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iDEAL Group Position Statement

How to maximise the impact of diabetes consultations: A guide for Healthcare Professionals

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The iDEAL (**Insights for Diabetes Excellence, Access and Learning**) Group exists to enable the delivery of best practice in diabetes care for every person living with diabetes. We are a highly engaged independent multidisciplinary team of representative experts with a visionary outlook to improve diabetes care outcomes across the UK.

The group includes the perspective of people living with diabetes, clinical service provider organisations and their professional bodies as well as the main charities and interest groups. This enables networking and outreach to gather, evaluate and share evidence to reach practitioners delivering diabetes care and those in need of it. We lobby policymakers and challenge perceptions to encourage the redirection of resources and influence education and training opportunities to meet the needs of all individuals living with diabetes.

Our programme of action is focused on harnessing our professional expertise to build consensus, network, research, share knowledge and collectively seek to make things better; both for practitioners working in partnership with and for people living with diabetes.

KEY RECOMMENDATIONS

- Every consultation is an opportunity for the Person with Diabetes (PwD) and Health Care Professional (HCP) to work in a supportive partnership, sharing knowledge and understanding of the PwD.
- The PwD is the expert in their life and their experience of living with diabetes.
- The HCP's role is as a source of information, providing encouragement, offering support and signposting.
- Psychological factors can act as a barrier to self-management and the importance of emotional wellbeing needs to be acknowledged and explored in each consultation.
- The language tailored with cultural awareness and competence employed in the consultation needs to be personalised to the individual's requirements, health and digital literacy and learning style and reflect Language Matters (NHS England, 2018).
- The skills required to support this approach should be embedded into all HCP training from the undergraduate level, pre-registration, and professional revalidation.
- Learning theories and principles that support PwD individualised education delivery should form part of every long term condition consultation and care planning process.
- Given the complexity of a consultation that supports people to manage a condition as demanding as diabetes there is a need to increase the General Practitioner and Practice Nurse primary care 10 minute consultation to 15 minutes or longer.
- HCPs should access ongoing education opportunities in diabetes care to maintain their competencies and develop new skills and have access to ongoing professional support and supervision.
- The language employed in the consultation needs to be tailored to the individuals requirements and learning style as Language Matters (NHS England, 2018).
- Encouragement for the PwD to plan for their consultation is an essential way to focus the consultation for both the individual and the HCP to enable them to work together on the important issues for the individual.
- Promotion of the **'LET'S TALK NOW'** Acronym can help HCPs in meaningful consultation conversations with PwD.

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INTRODUCTION

This iDEAL position paper acknowledges that it is the coming together of the PwD and the HCP, mainly within individual consultations, that forms the foundation of the support given to a person managing their diabetes within the NHS and within the context of each individual PwD lives. Even then consultations are only a fraction of the time that the PwD actually manages this complex, demanding and relentless condition (Doherty et al, 2012, Lhussier et al, 2013). It is imperative that this time is used to maximum effect. Thus creating a safe space whereby the PwD can explore without fear of judgement their everyday struggles, their concerns and the gaps in their understanding providing them with the scaffolding to continue to engage in their self-care and seek support.

CONSULTATION WITH PEOPLE WITH DIABETES

On average, PWD spend three hours a year with a healthcare professional. For the remaining 8,757 hours they manage their condition, making decisions influenced by a range of factors, including their beliefs, perceptions and information they access from a range of sources.

To have an impact, it is critical that both the PwD and the HCP are properly equipped and recognise what diabetes demands in individuals' lives. PwD appreciate being encouraged by the HCP about how they are and how they feel about their diabetes in an individualised way. HCPs need awareness that some PwD may be protective of their diabetes, potentially as a result of their prior experiences with HCPs or within the NHS. It is a huge responsibility that PwD have and living with all the demands of diabetes takes effort. For the PwD, preparation, perhaps with a checklist or aide-memoire to ensure the topics they wish to be addressed are covered is essential. This might include a personal assessment of their current diabetes management, their goals, their support needs and barriers to achieving them, and finally, awareness and understanding of clinical metrics.

Active listening and appropriate language from the HCP are critical to effective consultations. As is having absolute clarity of the outcomes of the consultation, decisions made, and actions to be taken. A record of this should be shared and maintained by both parties. IDEAL recommends an effective shared approach consultation relationship between the PwD or/and representative and HCPs, is best achieved with the acronym **'LET'S TALK NOW'**.

'LET'S TALK NOW':

L – Let the Person with Diabetes (PwD) have their choices heard in shared decision making

E – Encourage the PwD to share their emotional concerns without feeling judged

T – 'Two ears One mouth' proves listening twice as much as speaking is the path to shared decision making

S – Seek to meet the PwD where they are in their life rather than where you would like them to be

T – Talk with the PwD not at the PwD

A – Assess and accept what the PwD feels is within his/her control, and their right to disengage

L – 'Language matters' and turns the conversation into a safe haven for PwD to share their feelings

K – Keep to key messages and practical points so PwD can make informed shared decisions

N – Not managing but walking alongside PwD

O – Outcomes should be individualised and person focussed

W – Working in partnership enhances PwD self-efficacy

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WHY IT MATTERS

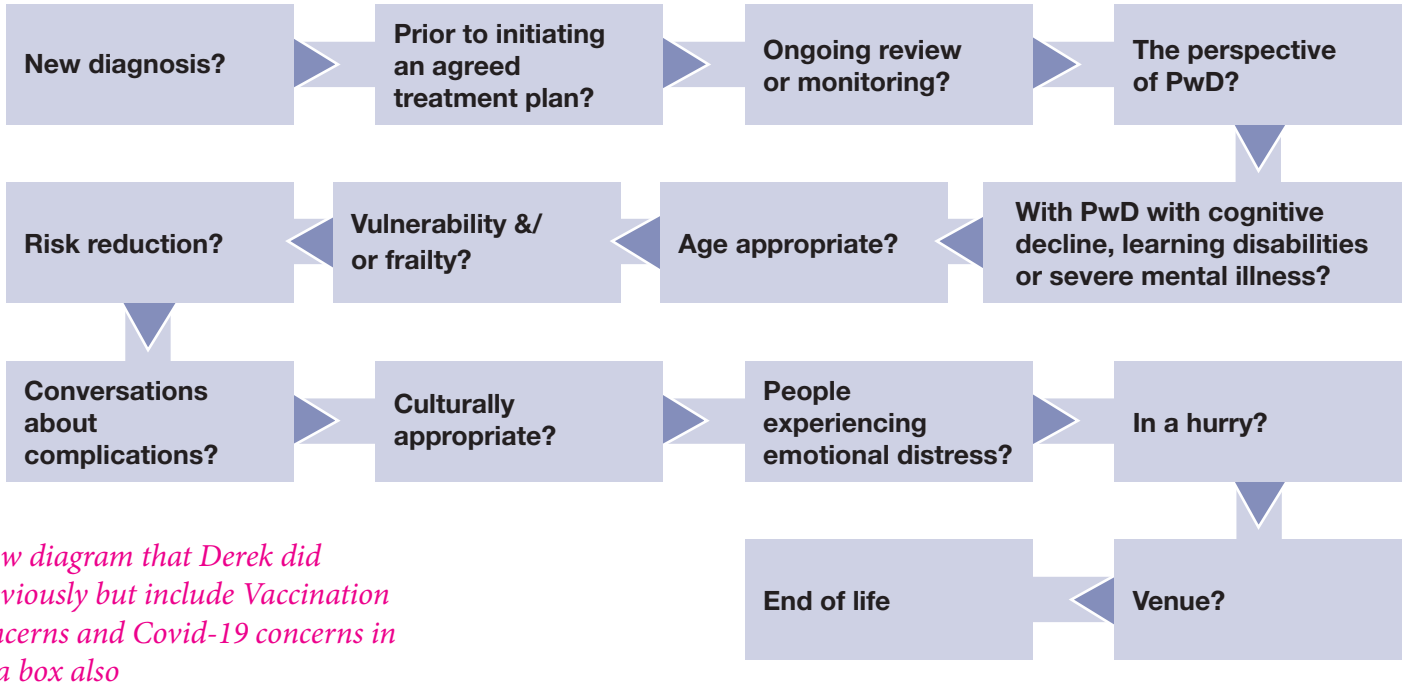
Consultation in healthcare practice is often described as an art and science; the science is the process of gathering and extracting information in a structured manner with the art being the aim of arriving at a care plan destination in partnership and collaboration with the PwD. With consultation models lending their formats as recommended structure outlines to help HCPs consult most effectively with individuals (Silverman, Kurtz and Draper, 2013; Centre for Pharmacy postgraduate education (CPPE), 2014, Bailey, 2014). However, consultation is an art and very much has its impact affected by multiple co-factors such as delivery style, communication skills, personality type, and HCP-PwD connectivity. Consultation models, on the whole, vary from each other either in conceptual structure, 'HCP versus PwD' centredness, and the degree to which the focus is on the aspect of healthcare to be achieved versus the behaviours needed in the consultation (CPPE, 2014, Denness, 2013, Bailey, 2014). Different styles of consultations affect outcomes and the emotional response of the PwD. Doherty et al (2012) through The Year of Care work in diabetes, suggested the consultation is seen as the essential 'tool' in facilitating self-management at the same time as making the best use of evidence based prescribing, whilst acknowledging that this takes skill and practice linked with tailored training. The type of consultation and the HCP who interacts at that time with the PwD is influential, as the context and content will differ according to the individual situation, so different styles are needed.

There should be consistency in approach, experience and education to support recognition and discernment in the conversation is fundamental. Coulter et al's (2015) Cochrane review highlighted key elements for successful care-planning and these include partnership working, use of 'plain' language, emotional health and promotion of well-being. This further accords with both NHS England's Year of Care Project and also Public Health England's, 'Making Every Contact Count' (MECC, 2016) approach, which supports HCPs promoting early intervention and emotional support. These approaches avoid missed opportunities by inexperienced HCPs to explore what the PwD is or isn't saying as previously highlighted by MacDonald et al, (2013).

Since March 2020 when the majority of consultations became virtual overnight due to COVID-19 rapid changes occurred and this position paper reflects the development of alternative consultation approaches and opportunities that are evolving within diabetes care.

Feedback from PwD focuses the context of the consultation as being paramount and that the short time spent within the HCP is a 'moment in time' during 'a lifetime spent with diabetes'. Recognition that approaches need to reflect the 'situation' and agreed plan of care are as highlighted in Figure 1.

FIGURE 1: THE CONTEXT OF THE CONSULTATION



Flow diagram that Derek did previously but include Vaccination concerns and Covid-19 concerns in as a box also

The fear that some PwD recount from the first conversations at diagnosis can cause potential diabetes related distress and difficulty in both accepting and engaging with their diabetes (DeGroot et al, 2019).

This must be acknowledged by HCPs in their everyday encounters with PwD, and the situation the consultation occurs in as illustrated in Figure 1. Undoubtedly, diabetes can occur as a multi-morbidity increasingly as illustrated by The Richmond Group of Charities work on Multi-morbidities and care approaches in the UK, (2019). It is imperative that the diagnosis of diabetes itself, along with the associated, and often competing, demands from the individual's family, social circumstances and physical and mental health are recognised by the HCPs at the point of consultation (RCGP, 2018, Stafford et al for The Health Foundation, 2018). This requires HCPs to approach individual needs with understanding by using different approaches, appropriate terminology, language skills and emotional intelligence depending on the PwD's situation, emotional wellbeing and coping skills at that point in their diabetes journey (Language Matters, 2018). This reflects with work undertaken in effective care planning by The Year of Care initiatives also (Lhussier et al, 2013).

As telehealth remote consulting becomes more of a norm, it is vital to ensure that health inequality gaps are not widened, and that the standard of quality diabetes care delivery is not diminished. The 2020 COVID-19 pandemic reinforced the need for user-friendly health information and access to digital healthcare as a proven essential. The Patient Information Forum (PIF) Health Digital Literacy Survey 2019/2020 suggested the pandemic highlighted the worsening of existing health inequalities, which hit already disadvantaged communities hardest as demonstrated via a strong links between low health literacy, digital literacy, and health inequality. Affected populations from lower socio-economic status and higher area deprivation localities, highlights access to care in socially deprived or rural communities needs to be enhanced and funded (Linder et al, 2017).

Available randomised controlled trials on highly selected populations who are not acutely ill suggest video consultations were associated with high patient and staff satisfaction, similar clinical outcomes and occasional average cost savings compared to traditional consultations. However, the literature research trials reviewed were in occasions underpowered (Shaw et al, 2020).

During a diabetes remote consultation, it is essential to ensure the PwD are comfortable with the medium (e.g., telephone and/or video) used, and the HCP has chosen the most appropriate medium to address the individualised review. For example, a video consultation is likely to be most appropriate compared to a telephone call for those with worsening diabetes parameters, anxious or with individuals' diabetes distress, hard of hearing, requiring third party translation where English is not a first language and those with more complexity associated with comorbidities (Greenhalgh, 2020). Always ensure to establish what the PwD wants out of the consultation and follow usual consultation etiquette applied during face-to-face consultations (Greenhalgh, 2020), that can be summarised in the acronym at the beginning of this document; 'LET'S TALK NOW'.

The consultation is a complex process, it is at the heart of an individualised approach but by its very nature, no one size fits all. There are a multitude of consultation models that seek to provide a structure to guide the busy clinician to make the most of this valuable time. Denness (2013) described several different consultation approaches for GPs to consider in primary care consultations, these approaches can work equally as well with other HCPs also. This consultation method is extremely useful as it conceptualises different approaches but in particular considers the need to acknowledge and deal with any emotions within the HCP that can arise during and after a consultation, in particular to prevent these emotions affecting other consultations thereafter.

For iDEAL there are core factors that are important to consider when working together with a PwD. A positive rapport is fundamental and based on core communication skills. The care approach of the clinic HCPs is to ensure they establish and share a 'common ground' in a consultation (Stewart et al, 2014), particularly when promoting shared decision making and problem solving. An awareness of the 'the inner consultation' (Neighbour, 1987) may enable the HCP to consult more skilfully, intuitively and efficiently. This has proved a challenge at times using telephone consultations and not video consultation approaches as much vital body language and non-verbal cues can be lost. Diggle, (2020) and Diggle & Brown, (2020) have created really useful checklists of how to undertake a virtual diabetes review and this aids to help make connections in virtual consultation environments.

Additionally, when experienced practice nurses allow themselves to employ intuition and 'just knowing' in their consultation conversations, this can help break down barriers. Whereas less experienced practice nurses have a tendency to be 'checklist' driven (MacDonald et al, 2013), thereby can miss the nuances of the consultation as detailed in the HCP Education Position Paper published by iDEAL (Phillips et al, 2019). Furthermore, Hendrieckx et al, (2020) created a really useful guide of how to

conduct 'more satisfying consultations. Which supports the importance of 'connecting with the PwD' and acknowledging that things might not always go to plan and 'safety netting' is beneficial. The HCP is also encouraged to accept there will be emotional responses within the consultation that will need to be explored.

Many HCPs struggle with the limited time available in consultations and by setting the time and context (Figure 1) at the outset will ensure a more focused agenda. Contextualising the consultation connects the HCP and PwD by personalisation and appropriation of conversation, considering diversity, emotional health and ensuring an agreed outcome reached by the partnership.

THE NEED TO ADDRESS HEALTH INEQUALITIES AND IMPROVE PHYSIOLOGICAL WELL BEING

Thomson and Khan (2015) however, question if in either consultation approach, there is a lack of emphasis on ensuring the emotional wellbeing and understanding of the nature of the PwDs condition. The term 'hardly reached groups' is advocated by The Australian Centre for Behavioural Research in Diabetes (2021) who advocate it is time for HCPs to acknowledge that we need to do more to reach out into our local communities and work alongside PwD from different geographical, cultural and socio-economic backgrounds. However, these are often PwD who do frequent HCP consultation rooms yet can have a disconnect in the HCP/PwD relationship. Those from different cultural and linguistic backgrounds access HCPs less, confronted with barriers such as language, legal restrictions, differing health beliefs and value systems (Handtke et al, 2019; Phillips et al, 2019).

Hill-Briggs et al, (2021) determines that decades of research have demonstrated that diabetes affects racial and ethnic minorities and low-income adult communities disproportionately, with relatively intractable patterns seen in higher rates of both preventable complications and increased mortality (Golden et al, 2012). Also, Hill-Briggs et al, (2021) suggest that health disparities cause divisions in communities and less favourable outcomes in diabetes care, for example when in the UK, equal access and availability of medications and practitioner knowledge and skill should be available to every individual and community equality requiring the same. Goff, (2018) and Whyte et al, (2019) both have reported about clinical inertia and discrepancies in treatment escalation experienced by individuals from the most deprived quintile of socio-economically challenged and deprived areas and from ethnic minority groups in the UK. This is a key area of practice that iDEAL urges HCPs to focus on to reduce health inequalities and clinical inertia in diabetes care.

As HCP understanding and experience of diabetes care evolves, it is fundamental to realise the strong relationship between diabetes and emotional wellbeing, which can yield diabetes fatigue, distress, burnout, depression and/or ambivalence.

Comorbid diabetes and depression can be considered major clinical challenges as the outcomes of both conditions are often worsened by the other. Integrated support for people with mental and physical health problems can be improved with increasing the appreciation of HCPs understanding of the role of emotional and mental health problems in reducing people's ability and motivation to self-manage their physical health (Holt et al, 2014). An iDEAL position statement by Doherty et al, (2020) suggested are many resources and published guidelines that provide practical guidance and are calls to action and change in this area (Young-Hyman et al, 2016, Diabetes UK 2019, Hendieckx et al, 2019).

Alongside this is a consideration of the HCPs emotional wellbeing and stress at the time of the consultation, a point being raised repeatedly currently about workers mental health and wellbeing in the work setting, especially undertaking virtual and remote reviews (Deloitte, 2017), especially undertaking virtual and remote reviews (an, 2020). This was acknowledged previously by Neighbours (1987) consultation approach, to recognise the emotional wellbeing and avoidance of transference of emotional reactions from one consultation to another. This does involve some HCP self-care and recognition of leaderfulness and team working as the essential conduit in the provision of effective diabetes care also (Phillips and Yates, 2017).

CONSULTATION AND COMMUNICATION SKILLS

Some studies (Rogers, 1957; Powell et al, 2016, American Diabetes Association, (2016), NHS Right Care: Diabetes Pathway, 2018) highlighted the benefit of an individualised person-centred approach as a therapeutic relationship that would self-empower the individual to work towards self-caring solutions. Especially when empathy, unconditional positive regard, congruence and genuineness are all demonstrated by the HCP. Keeping PwD engaged encourages the PwD's to review the main reason for consulting, hence leading to a more accurate diagnosis, appropriate shared decision management plan,

individual satisfaction and better health outcomes, especially when the principals of using Language Matters are applied (MacDonald et al, 2013, Beverly et al, 2016, Lloyd et al, 2018). Furthermore, Hawthorne (2018) Vice Chair of the RCGP advocated on 'jargon free' communication with people, which is especially important in diabetes care where the overuse of medical or technical terms can be very distant from the PwDs experience or interpretation of their diabetes.

The traditional medical model often impedes the PwD willingness to elicit information freely hence leading to the development of a hidden agenda with the PwDs' main issue being missed (Stewart et al, 2014).

Epstein et al. (2008) suggested that PwD, if allowed two minutes to explain their reasons for attending will offer up 80% of the diagnosis to the HCP. While Lefroy et al. (2014) suggested that closed questions from the onset of a consultation have a tendency to make the individual believe they are only allowed to elicit when asked a direct question. Language Matters (2018) and using language that is both understood by the PwD and also is supportive of them to offer motivation, help and comfort to disclose their realities and any problems.

Previous evidence (Teutsch, 2003; Matthys et al., 2009) suggested exploring the PwD's ideas, concerns, impact, effects of the problem and expectations (ICE E) are very important to establish the reason the individual has decided to consult and helps build the working relationship between the HCP and PwD. This will secure individual trust as well as identify critical clinical and psychosocial flags (CPPE, 2014, Bailey, 2014, Duncan, 2019). The process of extracting and gathering information from an anxious PwD can be very challenging, it is most imperative that a robust history taking technique is employed (Epstein et al., 2008, Young-Hyman et al, 2016). Furthermore, Haidet and Paterniti (2003) stressed the success that can be gained when the PwD is given time to elicit their story from their perspective with the aim being to build the history together with the individual, as this will boost rapport, increase the PwDs involvement which then provides further insight into the PwDs perspectives on therapy decisions and self-management advice.

There is evidence by Bailey, (2016) and Duncan (2019) to suggest that educating the PwD about the natural history of illness will lead to better individual self-management, assimilation of safety netting advice and use of the practice appointment system in the future.

PwD is more likely to be enabled to follow the advice and agree their management plan if it is created and agreed in partnership with effective communication and consultation skills having been applied. Use of Diabetes UK Information Prescriptions are useful tools to enable for example Practice Nurses, Dietitians or Community Pharmacists to generate these partnership agreements in general practice. Bailey (2014) suggested that individuals are more likely to resist or reject advice 'given to them' and feel their ability to self-manage has been questioned when they have not been first asked what they already know or would like to know. Findings from physical examinations and observation measures are powerful tools used to explain the rationale for care (Bailey, 2014), and for many anxious individuals a good consultation can have a calming and therapeutic effect.

Almond et al, (2009) reinforced the importance of safety netting advice which should include what alarming signs and symptoms the PwD should be mindful of, what to do if things get worse, as sub-optimal or poor safety netting or even absence of, could be endangering as the PwD could be discharged from the HCP consultation unsafe.

STRUCTURED PWD EDUCATION (SPE)

PwD are experts of their condition, they spend more time living with diabetes than HCPs spend caring for their condition. Bailey (2014) enhanced this further by suggesting the HCPs role in the consultation is to listen, as infinite details lie beneath the surface of a consultation and PwD histories can contain recurring patterns or themes. The use of virtual consultations needs careful listening skills to aim to uncover what is not being said and the fears PwD can be experiencing (Diggle, 2020, Hendrieckx et al, 2021).

The PwD should be the guide as to the direction of the consultation, and if the HCP tries to be too directive, then something of importance to the PwD can be lost. This dovetails with the accompanying position paper about PwD and their potential and actual roles within diabetes consultations. When talking about the potential risk of complications, iDEAL expert panel members suggest that the best way to approach risk is to change blame, shame and guilt to trust, understanding and healing. We must share an open, honest, non-judgemental and individualised conversation, which offers support, hope and empowers and enables the PwD who may be feeling very vulnerable (Bailey, 2014). The Behavioural Diabetes Institute (2009)

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suggested a really useful approach in terms of 'Diabetes Etiquette for people who don't have diabetes. This approach firmly places the consultation in the focus of the individual and their individual needs and is essential for HCPs to consider. Quality indicators for effective consultations have also been suggested and supported by Zulman et al, (2020), Launer, (2017) and Caldwell, (2019). Table 2 presents an amalgamation of these authors works into iDEALS for approaches within consultation in diabetes care.

TABLE 2: QUALITY INDICATORS FOR EFFECTIVE CONSULTATION IN DIABETES CARE (ADAPTED FROM LAUNER, 2017, CALDWELL, 20919 AND ZULMAN ET AL, 2020)

1	To enable to PwD to be prepared as possible for their consultation.
2	For the HCP to be as prepared 'with intention' as possible to have a meaningful interaction.
3	The HCP should know the person as a PwD and not as a 'patient' and listen intently and completely.
4	The consultation should feel unhurried for the PwD and HCP as the PwD's story provides valuable information and cues for the consultation.
5	The HCP should give their undivided attention to the PwD and agree with what matters most with the PwD for the health goals for now and for their future.
6	The HCP should be able to hear themselves think and make meaning to what the PwD shares and to concentrate on how positively they can contribute to the interactions.
7	Confidentiality and dignity must be maintained.
8	HCPs should explore and acknowledge emotional cues and validate the PwD emotions to become a trusted partner in diabetes care.
9	The PwD should be encouraged to have an important other person in their consultation.
10	The HCP should be regularly refreshed and have access to education and updates in diabetes care.

The HCP role is to come alongside the PwD, to listen and support them to explore their desires, wants and needs and where managing their health fits into that - 'doing with rather than doing to'; this enables the PwD to have the knowledge and tools to be able to self-care safely, effectively and independently, and also seek help when required.

The IDF (2019) and ADA (2019) suggested that any diabetes self-management education programmes content should offer information and understanding of healthy eating behaviours, physical activity, monitoring of disease, medications, problem solving, healthy coping, and complication risk reduction whilst we are aware that information provision alone is insufficient in supporting self-management (Speight et al, 2010, IDF, 2019).

The aim of introducing PwD education into routine HCP-PwD consultations is to support the PwD to develop their confidence to engage in self management thus increasing their self efficacy which should, in turn, improve diabetes self- management knowledge, capability and engagement. This also endorses Public Health England's MECC (2016).

PROMOTING SELF-EFFICACY

The iDEAL expert panel suggests that a successful connection between HCPs and PwD depends on an acknowledged idea that people want to maximise their quality of life. That the barriers of self-management are in the person's own world, the consequences of diabetes are experienced by the individual, and that ultimately the individual is responsible for their own self-management with support and partnership with their HCP (Skinner et al, 2003, McDonald et al, 2013, Bailey, 2014). If we start with the premise that all motivation is intrinsic to the individual and not something that is bestowed by a HCP onto the person then this has a huge impact on the style and shape of the consultations.

Depending on the PwDs individual situation (figure 1), for example at diagnosis or during annual reviews, this is where potentially the most impact of language used, emotional distress and fear can occur (Quandt et al, 2014, Papaspurou et al, 2015) depending on the understanding, health beliefs and experience of diabetes. This offers an opportunity for HCPs to explore attitudes and behaviours and support the person with their decision making. Embedding this approach into every HCP-PwD consultation setting means that the decision to change based on what is important to the individual rather than being extrinsically motivated i.e. based on fear of negative diabetes outcomes or to please the HCP (Skinner et al, 2003). PwD need to be encouraged and enabled to be involved in every decision using language that is understood (Language Matters, 2018) and paraphrasing techniques to ensure understanding, this reflects 'No decision about me, without me' (Department of Health, 2012).

The HCP can achieve this by ensuring the PwD feels in control of their decisions and self-management plans discussed in the consultation especially when setting targets using tools such as Information Prescriptions in General Practice. Motivating care and creating a different future for the PwD is a unique art and skill that experienced HCP do apply, and this can be endorsed by engaging with SMARTER individualised objectives in care planning (Klinkner et al, 2017).

When these are not applied effectively as can occur when a lack of communication occurs, PwD might experience dissatisfaction or feel they were not listened to, that the agenda of the consultation was designed to meet the HCPs needs and not those of the PwD.

CONSULTATION AND COMMUNICATION IN GENERAL PRACTICE

General practice has been based historically on providing short and increasingly virtual consultations to provide accessible treatment for common health problems while identifying patients with serious problems requiring specialist referral. Several trends are challenging this approach. The ageing population and the shift of work from hospitals into the community mean that the main role of general practice is now managing chronic conditions. Most patients consulting in general practice have multiple co-existing long-term conditions, or multi-morbidity, which means that during a typical consultation several different problems are discussed within the same consultation (Kings Fund, 2011). These changes increasingly make the traditional 10 minute consultation "unfit for purpose". The Royal College of General Practitioners advocates a move towards 15-minute consultation by the new standard with longer appointments for those who need it (RCGP 2014). Furthermore, care for PwD is increasingly being delivered by HCPs from different backgrounds such as Practice Nurses and Practice Pharmacists (HSCIC, 2014) without adversely impacting on the quality of care (Murrells et al, 2015). This gives an opportunity to continue to improve care despite the current workforce challenges.

Access to the Diabetes UK information prescriptions is possible in all the commonly used electronic care records used within England & Wales, combined with increased access for PwD to their own care record (McMillan et al, 2018) the opportunity to deliver care planning is perhaps the greatest it has been within primary care.

CONCLUSION

There are a lot of factors that impede changed behaviour, and it is often postulated that people are usually more convinced and self-motivated by the reasons they discovered themselves rather than those given to them by others. Structural educational diabetes programmes aim to effectively improve PwD self-management capacity and ability. However, as recognised, access needs to be enhanced by digital and virtual resources to extend outreach to socially excluded or vulnerable communities to eradicate health inequalities in diabetes care (Goff, 2018, Whyte et al, 2019, Phillips, 2021).

HCP need to incorporate into their routine diabetes related consultation conversations either virtually or face to face SPE principles and suitable consultation approaches if they intend to connect with PwD and educate them to the point of being able to self-manage their diabetes effectively and safely. However, firstly HCP must recognise the importance of being perceptive and attentive to the potential psychological issues of the PwD that arise during the consultation, be less reluctant to discuss the issues and create an atmosphere where PwD feel able to share without judgement. HCPs need to show empathy and be seen to be genuinely interested in the PwD concerns, ideas, beliefs, only then can the HCP build that much needed trust, connectivity and rapport that promotes an effective, safe and independent PwD self-management process.

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