**Questions and answers from Year of Care webinar - using the Year of Care approach to personalised care and support planning to deliver proactive care**

**16.08.24**

1. **Does this include cancer as a long term condition?**

Yes - personalised proactive care can apply to anyone living with complex needs; this includes all the conditions they live with, including cancer.

1. **How were carers and families involved in the process and did this lead to their own needs being identified?**

Carers and families are recognised as integral to working with those in the proactive care cohort. The care coordinators ask at the outset if carers/ families want to be involved in the process and to be present at both the information gathering and care and support planning appointments. Where carer needs are identified, these would be explored as part of the process with onward referrals for appropriate interventions and support made where appropriate.

1. **Where was the PCSP done? Was this also in the patient’s own home?**

Yes, the care and support planning conversation nearly always happen in the persons own home. This helps with the balance of power and gives vital clues about how the person is living their life that can assist with the care and support planning process. It also makes it easier to involve carers and relatives, where appropriate.

1. **Does the practice employ its own Allied Health Professionals?**

Yes - they have been funded through the primary care Additional Role Reimbursement Scheme (ARRS).

1. **Are the care coordinators employed by the practice?**

The care coordinators are based in the practice. In Carlisle they are directly employed by the PCN. In Keswick and Solway, they are employed via the community trust. Both are funded through the primary care Additional Role Reimbursement Scheme (ARRS).

1. **Who are the Care Coordinators?**

They are typically band 3 or 4 staff who come from a range of backgrounds. Many have experience of working in health and social care settings but nearly all will require support and training to develop the skills required for the role.

1. **Is there specific training for Care Coordinators?**

Care coordinators were trained alongside other professionals involved in the proactive care process. A formal training course was delivered by Year of Care over three half day sessions and was formulated around each stage of the new process of personalised proactive care (please contact us for information on this training offer at enquiries@yearofcare.co.uk). It was intended that this would help staff understand the purpose, tasks and communications skills associated with each stage of the process. In addition, care coordinators will require skills around long term conditions, similar to a Health Care Assistant in primary care, as well as knowledge of frailty. It would be beneficial to standardise the role and the supporting training as recommended in our final project report\*.

1. **If the care coordinator is the key contact for the patient, what has been the experience of this working in terms of contact time and feedback?**

At Carlisle Healthcare, the surgery front of house team is the initial point of contact for patients via a dedicated number for people who have been through the proactive care process. Messages will be passed onto the frailty team for action, with a “duty” GP available during core hours to deal with any urgent queries. Keswick & Solway are the second PCN who were involved in the pilot programme and here the care coordinator is the main point of contact. This works well since there is continuity and consistency for both the patient and the proactive care team (who work as part of a wider MDT for support and guidance).

1. **What training needs did you identify for those delivering proactive care?**

The delivery or proactive care requires a range of skills. Ideally staff would be supported by other members of the integrated neighbourhood team which could allow for some role extension. The Year of Care training programme ensures all involved in proactive care have the skills and knowledge required to implement and embed the method of proactive care we presented Knowledge around long term condition management, polypharmacy, frailty, advanced care planning and personalised care (including shared decision making) would be essential.

1. **What are the challenges and enablers of delivering proactive care within the PCN?**

We have themed our findings in chapter 6 of the final report\* around the areas of team working, IT, the process, the MDT and workforce – in this we highlight challenges and enablers. For Carlisle Healthcare Dr Robert Westgate found that working across practices (independent organisations) to agree a process and how best to pool funding to support implementation can be difficult. Primary Care IT hasn’t really kept up to speed with cross organisational working and can create barriers to joining up care. The Primary Care Network Directed Enhanced Service Additional Roles Reimbursement Scheme supported employment of staff dedicated to proactive care/home visiting across a PCN and so was an enabler for this.

1. **Do you experience a lot of generation of referrals to existing statutory services and/ or accept referrals from them?**

The ethos of proactive care is about reducing the number of professionals involved so that care is more personalised and focused on the things that would really make a difference. Referrals to services like social prescribing are common but where possible the MDT will work together to share expertise and support role extension to prevent many professionals having to become involved. Referrals as a process are necessary to transact between services and fulfil individual organisation’s own governance arrangements. Wherever possible bureaucracy should be kept to a minimum by better collaborative conversations between services to agree how best to meet someone’s needs. If a service develops as a natural extension of core general practice, then actions are delegated to team members rather than having to “refer”.

1. **Is the care plan template available on EMIS for other areas to use, or is it just for the pilot project area?**

Anyone in North East and North Cumbria can use the EMIS Web template as it was developed and made available by Primis - please contact us at enquiries@yearofcare.co.uk for advice.

1. **How do we access the training that you mentioned on the slide? And how do we get hold of the templates for the care plans you mentioned?**

Please contact us at enquiries@yearofcare.co.uk for details of training for primary care teams to implement our process of personalised care and support planning in proactive care. Please see question 12 regarding the care plan template.

1. **What were the outcomes of the project?**

The proactive care pilot programme was funded to explore how the national Proactive Care Guidance (Dec 2023) could be adopted in Primary Care Networks by emerging Integrated Neighbourhood Teams (INTs). The feasibility study explored all aspects of the model (the what), and its adoption (the how) in the ‘real world’. This was done successfully using the Year of Care methodology and exemplified throughout by a case study - ‘Eric’ - a person’s proactive care story.

This pilot explored the initial design and implementation of this approach; there are metrics in place to monitor factors such as healthcare use and admission rates however we are still in the very early stages following implementation. Staff reported may perceived benefits however including greater patient involvement, improved coordination of care, reduced treatment burden, enhanced ability to self-manage and improved access to preventative opportunities. This approach also offered the opportunity to have meaningful discussions about preferences and wishes that could form the basis for care both now and in the future. It was seen as a positive approach to working in a more proactive, personalised way.

1. **In the last session, we talked about sharing the results with patients. Would this not cause a sort of panic in the patients when they see ‘Red’ in their reports without being able to analyse the results and increase the call volumes or maybe stress the patients?**

This is answered specifically in the FAQ from the previous session. you many also want to read this. However, when results are shared as part of personalised care and support planning this is done with a clear explanation from the outset of what to expect and what results mean. Because people know they have an appointment to discuss their results they are aware that they will be offered support for managing these results. Increasingly, people have access to their own health information via the NHS app however we present it in a much more personalised and clear way. For the proactive care cohort of patients, information is shared in a different way with very little detail on tests and results and more commentary about what is important for the person and what normal looks like for them. This is documented and held in the person’s home together with other important documents that can be easily accessed by health care professionals. Results and plans are discussed during the care and support planning conversation as part of a wider discussion about the person’s life and wishes.

1. **How optimistic are you that this approach will be rolled out across the North East and North Cumbria ICB Footprint?**

We are very optimistic that this will become the normal way of working in the future. The population is ageing, they are living with more complex needs, and we are facing unprecedented demand. To help reduce pressure on services and improve outcomes and experience for patients, we must change the way we work and deliver care that is more proactive, coordinated and planned. This can be facilitated through the development of integrated neighbourhood teams who can deliver both reactive and proactive services in a way that is coordinated and wrapped around the person.

In North East and North Cumbria we are developing a regional toolkit together with training to help PCNs and other organisations embed proactive care in their practices and networks. This should be available in 2025.

**\*Proactive Care pilot project final report** - [Implementing Proactive Care Using the Year of Care Approach to Personalised Care and Support Planning](https://www.yearofcare.co.uk/sites/default/files/pdfs/Proactive%20Care%20Pilot%20Programme%20report%20V1.0%20final%20May%202024_0.pdf)