Working with Year of Care Partnerships to deliver Care and Support Planning

A Guide to Training, Facilitation and Train the Trainers

Version 1.6 May 2017

Contents

Purpose

The aim of this document is to set out a successful approach to embedding care and support planning into clinical practice based upon experiences from Year of Care Partnerships. This document has a focus on guidance about the process and organisational aspects of delivering Year of Care training, facilitation and, if required, Train the Trainers.

It outlines some criteria and prerequisites which have been identified as being critical to the successful delivery of the programme and the associated training, which have in turn led to changes in clinical behaviour. It is aimed at organisations wishing to systematically embed care and support planning using a proven successful implementation model which includes training delivered locally to equip healthcare professionals and wider teams with the skills and resources required to implement care and support planning.

It should be read in conjunction with the document 'Building Your House of Care - a Guide for Coordinators and Steering Groups'.

Background

The Year of Care programme has developed high quality training which focuses on delivering personalised care, through care and support planning, to people with long term conditions. The on-going delivery of the programme has highlighted the need for a number of factors to be present if the programme is to be successful.

Year of Care Partnerships provide a range of options to support organisations to implement care and support planning, including expertise, advice, facilitation, training and support materials. The level of support required will depend on a number of factors including the size of the local population, the number of practices involved and the clinical settings in which care and support planning is to be implemented.

If you would like to enquire about the training and support available from Year of Care Partnerships please contact us at enquiries@yearofcare.co.uk.

More information is available via our website www.yearofcare.co.uk.

Preparing to deliver Care and Support Planning

We would suggest that the Year of Care Partnerships team meet with the local leadership/commissioning group. Discussions would include what is involved in delivering care and support planning locally and what support is available from Year of Care Partnerships. This is aided by the completion of a series of questions ahead of the meeting which help us understand your local issues. This questionnaire is available in Appendix I.

There are a number of policy factors which might influence your decision to implement care and support planning as normal care for people with long term conditions. It might however be useful to consider a number of questions before you work out a plan to deliver the programme locally; these will in turn aid discussions with the Year of Care Partnerships team.

- What do you hope to achieve by implementing care and support planning?
- How does this fit with your local model of long term condition care and what is the current quality of care being delivered?
- In what clinical settings do you hope to implement care and support planning?
- Where are you going to focus your initial efforts for people with LTCs to receive a care and support planning approach?
- How does this link and fit with commissioning and quality improvement clusters?
- How engaged are your local clinical teams and who might be a good local GP champion?
- How is the implementation of the care and support planning going to be coordinated and monitored?
- What funding do you have to support the delivery of training and do you need to develop local capacity by training local trainers and facilitators?
- How are individual practice teams going to be supported after training delivery?
- How are you going to ensure that there is a 'portfolio' of services to support people in the community that they can link with following individual care and support planning?

We would suggest that you give some thought to the following:

- A local steering group to coordinate the implementation of the programme
- A process to engage and make practices aware of the Year of Care programme
- Identification of funding and suitable venues for training
- Identification of a local GP champion, facilitators and a project lead
- Potential local trainers if you require extensive delivery of local training
- Commissioning mechanisms to secure implementation and embedding of care and support planning
- User involvement
- Administrative support
- IT support to practices

We have a separate guide and template to help you cost a local work programme. This can be accessed by contacting enquiries@yearofcare.co.uk.

What support can Year of Care Partnerships offer?

This very much depends on what the local team need, but a flexible programme is available which can be costed to suit your requirements. Whilst high quality training is one of the key aspects of delivering the programme, the team also offer support and advice, using the experience they have gained from implementing this approach across many other organisations nationally.

Our experience has been that identifying local early exemplar practices is most effective as this gives an opportunity for shared learning amongst a small number of practices before branching out more widely. Often, from those early exemplar practices, you identify potential local champions, trainers and facilitators.

Year of Care Partnerships also have a range of resources that make it easier to implement care and support planning in practice which are available via training. We are also happy to support the development of local resources which can be incorporated into training delivery.

Support and Advice

- Support, advice and consultancy on the implementation of systematic care and support planning and support for self-management
- A robust case for change – clinical engagement
- A tested clinical model and pathway design
- In-practice facilitation
- Metrics and indices to assess impact

Training Programmes

- Taster sessions - Preparing for care and support planning - a short session aimed at ensuring practice teams know what is involved in reorganising care to implement care and support planning
- Care and support planning training - one and a half days of training for clinical/practice teams
- Admin and Practice Manager training- focussing on their role within care and support planning
- Healthcare assistant training - focusing on their role within care and support planning
- Train the Trainer and Quality Assurance Programme - for organisations who need to develop training capacity
- Facilitator training - a programme to develop local facilitators to support local teams to embed changes into clinical practice
- Extended consultation skills for clinical staff

Support Materials include

- Practice pack – tools and resources for primary care teams including patient materials e.g. sample letters, preparatory information, information sharing leaflets, care plans, awareness raising materials
- IT Guidance for Key Systems (EMIS,VISION, SystmOne)
- Evaluation framework and toolkit
- Video clips incorporating awareness raising and consultation skills
- Coordinator/Steering Group Guidance Document

We suggest most organisations receive a 'Taster' to engage practice teams and then receive local Care and Support Planning Training and if needed Train the Trainers or Facilitator Training. The next section gives a brief description of these key training programmes.

Taster Sessions - Preparing for Care and Support Planning

Implementing care and support planning in practice requires some organisational changes, which might impact on workforce if it is to be delivered in the most cost effective way. The aim of this Taster Session is to ensure practice teams know exactly what is required to deliver care and support planning and they are aware of the benefits and rationale for its implementation. The aim of the Taster is to recruit local practice teams and identify the early exemplar practices. It is normally a 2 hour session for up to 60 attendees.

Care and Support Planning Training

This training consists of a one day session and then a half day follow-up delivered 4-6 weeks later. It is aimed at teams who either:

- deliver routine long term condition care in general practice and who are prepared to restructure routine care around a care and support planning process. It should be attended by those who have authority and responsibility for changing the structure of care within a practice.
- deliver care and support to people within a community setting and as part of integrated pathway design are working towards implementing care and support planning as a key component of care delivery[1]

Specialist teams who work closely with their local Primary Care community to deliver care and support planning as part of their local model of care have also been successfully involved in training and have incorporated the Year of Care, care and support planning process in their clinic settings.

The training not only focuses on the attitudes and consultation skills to deliver a collaborative care and support planning consultation, but also shares tools and resources and local expertise to aid the practical implementation of care and support planning. It includes the following:

[1] ***It is usually critical to work with the local team to identify where care and support planning fits into the local care pathways, ahead of delivering this training***

- Discussion of the underpinning philosophy of using the approach
- Organisational aspects of implementing the programme
- Care and support planning consultation skills - modelling and observation
- Goal setting and action planning

The training provides healthcare professionals and wider teams with practical skills to implement care and support planning in routine long term condition care. As part of the training they are provided with a practice pack which contains a range of materials including patient materials and IT instructions for their practice system.

Facilitation training

Facilitation and hands on support is critical to the implementation of care and support planning both in terms of ensuring a whole team approach which maintains fidelity to the ethos and principle of care and support planning and which also builds in reflection and learning using the House of Care framework.

Facilitation can ensure teams are prepared ahead of training and supported following training in the implementation of care planning processes and conversations at a practice level, allowing broader team involvement to promote a clear understanding of the purpose, differences in approach, roles of team members and work to be done to change the ethos of care and put in place care processes at a grass roots level.

The training will help facilitators to:

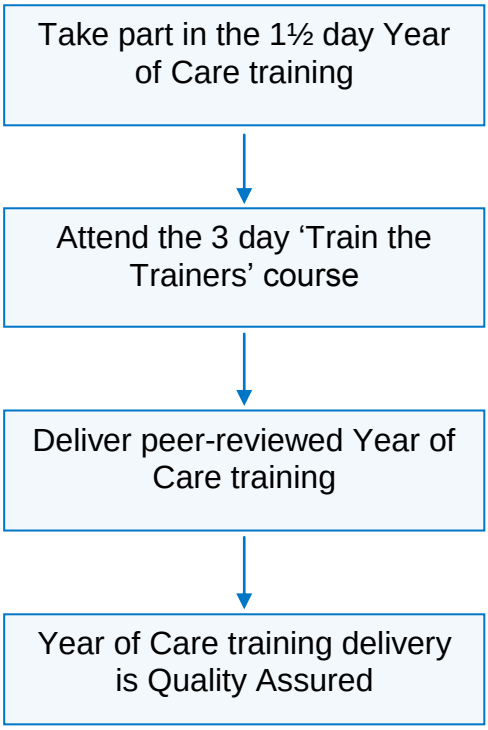
- Develop facilitation skills to enable them to support practice development and networking/sharing of good practice
- Develop a good practical and theoretical grasp of the Year of Care approach to care and support planning, including a robust case for change and ideas to support team engagement in the approach
- Create a cohesive understanding of care and support planning and how it differs from usual care, including its underpinning philosophy and the behaviours, roles and language of health care practitioners within the care and support planning conversation
- Share practical tools and resources to support the adoption of care and support planning
- Consider broader elements of the programme such as evaluation, IT requirements, more than medicine and on-going training and learning needs

Train the Trainers

Train the Trainers provides the most cost effective method of training local trainers to deliver care and support planning training across larger geographical/populated areas or where there is an aspiration to implement care and support planning across a number of clinical settings. By choosing this option organisations can develop capacity locally, whilst being assured that the training programme is of a high quality, delivered by trained and

quality assured trainers. It is essential that potential trainers are present at the delivery of the local training, delivered by the national training team and they meet the criteria set out in Appendix VI.

The process for becoming a national trainer



An overview: The process for receiving care and support planning training

The following steps detail the process to plan for and receive Year of Care training.

Step 1 - Making a decision to work with Year of Care Partnerships

- Expressions of interest to Year of Care Partnerships
- Discussion about your requirements and what our team can offer
- Preparatory questions for your organisation ahead of initial meeting
- First meeting with our team
- Agreement to proceed including costs
- Practices recruited to the 'preparing for care and support planning' Taster Session

Step 2 – Gaining interest and engaging practice teams

- Delivery of a two hour 'preparing for care and support planning' Taster Session to recruit first wave of practices and identify from those some early exemplar practices

Step 3 - Organising the delivery of first wave care and support planning training

- Practices confirmed for care and support planning training, including the presence of potential trainers

Step 4 - Delivery of care and support planning training

- National team deliver an agreed number of one day and follow up half day training sessions to local practice teams

Step 5 - Facilitated visits from the Year of Care team or facilitator training

- Year of Care trainers visit practices to offer support and guidance to solve practice-specific barriers to implementation and spread of care and support planning
- Alternatively Year of Care trainers deliver Facilitation Training to equip local facilitators to support practices

Step 6 - Training local trainers

- Recruiting and training local trainers - for train the trainers only
- Formal 'recruitment' of trainers that have been identified throughout the process and who meet the criteria (in appendix VI)
- Trainers attend train the trainers course
- Trainers peer reviewed whilst delivering care and support planning training
- Trainers quality assured whilst delivering care and support planning training

The process for receiving care and support planning training – in detail

Step 1 - Making a decision to work with Year of Care Partnerships

a) Expression of interest to the Year of Care Team

This can be via enquiries@yearofcare.co.uk.

We will usually aim to set up an initial phone call to hear about your local plans and share our experience with you. At this stage an estimate of costs can be calculated based on your initial ideas.

b) Information gathering ahead of initial meeting with local team.

In order to understand local thinking and need, the Year of Care Partnership team has found it useful to gather information prior to an initial visit to a new health community. This will include local data, details of the site's experiences of care and support planning and how this fits with the overall strategy and local model of care delivery for long term conditions (see Appendix I).

c) First meeting between the Year of Care team and the local team

The purpose of the meeting is to begin a dialogue and develop a common understanding of the needs of the local organisation and the Year of Care programme. This can be an opportunity to clarify what the Partnership can offer, but also for us to understand your local situation. A sample agenda and list of prerequisites is available in Appendix II.

The Year of Care team can then work out the final costs associated with delivering a programme that will be effective, including working with the local team to develop an action plan of what needs to done prior to training being received. In particular the following will need to be determined:

- A common vocabulary of the terminology used in the Year of Care programme and care and support planning
- The process by which care and support planning training can be rolled out locally
- Agreement of next steps and milestones

If you do decide to proceed with the programme we would recommend you identify the following structures, individuals and finance to form a local delivery team coordinated via a steering group.

d) Formation of a Steering Group and identification of a Site Coordinator

Steering Group

Our experiences suggest that a local steering group should coordinate the implementation of care and support planning and should be in a position to provide solutions to some of the issues that may arise, as practitioners implement this process. This might mean that as well as supporting practices and practitioners to implement care and support planning they might need to consider some of the broader issues relating to self-care and service delivery outside of practices and available in the wider community. We suggest that this should:

- include strong Primary Care leadership
- have sufficient authority to commit or spend existing resource including financial arrangements for practices (enhanced services), funding for training venues, catering and training team, backfill costs of staff involved with the local delivery of the programme
- have representation from people with long term conditions, in a way that is effective (i.e. either direct individual representation or from effective PPI or other lead)
- be able to source local support for practices e.g. IT

Clinical Champion

The effectiveness of this programme can be improved significantly by the presence of a local credible GP champion. Their role will be to enthuse peers in this approach and support the local delivery team. They should attend, if possible the first cohort of local training, should be an early adopter of this approach and will play a role in awareness raising locally. They should:

- be 'signed up' to the philosophy of Year of Care
- be familiar with the Case for Change and local data on outcomes and service delivery
- attend 'Preparing for care and support planning' session and subsequent training session
- be able to implement care and support planning in their organisation
- be credible amongst their peers
- potentially become a Year of Care trainer

Operational Lead

In order to work efficiently, one person with delegated authority should be nominated to ensure efficient communication between your team and Year of Care Partnerships. This will involve being:

- the first point of contact between the teams
- coordinating the organisational aspects of delivering Year of Care, including project managing all aspects of implementing Year of Care

Senior Commissioner

A key outcome of Year of Care is to provide services that meet the needs of people with long term conditions and support them to self-manage their condition. This requires senior support at a commissioning level. We think the involvement at this level will aid the organisation to:

- understand how this fits with their wider commissioning agenda
- commit or recommend the commitment of funds / resources
- justify a case for training within commissioning organisation
- developing a plan for sustaining and embedding the programme

Individual(s) with Primary Care Facilitation Skills

The outcome of any training will depend on how well it is supported at practice level and high quality facilitation will enhance the likelihood of adoption of care and support planning in practice. Please see 'Implementing care and support planning - the value of facilitation V1.0 final May 17'

Generally facilitators should:

- be 'signed up' to the philosophy of Year of Care
- have experience of working with primary care/community teams and demonstrate an understanding of its systems and processes
- be able to demonstrate an understanding that care and support planning will require on-going facilitative support
- (may) have a dual role as a local trainer
- meet the essential skills, knowledge and responsibilities for the Year of Care Facilitator (please see 'Essential skills, knowledge of YOC Facilitator V1.0 final May 17')
- be able to diagnose issues/problems
- be able to involve local people in "owning" these
- provide tailored support to address these

Administrative Support

Good quality administration and an administrative home for the programme will be essential to support training delivery, the steering group, sharing resources with practice teams and to aid the monitoring of practice delivery across the patch and its impact on care delivery and outcomes.

e) Sign up to Care and Support Planning Training

Once you have decided to go ahead with the programme and the costs have been agreed, you may be asked to complete and sign an application form to formalise arrangements. During this phase we are very happy to be contacted to discuss details and in particular:

- jointly agree dates for training and any further meetings that are required

- draw up plans to systematically train the practices in their area and put in place support mechanisms e.g. IT, facilitation, practice development

Step 2 – Gaining interest and engaging Practice Teams

Practices recruited for 'Preparing for Care and Support Planning' session

These sessions will be provided by the Year of Care Partnership Team. The purpose of these 'taster' sessions is to recruit about 10 local practices, up to 20 local clinicians who would be early adopters of care and support planning and who would be the first recipients of training. They should include potential trainers, local champions and facilitators. Ideally your local coordinator should be present at training to deal with and hear local questions – ideally these should be taken back to the steering group for local discussion/action.

Briefly this includes a 2 hour session:

- to clarify exactly what is meant by care and support planning
- to gain experience from practices elsewhere in the country who have already implemented the Year of Care programme and care and support planning
- to provide an opportunity for practices interested to clarify the commitment required to implement this approach
- with local representation to clarify how this fits with local services and how it is going to be supported

This is open to whole practice/community teams and is specifically designed to gain interest in training and implementation – non clinicians who are likely to be involved in the process of implementation are encouraged to attend with their team.

A sample brief, agenda and evaluation form are available from Year of Care Partnerships.

Step 3 - Organising the delivery of first wave Care and Support Planning Training

Practices recruited for training

As the purpose of the initial training is to support exemplars to create local learning and to identify potential trainers, facilitators and champions they should be prioritised as attendees at the first training cohort. This training will be delivered by our experienced training and support team. When organising attendance please consider the points below.

- Training is for practice teams and other clinicians in organisations that are committed to implementing this approach to care and support planning shortly after receiving the training. To that end the follow up session will include a review of action plans developed by each practice during the first day's training, which will be focused on delivering care and support planning within clinical teams.

- Training is therefore for people who have the authority to make change happen in practices and specialist/community care settings, and have the resources and organisational support to achieve this. **It is therefore essential that a GP or clinical manager/leads from each practice/service that is represented attends the training.** (The local coordinator needs to ensure that GPs are adequately represented amongst the leads).

- As many other representatives as possible should attend from each practice represented and these individuals should become the practice implementation team. There are up to 20 attendees in total at a single training session.

- Individuals to attend both sessions, and in order. (i.e. the full day followed by the half day)

A room specification for training is available in Appendix V.

Step 4 - Delivery of care and support planning training

Care and support planning training delivered (1 day)

The initial training cohort should be delivered to early adopting practices and can accommodate a maximum of 20 individuals.

It is vital that the following are organised by the local team:

- Venue / Equipment: Please see Appendix V for details of venue requirements
- Recruitment: Please provide a list of delegates, their job role, practice and practice IT systems (this is essential to provide the right practice pack and we need this 2 weeks before training where possible)
- Programme*, maps to be sent out to delegates
- Recommendations about local accommodation for the trainers if an overnight stay is required – ideally located near the venue
- Dissemination of IT instructions/resources supplied by Year of Care Partnerships to local practice/community teams following day one of training

* supplied by Year of Care Partnerships

NB: Training material (hand-outs and practice packs) will be brought by the Training Team or couriered to the venue/administrator if travel precludes this option. We will need to know who to courier the resources to and be able to get these from a named individual at least 40 minutes before training is due to commence.

Follow up to care and support planning training delivered (½ day)

This normally occurs about 4-6 weeks after the initial training and is focused on 'problem solving' some of the practical issues that may arise from having started to implement care and support planning.

This is a key part of training and should not be considered optional.

We have learned that any certificates of attendance or/and local enhanced arrangements should tie participants into attending both sessions.

Again, the initial date for this should be planned with the Training Team.

Step 5 - Facilitated visits from the Year of Care team or facilitator training

Facilitator training is available to support local organisations to embed care and support planning and to develop a mixture of trainers and individuals who can support practices in delivery – this maybe an option for your local coordinator.

Facilitated visits involve Year of Care trainers visiting practices to offer support and guidance to solve practice-specific barriers to implementation and spread of care and support planning.

Alternatively Year of Care trainers deliver Facilitation Training to equip local facilitators to support practices.

Step 6 – Training Local Trainers (only for those sites who choose to train local trainers)

a) Formal 'recruitment' of trainers that have been identified throughout the process

You will need to identify trainers who will undergo Train the Trainers and Quality Assurance and as a result will be 'registered' as National Trainers for Year of Care. Please see the recruitment criteria and overall training process on page 6 and on Appendix VI. It is really important to recruit good quality trainers who fit the criteria as they will be responsible for local delivery on an on-going basis.

b) Discussion with Year of Care: review of strategic plan

Once an initial training session has been delivered it is usually helpful to collaborate with Year of Care to discuss trainers, training and plan dates. This will include:

- checking trainers identified 'engaged' with training and the philosophy of care and support planning
- arranging future dates for local training
- feeding back issues raised and evaluation of the training
- reviewing local plans for implementing care and support planning

c) Trainers attend 'Train the Trainers' course

Train the trainer is three days of training to prepare new trainers to roll out care and support planning training within their area. This is usually delivered in the North East of England and involves bringing together groups of trainers from across the UK.

It aims to equip new trainers with confidence and competence to deliver care and support planning training.

Sites will need to fund backfill, travel and accommodation for their staff. The training team can provide local maps and information about good hotels on request.

d) Trainers peer reviewed delivering care and support planning training

Having attended train the trainers, new trainers can then deliver training in their local area, the first course is a 'supported' or co-delivered course to help new trainers gain confidence in running the training.

A national trainer will be in attendance to give informal feedback and support the delivery of the course.

e) Trainers quality assured delivering care and support planning training

The second local course will be delivered entirely by the new local team and will be quality assured using structured observational tools by an experienced National Trainer. This ensures that the training is delivered to the same standard as the Year of Care National Trainers and that the key messages are properly and accurately conveyed.

Formal feedback will be given and if successfully completed new trainers can then independently go on to deliver care and support planning training as required by the local team, including delivery of some of the other curriculums such as the health care assistant training and further delivery of Taster Sessions.

Other options

Some organisations choose to commission Year of Care Partnerships to deliver all of their local training (if they have a relatively small group of practitioners to train) or they may have several cohorts of training ahead of training local trainers.

It's worth remembering that training delivery will have to be introduced gradually and so if you are using a local enhanced service then agreements need to be timed to allow training to occur as well as implementation within a practice.

Advanced Communications skills training

This training is available via Year of Care and is aimed at practitioners who would like to develop their skills further having received initial training.

Appendix I – The YOCP preparatory questions ahead of initial meeting

Putting things into context: understanding the local situation

In order to understand local thinking and need, the Year of Care Partnership Team has found it is useful to gather information prior to an initial visit to a new health community. This will include in section A; local data, details of your local experiences of care and support planning and how this fits with the overall strategy and local model of care delivery for long term conditions.

Each area should also think through how the individuals, processes and infrastructure outlined in section B can be identified and adequately funded should they wish to take forward the Year of Care programme locally.

Although it might seem like a lengthy list of questions, in our experience the more we know about you beforehand the more productive the eventual meeting can be. All areas are different in size, ambition and intentions so there are certainly no right or wrong answers; however, other areas have commented that completing this questionnaire has acted as a useful 'prompt' for self-reflection as to how care and support planning is to be introduced and where links with other work streams should be made. The answers to these questions will not be shared outside of the Year of Care Partnership team. Please complete what you can, and consider the questions it raises.

Care and support planning was originally developed using diabetes as an exemplar. However the team has gained extensive experience of introducing care and support planning for other single conditions, people with multi-morbidity and people living with frailty or multi-morbidity who receive care and support at home. It is important to consider which group of patients (and therefore staff) you feel you want to begin with, but also consider how you might eventually implement care and support planning for broader groups in the population. In addition , care and support planning , doesn't just happen by chance – clinical pathways will need to be designed with care and support planning as a key component and organisational aspects of care will also need to change.

SECTION A – Information about your current situation and aspiration

Your interest and motivation for implementing care and support planning?	
Where / how did you find out about the Year of Care programme? What is your main reason to want to work with us? Please describe what the main driver is for your interest in the programme and what you hope to achieve? What difference would this programme make and what outcomes would you consider measuring? Are you primarily interested in care and support planning or the wider Year of Care programme (i.e. the House of Care and wider commissioning issues as well?)	
About yourself and your organisation	
Name of your organisation On behalf of what type of organisation(s) are you responding (e.g. health board, CCG other)? Please provide details of the individual or individuals who are leading on this, on behalf of your organisation (please include your role/title/ contact details) What is the most senior body / who is the most senior individual to whom your work in this area is accountable? Who is ultimately accountable for ensuring that local services for your target population deliver improved outcomes, or who is ultimately responsible for ensuring the quality of local services? Does this work form part of current commissioning priorities?	

Do you have a steering group for this work or would you need to form a new one? – What authority does it have to make appropriate changes?	
About your local population	
What is your total local population? How many people are registered with a Long Term Condition (LTC)? (Please add/append any additional relevant data – e.g. hospital admissions, population with specific conditions, information about outcomes you hope to improve etc.) What has been the reaction locally from people with LTCs about being offered more involvement in their care?	
Local primary care and community teams	
How many GP practices are there in your organisation? What IT systems are in use in primary care? How interested are clinical teams in working differently and implementing care and support planning? Do you have any identified clinical champions? If so, who? Are specialist teams involved in delivering or supporting this work?	
Your current model of care and local situation	
How would you describe your local model of care/care pathways for people with LTC (positives and negatives) - Single conditions such as Diabetes, cardiovascular disease, COPD? - People with multi-morbidity (QOF population)? - People who receive care at home? - People living with frailty?	

Implementing care and support planning	
In which group of patients are you hoping to implement care and support planning? Where will you start and where do you plan to get to? For this group of patients : Are you using a particular method/tool of risk stratification to identify groups of patients? – If not how will you identify the group of people you want to work with? Do you have a model of care which describes the role of specialists, community teams and primary care in overall care delivery? Where does the "annual review" currently take place for your LTC population/group you have identified for care and support planning? What ideas do you have for how care and support planning will be integrated into clinical pathways ahead of any decisions being made about individual care? Who will actually do the care and support planning? Is care and support planning specifically commissioned from any providers? Are you implementing an incentive scheme – would it be possible to share this? What plans do you have to support teams following training?	
Care and support planning – previous experiences	
What has already happened in relation to the delivery of care and support	

planning? Has care and support planning training or anything that could be perceived as care and support planning training (MI/health coaching) ever been offered in your area? Approximately how many people in your area have received training? • GPs • Practice nurses • Community/ Specialist Nurses • AHP • Administrative staff • Total How many entire practice teams have received training? Who has delivered this training, and what was the format (i.e. number of sessions, duration, and follow-up)? What has been the impact/reaction to the training?- In which clinical setting(s) does Care and support planning take place? Approximately what percentage of people with LTCs are 'prepared' for their care and support planning visit/appointment? Approximately what percentage of people with LTCs receive a written care plan following their consultation? Have you developed any care plans/care plan templates as part of this work? Do you have any existing exemplar practice teams?	
Support for self-management and more than medicine	
Do you have a specific self-care strategy? What support for self-management exists currently and how well used is it? What rehab or structured education	

programmes do you offer? What barriers exist to its use? What is the offer from the third sector/more than medicine approach locally? Do you have peer support groups?	
Year of Care support including training and Train the Trainers	
What would you like Year of Care Partnerships to provide? (for more information about our support and training packages please look at our website www.yearofcare.co.uk) Which groups of staff would you like us to train? What training options are you interested in? Would you need local trainers or/and facilitators?	
Any other important information/questions?	

SECTION B – Important success factors for your reflection

Making it work – 'critical success factors'

Detailed in the Year of Care final report is a number of 'critical success factors' which have been reported by all sites as key to the success of the programme at a local level. Whilst you maybe just thinking about the programme at the present, it might be worth giving the following some thought

How could the following be achieved and managed?

Human resource requirements (coordinated via a local steering group)

- Engagement of commissioning lead for long term conditions

- Operational 'Year of Care/ Care and support planning' project lead
- A local clinical 'champion' of care and support planning (either from, or with a practical understanding of and credibility within, Primary Care)
- Representative User involvement
- Individuals with Primary Care facilitation skills
- Local trainers who will be trained and quality assured in the national care and support planning training :including a doctor (will depend on whether local trainers are required)
- Administrative support

Financial requirements

- Financial levers in place to make care and support planning happen at grass roots levels built into service specification and model of diabetes/long term condition care
- Funding for training venues, catering and equipment
- Depending on the options chosen
- Funding for the National Year of Care team
- Backfill costs of personnel to coordinate, deliver training and facilitate the implementation of care and support planning within own organisation
- Backfill and travel / accommodation costs for new local trainers to attend and receive 'Train the Trainers'

Critical infrastructure

- A steering group (as above)
- IT support and templates that facilitate the care and support planning consultation (guidance documents are available for certain systems and conditions)
- Facilities for user involvement
- Awareness raising for healthcare professionals and people with long term conditions
- On-going support mechanisms for healthcare professionals implementing care and support planning
- Sign posting and information about local resources – including non-traditional support for self-management

Evaluation and monitoring framework

This will need to include methods to measure and act upon:

- Process measures – is care and support planning actually happening?
- Changes in healthcare professional behaviour- are they having different conversations?
- User feedback- do people feel more involved?
- Impact on service delivery and outcomes- does care feel more coordinated? – are clinical outcomes/processes improving?
- Changes in commissioning requirements

Date completed_____

Appendix II – Sample agenda for initial meeting

Prerequisites:

At least two weeks before the meeting:

- Location and exact timings confirmed.
- Agenda circulated including aims and objectives of the day.
- Preparatory questions completed and any additional, relevant information circulated.
- Complete list of attendees on the day, including job title and role within care and support planning.

On the day of the meeting:

- PowerPoint facilities available with sound for playing embedded clips.

Suggested agenda:

1. Welcome and introductions (15 minutes)

The Chair welcomes everyone to the meeting and facilitates introductions, including current and previous roles of the attendees and interest in care and support planning / Year of Care. The Chair outlines the context of the meeting and the objectives.

2. The local 'story' (15 minutes)

A representative from the local project's Steering Group (or similar) delivers a presentation, covering:

- Local history and further context.
- Key aims and objectives, motivations for this work.
- Summary of local situation with regards people with diabetes and associated services.
- Other significant local programmes of work.
- Progress to date, perceived strengths and weaknesses.

3. The Year of Care 'story' (30 minutes)

A representative from Year of Care Team delivers a presentation covering:

- The programme's history (briefly).
- The programme's aims.
- Ensuring everyone in the room uses a shared vocabulary.
- Key learning to date.

4. Discussion (15 minutes)

A chance for both the local and national teams to explore any issues in more depth.

5. Next steps and agreeing a way forward (15 minutes)

Appendix III – National Care and Support Planning training and Train the Trainers Application/information Form

Part 1: Information about your organisation

Section A: Name of Organisation

Site Name: .....

Address: .....

.....

.....

.....

.....

Post Code: .....

Section B: Invoicing Details

The following details are required for invoicing and delivery of training materials, course resources and training costs. To ensure safe delivery and monitoring of resources and invoices, could you please provide correct contact details.

Invoice details

Invoice name: .....

Position: .....

Address: .....

.....

.....

.....

Post Code: .....

Telephone number:

Email address: .....

Please supply specific information you require on invoices

……

……

Section C: Identified Staff Details

Commissioner (Senior Responsible Officer)

Name: .....

Position: .....

Telephone number: .....

Email address: .....

Clinical Champion

Name: .....

Position: .....

Telephone number: .....

Email address: .....

Local Coordinator

Name: .....

Position: .....

Telephone number: .....

Email address: .....

Administrator

Name: .....

Position: .....

Telephone number: .....

Email address: .....

Potential Trainers or/and facilitators

Please list individuals attending training who are potentially being put forward as new trainers , if possible give some indication of why they are being nominated.

You may not be able to complete this at this point but will need to retain this form for completion after initial training.

……

……

……

……

……

……

……

……

……

……

Appendix IV - An overview: The process for receiving national care and support planning training

The following steps detail the process to plan for and receive Year of Care Training, where on this process do you feel you are up to?

The following steps detail the process to plan for and receive Year of Care Training.

Step 1	**Making a decision to work with YOC** • Expressions of interest to Year of Care Partnerships • Information gathering for local 'Self-Assessment' and as preparation for initial meeting • First meeting between the Year of Care Team • Sign up to care and support planning training and local Preparation – completion of application form • Practices recruited for 'Preparing for Care and support planning' session
Step 2	**Gaining interest and engaging practice teams** • 'Preparing for Care and support planning' taster session delivered • 2 hour session to recruit first wave practices
Step 3	**Organising the delivery of first wave Care and support planning training** • Practices confirmed for care and support planning training , including the presence of potential trainers
Step 4	**Delivery of Care and support planning training** • Year of Care team deliver one day and follow up half day training to local practice teams
Step 5	**Facilitated visits from the Year of Care team or facilitator training** • Year of Care trainers visit practices to offer support and guidance to solve practice-specific barriers to implementation and spread of care and support planning • Alternatively Year of Care trainers deliver Facilitation Training to equip local facilitators to support practices

Step 6	**Training local Trainer (only for those sites who choose to train local trainers)** • Recruiting and training local trainers - for Train the Trainers only • Formal 'recruitment' of trainers that have been identified throughout the process • Discussion with YOC Team: Review of local strategic plan • Trainers attend 'Train the trainers' course • Trainers peer reviewed delivering co-deliver care and support planning training • Trainers quality assured delivering care and support planning training

Appendix V - Room specification for Year of Care training

To ensure effective delivery of training the following guidelines on training venue have been developed.

Essential

- Large room sufficient to accommodate 20 people (maximum participants group size) plus 3 trainers set up as a 'horseshoe' with all seats positioned so participants can see teaching processes
- Room set up to also allow for group work around tables **or** breakout rooms
- Access to the venue and room 1 hour before the training commences
- Projector
- Suitable projection surface
- Extension cables (or 3 sockets close to front table)
- Laptop with speakers or integral sound system and required software to play embedded film clips and PowerPoint from USB stick
- Flipchart stand, flipchart paper and flipchart pens
- Table for laptop (if not integral)
- Table for hand-outs/resources at the front of the room
- Breakout room nearby
- Tea, coffee, water, (buffet style lunch nearby) but preferably not in the teaching room **(if not offering lunch please inform participants and trainers)**
- Toilets nearby
- Ability to have resources couriered to venue

Desirable

- Adequate temperature and light control e.g. working blinds
- Onsite parking for trainers or good transport links
- Able to use Blu-tac on the walls or other surfaces (e.g. wipe boards)
- If supplying IT system please advise if IT support available

Appendix VI - Criteria for trainers wishing to receive training

The training team

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. The training process is critical to ensuring that people have a good understanding of care and support planning and what is involved in its delivery. As training is owned by Year of Care, trainers will be made aware that they will be asked to sign a contract stating they will not change any aspect of the training without the permission of Year of Care.

- As a minimum two trainers should have a clinical background and one of these should be a GP.

- At least one of these trainers should be experienced in the relevant setting e.g. primary care/LTC care (the context into which the training is to be delivered).

- All should have experience and be committed to the implementation of care and support planning, or be starting to implement it within their own workplace.

- All trainers should be experienced in delivering interactive training to groups of health and care professionals.

- One could be a non-clinician but have a dedicated role in implementing the programme at a practice based level or have experience of delivering training on consultation skills.

In our experience careful selection of trainers is more likely to result in individuals successfully completing quality assurance processes and becoming registered trainers.

Criteria for trainers

Trainers should have:-

- attended and participated in the Year of Care, Care and support planning training delivered over a day and a half.

- credibility with their training audience who will include GPs and may include senior CCG/health 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 care and support planning consultations or within their current role be using the consultation skills associated with care and support planning.

- an interest in personalisation, communication and consultation skills and an ability to teach these to others.

- engaged with the philosophy and principles of the Year of Care programme and care and support planning.

- experience of training health care professionals or running structured patient education in group settings using adult education principles.

- the support of a local team, who are committed to embedding this approach across a geographical area (e.g. CCG, health board).

- dedicated time allocated and agreement from their line manager to:
  - attend Train the Trainers (a 3 day course)
  - prepare for/deliver the training
  - provide local mentorship/facilitation
  - undergo Year of Care Quality Assurance

- dedicated time to undergo Peer Review and Quality Assurance, including reflecting on training and receiving feedback from experienced Year of Care trainers, in order to improve and develop care and support planning training skills.

- dedicated time to deliver training on a regular basis to maintain skills.