**Year of Care Webinar 29th June 2021**

***Using the Year of Care approach to personalised care and support planning (PCSP) to support people with long-term conditions in a post-COVID era***

Please find below a link to the full recording of the webinar (note – content begins at around 1 min 30 secs and the Q&A section begins at around 46 mins):

[**https://vimeo.com/571182121/e4a0701190**](https://vimeo.com/571182121/e4a0701190)

If you wish to contact the team with further questions or queries please contact us at enquiries@yearofcare.co.uk or look at case studies/reports on our website [www.yearofcare.co.uk](http://www.yearofcare.co.uk).

**Questions and answers from the webinar chat box**

During the panel discussion there were a few questions that we didn’t have time to answer- see thoughts from panel below.

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| **Questions/themes** | **Year of Care comments** |
| **HCA roles/training** What are they doing? Does this include all the checks for all the conditions e.g. spirometry? How do we ensure that people are triaged properly especially if people are not seeing fully qualified healthcare professionals - important that any red flags are not missed?  | Health care assistants (HCAs) have an important and enhanced role in the process and they carry out the introductory appointment. Tests, tasks and assessments are carried out here (bloods, BP, pulse, weight, oxygen sats, micro spirometry (although not routinely needed now for COPD) and foot checks). This also includes some screening questions e.g. falls. In addition to the required physical tests the HCA will also:* Navigate people through the PCSP process and preparation material they will receive - this is especially important when the process is new to patients
* Encourage people to make notes and have a look through/bring their preparation material back to the PCSP conversation
* Identify any early issues the patient is keen to raise or preferences the person has about the second appointment
* Noting any concerns e.g. change in mobility since the last review, death of a spouse/close friend

HCAs may need training in this and also in protocols for any red flags (there aren’t many - but e.g. suicidal). We aren’t asking HCAs to interpret information, mostly to gather it ahead of triage and review by fully trained and qualified health care professionals. This is an extended role for some HCAs and many value the new role but they will need to be provided with local training and supervision to take on new tasks.  |
| **Changing roles and training of practice team members** What training is provided to non-clinical staff? | Staff will find that their roles change when implementing PCSP and this has been a very positive thing for admin, HCA and nursing / medical staff. During Year of Care training and facilitation we explore this and support practices and groups of practices to find solutions that will work for them locally including knowledge and skills development. We encourage teams to think about the clinical training they may need and share examples of how this has been done across the country.  |
| **Information gathering** How does it work – timing for multiple LTC and making it flexible for e.g. severe frailty?  | Information gathering appointments aren’t vastly different, even for people with severe frailty. Increased complexity in terms of multiple LTCs doesn’t necessarily increase the time proportionately for the information gathering appointment:* 15 minutes for bloods/BP/screening questions only
* Increase to 20 minutes for people with diabetes
* Increase to a 30-minute appointment if people have diabetes and COPD (this is the maximum)

If you want to work differently with a particular group (e.g. terminally ill patients who happen to have LTCs), you can triage ahead of the HCA visit/remove certain groups of patients from the reviews. Using an IT template to set out the routine information gathering required can be helpful (some commercial IT companies provide this kind of product as part of existing EMIS Web/SystmOne/Vision packages and some areas have developed local solutions).In general, it’s worth frontloading time into the appointment to ensure all the tasks are completed by the HCA, keeping the second appointment free for the PCSP conversation.  |
| **Availability of CSP templates**  | Year of Care has developed PCSP tools and resources as demonstrated during the webinar and these are available as part of our training and implementation package – see below. It’s important that we stress PCSP is not as simple as an IT template or a care plan, but rather a whole system approach that enables a personalised conversation.PCSP implementation is an opportunity to put careful thought into how LTC reviews are organised in the practice and consider how conversations are personalised. Simply changing the system will likely not offer the personalised approach we hope to achieve. |
| **Preparation prompts** Are they sent electronically/digitally?  | In general, when practices start to implement PCSP they use paper-based resources to get people used to this way of working. It’s quite a change for patients to be experiencing these very different processes. To help people identify their preparation material in Becky’s practice they print onto yellow paper and call it the ‘yellow letter’.It’s important to consider health literacy and make the materials easy to navigate - simplicity is key. We therefore don’t advocate texting results or suggesting people use the online NHS results system which isn’t presented in an easy read/navigable way.We want people to be able to write comments in the preparation material and think about things that are important to them - paper still works well for this. This is to some extent population dependant, however. As time goes by there is the opportunity for people to express a preference and for practices to think about how else people want to receive their information. Some practices ask patients how they would like to receive the material and some now share this via email or using products such as accuRx by request. Year of Care worked with a team in South West London who created personalised video messages to share results for people with diabetes. They also worked on software for clinicians and an app for people with LTCs to support PCSP. This required significant investment however and, of course, there are always interoperability issues and the challenges of digital literacy to consider.  |
| **Preparation prompts** In languages other than English?  | The information we share is relatively simple and comes with RAG/colour rating which seems to help everyone understand better. It would be possible to translate resources locally but check this out with your local community before spending time creating new resources.In the early Year of Care pilot project we did extensive work in Tower Hamlets on this and we were advised by the local communities not to translate our materials. Family members often get involved in translating resources and in understanding and supporting their family member with their condition. Also, in Tower Hamlets, they employed health advocates who ran sessions ahead of PCSP to help people understand their diabetes results.  |
| **Multiple LTCs**The multiple LTC review is interesting but wondering how it works practically and if we have clinicians specialising how you go about training?  | Really good question and it reflects the way practices have evolved, and that people may be seen multiple times in disease silos within a practice. PCSP addresses this and also potentially helps with continuity and people navigating their health.We hope to have answered this on the webinar but in general we all have areas that we aren’t expert in. It’s possible that whilst someone is coming in for their diabetes, COPD or RA that the big issue for them is low mood or losing their job, so having a comprehensive knowledge of the condition or a ‘fix’ won’t always be needed.Where there are knowledge gaps practices/areas approach this in various ways. In Gateshead the clinical teams provided mini-master classes on topics like depression, diabetes, respiratory, MSK, pain. In other areas internal training and supervision sessions are used to share the combined expertise within the practice. In addition, not everyone has multiple LTCs so it’s possible for the nurse specialising in diabetes to see those people who only have diabetes.A recent Year of Care newsletter on the subject of multiple LTCs may be a useful resource:[www.yearofcare.co.uk/newsletters](http://www.yearofcare.co.uk/newsletters) - Issue 20 - Moving on |
| **PCSP conversation**Who holds the personalised CSP conversation – can this be non- clinical staff e.g. care coordinator?Are there conditions or patients that are not suitable for the nurse practitioners to see? | Triage will usually help work out who might be best to have the PCSP conversation - there maybe people e.g. with severe mental illness, cancer, epilepsy who always see the GP with an interest/expertise in these conditions. This therefore depends on the skill mix of your practice team and also the dominant clinical issue for the patient (and issues identified in test results).People also have preferences about who they see which should also be considered since continuity is important.In general, this isn’t a role for a care coordinator who isn’t clinically qualified as it will include a clinical review including medicines management. However, there may be people identified during PCSP who are ideal for some input with the care coordinator once all the medical and clinical issues have been reviewed. |
| **Avoiding a tick box approach**With frailty it often became a tick box exercise - what will make this not one? Which practical steps do you have in mind to make these conversations actually take place?  | We agree - PCSP shouldn’t be a tick box exercise!We recently did a piece of work looking at LTCs and frailty and the overlap is astonishing. If you are applying PCSP in practice for your LTC population you will also be including 70% of your frail population – mostly with mild and moderate frailty so hopefully not a tick box activity. We have amended the Year of Care preparation material a little for those with moderate and severe frailty and this has worked well. We included different topics to prompt people to mention them within the CSP conversation if relevant - getting out, hearing, staying steady, etc. This applied to the patient Becky talked about during the webinar (Beryl). By giving the opportunity to discuss such issues, supporting staff to have knowledge in these areas and know how to access support it helps to move the focus away from the tick box of LTC/frailty templates.A colleague has used this approach in care homes and for community patients where a specifically trained and supervised frailty nurse has the PCSP conversations. This includes all LTCs people have and also advanced care planning, and picks up on activities of daily living as well as other issues linked to frailty. |
| **Dementia**What about dementia? | Similar to above – we include dementia in the reviews and therefore people with dementia are recalled as part of the PCSP process. Usually there is no information gathering appointment – unless the person has other LTCs. PCSP can be included in community or practice-based reviews and there is also preparation material for this group of patients.Staff may need training in dementia-related support – see above the comments on LTCs and the local training which has been of wider value to practices as well.Some Year of Care newsletters on the subject of falls & dementia and community teams may be a useful resource:[www.yearofcare.co.uk/newsletters](http://www.yearofcare.co.uk/newsletters) - Issue 19 Falls and dementia January 2021 and issue 6 CSP and community teams  |
| **Time**Time for meaningful conversations is clearly necessary - and time is what we don't have  | There is a lot of template-based tick box activity going on for each of the LTCs people have – this work is often done by nurses – sometimes with a lot of repetition. As discussed in the Q&A session towards the end of the webinar it amounts to quite a few hours across the year if not done as part of PCSP. Practices who have implemented PCSP are now often saving time and have used a different skill mix, making the best use of people’s training and skills e.g. all task-based activities with a HCA and less task-based activity with the practice nurses/nurse practitioner. This frees up time for more meaningful conversations. |
| **Shared medical appointments**Is there any experience of running shared medical appointments in practice alongside the Year of Care approach – are these 2 models actually compatible ? | Yes – the approach is very compatible – but perhaps better suited to people with single conditions rather than multiple LTCs.So, for example, if you include a preparation step sharing results with people ahead of the session, and use a similar style of PCSP consultation during the group facilitation (including goal setting and action planning) it’s a good fit.  |
| **Patient Initiated Follow Up/Personalised Stratified Follow up (PIFU/PSFU)**Do you know if any areas are looking at embedding this approach alongside PIFU or PSFU? | PCSP has at its heart a personalised approach – using a structured process to offer a flexible opportunity to patients in which key decisions about care, including how things are followed up, are decided with the patient.However most of these conditions are lifelong with no cure and the need for ongoing management. So, some degree of planned follow up to monitor drugs or clinical parameters will be needed. We haven’t specifically worked on PIFU/PSFU but some elements, including self-management and planning care together seem like a good fit with the principles of PCSP.  |
| **Year of Care training packages** | Year of Care has over 15 years’ experience of supporting implementation of PCSP in primary care and other settings. Our training, facilitation and support offer for clinical and non-clinical team members helps organisations embed PCSP into routine practice emphasising what’s different and why including the new processes and skills that are needed. This requires local leadership and engagement.Year of Care training is accredited by the Personalised Care Institute. Our support, expertise and practical resources can support organisations in the design of CSP in novel settings, the opportunity to think through adaptations for local contexts and the implementation of CSP in primary care/community teams. This includes supporting system changes and advising on organisational processes as well as training for practice teams to engage them in the approach. We do not provide clinical training to support clinical role development e.g. HCAs.**Training and facilitation support for areas new to Year of Care**Our training and facilitation focuses on the process changes needed to implement PCSP as well as the conversations (purpose/ ethos/skills/ structure). We previously delivered this training face to face however have made adaptations to deliver remotely. We always work to understand the local area ahead of training to understand what is already working and what needs to change. **Training and facilitation support to existing Year of care areas**Where practices have implemented PCSP we run refresher sessions for new staff and have developed a ‘moving on’ workshop to support practices think through the practical issues of moving to a single PCSP for people with single and multiple conditions. Please contact us at enquiries@yearofcare.co.uk for more information on these. |
| **Lessons learnt**What would you do differently? | Implementing PCS is often complex and, in our view, always benefits from the following:* Strong clinical and administrative leadership
* A clear vision of what is to be achieved, purpose and benefits
* Close working with the team - engaging everyone – having a local steering group to work through local issues with access to the right kind of support e.g. IT, training, social prescribing, patient involvement
* Training and time for reflection
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