

A simple method for introducing care planning into specialist diabetes clinics. The WICKED project

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Abstract

Diabetes care planning is a systematic way of establishing a partnership between people with diabetes and health care services. We piloted a systematic patient-driven care planning consultation process in our routine specialist diabetes clinics.

A document based on all key care processes was given to and completed by patients prior to their consultation. The completed document was used to structure the clinic consultation. Patient and doctor outcomes were assessed by post consultation questionnaires.

Of 148 patients, 101 responded; 55 male, age 60±12 years, duration of diabetes 12±9 years, 67 on insulin, 3 new and 98 review patients; 63% were Caucasian, 14% Asian, 4% Afro Caribbean and 19% unknown ethnicity. In global assessment by patients, the process scored 'good' or 'very good' in 80%, as it did in the other more specific domains (n=7). Among doctors, 10 of 12 rated the structured patient-driven consultation process good or very good, reporting increased patient engagement, shared decision making and communication; they felt it was more time consuming though worthwhile. Crucially, it increased insight into patients' needs.

In patient-centric consultations: patients did use the opportunity to assess, categorise and prioritise their health concerns with a high degree of satisfaction; health professionals found that of benefit; this was implementable within busy routine specialist diabetes clinics.

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Key words

care planning; care delivery; diabetes

Introduction

There is a huge drive to promote care planning as a routine process in all long-term conditions, including diabetes, with the Department of Health envisioning that every one of the 15 million people with at least one long-term condition to have an agreed care plan.¹

Such care planning in diabetes should incorporate all of the key care processes of effective structured care.^{2,3} It should be based on principles of partnership working between patients and their health care teams⁴ and it should promote self-care which constitutes an important but often hidden role in the management of long-term conditions such as diabetes.⁵

Yet, despite several attempts to improve this partnership and engagement,^{6,7} it remains difficult to incorporate this approach in routine clinical practice.^{8,9} Professionals have identified lack of motivation, flexibility, resources, structure and finances in a constrained NHS as barriers to the practical implementation of care planning.^{10,11} There may be reluctance by professionals to explore this new arena which may

require modified skills to consult in a patient centric, patient empowered way, in order to encourage the patient's contribution in shared decision making.¹² From the patient's perspective there might be an element of fear of challenging the doctor–patient relationship or of taking responsibility for their own health.¹³ It may be that the whole process is perceived as being too complex. Even then, there is considerable variance in the understanding of what patient-centred care is.¹⁰

For a partnership to be effective, all stakeholders should be adequately informed and aware of their roles and responsibilities in that partnership. Shared decision making requires a constructive dialogue between a competent professional and a well-informed and activated patient.¹⁴ Patient activation is an understood process that requires a consistent and step-wise approach to enable patients to become competent in making day-to-day decisions about their own health.¹⁵ The nature of the transaction needs to shift away from a compliance model of care to one of concordance.¹⁶ All of this might require organisational