

Care Planning Improving the Lives of People with Long Term Conditions



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Acknowledgements:

Clinical Innovation & Research Centre (Royal College of General Practitioners)
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“Patients living with Long Term Conditions do not want to be defined by their condition and this report shows that by working in partnership with their GPs, they do not have to be.

The benefits of Care Planning are numerous and far-reaching for the patient; when patients self care and equally feel supported in doing so, they are more likely to have greater confidence and a sense of control, to have better mental health and less depression and to reduce the perceived severity of their symptoms, including experienced pain. These benefits combined can improve the quality of life for a patient with a Long Term Condition immeasurably. For GPs, Care Planning means more time to provide their care and services where they are needed more acutely.

In addition, the benefits that Care Planning provides for patients are matched by the benefits to the NHS as a whole. Giving patients the autonomy to self-manage their condition, with GP and primary care support, saves the NHS time and money and will lead to reduced hospital admissions, reduced A&E attendance and reduced medication expenditure, as well as improved patient satisfaction.

Care Planning is about making more effective the dialogue between the patient and GP that is so vital to the care we provide every day and changing the doctor-patient relationship into a doctor-patient partnership.

I would like to acknowledge the excellent work of RCGP Vice Chair Professor Nigel Mathers in producing this report along with Sue Roberts, Isabel Hodgkinson, Brian Karet and Julia Brown. I hope that GPs and their teams take the advice in this report on board and look at ways to implement Care Planning into their own practices. Doing so will not only improve the quality of life for patients with Long Term Conditions, but will also give them more control, better health and better well-being.”

Dr Clare Gerada, RCGP Chair of Council

Care Planning - Improving the Lives of People with Long Term Conditions

There are currently 15.4 million people in England with a LTC. People with LTCs account for more than 50% of all general practice appointments, 65% of all outpatient appointments and over 70% of all inpatient bed days as well as 70% of the total health and social care spend in England.

This document focuses on people who have long term physical health problems and describes how we as GPs and the other members of the primary health care team can support them to live their lives more comfortably with their condition. It is intended that all patients and clinicians who read it can feel more confident about how to use *Care Planning* in their daily practice to achieve better health outcomes, improve the efficiency of working together and reduce 'strain' on the NHS and social services

There is good evidence that our care of people with LTCs can be improved. Patients tell us that they want us to do more to support their own self-care.

However the evidence also tells us that this is not happening. While 95% of people with diabetes, for example, are seen annually, only 50% discuss a plan to manage their diabetes and less than 50% discuss their own goals for self management.

Despite considerable efforts to tackle the most important area, namely the effectiveness of consultations between patients and clinicians, the most significant problem is the reluctance of clinical staff to provide active support for patient engagement. Shared decision making for example, is less common in the UK than in many other countries.

There is also a lack of engagement by patients in consultations, which include a failure to attend follow-up appointments. Uptake of patient education, even when offered is often poor and as much as 50% of the medication prescribed for LTCs is not taken, or not taken as prescribed. All of these issues are likely to be associated with higher admission rates and greater cost to both patients and the NHS.

This document describes the evidence that working in this new way is likely not just to improve the experience for everyone, but also to lead to better outcomes and lower costs in the long run by focusing on and learning from:

- a. Support for Self Management (SSM)
- b. Improving Our Care for People with LTCs
- c. Improving Our Support for Self-Management (Self Care)
- d. Following lessons from other programmes eg the Diabetes *Year of Care Programme*
- e. Pilot site feedbacks

1: Introduction

Care Planning - Improving the Lives of People with Long Term Conditions

Encouraging Partnership; Increasing Quality of Care

1.1: Just imagine...

Just imagine one of your longstanding patients with diabetes, Mrs Smith, who has been coming to see you for years. However, instead of being the passive recipient of your 'worldly advice', she sets the agenda and with your guidance, decides what she is going to change, how she is going to do it and when she will come back and speak to you again.

Not only does this consultation work better than what you've been doing before, but it's more enjoyable and productive for you and your patients. It's about people taking ownership of their problems and making informed, supported choices about their lives.

Contrast this with something you may recognise, another overbooked diabetes clinic. It seems like you've been seeing the same people forever. They turn up every 4 or 6 months, sheepishly handing over their blood sugar readings and then politely nod as you suggest the same changes to diet and exercise you suggested before. It's almost like a game. You know that they haven't done anything different because the results don't change, but it seems they still expect you to trot out the same advice.

As clinicians most of us will have been taught communication skills at some stage during our careers and most of us try hard to use these skills in our everyday clinical practice.

We all believe that we are patient centred and that the patient is at the heart of all our consultations. We use our communication skills to ensure that our patients' voices are clearly heard when we are making a diagnosis based on the history and when we are discussing treatment options with them. Being patient centred is, of course, a worthy and desirable aim for every consultation. However, for people with LTCs we also need to provide active support, so they feel confident to manage their condition day by day - this is called supported self management (SSM)¹.

The evidence suggests that patient centredness certainly improves the health outcomes for our patients, but supporting self management takes us one step further.

Care Planning is a powerful way of creating an environment which helps clinicians to support self management by patients of their own LTC². This means supporting people to understand and confidently manage the condition itself, plus also supporting them to manage the inevitable consequences of living with a *long term condition* - consequences for the way they live their lives (their roles and responsibilities) and the way they think and feel about themselves and their relationships.

With *Care Planning* the patient starts to really understand the issues. They are given their own results (weight, HbA1c, lipids, blood pressure, foot and smoking status) one to two weeks before they see you or your nurse. But they're also given a clear explanation of what all the numbers mean and what positive effect changing them will have on their health and wellbeing. Then, taking into account their own issues, values and priorities and with your guidance and support, they come up with one or more goals which they feel they can achieve over an agreed period of time.

You know from your own experience that you can only make changes if you understand the problem and really want to do something about it.

1 Often referred to in the literature as 'self management support' (SMS).

2 Often referred to in the literature as 'chronic conditions.'

This document focuses on people who have long term physical health problems and describes how we, as GPs and the other members of the primary health care team can support them to live their lives more comfortably with their condition. Section 1 and 2 describe the principles that could apply to the majority of people with LTCs, Section 3 uses diabetes as an exemplar, Section 4 describes how we can evaluate the results of our *Care Planning* and Section 5 gives us a glimpse of the wider future. It is intended that all patients and clinicians who read it can feel more confident about how to use *Care Planning* in their daily practice to achieve better health outcomes, improve the efficiency of working together and reduce 'strain' on the NHS and social services.

1.2: The Case for Change

This document describes how to make *Care Planning* work in practice.

This section focuses on why it is worthwhile to undertake *Care Planning* and the many benefits you will see.

However, all general practice teams need to think through the case for change themselves to see the advantages for their patients and themselves of new ways of working.

This document provides a guide to doing just that.

You, as a GP, as well as the nurses and administrative staff in your practice will be provided with training on how this all works.

Here are some comments from patients who have tried it:

- *"I got my results before the appointment but this practice has done this for the last six or seven years. I do find it helpful to have them before the appointment – it helps me make an agenda. I think now it tends to be more focused on my agenda than it used to be. I find that having the results before means that I don't waste time absorbing the results in the doctor's appointment."*
- *"As a result of the information I was given I walk more and have lost weight. I have also changed my diet. The nurse has encouraged me to do these things."*

And GPs and practice nurses:

- *"Care Planning has made me look at patients differently. I focus less on the disease and take a more holistic perspective. For example, if someone has arthritis there is no point referring them for more exercise."* (Practice nurse)
- *"It has given a more structured, planned approach to diabetes. Year of Care³ enables us to present the approach to patients as something we do and I think this has enabled us to reach more patients. We now see them in a structured way and call them back."* (GP)

And the wider practice team:

- *"The new pathway is not only more patient centred but more efficient in time for both patients and health care professionals."* (Practice team member)

There is good evidence that our care of people with LTCs can be improved. Patients tell us that they want us to do more to support their own self-care.

However, the evidence also tells us that this is not happening. Although 95% of people with diabetes, for example, are seen annually, only 50% discuss a plan to manage their diabetes and less than 50% discuss their own goals for self management.⁴

3 Please see section A2, A2e, section B and Appendix G

4 Health Care Commission. 2007. Managing Diabetes: Improving services for people with diabetes. www.cqc.org.uk/db/documents/Managing_Diabetes_1_200707300356.pdf

Over 90% of people with LTCs say they are interested in being more active self managers and over 75% would feel more confident about self management if they had help from a healthcare professional or peer. Despite this, many people with LTCs have limited knowledge of, or influence over, their care⁵.

Despite considerable efforts to tackle the most important area, namely the effectiveness, quality and focus of consultations between patients and clinicians, the most significant problem is the reluctance of clinical staff to provide active support for patient engagement⁶. Unfortunately, *shared decision making* for example, is less common in the UK than in many other countries⁷.

There are also indices of a lack of engagement by patients in consultations, which include a failure to attend follow-up appointments. Uptake of patient education, even when offered is often poor and less than 15% of people with diabetes have attended⁸. As much as 50% of the medication prescribed for LTCs is not taken, or not taken as prescribed⁹. Only 50% of antihypertensive drugs are taken 6 months after the diagnosis¹⁰ and similar “drop offs” occur with statins¹¹. All of these issues are likely to be associated with higher admission rates and greater cost to patients and the NHS.

Of course, there are lots of reasons why people may not engage with the health services we provide. These include poor communication with patients; carelessly written invitation letters; insensitivity to the unique problems associated with mental illness; long waiting times or inflexibility about appointments; difficulties in contacting the practice.

Other factors which can act as a barrier to proactive care include: co-existing mental illness (e.g. depression); previous direct or indirect bad experience of services such as a mutual lack of understanding of the care and services to be provided and the likely benefits and consequences of treatment. Patients may not accept treatment and there may be unrecognised prejudice by the individual clinician or built into the system itself (age or perceived sexual orientation etc.).

The care which we offer to our patients may also be culturally inappropriate by not taking into account their lifestyle, beliefs, financial needs and their current situation. In addition, some of our patients may also have poor memory skills and/or limited communication skills or understanding of what they need to contribute to their own care.

All of these factors may also contribute to a high rate of Quality and Outcomes Framework (QOF) exception reporting in certain LTCs such as diabetes¹². The overall effective QOF exception rate for diabetes in England is currently 4.85% and there is considerable variation between the indicators of care. In general, the lowest exception rates relate to indicators that measure a process and the highest exception rates relate to indicators that measure outcomes. At practice level, 185 practices (2.25%) had overall exception rates higher than 10% demonstrating a large variation between practices (2009).

5 Department of Health. 2005. MORI Survey: Public Attitudes to Self Care Baseline Survey. www.dh.gov.uk/en/Publicationsand-statistics/Publications/PublicationsPolicyAndGuidance/DH_4111260

6 Richards N, Coulter A. Picker Institute Europe. 2007. Is the NHS becoming more patient centred? Trends from the National Surveys of NHS patients 2002 -07. www.pickereurope.org/Filestore/PIE_reports/project_reports/Trends_2007_final.pdf

7 Davis K, Schoen C, Stremikis K. The Commonwealth Fund. 2010. Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2010 Update.

8 Heath Care Commission. 2006. Diabetes: The views of people with diabetes. Key findings from the 2006 survey. www.cqc.org.uk/db/documents/Diabetes_survey_2006_summary.pdf

9 Kripalani S, Yao X, Haynes RB. Interventions to Enhance Medication Adherence in Chronic Medical Conditions A Systematic Review. *Arch Intern Med.* 2007; 167(6):540-549.

10 Vrijens, B. Vincze G, Kristanto P, Urquhart J, Burnier M. Adherence to prescribed antihypertensive drug treatments: longitudinal study of electronically compiled dosing histories. *British Medical Journal* 2008;336:1114-1117.

11 JS Benner et al. Long-term persistence in use of statin therapy in elderly patients. *JAMA* 2002 288: 455-461.

12 www.ic.nhs.uk/webfiles/QOF/2008-09/Exception/QOF_Exceptions_Bulletin_2008_09_v1.0.pdf

Finally support for self care makes economic sense: *“self care is one of the best examples of how partnerships between the public and the health service can work.... For every £100 spent on encouraging self care, around £150 worth of benefits can be delivered in return.”* Wanless 2002¹³

This document describes the evidence that working in this new way is likely not just to improve the experience for everyone, but also to lead to better outcomes and lower costs in the long run.

This section looks at why people with LTCs are ‘different’ from people with acute conditions and why our support for them needs to be different. It looks at how *Care Planning* can be a good way to support our patients with LTCs and uses the diabetes Year of Care model¹⁴ as an example of how we can make the necessary changes.

13 Wanless D. 2002. Securing Our Future Health: Taking a Long-Term View, Final Report. HM Treasury. webarchive.national-archives.gov.uk/www.hm-treasury.gov.uk/consult_wanless_final.htm

14 NHS Diabetes. 2008. Getting to Grips with Year of Care: A practical Guide. www.diabetes.org.uk/upload/Professionals/Year%20of%20Care/Getting%20to%20Grips%20with%20the%20Year%20of%20Care%20A%20Practical%20Guide.pdf

2: Long Term Conditions & Primary Care

2.1: Long Term Conditions

There are currently 15.4 million people in England with an LTC. Due to an ageing population, it is estimated that by 2025 there will be 42% more people in England aged 65 or over. This will mean that the number of people with at least one LTC will rise by 3 million to 18 million. Currently, people with LTCs account for more than 50% of all general practice appointments, 65% of all outpatient appointments and over 70% of all inpatient bed days as well as 70% of the total health and social care spend in England¹⁵.

2.2: Definitions

Some definitions are useful at this point. This document defines a *long term condition* as one that cannot currently be cured but can be managed with the use of medication and/or other therapies. This is in contrast to acute conditions which typically have a finite duration such as a respiratory infection, an inguinal hernia or a mild episode of depression.

Caring for people with LTCs is different from caring for people with acute conditions. The previous focus of the medical care provided in the 19th and 20th centuries was based on an assumption that the role of the professional was to identify the patient's problems and if possible provide some intervention that would put it right. This might involve something that only the professional could do, but increasingly the person also had to be involved in their own care, taking medicine or carrying out specific rehabilitation; the overall aim was to get the person back to their previous state of health and wellbeing.

However, a person with an LTC lives with the condition day by day for their whole life and it is the things they do or don't do that will make the difference to their quality of life and the long term outcomes they will experience.

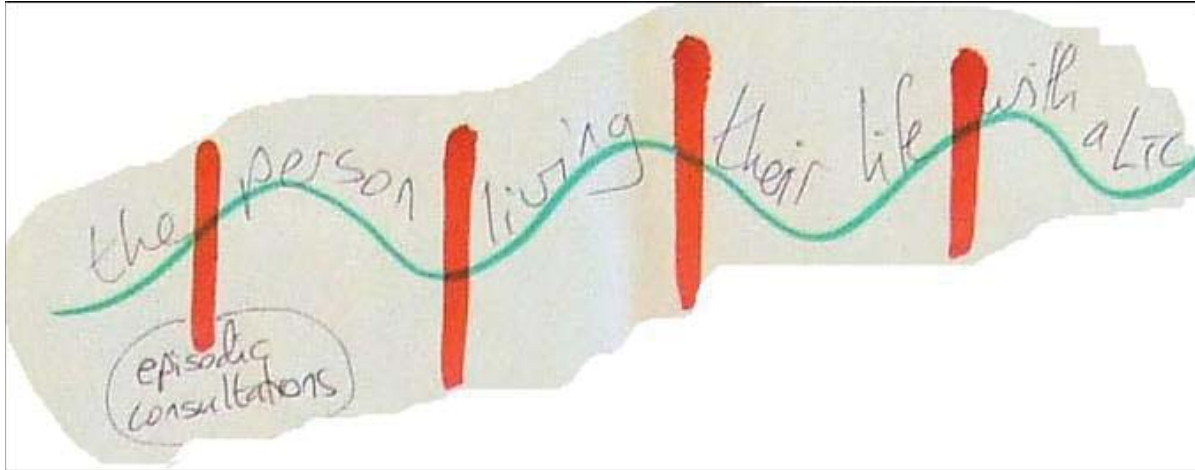
Support for Self Management (SSM) recognises that “people with LTCs are in charge of their own lives and self management of their condition and are the primary decision makers about the actions they take in relation to the management of their condition.” The desired outcome, e.g. someone who is an effective self manager, is a person “with the knowledge, skills and confidence to manage their own health and healthcare.” Various terms have been used for this; ‘engagement’, ‘empowerment’ or the word used in the Wagner model (please see next section) ‘activation.’ Whichever term is used, the focus moves from the clinician doing things, to the person, to one which enable clinicians to support people's confidence and competence to manage the challenges of living with their condition.

Care Planning is an example of putting self management support into practice, in a systematic way, as part of routine care for people with LTCs.

15 Department of Health. 2010. Improving the health and well-being of people with long term conditions. World class services for people with long term conditions: information tool for commissioners. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111122

Figure 1: 'Life' with an LTC – from the Individual's Point of View

This picture comes from a 'world café' workshop and was drawn by someone with a LTC on the tablecloth to demonstrate what life felt like for them on a day-to-day basis.



The wavy line represents the ups and downs of daily life, when the person is managing their condition and their life away from contact with health and social services. The vertical line represents this contact and demonstrates not only are these contacts short (3 hours versus 8757 hours of self care) but they are often arranged at regular intervals, unrelated to real life events or the needs of the person involved.

Care Planning focuses on the time the individual spends with the health care professional and its aim is to make that interaction more productive and relevant to their life with their LTCs. From time to time they may need traditional specific interventions, but they will always need help and support to be an effective self-manager. They may need information about their condition, personalised expertise, coaching, problem solving, or a chance to think things through and process the emotional burden of living with an LTC.

2.3: Improving Our Care for People with LTCs

There is lots of evidence of what works best in the care of people with LTCs. The Wagner Chronic Care Model¹⁶, for example, (see appendix B) shows that the best outcomes are achieved when three components of care are integrated.

These components are:

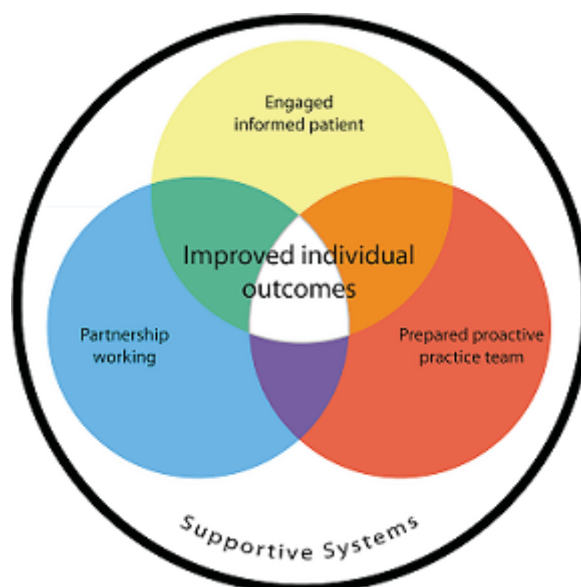
- a prepared proactive practice team
- informed engagement by people in their own care
- partnership working between health professionals and people with LTCs

These three components all need to be present together to get the best outcomes as illustrated in the diagram below - the 'White Light' analogy (adapted from the Health Foundation's *Co-creating Health Programme*)¹⁷. This uses the analogy of mixing light of different primary colours - one alone or even two is not enough to get the full effect and it is only when all three are mixed together that the 'white light' of better outcomes care is produced. The whole process also needs supportive systems (e.g. infrastructure) to work.

16 Wagner EH, Austin BT, Von Korff M. Organizing care for patients with chronic illness. *Milbank Q.* 1996; 74: 511-44.

17 www.health.org.uk/areas-of-work/improvement-programmes/co-creating-health/

Figure 2: The 'White Light' Analogy



Care Planning is a practical way in which these three components can be brought together in real life in general practice and primary care to improve the care of people with *long term conditions*.

2.4: Improving our Support for Self Management (Self Care)

*"Self care works, produces excellent outcomes, improves clinicians' job satisfaction, reduces workload and saves money. Most importantly patients want it."*¹⁸

Of all the components in the Chronic Care Model, self management support is the one with the most evidence of being effective, much of it gained from primary care settings in the UK and the USA. The Supporting Self Management intervention [SSM] for which evidence is strongest is a collaborative interaction between the clinician and the patient¹⁹.

There are a number of approaches to SSM which can help to understand how individuals change their behaviour.

Living with an LTC is of itself a journey of change. Adapting to the challenges of living with the condition involves acknowledging the condition and the impact it has on one's life in the present and that it could have in the future. Planning change and being in control of the process of change is a fundamentally important adaptation strategy. The clinician who can contribute to this by supporting people to evaluate their current situation, contemplate change, take action and continue to adapt and change is the most effective in supporting self management²⁰.

Motivational interviewing²¹ tells us that people who acknowledge both the costs and benefits as they contemplate change are more likely to achieve better outcomes than those who focus primarily on the benefit. As people set goals and action plans it is important that the change in the way they behave is realistic rather than overly optimistic. Nothing succeeds like success! Follow up to keep 'on track' is important too.

18 Tomkins S, Collins A. 2006. Promoting Optimal Self Care. Consultation techniques that improve quality of life for patients and clinicians. Dorset and Somerset Strategic Health Authority. www.ehealthnurses.org.uk/pdf/poselfcare.pdf

19 Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness: the chronic care model, Part 2. JAMA. 2002 Oct 16; 288(15):1909-14.

20 Prochaska JO, DiClemente CC. 2005. The transtheoretical approach. In: Norcross JC, Goldfried MR, editors. Handbook of psychotherapy integration. (2nd ed: p.147-171). New York: Oxford University Press.

21 Rollnick S, Miller WM, Butler CC. 2008. Motivational Interviewing in Healthcare. Helping patients change behavior. New York: Guilford Press.

Recently such ideas have been brought together in a theory of change based on patient *activation*²², a measurable outcome which has been associated with a wide variety of beneficial improvements²³. Compared to people with low levels of *activation*, people with high levels of *activation* have a higher quality of life, improved clinical outcomes and make informed and personally relevant decisions about accessing health or social care resources. As a result, people with high levels of *activation* (compared to people with lower levels of *activation*) for example choose to undergo less surgical interventions and are less likely to be admitted to hospital as an unscheduled admission²⁴.

Providing individuals with personally relevant information and prompts about how to reflect on this, prior to the consultation, is one of the most effective ways to increase engagement and leads to measurable improvement. For instance in people with diabetes the use of pre-consultation prompts is the best predictor of improved HbA1c levels²⁵.

There are many reports of interventions which support self management, ranging from the one to one consultations we discuss in this document, to group work with professional or lay leadership. Tables 1 and 2 below give the range of benefits that have been reported²⁶.

Table 1: Benefits of Self Management to the Individual

<p>When people self care and are supported to do this, they are more likely to:</p> <ul style="list-style-type: none"> ✓ experience better health and well-being ✓ reduce the perceived severity of their symptoms, including pain ✓ improve medicines compliance ✓ prevent the need for emergency health and social services ✓ prevent unnecessary hospital admissions ✓ have better planned and co-ordinated care ✓ remain in their own home ✓ have greater confidence and a sense of control ✓ have better mental health and less depression
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Table 2: Other Reported Benefits

<ul style="list-style-type: none"> ✓ Less duplication of effort ✓ Improved patient satisfaction ✓ Reduced visits to GPs ✓ Reduced hospital admissions ✓ Decreased number of days in hospital ✓ Reduced outpatient visits ✓ Reduced A&E visits ✓ Reduced medication expenditure ✓ Improved medicine utilisation

22 Hibbard JH, Stockard J, Mahoney ER, Tusler M. Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in patients and consumers. *Health Services Research* 2004; 39:1005-1026.

23 www.insigniahealth.com

24 Hibbard JH, Peters E, Dixon A, Tusler M. Consumer competencies and the use of comparative quality information: it isn't just about literacy. *Med Care Res Rev.* 2007 Aug; 64(4):379-94.

25 Greenfield S, Kaplan SH, Ware JE Jr, Yano EM, Frank HJ. Patients' participation in medical care: effects on blood sugar control and quality of life in diabetes *J Gen Intern Med.* 1988 Sep-Oct; 3(5):448-57.

26 Department of Health. 2006. Supporting people with long term conditions to Self Care: A guide to developing local strategies and good practice. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4130725

Testing the Models

The concepts and models for SSM have recently been brought together and tested in two UK 'laboratories' (communities of practice); the Diabetes Year of Care (YOC) programme²⁷ and the Health Foundation *Co-creating Health Programme* (CCH). The CCH programme²⁸ demonstrates how to introduce the principles of support for self care into clinical consultations across a range of LTCs.

The YOC programme focuses on the practicalities of the delivery of *Care Planning* in primary care settings using diabetes as an example of what can be achieved.

There is now a wealth of practical learning to help us put *Care Planning* into practice.

2.5: The Diabetes UK Year of Care Approach to *Care Planning*^{14,29,30,31,32}

The 'Year of Care' programme has shown how to implement the key features of *Care Planning*. People are involved in the care of their diabetes in quite a new way and enjoying it. People are setting personal goals and action plans relevant to their everyday life; take up of education programmes has improved and in very disadvantaged populations, poor attendance rates, biomedical outcomes and service use are also improving. Being systematic about the whole process of *Care Planning* enables us to focus on the particular needs of our own local populations and makes the process accessible and popular across very different populations.

Care Planning can also lead to better informed needs assessments. Collecting and aggregating data from care plans, including the services which people are requesting, is beneficial and affordable to determine their unmet needs. This can help commissioners deliver the services that people actually want and ensure a positive impact on their overall health and well-being.

In practice this means working in an environment that is person centred, encouraging, supportive and respectful and focuses as much on psychological and emotional support as on traditional biomedical aspects of care.

In such an environment, patients can learn how to develop more effective strategies for coping with exacerbations and make informed and personally relevant decisions about the care they access. The goal is that patients with LTCs become 'experts in themselves' by learning how to live their lives with one or more conditions.

General practices working to introduce *Care Planning* in *The Year of Care Programme* have quickly discovered that to embed this new approach to support decision making in partnership and self management by patients was only possible if the environment such as that outlined above was created. This has needed everyone in the multidisciplinary team to be involved, reorganizing their roles and ensuring that administrative support was good enough to make it all run smoothly.

The following lessons from *The Year of Care Programme* can be used as an illustration of how *Care Planning* can be introduced to a practice to improve the care of our patients.

The Two Visit Annual '*Care Planning*' Review

The annual diabetes review has been replaced by a two-visit approach. First of all; a data collection consultation (delivered most cost effectively by a health care assistant; HCA), followed by the delivery of their test results in a meaningful way to the patient. This has allowed time for the patient to reflect on their condition and to generate

27 www.diabetes.nhs.uk/year_of_care/

28 www.health.org.uk/areas-of-work/improvement-programmes/co-creating-health/

29 Joint Department of Health and Diabetes UK Care Planning Working Group. 2006. *Care Planning in Diabetes*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063081

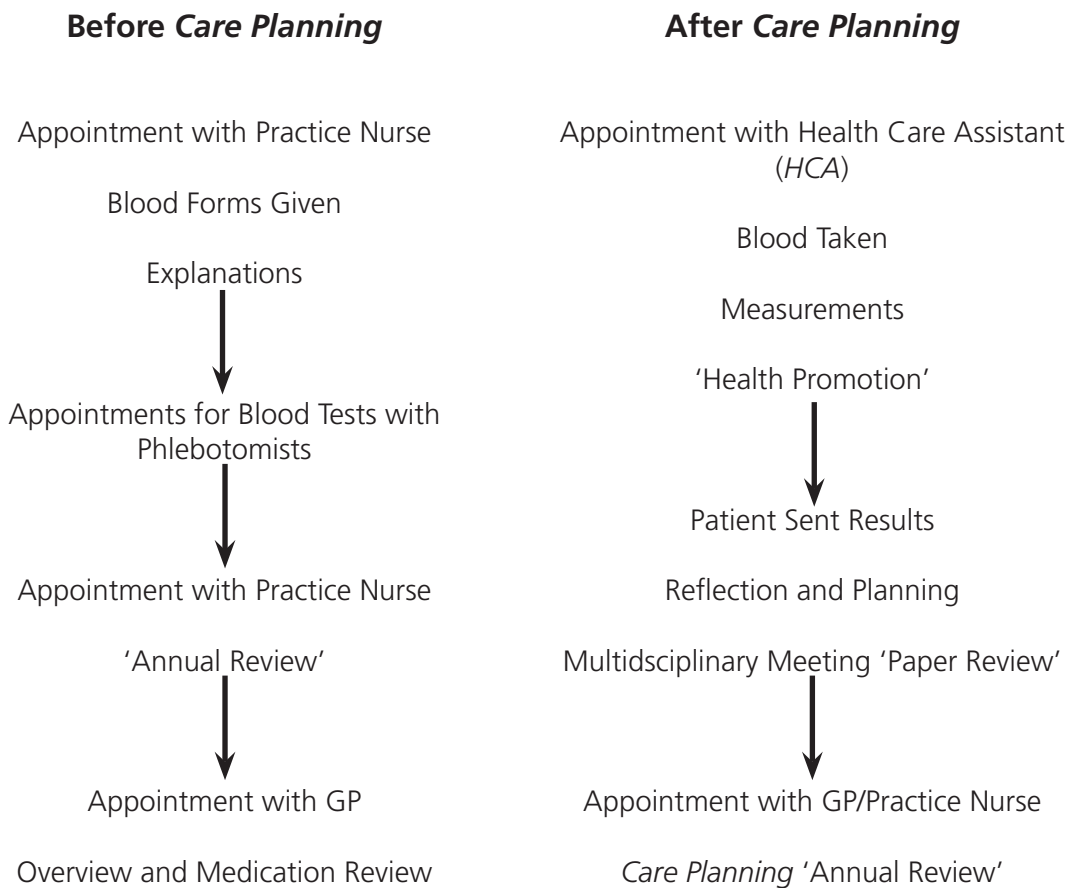
30 Graffy J, Eaton S, Sturt J, Chadwick P. Personalised Care Planning for diabetes: policy lessons from systematic reviews of consultations and self management interventions. *Primary Health Care Research and Development* 2009 10:3 210-222.

ideas about what would be important for them to cover in the second visit (goal setting and action planning).

The second visit then takes place a couple of weeks later and takes the form of a collaborative '*Care Planning*' consultation to support self management as well as to screen for complications and initiate medical treatment. The personal goals and action plans agreed in the *Care Planning* consultation are then worked on until the next *Care Planning* visit.

Figure 3: Worked Example of the New Approach to *Care Planning* and Some Potential Workforce Options and Costs

Example: Practice A



Different practices currently have different working arrangements and will choose different approaches as this example demonstrates (Appendix C).

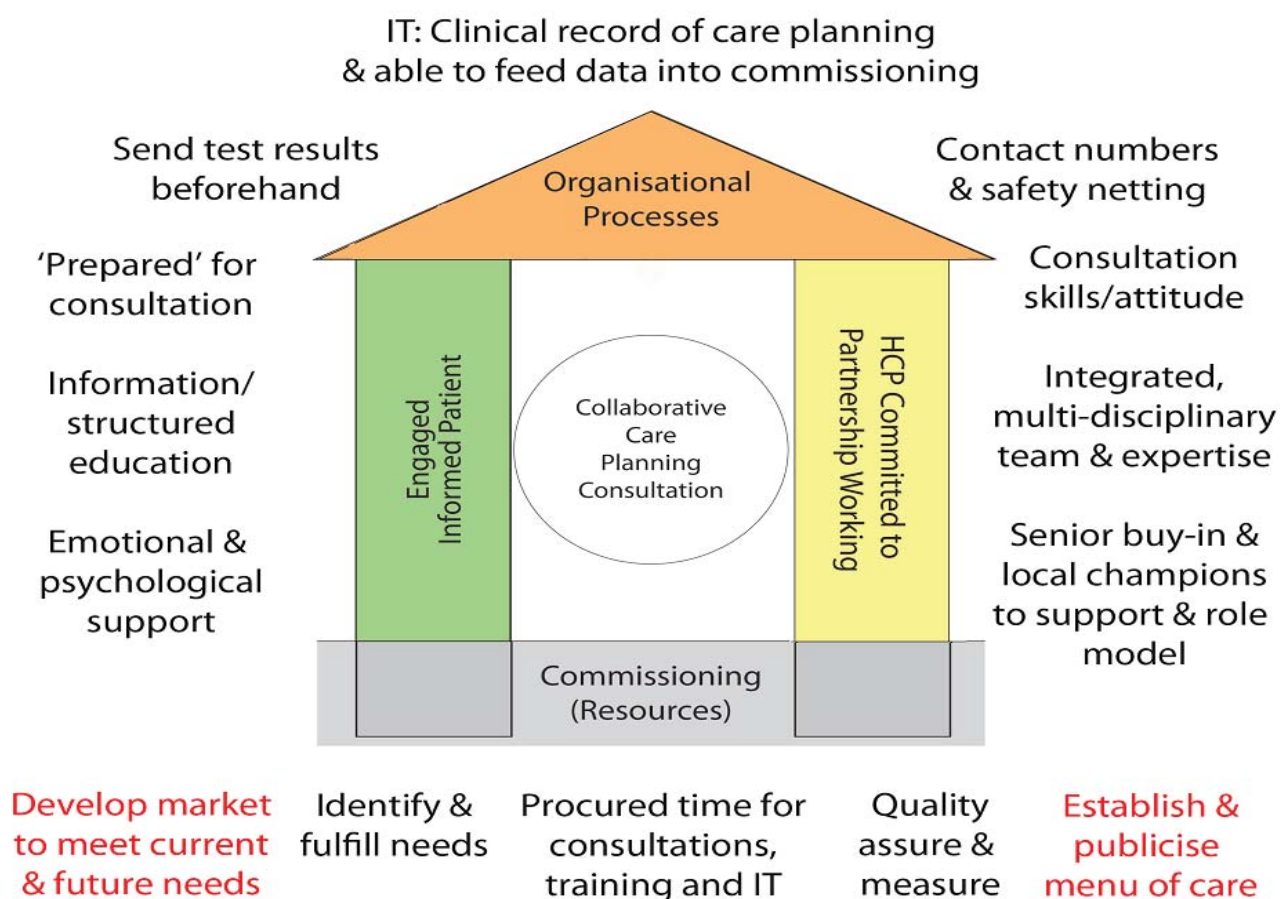
Feedback on the Two Step Approach from People with Diabetes and their Healthcare Professionals:

- "I could focus on the important things for me and get help" (Patient)
- "Time to read [results] and think about what to raise... you know what was coming" (Patient)
- "I enjoy doing the clinic a lot more now... working with them rather than at them"(Health Care Professional)
- "It's absolutely 100% better for me and for the patients" (Health Care Professional)

The Year of Care House

This kind of quality care doesn't happen in a vacuum. *The Year of Care Programme* has also worked to identify the infrastructure and the interdependencies needed within a general practice team to make this vision of care a reality and this learning can be summarised in the 'Year of Care House'³¹ (Figure 4).

Figure 4: The Year of Care House (with Permission from *The Year of Care Programme*)



This analogy of a 'house' is useful because it shows that unless your practice team has the walls, the roof and the floor in place, it is very difficult to deliver high quality *Care Planning*.

The next section describes how we can make *Care Planning* happen in UK general practice and primary care and illustrates the process with real examples of how *Care Planning* has been introduced into practice.

31 National Diabetes Support Team. 2008. Partners in Care: A guide to implementing a Care Planning approach to diabetes care. www.diabetes.nhs.uk/our_work_areas/supporting_self_care/

3: Making it Happen in General Practice & Primary Care

3.1: Pilot Site Experience

The following section outlines some of the experiences of the over 50 general practices who tested the Year of Care model in three diverse pilot PCTs. Teams reported that their experience was that *Care Planning* is a practical and helpful approach to improving the care of patients with diabetes. It also gave them a good framework to help individuals and teams to reflect on their attitudes, their current ways of working and to generate ideas for change.

Example 1: “We Already Provide a Good Service”

A GP in a small practice with very good diabetes outcomes agreed to switch to a *Care Planning* model because of the new provision of a well funded enhanced service.

He was extremely sceptical about it however; he was concerned that giving patients the freedom to make choices about goals and actions would lead to a deterioration in biomedical outcomes. Partly because of this concern he chose to do the *Care Planning* himself rather than delegate it to his practice nurse.

After further *Care Planning* training and six months of putting *Care Planning* into practice he was an enthusiast: the *Care Planning* encounter enabled him to explain to the patient their results, their risks and possible interventions, equally they were more able to share their beliefs and concerns. (London GP)

3.2: Taking Stock, Team engagement and Leadership

The Year of Care House (Figure 4) illustrates what is needed to create an effective system of *Care Planning* for *long term conditions* within a practice.

All of the members of the practice team need to understand their roles and tasks, the way in which they work together, have the appropriate attitudes and skills to support patients in self care and to work in an environment which motivates good performance (e.g. benchmarked performance data, incentive payments etc.). Any change on this scale often involves a ‘cultural change’ as well as time and resources during development.

When introducing *Care Planning* to your practice the teams have reported that it is important to start with three questions:

- What are the motivating forces for your team to make changes?
- What are the attitudes within your team about supporting patients to self care?
- How do you review your team working, organisational structures and current skill mix?

Many practices have found that the house framework has helped them to ‘stand back’ and look at their current practice to identify the possible areas for development and change. More detail of how to do this is shown below.

Example 2: Assessing our Current Service

A three-partner practice with 5,500 patients was achieving good QOF outcomes for diabetes with their service delivered almost entirely by a very experienced nurse practitioner with an interest in diabetes. However they were forced to review their service when she announced that she was pregnant.

They had no other members of staff with the appropriate skills. All call and recall was done on a paper register by the nurse practitioner who also had her own paper based system of all of the knowledge and information within the practice about services and patient materials. (London practice)

When introducing *Care Planning* to your practice, it is important to have a facilitated team meeting and ask yourselves the sorts of questions which are outlined below.

- What improvements do you hope and might you expect to see?
- How will you tell if the changes you have made are working?

As part of the discussion, the team need to know why you are making the change, what exactly you hope to achieve by the change and how you will know you have achieved it? Everyone needs to agree to buy in to the work and you will need to nominate a Clinical Leader/Champion for the process who will be responsible for engaging the team members in the process, energising them and overseeing the introduction of *Care Planning*. They should also be responsible for reporting the changes and the outcomes to the wider team.

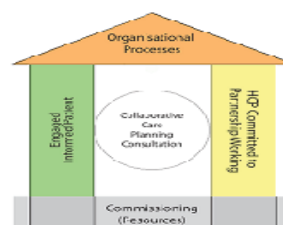
Example 3: Wider Benefits for the Practice

Before Year of Care we hadn't thought much about what needs to go on behind the scenes to make a clinical encounter effective and the practice nurse was struggling to do it all herself. The Year of Care house helped to clarify all the steps needed and gave us a framework to stand back and look at the service and to clarify roles and responsibilities so we now have far more robust organisational structures, better skill mix and better team work and communication. (London GP)

3.3: 'Walking Round' the Year of Care House

3.3.1: Team Members

HCP Committed to Partnership Working



One of the most difficult things for teams to consider is the question of attitudinal change and the need to acquire new skills. For example, ask yourself the following questions: How ready are members of the team to work in partnership with patients and how might supporting self management feel threatening to individual members of the team?

There are some tools referenced in section C (examples of which can be found in the appendices) which you can use to explore your own attitudes and skills as well as those of the other team members.

Example 4: Attitudinal Change

In one area they decided to implement results letters for patients without undertaking the team engagement and systems review processes described here.

When one of the nurses there was asked about using the results letter the reply was – ‘oh no, we’re not doing that it opens up too much of a can of worms’. (From practice external to YOC)

Many staff within general practice teams already have a lot of skills and resources to support patients to self manage. A good example is the current smoking cessation training which helps team members acquire brief motivational interviewing techniques. Specific *Care Planning*³² training which has been developed at a national level has also been found to be very useful.

If members of the team decide to introduce the idea of a two-visit annual review, then the initial data collection consultation can be delivered by a health care assistant (HCA). However, HCAs may need additional training to deliver this consultation. In diabetes, for example, it has been found that many HCAs had already been trained to deliver NHS Health Checks so the only additional training that was needed was for diabetes foot checks.

Example 5: Roles and Skills

This practice decided to reorganise all its work for people with Type 2 diabetes systematically when they introduced *Care Planning*. They also wanted to introduce a much more proactive approach to case finding. To support this they discussed and wrote down everyone’s role in the pathway (receptionist, chronic disease administrator, health care assistant, practice nurse and GP). They used the National Workforce Competencies from Skills for Health³³ to identify which competencies were relevant to the new role for the HCA and designed in-house training to meet these.

Care Planning consultations, however, can become ‘stuck’ or ‘derailed.’ Some of the common pitfalls are when a patient is not yet ready to work in partnership or when a clinician is finding it difficult to discuss psychosocial issues within the consultation. A forum for case based discussions or a learning set for the team can be very useful in such circumstances which may come to light during the evaluation.

Roles and Responsibilities

Another useful question to ask members of the team when instituting *Care Planning* is:

- are all members of staff clear about their roles and responsibilities?

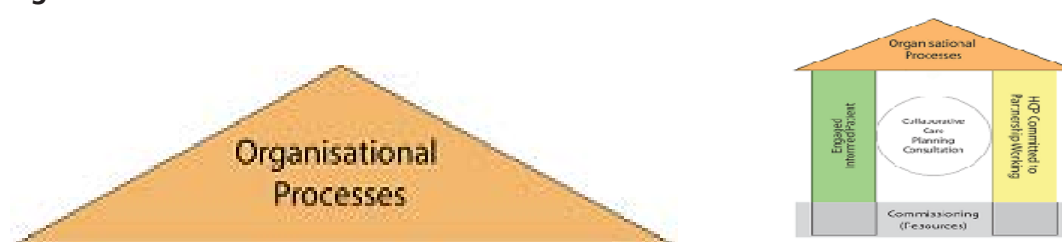
With more complex service structures communication across the team becomes especially vital. Comments from members of the team such as “*I’ve done my bit - over to you*” or “*I’m really struggling with Mr X, please could we discuss him?*” suggest the need for more team discussion at which it can be useful to ask the following additional questions:

- how do members of your team communicate with one another?
- is there a plan to cover the leave or sickness of individual staff members?

32 NHS Diabetes. 2008. Care Planning training. www.diabetes.nhs.uk/year_of_care/care_planning_training/

National *Care Planning* training courses have helped groups of practices to make the changes that will help *Care Planning* to 'get going'³². It is essential that for an effective 'start up', training needs to be provided not just for the 'care planners', but also for the whole practice team. *Care Planning* is new and the whole team needs not only to understand, but also to share the vision if *Care Planning* is to be a success within the practice. Training includes the opportunity to think about attitudes to patient autonomy and tips for getting the practice organisation ready, as well as an introduction to the clinical skills for supporting self management. However, as with all skills, these will need reinforcement, either by further training, or in local support groups where challenges and successes can be exchanged and skills practiced in a supportive environment. Additional courses are in the process of being developed and it is intended that further training will be made available as part of continuing professional development by the RCGP.

3.3.2: Organisation



Here are some more ideas about how to organise *Care Planning* in your practice. You can use them as part of the discussion by team members about how to implement the necessary changes in the organisation of your care. In *Care Planning* different members of the team are responsible for different components of patient care and for example, you need a system in place that ensures the person with an LTC sees the right person in the right place at the right time and all the appropriate tests and processes are completed including communication with other members of the team.

Another good question to ask is how do you make sure that all the receptionists know which sort of appointment to make when a person with diabetes, for example, requests a consultation.

Many teams are already working on ways of making such organisational processes as integrated into normal working as possible; for example pulling together the recalls for all routine blood tests needed for diabetes, hypothyroidism, lithium or warfarin monitoring.

There are many ways of getting in touch with patients ranging from text messages to letters. Many teams in the pilot studies of *Care Planning* reported that the patient acceptability, the effectiveness (e.g. nonattendance rates) and the cost of telephone or text based recalls was better than sending letters out. However, if teams were considering using these different methods, they needed to think about how patients could access their blood test results for example.

Example 6: Telephone Invitations

A London PCT has to deal with a very mobile population, with low levels of literacy in English, high levels of people with diabetes for whom English is not their first language and a poor postal service. Most practices found telephone invites to be far more effective in terms of actually getting patients to attend - this enabled them to negotiate times suitable for the patient to attend, to understand if patients were abroad and to explain to patients what their appointment was for and how long it would last. (London PCT)

The use of information technology (IT) is another area with which practice teams often need to 'get to grips'. It is particularly important that your IT call and recall system works well if *Care Planning* is to succeed.

For example, when generating letters for patients or developing more sophisticated call and recall systems you are going to need:

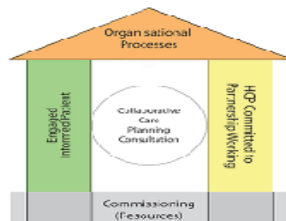
- support for call and recall
- data entry - are you capturing everything you can to measure that you need to?
- outputs for patients e.g. results letters and *Care Planning* output letters, electronic patient access to records, patient held smart cards
- internal prompts/fostering team interactions

The Year of Care Programme found that for most of us, current GP software doesn't fully support this full range of functions; the latter two functions in particular. Nationally, work is underway with TPP/System One and with EMIS/VISION (still in the pipeline) to improve the IT support for *Care Planning*.

Example 7: Calling and Recalling Patients

Developing specific codes for each of the elements of the annual review process:
The local PRIMIS group embedded follow up codes in the data entry template to enable administration teams to identify if a patient needed to be called for an annual or interim review. (London PCT)

3.3.3: Engaged Informed Patients



For many of us, *Care Planning* places far greater emphasis on involving patients than we are used to. However, if we are serious about creating the sort of environment which encourages and supports *Care Planning*, we need to be sure that we have good ways of checking with patients how they feel about the care we're delivering. When we make changes we must work out ways to inform people what these are and what they can expect. This is over and above the information we provide as part of the two step *Care Planning* approach itself.

The results letter itself is a powerful tool for patient engagement but can also be used to prompt the patient about issues they may wish to raise in their *Care Planning* consultation (Appendix D).

Example 8: Reducing Non Attendance

A practice nurse described 'I have a number of young men with diabetes who work away from home. They attend their screening but never come back to discuss any concerns with their diabetes. Since we have been *Care Planning* I now send the results to them with an explanation of what they all mean. They now make an appointment when they come home and seem more engaged.' (Northeast pilot practice)

The language, style and presentation of information can have an important role in informing patients about the new way of working as well as helping them to reflect on their own health. The practice team might find it useful to review the written material they give out to see if it promotes active patient involvement and the tools to support this are available³³.

While greater involvement in their care is appreciated immediately by many, this new relationship is something that may need to grow and those practices which have been working in this way for some time have noticed that 'engagement' may come with time as the new ways of working together are developed.

Example 9: Learning Over Time

As part of the review of the new approach to *Care Planning* a GP described a patient who on the first occasion she received the letter containing the test results, she brought it unopened to the appointment as she thought it was for the GP. The second time she opened it and understood bits of it. The third time she had worked out what to do and had generated some ideas to discuss. (Northeast pilot practice)

Another useful question to ask is are we and have we involved patients in every step of the way when we make *Care Planning* changes? This can be done through asking patient representatives to be involved or taking ideas/written materials to a patient group for testing.

Example 10: Feedback from Service Users

Focus groups in a London PCT emphasised the importance of colour and visual displays of results for those with poor literacy in English. (London PCT)

A continuous survey of patients about their views of a specific service is still in its infancy but as the NHS Outcomes agenda develops, this is likely to become far more common. A key issue about asking for views in this way is to then provide feedback to patients about what has been heard and what action has been taken in response to their views.

Recent innovations such as a friend or relative accompanying a patient during their visits can generate new perspectives and give further ideas for improvement. There are other recognised ways of reviewing the services provided by the practice (e.g. Lean³⁴).

Example 11: Getting an Outsiders View

A Year of Care project manager arranged a 'walk through' with a patient in each pilot practice. Patients were met on arrival at the surgery and accompanied during their appointment. Patients reported that they really liked receiving their results through the post and reported that they felt more informed and better prepared for their appointment. Initially health care professionals struggled with a collaborative approach in the consultations but following Year of Care training, practice staff felt more enabled to support the patient through the goal setting and action planning phases of the consultation. Variation in the clinical recording of agreed goals and action plans was also evident and processes were put in place to ensure consistent, auditable recording took place (Yorkshire PCT).

33 NHS Diabetes; The Year of Care Team. 'Mind your language.'

34 www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/lean.html

Patients need to be supported to understand and use this new way of working. Try asking yourself “*what methods to communicate these service changes would best suit our patients?*”

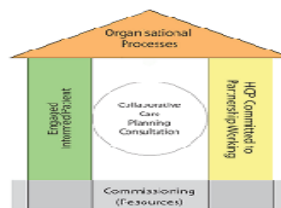
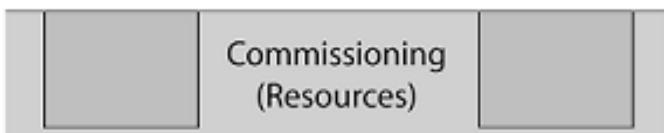
For many patients information alone is insufficient and they need additional training about goal setting and action planning and to understand the results of their investigations. One consequence of *Care Planning* may be to stimulate a desire for more patient education about specific conditions. Many patients are motivated by information and advice from fellow patients and by sharing their stories with them.

Example 12: Improving Health Literacy

An inner city practice have a large Bengali population. When they started doing two step annual reviews it got patients really asking questions about their diabetes and demonstrated a huge lack of knowledge and health literacy amongst the immigrant Bengali population. In response the practice devised a largely HCA led group training session, offered to patients at the time of their results letter, with some basic diabetes education and also opportunities for questions and answers with supported discussion within the patient group. (London practice)

Engaging with the wider community can also be of great value in supporting self management in people with LTCs. This might encompass work with faith groups, voluntary sector organisations and local authorities.

3.3.4: Commissioning



To deliver high quality *Care Planning* for people with LTCs adequate resources are required. In many areas this type of work is supported by enhanced service payments or driven by practice based commissioning savings. To deliver high quality *Care Planning* with people with LTCs, adequate resources are required. In many areas this type of work is supported by Enhanced Service payments or driven by Practice Based Commissioning savings (Appendix H).

Commissioners will need to support the required training of both patients and staff and ensuring appropriate IT procurement, software set up and staff support to ensure effective data capture and reporting.

Tailored IT systems will be necessary for the implementation of *Care Planning* to ensure, for example, feedback from patients to commissioners on the quality of care they are receiving and the services required to support their action plans. Ways are still being sought to identify and to communicate gaps in services which support the patients in managing their own conditions. It is, of course, important for commissioners to know if commissioned services are actually helping patients achieve their planned actions.

Another important task when introducing *Care Planning* to a practice is deciding how to communicate the menu of care to patients. This has been done through sign posting the care available or through the use of health trainers or websites.

Example 13: Comparing Services

It is challenging for individual clinicians to keep up with all the services available to support patients and their referral criteria, especially with third sector providers who often have short term funding.

Comparing knowledge of available services between diabetes leads in neighbouring practices has shown huge variation in knowledge. (London PCT)

3.3.5: Collaborative Care Planning



When we first implement *Care Planning* in the practice, we also need to be sure we allocate enough time for the first *Care Planning* consultation. Experience from *The Year of Care Programme* has demonstrated that an initial consultation will take about 20 minutes with a further 10 minutes required to provide the *Care Planning* documentation for the patient. Generally speaking, quite a large part of these consultations are taken up with explaining results to patients and ‘modelling’ a new way of working. Initially, patients who are more used to a doctor or nurse centred approach to care can find this difficult and may respond to invitations to *shared decision making* by declining to engage “*I don’t know, you’re the doctor/nurse, you tell me.*” However, in these circumstances where patients are not ready to work in this way, some consultation time needs to be spent exploring their concerns, their views and understanding of their health and their wishes.

Example 14: Connecting with Patients

The practice had found Mr B ‘infuriating’ to work with. It was very hard to get him to attend and when he was seen he was unwilling to engage in any planning and he seemed despondent and caught up in concerns about difficulties in his marriage. Further questioning about how the practice could help him become ready to work with us around his diabetes unearthed his clear conviction that none of this was relevant for him as he did not believe he had diabetes. (London practice)

Goal Setting and Action Planning

Individual goals for the care of the patient need to be agreed using the shared process of *Care Planning*. These goals need to feel important to the patient. However, action planning may feel uncomfortable to the clinician where the patient is not willing to agree to something which the clinician sees as important or is performance managed to deliver, e.g. taking a statin. Engaging with this process is essential to find out what the patient is prepared to do in terms of their own care which has the potential to maximise yours and the patient’s efforts to avoid, for example, non concordance with prescribed medication. Agreed actions need to be ones that the patient thinks they are likely to be able to deliver on and wherever possible their goals should be SMART (specific, measurable, achievable, relevant and timely).

Finally, a written record of what has been agreed needs to be made for both the patient and the practice. Completing the loop of *Care Planning* by following up the achievements of goals or objectives is crucial. We should ask our patients for example: “*How well are you doing with your goals/objectives which we agreed your*

care plan?” Written records should make it clear whom the patient is seeing for follow up and when and how the care plan will need to be continually adapted in the light of the patient’s experience during the year.

Many other demonstration programmes (including *Co-creating Health*) have found that people need ongoing motivational support to carry out and maintain changes in between structured *Care Planning* appointments. This support could be a self management programme, group appointments, telephone or email based coaching or a tailored programme of activities within their local community.

4: Evaluation of *Care Planning*

The *Care Planning* approach makes it easier for us to support people with LTCs, improves their experience and their sense of control over their condition and daily lives; things that we know improve quality of life and reduce complications in the future.

But how will we know how we're doing? And how can we do better?

Reflecting, measuring, getting feedback and audit are all ways to support improvement and are the aspects we cover in this section.

Measuring Patient Outcomes

Patients and clinicians have similar aims to improve long term outcomes by increasing length of life and reducing morbidity, also in the short term improving quality of life: but they often prioritise things differently, with clinicians emphasising the former and people with LTCs, the latter.

In general practice we know that being systematic and planned in what we do, such as registering and recalling patients for regular review has been the most important driver of the improvements we have all seen in the care for people with LTCs .

Example 15: Traditional Biomedical Outcomes in Diabetes³⁵

In diabetes these aspects are measured as part:

- of the National Diabetes Audit (NDA)³⁶ (this includes intermediate outcomes like HBA1c and BP and final outcomes like renal replacement and retinopathy).
- of QOF data (intermediate outcomes) – although this doesn't give such a clear picture of what is happening to the whole practice population.

Both of these tools can show how a practice is improving year on year. Specific audits from practice registers can give a detailed view of the section of the population we are focussing on.

Accepting an individual's quality of life and their knowledge, skills and confidence to manage their own health and healthcare ('*activation*') are important outcomes in their own right, poses newer and harder challenges, but there are a number of tools available to help us make such judgements.

Most GPs and nurses would value something 'ready made', not just because it's easier to take off the shelf, but because it means we can compare ourselves with others trying to improve in similar circumstances. A great deal of thinking is going on about PROMS (Patient Reported Outcome Measures) – but these are much more difficult to design in LTCs and there is currently no agreed list. Unfortunately at present, most of the currently available measures are not really satisfactory for routine use.

However, assessing the *activation* levels of a sample of patients or their quality of life is possible. Website links to a number of well validated instruments, including the Patient Activation Measure (PAM) (which is not yet available for unlicensed use²³) across a range of conditions are provided in the Appendices at the end of this report.

In LTCs many important outcomes for health or quality of life may be a long way off in the future for the individual and are dependant on a combination of factors related to the systems of care as well as the individual interactions with the practice; they are also affected by events outside the control of the practice.

To improve our *Care Planning* skills and processes we need more direct and timely measures of what we are doing.

35 www.knowledge.ic.nhs.uk/ebulletins/nda/index.asp

Looking at *Care Planning* from the Person's Point of View (Someone with Diabetes):

An example from *The Year of Care Programme* is shown below (example 16). This person's aspirations include an understanding that *Care Planning* is about integrating traditional biomedical aspects of surveillance and therapy with support for ongoing self management.

Example 16: Evaluation of *Care Planning* from the Patient Perspective

When I come out from my consultation I will be able to say:

- I feel supported and no longer alone in my struggle to control my diabetes
- I am motivated to take control of my diabetes because:
 - I have been listened to with appreciation
 - I have knowledge and understanding of the means of acquiring them
 - I know and understand the goals I have set and believe that, with support, I can achieve them
 - I know and understand the actions I have to take and those that will be taken by the *HCP*
 - I know how to get specialised support and am confident that it will be there
 - I know that all aspects of my diabetes will be looked after – retinopathy, dietetics, podiatry, exercise etc - and I know where and how to access these services as and when I need them
 - I want to be responsible for my care and want to make determined efforts to do it well
 - I do not expect miraculous changes and understand that I will make mistakes, which is all part of the learning process
 - I know that the *HCP* has confidence in my ability to self-manage with professional support
 - I feel respected and that my efforts are appreciated
 - I am confident that my quality of life will also improve and my social life extend
 - I can and will control my diabetes so that the diabetes lives with me instead of me living with my diabetes
- In one sentence I will say: I have the skills and knowledge and the motivation and support to control my diabetes

Avril Surridge July 2010 (A person with diabetes)

Standardised questions, assessing how successful a practice is in enabling people to self manage effectively, that could be useful as part of routine use, for an audit or to benchmark against colleagues, are shown in the box below.

Figure 5: Evaluating Practice Success^{34 36 37 38 39}

- From the annual GP Survey for England³⁷
 - Percentage of people with LTCs feeling supported to manage their condition
- From the consultation on the White Paper 'Liberating the NHS'³⁸
 - Percentage of people with an LTC who say they are confident that they can manage their own health.
- From the Quality Innovation Productivity and Prevention (QIPP)³⁹ programme (the LTC 6): Six questions for patients which cover the most important aspects of care for someone with diabetes (Appendix A2.1).
- Currently under test: A longer instrument 'Living with your LTC'³⁴ It incorporates the LTC 6: the Consultation Quality Index (CQI; see below) and a well validated health status questionnaire the EQ-5D⁴⁰ (also in the appendix). This is worth thinking about as a source for audit questions in practice.

How can we monitor how well we are doing with our *Care Planning*?

It is helpful to separate the monitoring of our process of *Care Planning* from the outcomes of *Care Planning*, some of which were discussed above. How can we, as health care practitioners, find out to what extent we are patient centred and to what extent we are supporting people with LTCs to self manage? At its simplest level, our behaviour is what we do with the skills and competences which we possess. As such, it can be measured using a variety of instruments such as the examples given in the figure below.

36 www.gp-patient.co.uk/info/

37 www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117583

38 www.institute.nhs.uk/cost_and_quality/qipp/cost_and_quality_homepage.html

39 www.euroqol.org/

Figure 6: Evaluating Our Behaviour^{40 41 42 43}

- We can video our own consultations and then ask for some feedback from our peers/colleagues and teachers. However, although useful, this is likely to be a fairly long and laborious process which all those of us who took the old mRCGP exam will know.
- We can ask one of our colleagues to sit in during a surgery – not always possible of course because we are all so busy seeing our own patients! However, there is good evidence that peer review can improve our performance in consultations⁴¹.
- We can ask for feedback from patients by, for example, giving them a questionnaire (see appendix) to complete at the end of their consultation.
 - The CQI⁴¹, either generic or adapted for diabetes⁴² has been shown to be useful for practitioners to use before training in *The Year of Care Programme*.
 - The Patient Partnership in Care (PPIC)⁴³ questionnaire has been used by *Co-creating Health* to highlight the areas where most improvement can be made.
 - The Health Care Climate Questionnaire (HCCQ)⁴⁴ which contains either six (short form) or 15 (long form) items. It asks about how the patient feels about their encounters with you in terms of the balance between being supported by you or 'controlled' in their consultations with you.
- We can recruit a small group of patients to follow through the process either by using the questionnaires above described or just by repeated interviews.
- These enable us to see to what extent in the last few consultations with us, we have satisfied the patient and helped them to look after themselves.

Amongst our many roles as clinicians, an important one is to help and support patients to make the necessary behavioural changes to improve their health. Working out where an individual is in the classic cycle of change⁴⁴ or their 'journey of activation'²³ and if they have moved on since their previous consultation can sometimes also be a useful way of monitoring whether you are making any difference to their care in terms of *Care Planning*.

As far as monitoring our own attitudes (defined as what we say we want) and beliefs (what we think is true), then a self-reflective exercise is probably a good way of checking these out⁴⁵. Such an exercise can, of course, be put into our ePortfolio for revalidation purposes.⁴⁶

Example 17: Thinking Things Through

'YoC has made me look at my role as a practitioner, to take a step back and look at the way I deal with patients. It has legitimised me saying to patients, it's all about you and your diabetes, you can use me as a resource.' (London GP)

40 Mercer S.W., Howie J.G.R. CQI-2 – a new measure of holistic interpersonal care in primary care consultations. *BJGP* 2006; 56: 262-68.

41 Eaton S. Measuring Consultation Quality in Primary and Specialist Diabetes Clinics. *Diabet Med* 2010; 27 (Supp 1):112.

42 Powell, R., Powell, H., Baker, L. & Greco, M. Patient Partnership in Care: A new instrument for measuring patient-professional partnership in the treatment of long-term conditions. *Journal of Management & Marketing in Healthcare*. 2009; Vol. 2 No. 4. PP 325-342.

43 www.psych.rochester.edu/SDT/measures/pashealth.php

44 Prochaska JO, DiClemente CC. The transtheoretical approach. In: Norcross JC, Goldfried MR, editors. *Handbook of psychotherapy integration*. 2nd ed. New York: Oxford University Press; 2005. p.147-171.

45 onlinelibrary.wiley.com/doi/10.1111/j.1369-7625.2009.00571.x/abstract

46 www.rcgp.org.uk/revalidation.aspx

Example 18: A Reflective Exercise

One interesting topic for reflection could be around, for example, the ethical issues of autonomy (patients making the choices about their treatment themselves) and paternalism (the doctor proactively deciding what is best for the patient and asking for their agreement).

The framework for significant event analysis (SEA) could be used for a situation in which you as a clinician are unsure what the right decision about the appropriate course of action is when advising a patient on their medication, could provide the opportunity for a structured reflection on the different ethical principles in *shared decision making*.

An alternative topic for a reflective exercise is shown in the scenario below, which focuses primarily on the clinical aspects of the care of an individual patient with diabetes.

Scenario 1³²

- 68 Year Old Male; Type II Diabetes for 3 years
- HbA1c 7.8% on Metformin 1g bd
- Ex-smoker, on Statin and Aspirin
- BP 154/88 on Nifedipine and Thiazide

“I’m not really keen on more tablets!”

One of the important aspects from both the patient and the practitioner point of view is how far the patient has been involved in the *Care Planning* process.

There are also many ways of monitoring the outcomes of the *Care Planning* process with patients, some suggestions for which are shown in Example 19.

Example 19: Monitoring the Outcomes of the *Care Planning* Process

Involvement in the *Care Planning* Process:

- Measures of clinic attendance
- The number of people who bring with them a considered response to preparatory material sent in advance (such as test results in diabetes or symptom diaries in other LTCs)
- Monitoring that every patient with a long-term condition has an action plan for the personal goals they have chosen recorded in the electronic medical records

It can also be very useful for us to review the personal action plans of people with LTCs and to record their achievements. These goals are reviewed at each subsequent visit and the outcome is noted. For example, has the patient done what they said they would do at their previous consultation? It is important to remember that praise for small successes and taking a positive approach towards learning from challenges can increase the engagement of our patients in the *Care Planning* process.

As a GP or nurse undertaking *Care Planning* you will find that you will acquire not only new transferable skills but also that you should be able to integrate these new skills into your existing skills set.

Finally, many practitioners report an increased job satisfaction and an improved confidence about their clinical work as well as a reduced staff turnover with the introduction of *Care Planning* to the practice, something that

provides a powerful incentive to sustain the process.

Try asking yourself the following question after three months:
Would you recommend this model of care to your colleagues?

Audit of Care Planning

One of the current requirements for revalidation is two completed audit cycles within a five year period. *Care Planning* lends itself naturally to an audit of your processes and standards. If, for example, you set your criterion for audit as “**100% of people with a long term condition will have an action plan recorded in their medical records**” – the corresponding standard could be that 75% of your patients with LTCs at the time of the audit met this criterion. This would enable you to monitor your own progress towards delivering *Care Planning*, although, of course, you can set your own standards depending on where you are starting from. Again, this could be included in your ePortfolio.

When evaluating the impact of *Care Planning* on your practice, it is important to monitor how the practice as a whole is supporting the *Care Planning* process.

This section has included many examples of material that is suitable for audit, ranging from the monitoring of patient views on the consultation to the administrative functions which support it (Appendix E). These will be important not just for revalidation but could be used as part of collaborative improvements within a wider group of local practices.

Internal Processes – Measuring What the Practice is Doing

Section B described how the practice infrastructure (the walls and roof of the house) is important in enabling *Care Planning* to take place effectively and provided examples of what can be achieved. Some of these are important for the practice as a whole and *Care Planning* should enable a better use of resources within our practices and promote multidisciplinary care. For example, *Care Planning* should improve the skill mix of your team as well as improved team working. The latter can be monitored using the Team Climate Questionnaire⁴⁷(Appendix A2.5). Such improvements may be reflected in better QOF returns.

A tool is available to enable you to assess the language used in the written material the practice produces for patients³⁵. A well validated measure is also available for practice teams to use to assess how the whole practice (or perhaps a GP Consortium) is developing in terms of supporting self management across the board (PCRS-UK)⁴⁸. This is something that could be used and discussed at a practice meeting.

A practice audit of how far the administration of *Care Planning* is ‘joined up’ e.g. letters sent out, tests obtained at the right time, induction and training of staff, the extent that everyone involved can explain the processes and the importance to patients would give a good overview of progress.

Linked to this outcome measure of how well the service is being used overall could include the number of patients who had received their laboratory results before their consultation and brought these with them to their consultation with you. Similarly, monitoring the number of attendances by patients with LTCs as a proportion of the total can act as a proxy measure for the quality of your *Care Planning* services. It is likely that nonattendance rates for planned appointments will be reduced.

Calculation of the amount of money saved by the reduced use of the clinical time of the doctors and nurses in the practice is also a useful way of monitoring the impact of *Care Planning* and the productivity of the practice (Appendix C). Further measures which you can use could be the yearly patient contact time and the clinical/

47 intranet.library.arizona.edu/teams/hroe/effectiveness/documents/TeamClimateAssessmentSurveys1007.doc

48 Primary Care Resources and Support (PCRS –UK): diabetesnpo.im.wustl.edu/support/primaryCare.html

administrative time ratio. We believe that such indicators will improve with the full implementation of *Care Planning* in the practice. Again, these measures lend themselves very easily to a revalidation audit cycle.

Feedback

Many GPs and practice nurses enjoy the challenge of competition and in general we all like to have feedback about how well we are doing. It can be really helpful to automate this as far as possible and to delegate the task of producing and circulating how well the team is doing to one of the administrative staff. This can provide a basis for multidisciplinary team discussions and shared learning by providing feedback to the practice. Sharing such evidence between practices or commissioning groups can be a really useful tool for learning and development.

External Impact

The impact of *Care Planning* can be monitored by external organisations such as a GP commissioning group who may also require key organisational elements to be in place.

Figure 7: Components of a Service Level Agreement for a Locally Enhanced Service

- The existence of a service level agreement
- The availability to patients of a menu of services
- The presence or absence of support for data entry/service documentation
- Provision of training needs assessment and relevant training
- Patient access to their individual electronic health records
- Provision of feedback on service 'gaps' to support commissioning groups when they are evaluating the implementation of *Care Planning* in a group of practices

Audit, monitoring and reflection will provide many opportunities to adjust performance and make improvements to meet externally or internally set standards.

5: The Future

Embedding Support for Self Management in Routine Care

From the Year of Care (YOC) pilot studies and talking to the clinicians involved, consistent themes have emerged. One of the most important, in pressured times, is that it is easy to slip back to paternalistic working models so constant support, encouragement and feedback is essential.

Support from Outside the Practice

While individual and practice behaviour has to be determined by the individuals involved, getting the support to “do the right thing” is likely to be essential to get initiate ‘Care Planning’. In the future, working through the local GP commissioning consortium to ensure support for the new approach, as well as recognition of the costs of training, changes to IT and the flexible community services people need to develop a menu of care, are likely to be as important as they were in the YOC pilot sites.

Support Across Groups of Practices

Ensuring the support services are joined up, that ongoing training needs assessments are responded to, that joint learning, audit and benchmarking is facilitated and indeed that motivation is maintained, does not happen without coordination. This all needs to be written into the service level agreements (SLAs).

Support Within the Practice

Ongoing skills training has been delivered within and between practices (for example in the *Co-creating Health Programme* and in the Tower Hamlets Pilot Practices). Regular small cycle improvement measures and audits and patient participation and feedback are all potential ways to keep up the momentum.

Care Planning & Other Long Term Conditions

Currently, this type of systematic support is provided for only a small number of LTCs such as primary care diabetes or in asthma clinics. The concept of the annual review for diabetes, as an exemplar, has become embedded in the clinical repertoire.

How Do We Expand on This?

Many people attending general practice have multiple conditions. However, where someone has more than one condition, with training, the professional should become skilled enough within the *Care Planning* consultation to integrate the issues to ensure that the goals and actions which emerge are holistic and relate to the individual living their life with their conditions and their resulting requirements.

From the patient perspective this makes total sense;

“it is a conversation about how I live my life with the burden of disease I carry and it is space to think about the ways I could improve on how I manage my problems as well as the supports and services I need.” (A London patient)

However the challenge for clinicians is then how to deliver all the condition-specific components of the patient’s care within an holistic approach. Integrated annual review/*Care Planning* for related conditions such as ischaemic heart disease, diabetes and chronic kidney disease feel comfortable. However adding in conditions like schizophrenia, Chronic Obstructive Pulmonary Disease (COPD) and epilepsy can sometimes be more challenging. Increasing numbers of patients over the age of seventy experience a number of simultaneous conditions (‘multimorbidity’) which can also make *Care Planning* more complex. However the *Care Planning* model lends itself to an integrated model of care whereby each condition has an individual relevant plan which can then be synthesised into holistic management. In addition there may be significant potential cost savings in terms of the number of visits that will then be needed.

For other LTCs where systematic support is not currently the norm, time needs to be set aside to provide and plan opportunities to think through management and self management with a trained health care professional. The

Care Planning model can also be used with, for example, the carers of patients with dementia.

Some examples of practitioners who are introducing systematic *Care Planning* for other conditions (or groups of conditions), including for patients who traditionally receive care at home, or who are in residential care, are described here. Each of these examples includes the same building blocks for care, but each has involved very different organisational approaches. Whatever approaches are adopted, support will be needed in a variety of new ways.

Example 20: *Care Planning* in the Community (Chronic Obstructive Pulmonary Disease - COPD)

A group of GPs has taken the principles of *Care Planning* in diabetes and adapted them for severe COPD. The two visits can be either at home or in the surgery. The district nurse (as key worker) carries out task based measurements (e.g. peak flow rate, oximetry, etc) and provides basic information about the condition. The second visit is the *Care Planning* consultation, where their self management plan is discussed, ideas and concerns about their illness are aired, rescue medication and inhaler management are put in place. There is a new linked pulmonary rehabilitation programme. A survey of the first 100 patients confirmed:

- 91% felt better able to manage their COPD
- 88% said they knew what to do when they got worse, 85% knew what medication to take, 87% were confident about taking rescue medication
- 50% said they now do things differently

(The integrated care pilot in the Northeast (Integrated Care Organisation pilot site))

Example 21: *Care Planning* for Prevention (Health Checks)

A vascular health checks programme has adopted a *Care Planning* approach. Results and explanations are sent to patients following the check of their weight, smoking, BP and cholesterol. At the *Care Planning* consultation they discuss their goals and actions. The clinician supports them to create a personal action plan. Master classes have been provided to support the health care professionals to work in this new way and discuss risk in a format which is understandable and attuned to the patient. (Northeast programme)

Example 22: *Care Planning* with Multiple Co-morbidities

A group of 12 practices are meeting together to work out how these lessons and particularly the concept of a two stage process, can be transferred to a wider range of *long term conditions* and those with multiple conditions. The aim is to offer a systematic and structured approach to partnership care for everyone with LTCs overcoming challenges in ways that fit with the needs of each practice and their population. (North East SHA Innovation Pilot)

Implications for Primary Care Computing

A majority of Practices are now paperless and YOC practices have had to be inventive in how to incorporate this new way of working into routine clinical practice. Prior to the YOC project, none of the major GP systems included ways to systematically record patients' concerns, goals, or action plans. There has also been a need to identify services in the community in order to inform local needs assessments and commissioning. Templates which enable this to be done systematically have now been designed and are available on System One and on VISION. It is

anticipated that similar programmes will become available on other systems in common use in England.

The YOC programme found that IT alone cannot change attitudes or build in the required new skills by itself, but it is one of the most important ways to ensure continuity and sustainability for the future.

Perhaps a final building block for the future should be to ensure that everyone can access their own individual medical records including the outcome of their own *Care Planning* in a variety of ways.

Just Imagine...

Just imagine a health service in which everyone with a *long term condition* is engaged in *Care Planning*: sharing decisions with their clinicians; being confident to manage their condition; knowing when to ask for help; with a better experience of care; better health outcomes and improved quality of life and greater job satisfaction for clinicians...

Appendix A: Additional Resources

Appendix A1 Patient Activation Measure/Patient Partnership in Care

1. A number of questionnaires for practice use have been identified.

The following are only available under licence but can be viewed from the following sources:

- Patient Activation Measure (PAM):
- Hibbard JH, Stockard J, Mahoney ER, Tusler M. Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in patients and consumers. *Health Services Research* 2004; 39:1005-1026.
- Patient Partnership in Care (PPIC):
- Powell, R. Powell, H. Baker, L. & Greco, M. (2009) Patient Partnership in Care: A new instrument for measuring patient–professional partnership in the treatment of long-term conditions. *Journal of Management & Marketing in Healthcare*. Vol. 2 No. 4. PP 325–342.

The Primary Care Resources and Support (PCRS – UK) is available for use and instructions for downloading it can be found at: diabetespo.im.wustl.edu/support/primaryCare.html

2. Questionnaires which are freely available for use are included in the following pages:

- a. *Long Term Conditions 6* (LTC 6)
(part of the *QIPP* programme) Department of Health
- b. Living with your *Long Term Condition* (LWYLTC)
Patient Survey 'The Year of Care Consultation Skills and Philosophy Toolkit : Mind your language.'
Copyright is owned by the Year of Care NHS Diabetes programme
- c. CQI (Consultation Quality Index)
Version adapted for Diabetes sourced from Year of Care website,
www.diabetes.nhs.uk/year_of_care/evaluating_the_year_of_care/what_is_being_measured/
- d. Health Care Climate Questionnaire (HCCQ)
Please note that all questionnaires on this web site, developed for research on self-determination theory, are copyrighted. You are welcome to use the instruments for your own research projects. However, you may not use any of them for any commercial purposes without written permission to do so from Edward L. Deci and Richard M. Ryan
- e. Team Climate Questionnaire (TCQ) Source National Patient Safety Agency

Appendix A2.1: Long Term Condition 6 (LTC 6)

Please think about the last 12 months, when you received care and support for your condition(s)...

Please tick one box for each statement and answer every statement:

Did you discuss what was most important for you in managing your own health?

Not at all Rarely Some of the time Almost always

Were you involved as much as you wanted to be in decisions about your care or treatment?

Not at all To some extent More often than not Almost always

How would you describe the amount of information you received to help you to manage your health?

I didn't receive any information I rarely received enough information I sometimes received enough information I always received the right amount of information

Have you had enough support from your health and social care team to help you to manage your health?

I have had no support I have not had enough support I have sometimes felt supported I have always felt supported

Do you think the support and care you receive is joined-up and working for you?

Never Rarely Sometimes Always

How confident are you that you can manage your own health?

Not at all confident Not very confident Somewhat confident Very confident

Appendix A2.2: Living with Your Long Term Condition: Patient Survey (LWYLTC)

What is this survey about? This questionnaire is about your views on the consultation you had today and your experience and understanding about the health and social care you have received over the last 12 months.

Who is carrying out the survey? The practice is taking part in a project to improve the way we provide care and support to people with long term conditions across the North East.

Why should I complete the survey? Understanding your views is vital to help us improve the support and services we offer.

Your participation in this survey is voluntary. If you choose not to take part in this survey, it will not affect the care and support you receive in any way.

Your answers will be treated in confidence. Please do not give your name or address anywhere on the questionnaire.

Questions or help? If you need any help in answering the questionnaire, please discuss with the clinician you saw or the receptionist.

Firstly, thinking about today's consultation:

1. As a result of your consultation today, do you feel you are...
(please tick one box in each row)

	Much better	Better	Same or less	Not applicable
a Able to cope with life...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b Able to understand your condition(s)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c Able to cope with your condition(s)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d Able to keep yourself healthy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Much more	More	Same or less	Not applicable
e Confident about your health...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f Able to help yourself...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. How well do you know the person you saw today?
(please place a circle round one of the numbers below)

(don't know them at all) 1 2 3 4 5 (know them very well)

Clinician to complete		Clinician Name/ID:			
Date:		Start time:		Finish time:	

3. Please rate the following statements about today's consultation
Please tick one box for each statement and answer every statement

How was the person you saw at...	Poor	Fair	Good	Very Good	Excellent	N/A
a Making you feel at ease... (being friendly and warm towards you, treating you with respect; not cold or abrupt)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b Letting you tell your "story"... (giving you time to fully describe your illness in your own words; not interrupting or diverting you)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c Really listening ... (paying close attention to what you were saying; not looking at the notes or computer as you were talking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d Being interested in you as a whole person... (asking/knowing relevant details about your life, your situation; not treating you as "just a number")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e Fully understanding your concerns... (communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f Showing care and compassion... (seeming genuinely concerned, connecting with you on a human level; not being indifferent or "detached")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g Being Positive... (having a positive approach and a positive attitude; being honest but not negative about your problems)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h Explaining things clearly... (fully answering your questions, explaining clearly, giving you adequate information; not being vague)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How was the person you saw at...	Poor	Fair	Good	Very Good	Excellent	N/A
i Helping you to take control... (exploring with you what you can do to improve your health yourself; encouraging rather than "lecturing" you)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j Making a plan of action with you ... (discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Now, please think about the last 12 months, when you received care and support for your condition(s)... Please tick one box for each statement and answer every statement:

a. Did you discuss what was most important for you in managing your own health?

Not at all Rarely Some of the time Almost always

b. Were you involved as much as you wanted to be in decisions about your care or treatment?

Not at all To some extent More often than not Almost always

c. How would you describe the amount of information you received to help you to manage your health?

I didn't receive any information I rarely received enough information I sometimes received enough information I always received the right amount of information

d. Have you had enough support from your health and social care team to help you to manage your health?

I have had no support I have not had enough support I have sometimes felt supported I have always felt supported

e. Do you think the support and care you receive is joined-up and working for you?

Never Rarely Sometimes Always

f. How confident are you that you can manage your own health?

Not at all confident Not very confident Somewhat confident Very confident

g. When you think about your healthcare in general, how often did you receive the healthcare you wanted when you wanted it?

Never Rarely Sometimes Always

h. In general, would you say your health is excellent, very good, good, fair, or poor?

Excellent Very Good Good Fair Poor

5. By placing a tick in one box in each group below, please indicate which statement best describes your own health state today.

Do not tick more than one box in each group

Mobility	I have no problems in walking about	<input type="checkbox"/>
	I have some problems in walking about	<input type="checkbox"/>
	I am confined to bed	<input type="checkbox"/>
Self-Care	I have no problems with self-care	<input type="checkbox"/>
	I have some problems washing or dressing myself	<input type="checkbox"/>
	I am unable to wash or dress myself	<input type="checkbox"/>
Usual Activities (e.g. work, study, housework, family or leisure activities)	I have no problems with performing my usual activities	<input type="checkbox"/>
	I have some problems with performing my usual activities	<input type="checkbox"/>
	I am unable to perform my usual activities	<input type="checkbox"/>
Pain/Discomfort	I have no pain or discomfort	<input type="checkbox"/>
	I have moderate pain or discomfort	<input type="checkbox"/>
	I have extreme pain or discomfort	<input type="checkbox"/>
Anxiety/Depression	I am not anxious or depressed	<input type="checkbox"/>
	I am moderately anxious or depressed	<input type="checkbox"/>
	I am extremely anxious or depressed	<input type="checkbox"/>

6. Finally, some questions about you:

Are you?

Male

Female

How old are you?

35 or younger

36-50

51-65

66-80

Over 80

What is your ethnic group?

White

Mixed

Asian or British Asian

Black or British Black

Chinese or other

Do you have any of the following conditions?

Please tick all that apply

Diabetes

Heart disease/angina/heart failure

High blood pressure

Previous stroke

Asthma/Chronic lung disease

Arthritis

Bowel problems (eg. Colitis, Coeliac, Chron's)

Chronic kidney disease

Depression/Anxiety/other mental health problem

Dementia/Epilepsy/other neurological

Other (Please specify)

Thank you very much for completing this questionnaire. Please hand it into reception.

Appendix A2.3: Consultation Quality Index – Version Adapted for Diabetes (CQI – DM)

Your views about the Consultation today

Please complete the questions below when you have finished in the clinic today.

Your responses and comments will be absolutely anonymous and confidential. We would therefore encourage you to be as open and honest as possible.

1. As a result of your visit to the clinic today, do you feel you are...
(please tick one box in each row)

	Much better	Better	Same or less	Not applicable
a Able to cope with life...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b Able to understand your diabetes...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c Able to cope with your diabetes...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d Able to keep yourself healthy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Much more	More	Same or less	Not applicable
e Confident about your health...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f Able to help yourself...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. How well do you know the person you saw in clinic today?
(please place a circle round one of the numbers below)

(don't know them at all) 1 2 3 4 5 (know them very well)

Please turn over page

.....

Clinician to complete		Clinician Name/ID:			
Date:		Start time:		Finish time:	

3. Please rate the following statements about today's consultation

How was the person you saw at...	Poor	Fair	Good	Very Good	Excellent	N/A
a Making you feel at ease... (being friendly and warm towards you, treating you with respect; not cold or abrupt)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b Letting you tell your "story"... (giving you time to fully describe your illness in your own words; not interrupting or diverting you)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c Really listening ... (paying close attention to what you were saying; not looking at the notes or computer as you were talking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d Being interested in you as a whole person ... (asking/knowing relevant details about your life, your situation; not treating you as "just a number")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e Fully understanding your concerns... (communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f Showing care and compassion... (seeming genuinely concerned, connecting with you on a human level; not being indifferent or "detached")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g Being Positive... (having a positive approach and a positive attitude; being honest but not negative about your problems)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h Explaining things clearly... (fully answering your questions, explaining clearly, giving you adequate information; not being vague)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i Helping you to take control... (exploring with you what you can do to improve your health yourself; encouraging rather than "lecturing" you)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How was the person you saw at....	Poor	Fair	Good	Very Good	Excellent	N/A
j Making a plan of action with you ... (discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please tick one box for each statement and answer every statement

4. Do you think the skills and attitudes listed above are important in a diabetes clinic?

Not important Of minor importance Moderately important Very Important

Thank you. Now please place questionnaire in box at Reception.

Appendix A2.4: Health Care Climate Questionnaire (HCCQ)

Health Care Climate Questionnaire

This questionnaire contains items that are related to your visits with your doctor. Physicians have different styles in dealing with patients and we would like to know more about how you have felt about your encounters with your physician. Your responses are confidential. Please be honest and candid.

1. I feel that my physician has provided me choices and options.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

2. I feel understood by my physician.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

3. I am able to be open with my physician at our meetings.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

4. My physician conveys confidence in my ability to make changes.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

5. I feel that my physician accepts me.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

6. My physician has made sure I really understand about my condition and what I need to do.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

7. My physician encourages me to ask questions.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

8. I feel a lot of trust in my physician.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

9. My physician answers my questions fully and carefully.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

10. My physician listens to how I would like to do things.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

11. My physician handles people's emotions very well.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

12. I feel that my physician cares about me as a person.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

13. I don't feel very good about the way my physician talks to me.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

14. My physician tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

15. I feel able to share my feelings with my physician.

1	2	3	4	5	6	7
strongly disagree			neutral	strongly agree		

Appendix A2.5: Team Climate Questionnaire (TCQ)

Team Climate Assessment Questionnaires
(10/07 – Phipps)

Work environment or climate assessment questionnaires collect “employees’ shared perceptions of the themes, goals, or imperatives that describe their workplace.”... (Reichers and Schneider, 1990 as quoted in Hanges, Aiken and Chen, 2006—authors of our recent OCDA Survey)

By answering the below Group Climate Questionnaire you will help your team develop a shared description of the current work environment. With this compiled description we can work together to discover steps to take to create and maintain a supportive, encouraging environment that will help all team members work together productively.

Option A

Please give your candid opinion of the team by rating its characteristics on the seven-point scale that follows each item. Circle the number on each scale that corresponds to your evaluation. Please give your opinion in each case, even if you are not certain.

1. Are the members of the team open in their relationships with others in the group?

1	2	3	4	5	6	7
Open					Guarded	

Comment:

2. Do team members have ‘hidden agendas’ (motives that they are unwilling to reveal)?

1	2	3	4	5	6	7
None Do					Do	

Comment:

3. Are some topics taboo for discussion within the group?

1	2	3	4	5	6	7
No Taboo Topics					Many Taboo Topics	

Comment:

4. Does the team have traditions that prevent it from working effectively?

1	2	3	4	5	6	7
No Unhelpful Traditions					Many Unhelpful Traditions	

Comment:

5. Are the ideas of senior members considered to be 'law'?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Sr .Members Are Challenged Ideas Of Sr. Members Are 'Law'

Comment:

6. Are radical views expressed freely?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Very Freely Not Expressed

Comment:

7. Do the team members collaborate with one another?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

All Collaborate Members Pull Against One Another

Comment:

8. What happens when a person makes a mistake?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

People Learn From Mistakes People Are Punished For Mistakes

Comment

9. Do more experienced members help members who are less experienced?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Helped Not Helped

Comment:

10. Are difficult or uncomfortable issues worked through openly?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Worked Through Not Worked Through

Comment:

11. Are conflicts between team members 'swept under the carpet'?

1	2	3	4	5	6	7
Confronted & Resolved				Swept Under The Carpet		

Comment:

12. Can team members openly disagree with the leader?

1	2	3	4	5	6	7
Can Disagree				Cannot Disagree		

Comment:

13. Does the team devote much energy to becoming efficient in its use of time?

1	2	3	4	5	6	7
Much Energy				Little Energy		

Comment:

14. Do team members believe that they can try new things, *risk* failure and still get support?

1	2	3	4	5	6	7
Support				No Support		

Comment:

15. Does the team encourage people to develop themselves?

1	2	3	4	5	6	7
Support				No Support		

Comment:

16. Have the team members worked through their own beliefs and values with others?

1	2	3	4	5	6	7
Values Have Been Explored				Values Not Explored		

Comment:

17. Do team members put energy into the team's tasks?

1	2	3	4	5	6	7
High Energy			Low Energy			

Comment:

18. Does membership in the team stimulate and energize the members?

1	2	3	4	5	6	7
Energizes			Does Not Energise			

Comment:

19. Do the team members trust one another as people?

1	2	3	4	5	6	7
High Trust			Low Trust			

Comment:

20. Does the team maintain positive relationships with other teams?

1	2	3	4	5	6	7
Maintained			Not Maintained			

Comment:

Are there incidents, trends, or concerns you want to share that will help assess the team's climate?

Option B

Please give your candid opinion of the team by rating its characteristics on the seven-point scale that follows each item. Circle the number on each scale that corresponds to your evaluation. Please give your opinion in each case, even if you are not certain.

Rating Scale: 1 = Extremely Low; 4 = Moderate, 7 = Extremely High

1. Commitment

Group members understand group goals and are committed to them.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

2. Acceptance

Group members are friendly, concerned and interested in each other.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

3. Clarifications

Group members acknowledge and confront conflict openly.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

4. Belonging

Group members listen with understanding to others.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

5. Involvement

Group members include others in the decision-making and planning processes.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

6. Support

Group members recognize and respect individual differences.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

7. Achievement

Group members recognize and respect individual differences.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

8. Pride

Group members value the contributions and ideas of others.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

9. Recognition

Group members recognize and reward the group's performance.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

10. Satisfaction

Group members encourage and appreciate comments about team efforts.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

Are there incidents, trends, or concerns you want to share that will help assess the team's climate?

Option C:

Please give your candid opinion of the team by rating its characteristics on the seven-point scale that follows each item. Circle the number on each scale that corresponds to your evaluation. Please give your opinion in each case, even if you are not certain.

Rating Scale: 1 = Extremely Low; 4 = Moderate, 7 = Extremely High

1. The level of trust in the group is:

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

2. The level of positive regard and respect for each individual is:

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

3. The level of openness (sharing of useful information) is:

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

4. The extent to which opportunities for information exchange and feedback are present is:

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

5. The ability and readiness to identify and solve problems are:

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

6. The level of opportunity for individual and team achievement is:

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

7. The extent to which resources, including appropriate equipment such as computers, are available is:

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

8. The degree to which incentives for individual and team achievement are available is:

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Comment:

Are there incidents, trends, or concerns you want to share that will help assess the team's climate?

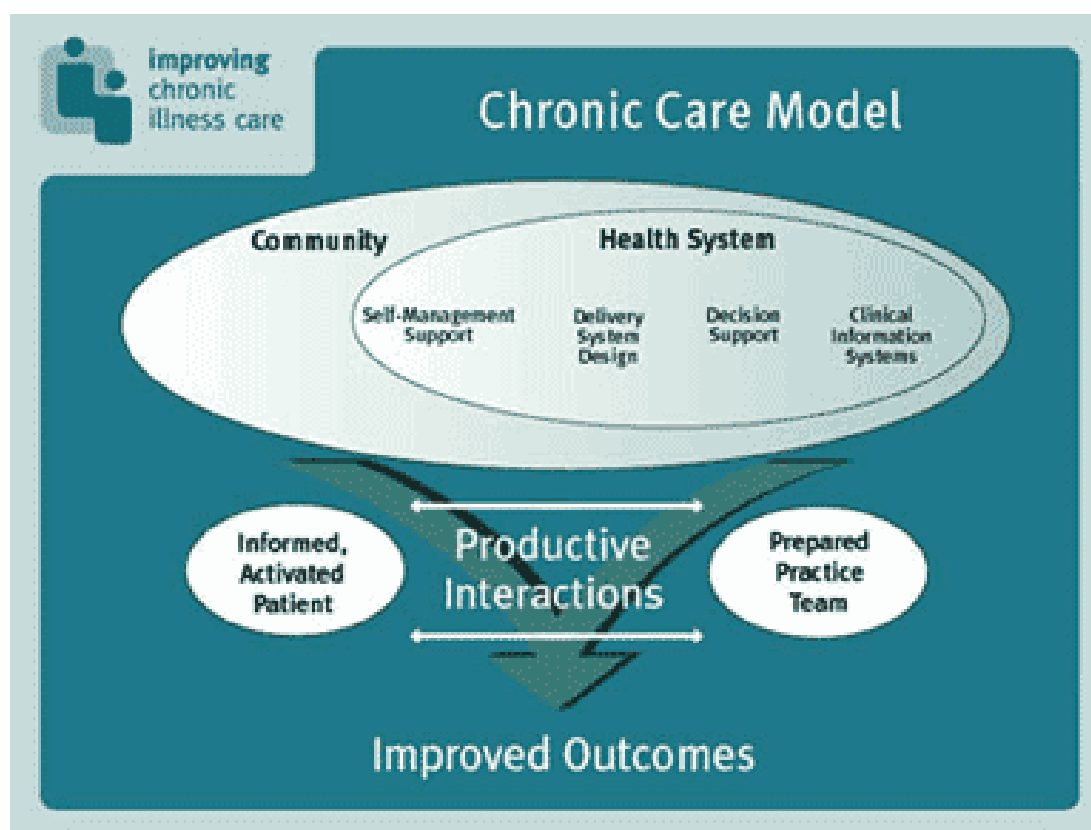
Appendix B: The Chronic Care Model

The Chronic Care Model (CCM)

The Chronic Care Model (CCM) is an organising framework for improving chronic illness care and an excellent tool for improving care at both the individual and population level. Based on a wealth of international evidence it has been widely adopted as a framework for health services delivery for people with LTCs and has been taken up by the World Health Organisation.

The model is based on the assumption that improvement in care requires an approach that incorporates patient, provider and system level interventions. It contains 6 elements but the model emphasises that it is the relationship between these – and in particular the productive interactions between an informed, activated patient and the prepared proactive team that is most effective in improving outcomes.

The Chronic Care Model was developed by Ed Wagner, MD, MPH, Director of the MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound and colleagues of the Improving Chronic Illness Care program with support from The Robert Wood Johnson Foundation.



[Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice. 1998; 1(1):2-4.]

Self Management

Effective self management is very different from telling patients what to do. Patients have a central role in determining their care, one that fosters a sense of responsibility for their own health.

Decision Support

Treatment decisions need to be based on explicit, proven guidelines supported by at least one defining study. Healthcare organisations creatively integrate explicit, proven guidelines into the day-to-day practice of the primary care providers in an accessible and easy-to-use manner.

Delivery System Design

The delivery of patient care requires not only determining what care is needed, but clarifying roles and tasks to ensure the patient gets the care; making sure that all the clinicians who take care of a patient have centralized, up-to-date information about the patient's status; and making follow-up a part of standard procedure.

Clinical Information System

A registry — an information system that can track individual patients as well as populations of patients — is a necessity when managing chronic illness or preventive care.

Organization of Health Care

Health care systems can create an environment in which organised efforts to improve the care of people with chronic illness take hold and flourish.

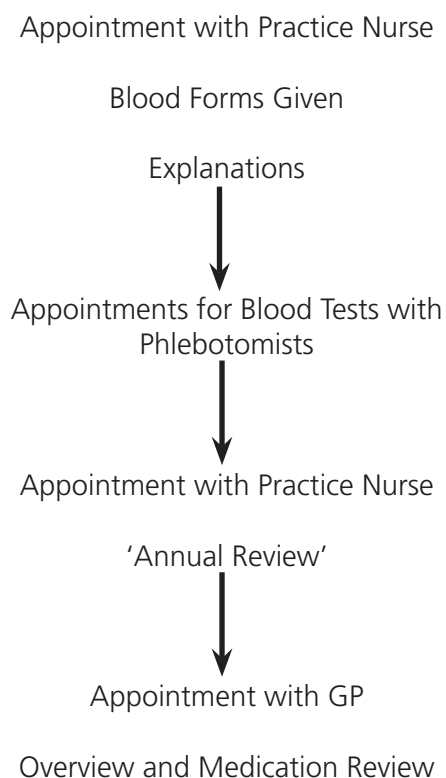
Community

To improve the health of the population, health care organisations reach out to form powerful alliances and partnerships with state programs, local agencies, schools, faith organisations, businesses and clubs.

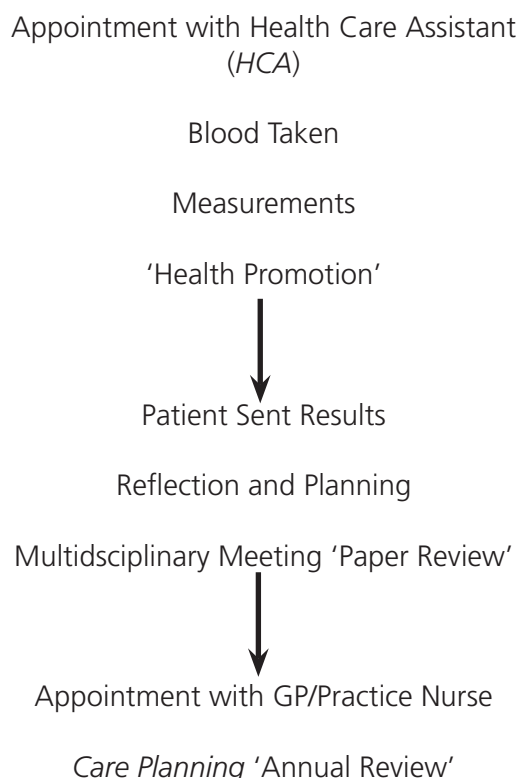
Appendix C: Worked Example of *Care Planning* with some Potential Workforce Options and Costs

Example: Practice A

Before *Care Planning*



After *Care Planning*



Each practice currently has different working arrangements and will choose individual approaches as these two examples demonstrate.

	Practice A				Practice B**			
	Before		After		Before		After	
	Person and time (mins.)	Cost £	Person and time (mins.)*	Cost £	Person and time (mins.)	Cost £	Person and time (mins.)	Cost £
Register and appointment	Admin (5)	2.03	Admin (5)	2.03	Phlebotomist (10)	2.11	Admin: robust search call and recall (10)	1.56
Tests ordering and taking	Nurse (15) Phlebotomist (10)	6.08 2.11	HCA – takes tests /send results (20)	3.17 1.06	Nurse practitioner 2 mins. call /recall 10 mins. invitation 30 mins. 'Annual review' discussion	16.65	HCA (20) Admin (5) Nurse practitioner (30)	3.12 0.78 11.89
Discussion / consultation	Nurse (30) Doctor (10)	12.16 8.00	Nurse (30)	12.16				
Total patient contact time with practice	4 visits 65 minutes		2 visits 50 minutes		1 visit 30 minutes		2 visits 50 minutes	
Total cost		30.38		18.42		18.76		17.35
*	Excludes multidisciplinary meeting to review records prior to consultation - and doctor time identified at that point							
**	Excludes supervisory and support role of doctor throughout							

Appendix D: Sample Letters

Kidneys: Your kidneys filter blood and make urine. High glucose levels and high blood pressure can damage your kidneys.

You have two tests.

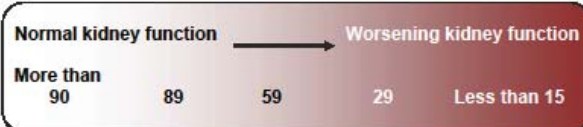
One test is a urine test which checks for protein kidney leakage (called an ACR, which stands for Albumin/Creatinine Ratio). The lower the number, the better.

ACR (urine sample)

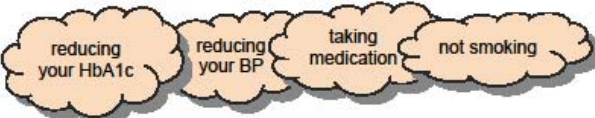


The other is a blood test which checks how your kidneys are filtering (called an eGFR, which stands for estimated Glomerular Filtration Rate). The higher the number, the better. It should be noted that the eGFR tends to worsen with age and the length of time you have had diabetes.

eGFR (blood test): this monitors kidney function

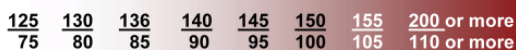


You can help reduce your risk of developing kidney disease by:



Blood Pressure (BP): Is the pressure of blood that flows through your body. The lower your blood pressure the lower your risk of developing complications like strokes and heart attacks

Best levels: You should aim for your blood pressure to be below 130/80, or below 125/75 if you have kidney problems.



You can help reduce your blood pressure by

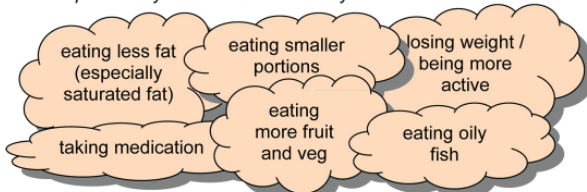


Cholesterol: Is a blood fat that can block blood vessels. Lowering your cholesterol can reduce the risk of heart attacks and strokes. Treatment to lower cholesterol is recommended in diabetes for people over 40. For other people treatment depends on your overall risk.

Best levels: Aim for 4 or less



To help reduce your cholesterol value you can

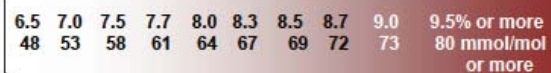


Your Diabetes Results



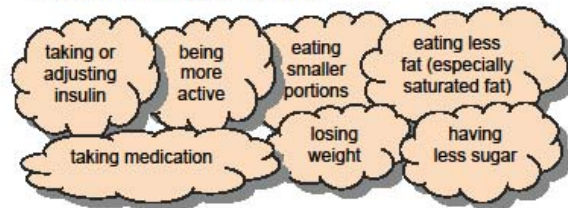
The purpose of this leaflet is to help you know what your results mean, and to help you consider your options to reduce the future chances of complications.

Diabetes Control/HbA1c: Glucose (sugar) travels around your body in your blood. The levels of blood glucose in your blood over the last few weeks can be measured and can show your future risk of developing complications. This test is called HbA1c. The higher the number, the higher the risk. (This is not the same as your blood glucose finger prick level)



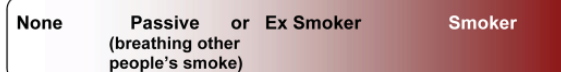
Best levels: Between 6.5%-7.0% / 48-53 mmol/mol is associated with your lowest risks of complications for the future.

You can help reduce your HbA1c by:

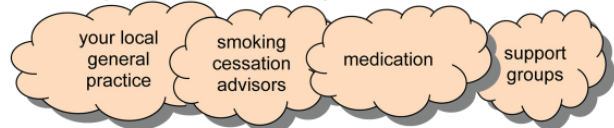


© Year of Care

Smoking: Causes many health problems but is particularly damaging for people with diabetes. If you smoke it can increase your risk of heart attacks and strokes. You are 9 times more at risk of a heart attack if you have diabetes and smoke than someone who does not smoke

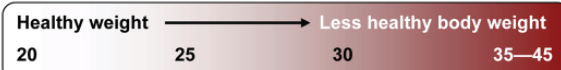


You can get support to stop smoking from:

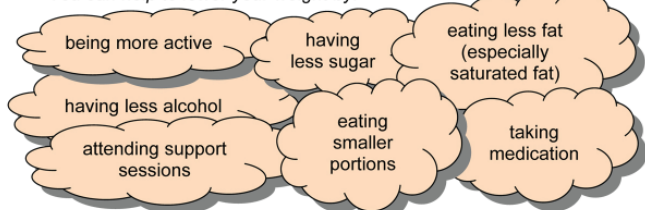


Weight: Being overweight increases your risk of medical conditions including heart disease, arthritis and earlier death. It can also make your diabetes and blood pressure more difficult to control.

Weight is measured as a **Body Mass Index (BMI)**. It compares your height to your weight and can be a way predicting your risk of developing a heart attack or a stroke.



You can help to lower your weight by:



Goal Setting and Action Plans

Goal Setting	Date:
--------------	-------

What do you want to work on?
What do you want to achieve?
How important is it to you?
Not important 1 2 3 4 5 6 7 8 9 10 Important

Action Plan

What exactly are you going to do?
What might stop you and what can you do about it?
How confident do you feel?
Not confident 1 2 3 4 5 6 7 8 9 10 Confident

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Diabetes Results and (Care) Plan

Diabetes Planning Appointment

Name:

Your Appointment:

Please bring this to your appointment as it will be used to record what you decide to do to manage your diabetes over the next year and what you would like to discuss at your review.

These are some of the things which people ask about. Circle any which are most relevant to you?

Medical check-ups	Your mood
Taking medication	Eating the right amount
Avoiding sugary foods	Giving up smoking
Monitoring glucose levels	Alcohol within limits
Healthier eating	Foot care
Pregnancy & Conception	Regular physical activity
	Sexual Health

What aspects of your diabetes would you like to discuss?

Your Results

Measurements that affect your future <i>risk</i> of health problems		
Diabetes Control: Your HbA1c is an overall measure of glucose control over the past 8-10 weeks. A level of between 6.5 and 7% or 48-53 mmol/mol is associated with the lowest <i>risk</i> of complications.		
Blood Pressure (BP): A target blood pressure of below 130/80 lowers the <i>risk</i> of complications (a target of below 125/75 is used if you have kidney disease)		
Cholesterol and Blood Fats: Lowering your cholesterol can reduce the <i>risk</i> of heart attacks and strokes. Treatment to lower cholesterol is recommended in diabetes for all people over 40 years. For other people, treatment depends on your overall <i>risk</i> . The target cholesterol is less than 4		
Smoking: Smoking causes problems with your health in many ways but is particularly damaging in people with diabetes.		
Weight: Being overweight increases the <i>risk</i> of many medical conditions including heart disease, arthritis and premature death. It can also make your diabetes and blood pressure more difficult to control.		
Mood: How you feel could make a big difference to your diabetes. What are your answers to these questions:		
<ul style="list-style-type: none"> • During the last month, have you been bothered by feeling down, depressed or hopeless? • During the last month have you had little interest or pleasure in doing things? 		
Your annual screening checks		
Kidney Tests: Your kidneys are tested by looking at a blood test (eGFR) and an early morning urine test (ACR). Ideally the higher the eGFR the better. Normally eGFR should be over 90. The ACR is better if under 3.0		
Eyes: Your eye check looks for any changes to tiny blood vessels at the back of your eye. This may be done at a different time to the other checks		
Feet: Your feet check detects if you have problems with circulation or the feeling (sensation) in your feet		

Appendix E: *Care Planning* Check List & Potential Items for Audit

Useful Features to Review at Setup

Lead clinician identified for practice

Practice meeting to agree aims and objectives and review attitudes to SSM

Whole team training around attitudes, SSM and *Care Planning*

Agree implementation team and reporting arrangements to the wider team

A practice 'pathway' for *Care Planning* identified

Roles and responsibilities of whole MDT identified (including administrative staff)

Training needs analysis for new roles

Training arranged and delivered

Review of IT arrangements for

- Call and recall and sending letters and results
- Recording goals and action plans
- Making available summary for clinician and person with diabetes
- Recording unmet need for commissioner
- Internal prompts to support practice

Availability of 'menu' of services to support self management

Agreement on audit and feedback arrangements for clinician and practice

Potential Items for Audit of Individual Care

No. of people in practice with diabetes where practice is responsible for annual *Care Planning*

% who have had information (chosen method) about the new arrangements

% who have been invited for first visit (data collection) and attendance rate

% who have had results and explanation provided some days prior to the consultation (chosen method)

% who have attended for second (*Care Planning* consultation)

% who have brought results and evidence of some reflection on them

% with goals and action plans recorded in the health record and available at next visit

% with individual review date agreed

% with record of discussion of action plans at next visit

From an agreed sample

% who have completed a 'tool' assessing the quality of the *Care Planning* consultation and its outcome e.g. CQI - DM, PPIC or HCCQ

% who have answered

- Either a single question e.g. Percentage of people who say they are confident that they can manage their own health.
- Or completed an 'outcome' questionnaire e.g. PAM

Useful Features for Ongoing Practice Support for *Care Planning*

Planned approach to reviewing how well the team is doing in supporting *Care Planning*

- Use of 'reflective' exercise by clinicians
- Review of team working eg TCQ
- Action on current audits
- Feedback from patient groups or representatives
- Arranged 'walk throughs' with patients

Ongoing skills development/maintenance e.g. case based discussions, further training

Reviewing systematic links with other parts of the condition pathway e.g. structure education

Induction of new staff

Patients access to e-health record and regular information on service developments

Feedback on use of community services (menu)

Review of costs, contact time, clinical/admin ratios before and after skill mix changes

Patient group or forum to support redesign and feedback on their experience

Appendix F: Policy Context

Care Planning has been recognised as a key component of care for people with *long term conditions* for 10 years. A sample of key policy documents which provide a wealth of information, are listed here.

The NHS Plan. A plan for Investment, A plan for Reform. 2000.

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960

The National Service Framework for Diabetes: Delivery Strategy. 2003.

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003246

Supporting people with *long term conditions* to self care. 2006 (includes the Expert Patient Programme (EPP)).

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4130725

High quality care for all: NHS Next Stage Review final report. 2008.

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

Supporting people with *long term conditions*: commissioning personalised *Care Planning* - a guide for commissioners. 2009.

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093354

Equity and Excellence. Liberating the NHS. 2010.

www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

Appendix G: Glossary of Terms

Activation: A person with a *long term condition* can be said to be 'activated' to self manage when they have the "*knowledge, skills and confidence to manage their own health and healthcare*".

Care Planning is a particular example of SSM for people with LTCs. Care Planning can be defined as the regular and repeated structured and proactive process that takes place between the person with an LTC and the health services, based on a collaborative interaction and replaces current routine care. It may include coordination of care components as well as SSM and will integrate the demands of more than one condition.

Case Management is a process of one to one care, usually for people who are frail or have multiple health and social care needs, where the coordination of care across various parts of the health and social care system is paramount. It may include decisional support, taking patient preferences into account across a wide variety of situations and involve supporting them to self manage when living independently.

Co-creating Health Programme is a programme within the Health Foundation. It consists of an integrated package of support, exploring the delivery of *support for self management (SSM) in long term conditions*, (diabetes, COPD, chronic pain and depression) via three interrelated programmes: a self management programme for people with long-term conditions, a skills based programme for practitioners (the Advanced Development Programme: ADP) and a programme introducing recognised improvement techniques to facilitate organisation development and partnership working in the clinical teams.

Discussing risk is an important element in all discussions with people with LTCs. The focus in *Care Planning* is often on medium to long term *risks* associated with one or more lifestyle changes or behaviours. In *case management*, the *risks* associated with various degrees of independence and the actions to mitigate these may be central. In *shared decision making*, *risks* of the various interventions under discussion is a key element of the discussion as are the tools available to support any particular intervention.

HCP: Health Care Professional

Long Term Condition: A *long term condition* as one that cannot currently be cured but can be managed with the use of medication and/or other therapies. This is in contrast to acute conditions which typically have a finite duration such as a respiratory infection, an inguinal hernia or a mild episode of depression.

QIPP stands for Quality, Innovation Productivity and Prevention, the key themes identified in the 'Darzi Review' - High Quality Care for All (2009). "*The QIPP initiative is identifying how efficiencies can be driven and services redesigned to achieve the twin aims of improved quality and efficiency.*" Equity and Excellence: Liberating the NHS, Department of Health white paper, July 2010.

Shared decision making is the process by which a health care provider communicates personalised information to patients about the outcomes, probabilities and scientific uncertainties of available treatment options and patients communicate their values and the relative importance they place on benefits and harms. *Shared decision making* is most appropriate where treatments are preference sensitive, e.g. situations where two or more medically acceptable options exist, such as treatment for prostate or breast cancer. In these situations the clinician will act on the outcome of the decision making process in terms of recommending the procedure or prescription. Decision support tools including videos and web based programmes can also be put in place which patients can use and which may increase their satisfaction with the decision making process.

Support for Self Management (SSM) acknowledges that "*people with LTCs are in charge of their own lives and self management of their condition and are the primary decision makers about the actions they take in relation to the management of their condition.*" The focus moves from the clinician doing things 'to' the person, to enabling clinicians to support people's confidence and competence to manage the challenges of living with their condition.

The Year of Care Programme is a partnership programme between the Department of Health, Diabetes UK, NHS Diabetes and the Health Foundation being developed in three diverse pilot PCTs. It has two components. It 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 Year of Care House developed by the programme, is a model for the organisational requirements to support the *Care Planning* consultation.

Appendix H: Commissioning *Care Planning*

Care Planning as described in this document encourages practice teams to develop new skills and use resources in new ways both within a practice and within the wider health community. In this way it impacts directly on commissioning. This section describes what might be involved.

Care Planning within a single practice.

You may decide to implement *Care Planning* in your own practice, working together as a team and reorganising your own resources. The check list in appendix E would be a good place to start. It includes the steps to ensure that there is a supportive environment for *Care Planning* to take place. Information for people with diabetes may have to be written or copied from the examples used here. Clinical staff can get feedback on their performance (using the recommended tools). Administrative staff can audit what happens now, how much it costs and how much it might cost in the future. Involving your patient participation group (if you have one) will also help your practice to match its approach to the needs of its population.

This will take time and effort on everyone's part. You may need to absorb both 'set up' and double running costs to begin with. Long-term *Care Planning* seems to be cost neutral in terms of the resources spent on an individual over a year and in practices where senior clinical staff currently do most of the tasks, there may even be savings. However, *Care Planning* is not primarily about cutting costs, it is about improving the quality of our care for people with LTCs. In addition you may also need outside support with your IT programme to implement *Care Planning* in your practice.

While a few practices have started in this way, the experience from *The Year of Care Programme* is that 'tailored training', eventually for the whole team, is essential and needs to be resourced. Section 3.3.1 describes the training that is currently available.⁴⁹ Economies of scale mean that this is best delivered to a group of around 10 practices, making it suitable for a cluster, Federation or local practice grouping. Working together with other practices also enables new staff to be trained as they are appointed and for high quality materials for people with diabetes to be produced in bulk.

Year of Care practices have also found that to realise all the benefits of *Care Planning*, they need to look again at the whole care pathway for people with diabetes. Those who had been on educational programmes such as DESMOND or local 'taster' programmes where health literacy was poor, were able to engage more effectively in *Care Planning* from the beginning. Developing a 'menu' of non traditional services to support people with carrying out their goals and action plans in the community also required external support and commissioning. Finally, all practices benefitted from having someone to coordinate the support and peer review, ongoing skills development, help solve incidental problems and ensure that *Care Planning* was developed and then sustained as an integral part of the local diabetes services (see Section 3.3.4).

Commissioning *Care Planning* for a Group of Practices

There are many benefits to introducing *Care Planning* across a group of practices with strong GP leadership. The proposed commissioning arrangements in 'Equity and Excellence: Liberating the NHS' provides ideal opportunities for groups of practices who wish to work in this new way.

This section considers how to commission *Care Planning* itself and the additional support services required. It also provides a framework for a commissioning group to consider the overall resource use for people with LTCs as a prelude to redesigning services across the whole local health economy.

Commissioning *Care Planning*

Until details of the new arrangements sign posted in the White Paper become clearer, *Care Planning* will need specific commissioning arrangements. This is usually in the form of a Local Enhanced Service (LES) agreement (often a component of wider LES for diabetes services). The boxes below outline some of the elements which are currently included in LES agreements. They all acknowledge that since *Care Planning* is relatively new, agreements need to include a variety of core and developmental components.

49 NHS Diabetes. 2008. Care Planning training. www.diabetes.nhs.uk/our_work_areas/year_of_care/care_planning_training1/

LES agreements stipulate certain practice behaviours such as attendance at training or use of certain codes for electronic health records. Commissioners also need to make provision for support activities (quality assured training, educational activities, IT support). They may choose to require the individual practice to access these themselves and cover the cost within the LES; or to commission these separately from other providers. This latter approach which is currently more common, is helpful in developing a local community of practice as well as for staff who may work across practices.

Box 1: Features Common to all Local Service Agreements

A Lead Individual within the Practice

A statement of the local model of care for diabetes e.g. which people with diabetes should have *Care Planning* in the practice (the denominator for monitoring)

A requirement to keep a register

A requirement to assess staff competencies (against a recommended list which usually maps to national competency frameworks but may include others) and to ensure they are up to date and include new staff

A requirement for test results to be made available to the individual in an understandable form one to two weeks before the consultation

A requirement for staff to have received quality assured *Care Planning* training

A requirement for information about the *Care Planning* process to be provided in an appropriate format for the individual

A requirement for individuals to receive a summary care plan in accessible form after the consultation and for it to be recorded systematically on the electronic health record (EHR) so it can be accessed as part of the ongoing diabetes care

A requirement for arrangements to be made for those with health literacy or language issues

A requirement for appropriate arrangements for vulnerable or disadvantaged groups relevant to the practice (BME, disability, housebound, travellers, residential homes)

A requirement to make anonymised data available to commissioners

Box 2: Features in some LES Agreements

Production of a Structured Annual Report

An outline of the expected *Care Planning* pathway (may include contact time , staff grades frequency of activities etc (see example))

Codes to be used

Taking part in ongoing educational activities e.g. sharing of data and peer review of *Care Planning*

Monitoring the 'quality' of care plans

Provide examples of outputs of *Care Planning* (goals and their achievement over a 6 month period) for the purpose of monitoring quality and tailoring further education

Reporting of unmet need for services to support self management in the community in anonymised form (IT dependant)

Reporting the use and usefulness of community services to support self management in anonymised (IT dependant)

Monitoring arrangements

There is currently no consistent approach, although metrics and codes have been developed for some aspects. Where there is a 'diabetes dash board' these can be added. Some commissioners choose to monitor the output of *Care Planning* (e.g. count care plans) and take the *risk* of encouraging a 'tick box' activity; others aim to incentivise the new approach and the process of *Care Planning*. They opt for proxy measures such as recording if test results have been sent out and attendance at educational activities. Some are allowing self reporting that *Care Planning* has taken place, most are highlighting their intention to include exit questions or questionnaires, 'mystery shoppers' or other means to assess this more formally in the future.

Box 3: Examples Used for Monitoring Performance in LES Agreements

Numerical indicators sometimes use standard and stretch levels (with linked payments)

The production of a structured annual report

% of registered patients who have 'undertaken *Care Planning*' (increasing year on year)

% of individuals who had test results sent out prior to the *Care Planning* appointment

% of individuals who have received test results prior to the *Care Planning* appointment

% of individuals who have received a summary care plan in accessible form

% of review or educational meetings attended

Objective completion of the *Care Planning* template provided to the system

Developmental

Practices that have completed self reflection tools and/or personal development plan for a specified number of patients

Increasingly positive scores for an exit question (Section 4)

Box 4: Financial Arrangements

A variety of payment methods are in use
Some make a distinction between payment for involvement in the process and payment for activity
Some pay for a percentage of the registered population or for a numbers of individuals to have been involved in *Care Planning*
Most include other elements of diabetes care over and above *Care Planning*
One LES included the requirement for 'open book' arrangements during the first year to enable better assessments of costs of *Care Planning* to be made

Commissioning *Care Planning* in the Future

At the time of going to press it is unclear what guidance the National Commissioning Board will provide about payment for activities by GP providers where part might be included in basic ('new GMS') care and part locally commissioned. *Care Planning* falls into this category. For instance national guidance^{50,51} including NICE Quality Standards for Diabetes (currently out to consultation)⁵² proposes *Care Planning* should be the norm for everyone. Consortia will have to be guided, or decide whether they continue with 'LES-like' mechanisms for all or part of such a process. Long term *Care Planning* may be considered part of routine care, with consortia commissioning for the additional resources required at start up, for very disadvantaged populations and for ongoing training and coordination. It seems likely that the Commissioning Board will encourage such local flexibility. This is potentially an area for learning by pathways consortia, supported by the current College Commissioning Centre.

Commissioning Non Traditional Community Services to Support Self Management.

The *Care Planning* process which replaces the annual review makes the need for referral/support services more transparent, potentially assisting commissioners in identifying the needs of their population more accurately. While some will involve traditional service use which will be better quantified, better support for an individual's self management goals is the key outcome. Currently such services are very patchily available from a variety of NHS, independent and third sector providers and are poorly linked with practices, who may have little idea of their function or effectiveness. Detailed information for commissioners on how to procure such services and specifically how these can be linked to the *Care Planning* process as a 'menu', will be available early in 2011. (YOC)

Additional Benefits for Commissioners

Introducing *Care Planning* has not only benefitted people with diabetes and other LTCs and improved job satisfaction for staff. It has led to a more systematic approach to care of people with LTCs within the practice. It has also had wider effects on commissioning for a whole population. Figure 1 demonstrates how Commissioners have been challenged to look at the whole budget for people with diabetes to enable them to resource increased personalised care, either within the health service structures or out in the community. It has provided the incentive to redesign services across the whole local system of care, with a greater emphasis on support for people to manage their condition more confidently closer to home, within their own communities and potentially at less cost. For instance the cost of seeing a dietician in a traditional setting for weight loss is £21.25 per hour. A senior health trainer working with them to design a tailored package to support the personal goals they have identified during *Care Planning* is approximately half that (£11.46 per hour).

50 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003246

51 www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/

52 www.nice.org.uk/newsroom/pressreleases/DraftQualityStandardsDiabetesGlaucoma.jsp

What Needs to be Commissioned from Available Resources?

