Issue 25
Proactive Care

The HOUSE Journal

The newsletter for the Year of Care Community of Practice

Welcome to The HOUSE Journal – Lindsay Oliver, Year of Care National Director

It's been a while, apologies for the radio silence! We've been busy with several programmes and projects which we hope to share with you at our in-person community of practice event (October 2024 – watch this space!).

In this newsletter we focus on our proactive care project which was supported by our local ICS. It sought to use the Year of Care approach to personalised care and support planning (PCSP) as a framework to deliver proactive care to people living with complexity including multiple long-term conditions (LTCs), frailty and those at risk of using unplanned care. The approach was delivered by integrated neighbourhood teams working into primary care networks and general practice.

The project has provided much learning and brought into focus the need to think about how we formally include screening for, and management of, issues related to frailty in existing LTC primary care based PCSP. This would support a much more holistic and coordinated approach to people's overall care.

The importance of a MDT with senior medical support working closely together to a common purpose and philosophical approach became clear during the project, in terms of ensuring care that was safe, effective and person centred. For this group of patients, continuity and care coordination from a team who knows them well was important. In addition, the focus of PCSP for proactive care is broader with greater focus on function and activities of daily living as well as managing exacerbations and emergencies, and advanced care planning.

We now have a method, resources and training to support the delivery of proactive care. Our thanks to the PCNs who worked closely with us to develop this approach.

Using the Year of Care Approach to Deliver Proactive Care

The NHS Long Term Plan set out a clear ambition to change the way we deliver healthcare; it emphasised the need for care to be more personalised, joined up and preventative. More recently the **'proactive care guidance'**[1](2023) focused on a shift from reactive care to a proactive way of working for a specific group of people - ***those living with multiple long-term conditions and frailty*** - particularly where they are beginning to use a lot of ***unplanned care***.

The Year of Care team was supported by the North East North Cumbria ICS to work with Carlisle Healthcare and Keswick & Solway PCN in North Cumbria to develop proactive care for this group of people using the Year of Care approach to personalised care and support planning (PCSP).

People were identified against the national criteria using a case finding tool which listed people who had multiple long-term conditions, including moderate and severe frailty and who were using unplanned care.

Our programme specifically aimed to:

- Provide earlier support; offering preventative care from a small team who knows the person well
- Ensure good clinical care, based on *only* doing the things that make a difference and focusing on what is most important to the person
- Avoid duplication and improve coordination of care
- Work with people to understand their preferences and wishes for the future

This builds on the existing Year of Care work around multiple long-term conditions in primary care, but focuses more on frailty, function and health inequalities. This is important not only for the healthcare system, but also for the person, particularly as this group of patients often receive care that is fragmented, task focused and doesn't involve them as much as they would like in decision making or planning of their care[2].

The final report can be found here https://shorturl.at/IM4Kn. We are also developing a regional toolkit to support local organisations to adopt the approach. Please contact us at enquiries@yearofcare.co.uk for details on our personalised proactive care and support planning training and facilitation programme and associated resources.

The programme was delivered as a collaboration between Year of Care Partnerships, Carlisle Healthcare PCN, Keswick & Solway PCN and the NENC ICS Personalisation and Ageing Well leads. Special thanks also go to Cumbria PRIMIS Informatics and to Northumbria University for their ongoing help and support.

[1] https://www.england.nhs.uk/long-read/proactive-care-providing-care-and-support-for-people-living-at-home-with-moderate-or-severe-frailty/

[2] https://richmondgroupofcharities.org.uk/sites/default/files/trg_one_in_four.pdf

Summer webinar series

To learn more please join our webinar on 14th Aug. It's one of three webinars we are delivering over the summer – info and booking at this link:

www.eventbrite.co.uk/e/year-of-care-partnerships-summer-2024-webinars-tickets-925378029597

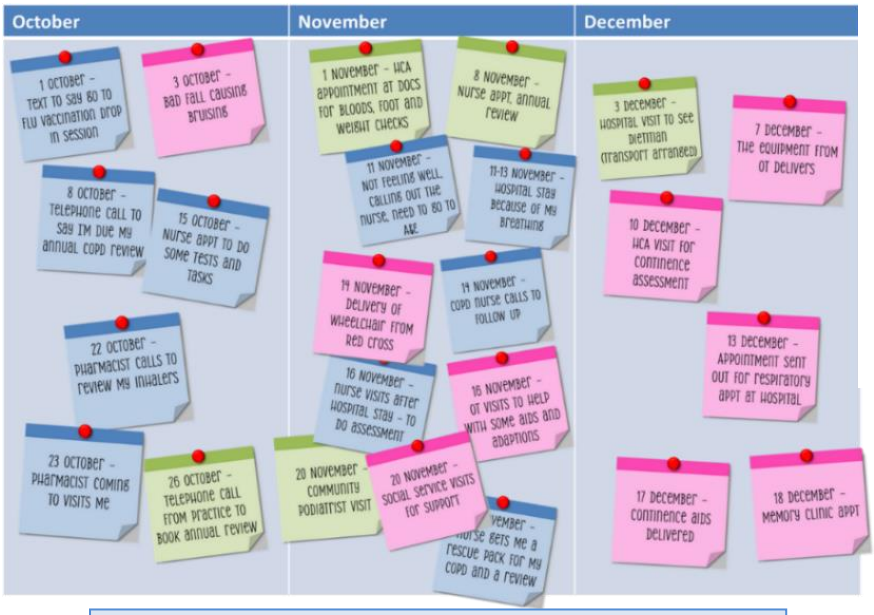
The **HOUSE** Journal

How the proactive care process works – meet Eric!

While working with PCN teams we used a fictitious patient called Eric to represent the complexity and issues that people in the proactive care cohort might be living with. Firstly, we detailed Eric's current healthcare journey and then considered how the Year of Care approach could be used to coordinate and personalise his care and help him to develop his own care and support plan.

Eric is 84 and lives alone in sheltered housing. He has mild dementia, high blood pressure, type 2 diabetes, COPD and has been hospitalised 5 times in the past year. He has back pain and has had 3 falls in the last 2 months. He is widowed and is largely independent, but his memory and functional ability are deteriorating.

What did Eric's care look like before proactive care?



Over a 3-month period Eric had

- 24 separate contacts
- 13 assessments

Eric sees 20 different professionals and is referred to many other services

Using normalisation process theory – the importance of clarity around coherence and purpose

Throughout the development of the process we invested time in being clear about the way we wanted to work and the purpose of proactive care for people like Eric. Training and facilitation always included reflective time about the value of proactive care, the philosophy of personalised care and the importance of this way of working set against acute pressures in the healthcare system.

Key lessons about clarity of purpose included:

- Generating a clear understanding of the purpose of proactive care and the expected benefits for the patient group, including a common understanding of what is meant by personalised care and how that will be applied to each individual patient.
- Making sure the induction of new team members, teamworking, processes, patient resources, and training are underpinned by this understanding.
- Having an established Year of Care process for people with multiple long-term conditions proved to be a good foundation to build in the additional elements of delivery of proactive care, with a different emphasis based on some critical differences in the proactive care group, mostly related to frailty and the use of unplanned care.

Principles of proactive care

We worked with the PCNs to develop some principles of proactive care based on the experience of people like Eric. This informed the way we worked and how processes were organised.

Principles of proactive care:

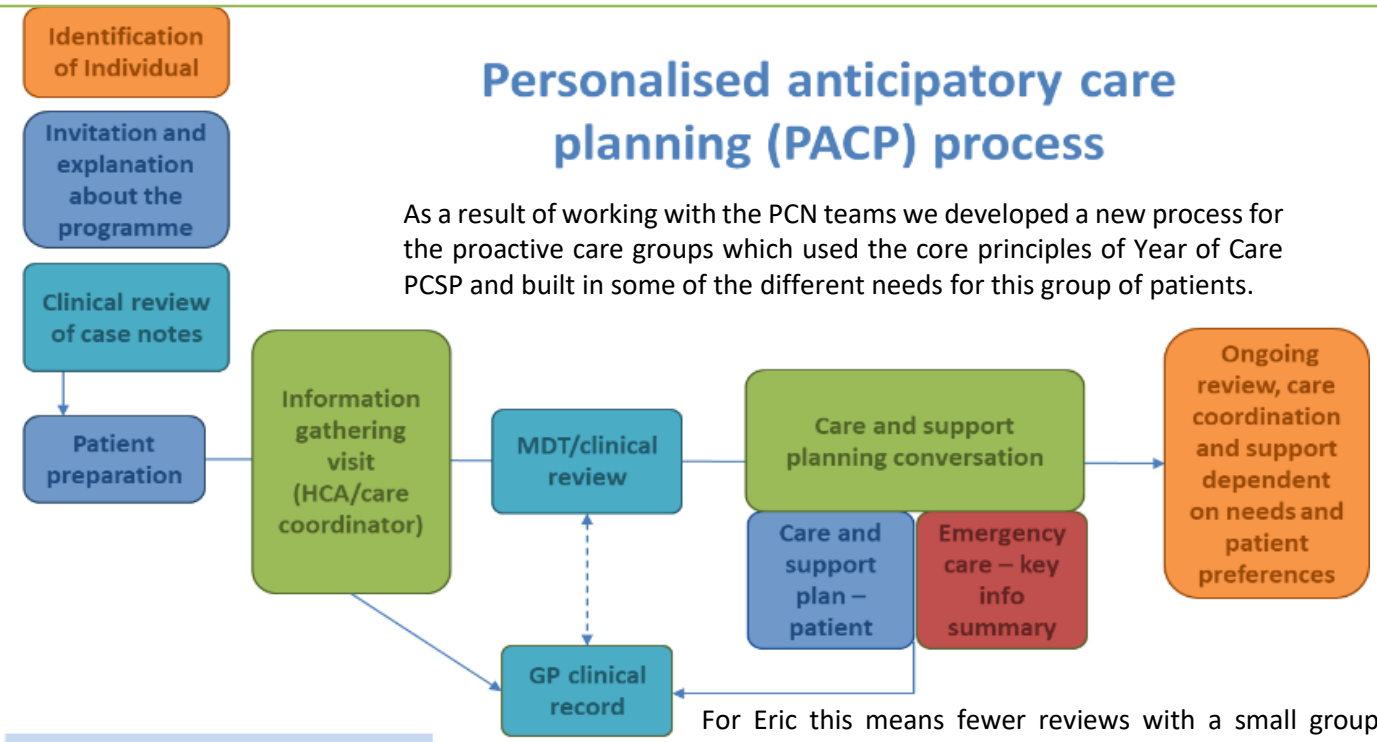
- Proactive, preventative
- Coordinated and ongoing
- Personalised and individual – focused on what matters and what will make a difference
- Assessments separated from conversation
- Meaningful conversations with prepared patients
- Holistic – not just medical (clinical, social, spiritual, psychological wellbeing)
- Context – recognising other members of households and community support
- Supporting people to live and die well alongside self-management

And what to avoid:

- Just ticking a box
- Reactive care based on episodes of care provision
- Multiple assessments, visits and professionals
- Duplication
- MDT making decisions for patients
- Taking over, creating dependency

Personalised anticipatory care planning (PACP) process

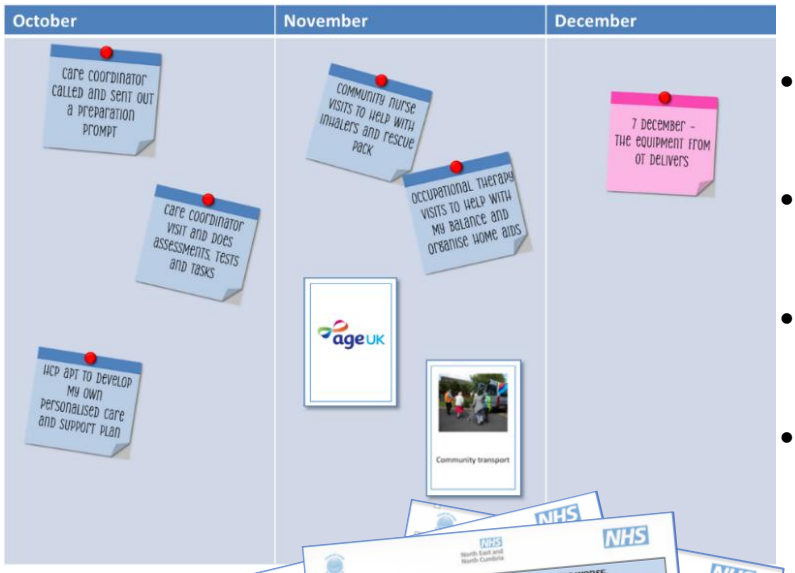
As a result of working with the PCN teams we developed a new process for the proactive care groups which used the core principles of Year of Care PCSP and built in some of the different needs for this group of patients.



Key	
Orange	Prior to and post PACP
Dark blue	Documentation for patient
Green	Face to face appointments
Turquoise	Clinical work and records

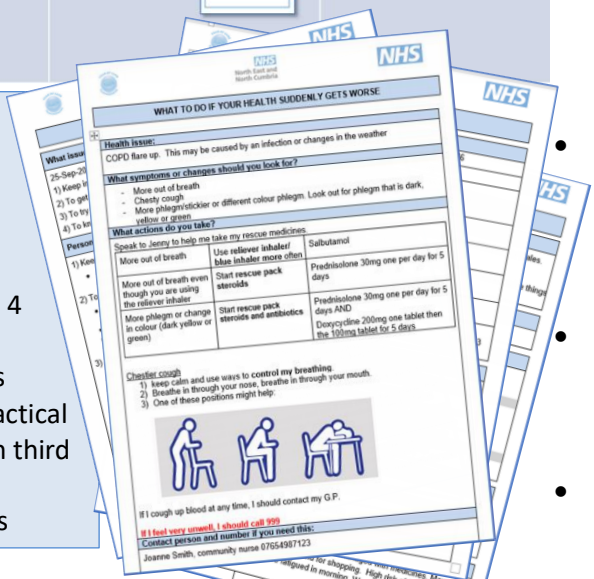
For Eric this means fewer reviews with a small group of professionals who can really get to know him; he feels understood and has the chance to talk about what matters to him. Eric makes his own decisions including support to stay at home, reducing polypharmacy and how to manage exacerbations. He knows his health issues are reviewed by a multidisciplinary team working with his GP practice and he has the opportunity to develop his own advanced care plans.

What does Eric's care look like with proactive care?



Eric now has:

- 8 separate contacts
- 1 holistic assessment
- Contact with 4 different professionals
- Access to practical support from third sector organisations

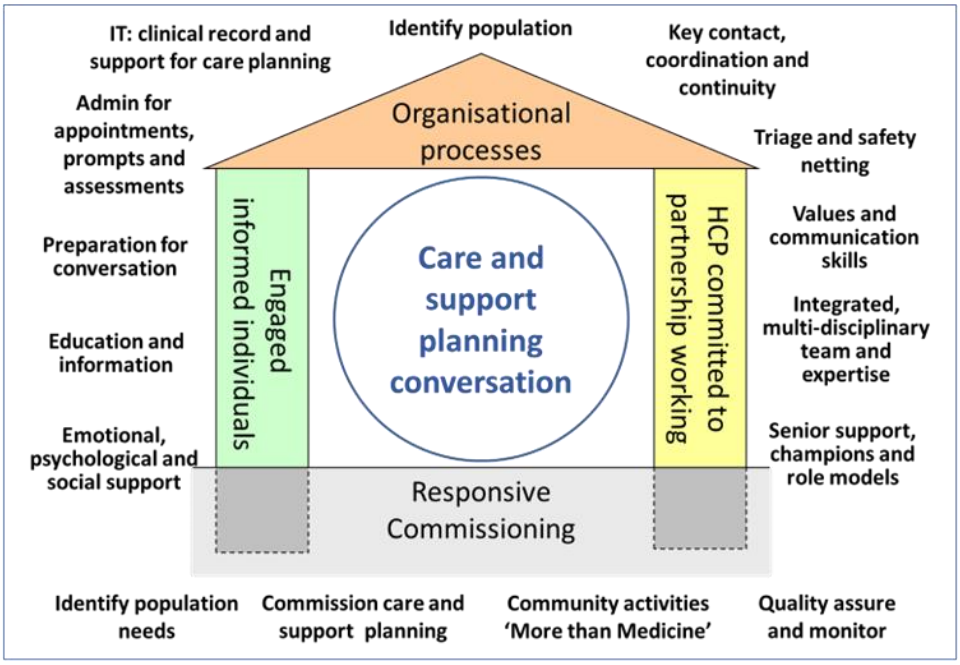


What's different about PCSP for proactive care?

- People are identified by a search tool and local practice intelligence so careful thought needs to be given to inviting the patient and explaining the service.
- There is a review of case notes before the process begins to understand the complex needs of the patient including current care and status of their conditions.
- Preparation documents are shared before the information gathering appointment and so don't include results, instead focusing on helping Eric identify what he wants to talk about.
- Holistic assessment includes social and functional review alongside tests needed for LTC reviews. Focus is on ensuring this is done by a care coordinator with the skills of both a health care assistant and social prescriber, in a conversational manner using prompts and self assessment tools.
- The information collected is multifaceted and reviewed by a MDT; the care coordinator represents what matters to the patient. The MDT does not make decisions for the patient but is a forum to share professional expertise and decide who is best suited to carry out the PCSP review.
- The PCSP conversation sometimes happens over two visits and includes issues such as LTC management, polypharmacy/medicines review, activities of daily living, social prescribing and advanced care planning.
- The care plan has sections for patients and for professionals to use in acute care situations.

What needs to be in place to deliver personalised proactive care for people like Eric?

The key components of personalised proactive care can be described across the four domains of the Year of Care House. There needs to be a method of identifying and inviting patients to receive the service, clear care processes which describe the roles and responsibilities of team members, digital support and personalised care and support planning training for multidisciplinary teams.

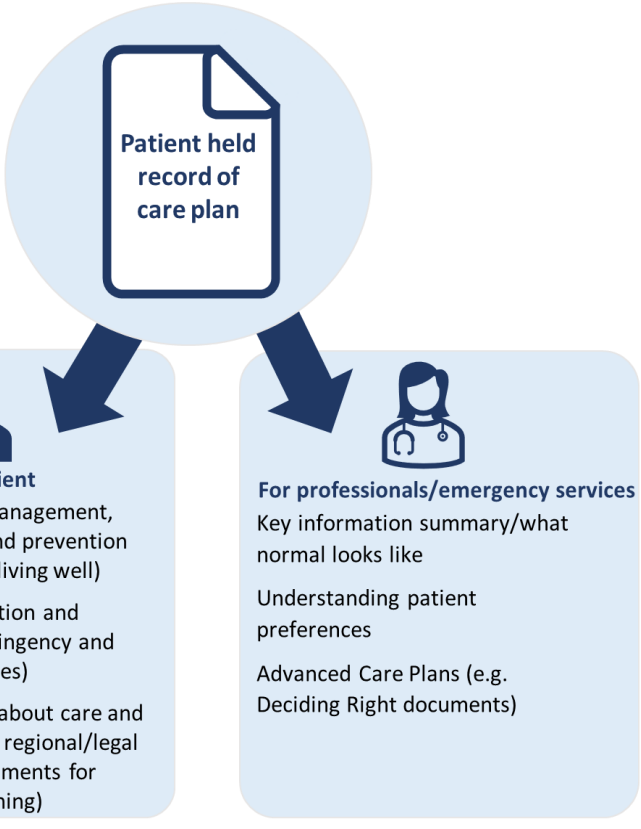


Multidisciplinary team working - since people may present with a range of conditions and issues integrated neighbourhood teams should include a range of roles and functions, with expertise in LTCs, polypharmacy, frailty, social prescribing and advanced care planning. Care and support planning is best delivered by a core team consisting of care coordinators (who usually initiate the process, listen to the patient's story and complete all initial tests and (assessments) frailty nurses and occupational therapists (who usually lead the care and support planning conversation and develop the proactive care plan with the patient). To support complex clinical issues such as polypharmacy it is essential that there is direct support from a GP who holds overall accountability. To avoid bringing in a range of additional professionals, the core team needed to extend and develop their overall role and seek advice and support from other professionals where necessary. Administration support is crucial and there needs to be a regular forum for MDT working, made easier by co-location to facilitate informal learning, appreciation of different team roles and the opportunity to share complex information about patient care.

Supporting workforce development – proactive care teams may be new to practice and sometimes in novel roles that aren't always understood by patients and other professionals. Teams benefit from training in PCSP to maintain focus on the ethos of personalised care and to ensure it is embedded into development of the proactive care and support planning processes. All team members need to develop their existing skills and competencies. Care coordinators who are asked to take on a complex range of activities may need to develop a range of new skills and learn to navigate both healthcare systems and the voluntary sector.

IT tools and systems to support the process – these are essential to support the process. As part of the development of the programme, searches were created to identify the patient cohort, although the quality of clinical coding of frailty made this more difficult. We also developed an IT template for EMIS which linked to existing long term condition templates and included all elements of the comprehensive geriatric assessment (CGA). It was important to separate assessments from the care and support planning conversation and to train the staff in a conversational approach that maintained focus on what was most important to the patient whilst completing templates.

Care and support plan - we developed a care and support plan that was for the patient and included personal goals and actions, but in addition identified information that could be used in an emergency by health and care professionals and for advanced care planning.



Our recommendations in full are in chapter 7 of our final report (https://shorturl.at/IM4Kn).