

**Information and Guidance
working with the Year of Care
Partnership
to deliver Care Planning**



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Purpose

The aim of this document is to set out a successful approach to embedding Care planning into clinical practice based upon experiences from the Year of Care Partnerships. This includes guidance on 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 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 planning.

Background

The Year of Care Programme was supported by NHS Diabetes and Diabetes UK and was focused on delivering personalised care, through Care planning, to people with long term conditions using diabetes as an exemplar. The delivery of the programme and the roll out to sites, not initially included in the pilot, 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 planning, including 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

Getting Prepared to Deliver Care Planning

We would suggest that the national 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 self-assessment is available in **Appendix I**.

There are a number of policy factors which might influence your decision to implement Care planning as normal care for people with diabetes/ 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 planning?
- How does this fit with your local model of diabetes/long term condition care and what is the current quality of care being delivered?
- In what clinical settings do you hope to implement Care planning?
- 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 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?

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

What Support can the Year of Care Partnership Offer?

This very much depends on what the local team needs, 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 can also offer support and advice, using the experience they have gained from implementing this approach across 12 sites nationally. They also have a range of products that make it easier to implement Care planning in practice which are available via training.

This could include:

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 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
- Care planning Awareness Raising - for practitioners who are not directly involved in Care planning but who would benefit from knowing what this is about
- Healthcare Assistant Training - focusing on their role within Care planning
- District Nurse Training in Care Planning
- Long term condition Care planning Training for practice teams
- Training for integrated community teams - working with people with long term conditions risk assessed as in the top 7% of the practice population as likely to use unscheduled care
- Extended Consultation Skills for clinical staff
- A programme to set up local mentoring and support, to build confidence, embed Care planning and transfer skills and attitudes across the local community

Support Materials include

- Patient Materials e.g. sample letters, information about results, care plans, awareness raising materials
- DVDs incorporating awareness raising and consultation skills
- Coordinator/Steering Group Guidance Document
- 'Mind Your Language' (publication available via NHS Diabetes website)
- Practice Pack
- Evaluation Framework and Toolkit
- IT Guidance for Key Systems (EMIS, VISION, SystemOne)

Core Care Planning Training and Train the Trainers

Many organisations have found it easier to start Care planning in diabetes, but other approaches can be discussed. 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.

Care Planning Training

This training consists of a one day session and then a half day delivered 6 weeks later. It is aimed at teams who deliver routine diabetes care in general practice and should be attended by those who have authority to change the structure of care within a practice.

Specialist teams (diabetes) who work closely with their local Primary Care community to delivery Care planning as part of their local model of care (NICE quality standard 3 for adults with diabetes) have also been successfully involved in training and have incorporated the Year of Care, Care planning model to use 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

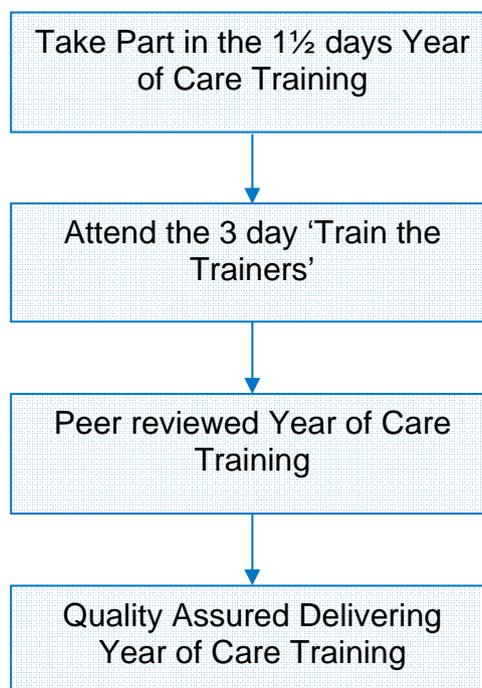
The training provides healthcare professionals with practical skills to implement Care planning in routine diabetes care. As part of the training they are provided with a practice pack which contains a range of materials including patient materials and IT instructions for their practice system.

If your focus is not on diabetes then training in other long term conditions is available. This follows a similar programme to the Core Care planning training with resources which are bespoke and relevant to the long term conditions and setting that Care planning will be delivered in. The Training team has developed training for multiple co-morbidities, COPD and integrated multidisciplinary teams, and would be happy to discuss the development of training in other settings and conditions.

Train the Trainers

Train the Trainers provides the most cost effective method of training local trainers to deliver Care planning 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- Deciding to Embark upon Year of Care (YOC)

- Expressions of interest to the Year of Care Partnerships
- Information gathering for site 'Self Assessment' and as preparation for initial site visit and list of questions to Year of Care Partnership
- First meeting between the Year of Care team and the site
- Sign up of site to Care planning training and local site / Preparation – completion of application form
- Formation of a local steering group and identification of a coordinator
- Practices recruited for 'Preparing for Care Planning' session

Step 2 – Gaining Interest and Engaging Practice Teams

- 'Preparing for Care planning' taster session delivered
- 2 hour session to recruit first wave 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 one day and follow up half day training to local practice teams

Step 5 - Training Local Trainer (only for those sites who choose to train local trainers)

- Recruiting and training local trainers - for Train the Trainers only
- Formal 'recruitment' of trainers that have been identified throughout the process
- Discussion with YOC Team: Review of local strategic plan
- Trainers attend 'Train the trainers' course
- Trainers peer reviewed delivering Care planning training
- Trainers quality assured delivering Care planning training

Further information on the individual steps is detailed in the following pages.

The Process for Receiving National Care Planning Training

Step 1- Deciding to Embark upon Year of Care

a) Expression of Interest to the Central Year of Care Team

This can be via enquiries@yearofcare.co.uk or 0191 2932794; - Contact Lindsay Oliver – The National Director of the Year of Care Programme.

b) Information Gathering for Site ‘Self Assessment’ and as Preparation for initial Site Visit.

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 diabetes and other long term conditions (see **Appendix I**).

In particular our experiences have shown that the following need to be in place:

c) First Meeting between the Central Year of Care Team and the Site

The purpose of the site visit 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 visit the local site team will need to decide if they are interested in the programme. The Partnership can then work out the 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 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 local issues that may arise, as practitioners implement this process. This might mean that as well as supporting practices 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
- Should have sufficient authority to commit or spend existing resource including financial arrangements for practices (LES/LIS), funding for training venues, catering and training team, backfill costs of staff involved with the local delivery of the programme
- Should 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)
- 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 within the site. They should:

- Be signed up to the philosophy of Year of Care
- Be familiar with 'Partners in Care: A guide to implementing a Care planning approach to diabetes care' and 'Getting to Grips with the Year of Care: A practical guide'
- Attend 'Preparing for Care planning' session and subsequent training session
- Be able to implement Care planning in their organisation
- Be credible amongst peers

Operational Lead

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

- The first point of contact between the central team and the site
- 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

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 and demonstrate an understanding of its systems and processes
- Be able to demonstrate understanding that Care planning will require ongoing facilitative support
- May have a dual role as a local trainer

Administrative Support

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 and a SLA. 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 national training team and support team. The purpose of these ‘taster’ sessions is to recruit 10 local practices 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.

Briefly this includes a 2 hours session:

- To clarify exactly what is meant by Care 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

Up to 15 practices can be invited, with a maximum of 30 attendees. At least one representative from each practice must have the authority and capability to make changes within their practice.

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 the national 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 general practices and specialist care settings, and have the resources and organisational support to achieve this. **It is therefore essential that the GP or diabetes lead 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.

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, an attendance register and 'name badges' for the training team
- Maps, programme* and 'homework'* to be sent out to delegates
- Accommodation for the trainers if an overnight stay is required

* supplied by National Training and Support Team

NB: Training handouts will be brought by the Training Team or couriered to the venue/administrator if travel precludes this option.

Follow up to Care Planning Training Delivered (½ day)

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

This normally occurs about 6 - 8 weeks after the initial training and is focused on 'problem solving' some of the practical issues that may arise from having implemented Care planning.

Again, the initial date for this should be planned with the National Training and Support 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

Local sites 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** (page 35).

b) Discussion with Central Team: Review of Strategic Plan

Once an initial training session has been delivered it is usually helpful to collaborate with the Central Team and national training team 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 by the national Training team.

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 support, 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 site, including deliver of some of the other curriculums such as the Health care assistant training.



Appendix I

The YOCP Preparatory Questions Ahead of Site Visit "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 the site's experiences of care planning and how this fits with the overall strategy and local model of care delivery for diabetes and other 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 a site 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 sites 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.

Care planning was originally developed using diabetes as an exemplar. It is in the process of being introduced to other long term conditions. Starting with diabetes remains an excellent way for practice / community teams to 'get to grips' with the new way of working and this approach is reflected in this questionnaire.

SECTION A - Information about your current situation

1 - Local aspirations and rationale for the proposed implementation of Year of Care

Where/ how did you find out about the programme?

Please describe what the main driver is for your interest in the programme and what you hope to achieve?

Are you hoping to implement Care planning in diabetes or other LTCs?

Are you primarily interested in Care planning or the wider Year of Care programme (i.e. wider commissioning issues as well?)

What has been the reaction locally from:

- People with diabetes/ LTCs
- Commissioners
- Healthcare professionals
- Executive team

2 - About yourself and your organisation

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)

Your organisation

What is the most senior body / who is the most senior individual to whom your work in this area is accountable?

On behalf of what type of organisation(s) are you responding (e.g. PCT, CCG other)?

Who is ultimately accountable for ensuring that local services for your target population (i.e. diabetes /other) deliver improved outcomes, or who is ultimately responsible for ensuring the quality of local services?

Does this work form part of current commissioning priorities?

3 - Your current Model of Care and local situation

Diabetes:

Could we please see your diabetes service specification? If your local 'model of care' (description of who will provide which services where) is not included, please describe

How many practices do you have in your area or consortium?

How many local people have diabetes

Where do people receive specialist care?

Where does the annual review currently take place?

What is your local model for structured patient education?

Other long term conditions:

If you intend to introduce Care planning for other groups please outline how services are currently configured.

What Primary Care IT systems are in use in your practices?

4 - Care Planning - previous experiences

What has already happened in relation to the delivery of care planning?

Has Care planning training ever been offered on your patch - If yes

- who by
- Approximately how many people in your area have received training?
 - GPs
 - Practice nurses
 - Diabetes Specialist Nurses
 - Administrative staff
 - Total
- How many entire practice teams have received training?
- Who has delivered this training, and what was the format (i.e. number of sessions, duration, follow-up)?
- Is there any ongoing support in place for healthcare professionals who have undergone the training?

Approximately what percentage of people with diabetes receive their results ahead of their appointment?

Approximately what percentage of people with diabetes receive a written care plan following their consultation?

How are people's goals captured?

In which clinical setting(s) does Care planning take place?

5 - Your Care Planning Adoption Strategy

Proposed Model of Care

In your model of care where will Care planning take place for the majority of people with:

- Type 1 diabetes
- Type 2 diabetes

Do you have a specific self care strategy?

Is care planning specifically commissioned from any providers?

Are you interested in training practice teams locally – if so how many?

Are you interested in developing local trainers and facilitators - if so how many?

SECTION B – Important success factors for your reflection

Making it work – ‘critical success factors’

Detailed in the Year of Care final report are 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 diabetes/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’

Please give details

Critical infrastructure

- A steering group (as above)
- IT support and templates that facilitate the Care planning consultation (guidance documents are available)
- Facilities for user involvement
- Awareness raising for healthcare professionals and people with long term conditions
- Ongoing support mechanisms for healthcare professionals implementing care planning
- Sign posting and information about local resources

Evaluation and monitoring framework

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

- Process measures
- Changes in healthcare professional behaviour
- User feedback
- Changes in commissioning requirements

Date completed



Appendix II

Sample Agenda for initial Site Visit

Prerequisites:

At least one 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 planning.

On the day of the meeting:

- PowerPoint facilities available with sound for playing DVD.

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 site's 'story' (30 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 the Central 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 (60 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 Form

Part 1: Information about Sites

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: [Information and Guidance about National Care Planning Training \(PDF 4.2MB\)](#) which you should have read, referred to and utilized in your site visit and for local planning.

Further information can be obtained from the NHS Diabetes website www.diabetes.nhs.uk

All sections of the form must be completed; this can then be faxed or emailed but the original signed copy must be posted to the following address:

c/o Janet Murphy
PA to Training Team
National Care Planning Training Team
Diabetes Resource Centre
North Tyneside General Hospital
Rake Lane
North Shields
NE29 8NH

Tel: 0191 2934170
Fax: 0191 2932734
Email: Janet.Murphy@northumbria-healthcare.nhs.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

.....

.....

Section C: Identified Staff Details

Section C: Commissioner (Senior Responsible Officer)

Name:

Position:

Telephone number:

Fax number:

Email address:

Postal address if different from Section B:

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Section C: Clinical Champion

Name:

Position:

Telephone number:

Fax number:

Email address:

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:
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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>Deciding to embark upon Year of Care (YOC)</p> <ul style="list-style-type: none"> • Expressions of interest to the Year of Care Partnerships • Information gathering (Word 91.5KB) for site 'Self Assessment' and as preparation for initial site visit. • First meeting between the Year of Care team and the site • Sign up of site to care planning training and local site / Preparation – completion of application form (Word 108KB) • 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"> • National 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 1x 'Preparing for Care Planning Training session' , 1x Care planning Training, 1x peer review visit and 1x 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 regional trainers

Criteria

- 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 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. SHA,PCO, PCT)
- Dedicated time allocated and agreed by line manager to attend/deliver:
 - Train the trainers
 - Deliver the training
 - Quality assurance
 - Support local efforts to embed Year of Care
- 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 a minimum of 4-6 training sessions annually , some of which may include time away from base, including overnight and evening stays

Evidence for application to become a Trainer

All potential trainers should provide evidence of how they meet the above criteria by providing:

1. A brief personal statement detailing:
 - Their views and understanding of principles and philosophy of care planning
 - Their interest in communication and consultation skills
 - Their experience of training health care professionals or running structured patient education in group settings using adult education principles
2. Care plans they have aided development of (for example: anonymous letters to patients, care plans, appraisals, student mentoring) demonstrating care plans/goal setting and action planning
3. A signed letter of support from their line manager to release their time to complete train the trainers, associated quality assurance and to deliver training (minimum of 4-6 courses annually)

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

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Dietary requirements:

Meeting the Trainers criteria

- Meet the criteria
- Have provided a written personal statement and an 'example care plan'
- Have permission from their line manager to commit to Care planning training process and delivery of Care planning training /are backfilled. (As outlined in 'Information and Guidance about National Care Planning Training')

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:

Enclosures:

- 1) personal statement (see suggested template)
- 2) example care plan (anonymised)

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

- Sufficient to accommodate 20 people
- Set up as a 'horseshoe' or 'Cabaret style' with all seats positioned so participants can see teaching processes
- Access to the venue and room the evening or morning before the training commences
- Projector
- Facilities to play DVD with sound (e.g. laptop with speakers or integral sound system and required software)
- Suitable projection surface
- Extension cables
- Flipchart and pens
- Table for laptop (if not integral IT system)
- Table for handouts/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 bluetak 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 regional trainers

- 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 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, PCT).
- Dedicated time allocated and agreed by line manager to attend/deliver:
 - Train the trainers
 - Deliver the training
 - Provide local mentorship to YOC team
 - 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 a minimum of 4 training sessions annually.

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 diabetes/primary care

1 should have a clinical background (not necessarily diabetes)

1 of these could be a non clinician but have a role in any one of the following within a diabetes 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