Education in care-planning models

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The National Service Framework for diabetes (Department of Health [DH], 2001) acknowledged that "self-management is the cornerstone of effective diabetes care", and encouraged healthcare professionals to work in partnership with people with diabetes to develop individual care plans. Central to the care-planning process is goal-setting, which involves working collaboratively with people with diabetes to identify their own priorities and work towards achieving these goals. However, a report by the Healthcare Commission (2007) involving 70 000 people with diabetes reported that less than half had had an opportunity to discuss their goals in managing their diabetes.

In October 2008 *Getting to Grips with the Year of Care: A Practical Guide* was launched (DH, 2008). The Year of Care programme is a partnership between the DH, Diabetes UK, The Health Foundation, and the National Diabetes Support Team, and sets out to learn how routine care can be redesigned to provide a personalised approach, including support for self-management for people with diabetes. Care-planning and goal-setting are central issues of the Year of Care approach.

The Year of Care "house" – a model for care-planning

The model used for care-planning is the "house" model (*Figure 1*), which shows that the foundation of the Year of Care approach is commissioning. The key components of care-planning form the roof and walls, and have been identified as:

- An engaged, informed person with diabetes.
- Healthcare professionals committed to partnership working.
- Organisational processes.

There are a variety of "building blocks" that support the key components, and these are shown surrounding the roof and walls, for example structured education and consultation skills. Each element of the house is interdependent, and a weakness in one area will reflect on the whole structure (i.e. the diabetes service).

Inside the house

The inside of the house represents the consultation and care-planning process, which can only take place when the rest of the house is in place. The consultation is based on equal sharing and discussion of concerns and information between the person with diabetes and the healthcare professional. This may involve factors related to any aspect of an individual's life with diabetes, for example education, glycaemic control, social or psychological issues. Following this discussion, any issues, priorities and goals can be established and a plan, including action points and when they will be reviewed, can be developed. The plan will then form the basis for the next consultation.

Many healthcare professionals working with people with long-term conditions will be used to working in a similar way to this model. However, for others this may require a change in consultation style, which may necessitate additional education, skills and training. In addition, many people with diabetes will require information and advice on how to voice their concerns and priorities to get the most out of the consultation. A skilled healthcare professional can be instrumental in facilitating the process.

In the model, an engaged, informed patient is a key component in the care-planning process. The building blocks to support this include structured education

and awareness of the options. In this issue, Jennie King and her colleagues from Australia have evaluated an educational DVD aimed at updating people with diabetes (and healthcare professionals) on current and emerging cell therapies that could perhaps be used in type 1 diabetes. The DVD proved to be accessible and acceptable, and the group felt it could be used as part of an educational package or as a stand alone resource – potentially another tool for our toolboxes.

As we are all aware, different individuals have different learning styles, and it is part of our role to direct people with diabetes towards appropriate learning resources, thereby supporting the engaged, informed individual with diabetes. ■

Department of Health (2001) *National Service Framework for Diabetes: Standards*. DH, London. Available at: http://tinyurl.com/39rf8g (accessed 23.02.08)

Department of Health, Diabetes UK, The Health Foundation, National Diabetes Support Team (2008) *Getting to Grips with the Year of Care: A Practical Guide*. Diabetes UK, London. http://tinyurl.com/d87r5x (accessed 23.02.08)

Healthcare Commission (2007) *Managing diabetes: Improving services for people with diabetes*. Healthcare Commission, London. Available at: http://tinyurl.com/d257bm (accessed 23.02.08)

National Diabetes Support Team (2008) *Partners in Care: A Guide to Implementing a Care Planning Approach to Diabetes Care*. National Diabetes Support Team, Leicester. Available at: http://tinyurl.com/c2cqkk (accessed 23.02.08)

"Different individuals have different learning styles, and it is part of our role to direct people with diabetes towards appropriate learning resources, thereby supporting the engaged, informed patient."

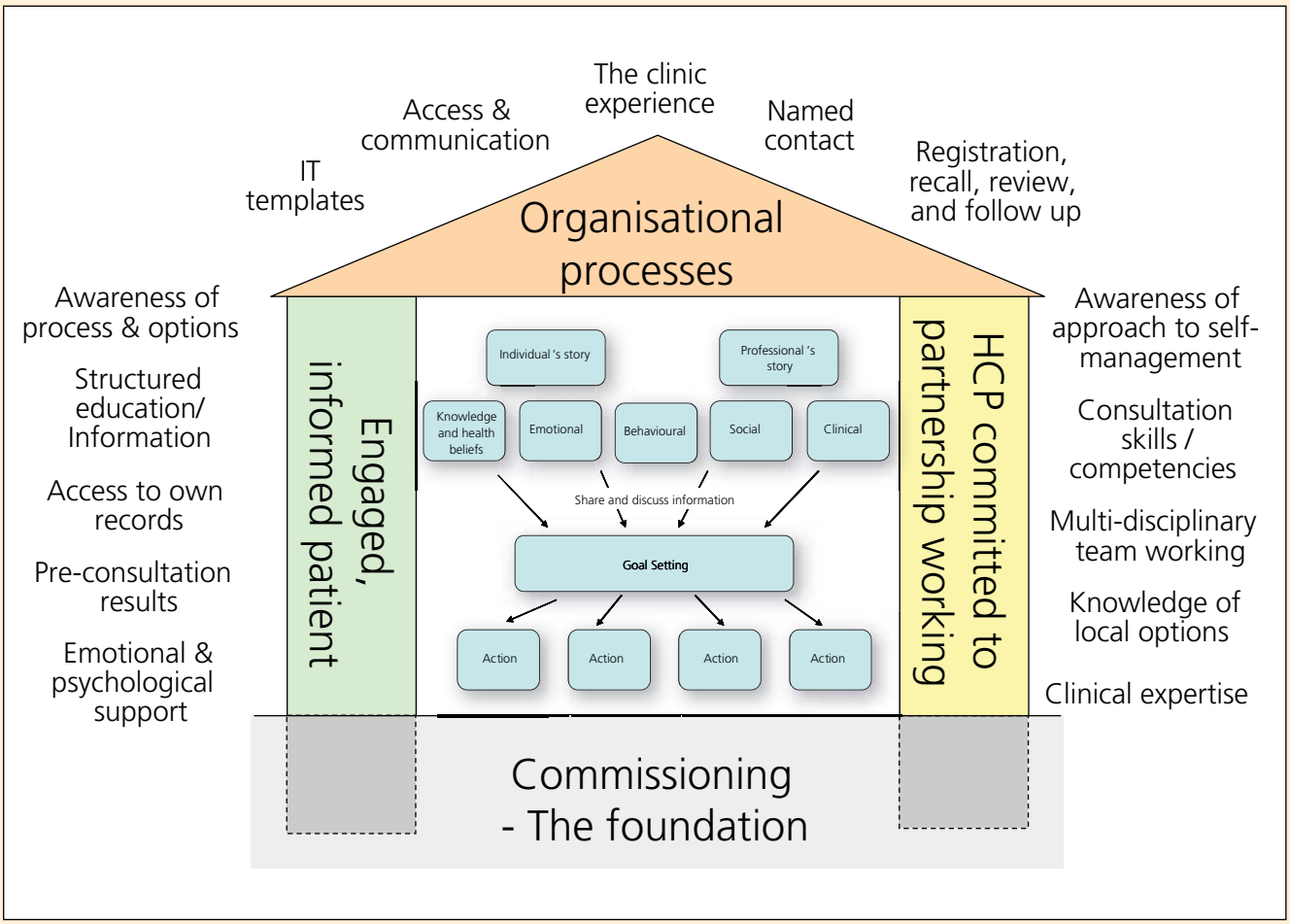

Figure 1. The "house" model for care-planning (National Diabetes Support Team, 2008). Figure reproduced with kind permission of the authors of the Year of Care Practical Guide (Department of Health et al, 2008).