Implementation guidance

Engagement phase

The key aim of the engagement phase is to share the frameworks in your local area and to understand local priorities and challenges that the frameworks may be able to address.

The key activities to focus on during this initial engagement phase are:

- Identify key stakeholders and understand their local priorities and existing projects regarding long-term conditions, personalised care, medicines optimisation
- Hold engagement sessions with stakeholders at ICS and PCN level to share frameworks and understand how it supports local priorities

By the end of the initial engagement phase, you would want to have achieved the following:

- Secured dedicated project and clinical leadership are key to success
- Met with key system stakeholders and secured their buy-in
- Developed a shared vision for implementing the Proactive Care Frameworks

Kick-off and mobilisation phase

Aims

The key aims of this phase are to build a shared understanding of how to adapt the frameworks, identify support needs, provide relevant training and prepare for implementation.

Key activities

The key activities to focus on during this initial engagement phase are:

- Establishing programme governance and delivery plan including links to national and local initiatives and reporting into local system governance for long-term conditions/personalised care/health inequalities
- Confirm the number of PCNs/practices to be involved
- Identify local clinical and non-clinical leads
- Identify key local system partners required to support implementation
- Identify patient cohort to focus on – priority group and condition
- Workforce planning: identify number of staff needed to support patient cohort, conducting training needs assessment [link] to inform training plan
- **Agree approach to patient engagement** to inform implementation of the frameworks.
- Define data and evaluation approach including key metrics required and data collection approach

- Adapt frameworks to fit local system e.g. social prescribing referral pathways
- Agree approach for sharing learning (community of practice) and use of quality improvement approaches

Outcomes

By the end of the kick-off and mobilisation phase, you would want to have achieved the following:

- Developed a plan for pilot focusing on small number of sites and patients
- Set up project and steering groups
- Developed and delivered training for staff
- Adapted frameworks, particularly pathways, to fit local system

Top tips for implementation

Choose the condition(s) you would like to start with then run the searches to guide the workforce numbers required to implement those frameworks (NB: the high-risk lists will have less patients and so is a good place to start). Consider discussing with the ICS lead for long term condition management support.

Find the right clinical or operational lead within your PCN/Practice to champion this work.

Consider thinking about how the Proactive Care Frameworks can help to deliver local or national initiatives (i.e. BP @Home, Quality Outcomes Framework, Locally Commissioned Services, Direct Enhanced Service, Impact Investment Fund) leading to more efficient ways of working.

Ensure that both staff and patients have been informed about the proactive care frameworks and any changes to the usual long term condition reviews (e.g. reviews by healthcare assistants, social prescribers etc).

Ensure a workforce mapping exercise has been conducted to review the skillsets of your current workforce and that all members are working to their maximum competencies.

Consider the metrics you would like to collect (see the implementation guide for more information). Ensure these metrics have been included within the templates that are used to document the proactive care reviews. (Look for any coding that is not routinely used in your region e.g. ‘provision of proactive care’)