD patients. Many of the respondents described systems for managing COPD without co-morbidities and other practices did not wish to be contacted further.

Six case studies were chosen by the authors which were thought to represent the various approaches that practices used to tackle the problem of chronic disease management of people with COPD and its co-morbidities.
Vauxhall Primary Health Care (VPHC) is an urban practice in Liverpool with a list size of 6,000 patients and a team including GPs, practice nurses and a health care assistant.

A quality improvement project has been running here for three to four years since the practice obtained funding from neighbourhood cluster efficiency savings for 1.5 days/week of GP time to address the question:

"How can we improve the care of housebound patients with complex needs registered at VPHC?"

What do they do?
First of all the practice established a register identifying patients at need, targeting first those who were housebound with more than one Quality & Outcomes Framework (QoF)-registered disease, multiple medications and unplanned admissions in the last year.

Patients were contacted by letter. All visits were carried out by GPs who completed an assessment, involving a review of the notes - including tidying up problem lists; medication review; care assessment (where possible involving carers themselves); assessment of level of need (low, medium or high) and a documented plan of care.

What did they achieve?
Recorded data was audited and experiences of staff, patients and carers reviewed. Results from initial data available indicated a lack of impact on admissions but a reduction in prescribing. Data showed that inappropriate medication was stopped in 54 patients out of 101 patients, due to a long-term view being taken about safety. Informal feedback was generally positive, especially from staff and carers (see table 2

Key learning points
- Identify your key ‘at-risk’ group that is most likely to benefit.
- Bear in mind the importance of holistic care - 63% of patients were found to have needs not met by existing chronic disease management or medication review processes and identifying these needs was difficult from routine collected data alone. Assessment by an experienced GP, with an ‘off-protocol’ patient-centered approach was found to be more useful.
- Make use of your community teams.
- Work through how much clinical time is required and how you will find or fund it.

Table 2: Feedback Summary

<table>
<thead>
<tr>
<th>Patients/carers</th>
<th>For some, surprise/suspicion/concern that doctor has visited for review, unsolicited by patient. From family/carers, support for opportunity for time for full assessment/discussion especially re medication.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff at care homes</td>
<td>Positive impact of proactive review of patients, including tidying up/rationalising medication.</td>
</tr>
<tr>
<td>Staff at VPHC</td>
<td>Useful impact of reviewing the patient’s list of problems, medication reviews etc; protected time for visits for complex patients valuable.</td>
</tr>
</tbody>
</table>

We are starting to make greater use of community matrons and also community pharmacy. Reserving GPs for the less straightforward cases...what we are still struggling with is how to predict who those are. But often it is where the DIAGNOSTIC issues are dominant.

Dr Joanne Reeve, Vauxhall Primary Health Care
Case study 2: Yellow Practice, Govan Health Centre, Glasgow

Yellow Practice is an inner city practice based in a health centre with three other Practices in Glasgow. It has a list size of 4,000 patients, four GPs and two practice nurses.

What do they do?
For three years the practice nurse has organised an ‘Annual Health Review Clinic’ for patients with multiple chronic diseases. Patients get a half hour appointment with the practice nurse, during which conditions including diabetes, heart disease, kidney disease, hypertension, heart failure, asthma, chronic obstructive pulmonary disease (COPD) and stroke can be reviewed. If more time is needed a further appointment is booked, and if necessary a six monthly review can be arranged.

Patients are invited by letter (or text message if they have a mobile phone) and administrative staff are aware they need to make thirty minute appointments for these reviews.

A second practice nurse is employed to carry out annual health checks for the housebound, and residents of care homes. These patients are seen annually, six monthly or more often if required. No other community teams are involved apart from the podiatry services that visit the housebound diabetic patients at home and review diabetic patients who have been identified as having high or moderate diabetic foot disease.

Why did they do it?
The practice nurse instigated this way of managing patients with multiple chronic disease because patients reported that they were tired of being invited for different reviews at different clinics several times a year.

What has been achieved?
Patients have provided positive feedback and comments on how much better the service is now. Fewer appointments are taken up as most of the conditions covered involve similar measurements and lifestyle issues. Receptionists also find it easier to book one appointment for the annual review.

The team has also found this system is better in relation to the practice’s QOF targets and Locally Enhanced Service (LES) requirements, as everything is tackled at once and it is easier to monitor targets and results.

What were the challenges?
• The lack of recall coding on the EMIS electronic records system.
• Evaluating cost benefits.

What were the key learning points?
• Create a code in EMIS for chronic disease management review - it is time consuming to code everyone with that code but once done it is very useful.
• When to time the recall - the team at Yellow Practice tried making the patient’s annual review in the month of their birthday but for those who didn’t respond straight away and were late it didn’t work. So reviews are now booked according to when the patient was last seen. This took time and effort to organise but now works very well.
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Case study 3: Leckhampton Surgery, Cheltenham

Leckhampton Surgery is an urban Practice of 12,000 patients, nine doctors, five Practice Nurses and three HCA’s.

What do they do?
The Leckhampton Surgery runs a ‘one-stop’ clinic for review of patients with multiple chronic diseases. Each condition is given 20 minutes plus extra time if needed. Patients are seen by a registered nurse who has skills and qualifications in chronic disease management, COPD, Asthma, Heart disease and diabetes. She is assisted by a health care assistant who completes all the clinical measurements beforehand such as spirometry, bloods and diabetic foot checks, having completed National Vocational Qualification (NVQ) training. The nurse is a prescriber but GPs are involved where necessary. Staff training has been funded by the practice and the pharmaceutical industry.

Patients are invited by letter and phoned or text messaged the week before to remind them of their appointment.

Housebound patients are visited by a practice nurse at request from a GP, or by the GPs themselves. Community staff are asked to contribute to the review of housebound patients but it is found that they have very little time to spend on these reviews and are not trained in chronic disease management of multiple conditions.

What did they achieve?
Attendance is very good, and patient satisfaction has increased due to only having to attend surgery once a year for review. In addition, more appointments are available for the nursing team.

“My advice is plan the clinic carefully. Work hard on the wording of the invite letter, keep it simple. Phone patients to remind them of the appointment - it’s a big chunk of time if they do not attend.”

Sharon Lamden, Lead Practice Nurse, Leckhampton Surgery
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Case study 4:
Woodbrook Medical Centre, Loughborough

Woodbrook Medical Centre is an urban 9,000 patient practice in Loughborough. There are six doctors, three nurses, a health care assistant and phlebotomist.

What do they do?
Woodbrook planned to set up a one-stop long term conditions clinic. They identified patients from the electronic records system with long term conditions such as chronic obstructive pulmonary disease, hypertension and diabetes and recorded the number of co-morbidities the patient had. Figure 2 compares the number of selected co-morbidities seen with each condition.

Disease severity was also stratified according to markers such as Forced Expiratory Volume and Medical Research Council (MRC) Score for breathlessness. Patients with two or more co-morbidities would be taken through the process summarized in the flowchart shown in Figure 3.

What were the challenges?
The practice organized a three-hour team meeting with all lead clinicians where a detailed notes review of six patients was undertaken. Although some savings were projected in terms of prescribing rationalization and reduction in appointments requested, they were unable to progress further due to a lack of funding for the extra clinical time that was needed.

What were the key learning points?
- Resources need to be identified to fund extra clinical time to get the project under way.
- A project manager is needed to create a timetable and to keep the process moving forward.

The multiplicity of long term conditions borne by many of our patients demonstrates the difficulties involved in obtaining optimal outcomes for these conditions both individually and collectively; focusing on what the patient wishes to achieve will be more useful in applying therapies rather than relying on single condition guidelines many of which will have conflicting objectives and recommendations. The future lies in navigating these guidelines guided by the patient’s wishes and moving away from strictly targeted control.

Dr Dermot Ryan, Woodbrook Surgery

Figure 2: Number of Co-morbidities with reference condition (on y axis) in Woodbrook Surgery, Loughborough.

Figure 3: Flow chart of organisation of care for patients with two or more co-morbidities in Woodbrook Surgery
Case study 5:
Birtley Medical Group, Gateshead

Birtley Medical Centre is an 80% urban and 20% semi-rural practice with a list size of approximately 14,500 in Gateshead, County Durham. For 8-10 years the nursing team have been running a Better Health Clinic for review of patients with chronic diseases and co-morbidities.

What do they do?
Patients are seen in a Better Health Clinic appointment of thirty minutes with a senior practice nurse or nurse practitioner (depending on their co-morbidities). All the nurses who are involved have at least diploma training in the illnesses reviewed.

Patients are informed of the need for their review by a note on their prescriptions. They are then asked to book in for appropriate tests (such as bloods and spirometry) with a health care assistant and the Better Health Clinic appointment is made with them for one to two weeks later. Making the appointment with the patient has been helpful in improving attendance rates which have been good.

Housebound patients are seen by GPs, practice nurses and community matrons as appropriate.

What did they achieve?
Patients report greater satisfaction with the new approach.

People have expressed their appreciation of the 'one stop shop' approach, particularly because there is a significant amount of interconnectedness.

Liz Bryant, Nurse Practitioner, Birtley Medical Group

What were the challenges?
- Training staff to an adequate level to meet the requirements of the clinic.
- Organising appointments so that enough time is allowed for review.

Key learning points
- Investment in nurse recruitment and high quality training is essential, and it is important to ensure that staff complete enough regular consultations to keep up their skills.
- Allow enough time for the review by making sure the blood tests and spirometry are planned and executed in advance.
Phoenix Medical Practice in Bradford, West Yorkshire, has a patient base of 3,600 patients and has been championing the concept of care planning with patients with multi-morbidity under the direction of Dr. Shahid Ali. This has centred on diabetes, but includes COPD and other long-term conditions.

**What do they do?**
40% of the practice patients had a long-term condition, of which 25% had two or more. These patients were invited to attend appointments for a care planning consultation. Using an integrated long term condition template the patients, in their own words, record the issues that are important to them and how these impact on self-caring and setting self-directed goals (e.g. giving up smoking).

Capturing this information ensures the goals are relevant to the patient and means the patient can relate back to them regularly. A follow up appointment is made to assess progress against these goals.

**What were the challenges?**
There is a need for practice meetings to change the culture of chronic disease management towards patient –centred and supported self-management. There is also a need for training on the multi-disease templates.

**What have they achieved?**
A health economic evaluation of 19 patients using the care planning approach was published in the Health Service Journal in 2010. This showed in a reduction in health service contacts from 529 to 246 in the 12 months pre and post care planning, a reduction in outpatient contacts and a reduction in overall health costs.

**What were the key learning points?**
The experience of being in control and making independent decisions is highly motivating for patients. The care planning approach has been further piloted by other practices in West Yorkshire. Patient empowerment is being further enhanced by electronic sharing of data including goal setting via the internet or via smart phones.
Findings from the survey suggest that whilst practices have started to implement systems which co-ordinate the organisation of care of people with COPD and its co-morbidities these systems are in their infancy and there has been little evidence of formal evaluation. This conclusion must be tempered by the fact that there was a relatively low response rate to the request to complete the survey.

There may be several reasons for this:
• Practices have not organised multi-morbid care around COPD. There is anecdotal evidence that practice systems have been built up with ischaemic heart disease or diabetes as the reference disease.
• General practices are under a lot of workload pressure at present, as evidenced by surveys from the British Medical Association and so response rates to surveys may not be optimum, especially when sent in a period around Christmas.

In spite of these limitations several themes emerged from those who responded to the survey:

1. MOTIVATION TO ORGANISE MULTI-MORBID REVIEWS
Some practices identified optimizing performance under the Quality and Outcomes Framework (QOF) as the main purpose for developing a system for managing patients with multiple problems, due to the opportunity to complete all reviews and templates at one consultation.

Some practices utilised Practice – Based Commissioning (PBC) or other sources of funding to develop ideas for new systems, and others were motivated by the need to increase patient satisfaction with the way their conditions are managed.

2. ORGANISATION
Nine of the thirteen practices who provided additional information used the concept of a nurse-led ‘one stop clinic’ reviewing multiple conditions in one consultation. Consultations tended to be structured around COPD and ischaemic heart disease/heart failure rather than other co-morbidities. Most of the nurse-led clinics involved a thirty minute appointment with measurements such as spirometry and bloods organised in advance. One practice used only fifteen minute appointments but found this challenging, especially as QoF data needed to be collected for all conditions using existing templates.

At one practice, a telehealth system using joint management plans issued by the local Community Partnership Trust enabled patients to self-manage their symptoms over a trial period of three months.

A key to successful organisation was prior planning by multidisciplinary members of the practice team.

3. TELEHEALTH & TECHNOLOGY
Few practices provided information on using telehealth or technology to support management of co-morbidity in COPD or in multi-morbidity generally. Furlong Medical Practice in Stoke on Trent, described how telehealth can enhance patient engagement in managing their COPD (see box on page 14 for details).

Nurses and patients have loved the system and it is being adopted more widely and extended to other conditions.

Successful implementation requires engagement of the whole practice team in the initiative through communication, incentives and training, and ensuring that there is a clear and consistent approach to identifying and recruiting appropriate patients to the service.
**Telehealth in COPD management**

Furlong Medical Practice, Stoke on Trent, adopted a Clinical Commissioning Group (CCG) funded Florence mobile phone texting service in January 2012 to enhance patient engagement in their COPD management. They identified patients on the COPD register whose clinical management could be improved and who could be given more autonomy. Specific patient selection criteria were used, including evidence of one or more of the following:

- excessive use of inhalers
- breathlessness on exertion
- productive sputum
- one or more exacerbations of COPD in last 12 months
- attended practice frequently in previous year for respiratory reasons, having been prescribed two or more courses of antibiotics
- been admitted to hospital with exacerbation of COPD in previous year
- attended Accident & Emergency, walk-in centre, out of hours service with exacerbation of COPD/chest infection – in previous 12 months.

A joint management plan is agreed between patients and the practice nurse which is supported by a written leaflet. Patients take home a pulse oximeter, thermometer, weighing scales and their rescue medication. They then receive daily texts asking about sputum colour and oxygen saturations. Depending on sputum colour, they are asked if they feel unwell, and if so, are asked to take their temperature. If their temperature is >37.5°C, they take rescue medication according to their agreed joint management plan.

Clinicians monitor patients’ readings twice a week. There is a monthly text enquiry about patient experience and the programme is run over three months. There is an evaluation form at the end of the programme and good patient self-care literature is given to patients to supplement their learning from the programme.

The practice believes telehealth enhances the care they deliver and offers patients an enormous advantage in understanding their condition, thus making them more likely to comply with any agreed joint management plan.

“Realise the potential of telehealth for enhancing quality of delivery of patient care and trial it in your team.”

Professor Ruth Chambers, Furlong Medical Practice

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**4. PATIENT IDENTIFICATION AND RECRUITMENT**

Most practices identified patients from their disease registers, with one using the patient’s birthday month as the month of their review. All practices used written letters to invite patients to their review, with one phoning patients a week before their appointment to remind them. Some practices also used text messaging for patients who had mobile phones.

The wording of the letter or message was identified as an important factor, as it influenced patient anxiety and attendance rate. One practice described inviting patients who were not engaging up to three times by letter, but if they did not wish to receive help they were not forced to take part but exempted for that year.

**5. STAFF**

The majority of the practices ran clinics led by practice nurses. Some practices had nurse prescribers to modify medications but in other cases medications were reviewed by GPs after discussion with the practice nurses.

Two practices also used junior nurses and health care assistants for spirometry, blood tests and diabetic foot checks.
Staff training was highlighted as an important issue. Most practices had nurses with qualifications in chronic diseases. In some practices, nurses had to be trained in chronic disease management or new nurses employed. The cost of this was balanced against the savings in nursing appointment time, due to multiple problems being addressed in one appointment.

In terms of community and secondary care involvement, one practice mentioned good links with secondary care and others mentioned liaison with pharmacists for medication review and district nurses and community matrons for the care of housebound patients.

However, some found that community staff did not have enough time to see all the patients identified or were not trained to manage multiple problems. Generally patients were referred to community staff if needed but one practice held fortnightly meetings with the community matrons to discuss housebound patients, as part of the requirement for the CCG Locally Enhanced Service (LES).

6. HOUSEBOUND PATIENTS
There was a range of care models used to manage housebound patients or patients with complex needs. At one end of the spectrum there was an integrated team approach with initial review by a community matron or GP, and subsequent support at home by the community team. At the other end of the spectrum, the GP carried out the reviews of housebound patients.

7. EVALUATION
Although there was a paucity of formal evaluation, informal feedback from practices found that resulting patient and staff satisfaction was high, mainly due to time saved due to multiple problems being addressed at one consultation. This also led to more nursing appointments becoming available. Some practices also reported increased adherence to medication and reduced Accident and Emergency Attendances.
Several practices highlighted training as one of the main challenges, saying high quality training was vital for success of the scheme to ensure staff were skilled in assessing and managing multi-morbidity.

Careful organisation and time management were also essential, with enough time needing to be given to appointments and all measurements such as bloods being taken beforehand.

Practical resources were another challenge. One practice needed to modify their invite letter to optimise patient attendance and found they lacked an appropriate template for entering all relevant data.

Funding was the other main challenge that many practices cited. This was generally funding for training or extra clinical time, with evidence of evaluation and successful outcomes needed before further funding could be provided.
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The way forward

The move away from a disease-centric model of care towards a patient-centred multimorbid system raises several challenges for those working to deliver structured care.

The current Quality and Outcomes Framework is a major driver in structuring chronic care in general practice, but tends to be disease-specific. As such, care needs to be taken to ensure it does not become a potential barrier to delivering effective integrated care in conjunction with community teams. Financing of schemes may be more appropriately made by using levers such as Commissioning for Quality and Innovation (CQUIN) payments across a locality to encourage a more integrated approach to care.

There is a major need to develop multimorbid disease management templates which are geared to the individual patient and which take into account common psychosocial factors such as depression and the needs of carers. Looking to the future there is also a need to look at new ways of developing patient pathways and guidelines away from the current disease specific models to more generic approaches around patient problems e.g ‘disability or breathlessness’.

The NHS has organised chronic care around a long term conditions model, shown diagrammatically in figure 4 below. In recent years integrated care models have concentrated on patients at level 2 and level 3 who are high risk or with ‘complex needs’. However, with the increased realization that patients with multi morbidity are the norm rather than the exception, there is also an increased need for integrated working at a practice level with level 1 patients. Examples of this are the involvement of Community Pharmacists to minimize polypharmacy and attached practice social workers to help deal with psychosocial problems.

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**Figure 4: NHS Long-Term Conditions Model**

- **LEVEL 3:** High complexity
  - Case management
- **LEVEL 2:** High risk
  - Disease/case management
- **LEVEL 1:**
  - 70-80% of LTC population
  - Self care support/management
Conclusion

Proactive chronic care of patients with COPD and its co-morbidities provides an exemplar for chronic care of patients with multimorbidity in general practice. Examples of such care are limited but the final section of this document uses the key learning points from this survey to give advice to general practices planning to offer structured chronic care for people with multimorbidities.

Learning from those sites who responded to the survey suggests there is a need for multimorbid disease management templates and care pathways, and that integrated working with community teams, including pharmacists, can improve outcomes, with the potential to reduce overall consultation times, increase patient satisfaction, reduce polypharmacy and reduce hospital admissions.
Points to consider when organising structured reviews for patients with COPD and co-morbidities in primary care

<table>
<thead>
<tr>
<th>KEY POINTS</th>
<th>QUESTIONS TO CONSIDER</th>
</tr>
</thead>
</table>
| **BE CLEAR WHY YOU ARE REORGANISING CARE** | • What are the benefits to the practice and to the patients, carers or family? e.g less consultation time, fewer visits for the patient, achieving the objectives of a locally enhanced scheme.  
• What are the likely financial consequences?  
• Consider canvassing CCG or local health group to provide finance/support for groups of practices under CQUIN/LES and to support work across boundaries. |
| **PRIOR PLANNING** | • Identify who is, could or should be involved in the organisation of care (e.g practice staff, community staff, pharmacist, social services, patients and carers)  
• Involve these stakeholders in the planning of care to increase understanding of what currently happens, what could happen and to encourage motivation for the service to succeed. |
| **IDENTIFICATION OF PATIENTS** | • Which co-morbidities will be included? Which are most common?  
• Are higher risk patients to be identified and how will this be done (e.g COPD patients with two or more exacerbations in the last year)? |
| **ORGANISATION** | • How will patients receive invitations and be reminded to attend appointments?  
• How will checks be organised? e.g number of appointments per patient, duration of appointments and which practice staff will be involved.  
• How much time is currently available and how is it used? How could it be used differently? Do you need any extra time?  
• What will happen in each appointment?  
• Do the staff have sufficient training in the co-morbid conditions to be reviewed?  
• How will the data be recorded? Are the disease templates sufficient for purpose?  
• Are practice management protocols sufficient for purpose?  
• Consider use of telehealth for higher risk patients. How could this enhance care? |
| **INTEGRATED CARE** | • How will care of patients be integrated with other members of the community team (and secondary care)? e.g pharmacist, social services, mental health services and specialist community teams.  
• How will the needs of patients deemed high risk and/or housebound be met by the community/practice team?  
• Will this satisfy the requirements of the QOF? |
| **EVALUATION** | • How will you evaluate success?  
• Baseline and improvement - Where are you starting from? What do you need to measure as a baseline so that you can tell whether your changes are making a difference? What will you need to demonstrate to others to ensure support for the change?  
• Patient feedback – what do you want to know? How will you find out? What do patients think of the current service? What do they suggest might work better? How will you measure a change in their experience or satisfaction?  
• Consultation time – how much time is needed? How much time overall is needed, before and after? Who currently does what?  
• Costs and benefits – can you demonstrate reduced hospital admissions, reduced exacerbations, prescribing and adherence, QOF impact, use of urgent appointments or A&E, total cost of time and resources required, reduced duplication of tests or appointments?  
• Improved Quality of Life - using generic questionnaires such as Euroqol (EQ5-D) or disease specific questionnaires e.g COPD Assessment Test (CAT)  
• Increased patient enablement - using Patient Enablement Instrument. |

Find resources such as *First steps towards quality improvement: A simple guide to improving services* to help you plan, deliver and evaluate your project at www.improvement.nhs.uk
References

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