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Evaluating pilot sites as they prepare for the 'Year of Care': Final Project Report

Diabetes UK

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Executive Summary

Background

1. Current figures indicate that 2.3m people in the UK have been diagnosed as having diabetes with a further estimated 0.5m people whose diabetes is undiagnosed. By 2020 the number of people with diabetes is expected to be around 4m, making it one of the major burdens on an individual's health and on NHS resources.

2. The Diabetes National Service Framework (NSF) sets out 12 standards to be achieved by 2013 and emphasised the importance of care planning in supporting Standard 3 concerning patient empowerment. Against this backdrop the joint Department of Health and Diabetes UK Care Planning Working Group (2006) published a report that described a partnership approach to care between health professionals and people with diabetes, and offered guidance on incorporating care planning into diabetes services. This work fed into *Choosing Health: Making healthy choices easier* (Department of Health 2004) where *Year of Care* was first recommended.

3. The *Year of Care* project presented in this report is a partnership between Diabetes UK, the National Diabetes Support Team, the Department of Health and The Health Foundation. Three healthcare communities, NHS North of Tyne, Calderdale and Kirklees Primary Care Trusts, and Tower Hamlets Primary Care Trust were selected as the project's pilot sites. Staff in these organisations have been preparing the ground over the last 12 months to make *Year of Care* a reality for people with diabetes.

4. During the preparatory phase pilot sites were required to:

   - Explore how services can be designed, developed and commissioned to offer people with diabetes appropriate options and genuine choice over a planned *Year of Care*, taking into account the needs and preferences of different population groups.
   - Deliver shared decision making between patients and healthcare professionals (via the care planning process) to support the design of a *Year of Care* that meets individual patients' needs (i.e. micro-level commissioning).
   - Test how commissioners can link micro-level commissioning at an individual level to commissioning across a whole population (i.e. macro-level commissioning).

Methods

5. The *Year of Care* evaluation aims to capture learning from the pilot sites as they prepare for the *Year of Care*, and to gauge the feasibility of these service developments. A range of methods were employed to capture data from across

the pilot sites including individual/group interviews and formal discussions, working groups, learning events, e-mail correspondence and the use of hard copy materials.

6. More than five field trips were made to each pilot site across a 10 month period. During these visits evaluation staff met with *Year of Care* team members at each site to capture project progress and learning. Additional data came from other sources including project learning events and written materials prepared by the pilot sites to support key activities such as staff training and clinical engagement. The multiple data sources were organised around nine key domains to reflect the organisational contexts and strands of activity that pilot sites had been engaged in.

Findings

7. The sheer volume of work undertaken by each of the pilot sites over the 10 month preparatory period is worthy of note. Each site took on a significant challenge to engage in whole systems change, and whilst the success of this work will ultimately be determined in the years ahead, it has been feasible across different contexts for services to prepare for delivering *Year of Care*.

8. Work streams were specified and stakeholders engaged with some ease. The *Year of Care* approach fits well with contemporary policy and has proved an attractive potential mechanism for developing services both within the pilot sites and among stakeholders further afield.

9. Different mechanisms were adopted for training clinical staff and these have been successfully implemented. Along side this work pro forma and other materials have been prepared to support and enable delivery.

10. The overriding message to date is that one size does not fit all contexts and there may be any number of legitimate ways to get from A to B. These differences are perhaps most evident in the approach taken by different pilot sites to commissioning processes.

11. One pilot site has been working ‘up stream’ with user and provider workshops to develop a broader economy of services. Another is taking a more iterative, ‘down stream’ approach, which in time should result in a broader economy of services.

12. A significant outstanding challenge relates to the documentation, retrieval and collating of care planning data. During this preparatory phase the project has come a long way in these respects linking up with Yorkshire and the Humber SHA to design the content and operations of an IT template. The field requires the IT template to further support their work and to ensure a mechanism that will allow individual patient level data to inform macro level commissioning decisions.

Conclusions

13. Each of the pilot sites has travelled a great distance in the last 10 months and each of them has found a slightly different route to prepare their workforce to deliver *Year of Care* services. Along side this work a methodology has been prepared with the sites to evaluate their delivery over the next 24 months and thereby understand what is being implemented in routine practice and how this makes a difference to the lives of people with diabetes.

14. In conclusion, preparing for the *Year of Care* has been successfully achieved, and the three pilot sites are now ready to implement the *Year of Care* approach. However, the work required and challenges faced have far exceeded those anticipated at the onset. This serves to emphasise the complex and challenging nature of such projects which involve extensive changes to culture and service delivery and rely on the enthusiasm and engagement of multiple stakeholders.

15. A series of recommendations are made to support the ongoing development, sustainability and evaluation of the *Year of Care* pilots for the implementation stage. Their progress and results over the next two years will be eagerly awaited by pilot site staff and patients, as well as by the broader community of stakeholders that the project has attracted.

1 Introduction

1.1 Background

Current figures indicate that 2.3m people in the UK have been diagnosed as having diabetes with a further estimated 0.5m people whose diabetes is undiagnosed. By 2020 the number of people with diabetes is expected to be around 4m, making it one of the major burdens on an individual's health and on NHS resources.

The Diabetes National Service Framework (NSF) sets out 12 standards to be achieved by 2013 and emphasised the importance of care planning in achieving these standards.

Choosing Health: Making healthy choices easier (DH 2004)[1] sets out a national strategy to improve health and prevent disease, and introduced a commitment to *Year of Care*. A *Year of Care* describes the on-going care a person with a long term condition should expect to receive in a year, including support for self-management, which can be costed and commissioned. A commitment to develop and test the *Year of Care* approach was reaffirmed in *Our Health, Our Care, Our Say* (Department of Health 2006)[2].

More recently, the NHS Next Stage Review (Department of Health 2008)[3] sets out its vision for a modern NHS. This includes a commitment to personal care plans for all patients with long term conditions, 5000 of whom will pilot personal care budgets. The *Year of Care* approach offers a potential framework through which these commitments can be realised.

Against this backdrop the joint Department of Health and Diabetes UK Care Planning Working Group (2006)[4] published a report that described a partnership approach to care between health professionals and people with diabetes, and offered guidance on incorporating care planning into diabetes services.

The *Year of Care* project arose as a response to the commitment laid out in Choosing Health and builds upon the approach outlined in the Department of Health and Diabetes UK Care Planning Working Group report.

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[1] DH (2004) Choosing Health: Making healthy choices easier. London: DH

[2] DH (2006) Our Health, Our Care, Our Say: a new direction for community services. London: DH

[3] High Quality Care for All: NHS Next Stage Review Final Report (2008) Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

[4] Care Planning in Diabetes: Report from the joint Department of Health and Diabetes UK Care Planning Working Group(2006). Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063081

The *Year of Care* project is a partnership between Diabetes UK, the National Diabetes Support Team, the Department of Health and The Health Foundation. Three health communities, NHS North of Tyne, Calderdale and Kirklees Primary Care Trusts, and Tower Hamlets Primary Care Trust were selected as the project's pilot sites.

Recognising that there is a great deal of work to do in developing the *Year of Care* concept into a practical model for implementation, staff in the three communities have been undertaking preparatory work over the last 12 months with the aim of commencing implementation in autumn 2008.

During the preparatory phase pilot sites were tasked with:

- Developing a model of shared decision making between patients and healthcare professionals (via the care planning process) to support the design of a *Year of Care* that meets individual patients' needs (i.e. micro-level commissioning).
- Exploring how services can be designed, developed and commissioned to offer people with diabetes appropriate options and genuine choice over a planned *Year of Care*.
- Testing how commissioners can link micro-level commissioning at an individual level to commissioning across a whole population (i.e. macro-level commissioning).

Alongside the preparatory phase, Diabetes UK commissioned Tribal Group to conduct an external study, evaluation and description of the work of the pilot sites and also put in place tools and processes for an evaluation of the implementation phase.

1.2 About this Document

This document presents the findings from the evaluation of the preparatory phase of the *Year of Care* project, and describes the progress made in defining the evaluation for the implementation phase. It contains the following sections:

- Methods.
- Background and context.
- Progress and findings from the pilot sites.
- Evaluation plans for the implementation phase.
- Key learning from the preparatory phase.
- Discussion and recommendations.

2 Methods

2.1 Evaluation Aims and Objectives

The evaluation aims to capture learning from the pilot sites as they prepare for delivery of the *Year of Care* in order to gauge the feasibility of the approach. It also seeks to agree measures and put in place plans for the evaluation of the implementation phase of the project.

Specific objectives stated in the original specification for this work are:

- To identify and explore the processes and people involved as the pilot sites prepare for delivering a *Year of Care* for diabetes.
- To identify tools (e.g. frameworks, assessments) used to support delivery of a *Year of Care*.
- To reflect on the levers and incentives, as well as the challenges, that impact on the process of preparing for delivery.
- To reflect on the feasibility of preparing for delivery and of measuring delivery.
- To determine the measures that pilot sites will put in place to evaluate delivery of a *Year of Care* (these may cover for example bio-medical factors, patient experience, quality of life, cost of services accessed, staff satisfaction, and impact on the local health system) including comparators at national or local level against which progress can be measured.
- To identify the processes and structures involved in assuring quality.
- To reflect on any unintended consequences.
- To identify transferable findings in terms of policy implications, practical tools/suggestions and theoretical underpinnings.

2.2 Theoretical Framework

This evaluation focuses upon the preparatory phase of the *Year of Care* project. Therefore, it provides a narrative and reflection on the approaches and progress made by the pilot sites. However, it cannot assess the success or otherwise of these approaches, which will only become apparent during the implementation phase.

Our evaluation approach draws from two disciplines. Action research describes how humans and organisations behave in the world and the change mechanisms that help them reflect on and change their own systems[5]. Realistic Evaluation[6] considers

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[5] Reason & Bradbury, Handbook of Action Research. Sage, 2001.

mechanism (i.e. the '*Year of Care*' project) and context (local conditions and adaptations to the approach), to understand what works and why, or why not. Realistic evaluation also supports identification of key enablers and barriers to change, as well as how these interact with local conditions.

2.3 Data Collection Procedures

In order to understand and capture the progress and experiences of the pilot sites in preparing for the *Year of Care*, the evaluation team worked closely with the pilot sites and *Year of Care* Programme Board and Reference Group. Developing open and honest relationships with these stakeholders was integral to the success of this evaluation and a great deal of time and effort was put into this aspect.

Data was captured through a range of methods including individual/group interviews and formal discussions, attendance at working groups and learning events, e-mail and telephone correspondence and the use of hard copy materials.

Each pilot site was visited at least five times during the 10 month preparatory period. During these visits evaluation staff met with *Year of Care* team members at each site to capture project progress and learning. A number of colleagues beyond the core teams were also interviewed including representatives from public health, patient and public involvement, and primary care. Interviews and discussions were semi structured and sought information and understanding in relation to the work streams that pilot sites had identified for their project. All field notes were collated and electronically recorded either during or immediately after each field trip.

Additional data came from other sources. For example, information from the project learning events was collated by the project's central team and forwarded to the evaluation team. Pilot site staff documented many of their activities and prepared a considerable volume of written material to support key activities such as staff training and clinical engagement. Whenever possible these materials were forwarded to the evaluation team. Ad-hoc telephone calls were also made between the evaluation team and pilot site staff for additional pieces of information or to seek clarification over existing data.

Against this backdrop the evaluation team also worked with the pilot sites to prepare an evaluation methodology that could be implemented over a 24 month period once *Year of Care* services began. Towards the end of the field work period this aspect of the work became more dominant. However, it necessitated closer liaison with primary care staff, which brought additional insights into the feasibility of preparing a field for the implementation of *Year of Care*.

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[6] Pawson & Tilley. Realistic Evaluation. Sage, 1997.

2.4 Data Analysis and Presentation

The multiple data sources were initially organised around nine key domains to reflect the organisational contexts and strands of activity that pilot sites had been engaged in. Within each domain data were triangulated to forge as accurate and comprehensive a picture as possible of the contexts and activities pilot sites had undertaken. Particular attention was paid to identifying approaches, levers and incentives that had worked well and to identify any outstanding challenges.

Findings are presented under each of the key domains which include: the *Year of Care* model; organisation and project contexts; stakeholder involvement; patient and public involvement; provider involvement; staff training; commissioning; delivery; and *Year of Care* central team support. A concluding section draws out the key learning from these project processes.

2.5 Ethics and Patient Involvement

This evaluation did not require ethical approval from NRES (National Research Ethics Service) as it was deemed a service evaluation.

The patient voice is fundamental to the *Year of Care* approach and patient involvement is a key aspect of the work undertaken by the pilot sites. Their approach to patient involvement is reported in the findings section of this report.

This evaluation of the preparatory phase of the *Year of Care* project has not directly involved patients. However, patient representatives provided regular input to the *Year of Care* project via the Evaluation Steering Group, Project Reference Board, and Management Board and at the learning events. The pilot sites also had a number of local arrangements to involve patients.

As described later in this report, the planned evaluation of the implementation phase will explicitly collect data from patients to capture understanding of their experiences of the *Year of Care* approach.

3 Background and Context

3.1 Introduction

This section sets the background and context for the evaluation documented in the remainder of this report. It begins by describing the project structures and processes and then presents the conceptual model developed by the pilot sites to help them understand and realise the *Year of Care* approach.

The organisational context of each of the pilot sites, including their population demographics, is described. This is followed by some early perceptions of the sites and finally a snapshot of their current status in terms of GP practices recruited and staff trained.

3.2 The Year of Care Project Structure and Processes

The pilot sites were chosen though a rigorous selection process that included submission of a formal written project proposal, interviews and site visits by the central *Year of Care* team. Selection criteria are documented in detail in the practical guide to the project but included the need for strong leadership in diabetes care, excellent people development and involvement, robust management processes, developed partnerships and a results oriented culture.

Each of the pilot sites received regular (monthly) progress monitoring visits from central *Year of Care* team staff. Typically these were generic project progress reviews but also included a specialist commissioning review. Additionally, the evaluation lead was regularly in the field. In combination these inputs kept the project high on the agenda of the pilot sites, as did the phenomenal amount of work put in locally.

During the preparatory phase six learning events were held which brought representatives together from each of the pilot sites, the central *Year of Care* team and evaluation staff. These events served to clarify key concepts central to the *Year of Care* model, share learning between sites on key issues such as commissioning, care planning and training, as well as to reflect on overall project processes and for project partners to report the distance they had come and the success they had amassed en route (as well as the pit falls).

3.3 Development of a Year of Care Model

At the onset of this project, the *Year of Care* approach was a concept rather than a practical application. Therefore, a great deal of the early work of the pilot sites involved the development of a theoretical model that describes the organisational processes and elements of care that are necessary to deliver effective services for people with diabetes. One of the pilot sites (NHS North of Tyne) had been instrumental in supporting the development of this model, which was further debated and elaborated by all project partners during learning events and other communications.

A core script was prepared early in the life of the project to accompany the model, which clarified the essential components of the *Year of Care* approach. The model and core script became a key reference point for pilot sites and was used to guide their direction of travel and thereby promote consistency across the field (see Figure 1 below).

A *Year of Care* describes the on-going care a person with a long term condition should expect to receive in a year, including support for self management, which can be costed and commissioned. The *Year of Care* approach puts patients in the driving seat of their care and supports them to self-manage effectively. It is *firstly* about making routine consultations between clinicians and people with long-term conditions truly collaborative, through care-planning, and *then* about ensuring that the local services people need to support this are identified and available, through commissioning. Collaborative care-planning means giving people more information, and understanding their individual issues, concerns and goals, before jointly agreeing on priorities and actions. It is a huge cultural change for people with long-term conditions and health-care professionals alike. But if the information about individual's priorities and goals is captured and fed into commissioning at population level, services can be truly planned based on what individuals need.

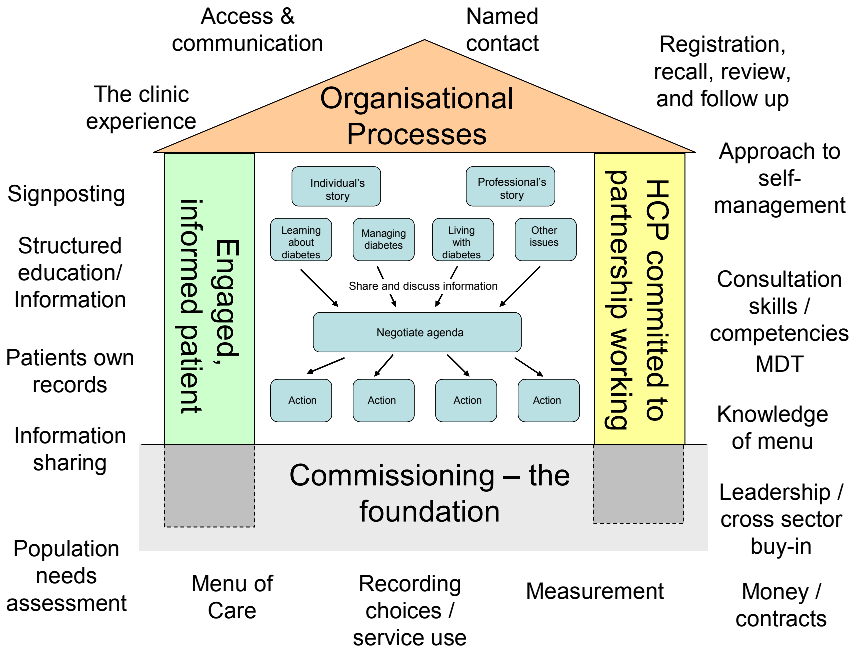

Figure 1: Core Script and *Year of Care* Model

The *Year of Care* model represents a house with foundations, walls and a roof. The walls represent the people involved in the delivery and receipt of care and the foundation and roof represent organisational processes. Contained within the house is the care planning consultation itself.

At project learning events staff from the pilot sites worked with this model in a number of ways. They specified many of the actions needed to ensure sound organisational and commissioning processes, as well as those needed to foster engaged patients and committed professionals. They also unpacked the care planning processes that lay at its heart.

Developing a clear understanding of the model and how it might operate in practice were important pieces of learning for the project. Importantly, this work provided a consistent reference point for diverse project partners to engage in a similar direction of travel.

3.4 Organisational Context of the Pilots

Starting Positions

Each of the three sites brought different strengths to the *Year of Care* project. Calderdale and Kirklees Primary Care Trusts were already developing *Year of Care* services for diabetes, heart failure and chronic obstructive pulmonary disease (COPD). Commissioning activities had included work to stratify local populations according to service needs and interventions to mobilise local health and social care markets, particularly those that promoted self-care.

In contrast NHS North of Tyne had taken a lead role in developing the national care planning model. Together with local practices they had developed and piloted care planning both as a concept and a service delivery model. *Year of Care* provided opportunity to capitalise on this expertise and in particular to develop a training programme for primary care staff.

Tower Hamlets was starting from a different position amidst the deprivation, health inequalities and diversity of an inner city community. There had been a more recent transfer of level one[7] patients with diabetes into primary care and there was an ongoing need to bring all primary care providers up to an appropriate standard. Tower Hamlets brought experience of dedicated projects for specific groups within their community e.g. the ‘Ocean Estate Diabetes Project’, which aimed to empower people to manage their own diabetes more effectively. This and other projects also emphasised their experience of successful partnership working with a range of organisations across different sectors.

There was a backdrop of organisational reform in terms of recent Primary Care Trust mergers in Calderdale and Kirklees and North of Tyne. This had typically been accompanied by changes in staff and in organisational cultures, a process that was recognised as ongoing and which *Year of Care* fed into. By and large staff felt enthusiastic about these changes reporting that *‘…something is really going on for the first time, something transformational’*. *Year of Care* was viewed as an important catalyst in these respects. However, it was also acknowledged that organisational

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[7] These are defined as 70-80% of the total population who have a chronic condition and can largely manage their own conditions with the help of primary care Kaiser Pyramid Level 1: *BMJ* 2002; 324:135-143

reforms of this type often result in a loss of intelligence as key people move on. This was particularly felt in relation to commissioning expertise which is scarce.

Policy Drivers

National policy developments that speak to the care of people with long term conditions including *Choosing Health*[8] and *Our Health, Our Care, Our Say*[9] were considered to be key levers that would help drive *Year of Care* developments.

There were other local policy implementation programmes underway among the *Year of Care* partners. For example, Calderdale and Kirklees had undertaken a *Looking to the Future* consultation to identify how local health services could meet the challenges of the next 10 years and beyond, including services for people with long term conditions. This work fed into *Year of Care* commissioning activities.

Tower Hamlets had been selected as one of 18 national Health Reform Demonstration Sites across the country. *'Making the Breakthrough'* is predicated on the 2010 inequality target and focuses on the largest contributors to the life expectancy gap in Tower Hamlets including diabetes. This work also fed into commissioning activities and provider development.

In relation to the *Year of Care* project the value of these drivers is tempered to some extent by their generic content. They are not predicated on diabetes alone. Primary care staff and commissioners deal with a much broader array of long term conditions and associated patient need. As one GP put it *'…diabetes is not the only fruit.'* Nevertheless, there is clear evidence of valuable synergies between these policy initiatives and *Year of Care* project objectives, which have been successfully exploited by pilot sites.

Population Demographics

Table 1 presents some important differences between the pilot sites. The scale of work is far greater in North of Tyne than at other sites. The Index of Multiple Deprivation (IMD) scores point to a gulf between North of Tyne/Calderdale and Kirklees and Tower Hamlets. Per capita Tower Hamlets also has the highest incidence of patients registered with diabetes. These characteristics amongst others resulted in different challenges across the pilot sites, which are reported in this evaluation.

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[8] DH (2004) Choosing Health: Making healthy choices easier. London: DH

[9] DH (2006) Our Health, Our Care, Our Say: a new direction for community services. London: DH

Table 1: Pilot Site Demographics

	Population Size	No. of patients registered with diabetes	IMD ranked position*
NHS North of Tyne	212,183	8,954	73
• North Tyneside • West Northumberland	80,106	3,070	87
Tower Hamlets Primary Care Trust			
• South West locality	50,000	3,648	3
Calderdale and Kirklees Primary Care Trusts	194,400	7110	75
• Calderdale • Kirklees	413,766	8662	60

*Index of Multiple Deprivation 2007 County Council Level

Local Project Arrangements

Each pilot site was required to specify their project management arrangements and the work streams they would follow during the *Year of Care* preparatory phase (Table 2). The proposed work streams were supported by local governance mechanisms. North of Tyne established a Project Team to operate as a Project Board with sub group meetings for different work streams. The Project Team aimed to meet on a monthly basis. Tower Hamlets established a Project Board as a sub set of their National Service Framework Local Implementation Team (LIT), which aimed to meet fortnightly. In Calderdale and Kirklees a Project Steering Group aimed to meet monthly and was supported by a Clinical Reference Group and a User Reference Group.

These variations in organisation and project contexts provide a rich backdrop against which the challenges, frustrations and successes of the pilot sites can be understood both during the preparatory phase and once *Year of Care* services are delivered.

Table 2: Project Work Streams

Pilot Site	Work Streams
NHS North of Tyne	• Commissioning review • Patient and public involvement • Training and education • Communication and engagement • Information • Benefits realisation • Evaluation
Tower Hamlets Primary Care Trust	• Commissioning • Data producing robust information • Clinical engagement and leadership • Patient and public involvement • Practice engagement and commitment
Calderdale and Kirklees Primary Care Trusts	• Project set up • Needs assessment • Development of service model • Provider model agreement • Information sharing and measurement • Staff training and development

3.5 Early Perceptions and Attitudes

At the onset the *Year of Care* concept did not have a formal definition in terms of how it will be practically delivered on the ground. Different pilot sites and the staff within these sites held different views of the meaning of a *Year of Care* and how it should be implemented. In many cases these views were coloured by the local context and experiences.

The *Year of Care* generated excitement, enthusiasm and engagement among project staff and service users across the pilot sites. However, this was accompanied by some anxieties, including the lack of understanding, short time frames and large amount of work required. Also there were concerns about the amount of change required of general practice. A gradual approach to the introduction of change was considered necessary in this respect.

Some staff felt they would need to work hard to avoid designing services around people who are already doing well rather than those whose who traditionally don’t engage well with healthcare services, e.g. minority and hard to reach groups. In these respects the use of care plan data to inform commissioning was seen as an important mechanism to guard against this. However, it was also acknowledged that this type of information would not begin to feed into commissioning processes for some time.

Pilot sites recognised the need to be clinically credible across different work cultures. Whole system redesign was acknowledged by some project staff as being necessary. For example, reductions in secondary specialist services were anticipated as primary care increased its capacity to deliver diabetes services. It was also recognised that the development of innovative community services would change the provider landscape and financial flows. Staff would need to buy into the *Year of Care* vision to enable such change. Investment in key clinical staff who could change mindsets and working cultures was seen as an important strategy by the pilot sites.

Overall however, a consistent message from staff across the field was that *Year of Care* represented their organisation's direction of travel and that involvement in the project would greatly facilitate their progress. This assessment of the relative advantage of *Year of Care* and its goodness of fit with organisational priorities is not specific to these pilot sites. It represents a national direction of travel and is therefore likely to resonate with many other healthcare providers.

3.6 Overview of Current Position

Over the last year the three pilot sites have worked hard to put in place project structures and processes and undertake the extensive and complex set of tasks needed to prepare for a *Year of Care*. They have also set about tackling the challenge of changing attitudes and culture amongst local staff and stakeholders.

Each pilot site has followed the overall direction set out by the *Year of Care* Programme Board. However, there have been many local variations in the vision for the pilot and approach to implementation.

North of Tyne has the largest planned pilot which covers 45 GP practices (30 in the North of Tyneside and 15 in West Northumberland). A total of 90 staff have been trained, including 37 GPs and 48 Practice Nurses.

Tower Hamlets is working with eight GP practices and has trained 45 staff to date of which there are 10 GPs and 24 Practice Nurses.

Calderdale and Kirklees have recruited three GP practices in Calderdale and three in Kirklees and have trained 21 staff to date, comprising 6 GPs, 3 Practice Nurses and 12 staff from other groups.

In addition, each site has a planned evaluation for the implementation phase, which is discussed later in this report.

The pilot sites are now ready to commence implementation in autumn 2008, with the evaluation running from autumn 2008 to autumn 2010.

4 Findings

4.1 Introduction

This section discusses the findings and emerging learning under a number of themes, namely local stakeholder involvement, patient and public involvement, provider engagement and development, training, commissioning, delivery of a *Year of Care* and project team processes.

4.2 Local Leadership Roles and Stakeholder Involvement

Leadership Roles

Staff at each site reported that there was one individual in their project team who had been responsible for driving their involvement in *Year of Care*. Without this person staff did not feel that their organisations would necessarily have been able to participate in the project. At two sites this person was a clinical member of staff (Calderdale and Kirklees and Tower Hamlets) and in North of Tyne they were a commissioner. The input of other team members also became critical but at the outset it was considered necessary to have a leading, inspirational figure who could communicate a vision and garner organisational support.

Clinical leadership across all sites was also considered crucial particularly the presence of a GP champion. These staff were integral members of the North of Tyne and Tower Hamlets project teams but were less evident in Calderdale and Kirklees. However, Calderdale and Kirklees had selected to work with a small group of enthusiastic early adopters of the *Year of Care* approach and thus GP leverage was less critical.

Securing senior leadership in the form of a dedicated Senior Responsible Officer (SRO) was seen as essential to successful project management. In Tower Hamlets and Calderdale and Kirklees these were Primary Care Trust Directors of Medicine and Patients and the Professions respectively. In North of Tyne it was the Head of Commissioning for Long Term Conditions.

Project staff with cross organisational responsibilities were perceived to be valuable levers to profile the project and promote organisational buy-in. For example, North of Tyne's *Year of Care* lead is a locally known and respected GP who receives considerable support from the acute sector and from service users. Tower Hamlets' Medical Director (SRO) who chaired the *Year of Care* project group is also a Primary Care Trust Executive Committee and Board member, thus ensuring a higher profile than the project might otherwise have received.

Stakeholders

There is a breadth of stakeholder involvement at each of the sites including staff from specialist secondary services, primary care, commissioning, pubic health, patient and public involvement, service improvement and performance, education and training, the voluntary sector and social services.

Table 3 summarises the breadth of stakeholder involvement across the three sites by grouping them according to project team membership, other internal stakeholders, patient and public stakeholders and external stakeholders. However, not all stakeholders were involved at all sites.

The project also attracted additional stakeholder involvement during this preparatory phase including The Health Foundation who contributed funding, Yorkshire and the Humber Strategic Health Authority, West Midlands Strategic Health Authority, Care Planning Champions Network and ad-hoc, multiple contacts from NHS Trusts and other health providers.

Challenges

Project plans at each of the pilot sites included project manager posts but it took much longer than anticipated to fill the positions. The post remained vacant in Calderdale and Kirklees and in both North of Tyne and Tower Hamlets it took approximately three months post project initiation to secure a member of staff. These time frames need to be built into projects of this type.

In Tower Hamlets there was considerable difficulty securing back fill for the clinical project lead who was a GP. It took many months and eventually the Primary Care Trust needed to go through an agency but this proved to be an expensive option. Furthermore, the more senior a clinician the harder it becomes to ensure all their responsibilities can be covered by back fill e.g. weekly teaching commitments. It is therefore necessary to consider the ongoing support of primary care colleagues when a seconded colleague’s responsibilities can not all be managed.

One site felt that primary care colleagues were much more responsive to change than their secondary care counterparts. The GP champion model and peer support works well in primary care. In contrast secondary care consultants tended to draw ‘battle lines’ with their peers that represented a resistance to change or to follow the lead of others. One pilot site in particular noted the need to be sensitive to the perceptions of secondary care consultants and work with them to understand their role in the *Year of Care* approach.

Table 3: Stakeholders

Group	**Stakeholders**
Project Team	• Senior responsible officer • Project manager • Medical director • Clinical lead • Commissioning lead • Head of diabetes • Diabetes physician • GP lead • Clinical psychologist • Public health lead • Patient representative • Dietician

Internal Stakeholders	• GPs • Practice nurses • Practice managers • Practice based commissioning chairs • GP leads for diabetes • Community nurses • District nurses • Secondary care consultants • Podiatrists • Dietetics • Ophthalmologists • Psychologists • Pharmacists • Director of nursing • Community matrons • Continuing professional development leads • Public health colleagues • Performance analysts • Long term conditions board members
Patient and Public Stakeholders	• PPI forums • Patient and service user groups • PALS co-ordinators • The public • Diabetes UK patients/supporters
External Stakeholders	• Voluntary sector services e.g. Upbeat Exercise Group, Black and Ethnic Minority groups, etc. • Healthy living centres • Public libraries • Adult social care • Education and training providers • Department of Health

4.3 Patient and Public Involvement

Consultation Strategies

In Tower Hamlets the Patient and Public Involvement Lead with responsibility for service user engagement was part of the *Year of Care* project team. A user engagement strategy was prepared which identified three key areas that consultations would need to focus on:

- The concept of self-care.
- Patients' experiences of currently commissioned services.
- Understanding from patients what other services would help them care for their condition.

A Primary Care Trust wide event was held and practices were also supported to set up practice level patient participation groups. These events were scheduled with practices pairing up to run them and took account of the need to get information right for patients particularly where there were language difficulties. Lunch and refreshments were provided at the PPI events to promote engagement and attendance.

In Calderdale and Kirklees a series of workshops and focus groups for service users were held in six localities. Chairman, facilitator and speaker notes were prepared to ensure consistency across each locality. In addition to providing an introduction to the *Year of Care* project the workshops invited service users and their carers to discuss five key topics or domains in relation to their diabetes care: Information and Education; Access to Services; Emotional Support; Lifestyle/Behaviour Change; and Social Aspects.

North of Tyne designed their engagement activities by building on the approach adopted by Calderdale and Kirklees. Four patient focus groups were held in areas where clusters of general practices coalesced. North of Tyne communications and graphics staff were used to prepare material, which was used for posters and leaflets, and to advertise the events in local press. The content of the events was based around the information given to clinicians by Calderdale and Kirklees and described the project, its aims, implications and the changes service users could expect. It also sought user views of gaps in services and their preferences for how these gaps might be filled.

Consultation Outputs

Across the pilot sites service users reported a good deal of satisfaction with the services that were being provided, they did not want lots of change but wanted services to be delivered more consistently and efficiently. An example of the preferences expressed by service users in relation to the discussion topics or domains used in Calderdale and Kirklees is presented in the table below.

Table 4: Service User Preferences

Theme	Service User Preferences
Emotional Support	• Someone to talk to/a buddying system/peer support • Support for families and carers • 24 hour telephone helpline with trained staff • Less busy staff with time to listen • More recognition, help and support for depression • Massage and meditation
Access to Services	• Closer to home • One stop shop e.g. pharmacists offering phlebotomy • Do not want to attend hospital for blood tests • Weekend/evening clinics with eye specialists • Easier/more available access to foot services • Longer opening hours with drop-in clinics • Professionals to keep to appointment times • Professionals to follow-up on what they say they will do e.g. telephone contact
Information	• Clearer communication of results with an explanation of what they mean • Innovative use of technology e.g. test results via e-mail • Information available in different languages

	• Information for people with disabilities e.g. deaf/blind • Need high quality information throughout care, not just at the beginning • More advice on food and weight management • A plan of what to expect in the next 12 months • More group education evenings
Lifestyle/social aspects	• Dosette boxes provided free to help with compliance • A greater range of activities to support a healthy lifestyle e.g. T'ai chi, yoga • Subsidised private gym membership • Subsidised weight loss classes • Training for staff in leisure centres • More emphasis/guidance from doctors and nurses on non-medical lifestyle activities • Single sex groups are needed for some • More local support groups to encourage lifestyle change

Challenges

Common to all pilot sites was an awareness and concern that they may only be consulting with the 'usual suspects' and not reaching those who do not currently engage in self-management activities. Similarly, people may be engaging with self-management but not with local services. Staff in Calderdale and Kirklees identified a variety of different methods to overcome this barrier though time and resource constraints during this preparatory phase have made these difficult to pursue. For example:

- One to one interviews with people who typically do not engage.
- Use of technology including e-mail access and chat rooms for consultation purposes.

Enrolment numbers for focus groups in North of Tyne were disappointing despite advertising in the local press and on community sites, although they did not follow-up the reasons why this was the case. One group in the North West of their locality had no attendees. On reflection North of Tyne staff would use a different approach to recruit people by inviting them personally with letters from their GP surgery rather than advertising more generally in local press, as they expect people to be more receptive to a personal invitation.

As well as hearing patients' views on services and informing them of intended *Year of Care* developments it was recognised by some staff that patients may need further guidance on using or making the most of the care planning and review process. For example, patients will be asked about the goals they want to achieve during their consultation, which will then be documented in their care plans. Patients might usefully think about these goals ahead of their appointment just as they will be invited to consider their test results in advance.

A corresponding need has been identified to develop patients' use of the *Year of Care* approach. Different methods have been adopted including the production of written material and in Tower Hamlets the production of a DVD, which presents a *Year of Care* consultation. Patients need to know that their relationship with healthcare professionals is changing and they will need support to relate to the healthcare system in different ways.

A key group of stakeholders that generate some concern in relation to this last point are those patients who appear disengaged from services or unwilling or unprepared to self-care. In Tower Hamlets their number is believed to be significant. It is also true that Tower Hamlets contains a large Black and Minority Ethnic community, a proportion of whom may equate self-care with a doctor's uncertainty about how to treat them.

There is no simple solution to these difficulties. However, Tower Hamlets employed a consultancy to identify and classify patient in terms of their preparedness to self-care. The resulting classification provides one approach to segmentation and gives an indication of the types of support or intervention that different patients will need.

4.4 Provider Engagement and Development

Engagement

Across each site there was an awareness of the pressures faced by primary care staff in their day to day operations and a corresponding need to develop a staged approach to engagement. There were particular concerns around bombarding primary care with too much information in one go.

Tower Hamlets developed a practice engagement strategy that began with the clinical lead e-mailing all GPs an introductory letter outlining the *Year of Care* project. A series of informal 'meet and greets' were then held at each practice with the medical director and project manager during which lunch was provided and project detail shared.

Initial responses to these practice visits were very positive with all GPs showing an interest in the project and agreeing to contribute their service data to a baseline assessment. The baseline captured key information on how each practice intended to deliver particular components of a *Year of Care* service. This information was then used in conjunction with locally benchmarked performance data to give practices a feel for where they were and where they would need to develop aspects of their service. This acted as an additional engagement mechanism.

The North of Tyne staged approach began with the commissioning lead visiting practice based commissioning groups to share project information and to get their provisional sign up. An information pack was then produced and distributed to practices which included project aims, implications for practices and an invitation for the diabetes lead GP and practice nurse to attend *Year of Care* training days. This approach proved successful with only four practices across North Tyneside not signing up.

A third phase of North of Tyne engagement activity was designed that involved sharing additional information which re-emphasised and reinforced the national perspective, links to policy and the expertise that was already present in North of Tyne to support these developments. Three practices were still outstanding following this third wave of engagement activity.

In Calderdale and Kirklees practices had been engaged in previous work to stratify patients with diabetes and the clinical lead had invested considerable time liaising with practices and giving presentations in relation to their *Looking to the Future* programme of work for long term conditions. This clinical lead then became the *Year of Care* project manager which provided an excellent basis upon which to engage early adopters of the long term conditions work as *Year of Care* pilots.

Development

Across the field there was recognition of the importance of the wider health and social care communities in which diabetes care takes place. Distinctions were drawn between NHS clinical need and other non clinical health and social need. Though primary care teams may be the first point of contact for people with diabetes they will need signposting to a much broader and perhaps wider menu of options including public health and voluntary services. Provider development was seen as a key task for this preparatory phase.

Public health policy and practice developments were seen as important parts of the equation, necessary for promoting self-care and independence in respect of many long term conditions. For example, in Calderdale and Kirklees a walking group used a local library as their regular meeting place. Whole systems integration of *Year of Care* into the wider health and well-being community was necessary and placed onus on primary care staff to be aware of the options available to their patients and to resource signposting materials.

Calderdale and Kirklees held two provider workshops within one month of each other. The first shared and examined the results of the user focus groups and the practice stratification exercise, mapped existing services and identified any gaps in services. Providers were asked to come back to the second workshop with plans to address the gaps and feed these developments into commissioning intentions. Examples include peer support and buddying services as well as the development of more flexible support for diet and exercise beyond typical local authority providers.

In Tower Hamlets a scoping exercise was undertaken to identify local services and facilities to support self-care for people with diabetes. This was sent to practices to both validate and add any additional detail. It has resulted in the production of a directory/booklet which contains a menu of options to support patients with self-care.

North of Tyne project staff built on their care planning expertise and undertook a focus group with practitioners already involved in care planning. This activity was designed to feed into the training, development and support of practice staff. Though variations to the patient pathway are anticipated across and within pilot sites, it is useful to consider the outputs of the focus group discussions in North of Tyne. These found that effective care planning involves:

- Having a written summary of the discussion.
- Sharing with the patient 'their plan'.
- Utilising the skills of the Health Care Assistant for biomedical checks frees up nurse time and is more cost effective.
- Very positive feedback from patients regarding receipt of biomedical indices.
- Consultations are less driven by biomedical indices and promote a more holistic approach to care.
- Increases patient choice and their sense of empowerment.
- Style of consultation allows for the development of long term relationships between patient and clinician.

As well as these potential benefits for patients and staff alike, the focus group also raised a number of challenges. In particular, the development of these care planning practices showed that patients need support to adapt to this approach and in a minority of cases sending out test results prior to an appointment can cause anxiety to the patient.

Challenges

For staff it was critical that they received support to develop their consultation and communication skills and their capacity to support self care. It would also fall to these staff to educate their patients about the care planning process in order that they could both mutually engage in new methods of working. Allied to this is the need for staff to produce the written care plans which need to be useful and accessible.

The *Year of Care* approach will mean an increased burden for administrative staff, at least initially. Letters would need to go out on time between pre-clinic appointments and annual reviews. The importance of good administrative support to ensure the system worked effectively was emphasised. From an organisational perspective there is an awareness of a fluid and challenging NHS climate that could impact on primary care's ability to participate in projects of this type.

The sites also identified a need to communicate changes to service delivery across the whole healthcare community, rather than just within pilot sites. Thus, in Calderdale and Kirklees and Tower Hamlets information was disseminated to practices throughout their patch, not just to those that would be initial pilots. Secondary and other specialist care providers were similarly included in communications and in some instances were integrated into the *Year of Care* patient pathway. For example, Calderdale and Kirklees have integrated the pharmacist's role into the *Year of Care* annual review process.

Approaches to training

Each of the pilot sites approached the development of training for local primary care staff differently depending on their local circumstances. Calderdale and Kirklees commissioned a one day training course specifically for *Year of Care* from Bradford Primary Care Training. In addition to a focus on consultation skills and joint decision making the training included motivational interviewing skills in order to equip staff with an approach for those patients who may not yet be ready to self care.

Tower Hamlets devised a one day training programme, which was developed and delivered in partnership with Warwick Diabetes Care (part of Warwick Medical School). It took participants through the care planning process (consultation skills, shared agenda setting, goal identification, action planning). Attendees were also encouraged to audit their existing practices against the *Year of Care* house model (Box 1) and were challenged constructively when appropriate.

North of Tyne used their care planning expertise and specialist staff to devise and deliver their own training programme, which was conceived as two half days and aimed to mirror the *Year of Care* process for patients in staff training. Ahead of session staff were sent a ‘preparing for care planning’ questionnaire (sharing information) and during the session were invited to write an action plan of what they would do between sessions one and two (goal setting).

North of Tyne provided four cohorts of training with up to seven practices represented in each cohort. Tower Hamlets delivered four study days for between six and eight people although one study day had 11 attendees. Calderdale and Kirklees provided two full training days and are now organising a half day update/refresh session. Table 5 presents the roles of staff who attended training.

Table 5: Staff Training

Pilot Site	No. of Practices	GPs	Practice Nurses	Other*
North of Tyne	40	37	48	5
Tower Hamlets	8	10	24	11
Calderdale and Kirklees	6	6	3	12

* other includes dieticians and diabetes specialist nurses, in Tower Hamlets, also link workers/health advocates, health care assistants, Chief Executive and consultant physician

Each of the approaches was highly interactive and used role play to demonstrate consultation styles and for participants to gain experience themselves. This aspect of the training was particularly valued, as was the opportunity for different disciplines and practices to come together. When asked what had been most useful about the training comments from Tower Hamlets included:

> *'…discussion, sharing and networking with other health professionals.'*

> *'…that there were different disciplines/people with varied interest in diabetes.'*

Across the field the training had inspired people who reported that they were now *'…understanding and feeling motivated about Year of Care'*. There was also a clear sense of the challenges that lay ahead. A number of Tower Hamlets attendees felt it had been particularly useful to *'…identify goals and ways of improving practice and making plans towards it.'* Some had started to look at changing their working methods such as using healthcare assistants to undertake roles currently managed by high grade nurses e.g. follow-up of non-attendees, delivery of smoking cessation information. One attendee planned to identify and work with new providers including Weight Watchers and local gym facilities.

Against this backdrop a number of participants commented that they wanted more support than just models or case studies to support patient engagement. There were many questions about how to manage disengaged or unmotivated patients. The Calderdale and Kirklees inclusion of motivational interviewing was useful in this respect and Tower Hamlets have subsequently undertaken a piece of work to identify patient types in terms of their preparedness to self-care. The resulting classification gives an indication of the support or interventions that different types of patient will need.

Common principles

A number of common principles emerged from training development and delivery across the three pilot sites. These are summarised in the table below.

Table 6: *Year of Care* Training Principles

Content

The training should include:

- Philosophy of care planning and self-care
- Consultation skills and techniques to engage patients
- Organisational and system aspects of care planning
- Awareness of non-traditional services and support (menu of care)
- Clear rationale for extra recording of patient information

Attendees

The training should be inclusive involving everyone in the practice including management and administration staff, and professionals working in the local community where appropriate and possible e.g. health visitors, dieticians, secondary care staff

Trainers

Training needs to be delivered by trained trainers but should involve senior clinicians and specialists from local services.

Other key levers for successful training include the need to have it endorsed at the organisational level by senior leaders. It is also important to make an assessment of each organisation's starting position and to feed this knowledge into the content and design of the training. Importantly, to embed and sustain the learning training needs to be followed up with further support for practices.

The mechanisms to deliver this ongoing support have not yet been finalised among the pilot sites. However, North of Tyne have started this process by administering a continuing support questionnaire which invites practices to indicate their preferences for a range of mechanisms including their frequency. Mechanisms include practice visits, small network groups, locality level meetings, learning sets and/or care planning away days.

Challenges

The effort required to deliver a purely in-house training course as North of Tyne have done across a large sample of GP practices should not be underestimated. In total North of Tyne trained 90 staff across North Tyneside and West Northumberland. North of Tyne were keen to promote consistency in their approach across four training cohorts using the same venues and same facilitators from among their specialist staff. This proved to be logistically very challenging particularly as the facilitators were clinical staff with busy schedules.

Getting these staff together to plan the objectives, content and process of the training was very difficult let alone ensuring their combined availability to deliver the training. Some templates and resources will be available from this preparatory phase for others to use. However, if delivering training with in-house staff diaries will need to be co-ordinated at least two months in advance.

There were also some disappointments in terms of attendees. Whilst some training days were over subscribed, some practices had difficulty releasing staff. For example, in Calderdale and Kirklees despite efforts on the part of the project team to remind people to attend, plus the offer of back fill support, some professional groups were unrepresented including representatives of secondary care, practice managers, administration staff and healthcare assistants.

A number of training attendees across the field reported that they believed they were already doing care planning. Successful strategies to counter this include the use of role play during which these individuals will receive candid feedback from their peers. Tower Hamlets encouragement for participants to audit their existing practices against the *Year of Care* house model and to be challenged constructively where their practice falls short of the model is also a valuable strategy.

4.5 Commissioning

This section begins with some outline information on the nature of commissioning across the three pilot sites, which provides an important backdrop to subsequent content. It then examines the different approaches taken by partners to population needs assessment, market mobilisation and monitoring. It also describes some of the plans and aspirations for feeding micro level care planning data in to macro level commissioning. As with other sections it draws out some of the levers and incentives that have been used as well as highlighting ongoing challenges.

Background

Across the field commissioners are dealing with national and local targets, being vigorously performance managed and tied to annual commissioning timetables. Capacity to deal with developments is limited and it can be difficult to look beyond immediate challenges. In North of Tyne where there had been recent organisational mergers a key focus for commissioners has been to *'…understand the pots of money and secure the budgets'.* In Tower Hamlets a key focus has been the need to address inequalities in service access. *Year of Care* is viewed as an enhancement of services for those who already receive care, which can create tension between commissioners and providers.

In truth however the *Year of Care* project has found complimentary and synergistic characteristics between different commissioning activities. For example, Tower Hamlets' *Making the Breakthrough (MTB)* programme is operating at a public or collective level across a range of long term conditions including diabetes, whilst *Year of Care* is enhancing individual service experience. The latter will benefit from infrastructure developments associated with the former and vice versa. This synergy and leverage has already borne fruit with the availability of *MTB* resources to develop *Year of Care* products.

There are several observations from this commissioning backdrop. Firstly, the complexity of the commissioning function results in competing agendas that can be tricky for commissioners to juggle.

> *'As a commissioner my job involves the re-prioritising of priorities on a daily basis.'*

Although all commissioners involved in the *Year of Care* are engaged in supportive project activities, none of the sites have gone through the systematic step by step process set out in the diabetes commissioning toolkit[10]. Realities on the ground do not allow such clean linear processes to flow.

> *'Not only are we trying to slow and turn a huge liner around but we're attempting to refit it whilst simultaneously providing a first class service to the passengers on board.'*

Commissioning time frames operate at a different speed and follow a much wider arc than the 12-month *Year of Care* preparatory time frame. Key commissioning outputs for *Year of Care,* such as the development of a menu of services and a shift toward self-care, may not be realised during this first 12-month period but that does not mean that commissioners will not have these objectives in their sights. As with patient experience and the impact of *Year of Care* services, the contributions of commissioning will only be fully realised in the years ahead.

Population Needs Assessment

Calderdale and Kirklees have used the Bolton Hospitals NHS and Primary Care Trust's practice stratification tool, which was developed to describe different levels and aspects of diabetes care, and to indicate responsibility for their delivery across primary and secondary care services[11].The tool uses an inductive approach to stratify patient populations. For Calderdale and Kirklees staff this involved:

- Visiting early implementer practices (n=4 for this exercise).
- Established an auditing team which included GP, practice nurse, consultant, diabetes specialist nurse and *Year of Care* programme manager.
- Randomly selected case notes and went through them as a team (n=700).
- Inductive process putting people in themes based on patient need: self-management, care management, case management

This proved to be a very labour intensive exercise which staff felt could not be done routinely. However, it did provide a useful benchmark based on the Kaiser Pyramid[12] categories from which discrete pathways could be commissioned. Calderdale and Kirklees staff were also aware that it is only half the story and represents a top down

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[10] Diabetes Commissioning Toolkit (2006). Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4140284

[11] Bolton Hospitals NHS and Primary Care Trusts Diabetes Service Strategy. Available at: http://www.bolton.nhs.uk/services/diabetes/0104strategy.pdf

[12] Kaiser Pyramid categories: *BMJ* 2002;324:135-143

approach. It will need to be married with the aspirations and wishes of service users themselves.

It is fair to say that in Tower Hamlets and North of Tyne less work was undertaken to stratify patient samples and commissioning arrangements are in place based on a largely historical understanding of population need. However, an interesting variation has been the work commissioned by Tower Hamlets to identify patient types in terms of their preparedness to self-care. The resulting classification provides one approach to segmentation and gives an indication of the types of support or intervention that different patients will need.

Service redesign

North of Tyne is undertaking Programme Budget and Marginal Analysis (PBMA) activities across diabetes services. PBMA is an appraisal of past and future resource allocation, and an analysis of the added benefits and costs of proposed investments or disinvestments.

The results of this exercise will help identify tariffs for elements of a service, which can then be put out to the market. This function is likely to be devolved to practice based commissioning groups. However, the time line for this exercise is different to the *Year of Care* time line and its impact may not be felt until next year. The diabetes PBMA is also one of four being undertaken in North of Tyne.

Within Calderdale and Kirklees there is significant buy-in to the *Year of Care* project at senior levels within the Primary Care Trust. The project now has support to 'double-run' services where new services will need to be introduced but others cannot be decommissioned as yet. This is part of an overall movement towards investing for quality and provides a mechanisms and safety net to mobilise healthcare markets.

Micro to macro level commissioning

The *Year of Care* project aspires to use micro-level information from care-planning to feed into macro-level commissioning decisions (see Figure 2 overleaf).

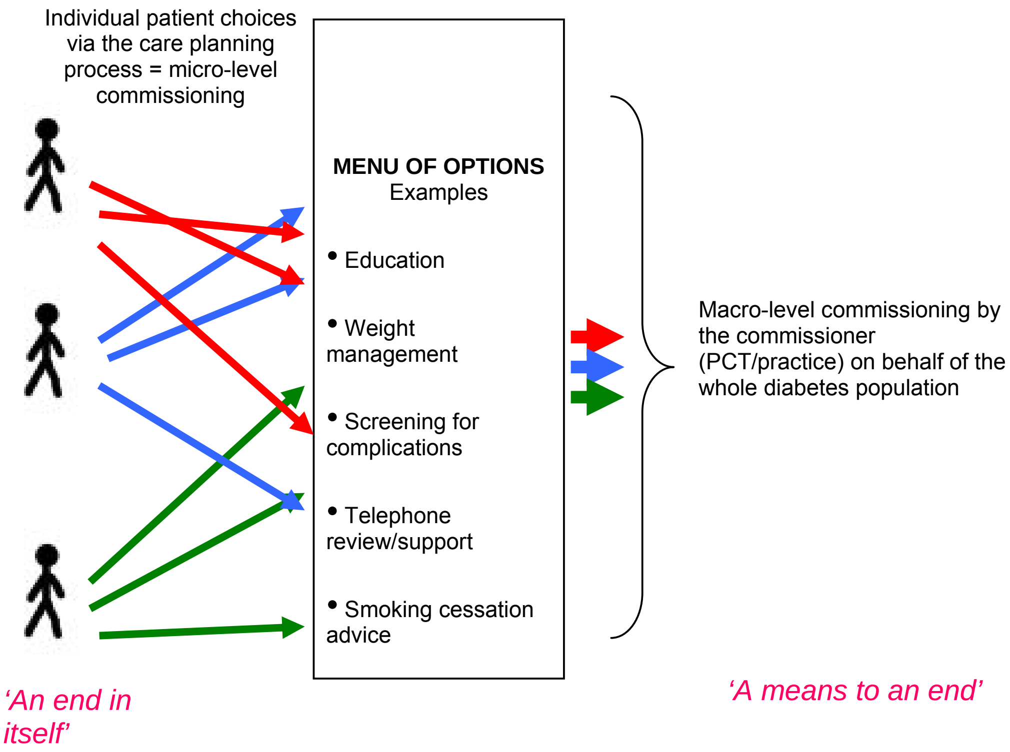


Figure 2: Micro to Macro Commissioning

This has been and remains one of the biggest challenges. Each of the pilot sites has been keen to explore this aspect of the project and to find solutions. The challenge includes issues around:

- Recording information from the care-planning discussion (needs, actions, choices, service use).
- Collating and analysing that information.
- Feeding it into macro-level decisions e.g. understanding its implications for planning local services.

Commissioning care planning offers one part of a solution (see monitoring below) but there remain significant data management and interpretation challenges. The *Year of Care* project team have been working with Yorkshire and the Humber Strategic Health Authority to develop an IT template that would allow this type of data to be systematically collected, recorded and collated. It has not been possible to complete this product during the preparatory phase of the project and services are due to begin without this resource in electronic form.

It is also true however that data of this type would be unlikely to feed into commissioning cycles and result in changes to the menu of care for at least 12 months. Interim solutions will therefore be necessary if the provider landscape is to change in the shorter term. Mechanisms of this type are available to the pilot sites. For example, Calderdale & Kirklees' 'double run' facility and in North of Tyne major gaps or needs in service provision can be addressed by 'in year' commissioning bids.

Monitoring

The care planning element of the *Year of Care* model provides a tangible service component that can be incentivised and monitored by commissioners. Service level agreements (SLA) provide a mechanism to achieve this.

In Calderdale and Kirklees SLAs have been agreed with the early implementers taking part in *Year of Care* that include provision for 30 extra minutes per patient with the practice nurse, and 15 minutes administration time per patient to generate the pre-consultation letter. It also includes provision to participate in the evaluation and collect necessary data.

SLAs for diabetes care also exist in Tower Hamlets and North of Tyne though they have not been developed as specifically as that described for Calderdale & Kirklees. There have also been questions raised across the field about whether SLAs have the formality they need to really make a difference.

Other complimentary mechanisms are being used in North of Tyne and Tower Hamlets including MEDICS and EMIS Web. Both systems allow biomedical data to be documented and/or retrieved for audit and other purposes. In Tower Hamlets they have developed colour coded tables that follow the traffic light system to return this data to practices, thereby allowing them to gauge their performance and identify areas of developmental opportunity.

Challenges

As with providers there are many challenges that commissioners face if the potential of the *Year of Care* approach is to be fully realised. Important also for others to recognise the bigger time frame within which commissioning operates and the likelihood that tangible benefits for this project may not be realised until the medium or longer term.

Population need assessment has been a challenging task for the pilots and is not a one off activity. Calderdale and Kirklees staff have experience of its labour intensive nature when they undertook this work across four practices. Mechanisms to systematically collect and collate care planning data (including the documentation of unmet need) are clearly necessary to support this aspect of the commissioning cycle.

Even then, as in Tower Hamlets, commissioners will need to be aware of those sections of their population that are not engaged with services and whose preferences are not reflected in existing data sets. There will remain an ongoing need to consult with communities in innovative and creative ways in order to reach as broad a constituency as possible. Devolving needs assessment duties to practice based commissioning groups may offer one possible way forward.

This last point hints at the importance of a partnership approach between commissioners and providers. This section ends with a list of perceived critical ingredients if partnerships are to work effectively and enhance service provision:

- Openness between commissioners and providers.
- Key senior people that span commissioner/provider boundaries.
- A delivery model that integrates the primary and secondary care interface.
- Diabetes lead GP and nurse in each practice supported by SLA and Local Enhanced Service agreements.
- An embedded leadership culture that is hierarchical and structured (safe) but also flexible and responsive.
- Stability within the workforce and trust between professionals.

4.6 Delivery of Year of Care

Across the field there are practices that have been delivering care planning services for some time, practices that believe they are already delivering a *Year of Care* service to patients and those that are incorporating new working practices. There is then no single point at which *Year of Care* services are ‘switched on’.

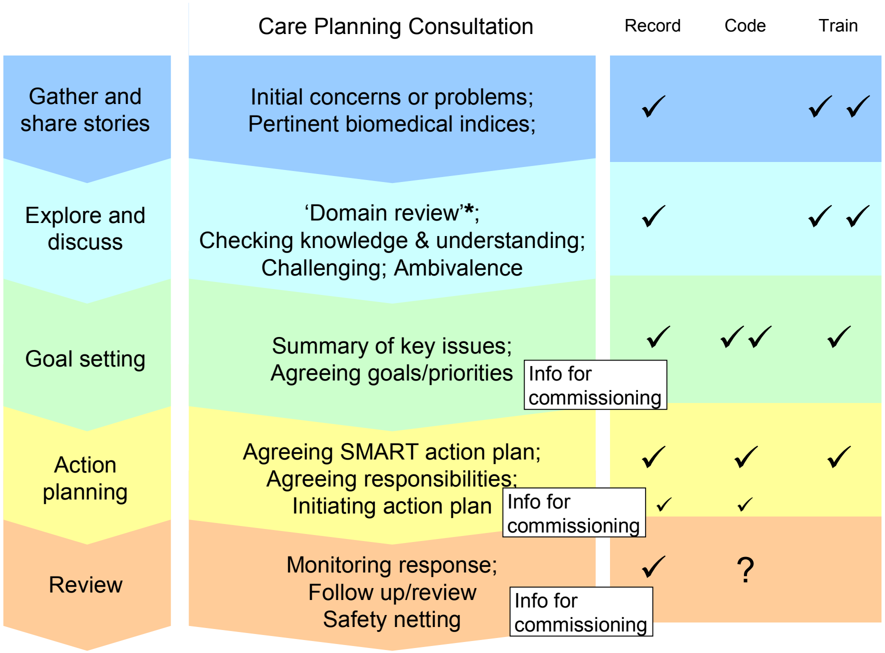
Nevertheless, each pilot site has prepared for all services to move towards a model of care that involves sending biomedical test results to patients ahead of their consultation, tools to help ‘stimulate their thinking’, providing a comprehensive and patient centred consultation in which the individuals personal goals are identified from which an action plan will be agreed and the production of a written summary (care plan).

To these ends pro-forma have been prepared to support these processes. Tower Hamlets have worked through social marketing to produce posters and leaflets to reinforce *Year of Care* developments for both patients and staff. Folders have been produced for patients in which the normative ranges for biomedical indices are included on the inside covers. These folders will be used to house test results and care plans for patients.

Calderdale and Kirklees have similarly produced pro forma including a results sharing sheet, a ‘getting the most from your appointment’ sheet, which encourages patients to set out the agenda they would like to discuss during their consultation, and a care plan pro forma. Products of this type will be critical to ensuring consistency across services and to sustaining these practice developments in the medium and longer term.

An IT template is considered critical to enabling the whole systems management and change that the *Year of Care* project aspires to. Delays in developing such a template were inevitable, given the prior need to define in detail the care planning approach and its elements. However, Yorkshire and the Humber SHA worked closely with the central *Year of Care* team to produce a suitable template. This involved mapping the stages of the consultation and identifying both those areas which would need to be included in training, and also where data would need to be collected as part of clinical care and for the commissioning process. The inevitable delays of translating this into a template was frustrating for the sites, as were the further delays which arose out of the initial template being developed on a different Primary Care system to those being used in the sites. Work is ongoing to rectify this issue. However, the template produced, as shown below, contains all of the elements which will be required to support the *Year of Care* approach, namely:

- Administrative support.
- Prompt patient centred care.
- Collate patient data for commissioners.



	Care Planning Consultation	Record	Code	Train
Gather and share stories	Initial concerns or problems; Pertinent biomedical indices;	✓		✓ ✓
Explore and discuss	‘Domain review’*****; Checking knowledge & understanding; Challenging; Ambivalence	✓		✓ ✓
Goal setting	Summary of key issues; Agreeing goals/priorities Info for commissioning	✓	✓✓	✓
Action planning	Agreeing SMART action plan; Agreeing responsibilities; Initiating action plan Info for commissioning	✓ ✓	✓ ✓	✓
Review	Monitoring response; Follow up/review Safety netting Info for commissioning	✓	?	

Figure 3: Template to capture content and functions

4.7 Year of Care Project Team Processes

This final section acknowledges the selection and support mechanisms that the three pilot sites have received and which are likely to have contributed to their achievements during this preparatory phase.

These mechanisms include a rigorous selection approach, monthly progress monitoring visits from central *Year of Care* team staff and attendance at six learning events.

It is difficult to judge the degree to which these elements of the project have contributed to progress. Certainly they led to a sense of community in so far as the three pilots had survived a rigorous selection process that others had not and then met regularly during the course of the project to share their successes and frustrations. Without the resources available to this project it may be difficult for others to recreate this degree of infrastructure. Nevertheless, learning from and with others lies at the very heart of the *Year of Care* model between practitioners and patients. Reflecting that dynamic in service developments would seem both advisable and necessary.

5 Evaluation Plans for the Implementation Phase

5.1 Introduction

A large part of the evaluation during this preparatory phase has involved working closely with the three pilot sites and *Year of Care* Steering Group to plan for the evaluation of the implementation phase.

The evaluation of the implementation phase will consist of two parts:

- A formative evaluation, including case studies to be conducted by the external evaluation team.
- A set of three local evaluations, collecting measures to evaluate the impact of the *Year of Care* approach.

The local evaluations will focus upon measures that pilot sites will put in place to evaluate delivery of a *Year of Care* (these will cover bio-medical factors, patient experience, staff satisfaction, and impact on the local health system) including comparators at national or local level against which progress can be measured.

This section provides an overview of the local evaluation plans and highlights some of the key challenges for the implantation of these plans.

5.2 Tools for Local Evaluation

As part of our evaluation of preparing for the *Year of Care*, we undertook an extensive literature review to identify the full set of tools and measures which may be applicable to the evaluation of the delivery phase. This was presented in the comprehensive report "Indicators and measures" which contains information about more than 40 potential measures.

The table below shows the tools provisionally agreed with the pilot sites and *Year of Care* Steering Group.

Table 7: Tools selected for local evaluations

Focus of data collection	**Tools**
Service, care planning and commissioning audits	Tools - PCRS (Primary Care Resources and Support for Chronic Disease Management) Commissioning Inventory
Patient data	Tools – Consultation Quality Index-DM Diabetes Treatment Satisfaction Questionnaire Quality of Life EQ-5D Health Care Commission Diabetes Omnibus Biometrics (e.g. HbA1c, blood pressure) – extracted from patient notes, and goals/actions captured on an IT template. Ad-hoc patient feedback
Cost data	Tools – CSRI (Client Services Received Inventory)
Staff survey/interviews	Tools – Interview schema to be developed

Primary Care Resources and Supports for Chronic Disease Management

The PCRS was developed by the Advancing Diabetes Self Management Programme of the Robert Wood Johnson Foundation, USA. It rates the primary care organisational and patient support (including care planning) deemed necessary to promote self management by patients with diabetes.

Tower Hamlets rapidly adopted the PCRS and have been working with practices to complete it. Their pilot feedback has resulted in the first draft of a UK version of the PCRS, which is now available on the Foundation's website.

Commissioning Inventory

An inventory has been prepared and submitted for review. It is designed to capture the complexities (and uncertainties) of commissioning and is organised under eight headings that loosely follow the commissioning process. It has been informed by a working knowledge of the field and takes account of the wider organisational contexts in which the *Year of Care* project sits as well as the different approaches taken by project partners to key elements of the commissioning cycle.

Consultation Quality Index-DM

CQI – DM is an instrument that measures aspects of the consultation structure, process and outcome in one holistic tool.

Diabetes Treatment Satisfaction Questionnaire

The DTSQ is a widely used questionnaire that is suitable for use by people with both type 1 and type 2 diabetes. The questionnaire contains eight items, 6 measuring treatment satisfaction and 2 measuring perceived hypo or hyperglycaemia, and are scored on a 7-point scale of very satisfied (6) to very dissatisfied (0).

License approval has been granted for the DTSQ.

Quality of Life EQ-5D

EQ-5D is a standardised instrument for use as a measure of health outcome. Applicable to a wide range of health conditions and treatments, it provides a simple descriptive profile and a single index value for health status that can be used in the clinical and economic evaluation of health care as well as population health surveys.

Health Care Commission Diabetes Omnibus

A survey tool which asks about check-ups and tests, participation in decision making, management, education and training received and emotional support provided.

An abridged HCC survey has been drafted with input from partner sites and approval secured from the Department of Health for its use.

Biometrics

Biometrics give an indication of disease management and include measures such as HbA1c, blood pressure, weight, etc. These are collected as part of routine monitoring of patients, but will need to be collated and analysed separately for the pilot evaluation.

Currently, work is being undertaken to agree a data capture template and explore the development of an IT system to support collection and analysis.

Cost Data

The CSRI questionnaire collects data about services received by patients. We propose to use this as a means of identifying the costs and impact of a *Year of Care* in terms of the receipt of services over time.

Ad-hoc Patient Feedback

The evaluation lead has met with the Hot Topics team at Diabetes UK to secure dedicated e-mail and telephone messaging for patients to leave qualitative comments about their *Year of Care* experience.

Staff Survey

A large number of staff will be involved in the delivery of the *Year of Care*. A survey provides the most practical method of ensuring we gather feedback from everyone involved. It will augment qualitative data captured through interviews and case studies.

5.3 Challenges

The pilot sites fully acknowledge the importance of putting in place measures for evaluating the implementation phase. However, their prime objective is to be ready to implement a *Year of Care* as defined by the project timescales.

Planning for evaluation has involved a great deal of thought, adding further burden to the work load of the pilot sites. The progress made should be seen as a great success, given it has addressed a number of key challenges.

The evaluation of the Year of Care preparatory phase and planning for the evaluation of the implementation phase is complex and needs careful consideration of the balance between feasibility and robustness of data. Therefore, a great deal of effort and time has been spent by the evaluation team explaining the purpose, requirements and potential approaches to the evaluation. In some cases, this has involved site visits to speak directly with GPs and others who will be integral to data collection.

A key concern for pilot sites is the additional workload associated with collecting measures, which will add to the burden of implementation and may even detract from it. The measures agreed are a compromise between what is practically achievable and the minimum needed to demonstrate impact. However, there is still some concern that this aspect of the project will be a deterrent for some stakeholders and sites may not sign-up to collect the full set of measures identified above.

Some staff feel that the evaluation may serve to judge their performance, allowing comparisons to be made between GPs and other pilot sites. The evaluation team have agreed that all data will be rendered anonymous to avoid such comparisons being made.

Ideally, a large amount of the measurement data will be extracted from existing data captured in IT systems, avoiding duplication of effort. However, this requires the development of a data capture template and updates to GP software systems. The former has been agreed as discussed in the former section, whilst updates to GP software are still pending.

Overall, planning for the evaluation of the implementation of *Year of Care* has been a great deal more challenging and labour intensive than anticipated. This lesson highlights the need to encourage and support sites in data collection and is also important for others seeking to implement the *Year of Care* approach.

6 Key Learning

6.1 Introduction

This section provides a synthesis of the findings in this report together with some final reflections from pilot site staff. It distils the key learning that has accrued from the *Year of Care* preparatory phase.

The learning has been organised into key themes which reflect the preparatory process, beginning with project initiation, organisational processes, engaged informed patients, healthcare professionals committed to partnership working and foundations of commissioning.

Most of the learning described in this section relates to the preparation phase of the *Year of Care* project. However, there are also some insights which can inform future direction in the pilot sites, for example where emerging issues have been identified by the evaluation team but not yet experienced by the pilot sites.

6.2 Project Initiation

Motivations

It is useful to consider in the first instance why a service would want to undertake a project of this type. A clear articulation of the rationale for change was found to be useful when communicating the direction of travel to others and motivating them to join up.

Year of Care has a high 'relative advantage'[13] in the contemporary healthcare context. It dovetails with current policy and organisational reforms and provides a platform from which patient centred services can be delivered and developed. Its 'goodness of fit' is impressive both now and for the future. For example, the introduction of individual budgets for people with long term conditions including those with diabetes will require mechanisms of this type.

Year of Care has the potential to reform the way services are commissioned and delivered according to the expressed wishes of the people who use them. This reflects a direction of travel that the health service aspires to. Recognising, understanding and clearly articulating this rationale was found to be an important starting point.

Project staff

All three pilot sites recognised the need for a project champion. Someone who can inspire people, communicate a vision and garner organisational support. *Year of Care* spans different systems within an organisation and therefore different types of champion are necessary including a clinical lead, a commissioning lead and a GP

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[13] Berwick, DM (2003) Disseminating Innovations in Health Care. JAMA 289 1969-1975

lead. Leaders with cross organisational responsibility e.g. commissioning and primary care were considered to be particularly valuable.

Each of the pilots set up their projects with a Senior Responsible Officer (SRO) who held a senior organisational position. Additional project membership across the sites included staff from specialist secondary services, primary care, commissioning, public health, patient and public involvement, service improvement and performance, education and training, the voluntary sector and social services. With such a large number of project members, a clearly defined set of roles and responsibilities is essential for effective project management.

Governance mechanisms need to be in place to enable these stakeholders to work collectively toward desired objectives and to monitor project progress. A project board with additional sub group meetings provides one approach as used in North of Tyne and Tower Hamlets. An alternative approach was adopted by Calderdale and Kirklees and involved a project steering group supported by clinical and service user reference groups.

During the preparatory phase pilot sites noted the importance of having a central co-ordinator or project manager in place from the beginning. Though this was considered important for the project’s credibility real difficulties were encountered filling these posts. Experience from the preparatory phase indicates it can take up to three months and in one site the post remained vacant.

Project plans

A project plan needs to be prepared and put in place at the outset. The work streams in Table 2 give an indication of what needs to be included. Experience from the field indicates that these plans should reflect gradual, incremental step changes rather than a big bang approach.

Project teams/steering groups need to spend time familiarising themselves with the *Year of Care* house model and developing a clear understanding of its implications for their own service developments. During the preparatory phase a lot of this work took place at the learning events and consensus was only forged after considerable deliberation and debate. Group work is important to develop collective understanding and should be factored into project planning.

6.3 Organisational Processes

Alignment with local culture

It was considered vital by the pilot sites that their own Primary Care Trust structures were congruent with the *Year of Care* diabetes strategy and service model. This specifically refers to the patient and pubic involvement approach to service development and the focus on services and interventions that support self-care.

Communications

The project team need to connect widely across all possible stakeholders within an organisation to communicate developments and to avoid ‘silo’ working, which carries the risk of different teams and services reinventing wheels differently. Disseminating project aims and regular updates through established communication channels in an organisation supports this aim.

As well as communications to other staff and services it is necessary to keep service users and their carers at the forefront of developments. During the preparatory phase this was done via various media channels including the use of local press.

Data capture tools and pro forma

A range of pro-forma is required to support *Year of Care* reviews including standard letters and templates for test results and care plans. It is important also that patients have straightforward ways of interpreting their test results such as the folder with colour coded ranges prepared by Tower Hamlets.

A standard IT template for recording review and care plan data has been recognised as critical during the preparatory phase, particularly as a way of collating micro level patient data in order to inform macro level commissioning decisions. Organisations will need to think carefully about this mechanism and whether existing monitoring systems can allow this type of data extraction.

6.4 Engaged Informed Patients

The pilot sites felt it was essential at the outset to understand what each organisation involved in the project meant by Patient Public Involvement and as far as possible to embed the activities in mainstream work. Throughout the preparatory phase there were three main levels of PPI.

Project level

Service users were actively involved in project steering groups in Calderdale and Kirklees and North of Tyne. Project level consultation events were also undertaken at each of the pilot sites including the systematic application of the workshops/focus group approach in Calderdale & Kirklees. It is important at the outset to have patient information sheets prepared that detail the purpose of the project and the event that people attend. Not everyone will want this level of information but it should be available for those who do.

When planning user groups it is also important to think about how to proactively engage those people who are harder to reach. Different methods will be needed including one to one contact, e-mail, virtual consultation and chat rooms. In North of Tyne the use of personalised letters sent from practices was thought likely to work better than the general advertising strategy they had used.

Practice level

In Tower Hamlets practices paired up to deliver consultation events. Front line staff were used to engage patients and food/liquid refreshments were provided. These events were very well attended and it appeared that recruitment via practices is a more effective method than advertising through local media.

It is important at the outset of these events to be clear about what the project is trying to achieve and check for understanding and agreement from patients. It is important also that patients' perceptions, feelings and preferences are not taken for granted and the process and outputs of any event are carefully documented and fed back to patients or their representatives for validation/approval.

Events of this type provide an excellent opportunity to hear about the services and supports that patients currently use in their communities as well hearing about their aspirations. Since *Year of Care* aims to increase the menu of treatment and care options these opportunities can be used to learn from patients.

Patient level

Pilot sites consistently reported the need to educate individual patients on how to use the new *Year of Care* approach. Not all will have been involved in consultation events or be aware of the planned changes to practice. Information leaflets detailing changes to patients' receipt of test results, consultations and written care plans are advised. This is all the more important when some staff at North of Tyne suggested that for some patients, receipt of test results generated some anxiety, although the extent to which this is true or the types of patients affected has not been explored.

6.5 Health Care Professionals Committed to Partnership Working

Primary care engagement strategy

It is important from the start to be absolutely clear what primary care staff are expected to do before engaging them. This information could be collated into information packs that go out to primary care colleagues ahead of any meeting.

Each of the pilots had some sort of strategy to engage primary care, which reflected a staged approach rather than trying to introduce all aspects of the project at once. Some of the key elements which have worked well include:

- Informal 'meet and greets' involving senior Trust staff and primary care.
- A clinical lead or champion who has time dedicated to go out to practices and 'sell' the approach.
- An information pack setting out what's involved in *Year of Care* and linking it to national policy.
- Keeping the wider community (other practices) up to date with the project.

- Sharing the tangible benefits of care planning to practice managers including the move toward self-care.
- Including primary care receptionists and administrative staff.
- Sharing invitations to the training and explaining what would be involved.

During primary care engagement it was important to keep in mind that this is a potentially revolutionary shift in the way services are delivered with significant time and money implications for staff. Taking a steady drip-drip developmental approach rather than pushing too hard at the outset was found to be best.

Different people will respond differently to the intended developments and will be motivated by different opportunities e.g. the chance to be part of a leading initiative, financial incentives or the chance to improve patients' quality of care. All possible benefits need to be shared with staff.

During primary care engagement some local champions become apparent. These individuals were noted and co-opted as clinical and opinion leaders for subsequent stages of the project. Primary care engagement also provides opportunity to ask practices about local services that are being used to support people with diabetes. The experience of Tower Hamlets is that local services hold a wealth of information in this respect.

Staff training

Primary care staff were receptive to the training across the pilot sites and some of the common principles that emerged were presented in the previous section. North of Tyne's approach to having the training in staggered sessions allowing time for goal setting, action planning and reflection between sessions is a useful mirror of the *Year of Care* consultation process and it may have particular merit organising the training in this way.

More generally there is a need to build in time for reflection of the training, and for the *Year of Care* project team to review progress and refine elements of the training as necessary. The pilot sites have also recommended that it be inclusive involving as many members of the multidisciplinary team as possible.

Training must focus on the whole person rather than the disease and needs to be connected to the wider self-care agenda. As well as dealing with the attitudes, skills and competencies of staff it needs to address changes in organisational processes.

The training should not be a one off event. This type of practice and organisational development will need ongoing support. Refresher sessions will be necessary such as those planned in Calderdale & Kirklees, and evening sessions in Tower Hamlets. It is also advisable to ask practices themselves what ongoing support they feel they will need as North of Tyne has done.

6.6 Foundations of Commissioning

Backdrop

The backdrop to commissioning is a complex one that is coloured by many different policy strands. Recognising the bigger picture and finding the synergies between *Year of Care* and other initiatives is important e.g. *Making the Breakthrough* in Tower Hamlets.

The commissioning process does not necessarily flow in a linear fashion and time frames may not immediately dovetail with *Year of Care* project processes. Therefore the leverage that commissioning can bring to the development of services for people with diabetes may not be fully realised until the medium term. However, some mechanisms were identified to support in-year commissioning bids outside of the usual commissioning cycle such as the ‘double run’ option in Calderdale & Kirklees.

Models and frameworks

During the preparatory phase a number of models or frameworks were used to enable different types of population stratification including Calderdale & Kirklees use of the Bolton model, Tower Hamlets categorisation according to preparedness to self-care, and North of Tyne’s use of Programme Based Marginal Analysis. We await a fuller understanding of their impact on the development of diabetes services.

Levers and incentives

An IT template to record patient level data that then allows aggregate pooling to inform macro level commissioning decisions is an important lever that this project has identified and specified, and which we anticipate will be available to the pilot sites in the near future. Without such a mechanism the shift from micro to macro based on assessed need and services received will be difficult to make.

However, commissioning has still been able to lever elements of the *Year of Care* service that should help ensure macro level data is fully realised a little further down the line. For example, care planning as part of SLA for pilot practices and care planning preparation in none-pilot practices.

Key recommendations that have come from the field to support and develop the commissioning function include:

- Understand current provider arrangements.
- Understand what is needed by the population in concert with public health.
- Develop a common understanding of commissioning requirements.
- Incorporate local views and patient experiences.
- Commission elements of *Year of Care* e.g. the project team, training, care planning.

- Develop mechanisms to process micro level commissioning/care planning information.
- Don't proceed without effective systems to process data.
- Recognise at the outset that this is not an easy task.

7 Discussion and Recommendations

7.1 Introduction

Specific objectives stated in the original specification for this work are stated in Section 2 and apart from the sixth objective (to reflect on the feasibility of preparing for delivery and of measuring delivery) these have been met in the body of this report. In terms of feasibility of preparing for delivery and of measuring delivery, the following observations can be made.

7.2 Feasibility of Preparing for Delivery

The sheer volume of work that has been undertaken by each of the pilot sites is worthy of note. Each site took on a significant challenge to prepare and engage in whole systems change across a 10 month period. The success of this work will ultimately be determined in the years ahead as its impact on patients and treatment processes is evaluated.

Nevertheless, across different contexts it has been feasible for this field of pilot services to prepare themselves for delivering *Year of Care*. Work streams were specified and stakeholders engaged with some ease. The *Year of Care* approach fits well with contemporary policy and has proved an attractive potential mechanism for developing services both within the pilot sites and among stakeholders further afield.

Different mechanisms have been adopted for training primary care staff and these have been successfully implemented. Along side this work pro forma and other materials have been prepared to support and enable delivery.

The overriding message from this preparatory phase is that one size does not fit all contexts and there may be any number of legitimate ways to get from A to B. These differences are perhaps most evident in the approach taken by different pilot sites to commissioning processes.

A significant outstanding challenge relates to the documentation, retrieval and collating of care plan data. During this preparatory phase the project has come a long way in these respects linking up with Yorkshire and the Humber SHA to design the content and operations of an IT template. The field needs its translation into GP e-systems to further support their work and to ensure a mechanism that will allow individual patient level data to inform macro level commissioning decisions.

In conclusion, each of the pilot sites has travelled a great distance in the last 10 months and each of them has found a slightly different route to prepare their workforce to deliver *Year of Care* services. Along side this work a methodology has been prepared with the sites to evaluate their delivery over the next 24 months and thereby understand what is being implemented in routine practice and how this makes a difference to the lives of people with diabetes. The progress and results of that methodology will be eagerly awaited by pilot site staff and patients, as well as by the broader community of stakeholders that the project has attracted.

7.3 Recommendations

The evaluation findings point to a number of recommendations aimed at the *Year of Care* project team and pilot site staff and stakeholders:

- The *Year of Care* project team should support dissemination of the achievements of this preparatory phase, which contains valuable evidence of organisational developments for other providers across a range of contexts.
- The *Year of Care* project team should develop a resource of the pro forma, materials, training outline, workshop procedures etc. that have been prepared and /or written up by the project partners. These should be available in e and hard copy for other stakeholders who may wish to use or adapt them.
- Senior stakeholders in the *Year of Care* project team should systematically disseminate phase I achievements and phase II developments to senior staff across Department of Health directorates and further afield as necessary.
- The content of this report and materials from the field should be used by project staff to support the production of a practical toolkit for implementing *Year of Care* services.
- The *Year of Care* central team should establish mechanisms to ensure the sustainability of this programme in the medium and longer term. This might include continued learning events or similar fora for staff and service users to come together and share learning.
- Pilot partners should further emphasise the need for clear roles and responsibilities to their core *Year of Care* team for phase II to maintain these service developments.
- Pilot partners should establish mechanisms to ensure the sustainability of *Year of Care* delivery in primary care. This might include training refreshers, ongoing network development and outreach/liaison visits to primary care providers.
- Pilot partners will need to maintain flexibility over the coming years to ensure their operating model can bend and adjust to future policy initiatives.
- Work to deliver and implement an IT template should be encouraged and supported as a matter of priority. This may necessitate additional funds being made available to support training as part of an implementation process.
- Increased attention should be given to the commissioning function during phase II, particularly to support its potential to mobilise the

health and social care markets in favour of the wishes of those who use them.

- The pilot sites should engage in the proposed evaluation methodology over the coming 24 months and ensure there are personnel and mechanisms in place to sustain the activity.
- Particular attention should be paid in phase II to variations or exceptions to the model and how these might impact on the experiences of patients and their care e.g. hard to reach, disengaged patients, those living in rural areas and those people from cultures in which self-care does not easily translate.

7.4 Conclusions

In conclusion, preparing for the *Year of Care* has been successfully achieved, and the three pilot sites are now ready to implement the *Year of Care* approach. However, the work required and challenges faced have far exceeded those anticipated at the onset. This serves to emphasise the complex and challenging nature of such projects which involve extensive changes to culture and service delivery and rely on the enthusiasm and engagement of multiple stakeholders.