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The 'Year of Care' in Leeds: implications for primary care practice

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- **What does this article tell us?** The paper reports the learning from implementing 'Year of Care' in Leeds where nine 'early adopter' sites rolled out the programme. It highlights process and delivery issues associated with the approach which focuses on personalised care planning, including the challenge of navigating cultural change in general practice and training and support issues.
- **Why is it important?** Learning and insight from delivering 'Year of Care' in Leeds should enable commissioners in other areas to replicate successes and to avoid challenges faced in delivery.
- **How can I apply this knowledge to my practice?** Focusing on the key points in this article should help practices implement 'Year of Care' in their local situation.

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There is a clear need for a shift in the way that care is delivered for people with long-term conditions – moving from an expert-driven consultation to one based on collaboration and partnership. 'Year of Care' is a systematic approach to managing long-term conditions, focused on personalised care planning where patients work with the clinician to agree goals, identify support needs, develop and implement action plans, and monitor progress. In this paper we report the learning from implementing 'Year of Care' in Leeds where nine 'early adopter' sites rolled out the programme. We hope that the learning and insight we gained during the process will be useful to other areas adopting greater patient-centred care models.

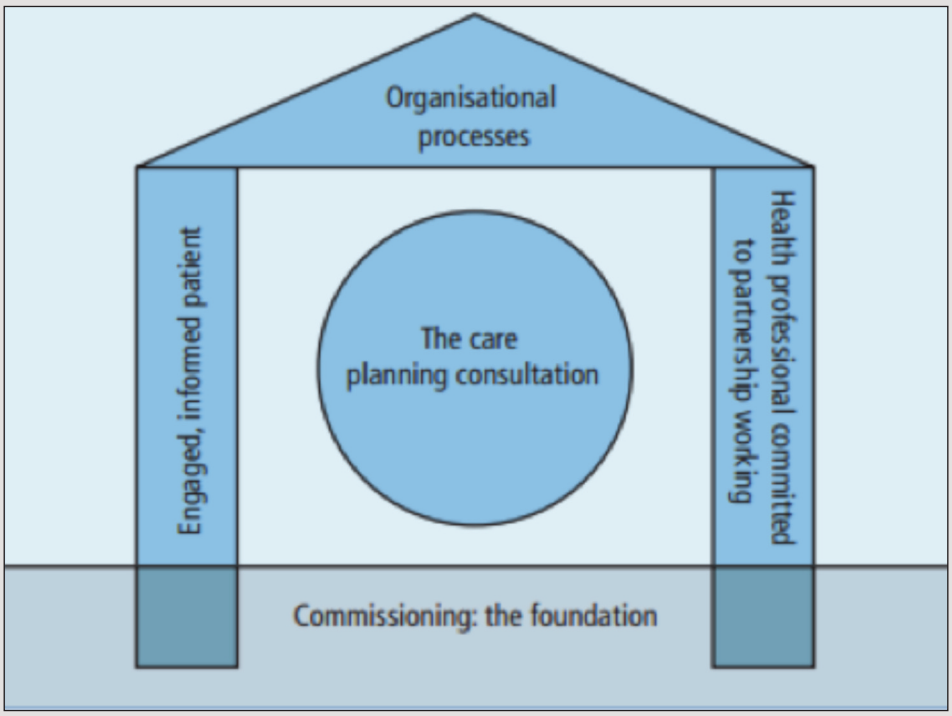
The increasing cost and complexity of caring for patients with long-term conditions means that health commissioners and providers are being increasingly challenged to develop innovative approaches to meet patients' needs.[1] In response to this, there is growing discussion and empirical evidence suggesting a need to shift the way that care is delivered for people with long-term conditions – moving from an expert-driven consultation to one based on collaboration and partnership between the healthcare professional and patient.[2] A pledge toward greater 'patient-centred care' and 'personalisation', for example, has been a key principle of national policy for over a decade.[3]

'Year of Care' is both a policy and general practice solution which offers an approach to managing long-term conditions based on a collaborative care planning model between patients and clinicians. 'Year of Care' is centred on the House of Care concept (Figure 1) and is a key mechanism for supporting the policy imperative of 'no decision about me without me'.[4] The House of Care places the consultation in the heart of the framework, with the walls representing both the engaged and informed patient and healthcare professional committed to partnership. The roof highlights the administration required for the process to run smoothly, with modifications in skill mix and resources to be commissioned as the foundations.[2]

'Year of Care' aims to provide personalised care planning where patients with long-term conditions work with the clinician to agree goals, identify support needs, develop and implement action plans, and monitor progress. This approach aims to build skills, knowledge and confidence to allow people to self-manage their condition with the support of the healthcare professional. 'Year of Care' consultations see patients at the centre of care planning and making decisions based on access to their own clinical records and having greater awareness of self-care and self-management options.

Evaluation of the national 'Year of Care' pilot programme concluded that 'Year of Care' puts people with long-term conditions "firmly in the driving seat of their care".[3] In turn, patients reported improved experience and positive changes in self-care, and

Figure 1: The House of Care



healthcare professionals improved clinical skills and productivity. Other publications have shown 'Year of Care' is valued by both patients and clinicians as a means of supporting self-management [2] and facilitating a care-centred approach around an individual's needs.[5,6] Evidence suggests that the successful implementation of 'Year of Care' requires appropriate sustained systems, education and support to be in place from the outset.[7,8]

THE 'YEAR OF CARE' EXPERIENCE IN LEEDS

The 'Year of Care' is being used in nine early adopter practices in Leeds. Since April 2015, 5563 patients have been supported to review and manage their long-term condition(s). The majority of these patients were 55-84 years old with an equal balance between males and females; a total of 78% had diabetes and 23% had coronary heart disease. As a result of the process, 5389 patients had goals set related to disease prevention (36.8%), maintaining wellbeing (29.5%) and the management of complications relating to conditions (28.3%).

Five of the early adopter sites took part in an evaluation of the programme.[6] As the 'Year of Care' is still in its relative infancy, it is difficult to provide quantitative measures of its effectiveness. However, qualitative interviews with patients, clinicians and other key stakeholders involved in the implementation and roll-out of 'Year of Care' across these sites have revealed a number of key lessons that may have application to other areas hoping to adopt 'Year of Care' principles.

A 'WHOLE PRACTICE' RESPONSE REQUIRED

A critical component for the sustainability of 'Year of Care' is that all practice staff are committed to the programme and open to changing traditional ways of working. All members of staff need to be engaged and committed to 'Year of Care' if it is to operate successfully. 'Year of Care' has been described as a 'whole system change', which requires GPs, nurses, healthcare assistants and administrative staff to all understand the philosophy and underpinning rationale. Having co-produced conversations between clinicians and patients may require additional effort.[9] Evaluation of the early adopter practices in Leeds showed that some clinicians had 'defaulted' back to their previous working practice – often due to 'reluctant patients' who found the 'Year of Care' process unhelpful – and therefore required additional support to sustain the 'Year of Care' delivery model.[6]

SUPPORTING PATIENTS ON THE JOURNEY

Navigating and managing changes for staff and having support in place to do this is a key consideration, but patients' expectations and understanding also require careful management. Educating patients is vital to ensure the full benefits of 'Year of Care' are realised. Informing patients about 'Year of Care' and the changing nature of the patient-professional relationship is very important. A number of engagement and awareness-raising techniques have been useful in informing patients with long-term conditions about 'Year of Care'.[2] It is important that these materials are appropriate for those patients most likely to use 'Year of Care'.

STAFF TRAINING

The likelihood of 'Year of Care' succeeding is increased if staff engage in training programmes and support packages. This training needs to be flexible and regularly available, and delivered with a good understanding of the operational realities in busy primary care settings. In Leeds, healthcare professionals felt the 1.5-day training course was

Key lessons from the Leeds experience

- Commitment by the whole practice team to the process
- Supporting and educating patients in the changing nature of the patient-professional relationship
- Flexible staff training
- Support from other healthcare professionals
- Strong administrative support structure
- Tailoring delivery to each individual practice
- Capturing long-term outcomes (including qualitative information) to demonstrate cost-effectiveness and patient/practice benefit

too long and they preferred the 1-day session that covered the essential principles. Some staff praised the trainers for responding to feedback and reducing the length of the training in light of their feedback. The timing of the training was also critical for effective implementation and participants said that training should be as close as possible to implementation of 'Year of Care' in a practice.[6]

SUPPORT FROM OTHER PROFESSIONALS

The sustainability of the programme was improved by establishing mechanisms outside the formal training processes where practitioners can seek support from other professionals engaged in 'Year of Care'. Network meetings or establishing groups of clinicians (virtual or face-to-face) who have engaged with 'Year of Care' allows individuals to share good practice and highlight challenges in implementation. One clinician in Leeds suggested the benefit of simply enabling people to know "how everybody else is getting on…and what problems they're encountering".[6]

More formally, appointing a dedicated 'Year of Care' facilitator overseeing progress and implementation enabled a smoother transition from traditional ways of working to collaborative and empowering clinical discussions. Having a dedicated facilitator available to practices in Leeds was thought to make a big difference as practices "perhaps need a little bit of hand-holding to get going."[6]

ADMINISTRATIVE INFRASTRUCTURE

There is clear evidence that practice information exchange between clinicians and patients is critical for 'Year of Care' to work successfully.[10] This requires sound administrative processes [3] as consultations within a 'Year of Care' framework mean information, such as test results, is shared in advance and longer appointments can be arranged. Resources need to be allocated to create and maintain effective support systems, including reliable IT systems. This is critical for commissioners to recognise and while this may mean additional spending, the cost-benefit of engaged patients taking control over their long-term condition may yield financial dividends.

TAILORING FOR EACH PRACTICE

Ensuring that the delivery of 'Year of Care' is tailored to the needs of each practice increases the likelihood of success. In the evaluation of roll-out in Leeds, it was important for commissioners to recognise that individual practices work at different speeds and required varied levels of support.[6]

EVALUATION AND MONITORING

The need to capture longer-term outcomes from 'Year of Care' is essential to demonstrate that a shift in more person-centred care in clinical consultations is worthwhile and cost-effective. Patient Activation Measures (PAM) are important tools to show levels of personalised support,[9] but capturing evidence through routine practice data systems is also essential in order to show impact and outcomes for individuals with long-term conditions. The value of qualitative information should also not be underplayed as this approach is more likely to capture both cultural changes in practice and also case studies of patient success and challenges.

CONCLUSIONS

The aim of this paper was to highlight some of the practical issues and learning which emerged from the roll-out of 'Year of Care' in Leeds – an approach designed to create a more collaborative partnership between patients and clinicians. Evidence shows that reconceptualising the way that support for people with long-term conditions is provided offers potential benefits, including improved wellbeing, patients developing a more positive sense of control, better health outcomes for individuals and potentially lower healthcare costs.[11] Nevertheless, some of the process issues involved in delivering new ways of managing patients with long-term conditions are frequently under-reported. It is hoped that learning and insight from delivering 'Year of Care' in Leeds will enable commissioners in other areas to replicate successes and to avoid challenges faced in delivery.

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