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Care Planning in the Year of Care Programme:
Making it easier to do the right things

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- on behalf of the national Year of Care for diabetes programme

Background

Committed partnership working between people with long term conditions (LTC) and those caring for them has been shown to be one of the most effective ways of improving outcomes[1]. However less than 50% of diabetes consultations result in a care plan or address an individual's goals and actions[2].

Care planning is an approach to delivering partnership in practice. Recommended in the Diabetes NSF (Standard 3) it is a national target for everyone with a LTC by 2010[3]. However it is a complex intervention that challenges clinical and organisational norms. The Year of Care pilot sites have provided a test bed for exploring how to overcome these barriers and embed this approach to supporting self management (SSM) in the NHS.

What is Year of Care?

The Year of Care (YOC) programme is *firstly* about making routine consultations between clinicians and people with LTCs truly collaborative through care planning, and *then* ensures that the local services people need to support this are identified and made available through commissioning[4]. Care planning is viewed as both a means to an end (better care) and an end in itself (a new therapeutic alliance) and is the focus of this report. The Year of Care programme is a feasibility study with the aim of testing whether care planning can be introduced into routine care.

Care Planning preparation / consultation

For patients a Year of Care approach involves two visits.

The first is for information gathering (Wt., BMI, BP, blood tests, foot review etc.)

Results are then shared through a standard letter and information sheet.

The second care planning visit is for the consultation, joint decision making, goal setting and action planning.

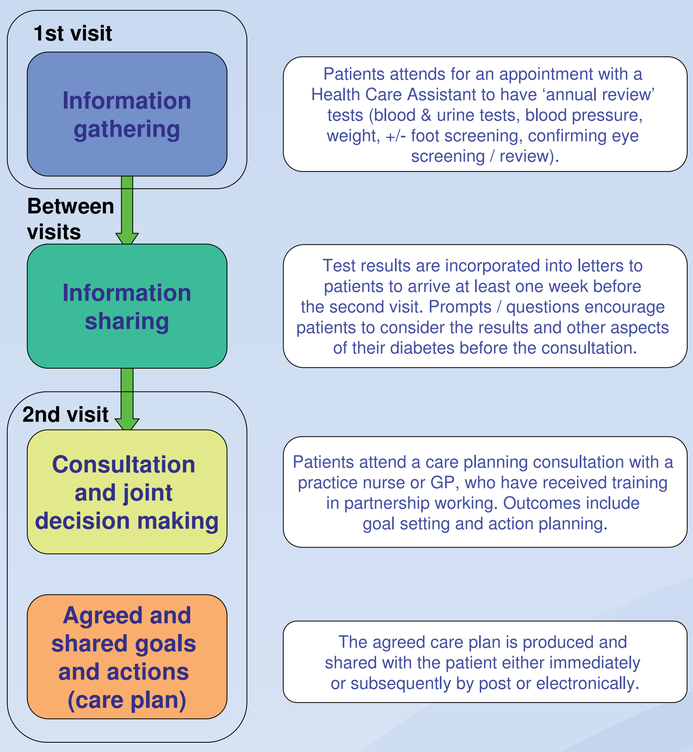


Figure 1: The process of annual visits in Year of Care

Methods

The existing diabetes annual review was transformed into a partnership based visit involving joint information review, decision making, goal setting and action planning. The components were drawn from a national consensus report, literature review of evidence[5], and successful testing in primary care.

Three pilot sites with diverse populations brought different skills and experience. Learning events were used to develop models for delivery, provide support and share experiences. Each pilot site developed a work plan and reported on progress regularly. An external evaluation ran alongside the project providing regular qualitative and quantitative assessment. Concepts were tested by visits to reference sites.

In the second year a National Training Team was commissioned to deliver quality assured training and develop a 'Train the Trainers' programme. The curriculum was refined via successive waves in pilot and non pilot sites.

The organisational framework

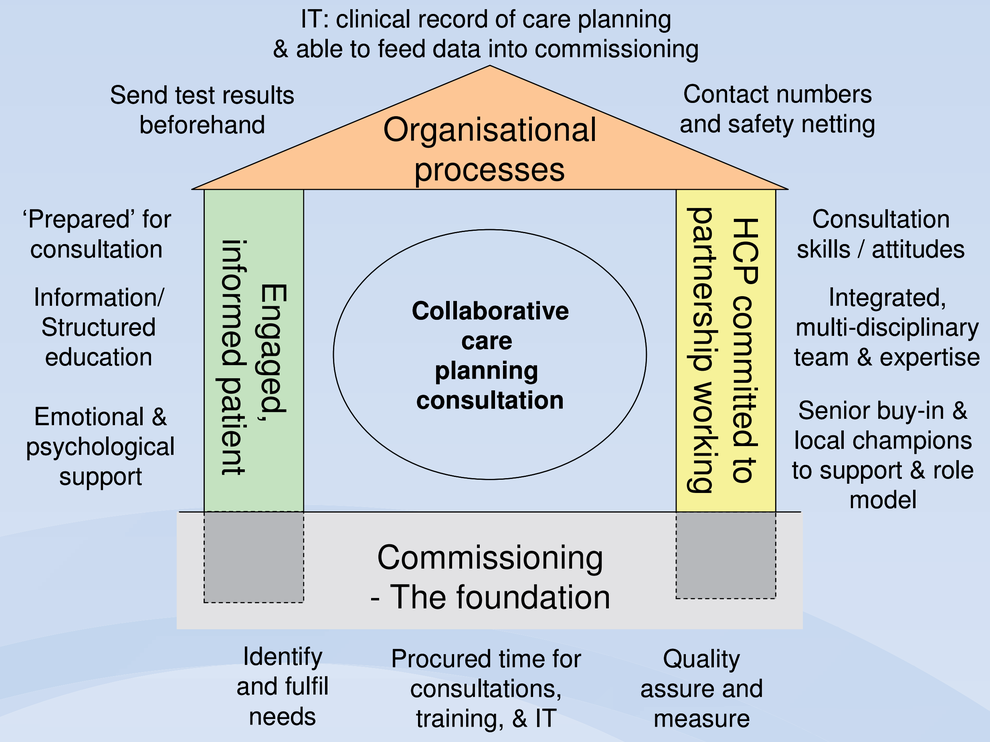


Figure 2: Organisational framework to enable care planning consultations

Recommendations and support

Critical success factors

The following organisational features have led to a high level of motivation and professional and patient satisfaction. Where these have been included, care planning has spread by word of mouth across primary care, and the enthusiasm has led to wider improvement initiatives across the health care community.

- Commissioner engagement through senior level buy in; commissioning care planning within whole system development of diabetes services, and supporting the House Model via a LES (local enhanced service agreement)
- Primary care based leadership and implementation, with GP champion(s) doing care planning themselves
- Senior level stakeholder steering group and project management : 'right from the top, right from the start, right the way through'
- Locally coordinated preparation for training
- On going local facilitation linked to training and IT systems and matched to the Model

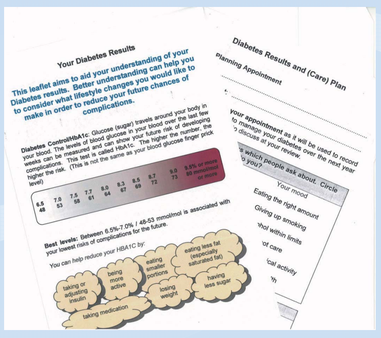
Resources

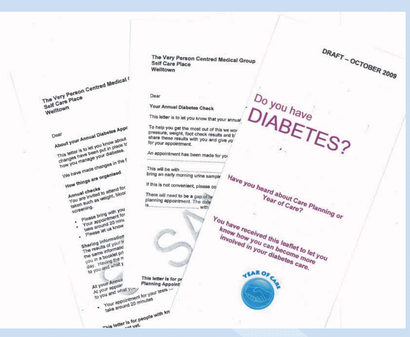
A package has been developed to support the introduction of routine care planning

- The case for change
- The evidence base[1, 5]
- The consultation model [6] (Fig.1)
- An organisational framework: The House (Fig. 2)
  - A visual checklist of issues to be considered
  - The key action of sending test results to the patient before the consultation [7].
- A tailored training programme, quality assured with 'Train the Trainers' modules:
- IT templates to promote the care planning approach and record an individual's goals and action plans to enable micro- to macro- commissioning

The steps for receiving care planning training

Step 1	Expression of interest to the Year of Care team
Step 2	Information gathering for site and preparation for initial visit
Step 3	First meeting between the Year of Care team and the site
Step 4	Sign up of site to care planning training and local site preparation
Step 5	Practices recruited for 'Preparing for Care Planning' session
Step 6	'Preparing for Care Planning' taster session delivered
Step 7	Practices recruited for care planning training
Step 8	Care planning training delivered (1 day)
Step 9	Follow up to care planning training delivered (½ day)
Step 10	Formal 'recruitment' of trainers, identified through the process
Step 11	Strategic plan for managing support with YOC team
Step 12	Trainers attend the 'Train the Trainers' course
Step 13	Trainers co-deliver care planning training
Step 14	Trainers quality assured delivering care planning training





Applicability to those with poor health literacy

Care planning has proved possible across very diverse populations. Tower Hamlets is a PCT with high levels of deprivation and multiple languages and cultures. Engaging this population, some of whom have very low levels of health literacy, has been achieved. This has needed additional resources, imagination and active user involvement. Feedback from both English and non English speakers has been positive.

Local people were involved. Patient events identified the need for test results to be presented in colour, and the need for a wider range of educational formats with more flexible access. Over 6600 people have accessed education programmes of some form to equip them to take part.

Health Trainers and Ideas Stores/Libraries have been identified as good avenues for disseminating information. In addition 7 advocates have taken part in the national training, and 3 out of 8 practices use group sessions to explain the process.

Micro- to macro- commissioning

Supported through partnership working and care planning, each individual will decide their key priorities, goals and needs, often leading to action they can take themselves. They may also choose how these will be supported from a wide range of differing service and support options (*micro*-level commissioning). The YoC programme has also addressed the challenge of linking these individual choices and service use into commissioning decisions that take place at the population level (*macro*-commissioning).

Transferability to other LTCs

The YOC programme has successfully incorporated care planning into routine care for people with diabetes. Pilot sites are transferring the principles to other LTCs and those with multiple LTCs. The 'House' is the check list for the team, emphasising the three key areas: what happens before, during and after the consultation. Skills and principles are common to all; content and context vary.

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