The HOUSE Journal

The newsletter for the Year of Care Community of Practice

Issue 24
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Welcome to The HOUSE Journal - Lindsay Oliver, YOC National Director

In this edition of the House Journal we focus on some recent work the Year of Care team have been doing to look at **how personalised care and support planning (PCSP) and shared decision making (SDM) can be applied to new settings and contexts**. This includes international work in Singapore, and the transfer of PCSP into specialist long COVID clinics and community anticipatory care teams in the UK.

What really stands out is that no matter where people live in the world, and at what stage of life they are at, they want care that is personalised and where their ideas and preferences are valued and central to agreeing the outcomes they want and the care they receive.

In all of these programmes we are working closely with clinical experts to understand the context and issues before working out how PCSP processes are modified for their particular setting. This includes how people can be prepared, the focus of the PCSP conversation and how it is captured meaningfully for both the person and the healthcare team and/or wider system.

It has been imperative to work through this as part of creating a clear vision for how PCSP will apply in these settings, and therefore how our training should be adapted. Only then will practitioners see how PCSP can work in their care setting and therefore actively engage with its implementation.

Personalised care and support planning and anticipatory care

There are numerous definitions of anticipatory care, and in England this work is focused on particular groups of people who live with complexity around multiple long-term conditions and/or frailty, who may be in a health inequalities group, and who are most at risk of using unplanned care.

A personalised anticipatory care and support planning approach focuses on people's priorities alongside prevention and self-management, whilst planning for exacerbations in health conditions and understanding people's priorities for care in emergency situations or at end of life.

The Year of Care team are currently working with North East North Cumbria ICS and two PCNs in North Cumbria to work out how PCSP can be implemented practically for the anticipatory care group of patients.

This approach will pull together a number of strands of healthcare and coordinate them within a single PCSP process. This will focus on the things that matter to people and what will make the biggest difference to how they live with, and manage, their health.

As part of this programme we are looking at a number of factors including processes and the 'new roles' in primary care as part of the care pathway. In addition, we are working with a regional team on:

- Identification of the patient cohort
- A flexible care pathway that clarifies what happens at each stage in the process and how different professionals contribute (including IT templates)
- Thinking through how patients are prepared for the PCSP conversation including developing patient resources
- How the care and support plan is recorded for the patient and within the healthcare record, including a key information summary for use in an emergency situation
- How the MDT works and avoids making decisions for people, and minimises the number of different professionals involved in the process
- Understanding the training, support and supervision needs of professionals who may be in new roles, either in relation to the clinical content of assessments and support offered to patients, or the PCSP conversation

In our next edition of the House Journal we will share some of the lessons learned from this programme of work.

Shared Decision Making (SDM) training accreditation

We are delighted to confirm that our SDM course received accreditation from the Personalised Care Institute (PCI) in Oct 2022, in addition to our core PCSP training courses.

The PCI was established in September 2020 to set the standards for high quality evidence-based training in Personalised Care. As one of the first providers to receive accreditation from the PCI, Year of Care are strong advocates of their objective of supporting health and social care professionals to develop skills and behaviours to apply personalised care approaches in their day-to-day practice.

Please contact us for more information at enquiries@yearofcare.co.uk.

Adapting personalised care and support planning for long COVID services

Helen Kleiser and Louise McFarlane

Since the onset of the COVID-19 pandemic the prevalence of people living with long COVID in the UK (symptoms persisting longer than 4 weeks) has risen to 2.2 million people[1]. The diagnosis of long COVID is made on the presence of wide-ranging and fluctuating symptoms and can include breathlessness, chronic fatigue, 'brain fog', anxiety and pain, all of which can have a huge impact on an individual's day to day life.

Health care services in London responded to the need to support people by developing specialist long COVID services, however feedback from Healthwatch[2] highlighted delays for people in accessing this support. This was compounded by frustrations that when people finally got to access the specialist service there was focus on assessment rather than the impact that COVID was having on individuals and what would really make a difference. When people eventually discovered self-management strategies and were able to access 'more than medicine' activities these tended to be most beneficial.

The London Personalised Care Network recognised the need to apply a more personalised approach to this service and came to the Year of Care team to develop and deliver a training programme. As a team we recognised that whilst the framework of PCSP could be applied within this setting, that there were some key differences around the roles of practitioners and the clinical management options for long COVID. We spent time understanding this to create a bespoke training programme that would align the Year of Care approach to PCSP with the long COVID pathway.

In particular we applied the following adaptations to PCSP:

- Enhancing patient experience and involvement through preparation focused on what's important for the person
- Also, by moving some of the routine assessment of symptoms into a self-assessment approach as part of preparation prior to the first appointment
- Using the preparation prompt and self-assessment completed by the patient to reduce the burden of assessments in the first appointment
- Using a narrative approach to assessment within a collaborative conversation
- Having more time to understand the patient's perspective and explore options to develop plans to self-manage their health and live with the physical **and** social impact of long COVID

A range of professionals from long COVID services across London joined the interactive sessions. These included GPs, therapists, clinical leads and care-coordinators bringing a richness to the conversation and generating lots of ideas to take forward to improve patient experience.

PCSP in long COVID services - training overview and feedback

Session One

We outlined some of the issues around personalised care for people in this group and highlighted the protracted journey that people had in the months before they accessed the service. We also introduced the three Year of Care principles of preparation, meaningful conversations and supported self-management and thought about how they might work in this care setting.

Session Two

This session focused on the PCSP conversation and the structure and skills of the approach. This specifically seeks to move away from a professionally-focused assessment and the need to fix people, to a holistic approach that involves people in decision making about health care, building knowledge and confidence to self-manage and linking in with community resources and services.

"I will discuss more about options with the patient and let them decide what is best rather than suggesting to them the option I think is right for them"

"I have ideas - to implement processes and gain the patient perspective. I liked the practical things to incorporate that will make a difference"

"I will review our use of forms so that they are as helpful as possible; as previously seen as barriers to engagement - modifications could assist with this being a useful additional tool"

"It was useful to explore patient preparation and understand how it influences their satisfaction, commitment and engagement in long term care. Breakout rooms, patient demo videos, and the opportunity to participate in the group was also well led"

For more information on how Year of Care Partnerships could support your service delivery, contact us at:
enquiries@yearofcare.co.uk

[1] Office for National Statistics (2022) *Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 1 December 2022*
[2] https://www.healthwatchislington.co.uk/sites/healthwatchislington.co.uk/files/North%20Central%20London%20Healthwatch%20-%20Long%20COVID%20Report.pdf

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Singapore 2022

How does a Year of Care approach work in Singapore?

The Year of Care team have been supporting the implementation of personalised care and support planning (PCSP) in Singapore as part of a multidimensional partnership over the last 7-years. The Singapore health system is very different from the UK, it is publicly subvented and the population is under the care of 3 health clusters. Year of Care have visited Singapore on 4 occasions delivering training and train the trainers, and consultancy and support in thinking through staff engagement and system implementation.

The collaboration began when Dr Tong Wei Yew, who had experienced PCSP while working in Scotland, became interested in exploring whether PCSP could be delivered routinely in diabetes clinics in Singapore, including how professionals would engage with the approach. This was supported by Year of Care and Professor Vikki Entwistle who provided research expertise. More recently, following a visit to the UK in late 2019, we developed a collaboration with Dr Sweet Fun Wong and her Population Health team. There was growing momentum for PCSP to become a routine approach for people with long term conditions (LTCs) in the community, and a way to support health eco-systems that promote wellbeing.

As part of this ongoing work, in the Western Region (the National University Health System), Dr Yew and his team initially started PCSP in the diabetes specialist clinic and subsequently ran a trial[1] (PACE-D) of PCSP in polyclinic[2] primary care settings. Evaluations in the specialist setting and PACE-D (which is now close to reporting) have shown many of the benefits seen in the UK. Taken together, they very elegantly demonstrate the sequence of benefits in ways which resonate with clinical experience and just make sense!

- Early in a person's journey there was a temporary worsening in diabetes distress as people engaged with the challenges of their health - this initial increase in distress was then followed by a clear and persistent reduction.
- Despite this there was improved experience of shared decision making (involvement) right from the start of PCSP being introduced.
- Patient activation (self-efficacy) improved within 6 months
- This was followed by better and sustained clinical measures (cholesterol, HbA1c, weight) which has now been sustained over 12-36 months.

Meanwhile in the Yishun Health Zone (part of the Central-North Region – National Healthcare Group (NHG) cluster), Dr Wong and her Population Health team have been successfully testing the Year of Care approach in new and more unusual ways by:

- Engaging people using Community Nurses and Connectors based in community health posts and nodes, who support residents to live well within their communities.
- Linking this to a wider, ambitious and very successful programme[3] of wellbeing and building on community assets. This is a really exciting iteration of the Year of Care approach and is making a significant difference to Singapore citizens.
- Looking at options to deliver PCSP in specialist and primary care settings.

Most recently (September-October 2022), Lindsay Oliver and Nick Lewis-Barned visited to work with these teams to deliver further training to teams in Yishun, to train trainers, and to support the ongoing development of a local Year of Care team including 'super trainers' (people who will themselves train trainers) and to oversee the quality assurance for all of this. Over a very intense month we saw first-hand the extraordinary work both the Yishun Health and NUHS teams have been doing, learned much about how the approach can maintain fidelity with flexibility right across the system and were reassured that Year of Care principles make just as much sense, and work just as well in Singapore as in the UK, despite different cultures, languages and health systems. We spoke with healthcare leadership, clinicians and care delivery teams, and presented at a national conference. We were hugely encouraged by the rich collaboration that is developing across the 3 health clusters and nationally to take PCSP forward in practical ways. We were also hosted wonderfully and came back exhausted but excited for the future.

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1. doi: 10.1186/s12875-020-01173-2
2. These are best characterised as very large primary care hubs in multi-storey bespoke buildings.
3. Caring Communities by Yishun Health

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Our new Year of Care team members!

Helen Kleiser - National Trainer and Facilitator

Helen is an occupational therapist who has worked in the NHS for over 20 years. During her career she has worked in a wide range of settings, and held both senior clinical and managerial roles. Her clinical expertise lies within the care of older people and she has a real passion for service improvement and workforce development. Over the last few years, she led a transformation workstream within public health focusing on falls prevention. She has also been involved in developing the Enhancing Care for Older People Competency framework (EnCOP), which focuses on learning and development as a tool for improving quality in healthcare delivery.

Helen was keen to join the Year of Care team after collaborating on a project implementing falls and frailty into routine PCSP. She recognised an affinity with her own core values and beliefs around the delivery of personalised care and was keen to support other organisations to adopt this approach in practice.

Louise McFarlane - National Trainer and Facilitator

Louise is a registered nurse with an additional qualification in specialist community public health nursing. She has experience of supporting communities and populations to address the wider social determinants of health, as well as designing and delivering interventions to help 'close the gap' on health inequalities. Before joining Year of Care Louise was lead mental health and wellbeing coach for a primary care network, supporting people of all ages to thrive and live well. She worked closely with voluntary, community and social enterprise organisations and values the contribution these services make in personalised care.

Louise is a huge advocate of empowering people to have more control and choice when it comes to managing their care. For this reason, she was delighted to join the Year of Care team to support organisations to implement personalised care.

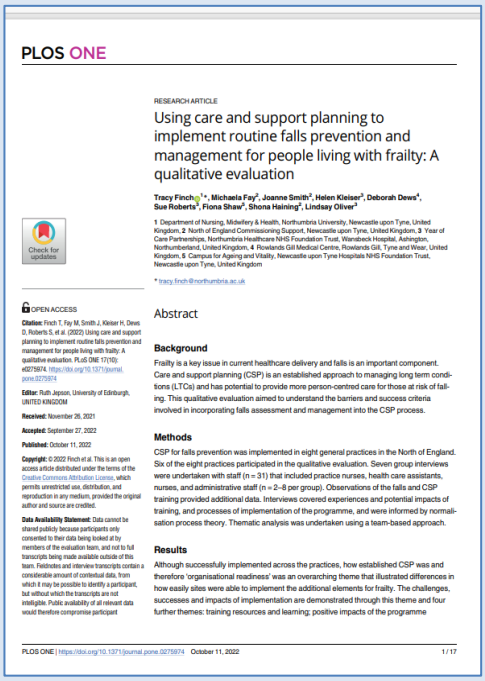
Falls publication

Using personalised care and support planning to implement routine falls prevention and management for people living with frailty: a qualitative evaluation

This publication in PLOS ONE from October 2022 distils our learning around the successful implementation of falls as an element of frailty within the PCSP process.

It details a qualitative evaluation which sought to understand the barriers and success criteria involved in incorporating falls prevention, assessment and management.

https://bit.ly/3JXual3



PLOS ONE

RESEARCH ARTICLE

Using care and support planning to implement routine falls prevention and management for people living with frailty: A qualitative evaluation

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Abstract

Background

Frailty is a key issue in current healthcare delivery and falls is an important component. Care and support planning (CSP) is an established approach to managing long term conditions (LTCs) and has potential to provide more person-centred care for those at risk of falling. This qualitative evaluation aimed to understand the barriers and success criteria involved in incorporating falls assessment and management into the CSP process.

Methods

CSP for falls prevention was implemented in eight general practices in the North of England. Six of the eight practices participated in the qualitative evaluation. Seven group interviews were undertaken with staff (n = 31) that included practice nurses, health care assistants, nurses, and administrative staff (n = 2–8 per group). Observations of the falls and CSP training provided additional data. Interviews covered experiences and potential impacts of training, and processes of implementation of the programme, and were informed by normalisation process theory. Thematic analysis was undertaken using a team-based approach.

Results

Although successfully implemented across the practices, how established CSP was and therefore 'organisational readiness' was an overarching theme that illustrated differences in how easily sites were able to implement the additional elements for frailty. The challenges, successes and impacts of implementation are demonstrated through this theme and four further themes: training resources and learning; positive impacts of the programme

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