

Year of Care Guidance - Incentives and Commissioning Approaches

Background

A number of areas who have implemented care and support planning have used a variety of incentives and commissioning approaches to support its adoption. This document aims to bring together the learning from the various approaches taken.

Considerations

There are a number of considerations which need to be taken into account when developing incentives / commissioning approaches to care and support planning.

The providing of any incentive is by its very nature, meant to influence behaviour. As we know, the definition of incentives may, at times, fail to drive desired behaviour, and could encourage a “mechanical” approach to the adoption of care and support planning instead of a cultural shift in practice.

Being a complex intervention, there are a number of inter-related elements which need to be in place to ensure effective care and support planning. Incentives and commissioning undoubtedly encourage focus and enable change, although care should be taken to ensure such schemes continue to support the approach, and do not simply narrow the focus / priorities of practices into achieving progress against incentivised elements only. This would potentially be to the detriment of the complex, multi-faceted nature of Year of Care.

Different Approaches

Sites have varied their approach to incentives / commissioning. A range of single / combination of options have been used. Options include such things as:

1. Resource incentives e.g. provision of colour printers, stationery, patient materials (leaflets etc.) and IT support (templates / letter formats etc.)

Pros	Cons
Simple to administer Relatively low cost	Consider how long incentive will be in place, and how long term provision will be covered.

2. Bids to remove barriers. Some sites have allocated a small pot of funding to help remove barriers to implementation at a practice level, asking for practices to “bid” for elements of the fund.

Pros	Cons
Allows limited funding to be focused in practices that need it most and acknowledges the need for time to plan and develop changes.	Need to develop criteria for selection Managing expectations if bids rejected

3. Some sites have incentivised attendance at training by providing backfill / travel funding.

Pros	Cons
Allows day to day operation to be covered during training	Costs can be significant if implementing at scale – and doesn't include "work" / time needed at practice level.

4. Some sites have chosen to incentivise an encouraged focus on "more than medicine" by incentivising referral to link workers / community navigator roles.

Pros	Cons
Encourages HCPs to widen discussions to include "more than medicine"	Often incentivise referrals rather than take up rates (potentially encourages inappropriate referrals). "Need" may vary according to socio-economic demographics.

5. Some sites have chosen to incentivise continued referral to "traditional" services such as weight management, smoking cessation, structured education etc.

Pros	Cons
Encourages HCPs to widen discussions to include support beyond the initial care and support planning conversation.	May encourage a traditional / limited approach to "more than medicine".

6. Some sites have incentivised the development of a whole practice-based approach to implementing the Year of Care by rewarding the development of implementation plans at a practice level around Year of Care.

Pros	Cons
Helps practices focus on a practice-wide approach	Can be time-consuming. Pressure to submit plans to commissioning deadlines may not fit with the practice’s natural development timetable. Hurried plans are not always the best. Teams will require support ahead of training to develop realistic plans and an understanding of the approach.

7. Some sites have chosen not to incentivise Year of Care directly, but to incentivise the move to a multi-morbidity approach.

Pros	Cons
Can encourage practices to implement multi-morbidity approaches, with significant benefits in streamlining appointments for people with LTCs.	May encourage a focus on processes for appointments only and less of a focus on improving conversations. Need to consider how can achieve both. May exclude practices who want to start the approach with single conditions or/ and people with single conditions.

8. Some sites provide an incentive payment per patient.

Pros	Cons
Can be measured by use of READ codes. Can encourage practices to adopt the approach across large parts of their patient population.	Need to clarify how you distinguish CSP from traditional structured care. May encourage a mechanistic approach to the process without any thought to the quality of the care planning conversation. Need to consider how to manage withdrawal of incentives – to ensure CSP remains “the norm” rather than being withdrawn once incentives finish.

9. Incentivise set up – recognising the approach could help streamline practices e.g. through multi-morbidity approach.

Pros	Cons
Acknowledges the work and implementation effort involved in at a practice level. Helps support e.g. system changes, practice meetings and staff development which would not otherwise be done.	If incentivising start up, the “end point” of the incentive occurs while there may still be more to do to truly embed CSP as the norm. Risks practices losing focus half way through.

10. “Opt in” incentive for early adopters.

Pros	Cons
Fixed incentive allows practices flexibility to decide how best to use funding to address their own local priorities.	Due to the range of elements which contribute to CSP, incentive may only have an indirect impact on CSP.

11. Practices not directly incentivised, but funding provided to recruit support which can be shared across practices e.g. project manager, IT support, facilitators etc.

Pros	Cons
Sites can have a co-ordinated / shared approach to elements of the project which need to be repeated across practices (e.g. only need to design letters once). Support teams working across multiple practices can help share learning.	Staff resources will be time limited and so need to consider what longer term support will be once the team are no longer available.

Learning from Existing Sites

There are a number of sites who are in the position to be able to review the success (or otherwise) of the approaches taken. Some of the potential learning that has come from these sites includes:

1. **Complexity.** The Year of Care approach has a number of different facets, (represented by the House of Care). Need to consider if commissioning is intended to drive the overall approach (e.g. incentivising development of action plans against all elements of the House), or individual components within it (e.g. incentivising training of healthcare practitioners only).
2. **Making Sense of It.** When practices look superficially at care and support planning, they may think “we already do this”. A full understanding of all elements of the approach, and how it differs from the current picture must be made clear to avoid practices claiming incentives for an approach that they feel they currently already provide. The use of the Year of Care Quality Mark can be a useful framework for this. Local Year of Care taster sessions are useful.
3. **Remember the person with LTC is at the heart.** Useful to make reference to, or include, specific involvement in services users in the development and implementation of the approach.
4. **Realistic timeframes.** Improved patient outcomes as a result of effective CSP can take years to be realised. People often need to go through a number of cycles of CSP before improved outcomes can be realised.
5. **Variation of rates of adoption / implementation.** When a CCG implements the Year of Care approach, often practice take-up and rate of progress made varies across practices. Some CCGs implement the approach in phases, bringing on board groups of practices at a time. Some sites have a “menu” of options which practices can choose from. The menu can be flexed to their particular stage of development. Commissioning specifications will need to be flexible enough to accommodate this variation.
6. **Variation in “starting points”.** Some practices when choosing to adopt the Year of Care, will opt to try the approach within one disease group, and then move to other groups / multi-morbidity approach over time. Commissioning should be flexible enough to accommodate this variation and allow practices to do as much as they can.
7. **Overlaps with other commissioned elements.** Due to the complexity of the Year of Care approach, there are likely to be other commissioned elements which have

incentive schemes already in place e.g. referrals to stop smoking services. Need to ensure incentives do not duplicate what is already in place.

8. **Philosophy not tick box.** The Year of Care is a philosophy and approach which needs to be adopted into hearts and minds to be fully effective. Many elements of what makes the approach effective cannot be easily captured in a tick box / performance reporting framework.
 9. **Feedback Loops are important** Any commissioning approach can benefit not only from commissioners obtaining information about how practices are progressing, but the distribution of progress across a whole site (e.g. sharing cast studies, summary evaluation data, site update on progress across all practices etc.) can be useful to help celebrate successes and keep motivation for the programme going.
 10. **Learning does not just happen in training sessions.** Some sites incentivise attendance at Year of Care training. Need to consider that for more established practices in particular, on-going learning may not be limited to attendance at training courses. Participation in local shared learning events, cascading learning within practices, and the role of facilitators supporting practices can be considered.
 11. **Evaluation.** There is no single evaluation tool which has been specifically designed to evaluate the Year of Care approach. Qualitative as well as quantitative feedback can be valuable in both maintaining momentum as well as showing progress. Some sites have incentivised practices to participate in evaluation (e.g. payment for questionnaires completed / focus groups held etc.).
 12. **Don't re-invent the evaluation wheel.** The Year of Care approach has been developed, implemented and evaluated previously. Some elements of the approach may need to be adapted and evaluated locally and some may not. There is existing reports outlining the case for change (appendix 1) and Year of Care evaluation reports can be found here: http://www.yearofcare.co.uk/sites/default/files/images/YOC_Report%20-%20correct.pdf
- It is useful to provide local / practice level information to support the case for change e.g. obtaining population disease profiles / predicting future primary care demand / extracting national GP survey data etc.
13. **READ codes** can be a useful way to automate the tracking that the fidelity of the approach is being followed. A summary of possible fidelity measures and the range of READ codes are available in appendix 2.



Commissioning Specification – Template

An example of a comprehensive commissioning specification covering Year of Care can be found in appendix 3 together with an outline suggested practice action plan for care and support planning implementation in appendix 4.

Appendix 1 Case for change

Appendix 2 Fidelity measures and READ codes

Appendix 3 Template Commissioning Specification

Appendix 4 Practice plan for care and support planning

Appendix 1 – Case for Change - The House of Care - the evidence base and impact in the UK

Care and support planning delivered via a house of care (HOC) approach was derived from the Chronic Care Model (CCM)¹. This summarises a wealth of international evidence into 6 core components which all need to be in place to deliver better outcomes for people living with long term conditions (LTCs). Support for self-management is the strongest independent variable within this complex intervention but the headline message is that all the components need to come together as ‘productive interactions’ between ‘empowered and activated patients’ and ‘proactive systems’. This hypothesis has been given further weight by a recent Cochrane Review of care planning² which found improvements in physical health and depression as well confidence and self-efficacy when all of the steps were in place, and integrated into routine care.

The Year of Care Programme (YOCP)³ successfully showed how to make this the norm for everyone living with one to more LTCs. They developed the HOC framework as a way to make the ‘dry’ CCM model practical and accessible to grass roots teams and local communities. The HOC provides the framework both for local teams to redesign the way they work using CSP and also as a means of transferring this reproducible approach to new communities⁴. Because introducing CSP involves changes to attitudes (mind-sets), skills and clinic infrastructure it is a powerful lever for culture and systems change within teams and across the wider community. More recently new communities focussed on introducing CSP have learnt by experience that wider changes and a whole system approach are necessary to maximise its potential.

Impact

CSP delivered via the HOC approach has immediate benefits in terms of improved patient and staff experience. Changes in healthy behaviours begin after one cycle but changes to population level intermediate clinical measures take longer to demonstrate. The headline messages are that there is

- improved experience of care
- real changes in self-care behaviour
- improved knowledge and skills and greater job satisfaction for health care professionals
- better organisation and team work
- improved productivity: care planning is cost neutral at practice level: there are savings for some.
- CSP takes time to embed: changes in clinical indicators across populations may be seen after two or three care planning cycles.

¹ Wagner EH, et al. Organizing care for patients with chronic illness. *Milbank Q.* 1996;74:511-514

² Coulter A, et al. Personalised care planning for adults with chronic or long-term health conditions. *Cochrane Database of Systematic Reviews* 2015, Issue 3. Art. No.: CD010523. DOI: 10.1002/14651858.CD010523.pub2.

³ Year of Care. Report of findings from the pilot programme. 2011

http://www.yearofcare.co.uk/sites/default/files/images/YOC_Report%20-%20correct.pdf

⁴ Coulter A, et al. Delivering better services for people with long-term conditions. London: Kings Fund; 2013

Most of the available data comes from diabetes because the YOCP pilots were focused on developing CSP (2007-2010) and testing the transferability in diabetes (2009-2011). Subsequently the approach has been shown to be generic and has been introduced in other single conditions and for people living with multimorbidity within multidisciplinary community teams or within general practice (2012 – 2014), from where significant data is only just emerging. However the examples below from diabetes demonstrate consistent changes in support of the headline messages (above) despite the local populations and organisation (each ‘local HOC’) being very different.

Tower Hamlets (95% of practices)

	2009 (QOF with exemptions)	2012 (Dashboard – no exemptions)
HbA1c <7.5%/58mmol/mol	37%	55%
BP ≤145/85	70%	90%
Cholesterol <5mol/l	65%	83%
3 combined		35% (national 19%)

- Patient perceived ‘involvement in care’ rose from 52-82%
- Diabetes Care processes: 2006 – in worst 10% in England. 2012: Best in England
- *‘YOC is a great idea because it is focused around the individual. I’m happy that I get more of a say in my care.’* (Person with diabetes from Bengali community - TH submission)
- *‘Each time I get a greater understanding of my condition and...and how I can go about maintaining and improving it.’* (Person with LTC)
- *‘I focus less on the disease and take a more holistic perspective’* (PN)
- *‘It’s 100% better for me and the patients’ – GP*

Berkshire West (70% of practices)

	June 2012	June 2014
HbA1c <60mmols / mol	47%	57%
Cholesterol <5mmols	46%	79%
BP ≤ 140/85	66%	78%
Prescribing savings		£800,000

Appendix 2 – Fidelity Measures

Care and support planning: Fidelity of the processes

(‘How do we know high quality care and support planning (CSP) is taking place?’)

Individual process		V2- = Version 2 of Read Coding = EMIS LV, EMIS PCS, Vision, Synergy	CTV3 = Clinical Terms Version 3 = SystemOne
Who is involved	Number of people on CSP ‘register (denominator)		
Essential administrative steps	Number sent first letter including explanation, appointment for HCA / or reflective prompt	None	XabEf or XabEd
	Number attending first appointment with trained* /supportive HCA/ practitioner	9r	XoafN
	Number sent results /tests/assessments, explanations and reflective prompt	9NC33	XaZyi
	Number attending CSP ‘conversation’ appointment with trained** practitioner	8CS	Xa4HX
	Number with recording of individual goals /equivalent	67L2.	Xa4HX
	Number with recording of actions for person and service	8CS6. and 8CCS5	XaZYs and XaZYr
	Number recording review arrangements		
	Number attending a planned review with trained** practitioner		
Activities relevant to CSP process in individual sites / or intermittent audit	Number planned for individual CSP outside routine recall		
	Length of the appointment allotted to CSP ‘conversation’		
	‘Conversation’ appointment with trained practitioner** by telephone		
	Review appointment with trained practitioner** by telephone		

	Number of first and second appointments with <i>non – trained</i> HCA* or practitioner**		
	DNAs followed up		
	No of practitioners who have undertaken reflective activities		

*Trained to provide a person centred approach explaining process, encouraging engagement and carrying out technical aspects (see competency check list)

** Core CSP training with or without advanced consultation skills (see competency check list)

Additional READ codes

Comment or definition	SH suggested/actioned via Carol	
	V2- = Version 2 of Read Coding = EMIS LV, EMIS PCS, Vision, Synergy	CTV3 = Clinical Terms Version 3 = SystemOne
TESTS CARRIED OUT		
Education for care planning	67S..	XaYrk
CARE AND SUPPORT PLANNING		
Assessment of Year of Care goal importance	38L.	XaZTk
Assessment of Year of Care action confidence	38M..	XaZTI
Provision of copy of care plan	8CMS	XaXrF
REVIEW OF CARE PLAN		
Review of care plan	8CMG	XaJQn
Review of patient goals	8CMX	XaXfH
Goal achieved	67L0	XaXfH
Goal not achieved	67L1	XaIOY
Identifying barriers to goal achievement	67R..	XaYal
Unmet need identified from care plan (finding)	8CMJ.	XaXQF

Appendix 3 - Template Commissioning Specification

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement

Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	
Service	Care and Support Planning for Patients with xxx in Primary Care
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs
<p>1.1 National/local context and evidence base</p> <p><u>National Context</u></p> <p>General case for change:</p> <ul style="list-style-type: none"> • the national picture regarding the targeted condition(s). • the rates of long term conditions (LTCs) are increasing, people tend to get more LTC as they age, and the impact of an ageing population is increasing demand on primary care. • Effective approach needs to rely on improving patient self-management • People spend very little time with a healthcare practitioner (HCP), CSP allows us to make the best use of the time with the HCP and supports people to self-manage <p>Condition-specific case for change</p> <ul style="list-style-type: none"> • Details from any national audit data around e.g. life expectancy, biomedical information / QoF results, national strategy/goals • Any data around cost of current approach • What proportion of national NHS spend is impacted

Local Context

- Include any local data for example
 - evidence of local areas for potential improvement where CSP could help
 - data regarding attendance rates at annual reviews / DNA rates
 - availability / attendance at education programmes
 - any focus on identifying and providing community assets

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

2.2 Local defined outcomes

In xxxxx, the desire is to see improved outcomes for patients with xxxxxx through the provision of care and support planning as an enhanced service to primary care, based on the Year of Care model.

The aim is to implement the Year of Care approach to CSP which will optimize the conditions to allow patients to work collaboratively with their healthcare practitioner in a care and support planning appointment which will:

- improve the patient experience of primary care
- improve ability to self-manage
- Improve patient's experience of living with xxxxx.

3. Scope

The provider will deliver care and support planning to patients??xx aged xxx with xxxx conditions, in accordance with the guidelines laid out in this specification. This does not include patients with diagnoses of xxxx.

3.1 Aims and objectives of service

The aim is to re-design and implement a 2 step approach to care and support planning process for people with xxxx undergoing an annual review.

To be eligible to provide this enhanced service, practices will be expected to provide the standard level of care which anyone with xxx should expect from their general practice, This should include:

- Maintain a register
- Have a nominated lead
- Identify and provide optimal care for those people who are housebound or live in residential / nursing care
- Work towards maximum achievement of QoF in xxxx with an acceptable level of exception reporting against national benchmarks.
- Participate in national audit xxxx.

Key components:

- Implementation of a Care and Support Planning approach
- Practice clinical lead and relevant staff to attend Year of Care CSP training:
- Arrangements to brief and engage whole practice approach.
- Whole practise team to develop an action plan to implement the Year of Care approach. The attached template can be used to help. (xxx attach Year of Care planning checklist, or other alternative approach). Plan to contain but not be limited to:
 1. How will target group be defined (e.g. through registers / IT flags
 2. Approach to call / recall processes
 3. Information gathering appointments – who and how
 4. Information sharing / results letters to be shared in advance of CSP
 5. CSP appointments
 6. More than medicine
- Identify and develop a plan to cover both clinical and CSP training needs.
- Measure impact on patient enablement using the xxxx survey, (xxx per care planning practitioner, at least one practitioner per practice). Summary of findings to be relayed back to relevant HCPs on a regular basis and reported to the CCG at least annually.
- Assess qualitative feedback from patients and HCPs using xxxxx survey. (At least 1 patient per year per HCP). Summary of findings to be relayed back to the practice and HCPs on a regular basis, and reported to the CCG at least annually.

- Ensure patient involvement in development of approach.
- Practice to establish means of identifying “gaps” in service provision revealed during CSP conversations through feedback from HCPs, or through the use of relevant READ codes to record unmet need. Participate and feed unmet needs into CCG for commissioning consideration.

3.2 Service description/care pathway

Step One: Information gathering appointment

Appointment of appropriate duration (minimum 20 minutes for a single condition) to carry out biomedical tests and help prepare the patient to identify issues they might want to talk about during their CSP, and to help them understanding how the new CSP approach will work.

Tests should include those already covered by QoF / other specifications including

- Blood Pressure
- Weight
- xxxxx

Step Two: Information sharing / Agenda setting prompts

Year of Care Letter sent to patients outlining their results prior to the care planning appointment at least one week before the appointment. Letter should prompt the patient to consider what’s important to them, and crucially, what they want to get from the care planning consultation.

Step Three: Collaborative CSP

The care planning consultation should include an exploratory discussion of what matters to the person, highlight any professional issues and once a main goal is agreed and action plan should record the main actions agree for the person and the professional.

Percentage of people who have been coached to develop goals.

Step Four: Goal setting and action planning (as part of the CSP appointment)

Percentage of people given a summary of the conversation.

3.3 Population covered

All ??? on ??? register.

3.4 Any acceptance and exclusion criteria and thresholds

In order to participate in the scheme, providers must already participate in the ??? elements of the Quality and Outcomes Framework (QOF), and xxxx national audits??.

3.5 Interdependence with other services/providers

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule xx)

5.2 Applicable CQUIN goals (See Schedule xx)

6. Location of Provider Premises

The Provider's Premises are located at:

7. Funding and Payment Levels

In order to receive payment, the provider must:

- Submit evidence that healthcare professionals (one GP and one nurse as a minimum) have attended the day and a half CSP training – provision of names and dates of training.
- Submit evidence that a care planning consultation has taken place, goals have been identified and a care plan has been agreed with the patient. This can be achieved through recording of the process using the relevant care planning codes (see monitoring arrangements).
- Evidence that “more than medicine” is being discussed during CSP – qualitative feedback from patients, minutes of practice meetings where patient-identified unmet needs have been discussed.
- Evidence that education courses have been recommended to the patient.
- Patient Satisfaction survey report– Patient activation score – pre and post consultation.
- Healthcare professionals’ survey report– what difference has it made to relationships with patients?

Payment levels are:

8. Monitoring Arrangements

The relevant read codes will be used at each stage, and in the correct order for the provider to achieve a payment. Read codes to be used are:

9r Information gathering appointment

67S .. education for care planning

9NC33 Long term condition summary sent to patient

67L2 Agreeing personal goals

8CS Agreeing care plan

8CMJ Unmet need identified from care plan

Annual/quarterly reports

Quarterly report quantifying:

- Number of invited to information gathering

- Number of people attending information gathering

- Number of people where results sent

- Number of people invited for care and support planning

- Number of people attending care and support planning

Annual report:

Report of patient satisfaction survey findings (local survey specification).

Report of healthcare practitioner satisfaction survey findings (local survey specification).

Appendix 4 - Practice Plan for Year of Care – Care and Support Planning

Practice Name:				
Date attended Year of Care - care and support planning taster session (please circle):				
Dec 2015 Jan 2016				
Care and Support Planning Leads within your practice				
Name of identified clinical lead:				
Name of identified administrative lead:				
Names and designations of those identified to attend 1 ½ day YOC Core Training:				
Names:	Designations:	Email address:		
Patient Groups to be involved in Care and Support Planning				
Which LTCs do you plan to include?				
<ul style="list-style-type: none"> • • • • • 				
How many patients in the practice population have a LTC?				
Part of the process is applying care and support planning to people with more than one LTC. Please show us in the table below how many of your LTC population have one or more LTCs.				
Number of LTCs	1	2	3	4 or more
Number of Patients				

How many patients do you anticipate offering care and support planning to?

How will this be different to current care provision, and what improvements would you like to see?

Care Planning Process – who will be doing what?

Which team members will be involved in care planning processes? How will this happen in a prepared and organised way?

Identifying <i>e.g. identifying patients for care and support planning, call and recall systems, performance of tests</i>	Preparing <i>e.g. preparing patients for a new care planning approach, sharing results and preparing patient for care and support planning conversation</i>	Discussing <i>e.g. consultations, identifying what is important to the patient, goal setting and action planning, linking patients to support for self-management / co-ordinated care</i>	Documenting <i>e.g. IT systems, recording patient test results, documenting patient goals and an action plan of what needs to be done and by whom, sharing a copy of this with the patient</i>	Reviewing <i>e.g. monitoring of outcomes, patient goals and experiences, measuring of process change and on-going service improvements</i>

Describe the changes you are planning to make to:

Registers and recall systems

HCA – information gathering appointments

Patient Preparation

Care Planning consultations

What additional support / training do you anticipate needing to implement care and support planning?

What is your preferred format for receiving support throughout this process? (Please tick all that apply)

- Individual practice visits / meetings
- Time In sessions
- Locality based workshops involving other practices

Other, please specify:

What key outcomes would you hope to see from this support?

How will you know that you have achieved these?

How confident do you feel about, in time, being able to implement the approach?

(1 being not at all, 10 being highly confident?)

1	2	3	4	5	6	7	8	9	10