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Year of Care

Pilot case studies

Author: Dr. Anthea Duquemin with contributions from pilot sites and YOC central team.

Contents

Case study 1: NHS North of Tyne 5

Background 7

- Context: key points about setting 7
- Why did this site participate in Year of Care? 7
- Key individuals involved at outset 8

Establishing and implementing Year of Care: activities at site level 8

- Governance 8
- Project management 9
- Funding 10
- Practices involved 11

Establishing and implementing Year of Care: activities at practice level 12

- Engaged informed patient 12
- Healthcare professionals committed to partnership working 13
- Commissioning 15
- Organisational processes 16

Learning from Year of Care 17

- Costs and resources 17
- Evaluation 17
- Evidence of change 18
- Enabling factors and challenges 19
- Plans and hopes for the future 21

Appendix: NHS North of Tyne 22

- Figure A: The Journey of North of Tyne through Year of Care 22
- Figure B: Summary house model for North of Tyne 23
- Figure C: A sample of costs for NHS North of Tyne before and after Year of Care 24
- Figure D: Advice from practices to organisations starting care planning 25

Case study 2: NHS Tower Hamlets 27

Background 29

Context: key points about setting 29

Why did this site participate in Year of Care? 29

Key individuals involved at outset 29

Establishing and implementing Year of Care: activities at site level 29

Governance 29

Project management 30

Funding 30

Practices involved 31

Establishing and implementing Year of Care: activities at practice level 32

Engaged informed patient 32

Healthcare professionals committed to partnership working 34

Commissioning 36

Organisational processes 37

Learning from Year of Care 37

Costs and resources 37

Evaluation 38

Evidence of change 38

Enabling factors and challenges 40

Plans and hopes for the future 41

Appendix 42

Figure A: The journey of Tower Hamlets through Year of Care 42

Figure B: Summary house model for Tower Hamlets 43

Figure C: A sample of costs for NHS Tower Hamlets before and after Year of Care 44

Figure D: Advice from practices to organisations starting care planning 45

Case study 3: NHS Calderdale and Kirklees 47

Background 49

Context: key points about setting 49

Why did this site participate in Year of Care? 49

Key individuals involved at outset 49

Establishing and implementing Year of Care: activities at site level 49

Governance 49

Key aspects of work conducted for Year of Care during each year of the project: 50

Project management 51

Funding 51

Practices involved 52

Establishing and implementing Year of Care: activities at practice level 53

Engaged informed patient 53

Healthcare professionals committed to partnership working 54

Commissioning 55

Organisational processes 56

Learning from Year of Care 57

Costs and resources 57

Evaluation 57

Evidence of change 58

Enabling factors and challenges 59

Plans and hopes for the future 60

Appendix: NHS Calderdale and Kirklees 61

Figure A: The Journey of NHS Calderdale and Kirklees through Year of Care 61

Figure B: Summary house model for NHS Kirklees 63

Figure C: A sample of costs for NHS Calderdale & Kirklees before and after Year of Care 63

Figure D: Advice from practices to organisations starting Year of Care/care planning 64

Case study 1

Introducing and implementing Year of Care

North of Tyne

Background

This case study is derived from reports written by staff at PCT level, interviews with PCT staff, reports by external evaluators, and discussions with PCT staff. Figures in the appendix to this case study are derived from visits to individual practices and contributions from PCT staff.

Context: key points about setting

The Year of Care pilot included diabetes services commissioned by NHS North of Tyne on behalf of NHS North Tyneside, and one locality, West Northumberland, within The Northumberland Care Trust; together with specialist diabetes service within Northumbria Healthcare NHS Foundation Trust. North Tyneside has 29 practices and a population of 212,000, and West Northumberland has 15 practices and a population of 80,000 of which 4.5% and 4,6% respectively are registered with diabetes.

North Tyneside, an area of high population density, includes pockets of post industrial deprivation and wealthy commuter communities. West Northumberland has a rural population with pockets of deprivation between market towns. Both have very small ethnic populations.

Why did this site participate in Year of Care?

A whole system approach to diabetes care had been established over many years in North Tyneside and Northumberland, with a clear service model, culture and approach. More than 80% of people with diabetes in the area received their care in a primary care setting, supported by a proactive and community focussed specialist diabetes service, with a locality orientated structure and strong links with individual primary care teams. Regular training for staff and patient education were in place. The specialist service was committed to service user involvement and had been significantly involved in the development, trialling and implementation of both the DAFNE and DESMOND programmes. In both of these there is a strong emphasis on collaborative working with service users and shared decision making. There were also established service user representative groups in both North Tyneside and West Northumberland. Prior to introduction of Year of Care one practice in North Tyneside and one in West Northumberland had already piloted care planning and a care planning style clinic had been established in a specialist clinic in North Tyneside.

At the time of the Year of Care pilot a service review of diabetes was under way, led by the commissioners. Year of Care became part of this review.

Having established a culture of local diabetes service delivery, and having piloted care planning in a small way locally, NHS North of Tyne recognised participation in the Year of Care pilot as an opportunity to engage in something that they already perceived to be the right approach for people with diabetes.

From the perspective of the clinical teams involved, benefits from engaging in the pilot included the following:

- a focus on better outcomes for people with diabetes
- support and alignment with a national approach to partnership working with patients, by establishing care planning as routine for all annual consultations for diabetes
- formal measurement and evaluation
- opportunity to learn from other pilot sites with different skills, experience, population demographics and challenges
- support for training professionals locally (and potentially nationally) to implement care planning approaches, and to use this as a way of influencing the local health culture and behaviours
- could support sustainable, functional and effective local commissioning of services for diabetes, through using individual choices to inform service provision and identify and respond to unmet need – this would include understanding the costs of implementing a Year of Care approach
- the opportunity to participate in and influence the next iteration of partnership working nationally
- provision of a validated model for care planning that could be extended for other long term conditions.

Key individuals involved at outset

Initial interest in Year of Care came from the specialist diabetes team, and was quickly taken up in other areas. The diabetes specialist team, local practices and NHS North of Tyne all supported the idea of North of Tyne becoming a pilot site in the Year of Care study. Support from senior management at NHS North of Tyne and Northumbria Healthcare NHS Foundation Trust was critically important in giving impetus to the project. An initial project proposal group was established, and once appointed as a pilot site, the same group continued as the steering group for the site.

Establishing and implementing Year of Care: activities at site level

Governance

Steering group

Membership of the steering group for North of Tyne Year of Care demonstrated the high level of support from primary and specialist care, and from commissioners. A strong clinical input was maintained from the outset. Initial members were the associate director and commissioner for long term conditions, NHS North of Tyne (also senior responsible owner for North of Tyne Year of Care); consultant physician and head of service, Northumbria Diabetes Service (NDS) (also clinical lead for North of Tyne Year of Care); service user representative; consultant specialist psychologist in diabetes NDS; consultant physician and National Care Planning clinical lead, NDS; dietitian and diabetes partnership director NDS; consultant dietitian NDS; two general practitioners, one of whom was medical director of Northumbria Healthcare NHS Foundation Trust; and the project manager for Year of Care.

> "I think from the very outset we were really clear that the project steering group had to be representatives from all of the areas because that's what we signed up to deliver as part of the bid..."

Later in the project, the service improvement manager, NHS North of Tyne also became involved...NHS North of Tyne also became involved and later took over as project manager. Other people involved with the steering group included the primary care data quality manager, NHS North of Tyne, who was engaged in measuring the recording of care planning, and clinicians from the Burn Brae Medical Group who were considering adaptation of the care planning approach to other long term conditions, and financial incentives to encourage West Northumberland PBC group to participate.

The steering group operated with a sense of enthusiasm and a positivity:

> "I think we've all approached this with a very kind of can-do attitude, so never did we think that we would ever going to kind of fail, so I think people have been genuinely very positive and I think having that positive attitude has been really helpful."

The steering group met every month during the first 18 months. Later meetings were less frequent.

The group benefitted from strong leadership, commitment and ownership across both sectors. It also benefitted from some degree of stability. As the following person pointed out, while other staff change positions clinicians tend to bring stability.

> "We set up a steering group at the very beginning of the project with the key people who were signed up to the project in the first instance. We've carried on with the format of that steering group... there have been times when because some of the key people on the steering group... haven't been able to turn up for meetings, so you know, keeping the momentum... I think people have had ownership of this project, I think people have seen it as their responsibility to see the project through to the end. And you know, people's commitment have come and gone over the time, but generally it's the same people at the beginning of the process that are still there and taking the accountability for it... Key people have come and gone but on the whole we've had stability and I guess the rock in all of that has been some of the clinical people involved in the process."

The importance of strong support and leadership from the top of the organisation has been stressed by several of those involved with North of Tyne Year of Care. Another crucial component has been time to develop trust and sound relationships that enable exploration and open discussion.

Sub groups

The steering group developed a project plan and timeline for the duration of the pilot, and identified the following eight work streams:

- project management
- commissioning review
- communication and engagement (with practices and stakeholder organisations)
- patient and public involvement
- training and education for healthcare professionals
- information and evaluation
- benefits realisation
- local evaluation.

Each work stream was managed by a work stream lead.

Project management

Project manager

Prior to recruitment of a project manager a senior member of the commissioning team supported and managed the project. A full-time project manager was then appointed with the following responsibilities:

- organisation of all steering group meetings, setting the agenda and maintaining minutes
- liaison with work stream leads and monitoring progress
- co-authoring documentation where needed including communications with practices, local press, supporting publications in journals
- supporting the production of video material to explain Year of Care (an NHS Alliance request developed on behalf of all of the pilot sites)
- direct links with practices, PBC groups and local medical committee
- introducing practices to IT that supports care planning
- meeting with existing service user groups and helping to produce service user information for distribution within practices
- arranging and facilitating focus groups with service users
- links with operational and strategic activities related to the diabetes service review
- links with the national project team.

The project manager proved to be central to the project's progress. All steering group members were heavily committed in clinical or management roles. The work of the project manager, her grasp of the concept and relationship with the steering group enabled and encouraged members to maintain motivation and develop their ideas and thinking. At a practical level the project manager ensured that the project operated in a co-ordinated way locally and in step with other pilot sites.

Valuable skills that the project manager brought to the role included an ability to work with the range of people across the team, coordinating and collating activities and also, crucially, linking with individual participating practices.

After 18 months the original project manager moved elsewhere. Rather than recruit into a separate post, the project was included within the portfolio of a service improvement manager within the commissioning function of NHS North of Tyne. Year of Care was one of several within the new project manager's portfolio. This resulted

in dilution of input to the steering group and practices, and led to loss of momentum within the project, demonstrating the critical importance of dedicated and effective project management at all stages of the project.

> "...one of the learnings for us is that it needs dedicated time as opposed to being part of somebody's portfolio, because of it being a large project, a complex project... So somebody who's got some dedicated time to see, to have that oversight of all aspects of the project, but also to be a key resource for the practices because part of embedding and sustaining change at primary care is that it's not just a short intervention, you go in and you do something, it's about how you embed some of those behaviour changes and how do you sustain it and it's just being that key person to do some of the follow up and all of the kind of like the groundwork, I think is really important learning..., developing the relationships, following through, working through problems with individuals and then feeding that back up where necessary."

> "...maybe not full-time but dedicated, so it's not just part of a wider portfolio, it's a dedicated resource that's solely there to work through some of the technicalities and the issues at a very local level."

Contact with national team

Members of the steering group attended the learning events organised by the national Year of Care team and contributed strongly to them.

> "...what's been helpful is the focus of the learning events so as we've gone through this process, and certainly in year one and year two of the programme, we had quite a commitment in terms of the base sites to the learning events and quite a lot of the intellectual thoughts and the cross fertilisation and the sharing and learning from each other and picking up hints and tips and how people are managing things, was actually done through that learning exchange."

By Year 3 of the project fewer learning events were held, but the national programme board had been extended to include, first, senior responsible owners and, later, project managers, so that ongoing opportunities were available for interaction.

Funding

Funding overall

North of Tyne received £98,000 from the Year of Care Programme for initial set-up costs of the first project. Of this, £10,000 was allocated to fund local qualitative evaluation and the remaining sum funded the project manager during the set up phase (nine months), and covered initial costs of delivering training, providing backfill to allow practice teams to attend, and supported user focus groups and travel costs.

North of Tyne covered the salary for the project manager after the initial set-up year (until the initial project manager left) and other ongoing costs.

Financial incentives

Funding arrangements for diabetes in primary care differed in North Tyneside and Northumberland.

North Tyneside PCT already had a local enhanced service agreement (LES), which was revised so that practices received a premium rate for delivering care planning, or a lower rate for structured care. Twenty-eight of the 29 practices opted to engage with Year of Care, thus receiving the higher rate. Each practice participating in the LES is required to produce an annual report that includes reporting on aspects of care planning.

Northumberland Care Trust operated through a PMS contractual framework rather than through LES arrangements. Diabetes had, for many years, been a quality initiative within the PMS quality framework, allowing enhanced delivery of diabetes care in the community. During the set-up phase of Year of Care an alternative incentive scheme was introduced, using non-recurring funding from PBC service improvement funds.

Financial levers to incentivise engagement proved to be an important factor in achieving engagement.

After the set up phase ongoing financial support became more difficult. In North Tyneside enhanced LES arrangements remained in place and this encouraged practices to maintain a care planning approach. NHS North of Tyne supported the project manager, albeit with a wider portfolio, for a further 12 months, but no new funding to provide specialist support or administrative support to embed the pilot was identified. To some extent this reflected difficulties within the progress of the wider North of Tyne diabetes review.

Practices involved

Unlike the other two pilot sites, North of Tyne invited all practices, first in North Tyneside, then in West Northumberland, to participate in the Year of Care pilot at the outset.

As noted above, in North Tyneside 28 out of 29 practices agreed to take part (four PBC cluster groups). In West Northumberland 11 practices agreed to participate (the whole PBC cluster). Participation in Year of Care was seen by practices as a natural next step in the development of diabetes services.

> "...in the whole population of North Tyneside you've got four practice based commissioning groups and we wanted to work with practice based commissioning groups to make this link with commissioned services locally for local populations further down the line, and we didn't expect at the very beginning that we were going to get all of the practices involved. But what happened was, we had one GP for a practice based commissioning group that would say, you know, we want to do this as a practice, can we do it as a group? So I think as groups of local commissioners they've worked well together. And again in West Northumberland they tied it in as an initiative as part of their practice based commissioning scheme that they would participate in and engage in Year of Care, which was also about implementing care planning and doing all the structural changes, but also about we're all in this and we'll participate in the evaluation. So there's been some really interesting levers and you know, sort of engagement with primary care."

Activities at site level to promote and support engagement

Clinical engagement in Year of Care was supported by building on pre-existing knowledge and relationships, and through deliberate strategies and activities.

The vision of Year of Care was shared with practices through existing relationships, supported by detailed knowledge about which GPs and practice nurses delivered diabetes care, and by linking with PBC leads and local clinical primary care diabetes champions. These were also useful links for addressing ambivalence about the project. Information about Year of Care and occasional newsletters were mailed to practices.

As noted above, financial support provided backfill for staff attending Year of Care training, and financial incentives were available to promote uptake of care planning.

Primary care training meetings were used as opportunities to introduce Year of Care, and the first practices to adopt care planning were given considerable support. All practices that adopted care planning were given feedback on the numbers of patients with documented care plans, using a MYQUEST search of EMIS primary care systems.

Resources were produced to support primary care in delivering Year of Care, including document templates for feeding back results to patients. The template also prompts patients to consider areas that they may wish to discuss during their consultation. Individual practices later adapted the templates for their own situation. Other resources included information for patients to help them interpret their results. During development of patient tools and resources special attention was paid to compatibility of language and approaches in the Year of Care materials with those in the DESMOND resources.

Feedback was sought from practices about the type of support that would sustain the Year of Care approach. As part of the local qualitative evaluation process, focus groups were held to hear from practices their experience of participation in the pilot.

Much of the early and ongoing support relied on existing collaborative relationships that had been established in the model of care between clinical teams, and on the good relationship with the lead commissioner (SRO). Trust developed over time and was especially important for supporting change through times when implementation proved difficult.

While the emphasis for Year of Care was on primary care adoption of the model, it became apparent that patients attending specialist services risked missing out on the care planning approach. A specialist clinic in North Tyneside had already been testing whether a care planning approach could be implemented, and found that it was not only possible, but highly valued by patients and staff. This led to training being delivered to diabetes specialist clinicians in the same way as to primary care teams.

The experience of North of Tyne demonstrated that a 'whole system' approach allowed cross-organisational change to be adopted. Where there is an existing network this can be built on. If no such network exists something similar needs to be developed.

Figure A (The Journey of North of Tyne through Year of Care), in the appendix to this case study, provides a pictorial illustration of key steps for the site as it progressed towards adopting Year of Care.

Establishing and implementing Year of Care: activities at practice level

In keeping with the approach used in the external evaluation, headings used to report practice level activities are categorised under components of the 'House' model.

Engaged informed patient

Informing patients about Year of Care

The most evident change for patients with diabetes in practices that adopted a Year of Care approach was that their annual consultation now involved two visits: the first to gather biometric information, and the second for consultation and care planning. Between the two visits patients would receive copies of their biometric results by post.

Together with the project manager practices developed posters that they displayed in waiting rooms, informing patients of these changes. Matching leaflets were left in waiting rooms, and most practices mailed leaflets to patients with their invitation to the pre-consultation information gathering visit.

Awareness meetings and focus groups were also advertised in the local press and in practices. Presentations were made to local diabetes support groups in North Tyneside and West Northumberland with opportunities to raise questions and concerns.

Structured education

The local diabetes community had been early adopters of both DAFNE and DESMOND. While the process of offering these programmes to newly diagnosed patients was still in its early stages, and had not yet been introduced for people with established diabetes, the adoption of Year of Care gave impetus to the extension of DESMOND, and this was incorporated into the wider ongoing diabetes service review that was being undertaken by commissioners. This emphasised the fact that patient education programmes should be linked fundamentally to a Year of Care approach and that they require commissioning.

Additional support for patients

As noted above, practices made use of a template, developed by the local steering group, which, along with feedback of results, also prompted patients to consider issues they might raise during their consultation. Patients

were also given supporting information that helped them interpret their results and understand actions they could take to influence them.

Considerable debate took place about these tools, particularly about whether patients would become anxious about 'bad results' and about the need to balance technical and complex language so that patients would absorb enough information to consider the implications of their results. The importance of specific, personal, comprehensible information was emphasised, and the need to identify actions that could favourably influence results.

Healthcare professionals committed to partnership working

Workforce training

In North of Tyne a long standing collaborative relationship existed between Northumbria Healthcare Diabetes Specialist Service and practices in Northumberland and North Tyneside, which included a focus on developing approaches to patient partnership. Primary care training events had been held in both localities, a Masters level diabetes training programme had been developed, and the specialist service delivered ongoing training in communication and motivational skills.

Based on this experience, several GPs and practice nurses involved in diabetes were already familiar with some of the principles underlying Year of Care, and two practices had already piloted a care planning approach to service delivery. At this stage however, the care planning approach was not part of the whole system organisational change nor was it part of the changes in commissioning of services.

Early in the process of implementing Year of Care, the steering group recognised the need to develop and deliver training that built on the experience already developed amongst their multi-disciplinary team. A programme of two half days of training was designed, with input from individuals from both primary and secondary care, allowing for shared ideas and knowledge about current skill and competency levels. The training was designed with the first session introducing Year of Care and care planning, aiming to prepare practices to implement changes in their approach. The second session addressed their early experiences in doing this and focused on consultation micro-skills.

> "...we got to a point in the project discussions around 'do you think the central team are expecting us to deliver a training programme for our practices?'... So that's when as a specialist team, they got together and said, 'well what would a training programme look like? So if we were devising a two day training programme, what would it look like?' And then kind of you know, built out the component parts of it with the input from the diabetes specialist nurse, the consultants – now we're really fortunate that the consultants we've been working with have been involved in care planning for many years, have influenced the national thinking about it, who have contributed to the national documents. So I think we've been very fortunate. So I think for them as a multi-disciplinary team, that was their way of thinking, so they came up with a programme which for us was incredibly successful, (a) because it was delivered by a team of people who are used to going in and supporting primary care and have been for years, but also because of the expertise they took as individuals, in terms of building that programme. So I think you know, from our perspective, we've been really fortunate to have the individuals and the expertise..."

Training was delivered to six to eight practices (12–14 individuals) at a time, aiming to train a doctor and practice nurse involved with diabetes from each participating practice. Two or three trainers delivered each session. Funding was provided to release staff for the training. Six cohorts of training were needed to deliver training to all practices. Comments collected by external evaluators from participants who attended the early training sessions are noted below.

> "My consultation technique has changed. The patient takes the lead. I always thought this was the best way of doing things but this has formalised the approach."

> "I had half a day of training last year. It covered what Year of Care is about and why it is being piloted. It was helpful – it did get goal setting across well and made you think. The best thing about it was the session with other practices to share what we are doing. It is good to hear how everyone is getting along with it. Our admin team has received training from the GP – explaining what they need to do and why. They are on board and tend to be more pushy with patients about their appointment because they understand why it is important for them to come in."

> "I did the training. It was interesting, I learnt a lot, all about the different parts of putting together the Year of Care package. Everyone was doing it differently, and we could iron out problems. It gave a clear view of what we were meant to do. There was group work, a mix of nurses and doctors, primary and secondary care. The consultants were very upbeat and keen. The role play was cringe making but it served its purpose. The video was a bit stage managed. Would all of it happen in real life? It was OK. The follow up days were good."

It became apparent that practices differed widely in their starting point. Feedback was collected from trainees and, incorporating reflection amongst trainers after each session, the programme was incrementally modified. The North of Tyne training programme went on to form the building blocks of the National Care Planning training programme.

> "I think that the key success from our pilot site has been the education and training programme that was developed and tried and tested locally and then obviously that's grown into something that's got much more national prominence, so I think that's been a real success."

During the final year of the Year of Care, NHS North of Tyne pilot (through Northumbria healthcare diabetes service) was commissioned by Diabetes UK to develop a national training programme to train trainers, so that health communities can develop their own capacity to develop care planning skills in their own area. A shorter training programme has also been developed for healthcare assistants and practice managers.

Once the training had been delivered to practices in North of Tyne it was also delivered to the diabetes specialist team, since it was recognised that a consistent approach would be needed across the system for patients receiving care in different settings.

Alongside the training, resources were created for practices. These included all materials needed for inviting patients to care planning consultations, documenting and sharing results, prompting patient reflection on needs within a care planning consultation, documentation of goals, actions and follow up, leaflets and posters for surgeries, and prompts to support core consultation skills as the consultation moved from being led by a health professional to a patient-led style. Feedback from practices allowed this material to be tested, adapted and improved. At the same time, a *Partners in Care* booklet was being tested amongst practices, as another resource for care planning.

With time it has been recognised that ongoing training for Year of Care is needed as staff in practices change. A need is also identified for diploma level diabetes training for nurses, in addition to Year of Care training, highlighting the ongoing dilemma of generic versus specific training.

Care planning

Following initial training all practices adopted some aspects of care planning, though not all have yet adopted all components of the Year of Care model. One person gave an estimation based on their contact with practices.

> "...some might be doing little bits of it, it's 12 [in North of Tyne] doing what we would call it as maybe 'properly', the way they were trained... Well I would say where they're doing the full consultation and they're sending out the results and they're giving them care plans and they're recording the care plans and coding care plans and doing the whole kind of kit and caboodle."

An ongoing challenge during Year of Care has been the inability to adapt existing primary care electronic record systems to support routine generation of information about activity and outcomes from care planning, that

could then be used for commissioning. Practices that have not adopted the full Year of Care tend to name inadequate IT systems as a major reason limiting full adoption. This same block has made it difficult to measure the extent to which care planning is taking place.

Workforce changes

As practices adopt the Year of Care approach changes have taken place, with a more rational division of roles.

> "...they're seeing the benefits from maybe changing the way that they do the whole consultation so they might have perhaps instead of the GP seeing the patient, the practice nurse now sees the patient, instead of the practice nurse maybe doing the bloods, the healthcare assistants do the bloods. So it's maybe changed the way that they see the whole appointment and the whole consultation mode has maybe changed... and I think the more they get to grips with it, the more they embrace it and kind of go into it more and can see the benefit..."

Commissioning

Identifying and meeting needs

North of Tyne has strong leadership in commissioning, but when it first became a pilot site for Year of Care there was no detailed locality-based needs assessment for diabetes for the area. To address this gap a review of commissioning arrangements for diabetes was undertaken as a comprehensive service review. A programme budget analysis was undertaken for diabetes and a service model and service specification for strategic commissioning was recommended to the North of Tyne commissioning board.

As Year of Care progressed a Joint Strategic Needs Assessment (JSNA) was developed, agreeing priority areas within the framework of Health & Wellbeing partnership arrangements between health and local authorities.

A service directory was compiled documenting the range of commissioned lifestyle services across North of Tyne. This was beneficial in informing the menu of care, but the directory was difficult to generate and even more difficult to keep updated. It was also recognised that developing new services for the non-traditional provider market remained a challenge, as did identifying unmet need.

As noted below, during the implementation phase of Year of Care, IT links between care planning and commissioning proved an ongoing limitation in identifying unmet need. In the face of the challenge, the steering group and commissioners took a proactive approach, using available data to guide their decisions.

> "...we can use IT as a kind of barrier or we can say 'actually we realise that would be the perfect solution, but it's not going to be there for a while'. So we navigate it and say, well actually this is what people are telling us: we've used the initial evaluation from Tribal, we've used some of the indicators to say people feel that they're confident and they trust and they're satisfied with the support they get from primary care, but actually there's some information needs there, and that's come out. So we've actually said, well that's near enough an unmet need, so that's near to an unmet need we need to do something about it."

A general finding related to commissioning arrangements at PCT level was that existing, historical commissioning arrangements were inflexible, with very limited ability to decommission from one element of the pathway to re-invest in another, emphasising the fact that more responsive approaches were needed.

> "...it confirmed for us that our investment in diabetes predominantly sits in the specialist end of the service. So if we're talking about support for self management or developing alternative providers, how do you commission that? Well in order to commission it in this financial climate you need to de-commission something else. So thinking about how you move money around the system means that you've got to stop doing part of something to fund that shift and part of the move to support long term conditions and self management is exactly that shift. We all know that we need to invest more in public health programmes

> but actually making the move is really quite hard and that was illustrated through our service review."

Since the end of the pilot, work has been undertaken as part of a project with an emerging primary care consortia in North of Tyne, funded by the Strategic Health Authority, to look at ways to identify unmet need and develop non-traditional providers.

> "...we haven't got a systematic IT solution to identify unmet need at the care planning consultation. That's a bit of work that needs to be integrated into the agenda as well. But then also provider development, so if we're really going to achieve a major behaviour change for long term conditions, we need to crack this bit about how do we link people's ongoing management and life style intervention and advice into a more community based programme. And that's the bit that, when we finish our provider development project, will actually complement this. Yeah, that's a bit about commissioning the provider development and the commissioning aspect which is identifying local needs and transferring that into services that are commissioned."

Organisational processes

IT templates

Practices across North Tyneside and Northumberland use a range of patient information systems. This has presented challenges for developing standardised care planning templates that capture goals and action plans together with biometric data.

In the absence of an ideal solution local approaches were developed and shared with other practices and other sites. The following approach was described during interviews with external evaluators.

> "We have EMIS LV. EMIS is great. It works well. The care plan is on a Word document and it merges onto the medical record. Anything we write on plans isn't scanned. We write after the patient's been in. If they want it they can get it. It's not major, it's up to them if they want to write it down. It works, not a problem that care plan isn't on the computer. It's only a Word document that prints off and hand write in."

At national level work has been conducted to achieve a care planning template for diabetes for SystmOne practices. Solutions are being explored and discussed with other software manufacturers at national level.

Call/recall systems

All practices had functioning call-recall systems.

Figure B (Summary house model for North of Tyne), in the appendix to this case study, presents processes in NHS North of Tyne that were put in place prior to and during implementation of Year of Care. The changes were described during visits to six practices in February/March 2011 and are listed under the five components of the 'House model', which proved to be a valuable conceptual tool for identifying components that support effective care planning. Comments from members of the steering group are also included.

Learning from Year of Care

Costs and resources

Costs specific to pilot sites

Much of the time spent developing ways of implementing Year of Care, engaging with the national team, contributing to the external evaluation and developing training and resources were specifically associated with North of Tyne's status as a pilot site.

Typical costs

A major component of the costs involved in adopting Year of Care came from significant input of time from the specialist service, commissioners and other members of the steering group. Additional costs included time developing resources, developing and delivering training, printing and mailing results and letters, and undertaking qualitative evaluation. While, as noted above, aspects of this work will be reduced for non-pilot sites, inevitably the cost of implementing Year of Care includes time and expertise. The experience of North of Tyne demonstrated that costs were best addressed through strategic alignment of the programme to desired service developments.

Other costs included the financial incentives for practices that adopted Year of Care.

An analysis of workforce and skill mix costs before and after the Year of Care Pilot Project has been undertaken from a sample of practices in the three pilot sites and has demonstrated that some practices have reduced costs, some have increased and some have remained cost neutral. Figure C (A sample of costs for NHS North of Tyne before and after Year of Care) in the appendix to this case study outlines costs for eight practices in North of Tyne before and after involvement in Year of Care, calculated as £s per patient.

Evaluation

External evaluation

An external evaluation was commissioned by Year of Care at national level. During 2009 two consultants from the evaluation company visited North of Tyne and interviewed 25 patients and 14 healthcare professionals to hear views about the early stages of implementation of Year of Care. A range of quantitative tools were applied, at organisational level (Primary Care Resources and Support Assessment, and the Commissioning Inventory); collecting patient data (Consultation Quality Index for diabetes, Diabetes Treatment Satisfaction Questionnaire, Quality of Life EQ-5D, Healthcare Commission Diabetes Omnibus, and biometrics captured from practice IT systems) and collecting cost data (Client Service Receipt Inventory), though results from the latter were not useable.

Many practices found the scale and detail of the evaluation difficult and were concerned about the burden on patients, whose experience was being assessed in a number of ways. Nevertheless, most practices persisted with the external evaluation, wanting to learn the outcomes.

Internal evaluation

Both qualitative and quantitative evaluations were conducted at local level.

As part of the original bid to become a Year of Care pilot site a small amount of funding (£10,000) was set aside for a psychology research assistant to conduct an in depth qualitative assessment of the impact of implementing Year of Care and the responses of service users and healthcare professionals. Fourteen patients and five healthcare professionals were interviewed mid 2009 for this study.

At a quantitative level, as noted above, difficulties with IT programmes limited the ability of electronic record systems to record care planning activity. To address this problem the North of Tyne informatics team wrote a MIQUEST query to extract data from practice IT systems on a quarterly basis. A baseline was set to mark improvement over a range of indicators including the number of people with a personalised care plan.

It has since been recognised that further use could have been made of this data at local practice level. So far the data collected has been used only to indicate numbers of people with care plans, but it is intended that further analysis will be conducted to explore the extent to which actual care planning has occurred, and to develop a systematic approach for feeding back this data to primary care.

Evidence of change

Implementation

Of the 39 practices in North of Tyne that received training for Year of Care all have adopted some aspects of care planning, but it is not fully known how closely they are following the Year of Care approach. Quarterly extraction of data from practice systems demonstrate that increasing numbers of patients have received a care plan (document), but for North Tyneside practices, it is not known how fully the care planning process has been conducted. Practices in West Northumberland were, however, able to demonstrate improvements in their recording of completed care planning consultations over the course of the pilot.

Impact for patients

During 2009 when external consultants interviewed patients, they found that few patients had noticed significant difference in the care they received. However it must be recognised that North of Tyne already delivered highly patient-centred services prior to involvement in Year of Care. The evaluators commented that patients had not received enough information about the new approach. At this stage, some patients interviewed were not receiving written care plans, but others were and appreciated them.

> "I see the nurse and have my blood results two weeks before. They are sent out before the appointment so we can talk about goals. The goals we agree are written down – for example weight reduction and keeping cholesterol down."

> "The goal setting is done together – we talked about losing weight as this will reduce my blood pressure. They are my goals. I get the care plan with my results at the appointment. I find this very helpful and we refer to the previous year's tests. At my last appointment they tweaked my blood pressure tablets and we agreed I need to lose weight."

> "He gave me a ruled page. He wrote down on there the things I said I would continue to do. He asked me what I thought I could do to improve things. These were things we discussed. I thought 2009 is the year I did something."

The qualitative study conducted locally in North of Tyne during Year 2 of the Year of Care pilot found overwhelming support from the 14 patients interviewed, who said that sending out results in advance and the changed style of consultation gave them a sense of greater involvement in decision making and planning their own care.

In 2010 the external evaluation noted that during the two years of implementing Year of Care in North of Tyne over 1,800 patient responses had been received. They noted that by Year 2 there was an increase in the number of patients receiving test results in writing, in those receiving a written copy of their care plan, and in the proportion who found that the care plan helped manage their diabetes.

Impact for clinicians

Amongst the 14 clinicians interviewed by the external evaluators in 2009 the general view appeared to be that Year of Care made consultations more individual and structured and helped healthcare professionals to encourage patients to use them as resource. It was recognised that patients vary in the extent to which they engage in the care planning process, but overall comments appeared positive.

> "Blood results are sent out two weeks before. 5% are latched on, 5% will bring their care plan. 5–10 will bring the letter. 10–15 won't bring the results letter even though it was written on it to bring it back. It's a big cultural change. Some patients say, thanks for sending it but I don't understand it. Some, why did you send them. We reinforce each visit – we've changed the way the clinics are run. Results are there to bring… Need constant reinforcement."

> "How the approach is received varies from individual to individual. Some are very clued up and some find it very foreign. Some are hard to manage through the process – you can't force them to do it. Very few don't want a goal. Quite a few have written on their plan when they come back. Some get enthusiastic about their goals and they become part of their daily life. Most do take some ownership."

> "I work through the template and the care plan. They and I both identify. [when asked what proportion] I'd like to say 50:50 but it could be 25:75 either way. Elderly patients are happy for me to do most of the talking... Previously I was never, you must do this, you must do that. I always had a conversation and listened to their views. Now it is more structured. The thinking is more from the patient's point of view rather than the professional point of view. It focuses your mind on their motivations to make changes... I'm more aware if patients come in with knowledge, we can have a discussion. I'm in line with their thoughts. It's more a partnership to achieve their goals. Much more of a two way street."

In the local qualitative study, the five healthcare professionals interviewed in 2009 were extremely positive about the changes and enjoyed and valued a sense of greater joint working with patients, with less focus on a 'tick box' approach. However, there was also more ambivalence than amongst patients about allowing patients to lead consultations, and about some of the practical adjustments that had been needed to accommodate the new way of working. As another clinician pointed out recently:

> "It probably takes two years or more for people to get the hang of it and know what to expect. It's difficult to prepare people for this in advance though..."

Impact for organisation

The experience of adopting Year of Care in North of Tyne has demonstrated that considerable organisational change is needed amongst all parts of the 'House' in order to support a Year of Care approach, and that this requires considerable planning, training, practice restructuring, new ways of commissioning and robust IT processes and metrics. Of these, the IT systems and metrics proved the most challenging.

Early in the implementation phase of the programme, the project manager introduced practices to IT resources that supported some of the administrative tasks related to care planning. This provided valuable help, but the challenge of applying a care planning template to IT practice systems, other than SystmOne, has not yet been resolved in any elegant way. Nevertheless, most practices have found their own solutions to address this gap and negotiations with software suppliers are underway to develop a national solution.

The programme has involved considerable commitment in terms of releasing staff from both the PCT and Acute Foundation Trust and huge changes for the practices involved. This has involved a cementing of working relationships between primary care and specialist services and development of new structures, patient flows and processes to adapt to the new way of working. The structural changes are now in place in primary care and are still in evolution in the specialist clinics. To maintain the success achieved so far, and for further development of Year of Care, it is recognised that ongoing collaborative engagement is needed from commissioners, primary care and specialist services. Some form of ongoing project development will also be needed, with committed resources.

Some local practices have sought to adapt the Year of Care approach to other long term conditions. In addition, projects have been established to consider ways of delivering a similar approach for COPD and, since the Year of Care pilot phase ended, to explore generic care planning for all patients with a long term condition. These approaches are being evaluated and training programmes adapted to cater for them.

North of Tyne practices that were not involved in the pilot (Northumberland practices excluding West Northumberland and Newcastle practices) have asked for training for a Year of Care approach and this has been delivered during 2011.

Enabling factors and challenges

Enabling factors:

- High level support 'right from the top, right from the start' was shown to be invaluable for achieving the necessary change processes. Senior buy-in has been crucial for North of Tyne's success.
  > "... it's a complex intervention and embedding it is part of the ongoing sustainability. You need to understand primary care... and sometimes you need to get your sleeves rolled up to find a practical solution. So I think we've had that level, we have had levers, we've had commissioning levers... there's been a lever to achieve some of that change."

- Engagement and shared vision across the whole system. Commissioners, primary care, and specialist services worked closely together to identify, support and coordinate solutions.

  "...if you learn from the experience that we had, you need across your diabetes network, you need total engagement. So you know, if it was a project that was led by your specialist team without GP engagement or commissioning engagement [it wouldn't work]... all the parts of the jigsaw need to be in place. So I think it needs to be part of a network initiative if there's a network there. If not, it needs to be led or supported by commissioners, whether that's local groups of practice based commissioning or whether that's PCT commissioners... it's about aligning all of the players in the economy for diabetes to the vision and once you've got the vision it's about what's the action plan that you're going to put in place to achieve where you want to go."

  "I guess we're lucky because we've got our providers, our GPs and our commissioners talking in the same way, and if we're all enthusiastic and see the benefit, and it's part of the modernisation programme for long term conditions, then I think we're not working against each other. Whereas potentially you know, it's somebody's idea and how do you get your idea sold to somebody else? So I think we're all like minded people, you know, we've developed some pretty good relationships and some trust in there and I just think fostered an environment where we can have open and really constructive dialogue."

- Effective clinical champions who could motivate peers, challenge models and find practical solutions.

  "... we had really effective clinical champions, so we had GPs in our areas who were the spokespeople, the spokesmen of the Year of Care project who saw the bigger picture, who did all of the kind of motivation with their peers about trying to get people involved, but also thinking about it from a practical point of view, so coming in with, and some of the models that were developed as part of this project was around kind of this is the kind of theory, this is a model, how will it work in practice? And for people to come in and challenge that, which I think was really helpful."

- Effective, committed steering group that allows sound discussion. The extended period over which the steering group has been working, and the relative stability that clinical members of the group have brought, while other members changed, has allowed trusting relationships to develop.

  "...we have good relationships across the steering group, I think if something's not right I think people are quite open to say, you know, this hasn't gone really well. And you know, just be open to challenge, if somebody says something at a steering group meeting, then exploring and challenge around what do you mean by that? Be critical of ourselves as well, because it hasn't been all sunshine and roses, there's been some difficult conversations we've had. There's been some challenges in terms of you know, what is it we think we're here to do? So yea, I think, and people respect each other, so I think some of those softer things around relationships, trust, all of that stuff. And that takes time to work on."

- Dedicated and effective project management throughout. The experience in North of Tyne demonstrated that project management is a crucial component when introducing Year of Care. Practices need dedicated, ongoing support to adopt and then maintain the approach.

  "I think what we do is we underestimate the support and the ongoing development that needs to be there at a very local level to kind of help people through that process. So I think that's one of the key things, this whole project or this whole care planning process and you know, you hear it recurringly, is a complex intervention, everybody will tell you it's a complex intervention. How are we supporting the on-going implementation and embedding of that complex intervention? And if we don't do that, if we don't support it and embed it, then people are going to tail-off at the end of the day. that's part of it being a whole system programme, so that we continually come back to it, you know, we've got some practices who have been really successful, they've made the changes, they're doing, they're seeing some good results. What are we doing to get everybody else up to that same level?"

- Financial incentives. The financial levers introduced in North of Tyne, through a local enhanced service agreement in one area, and PBC service improvement funds in the other, proved effective in achieving uptake of Year of Care.

Challenges:

- External evaluation.
- The extent and complexity of the external evaluation was a challenge for practices, and for staff at site level.

  "I honestly think the evaluation, the way all the forms and people filling it in and doing it, I just don't think that was friendly, user friendly enough and I think it put a lot of people off."

- IT templates. Practices experienced challenges linking care planning templates to practice systems.
- Staff turnover. Loss of people in key positions in the steering group and management threatened momentum of the project, leaving too few people doing too many tasks.
- Maintaining and enhancing skill levels.

  "...refreshing people, because what we've done is, we've developed our providers around their consultation skills and obviously motivational interview and all of the stuff that goes around care planning with the process, so we've invested in that. So we need to kind of say, 'ok, that's been the initial investment, they've gone away, they've tried and tested it, patients have been through the process, this is some of the evaluation'. But we also then need to say, 'well this is what your experience of the whole process has been, how is it going to continue in the future? How do we support that?' And I think that's really, really important, because if not, what you're going to get is, you're just going to get everybody with a long term condition with a piece of paper that's a check list."

- Funding. It is not clear, in North of Tyne, how support and maintenance of the Year of Care approach will be funded, especially within the proposed new structures for health services.

During visits to six practices in North of Tyne during February/March 2011, staff were asked what advice they would give to practices that were considering adopting a Year of Care/care planning approach. Figure D: (North of Tyne: Advice from practices to organisations starting Care Planning), in the appendix to this case study summarises their responses.

Plans and hopes for the future

- Develop an infrastructure to sustain Year of Care style service delivery. This is still needed and is the subject of ongoing discussions.
- Year of Care has been delivered to over half of practices in North of Tyne. Training is now underway to provide training to the remaining practices in Northumberland and all Newcastle practices
- Develop further support and training modules. While training has been delivered first to doctors and nurses, other staff, (including practice managers, receptionists, administrative staff, healthcare assistants, and clinical team members not involved with diabetes) are also important when delivering Year of Care. Short modules (two hour training sessions) have been developed to help inform and engage staff.
- Extension of the approach to other long term conditions is under way. Specific areas where it is intended to apply the approach are COPD, NHS Health Checks, musculoskeletal conditions, care home residents, palliative care and there is an aim to develop an approach that recognises multisystem conditions (generic care planning).
- Further work on provider development. A local project has considered how this could be conducted; the next step is to consider feasibility.

Appendix: NHS North of Tyne

Figure A: The Journey of North of Tyne through Year of Care

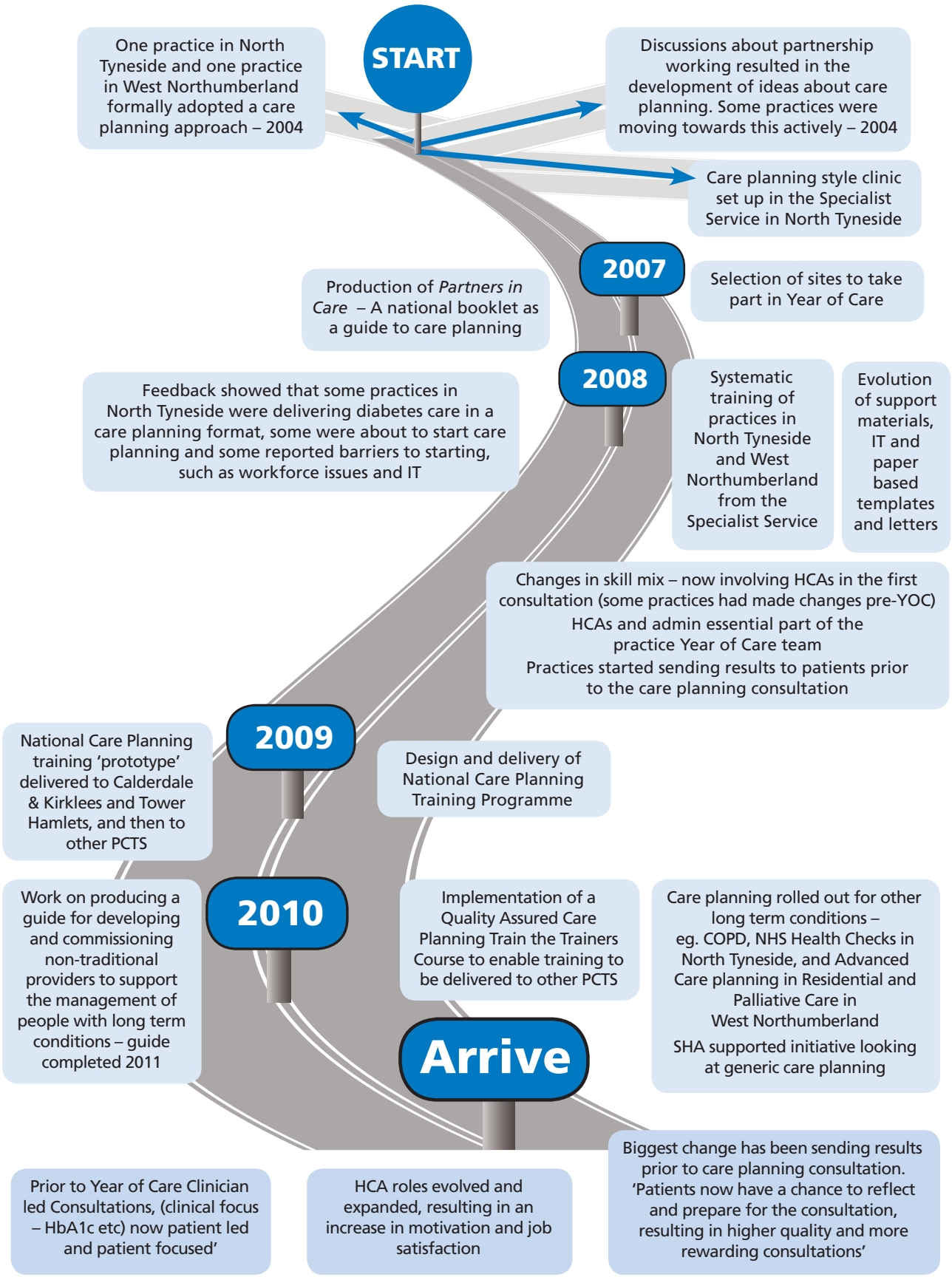

Figure B: Summary house model for North of Tyne

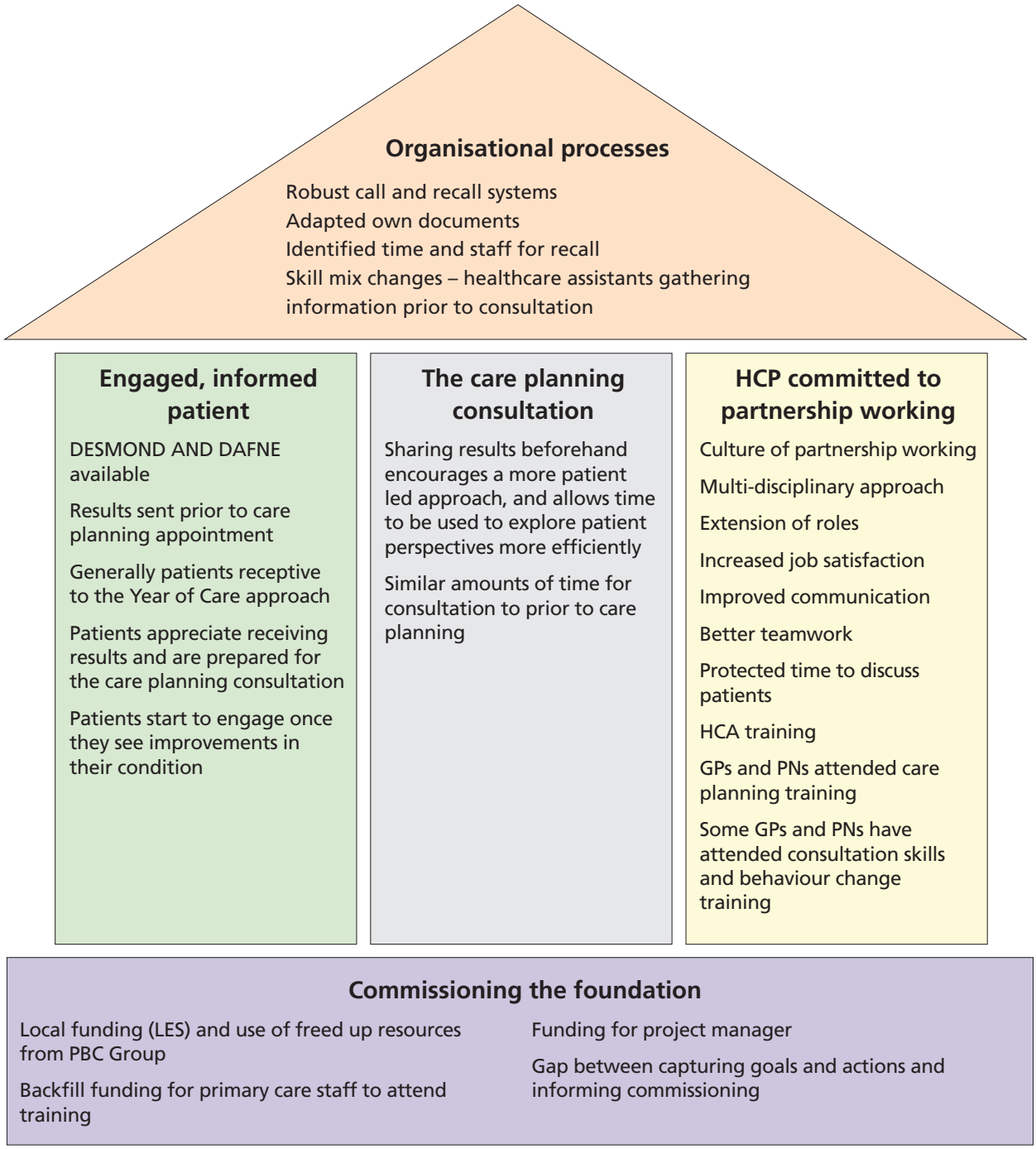

Figure C: A sample of costs for NHS North of Tyne before and after Year of Care

A sample of costs for NHS North of Tyne before and after Year of Care outlines costs for eight practices, calculated as £s per patient.

The total costs include administrative time for searches, making appointments, consultation time for tests, and the annual review/care planning consultation. The numbers of visits refer to consultations/patient contact time at the surgery.

*costs indicate if the care planning consultation is with a practice nurse or general practitioner.

	No of visits pre-YOC	No of visits post-YOC	Costs Pre-YOC* Including admin and clinical costs	Costs Post-YOC* Including admin and clinical costs
Practice A	2 visits 35-45 mins	2 visits 35-45 mins	£17.00 with PN £28.50 with GP	£15.05 with PN £26.55 with GP
Practice B	2 visits 30-40 mins	2 visits 40-50 mins	£10.82 with PN £23.37 with GP	£12.08 with PN £24.63 with GP
Practice C	2 visits 40 mins	2 visits 30-50 mins	£14.40 with PN £28.31 with GP	£14.36 with PN £15.22 with GP
Practice D	1 visit 40 mins	2 visits 40 mins	£9.82 with PN	£11.44 with PN £30.69 with GP
Practice E	2 visits 40 mins	2 visits 40 mins	£11.58 with PN	£11.58 with PN
Practice F	2 visits 50 mins	2 visits 50 mins	£11.90 with PN	£12.45 with PN
Practice G	2 visits 50 mins	2 visits 75 mins	£16.15 with PN	£18.90 with PN
Practice H	1 visit 30 mins	2 visits 30 mins	£17.88 with PN	£14.07 with PN

An analysis of costs across the three pilot sites has demonstrated a huge variation in primary care, with practices having different starting points and choosing to do things differently. Four practices have increased costs per patient, three have reduced costs and one has remained cost neutral.

Many practices in North of Tyne had been using a patient centred care approach before the Year of Care Pilot and have been involving Health Care Assistants for taking and ordering tests, and for some practices the HCA role has evolved and extended. One of the biggest changes has been sending results to patients prior to the care planning consultation. The information above was submitted by six practices in North Tyneside and two practices in West Northumberland. In three of the practices, a Practice Nurse did the biomedical tests but since involvement in the project this is now done by a Health Care Assistant. In some practices, there has been an increase in Health Care Assistant time as their roles extended and they starting undertaking all biometric tests and doing foot checks. As can be seen above, for most of these practices, the patient contact time has either remained the same or there has been a slight increase. One practice has an increase of 25 minutes patient contact time, with an increase of 10 minutes for ordering and taking bloods (this was previously done by a Practice Nurse and now involves a Health Care Assistant) and an increase in Practice Nurse time for the care planning consultation.

Figure D: Advice from practices to organisations starting care planning

Training

- Embed with key people who understand the approach
- Offer care planning training*
- Staff training is important
- There is a need for IT training for using the templates
- The training is enjoyable
- Ongoing training is important to help with consultation skills for dealing with behaviour change, to help patients who don't want to engage in care planning or manage their own condition

Communication/Teamwork

- Health Care Assistants and admin are an essential part of the Year of Care process
- Needs to be a multi-disciplinary approach
- Need to have a named person for managing and co-ordinating
- Everyone involved has to be motivated
- Clarity of roles necessary

Patients

- Majority of patients appreciate receiving results prior to the care planning consultation, which helps them to be prepared for the consultation
- Write to patients about the change in consultations
- Slow initially but patients start engaging once they start seeing improvements in their condition

Organisation

- Changing the system and processes requires a lot of time and effort, but these become more efficient and effective by making the changes – many patients have now forgotten that things were previously done differently
- Now more streamlined
- Start slowly and then increase the number of people going through care planning consultations
- IT and a dedicated IT person is important
- Management of the process, eg searches, appointments etc has to be done regularly
- The process isn't difficult or onerous
- Easier with newly diagnosed who have not experienced the previous system

Where next?

(what do you want to keep, develop or change)

Keep

- The system and processes are working well and running smoothly
- Multi-disciplinary approach
- Robust call and recall system
- Own version of care plan letter
- Care planning – much better than the previous system
- Care planning entrenched in general practice diabetes
- Continue using a care planning approach in other long term conditions

Develop

- HCA role – podiatry training
- More clinicians attend care planning training
- Write and develop directory of local services for patients
- Educate carers to understand results
- Gap between capturing goals and informing commissioning
- District Nurses to attend Year of Care Training
- Communication – regular meetings between the diabetes practice team
- Care planning for people in care homes and for people with a terminal illness

Change

- DESMOND training offered more frequently
- Current IT systems

***National Care Planning Training Programme**

- National Care Planning Training Programme – 1.5 days
- Healthcare assistant training for care planning
- Care planning training for district nurses
- Care planning training for administrators, managers etc

Case study 2

Introducing and implementing Year of Care

NHS Tower Hamlets

Background

This case study is derived from reports written by staff at PCT level, interviews with PCT staff, reports by external evaluators, and discussions with PCT staff. Figures in the appendix to this case study are derived from visits to individual practices and contributions from PCT staff.

Context: key points about setting

Tower Hamlets is a PCT with high levels of deprivation and multiple languages and cultures. Prior to becoming a Year of Care pilot site the PCT had identified diabetes as a key priority, having been shown, in the 2006 Health Care Commission Survey, to have some of the poorest results in the country. There are 36 general practices in the borough with a total population of about 260,000; approximately 12,000 patients (4.5%) across all practices have diabetes.

Why did this site participate in Year of Care?

Having acknowledged the need to improve diabetes care, the Tower Hamlets commissioning group had been uncertain how to address the challenge. Year of Care, though not fully understood at that time by those in the group, appeared to offer solutions.

> "And then along comes this idea... and it's like, ah, that looks like it, meshed really quite nicely with a lot of the areas of concern that we'd been trying to work on but feeling not very successful. So I think it was just that sense of that there was actually quite a lot of congruence between the areas that we were struggling with and then this coming along as a new idea that we could see would fit, if we could make it happen..."

Of the 23 PCTs that applied to pilot Year of Care, NHS Tower Hamlets was selected for its diverse range of ethnicities, high levels of deprivation, and wide variety of practices in terms of size, patient mix, and delivery against diabetes performance measures.

Key individuals involved at outset

The GP lead for diabetes and the medical director were amongst the first people in Tower Hamlets to recognise the potential value of Year of Care to the PCT. They became clinical champions for the project, with the medical director taking the role of senior responsible owner. Both became thoroughly committed to the project.

Establishing and implementing Year of Care: activities at site level

Governance

Steering group

A project board of providers and commissioners was established. The board had 11 members including the senior responsible owner for Year of Care, GP lead, Year of Care project manager, manager of the local diabetes research network, assistant director for diabetes and older people, assistant director for community engagement, lead nurse for diabetes, a service user representative, commissioning manager for diabetes and commissioning manager for self care and healthy lifestyles. Strong clinical leadership was maintained throughout the whole project by the senior responsible owner and GP lead. Board members were enthusiastic and committed, as demonstrated by the fact that throughout the three years of the project no meetings were cancelled. During Year 1 meetings were held fortnightly, then monthly during Years 2 and 3.

Project management

Project manager

During the Year 1 of the programme, a project manager position was created. This was initially filled by a part-time worker. The arrangement proved unsatisfactory, and in October 2008, the position was taken by someone with extensive experience in primary care, who had previously been employed in NHS Tower Hamlets. Her skills, as described by a member of the project team, in 'how to get past the front desk and into the practice manager's office' were seen as central to the success of Year of Care, as was her sensitivity to issues that concern general practice and her understanding of the local community.

> "So there's all that kind of emotional intelligence that's needed, and understanding the local community, so I think it's a skill set that pure project management... doesn't give you, that's a valuable add on. And without your project manager, the whole thing will not succeed..."

Meetings were held monthly between the lead GP for Year of Care and the Year of Care project manager. This regular contact was crucial for effective and timely management.

Contact with national team

Throughout the programme's three years, learning events were organised by the central team, attended by members of the central team and each pilot site. Regular attendance has been maintained by Tower Hamlets project board members.

During the Years 1 and 2 of the project the national Year of Care Programme manager made several visits to the site and was available to provide support and advice to the local project manager by email and telephone. Visits reduced in frequency during Year 3 but regular contact with the national team, including the clinical lead and programme manager continued.

Funding

Funding overall

During Year 1 each pilot site received £98,000 from the national Year of Care Programme to establish the project. From the Year 2 on, since introduction of the diabetes care package in Tower Hamlets, practices have accessed additional funding for diabetes through the commissioned package.

Financial incentives

During 2009, Tower Hamlets became a pilot site for the Department of Health Integrated Care Programme, designing new ways of moving diabetes care from hospitals into the community. As part of this, the PCT established federations of practices, referred to as networks. Each network consists of three to five practices from the same locality, with commissioning occurring across networks rather than through individual practices. The networks were commissioned to deliver an enhanced care package for diabetes. Care planning, training, patient education and an annual review with results sent out beforehand are all intrinsic parts of the commissioned diabetes care package.

> "...they took the tools and resources from Year of Care... the invitation letters, the results letters, the care plan document, we supplied folders... And the other tool that we used is obviously the training. And in the care package it then became mandatory that people had to do a diabetes management course... plus they had to do the care planning training."

A 10% sample of anonymised care plans for each practice is audited each year. If any practice within a network fails to incorporate the component parts, the network as a whole incurs a financial penalty.

> "So that package is unlikely to be thrown away because it carries a financial penalty with it as well, if it goes...The training and care planning, the disaggregation of the annual

> review, the package of care designed around the four stratifications and the care planning approach and the patient evaluation satisfaction and the education, are all embedded within that. And that's over and above the national contract, so I think the local GPs are now wedded to that, because it's tied into the way of doing things in networks and so networks is a key component, working out above practice level using data and disease registers."

Practices involved

Initial pilot practices

The initial pilot operated in each of the eight practices in the south west of the borough, covering a total of about 3,000 patients with diabetes. The eight practices illustrated the diverse range in Tower Hamlets, including six practices – five large and one small – with a high proportion of non-English speaking people with diabetes and high levels of deprivation; one practice with predominantly white, less deprived English speaking patients; and one smaller practice with predominantly white English speaking patients. The practices were deliberately selected on the basis of locality, not readiness to adopt Year of Care, allowing a genuine assessment of whether, with support, the Year of Care approach could operate in any practice. The pilot practices started care planning between April and November 2008.

Spread to other practices in site

Following establishment of the diabetes care package, between September 2009 and April 2010 all remaining 28 practices in Tower Hamlets began care planning.

Other activities at site level

Tower Hamlets worked hard to inform patients about Year of Care and to gain their input. At the start of the project (2008) the PCT held a series of patient events in the spring, and again in the autumn, to promote Year of Care, consult on the new approach to annual reviews and on the patient materials that were being developed. Learning from experience, personal invitations to these events were given by practice staff and the events were held in local practice areas.

> "Well, one of the things Year of Care taught us is, if you send out a poster with the PCT logo on it, a certain type of person will read that and attend that. If on the other hand you engage practice receptionists who are day to day making the appointments for people, handing out the prescriptions to people, arranging the appointments for people, and who live in the communities where those patients live, whose children go to the same schools, who shop in the same shops, they are incredibly powerful in engaging large groups of patients."

Attendance was high (approximately 200 in the spring, 150 in autumn). Other patient events have been held since, though attendance has not been so high, possibly due to the proven effectiveness of contact by practice staff for achieving engagement, yet the limitations imposed by pressure on practice staff time.

The PCT also commissioned an organisation to produce posters and leaflets explaining Year of Care and care planning.

> "...so as we got going with Year of Care, we had the patient engagement events, where we had these massive turnouts and we had a lot of information back about what people wanted. We had some social marketing where we said, well we want to separate out the annual review into data collection, [give] data back to you, think about it and then come in and talk about it. And how do you want that information? And they told us they wanted it in colours, so we got colour printers to go into practices."

Building on comments received during the patient involvement activities, materials were designed for practices to use when feeding back results to patients. The eight pilot practices were supplied with colour printers so that results could be presented in colour, and each patient was given a folder with their individual results. A traffic light system was designed, so that patients received their results in a way that could be readily interpreted.

"...so basically what you would've got in year one would have been an initial invitation letter or an invitation phone call and then be asked to collect the leaflet, because a lot of practices round here invite by phone not by letter. And then you would have come for your first visit with an HCA or your first visit if they didn't have an HCA, with whoever, for the measures. Then after that you would get your results letter, which is the one with all the colours and everything. And then after that you come for your care planning encounter.

And the other piece of kit that we have that patients seem to quite like is we've developed a folder, which different practices gave at different times. Some practices gave it at the first encounter and then some practices were nervous about people not bringing them back so gave it at the second encounter. But there's this big blue, it's just an A4 cardboard wallet, but the idea being that people put various letters into it and then again have the colour coding on what the results meant on the front cover, on the inside cover. So again a piece of kit and in fact it was very gratifying, and I wasn't at this particular one of the events we ran shortly after the launch got going, was patients came in clutching them. They're pale blue so they're very, very noticeable and lots of people were in clutching their folders and so with a sense of going-home present."

Later, during 2010, the PCT launched a website to inform patients of the services available in their area that support self care.

Tools and resources designed by the PCT for use, initially by pilot practices, and later by all practices as part of the diabetes care package, included the following:

- self care directory
- menu of services
- care plan pack for patients
- results letters in colour
- posters and leaflets
- care planning template
- electronic access for practices to key Year of Care documentation
- information sheet for pilot practices
- colour printers supplied to pilot practices
- 'Make a Change' website
- audit of anonymised care plans undertaken to:
- assess and inform commissioning about services patients prefer
- ensure that healthcare professionals understand and adopt care planning.

Figure A (The Journey of Tower Hamlets through Year of Care) in the appendix to this case study provides a pictorial illustration of key steps for the site as it progressed towards adopting Year of Care.

Establishing and implementing Year of Care: activities at practice level

In keeping with the approach used in the external evaluation, headings used to report practice level activities are categorised under components of the 'House' model.

Engaged informed patient

Structured education

The 2006 Health Care Commission Survey identified a severe lack of structured education for patients with diabetes in Tower Hamlets (86% of those who responded said that they had never participated in diabetes

education). The standard local approach for diabetes structured education was an adapted version of X-PERT, named HAMLET, consisting of four three-hour sessions.

At the start of Year of Care, massive efforts were put into delivering structured education. PCT staff recognised that the programme needed to be further adapted to suit specific needs of their varied population.

> "...But what we found was, the structured education which requires, you know, group work, a psychological approach, and fixed sessions over time, of so many hours repeated at these intervals, for some of our population, just didn't work. The attrition rate was very high, it didn't fit with the Muslim culture of prayer times... Some of the food offers weren't quite right, so we had to completely reconstruct a training package that fitted our community... So we had a menu of different options."

Considerable effort was put into understanding needs of the local population. Options were designed to meet a range of needs, personal choice and learning style. Along with the HAMLET structured course a two hour Key Message course was available, Healthy Moves exercise and cookery classes, and drop in sessions. A one hour taster session was also designed. Of those who attended the taster session over 90% went on to do a full course. Everyone who attended any session received a DVD and workbook, which was available in three languages. During 2009 educational sessions were presented at 52 venues, during each day of the week, at various times, and in 18 different languages. In total there were 9940 attendances at educational interventions, reaching 6640 individuals, comprising 60% of the diabetes population.

Additional support for patients

A diabetes support group was organised for patients in Year of Care practices with input from Diabetes UK. Membership is small, but some participants attend regularly. The aim of achieving a self-supporting group has not yet been successful. The initial intention was to develop a borough-wide support group, but patients have demonstrated their preference for attending meetings close to home, and the option of starting small support groups within networks has been considered.

Not all practices in Tower Hamlets are currently sending out test results to patients in advance, citing concerns about the postal service. Discussions continue about alternative approaches. The PCT is adamant that patients need the opportunity to study their results prior to the consultation, and receipt of results ahead of the care planning consultation is a mandatory component of the commissioned package.

Some pilot practices have adopted their own innovative approaches to support patients.

One practice with a largely non-English speaking population, high levels of deprivation and high numbers of patients with diabetes and persistently high non-attendance rates for clinics was concerned that some patients were not taking ownership when receiving their results prior to the care planning consultation. The practice ran group sessions to prepare patients for care planning. Instead of sending out results, patients attending the group sessions received their results at that time, and during preparation meetings were given information about the meaning of the tests and aspects of self-management, including physical activity, healthy eating and smoking cessation. Patients attending the sessions were asked to indicate their preference for when to attend their care planning consultation and whether they would like to see a GP or practice nurse. Most patients are Bengali; an interpreter attends the meetings and a Bengali speaking receptionist calls patients with reminders about tests, preparation sessions and the care planning consultation.

In another practice the practice nurse was concerned about patients with persistently high HbA1c levels. One patient did successfully control her HbA1c levels through self management. The practice nurse held a group meeting at which the successful patient presented information about the steps she had taken to control her blood glucose.

Healthcare professionals committed to partnership working

Workforce training

Initial training for Year of Care was commissioned by Tower Hamlets in March 2008 and delivered to GPs and practice nurses from pilot sites, and to other practices that were interested in the programme. Workshops were held in 2008 and 2009 for staff from the eight pilot practices to facilitate sharing of ideas and practices.

In July 2009, the national Year of Care care planning training became available and this training (lasting one and a half days) was delivered to GPs and practice nurses across the borough. The training generated genuine enthusiasm for Year of Care. Diabetes specialist nurses, Diabetes specialist advocates, community matrons and district nurses also attended training.

Following introduction of the commissioned diabetes care package it is now a requirement that all GPs, practice nurses and network nurses providing diabetes management must receive care planning training. The purpose of the training is to skill healthcare professionals in goal setting and action planning, and to support attitudes that enable consultations to be conducted collaboratively.

> "...you actually see the light bulb go on, during the training... So I think it's a cultural shift. You know: 'it's not going to work in our practice', 'it's not going to work in Tower Hamlets', 'it's not going to work with our patients', for people to see that it does work, although obviously we've still got work to do with patients who don't want to engage. So I think that is an outcome."

By the end of 2010, a total of 150 practice nurses and GPs practising in Tower Hamlets had been trained in care planning. More have undergone training but moved elsewhere.

In addition to the full care planning training, a half-day care planning awareness training has been developed for Health Care Assistants, managers, administrators and receptionists. Approximately 70 people have attended this training.

> "...And what we found was that another learning point in practices, is that while a practice is a bigger organisation than just the champions who come to the meetings, and they vary in how well they disseminate the information throughout the rest of the team... So if you've got a salaried doctor who's only there one day a week, how do they know what's going on?... And so that, there's always a risk of erosion of the message into the team, that's the challenge for this coming year, is to embed more fully the ethos of Year of Care working and to make sure that we've got the whole team engaged, not just two or three champions."

The vital importance for all staff involved in any way in the care planning process to undertake some level of training has been an important learning point. Engaging support from the wider practice team was initially challenging for some practices; an agreed and shared vision for care planning was found to be important.

> "...so there is something about actually being very clear about who is this change going to impact on?... we didn't manage to make it somehow get that clarity. And several of the practices said, it was so hard to get everyone on board."

Seven people from Tower Hamlets have now qualified as local and national trainers for Year of Care, including GPs, diabetes nurses, a dietitian, and the project manager. During the Years 2 and 3 of the project one trainer from each site (the project manager in Tower Hamlets) met with the central team and other trainers to assess and plan how to address training needs.

Care planning

Initially, healthcare professionals in pilot practices reported that the new care planning approach took longer than the previous annual review, partly because patients were so unfamiliar with test results that much time was spent in explanation, and often a second appointment was necessary.

> "...we had handouts, and we had a DVD that went to the practices to show patients and there was input to the patients at patient engagement events, but I think certainly in year

one, the experience for many of the practices, the patients turned up for their care planning encounter and actually pretty much the whole of the time was spent on education about what an HbA1C is. And I think that just represents the huge black hole that we had and people just didn't know the most simple basic things about their own diabetes... Well in fact often people had to come back again, so you had that appointment and actually never got on to the care planning because you were still explaining why blood pressure mattered."

Over time, with the increase in patient education, and as patients and clinicians have increased their familiarity with care planning, the process has become easier and faster. Nevertheless, readiness to set goals varies between patients and between practitioners.

"I try to set specific goals and things that they can achieve rather than big broad goals that are unrealistic. It is important to identify goals that the patient finds acceptable. The goal setting mainly comes from us – patients have a very hazy idea of how diabetes works. If you ask them about goals they generally say they want to lose weight and come off their tablets... Care plan is a shared task. It is a cooperative task. We show them that it is within their power to make changes. However some things are harder for them to control than others."

"With the goal setting I gauge it to see what is realistic in both the short and long term. It tends to be driven by them – there is no point in setting goals that they don't think they can achieve. It's about what is important to them."

Clinicians found the initial care plan document, designed as a Word document to be integrated into EMIS Web, time consuming and challenging to use. Discussions are being held with EMIS to resolve the difficulties.

Linguistic challenges add to the time required for care planning. In some practices, interpreters participate in care planning; in others health advocates play that role. To support them in this work, several health advocates attended care planning training.

"Only a very small percentage of our patients speak English. We have interpreters at the practice – two in the morning and one in the afternoon, but we have a number of doctors and nurses here – five or six – and when we are doing six clinics a week we can't resource it. We don't like to rely on family members for interpretation and so we can struggle with this. Both the HCAs speak Bengali and we help out where we can but we can't always help if we have our own clinics."

"Some health advocates are heavily involved in care, they interpret and assist the patient in healthcare. We must not only train diabetes workers but also advocates."

Workforce changes

Following the introduction of Year of Care, pilot practices analysed the skill mix in their teams. This resulted in a changed approach, with Health Care Assistants (HCAs) conducting the first consultation and biometric tests. The clinician receives the biometric results, reviews them and sends a care plan with the results to the patient. The clinician then sees the patient for their annual review with the care plan.

For HCAs who previously were working as receptionists, this change has extended their responsibilities with a subsequent increase in job satisfaction. The clinician now has more time to spend with the patient, discussing their diabetes care and motivating them for change.

Nurses spoke of increased satisfaction.

"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.

I'm having to spend more time with patients, having to look at them more holistically. When you deal with patients you begin to understand them more. Before, blah blah blah, you've finished. Now sitting a long time with them, talking through lots of issues, goals, objectives, what they can do for themselves."

In all pilot practices application of Year of Care led to diabetes care being delivered by a team, resulting in increased clarity of roles and responsibilities, better communication and improved meeting structures. The infrastructure around diabetes care also improved, with templates for letters, standard referral forms, better information about available services, and better links to them. Staff reported that they found the diabetes care package benchmarked performance dashboards and the peer discussion with network colleagues stimulating and rewarding.

Another change in some practices has been the creation of the position of long term conditions coordinator to control administrative tasks connected with call and recall.

> "One of the key successes has been the importance of admin, having admin, that long term conditions coordinator who runs the call and recall systems. And we've got practices saying that that's probably the most important role in the whole Year of Care process."

Part of the aim of the diabetes care package was to achieve changes in skill mix: many practices have aimed to extend the role of nurses, thereby freeing up GP time. The following comment is from a practice manager:

> "We feel the changes have all been positive and will not be changing back to the old style of working."

Commissioning

Identifying and meeting needs

In 2007, prior to the introduction of Year of Care, GPs had commented on the difficulties they experienced in referring patients to the many self care and healthy lifestyle programmes available, because they had inadequate information on their availability and how to refer people to them.

In response, during 2008 the commissioning manager for self care and healthy lifestyles developed a self care directory identifying services across the borough that could help patients manage their health. The directory was distributed as booklets to all 36 practices in Tower Hamlets, available in English, Bengali and Somali. An online version of the menu of services was also available as a leaflet through the Tower Hamlets PCT intranet.

A key learning was the speed with which the self care directory and printed booklets became outdated. Building on this recognition, in September 2010 the public health team launched a website of local services, the 'Make a Change' website, which is available to patients and healthcare professionals.

As noted below, all practices in Tower Hamlets use EMIS, which does not yet support an electronic link with care plans. Without the opportunity to electronically record and collate individual requirements the intended link between micro and macro commissioning has not been feasible, other than through conversations between groups of practitioners.

> "...each patch of Tower Hamlets has their own network and those practices meet monthly for multi-disciplinary team meetings. And there definitely is conversation going on about oh, I can't get, I've got a Bengali woman who wants to go swimming but you know we can't get that. So at that level, but that's not going anywhere very powerful at this point..."

Nevertheless, despite not being able to put it fully into practice, practitioners have increased their understanding of the concept behind micro macro commissioning.

> "...we've learnt a lot about what the barriers to doing it were and I think that in a sense conceptually people are in a place much more where they understand, and in fact one of the ways that I often talk to people about care planning is, I say... you shouldn't think about this as a diabetes visit. Think about it as a commissioning visit. And this is about working with that patient about what supports, what do they want and need to help them work with their chronic disease... So you're getting that idea about micro commissioning on board now.... I think before that it was people knew there were three services and people all just got plugged into those three services."

At the broader level of commissioning Tower Hamlets has stratified the diabetes population into four groups: newly diagnosed; complex with multiple co-morbidities; at risk of becoming complex; well controlled. A care package is commissioned for each group; any options beyond those in the care package are not funded by the PCT.

> "I think Year of Care has also helped us take a step back from how we [the PCT] work as commissioners and has given us a deeper understanding of the difference between commissioning and providing... Saying, here's a population, here's its health needs, these are the outcomes we want, and we're wanting you to do this and there's some money for doing it. If you choose to do other stuff, that's your problem, we're not paying you for that, and if you don't deliver what we want, we're taking the money back."

As part of the shift from practice to network based commissioning, the PCT appointed four healthy lifestyle programme managers with responsibility to monitor availability and gaps in facilities that support self management, working in partnership with the local authority.

Organisational processes

IT templates

All practices in Tower Hamlets use EMIS, either LV or PCS, neither of which fully support use of a care planning template. Year of Care developed a framework for care plans as a Word document, but it has not been possible to devise an electronic means of capturing the micro-commissioning outputs from care planning consultations.

The lead GP for diabetes/YOC and Tower Hamlets IT staff have participated, with members of the Year of Care national team, in a series of meetings with national EMIS to refine a specification for EMIS to develop functionality to better support care planning in their new product, EMIS Web, which is expected to come into use in 2012–13.

Call and recall systems

With funding from the diabetes care package, additional administrative input has been employed in all practices to effectively manage call and recall systems. Some practices appoint named personnel as long term conditions care coordinators. Practices reported lessons learned about effective approaches for maximising attendance at appointments, many using telephone calls to arrange appointments and text as a reminder.

Figure B (Summary 'House' model for Tower Hamlets) in the appendix to this case study, presents processes in NHS Tower Hamlets that were put in place prior to and during implementation of Year of Care. The changes were described during visits to seven practices in September/October 2010, and are listed under the five components of the House model, which proved to be a valuable conceptual tool for identifying components that support effective care planning. Comments from the lead GP and project manager are also included.

Learning from Year of Care

Costs and resources

Costs specific to pilot sites

Costs connected with implementing Year of Care as a pilot site included time spent in development of processes, resources, and training, contact with the national team and external evaluation. These costs, however, do not apply to practices adopting Year of Care now that it has been developed as a model, ready for implementation.

Typical costs

Under Year of Care the care planning consultation takes significantly longer than a typical general practice consultation and additional financial support was needed. Tower Hamlets covered these costs with the diabetes care package.

An analysis of workforce and skill mix costs before and after the Year of Care programme has been undertaken from a sample of practices in the three pilot sites and has demonstrated that some practices have reduced costs, some have increased and some have remained cost neutral. Figure C (A sample of costs for NHS Tower Hamlets before and after Year of Care) in the appendix to this case study outlines costs for two practices in Tower Hamlets before and after involvement in Year of Care, calculated as £s per patient.

Evaluation

External evaluation

The national Year of Care programme commissioned an external evaluation. In autumn 2009 evaluators visited the eight pilot practices and conducted interviews with 19 patients and 30 other people connected with Year of Care including doctors, practice nurses, HCAs, practice mangers, commissioners, providers and three other members of the local Year of Care project board.

NHS Tower Hamlets commissioned the Picker Institute Europe to conduct a postal survey to investigate the experiences of people with diabetes across general practices, comparing findings with those of the 2006 Health Care Commission Survey, and evaluating patient experience across the eight pilot practices. The survey was delayed due to concerns around privacy of information; it was finally completed in November 2009 by which time care planning for diabetes had been introduced across the PCT, limiting the opportunity to explore differences in impact between pilot and non-pilot practices.

Internal evaluation

Tower Hamlets requested pilot practices to complete the 'Assessment of Primary Care Resources and Supports for Chronic Disease Self Management' (PCRS) – a self assessment tool to help healthcare professionals assess the level to which self management is integrated into their practice. The Year of Care practices were asked to complete the PCRS in three consecutive years. Feedback from each practice was analysed and considered alongside the different components of the Year of Care 'House'.

In autumn 2010 the lead GP for Year of Care in Tower Hamlets, and the project manager made final practice visits to seven of the eight pilot practices to assess the impact of the intervention.

Evidence of change

Implementation

Initial concerns that language and cultural barriers would make the philosophy and process of care planning unsuitable for Tower Hamlets have proved to be unfounded. Despite initial low levels of health literacy among some of the population, patients in most practices are now engaged with the process. This has been achieved through active user involvement. Information has been widely disseminated, using health trainers, libraries, local mosques, community centres and a local health advocacy organisation to promote awareness of the approach and invite engagement.

Over 6640 people have accessed structured diabetes education.

Impact for patients

During interviews with external evaluators in 2009 many patients said they valued receiving results from their blood tests in advance, and having time to consider them with a healthcare professional. Some spoke of understanding what the results meant.

> "There was enough time to go through everything. The doctor asked about my priorities. He does focus on my agenda... It was great, really good."

> "I am now in more control. I have my results and information so I am not so reliant on the system. I can share the information with my own family and encourage them to be healthier."

Many of the patients interviewed in 2009 reported high levels of satisfaction with their consultation.

> "We discuss my priorities in the session. We did talk about goals and targets. We set a goal to bring my blood sugar level down – it felt like a joint goal between me and the nurse – she advised me and I felt that I needed to do it."

> "I did get a plan and it was helpful. I refer back to it as I work towards my goals. My readings are coming down and I feel as if I am achieving something. I reduced my insulin at the last review."

> "Yes it was helpful. I have something in writing that I can go back to. I do look at it from time to time."

Patients spoke of not missing appointments, and of being encouraged to change their diet and increase their levels of exercise.

> "I saw the nurse. It was good. She understood the position and explained that my BMI has improved. She gave me plenty of time and we talked about lots of things – swimming, diet, exercise etc. It was good – I felt informed about where I am with controlling my diabetes... I was given examples of exercises that would suit me and also given a diet sheet."

The same high levels of satisfaction were upheld during practice visits in 2010, with positive feedback from both English and non-English speaking patients.

The 2009 Picker survey indicated a good standard of care and good level of patient engagement. It noted real improvement since the previous (2006) survey across all practices in care planning, education and training courses, tests and patient involvement.

Pilot practices were shown, through the Picker survey, to have made significant advances beyond non-pilot sites in the likelihood of a patient having developed a care plan with a clinician, receiving a copy of the plan, and having a perception of how the plan could be useful.

It is too early to expect clear evidence from biomedical markers, but indicators showed that while pilot practices started at a lower baseline (when recording percentage of HbA1c levels lower than 7.5%) in May 2008, by January 2010 both pilot and non pilot practices had reached 50%. It is too simplistic to attribute causal influence at this stage, especially because of other activity related to diabetes, though it is reasonable to consider the possibility that care planning and/or increased uptake of structured education could be at least contributing factors.

Impact for clinicians

Care planning had led to changed work roles with HCAs conducting biometric tests and health promotion, freeing clinicians to spend more time in direct discussion with patients.

Health care professionals generally commented that they found care planning resulted in higher quality consultations, which was clinically rewarding. As one nurse practitioner noted:

> "We feel the changes have all been positive and will not be changing back to the old style of working.'

Staff said that they had gained more clarity around roles and responsibilities for team members, and reported improved communication and teamwork.

Impact for organisation

All practices have adopted systematic approaches to calling and recalling patients for annual reviews and follow up.

Improved resources and templates have been developed and are being used for contacting patients, referral, linking to other services etc.

Work has been conducted to enable care plans to operate as Word documents alongside EMIS, and discussions are continuing at national level to develop an approach that more effectively links a care planning template to EMIS software allowing use of the data to inform commissioning.

Enabling factors and challenges

Enabling factors:

- Tower Hamlets benefited from having a full-time project manager with knowledge of and sensitivity to issues relating to general practice and the local community, as well as having sound project management skills
- strong proactive clinical leadership by the medical director (senior responsible owner) and lead GP for diabetes (lead GP for Year of Care)
- having a strong project team with senior leadership and buy in was also crucial
- multi-disciplinary approach with intention of widespread engagement
- genuine efforts to hear and respond to a wide range of patient views
- regular contact between GP lead for Year of Care and project manager
- financial support is needed to encourage practices to adopt and maintain care planning. This was achieved in Tower Hamlets with the diabetes care package.

"...why has it worked for us? How did we make it work? And I think the key thing is, charismatic clinical leadership, clinical engagement and engagement across the whole pathway. And thinking about the patient... and letting go the medicalised model of care, and allowing patients to choose things that aren't necessarily medical, that are more about how they live their lives and how they prioritise things. But we had GPs, nurses, psychologists, dietitians, patient representatives and consultants, sat round the table discussing the care package and agreeing how things should happen. That for me is that really engaged, often quite contentious discussion between groups, and it was multi-disciplinary, and it had a patient voice. That's what's made it, I think, for us successful."

Challenges:

- high staff turnover in Tower Hamlets practices, particularly for nurses, HCAs, and administrative staff is a challenge as new staff coming into the PCT need Year of Care training

  "We give them all this lovely training, they then become incredibly employable somewhere else, so they leave! And we've seen a bit of that churn happening, so there's something about the new networks putting pressure on to stabilise the workforce so that nurses don't feel in order to get a pay rise, they have to leave and go somewhere else, that they get valued for what they do within the network. So it's starting to inform our thinking about the workforce, the career pathways, how there are unintended consequences of actions that you take."

- constraints in recording and collating needs and referrals to non-traditional services. The current inability to record care planning referrals electronically on EMIS means that there is no formal structure for identifying mismatch between needs and available services, until the new EMIS system becomes available
- inability to electronically record and monitor individual uptake of recommended services and progress towards goals prohibits learning about which activities and services are most effective in supporting progress towards goals
- evaluation – the external evaluation was considered too complex by the PCT, too demanding of patients, and risked breaching information privacy rights. While not happy with the approach taken

by the external consultants, Tower Hamlets PCT acknowledged that there was no obvious method for evaluating a complex project in a mobile and diverse environment.

"I think we're really kind of fumbling around about how do we hear from patients about the issues that they're facing? How do we hear from patients about what the service was like? And I don't think we have an answer. So that's one of the things that we've discussed a lot in the steering group is actually, well how do we do this? Particularly in a set up like ours where we've got high mobility, we've got people without English as a first language, people without literacy in any language."

- challenge of refining the care planning concept to include all types of patients. For many patients who are unfamiliar with the concept of self management, collaborative care planning requires considerable input of time from healthcare professionals, to educate and empower the patient. It is important that the Year of Care model does not convey the output of a care plan as the central point of care planning, but instead, acknowledges that the collaborative process is more important than the product.

  "...you can't necessarily get people far enough through the process to produce a care plan in the first or second iterations. And again what many of the practitioners see when they see that 'House' [model], is that care planning, they've got to actually produce a plan. Whereas actually, for some patients, and I have this image of them being outside the 'House' and up the garden path, you know, we need to kind of, they need to understand what we're trying to do, they need to understand much more about their own diabetes. A lot of them have been used to being told what to do by their clinicians. So they need to be kind of reeled in."

During visits to seven practices in Tower Hamlets during September/October 2010, staff were asked what advice they would give to practices that were considering adopting a Year of Care/care planning approach. Figure D (NHS Tower Hamlets: Advice from practices to organisations starting Year of Care/Care Planning) in the appendix to this case study summarises their responses.

Plans and hopes for the future

A need has been recognised for additional support for clinicians to sustain the skills they gain in the national Year of Care care planning training, and to gain additional skills in helping patients set SMART goals and actions as part of the care planning consultation. Tower Hamlets PCT commissioned development of a behaviour change tailored package from 'Change Matters' to enhance and sustain care planning in practice. This was initially piloted in one practice, with the intention to then expand it after any necessary refinement. Change Matters sat within the Clinical Health Psychology team and emerged in the context of the NHS self care agenda, but has subsequently been decommissioned by the acute trust.

- further funding has been accessed to identify basic and advanced competencies for delivering high standard care for people with long term conditions and to create a competency assessment framework for use across Tower Hamlets. The project is almost completed, and, in its final form will be used to map the training needs of all staff
- specifically, more work is needed to devise skills for working with patients who are not currently engaged or interested in working to address their diabetes
- greater clarity is needed about the ongoing process and purpose of care planning, avoiding undue emphasis on the production of a care plan per se
- in order to facilitate evaluation and follow up, patients should have the benefits of follow up explained to them, and requested to give consent to access to their data
- more consideration will be given to ways of supporting clinical champions in practices that adopt care planning for the first time. Those who had acted as clinical champions in new practices spoke of the need for frequent review and discussion in their first one or two years
- additional work is needed to inform, coach, educate and support people with diabetes and other long term conditions about the care planning process and how to manage their condition. In the future this may become the responsibility of networks.

Appendix: NHS Tower Hamlets

Figure A: The Journey of Tower Hamlets through Year of Care

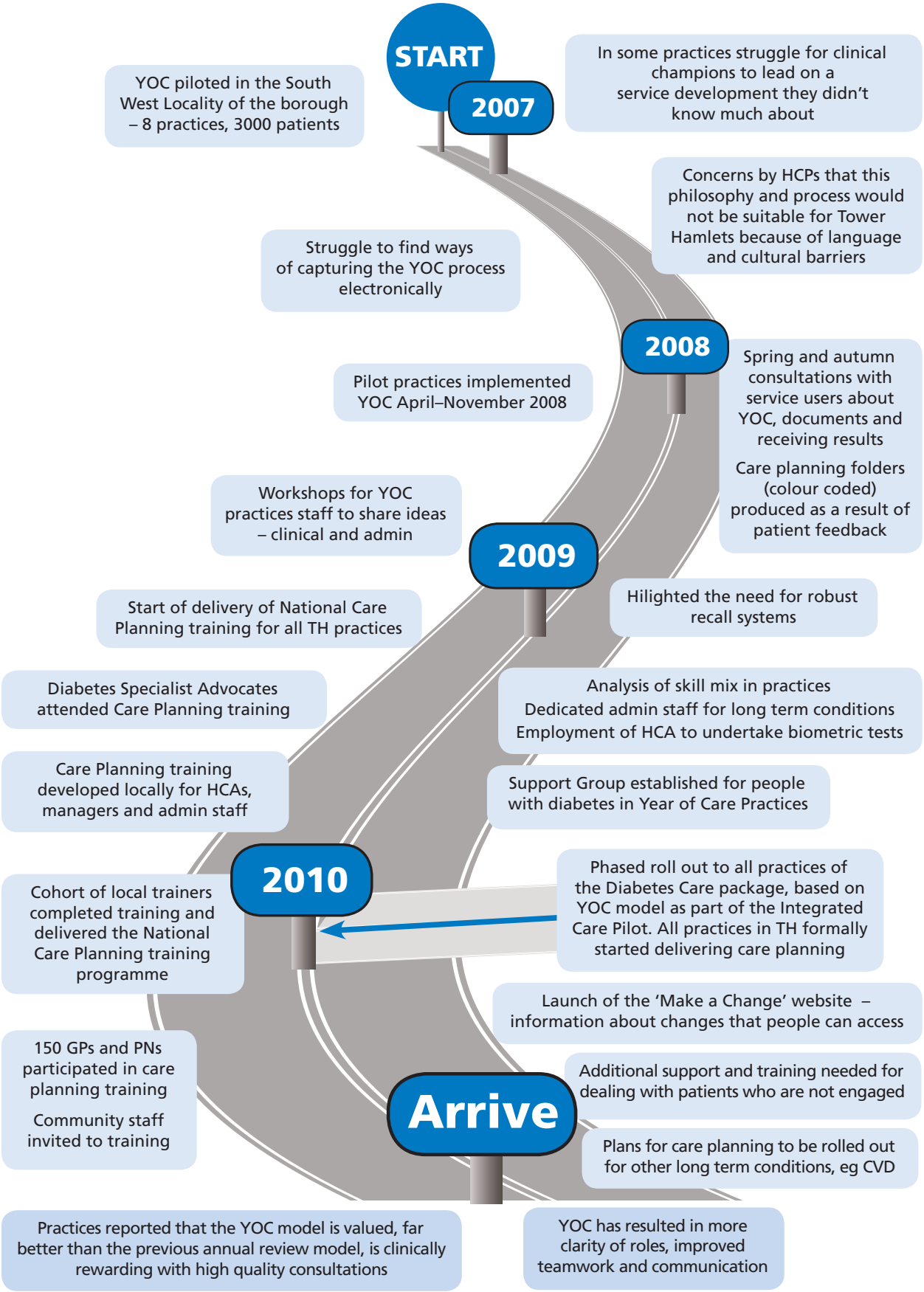

Figure B: Summary house model for Tower Hamlets

Dedicated admin staff/network co-ordinators help with recall
More structured, robust recall systems
Word configured results and care plans
Amended data entry templates to capture more information about referrals

Engaged, informed patient

Patient events held to explain Year of Care

More understanding in the second year

Colour printers for results in colour

Colour folders

Innovation in some practices – preparing for care planning sessions

Care planning explained with the help of health advocates

Sending results prior to the care planning consultation is mandatory

'Make a Change' website – information on local services to help self manage

The care planning consultation

Year of Care model is clinically rewarding with higher quality consultations

Gets easier year on year

HCPs now have time to explain things to patients during the consultation

HCP committed to partnership working

Local care planning training developed for HCAs, admin and managers

GPs and PNs attended CP training

Need for additional support/ training for motivational interviewing and consultation skills

Multi-disciplinary team meetings in networks with support from Consultant

Clarity of roles

Improved teamwork and communication

Skill mix (HCAs/admin), extension of roles, increased job satisfaction

Commissioning the foundation

Funding for Project Manager

Funding for network nurses and co-ordinators through the Diabetes Care Package

'Make a Change' website commissioned by the PCT

Figure C: A sample of costs for NHS Tower Hamlets before and after Year of Care

A sample of costs for NHS Tower Hamlets before and after Year of Care outlines costs for two practices, calculated as £s per patient.

The total costs include administrative time for searches, making appointments, consultation time for tests, and the annual review/care planning consultation, taking into account any changes made in time commitment and personnel involved. The number of visits refers to consultations/patient contact time at the surgery

	No of visits pre-YOC	No of visits post-YOC	*Costs Pre-YOC Including admin and clinical costs	*Costs Post-YOC Including admin and clinical costs
Practice A	4 visits 35–55 mins	2 visits 50 mins	£30.38 with team	£18.42 with team
Practice *B*	1 visits 30 mins	2 visits 50 mins	£16.65 with PN	£17.35 with PN

*costs indicate if the care planning consultation is with a practice nurse or GP

An analysis of costs across the three pilot sites has demonstrated a huge variation in primary care, with practices having different starting points and choosing to do things differently. As can be seen above, one practice has decreased their costs per patient and the other shows an increase.

One of the above practices changed their system and processes as a result of the learning from the Year of Care pilot. The other had undertaken an in-depth analysis of the pathway in the practice.

Figure D: Advice from practices to organisations starting care planning

Training

- Important in early stages
- Engage the whole team in care planning training*

Communication/Teamwork

- Involve the whole of the practice diabetes multi-disciplinary team
- The whole team needs to be aware of the importance of care planning
- Constant communication: hold regular team meetings
- Ensure all staff have an understanding of Year of Care/care planning and are engaged with the philosophy and process

Patients

- Constant communication – keep people engaged

Organisation

- Essential to have robust call and recall system
- Cleaning of register important
- Ensure that the IT works
- Ensure that documents and templates are in place
- Need effective administrative lead, this role is crucial and is the key person to effective care planning
- Need named person with good IT skills
- Clarification of roles important – consider how skill mix can help

Where next?

(what do you want to keep or develop)

Keep

- Current structure/skill mix with HCAs and admin support
- Results letters in colour
- Enjoy doing care planning and appreciate quality of time in consultations
- Involvement of other agencies, eg health trainers
- Ongoing care planning training after the end of the project

Develop

- Group meetings with the newly diagnosed to explain care planning
- Training for working with patients who do not want to engage in care planning
- Ongoing support for patients who don't want to engage
- Increase patients' understanding of care planning
- Introduce care planning for other long term conditions

Figure D continued

*National Care Planning Training Programme

- National Care Planning Training Programme – 1.5 days
- Healthcare assistant training for care planning
- Care planning training for district nurses
- Care planning training for administrators, managers etc

Case study 3

Introducing and implementing Year of Care

NHS Calderdale and Kirklees

Background

This case study is derived from reports written by staff at PCT level, interviews with PCT staff, reports by external evaluators and discussions with PCT staff. Figures in the appendix to this case study are derived from visits to individual practices and contributions from PCT staff.

Context: key points about setting

The total population of Calderdale in 2008/9, when Year of Care started, was just over 200,000 of whom 10% were non-white. Calderdale ranked 107/354 on the Index of Deprivation with 4.4% of the population being unemployed (compared with 3.6% for UK). There are 27 GP practices within the PCT area and in 2008/9 diabetes prevalence was 4.1%.

During the same period Kirklees had a total population of over 400,000 of whom 16% were non-white. It ranked relatively high (82/354) on the Index of Deprivation; 4.2 percent of the population was unemployed. There are 71 GP practices within the PCT area and diabetes prevalence was 4.2%. Practices in both Calderdale and Kirklees cover a wide social spread.

Why did this site participate in Year of Care?

Prior to the introduction of Year of Care, both PCTs (Calderdale and Kirklees) had begun redesign of their diabetes services. Their recognition of the need for change and ideas about how to do it were part of the reason Calderdale and Kirklees were selected as pilot sites.

The patient-centred ethos of Year of Care was attractive to the PCTs, complementing aspects of the models that underpinned their new design.

Differences inherent in the new model, as Year of Care was adopted, were not fully absorbed by all. With the range of people, places and previous models involved there was a tendency in some areas for people to think Year of Care principles were being followed when in fact they were still following a previous approach. Misperceptions only became evident as the project proceeded.

Key individuals involved at outset

The director for patient care and professions for NHS Kirklees acted as senior responsible owner (SRO) for the Year of Care project and a steering group was appointed with representation from key stakeholders from both PCTs.

Establishing and implementing Year of Care: activities at site level

Governance

Steering group

A large steering group was appointed. Members included the senior responsible owner, project manager, clinical project lead, the project administrator, assistant director of medicine, two consultant diabetologists, long term conditions lead, practice-based commissioning manager, self care programme lead, public health manager for diabetes, medicines management representative, DESMOND educators, GP representatives, patient representatives, local Diabetes UK group representative and a representative from the external evaluation agency.

Meetings were initially held monthly, then quarterly, and throughout the three years of the project none were cancelled. All members were invited to attend each meeting. By the third year the diabetologists, DESMOND educators, medicines management and Diabetes UK representatives no longer attended regularly, however

GP membership did continue. Non-attendees were kept informed of the progress of the project by attending other meetings. The user reference group continued to attend each meeting.

Meetings of a separate NHS Kirklees sub-group, established specifically to support introduction of Year of Care into Kirklees PCT, were held as needed. Membership of this group consisted of the project manager, long term conditions lead, practice based commissioning manager, self care programme manager, and a local DESMOND educator who is also a diabetes dietitian. In Year 3, the diabetes dietitian trained as a national Year of Care trainer and was employed by the PCT one day per week to provide training, support the introduction of Year of Care and review the DESMOND programme.

Key aspects of work conducted for Year of Care during each year of the project:

2008

Set up and support pilot practices
Deliver training for pilot sites
Deliver awareness training for both PCT communities
Identify clinical project lead
Review working with hard to reach groups
Explore BME work
Review IT templates
Plan patient involvement
Provide quarterly newsletters
Include care planning in Local Incentive Scheme for Kirklees

2009

Support pilot practices
Deliver National Care Planning training to early adopter practices
Develop IT Solutions
Continue hard to reach and BME work
Continue with newsletters
Include care planning in Local Incentive Scheme for Kirklees
Work with Calderdale to promote care planning
Develop self care handbook to support patients
Develop links with Co-creating Health

2010

Deliver awareness training for Kirklees
Deliver further care planning training for Kirklees
Continue developing IT solutions
Include care planning in Local Incentive Scheme for Kirklees
Extend delivery of care planning training to community staff
Strengthen links with Co-creating Health pilot
Provide refresher training for pilot sites

2011

Continue delivering National Care Planning training
Deliver diabetes and care planning training to healthcare assistants
Continue developing IT solutions
Develop an education programme merging both Year of Care (care planning) training and Advanced Development Practitioner training.

Project management

Project manager

At the outset, Year of Care employed a full-time project manager, based in Calderdale, for both PCTs. The project manager had a background in specialist and secondary care and was based in the acute Trust. She had support from a project officer (0.4 FTE). A part-time administrator was also employed.

During the second year, the project manager left. She was replaced by the person already working as the diabetes facilitator/coordinator in Kirklees, and adopted the role alongside her existing position. The new project manager had extensive experience of primary care, including IT systems. In this way, the focus for Year of Care shifted, from Calderdale to Kirklees, and from secondary to primary care.

With her active involvement in service redesign, the project manager's two roles complemented each other well, but reduced considerably the time available for Year of Care. In contrast with with the previous full-time position, the role became approximately 0.4 FTE. A member of the steering group acknowledged the crucial importance of the project manager's role:

> "...the other thing is, don't underestimate engagement, the time it takes to engage, the amount of effort you have to put into engagement, and that your project leader and her skills, her political skills.. her negotiating skills are absolutely crucial in this... I think they do need to have proper project management skills, we put far too many people into project management roles who are clinicians who have never done project management in their life before, without giving them... proper skills and competencies to do it..."

Contact with the national team

During Year 1, several learning events were held for pilot sites. NHS Calderdale and Kirklees attended and constructively contributed to these. Pilot sites continued to meet, but less frequently, during the following two years.

Funding

Funding overall

Year of Care provided £98,000 for establishment costs of the project during the first year, but made clear that no further funding would be available from the programme for subsequent years. Additional funding (£85,000 for 2009/10 and £35,00 for 2010/11) was provided by Calderdale PCT and Calderdale and Huddersfield Foundation Trust, with the shortfall in 2010/11 funding being made up by NHS Kirklees.

Financial incentives

A financial incentive scheme (FIS) was established in NHS Kirklees to encourage practices to engage in care planning. During 2008 the FIS was available for any practice that undertook care planning, for any long term condition, with at least 10 patients. The FIS continued for the second and third years of Year of Care, but with different arrangements. In 2009, the FIS required attendance at a half day introductory training session, entitled Preparing your Practice for Care Planning, for practice managers and leaders conducted by the national Year of Care care planning training team. Qualification for the FIS also required production of an implementation plan for introducing care planning. In 2010, practice staff were required to attend the full National Care Planning training, complete care planning templates and submit 25% of their care plans for audit. Each year the FIS paid 26 pence per patient on the practice register. There was no FIS in Calderdale.

> "...so [the Kirklees practices are] bought in because of the [Financial Incentive] Scheme and we've got very strong support from the practice data commissioning team who are sort of encouraging people to do this as well. So without them it wouldn't have been as successful perhaps in this area and I think working with a practice initiative made a difference..."

Practices involved

Initial pilot practices

While the FIS was available to all practices in Kirklees, six practices were identified (three in Calderdale and three in Kirklees) as pilots to implement the full Year of Care model. In its ideal form the Year of Care model for Calderdale and Kirklees was described as follows:

- review of the 'House' model at PCT and individual practice level
- preparing the patient for the care planning review: invitation and explanation sent to the patient; a two-step appointment approach with biomedical/screening tests being taken several weeks prior to the care planning consultation and test results posted to the patient; referral to the DESMOND programme; prepared healthcare professional via training and the adoption of care planning templates
- protected time allocated for the care planning review; sharing stories; exploring and discussing; goal and action plans agreed; setting review dates
- robust documentation for practice and patient
- feedback to commissioning.

During the first year, one of the Calderdale pilot practices withdrew from the project. Early in the second year, one of the Kirklees pilot practices also withdrew, finding the demands of the external evaluation too great.

Spread to other practices in Kirklees

By the end of Year 1, the intention was that Year of Care would spread to the whole of Kirklees.

The view in Calderdale was less enthusiastic, influenced by staff turnover. Commissioners who had been supportive of Year of Care were replaced by others who had different expectations of the intervention: they anticipated immediate measureable changes in hospital admissions, being influenced by a previous diabetes model. With no support at commissioner level, no financial incentive and no local project officer, no new practices in Calderdale adopted Year of Care.

> "...another key necessity is ensuring key commissioners are on board with this... when people want the training... you meet with senior commissioners and make sure they realise they need to certainly fund something to encourage practices to do it."

Difference in uptake between the two sites highlighted the crucial importance of high level support for the initiative, and especially of support from commissioners when financial incentives are a central element in persuading practices to adopt the approach.

Figure A (The Journey of Calderdale & Kirklees through Year of Care) in the appendix to this case study provides a pictorial illustration of key steps for the sites as they moved towards adopting Year of Care.

Establishing and implementing Year of Care: activities at practice level

In keeping with the approach used in the external evaluation, headings used to report practice level activities are categorised under components of the 'House' model (see appendix).

Engaged informed patient

Informing patients about Year of Care

At the outset, practices recognised that it would take some time before patients became familiar with the changed system.

> "...getting patients engaged, takes some time and they don't understand the process, they don't understand the changes, they don't understand why they've got the results in a letter form. They bring them into the practice and say, oh I think you've sent me this by mistake! And so if they're only seen once a year or twice a year, it's going to take a couple of years before it really starts working properly for everybody. And then maybe not everybody, so they see that, you can't expect change overnight I think."

An interim evaluation report confirmed this fact. In 2009 external evaluators interviewed 26 patients from practices in Calderdale and Kirklees and found limited understanding and awareness of Year of Care. Many patients were not aware of receiving their results prior to their consultation (a covering letter was not always included), and of those who did remember receiving results, many seemed not to understand them and spoke of taking the form to the clinic for an explanation.

In retrospect, a member of one PCT reflected that, given the chance to start again, it would have been better to spend more time ensuring that staff and patients at each practice were more fully informed and supportive of Year of Care, before embarking on the change.

> "I'd make sure we had the patients and the practices completely on-board so there would be an awful lot more of focus groups before we started, with practice population and practice staff about what we needed to do... I think we probably could have done it a bit faster if we'd been a bit more focussed..."

Structured education

During Year 1, both PCTs significantly increased their provision of structured education for patients (DESMOND), including provision of courses in languages other than English. There was, initially however, no structured pathway in place to ensure that patients who were part of Year of Care would receive diabetes education.

> "We've worked very closely with the self care team to embed self care in Year of Care so that if the GPs need to refer anybody on there's lots of pathways for them and we've really built our DESMOND and DAFNE and all of those services up. But that's, we've done that right across the piece, but Year of Care if you like, has been a bit of the kick to do it."

During Years 2 and 3, NHS Kirklees placed increased emphasis on marketing the DESMOND programme and the Expert Patient Programme.

Additional support for patients

As further support for patients, NHS Kirklees developed the self care handbook for patients, providing information about care planning and self management.

> "...we're now developing the self care hand book which is for patients and when they're diagnosed or when they come to clinic they'll get this little file, a bit like those things they get for DESMOND and it's got a chapter on diabetes, managing diabetes, and it's got a chapter on self care, what services are available and how to contact them and refer yourself to them and at the end it's got a chapter on care planning..."

Workforce training

Early in the establishment phase, the steering group recognised the need for practice staff to receive training to help them with care planning. They commissioned several local providers to deliver training which included motivational interviewing and cognitive behavioural therapy. The training was attended by GPs and practice nurses from pilot sites, as well as other members of the diabetes healthcare community, including consultant diabetologists, diabetes specialist nurses, dietitians, podiatrists, PCT staff and GP diabetes leads.

Staff reported having found the training interesting and some found it useful, but it did not provide all the information necessary to support effective care planning, leading to some initial disillusionment with the project.

In Year 2 of the project the Year of Care national training programme became available to practices in Kirklees and Calderdale. Training was provided free of charge. The national training team twice delivered the full basic care planning training (one and half days). The course was well attended by people from Kirklees, though only one person from Calderdale participated. At these sessions the importance became evident of clarifying the most appropriate participants for initial training. Although they found the information valuable, many who attended (district nurses, community matrons, specialist nurses) did not have power or influence to initiate and implement care planning at practice level. The necessity of specifying who should attend training was a useful learning point.

Over this same period the local Year of Care project manager and a locally based dietitian were trained by the national Year of Care training programme to become local trainers. Two half-day sessions entitled 'Preparing your Practice for Care Planning', aimed at practice teams, were then provided with support from a local GP and practice nurse and the national training team. These were followed by further training sessions (one and a half days) delivered by the local trainers.

To qualify for attendance at the national training in Kirklees, practice teams had to first attend the preparing your Practice for Care Planning session and develop an implementation plan (also required to qualify for the FIS). By the end of the third year the full (one and a half days) National Care Planning training had been delivered to staff from 83% of practices in Kirklees, but none in Calderdale.

> "I think when we started running the training fully, that really does get that side [the ethos of Year of Care] across and the people, like I say, come on the training, often are a bit disengaged, disillusioned, thinking they're already doing it and often that's come up: 'well I do it with some patients', but they go away feeling quite different. But I'd say the strongest element is the training."

During the third year local trainers also developed and delivered an additional extended form of the care planning awareness training to other community and primary care staff, mainly district nurses and community matrons. The half-day training defined care planning and clarified the principles of self management, goal setting and action planning. This training became mandatory for community teams in NHS Kirklees in order to meet the regional CQUIN target to support care planning for patients in the community with a long term condition.

During the third year of the programme it became evident that while healthcare assistants play a key role in care planning in GP practices, no specific training had been developed for them. To meet this gap a half-day training module, developed in North of Tyne, was delivered in the final year. A key learning point was the recognition that practices would have been better supported had this training been delivered at the same time as the full National Care Planning training.

Following feedback from trainees, it was also evident that further consultation skills training was required by some practitioners, as part of their continuing development needs. To support this a programme has been developed that merges the national Year of Care training with the Advanced Development Practitioner training, the latter being a course that focuses more on consultation skills and was being delivered in Kirklees at the same time.

Care planning

Although only four of the six practices that originally undertook to pilot the Year of Care approach continued with the project, as noted above, 83% of all practices in Kirklees underwent National Care Planning training and most of those had developed implementation plans. It is not known what proportion are actively implementing care planning along the lines of the training, but it is known that the experience for these later practices of training, and of the supporting resources (paperwork and IT templates), was considerably more positive than for the first practices who attended the original training.

During the implementation phase Calderdale and Kirklees began to consider applying the Year of Care approach to patients with heart failure and to chronic obstructive pulmonary disease, but this work remains in its early stages of development and is not addressed in the national training programme.

Workforce changes

Participation in the National Care Planning training resulted in practices reviewing their models of care and the structure of their workforce. As a result, some practices identified a need for more input from healthcare assistants and others for practice nurses, resulting in a more multi-professional team working approach. Additional liaison with district nurses and community matrons was needed, to include housebound patients in the care planning approach.

As the following quote suggests, changing a practice's system to adopt Year of Care tended to be very manageable for smaller practices, where agreement and motivation could be easily shared. Larger practices could prove more challenging, often due to communication difficulties.

> "So a lot have moved to having two appointments for patients anyway, so they bring them in, perhaps the healthcare assistant if they're lucky enough to have one, and get all the bloods done and then the nurse sees them two or three weeks later. So if they've got that model up and running, it's not much more for them just to have some added time around the results going out. They're probably doing it quite easily. The smaller practices often do crack on with it quite quickly as well, because if it's a small practice and they're quite motivated and are a good team, then there's only a few people to involve and it works. It's probably, I find it more difficult in the larger practices where they have a few nurses who all work different hours or are ships that pass in the night, getting them meeting with everybody, you know, practice team, practice manager etc. It's difficult and then they've got that much on the agenda, finding time to discuss year of care. So in the smaller practices it often does work well."

Commissioning

Identifying and meeting needs

During the first year of the project focus groups were held with clinicians and people with diabetes, gathering views about the menu of options most commonly identified in each locality, and unmet needs.

Focus groups were also held with social care providers, encouraging them to consider alternative approaches to meeting needs.

> "And we did a lot of work with providers around about what they could provide, you know, what could they provide differently, so we looked at the provider market and told them to go away and think about how they delivered their services. So if the people had the money in their hand, would they buy their services, listen to what people were saying they wanted... [these were providers] from voluntary, social care... well beyond the people we traditionally would commission."

A self care directory which already existed, entitled the *Self Care Toolkit*, listing self care services in Kirklees was re-launched as part of Year of Care and made available online. Increased effort was put into raising awareness among primary and community care workers about the self care toolkit and the availability of the health trainers service.

> "...we've got a good, a strong self care team and they've been involved in the project all along and they've got... a compendium of all the self care services that are available in Kirklees, it's called the self care toolkit. And the training and care planning has kind of re-launched the toolkit. So if people have forgotten about it, they've got it dusty on the shelf, they're all getting it down and dusting it off now because they need to know what the toolkit refers people. So in a way it's heightened or marketed all the services we've got in the area and so people are much more aware about the services... and we talk about it in the training so people know that is now on the internet... so it's marketed the whole self care side of it as well, which is great.'

Kirklees PCT also provided £250,000 to the local authority to buy self care books for the local library.

Also during Year 1, a health needs assessment was conducted in an area of deprivation and the findings used to adapt the Expert Patient Programme to address diabetes and deliver it to separate male and female groups of Asian patients in Urdu and Gujerati.

Ongoing information about individual needs is now recorded through care planning. The SystmOne template has a function for recording unmet needs, but this option is underused among practices that use this system, and the PCT acknowledges that this data should not be the sole means of recording and identifying gaps in services. As part of the requirement for FIS, 25% of care plans are submitted by practices to the PCT, providing rich information on use of and demand for self management options. This data has not yet been analysed, but will be used to inform development of traditional and non-traditional services.

Organisational processes

IT templates

GP practices in Calderdale and Kirklees use either EMIS or SystmOne.

During Year 1 of Year of Care, Yorkshire and Humber Strategic Health Authority developed a new template for SystmOne users for recording care planning; this was piloted in some practices in Kirklees. The template was introduced increasingly widely during the second year of the project, but its application brought challenges for practices.

Practices that attended the national training were offered support from the project manager in applying the SystmOne template. Practices using EMIS are not able to apply the template but have developed approaches for recording care planning using Read codes. The original pilot practices that started care planning prior to development of the template developed their own approaches to recording care planning. All have been considered eligible to qualify for the FIS.

As noted above, use of the SystmOne templates in association with data collected through the FIS provides information about patient goals, action plans, progress, service use and unmet needs.

Call/recall systems

Resulting from their participation in Year of Care, some practices have overhauled their patient recall methods. Extra administration time was required by all practices that adopted care planning.

Figure B (Summary house model for Kirklees) in the appendix to this case study lists processes in NHS Kirklees that were put in place prior to and during implementation of Year of Care. The changes were described during visits to two practices in May 2011 and are listed under the five components of the 'House' model, which proved to be a valuable conceptual tool for identifying components that support effective care planning. Comments from the project manager are also included.

Learning from Year of Care

Costs and resources

Costs specific to pilot sites

Some of the costs and resources associated with introducing and establishing Year of Care in Calderdale and Kirklees (intensive contact with the national team, engagement with external evaluators, designing training and templates) were one-off costs, relevant only to pilot sites.

Typical costs

Resources required included the project manager positions; costs of providing and delivering the FIS; and costs associated with the training. Other staff time included input to the steering group; support from practice based commissioning and self care teams to develop the FIS and market it to practices; and involvement from the self care team who promoted care planning in their documents and in their events for patients. In Calderdale and Kirklees it is difficult to separate costs attributable to Year of Care from those associated with the overall diabetes service reorganisation. Most roles and functions could be performed as part of other activities, or for a range of conditions beyond diabetes.

Savings are anticipated, resulting from reduced hospital admissions and readmissions, fewer A&E attendances and ambulance call outs and a lower rate of diabetes complications. It is possible that identification of unmet needs could raise some costs; current service re-configuration should cause other costs to decrease, but it is too early to look for outcomes of this nature.

Costs and predicted savings have been calculated for the entire diabetes service redesign for Calderdale and Kirklees. Over time it has become evident that rather than being a supportive element of the planned redesign, Year of Care has become the central point, cementing together the different elements. Since incorporating Year of Care into plans for service redesign projected costs have reduced, influenced by the new approach that Year of Care introduced. Previous plans were for primary care staff to attend a locally developed university course, and then to bring specialist teams – a local diabetologist and diabetes specialist nurse – into practices at three-monthly intervals. Under the new approach, following attendance at the university course, groups of staff will attend the diabetes centre quarterly for two hour mentoring sessions where they can discuss difficult cases. Not only will the new approach strengthen relationships between primary and secondary care, it will also allow practitioners to learn from each other, rather than remain isolated in practices.

An analysis of workforce and skill mix costs before and after the Year of Care Pilot has been undertaken from a sample of practices in the three pilot sites and has demonstrated that some practices have reduced costs, some have increased and some have remained cost neutral. Figure C (A sample of costs for NHS Calderdale and Kirklees before and after Year of Care) in the appendix to this case study outlines costs for three practices in Calderdale and Kirklees before and after involvement in Year of Care, calculated as £s per patient.

Evaluation

External evaluation

An external evaluation was commissioned by Year of Care at national level. In 2009 (the first year of implementation) information was collected from questionnaires completed by patients from pilot practices. Evaluators visited five of the original Calderdale and Kirklees pilot practices and conducted interviews with 26 patients and 24 others including GPs, practice nurses, practice managers, other practice staff and commissioners. Their findings, however, relate only to the original pilot practices and not to practices that adopted care planning after attending the National Care Planning training. In many ways it has been the later practices that benefitted most from the intervention, having received specifically relevant training and had access to processes and resources that were designed as the programme developed.

One year later, external evaluators conducted interviews with three patients and 10 healthcare professionals, though again, all were from the pilot sites, not from other practices.

The same pilot sites supported the external evaluation by continuing to request patients to complete questionnaires, so that by the end of the project over 750 patient responses had been received to two different questionnaires, collecting data using the following range of tools: Consultation Quality Index for diabetes, Diabetes Treatment Satisfaction Questionnaire, Quality of Life EQ-5D, Health Care Commission Diabetes Omnibus, and Client Service Receipt Inventory, though results from the latter were not useable.

Internal evaluation

For internal evaluation, data from claimants of the FIS provide an indication of the number of practices attending training, developing implementation plans and submitting care plans for audit, but ideally local evaluation would be developed further to identify a means of evaluating the extent to which practices had changed their approach since adopting the Year of Care approach, and to measure changes in patient experience.

In order to evaluate the number of practices now fully implementing care planning, the FIS for 2010/11 includes completion of a locally developed self-reflection tool. This is also a requirement of a recently launched Local Enhanced Service payment supporting diabetes service redesign.

A self-reflection tool for patient use is also being developed, in collaboration with the Co-creating Health team.

Other data recorded at practice level that will provide relevant indicators are HES; QOF; CQUINS; DiabetesE; and National Patient Audit. None of these are available at the time of writing.

Evidence of change

Implementation

Four of the six pilot practices completed the pilot and continue to apply the Year of Care approach, offering a data collection appointment with results posted to the patient two or three weeks prior to the care planning review. At the end of Year 2, the external evaluators commented on the different approaches each practice demonstrated towards implementing Year of Care, illustrating the impact of local conditions, histories and personalities. They also noted that Year of Care took longer than anticipated to become embedded in practice in Calderdale and Kirklees.

By the end of Year 3, the majority of practices (83%) in NHS Kirklees had attended care planning training and qualified to receive the FIS by designing an implementation plan and providing care plans for audit. Most of the remaining practices that have not yet attended training explain their absence as being due to staff shortages.

> "We've got about 14 practices... who are not engaged with it and I've spoken to every one of them and they're all, their reasons are almost universal in that they can't cope with the extra work load because of staffing problems. They've had practice nurses on sick, they've had new practice nurses in post and one or two of them have had to employ practice nurses who have no experience, so they're having to send them on courses for everything and at the moment they're going on that many courses, they're not actually in the practice to deliver care. So they're in positions where it's just not practical to take on anything new. A couple of sites who perceive Year of Care to be something that they should only do for the difficult patients or the patients who aren't well controlled and they then give me responses such as, my patients are all very well controlled, I've only got a few who aren't... Or perhaps that they think they offer a really good diabetes service currently and they don't feel it needs changing. So there are a couple of practices with that kind of attitude, but generally they all feel its beneficial, but some of them have just got the barriers around workforce."

Care planning has also been delivered to community staff (district nurses and community matrons).

NHS Calderdale plans to implement the Year of Care model during 2011/12.

Impact for patients

During the first year of implementation (2009) external evaluators noted that amongst patients they interviewed there was little recognition of the term 'Year of Care' or understanding of what it meant. Although all five practices from which the patients came (the initial pilot practices) were sending out blood results after the first consultation (other than one which was sending results to a selected group of patients), many patients were not aware of having received their results. Some, however, did recall receiving them and said they found the goal planning process useful in helping them manage their diabetes.

Amongst the three patients interviewed one year later, there was little increased recognition but, clearly, this is a tiny sample, and as noted above, the initial pilot practices were those that benefitted least from later developments in Year of Care training and resources.

Patient surveys showed an increase, between 2009 and 2010, in patients receiving a written copy of their care plan.

Until data collected locally is analysed there is no evidence available about the extent to which practices that adopted Year of Care following the national training have made an observable impact on their patients.

Impact for clinicians

Most clinicians to whom the evaluators spoke after Year 2 of Year of Care said there was little change to their roles. Some clinicians noted the challenge of encouraging patients to actively participate in goal setting, with patients having a tendency to let the clinician lead the process.

It should be noted again that the external evaluators spoke only to clinicians from the initial pilot practices, some of whom commented on their need for training that was more appropriate to care planning. Practices that adopted Year of Care later, having attended the national Year of Care training may have a different view.

Another point to be noted is the fact that, prior to Year of Care, most practices in Calderdale and Kirklees were already conducting tests for diabetes patients at an appointment that preceded their annual review, and most already believed that they offered a patient-centred service. Thus, although sending out results to patients was a new process for practices after adopting Year of Care, the practical change in their systems was less significant than in some other sites.

Impact for organisation

External evaluators noted in 2009, that healthcare professionals they interviewed saw lack of a useable Year of Care template for IT systems as a major setback. In 2010 some still identified this as a problem and felt they had not had the support they needed. At other practices, clinicians have found ways of working satisfactorily with the current system.

As above, until local data is analysed the organisational impact of Year of Care on a wider range of practices, and on practices that started out with the national Year of Care training, cannot be known.

Enabling factors and challenges

Enabling factors:

- dedicated project management from someone with effective project management skills, a facilitative approach, and who is already familiar with primary care (additional administrative support is also needed)
- commitment, clarity and active support from senior management
- buy-in from senior commissioners
- a good fit between the Year of Care approach and the intended local service redesign
- the financial incentive offered to practices that adopted care planning (to cover basic increase in practice costs)
- effectiveness of the National Care Planning training
- support of local teams (practice based commissioning and self care teams).

Challenges:

- staff turnover (in Calderdale the diabetes project manager who would originally have supported uptake left, as did diabetes commissioning leads who were supportive of Year of Care)
- no paid local clinical champion (GP)
- lack of clarity about direction and purpose of the approach, at practice and board level
- initial lack of appropriate training (now rectified)
- initial lack of templates and other supportive resources (now rectified)
- inadequate project management time (0.4FTE was not enough) in second and third years
- under-estimation of the complexity of implementing Year of Care (Calderdale initially intended to introduce Year of Care for all long term conditions, but experience in NHS Kirklees demonstrated that implementing and embedding the approach for diabetes first, prior to extending it further is the better option)
- planned new commissioning arrangements will bring new challenges.

During visits to three practices in Calderdale and Kirklees during May 2011, staff were asked what advice they would give to practices that were considering adopting a Year of Care/care planning approach. Figure D (Calderdale and Kirklees: Advice from practices to organisations starting Year of Care/Care Planning) in the appendix to this case study summarises their responses.

Plans and hopes for the future

The following cover immediate and middle term plans and hopes for NHS Kirklees and NHS Calderdale:

- continue to raise patients' awareness of Year of Care
- continue to keep practice and community staff informed of and engaged with Year of Care
- offer care planning training to the 17% of NHS Kirklees practices not yet engaged
- identify and support potential new Year of Care trainers
- offer advanced development practitioner training to all staff who have undertaken national care planning training
- further development and improvement of SystmOne pilot templates
- engage with consortia leads to ensure Year of Care for diabetes remains a priority
- include provision of the Year of Care model as part of the Local Enhanced Scheme (LES) for Diabetes Service Redesign
- establish senior level buy-in for implementation of Year of Care for diabetes in NHS Calderdale
- build on learning from experience of implementation in NHS Kirklees to develop an efficient and effective project delivery plan for NHS Calderdale
- extend Year of Care model to patients who currently have their annual review from specialist teams
- develop a model to extend Year of Care to other long term conditions and review and revise the training programme to support it.

Appendix: NHS Calderdale and Kirklees

Figure A: The Journey of NHS Calderdale and Kirklees through Year of Care

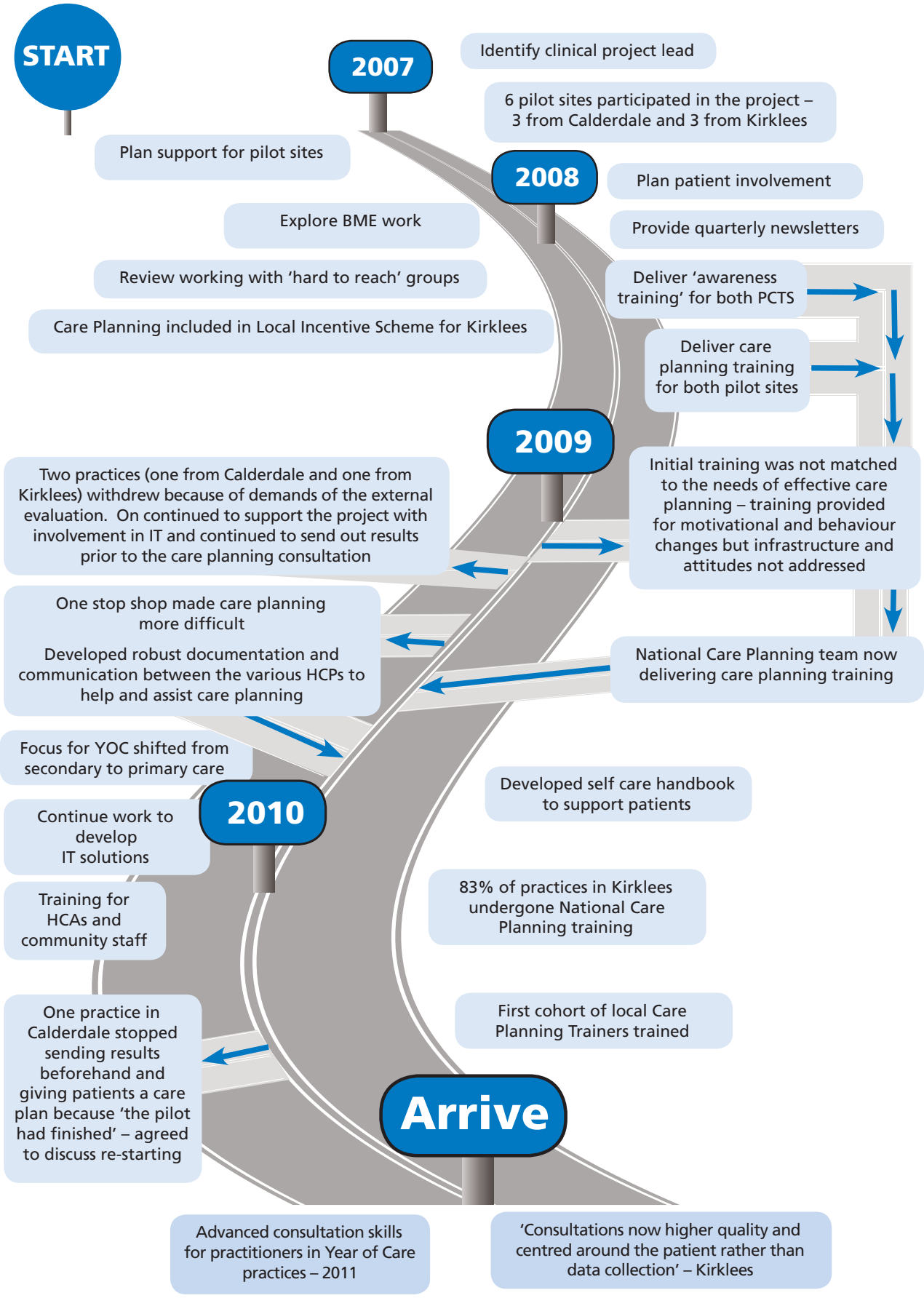

Figure B: Summary house model for NHS Kirklees

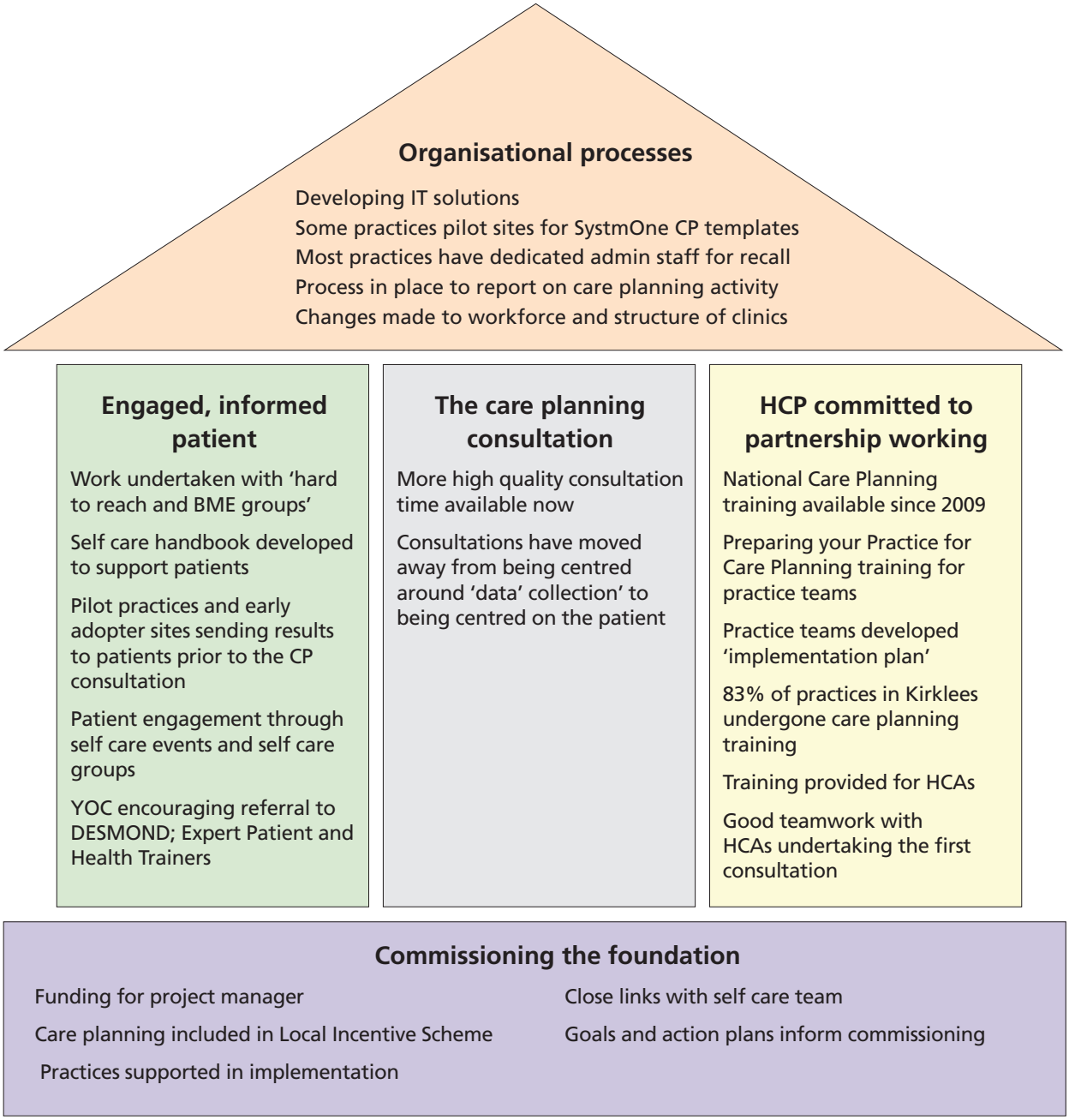

Figure C: A sample of costs for NHS Calderdale and Kirklees before and after Year of Care

A sample of costs for NHS Calderdale and NHS Kirklees before and after Year of Care outlines costs for three practices, calculated as £s per patient.

The total costs include administrative time for searches, making appointments, consultation time for tests, and the annual review/care planning consultation, taking into account any changes made in time commitment and personnel involved. The number of visits refers to consultations/patient contact time at the surgery.

	No of visits pre-YOC	No of visits post-YOC	Costs Pre-YOC* Including admin and clinical costs	Costs Post-YOC* Including admin and clinical costs
Practice A	2 visits 40 minutes	2 visits 50 mins	£39.57 with GP	£ 44.12 with GP
Practice B	2 visits 50 mins	2 visits 50 mins	£11.54 with PN	£11.54 with PN
Practice C	2 visits 20 mins	2 visits 20–25 mins	£7.49 with PN	£7.56 with PN £18.81 with GP

*costs indicate if the care planning consultation is with a practice nurse or GP

An analysis of costs across the three pilot sites has demonstrated a huge variation in primary care, with practices having different starting points and choosing to do things differently. Two of the above practices have increased costs per patient (one very small) and one has remained cost neutral.

Practice A involved a Health Care Assistant before and after Year of Care and is GP led. The increase in costs reflects an increase in administration and Health Care Assistant time. The GP feels that there is now less time spent in follow-ups but this is early days.

Practice B is a 'first phase roll out' practice for care planning and is nurse led. They reported that they operated the same system pre and post Year of Care, involving a Nurse Administrator and Health Care Assistant.

Practice C is one of the original Year of Care pilot practices, and now has General Practitioner involvement.

Figure D: Advice from practices to organisations starting Year of Care/care planning

Calderdale and Kirklees
Advice from practices to organisations starting Care Planning

Training

- Awareness training important for the whole practice diabetes team*
- Communication/Teamwork
- Teamwork important – clinical team, admin and HCA all important roles
- Explain the process to the whole team
- Patients
- Develop and tweak systems to suit practice and patients
- Organisation
- Robust IT system and dedicated person who is knowledgeable about IT

Where next?

(what do you want to keep or develop)

Keep

- Happy with current system which seems to be working well

Develop

- Information to patients about the care planning process
- Patient engagement in the care planning process
- Generic document for care planning

*National Care Planning Training Programme

- National Care Planning Training Programme – 1.5 days
- Healthcare assistant training for care planning
- Care planning training for district nurses
- Care planning training for administrators, managers etc

Diabetes UK

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