DIABETES – CARE PLANNING (1)

The North West London health and care partnership

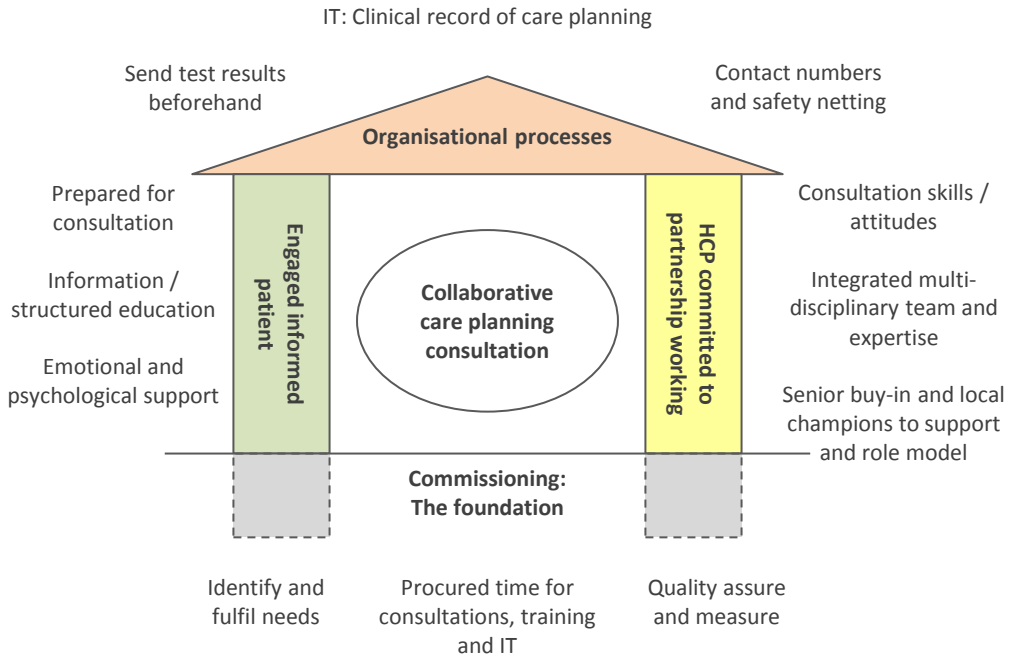
'An ongoing process of two-way communication, negotiation and joint decision-making in which both the person with Diabetes and the healthcare professionals make an equal contribution to the consultation.'

THE HOUSE OF CARE:

The "house of care" highlights the importance of each part of the process:

- Commissioning
- Autonomous, engaged informed people with diabetes
- Health care professionals committed to partnership working
- Organisational processes

Without any one of these the house collapses



Useful tools:

Partners in Care: Diabetes UK guide to care planning

Consultation Quality Index (CQI-2): a questionnaire for understanding patient's perception of clinician skills

PERSON CENTRED:

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.

See Language Matters, Language and Diabetes for guidance on principles and practices for better communication with people with diabetes.

Many people may not really have considered a lifestyle or behaviour change, or may 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. If they are struggling with their mood or anxiety or coping with diabetes they usually want to be asked about this as this may be the thing that is standing in their way.

Goal setting and action planning are inextricably linked but they should be seen as separate stages.

THE INFORMATION SHARING PROCESS:

Information gathering: The patient attends for an appointment with the Health Care Assistant or Nurse to have their 'annual review' tests (e.g. blood and urine tests, blood pressure, weight +/- foot, eye screening and mental health screening -PHQ4 (in primary and community care) OR DDS2 (in secondary care). Use 6 item Cog if over 60. See slide 31 for tools.

Information sharing: The annual review test results are included into a letter and posted to the patient to arrive at least one week before the Care consultation. Prompts and questions in the letter encourage the patient to consider the results and other aspects of their Diabetes before the consultation

Consultation and joint decision making: The patient attends the Care Planning consultation with the practice nurse or GP, who have received training in partnership working.
This should include the elements outlined later in the guide (goal setting and action planning).

Agreed and shared care plan: The agreed care plan is produced and shared with the patient either immediately or subsequently by post or electronically

Gather and share stories | Explore and discuss | Goal setting | Action planning | Review

GOAL SETTING:

SUMMARISE AND PRIORITISE

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?"

ASSESS IMPORTANCE

When changing something is difficult, the reason for 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?"

If they score e.g. 6, you could ask why it isn't 7 and ask what would need to happen to make it 7. You could also ask why it isn't 5 as this will help you and them explore why it IS important. This process illuminates their ambivalence and facilitates a motivational conversation.

REASSESS IMPORTANCE

If the score is lower than 7 then the reason for picking that goal needs to be explored.

AGREEING ACTIONS:

FOLLOW people' PRIORITIES

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.

SMART GOALS

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' 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

ASSESS CONFIDENCE

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. 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?"
If they score e.g. 6, you could ask why it isn't 7 and ask what would need to happen to make it 7. You could also ask why it isn't 5 as this will help you and them explore what skills they DO have. This process illuminates the support and skills they can draw upon including you.