



Working with the Year of Care Partnership to deliver Care and Support Planning

A Guide to Training and Train the Trainers



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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 the Year of Care Partnerships. This document has a focus on guidance about the process and organisational aspects of delivering Year of Care Training and, if required, Training 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 with the skills and resources required to implement care and support planning.

It should be read in conjunction with the Coordinator and Steering Group Guidance

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.

The Year of Care Partnership can now provide a range of options to support organisations to implement care and support planning, including expertise and advice, 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 planning is to be implemented.

If you would like to enquire about the training and support available from the Year of Care Partnership 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 team meet with the local commissioning group to discover what is involved in delivering care planning locally and what support is available from the Year of Care Partnership. This is aided by the completion of a series of questions ahead of the meeting which help us understand your local issues. This short 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 discussion with the Year of Care Partnership 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?
- How are you going to stratify your population of people with LTCs to receive a care planning approach?
- How does this link and fit with commissioning?
- 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?
- 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 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 Year of Care
- 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 planning
- User involvement
- Administrative support

What support can the Year of Care Partnership 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. They also have a range of products 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.

This could include:

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
- Facilitation
- Metrics and indices to assess impact

Training Programmes

- Taster sessions - Preparing for care planning - a short session aimed at ensuring practice teams know what is involved in reorganising care to implement Care planning
- Care and Support planning Training - one and a half days of training for clinical teams
- Train the Trainer and Quality Assurance Programme - for organisations who need to develop training capacity
- Healthcare Assistant Training - focusing on their role within care planning
- Extended Consultation Skills for clinical staff
- Facilitator Training - a programme to develop local facilitators to support local teams

Support Materials include

- Patient Materials e.g. sample letters, preparatory information, care plans, awareness raising materials
- DVDs incorporating awareness raising and consultation skills
- Coordinator/Steering Group Guidance Document
- 'Mind Your Language' – a reflective tool for health care practitioners
- Practice Pack- for primary care teams
- Evaluation Framework and Toolkit
- IT Guidance for Key Systems (EMIS, VISION, SystemOne)

Core Care Planning Training and Train the Trainers

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

Taster Sessions - Preparing for Care Planning

Implementing care 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 planning and they are aware of the benefits and rationale for its implementation. It is normally a 2 hour session.

Care Planning Training

This training consists of a one day session and then a half day 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 planning process. It should be attended by those who have authority to change 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 delivery¹

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

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

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

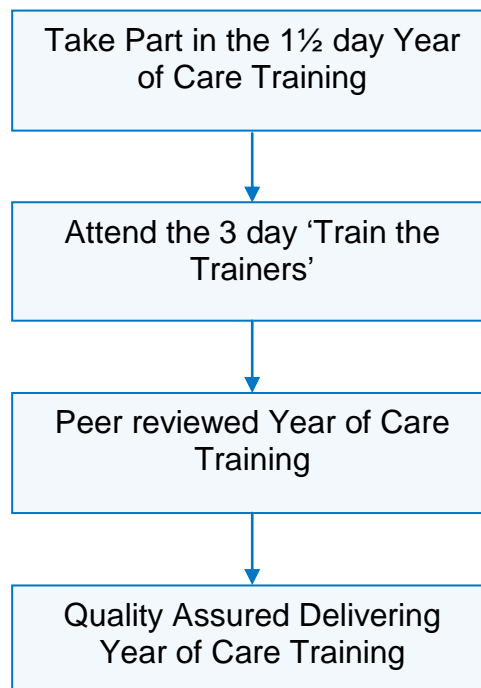
The training provides healthcare professionals with practical skills to implement care planning in routine long term condition care. As part of the training they are provided with a practice pack which contains a range of materials including patient materials and IT instructions for their practice system.

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*

Train the Trainers

Train the Trainers provides the most cost effective method of training local trainers to deliver care planning training across larger geographical/populated areas or where there is an aspiration to implement care 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 V](#).

The process for becoming a national trainer



An overview: The Process for receiving National Care 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 for preparing for care planning session

Step 2 – Gaining interest and engaging practice teams

- Delivery of a two hour 'preparing for care planning' taster session to recruit first wave of practices

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

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

Step 4 - Delivery of care planning training

- National team deliver a one day and follow up half day training session to local practice teams

Step 5 - Training local trainer (only for those organisations 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
- Trainers attend train the trainers course
- Trainers peer reviewed delivering co-deliver care planning training
- Trainers quality assured delivering care planning training

For further information on each step – please read the following pages.

The process for receiving National Care Planning Training

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 or - Contact Lindsay Oliver – The National Director of the Year of Care Partnerships. Lindsay.oliver@nhct.nhs.uk

We will usually aim to set up an initial phone call to share our experience with you and work out if we can support your local programme. At this stage costs can be calculated based on your initial ideas in order to support your decision about whether to work with the Year of Care Partnerships.

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 is 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 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 Year of Care programme and the needs of the local organisation. 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](#).

At the end of the meeting you will need to decide if you are interested in the programme. The Partnership 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 be done prior to training being received. In particular the following will need to be determined:

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

If you do decide to proceed with the programme we could 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 planning locally and should be in a position to provide local 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 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, if required 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 planning’ session and subsequent training session
- be able to implement care planning in their organisation
- be credible amongst their peers

Operational Lead

In order to work efficiently, one person with delegated authority should be nominated to ensure efficient communication between your team and the Year of Care Partnership. 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 planning in practice. 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 planning will require ongoing facilitative support
- may have a dual role as a local trainer

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 Planning Training

Once a site has decided to go ahead with the programme and the costs have been agreed, they will 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 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 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 hours session:

- to clarify exactly what is meant by care and support planning
- to gain experience from practices who have already implemented Year of Care and care 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 very welcome 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 Planning Training

Practices recruited for training

As the purpose of the initial training is 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 and will therefore need to be planned according to their availability. When organising attendance consider:

- Training is for practice teams and other clinicians in organisations that are committed to implementing this approach to care 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 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 the 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).
- A minimum of two people should attend from each practice represented. More would be welcome if capacity was available; 20 attendees in total at a single training session.
- Individuals need to attend both sessions, and in order.

A room specification for training is available in [Appendix IV](#).

Step 4 - Delivery of Care Planning Training

Care Planning Training Delivered (1 day)

The initial training cohort should be delivered to 8 - 10 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 IV](#) 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)
- Maps, programme* 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 Planning Training Delivered (½ day)

This is a key part of training and shouldn't be seen as optional. We have learned that any certificates of attendance or/and local enhanced arrangements should tie participants into attending both sessions.

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 planning.

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

Step 5 - 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 V](#). It is really important to recruit good quality trainers who fit the criteria as they will be responsible for local delivery on an ongoing 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 the Year of Care to discuss trainers, training and plan dates. This will include:

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

c) Trainers attend 'Train the Trainers' course

Train the trainer is three days of training to prepare new trainers to roll out care planning training within their area. This is usually delivered in North Tyneside.

It aims to equip new trainers with confidence and competence to deliver care 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 Planning Training

Having attended train the trainers, new trainers can then deliver training in their local area, the first course is a 'supported' 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 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. Formal feedback will be given and if successfully completed new trainers can then independently go on to deliver care planning training as required by the

local team, including deliver 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 local enhanced service agreements need to be timed to allow training to occur as well as implementation within a practice. It is unlikely that practices will be recruited, trained and implementing this with their whole population within a year if it is to be anything other than another tick box exercise.

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.

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 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 Year of Care 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 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 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?	

<p>What difference would this programme make and what outcomes would you consider measuring?</p> <p>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?)</p>	
<p>About yourself and your organisation</p>	
<p>Name of your organisation</p> <p>On behalf of what type of organisation(s) are you responding (e.g. health board, CCG other)?</p> <p>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)</p> <p>What is the most senior body / who is the most senior individual to whom your work in this area is accountable?</p> <p>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?</p> <p>Does this work form part of current commissioning priorities?</p> <p>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?</p>	

About Your Local Population	
<p>What is your total local population?</p> <p>How many people are registered with a Long Term Condition (LTC)?</p> <p>(please add/append any additional relevant data – e.g. hospital admissions, population with specific conditions, information about outcomes you hope to improve etc)</p> <p>What has been the reaction locally from people with LTCs about being offered more involvement in their care?</p>	
Local Primary Care and Community teams	
<p>How many GP practices are there in your organisation?</p> <p>What IT systems are in use in primary care?</p> <p>How engaged are clinical teams in working differently and implementing care and support planning?</p> <p>Do you have any identified clinical champions?</p> <p>Are specialist teams involved in delivering or supporting this work?</p>	
Your current Model of Care and local situation	
<p>How would you describe your local model of care/care pathways for people with LTC (positives and negatives)</p> <ul style="list-style-type: none"> - 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	
<p>In which group of patients are you hoping to implement care planning?</p> <p>(Where will you start and where do you plan to get to?)</p> <p>For this group of patients :</p> <p>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?</p> <p>Do you have a model of care which describes the role of specialists, community teams and primary care in overall care delivery?</p> <p>Where does the “annual review” currently take place for your LTC population/group you have identified for care and support planning?</p> <p>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?</p> <p>Who will actually do the care and support planning?</p> <p>Is care planning specifically commissioned from any providers?</p> <p>Are you implementing an incentive scheme – would it be possible to share this?</p> <p>What plans do you have to support teams following training?</p>	
Care and Support Planning - previous experiences	
<p>What has already happened in relation to the delivery of care and support planning?</p> <p>Has care planning training or anything that could be perceived as care planning training (MI/health coaching)</p>	

<p>ever been offered on your patch - If yes – please give some details such as :</p> <p>Who by</p> <p>Approximately how many people in your area have received training?</p> <ul style="list-style-type: none"> • GPs • Practice nurses • Community/ Specialist Nurses • AHP • Administrative staff • Total <p>How many entire practice teams have received training?</p> <p>Who has delivered this training, and what was the format (i.e. number of sessions, duration, and follow-up)?</p> <p>What has been the impact/reaction to the training ?- for example:</p> <p>In which clinical setting(s) does Care and support planning take place?</p> <p>Approximately what percentage of people with LTC are “prepared” for their care planning visit/appointment?</p> <p>Approximately what percentage of people with LTC receive a written care plan following their consultation?</p> <p>Have you developed any care plans/care plan templates as part of this work?</p> <p>Do you have any existing exemplar practice teams?</p>	
<p>Support for Self-Management and more than medicine</p>	
<p>Do you have a specific self-care strategy?</p> <p>What support for self-management exists currently and how well used is it?</p>	

<p>What rehab or structured education programmes do you offer?</p> <p>What barriers exist to its use?</p> <p>What is the offer from the third sector/more than medicine approach locally?</p> <p>Do you have peer support groups?</p>	
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Year of Care Support including Training and Train the Trainers

<p>What would you like Year of Care to provide?</p> <p>(for more information about our support and training packages please look at our website www.yearofcare.co.uk)</p> <p>Which groups of staff would you like us to train?</p> <p>What training options are you interested in?</p> <p>Would you need local trainers or/and facilitators?</p>	
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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 planning’ project lead
- A local clinical ‘champion’ of care 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 planning training :including a doctor (will depend on whether local trainers are required)
- Administrative support

Financial requirements

- Financial levers in place to make care 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 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 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
- Ongoing 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 week 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 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's '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 Planning Training and Train the Trainers: Application/Information Form

Part 1: Information about your organisation

This form is to be completed once local funding has been secured for the Implementation of Care Planning, including Care Planning Training, Train the Trainers and associated Peer Review and Quality Assurance.

This form is supported by the document: *“A Guide to Training and Train the Trainers”*.

Further information can be obtained from the Year of Care website www.yearofcare.co.uk

All sections of the form must be completed; this can then be emailed enquiries@yearofcare.co.uk

Once this has been agreed we will contact you to organise the following dependant on where your organisation is in the application process:

- ‘Preparing for Care Planning’ taster session
- The first Care Planning training session
- Train the Trainers
- Peer reviewed Care Planning training
- Quality Assured Care Planning training

Section A: Name of Organisation

Site Name:

Address:

.....

.....

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.....

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

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Section C: Identified Staff Details

Section C: Commissioner (Senior Responsible Officer)

Name:

Position:

Telephone number:

Fax number:

Email address:

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Postal address if different from Section B:

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Section C: Clinical Champion

Name:

Position:

Telephone number:

Fax number:

Email address:

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Postal address if different from Section B:

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Section C: Local Coordinator

Name:

Position:

Telephone number:

Fax number:

Email address:
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Postal address if different from Section B:
.....
.....

Section C: Administrator

Name:

Position:

Telephone number:

Fax number:

Email address:
.....

Postal address if different from Section B:
.....
.....

An overview: The process for receiving National Care 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	<p>Making a decision to work with YOC</p> <ul style="list-style-type: none"> • Expressions of interest to the 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 planning training and local Preparation – completion of application form • Practices recruited for 'Preparing for Care Planning' session
Step 2	<p>Gaining interest and engaging practice teams</p> <ul style="list-style-type: none"> • 'Preparing for Care Planning' taster session delivered • 2 hour session to recruit first wave practices
Step 3	<p>Organising the delivery of first wave Care planning training</p> <ul style="list-style-type: none"> • Practices confirmed for care planning training , including the presence of potential trainers
Step 4	<p>Delivery of Care planning training</p> <ul style="list-style-type: none"> • Year of Care team deliver one day and follow up half day training to local practice teams
Step 5	<p>Training local Trainer (only for those sites who choose to train local trainers)</p> <ul style="list-style-type: none"> • 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 planning training • Trainers quality assured delivering care planning training

Further comments

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Declaration

I the undersigned have read the notes for Part 1 and understand the time commitment involved and I confirm that our organisation will:

- Release staff for training
- Fund travel and accommodation for the national trainers to deliver 1 x 'Preparing for Care Planning Training session' , 1 x Care planning Training, 1 x peer review visit and 1 x QA visit
- Identify and backfill staff to participate in the Care Planning Train the Trainers and Quality Assurance process
- Identify and backfill local staff to support implementation of Year of Care following on from training

Signed:

Position:

Date:

National Care Planning Application Form

Part 2: Information about trainers

Criteria for trainers wishing to receive training

The training process is critical to ensuring that the Care planning intervention is delivered reliably following training. In order to ensure trainers are of a high caliber, both training criteria and associated evidence of skills have been developed to guide organisations in the identification of suitable local trainers

Criteria

- Credible with their peer group and working within the setting or having sufficient knowledge of the setting for care planning delivery- integrated teams/primary care
- Within their current role proven experience of using goal setting and action planning skills as part of patient consultations, student training or staff appraisals.
- Proven interest in personalisation, communication and consultation skills.
- Engaged with the philosophy and principles of Year of Care and Care Planning.
- Experience of training health care professionals or running structured patient education in group settings using adult education principles.
- Supported by a local team, who are committed to embedding this approach across a geographical area (e.g CCG, health board).
- Dedicated time allocated and agreed by line manager to attend/deliver:
 - Train the trainers
 - Deliver the training
 - Provide local mentorship/facilitation
 - Quality assurance
- Prepared to undergo Quality Assurance, including reflecting on training and receiving feedback from experienced trainers, in order to improve and develop Care Planning Training Skills.
- Able to deliver training on a regular basis to maintain skills.

Trainer Information (one per nominated trainer)

Contact details and address are required to send information.

Name:

Position:

Telephone number:

Fax number:

Email address:

Bleep (if applicable):.....

Postal address

Dietary requirements:

Meeting the Trainers criteria

Meet the criteria

Further information

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.....

Service Managers

I understand the time commitment required and agree to ensure that this time is made available for the above to complete and deliver Care planning, Train the Trainer and peer supported/ quality assured care planning training.

Service Manager Name:.....

Signature:

Date:

Name Profession Organisation
Current experience of Care Planning
Your views and understanding of principles and philosophy of care planning
Your interest in communication and consultation skills
Your experience of training health care professionals or running structured patient education in group settings using adult education principles
Any other comments/relevant qualifications

Appendix IV

Room specification for year of care training

To ensure training isn't hampered due to the training venue the following guidelines on training venue have been developed.

Essential

- Large room sufficient to accommodate 20 people (maximum group size) along with separate areas for workshop activities
- Set up as a "horseshoe" with all seats positioned so participants can see teaching processes
- Access to the venue and room the evening or early morning before the training commences
- Projector
- Suitable projection surface
- Extension cables (or 3 sockets close to front table)
- Facilities to play Powerpoint and embedded film clips with sound (e.g. laptop with speakers or integral sound system and required software)
- 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
- Toilets nearby

Desirable

- Adequate temperature and light control e.g. working blinds
- Onsite parking for trainers or good transport links
- Able to use Blue-tac on the walls or other surfaces (e.g. wipe boards)
- Integral sound system
- IT support

Appendix V

Criteria for Trainers Wishing to Receive Training

The training process is critical to ensuring that the care planning intervention is delivered reliably following training. In order to ensure trainers are of a high calibre, both training criteria and associated evidence of skills have been developed to guide organisations in the identification of suitable local trainers

- Credible with their peer group and working within the setting or having sufficient knowledge of the setting for care planning delivery- integrated teams/primary care
- Within their current role proven experience of using goal setting and action planning skills as part of patient consultations, student training or staff appraisals.
- Proven interest in personalisation, communication and consultation skills.
- Engaged with the philosophy and principles of Year of Care and Care Planning.
- Experience of training health care professionals or running structured patient education in group settings using adult education principles.
- Supported by a local team, who are committed to embedding this approach across a geographical area (e.g. CCG, health board).
- Dedicated time allocated and agreed by line manager to attend/deliver:
 - Train the trainers
 - Deliver the training
 - Provide local mentorship/facilitation
 - Quality assurance
- Prepared to undergo Quality Assurance, including reflecting on training and receiving feedback from experienced trainers, in order to improve and develop Care Planning Training Skills.
- Able to deliver training on a regular basis to maintain skills.

The Year of Care Training Team

The team should all meet the above criteria, and it is suggested 3 trainers should be identified by a new site, of which:

- 1 should ideally be a GP
- 1 should be experienced in relevant setting eg primary care/LTC care
- 1 should have a clinical background
- 1 could be a non clinician but have a role in any one of the following within a LTC setting (training, PCT, management, commissioning, organisational management, facilitation/service improvement, primary care)

This can be flexible and if you wish to discuss this further please contact the national Training and Support Team.