Implementing Personalised Care and Support Planning across Thames Valley

"For the successful adoption of transformational change across a wide geographical area there needs to be a 'pull' from each local system" **Julia Coles – Programme Lead, TVSCN**

From 2014 to 2021 the Thames Valley Strategic Clinical Network (TVSCN) ran a Person-Centred Care Programme. The programme led the implementation of personalised care and support planning as normal care in primary care for people with long-term conditions.

By 2021 over 95% of GP practices had engaged in training, local sustainability infrastructure was in place and personalised care and support planning was the normal experience for many people.

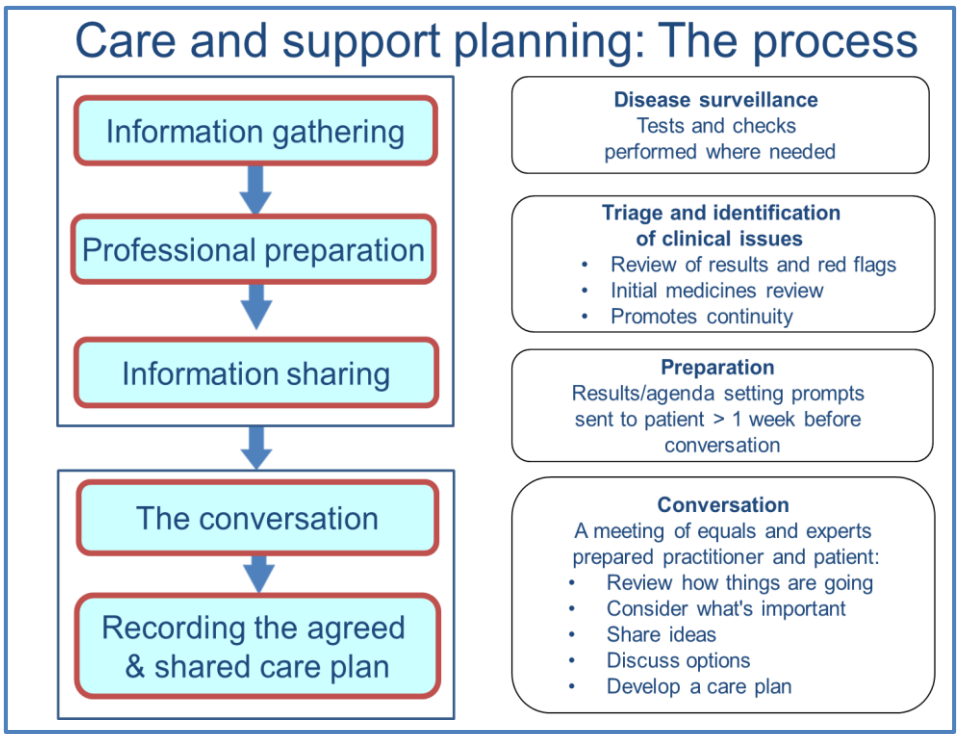
Personalised Care and Support Planning: Policy and Aims

Personalised care has always been a key feature in health policy and in 2013, at the onset of the implementation of this piece of work, it was highlighted in domain 2 of the NHS Mandate. Personalised care continues to be a core component of healthcare today, threaded throughout the NHS Long-Term Plan and manifested in the Universal Model of Personalised Care. This promotes personalised care and support planning (PCSP) for all people with long-term conditions (LTCs) in primary care and for those with complex needs.

Strategic Clinical Networks were set up to deliver clinical improvements via large-scale transformational change. The vision for the TV[1] programme was to lead the adoption and sustainability of PCSP based on the Year of Care (YOC) approach across primary care for people with LTCs.

The YOC approach to PCSP had already been developed and tested by clinicians and patients and demonstrated improved patient experience of care by helping people feel more prepared for, and involved in, the conversations they have with healthcare professionals (HCPs). These conversations enabled and supported people to live with and manage their LTCs including linking to appropriate support where needed.

Personalised care and support planning - a process that balances good clinical care with what matters to people



[1]TV in 2014 was Buckinghamshire, Oxfordshire, Berkshire East and Berkshire West. Since 2020 Integrated Care Systems (ICS) have been established and TV is now BOB which is Buckinghamshire, Oxfordshire and Berkshire West.

The PCSP process works by:

- Separating out clinical tests and assessments into an information gathering appointment with a healthcare assistant, guided by a structured data gathering template, creating the space for a PCSP conversation at the next visit
- Sending agenda setting prompts and routine results with explanations to patients ahead of their PCSP conversation so that they can prepare and get more out of the review
- Including a triage step in the process so that clinicians with the appropriate skills see people who have complex issues or/and live with multiple LTCs
- Ensuring a safe but patient-centred approach to polypharmacy via structured medication review
- Emphasising the change in the relationship between the clinician and the individual, acknowledging the expertise of the person who lives with LTCs

What has been achieved across TV?

To date HCPs from over 95% of GP practices across TV have received PCSP training, with PCSP being 'routine care' in most GP practices. Practices have expanded PCSP across a wide range of LTCs including people with multiple LTCs and frailty. This includes some exemplar work around PCSP for people living with dementia.

To support sustainability there was investment in training and developing local capacity by funding a team of quality assured YOC trainers to deliver local PCSP training. This core resource was complemented by the investment by CCGs in trained PCSP facilitators to provide on-going support to practices. This provided an expert resource and critical mass of PCSP understanding as well as local flexibility to support practices with implementation.

To date the programme with Year of Care Partnerships (YOCP) has delivered:

- 14 x YOC engagement sessions
- 39 x YOC training courses
- 6 x whole practice team workshops
- 4 x Moving On workshops
- 2 x 3-day Train the Trainer programmes
- 3 x 2-day facilitator courses

Over 200 GP practices and more than 600 HCPs have attended training, with 90% of attendees reporting they have a better understanding of the YOC approach and the PCSP conversation as a result.

How the programme was established

The mandate for the programme was given by the CCG accountable officers following the development and presentation of a compelling case by the TVSCN.

It was critical that this change was built into existing systems of care, so adoption was led in partnership with each CCG's clinical and strategic leads. A small expert reference group including local clinical champions and trainers was established, and the programme lead worked with the CCG leads to develop operational plans that included training, facilitation, sustainability and evaluation. This ensured that each CCG had the essential building blocks to enable delivery and capacity building and for the approach to become embedded as 'routine care'.

The programme was jointly funded by Health Education Thames Valley and TVSCN. This enabled funding for YOCP to deliver initial engagement and training sessions and offer expertise and advice around the set-up of the programme.

Within TV there were already HCPs who had been trained and were implementing the YOC approach, some of whom were quality assured local YOC trainers. They delivered initial training cohorts alongside YOC national trainers and subsequent funding enabled further trainers to be identified, trained and quality assured, establishing a self-sufficient TV trainer pool.

Each CCG working with the programme undertook implementation at a time and pace that suited their strategic plans, championed by GP leads, some of whom were early adopters of the approach and so could speak from their own experience.

PCSP was a strategic imperative and was in most cases supported by a local enhanced service which helped practices make the changes needed to clinical pathways alongside YOC training.

YOCP has been a source of expertise, support, facilitation and training throughout the programme and has collaborated on successive projects such as PCSP for people with multiple LTCs. Nationally they host a community of practice and hold events to provide updates and share learning.

What were the critical success factors?

Engagement – 'winning hearts and minds'

- The mandate and support of the CCG executive teams and the clinical leads working within their GP practices.
- The programme focused on engaging, informing and working initially with the willing. This, together with patient and CCG support, helped convince others as the programme progressed.
- The taster sessions introduced the concept and recruited early adopters. They championed the approach and its impact in their practice, promoting the benefits for both staff and patients.
- The YOC training, support and delivery model for PCSP provides a compelling case for change, including evidence of impact in routine general practice across a range of demographics.
- Having trainers who are themselves GPs and practice nurses (many of whom were local) delivering the training and facilitation ensured the approach was grounded in real-life delivery.
- Local incentive schemes supported the implementation of the approach and gave choice and control to practices around the scope and rate at which they implemented the approach.

Delivery – 'working flexibly at scale'

- PCSP was built into each CCG strategy for LTCs care as a way of delivering routine healthcare with a strong patient-focused ethos.
- Establishing a TV pool of trainers meant the training was delivered in each CCG at dates/times best suited the local system.
- The 'suspension' of QoF for a year (by one CCG) allowed practices to embrace a more ambitious LTCs approach and make practical changes to culture as well as processes with no deterioration in clinical parameters.
- The training provided a safe environment to explore critical components of the model including changing processes to create space for a more useful conversation related to issues that mattered most to the patient.
- CCG steering groups monitored and supported practice adoption and provided solutions to issues such as IT and ensured support to practices during implementation.

Sustainability – 'maintaining PCSP requires focus and investment'

The programme has:

- Provided ongoing training across the localities, including a shortened version of YOC training for staff new to practices that have already introduced PCSP.
- Trained and encouraged long-term investment in facilitators who worked with practices to troubleshoot, provide constructive challenge and support the principles of PCSP.
- Directed support to practices to extend the scope of PCSP including increasing the range of conditions and adapting the principles to new settings.
- Identified additional training needs around areas of discomfort including low mood, psychological issues and clinical topics such as dementia, MSK and multiple LTCs.
- Encouraged investment into ongoing training/support in conversation skills for clinical staff.
- Enabled practice reviews to ensure fidelity of the model and identify areas for further support.

Working at scale

The TV-wide programme utilised economies of scale enabling:

- Tailored delivery to individual CCG timescales and requirements.
- Creation of a pool of YOC trainers who delivered the training across TV, and a robust and flexible network of facilitators and champions.
- Provision of practice facilitator support to CCGs whilst they implemented local sustainability plans.
- Establishment of regular trainer and facilitator meetings to plan future work, provide peer support and maintain strong engagement with YOCP and colleagues from the NHSE national and regional personalisation programme.
- Shared learning from the programme, for example local enhanced service schemes, job descriptions for facilitators, evaluation of impact, the challenges of moving to a multi-morbidity approach etc.
- Recognition as a core resource of knowledge and expertise of PCSP to CCGs and emergent ICSs, and other clinical network programmes i.e. cardiovascular and cancer.
- Working with other ICS systems in the South East region on their adoption of PCSP.

Moving on to people with multiple long-term conditions including dementia

The majority of the CCGs adopted PCSP as part of their strategic plans for diabetes care. One CCG took an innovative approach and offered a local enhanced service that set out different levels of PCSP that practices could sign up to. Each level built on the clinical conditions to be embraced by the PCSP approach, starting with diabetes then including respiratory conditions and dementia.

The challenges and learning from this have been invaluable for practices now wishing to expand from a single disease approach to a more unified approach for those with multiple LTCs.

To support this growing interest by HCPs to move to a multiple LTCs model, practices were invited to attend a YOC 'Moving On' workshop to help them work through how this would streamline their care processes and broaden the PCSP conversation.

Impact

Patients

This programme of work was primarily focused on improving patient experience of care and providing a more meaningful and personalised approach to routine reviews.

96% of people who received a preparation prompt said it was useful to help them prepare for their PCSP conversation.

After the PCSP conversation 80% of people felt much more able to understand and cope with their condition.

> *"I felt I was always being told off now I feel I am the one in control"* **Patient**

Practices

Practices now have more unified care pathways and practitioners feel that it is a better way to work, increasing job satisfaction. This was achieved without any deterioration in clinical outcomes.

West Berkshire was able to demonstrate improved clinical outcomes for people with diabetes, whilst reducing costs of prescribing.

> *"Makes my job easy and effective and means patients get the right issues addressed and can voice their own point of view"* **HCP**

Future opportunities – fit with policy

The TVSCN Person-Centred Care Programme puts the BOB ICS in a strong position ahead of new drivers to embed PCSP. The ICS can demonstrate in a meaningful way that they deliver PCSP and have experience of how the process promotes the opportunity for shared decision making, support for self-management, social prescribing and patient choice.

Inevitably as time goes by new policy will come and go but the need to involve and support people to live with and manage their LTCs by having more 'human' interactions will never change.

Implementing PCSP within primary care creates a bedrock for this to happen practically.

"If you adopt care and support planning, and implement it well, from whichever aspect you look at it, it's a win"

Julia Coles, Programme Lead TVSCN

For any further information or to contact colleagues in Thames Valley please contact enquiries@yearofcare.co.uk.