In the consultation room

Goal setting and action planning

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About this series

The aim of the "In the consultation room" series is to provide readers with brief, practical reviews of key aspects of diabetes care that should be covered in the clinic setting.

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Author's introduction

Many health professionals do not yet feel skilled or confident enough to support people effectively in setting their own goals and action plans, relying instead on the more familiar and traditional consultation style, with a focus on giving advice and instruction. This article aims to help address this potential key gap in effective care delivery by describing some practical ways to make collaborative goal setting and action planning a reality in consultations.

Collaborative goal setting and action planning have been recommended for routine consultations in recent guidelines and reports on diabetes and long-term conditions (e.g. Hambly et al, 2009; Clinical Innovation and Research Centre, 2011; NICE, 2011; NHS England, 2013; 2014). They are a key part of new approaches such as personalised care planning, which have been shown to be effective in promoting participation, satisfaction, behaviour change and self-management among people with diabetes (Hong et al, 2010; Walker and Rogers, 2011; Walker et al, 2012; Quality in Care Programme, 2013).

However, many health professionals do not yet feel skilled or confident enough to support people effectively in setting their own goals and action plans, relying instead on the more familiar and traditional consultation style, focusing on giving advice and instruction (Walker and Rogers, 2011; Ahola and Groop, 2013), which are less useful skills for modern-day long-term conditions care. There is also evidence that people with diabetes and health professionals can have markedly different perceptions of goals and actions agreed during a consultation (Parkin and Skinner, 2003), and only 35% report having an agreed and shared care plan (Diabetes UK, 2013).

Goal setting

Goal setting is a major way to improve confidence and promote behaviour change (de Silva, 2011), which are arguably the two essentials for successful diabetes self-management. People tend to act towards *their own* goal, rather than that of someone else, such as a health professional. Hence, the main skill to develop relates to asking a person what his or her personal goal is, regardless of what you think it should be. You can use different words than goal, if that makes it easier, such as "aim", "ambition" or "achievement". Also, goals can be long- or short-term and it's likely that people will have a mixture of both in their minds, so clarifying timescales is useful.

An ideal way to get started with goal setting, while avoiding the temptation to interrupt or hurry along the process in the sometimes time-constrained consultation, is to invite people to consider their goals prior to their next consultation. This way, the consultation time can be used effectively to discuss realising the goal, rather than trying to identify it. This approach is particularly helpful when goal setting is a new way of working for both you and the person with diabetes.

Once a goal (or goals) is identified, it's useful to decide how important it is to the person to achieve the goal(s). A straightforward way of doing this is to use a 0–10 scale, where 10 is high. Inviting the person to give a rating can clarify its importance for both of you. A similar rating can be used to identify a person's confidence in achieving the goal. Both these ratings can be done in advance, with the consultation focussing on discussing the rating scores.

In general, the higher the rating, the more likely it is that the goal will be acted upon, and a lower score gives an indication that it may be too ambitious in its present form. If this is the case, then SMART (Specific; Measurable; Achievable; Realistic; Timescaled) is a useful acronym to apply to a goal, to ensure all these dimensions have been considered. A

goal can be refined in any aspect, if needed, to help boost importance and confidence scores.

Two example dialogues that illustrate some of the points above are presented in *Box 1*.

Action planning

A key aspect of action planning is that it follows goal setting, on the basis that "if you don't know where you're going, you might end up somewhere else." Action planning is deciding on the steps needed, or at least the first steps, towards achieving the goal. Whereas the goal is the person's own, actions towards it might be for both the person with diabetes and the health professional, since the role of the latter in collaborative consultations is to support the former on the journey towards the goal. For example, actions for the person whose goal is to lose weight might involve food-related behaviour changes or increasing daily activity. Those for the health professional might include referral to a weight-loss group, medicines prescription and arranging ongoing support methods. Deciding on how and when to review progress on the action plan is also an action for both.

As with goal setting, applying SMART criteria will make it very precise and also checking for potential barriers to the action plan is important. Importance and confidence ratings are also useful, to help clarify the likelihood of success and as a baseline for future consultations. High ratings and a SMART action plan equal enhanced motivation and determination. ■

Author's conclusion

This short article has shown you how you can start to use collaborative goal setting and action planning before and during a consultation. Actively using these approaches regularly will make them become more familiar and even regular habits. When you use collaborative goal setting and action planning effectively in a consultation, you will see an increase in people's confidence and skills to self-manage, which can result in reduced time and cost of face-to-face appointments. Best of all, you'll find an increase in satisfaction with the consultation for everyone, including yourself.

Box 1. Two hypothetical dialogues in a consultation illustrating goal setting.

Dialogue one

Context: A personalised care planning consultation, where the person with diabetes has received the results and an invitation to reflect and plan in advance of the consultation, using a "traffic light" indicator.

Practitioner: In your thinking about your diabetes and results, what in particular would you like to aim for?

Person: I noticed that my blood pressure was still in the red zone – that's scary! I would really like it to be at least in amber and ideally, green next time.

Practitioner: It sounds really important to you to get it down. What score would you give it for importance, say between 0 and 10 – 10 is high?

Person: Probably at least an 8. It really worries me because my dad had high blood pressure and ended up with a stroke. I don't want that.

Practitioner: That does sound worrying and I really want to help you get the level down, too. On the same scale, how confident are you that you can do it?

Person: A bit less I guess as I'm not sure what I need to do. Maybe a 6 or 7?

Practitioner: Are we saying then that getting your blood pressure down to the amber or green zone is your main priority, and you want to get it there by your next appointment?

Person: Yes, definitely.

Practitioner: Great. How about we talk about the different ways that might work, and then make a detailed plan to get you started with confidence?

Person: I'm up for that!…

Dialogue two

Context: A consultation without prior result sharing.

Practitioner: What's the most important concern to you about your diabetes at the moment?

Person: Well, I don't seem to be getting anywhere with my blood testing to check my levels. I start off with great intentions, but I just forget and then I lose track. I know things aren't great with my levels, but I just don't seem to be very motivated to check them

Practitioner: What would it mean to you to be able to "keep track" of the levels?

Person: It would be great to see some progress, especially when I'm being good! At the moment, nothing seems to make much difference and I think that's why I put it in the back of my mind. It's a bit like a vicious circle thingy.

Practitioner: Sounds like you really want to do something about it but you don't have a clear goal? Do you think that would help?

Person: Yes, something really small though, I get so distracted!

Practitioner: How about saying one thing you'd like to have achieved in relation to your testing by the end of 2 weeks?

Person: Mmm – I'd like to have done at least one test a day. That would make me feel good, I think.

Practitioner: So at the end of 2 weeks you would like to have 14 test results? Is that right?

Person: Yes, putting it like that makes it sound really possible. I think that could help…

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Further reading

- Walker R (2013) *Person-Centred Practice for Long-Term Conditions: A Concise Guide to Success* (eBook). SD Publications, Ipswich. See: www.successfuldiabetes.com/books
- Year of Care website – http://www.yearofcare.co.uk/