



HOW YEAR OF CARE PUTS PATIENTS IN THE DRIVING SEAT

Dr Caroline Sprake explains how a pilot in her area has created more personalised care for patients and will lead to better commissioning decisions

As a GP I have always felt there was more we could do about care planning and involving patients in the management of their condition.

The Year of Care programme, developed to promote a personalised approach for people with diabetes, has provided us with the perfect opportunity to do just that.

I have been involved since the very beginning and was the GP on the steering group of the programme which is a partnership between the Department of Health, Diabetes UK, The Health Foundation and NHS Diabetes.

A trigger for the pilot was a report in 2007 from the Healthcare Commission. The Improving Services for People With Diabetes Service Review showed that although people were having all the right tests in terms of managing diabetes, only 50% reported being involved in discussions with healthcare professionals about their management or agreed a plan to manage their condition over the next 12 months. The structured care patients received was led by healthcare professionals.



Initiative	Year of Care project to improve care planning for patients having their annual diabetes review and to use the care planning process to better inform local commissioning
Start-up costs	Funded through local enhanced service of £43.37 per patient to cover 20-minute appointment with healthcare assistant and 20-30-minute appointment with health professional who has care planning skills
Staffing	Healthcare assistants for first consultation. Existing healthcare professionals carry out care planning consultation – either GP, dietician or practice nurse – but may have to change existing role.
Savings	Anticipate showing process is cost neutral over time as result of appointments saved
Outcomes	Patients have more understanding of their condition and are more involved in their care. Some early results show better clinical outcomes. Healthcare professionals get a better quality consultation with patients. The process can help to inform commissioning of local supporting services.
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North of Tyne was one of three areas chosen to pilot the Year of Care programme in patients with diabetes. There were two aspects to what we set out to achieve.

First, we wanted to improve the routine annual diabetes review by enabling the patient to collaborate with us in care planning.

And second, we wanted to use that care planning to better inform local commissioning and ensure people had the right services available to manage their condition and improve their health.

WHAT WE DID

We started running the Year of Care programme in 39 practices in North of Tyne – 28 in North Tyneside, 11 in West Northumberland – in 2007.

Training for staff on facilitating care planning and consultation skills was developed during the Year of Care programme by the North of Tyne steering group and has now been made into a national training programme.

Patients due to attend their annual

review were asked to come for an appointment with a healthcare assistant. The 10-minute appointment was increased to 20 minutes to allow all the task-based assessments such as height and weight. The healthcare assistant carries out a blood pressure check, blood and foot screening.

Results from that first visit are then sent to the patient. We developed a system where we can merge their results with a standard letter asking them to a second appointment. In that letter they also get an explanation of what the results mean so they can come prepared for the care planning consultation with queries and concerns.

On their second visit to the surgery for their care planning consultation, they either see the GP, practice nurse or dietician, depending on their needs.

At this 20-30 minute appointment the patient discusses their results with the healthcare professional and goals are set for the next year – some short term, some long term. An action plan is made for how the condition will be managed.

This care planning has input from the patient and the healthcare professional and could include goals such as losing weight or increasing exercise to improve HbA_{1c}.

The action plan would outline what they need to do to achieve that goal, which in many cases is around lifestyle or behaviour change. It may include psychological support or signposting to local services, including those in the voluntary sector.

SMART criteria were used to form the action plan – goals had to be specific, measurable, achievable, relevant and timely.

The key aspect is helping the patients to identify specific goals and actions. The process is dictated by the patient, and is about them understanding their condition and being involved in managing it.

At the end of the consultation the patient gets a copy of the care plan to take away. A copy is also kept in their medical records.

In North of Tyne, the pilot was supported by the PCTs and funded by an existing local enhanced service for diabetes management. This allowed £43.37 per patient based on a 20-minute appointment with the healthcare assistant, the sending of results to patients before their care planning appointment and a 20-30-minute consultation with a healthcare professional who has undergone the care planning training. In our urban practice of 9,000 patients with 350 diabetes patients we already had healthcare assistants in post but other practices had to reconsider staff roles to provide the care planning programme.

LESSONS LEARNED

The administrative support needed for this approach to care planning is substantial. Time had to be taken to get those systems in place and working well.

IT systems need to be in place to allow merging of results and to capture the planning process during the consultation.

It is important that staff are aware that some roles in the team may need to change, depending on the current set-up.

The process was challenging and on reflection individual practices could have

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been given more on-the-ground project management support to ease them through a sea change in systems and staff training.

We could have perhaps achieved more earlier in the programme if there had been more feedback of data, contact between practices to promote local learning and support for specific problems practices faced with implementing the programme. It may have been better to start with a smaller number of practices. It really does need a clinical champion and good project management but the systems for those functions are now in place.

Work is now progressing to use the information from care planning consultations to inform local commissioning.

We found that it was important to get the basics of the Year of Care programme in place first before spending time developing non-traditional providers in the community who support people with long-term conditions.

One of the key changes we have more recently implemented is being able to record the output of the care planning discussion electronically so it can inform commissioning of services for both traditional and non-traditional providers, such as health trainers or services provided by voluntary organisations.

Among the other barriers we identified in improving local commissioning to support this approach was a lack of knowledge among healthcare professionals about the range of services already available through non-traditional providers.

We also found that patients needed more information and support to access these services.

OUTCOMES

Of the practices involved in the pilot, not one has returned to the old way of doing things and there has been a real shift in how we approach care planning.

When the system works well the patient can identify for themselves when they require follow-up rather than being fitted into routine GP appointments. The hope is

TURNING INFORMATION INTO COMMISSIONING

Data required	How practice collects data	How this informs commissioning
Unmet need	Collected at annual care planning appointment and fed into GP electronic record system. Admin staff collate data and feed back to commissioning body	Collated unmet needs can feed into future commissioning rounds such as Joint Strategic Needs Assessment and Health and Wellbeing boards
Patient outcomes	Tool used for patients to assess their own progress. A validated tool (others are available) is the Outcomes Star www.outcomesstar.org.uk. Scores recorded on GP electronic record system, collated and fed on to commissioning body by admin staff	Use collated information on outcomes to expand local evidence base of effective interventions and so inform commissioning decisions
NHS cost efficiencies	Data of patients' 'NHS use' before and after a service, such as number of GP or A&E attendances, prescriptions, unplanned admissions	CCGs use anonymised information on individual patient usage and cost of NHS intervention to analyse extent of NHS cost efficiencies

Source – Year of Care, 'Thanks for the Petunias' - A guide to developing and commissioning non-traditional providers to support the development of people with long-term conditions 2011, www.diabetes.nhs.uk/year_of_care

that over time there is the potential to reduce the number of appointments needed for patients with diabetes.

For the patient, the benefits have been a better understanding of their condition, personalised support, involvement in decisions about their care, information about local services, as well as some input on what local services should look like.

For the healthcare professionals involved, consultations are of better quality and more satisfying. These professionals are also working with the knowledge that the information gathered during the consultation can be used to properly inform the development of local services.

Commissioners can benefit from having detailed information on what services patients require and that they are developing services that will be truly valued by clinicians and patients.

It has not been easy to demonstrate specific health outcomes but in practices where the Year of Care programme has been running for a while we are starting to see improvements in biometrics.

In addition, there is the opportunity for fewer consultations as over time patients can choose when they need their review, although that is a long-term goal.

One of the practices in West Northumberland has done an analysis of measures such as HbA_{1c} and the results show signs of improvement with a definite trend in reduction of BMI.

THE FUTURE

We are now in a better position to use the information we are gathering from care planning consultations in commissioning decisions. And in North of Tyne we have taken the learning from Year of Care with diabetes patients and used it to start similar work in integrated care planning for patients with COPD.

So far feedback from patients in the COPD programme has been good. Some of the comments included:

'I'm now aware of my condition and know how I can improve and look after my health better.'

'I've got out and about more and got a lot more things done.'

'Everything about my illness was explained to me in a way I could understand.'

The programme has also shown reduction in COPD exacerbations.

We hope eventually to use this approach for other long-term conditions. We want to see a philosophical shift and partnership approach to facilitate support for self-management of long-term conditions.

The CCGs in the area will be taking over the commissioning role for Year of Care from the PCTs and will have to decide if the locally enhanced service is the best way to fund it and whether it should be delivered in the same way.

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