

Proactive Care Pilot – an early evaluation summary

In 2022 the Year of Care team led a proactive care pilot programme funded by North East North Cumbria ICS to explore all aspects of what a personalised proactive care model could look like, and how it could be adopted in the ‘real world’.

A mixed methods evaluation was completed early in the pilot programme to determine views of staff involved including their experiences of proactive care, the benefits and challenges, how they understood their role and contribution, and how the overall process worked in practice.

Prof Darren Flynn and Dr Debra Morgan of Northumbria University conducted this service evaluation to capture learning around implementation issues and processes using Normalisation Process Theory (NPT).

Staff views on value, purpose and delivery

All staff involved in the organisation and delivery of the proactive care programme were invited to complete an anonymous survey via the Qualtrics platform. The survey consisted of the 23 item Normalisation Measure Development (NoMAD) questionnaire (based on Normalisation Process Theory (NPT)). The aim was to collect data on implementation processes from the perspective of those directly involved.

Following survey completion all staff were invited to attend face-to-face interactive group workshops where, supported with appropriate information from the aggregated analysis of the NoMAD questionnaire, staff perceptions were further explored around key implementation issues. The workshops were held with the individual PCNs and facilitated by researchers from Northumbria University.

The responses from both the questionnaire and focus groups were analysed using NPT to establish identification of relevant themes, and these are summarised below (the formal report is at the end of this document).

Coherence and purpose

Coherence and clarity of purpose across a team is an important part of the initial implementation of any new way of working to ensure teams stay on track with the work they do and are clear about the issues they are trying to tackle and outcomes they’re trying to achieve. During this pilot programme Year of Care delivered launch events and in-practice facilitation to support this outcome.

The evaluation identified a strong sense of coherence and purpose around proactive personalised care; the staff recognised that it is a positive way of working with many benefits for both patients and practices. Their views demonstrated a strong commitment from the PCNs to work in this way, regardless of national policy, with staff supporting an approach that is planned and forward focused rather than acute and reactive.

“More proactive and preventative care hopefully reducing the number of unplanned visits to hospital and to the GP practices, this will allow teams to be prepared and patients to have the confidence that they have a care plan which is tangible”

There was also clear agreement that this should be delivered in a way that is person centred and focused on the individual to achieve the best outcomes.

“Listening to the patients’ needs, not just being driven by their medical needs but a complete holistic assessment. Patients should then feel valued, empowered and unscheduled GP visits/ hospital admissions should be reduced”

Whilst there was a strong sense of common purpose and ethos there appeared to be a lower level of coherence around ‘who’ this approach was best for and ‘how’ it might be delivered.

There were also concerns that new team members or those in the wider MDT might not always understand the purpose of this work and drive a culture that is transactional and reactive rather than personalised and proactive.

Views on the extent to which the PAC programme offers a different way of working

The evaluation demonstrated a good level of awareness of this as a different way of working in terms of spending time with patients and actively engaging them in a conversation about their life, how they manage, what’s happening, and what’s important to them, including provision of supported self-management to help patients fulfil their goals and change their health behaviour.

This way of working was considered more than simply making assessments and documents more personalised:

“Instead of going in with a bit of paper and a load of questions, going, “right, I need to get through these, ‘cos it’s a tick-box exercise”, is actually sitting with the patient and having a conversation about their life, how they manage, what’s going on and what is important to them, so there’s no point helping to change something if that’s not what the patient wants to do”

“More person centred, using the patient’s goals to enable them to gain knowledge and understanding of their own conditions and how to help themselves”

There was also recognition that supporting patients to be prepared was a crucial element of this work.

“Well, you know yourself, if somebody turns up at your door for an hour’s visit and you weren’t expecting them, once you’ve left, they’ll think of a thousand questions, whereas if you’ve prepared them for what you’re going in for, the questions are already thought of, so can be dealt with during the visit”

There was also broad agreement that a new personalised proactive care approach would enable time to work with patients to anticipate their future care needs, and to develop appropriate plans that addressed what matters to patients. This was described as a ‘massive shift’ from the current way of working.

Benefits to patients

Staff were able to identify many benefits for patients which align well with the principles and purpose of the pilot programme and demonstrated coherence at a high level around the aims. This included being more holistic, personalised and preventative. It also recognised the value of engaging people differently so that they felt heard, more involved and in control of their health.

“Listening to the patients’ needs, not just being driven by their medical needs but a complete holistic assessment. Patients should then feel valued, empowered and unscheduled GP visits/ hospital admissions should be reduced”

Staff also recognised practical benefits such as having more time and being able to see patients in their own homes.

“That’s the good thing about like, seeing them in the home environment as well; you can see other things that you wouldn’t necessarily see if they just came into the surgery and what other factors around them might be affecting them as well”

There was clear recognition of the benefits of this preventative approach in reducing treatment burden for both planned and unplanned care.

“Having a look into this approach and working, it should potentially prevent hospital admissions, or at least keep people closer to home, when they do get into these crisis situations, they’ve got a plan in place as to who to contact first, rather than just dialing that 999.... rather than just feeling out of control”

Within Carlisle Healthcare, there was also a strong sense that long-term condition management should form part of this approach to reduce treatment burden for patients, delays in care and hospital admissions. Other specific benefits identified were:

- Developing a therapeutic alliance
- People knowing what to do in a crisis or emergency
- Access to wider multidisciplinary team support
- Social prescribing and self-management
- Potential for avoiding unplanned visits to primary and secondary care
- Identifying and broadening the cohort of people who are involved

Coordination of care

Care coordination is an important outcome of personalised care and support planning for people with multiple long-term conditions, frailty and complexity since they are often seen by many professionals across a variety of organisations as part of their total care, which increases overall treatment burden. In Keswick & Solway the role of the care coordinator was seen as critical to delivering this aspect of the programme, including being a named contact and advocate for the patient.

“If they’ve got a lot of long-term conditions, they’ve just got loads of individuals going in and out all the time and not really being able to keep track on what’s going on, so the care coordinator will be kind of their point of contact”

In Carlisle Healthcare, care coordination was considered as a function of the process, rather than as the role of a single member of staff. This was facilitated in several ways including having multidisciplinary team meetings and huddles to share professional expertise, combining all aspects of the person’s care within the personalised care and support planning process, and having a single known point of contact within the community hub. This function was achieved by teams who may be co-located working alongside each other and sharing of expertise and experience.

Patient awareness of the proactive care process

Patients for this programme are identified from practice registers and are offered support proactively before needing to ask for it. Both PCNs recognised that this approach differed from how people currently accessed services, and it was important to consider how to engage people with the process and the clinicians who delivered it. Teams identified that this was something that needed to be done using interpersonal skills to build trust and rapport with the individual and not something that could be done solely via a letter or text. It was important to support patients to understand the potential

benefits and ways of working of the PAC programme. It was also important to express that this was an ongoing service (in that people wouldn't be 'discharged' from it) and that support would be dependent on the needs and wishes of the individual.

Multidisciplinary teams (MDTs)

Staff viewed the multidisciplinary team as being critical to delivering proactive care; consequently, both PCNs employed additional staff to deliver proactive care. It was acknowledged that proactive care needs to be separated, in terms of staffing resource, from the acute reactive work which had the potential to take priority.

The broader emphasis on personalised care and support planning facilitated a transition from a purely medical model to a biopsychosocial model, which brought an understanding that people engaged in the programme are living with complexity and highlighted the need for teams to have access to a wide range of expertise (other professionals, services and third sector organisations).

"Well we have daily huddles as well, and MDT meetings, and once a week, professionals out of the surgery or the ICC come in, adult social care and the community mental health team as well, and again, it's another opportunity to see who's going to be best placed to go and see that patient and get updates of what's happened with that patient, isn't it?"

The role of the medical practitioner

There was recognition from both PCNs that GPs have ultimate accountability for clinical aspects of care, but also an acknowledgement that this would be delegated to the team who are responsible for their own actions as professionals. The role of the medical practitioner is seen as pivotal to this way of working in terms of both holding and sharing risk due to the complexity of the patient group.

It was recognised that GPs should supervise and support staff, provide medical oversight (e.g., test results, medication, diagnosis and prognosis) and where appropriate stand down redundant medical/clinical activity whilst not usually seeing the patient themselves. It was also recognised that patients would feel more confident in the service if they knew it was anchored to the primary care team and was a method of getting a view from a medical practitioner.

"In that whole governance and responsibility, the general practitioner maintains overall clinical responsibility for the patient in terms of chatting about medical things, and so the GP practice maintains overall responsibility for viewing any results, actioning them and receiving concerns in a timely manner. So if a care coordinator has been out to see someone and is concerned about their, medical condition, in the same way that a district nurse might do, or anybody going out to see a patient, then the responsibility is on the general practitioner to make sure that they're accessible and responsive in a timely manner and take appropriate action, I suppose"

There was concern raised about potentially adding to the burden of already high GP workloads where GP support hadn't already been identified as a component of proactive care. To create support for the proactive care team it was deemed important to raise their profile and promote the benefits of working in this way.

"It goes back down to the comms, doesn't it. We need to communicate it the best way possible, to show that this team is of benefit to you in the long run, so there will be work that will be generated by it. But you're going to have to suck that up because the rewards will come down the line when the triage list is not as high

The purpose of the care plan

Staff said that taking part in this pilot programme had led them to really think about the purpose of the care plan and who it is for.

In Carlisle Healthcare the care plan document had previously been considered a vehicle to convey information about the patient in an emergency to the ambulance and out of hours services. In addition, there was a section of the care plan which summarised 'what normal looks like' that had been helpful for practice team members during acute visits, at times preventing treatment escalation and admission. Whilst recognising that it was important that this function remained, this programme also led the PCNs to consider the value of the document for the individual patient.

"I guess my first thought is that it's for the patient and it's for them to hold and erm, feel control over, such that the contents of it reflect exactly who they are and what their wishes are and what their aspirations are, so primarily, it's for them and for them to have that record of being heard and listened to and that we've written down"

The additional elements that the teams felt were required on the care plan were focused on patient needs including understanding what's important to the patient, 'self-help' (knowing what to do when they become unwell), their goals and how they want to live their lives and manage their health. There was recognition that some focus was needed on long-term condition management and maintaining function for professionals, whilst enhancing the self-management and daily living aspects for the patient.

The care plan was designed to be printed and left with the patient in their home, and teams felt that in future this should be shared digitally, particularly for sharing patient goals and preferences and emergency care details.

Training needs

Alongside the introductory session and support the teams recognised the need to understand each other's roles, which in part would be achieved by working alongside each other. Other training needs that were identified were:

- Long-term conditions – general training (including co-morbidities and complexity)
- Frailty including the comprehensive geriatric assessment and the use of Rockwood Frailty Scale
- Identifying red flags and signs of deterioration and knowing what to do or where to go
- Person centred communication skills (personalised care and support planning)
- Coaching and behaviour change approaches
- Awareness of local organisations (e.g., social prescribing and third sector) that could support aspects of proactive care
- IT systems, coding and templates

The teams subsequently highlighted the need for support with serious conversations about advanced care planning.

IT systems and documentation

One of the key enablers identified by the teams was a high-quality IT data entry template and patient centred preparation and care planning documents. The teams noted that these tools needed to support the programme and would make it easier to deliver, however raised concerns these can be used in a 'tick box' manner, rather than supporting a good quality conversation with the patient.

Generally, a single shared IT data entry template was seen as a key enabler to record assessments and care plans, avoid duplication, and sharing with a range of health and social care professionals.

Summary of independent evaluation

This independent evaluation highlighted a strong consensus amongst team members about the importance and value of proactive care as an approach for people living with multiple long-term conditions and frailty. Teams recognised this required a team approach, prioritisation within a busy health system and medical oversight to provide accountability and handle risk and complexity. It was deemed important to ensure any new team members understood the purpose and value of this way of working and how it differs from usual approaches to unplanned and/or reactive care.

The original formal evaluation report is linked below:



Project Report_PAC
evaluation_v9 04.10.2

Contact details

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