

# Care Planning in Diabetes



Report from the joint Department of Health and Diabetes UK Care Planning Working Group

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## Foreword



People with diabetes have a crucial role to play in managing their condition on a day-to-day basis and care planning, a key component of Standard 3 of the Diabetes National Service Framework (NSF), can support them to do this.

The NSF Standard 3 sets out a change in traditional practice and this report will help everyone in diabetes services to move towards a partnership approach between health professionals and people with diabetes. It offers guidance on incorporating care planning into diabetes services and includes examples and signposts to good practice. For the first time, the evidence to support care planning in diabetes is brought together in a useful and practical form and the opportunities for further research are highlighted.

These changes will challenge diabetes teams to work in new ways. However, where this is being tried, there is not only improved patient experience, but staff report greater job satisfaction.

I would like to thank the members of the joint Department of Health and Diabetes UK Care Planning Working Group for developing the guidance contained in this report. It will help diabetes teams to offer a service that encourages partnership in decision-making and supports people in managing their diabetes, enabling them to experience the best possible quality of life.

**Rosie Winterton MP**

Minister of State for Health Services



## Executive Summary

Care planning can be defined as a process which offers people active involvement in deciding, agreeing and owning how their diabetes will be managed. It aims to help people with diabetes achieve optimum health through a partnership approach with health professionals in order to learn about diabetes, manage it and related conditions better and to cope with it in their daily lives. Care planning is one of the key interventions required to achieve Standard 3 of the Diabetes National Service Framework: empowering people with diabetes.

This report, from the joint Department of Health and Diabetes UK Care Planning Working Group, contains guidance on the care planning process for diabetes services.

- Section 2 sets out the policy context in which care planning for people with diabetes has been developed.
- Section 3 describes in detail the principles and processes of care planning and provides an example of what it might look like in action.
- Section 4 outlines the evidence base for the model of care planning contained in this report.
- Section 5 focuses on workforce issues, outlining the National Workforce Competences for Diabetes that are relevant to care planning and which could form the basis of skills development in this area.
- Section 6 concentrates on putting care planning into practice. It lays out the key elements of a care planning process with some suggestions and examples of how it might be incorporated into diabetes services.
- Section 7 deals with quality assurance of the care planning process.

The report aims to be a useful point of reference for all involved in the care planning process.



## Section 1: Introduction

Diabetes is a chronic and progressive disorder that can have an impact upon almost every aspect of life. It can affect children, young people and adults of all ages, and is becoming more common. In 2005, it was estimated that 2.35m people in England, 4.7% of the population, had diabetes, of which 1.8 million were diagnosed. It is predicted that, by 2010, 5.05% of the population, or more than 2.5 million people, will have diabetes. Some sectors of the population are more prone to diabetes than others, with black and minority ethnic groups being particularly adversely affected.<sup>i</sup>

Delivering effective care planning is an integral part of delivering both the Diabetes NSF and the broader agenda for NHS and social care reform. However, the care planning process is not widely understood and is frequently confused with the concept of a care plan. In order to develop further guidance on how the care planning process should work within diabetes services, the joint Department of Health and Diabetes UK Care Planning Working Group for Diabetes was established in July 2005. The remit of the group was to:

- Define care planning
- Identify criteria for quality and how to assess it
- Highlight examples of care planning in practice
- Identify gaps where more work could be done
- Review the evidence base for care planning
- Publish a report setting out guidelines for care planning, to be implemented at local level.

Simon O'Neill, Director of Care and Policy, Diabetes UK, and Dr Sue Roberts, National Clinical Director for Diabetes, jointly chaired the Working Group. A full list of contributors to the report is attached at Appendix A.

<sup>i</sup> Further information is available from the 2004 Health Survey for England and from the Yorkshire and Humber Public Health Observatory Diabetes Key facts document. See <http://www.ic.nhs.uk/pubs/hlthsvyeng2004ethnic/HSE2004Headlineresults.pdf> file and <http://www.yhpho.org.uk/download.aspx?urlid=356&urlt=1> . .

## Introduction



A policy collaborative has been launched to support the Department of Health in taking forward the commitments made in *Our health, our care, our say* in respect of a common assessment framework for adults and integrated personal health and social care plans.<sup>ii</sup> This work is expected to define common principles for assessment and care planning for adults with long term care needs. The proposed principles of care planning as set out in this document will inform the ongoing work of the collaborative and will be reviewed in the light of the outcomes of the collaborative.

ii Information about the ongoing work of the collaborative is available at [www.socialcare.csip.org.uk](http://www.socialcare.csip.org.uk)



## Section 2: Policy context

Engaging patients in their own healthcare and encouraging people to take responsibility for protecting their health is widely seen as the best way to ensure the sustainability of health systems in a time of technological progress and increasing demand<sup>1</sup>. In a report for the UK Treasury, Wanless<sup>2</sup> argued that encouraging effective self care, along with measures to promote prevention and the appropriate use of community care, rather than more expensive secondary care provision, could slow the increase in spending on health services. Achieving this may however require a significant change in the way that health professionals in the UK work with patients, according to evidence from comparative surveys conducted around the world<sup>3</sup>. In these surveys only 42% of UK adults said that their regular doctors usually involved them in treatment decisions and only 74% said their doctors gave clear goals and a treatment plan. Both percentages were less than in the other countries surveyed. The Diabetes Information Jigsaw Report<sup>4</sup> suggests that more could be done to engage people with diabetes in the UK.

The role of care planning to support people with long term conditions is outlined in several national policy documents, which highlight the importance of incorporating care planning into any local diabetes service.

### The Diabetes National Service Framework (NSF)

The Diabetes NSF was established to drive up service quality and tackle variations in care.<sup>iii</sup> It sets out twelve standards to be achieved by 2013. Standard 3 of the Diabetes NSF highlights the importance of empowering people with diabetes to take an active role in managing their condition:

“All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be

iii Department of Health (2001), *National Service Framework for Diabetes: Standards*.





reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in the process.”

The Diabetes NSF Delivery Strategy further states:

“A care plan is at the heart of a partnership approach to care and a central part of effective care management. The process of agreeing a care plan offers people active involvement in deciding, agreeing and owning how their diabetes will be managed. Whilst the overall goal is a genuine partnership, the person with diabetes must feel that they are comfortable with what is proposed and that they do not have to bear more responsibility than they wish”.<sup>iv</sup>

## Our health, our care, our say: a new direction for community services

The recent white paper, *Our health, our care, our say*, sets a new direction for the whole health and social care system.<sup>v</sup> Services will be designed around the individual, rather than the needs of the person being forced to fit around the service already provided. The emphasis is on supporting self care, promoting well being and community engagement, as well as prevention and early intervention. There will be more support for people with long term conditions who will be encouraged to manage their conditions themselves with the right help from health and social care services. Steps to help local services develop strategies to support self care for people with long term conditions are set out in *Supporting people with long term conditions to self care: a guide to developing local strategies and good practice*.<sup>vi</sup>

Care planning is an integral component of delivering support for self care for people with long term conditions. The white paper contains the following commitment:

“We will ensure that, ultimately, everyone who requires and wants one will have a personal health and social care plan as part of an integrated health and social care record. Initially we will focus on offering integrated care plans to those individuals

iv Department of Health (2002), *National Service Framework for Diabetes: Delivery Strategy*.

v Department of Health (2006), *Our health, our care, our say: a new direction for community services*.

vi Department of Health (2006), *Supporting people with long term conditions to self care: a guide to developing local strategies and good practice*.



who have complex health and social care needs. By 2008 we would expect everyone with both long term health and social care needs to have an integrated care plan if they want one. By 2010 we would expect everyone with a long term condition to be offered a care plan”.

It is through the care planning process that these care plans will be developed. It is therefore vital for local service providers to ensure that care planning is available to all people with long term conditions. As stated on page 5, a policy collaborative has now been launched to support the Department of Health in taking forward the commitments made in *Our health, our care, our say* in respect of a common assessment framework for adults and integrated personal health and social care plans.

## Building on the best: Choice, responsiveness and equity in the NHS

Patient choice is designed to support the shift in the NHS to a patient-centred service and improve patient experience.<sup>vii</sup> In addition, increased choice should encourage providers of services to become more responsive to patients’ needs.

The Department of Health wants to extend choice beyond elective hospital care to a wider group of patients. The Department is now developing a “Framework for Choice” which will take forward *Building on the Best* by setting the policy direction and priorities for increasing choice in other service areas, for example for people with long term needs.

Care planning should be an integral part of the process of providing meaningful choice for people with diabetes. By ensuring that people with diabetes are informed and engaged in their care, they can take a more active role in making decisions between the different care options that are available.

vii Department of Health (2004), *Building on the best: Choice, responsiveness and equity in the NHS*.

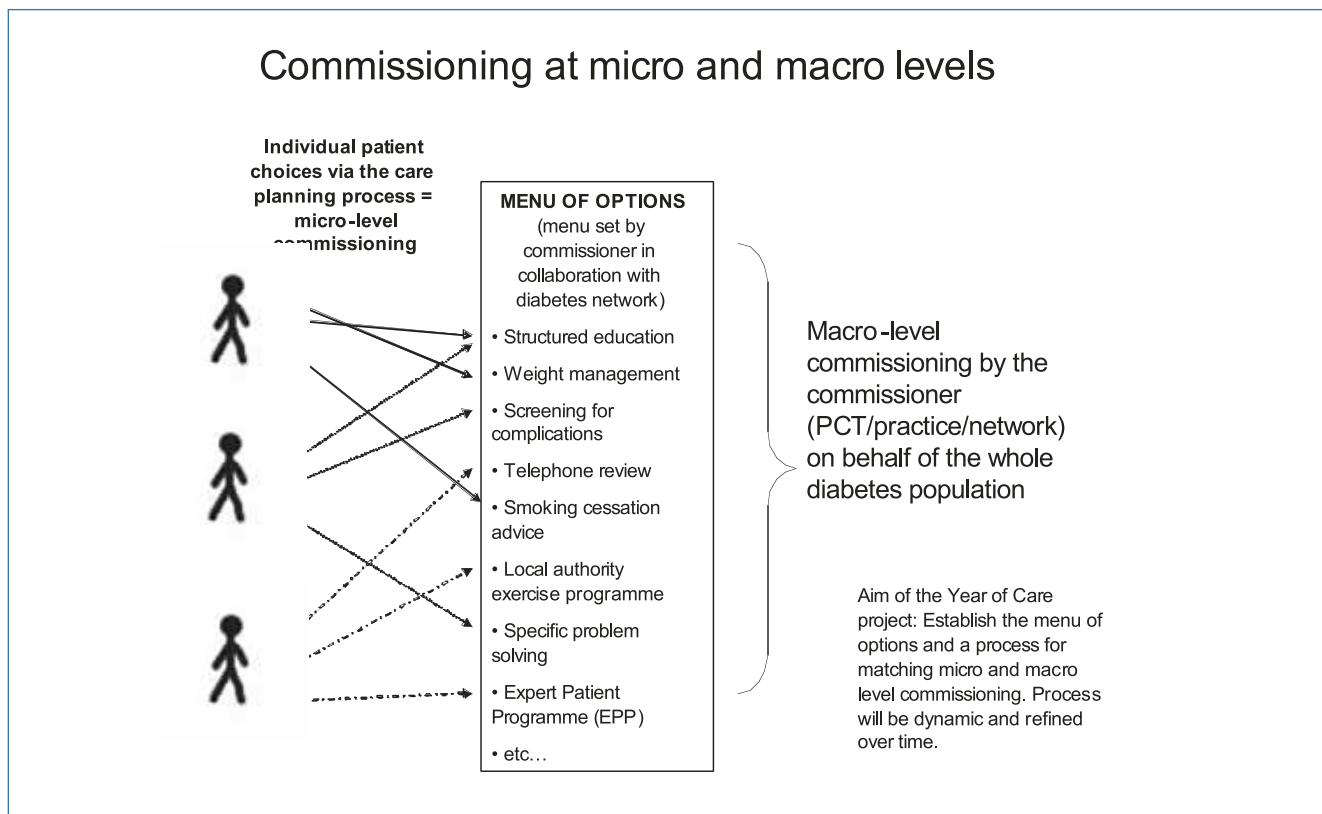


## Commissioning

Commissioning is seen as the mechanism by which services can be improved and money invested according to local priorities. Every PCT is responsible for commissioning the full range of health services for its population, working in partnership with practices and diabetes networks. Commissioning is therefore the main process for deciding what services will be delivered and how much will be invested in different service areas. This report aims to provide local commissioners with the information they need in order to implement high quality care planning for their local populations.

## The 'Year of Care' Project

A 'Year of Care' describes the ongoing care a person with a long term condition should expect to receive in a year, including support for self management, which can be costed and commissioned [see diagram].





Each 'Year of Care' will be designed by a person with diabetes and a healthcare professional via the care planning process. The person's individual needs should form the basis of each 'Year of Care'. The project should therefore help to open up choice for people with long term conditions.<sup>viii</sup>

Care planning can be described as commissioning on a 'micro' level, where individual patients are supported to make decisions about their own care. The national 'Year of Care' project is planning to test the application and impact of system reform policies such as choice and commissioning in an important group of people with long term conditions. The *Choosing Health, making healthy choices easier* White Paper set out a national strategy to improve health and prevent disease. It stated that "The independent sector may have a key role in providing effective behaviour change programmes in ways that are more acceptable than traditional NHS care to some groups of patients. We will test this as part of a procurement for a 'year of care' for diabetic patients".<sup>ix</sup> The commitment to test a Year of Care approach was reinforced in *Our Health, our care, our say*.

## Further information

Further information on the policy context can be found at appendix B.

viii Further information about the Year Of Care Project can be found at:  
[http://www.diabetes.nhs.uk/Work\\_areas/Year\\_of\\_Care.asp](http://www.diabetes.nhs.uk/Work_areas/Year_of_Care.asp).

ix Department of Health (2004), *Choosing Health: Making Healthy Choices Easier*, pp. 143-145.



## Section 3: What is care planning?

### Care planning and diabetes

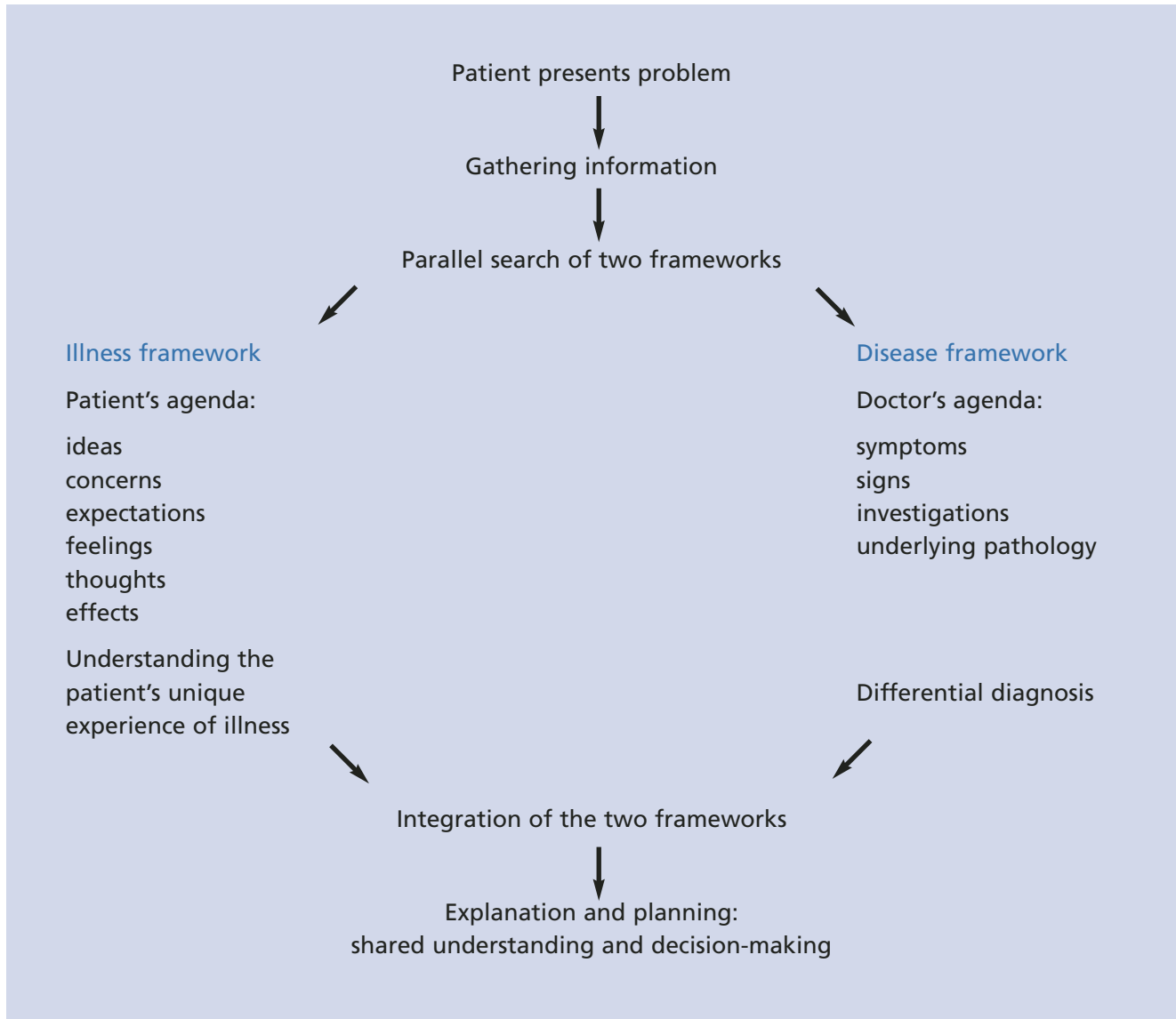
Care planning, combined with structured education, can empower people with diabetes to make choices about how they manage their condition on a day-to-day basis.

Care planning can be defined as a process which offers people active involvement in deciding, agreeing and owning how their diabetes will be managed. It aims to help people with diabetes achieve optimum health through a partnership approach with health professionals in order to learn about diabetes, manage it and related conditions better and to cope with it in their daily lives.

### The principles of care planning for diabetes and other long term conditions:

Care planning is underpinned by the principles of patient-centredness and partnership working. It is an ongoing process of two-way communication, negotiation and joint decision-making in which both the person with diabetes and the healthcare professional make an equal contribution to the consultation. It differs from the 'paternalistic' or 'healthcare professional-centred' model of consulting, traditionally applied in acute settings.

The *Disease-Illness model* has been proposed as a means of achieving this<sup>5</sup>. It emphasises the importance of the healthcare professional's perspective of disease and pathology but suggests these should always be considered in parallel with, and in equal importance to, the patient's individual experiences of their condition (see figure). This specifically includes eliciting the individual's ideas, concerns and expectations of their condition and treatments.



### The "Disease-Illness model" as described by Stewart and Roter, 1989

During a care planning consultation, the person with diabetes and the healthcare professional raise and discuss their respective concerns, prioritise these, explore the options available and make mutually agreed informed decisions about ongoing care. A care planning approach recognises that people with diabetes may engage with the process in different ways, with one individual choosing a very different degree of control over their care from another. Therefore the environment in which care planning takes place should be flexible and responsive.

## What is care planning?



This report focuses on people with diabetes, but care planning is an inherently holistic and person-centred rather than condition-centred approach. Therefore, it is ultimately envisaged as a model of care for all individuals with long term conditions. For those with more than one long term condition, care planning could provide a single, comprehensive and patient-centred review, rather than multiple reviews for each individual condition. At an organisational level, care planning should therefore enhance and promote coordination of health and social care services and support local commissioning. At an individual level, this ensures that all personal, social and health-related issues are given the appropriate level of consideration.

The components of care planning can improve the experience and satisfaction of both people with diabetes and healthcare professionals.<sup>x</sup> The crucial aim of improving health outcomes will be facilitated by combining effective, systematic and evidence-based clinical care with the collaborative decision-making process that care planning provides.

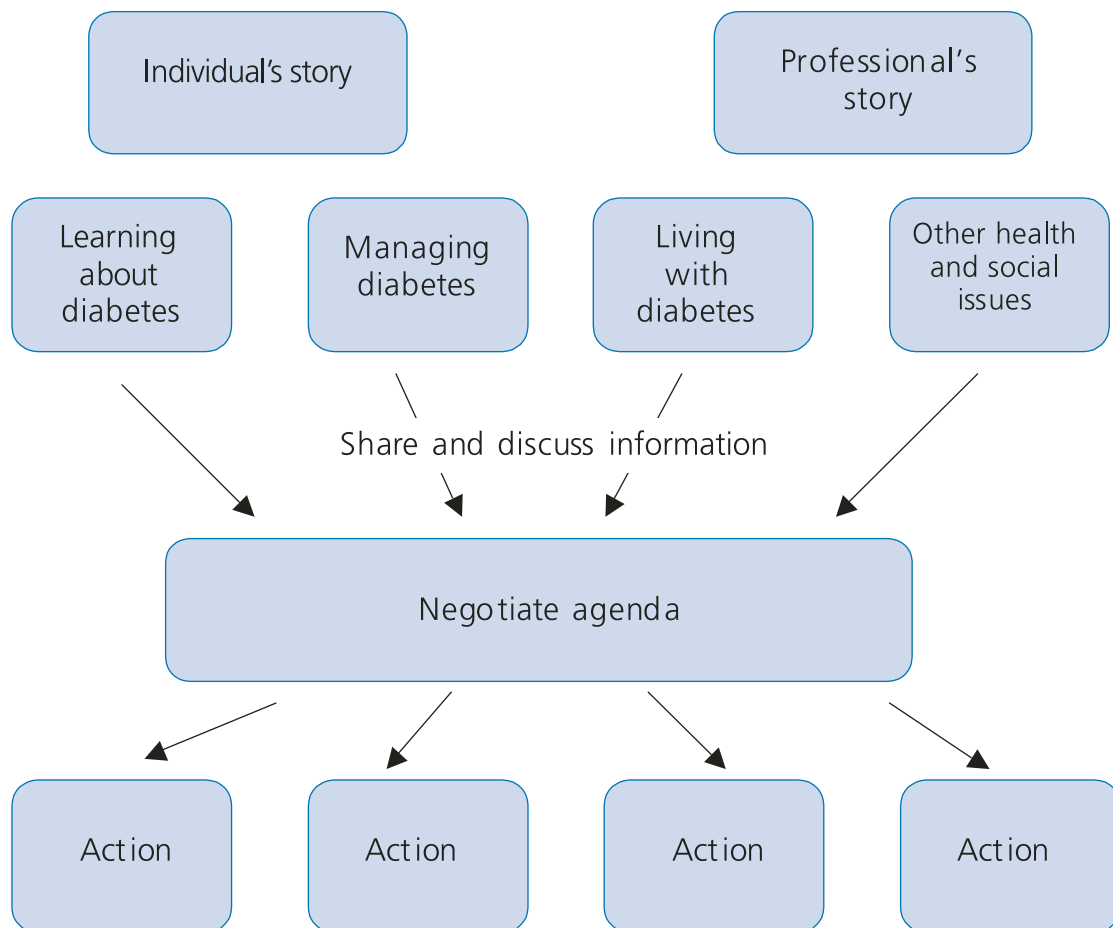
People with diabetes need to be enabled to take part in the care planning process. It is therefore important that it is flexible and adaptable so that the individual needs and preferences of the person with diabetes can be met. These might include, but are not limited to, language barriers, learning disabilities and other communication needs. In some situations, it will be important for others, e.g. parents or carers, to be involved in an holistic assessment and mutually agreed action plan.

x See section 4: The evidence base for care planning..



## The care planning model:

The National Diabetes Care Planning Working Group has developed a model for effective care planning based on the vision set out in the Diabetes NSF and the Matrix report *Good care planning for people with long term conditions* commissioned by the NHS Modernisation Agency.<sup>xi</sup> The model draws on research in clinical practice, psychology and education to set out a process of negotiation and shared decision-making between the healthcare professional and the person with diabetes. Where appropriate, family members or carers should be involved in this process.



xi NHS Modernisation Agency (2004), *Good care planning for people with long-term conditions*. This report is available electronically at: <http://www.networks.nhs.uk/news.php?nid=289>.



# What is care planning?



## Components of the model:

### The individual's story and the professional's story:

The care planning model is based on the principle that both the individual person with diabetes and the healthcare professional will bring an agenda or 'story' to the consultation. In order to facilitate the making of mutually agreed informed decisions, eliciting and understanding the various concerns and perspectives of each participant is paramount.

The process provides the individual with the opportunity to raise concerns, ask questions and explore their position on topics raised. These topics may not necessarily be exclusive to their diabetes, but may include psychological and social concerns.

The healthcare professional's agenda will, at least in part, relate to the health prevention and biomedical management aspects of care.

### Possible topics for discussion:

Four broad domains are included in the model as potential areas for discussion. These are not intended as a checklist and may not all be relevant to each individual. They recognise the multifaceted impacts of living with diabetes, and any co-morbidities, and facilitate a holistic approach. This ensures one issue does not dominate the consultation at the expense of other potentially more relevant topics.

## 1. Learning about diabetes

This might include:

- Discussing questions asked by the person with diabetes.
- Identifying sources and means of obtaining information that are most helpful for the person.<sup>xii</sup>

xii *Our health, our care, our say* contained a commitment to introduce Information Prescriptions for everyone with a long term condition or care need by 2008. These individual prescriptions – drawing on local as well as national knowledge and information – will point people to the relevant websites, telephone numbers and support groups for their condition. They will help people with long-term conditions to stay independent and take control of their illness. Further information can be obtained from the press release 'Tomorrow's patients will have information prescribed alongside medicines', issued on 18 October 2006 and available from <http://www.gnn.gov.uk/>.



- Proactively considering future information needs and how these might be met.
- Reflecting on the impact of structured education.
- Discussing what learning has arisen for the person as a result of their day-to-day experiences and how this will affect their future behaviour in similar circumstances.
- Practical demonstrations and information about new equipment and resources that become available.

## 2. Managing diabetes

This might include:

- Medications and treatments for diabetes and related conditions, as well as perceived and real side effects.
- Monitoring and surveillance processes.
- Self monitoring.
- Managing situations such as illness or lack of medication.
- Health-related behaviour such as smoking, diet and physical activity
- Referrals to other agencies or health professionals.
- Planning future treatment changes such as commencing insulin therapy or renal replacement.

## 3. Living with diabetes

This might include:

- Day-to-day social, work and family issues.
- Practical considerations such as travel and physical activity.
- Managing the effects of medication such as hypoglycaemia.
- Managing the effects of long term diabetes complications.
- Psychological effects and coping strategies.
- Planning for future life events such as pregnancy and retirement.

# What is care planning?



## 4. Other health and social issues

Many people with diabetes have other health and social issues. Including these in the care planning discussion may apparently increase the complexity of the process, but can simplify the totality of care for the patient.

Other health and social issues might include:

- Other long term conditions. These should be part of the overall care plan, and may affect the agreed decisions.
- Exploring concerns about other health issues which at any one time may take priority over diabetes but may be affected by it and vice versa.
- Mental health problems such as depression, social exclusion, isolation or poverty may need to be addressed more promptly than diabetes itself.
- People living in institutions or in prison may not be in direct control of their diabetes and need structured support from others.

## Sharing and discussing information and negotiating the agenda

In the care planning review there may therefore be several potential issues for discussion. Clarifying and exploring these issues in order to decide which are to be focussed upon during the consultation requires specific skills. The healthcare professional's responsibility is to ensure that the discussions and decisions are made in full collaboration with, and are appropriate to, the individual they are consulting with. Healthcare professionals will need to develop and utilise particular listening, communication and consultation skills, especially when discussing difficult or challenging issues. They may have to learn to accept the patient's choice to engage in potentially risky behaviours, such as smoking, and to become experienced in handling situations where there may be very difficult outcomes, such as rejecting support during pregnancy. Further information about training for healthcare professionals, and for people with diabetes is available in sections 5 and 6.

## Action planning

At this stage of the consultation, the person with diabetes and the healthcare professional should agree a set of action points, decide who will be responsible for



achieving each of the actions and agree when the actions will be reviewed. For the person with diabetes, the actions are likely to relate to aspects of self management. For the healthcare professional, they might include referrals, investigations etc. Actions are more likely to be undertaken by either party if they are detailed and specific and set out within a given timescale. An action is more likely to be achieved if the person has a high level of confidence in their ability to complete it (efficacy expectation), if it has a personally desirable result (outcome expectation) and if they have the practical means and resources to undertake the action<sup>6,7</sup>.

## Documentation

The outcomes of the care planning consultation should be recorded in some form of document, and a care plan would be appropriate for this. However, it is important to recognise the distinction between the care plan and the care planning process. Care planning is a dynamic process of negotiation and shared decision-making. The care plan is a means by which the outcomes are recorded. This will include choices, preferences and action plans. The care plan should be available when the person with diabetes accesses any part of the service, including during an in-patient or acute episode. Some examples of care planning documentation are included at appendix C.

## The Care Planning Consultation

The principles and philosophy of the care planning approach outlined above can be applied to any consultation or interaction between healthcare professionals and patients.

The care planning consultation, which incorporates this approach, could be considered as an adaptation of the traditional annual review. The aim of this consultation is to discuss, prioritise and plan the forthcoming year of care. It is anticipated that this would usually occur annually, but the actions resulting from it may need to be reflected on and revised at shorter intervals. This could be due to a specific health or personal event, such as a pregnancy, heart attack or a significant change in working arrangements. These may require reconsideration of the planned care and a further care planning consultation would be appropriate.

# What is care planning?



## Case Study: An example of care planning in action

Mrs Smith attended her care planning consultation with a practice nurse. The results of her annual review tests had already been shared with her by post following an appointment with the healthcare assistant 3 weeks earlier. She had used the opportunity to think about these and talk to her husband about them. They were pleased that most of the results were in the target range except her blood pressure and weight. She had made a note of these in the 'issues for discussion' section of the information sheet containing the test results.

The practice nurse discussed the results with Mrs Smith and clarified that there were no other specific concerns or questions. She noted that Mrs Smith was a smoker but Mrs Smith explained that she was not contemplating giving up at present and was aware of the potential risks. Mrs Smith and the nurse agreed to discuss this again in the future and the nurse explained that Mrs Smith could get in touch at any time if she changed her mind and wanted support to give up smoking.

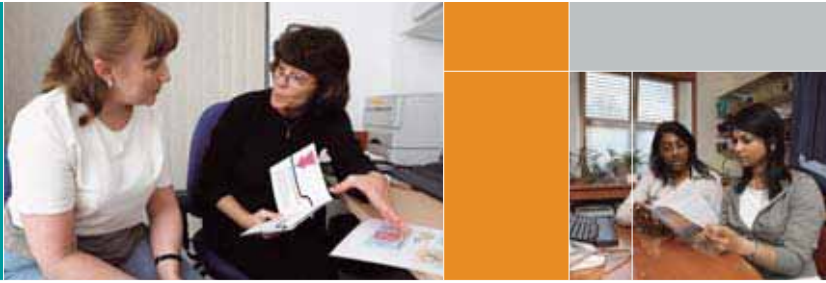
Mrs Smith decided that her current priorities and goals were better blood pressure control and to lose a stone in weight. She elected to self monitor her blood pressure and to see the GP after 2 months if it remained above target levels. She also decided to go back to a local slimming group, where she had previously had success at losing weight.

It was jointly agreed that Mrs Smith would visit the nurse for her next care planning consultation in a year's time, but that she could contact the practice nurse in the meantime if she had any concerns.

### Two months later

Her blood pressure readings were still high so she made an appointment to see her GP and they agreed to start treatment. The GP was also able to elicit that Mrs Smith had become concerned about diarrhoea, and wondered whether this was due to the Metformin she had been taking. They agreed to try a reduction in dose and to check HbA1c in a couple of months.

The diarrhoea improved immediately. The combination of weight loss and reduced Metformin resulted in no change in HbA1c and Mrs Smith understood that she might need to try other tablets in the future.



## Section 4: The evidence base for care planning

### Development of the model

A diagram of the care planning model can be seen on page 14. This represents a complex system which enables the key people involved in diabetes care (the person with diabetes and the practitioner) to share their perspectives and make shared decisions on what actions are needed. The model draws together several interlocking strands of work including contributions from the perspectives of people with diabetes, of practitioners and of researchers with an interest in the condition. Additionally, the model takes into account the social and health service context in which these decisions are taken, the way care is organised and the way that information is communicated and managed.

Responses to a discussion paper on an initial draft of the model suggested that it would be useful to clarify the model's theoretical basis and to review the evidence for the approach. In order to do this, four members of the working group searched the Cochrane Library for reviews that were relevant to promoting patient-centred care and self management and met the criteria for inclusion in the Database of Reviews of Effectiveness (DARE). Reviews relating to other long term conditions apart from diabetes were also included, but not those of self management education outside the setting of the consultation, which have been extensively reviewed elsewhere<sup>8</sup>. The findings of these reviews were then related to the main components of the model.

### Evidence for components of the model

#### **The individual's story and the professional's story**

Observational studies of communication in the consultation have demonstrated associations between communication skills and health outcomes, such as symptom resolution, functional status, blood pressure and glycaemic control. Specifically, the professional expressing empathy, allowing the patient to ask questions and asking

## The evidence base for care planning



about their concerns and expectations all correlated with positive health outcomes. Furthermore, interventions designed to enable patients to play a more active role in the consultation, such as by asking more questions, made them feel more involved and resulted in improved outcomes<sup>9</sup>.

Training healthcare professionals to focus on the patient as a person, rather than an illness, and to share control of the consultation has been shown to increase measures of patient-centredness. There is, however, limited evidence that this translates into improved health outcomes<sup>10</sup>. Pill et al found that health professionals found it difficult to sustain a patient-centred approach, particularly if they perceived this as conflicting with their efforts to help patients achieve better biomedical outcomes<sup>11</sup>. Another trial of patient-centred diabetes care found that although patients in the intervention group reported better communication, treatment satisfaction and well being than control group members, they gained more weight and had lower knowledge scores. The authors concluded that those committed to achieving the benefits of patient-centred consulting should not lose the focus on disease management<sup>12</sup>. This underlines the importance of drawing on both the perspective of the individual with diabetes, and the professional's biomedical agenda in planning diabetes care. Indeed a central aim of care planning is to engage people with diabetes in improving biomedical outcomes by self management.

### Learning about and managing diabetes

Improving people's understanding of their condition is vital in ensuring their active engagement in their own care. Therefore, a fundamental principle of the care planning process is that it should run in parallel with effective educational interventions.

There is evidence that if written information is tailored to the needs of the individual or a group of people, then it is more likely to be seen as relevant and lead to behaviour change<sup>13</sup>. Studies of educational interventions about hypertension suggest that personalised counselling does more to improve blood pressure control than didactic, curriculum-based approaches<sup>14</sup>.



Computerised systems are increasingly used to organise care, support decision-making and provide patients and practitioners with relevant information. These interactive health communication applications have now been shown to be beneficial for patients with a range of conditions<sup>15</sup>. For diabetes specifically, several computerised educational programs have been shown to improve diet and metabolic indicators<sup>16</sup>.

### **Living with diabetes and other health and social issues**

In contrast to managing diabetes, this component of the model focuses on managing life with diabetes. Several reviews<sup>17,13,18</sup> and theoretical literature (Bandura, 1977)<sup>6</sup> and Funnell et al (1991)<sup>19</sup> indicate that self management improves psychological health, empowers people and enhances self efficacy. This in turn leads to behavioural changes and improved clinical outcomes.

Steed et al (2003) reviewed the impact of skills-based self management information and psychological interventions on psychosocial outcomes in adults with diabetes<sup>20</sup>. Although the review has some methodological weaknesses, the findings suggest that self management improves psychological health.

The domain of other health and social issues is specifically included in the model to recognise that people with diabetes frequently also have other long term conditions. If these affect their well being and lifestyle, this may influence their capacity to self manage. A holistic approach to diabetes care therefore needs to encompass the range of health and social issues that people with diabetes also have to face.

### **Sharing information and negotiating an action plan**

Interventions that aim to enhance the role, or 'activate' the patient within the consultation seem to be effective across a range of conditions<sup>21</sup>. For diabetes, pre-consultation coaching, learner-centred group education and group consultations have been shown to provide benefit<sup>22</sup>.

Several reviews of the impact of decision aids and the provision of personalised information on the risks and benefits of treatments or behaviours, suggest that good decision aids could make a useful contribution to the care planning process. For example, decision aids have been found to improve knowledge and participation in



## The evidence base for care planning



the decision-making process<sup>23</sup>. Aids focussed on screening, mainly relating to cancer, appear to increase the uptake of screening tests<sup>24</sup>.

### Taking action:

Behavioural scientists have identified a number of approaches to understanding the factors which influence people's intended and actual behaviour<sup>25-27</sup>. Motivational interviewing has been proposed as a means to promote behaviour change. Although there is some evidence that the approach may assist in helping people overcome substance abuse<sup>28</sup> and improve their diet<sup>29</sup>, it is unclear how relevant these findings are to routine diabetes care, because most studies involved patients attending separate sessions.

Many people with diabetes need to take regular medicines but the results of much of the research on adherence appear inconclusive<sup>30</sup>. Reviewing studies from across a range of conditions, Haynes et al<sup>31</sup> found that although most simple measures did lead to adherence to short term treatment regimes, interventions for long term conditions seemed less effective. These reviews do not however answer whether adopting a shared approach to treatment would ensure the decisions made are more appropriate for that individual and therefore more likely to be put into action.

## Lessons for the implementation of care planning

The benefits of systematic approaches to care, recall systems and routine surveillance have been long established and are now standard elements of diabetes care within the UK<sup>32;33</sup>. It is however important to keep in mind that efficient systems are a prerequisite for many aspects of care planning.

This review suggests that while care planning is a complex intervention, there is good evidence for many of the processes involved. Both the patient's and practitioner's perspectives need to be heard. The agenda listed in the model seems appropriate and there are a number of ways to help patients and practitioners share information and negotiate action plans. Exactly what that negotiation involves will depend on



discussions between individual patients and practitioners, but the framework allows patients to determine how active a role they wish to take in decisions about their care.

Because much of this evidence has been drawn from related conditions, rather than studies on the care planning approach being proposed for diabetes, there is a need for more research. Care planning, as a complex intervention, needs further development work and piloting<sup>34</sup>. There would then be a strong case for testing an intervention based on this approach in an adequately powered randomised controlled trial.



## Section 5: Workforce

The White Paper, *Our health, our care, our say: a new direction for community services*, identifies that new skills around supporting self care and empowerment will be required if care for people with long term conditions is to be truly patient-centred.<sup>xiii</sup> The recent Department of Health guidance document, *Supporting people with long term conditions to self care: a guide to developing local strategies and good practice* outlines the role of the healthcare professional in a patient-led NHS and highlights the need for a change in approach.<sup>xiv</sup> Professionals more used to identifying illness and deciding on treatment may not be used to asking themselves how they can help a patient manage their own condition. In a patient-led NHS, the professional/patient relationship is a meeting between two experts working together to support the individual to manage their own condition as effectively as possible.<sup>xv</sup>

Successful care planning for people with diabetes, using the model outlined in section 3, will be dependent on equipping staff with the skills and competences that they need to do this. Central to the care planning approach is the adoption of a patient-centred consultation style by the professional. Examples include the Calgary Cambridge approach<sup>35</sup> and Neighbour's work<sup>36</sup>.

Local health communities, diabetes networks and their constituent organisations will need to think carefully about this approach to patient care, considering how staff will be equipped with these new skills and building on the competences that they may already have. This will obviously include those skills that are needed for care planning, which should be a key function of self management and empowerment. Collaborative working across the plurality of providers will be vital to ensure that all staff across the healthcare service are able to deliver high quality care planning services.

xiii Department of Health (2006), *Our health, our care, our say: a new direction for community services*.

xiv Department of Health (2006), *Supporting people with long term conditions to self care: a guide to developing local strategies and good practice*.

xv The Royal College of Physicians Patient and Carer Involvement Steering Group (PCSG) has worked on a project entitled 'Explaining the risks and benefits of treatment options'. The aim of this project has been to ensure an appropriate dialogue between the individual (hospital) doctor and patient (carer) to enable an informed choice about treatment to be made. Further information can be found at: [http://www.rcplondon.ac.uk/college/PIU/piu\\_risk.asp](http://www.rcplondon.ac.uk/college/PIU/piu_risk.asp).



Table 1 outlines the National Workforce Competences for Diabetes produced by Skills for Health that are related to care planning and which could form the basis of skills development in this area. These are all specific to diabetes and it may be useful to think of these as the core competences required for care planning.

**Table 1:**

Ref. no	National Workforce Competence	Related KSF <sup>xvi</sup> dimension & level
Diab HA1	Assess the health care needs of individuals with diabetes and agree care plans	HWB6 level 3
Diab HA2	Work in partnership with individuals to sustain care plans to manage their diabetes	HWB7 level 2
Diab HA6	Help individuals with diabetes to change their behaviour to reduce the risk of complications and improve their quality of life	HWB4 level 3
Diab HD7	Monitor and support a care plan for an individual with diabetes admitted to a general ward	HWB7 level 2
Diab HD8	Review and evaluate the progress of a care plan for an individual with diabetes admitted to a general ward and prepare for discharge	HWB6 level 3

A wide range of staff provide care to people with diabetes and they will all be required to demonstrate competence in at least some of these areas. In general, qualified staff will need skills to assess the needs of individuals and to plan, implement, monitor and review care plans. Unqualified staff, on the other hand, are more likely to require skills in supporting individuals to sustain and maintain these care plans.

In addition to these core competences, staff with particular roles may require more specialist competences and some examples of these are given in Table 2.

<sup>xvi</sup> Key Skills Framework.



**Table 2:**

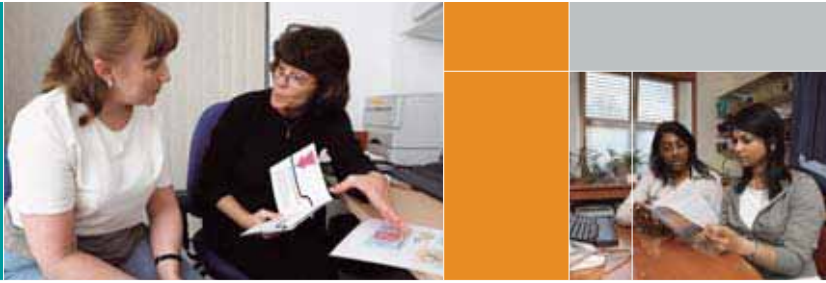
Ref. no	National Workforce Competence	Related KSF dimension & level
CS4	Plan, implement, monitor and review individualised care plans to meet the needs of children and young people	HWB2 level 3
CS6	Plan and implement transfer of care and discharge with young people and those involved in their care	HWB2 level 3
CM B1	Plan, implement, monitor and review individualised care plans with individuals who have a long term condition and their carers	HWB2 level 3

Having identified the relevant competences for an individual or group of staff these can then be used to support skills development in a variety of ways:

- Used alongside the Key Skills Framework (KSF) for development of an individual
- Identifying individual learning needs
- Identifying group learning needs
- As a format for structured learning in the work environment
- To commission and develop training programmes
- To evaluate individual/group training programmes

As a first step, networks should undertake a workforce skills profile, based on the identified competences, identify any gaps and then develop a strategy to meet these gaps. Individuals should be encouraged to identify the relevant competences when developing their KSF post outline.

Further information about workforce issues can be found on the Skills for Health website at: <http://www.skillsforhealth.org.uk/>



## Section 6: Putting it into practice

This section lays out the key elements of a care planning process with some suggestions and examples about how to put them into practice. Many local areas will already have some of these elements in place, using different models. Others may need to undertake considerable redesign of their local services. Therefore, implementation of the care planning process will vary according to the current systems and resources and local need. The existing practitioner-led annual review process, usually focused on surveillance for complications, should be adapted locally to incorporate the principles of care planning.

### Commissioning care planning

Commissioners should ensure that the following elements are in place in order to put the care planning process into practice:

- There is an environment which enables equal opportunity for participation for both healthcare professionals and people with diabetes
- People living with diabetes are offered structured education and are involved in the process of developing the environment in which effective care planning can occur
- All staff are supported to develop the necessary skills and competences
- People with diabetes, healthcare professionals and organisations are committed to the principle of a partnership approach to care planning
- Information is available to all parties, to support the care planning discussion
- Systems are in place to support sharing of information between people with diabetes, healthcare professionals and organisations
- Where possible, there is continuity of contact between healthcare professional and the person with diabetes
- There are regular opportunities for review



- Services and support are available to meet the agreed aims of the care planning process
- There is a robust evaluation process in place, including quality assurance and audit measures and obtaining constructive feedback from all parties involved

## What this means for people and organisations:

### People with diabetes

For people with diabetes to be able to engage effectively in the care planning process, they may need to be helped to understand the process and how their experiences of consultations might start to differ in future. They need to know that their own questions and experiences, thoughts and feelings and hopes for their diabetes will be sought along with priority given to planning the actions they wish to undertake. They may need to have some written or verbal information about care planning and what it involves and their role in it.

In order to facilitate this, and as part of the orientation towards a more collaborative experience, people with diabetes should be offered structured education when they are newly diagnosed and receive information updates and skills training throughout the progression of their life with the condition. Structured education is a key intervention needed to deliver Standard 3 of the Diabetes NSF and is supported by the National Institute for Health and Clinical Excellence Health Technology Appraisal on Patient Education Models for Diabetes (NICE HTA #60). Education and skills training for people with diabetes are currently available through programmes designed specifically for people with diabetes:

- The DAFNE programme for people with Type 1 diabetes.<sup>xvii</sup>
- The DESMOND programmes for people with Type 2 diabetes.<sup>xviii</sup>
- The X-Pert programme for people with Type 2 diabetes.<sup>xix</sup>

xvii [http://www.diabetes.nhs.uk/Work\\_areas/Patient\\_education.asp](http://www.diabetes.nhs.uk/Work_areas/Patient_education.asp) or <http://www.dafne.uk.com/>.

xviii [http://www.diabetes.nhs.uk/Work\\_areas/Patient\\_education.asp](http://www.diabetes.nhs.uk/Work_areas/Patient_education.asp) or <http://www.desmond-project.org.uk/>.

xix <http://www.xpert-diabetes.org.uk/artman/publish/>.



- Local structured education programmes which meet the key criteria detailed in the joint Department of Health and Diabetes UK Patient Education Working Group Report.<sup>xx</sup>

There is also general support for self management available through the Expert Patient Programme.<sup>xxi</sup>

In addition, it is important that the person with diabetes knows how to get in touch with the relevant healthcare professional or supporter and arrange another appointment if needed. The use of a named contact, as set out in the Diabetes NSF, would fulfil this need.

## Healthcare Professionals

For care planning to work in practice, it is also important that healthcare professionals understand the principles and benefits of care planning, and how a care planning approach for long term conditions such as diabetes differs from an acute model of care. They will be committed to the principle of working in partnership with people with diabetes and supported to develop the necessary skills and resources to engage them, as laid out in the model components and the competencies in sections 3 and 5. In order to achieve this, professionals may need to undergo skills development in areas such as communication, discussing risk, and shared decision-making, in order to be able to engage most effectively in the care planning process.

It is vital that healthcare professionals recognise and accept that people have different decision-making preferences and will want to be involved to different extents in a care planning process.

Healthcare professionals should also take active steps to support the person with diabetes to participate in the care planning process. For example, sending the results of the annual review tests to the person, in advance of a care planning session, along

xx Department of Health (2005), *Structured Patient Education in Diabetes: Report from the Patient Education Working Group*. A toolkit is available to help local services to deliver high quality structured education to their diabetes populations: *How to Assess Structured Diabetes Education: An Improvement Toolkit for Commissioners and Local Diabetes Communities (2006)*. See: <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en> or [http://www.diabetes.nhs.uk/Work\\_areas/Patient\\_education.asp](http://www.diabetes.nhs.uk/Work_areas/Patient_education.asp) or <http://www.diabetes.org.uk/sharedpractice>.

xxi <http://www.expertpatients.nhs.uk/>.





with an invitation to reflect on them and bring questions to the consultation, will help to encourage active participation in decisions made about them.

Local patient groups and representatives can provide direct feedback from people about how best to involve them in decisions. The local Expert Patient Programme, Diabetes UK groups and any local patient involvement groups could therefore contribute to the planning and implementation of the care planning process. For instance, user representatives could attend a workshop with health professionals to take part in simulated care planning discussions and give professionals feedback on what went well and what could be improved. Additional resources could include: local involvement networks (LINKs) , overview and scrutiny committees and the use of discovery interviews.

### Managers and team leaders

Managers and organisations should put in place systems that coordinate and facilitate the care planning process. In order to do this, they need to understand the complex inter-related aspects of care planning and ensure that all the necessary components and local operating protocols are in place and audited.

Furthermore, they should ensure that the workforce has the necessary skills and competences to support care planning, making sure staff are appropriately inducted into the process and that a skills assessment and gap analysis process are performed. Crucially, managers and team leaders should also make certain that systems support patient involvement at all levels.

## Systems and processes

The following processes can help to facilitate an effective care planning consultation:

### Before

- Relevant tests are carried out in advance and, where possible and appropriate, results are made available to the person with diabetes before the care planning consultation.



- Sufficient information and explanation, or sources of additional information, should be included to enable the individual to make sense of the results and their implications. Where a person with diabetes has participated in a structured education programme this information may already be available in the course content or resources.
- Furthermore, prompts should be included to encourage people with diabetes to think through their questions, concerns and priorities in all the domains in advance of the consultation.

### During

- A review of any previous care plan is included.
- The shared results sheet and questions/concerns prompt sheet are used to help set the agenda for the consultation.
- Information should be available to all parties about locally available services and potential options for treatments or care.
- Furthermore, detailed written information should be made available about the risks and benefits of different treatment options. Where possible these should be personalised and should link in with information received during the education programme(s).
- The needs of individuals with learning disabilities and/or specific communication needs will need to be taken into account and addressed appropriately.

### After

- A clear summary of the consultation, with details about the person with diabetes, their experiences and treatments, should be kept and maintained for reference purposes (hand-held and/or electronic record).
- In addition to clinical data, the following information should be recorded in all domains, as appropriate:
  - Person's issues, concerns and questions
  - Information needs and action required

## Putting it into practice



- Agreed priorities and goals
- The agreed action plan with details of how it will be measured, actions and responsibilities.
- Crucially, a copy of the completed summary should be held by both the health professional and person with diabetes. It should include details of who to contact if they would like to correct any of the information or discuss issues further.

An example of a potential interim report, sent before the consultation, and the final report, summarising the discussion and action plan, are included in appendix C.

Suggestions for setting up a care planning process:

- Ensure that people with diabetes and healthcare professionals understand and support the care planning process. Conduct broader training and information during implementation.
- Set up local consultations, eg face to face, focus groups, electronic or postal communication to gain the engagement of people with diabetes in the care planning process.
- Identify any disease areas that are currently delivering care planning as defined within this document (i.e. other LTC, social care organisations) and liaise with them to share practice
- Review current practices for annual reviews or any identified care planning processes
- Carry out a review of the personnel currently delivering any form of care planning process/annual review and identify potential training needs against the defined criteria in this document
- Identify any reconfiguration of time/work plans to accommodate a care planning process or any additional personnel resource.
- Review what services are available to coordinate the outcome of an agreed care plan. For example:
  - Education programmes



- Weight Management Programmes
- Exercise Programmes
- Social service support
- Pharmacy support
- Identify a clear booking process to ensure that patients are recalled to the subsequent care planning consultation at the point that has been agreed within the care plan.
- Establish the information links and systems needed to ensure that the clinical information needed to support the care planning process is in place.
- Identify how/whether the care planning record can be developed electronically
- Identify processes for circulating the summary of the care planning consultation to all relevant parties
- Develop monitoring/audit/patient experience tools to ensure that the care planning process is effective and supportive to the individual person with diabetes
- Consider road testing of some or all of the local plans prior to launch.



### Care Planning Pilots

Two pilots in Northumberland and North Tyneside have demonstrated the feasibility, sustainability and transferability of a care planning approach to diabetes care.

In place of a traditional annual review, patients had all relevant tests completed with a healthcare assistant and the results were posted to them prior to their care planning appointment. The practitioners were trained to elicit the patient's agenda and agree priorities and goals in collaboration with the patient. This was assisted by a prompt sheet accompanying the results which encouraged involvement in the consultation and listing of concerns or questions (examples of the documentation are in appendix C).

A formal questionnaire evaluation of a total of 70 patients indicated very high levels of satisfaction with the process (91% response rate; 98% reported finding it helpful to have results before consultation; 98% felt more involved in decision-making). This process has now been adopted as the standard model of diabetes care in a number of practices in the area, including the pilot practice.

### Other examples of elements of care planning in practice:

- As part of the new pharmacy contract, all community pharmacists are expected to carry out Medicine Use Reviews (MURs) on up to 400 of their patients per year. These reviews are carried out using the principles of care planning. For an example of a completed MUR see appendix C.
- In Nottingham, the Diamond diabetic register is used to store records of discussions electronically. Patients are not able to view the browser directly but they receive print outs of any information capture forms generated after each appointment, with an explanatory leaflet.
- In Devon, a care planning process for renal patients has been developed that uses



a web based tool to share information between patients and professionals. Renal Patient View (RPV) puts a selected set of data from existing electronic patient records onto a website that is accessible via an individual login. It shows results, diagnosis and selected information links according to diagnosis and treatment type. The system is very popular with patients and the units using it have not found it be a time consuming or resource intensive system to use. More information is available at <https://www.renalpatientview.org/index.do>.

- The national Ask About Medicines initiative, an independent campaign that encourages better communication between people and health professionals and aims to change expectations so that asking questions about medicines becomes the norm. Materials include a set of simple questions that people can be encouraged to ask about their medicines <http://www.askaboutmedicines.org>
- Medicines Partnership within the National Prescribing Centre offer a range of resources and training programmes related to shared decision-making and communication ([www.npc.co.uk/med\\_partnership/index.htm](http://www.npc.co.uk/med_partnership/index.htm))



## Section 7: Quality Assurance

### What is Quality Assurance?

Quality Assurance (QA) is a systematic process of developing and using a set of indicators to assess whether a service or intervention is being delivered to specified requirements. It is concerned with the **PROCESS** of care planning rather than the **OUTCOMES**.

QA should be a helpful and supportive developmental process rather than a punitive or judgemental one. The direct involvement of those people delivering the service or intervention in the development of QA is key to setting up a successful and robust QA process. This helps to ensure that all parties are engaged in the process and committed to delivering an agreed set of indicators. Appropriate organisational structures will need to be put in place to provide an effective QA process.

### The purpose of quality assurance in Care Planning

A QA process for care planning will need to assess whether care planning is being delivered according to the principles set out in the definition.

A quality assurance process will also:

- Ensure that all people with diabetes receive a high quality care planning service.
- Ensure that care planning is of high quality, regardless of the individuals and organisations involved in an individual consultation.
- Provide the mechanism for constant review and improvement of the care planning service.
- Provide continuing professional development for healthcare professionals.

### Quality Assurance elements

QA comprises two key elements:

- Quality Indicators – the agreed standards for service delivery.
- Quality Measures – observable characteristics which describe the indicator in detail.



An individual, either internal or external to the service, observes whether the measures are in place for a care planning process, to determine whether the quality indicators are being met. The frequency of observations, and systems for managing the observation process, should be set up as part of QA development. In advance of an observation, the observer and the person being observed should discuss the process. The person being observed should be given an opportunity to specify any aspect of the QA indicators that they are particularly concerned about. Following the observation itself, a further discussion should follow about the extent to which the quality measures have been observed to be in place. After the discussion, the results of a QA observation should be documented and a future action document drawn up.

### Getting started

The following questions may be helpful to consider when thinking about developing QA. They ask about the overall service in which care planning takes place, as well as the care planning process itself:

- Is care planning available to everyone with diabetes within the service?
- Do the participants who will be involved in care planning understand the process and preparation needed?
- Is there a system for obtaining the necessary information for the care planning process in a timely fashion, e.g. biomedical results available to both healthcare professional and person with diabetes; any previous action plan available for review?
- Are all participants involved in care planning adequately prepared, e.g. meeting identified competency levels for healthcare professionals (see section 5); opportunity to attend patient diabetes structured education programmes?
- Do participants explicitly agree the care planning process together at the start of the interaction?
- If the process includes paperwork and/or electronic process is this information shared?

For the purposes of QA, the key elements of the care planning process can be found in section 3.





## 'Starting small with QA': An example of getting started in developing quality assurance for care planning

A diabetes network has already implemented a successful system for regular and annual review and many staff have undertaken accredited courses in diabetes care. They also have a patients' forum, made up of people living with diabetes and using the diabetes service, which meets every six months with clinical and managerial members of the diabetes service. The Network is keen to implement more formal care planning. They feel that much of what is recommended is already in place, although it is not called care planning.

The first step is to meet with the patients forum to gather their views, in particular about the extent to which they feel the care planning process is already in place and what quality indicators could be set to measure this.

This meeting identifies the following quality indicators and measures:

- Indicator: Care planning takes place in the diabetes service.
  - Measure: all people with diabetes have an plan of care, documented in some way (including in their case notes, in a letter, in their monitoring diary etc).
- Indicator: Care planning includes the process in the document.
  - Measure 1: people with diabetes have a specific care planning appointment / time in an appointment.
  - Measure 2: the care planning consultation includes the perspectives of both the person with diabetes and the healthcare professional.
  - Measure 3: the resulting care plan is understood and agreed by both.
  - Measure 4: the care plan is held by both the person with diabetes and the diabetes service and is readily accessible.



A care planning action group is set up to test out these measures on a random sample of people and records in different parts of the service (specialist care; general practice; nursing homes) over the next 3 months.

The results of these investigations, presented at the next meeting, reveal that there is some care planning taking place but that it is not being carried out universally. In particular, health professionals tend to make and hold the care plans.

People with diabetes are not as fully involved at the level of the individual consultation as had appeared to be the case.

Piloting these two indicators has shown that the process of care planning needs to be refined to meet the recommendations. The meeting decides, as first steps, to focus on:

- Giving people with diabetes more information about care planning.
- Working with staff to find ways of making copies of documented care plans available to patients.
- Considering the logistics of providing professional development in care planning consultation skills to staff.

In the meantime, further indicators will be created and measured. The existing indicators will be revisited in six months time.



## Appendix A – Contributors to the Care Planning working group report

Simon O'Neill	Director of Care and Policy, Diabetes UK (Joint Chair)
Sue Roberts	National Clinical Director for Diabetes, Department of Health (Joint Chair)
Jean Benton	Diabetes UK representative
Abigail Bissill	Regional Programme Manager for the National Diabetes Support Team (South East)
Sally Brooks	Writer, National Diabetes Support Team
Paul Chadwick	Professional Lead Podiatrist Salford PCT and Secretary FDUK
Dorothy Clohesy	Professional lead for Diabetes/CHD, North Staffs PCT
Georgina Davis	Diabetes Expert Patient
Simon Eaton	Consultant Diabetologist, Northumbria Healthcare NHS Foundation Trust
Jonathan Graffy	General Practitioner and Senior Clinical Research Fellow, University of Cambridge
Anne Greenley	Network Manager, South of Tees Diabetes Network, Middlesbrough PCT
Irene Gummerson	Primary Care Pharmacist
Caroline Kelham	Project Manager, Medicines Partnership
Pat Lister	Patient Carer Network Member, Royal College of Physicians



- Kate Leivesley      Community Diabetes Specialist Nurse, Manchester PCT and  
Diabetes UK advisory council
- Suzanne Lucas      Independent Consultant
- Bill O’Leary      Head of Communications, National Diabetes Support Team
- Madeleine Percival      Project Manager, Diabetes Policy and Development Team,  
Department of Health
- Claire Pesterfield      Paediatric Diabetes Specialist Nurse, Cambridge University  
Hospitals NHS Foundation Trust
- Jackie Sturt      NHS R&D Senior Lecturer in Social Sciences, Warwick Medical  
School
- Karen Walker      Diabetes Workforce Development Manager, Skills for Health
- Rosie Walker      Health Education Specialist, In Balance Healthcare UK
- Sarah Walter      System Reform Manager, National Diabetes Support Team

### **Members of the Research Group**

Jonathan Graffy, Simon Eaton, Paul Chadwick, Jackie Sturt



## Appendix B – Care planning and the policy context: further reading

Further information about the role of care planning in the national policy context can be found in the following documents, all of which can be accessed via the Department of Health website: [www.dh.gov.uk](http://www.dh.gov.uk).

*National Standards, Local Action* (July 2004)

*Choosing Health: Making Healthy Choices Easier* (November 2004)

*Self care – A real choice: self care support – a practical option* (January 2005)

*Supporting People with Long term Conditions* (January 2005)

*The National Service Framework for Long term (Neurological) Conditions* (March 2005)

*Our health, our care, our say: a new direction for community services* (January 2006)

*Supporting people with long term conditions to self care: a guide to developing local strategies and good practice* (February 2006)

Also of interest are:

NHS Modernisation Agency (2004), *Good care planning for people with long-term conditions*.

The Diabetes Do Once and Share project. This can be viewed electronically at: <http://homepage.mac.com/marksmith2/DOaS/>



## Diabetes Care Planning Interim Results

Name

Address

D O B

Trust No:

NHS No:

GP:

You have recently had a number of tests done, looking at your diabetes. The results from some of these tests are enclosed. Please take time to read these results and have a think about what they mean to you. Any other results (including foot and eye screening) can be discussed at your appointment.

An appointment has been made for you to discuss these results and any other things that you may like to talk about regarding your diabetes:

20<sup>th</sup> July 2006 at 10.30 at the Health Centre

If this appointment is inconvenient for you, or if you feel you need to discuss these results more urgently, please contact ..... at the Health Centre on Tel No.....

**Please feel free to write down any questions or issues that you might like to discuss at this appointment in the space provided and bring this along to your appointment.**

These are some questions you might like to think about before the appointment:

What aspects of your diabetes you would like to discuss?

What aspects of diabetes would you like more information about?

These are some of the things we know have an effect on you and your diabetes control. Which are most relevant to you?

Medical check-ups

Eating the right amount

Taking medication

Giving up smoking

Avoiding sugary foods

Alcohol within limits

Monitoring sugar levels

Foot care

Healthier eating

Regular physical activity

## Care Planning Results - Interim

	Your result was:	Please feel free to write any questions or comments you may like to discuss
<p><b>Diabetes control</b> Your HbA<sub>1c</sub> is an overall measure of glucose control over the past 8-10 weeks. A level of between 6 and 7% is associated with the lowest risk of complications.</p>	HbA <sub>1c</sub> 6.6%	
<p><b>Blood pressure (BP)</b> A target blood pressure of below 140/80 lowers the risk of complications (a target of below 135/75 is used if you have kidney disease).</p>	BP135/72	
<p><b>Cholesterol and blood fats</b> Lowering your cholesterol can reduce the risk of complications such as heart attacks and strokes. Whether or not you need treatment depends on your overall risk. If you are on treatment the target cholesterol is less than 5.</p>	Cholesterol 4.2	
<p><b>Kidney tests</b> Your kidneys are tested by looking at a blood test (creatinine) and the leak of protein from your kidney.</p>	<p>Creatinine 146 Urine: Normal</p>	This result is stable but may indicate some kidney problems. This can be discussed in more detail at your appointment.
<p><b>Weight &amp; body mass index</b> Being overweight increases the risk of many medical conditions including heart disease, arthritis and premature death. It can also make your diabetes and blood pressure more difficult to control. The body mass index (BMI) is another way to look at your weight by adjusting for your height. A BMI between 19 and 25 is associated with the lowest risk to your health.</p>	<p>Weight 104.6kg BMI 34.95</p>	
<p><b>Smoking</b> Smoking causes problems with your health in many ways but is particularly damaging in people with diabetes.</p>	You are an ex-smoker	

Name:

Date of Birth:

Date sheet completed:



## Diabetes Care Planning Summary 2006

**Name**

Address

D O B

Trust No:

NHS No:

GP:

This is the summary of the care planning Consultation on 20<sup>th</sup> July 2006 with **Doctor/Nurse A**

The tests results and comments are overleaf along with more details of the consultation where necessary.

### **This is the plan we agreed for your diabetes over the next year:**

1. You aimed to lose further weight (see below)
2. Reduce the evening Glicazide aiming to keep morning sugars above 4.0
3. Clinic review in 12 months and keep in touch with practice nurse in meantime.
4. I would suggest a further HbA1c in 4-6 months to make sure hasn't crept up with less tablets.

### **Further details of the consultation or plan:**

Your current treatments are:

Glicazide 80mg am, 40mg pm (reduced from 80 today) – for your diabetes)  
 Rosiglitazone 8mg daily (for your diabetes)  
 Simvastatin 10mg daily (for cholesterol)  
 Aspirin 75mg daily (to thin blood)  
 Omeprazole  
 Metoclopramide  
 Cocodamol  
 GTN

**Report completed by Doctor.Nurse A on 20<sup>th</sup> July 2006.**

**Signed:**



## Care Planning Results

	Your result was:	Comment
<p><b>Diabetes control</b> Your HbA<sub>1c</sub> is an overall measure of glucose control over the past 8-10 weeks. A level of between 6 and 7% is associated with the lowest risk of complications.</p>	HbA <sub>1c</sub> 6.6%	This shows good control but you are getting sugars frequently below 4 in the morning. We agreed to reduce your evening Glicazide to 40mg (half a tablet) or perhaps even stop it.
<p><b>Blood pressure (BP)</b> A target blood pressure of below 140/80 lowers the risk of complications (a target of below 135/75 is used if you have kidney disease).</p>	BP 135/72	Excellent
<p><b>Cholesterol and blood fats</b> Lowering your cholesterol can reduce the risk of complications such as heart attacks and strokes. Whether or not you need treatment depends on your overall risk. If you are on treatment the target cholesterol is less than 5.</p>	Cholesterol 4.2	Excellent
<p><b>Kidney tests</b> Your kidneys are tested by looking at a blood test (creatinine) and the leak of protein from your kidney.</p>	Creatinine 146 Urine: Normal	Your creatinine is slightly high (eGFR 45) but this has been stable since at least 2001. I explained this does demonstrate some damage to the kidneys but suggested I was not too worried about this at the moment
<p><b>Weight &amp; body mass index</b> Being overweight increases the risk of many medical conditions including heart disease, arthritis and premature death. It can also make your diabetes and blood pressure more difficult to control. The body mass index (BMI) is another way to look at your weight by adjusting for your height. A BMI between 19 and 25 is associated with the lowest risk to your health.</p>	Weight 104.6kg BMI 34.95	We discussed this in some detail today and used the action planning approach sheet. You have already made some changes such as cutting down portion sizes and avoiding fatty foods which seem to be working (you have lost some weight since the last appointment). You are quite confident you will be able to keep these up.
<p><b>Smoking</b> Smoking causes problems with your health in many ways but is particularly damaging in people with diabetes.</p>	You are an ex-smoker	

Name:

Date of Birth:

Date sheet completed:

## Community Pharmacy Medicines Use Review & Prescription Intervention Service

Patient Details			
<b>Date of review:</b> 07.09.2006	<b>Title:</b> Mr	<b>Name:</b> John Edwards	<b>NHS Patient Code:</b> 987654321
<b>Address:</b> 24 Any Street, Anytown AN1 0YT			<b>Pharmacy (PMR) ID:</b> MUR 92
			<b>DOB:</b> 01.01.1924
<b>GP:</b> Dr Ann Smith		<b>GP address:</b> Surgey Street, Anytown AN1 3YT	
		<b>Tel:</b> 01234 567890	
Recording of patient's informed consent (must be completed before the review can proceed)			
Patient has received information on and consented to the review process.			<input checked="" type="checkbox"/>
Patient has agreed that information may be shared with their GP.			<input checked="" type="checkbox"/>
Patient has agreed that information may be shared with others such as carers.			<input type="checkbox"/>
Specify others by name:			
<b>Reason for review:</b>		Pharmacist identified <input checked="" type="checkbox"/> or	
Annual Review (MUR) <input checked="" type="checkbox"/>		Referral from <input type="checkbox"/>	
Prescription Intervention <input type="checkbox"/>			
What would the patient like to get out of the review? (including the need for information) He would like to know whether he REALLY needs all his medication.			
Basic health data			
Significant previous ADRs:		Known allergies/sensitivities: <b>penicillin</b>	
Medical history as described by patient and from information recorded in PMR		Monitoring as described by patient and from information recorded in PMR	
<b>Type 2 diabetes</b>		<b>6 monthly</b>	
<b>high blood pressure</b>		<b>6 monthly</b>	
<b>indigestion</b>		<b>6 monthly</b>	
<b>painfull feet - 'shooting pains'</b>		<b>6 monthly</b>	
<b>arthritis</b>		<b>6 monthly</b>	
<b>poor sleep pattern</b>			
Name of Pharmacist conducting the review:			
Mrs Mary Jones			
Pharmacy name & address:			
Wellness Pharmacy, Any Crescent, Anytown			
<b>Location of review:</b>		<b>Outcome of Review:</b>	
Pharmacy <input checked="" type="checkbox"/>		Copy of care plan given to patient <input checked="" type="checkbox"/>	
Other location <input type="checkbox"/>		Referral made to GP <input checked="" type="checkbox"/>	
(state location used)		Pharmacist actions completed and recorded in care plan <input checked="" type="checkbox"/>	
Telephone <input type="checkbox"/>			
(record reason why face to face was not possible)			

Patient Name: John Edwards

DOB: 01.01.1924

Is the formulation appropriate?	Is the medicine working?			Are side effects present?		General Comments		
	yes	no	yes	no	unknown		yes	no
1. <input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Takes all the morning tablets on an empty stomach (does not have breakfast). Sometimes forgets to take 2 <sup>nd</sup> dose of the day. Reports flatulence
2. <input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Has never had fluid retention. It was explained that the medicine was also used to control blood pressure
3. <input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reports a persistent dry cough. He has not discussed it with the doctor
4. <input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	heartburn
5. <input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	This was prescribed for the neuropathy (shooting pains) - at this dose. I explained these also work on painful nerves and take some weeks to work. I suggested he talk more about the pain and his mood with his GP
6. <input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
7. <input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
8. <input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
9. <input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	He is having too many fat-soluble vitamins (with the Cod Liver Oil).
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Explanatory notes:**

**Is the formulation appropriate?** – use to identify problems with formulation, e.g. swallowing difficulties suggest a liquid product may be more suitable, include poor technique with inhaler devices here.

**Is the medicine working?** – if you have objective evidence such as BP or cholesterol level then you may indicate whether the medicine is effective or not. In many cases this may be a subjective response based on the patient's view of their treatment. In other cases it may be unknown such as antiplatelet therapy.

**Are side effects present?** – indicate patients reported response supplemented by a professional decision as to which drug a particular side effect may be attributable to.

**General Comments** – add any additional information here for example if you have ticked a positive response for side effects present it would be helpful to add detail (such as cough and skin rash) which may help you when you develop your action plan and when completing a follow up review with the same patient at a later date.

**Patient Name: John Edwards**

**DOB: 01.01.1924**

Prescribed medicine and dosage regimen	Dosage regimen as patient takes it  (including OTC & complementary therapies)	Patient's knowledge of the medicine's use	Compliance			
			<i>always</i>	<i>frequent</i>	<i>seldom</i>	<i>never</i>
1. metformin tabs 500mg two twice a day after meals	two twice a day; only the evening dose is after food	diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. bendroflumethiazide tabs 2.5mg, one each morning	one each morning	'water' tablet	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. enalapril tab 20mg, one each morning	one each morning	'not sure'	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. aspirin tab 75mg, one each morning in water, after food	one each morning	thins the blood?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. amitriptyline tab 25mg, one at night		not sure what the doctor said, but the leaflet says it's for depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. paracetamol tab 500mg 1-2 three times a day if needed	two up to three times a day	pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. lansoprazole caps 15mg one daily	one each morning	'acid'	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Buys Cod Liver Oil (high strength) from Health Shop	Takes one daily	arthritis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Buys multivitamins from Health Shop (Dosage one daily)	Takes two daily because he's feeling lethargic	tiredness	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Explanatory notes:**

**Patient's knowledge of the medicine's use** – record what the patient thinks the medicine is for and highlight where response would indicate need for further information.

**Compliance** – Use open, non-judgemental questions to establish how the medicine is being taken, and tick the box which best indicates the patient's level of compliance, i.e. always takes the medicines as prescribed through to never takes the medicine as prescribed. Leave blank for 'PRN' medicines.

## Medicines Use Review Action Plan

Date of review: 07.09.2006

Patient's name: John Edwards	Date of Birth: 01.01.1924	GP's name: Dr Ann Smith
	NHS Patient Code: 987654321	

Medicines Use Issue	Priority	Proposed Action	Action by	Outcome if known with dates
Taking the metformin in the morning on an empty stomach	High	To have breakfast, and to take the medicines afterwards	Mr Edwards	Reduced flatulence and heartburn
enalapril - could be causing the cough	High	To discuss with Dr Smith	Mr Edwards	Dr Smith has changed his enalapril to amlodipine. Mr Edwards reports that the cough has gone
aspirin - may be causing heartburn because it is being taken undissolved on an empty stomach. Mr Edwards reports he drinks lots of fruit juice	High	To always dissolve it in water, and have it after a meal. To drink only a small glass of fruit juice a day - after food (due to the sugar & acid content)	Mr Edwards	Mr Edwards reports the heartburn has stopped and he will discuss stopping the lansoprazole with Dr Smith
* paracetamol - not controlling the pain. * Vitamins-overdose? The tiredness may be due to poor diabetes control	High High	* To discuss with Dr Smith  * To stop taking the multivitamins (he reports eating a healthy diet)	Mr Edwards	* Dr Smith has discussed his poor mood. Mr Edwards is taking amitriptyline. Pains are improving.

Pharmacist name (block capitals) Mary Jones	RPSGB registration number 987654	Pharmacist signature	Telephone number of Pharmacist: 876543
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### Next steps:

- PATIENT:**  
This is your copy; please retain it for your personal use. You may wish to show it to other health care professionals if you wish to share this information.
- Please make an appointment with your GP to discuss within  weeks.
- Take this form to your next scheduled GP appointment.
- Follow your actions agreed above.

- GENERAL PRACTITIONER:**  
This is your copy; please retain a copy in your patient's notes.
- For information only – no action required.
- Please review the actions proposed above.

This review is based on information available to the pharmacist held on the pharmacy medication records and from information provided by the patient.



## Appendix D – Reference List

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