

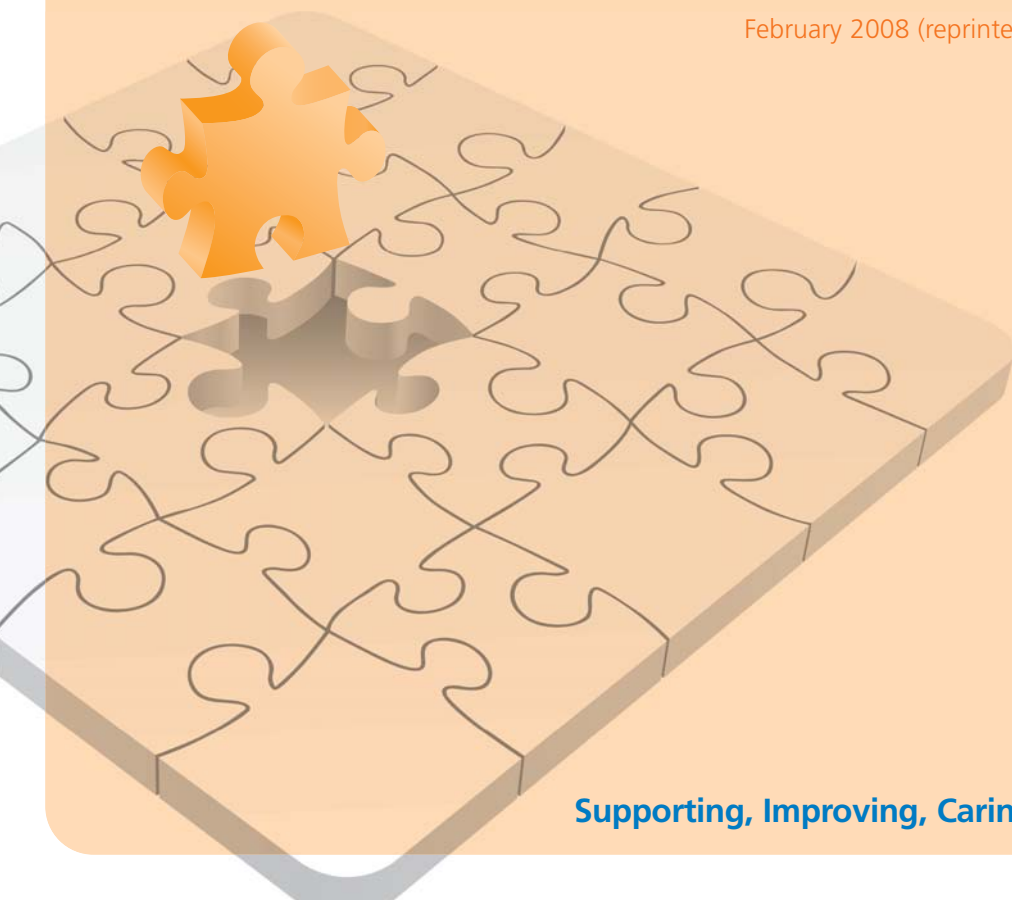
Support for  
Self-care



Diabetes

# Partners in Care: A Guide to Implementing a Care Planning Approach to Diabetes Care

February 2008 (reprinted)



Supporting, Improving, Caring

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# Foreword

Dear Colleagues

If I was asked to name one thing that would dramatically improve the health and well being of people with diabetes it would not be more doctors, nurses, clinics or beds. They all have their part to play, but for me the number one improvement would be properly supporting and empowering people with diabetes so that they are truly confident about managing their own condition on a day to day basis calling on help from healthcare professionals when they choose and for the reasons that are important to them. This is in no way to denigrate the essential contribution that healthcare professionals make in their role as advisors and source of expert medical care advice and information. However it is recognised that people with diabetes are the real “experts” on their condition and living with it; developing systems and processes that support, develop and inform that expertise for everyone would be a significant achievement. This approach was at the heart of the Diabetes NSF and in some places professionals are changing the way they work to support this. But it needs to be happening everywhere, in specialist as well as primary care practice.

To that end this guide is a really useful contribution as it places Care Planning right at the centre of the clinical consultation and spells out simple steps and strategies to enable everyone to do it. It shows that Care Planning is not some airy theory about patient choice and involvement. It is based on practical, hard headed research that convincingly demonstrates the pivotal role of patient engagement in delivering changed behaviours and improved outcomes in people with Long Term Conditions. It overturns the often heard complaints that “it is too difficult” and “patients want to be told what to do” by showing how it can be done and that it also provides a mirror for those who hope they are doing it already and there is little they need to change.

As we come to the half way point in delivering the 10 year NSF Delivery Strategy I am delighted by the enormously increased focus on self management as a core part of diabetes care. This is witnessed by the emphasis on structured patient education, which meets agreed criteria, now seen in many primary and acute trusts, the release of the Care Planning report and by the enthusiasm for involvement in the Year of Care project. This guide is yet another example of the drive towards having fully engaged patients meeting fully committed healthcare professionals to agree goals and priorities to improve outcomes. I am confident it will be enthusiastically welcomed by the diabetes community and will be well used by them in delivering effective Care Planning.

A number of people have contributed to this report and I thank them all for it but special mention needs to be made of Simon Eaton and Rosie Walker for their enthusiasm and commitment in writing this guide.

**Dr Sue Roberts**  
**Clinical Lead for the Year of Care Programme**





## Using this guide

Diabetes care is a team effort. To reflect this we have tried to make this guide appropriate for anyone involved in diabetes services, whether you are someone who uses diabetes services, a commissioner, a network manager, a clinician, a receptionist, a health care assistant or technician. Some sections lend themselves more to one group or another - for example the skills section tends to focus on health care professionals' skills. However, we hope that every reader will find something of use in the guide, either as practical actions to take or 'food for thought' about how they can contribute.

The context of this guide is very much tied up with that of the joint Department of Health/Diabetes UK working group report on Care Planning in Diabetes,<sup>1</sup> the Year of Care Project<sup>2</sup>, and the wider health policy context of support for people living with other long-term conditions.<sup>3</sup> We recommend that you bear this in mind when reading the guide. We hope that you will be inspired by what you read and wish to know more. To enable you to find out more, we have included references to these and many other resources for further reading.

We hope the guide offers you some opportunity for reflection and maybe something of a gateway to more satisfying and effective consultations – we have included reflective activities deliberately for this purpose – both personal and service orientated, as we recognise that sudden, wholesale change is usually neither helpful nor desirable and we have to 'start where we are'. We hope the various quotations, sayings and analogies we have included help in the reflective process.

A small caveat - there are many elements to implementing Care Planning within the Year of Care context including ongoing care and support and social care, as well as considering the commissioning framework. However, these are beyond the scope of this guide. The Year of Care project is using Care Planning as the vehicle to engage and empower individuals, so the guide focuses on the clinical setting of the Care Planning consultation between HCPs and people with diabetes and what systems are needed to make this effective.

*A gateway to more satisfying and effective consultations*



## For reflection – Embracing the vision

Consider the following:

Bob is attending his appraisal. He is nervous as he hasn't yet seen the results of his 360° assessment. The appraiser puts him at ease and suggests that overall things were pretty good. However, there did seem to be some issues with his time-management and team-working. This comes as a surprise to Bob and he is not sure what to make of it.

What was the impact of Bob having not seen the 360° results prior to the meeting? The process is intended to be constructive and to help him develop further but, no matter how good the skills of the appraiser were, the emotional impact of receiving the news in this manner overrides Bob's ability to consider it rationally and decide what it really means to him. Would you stand for this in your appraisal? Wouldn't you insist on having time to think about and digest the assessment results beforehand?

How does this relate to diabetes and Care Planning? What if Bob had diabetes and was coming to see you (his diabetes "appraiser") in the annual review clinic? Do we ensure that the people that see us get their results before clinic? Do our patients get enough time to reflect and consider the options, before we ask them to make decisions?

What if Bob had received the results a couple of weeks earlier? Initially he may still be quite disappointed and surprised, but he may have been able to think about what the results meant, get more detail from his colleagues to help make sense of them and develop his own plan of how this could be addressed.

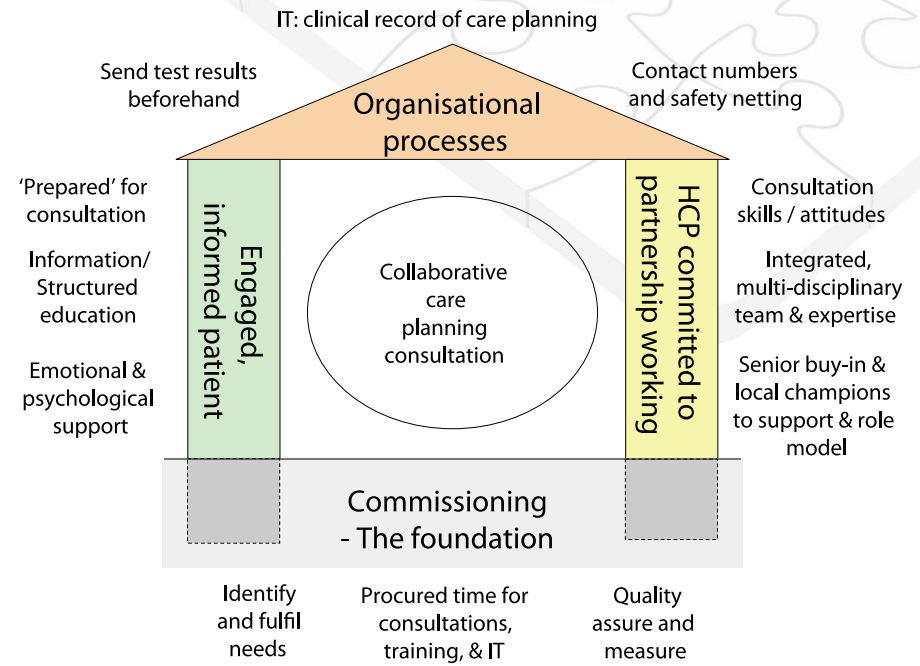
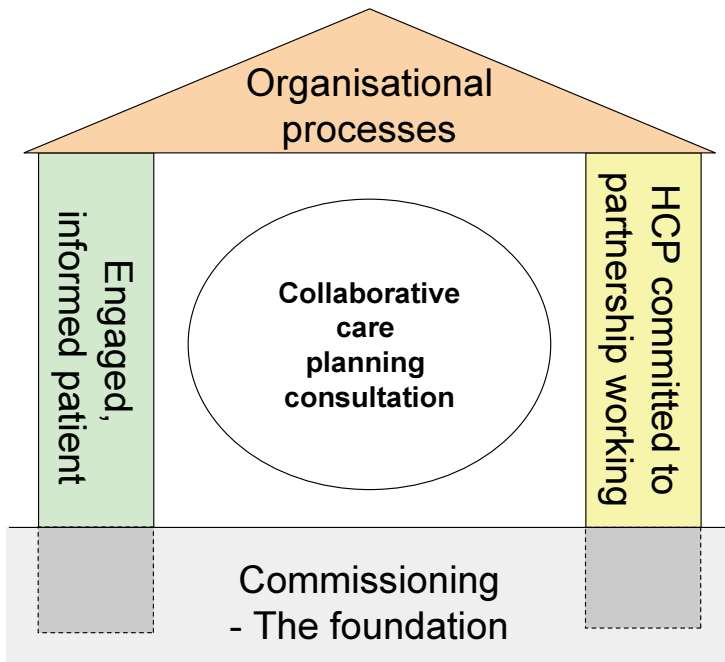
However, simply sharing the results alone is not enough. If the appraiser didn't really listen to Bob's ideas and preferred to make his own suggestions, this may also have not been helpful to Bob's development. Similarly, if on the day of the appraisal Bob finds out there are 15 other people being appraised that day and he only actually gets 10 minutes, or that the time-management course they eventually agree on won't be funded this year, these will have equally negative effects.

These scenarios demonstrate the importance of ensuring that all the relevant elements are integrated, supported and resourced to ensure that Bob and his appraiser can work in partnership together to achieve the best outcome for all.

Implementing a Care Planning approach to improve outcomes in diabetes is about achieving exactly this in your diabetes services. If this seems like a good idea to you, if you feel there are things that could be done to improve your services, if you would like to embrace and develop this vision – read on!

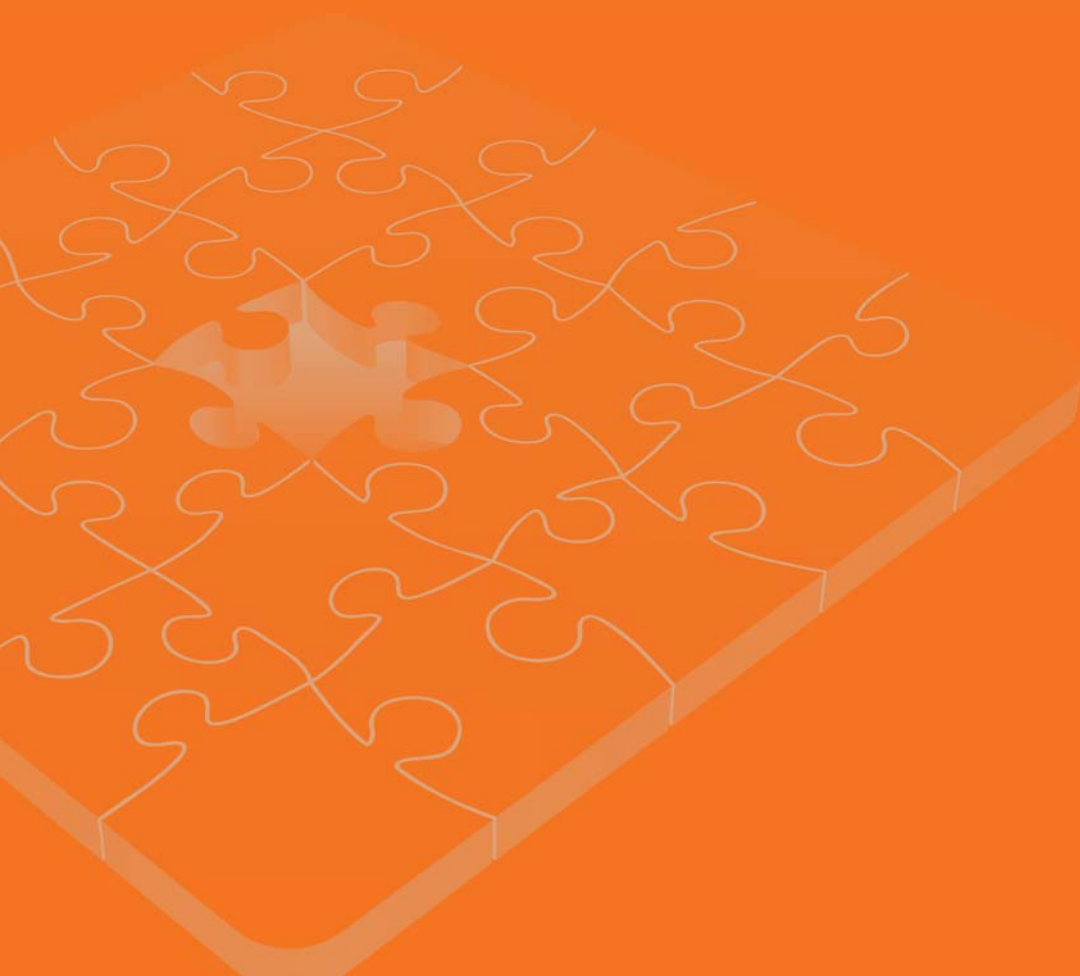








# 1. What is care planning?



# 1. What is Care Planning?

*'Looking **with** rather than **at** someone with diabetes'*

In the joint Department of Health/Diabetes UK Care Planning in Diabetes working group report<sup>1</sup> Care Planning is 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.' (p.11)

The report also states that:

'It 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 health care professionals make an equal contribution to the consultation.' (p.11)

## **Some principles of the Care Planning approach to consultations**

- A partnership approach offers people active involvement in decision making
- A partnership approach is more likely to lead to successful self-management strategies than a dictatorial one
- A person-centred, holistic approach is more satisfying and effective in diabetes care consultations
- HCPs and people with diabetes wish for optimal health and quality of life outcomes
- Preparation for the Care Planning consultation including sharing both clinical and practical information about the process, leads to realistic expectations and outcomes

## **Why is this approach important?**

The involvement of people with long-term conditions in planning their own care and choosing how to manage their own condition is a critical step towards improving patient related outcomes. This approach was espoused in standard 3 of the National Service Framework (NSF) for diabetes.<sup>4</sup> Additionally, it was mentioned in the White Paper *Our Health, Our Care, Our Say*<sup>3</sup> and is included in the NHS Operating Framework for 2008.<sup>5</sup>



However, the evidence is that we still have a long way to go to achieve that aim. Over recent years, both the National Audit Office report Testing Times,<sup>6</sup> and the Diabetes Information Jigsaw<sup>7</sup> report highlighted the gap between what patients want and what is provided. In 2007, the Healthcare Commission published their review of almost 70,000 people with diabetes in England.<sup>8</sup> They found that while 95% of people had diabetes checks at least once a year less than half discussed their goals in managing their condition.

## What can the Care Planning approach offer me?

*'Diabetes is a marathon, not a sprint; I need help to stay in the race'*  
(person with diabetes, 2001)

The Diabetes NSF explicitly stated that 'a paradigm shift' was needed to deliver the standards it laid out.<sup>4</sup> This shift was from systems centred round acute delivery of care towards those centred around the needs of people to live long and healthy lives with long-term conditions which are self-managed, day to day.

Along with this shift comes the need for a different set of skills for health care providers, a different set of expectations among people with diabetes and a different set of systems to support both. It's a bit like the difference between the training for and running a marathon and that for a sprint – each need very different approaches to be successful. You could see the 'sprint' as the traditional, acute model of treating illness, where the treatment is quickly effective and you get to the 'finish line' in a short time. Treating a long-term condition is more like the 'marathon', where it takes much longer to get to the finish, different techniques are needed in different parts of the race and the need for ongoing support along the way is much more obvious.

In neither case of course, can health professionals 'run the race' for the person, but their involvement is very different. This means that health professionals' preparation for supporting people, i.e. their skills, will be different for each type of race and people's expectations of each will be different. We believe that the Care Planning / collaborative approach offers the opportunity to hone the skills needed for the 'marathon', complementing those that are already there for the 'sprint'.

Put in place systematically and wholeheartedly the Care Planning approach could offer these benefits to the various participants in diabetes care services.

Benefits to people with diabetes:

- Greater participation in making decisions and planning care that they are more likely to want to follow through
- A better understanding of both their condition and of the clinician's agenda, goals and ways of working
- Receiving a more consistent and clear, predictable programme of care
- Respect and recognition of their everyday effort of self care



## Benefits to clinicians

- Having more satisfying consultations
- Assuming less direct responsibility for outcomes (allowing people with diabetes to assume greater responsibility for their own health)
- Using the Care Planning approach to clarify their own thinking about clinical issues and interventions in discussion with people with diabetes
- The Care Planning approach increasing the chances of successful behaviour change / lifestyle among people with diabetes
- Being able to measure their activity through audit and quality assurance standards, and to show the impact of their work
- Having the opportunity for system, service and role redesign

## Benefits to Commissioners

- Being able to commission services that people want to experience and clinicians want to provide – reduces tensions between commissioners and providers and improves job satisfaction and the experience of care
- Offers a measurable assessment of an individual's needs or goals to guide commissioning of appropriate services
- Facilitating systematic diabetes surveillance and care, such as annual review
- This approach having a positive impact on other 'must dos' in health policy – e.g. reducing acute admissions, improving the patient experience
- The Care Planning approach having measurable outcomes
- Increasing effective self-management, identified in the Wanless reports as being important to reduce increases in health service expenditure

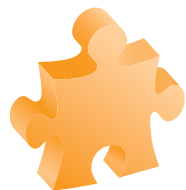
## Challenges that might arise in implementing the Care Planning approach

There are a number of 'what ifs' about the Care Planning approach that will inevitably arise in the minds of all participants in diabetes care. These are important to consider, along with possible ways of dealing with them, in order that they do not present unexpected barriers. Proactive troubleshooting like this can increase the chances of success in implementing the approach. As the sayings go 'the best way to predict the future is to invent it' and 'forewarned is forearmed'.

### What if.....

**....providers are not committed to this way of working, or even willing to experiment with it?**

Any change to practice will take some reflection and time. It is hard to change familiar and well-rehearsed behaviours overnight. People will need to believe that what might be a new approach to them is worthwhile and beneficial.



Some resistance is to be expected. Making gradual changes with structured and constructive feedback is known to work successfully.

I have no idea whatsoever why I do daily blood checks.....

I have not the remotest idea what I am keeping the record for.'

(Testing Times<sup>6</sup> p.58)

#### **....people with diabetes do not want this approach?'**

There is considerable evidence that people with diabetes wish for more information and to work in partnership for better shared decision making.<sup>6,9</sup> However, many people have not experienced this so, just like providers and practitioners, this approach may be unfamiliar to them at first. Discussing the extent to which they wish to be involved is part of the approach, and if people explicitly and genuinely choose for professionals to make decisions on their behalf, this can be documented and actioned. However, it remains the case that the majority of decision-making about diabetes management occurs outside the consultation with health professionals and this needs to be borne in mind by all parties.

#### **...'you cannot measure this approach effectively?'**

Many existing approaches to care are not amenable to effective measurement. Implementing the Care Planning approach is an opportunity to devise creative assessments of success and impact, including defining and recording an individuals goals. Indeed, this is a fundamental aspect of the Year of Care project, using the needs and choices identified in the consultation (micro-commissioning) to inform Commissioning across the whole health community (macro-commissioning). Crucially, definitions of success will need to include the point of view of people with diabetes, as well as health outcomes.

#### **...'working like this takes up too much time?'**

Time allocation and how it is used is a key part of the process. A change in system gives an opportunity to consider how the time available to diabetes care is used, including the time of people with diabetes who may currently need to attend (and wait for!) services at many different locations. Reflection with *all* involved in services on how everyone's time is used can reveal where changes might be beneficial. The outcome of a person who is more effectively self-managing may mean less routine follow-up appointments are needed, for example. Experience has shown that, after the initial effort of service redesign, the process may be resource neutral or even resource saving.

#### **...' People disagree with your care plan?'**

The process of Care Planning allows for negotiation of goals and action plans and recognition of sharing expertise. The focus of Care Planning is on the person with diabetes. The resulting plan is *their* plan and is unlikely to be actioned or implemented successfully if they do not agree with it. Disagreement may indicate that the goals or actions being discussed may need to be re-explored to ensure they are consistent with what is right for that individual person.



### ...‘doing Care Planning means we will lose Quality and Outcome Framework (QOF) points?’

A fundamental principle of Care Planning is that working in partnership with the person with diabetes is more likely to achieve the optimisation of health outcomes and therefore the QOF points related to this. Diabetes outcomes are influenced by the behaviour of the person with diabetes, day to day. Offering effective medical care and treatment is vital, but the only person who can influence whether it is taken up (e.g. attend for screening) or taken in (e.g. take tablets regularly) is the person with diabetes. However, the approach used in a consultation, and the level of support and confidence offered by the HCPs, can influence a person’s health related behaviour positively e.g. by increasing a person’s motivation to take tablets, lose weight, be more physically active. It is these behaviours that are likely to achieve the target levels, rather than any desire or action on the part of the HCPs. So QOF points in terms of achieving target levels are actually achieved by the person with diabetes. Hence a partnership approach is essential.

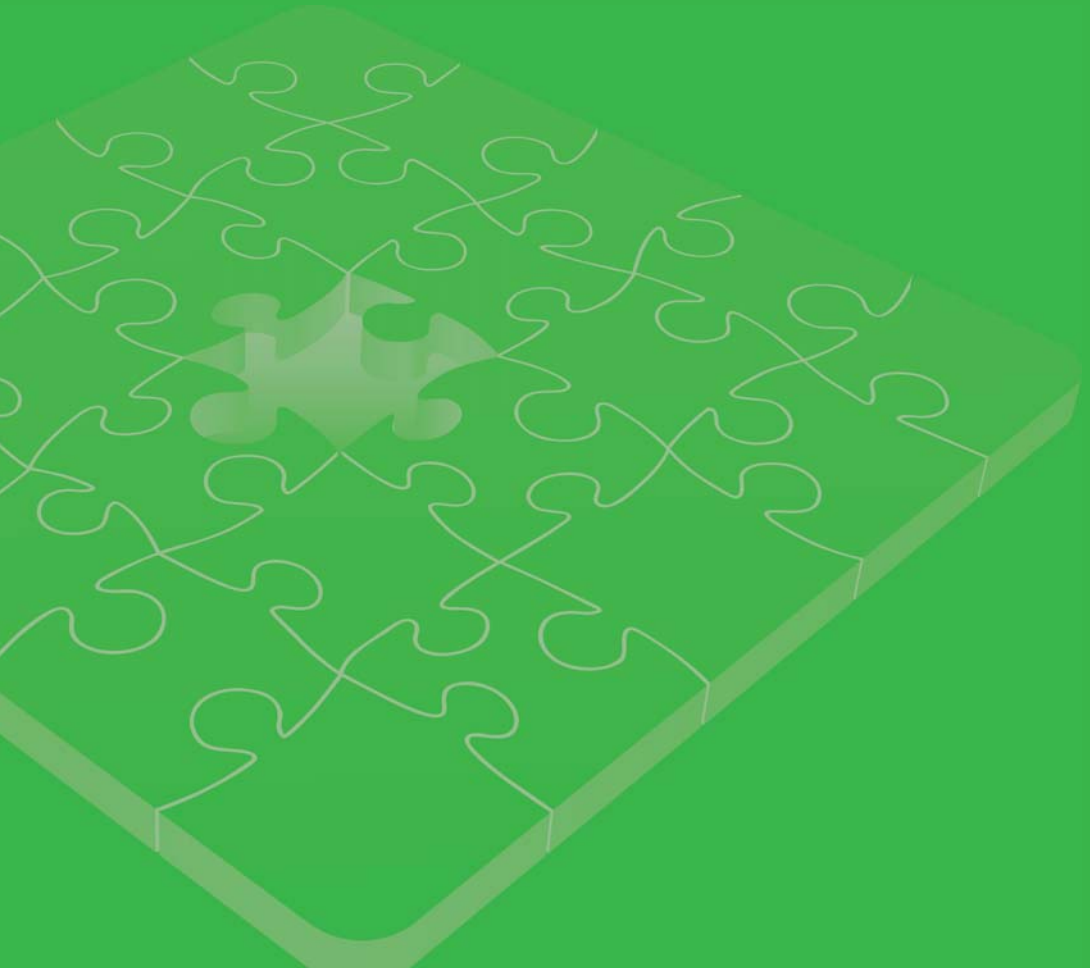
*‘In terms of physical outcomes, QOF points are actually achieved by the person with diabetes. Hence a partnership approach is essential.’*







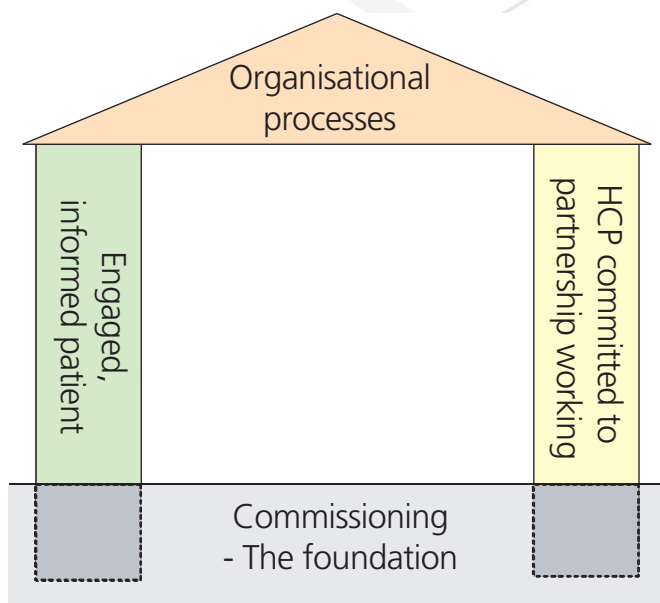
## 2. What needs to be in place to make a Care Planning approach happen?



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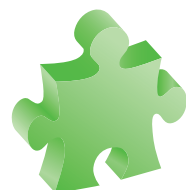
For the purposes of this guide we have separated out the context or systems that are required to support Care Planning and the skills that are required within the consultation (see chapter 3).

The crucial contributions of an engaged, informed patient, a health care professional committed to partnership working and the organisational processes in which they interact are recognised. In addition the systems need to be rooted in an effective commissioning process in order to be sustainable. These are represented visually below.



The 'house' metaphor emphasises the importance and inter-dependence of each element – if one is weak or missing the structure is not fit for purpose. The following section considers some of the specifics of these elements.

It is beyond the scope of this guide to consider the commissioning element in detail. We very much hope that Commissioners will find this guide of value in understanding the practical implications of implementation of a Care Planning approach. More specific guidance for Commissioners regarding Care Planning in the broader context of health and social care will be published shortly.



## HCPs committed to partnership working

Implementing Care Planning may require HCPs to change the way their consultations are conducted and to reconsider their beliefs about working in partnership with people with diabetes.

### Approach to Care Planning

For Care Planning to work in practice, it is important that HCPs understand its principles and how a Care Planning approach for long term conditions such as diabetes differs from an acute model of care. They need to 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 we have said, for many HCPs this may represent a change to their normal and familiar practice and may therefore be challenging. It will be important for HCP to be aware of their 'philosophy' of diabetes care and management, what they think about their role and responsibilities, to gain insight into their particular consultation style and to consider how their practice might develop to enable or support partnership working. You might find it useful to consider your approach using the reflective exercise we have included.

#### Reflective exercise – What is my approach to self-management?

The following activity is designed to raise your awareness a little, of your personal philosophy in relation to diabetes. You may find it useful to continue reflecting on what you find, using some of the references and opportunities in Chapter 4. There are no 'right' answers, just material for reflection.

Which of these most closely represents your thoughts?

1. 'My work is concerned with getting better control of diabetes, blood pressure, cholesterol, (etc) among my patients'
2. 'My work is concerned with teaching my patients, so they can be more healthy'
3. 'My work is concerned with creating an environment where people can reflect on, and make decisions about, their behaviour'
4. 'I get frustrated in my work when people don't take professionals' advice about what works in managing diabetes – especially the lifestyle issues like diet and exercise'
5. 'When patients achieve levels within recommended targets, I congratulate them'

Follow up questions for reflection (whichever is chosen)

How does your service in general and your behaviour in a consultation reflect the view you have chosen? How do you communicate this view to the people you consult with? How might they respond if you presented them with the statement you have chosen? Would they recognise it? How comfortable are you with the view you have chosen that it represents how you feel about your work? In what way would you describe it further?



Your view of self management in diabetes

Which of these most closely represents your thoughts?

1. 'Self management is essential to living with diabetes – I tell all my patients this'
2. 'Self management is really a partnership between me and my patients – if I do my job properly, they can do theirs'
3. 'Most people with diabetes don't want to take responsibility for their diabetes, so I have to keep checking up on them'
4. 'I really try to see diabetes as part of the person's life and help them make decisions about it in the same way as they make decisions about other aspects of their life'

Follow up questions for reflection (whichever is chosen)

What effect does the view you have chosen have on your work and your life?

How successful at self-managing would you say most people you see are? What relationship is there between the view you hold and their behaviour? How do the people you see respond in your consultations?

You may find that your views or philosophy unveiled a little here lead you to feel more or less comfortable with the idea of the Care Planning consultation presented in this guide. For example, if you have found that your philosophy tends to make you quite directive in consultations, or if you see yourself as more responsible for the outcomes people achieve than they are, it will be harder for you to adopt a partnership approach than if you see the consultation as a vehicle for people to make their own decisions, with you lending your experience and expertise to help them do this.

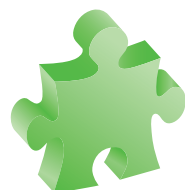
### Helping people make changes

When was the last time you did something because somebody else told you to?

We all know how irritating it can be for people to make suggestions to us such as 'I think you should keep more up to date with your paperwork', '...drive more slowly' or '...drink less', even if they might actually be sensible and correct. We find it difficult to do things that involve a significant change or a sacrifice unless they make real sense to us and are something we are really committed to doing. Simply put – we only do things if we really want to do them or if there is a really good reason to do so. Our patients are exactly the same.

Therefore, if we want to be more helpful to people who are trying to make changes but are finding it difficult, we need to base consultations on *their* concerns, *their* goals and the practical actions *they* wish to follow.

This does not mean that the HCP is passive, unresponsive or does not have a view – the consultation shares the expertise and experience of both parties in order to influence the outcome.



Many people may not really have considered a lifestyle or behaviour change, or feel ambivalent about making a change. In this situation, pushing or encouraging them to plan to change may not be appropriate. Indeed, a possible goal for that person might be to decide whether they do want to make a change. Their action plan may be to work out the 'pros and cons' of both making the change and not making the change, along with assessing its importance to them. This is discussed further in later sections of this guide.

A key role for the healthcare professional, therefore, is to be able to work with the individual to assess their readiness to make changes. This will include exploring how well a person understands their condition and the risks of certain behaviours or lifestyle choices. HCPs also need to be aware of how people go through the process of making a change and the part they can play in promoting change. Therefore, a good understanding of the behaviour change cycle<sup>10</sup> and the different techniques that can be used at the various stages, or of techniques such as Motivational Interviewing, will be important.<sup>11</sup>

### **For reflection – Helping people change**

Consider messages or warnings you have received from authority figures such as parents, teachers, the police or government encouraging us to change or modify our behaviours. Think about the ones that worked to help you change and the ones that didn't. What was it about the message that made the difference? Write down a list of the type of messages that worked for you and those that didn't.

Now you have your list, think about the way you behave in a consultation. Do you ever find yourself using some of the messages that you don't think work very well? The answer will almost certainly be yes – it is very difficult to resist sometimes and we all do it from time to time. What can you do to try to use more of the messages that work to help people change?

### **Shared decision making**

No-one can participate fully in making decisions if they don't have access to enough information and/or time. Or rather perhaps a decision gets made, but it isn't necessarily the right one. Remember, we wouldn't expect to be harried into a bad decision by our bank manager, or the estate agent, or the double-glazing seller, so we need to ensure we don't do this in our consultations.

It is vital that HCPs recognise and accept that people have different decision-making preferences and will want to be involved to different extents in a Care Planning process. Whatever involvement they choose, the decisions people make themselves about their care and diabetes management are likely to be the ones that they can put into practice and work well. As we note throughout this document a fundamental principle of Care Planning is that decisions made for a person by the HCPs are much less



likely to be put into practice than decisions they make themselves.

Shared decision making can be defined<sup>12</sup> as:

‘the concept of involving patients with their health care providers in making treatment decisions that are informed by the best available evidence about treatment options, potential benefits, and harms, and there consider patient preferences’

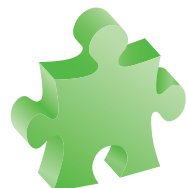
This can be distinguished from paternalism (where a HCP essentially makes decisions on behalf of the patient without taking into account their wishes or preferences) and informed consent (where the HCP presents options and information without guidance or direction). Supporting someone through the decision making process is a key element of shared decision making.

There are several excellent accounts of the competencies required by professionals to involve patients in shared decision making including by Towle and Godolphin.<sup>13</sup> They also suggested a potential list of competencies for patients. This is crucial as it underlines that patients need to be orientated to the decision making process, especially when they have been used to a less collaborative approach in the past.

### **Risk and uncertainty**

In addition to these competencies patients (and professionals) need to be familiar with dealing with risk and uncertainty. People often don't realise, even in the context of evidence-based medicine, there a lot of uncertainty remains in day-to-day clinical practice. As a consequence, many of the decisions people will be making do not have a clear right and wrong answer. Furthermore, we need to acknowledge and accept that medical knowledge (and uncertainty) is constantly changing.

Risk is therefore a fundamental concept in diabetes care and is central to many decisions about treatments or changes in behaviour. With greater participation in decision-making comes the need to discuss and understand the risks and benefits of difference choices. These are challenging concepts and there is certainly more we all need to learn about how to address and communicate risk effectively. However, the foundation to discussing risk remains good communication skills such as the use of open questions, reflective listening and expressing empathy.



### **For reflection – Risk communication**

Discussing and communicating risk can be extremely challenging even though we face and make decisions about risks everyday. Consider the following:

- Do you always drive below the speed limit?
- Do you always drink within the recommended safe alcohol limits?
- Are you up-to-date and fully confident about your life insurance, sickness cover, pensions etc.?
- Do you back up your computer files regularly?

Did you answer 'No' to any of these questions? If you did (and that is quite likely!) you will know that there are risks associated with these decisions (and countless others on a daily basis) whether we are conscious of them or not. If it is reasonable, even normal, for us to take some risks, then surely we should acknowledge that this is the same for our patients. Our role is not to offer approval or disapproval, but to offer people information and resources to understand the currently known implications and consequences associated with the behaviours they choose to undertake, so they, like ourselves, are in a position to make informed decisions.

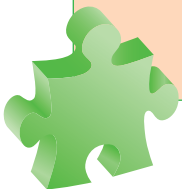
### **Skills development programmes**

HCPs who would like to expand their understanding and skills may wish to attend specific development programmes to explore their attitudes and approaches to self-management and develop appropriate skills to enable partnership working. Further reading, resources and potential programmes are outlined in Chapter 4.

Additionally, there are measures of the quality of the consultation to guide learning and skills development. Examples of potential measures, available as questionnaires that patients complete following the appointment, include the Consultation Quality Index<sup>14</sup> (CQI-2, including the Consultation and Relational Empathy (CARE) measure) or the SHEFFPAT questionnaire.<sup>15</sup> The Year of Care project is currently piloting an adapted version of CQI-2, reflecting the nature of diabetes care and the multidisciplinary nature of the team. The aim is to generate normative data for diabetes care (which may be different from a usual general practice clinic).

### **Ideas for practice development: How can I discover what the people I see in clinic think of my consultation style and communication skills?**

- Using the CQI-2 (or similar questionnaires) can help gain insight into the strengths and weaknesses of your consultation skills. These measures will also allow you to compare yourself to other HCPs in diabetes clinics.





## An engaged, informed patient

To enable an individual to self-manage effectively and participate fully in any decision making processes an individual will need a good understanding of their condition and how they can access any additional information they need. They also need to be familiar and comfortable with their potential role in partnership with the HCP in the consultation and decision-making.

### Signposting & Orientation to Care Planning

Individuals may need help to understand the process and how their experiences of consultations might start to differ in future. They need to know that their own questions, experiences, thoughts, feelings and hopes for their diabetes will be sought along with priority given to planning the actions they wish to undertake. They will need to be aware of the components of self care (monitoring, food intake, physical activity, medication management) and setting their own goals. They may need to have some written and/or verbal information about what Care Planning involves and their role in it.

#### For reflection – Orientation to Care Planning

- Consider how all people attending a Care Planning consultation could receive appropriate written or verbal information to find out more about Care Planning, what it involves and their role in it.
- Considering using the NHS Diabetes Care Planning information sheet.<sup>16</sup>

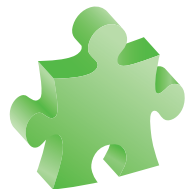
### Structured diabetes education for self-management

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 include effective educational interventions.

Participation in structured diabetes education for self-management can empower people with diabetes to make choices about how they manage their condition on a day-to-day basis. This should be offered when they are newly diagnosed and they people should receive information updates and skills training throughout their life with the condition.

Education and skills training for people with diabetes are currently available through programmes designed specifically for people with diabetes:

- The DAFNE<sup>17</sup> programme for people with Type 1 diabetes
- The DESMOND<sup>18</sup> or X-Pert<sup>19</sup> programmes for people with Type 2 diabetes
- Other locally developed programmes which meet the key criteria detailed in the joint Department of Health and Diabetes UK Patient Education Working Group Report:



## DH/Diabetes UK Key Criteria for a Structured Education Programme:<sup>20</sup>

- Philosophy
- A structured curriculum
- Trained educators
- Be quality assured
- Be audited

[http://www.diabetes.nhs.uk/downloads/structured\\_patient\\_education\\_diabetes\\_report.pdf](http://www.diabetes.nhs.uk/downloads/structured_patient_education_diabetes_report.pdf)

There is also generic support for self management available through the Expert Patient Programme.<sup>21</sup>

### Information

The key to effective diabetes self-management is for the individual to have timely access to appropriate information allowing them to make decisions that are appropriate to them. The simplest examples are leaflets or information sheets that have been developed locally or are available through other sources such as Diabetes UK or pharmaceutical companies.

The white paper *Our Health, Our Care, Our Say*<sup>3</sup> committed to the provision of Information Prescriptions which are currently being piloted with intended national rollout in 2008.<sup>22</sup> The intention is to help individuals assess their needs and signpost them to potential sources of information, how to make contact with other people with a similar condition and to important and relevant national and local resources.

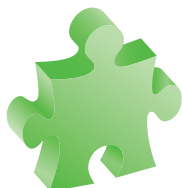
### Menu of options

The Care Planning approach will require a variety, or 'menu', of options to ensure the care plan is appropriate and personalised to the needs and preferences of the individual. The exact nature of these care options will depend upon the needs of the health communities and the availability of services but will require detailed re-consideration of existing services and options within the commissioning framework incorporating the views of people with diabetes.

To facilitate the making of individual decisions and the exact choice the HCPs, and the person with diabetes, will need to have a good understanding of the services available and how they can be accessed. In addition, there need to be effective mechanisms to ensure that health needs, preferences and appropriateness of existing and potential services are fed back into the commissioning process.

### Information sharing

The reflective exercise, *Embracing the vision*, at the start of this guide demonstrated the importance of having access to information to enable people to make personally relevant decisions and achievable action plans. For people with diabetes this includes the results of tests and treatment options.



Traditionally a person's day-to-day life is considered to be the patient's agenda whilst the biomedical tests are often thought of as the professional's agenda. This is more a reflection of people not having access to their test results than a lack of interest. Even when results are shared in a consultation the person is typically not given sufficient detail or time to consider the issue carefully and make a personally relevant decision.

The sharing of all results before the consultation, in a format that is appropriate and understandable to the person, could therefore be considered an essential component or pre-requisite to the Care Planning process. This will often be a novel experience for many in the context of healthcare interactions and should be accompanied by prompts to encourage people to think about what these results mean to them and list any questions or concerns they wish to discuss.

The sharing of results and other information prior to the consultation has been piloted and successfully implemented in a number of settings in both primary and specialist care in North Tyneside and Northumberland, and has proved highly valued by both patients and HCPs. The common components of the process outlined in Figure 1 and examples of the results sharing sheets are included in the Appendix.

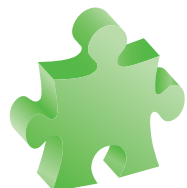
In addition, following the consultation, the person should be offered a copy of the agreed care plan including details of who to contact if they would like to correct any of the information or discuss issues further.

#### **Ideas for practice development – Information sharing**

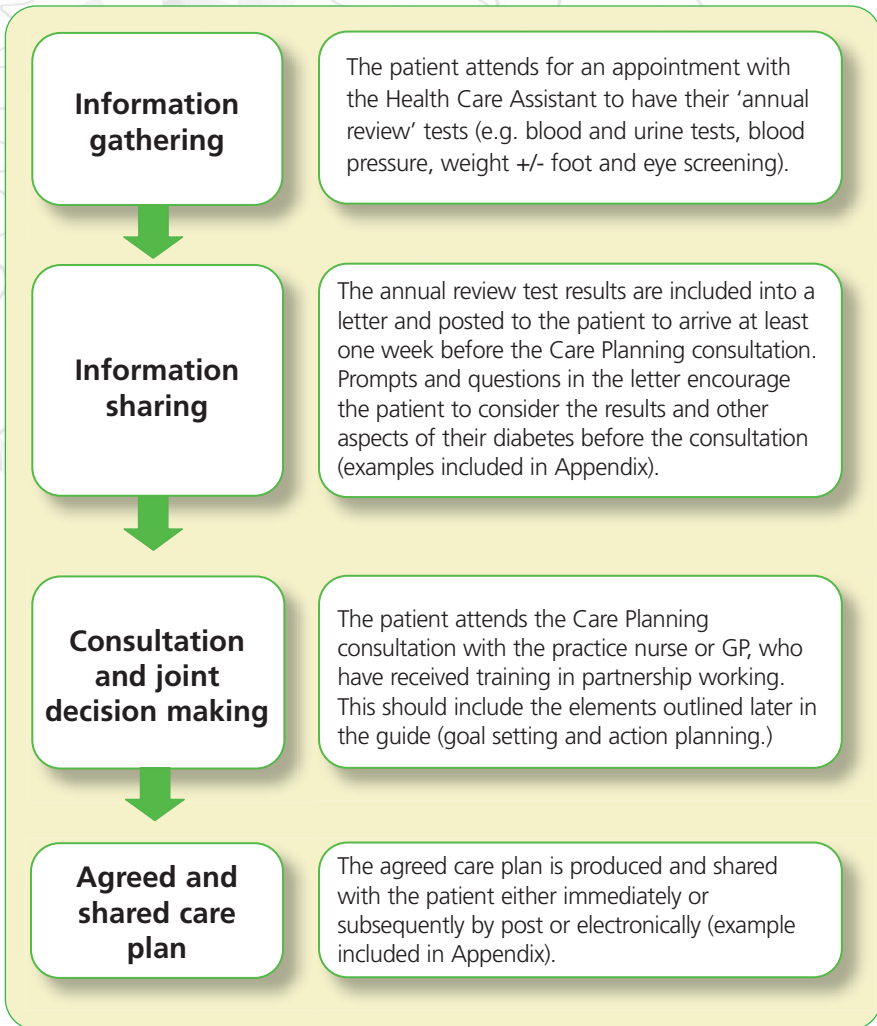
- Consider how you can ensure results can be shared with people before the consultation if they wish to have them
- Ensure that people are offered copies of their agreed care plan with appropriate contact details

#### **For reflection – Information Sharing**

- How do I currently share results and other information with the people I consult with?
- How would I feel if I received information about my health and its implications in this way?



**Figure 1: The information sharing process**



**Sharing letters and records**

A further tool that can allow an individual to have a better understanding of their care and condition is having access to, or ownership of, their own clinical records. However, it is important that this document reflects a collaborative Care Planning process rather than simply being a document where the instructions from the health care professionals are recorded.

Additionally, copies of all clinical correspondence should be offered to patients, already established as best practice in Department of Health guidance.<sup>23</sup>



## Organisational processes that enable Care Planning

Carefully thought out and quality assured processes of care underpin the Care Planning approach. These should include the following considerations.

### The clinic experience

'We don't need to agonise over how best to empower people, we just need to stop disempowering them.'<sup>24</sup>

All too often the systems in which we work can undo the fantastic work that individual HCPs are doing in their consultation rooms. The experience of the person attending the appointment or clinic will have a massive impact upon their ability to participate in the discussions and decision-making process. The experience is often 'disempowering'. Someone who has waited for 50 minutes in a hot, stuffy waiting room without explanation or apology is unlikely to feel they are valued in the subsequent consultation.

Factors which may have a potential positive or negative effect might include whether the appointment has been cancelled or moved at short notice, the convenience of appointment time, ability to park or access the venue, booking at reception, courteousness of clinic staff, getting weighed or blood tests taken, waiting times, the waiting environment and the welcome to the consultation room. Many of these issues may be outside the direct control of the HCPs or team but often simple ideas or small changes can have a significant effect.

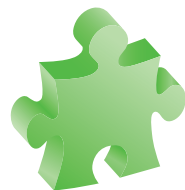
#### For reflection – the clinic experience

- What is the 'journey' like for people attending the clinic?
- Do I know what people coming to my clinic think of the experience?
- How can I find out whether the people coming to my clinic have any suggestions?
- How do I react if I sense someone is unhappy with what has happened today?
- What are my own frustrations with the clinic system in which I work?
- What steps can I take personally, to improve things?

### Flexibility and responsiveness

The 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 participation in decision-making and control over care from another. It is therefore important that the environment in which Care Planning takes place should be flexible and adaptable to ensure that the individual needs and preferences of the person with diabetes can be met. No one-size will fit all.

The care system also needs to be responsive to changes in circumstances, health or social care status or preferences over time. It should enable and support the individual to understand the care system and navigate their way through it effectively. Information



needs to be available for everyone with diabetes outlining a defined and systematic care system with potential options, contact numbers and access points.

The Care Planning process should attempt to meet the needs of all people with diabetes. Potential barriers which will need to be considered and overcome might include, but are not limited to, language barriers, literacy, learning difficulties and access problems such as being housebound or unregistered.

### **Registration, recall, review**

Care Planning is an ongoing process, rather than a one-off event, requiring established systems of registration to be utilised or strengthened to ensure recall for ongoing review at agreed intervals. The system should be transparent and understandable to all involved including the HCPs and people with diabetes and needs to include what arrangements there are for people who are repeatedly unable or unwilling to attend appointments. This highlights how important reception and administration staff are to the implementation of Care Planning.

### **Access and communication**

To enable people to be more in control of their care, and to effectively self-manage, we will need to establish or develop novel mechanisms of accessing health services. The simplest method may be more direct telephone access to advice or opinions but could also include embracing information technology providing e-consultations through email or websites. The key is that, whichever medium is used, the principles of Care Planning continue to be applied.

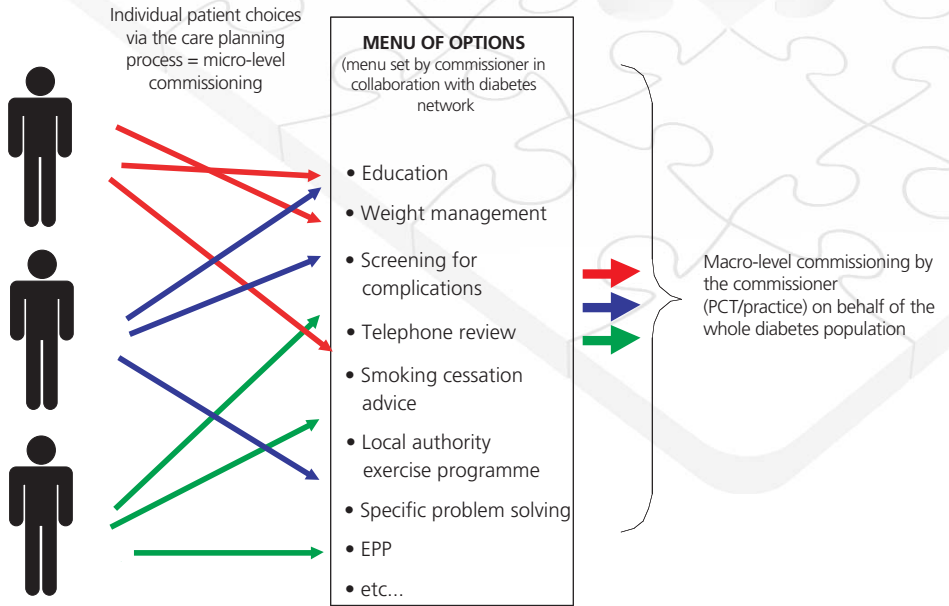
### **Moving towards a year of care**

Considering the needs of individuals and health communities within the context of the forthcoming year of care will facilitate a change in the focus of the consultation towards looking forwards and anticipating requirements beyond the next review appointment. Indeed it may allow a move beyond routine 3 or 6 monthly review appointments to considering the most effective and responsive mechanism to achieve short and longer term goals.

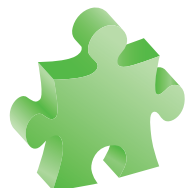
Effective commissioning of diabetes services requires a detailed understanding of the specific needs of individuals and the wider population. Establishing and recording an individual's goals for the forthcoming year (micro-commissioning) allows the service requirements to be understood and provide a tool to guide population-wide macro-commissioning. Additionally, capturing the specific action plan and outcomes allows the effectiveness of the services to be determined. This is the fundamental axis of the Year of Care concept from a commissioning perspective and underlines the vital role of shared decision making within the consultation to derive this essential information.



**Figure 2: Commissioning at micro and macro levels**



This diagram demonstrates the relationship between micro-commissioning, the individual choices each person makes from the 'Menu of options' available in that health community, and combining these into an understanding of the needs of the community to guide macro-commissioning. This concept is being tested in the Year of Care project.



### **For reflection – clinic appointments**

- How are changes in the appointment system communicated to people who attend the clinic?
- How can people make, move or clarify appointment dates?
- How do people know when their next appointment will be and how to access services in the meantime?
- How do people know whom to contact and how (names, email addresses and numbers) if they have any questions or concerns?

### **Ideas for service development: How do I know what people think of the clinic?**

Consider doing one or more of the following:

- Place a comments box in a prominent place in the waiting room – with encouragements to use it and review regularly!
- Ask the people you're seeing what the experience has been like and whether they have any suggestions for improvement
- Use a reliable and valid questionnaire to survey people's views
- Accompany someone through the clinic experience, to look critically at it and to identify issues of concern to them.
- Invite user representatives to attend team meetings to participate in discussions and suggestions about potential improvements
- Organise a focus group (NB: need considerable skills for this to be meaningful, and needs to be followed up to be effective)
- Consider contacting by telephone, or by sending a questionnaire, to people who have missed appointments to find out what prevented people from attending and if there are service delivery implications.

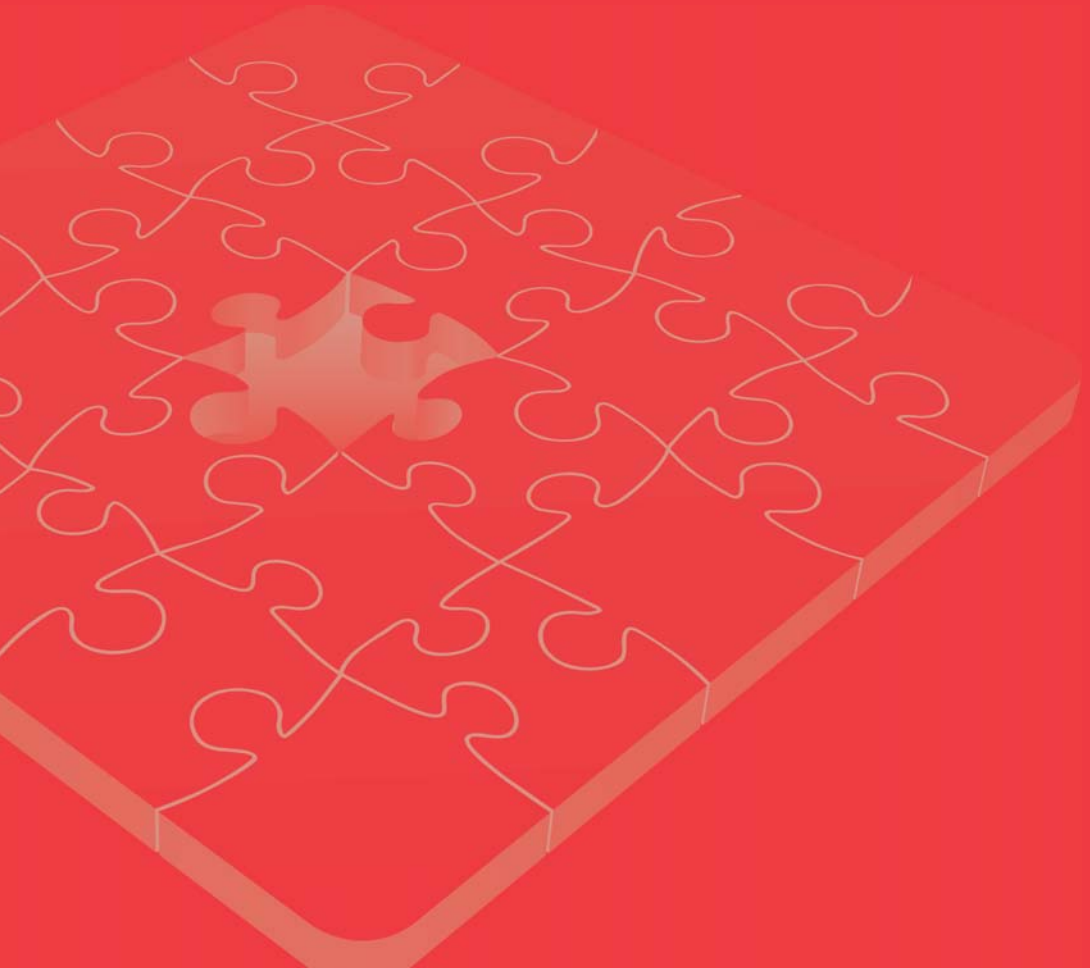
### **Ideas for service development: Improving the clinic experience**

- Provide information about the clinic in advance. Possibly send the NHS Diabetes leaflet on care planning<sup>16</sup> or a similar leaflet on 'making the most of your appointment'.
- Have a notice board outlining who's who in the team today and explaining who they should speak to if they have any questions whilst waiting
- Where possible make sure appointment times are suitable to the purpose of the visit, to avoid delays as much as possible
  - Ensure toilets, refreshments and other facilities are easily available close to the clinic and well signposted
  - Pay attention to the information and resources available to people whilst they are waiting
  - Consider the clinic venue – are there more appropriate or accessible places to hold appointments, including, for secondary care settings, the possibility of outside the hospital environment





### 3. What does a Care Planning Consultation look like?



### 3. What does a Care Planning Consultation look like?

#### The Care Planning Model

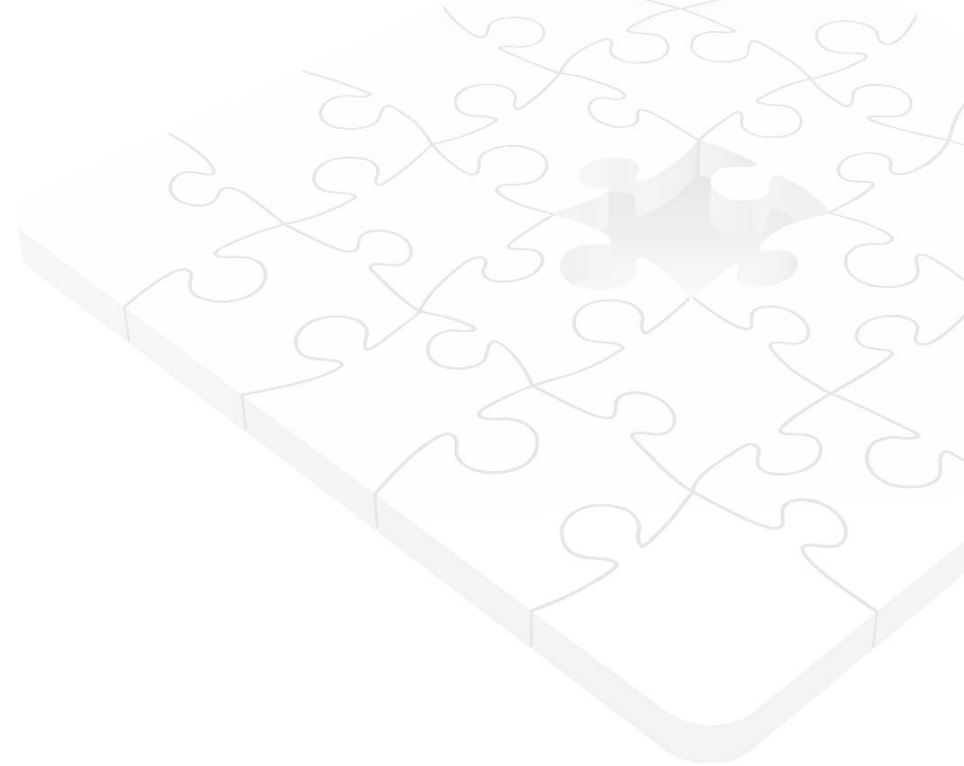
There are two models presented in the Figure 3 overleaf. The left hand side model was originally described in the Care Planning working group report.<sup>1</sup> Please note that the text within the larger blue box has been changed from 'negotiate agenda' to 'goal setting' as it is felt that this describes the stage of the model more appropriately.

The principle of the model is that the individual's and professional's 'stories' are shared and discussed encompassing a range of 'domains' that ensures an holistic, person-centred approach. These stories are brought together, issues prioritised and the goals for future care agreed. The specific actions that are required in order to achieve these goals are then discussed, agreed and implemented.

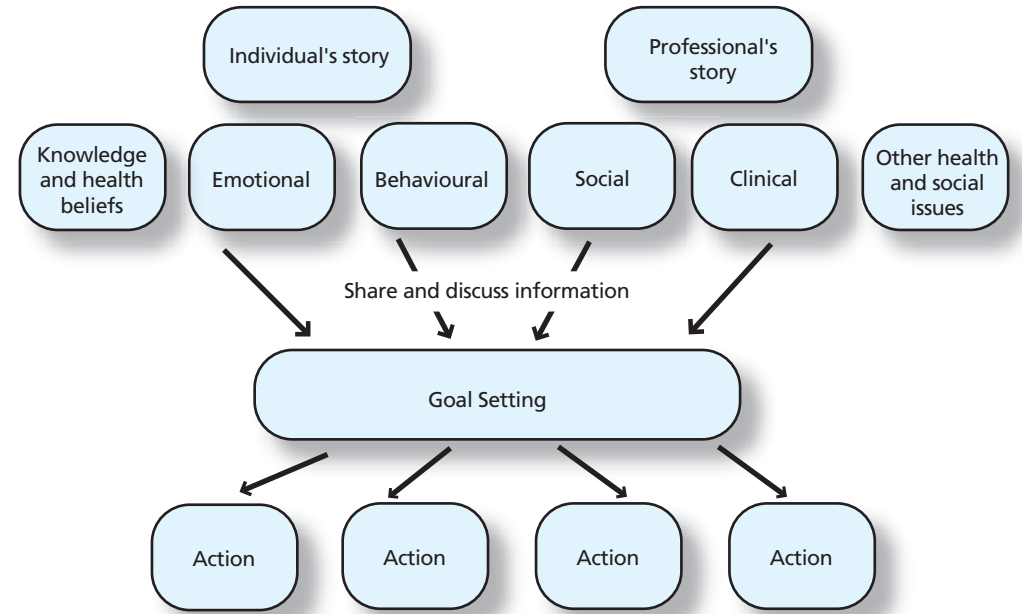
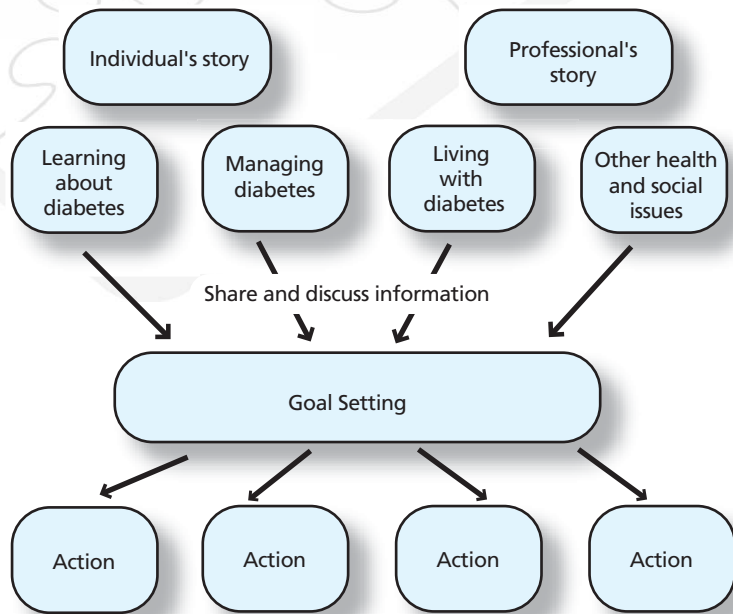
The right hand side model is included to suggest an alternative set of 'domains', which may be preferred by some practitioners and is more readily comparable in some elements of the literature or guidance. This may be particularly useful when attempting to capture and code issues into clinical information systems<sup>25</sup> in order to evaluate the needs of the population in the commissioning process.

As we have stated the principle of including the 'domains' is to ensure recognition of the multifaceted impact of living with diabetes, and any co-morbidities, and to facilitate a holistic approach. They are not intended as a checklist, but may ensure one issue does not dominate the consultation at the expense of other potentially more relevant topics or without taking the larger context into account.

One criticism of this model was that it was difficult to see easily how this might relate into practice – 'what will it actually look like?' In the next section we will attempt to describe the practical application and put it into context of the consultation frameworks in which we may be more familiar.



**Figure 3: The Care Planning Model** (with alternative sets of domains)



### The framework for the consultation

As we have indicated in earlier sections, a care planning consultation may present some healthcare professionals (HCPs) with a completely different way to practice. For others it will represent a development of pre-existing consultation skills.

It is not the aim of this guide to present or validate a specific model of consultation skills. Indeed, we believe that highly skilled professionals will be aware of and well versed in a variety of models and specific micro-skills, and will be capable of adapting and using these in a manner appropriate to a particular setting or circumstance.

Nevertheless, a framework and terminology are required to allow the practical application of the care planning model as outlined in the working group report. These are depicted in Figure 4 overleaf.

The terminology we have chosen aims to provide a clear understanding of the model and highlight the similarities with a variety of other models and approaches. The pre-existing models we have chosen to demonstrate this are not exclusive or exhaustive, but do represent approaches to support self-management frequently used or advocated in diabetes care internationally.

Many practitioners will have other preferred approaches. Please do not feel alienated by our choice of words. As long as we are aiming to fulfil the philosophy and vision of care planning, working in partnership with people with diabetes, this is not a problem. Furthermore, concepts such as the trans-theoretical model of behaviour change<sup>10</sup> or Motivational Interviewing<sup>11</sup> are techniques that are entirely consistent with the care planning approach and can be applied to improve its effectiveness.

The framework demonstrates that the care planning consultation should potentially be as robust and structured as traditional clinical history taking. Indeed it highlights similarities between these frameworks. It is important to note that whilst the care planning consultation presented in this way has something of a progressive sequence, it is not a format to be applied in a mechanistic manner, or to be followed at all costs.

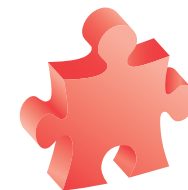
Not all patients may be ready or able to set specific goals or agree an action plan, especially if they are experiencing a new kind of consultation or if they have not been led to expect to do this. For example, people who are not currently engaged with their diabetes or may not have come to terms with their condition may need to concentrate on sharing and exploring their story and health beliefs. Individuals who are very engaged and/or well informed may have clear ideas about what they'd like to achieve and may wish to concentrate on action planning and reviewing how they get on.

### Time for Care Planning

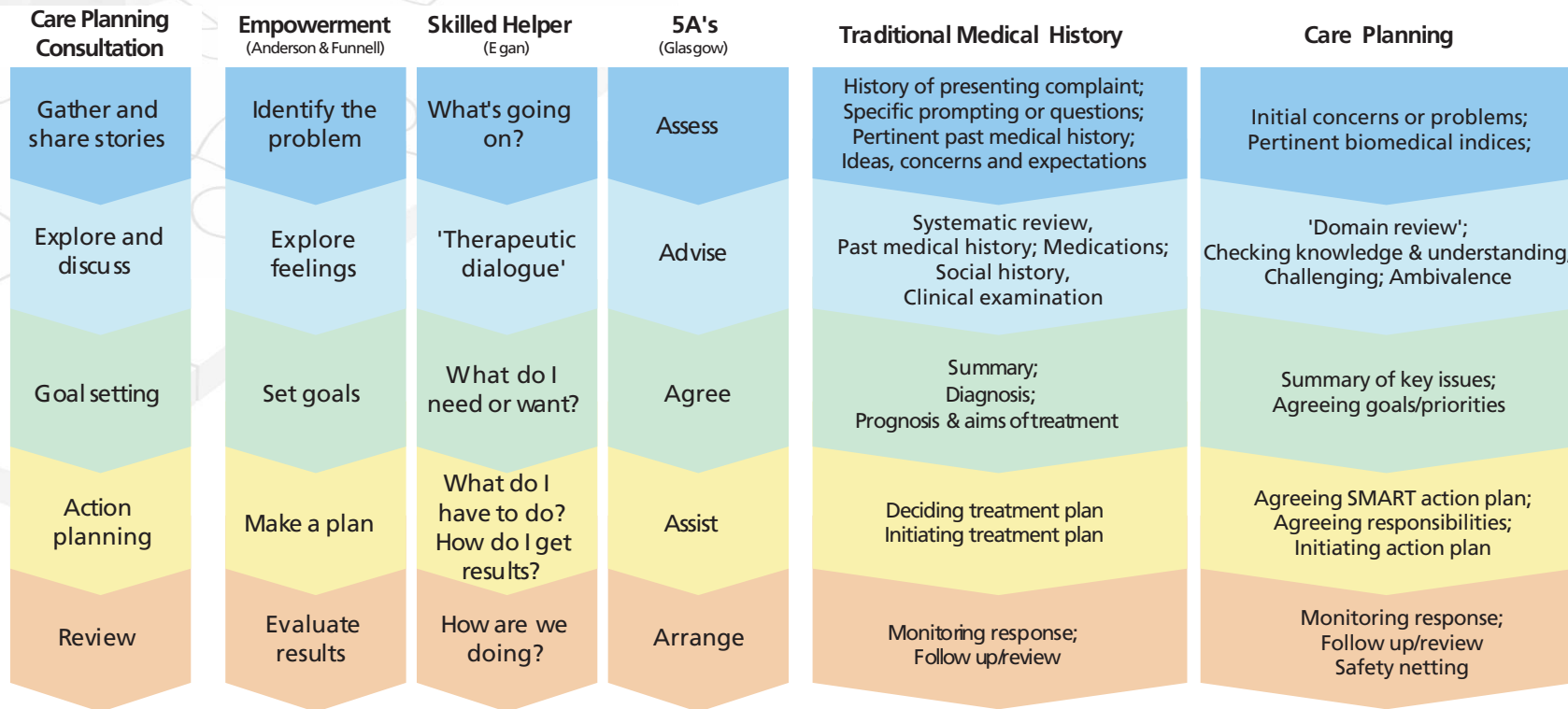
Described in this way, it may seem that the care planning consultation is more time-consuming activity than 'traditional' annual reviews. Like any new or unfamiliar activity, it is likely to take more time than longstanding and frequently used behaviours and this applies to both the HCPs and the person with diabetes. The key to efficiently using the whole care planning process is for it to be expected and prepared for. This emphasises the importance of orientating people with diabetes to what will happen and the kinds of questions they may be asked as well and for the health professional to be willing to gain experience in the process of care planning. Any new activity is performed more quickly with repeated practice. You only need to consider how difficult driving a car was when you were first learning, and how instinctive, even unconscious, it is now you've had years of practice. The same applies to developing new consultation skills.

It is also true that the time allocated in practice for diabetes care may need to be re-organised to accommodate care planning. For example, more time for care planning consultations, group-based education and telephone and email consultations may be needed. However, the experience to date has suggested that if service re-design is implemented fully the extra time that may be taken for these can be off-set by a reduction in needless routine follow-up appointments.

A further key factor in the success of the care planning approach is the use of other staff, for example, health care assistants/technicians to perform the information gathering and sharing elements. This has the advantages of creating a more satisfying and expert role for these staff as well as freeing up the practice nurse or GP to concentrate on the care planning consultation. It also promotes recognition of co-working and equality of contribution among team members.



**Figure 4**



**The Framework for the Care Planning Consultation**

We have compared the framework to some of the established frameworks or approaches advocated to support self-management in diabetes care internationally.<sup>24,26,27</sup> The similarities are clear.

We also present a traditional framework to medical history taking (column 5) to demonstrate that this also follows a similar pattern. In the final column we present a more detailed account of the approach to a care planning consultation. Again the intention is to emphasise the consistency of the approach even though the focus moves away from making a diagnosis towards understanding and clarifying the issues or problems facing a person living with and trying to self-manage a long term condition and helping them make a plan to overcome these.



## Gather and share stories

In the framework we have adopted in this guide we have chosen to separate the concept of agenda setting into 'gather and share stories' followed by 'explore and discuss'. As we have stated previously, this isn't to deny or ignore previous terminology, but simply that it was felt that this reflected the principles of Care Planning more accurately. This is particularly true of 'gathering the story' with information sharing prior to the consultation, which is a fundamental, if somewhat novel, element of this approach.

### Gathering the stories

How often have you had a phone call with someone and after you've put the phone down suddenly remember another issue you wanted to speak to them about, which may actually have been the reason why you made the phone call in the first place? Frustrating isn't it? - but then you could always email them or ring them back.

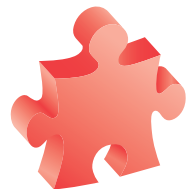
People attending your clinic have the same problem, exacerbated by it very often being a stressful experience, and may feel that they can't actually get back in contact with you very easily. This frequently results in the 'door handle question' when someone remembers just as they are leaving the room that 'there was just one other thing I wanted to ask you...' Even worse the question may ultimately go unanswered or their concern unaddressed.

This emphasises the importance of 'gathering the stories', which is usually done prior to the two parties coming together.

For the HCPs, this may be quickly scanning the person's medical records prior to inviting them into the room. This minute or so reminding themselves of previous consultations and action plans, or reviewing recent test results, often proves invaluable in helping them understand what it is that they would like to catch up with or discuss during the appointment. This also emphasises the importance of having the tests done, and results ready, before the consultation. How did we ever think it was acceptable to do tests after the consultation; to discuss and plan future diabetes care without crucial information such as the HbA1c being available to us?

For the patient, telling the HCPs about significant changes since their last appointment, and considering what they would like to get out of the appointment is vital, but may not be a task or skill that they are familiar with, usually because they have never been encouraged to do this in the past. Some people might have thought about this or come along with a list, but others may feel discouraged from doing so as they don't wish to '*bother the doctor.*'

One solution is to actively encourage people to think about what they'd like to discuss in the appointment before they come and to bring a list along with them.



This could be done by the inclusion of a simple statement in the appointment letter, or by the use of specific prompts.

The *'Making the most of your appointment'* prompt has been developed by the NHS Diabetes, in collaboration with a group of people with diabetes, and is available on the NHS Diabetes website.<sup>16</sup> It can be sent to patients prior to the clinic with their appointment reminders and aims to orientate people to the clinic experience and encourages them to consider the questions they'd like answered and what they'd like to get out of the clinic visit. A similar format prompt could alternatively been given to patients by the receptionist or clinic nurse to consider whilst in the waiting room.

The Bolton diabetes team have developed a series of agenda setting cards to enable this process.<sup>28</sup>

Another key element of gathering the stories is the sharing of information and test results prior to the consultation. How can someone make a robust and carefully considered decision on their blood pressure treatments or whether to start insulin if they have only had a few seconds or minutes to give it any thought? This issue has been discussed in detail in Chapter 2 but it is worth re-emphasising as it is such a crucial and fundamental prerequisite to involving people in their care.

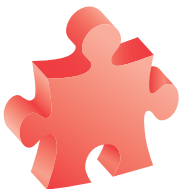
### **Importance of sharing stories**

The importance of 'sharing stories' to allow both the healthcare professional and the patient to understand each others perspective may be best illustrated by considering some potential scenarios. Patient A is a lady who has had a very difficult time recently as her marriage is on the rocks, her son has been in trouble with the police and her mother has been very unwell in hospital. As a consequence she has not been caring for herself, has often been forgetting her tablets and she has become depressed. Patient B has been suffering with excruciating painful neuropathy limiting his day-to-day activities and causing him to have very disturbed sleep. Clearly it would be inappropriate to start either consultation by saying:

*'I'm really pleased you've come along today as I'm very concerned about your diabetes control, which is very poor at the moment, and I think it is time we thought again about starting you on insulin.!'*

A better example might be:

*'Hello, I'm xxxx. We have about 15 minutes or so today to think about your diabetes and how things are going at the moment, but I'd like to start by asking you if there are any particular issues or concerns that you would like to make sure we think about today.'*



On the flipside the HCPs may feel very uncomfortable if the risks and consequences of the poor diabetes control aren't considered. Working in partnership does not mean that legitimate concerns cannot be raised by the HCPs. Specifically, both parties should have the opportunity to raise issues and negotiate and prioritise which will be discussed, ensuring that neither the person with diabetes nor the HCP dominate at the expense of the other. It is therefore entirely appropriate for the HCP to suggest issues of concern to them could be discussed:

*'So we need to talk about how difficult things have been for you recently and the pains in your feet. I wouldn't mind us having a think about your diabetes control as well, if that's alright. Where shall we start?'*

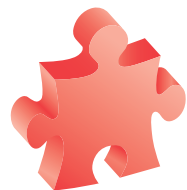
Whilst this may almost sound too obvious to need to be stated there is very clear evidence that patients will often feel that their concerns were not addressed fully which leads to dissatisfaction with the consultation. Time restraints are often quoted as a barrier to this process of setting the agenda, but there is evidence that done effectively it does not add significantly to the length of the consultation. Furthermore, 15 minutes spent discussing issues that are of no relevance to the patient at that time, and imposing a plan that they have no intention or will not be able to follow, is clearly 15 minutes wasted.

There may need to be negotiation as to how the issues are prioritised, whether they can all be covered in this consultation and which should be focussed upon.

*'That's quite a list for us to get through and we may not have enough time to do it all justice today. Which one would you like to start with?'*

### **Establishing rapport**

For sharing stories to be truly effective it requires more than simply agreeing a list of items for discussion. Very quickly, at the beginning of the consultation, an individual will decide how much of their personal information or concerns they wish to disclose. This may partly depend upon how prepared they are for the consultation process but will also reflect how much they trust the HCP and how interested they seem to be to listen. It is vital that the HCP demonstrates respect and empathy for the person and establishes initial rapport, especially if they are not well known to them.





## Explore and discuss

### Like falling off a log?

If we accept that the partnership approach is valid, that both the healthcare professional's and the individual patient's stories and perspectives are equally important, there is little need to emphasise that these need to be explored and discussed together. It is manifest and obvious. If we value another person's opinion then we need elicit it and listen to what they have to say.

In theory, written down in a guide like this, or discussing it with colleagues, it is easy: "I do it with all my patients; I listen to them all the time..." Like falling off a log. However, patients frequently report that they don't feel completely understood or that their perspective has been taken into account.

The truth is that it is difficult. Truly listening, appreciating and understanding another person's view is not a simple task. It is complex and challenging. How often do you misunderstand, or are you misunderstood by, your partner or a close family member? If this happens with someone you know extremely well, why should we expect it to be easy in a consultation with a patient?

That is not to say that it is too hard and we shouldn't even bother trying. But rather we should accept that it takes effort, application and specific skills. If we think we are doing it without even trying than we probably aren't doing it at all. For some practitioners it will be more natural than others, but with practice and experience it will become a genuine and comfortable part of practice. However, it will always require attention and focus.

### Making it happen

Exploring and discussing stories essentially requires the use of good communication skills. Whichever approach or approaches you prefer.

However, we feel perhaps the simplest summary of the basic but fundamental skills is found in Miller and Rollnick's *Motivational Interviewing*.<sup>11</sup> They describe four 'early methods' (by which they mean skills that should be used from the start of the consultation and continued throughout) by the acronym OARS.

#### OARS: Fundamental Communication Skills<sup>11</sup>

- Open questions
- Affirming
- Reflective Listening
  - Summarising

#### Open questions

These are questions that require more than a brief or simple yes or no answer, and therefore encourage respondents into talking. Closed questions will occasionally be necessary when checking or clarifying, but in general, the use of open questions is more likely to allow you elicit and explore someone's story. For example, "Has your diabetes



control improved?" is likely to get a short "not really", or "yes, a bit" response, which might require you to ask another question. Whereas, "Tell me, how has your diabetes control been lately?" may open the door for a more detailed answer.

### *Affirming*

Use of affirming statements can support and encourage the patient and demonstrate understanding and empathy. Simple examples such as "Thanks for coming to see me today" or "I can see that you've been trying really hard with your diabetes" can show that you are interested in that person and what they have to say. However, such statements do need to be genuine and congruent or they may have the opposite effect. Reassuring someone that "I'm sure you've tried the very best you can" when they don't feel this is the case may make them feel guilty and not want to admit that they don't think they have.

### *Reflective listening*

Effective listening is an active process. It is not just keeping quiet so that someone else can talk or simply showing that you are listening by nodding or other non-verbal clues. These are important elements but it is also verbally checking that your understanding is correct and encouraging the patient to continue to tell their story:

*"It seems like you are disappointed that you've gained weight, particularly because you have been trying to be careful."*

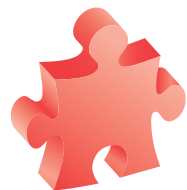
Acknowledging emotion is a particularly important part of reflective listening however, reflecting feelings should be done tentatively so that the person can correct you if you have misunderstood. For instance,

*"You feel your partner doesn't quite understand how difficult this has been for you recently, and, if I'm getting this right, it's making you pretty angry. Is that right?"*

### *Summarising*

Summary statements can be used to reinforce and check what has already been said, as well as continue to build rapport with the person and encourage them to elaborate further by demonstrating that you have been listening carefully to them:

*"So, I'd like to just pull together what we've been saying so far and check that I'm understanding you correctly. Overall you feel that things have been going pretty well and you didn't have any major concerns about your diabetes. But as we've been talking you mentioned that you did want to make sure that the diabetes wasn't, I think the words you used were, 'damaging me for the future'. So we've talked about this a little and I've suggested that perhaps your diabetes control isn't ideal and also your blood pressure has been a bit high. We've agreed that both of these may have risks for the future but at the same time you find it difficult to think about these as you feel really well at the moment. Is that correct? Have I missed anything out?"*



### *Domains*

So far we have established that working in partnership and sharing stories is important and that good communication skills are essential to make this happen. The other element of the stories we would like to consider is ensuring that the broader context of the individual and their life is considered and taken into account; a person-centred, holistic approach.

As we have previously stated earlier in this chapter, we have included 2 alternative sets of domains. Again, this is in an effort to ensure that readers are not alienated by the words used, but rather have a good understanding of what we are aiming to achieve.



## Goal setting

*'If you don't know where you are going, you might well end up somewhere else'*

### What is goal setting?

In his book *The Inner Consultation*,<sup>29</sup> Roger Neighbour presents a beautifully eloquent description of goal setting as:

'fixing in mind at the start a clear idea of the end point, the outcome, the result you are wanting to achieve. The desired outcome needs to be visualised or imagined in as much specific sensory and behavioural detail as possible, and acts as the equivalent of focussing on the bull's eye, or hearing the piece [of music] you're practising played by an expert' (page xxii)

Goal setting and action planning are inextricably linked but they should be seen as separate stages. Goals are outcomes, not actions – it's where you want to get to. For example, the goal of running a marathon (to use our earlier example) can only have been achieved when you get to the finish line - but the actions you take in preparation and taking part on the day will determine whether that goal is achieved. A goal will not be achieved without an action plan, it will remain an aspiration. The action plan is concerned with the actions needed to take to achieve the goal.

### Whose goal is it anyway?

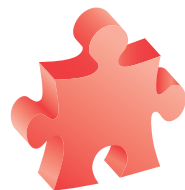
'Goal setting' is the term used in the Care Planning framework presented here, but in everyday language, you might choose a different term – an 'aim', perhaps, or a 'target' or a 'mission'. You can use whatever term you and the person with diabetes feel comfortable with to express the idea that it is what they want their efforts to achieve.

There is a danger with terms such as 'goals', and particularly 'targets', in that they may have been used in a different capacity in the past as things that were imposed upon the person with diabetes. "I think your goal should be to lose at least 2 stones" or "You're still a little way off our target of an HbA1c of less than 7%." A fundamental tenet of Care Planning is that the goals under discussion are those of the person with diabetes. It is their goal. These will derive from the exploration and discussion of the HCPs and the individual's 'stories'.

### Goal setting in practice

Goal setting involves summarising and prioritising the various issues that have been explored and discussed so far in the consultation. For instance the healthcare professional might say "what, of all the concerns we have talked about, rise up for you as the important things to aim for in relation to your diabetes, over this coming year?"

As Neighbour's description above indicates a goal needs to be very clear. The person should almost attempt to create a 'vision' of what they would



like to achieve.

In practice this may require some time to clarify and refine the goal. For example, a person might suggest that their priority might be 'to lose weight'. However it is important to clarify how much weight they would like to lose. More specifically perhaps how much they feel is realistic to lose over the next 6 to 12 months. How disappointed would they be if they only lost half that?

### **How important is it to you?**

When changing something is difficult, the reason the change, the place where someone would like to be, has to be worth the effort of changing. If the goal is of low importance, but the difficulty of achieving it is high, then it is unlikely to be successfully achieved. Why would you want to put yourself through that?

The value to someone can be assessed quite simply by asking the person to consider how important the goal or outcome is for them using a rating scale of 0 – 10 where 0 is low and 10 is high importance. For instance:

*"If I asked you to tell me how important this change is for you, where zero was not important at all and 10 was really, really important, where would you put yourself between zero and ten?"*

The higher the score, particularly 7 and above, the more important the change feels for that person and therefore the more likely they are to put the effort into making a change. You can also explore what it is that makes it important to them whether it be "making them feel better", "seeing my grandchildren grow up" or "getting into my dress at the Christmas party". These are the things that might help people keep on track when making the change gets difficult.

If the score is lower then the reason for picking that goal needs to be explored. Perhaps they have picked it because they thought it was important to the HCPs, but remember they still have to make the changes. If it is not *their* goal, if it really isn't important to them, or there are other things that are more important, they simply aren't going to be able to do it.

### **Goal setting is the key**

In the consultation framework we compared the Care Planning consultation with traditional history taking. In this we have equated goal setting to making a diagnosis. In the acute medical role, no-one would doubt the central importance of understanding and interpreting the medical history and findings in order to make an accurate diagnosis. We would contend that goal setting has the same significance within the Care Planning consultation. Just as, if the diagnosis is incorrect the treatment is likely to be ineffective; unless the goal is what that person wants, they are unlikely to be able to achieve it.

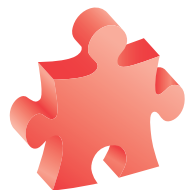
This emphasises the crucial role of the stages prior to goal setting, to agree a goal or goals that are indeed right for that individual, prior to moving on



how to achieve the goal through action planning. In many ways the summarising, prioritising and goal setting is the pivot point for the consultation in moving from exploring and understanding into action.

We hope that, presented in this way, the central value of goal setting is compelling. However, we would argue this is an often overlooked or scantily attended to part of a consultation. The recent Healthcare Commission survey revealed that less than half of respondents recall even discussing their goals in the diabetes appointment.<sup>8</sup>

To an extent this may be because neither party is used to, or 'orientated' to, attending to goals explicitly. Also, if the HCPs hasn't properly understood the person's perspective on the issues, they are likely to make inaccurate assumptions about what they wants or needs are. Research has shown that HCPs and patients frequently have very different opinions about what treatment decisions were made, even immediately after the consultation.<sup>30</sup> It is possible that the central 'checking' role of goal setting presented here could help to minimise these differences and mean that both are 'singing from the same songsheet' together.



## Action Planning

*'Someday is not a day of the week'!*

As we have said, the reason that many goals for lifestyle or behaviour change – or any outstanding task for that matter - are not realised, is because they remain goals and not actions. Examples of goals are 'I would like to be 3 stones lighter', 'I'd like my patients to be more motivated', and 'primary and secondary care services should communicate better'. These are outcomes, not actions, and they will never be achieved unless an action plan is put in place. Action planning is the detailed process, often broken into very small chunks, that needs to be put in place to realise the goals and the desired outcomes.

As can be seen from the examples given above, action planning is not confined to changing health care services or role redesign. The principles apply equally to a consultation with an individual person with diabetes, a team meeting or our own personal lives. The actions in the plan will be different, but the principles are the same. The key is to increase on the chances of success by reducing potential barriers from the start.

### Key ingredients of successful action planning

- Plans need to be SMART
- Success is addictive
- Barriers to success need to be considered
- Rating scales to assess confidence and readiness
- Success really is addictive
- Take the time to do it

### SMART Plans

Plans that are SMART are more likely to be put into action. Consider an example of a person with a goal to eat more healthily. A plan such as 'next week I will try to eat some fruit' is not specific or tightly time-scaled. However, a plan that 'on Tuesday and Wednesday next week at work I will eat fruit instead of the usual cake in the morning and afternoon' is much more specific and time-scaled and therefore more likely to be achieved.

### SMART explained

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

- S = Specific
- M = Measurable
- A = Action
- R = Realistic
- T = Time-scaled

If an action plan can 'tick the boxes' of the above features, it is more likely to be successfully achieved.



## Success is addictive

People are often keen to achieve a goal but may have difficulty deciding exactly what they feel they can do to achieve it. Again, this may reflect many years of trying and ‘failing’ – ‘I really would like to lose some weight, but I’ve tried everything and although I lose weight to start with, I always end up putting it back on...’ In this situation you may ask ‘So, this is really frustrating for you and you feel you’ve tried lots of things in the past, but I’m interested to know whether you have lost weight before - what worked for you last time?’ Things that have worked in the past are more likely to work again in the future, so it may be worth exploring whether they feel they can do the same or similar again.

## Consider the barriers

A key aspect of action planning is discussion and consideration of potential barriers to success. Open questions such as ‘what might stop you doing this?’ can be useful perhaps followed by some more specific questions. For example, if someone sets themselves the action plan of ‘next week, eating fruit instead of cakes at coffee break at work’ you might ask ‘how will you ensure there is fruit available to you?’ or ‘how will you cope when the cakes are offered round at coffee time, and you are hungry?’ If there are things that might get in the way, consider how these can be overcome.

It may emerge that there are too many barriers for this plan to be achieved after all, as perhaps it wasn’t realistic, in which case the plan may need to be altered or refined.

## Rating confidence

Self efficacy theory holds that a key determinant of a person’s ability to take action is the confidence they have in their ability to successfully undertake that action.<sup>31</sup> So, a further way of assessing how realistic a plan is to ask the person to rate their confidence that they will be able to do it. This can be done in a similar way that we rated the importance of goals:

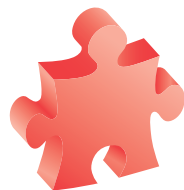
*“If I asked you to rate how confident you feel you are to be able to do this, where zero was not at all and 10 was absolutely definitely, where would you put yourself between zero and ten?”*

Once again a score of 7 and above is likely to mean that the plan feels realistic for that person and the more likely it is to be put into action. Lower scores do not necessarily indicate that no action will take place, just that there will be more barriers to overcome, which may make it very difficult.

In the case of a lower score, ask the person what it was that had made them score their plan so low and what might need to be different to make it a higher score. A smaller or easier action plan needs to be put in place - using the watermelon analogy; a smaller slice needs to be cut!

*‘You can’t eat a watermelon whole...you have to cut it into slices’*

Action plans sometimes need to be refined and refined in this way until they are truly SMART and the person has a high confidence in





their achievement. In this example, the final action plan may look like this:

'On Monday, at home, I will eat a banana at 11am when I have my morning coffee.  
Confidence level = 9.'

### **Success really is addictive**

Even though the action plan outlined above might look very small, the experience of success in this action will inspire the person to repeat the behaviour. Often people will have struggled with the behaviour they are trying to change for many years and will have experienced 'failure' on many occasions. This may be because the actions they decided upon, or more likely, were recommended by others, were simply too ambitious to be SMART. These negative experiences may put them off trying again and may certainly make them feel it is unlikely to ever happen for them. Setting another daunting and unrealistic action plan, which is unlikely to be successful, will simply reinforce feelings of failure.

### *'the longest journey starts with a single step'*

Success is an addictive feeling and if this person is able to achieve the small change they are hoping for then they are much more likely to make the next change. It is often helpful for people to plan positive rewards or incentives to encourage them to continue along their journey. These may include success in achieving the small steps, or can simply be things they enjoy. An example may be someone saying to themselves "if I am careful with what I eat all week, I will allow myself a scone with my coffee when I'm shopping on Saturday".

### **Take the time to do it**

Action planning in this way is a skill. It can feel awkward and be difficult to master at first. It can also feel time consuming. However, it is the crucial step in helping people make a change. Time does need to be spent on the early elements of the consultation or else the action planning could be for the wrong goal or reason. But, running out of time and missing out a specific action plan could mean that the goal will never be achieved, which will be frustrating for the healthcare professional, but imagine how that feels for the individual who has 'failed' to do it again. We would strongly recommend that the few minutes taken to agree a really SMART action plan will be the most valuable minutes you spend in that entire consultation or even the whole clinic.

Many people find it helpful to use prompts which the person can then take away with them to remind them of their plan. This also has the advantage of reminding you of the next steps and making the process as effective as possible. An example of an action planning prompt is included in the Appendix.

It is important to re-emphasise that although these elements of the Care Planning consultation are portrayed in linear form it is actually far more dynamic process. Sometimes people may have a goal in mind and feel it is important to them, but may have difficulty in deciding on an action plan. This may still indicate that the goal isn't quite right or isn't something they



## Joint review

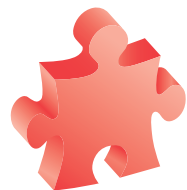
Joint review essentially refers to the mechanisms agreed and put in place to monitor and review the planned and unplanned care and action plans between Care Planning consultations. For example, the action plan of monitoring blood pressure at monthly intervals implies that review of the results is needed. This might be by telephone, email or face to face. Alternatively, the patients themselves can be taught to interpret the results but would still need a mechanism for contacting the healthcare professional if they need to.

The exact nature of the way joint review takes place will be agreed and implemented according to individual agreements with patients during the Care Planning consultation and within local service constraints. However, it is anticipated that this will be more progressive and innovative than simply 3 or 6 monthly interim appointments.

In the context of Year of Care this will also relate to the 'menu of care' element of the Care Planning process. Service development and re-design is an essential part of the Year of Care pilot,<sup>2</sup> and for that reason this element is not considered here in detail at this time, although experiences and learning may allow further elaboration in the future.

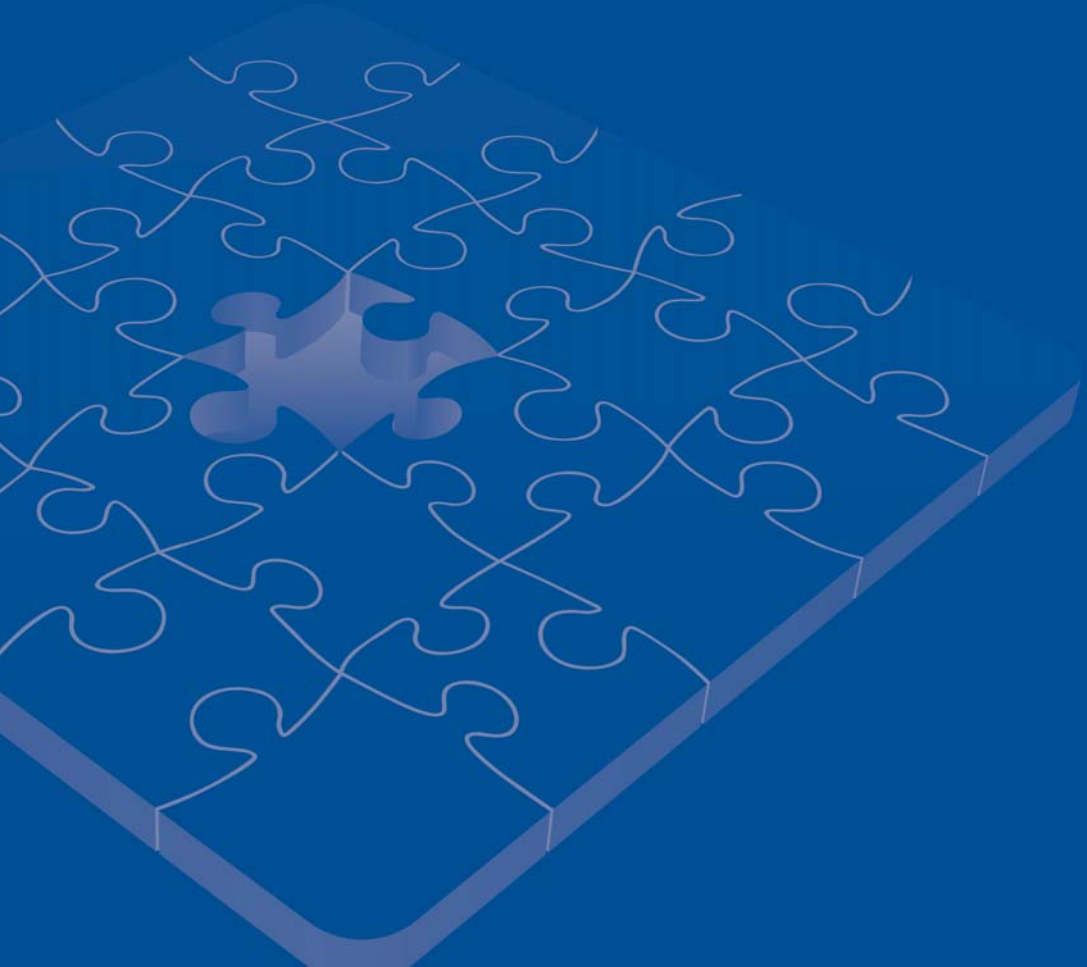
## Quality assurance

Similarly, there will be a requirement in the future for effective mechanisms to monitor and quality assure the Care Planning process and involvement of patients. This is considered briefly in the Care Planning Report<sup>1</sup> and is not considered in this guide in further detail at this time. The Year of Care pilots should illuminate what effective measurement and quality assurance of Care Planning might comprise.





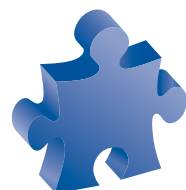
## 4. Further reading, resources and contacts



## 4. Further reading, resources and contacts

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## Additional reading

There are many excellent books, reports, papers or other resources that may provide further reading and insight including the following:

### **NHS Diabetes website**

Excellent resource including links to further reading and examples of good practice (infopoints) and Year of Care information.

<http://www.diabetes.nhs.uk/>

To receive a regular update on the Year of Care project, email Kathy Wilson on [yearofcare@diabetes.org.uk](mailto:yearofcare@diabetes.org.uk)

The Year of Care website

<http://www.dur.ac.uk/ccmd/yoc/>

### **Policy Context**

Department of Health (2006) Care Planning in Diabetes

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_063081](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063081)

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Department of Health (2006) Our health, our care, our say

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Department of Health (2006) Supporting people with long term conditions to self care: A guide to developing local strategies and good practice 2006

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH\\_4100317](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4100317)

The Diabetes Information Jigsaw report

[http://www.abpi.org.uk/%2Fpublications%2Fpdfs%2Fdiabetes\\_jigsaw.pdf](http://www.abpi.org.uk/%2Fpublications%2Fpdfs%2Fdiabetes_jigsaw.pdf)

Healthcare Commission Service Review of Diabetes (2007)

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[http://www.hm-treasury.gov.uk/consultations\\_and\\_legislation/wanless/consult\\_wanless\\_index.cfm](http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless_index.cfm)

### **Empowerment, Motivational Interviewing, patient-centredness & patient involvement**

Anderson R, Funnell M (2006) The Art of Empowerment American Diabetes Association – Originators of the empowerment approach, easy to read and encourages reflective practice and self and team development - available through Amazon etc (~£22)



Miller WR, Rollnick S. Motivational Interviewing: Preparing people for change. 2002. Guildford Press. Widely available

Rollnick, S., Mason, P., Butler, C. (2005). Health Behaviour Change. London. Churchill Livingstone. Includes 'stages of change' model and examples of practical techniques of Motivational Interviewing. Available from Amazon.

Wagner's Chronic Care Model <http://www.improvingchroniccare.org>

### **Communication & consultation skills**

Egan, G. (2002) The Skilled Helper Wadsworth – Detailed account of communication and counselling skills - available through Amazon etc (~£25)

Neighbour, R. (2002). The Inner Consultation. – Archetypal textbook, widely available

Silverman J, Kurtz S, Draper J. Skills for Communicating with Patients. Radcliffe Medical Press, Oxford, 1998 – An excellent textbook and the basis of the Calgary-Cambridge model, available through Amazon etc (~£27).

Tomkins S, Collins A. Promoting Optimal Self Care. Nicely written and easily accessible 'handbook' to techniques that promote optimal self care.

[http://www.networks.nhs.uk/uploads/06/02/optminising\\_self\\_care.pdf](http://www.networks.nhs.uk/uploads/06/02/optminising_self_care.pdf)

### **Shared decision making & risk communication**

Towle A, Godolphin W. Framework for teaching and learning informed shared decision making. BMJ 1999; 319: 766-71 – Nice summary, available free through bmj.com (<http://www.bmj.com/cgi/reprint/319/7212/753>)

Elwyn G, Edwards A, Kinnersley P, Grol R. Shared decision making and the concept of equipoise: the competencies of involving patients in healthcare choices. Brit J Gen Prac 2000; 50: 892-897 – Further consideration and iteration of Towle and Godolphin's competencies

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Gigerenzer G. Reckoning with Risk. Penguin, London 2003 – Wonderful book – not specifically a medical text, but general interest read – definitely recommended, available through Amazon etc (~£7)

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<http://www.bmj.com/content/vol327/issue7417/index.dtl>

National Prescribing Centre (2007). A competency framework for shared decision making with patients – summarises evidence, further reading and presents a competency framework

[http://www.npc.co.uk/pdf/Concordant\\_Compentency\\_Framework\\_2007.pdf](http://www.npc.co.uk/pdf/Concordant_Compentency_Framework_2007.pdf)



## Consultation skills development programmes

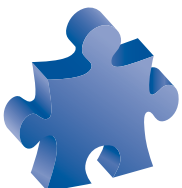
The following list, compiled by the NHS Diabetes, provides details of current training programmes for consultation skills in the care of people with diabetes, other long term conditions and perhaps wider healthcare areas. This list will evolve over time as more courses are developed but aims to provide an introduction to those currently available and where to go for further information.

1. **Diabetes Manual** is a self-management/structured education programme for type 2 diabetes delivered by practice nurses and other health care professionals (Diabetes Manual facilitators) in 1:1 consultations. The facilitators undertake a two-day training to learn the psychological principles and processes involved in supporting patients in behaviour change. Much of the training is experiential in goal setting, self-efficacy enhancement, anxiety reduction along with developing new skills in techniques like telephone support. For further details please see - [http://www2.warwick.ac.uk/fac/med/study/cpd/subject\\_index/diabetes/manual/](http://www2.warwick.ac.uk/fac/med/study/cpd/subject_index/diabetes/manual/)
2. **Theory and practical technique in self-management** is a 5-day module run by Warwick University can be taken as part of a masters degree or as a stand alone "post-graduate award" where the Healthcare Professional undertakes the assignment and receives CATS points. Alternatively, it can be attended for skill development without the assignment aspect if people prefer. For further details please see - [http://www2.warwick.ac.uk/fac/med/study/cpd/module\\_index/pc912/](http://www2.warwick.ac.uk/fac/med/study/cpd/module_index/pc912/)
3. **The Knuston Hall Diabetes Counselling Skills Course**, developed by Charles Fox, consultant diabetologist, and Chris Gillespie, clinical psychologist has been running for over 20 years. The course, designed for health care professionals working in the field of diabetes, teaches the listening skills necessary to help the client explore their problem and clarify their thoughts. The underlying philosophy is based on the Helping Relationship described by Gerard Egan (The Skilled Helper, 8th edition). Since 2007 the course has included training in empowerment techniques. Video real play in small groups is designed to allow learning and discussion in a secure, unthreatening environment. At the end of the course, trained actors play client roles, thus enabling participants to practice their skills in a realistic setting. For further details please email: [diabetescc@aol.com](mailto:diabetescc@aol.com)
4. **Clinical Decision Making and the Consultation** is a 4-day classroom based and self-directed learning module. Placing the patient at the centre of the process, this course has been developed to enhance medical practitioners' consultation skills.

The course will enable attendees to maximise the outputs from the consultations and test and hone decision making abilities. For further details please see -

<http://www.pphi.ac.uk/short/short.php?page=advHealth>

5. **Advanced Consultation Skills** is a course specifically designed to enhance attendees skills in their work with people with diabetes. It is

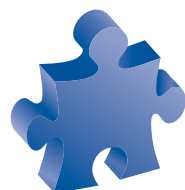




run by In Balance Healthcare which was set up by two former Diabetes Specialist Nurses, now health education specialists, focussed on helping NHS Trusts and Diabetes Specialist Teams develop their skills and services in diabetes care to meet the requirement of the Diabetes National Service Framework. The actual course, structured as one-day workshops, explores the skills needed in a consultation to: match patient and professional agencies, explore issues and agree an action plan. For further details please see - <http://www.ibhuk.com/>

6. **Education for effective self care** is a module run at Portsmouth University which explores the empowerment of the person with diabetes and the potential roles and responses from professionals. Part of the aims of this course is to develop effective consultation skills for supporting effective behaviour change. For further details please see - [http://www.tech.port.ac.uk/tud/dbp/UnivPort/level\\_M/ED4EFFSELFCA.htm](http://www.tech.port.ac.uk/tud/dbp/UnivPort/level_M/ED4EFFSELFCA.htm)
7. **Improving doctors' communication skills: teaching what is measured (Michael Greco)** -This workshop trains doctors in communication skills to improve patients' experience. It presents evidence on the factors that motivate patients to complain about, or sue, their doctor. For further details please see - [http://www.cgsupport.nhs.uk/downloads/Patient\\_Experience/EACH\\_poster\\_hando ut2.pdf](http://www.cgsupport.nhs.uk/downloads/Patient_Experience/EACH_poster_hando ut2.pdf)
8. **The Flinders Model of Chronic Care** - Flinders Human Behaviour & Health Research Unit (FHBHRU) has developed a generic set of tools and processes that enables clinicians and clients to undertake a structured process that allows for assessment of self-management behaviours, collaborative identification of problems and goal setting leading to the development of individualised care plans. These care plans are the cornerstones in enhancing self-management for people with chronic conditions. For further details please see - <http://som.flinders.edu.au/FUSA/CCTU/Chronicconditionselfmanagement.htm>
9. **Patient-focused interventions: A review of the evidence** – This publication from the Health Foundation provides a concise and comprehensive overview of the evidence base for a number of patient-focused interventions. The aim is to identify best practice and inform decision-making in healthcare policy, management, practice and research. In particular, Chapter 2: Improving clinical decision making, has information on studies which have focused on communication skills training for clinicians. For further details please see [http://www.health.org.uk/publications/research\\_reports/patientfocused.html](http://www.health.org.uk/publications/research_reports/patientfocused.html)

If you know of any more useful resources to support consultation skills development then please email details of these to [ndstenquiries@diabetes.nhs.uk](mailto:ndstenquiries@diabetes.nhs.uk)



## Development of this guide

This guide is built upon the talents, experiences, ideas and inspirations of very many people in diabetes care and other long-term conditions. The origins, development and direction of this guide can be attributed to:

The National Service Framework for diabetes, which highlighted the importance of empowering people with diabetes to take an active role in managing their condition.

Much of the original thinking and piloting of the Care Planning approach took place in Northumbria Specialist Diabetes Service and their colleagues in primary care. Worthy of particular mention are Linda Helmore and Paul McClintock, who, along with their colleagues at Burn Brae surgery in Hexham, were the first to take the theory and put it into action. We have learnt from their experiences, and that of other surgeries in North Tyneside and the north of Northumberland who have followed suit.

The Care Planning model and guidance for implementation was published by the joint Department of Health and Diabetes UK Care Planning working group, co-chaired by Simon O'Neill and Sue Roberts. An understanding of the evidence base and the areas in need of further research was provided by the research group (Jonathan Graffy, Simon Eaton, Jackie Sturt and Paul Chadwick), shortly to be published in more detail.

Further guidance and direction has been provided by an ongoing workstream of the NHS Diabetes Supporting Self-management Group. Clare Beard, currently the programme lead of this group, has been centrally involved in developing the approach for national implementation.

The Year of Care project pilot sites, Calderdale and Kirklees PCT, Tower Hamlets PCT and NHS North of Tyne, led by Project Manager, Kathy Wilson, have done a huge amount of work conceptualising the model for practical implementation across health communities. This project has been funded jointly by Diabetes UK, the NHS Diabetes, the Department of Health and the Health Foundation.

Finally, but perhaps most importantly the people with diabetes that have been involved in every stage either through experiencing the approach when it was first being tried out, and/or as partners in thinking through the model and approach and feeding back their experiences and as guides, continuing to remind us that better services are required.

Individuals mentioned above and many others have commented upon previous drafts and provided insight and inspirational support.

Yet, we also see this guide as a 'work in progress'. We are all only starting along the journey to provide innovative and more responsive diabetes care, fit for the purpose of understanding and addressing the needs of people with diabetes and enabling them to take a greater role in managing their condition. We would truly value your experiences, feedback and suggestions, so together we can make this happen.

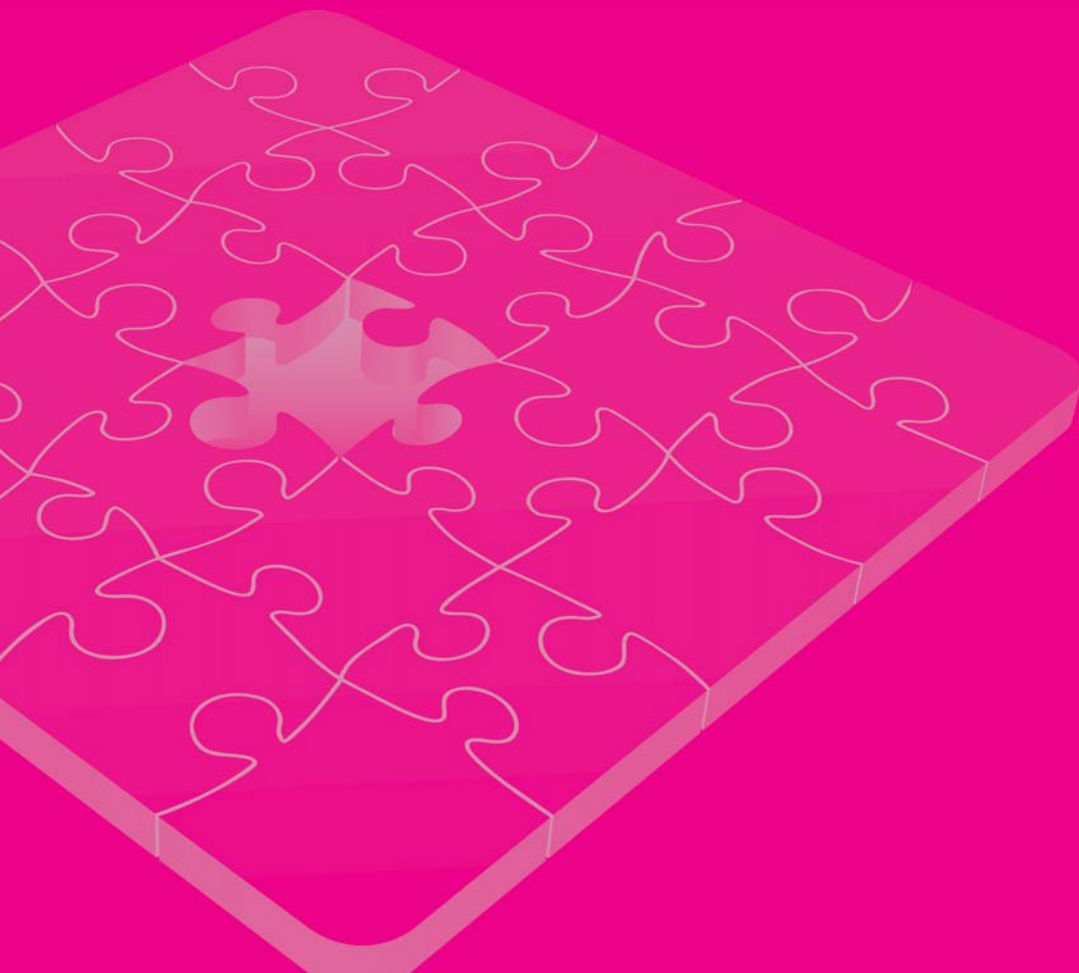
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## 5. Appendices



# Appendices

We have included a number of examples referred to in sections of the text. These are not exhaustive and can be adapted as appropriate for local use.

## Results sharing sheet (page 55)

Derived from the results sharing pilots at North Tyneside General Hospital. The patient's details and test results are added to the template and posted to them 1-2 weeks prior to the care planning appointment. Folded into A5 to form booklet.

## Consequent care plan

This builds from the results sharing sheet above. The details of the care planning consultation are written into the template and for the substantive record of the consultation and plan. This can then be shared with the patient and other health care professionals as appropriate.

## Action planning proforma

Derived from In Balance Healthcare UK materials. Can be used as a prompt to ensure action plan is SMART and guide through action planning process

## Goal setting and Action Planning Proforma

Adapted from DAFNE and DESMOND resources to guide through goal setting and action planning process.

## Results sharing sheet

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

### 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 Diabetes Resource Centre

If this appointment is inconvenient for you, or if you feel you need to discuss these results more urgently, please contact ..... at the Diabetes Resource 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.

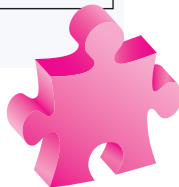
### Care Planning Results - Interim

	Your result was:	Please feel free to write any questions or comments you may like to discuss
<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.	HbA <sub>1c</sub> 6.6%	
<b>Blood pressure (BP)</b> A target blood pressure of below 130/80 lowers the risk of complications (a target of below 125/75 is used if you have kidney disease).	BP 125/72	
<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.	Cholesterol 4.2	
<b>Kidney tests</b> Your kidneys are tested by looking at a blood test (creatinine) and the leak of protein in your urine.	Creatinine 146 Urine: Normal	This result is stable but may indicate some kidney problems. This can be discussed in more detail at your appointment.
<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.	Weight 104.6kg BMI 34.9	
<b>Smoking</b> Smoking causes problems with your health in many ways but is particularly damaging in people with diabetes.	You are an ex-smoker	

Name:

Date of Birth:

Date sheet completed:



## Consequent care plan

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  
 Metoprolamide  
 Coodamol  
 GTN

### 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.

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

Signed:

### Care Planning Results

	Your result was:	Comment
Diabetes control 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.	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.
Blood pressure (BP) A target blood pressure of below 130/80 lowers the risk of complications (a target of below 125/75 is used if you have kidney disease).	BP 125/72	Excellent
Cholesterol and blood fats 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.	Cholesterol 4.2	Excellent
Kidney tests Your kidneys are tested by looking at a blood test (creatinine) and the leak of protein in your urine.	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
Weight & body mass index 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.	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.
Smoking Smoking causes problems with your health in many ways but is particularly damaging in people with diabetes.	You are an ex-smoker	Excellent

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date sheet completed: \_\_\_\_\_

## Action planning proforma

Use this sheet to record what actions you are going to take. Ensure that your action plan is SMART:

- S - Specific
- M - Measurable
- A - An Action
- R - Realistic
- T - Time-scaled

NB ensure that you include WHEN you are going to take the action, also that if any barriers exist which might prevent you acting, include a plan of how to overcome them. You might also like to give yourself a score between 0-10 as to how likely it is that you will undertake your action. If your score is 7 or less, you may need to 'smarten' it up!

Action I am going to take: \_\_\_\_\_ confidence level \_\_\_\_\_

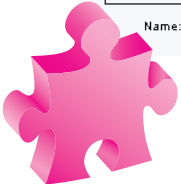
Is this action plan SMART? \_\_\_\_\_

Potential barriers to success \_\_\_\_\_

Revised action plan \_\_\_\_\_ confidence level \_\_\_\_\_

Is this action plan SMART now? \_\_\_\_\_

(Adapted from In Balance Healthcare UK materials.)



## Goal Setting

What sort of things would I like to achieve?

What one thing do I want to achieve?

How important is it to me?

Not  
Important

Very  
Important

1 2 3 4 5 6 7 8 9 10

## Action Plan

What exactly am I going to do?  
(How, what, when, where, how often)

What could get in the way?

What can I do about this?

How confident do I feel?

Not  
Confident

Very  
Confident

1 2 3 4 5 6 7 8 9 10



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