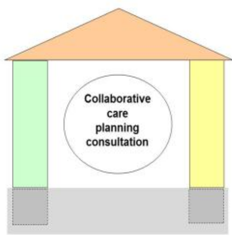

The HOUSE Journal

The newsletter for the **Year of Care Community of Practice**

Issue 6 – Mar 17

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Welcome to The HOUSE Journal Lindsay Oliver, National Director YOCP

In this issue we turn our attention to care and support planning centred on community teams, including people who are housebound. An exemplar of this work is highlighted in a featured story from Carlisle Healthcare kindly shared with us by Dr Robert Westgate. Care and support planning has enabled the local health and social care team to work with people in a proactive way to support self-care, but also to ensure their wishes and preferences are known and recorded ahead of any deterioration or exacerbation of their conditions. This is very timely as a CQUIN, which focuses on care and support planning within community teams, has just been launched in England. We also introduce you to some new tools and resources on our Year of Care secure website.

How care and support planning friendly is your practice website?

When a member of the team recently looked through a couple of practice websites it was noticed that there seemed to be a lack of information about care and support planning! We then randomly checked 100 practice websites and only 3 had any information about care and support planning. As a result we have created some standard information for practice websites that you can tailor locally. It can be obtained from the secure area of the Year of Care website and is now included in the practice pack.

Train the Trainers – now open for registration

The next round of Train the Trainers will run on 16th, 17th and 18th May 2017 at Hexham General Hospital. Please get in touch at enquiries@yearofcare.co.uk to book places.

The train the trainers programme enables organisations who are working with Year of Care to train local individuals to deliver quality assured training themselves.

It is suggested that groups of three trainers should be identified and consideration given to the blend of skills and experience they offer as a team. Trainer criteria include having:

- attended and participated in the Year of Care, care and support planning training
- experience of care and support planning consultations or within their current role be using the consultation skills associated with care and support planning
- credibility with their training audience who will include GPs and senior CCG/board leads
- worked within the clinical setting or have sufficient knowledge of the clinical setting where care and support planning is being implemented
- experience of training health care professionals or running structured patient education
- the support of a local team, who are committed to embedding this approach across a geographical area (e.g. CCG, health board)

Please contact enquiries@yearofcare.co.uk for a copy of the criteria in full and to discuss your potential training teams.

Care and support planning at the heart of an integrated care community

Care and Support Planning at the Heart of an Integrated Care Community

12 months ago Carlisle Healthcare embarked upon their implementation of an integrated approach to personalised care and support planning (CSP) for those with multi-morbidity and frailty who would otherwise be unable to attend their usual surgery for routine care. This built on an established approach to care and support planning for people with long term conditions who would usually attend the practice for their care.

Robert Westgate, a GP at Carlisle Healthcare and Year of Care Trainer told us about their journey.

"We identified the housebound/elderly frail from our practice registers and co-ordinated a birth month based annual CSP home visit - this is preceded by a home visit from a health care assistant to take blood, capture key metrics and leave information about the CSP process as well as some reading material about last years of life (Deciding Right booklet).

Metrics for appropriate co-morbidities are then posted to the patient along with a generic CSP cover sheet and the usual goal setting sheet. The health professional (usually a senior nurse or advanced nurse practitioner) then undertakes the CSP visit, completes documentation and then shares this with the patient and, with permission, the local out of hours organisation. The document provides a summary of the medical record as well as patient goals, actions, preferences etc.

We have also used funding from a part unfilled GP post to appoint an advanced nurse practitioner to work with the practice as an "acute response" visitor to allow same day assessment of people we know, and have been through care and support planning, to be assessed by hopefully a familiar face when they have a sudden change in their wellbeing."

"In addition, we have convened a daily morning care coordination meeting (attended by a GP, nurse practitioner, community nurses, a representative from social care and older adult's mental health).

This meeting is informed by overnight contacts of our elderly frail population with the out of hours service, recent hospital discharges and admissions, people causing professionals concern and people with active palliative care needs.

Carlisle Healthcare

This allows for discussion of patients causing concern and has allowed earlier interventions and more rapid responses to patients at high risk of unplanned hospital admission.

The meeting has strengthened team working through regular communication and also developed greater understanding of the roles of different health professionals. The members of the District Nursing team also feel it is an opportunity for shared learning which has been a positive and beneficial experience."

CQUIN

Commissioning for Quality and Innovation (CQUIN)

The 2017/19 CQUIN was recently published. Within the indicator specification there was a section on Personalised Care and Support Planning (page 134 onwards). This details what providers in England are required to do and also gives deadlines for the achievement of milestones. See https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/.

Community based providers need to submit a plan outlining their approach to delivering personalised care and support planning to an identified cohort of patients by September 2017. Providers would need to identify relevant staff and record that they have undertaken training in personalised care and support planning.

Appropriate training is defined as training that:

- Explores the role of care & support planning in empowering patients and carers
- Clearly defines the role and expectations of the member of staff and the patient and/or carer
- Provides a framework for staff to follow in having structured care and support planning conversations based around what is important to the person living with a long-term condition and their holistic needs, not just their medical needs
- Helps staff develop skills in motivational interviewing to help them encourage patients and carers to actively participate in planning discussions, and how to tailor their approach based on the individual's levels of knowledge, skills and confidence, and their communication needs
- Helps staff deal with sensitive discussions such as consent, mental capacity, and end of life care

For our current trainers this would mean using resources such as the ***Tommy game*** to highlight the issues and the ***TLAP or pathway game*** to support the systems design of how care and support planning will be operationalized locally.

Our current training programme also includes an option to run the training for integrated care teams using for example the Harry scenario instead of Barbara! If your team would like an update or refresher on how to deliver this or want to work with Year of Care to develop a local programme of work around this group of patients please get in touch at enquiries@yearofcare.co.uk.

New tools and resources for facilitation and training

Multi-morbidity cases for half day training sessions

We have recently produced new cases to use in training for teams who are delivering care and support planning for people with multi-morbidity. Liz has Diabetes and COPD and Jimmy has CVD and COPD. To "meet them" just visit the long term conditions training area of the Year of Care secure website.

Fidelity toolkit for practice facilitators

This newly developed toolkit has been produced to support facilitators who work with practices to support approaches that enhance the fidelity to care and support planning. Its 3 sections cover: Care and Support Planning Processes; Preparation and Care and Support Planning conversations.

You can find it in the Information and Resources area of the Year of Care secure website under Evaluation Frameworks and Tools. If you don't have access to the secure site please contact your local coordinator or enquiries@yearofcare.co.uk.

Meet the team!

Helen Pearce

National Trainer and Assessor

Helen qualified as an RGN in 1987 and she later obtained her BSc (Hons) in community health care studies.

She has worked in hospital, community and primary care settings.

Prior to joining the Year of Care team Helen worked as a mentor/trainer within a behaviour change service.

Diabetes UK professional conference 2017

Lindsay Oliver, National Director of Year of Care Partnerships and Consultant Dietitian in diabetes care, has been awarded this year's prestigious Janet Kinson lecture at the 2017 DUK Professional Conference, Manchester Central.

You can see Lindsay's presentation 'Whose diabetes is it anyway?' on Thursday 9th March 2017 in the Exchange Hall at 16:40-17:20

You can also visit Year of Care Partnerships at stand E40 in the Diabetes UK professional conference exhibition hall.

We look forward to seeing you there!

Year of Care Partnerships is on social media!

Please like us on Facebook and follow us on Twitter for the latest Year of Care news and events.