

Care Planning in Diabetes

Introduction

This Factsheet explains the concept of Care Planning in diabetes care as laid out in *Care Planning in Diabetes: Report from the joint Department of Health and Diabetes UK Care Planning Working Group*:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063081

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.

Empowerment

Care Planning is one of the key interventions required to achieve Standard 3 of the *Diabetes National Service Framework (NSF)*, which highlights the importance of empowering people with diabetes to take an active role in managing their condition:

All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in the process."

Diabetes NSF:

http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=SS_GET_PAGE&siteId=en&stargetNodeId=566&ssDocName=DH_4002951

The importance of Care Planning is also highlighted in Department of Health documents:

Our Health, Our Care, Our Say: a new direction for community services:

http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=10484&Rendition=Web

Building on the Best: Choice, responsiveness and equity in the NHS:

http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=22130&Rendition=Web

Principles

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

The Disease-Illness model¹ is suggested as a way to make this happen. The model emphasises the importance of the healthcare professional's perspective of disease and pathology but suggests these should always be considered in parallel with, and in equal importance to, the patient's individual experiences of their condition. Specifically, this includes listening to the individual's ideas, concerns and expectations of their condition and treatments.

During a care planning consultation, the person with diabetes and the healthcare professional raise and discuss their respective concerns, prioritise them, explore potential risks and available options and make mutually agreed informed decisions about ongoing care.

A care planning approach recognises that people with diabetes may engage with the process in different ways, with one individual choosing a very different degree of control over their care from another. Therefore the environment in which care

¹ Stewart M, Roter D. *Communicating with medical patients*. Newbury Park, Ca: Sage, 1989

planning takes place needs to be flexible and responsive.

Care Planning is not just for people with diabetes, it is something that can cater for anyone who lives with one or several long-term conditions. In fact, for those with more than one condition, care planning could provide a single, comprehensive and patient-centred review, rather than multiple reviews for each individual condition. At organisational level, care planning should therefore enhance and promote coordination of health and social care services and support local commissioning. At individual level, this ensures that all personal, social and health-related issues are given the appropriate level of consideration.

People with diabetes need to be enabled to take part in the Care Planning process. It is therefore important that it is flexible and adaptable so that the individual needs and preferences of the person with diabetes can be met. These might include, but are not limited to, language barriers, learning disabilities and other communication needs.

Components

The principles and philosophy of the Care Planning approach can be applied to any consultation or interaction between healthcare professionals and patients.

The Care Planning approach, could be considered as an adaptation of the traditional annual review. The aim of this consultation is to discuss, prioritise and plan for the forthcoming year of care. It is anticipated that this would usually occur annually, but the actions resulting from it may need to be reflected on and revised at shorter intervals.

The individual's story and the professional's story

The stories, or agendas, of both the person with diabetes and the healthcare professional play a dual role in Care Planning. These are brought to a consultation where various issues will be discussed.

Four broad domains are included in the model as potential areas for discussion:

1. Learning about diabetes, which might include:
 - Discussing questions asked by the person with diabetes.
 - Identifying sources and means of obtaining information.
 - Proactively considering future information needs.
 - Reflecting on the impact of structured education.
 - Discussing what learning has arisen for the person as a result of their day-to-day experiences.
 - Practical demonstrations and information about new equipment and resources.
2. Managing diabetes
 - Being supplied with test results before you attend your review appointment.
 - Medications and treatments.
 - Monitoring and surveillance.
 - Self monitoring.
 - Managing situations such as illness.
 - Health-related behaviour such as smoking, diet and physical activity.
 - Referrals to other agencies or health professionals.
 - Planning future treatment changes.
3. Living with diabetes
 - Day-to-day social, work and family issues.
 - Practical considerations such as travel.
 - Managing the effects of medication such as hypoglycaemia.
 - Managing the effects of long-term diabetes complications.

- Psychological effects and coping strategies.
 - Planning for future life events such as pregnancy and retirement.
4. Other health and social issues
- Other long-term conditions.
 - Exploring concerns about other health issues which may on occasion take priority.
 - Mental health problems such as depression social exclusion, isolation or poverty may need to be addressed more promptly than diabetes itself.
 - People living in institutions or prison may not be in direct control of their diabetes and need structured support from others.

Sharing and discussing information and negotiating the agenda

In the care planning review there may be several potential issues for discussion, as identified above. Clarifying and exploring these issues in order to decide which are to be focussed upon during the consultation requires specific skills.

The healthcare professional's responsibility is to ensure that the discussions and decisions are made in full collaboration with, and are appropriate to, the individual they are consulting with.

Action Planning

At this stage of the consultation, the person with diabetes and the healthcare professional should agree a set of personal goals and the actions needed to support them. They will also decide who will be responsible for achieving each of the actions and agree when then actions will be reviewed.

For the person with diabetes, the actions are likely to relate to aspects of self management. For the healthcare professional, they might include referrals or investigations.

Actions are more likely to be undertaken by either party if they are detailed and specific and set out within a given timescale.

Documentation

The outcomes of the Care Planning consultation should be recorded in some form of document, and a care plan would be appropriate for this. However, it is important to recognise the distinction between the care plan and the Care Planning process. Care Planning is a dynamic process of negotiation and shared decision-making. The care plan is a means by which the outcomes are recorded. This will include choices, preferences and action plans.

The care plan should be available when the person with diabetes accesses any part of the service, including during an in-patient or acute episode.

Putting it into practice

Commissioning care planning

Commissioners should ensure that in order to put the Care Planning process into practice:

- There is an environment which enables equal opportunity for people with diabetes and healthcare professionals.
- People with diabetes are offered structured education and are involved in the process of developing the environment in which effective Care Planning can occur.
- All staff are supported to develop the necessary skills and competences.
- Systems are in place to support sharing of information between people with diabetes, healthcare professionals and organisations.
- Where possible there is continuity of contact between healthcare professional and the person with diabetes
- There are regular opportunities for review.

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

What this means for people and organisations

For people with diabetes to be able to engage effectively in the Care Planning process, they may need to be helped to understand the process and how their experience of consultations might start to differ in future. They need to know that their own questions and experiences, thoughts and feelings and hope for their diabetes will be sought along with priority given to planning the actions they wish to undertake.

For Care Planning to work in practice, it is also important that healthcare professionals understand the principles and benefits of Care Planning, and how a Care Planning approach for long-term conditions such as diabetes differs from an acute model of care. They will be committed to the principle of working in partnership with people with diabetes and supported to develop and necessary skills and resources to engage them.

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

Evidence

Pilots in Northumberland and North Tyneside have demonstrated feasibility, sustainability and transferability of a care planning approach to diabetes care, including very high levels of satisfaction.

Workforce

Our health, our care, our say identifies that new skills around supporting self care and empowerment will be required if care for people with long-term conditions is to be truly patient-centred. *Supporting people with long-term conditions to self care: a guide to developing local strategies and good practice* outlines the role of the healthcare professional in a patient-led NHS and highlights the need for a change in approach. In a patient-led NHS, the professional/patient relationship is a meeting between two experts working together to support the individual to manage their own condition as effectively as possible.

View the document today:

http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=27423&Rendition=Web

Successful Care Planning for people with diabetes will be dependent on equipping staff with the skills and competences that they need to do this. Local health communities, diabetes networks and their constituent organisations will need to think carefully about this approach to patient care, considering how staff will be equipped with these new skills and building on the competences that they may already have.

Information on skills and competences needed for Care Planning can be found on the Skills for Health website at: www.skillsforhealth.org.uk

Further information

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

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063081

National Diabetes Support Team website: www.diabetes.nhs.uk