

Care planning in action: Learning from the Year of Care pilot

Simon Eaton

Care planning offers enormous potential for improving outcomes by working in more productive and meaningful ways with people with diabetes. This article outlines the background and policy context of care planning and considers what needs to be in place to make it happen, drawing on experience from the diabetes Year of Care pilots. The importance of the process of care planning rather than the product of the care plan is emphasised. A key and highly effective first step is sharing results with people prior to the consultation.

Care planning was a central component of person-centred care in the diabetes National Service Framework (Department of Health [DH], 2003). Subsequently, a commitment to offer care plans to all people with long-term conditions (LTC) was included in *Our Health, Our Care, Our Say* (DH, 2006). This was reinforced in Lord Darzi's (2008) report *High Quality Care for All*, and is reflected in the 2009/10 NHS operating framework commitment (DH, 2008):

“Over the next 2 years, to ensure that those living with long-term conditions receive a high quality service and help to manage their condition, everyone with a long-term condition should be offered a personalised care plan.”

Personalised care

While no singular definition has been evident in these policy statements, the principles have been very consistent. Personalised care means supporting people to understand their condition better, allowing them to be

more able to participate and be involved in care decisions to be able to self-care more effectively. This is key from a clinically effective, high-quality service perspective as the evidence base demonstrates that this is the way to achieve better outcomes in both health and wellbeing (Michie et al, 2003; Newman et al, 2004). Furthermore, the simple truth is that a person with diabetes may only spend 2–3 hours in contact with a healthcare professional each year, which means they need to be able to make decisions for themselves in the remaining 8757 hours.

Care planning is seen to be a key vehicle for achieving personalisation and support for self-care. The care-planning consultation should be between a well informed person with diabetes and a healthcare professional trained to promote resourcefulness in the person to support them to identify their own goals and develop problem-solving strategies. It is the process of agreeing the care plan, involving individuals in the decisions, allowing them to plan care appropriate to them, that is key, rather than the outcome of providing a care plan.

Article points

1. The care-planning consultation should be between a well informed person with diabetes and a healthcare professional trained to promote resourcefulness in the person to support them to identify their own goals and develop problem-solving strategies.
2. The Year of Care pilot sites have explored the practicalities and implications of implementing the care planning processes to promote partnership working in everyday clinical practice.
3. A key and highly effective first step is sharing results with people prior to the consultation.

Key words

- Care planning
- Person-centred care
- Year of Care

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Page points

1. The Year of Care programme is a partnership between the Department of Health, Diabetes UK, NHS Diabetes and The Health Foundation to explore how care planning could be delivered and commissioned on a larger scale.
2. For an individual to self-care effectively, they need to make well-informed decisions about their health and healthcare and the lifestyle and behaviour changes that are right for them.
3. The Year of Care pilots have demonstrated that sending people the results of their test 1–2 weeks before the consultation is a practical and powerful first step.

A significant amount of progress was made in diabetes through a working group co-hosted by the DH and Diabetes UK (DH et al, 2008), which generated a report, a model framework for a consultation, and spawned a literature review (Graffy et al, 2009). This was followed by a practical guide, *Partners in Care*, published by NHS Diabetes and incorporating learning from early pilots and experiences (National Diabetes Support Team, 2008).

The diabetes Year of Care programme

The Year of Care programme is a partnership between the DH, Diabetes UK, NHS Diabetes and The Health Foundation to explore how care planning could be delivered and commissioned on a larger scale (National Diabetes Support Team, 2008). It is being piloted in NHS Calderdale, NHS Kirklees, Calderdale & Huddersfield NHS Foundation Trust, NHS North of Tyne, and NHS Tower Hamlets.

The Year of Care 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.

The first steps for the pilot sites were to consider what care planning really meant and how this approach could be implemented in everyday

practice. The “house” model (*Figure 1*) was developed to describe the various elements that are required. It also emphasises their interdependence – if any of the elements are missing or weak, then the structure is not fit for purpose.

This model builds on the Chronic Care Model (Wagner et al, 1996), and a systematic review of the literature on care planning (Graffy et al, 2009), which concluded that narrowly focused interventions appeared less effective than whole system approaches. It also acknowledges the role of commissioning as the foundation on which the system of care is built. This has been reviewed in a recent article in this journal (Thomas and Roberts, 2009).

Engaged, informed people

For an individual to self-care effectively they need to be supported to make well-informed decisions about their health and healthcare and the lifestyle and behaviour changes that are right for them. To achieve this, individuals need to have a good understanding of their condition and the consequences of their decisions. This may well require provision of personally relevant and timely information, as well as participation in disease specific, or generic self-management structured education courses, or both. Additionally, they may need emotional and psychological support to come to terms with their condition and the impact it will have on their lives.

Crucially, however, it is important to consider how people can be better “prepared” for their consultation. In a context where time pressures are significant, healthcare professionals spend a huge amount of time gathering or sharing information that could have been done prior to the consultation. It is hard to think of any walk of life outside the NHS where an individual would experience a meeting in a less prepared fashion than a health consultation. *Box 1* contains a reflective exercise to draw attention to this.

While the array of activities around the “house” in *Figure 1* may seem daunting, the Year of Care pilots have demonstrated that sending people the results of their HbA_{1c} test 1–2 weeks before the consultation is a practical and powerful first step. This system change can be challenging to implement, but it allows

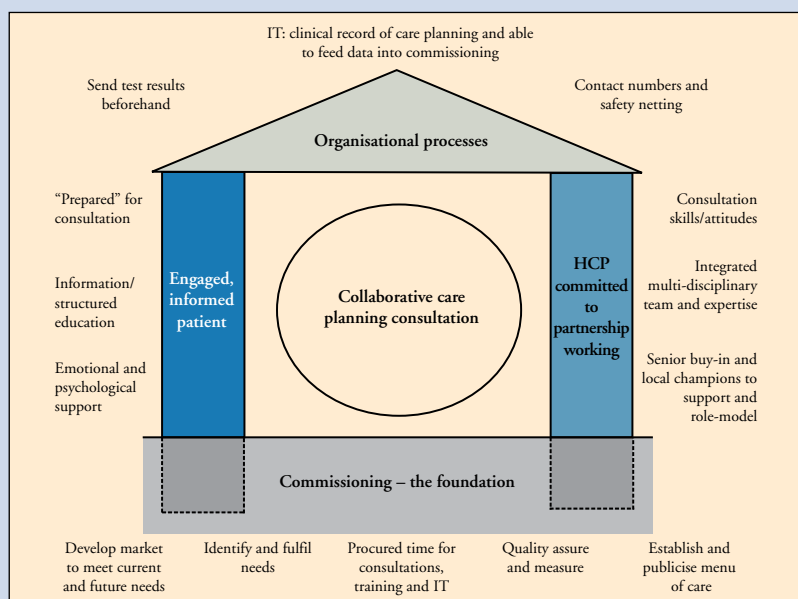


Figure 1. The care-planning house.

the individual to consider what is important or particularly relevant to them and can provide a positive change to the consultation.

Experiences from the Year of Care pilots have been extremely positive. Many practices have made the system change required for implementation, and have learnt from each other along the way. Detailed qualitative research, based on interviews with clinicians and people with diabetes, supports this (Ludbrook et al, 2009). Quotes from people with diabetes have included:

- “You have time to read [the test results] and think about what to raise.”
- “I could focus on the important things for me and get help.”

Examples of quotes from clinicians included:

- “I enjoy doing the clinic a lot more now, working with them rather than at them.”
- “It’s absolutely 100% better for me and for the patients.”

Healthcare professionals committed to working in partnership

Providing effective support for self-care is fundamentally different to the traditional biomedical care model whereby a diagnosis is made and curative treatment is provided. By definition, long-term conditions are incurable and the effects are permanent and variable. People who have long-term conditions cannot expect full recovery and need to acknowledge, understand, incorporate, accommodate and adapt to their condition before they can truly move on.

Healthcare professionals are the experts in the understanding of disease. However, those individuals with the long-term condition will know best how proposed treatments or support mechanisms fit into their lives, and what will work for them in their situation. While they may value help to work this out, they need to be the final decision-makers to put their plans into action. The key to supporting self-care is bringing these two perspectives together in partnership. In the context of the consultation it is the clinician’s role to facilitate this process, which will require new expertise that builds on and exceeds current knowledge and understanding in the communication skills literature. However, this is not provided effectively or consistently in current

models of medical services. One issue is that many GPs express concerns about whether people are capable of effective self-care and about how best to use their clinical expertise to support this (Blakeman et al, 2006).

The second barrier is that many people say “we are doing this already”, even though general and specific data would demonstrate that this is not always the case. The Healthcare Commission’s (2007) survey of 66 000 people with diabetes in England found that while 95% of people had check-ups at least annually, fewer than 50% discussed their goals in managing their conditions with health service staff.

The recognition that this requires a different approach to the consultation and learning of new skills has led to the development of a quality assured training programme. In addition, the Year of Care programme has been using a variety of evaluation measures, including a measure of consultation quality (Mercer and Howie, 2006).

Organisational processes

Unless the working environment is supportive, no amount of good intentions will change practitioner behaviour. If the timing of appointments is wrong, if people do not have the information or understanding to take part, if the working practices are geared to tick-boxes, and if the commissioner is measuring the number of care plans rather than involvement in the new process of care planning, things are unlikely to change.

Developing a system to share test results with people before the consultation makes it easier for them to be involved in decisions and for healthcare professionals to support this. IT systems can either support healthcare professionals to do the right thing, or reinforce old ways of working.

The Year of Care project has worked with Yorkshire and the Humber Strategic Health Authority to develop templates that support partnership working and record the things that are important to people with diabetes, and also to healthcare professionals and commissioners. They facilitate the care-planning consultation, while also allowing individual decisions to be collated together across the health community to guide the commissioning of the support and care services they need.

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1. The Year of Care pilot sites have explored the practicalities and implications of implementing the care-planning processes to promote partnership working in everyday clinical practice.
2. Improvements in care and outcomes for people with diabetes require new ways of working to allow more involvement in decisions and support effective self care. The diabetes Year of Care pilots have explored the implementation of a care-planning approach that aims to achieve this.

Implementing the Year of Care

The Year of Care pilot sites have explored the practicalities and implications of implementing the care-planning processes to promote the previously discussed partnership working in everyday practice. It is clear that care planning is valued and motivating to a range of staff, but involves a culture change that needs to be actively managed. The key components of this are:

- Senior organisational buy-in, including local commissioning to provide the resources needed to support it.
- Senior clinical buy-in, to model, promote and sustain the changes and help work through barriers.
- Training for healthcare professionals directly involved, but also administrative and support staff.
- Development of mechanisms to engage people with diabetes involved in the new approach.

- Reorganising the basic workflow and workforce within the practice clinic to ensure that: collecting annual surveillance results is coordinated; that results are sent to the individual 1–2 weeks before the care-planning consultation, in a form and using language to encourage active participation in the decision-making process; that the clinic environment is redesigned to reinforce this.
- Routine feedback of patient experience set up by the practice and clinicians.

Summary

Improvements in care and outcomes for people with diabetes require new ways of working to allow more involvement in decisions and support effective self-care. The diabetes Year of Care pilots have explored the implementation of a care-planning approach that aims to achieve this. Articulation of the “house” model has provided a greater clarity to the importance of a multi-faceted approach. Key interventions have included clinician engagement, skills training and processes to share results with individuals before the consultation. ■

Box 1. New ways of working – sharing results before the consultation.

Narrative

Bob is attending his appraisal. He is nervous as he hasn't yet seen the results of his 360° assessment. The appraiser puts him at ease and suggests that, overall, things were pretty good. However, there did seem to be some issues with his time management and team-working. This comes as a surprise to Bob and he is not sure what to make of it.

Discussion

What was the impact of Bob having not seen the 360° results prior to the meeting? The process is intended to be constructive and to help him develop further but, no matter how good the skills of the appraiser were, the emotional impact of receiving the news in this manner overrides Bob's ability to consider it rationally and decide what it really means to him. Would you stand for this in your appraisal? Wouldn't you insist on having time to think about and digest the assessment results beforehand?

How does this relate to diabetes and care planning? What if Bob had diabetes and was coming to see you (his diabetes “appraiser”) in the annual review clinic? Do we ensure that the people that see us get their results before clinic? Do our patients get enough time to reflect and consider the options, before we ask them to make decisions?

What if Bob had received the results a couple of weeks earlier? Initially he may still be quite disappointed and surprised, but he may have been able to think about what the results meant, get more detail from his colleagues to help make sense of them and develop his own plan of how this could be addressed. However, simply sharing the results alone is not enough. If the appraiser didn't really listen to Bob's ideas and preferred to make his own suggestions, this may also have not been helpful to Bob's development. Similarly, if on the day of the appraisal Bob finds out there are 15 other people being appraised that day and he only actually gets 10 minutes, or that the time-management course they eventually agree on will not be funded this year, these will have equally negative effects.

These scenarios demonstrate the importance of ensuring that all the relevant elements are integrated, supported and resourced to ensure that Bob and his appraiser can work in partnership together to achieve the best outcome for all. Similar efforts need to be made in our diabetes clinics.

Blakeman T, Macdonald W, Bower P, Gately C (2006) A qualitative study of GPs' attitudes to self-management of chronic disease. *Br J Gen Pract* **56**: 407–14

Darzi A (2008) *High Quality Care for All: NHS Next Stage Review Final Report*. DH, London

Department of Health (2003) *National Service Framework for Diabetes: Delivery Strategy*. DH, London

Department of Health (2006) *Our Health, Our Care, Our Say: A New Direction for Community Services*. DH, London

Department of Health (2008) *The NHS in England: The Operating Framework for 2009/10*. DH, London

Department of Health, Diabetes UK, NHS National Diabetes Support Team, Health Foundation (2008) *Getting to Grips with the Year of Care*. DH, Diabetes UK, NHS National Diabetes Support Team, Health Foundation, London

Graffy J, Eaton S, Sturt J, Chadwick P (2009) Personalized care planning for diabetes: policy lessons from systematic reviews of consultation and self-management interventions. *Prim Health Care Res & Devel* **10**: 210–22

Healthcare Commission (2007) *Managing Diabetes: Improving Services for People with Diabetes*. Healthcare Commission, London

Ludbrook S, Doherty Y, Lewis-Barned N (2009) What do patients and clinicians think of the Year of Care? *Diabet Med* **24**(Suppl 1): P296

Mercer S, Howie J (2006) CQI-2 – a new measure of holistic interpersonal care in primary care consultations. *Br J Gen Pract* **56**: 262–8

Michie S, Miles J, Weinman J (2003) Patient centredness in chronic illness: what is it and does it matter? *Patient Educ Couns* **51**: 197–206

National Diabetes Support Team (2008) *Partners in Care: A Guide to Implementing a Care Planning Approach to Diabetes Care*. NDST, London

Newman S, Steed L, Mulligan K (2004) Self-management interventions for chronic illness. *Lancet* **364**: 1523–37

Thomas J, Roberts S (2009) Year of Care: Effective commissioning for diabetes services. *Diabetes & Primary Care* **11**: 240–3

Wagner EH, Austin BT, Von Korff M (1996) Improving outcomes in chronic illness. *Manag Care Q* **4**: 12–25