Year of Care initiative: Doing it, not just talking about it

Sheree Margerison, Helen Mitchell

Article points

1. The Year of Care is a partnership initiative to help improve care for people with long-term conditions by putting individuals at the centre of their care.
2. The key to success of the care-planning approach is in the use of all members of the healthcare team.
3. Some healthcare professionals may require additional training to enhance their existing skills and formalise the care-planning process.
4. Implementation of the care-planning approach can now be achieved using a nationally available Year of Care IT template.

Key words

- Care planning
- Empowerment
- Self-management
- Year of Care

Sheree Margerison is a Primary Care Diabetes Nurse and Year of Care Lead, Bradford and Airedale Community Health Services; Helen Mitchell is Diabetes Specialist Dietitian, Bradford Teaching Hospitals NHS Foundation Trust, Bradford.

On average, people with diabetes have contact with their healthcare professionals for approximately 3 hours per year; for the remaining 8757 hours they self-manage their condition. Empowering people with diabetes to enable them to self-care can result in better physical and mental health and a reduced risk of depression. It also improves medicines adherence, less emergencies and hospital admissions, increases the individual's confidence and control over the condition, and helps with care planning. This article looks at the Year of Care initiative and how the care-planning approach can be implemented in practice for the benefit both of people with diabetes and of healthcare professionals.

While most healthcare professionals (HCPs) would like to think that they work in collaboration with people with diabetes, data from a national patient survey by the a Healthcare Commission (2007a) suggest that the majority of these individuals remain unconvinced. Of the 68 500 people questioned, over 90% indicated that they had received at least one review for their diabetes in the previous year; however, only 47% reported that they "almost always" agreed a care plan and only 39% said they "almost always" discussed their goals in caring for their diabetes (Healthcare Commission, 2007a).

The Year of Care initiative will give the necessary direction and tools to facilitate HCPs to achieve what everyone is striving towards – collaborative working with people with diabetes.

What is the Year of Care?

The Year of Care project is a partnership initiative by the Department of Health (DH), Diabetes UK, The Health Foundation and the National Diabetes Support Team (NDST; now NHS Diabetes) to help improve care for people with long-term conditions. It aims to support people in the self-management of their condition by putting the individual at the centre of their care, and addresses the ongoing care a person should expect to receive in the year ahead.

Partnership working between the HCP and their patient, making decisions and agreeing action plans are recommendations found in Standard 3 of the National Service Framework (NSF) for diabetes (DH, 2001). These principles are reiterated in other government documents, such as *Our Health, Our Care, Our Say* (DH,

Page points

1. The Year of Care project sees care planning as an active process and not just an endpoint.
2. The Year of Care for diabetes allows people to access their own health data and clinical results, consider the information and, through support from their healthcare professional (HCP), decide on a way forward for their diabetes management.
3. Individuals with diabetes and their HCPs should be equal contributors to the care-planning consultation. To facilitate this, the person with diabetes needs to be aware of their test results prior to the consultation, allowing sufficient time to consider, understand and reflect upon the implications of these biomedical markers and begin to move towards forming goals and actions.

2006a), which stated that "by 2010, we would expect everyone with a long-term condition to be offered a care plan".

It is on this basis that all HCPs are encouraged to begin to look at their own practice to see where changes can be made to implement and embrace the Year of Care philosophy and empower the people with diabetes whose care they are charged with.

The Year of Care project sees care planning as an active process and not just an endpoint. It has been described as "a process which offers people active involvement in deciding, agreeing and owning how their diabetes will be managed" and "aims to help people with diabetes achieve optimum health through a partnership approach with HCPs in order to learn about diabetes, manage it and related conditions better and to cope with it in their daily lives" (DH and Diabetes UK Care Planning Working Group, 2006).

Care planning is a culmination of sharing information, education and joint decision-making to empower people to take ownership of their condition. Ultimately, the Year of Care for diabetes allows people to access their own health data and clinical results, consider the information and, through support from their HCP, decide on a way forward for their diabetes management. Part of this process is prompting people with diabetes to think about the questions or issues that they would like to discuss prior to the consultation.

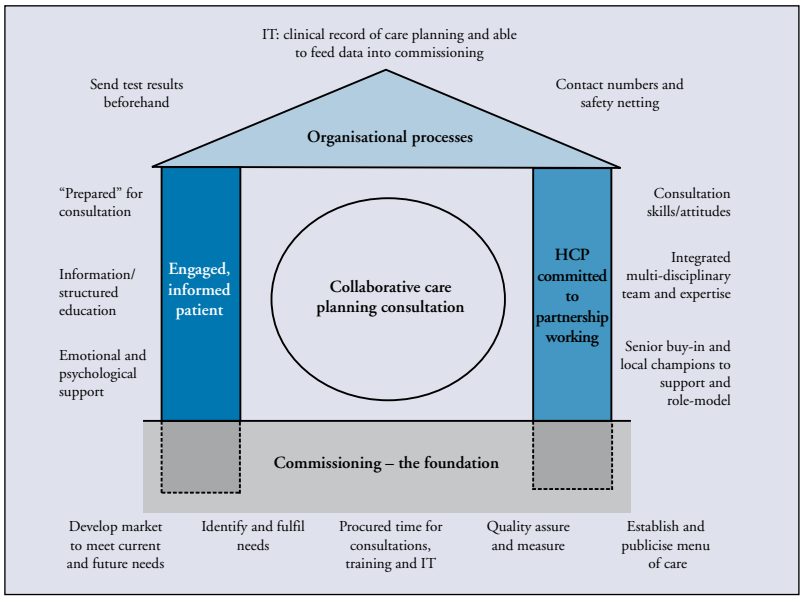

Figure 1. The care-planning house.

The NDST (2008a) uses a "house" metaphor to describe the philosophy behind the Year of Care planning approach, emphasising the importance and interdependence of each element (*Figure 1*). If one element is weak or missing, the structure is not fit for purpose and the desired endpoint is not achieved. Essential elements contributing towards care planning include:

- ***Commissioning***: Procured time for training consultations, staffing and IT services, and quality assurance and identifying local needs. It is envisaged that the data produced locally, through developing individualised care plans, will influence the commissioning of services and help to improve access and availability both locally and nationally.
- ***Engaged, informed patients***: Awareness of own test results and biomedical markers, participation in structured education, and supported both psychologically and emotionally.
- ***HCP committed to partnership working***: Working as part of an integrated multidisciplinary team, appropriate consultation skills and attitude, and support from employer/PCT.
- ***Organisational processes***: Ability to send test results to people with diabetes prior to the care-planning consultation, administration support and appropriate IT systems.

Involving people in the planning of their own care is a critical step towards improving patient-related outcome measures (DH, 2006b). Individuals with diabetes and their HCPs should be equal contributors to the care-planning consultation. To facilitate this, the person with diabetes needs to be aware of their test results prior to the consultation, allowing sufficient time to consider, understand and reflect upon the implications of these biomedical markers and begin to move towards forming goals and actions (*Figure 2*).

Education is still fundamental to care-planning consultations and the role of the HCP as an educator continues. Informing, explaining, facilitating and supporting the individual with

Page points

1. GP practices may need to reform service delivery and healthcare teams may need to be innovative and inventive in terms of how time, resources and workforce are used if the change toward the care-planning process is to be successful.
2. It is fundamental that all members of the healthcare team are involved from the outset and have an understanding of the philosophy and vision of the Year of Care and what this means to healthcare professionals and people with diabetes alike – it is more likely to be a success if all parties are on board.
3. Standard 3 of the National Service Framework for diabetes sets out an expectation that people with diabetes will be encouraged to enter into partnerships in decision-making (Department of Health, 2001).

a chronic condition are essential processes in choosing priorities and deciding action plans for change. The NDST (2008b) reported that having "clearly articulated goals is the most important link with changing behaviours", and it is widely accepted that if a person is to set their own goal or actions they are far more likely to be engaged and to achieve that goal than if they are "told" what to do.

Practicalities of implementing the Year of Care and care planning

To effectively implement the Year of Care, adoption of a whole system approach is essential. GP practices may need to reform service delivery and healthcare teams may need to be innovative and inventive in terms of how time, resources and workforce are used if the change toward the care-planning process is to be successful.

The key to success of the care-planning approach is in the use of all staff; for example, healthcare assistants may gather patient information and share elements of the care-planning approach to allow more time for the nurse or GP to focus on the joint decision-making and goal-setting process (NDST, 2008a). Initially, as with any new or unfamiliar activity, this may require more time and effort and thus may need to be taken into consideration during the planning stages.

It is fundamental that all members of the healthcare team are involved from the outset and have an understanding of the philosophy and vision of the Year of Care and what this means to HCPs and patients alike – it is more likely to be a success if all parties are on board. Evidence of the benefits of care planning would suggest that people who are more involved in the decision-making process are more likely to take ownership and achieve changes in their behaviour, promoting self-management and therefore reducing GP and outpatient appointments (DH, 2007; *Table 1*).

Standard 3 of the NSF for diabetes sets out an expectation that people with diabetes will be encouraged to enter into partnerships in decision-making (DH, 2001). This needs to be encompassed in care planning and encouraging patient involvement – an essential component of the care-planning consultation. This new concept may take time both for people with diabetes and for HCPs to adopt successfully.

Anderson and Funnell (2000) suggest that successful and empowered relationships usually begin with a discussion about the degree of involvement and who is responsible for what in the management of diabetes. However, it is important to accept that some people may not be ready or able to set specific goals or agree to an action plan, as they may need time to adjust to this new kind of consultation, especially if

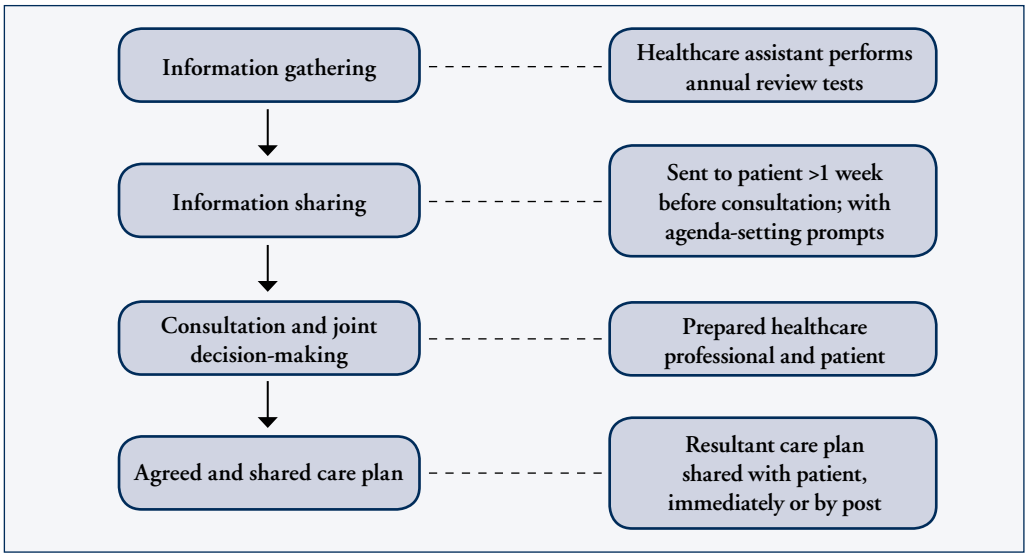

Figure 2. What does a care-planning consultation look like?

Page points

1. Encouraging a partnership approach between the individual and healthcare professional (HCP) to facilitate empowerment is fundamental in helping people make positive behavioural changes.
2. To facilitate empowerment, people require knowledge of their condition as well as the skills, attitudes and self-awareness necessary to influence changes in behaviour. These skills are often learnt through structured education programmes.
3. People with diabetes in Bradford and Airedale PCT are given the opportunity to attend X-PERT, a structured group education programme with a theoretical basis underpinned by empowerment and discovery learning, encompassing behaviour change using lifestyle experiments.

Table 1. A care-planning approach.

Benefits to people with long-term conditions such as diabetes:	● Better understanding of their condition. ● Be in control of *their* condition. ● Respect and recognition of their everyday effort to self-care. ● Be part of the decision-making process. ● Goals will be their choice, achievable and specific. ● Signposting to local services to aid management.
Benefits to healthcare professionals:	● Commissioning influenced by genuine clinical data. ● Having motivated and empowered people with diabetes. ● Better clinical outcomes. ● Reduced reliance on healthcare professionals in longer-term (due to increased self-management).

they have not been informed or involved in the process (NDST, 2008a).

Empowerment

Anderson and Funnell (2000) assert that, only when HCPs recognise and acknowledge that diabetes is a self-managed condition with the responsibility resting with the individual with the condition can the foundation for an empowerment-based relationship be laid.

Many HCPs are already proficient and skilled in using communication and consultation styles such as motivational interviewing techniques and behaviour change models. However, this may be a new concept for some and will require additional training, particularly as an empowerment approach calls for HCPs to "unlearn" their traditional controlling approach to treatment. The Year of Care goal-setting approach will assist HCPs in enhancing their existing skills and formalising the care-planning consultation.

As mentioned previously, care planning is defined as a process that offers people active involvement in deciding, agreeing and owning how their diabetes will be managed. Encouraging a partnership approach between the individual and HCP to facilitate empowerment is fundamental in helping people make positive behavioural changes.

Empowerment has been studied by a myriad of educators and has been recognised as an efficacious and practical approach to self-management of diabetes (Funnell and Anderson, 2003). It has been described by Anderson and Funnell (2000) as "a patient-centred approach based on compassion with emphasis on collaboration with patients (including goal-setting), self-management skills and psychosocial issues". To facilitate empowerment, people require knowledge of their condition as well as the skills, attitudes and self-awareness necessary to influence changes in behaviour. These skills are often learnt through structured education programmes.

People with diabetes in Bradford and Airedale PCT are given the opportunity to attend X-PERT, a structured group education programme with a theoretical basis underpinned by empowerment and discovery learning, encompassing behaviour change using lifestyle experiments. People who have attended the X-PERT programme are already familiar with the skills required to be able to self manage their diabetes, therefore this cohort

Box 1. SMART explained.

"SMART" is a well known acronym, the letters of which stand for:

S = Specific
M = Measurable
A = Action
R = Realistic
T = Timescaled

If an action plan "ticks the boxes" of the above features, it is more likely to be successfully achieved.

of people will be accustomed to the SMART action plan model (*Box 1;* Project Smart, 2009) used as part of the goal-setting process in the care planning consultation.

Resources and IT systems

Implementation of the Year of Care process and care-planning approach using an IT clinical system (developed by Year of Care; Richard Pope, Consultant Diabetologist; and NHS Yorkshire and Humber) was facilitated by the secondment of three clinical champions in Bradford and Airedale PCT for a total of 12 months – 1 day a week for the first 6 months followed by half a day per week for the next 6 months. Practice staff from pilot sites across the PCT were supported within the clinical area on a one-to-one basis, assisting them in the navigation and use of the IT template, facilitating the care-planning consultation through the goal-setting process.

The Year of Care IT template (now available nationally) supports care planning by capturing individuals' goals in their own words and collating data in such a way as to be meaningful to commissioners and to inform local and national services. The importance of effective communication with people with diabetes prior to, and during, the whole Year of Care process cannot be underestimated.

To facilitate effective communication between HCPs and people with diabetes, it is essential to ensure adequate resources are available detailing an explanation of the Year of Care process and the shift in the way that a diabetes review is performed, e.g. replacing the "traditional" annual review with a care-planning consultation.

Conclusion

Our Health, Our Care, Our Say (DH, 2006a) advocated that "by 2010 everyone with a long-term condition should be offered a care plan"; to ensure that this happens, HCPs need to fully engage with the care-planning philosophy and begin to participate in the move towards collaborative and partnership working.

The Year of Care planning process can help to facilitate the paradigm shift as recommended in the NSF for diabetes, from a systems- to a care-centred approach based on the individual's needs. When HCPs recognise and acknowledge that diabetes is a self-managed condition, where responsibility rests with the person with the condition, a foundation for a truly effective partnership approach can be adopted and integrated into routine care. ■

More information about Year of Care, implementing the care-planning approach and standard resources for use with people with diabetes can be found at: www.diabetes.nhs.uk/year_of_care.

"When healthcare professionals recognise and acknowledge that diabetes is a self-managed condition, where responsibility rests with the person with the condition, a foundation for a truly effective partnership approach can be adopted and integrated into routine care."

Anderson B, Funnell M (2000) *The Art of Empowerment: Stories and Strategies for Diabetes Educators*. 2nd edn. American Diabetes Association, Virginia, USA

Department of Health (2001) *National Service Framework for Diabetes: Standards*. DH, London. Available at: http://tinyurl.com/y9kxcnm (accessed 10.06.10)

Department of Health (2006a) *Our Health, Our Care, Our Say: A New Direction for Community Services*. DH, London. Available at: http://tinyurl.com/2v9kd5k (accessed 10.06.10)

Department of Health (2006b) *Supporting People with Long Term Conditions to Self Care: A Guide to Developing Local Strategies and Good Practice*. DH, London. Available at: http://tinyurl.com/38pctad (accessed 10.06.10)

Department of Health (2007) *Research Evidence on the effectiveness of Self Care Support: Report*. DH, London. Available at: http://tinyurl.com/2wft3yz (accessed 10.06.10)

Department of Health and Diabetes UK Care Planning Working Group (2006) *Care Planning in Diabetes*. DH, London. Available at: http://tinyurl.com/36ksulo (accessed 10.06.10)

Funnell M, Anderson RM (2003) Patient empowerment: a look back, a look ahead. *Diabetes Educ* **29**: 454–62

Healthcare Commission (2007a) *Diabetes: The Views of People with Diabetes. Key Findings from the 2006 Survey*. Healthcare Commission, London. Available at: http://tinyurl.com/2uzmqjf (accessed 14.06.10)

National Diabetes Support Team (2008a) *Partners in Care: A Guide to Implementing a Care Planning Approach to Diabetes Care*. NDST, London. Available at: http://tinyurl.com/24qgyns (accessed 07.06.10)

National Diabetes Support Team (2008b) *Getting to Grips with the Year of Care: A Practical Guide*. NDST, London. Available at: http://tinyurl.com/2wk2b89 (accessed 17.06.10)

Project Smart (2009) SMART goals. Available at: http://tinyurl.com/36plm7g (accessed 11.05.10)