The impact of implementing the Year of Care approach to personalised care and support planning

July 2021

(updated links Mar 2025)

Contents

Overview ... 3

Year of Care Partnerships – over a decade of experience, expertise and learning ... 3

Patient experience: What do people who live with a long-term condition think about personalised care and support planning? ... 5

The value of preparation ... 5

Having a different kind of conversation ... 7

A process which supports self-management ... 7

Linking to 'non-traditional' support ... 9

How do health and care professionals view personalised care and support planning? ... 9

Improved care processes and care coordination ... 10

What's the impact on clinical care? ... 13

Diabetes: Clinical Outcomes – Tower Hamlets, West Berkshire and North East Essex ... 13

Other clinical areas ... 14

COPD ... 14

MSK conditions ... 14

Frailty ... 15

Dementia ... 15

Reports and summaries ... 15

Matter of Focus report summary ... 15

A realist evaluation of PCSP – Dr Sarah Brown ... 16

Links to personal narratives and case studies on website ... 17

Overview

Personalised care and support planning (PCSP) has proven to be a flexible framework to deliver personalised proactive care to people with long-term conditions, including those with multiple conditions, increasing complexity and frailty.

Evaluating complex interventions such as care and support planning requires a high degree of fidelity to the 'intervention', and an understanding that individuals gain benefits from different parts of the process. It's very difficult to predict the exact gain to an individual from a 'personalised process'. This means that evaluation is challenging and success cannot be easily described in terms of straightforward cause-and-effect relationships.

However, independent and in-house evaluation of Year of Care implementation programmes have all demonstrated that a structured PCSP process, delivered by trained, high quality care teams, has the flexibility to include the different issues that people face across a lifetime, within a single care and support planning process, no matter how many conditions a person may live with.

In this document we outline some of the quantitative and qualitative findings and feedback we have gathered over the past decade. These broadly fall into the themes around patient experience, job satisfaction for staff, clinical care and how care is organised.

"I have appreciated both visits, it is good to see how we are doing in black and white, I have left feeling helped and encouraged" **Patient**

"PCSP creates happier teams" **GP**

Year of Care Partnerships – over a decade of experience, expertise and learning

Year of Care Partnerships has extensive experience in the development, delivery, implementation and expansion of personalised care and support planning. The programme was initially set up, using diabetes as an exemplar, to work with people who lived with a long-term condition to determine how they would like their routine care to be delivered.

The process, ethos and steps of personalised care and support planning were defined as part of initial programme development sponsored by the Department of Health and Diabetes UK. We then worked with clinical teams to work out how personalised care and support planning could be applied practically to the routine care of people with long-term conditions, including an initial pilot programme in diabetes which was independently evaluated.

Subsequent programmes of evaluated work tested the approach, for example in respiratory conditions. In a project with the British Heart Foundation that reached over 13,000 people with cardiovascular disease. We also completed a programme of work with Versus Arthritis to include musculoskeletal conditions within the personalised care and support planning process despite their lack of prominence within the quality and outcomes framework in primary care.

This accumulation of learning across multiple long-term conditions has more recently focused on developing the approach as a single process for people with single or multiple long-term conditions including frailty and complexity, supporting a preventative approach to healthy ageing by including

falls detection and management within the overall process, and linking this to conversations about wider frailty issues.

In Scotland the approach is called 'House of Care' and is now being used across 11 health boards and 135 GP practices; the evaluation of House of Care was compiled into a national report by Matter of Focus. There is a summary of the Matter of Focus study on page 15 of this document.

Our overall learning has helped us define critical success factors, support successful implementation and provide numerous examples of the benefits of this way of working. Many areas are now adopting this approach at pace and scale with thousands of individuals benefiting.

Our publication 'The Year of Care approach: developing a model and delivery programme for care and support planning in long-term conditions within general practice' summarises our extensive experience and expertise in this area.

Patient experience: What do people who live with a long-term condition think about personalised care and support planning?

The primary purpose of the personalised care and support planning process is to enable a more collaborative conversation between a prepared patient and a healthcare professional committed to partnership working. This recognises the importance of creating the conditions for a useful, productive conversation which supports individuals to understand their own health better and be more involved in discussions, decision making and planning care with their healthcare professional.

To some extent measuring patient experience is both a measure of fidelity (is it happening?) and of the impact of successful implementation. Over the course of delivery and expansion of the programme we have conducted focus groups, qualitative research, collected patient feedback through the use of questionnaires, simple feedback postcards and formal qualitative tools.

The value of preparation

Supporting people to be prepared is a key component of the personalised care and support planning process. This important aspect is unique to PCSP and seems to make a real difference to how patients can contribute and get their ideas, questions and concerns into the personalised care and support conversation. It is always rated positively by patients in any feedback:

"It prompts you to think about all aspects of your health…encourages you to talk to the doctor or nurse..."

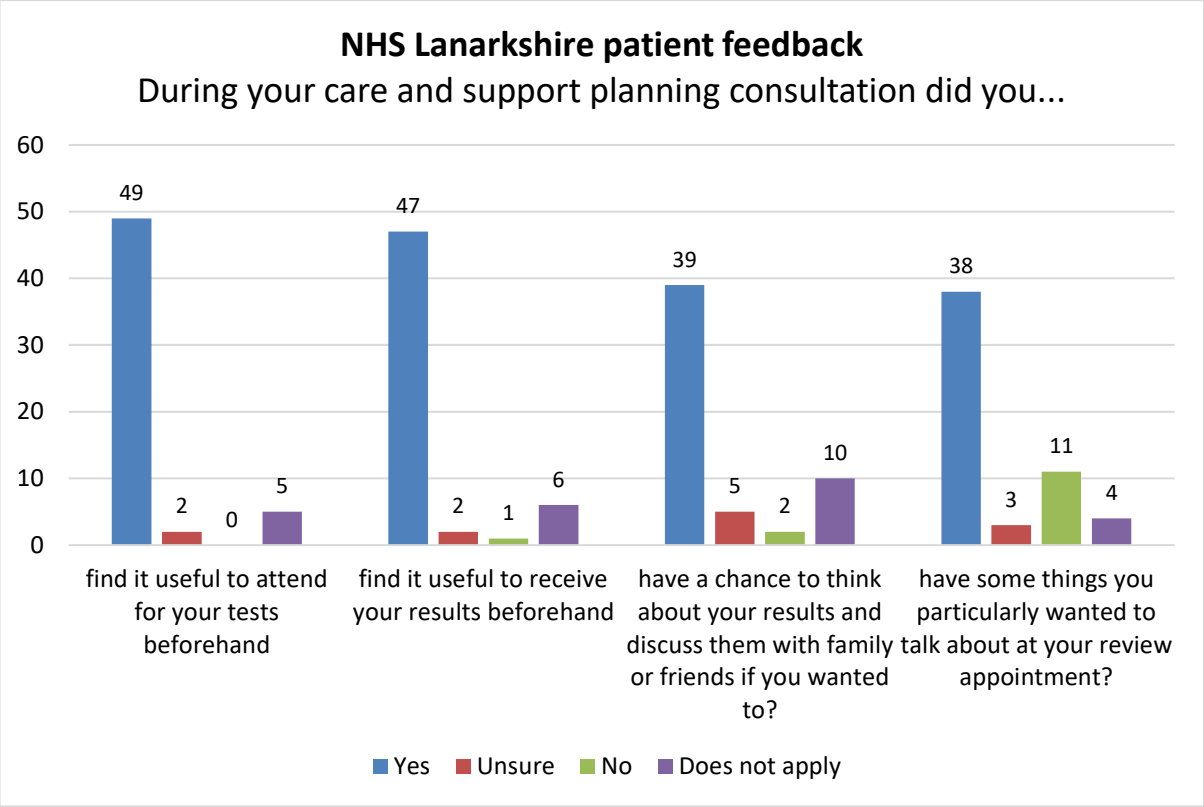
"Time to read (results) and think about what to raise...you know what was coming"

"It's better now. There is more chance to see things and judge for yourself. My family can look at the information – it's helpful for them to understand. Things are better...It is a lot better for me to understand these things"

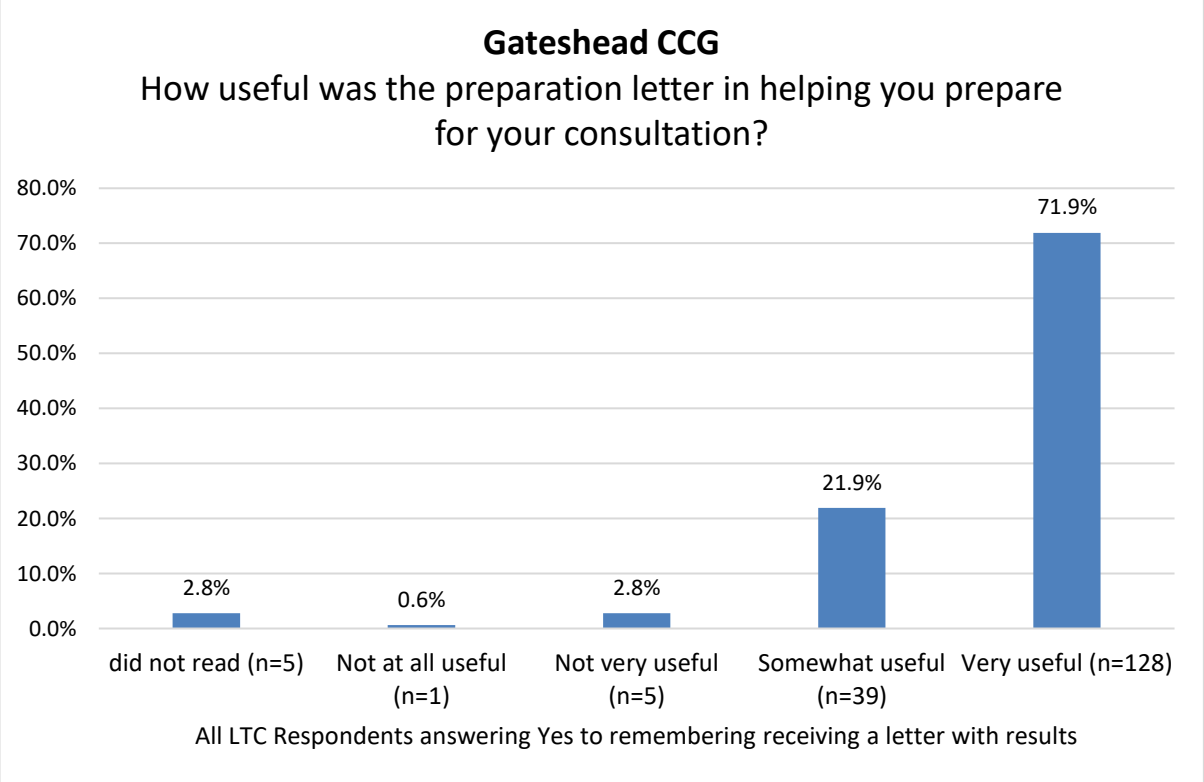
"…sometimes…when you get to the surgery you forgot half of it! I had it all written down…was able to ask her what I feel were the more important things"

"I've never talked to anyone about these issues"

NHS Lanarkshire - patient feedback on preparation following the introduction of care and support planning



Gateshead CCG - patient feedback on preparation from the BHF programme



Having a different kind of conversation

A key indicator of success is people feeling more involved in their care – this has been measured across a range of programmes.

In Tower Hamlets during initial pilot work and in an independent survey by the Picker Institute positive answers to the question *'have I had about the right amount of involvement in my care?*' rose from 52% in 2006 to 82% in 2009.

"Sometimes when you have done it before, things seem to get forced on you, whereas this way I prefer to discuss it myself...there is more of a choice now, it's my choice rather than someone else's choice, that's why I like it."

"Year of Care is a great idea because it's focused around the individual. I'm happy I get more of a say in my care."

"I felt I was always being told off now I feel I am the one in control."

CSP has been widely adopted across Newcastle and Gateshead and a CCG wide patient survey in 2019 confirmed positive findings were sustained 5 years on from initial implementation:

- 97.3% of patients knew who to speak to about their health/wellbeing
- 94.0% had a plan for managing their health/wellbeing
- 90.6% felt more involved in their health/wellbeing
- 89.5% felt more able to manage their health/wellbeing
- 86.9% had developed their own ideas about managing their health

Across other programmes of work the theme of involvement and more positive experiences of personalised care and support planning conversations persists.

"They were interested in how I felt, I got a chance to ask things rather than being asked. I learnt a lot."

"After discussing things, it gave me a better perspective of where I wanted to be and do."

"Had time to talk…answers to my problems are not more medicine."

"We are a team, a real partnership. I feel that I understand her, and she understands me."

A process which supports self-management

72% of people living with LTCs involved in the NHS Grampian interim evaluation felt the PCSP conversation had supported and enabled people to make positive steps to keep themselves healthy when compared to traditional consultation methods

"This review has really made me think about my health and take ownership of it…I will consider my health much more closely as a result."

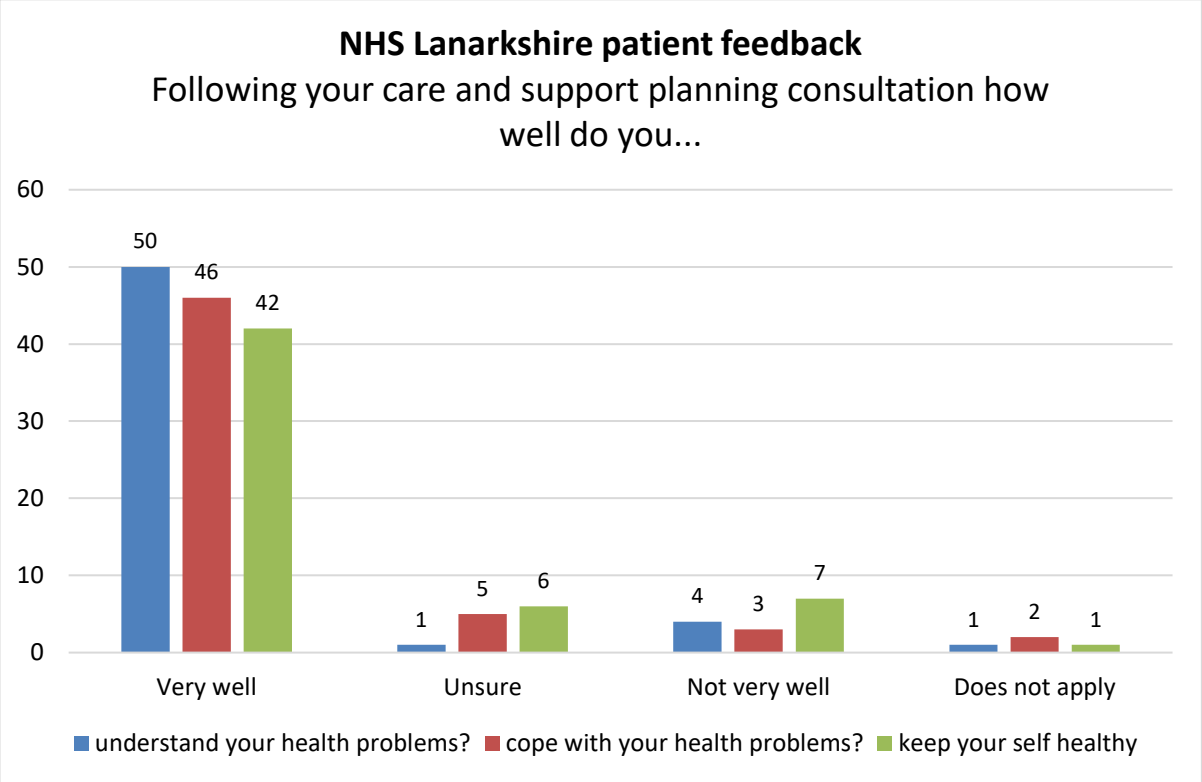
In both Lanarkshire as part of Scotland's House of Care Programme and Newcastle and Gateshead as part of the British Heart Foundation programme patients reported improvements in their understanding of their health problems and their ability to stay healthy and cope with their health.

"It prompts you to think about all aspects of your health, so you can make a comparison. And then you can say 'oh crikey I better drink a bit less."

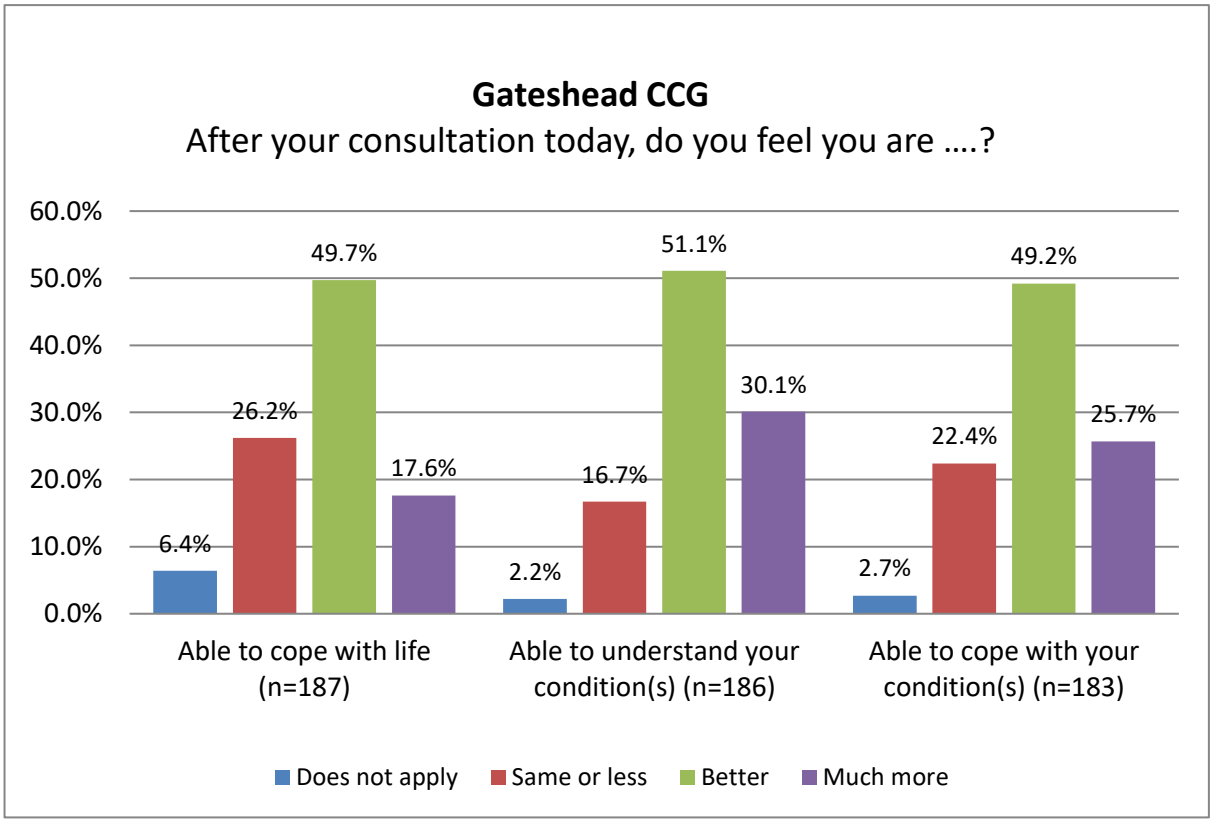
"I said I wanted to lose weight...I've gone from 12st6 to 9st6 and I've done it all myself."

"Each time I get a greater understanding of my condition …and how I can go about maintaining and improving it."

NHS Lanarkshire - patient feedback on understanding and managing their conditions following the introduction of personalised care and support planning



Gateshead CCG - patient feedback on understanding and coping from the BHF programme



Linking to 'non-traditional' support

PCSP conversations recognise the social and psychological aspects of health and how they impact on self-management. PCSP conversations often tackle these issues and can result in more effective joining up with 'more than medicine' activities.

Patients who took part in an interim evaluation in NHS Grampian were asked whether they had been signposted to relevant support in their local community during their PCSP conversation, with 70% answering yes.

"Getting up to speed with what facilities are out there, now we are referring to agencies which you maybe knew of but were not used to referring to, money issues, we are only used to dealing with health issues and I know a lot of other things come into it also but it is just getting your head round what is available locally and doing work to get that information" **Practice nurse**

How do health and care professionals view personalised care and support planning?

One of the unexpected benefits of introducing PCSP is the way in which it connects staff to their core values and enables them to work in a way which supports them to treat everyone as an individual.

This is particularly evident from the practitioners who report an increase in their job satisfaction and a greater pride in the service they provide for people with long-term conditions.

'Improves job satisfaction – more time to spend with the patient…and a conversation based on what's important to them…so much more worthwhile than ticking boxes." **GP**

"You build relationships and then see results." **Practice nurse**

"It makes you feel you've achieved something like a proper job." **Healthcare assistant**

"I focus less on the disease and take a more holistic perspective." **Practice nurse**

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

"It's actually more rewarding. We don't spend so much time doing heights, weights etc. We spend more time engaging with patients and finding out about their problems at home rather than ticking boxes." **Nurse practitioner**

"Conversations are different now - the agenda setting prompt has given patients permission to talk about things and has led to some more interesting conversations." **GP**

"*More rewarding, patients are helping themselves. When you just give people advice, they do nothing and it gets worse. Working in this way will get easier, it is no longer about a 'Fix' it approach, we are now changing, learning."* **Practice Nurse**

"We describe this work as the best thing ever, we are talking less and giving the person more control- we are using the tools and focusing on people's strengths and we are noticing the changes people are making." **Practice nurse**

"Makes my job easy and effective and means patients get the right issues addressed and can voice their own point of view." **HCP**

Improved care processes and care coordination

PCSP puts in place a structured approach to delivering care, including care processes and completion of routine assessments and clinical measures. The implementation of the modified pathway gives practices an opportunity to look at skill mix, roles and the streamlining of routine clinical care, ensuring both quality and efficiency.

Better organisation of care

"Before Year of Care we hadn't thought much about what needs to go on behind the scenes to make a clinical encounter effective and the practice nurse was struggling to do it all herself. The Year of Care helped to clarify all the steps needed and gave us a framework to stand back and look at the service and to clarify roles and responsibilities so we now have far more robust organisational structures, better skill mix and better teamwork and communication." **GP**

"Less DNA, less stress because people are not having their blood taken multiple times. More time for them to get on living their lives rather than focusing on the next appointment." **Practice Manager**

"We have identified clear roles for everyone involved in CSP for patients with LTCs. The HCAs and Practice Nurses work from separate 'smart' templates. This prevents duplication of work and helps to ensure that all aspects of care are addressed." **GP**

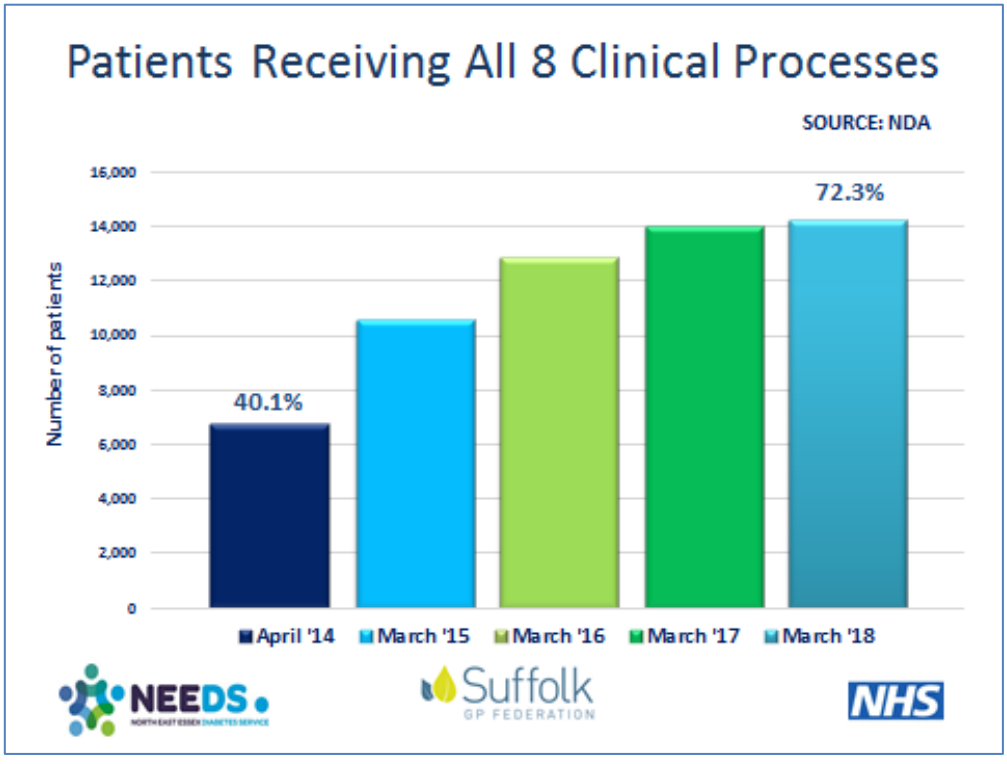
''People are attending fewer general appointments because they are keeping well, this is reducing our costs" **Practice Manager**

Diabetes – care processes

Both North East Essex and Tower Hamlets have all been able to demonstrate improvement in the completion of care processes for people with diabetes. This is achieved by putting in place staff training, clinical templates, Year of Care processes and investment in general practice.

North East Essex

- 72.3% of people with diabetes received all 8 care processes (previously 40.1% in 2014)
- North East Essex is now amongst the best performing area for patients receiving all 8 care processes (previously 119th in 2014)
- Vastly improved rates of foot screening and a reduction in the rate of amputation despite growing numbers of people with diabetes
- Following on from Year of Care training 78% of people receive a Year of Care preparation prompt which has contributed to the increase in people receiving all 8 care processes



Tower Hamlets

During the pilot period **Tower Hamlets** achieved **72**% of completion of what were then the 9 key care processes (UK average 49%).

Creating a single PCSP process for people with single and multiple long-term conditions

PCSP when applied to multiple long-term conditions can result in fewer separate appointments and less routine referrals or more relevant referrals to specialist services.

"My son was always saying "dad, you're never away from that surgery" …this has made such a difference" **Patient**

"As a practice we have seen real benefits…for our patients with LTCs…we have one single system, one process for inviting patients in, that everyone understands and…their role in it. We have cut down massively on the number of encounters patients have…" **Practice Manager**

"The new pathway is not only more patient-centred but more efficient in time for both patients and healthcare professionals. The MDT meeting…useful learning experience and an opportunity to discuss the hard to reach, the housebound and those with the most complex needs. It maximises the use of individuals' skills and competencies within the practice." **Practice Manager**

"My impression is we aren't swamped as we used to be. The workload has eased because the number of interim reviews has gone down. It's more manageable but we've needed strong admin to make it work" **Practice Manager**

"While the improvement in quality of care was the prime aim of the Year of Care programme it is important to understand the costs involved. Within the practice the biggest cost is staff time and the longer consultation. The natural assumption would be that this would lead to increased costs. However this proved not to be the case." **Project Manager**

Cost analysis from a Newcastle practice

A practice in Newcastle reviewed the number of people having single reviews and considered the total cost of moving to a single coordinated care and support planning process across all of the QoF conditions.

The practice was able prove the case ahead of implementation that merging disease reviews alone would offset any costs of implementing PCSP even with existing improvements in skill mix and with longer appointments for people with multiple conditions. This was mostly achieved by creating a single process for people with multiple conditions.

Total cost for 1-month pre CSP	Total cost for 1-month post CSP
£2582.55	**£2035.12**
Freeing up £6569.16 per annum for other practice activities (reduction 21%)	

What's the impact on clinical care?

There is a perception that clinical outcomes will worsen when care becomes more patient focused. Across our programmes of work this has not been the case. PCSP aims to put in place a systematic process and clinical method that combines high quality clinical care with a patient focused approach, which supports the involvement of people in their own care.

"We suspended QoF and were worried that we might see some decline in measurement, in fact it's actually improved a little bit - by putting in systematic care and support planning." **Clinical lead**

"If you compared this year and last year…we had a lot less work to do in the last 3 months of the year. Our QOF data is a lot better, specialist respiratory and BP…for people with a range of conditions." **Practice manager**

"A concern that clinical outcomes might worsen was not born out. There was an 11% increase in people who had BP recorded and 11% reduction in CHD patients with a BP of 150/90 or less vs 0.4% across the whole CCG." **GP lead BHF project**

Diabetes: Clinical Outcomes – Tower Hamlets, West Berkshire and North East Essex

Diabetes was one of the first pilot programmes for PCSP and continues to be an area in which PCSP can demonstrate the most immediate clinical benefits.

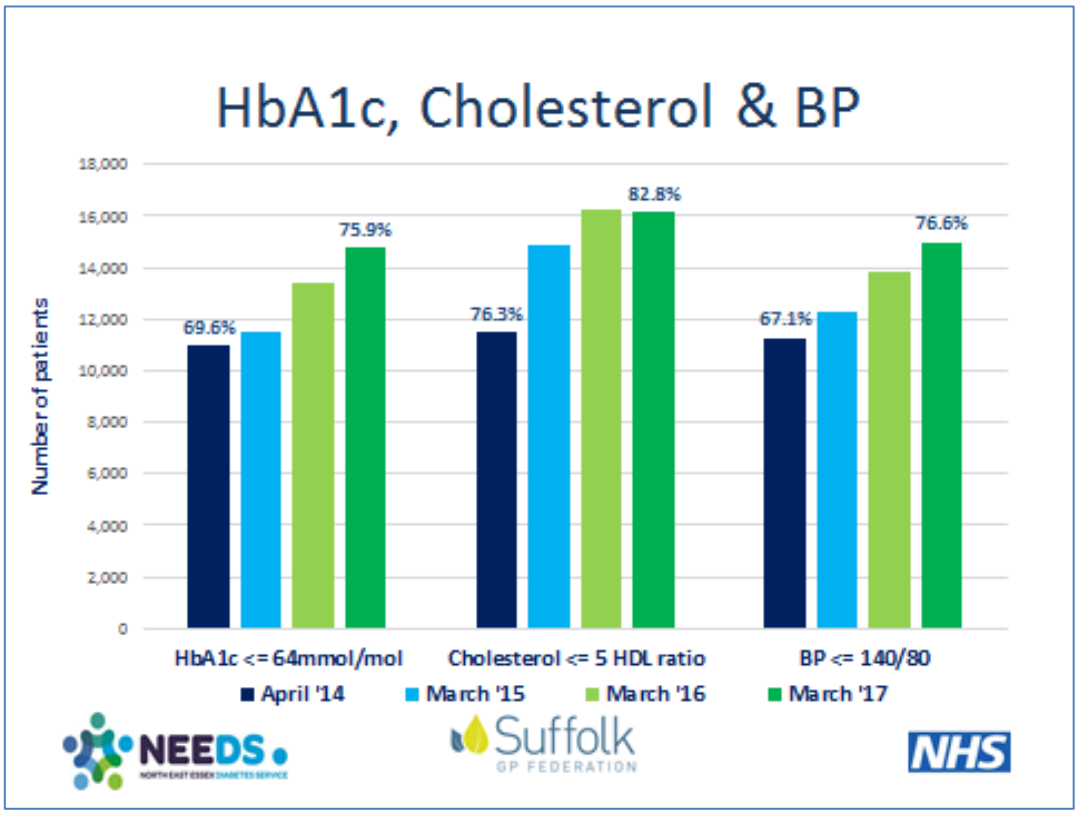
Tower Hamlets CCG have shown sustained improvement in their clinical data.

	2009 QOF	2012 Dashboard	2015-16 NDA	2016-17 NDA	2018-19 NDA
HbA1c ≤58mmol/mol	37%	55%	62%	62%	63%
BP ≤145/85	70%	90%	81% (new target 140/80)	83% (new target 140/80)	79% (new target 140/80)
Cholesterol <5mmol/L	65%	83%	85%	85%	86%
3 combined		35%	45%	46%	44%
National average		19%	40%	41%	42%

Berkshire West CCG audited their achievements during the initial introduction of PCSP and were able to demonstrate improvements in biometric outcomes.

	2012 Dashboard	2014 Dashboard	2018-19 NDA
HbA1c ≤60mmol/mol	47%	57%	65% (≤58mmo/mol)
BP ≤140/85	66%	78%	76% (≤140/80)
Cholesterol <5mmol/L	46%	79%	78%
Prescribing savings		£800,000	

North East Essex introduced personalised care and support planning as part of a package of support for people with diabetes and were able to show a range of clinical improvements.



Other clinical areas

PCSP is an approach which can be applied to planned clinical care settings and contexts.

COPD

In a local COPD pilot which included a keyworker approach and self-management activities practices that implemented PCSP had lower rates of emergency admissions and A&E attendances.

MSK conditions

In other feasibility work we have looked at the inclusion of MSK conditions within the PCSP process. The feedback from patient exit questionnaires demonstrated that 97% of people felt able to talk about things that were important to them with 100% saying they would recommend PCSP for others with similar MSK conditions.

This work demonstrated a number of positive benefits including 272 individuals whose prescription analgesics for pain including opioids were stopped or reduced and replaced with self-care activities.

"Our prescribing lead was initially quite anxious that the project would lead to increased use of painkillers, but that hasn't happened. We've actually done quite a lot of deprescribing. Many patients are pleased to stop taking painkillers." **GP**

"Asking the question "is the analgesia effective?" has really changed things." **Nurse practitioner**

"Totally thrilled, I have been out of the house by myself for the first time in years." **Person with MSK condition**

Frailty

We have also sought opportunities to use PCSP as a vehicle to introduce the topic of frailty. This includes a programme of work focused on proactive case finding and prevention of falls.

Many people with multiple long-term conditions also have a positive frailty score. Asking questions about falls including slips and trips identified a previously unidentified cohort who were either at risk of falls or reported falling, with 50-74% of this group having new postural hypotension.

Practitioners reported modifying medicines, self-management and formal strength and balance classes as outputs of a falls discussion within the conversation.

Dementia

In a programme of work lead by the Thames Valley strategic network dementia was formally included within the PCSP process. Practitioners were given more training on this topic and provided with a toolkit of resources which supported practitioners who often felt under confident in this topic.

"I used to dread doing dementia reviews; I was really under confident, as I wasn't sure what I could do to help patients or their carers. Using the care and support approach has changed all this - the toolkit is easy to use, and patients choose what they want to discuss. It's now one of the most satisfying reviews that I do!" ***Practice Nurse***

Reports and summaries

Our website hosts a number of reports, publications and summaries including many of the reports which are the sources of information within this document:
https://www.yearofcare.co.uk/publications-and-references

In addition, the reports below provide a useful synopsis of learning across a range of projects.

Matter of Focus report summary

In 2019-20 Matter of Focus worked with 11 health boards in Scotland and a core group of Scottish government together with Social Care Alliance Scotland and Year of Care Partnerships to gather and assimilate evidence from sites that had implemented the House of Care approach (the name given to the Year of Care model in Scotland) in practice.

The report concluded that the House of Care approach had been successfully implemented across many areas of Scotland and 'people with LTCs are leading better lives' as a result. This is a significant achievement for local adopter sites and the core team who have made these changes during a challenging period for primary care, with austerity, changes to the GP contract and structural reorganisation all providing barriers to change.

The report highlighted 3 key factors that contributed to this success:

- Local leadership
- High quality training
- Ongoing support to practices

Improved outcomes as detailed in the Matter of Focus report:

- People with long-term conditions enjoyed the approach and felt more prepared and empowered
- People reported they were more able to take control and keep themselves healthy compared to more traditional consultations
- Professionals feeling more confident in engaging with people with long-term conditions around setting goals
- Evidence that practices continue to embed the approach so it becomes the normal way of care
- Some evidence that the House of Care approach is mitigating health inequalities (further work to investigate this is necessary)

The report identified some key recommendations to take forward including the need for a continued shift to more enabling, community-based approaches to improving outcomes for people with long-term conditions, continuing to promote House of Care as an effective approach to primary care transformation that is closely aligned with national policy and continuing to offer ongoing expert support to GP practices to sustain progress and enable spread of the approach.

A realist evaluation of PCSP – Dr Sarah Brown

Dr Sarah Brown completed a PhD in 2019. This was a 4½ year project exploring how, why, for whom and in what circumstances personalised care and support planning works best. The project used a realist evaluation approach and took place in three phases:

Phase 1: The 'inner workings' of PCSP were explored and programme theories identified through review of 51 peer reviewed articles
Phase 2: Theories were discussed and refined during focus groups with expert stakeholders
Phase 3: Theories were tested in practice involving 9 healthcare professionals and 11 people living with long-term conditions.

The research successfully explained PCSP through the development of 6 tested theories (which make sense to people involved in or experiencing PCSP). Through the systematic 'unpicking' of PCSP, these theories were shown to be more than just a 'gut feel' of what might work, but represent tested descriptions of how, why and in what circumstances PCSP works best.

The research showed that effective PCSP:

- Begins with preparation of people living with long-term conditions as well as better prepared healthcare professionals.
- Ensures people with LTC have sufficient time in the PCSP conversation to focus on their agenda; the person with LTCs and the healthcare professional collaboratively can make a decision (when a decision needs to be made) and/or set goals; throughout the whole process effective communication is vital.
- If all of this is done well, support for self-management is achieved.

Links to personal narratives and case studies on website

We have given a snapshot of the work that Year of Care Partnerships has completed with partner sites over the past 10-15 years.

We have also worked with a number of other organisations to implement PCSP in a variety of settings and for people with different conditions including diabetes, multiple long-term conditions and older people living with frailty.

You can read more case studies and blogs from those involved in our work here:
Case studies - https://www.yearofcare.co.uk/personalised-care-and-support-planning/case-studies/
Blogs - https://www.yearofcare.co.uk/about-us/year-of-care-blogs/