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 approach puts people with LTCs firmly in the driving seat of their care and supports them to self manage. It transforms the diabetes 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.**

YOC provides practical evidence and support to implement the White Paper *Equity and Excellence: Liberating the NHS* proposals for personalised care *'no decision about me without me'* and locally-driven flexible commissioning for people with LTCs and the QIPP agenda. Care planning is included in the NICE Quality Standard for diabetes. YOC has worked closely with the Royal College of General Practitioners (RCGP) who are developing professional standards for care planning to be incorporated into training.

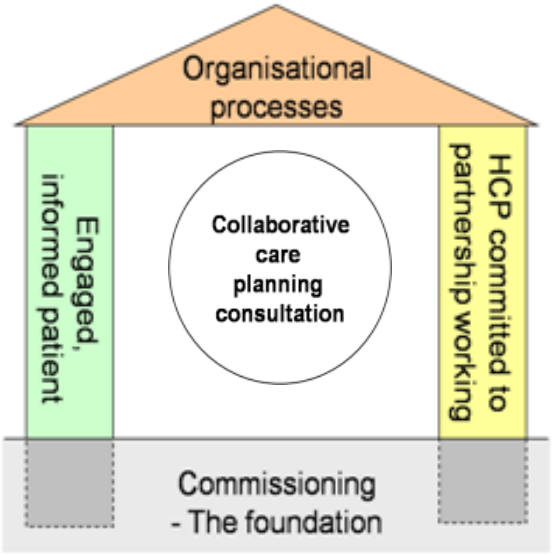
Care Planning

"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

Care planning is a process which offers people active involvement in deciding, agreeing and owning how their diabetes will be managed. It replaces current routine care.

The YOC Programme found that effective care planning consultations rely on three 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. This is illustrated by the YOC care planning House Model (right). This model emphasises the importance and interdependence of each element – if one is weak or missing the structure is not fit for purpose.



YOC worked with 3 pilot PCTs: Tower Hamlets (TH), Calderdale and Kirklees and North of Tyne – North Tyneside (NT) and West Northumberland (WN) – and 12 other health communities to test transferability.

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Key achievements over 3 years

- 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.

Care planning: the benefits

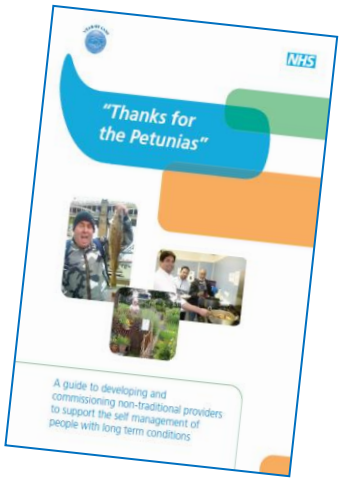
- People with diabetes report improved experience of care and real changes in self care behaviour.
- Professionals report improved knowledge and skills, and greater job satisfaction.
- Practices report better organisation and team work.
- Productivity is improved: care planning is cost neutral at practice 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.

Key lessons for wider implementation

- 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 is being tested in other LTCs.

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.***

Year of Care makes available

- A tested ***National Training and Support Programme*** to support delivery of care planning in primary and specialist care. This includes quality-assured 'training the trainers', facilitation of delivery, and links with unique IT templates to record patient goals, action plans and service needs.
- With thanks to the RCGP; their Report ***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.

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

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A partnership programme delivered by the Department of Health, Diabetes UK, The Health Foundation and NHS Diabetes