The Year of Care Programme

'Working together for better healthcare and better self care'

Year of Care – Introduction

The Year of Care (YOC) Programme has demonstrated how to deliver personalised care in routine practice for people with Long Term Conditions (LTCs), using diabetes as an exemplar.

The aspiration

The overall aim of the programme was to embed care planning as the normal way to deliver care so that everyone with diabetes or other LTCs could have active involvement in deciding, agreeing and owning how their condition is managed.

The approach puts people with LTCs firmly in the driving seat of their care and supports them to self manage. In diabetes it transforms the annual review into a constructive and meaningful dialogue between the healthcare professional and the person with diabetes. Year of Care programme has two components:

- *Firstly* it enhances the routine biomedical surveillance and 'QOF review' with a collaborative consultation, based on shared decision making and self management support, via **care planning**
- *and then* ensures there is a choice of local services people need to support the actions they want to take to improve their health, wellbeing and health outcomes, available through **commissioning.**

Care Planning

Care Planning recognises that both the health care professional and the person with a long term condition bring different expertise and experience to a consultation. Although healthcare professionals have knowledge and expertise about the clinical care of a particular condition, it's really only the person with the condition who knows how it impacts on their life. Care Planning aims to transform the annual review from ticking boxes into a genuinely collaborative consultation. There is a real opportunity for people to share information with their healthcare team and openly discuss issues and concerns, as well as get help with accessing the services and support that they require to self manage their condition.

The two key aspects that enable this change are

- Sending out test results with a short explanation and agenda setting prompts in easily understood language ahead of the annual care planning review (This allows people to sit down and think about their condition, talk it through with their family and carers and decide what their specific goals are for the coming months.)
- A patient centred consultation delivered by the health care professional committed to partnership working, which explores and discusses agendas and helps individuals develop their own goals and actions

However there was very clear learning from the pilot programme that these changes in themselves are not enough to implement Year of Care and a whole host of other changes across an organisation are needed to make this work. The Year of Care pilot sites identified the key factors needed to embed Care Planning using the Model of the Care Planning House

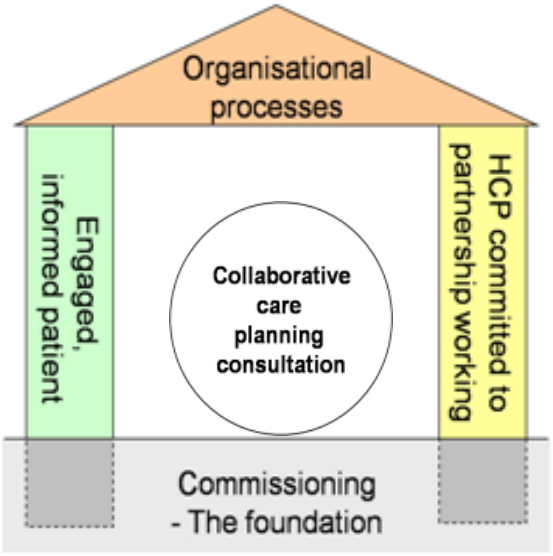
"Care planning has made me look at patients differently. I focus less on the disease and take a more holistic perspective." Practice Nurse

"Each time I get a greater understanding of my condition and understand more about how I can go about maintaining and improving it." Person with diabetes

The Year of Care Pilot Programme

The Year of Care – Care Planning House

The YOC Programme found that effective care planning consultations rely on four elements working together in the local healthcare system: an engaged, empowered patient working with Health Care Professionals (HCPs) committed to a partnership approach, supported by appropriate/robust organisational systems and underpinned by responsive whole system commissioning. These are brought together in the YOC care planning House Model which illustrates the importance and interdependence of each element – if one is weak or missing the structure is not fit for purpose.



The Pilot Programme

YOC worked with 3 pilot PCTs: Tower Hamlets (TH), Calderdale and Kirklees and North of Tyne – North Tyneside (NT) and West Northumberland (WN). These sites were chosen because of their spread of demographics, standards of existing care and geography. All of the sites have been able to implement Care Planning as the normal method of delivering care and have rolled out this approach beyond the pilot practices**.**

Key achievements

- Care planning has been adopted as the norm in a majority of practices across the pilot communities: TH = 97%, Kirklees = 83%, NT = 79% and WN = 73%.
- 76% of people with type 2 diabetes on practice registers have had at least one care planning consultation.
- Care planning works across diverse populations thus addressing inequalities.
- The National Training and Support Programme has trained 1,000 HCPs and quality assured > 40 local trainers
- The programme has been tested in other LTC and in different settings

Key Learning from the Pilot programme

- Culture ***and*** systems must change to support a new way of working.
- Successful implementation across a health community involves a partnership between grass roots ownership, local innovation and tailoring, and strong clinical (usually primary care) leadership - *'right from the top, right from the start, right the way through'.*
- This must be supported by local flexible commissioning, practice facilitation and tailored training - *'making it easy to do the right thing.'*
- Staff must be clear about their roles, and where care planning fits in the local pathway / model of care .
- There are extra costs at start up for communities with poor health literacy.

Care planning: the benefits

- People with diabetes report improved experience of care and real changes in self care behaviour.
- Professionals report improved knowledge and skills, and greater job satisfaction.
- Practices report better organisation and team work.
- Productivity is improved: care planning is cost neutral at practice level: there are savings for some.
- Care planning takes time to embed: changes in clinical indicators across populations may be seen after two or three care planning cycles.

Extending the programme- rolling out to new sites and other conditions

The programme has now been rolled out to 12 further sites and **t**he experiences of working with these new sites mirrors the experiences and learning of the pilot sites and confirms that issues will be similar where ever this is adopted. Crucially training should not be viewed in isolation from the changes in the organisation and infrastructure needed to support the introduction of the YOC approach. The Training and Support Team has become the natural home for and vehicle to roll out the whole programme and have developed a host of new resources to support new sites.

Products include

- Patient Materials e.g. sample letters, information about results, care plans, awareness raising materials
- DVDs of awareness raising and consultation skills
- Guidance Document – National Care Planning Training
- 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,SystmOne)

Training Curricula include

- Taster sessions - Preparing for Care Planning
- Core Care Planning Training
- Train the Trainer and Quality Assurance Programme
- Care Planning Awareness Raising
- Healthcare Assistant Training
- District Nurse Training in Care Planning
- LTC Care Planning Training for practice teams
- Training for integrated community teams - working with people with LTCs risk assessed as in the top 7% of the practice population as likely to use unscheduled care – (under development)
- Extended Consultation Skills for clinical staff (under development)
- A programme to set up local mentoring and support to build confidence, embed and transfer skills and attitudes across the local community. (Under development)

The National Training and Support team

As the programmes extended and developed it became apparent that high quality training was crucial to the delivery of the programme. The National Training and Support team have developed a quality assured training programme to allow for scaling up and embedding of Year of Care across health communities. In order to fulfil its function, the Training Programme has become the hub of the Year of Care Programme and is the means of disseminating the learning and resources. The Pilot Programme was originally hosted by Diabetes UK on behalf of a partnership between them , the Department of Health , NHS Diabetes and The Health Foundation. The National Training and Support programme is now house at Northumbria Healthcare Foundation Trust and can be contacted at

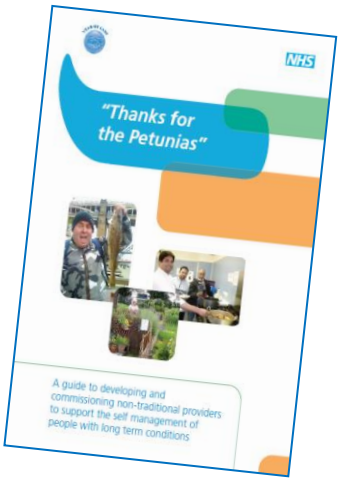
enquiries@yearofcare.co.uk

"It's made me reconsider my consultation skills and I will definitely change my practice to make it more patient-centre "

"You have converted a cynic"

Key lessons for wider implementation

Commissioning



YOC seeks to ensure that appropriate local services are commissioned to support the choices people make with their HCPs during care planning to support self management to achieve and maintain good health and wellbeing. The YOC IT project improves capture and transfer of care planning information. YOC have also published ***Thanks for the Petunias – a guide to developing and commissioning non-traditional providers to support the self management of people with LTCs,*** which describes the barriers and suggests solutions.

Introducing care planning and better support for self management at the centre of care for people with LTCs stimulated service redesign, new approaches to commissioning and whole system change, leading to better integration of services. Examples including real reduction in costs are outlined in YOC information sheet ***Commissioning for Diabetes and other Long Term Conditions: Spring 2011.***

Fit with policy

Care planning provides a framework to support the policy imperative **of 'no decision about me without me'** prioritised in the 'Equity and Excellence: Liberating the NHS (2010), and the delivery of shared decision making. It provides a gateway for the delivery of choice through personalisation, (Personal health Budgets), Information Prescriptions, telehealth and Any Qualified Provider

YOC has provided the practical base from which the **Royal College of Physicians (RCGP) plan** to produce professional standards for care planning and on which the **NICE quality standard** for care planning in diabetes is based.YOC is supporting the LTC QIPP programme to deliver the self care component of their programme.

Key Publications

- The report of the findings from the Year of Care Programme- 2011
- Thanks for the Petunias – A Guide to commissioning non traditional providers to SMM for people with LTC 2011
- RCGP: Care planning – improving the lives of people with long term conditions; a practical guide for clinical teams on putting the YOC care planning model into practice. 2011
- Partners in Care 2010
- Getting to Grips with the Year of Care: A Practical Guide 2007
- Care Planning in the Year of Care Programme: Making it easier to do the right thing 2010
- 1-2 page summaries
    - Summary of the YOC Programme
    - The YOC LTC commissioning model
    - YOC Workforce Matrix

'It's 100% better for me and the patients' **A GP**