The Year of Care Programme

"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***

Year of Care (YOC) Partnerships provides advice, support and training to enable local communities to introduce collaborative care and support planning (CSP) as normal care for people living with one or more long term conditions (LTCs) or multi morbidity which is linked with activities in a supportive community.

The core aim is to transform the current fragmented annual 'tick box' review into a constructive and meaningful dialogue between those with technical expertise (professionals) and those with lived experience (patients) focussed on what matters to each person. It puts the individual in the driving seat with active involvement in deciding, agreeing and owning how their conditions are managed and enables support, services and community activities to be tailored for each individual.

CSP brings together physical, psychological, mental health and social care issues in a single care and support planning conversation however many conditions or issues the person may live with.

- **For the individual:** CSP **links** traditional clinical care with support for self-management and structured education; **signposts** the person to activities within a supportive community (social prescribing); and **coordinates** across health and social care.

- **For the healthcare system:** CSP is a systematic process which **brings together primary and specialist care** across common pathways; is welcomed by **diverse groups** including those with disadvantage; and **smooths out variation** and inequalities.

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

Impact and benefits

The YOC approach to CSP was developed and tested using diabetes as an exemplar. The benefits and impact observed in the pilot programme have been replicated for those with other single LTCs or multi morbidity and include:

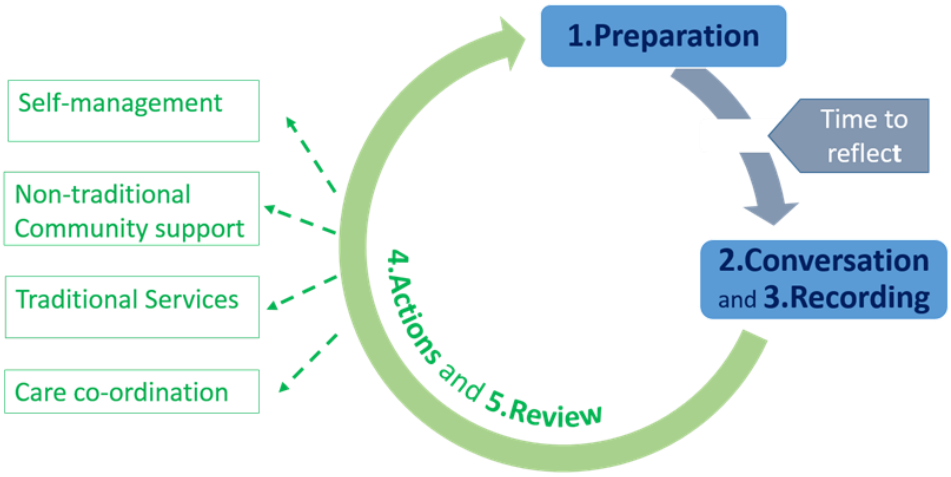
- People with LTCs report **improved experience of care** and real **changes in self-care behaviour.**
- Professionals report **improved knowledge and skills,** and greater **job satisfaction.**
- General Practices report **better organisation** and **team work.**
- **Care processes** (including the National Diabetes Audit) are completed more systematically.
- Productivity is improved: CSP is **cost neutral** at practice level: **savings** are frequent with multi morbidity.
- CSP takes time to embed: changes in **clinical indicators** across populations may occur after 2 or 3 cycles.
- CSP levers in changes across **disease pathways**, including closer working between primary and specialist care and reduction in **drug spending** in diabetes.
- CSP is suitable for **diverse groups** reducing **inequality**. Setup costs may be increased for disadvantaged populations.
- CSP provides **economies of scale** with a common approach spanning a 'lifetime of care' including prevention, single conditions, multi morbidity and end of life.

"The new pathway is not only more patient centred but more efficient in time for both patients and health care professionals." ***Practice team member***

Care and support planning - the steps

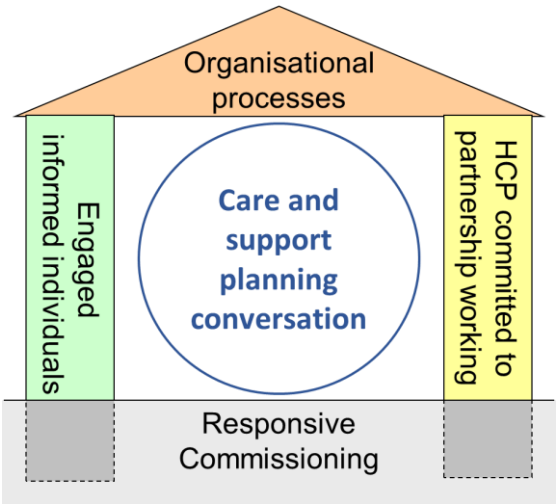
The central aim of CSP is better, solution orientated conversations with health / social care practitioners (HCPs). These identify what is important to the person, discuss and explore issues and develop priorities, goals and actions to support them to live well with their condition/s. **The process of preparation** is critical to enable this and ensures the person has time to think through and identify the issues that are important to them ahead of any discussions with the health or social care practitioner. An initial appointment also ensures that all the **processes of disease surveillance are carried out systematically** and sent to the person together with reflective prompts.

CSP is a systematic continuous process, not a one-off event. It involves specific, observable steps.



The House of Care (HOC)

CSP depends on changes to attitudes, skills and clinic infrastructure all being introduced together. The HOC brings together the many practical issues involved, emphasising the engaged, empowered person working with HCPs committed to a partnership approach **(the walls)**, supported by appropriate/robust organisational systems **(the roof)** and underpinned by responsive whole system commissioning **(the foundation).**



The Year of Care House

- acts as a check list for what needs to be in place
- is a metaphor for the interdependence of each part, if one is weak or missing the structure is not fit for purpose
- provides a flexible framework to enable communities to get started and design the sort of house that suits their population

The YOC team have used the HOC to introduce CSP in a variety of settings including general practice, multidisciplinary community settings, personal health budget teams and specialist outpatients.

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

Introducing CSP across a healthcare community

The YOC approach recognises that ***how*** CSP is introduced is as important as the components themselves.

YOCP recognise three phases of **set up**, **implementation** and **maintenance** all requiring specific, tailored work at local level. The team works alongside communities, local people and practitioners to ensure that the critical components are maintained while being tailored by 'local wisdom'. This can include

- Advice and support to build a strong local delivery system, focussed on care pathways for single and multiple LTCs, multi morbidity and frailty that are designed with CSP as a central component
- Support for steering groups and local programme managers
- Local awareness raising to identify early adopters
- In depth work with practices / teams to develop local exemplars and support new facilitators
- Tried and tested and new local bespoke resources
- Engagement and training for practitioners to support culture change / develop skills to deliver CSP
- Building local capacity / sustainability via champions, 'quality assured' trainers and facilitators
- Access to YOCP network of sites and patient/practice resources

Training options include:

- Taster sessions - preparing for CSP
- Training/induction for leadership teams and clinical champions
- CSP training - one and a half days of training for clinical and practice teams
- CSP training for new members of established teams – one day
- Healthcare Assistant Training - focusing on their role within care and support planning
- Administrator and Practice Manager awareness session
- Training for integrated community teams working with high risk groups
- In-practice system design for CSP for all LTCs
- Extended consultation skills for clinical staff
- Train the Trainer and Quality Assurance Programme
    - The only quality assured national training programme that commissioners can be sure will deliver the key learning and positive impact from the YOC pilot programme
- Facilitation training
    - A unique programme tailored to support local delivery of high quality CSP at grassroots level

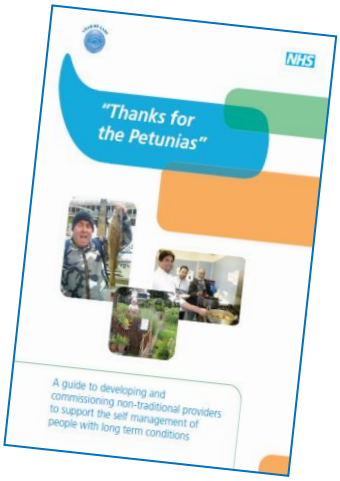
Other resources include:

- Coordinator and steering group guide
- Local programme cost considerations document and cost considerations model
- Commissioning approaches and incentives guide
- Practice Pack: all the tools and resources a practice needs to introduce CSP (including IT templates / read codes for EMIS, VISION, SystmOne)
- Patient materials e.g. sample letters, information about results, care plans and awareness raising materials
- Practice checklists and tools / evaluation frameworks for practice teams / local steering groups
- Quality Marker
- Fidelity Toolkit

"I was sceptical to the extreme about attending this training however I am now persuaded that this approach will contribute hugely to the care provided in the practice". GP

The Big Picture

The YOC approach seeks to ensure that there are a wide range of activities within local communities to support individuals to achieve and maintain good health and wellbeing following care planning. Many of these will be specific to local community needs. Commissioning is one route to achieve this. YOCP have produced ***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 CSP and better support for self-management stimulates service redesign, new approaches to commissioning and whole system change, leading to better integration of services.

Practical fit with policy and guidance

Care and Support planning (CSP) and the principles that underpin it have been important components of UK health policy over the last 10 years and are now a core component of social care within Care Act. How the House of Care supports this is described the King' Fund report - ***Delivering better services for people with long term conditions. Building the House of Care.***

Recently Chapter 2 of ***Five Year Forward View: NHSE 2014*** sets out 'six principles' as the basis of good person centred, community focused health and care of which CSP is a key component. NHSE guidance to CCGs ***Transforming Participation in Health and Care guidance, 2013*** includes the House of Care as a way *'to ensure that every person with a long-term condition or disability has a personalised care plan supporting them to develop the knowledge, skills and confidence to manage their own health.'*

The Care Act: 2014 introduces a duty on councils to ensure that everybody eligible has a CSP plan and personal budget. YOCP co-authored ***Personalised Care and Support Planning – Supporting integrated care for people with health and social care needs. TLAP 2015.*** This interactive tool demonstrates how the CSP steps are generic to and match with the recommended approaches for people with multi morbidity, mental health needs, disability and special educational needs.

CSP has been strongly advocated by the voluntary care sector. ***A Narrative for person centred coordinated care (the 'I' statements): National Voices 2013*** was a seminal piece of work setting out what matters most to patients and service users from their perspective, supported recently by ***What is the Role of voluntary, community and social enterprise (VCSE) organisations in care and support planning? A discussion paper. National Voices 2016.***

CSP has an important role in **clinical quality** as described in a ***Cochrane Review: Personalised care planning for adults with chronic or long term health conditions.*** The RCGP has built on ***Care planning – delivering better services to people with long term conditions: 2011*** as a professional standard and curriculum component for GP's. CSP is a quality statement in ***Diabetes in adults. Nice Quality Standard. Update: 2015*** and has the potential to support the ***Right Care programme*** to reduce variation in outcomes for people living with LTCs including diabetes.

Year of Care Partnerships (YOCP) is an NHS organisation, based within Northumbria HCFT, set up to offer commissioners and providers expertise, practical support and training to put collaborative CSP into routine practice for people with (LTCs) as part of a whole system approach. This includes links with activities in a wider community, including social prescribing. Working with over 40 organisations including CCGs, individual and groups of practices, charities and the Scottish Alliance for the Scottish government YOCP supports a network of quality assured trainers and a community of practice including trainers, clinical champions and exemplars to share and develop learning.

Contact us at *enquiries@yearofcare.co.uk* or for more information visit our website *www.yearofcare.co.uk*