

Case study: Cambridge University Hospitals NHS Foundation Trust

Developing a LES and Diabetes Education Programme for Patients with Diabetes

The challenge

Cam Health is a cluster of GP practices which has staff based across Cambridge and provides services to a population of 73,863 (at June 2011). There is significant deprivation within the population served by Cam Health, and it is well known that deprivation is associated with poorer health outcomes for patients with long term conditions.

The Co-creating Health team was already working closely with the Cam Health practices supporting them to meet their responsibilities around delivering personal health planning and training and education for patients with long term conditions by developing a process for the introduction of self management and more specifically Personal Health Plans for patients with COPD. We had also trained all staff in at least one of the practices and many staff in the other cluster practices in supporting self management.

Within Cam Health's patient population there are 2,580 people registered with diabetes (at March 2011), a number which has increased over the last three years and is projected to continue increasing due to a growing population and increased longevity. The cost of treating this cohort of patients in secondary care in 2010/11 was £3m.

As it is well evidenced that better control of diabetes leads to better health outcomes, the local commissioning group felt that some of the resources invested in treating the consequences of diabetes would be better invested in minimising the harmful effects of the disease. The cluster was keen to support patients with diabetes to self manage and to consider new ways of doing this.

The Co-creating Health team were approached by the cluster lead to help them to develop a Local Enhanced Service (LES) which integrates self management support into an enhanced service for patients with diabetes.

What we did

The aim of the LES is to support the provision of a quality integrated community based diabetes service, with care provided closer to home. The LES aims

to reduce the cost of secondary care treatment by providing care within the practices, community clinic or at home.

As the enhanced service was being developed with co-operation across the cluster and the specialist team in secondary care, this was an ideal opportunity to include self management and the use of Personal Health Plans into the service design.

The service is proposed in the context of the standards set out in the National Service Framework (NSF) for Diabetes 2002 and National Institute for Clinical Excellence (NICE) guidance on Diabetes 2008 which set out the clinical targets, treatment pathways and goals for secondary and primary care. The model of care is based on the pilot work done in partnership by Cambridgeshire Community Services NHS Trust and Cambridge University Hospitals NHS Foundation Trust. Findings from the evaluation of the service piloted in East Cambridgeshire and Fenland were published as 'It's time for integrated care for people with diabetes', Diabetes Integrated Care Initiative in East Cambs and Fenland 1 April 2009 – 31 March 2010. D.Simmons, H.Hollern.

The scheme will provide a consistent and quality service through a patient-centred and collegiate-based approach. Support will be provided for effective self-management of glucose levels, weight and lifestyle changes through education and personal health plans (PHPs).

The LES will ensure diabetic leads:

- continue with their professional development
 - review the cluster practice for identifying patients who need enhanced assessment or support
 - consider referral to community services
 - provide annual testing
 - offer and support the pilot and evaluation of Co-creating Health's Personal Health Plans (PHP) for a small group of high risk patients.
- The Co-creating Health team will provide the PHP introduction consultation with the patient and offer training for a member of your staff.
- provide appropriate referrals to patient education

programmes such as the Diabetes Education Programme (DEP) or DESMOND.

Whilst the last two are still in development, considerable time has been spent on developing the new enhanced DEP. This increases the amount of time patients will spend in education, and now includes goal setting and follow up at every session, along with the delivery of self management tools and techniques and a PHP. The PHP includes generic pages from the COPD PHP but with additional fact sheets for patients with type 2 diabetes.

We have developed a process for coaching patients either on a one to one basis or in a group setting to consider self management and to introduce the PHP. This involves identifying at risk patients and inviting them in to see the lead for patient education (Tracy Watts) after their annual review and/or inviting a group of at risk patients to a group meeting where the PHP is introduced.

The proposal was led by the cluster, supported by consultants and staff in secondary care and the Co-Creating Health team, submitted to the local commissioning group and approved in January 2012. The LES will run until March 2013 and will be evaluated.

Next steps

Our lead for patient education is continuing to work with Mark Brookes (GP at Nuffield Road practice) to consider how we develop with systemone to ensure that we can capture the goals, ensure follow up and flag these patients so that they are identified easily by other health care professionals.

Some of this work is still in development. The enhanced DEP is in its final stages of completion and we expect that we can train our first programme in late summer. The PHP is in use in other programmes and is being used on a one to one for patients with COPD, sign off for the diabetes fact sheets is complete and dates are planned for one to one work with these patients and some group sessions are planned for late summer.

Impact

This work is a direct result of the work with patients with COPD in one of the cluster practices – showing how approaches to self management can be sustained and spread across conditions. During our work with that practice the cluster has been formed and we have continued to work with them, presenting at cluster meetings and demonstrating how the principles can be used across other long term conditions.

Including the PHPs and the enhanced DEP programme in the LES shows that self management is now recognised as an important element of looking after patients with long term conditions and forms part of every day health care.

Our learning

- Linking the personal health plan to all self management work improves sustainability and spread.
- Tenacity is one of the most important factors in delivering this type of work!
- Beliefs, attitudes and behaviours of this group of staff are influenced by demonstrating that this work benefits patients and success in one long term condition leads to more buy in from clinicians.
- Working on the back of successful personal health planning, clinician training sessions help to embed the work and pull the strands together and increase staff confidence.
- Supporting the whole process was crucial in ensuring that the process is followed up, including development and evaluation.
- Providing support to develop the context and back up IT skills (systemone) means that the changes are more likely to embed.