Year of Care Partnerships: Self-Assessment/Quality mark

How to use this document:

1. For each principle, consider the statements and decide which you feel best matches your practice or service currently.

2. Based on which statements you feel fit best, now score your practice or service between 1 and 4 in the row below. Be challenging to yourself and consider whether you have any evidence to back up your thoughts.

3. Now, consider the statements again and think about what you would like to achieve over the next 6-12 months and mark this between 1 and 4.

4. Consider what you feel you would need to do to achieve this and how you are going to do this.

5. Finally, when you have completed all 10 principles, move to the action planning page to decide what you are going to prioritise and how you are going to make sure your achieve your plans.

To consider you an “exemplar” practice we suggest that no item should score less than 2 and at least three items should score 4.

Changes to this document

This version of the Year of Care Quality Mark replaces the previous version (April 2015).

The improvements in this version have been based on feedback/recommendations from users, along with reflections from the Year of Care Partnerships based on learning across a number of implementation sites.

The main improvements that have been made include:

1. **Recognising the importance of an implementation team and team working across the whole practice**, Question 1 has been amended to 'Training and Practice Involvement', and amendments have been made to Question 7 around involving the whole practice in consultation skills development and to Question 10 to include the use of a dedicated implementation team within the practice.

2. **Clarifying activities around whole practice populations /health literacy** by re-wording mention of 'health literacy mapping' and replacing this with 'acting on the needs of our local population to ensure maximum participation' in Question 3,

3. **Emphasising involvement of people with long term conditions** in the development of patient literature in Question 4

4. **Updating preparation to reflect that 2 appointments are not always necessary** (where a reflective preparation tool can be used instead) in Question 6.

5. **Highlighting different approaches to consultation skills development** We removed the specific need to use a recognised consultation skills tool and replaced this with having 'a systematic approach' in Question 7.

Using the document within a team:

Complete the document as individuals to start with. Then, as a team compare your thoughts, scores and ideas. Discuss similarities and differences in order to decide as a team how you are doing and how you wish to take things forward. You may then wish to agree an action plan for the team as a whole.

The following principles would describe “exemplar “practices that are implementing care and support planning (CSP) conversations with people with LTC.

1. There is a leadership group (implementation team) who meet regularly to support implementation in the practice. Members of the practice team most involved in delivery have attended Year of Care core training. There is support for the team to understand the process and ethos and develop the skills to implement the approach.
2. The practice has a systematic method of recall for people living with LTC and is able to identify which patients have had a care and support planning conversation.
3. Individuals with long term conditions have been made aware of the care and support planning process (most will have received written material or had an explanation of the care and support planning process). Systems will be in place to identify each individual’s need for support to take part.
4. Patient literature (including letters, leaflets, videos, websites etc.) are produced with patient involvement and feedback using language which reflects the CSP approach and engenders a spirit of collaborative working.
5. Clinics will have been organised in a way that enables a data collection appointment with a Health Care assistant (where necessary), followed by an appointment with a practitioner with care and support planning skills. There will be sufficient time allocated in both these appointments to enable them to take place effectively
6. There is a system in place to enable preparation to happen including the sharing of biomedical test results and assessments with patients before the consultation. The practice is able to identify the percentage of patients on their LTC register who have received these and/or preparation prompts 1-2 weeks prior to the consultation. Most people on this register receive these before their appointment.
7. Evidence is available to demonstrate that there is support in the practice to enable team members to move towards consultations which are patient centred and truly collaborative. (Questionnaires and self-assessment tools are available) The clinical record documents, where appropriate, that a goal has been identified, together with a specific action plan. If this was not appropriate in the conversation, evidence of the person’s main issues or concerns and the options/solutions discussed for addressing this is documented. Plans also include contingency planning where appropriate
8. The practice has a system in place to sign post patients (or provide a link worker) to 3rd sector and non-traditional services (more than medicine) and link with social care as well as traditional NHS referrals and can easily access what is available locally. There is evidence that the persons support needs have been discussed and an appropriate times scale for joint review agreed.
9. The team meet regularly to reflect on the care and support planning process, consultation skills and use routinely collected data for reflection and review.

1) Training and Practice Involvement

There is a leadership group (implementation team) who meet regularly to support implementation in the practice. Members of the practice team most involved in delivery have attended Year of Care core training. There is support for the team to understand the process and ethos and develop the skills to implement the approach.

		Limited progress	Getting there	Doing well	Cracked it!
Which statements fit best?	***Consider each of these statements***	Members of the practice team have attended training.	Our practice has undertaken process mapping and has identified an implementation team	Our whole practice is aware of our approach and implementation Our HCA and nursing team have identified additional training needs	Implementation is well underway and regular reviews are held keeping the whole practice informed and involved
Score	***Circle the number which you feel applies best for you presently***	1	2	3	4
Ideal	***Now, circle the number you would like to achieve over the next 6-12 months***	1	2	3	4
Plan	***What do you need to do to get there?***				

2) Recall system and identification of people who have experienced care and support planning
The practice has a systematic method of recall for people living with LTC and is able to identify which patients have had a care and support planning conversation.

		Limited progress	Getting there	Doing well	Cracked it!
Which statements fit best?	***Consider each of these statements***	We have individual disease specific recall registers	We are developing a recall system for individuals which lists all the conditions they have and creates a single recall process for people with single and multiple long term conditions	We are beginning to use our recall system to call patients for CSP appointments and have a way of ensuring patients get the right type/length of appointment	We are up and running with the recall process and can easily identify who has had a CSP consultation in the last year. We have ironed out a few teething problems along the way.
Score	***Circle the number which you feel applies best for you presently***	1	2	3	4
Ideal	***Now, circle the number you would like to achieve over the next 6-12 months***	1	2	3	4
Plan	***What do you need to do to get there?***				

3) People with Long Term Conditions are aware of the care and support planning process

Individuals have been made aware of the care and support planning process (most will have received written material or had an explanation of the care and support planning process). Systems will be in place to identify each individual's need for support to take part.

		Limited progress	Getting there	Doing well	Cracked it!
Which statements fit best?	***Consider each of these statements***	We have begun to think through some methods such as letters/website/notice boards to inform people of the system changes	We have multiple methods of informing people of the process changes including written/visual and verbal communication. We are beginning to ask people what support they need.	Its normal practice to do care and support planning and most of our LTC population could describe how it happens	We have a system of identifying those who need additional support such as interpreters or volunteers to support them through the process. We are acting on the specific needs of our local population to ensure maximum participation, and are actively following up those not engaged.
Score	***Circle the number which you feel applies best for you presently***	1	2	3	4
Ideal	***Now, circle the number you would like to achieve over the next 6-12 months***	1	2	3	4
Plan	***What do you need to do to get there?***				

4) Language and literacy

Patient literature (including letters, leaflets, videos, websites etc.) are produced with patient involvement and feedback using language which reflects the CSP approach and engenders a spirit of collaborative working.

		Limited progress	Getting there	Doing well	Cracked it!
Which statements fit best?	***Consider each of these statements***	We are discussing what needs to be in place for this to happen	We have reviewed the wording of our letters and materials with people with long term conditions, and have identified some changes we could make	We have produced patient centred material or adopted the YOC material with minor adaptations for local use.	Our patients report finding the information we share useful and informative and written in a way that supports their involvement in the care and support planning process
Score	***Circle the number which you feel applies best for you presently***	1	2	3	4
Ideal	***Now, circle the number you would like to achieve over the next 6-12 months***	1	2	3	4
Plan	***What do you need to do to get there?***				

5) Clinics appointment systems

Clinics will have been organised in a way that enables a data collection appointment with a Health Care Assistant (where necessary), followed by an appointment with a practitioner with care and support planning skills. There will be sufficient time allocated in both these appointments to enable them to take place effectively

		Limited progress	Getting there	Doing well	Cracked it!
Which statements fit best?	***Consider each of these statements***	We have had a meeting to discuss the appointment system and the practice team are aware of our intentions	We have identified who will do what from both an administrative and clinical point of view – we have an agreed plan of implementation including a start date	We have set up the appointment systems but need to refine the appointment processes based on our initial experience. Our reception and admin team are very clear about how things work.	We have an appointment system with allotted times, templates that aid information gathering and have trained our HCA to feel confident in their role Our admin and reception team are clear about their role and run an effective appointment system
Score	***Circle the number which you feel applies best for you presently***	1	2	3	4
Ideal	***Now, circle the number you would like to achieve over the next 6-12 months***	1	2	3	4
Plan	***What do you need to do to get there?***				

6) Preparation - Sharing results/assessments and reflective prompts

There is a system in place to enable preparation to happen including the sharing of biomedical test results and assessments with patients before the consultation. The practice is able to identify the percentage of patients on their LTC register who have received these and/or preparation prompts 1-2 weeks prior to the consultation. Most people on this register receive these before their appointment**.**

		Limited progress	**Getting there**	**Doing well**	**Cracked it!**
Which statements fit best?	***Consider each of these statements***	We are discussing what needs to be in place for this to happen	We have results sharing/preparation prompts installed on our IT systems	We have a system in place to share results/preparation prompts. We have a member of our team whose role this is	Our system is working. Most of our patients with LTC receive their results and preparation prompts before their appointment and we have a means of recording that it has happened
Score	***Circle the number which you feel applies best for you presently***	1	2	3	4
Ideal	***Now, circle the number you would like to achieve over the next 6-12 months***	1	2	3	4
Plan	***What do you need to do to get there?***				

7) Consultation skills development Evidence is available to demonstrate that there is support in the practice to enable team members to move towards consultations which are patient centred and truly collaborative. (Questionnaires and self-assessment tools are available)[1]					
		Limited progress	**Getting there**	**Doing well**	**Cracked it!**
Which statements fit best?	***Consider each of these statements***	Our staff think they are good at consulting with patients	People doing care and support planning conversations have been trained.	Our practice has systems in place for reflection, assessment and development of consultation skills	The whole practice team has a systematic approach to supervision and support for communications skills.
Score	***Circle the number which you feel applies best for you presently***	1	2	3	4
Ideal	***Now, circle the number you would like to achieve over the next 6-12 months***	1	2	3	4
Plan	***What do you need to do to get there?***				

[1] See Year of Care Practice Pack for examples of Fidelity Toolkit and Reflective Prompts

8) Goals and Action planning

The clinical record documents, where appropriate, that a goal has been identified, together with a specific action plan. If this was not appropriate in the conversation, evidence of the person's main issues or concerns and the options/solutions discussed for addressing this is documented. Plans also include contingency planning where appropriate

		Limited progress	Getting there	Doing well	Cracked it!
Which statements fit best?	***Consider each of these statements***	We are aware that we should be aiming to identify goals and action plans with people with long term conditions	We are starting to discuss goal setting and action planning with people with LTCs in the CSP conversations. The details may not always be recorded	People routinely have a conversation about identifying a personal goal and developing an action plan. We write this down. We have decided who might need contingency planning as part of the discussion.	People routinely have a conversation about identifying a goal and developing an action plan. There is a system to record their plan in their own words in their record. If a goal or action plan is not appropriate the person's main concern is recorded. We are counting how often contingency planning is recorded
Score	***Circle the number which you feel applies best for you presently***	1	2	3	4
Ideal	***Now, circle the number you would like to achieve over the next 6-12 months***	1	2	3	4
Plan	***What do you need to do to get there?***				

9) Sign posting, referral and review

The practice has a system in place to sign post patients (or provide a link worker) to 3rd sector and non-traditional services (more than medicine) and link with social care as well as traditional NHS referrals and can easily access what is available locally. There is evidence that the persons support needs have been discussed and an appropriate times scale for joint review agreed.

		Limited progress	Getting there	Doing well	Cracked it!
Which statements fit best?	***Consider each of these statements***	We are working on a system to find out what is happening in our local area. We tell people when their next review is	We have a system to keep a record of what services are around locally. We ask people when they would like to have a review	We have a signposting system in place including face to face links for people with low confidence. We ask people when they would like to come back for follow up review	We have a regularly updated system to signpost people to 3rd sector/non-traditional services. People let us know the level of support they would like from us .
Score	***Circle the number which you feel applies best for you presently***	1	2	3	4
Ideal	***Now, circle the number you would like to achieve over the next 6-12 months***	1	2	3	4
Plan	***What do you need to do to get there?***				

10) Reflective Practise and on-going review of team working The team meet regularly to reflect on the care and support planning process, consultation skills and use routinely collected data for reflection and review.					
		Limited progress	**Getting there**	**Doing well**	**Cracked it!**
Which statements fit best?	***Consider each of these statements***	We occasionally meet as a team to refine the process or our skills of care and support planning	We have set up an implementation team and the implementation of care and support planning is routinely discussed at our practice meetings	We have reviewed our care and support planning processes and made further adaptations. A dedicated implementation team meet regularly to discuss how it's going	We have built in time for reflection and supervision around care and support planning processes skills. We routinely access further skills training. We monitor a number of outcomes as a team and build these into our planning
Score	***Circle the number which you feel applies best for you presently***	1	2	3	4
Ideal	***Now, circle the number you would like to achieve over the next 6-12 months***	1	2	3	4
Plan	***What do you need to do to get there?***				

Goal Setting

What sort of things would I like to achieve?

What one thing do we want to achieve?

How important is it to us?

Not important **Very important**

1 2 3 4 5 6 7 8 9 10

Practice Action Plan

What exactly are we going to do?
(How, what, when, where, how often)

What could get in the way?

What can we do about this?

How confident do we feel?

Not confident **Very confident**

1 2 3 4 5 6 7 8 9 10