







Celebrating the achievements of

Year of Care 2003 – 2025

Over the last 2 decades the Year of Care Programme (YOCP) has led the way in pioneering, refining, adapting and delivering Personalised Care and Support Planning (PCSP) at scale across England, Scotland and overseas.

It has been the longest running programme of its kind with the primary goal of delivering high quality clinical care, using a person centric approach which embraces the biopsychosocial model of health and care. Our focus has been on changing systems and pathways, influencing professional values and enhancing consultation skills to enable truly collaborative conversations between people with long-term conditions (LTC) and practitioners.

Working with primary care teams, and often starting with diabetes, it has shown that evidence-based theory can be transferred into practice and become a reality for thousands of practitioners and over a million service users, improving the experience and outcomes for both.

The result has been an approach that recognises and respects the agency of people over their lives and works with them to support the health outcomes they want for themselves. Along the way it has shown that the principles of personalised care and support planning can be used in any planned care setting, and in widely different health economies.

We hope you enjoy this memento, and that it reflects the achievements of the Year of Care programme and the team behind it all!



"It has been such a pleasure working with your team, and for me totally transformed the way I thought about interactions with patients."

"You and the team have been a constant presence and *the* quality standard re: PCSP and SDM in this country (and other countries of course) for so long...the work, experience, expertise and leadership of you and your team has been exemplary."

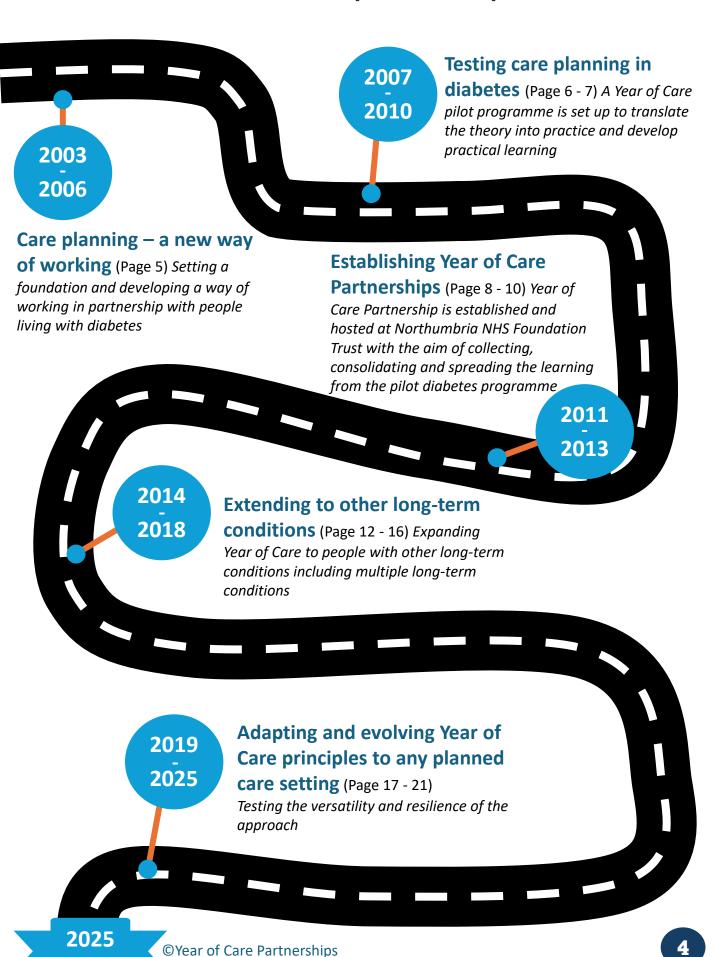
"Year of Care has been one of the PCI's most valued training partners since we started, your contribution to advancing personalised care has been exceptional and I am sure the impact of your work will continue to be felt across the system for a long time..."

"You and the team have done a huge amount over the last 20 years to highlight the need for personalised care and provide resources to help clinical teams deliver this."

"The aspirations and achievements of the Year of Care Programme have been so inspiring and absolutely what healthcare needs. We are so grateful to have access to the resources the team have created."

"From my perspective the opportunity to be involved with the Year of Care Partnerships, the people who worked within it and the changes it delivered for patients has and will always be one of the highlights of my career and something that makes me feel very proud to reflect on."

The Year of Care Partnerships Roadmap 2003 - 2025



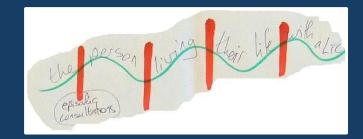
2003-2006: Care planning - a new way of working

Setting a foundation and developing a way of working in partnership with people living with diabetes

Patients and clinicians are frustrated by the current biomedical, tick box approach to long-term conditions care and are looking for better ways of working together

- Influenced by the Chronic Care Model a national working group is set up to review the evidence for models of care that deliver good outcomes for people with diabetes. They develop
 - Principles and a case for change
 - o A definition of "what care planning should look like in practice"
- This group publish their findings in: Care Planning in Diabetes: Report from the Joint Department of Health and Diabetes UK Care Planning Working Group (2006)
- The Diabetes National Service Framework includes "partnership in decision making and agreed, shared care plans" within the delivery strategy
- A Care Planning champions network is established to create practical learning about implementation in the real world of the NHS









This sets the foundation for the next 2 decades of policy and practice and what eventually becomes known as personalised care and support planning

2007-2010: Testing care planning in diabetes

A Year of Care pilot programme is set up to translate the theory into practice and develop practical learning

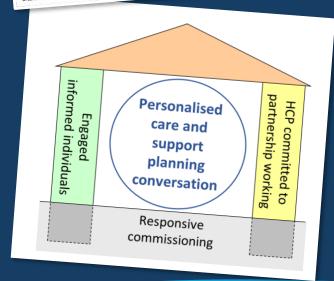
- A successful pilot programme is set up across 3 diverse health communities to identify what is needed to establish high quality care planning for people with diabetes, in a primary care setting
- This includes describing the care planning process and its component parts in detail
- Central to the approach is a philosophy which recognises the agency of the patient and so focuses on partnership working which has remained at the heart of the programme throughout
- To support implementation the 'Year of Care House' is developed to describe what needs to be in place to implement care planning





Personalised care and support planning philosophy

- The person with a long-term condition is in charge of their own life and managing their conditions
- The person with a long-term condition is more likely to act upon the decisions they make themselves, rather than those made for them by a professional
- The clinical consultation between a healthcare professional and a person with a long-term condition is a meeting of equals and experts
- The collaborative personalised care planning consultation (how the care plan is agreed) is more important than the care plan itself



2007-2010: Testing care planning in diabetes

Training is developed to support the implementation of the programme and patients and practitioners report that's it's a better way to work

Clinical benefits and

improvements

72% received all 9 processes in National Diabetes

Tower Hamlets Biomedical impact

Audit: Best in England (Average 49%)

Tower Hamlets

care planning

92% of registered population (Type 2 diabetes) taking part in

Patient perceived 'involvement

in care' rose from 52-82%

- The training package developed Northumbria is used across all 3 sites to support clinical teams to understand the rationale, the relational approach and the care planning consultation skills needed to deliver Year of Care
- People with diabetes report feeling more involved in their care, staff satisfaction improves and in Tower Hamlets this leads to ongoing improvements in clinical outcomes after several cycles of care planning
- The learning is curated and shared in a variety of publications including Getting to Grips with the Year of Care (2008), Partners in Care: A Guide to Implementing Care Planning Approach in Diabetes Care (2008) and the Health Service Journal supplement: Diabetes Year of Care (2009)



In testing, designing and implementing care planning, the team created a blueprint for all that follows

2011-2013: Establishing Year of Care Partnerships

Year of Care Partnerships is established and hosted at Northumbria NHS Foundation Trust with the aim of collecting, consolidating and spreading the learning from the pilot diabetes programme

The findings from the pilot programme are published in 2011 and are shared widely

- RCGP publication Improving the lives of people with long-term conditions (2011)
- The NICE quality standard for diabetes in adults recommends people with diabetes are offered personalised care and support planning as routine (2011)
- The Year of Care Programme wins a Quality in Care award for the best initiative supporting self-care (2012)
- Evidence is presented to the Health Select Committee for Long-Term Conditions (2013)
- The Kings Fund publish Delivering better services for people with long term conditions: Building a House of Care (2013)
- The Year of Care programme is presented to Scottish Government (2013), who later adopt the programme as 'Scotland's House of <u>Care'</u>









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Care planning is delivered to 9 new sites as part of a Diabetes UK supported extension to the programme

- The first Year of Care learning event is held in Manchester
- A train the trainers programme is established to support capacity building and quality assure the spread of the programme, and the first course is delivered in 2010
- Mind Your Language is developed to highlight the importance of words in supporting self-management and patient partnership - 'working with, not doing to'
- Thanks for the Petunias is published to show the strong links between personalised conversations and more than medicine approaches

NHS

Individual patient planning process = micro-level

Care planning

An end in itself



"Thanks for the Petunias"

A guide to developing an

commissioning non-traditio to support the self manage

people with long term con

2011-2013: Establishing Year of Care Partnerships

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The team begins to notice the utility of Year of Care principles in other settings and conditions and our expertise influences other programmes

- The Year of Care website is launched to promote the approach and curate learning, publications and resources (www.yearofcare.co.uk)
- Nick Lewis-Barned is appointed as Clinical Fellow for Shared Decision Making and Support for Self-Management at the RCP. The Council adopts a position statement on person centred care
- Simon Eaton leads the delivery of a North East pilot programme which seeks to extend care planning beyond diabetes
- The national Personal Budgets team approach Year of Care to develop a training programme to support the personalisation of PHBs







The Year of Care approach continues to be valued by both professionals and patients alike as word spreads about "a better way to deliver long-term condition care". The approach begins to extend beyond the initial Diabetes UK programme and by 2013 we have worked with 32 localities across England.

"The principles and approach you pioneered have now entered the mainstream, successfully influencing the rhetoric even if the reality often lags behind."

"You have had such a huge influence on primary care and chronic disease management, at so many levels, including policy."

"The legacy is everywhere – recently and most obviously seeing specific key elements so prominently in the new patient charter."

"Just to say a huge THANK YOU for all that you have given patients and their advocates over the last twenty years – and another THANK YOU from a HCP who flourished and delighted in your guidance and the shared journey with patients."

"There is no doubt that you have all had a positive impact on the care given to our patients and communities over the years. I thank you for all the help and support you gave to me, my team and the practices."

"The excellent work of Year of Care will continue beyond, you have embedded new ways of working which will continue for years to come with the patient at the heart."

Expanding Year of Care to people with other long-term conditions including multiple long-term conditions

The news about Year of Care is out and organisations are keen to work with us to

develop guidance and supporting health policy

- In Scotland the 'House of Care' approach is included in the first publication of *Realistic Medicine* and a team at Scottish Government apply to be part of the British Heart Foundation programme to test Year of Care in the prevention and treatment of cardiovascular disease
- Year of Care works with both National Voices and Think Local Act Personal to develop guidance on the generic principles of personalised care and support planning which can be used across health and social care
- A Cochrane review of personalised care and support planning is published in 2015 which demonstrates that when it is implemented with a high degree of fidelity outcomes improve
- In 2015 the BMJ publishes Delivering person centred care in long-term conditions which extols the importance of proactive care for people with LTCs and the Year of Care approach as a means of delivering this
- Following a successful training programme with a cohort of RCGP champions the RCGP adds personalised care and support planning to the GP curriculum







Expanding Year of Care to people with other long-term conditions including multiple long-term conditions

The team continue to advocate for the approach in diabetes, and many areas start with diabetes before moving onto other conditions. Local evidence suggests it improves clinical outcomes.

- In 2017 Lindsay Oliver delivers the Janet Kinson lecture at Diabetes UK 'Whose Diabetes is it Anyway?'
- We launch our first newsletter and establish a community of practice with annual learning and sharing events
- We go international Jersey and Singapore both adopt the Year of Care approach
- We collaborate with South West London to test how digital can enhance the Year of care approach in Diabetes





Expanding Year of Care to people with other long-term conditions including multiple long-term conditions

We test the utility of Year of Care for other single conditions

- A pilot in North Tyneside tests the applicability of Year of Care for respiratory conditions with a focus on COPD
- The British Heart Foundation supports Year
 of Care to work with 3 Scottish sites and 2
 English sites to implement Year of Care for
 cardiovascular disease it soon becomes
 evident that practices want to move to a
 combined approach for people with multiple
 and single conditions
- The Scottish Health and Care Alliance promote 'House of Care' as a high quality, patient centred approach to use as QOF is phased out in Scotland
- The local AHSN supports the pilot of a project to include falls prevention and frailty within the Year of Care approach, and the findings are published
- Versus Arthritis approach Year of Care to 'bring MSK conditions in from the care planning cold' and we work with local practices to include MSK as part of routine personalised care and support planning





Expanding Year of Care to people with other long-term conditions including multiple long-term conditions

Year of Care turns its focus to working out how to extend the approach to other conditions, beyond diabetes and to those who live with multiple long-term

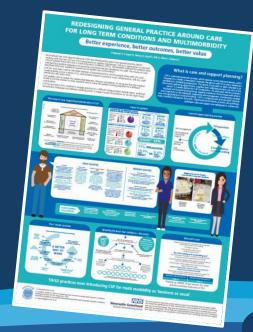
conditions and frailty

- Holmside practice in Newcastle works closely with Year of Care to clarify the detail of how to do multiple long-term condition reviews - they share their learning in a case study, and we develop a video to help other practices see how it works
- Other practices (Glenpark Medical Centre in Gateshead, St Triduanas in Lothian and Burnbrae in North Lanarkshire) all help us write up case studies to demonstrate how to deliver Year of Care for people with multiple long-term conditions
- Newcastle and Gateshead CCG publish a joint poster for the Kings Fund conference Redesigning general practice around care for long-term conditions and multimorbidity
- In Cumbria, Robert Westgate pioneers the development of a community frailty team who deliver Year of Care to people unable to attend the practice and this is shared in a newsletter and case study



To support implementation for multiple long-term conditions training is redeveloped and now includes facilitation to help practice teams work together

- 'Moving on Training' is developed for practices who use Year of Care for people with diabetes to extend to other long-term conditions
- Resources are developed to support facilitation including a practice pack, critical success factors, IT guidance and facilitation training for our community of practice
- The IMPACT tool is developed to help practices plan their time and see the benefit of combined reviews
- Collaboration with Tim Rapley, Monique Lhussier and Tracy Finch, and engagement with Normalisation Process Theory, helps to clarify the complexity of working with teams, the centrality of 'coherence', and provides a theoretical framework for implementation in long-term conditions - we include this in our training and facilitation programmes



Expanding Year of Care to people with other long-term conditions including multiple long-term conditions

Our philosophy recognises that at the heart of this approach is a way of working which creates the conditions for people to have 'better' conversations which equip them to live well with, and manage their own health based on their own values and priorities

- Just asking people what matters isn't enough!
- Working with academic Vikki Entwistle to think through the importance of purpose and the role of the professional in a personalised care conversation and add this thinking to our training programme
- Collaborating with consultation guru
 Jonathon Silverman to look at the similarities
 and differences between the acute and
 chronic care conversations
- We film multiple long-term conditions care planning conversations with Becky Haines and the team at Glenpark to use during training
- Health psychologist Yvonne Doherty develops 'advanced conversations skills training'







And as if we weren't busy enough, our key interest in person centred care sees us working with Professor Richard Osborne and his team at Deakin University, Australia to deliver 2 local OPHELIA health literacy programmes, one working with migrant communities in the West End of Newcastle and the other working in a specialist respiratory clinic at North Tyneside General Hospital.

This identifies the phrase "It's All About You" which is then adopted for Northumbria's outpatient programme.

Testing the versatility and resilience of the approach

The Year of Care approach seems to work across a lifetime. The team are confident about how it can be implemented and we continue to deliver, refine and extend the approach so that more patients can benefit from being involved in their own health care and supported to live well with, and manage their own health

We continue to share our learning and develop partnerships with like-minded

people

- In 2019, just before the pandemic, we publish our key paper in the BMC Family Practice journal The Year of Care approach: developing a model and delivery programme for care and support planning in long-term conditions in general practice
- The Gateshead team produces a case study with the Richmond Group of Charities taskforce on multimorbidity to showcase the work they have done using Year of Care to combine conditions reviews
- Newcastle facilitators interview staff in practices and share 'Stories from the Frontline'
- Collaborating with academic GPs in Bristol we support local initiatives and research using the Year of Care approach to multiple condition care in general practice
- Thames Valley ICS develop a case study detailing their 7-year partnership with Year of Care and identify how personalised care and support planning has been systematically embedded across practices
- Scotland holds a celebration event 1 in 5 general practices are using House of Care to routinely deliver long term condition care, 'Fixer to Facilitator' is published to collate the learning from all the House of Care sites in Scotland
- Teams from Singapore (Yishun Health and NUS),
 Gothenburg and Denmark visit the team to see the approach in action
- Reports are published from our work with Versus
 Arthritis Bringing MSK conditions in from the care
 planning cold and the study of Frailty and Falls using care and support planning to implement
 routine falls prevention and management for people
 living with frailty: A qualitative evaluation







Testing the versatility and resilience of the approach

Personalisation becomes a key policy priority in England

- In 2019 the Universal Model of personalised care is published as part of the long-term plan – this recognises shared decision making and personalised care and support planning as the 2 major clinical approaches to planned conversations
- The Personalised Care Institute (PCI) is established, and Year of Care is one of the first organisations to have its training accredited
- We develop shared decision making training which is well received with specialist teams and is accredited by the PCI
- As leading experts in person centred care, we deliver a series of summer webinars which highlight how the Year of Care approach can be used to implement high quality care















Testing the versatility and resilience of the approach

The pandemic strikes!

- When all long-term conditions care is suspended, we work with practices to adapt processes and consultations to maintain the integrity of personalised care and support planning – this includes developing guides for remote consultations
- Working with academics we explore the experience of remote care and support planning (CASPER) and these findings are published in 2024 in BMC Primary Care
- We develop remote training, which allows us to work with new areas, including Shetland and our 'super trainers' in Singapore
- Year of Care works with teams delivering specialist COVID clinics and provide training around person centred pathways and Year of Care principles
- Our blog Have we lost sight of long-term conditions? summarises widespread concerns about the lack of focus on person centred, planned care for people with long-term conditions and the implications this has for the NHS as a whole





Testing the versatility and resilience of the approach

We take our key principles and adapt them to other planned care settings

- Our team visits Singapore for a month and sets up a local Year of Care programme, helping teams locally explore how Year of Care works in a community setting – including super trainers
- Year of Care works with a mental health trust to develop remote personalised care and support training for community mental health teams
- We are commissioned by Coventry and Warwickshire to deliver a personalised care workforce plan, design workshops for teams seeking to implement personalised care and a leadership course and training programme
- The NENC ICS supports us to work with 2 PCNs in North Cumbria to develop a proactive care process, associated resources and training for neighbourhood teams working with people living with frailty - we publish our learning in a final report and produce a toolkit to support implementation





HEaT

Hypertension

Education and

Treatment

Testing the versatility and resilience of the approach

The team support initiatives across Northumbria

- We work with practices to implement personalised care and support planning for people with multiple long-term condition
- We develop and pilot a hypertension patient education programme (HEaT) which addresses the gap in care provision for those with newly diagnosed hypertension
- Community nursing teams are supported to think though how the workforce can use a structured and facilitative approach to support people to manage their own health, including injectables and wound care
- The team works with the public and supports the patient experience team at Northumbria and the Realistic Medicine group to develop a local Patient Charter which sets a standard for how interactions take place with patients locally

The Northumbria
Patient Charter





After more than 20 years and working across 62 areas the Year of Care programme has demonstrated that personalised care can and should be part of routine planned care and has developed the practical approaches to make this possible.

As the programme comes to an end, we hope that person centred care continues to flourish and be central to the way people experience their care.

Year of Care Network events



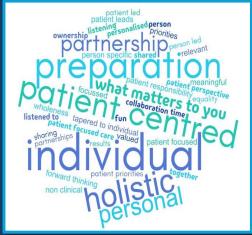
















The National Year of Care Partnerships Team dedicated to and passionate about spreading person-centred care

Leadership Team

Lindsay Oliver – National Director Sue Roberts – Chair Nick Lewis-Barned – Chair and Clinical Lead Rebecca Haines – GP Clinical Lead Caroline Sprake – GP Clinical Lead Simon Eaton – Clinical Lead Yvonne Doherty – Psychologist

Programme Management

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Dawn Temple-Scott
Rachel Turnbull – pilot programme
Gillian Johnson – pilot programme

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Susan Robinson

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We would also like to thank the many patients who gave us feedback, participated in our events and projects, and who were the stars in our consultation training videos.

