IMPROVING DIABETES SERVICES

in north central London to support patient self-management

The Health Foundation Inspiring Improvement | Co creating Health

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Context The Whittington Hospital NHS Trust, NHS Islington, NHS Haringey in north central London serve a deprived, ethnically diverse population where the impact of poor diabetes management is significant. We were selected as a diabetes site for the Health Foundation's Co-creating Health (CCH) programme. We formed a collaborative partnership between primary and secondary care and between patients and clinicians.

Problem

London's diverse, mobile population makes delivering diabetes care challenging. There is a higher proportion of at-risk communities in London. There is not enough support to help people manage their own condition through self-care. Organisational boundaries significantly affect diabetes care provision and access to services. This particularly disadvantages patients with more complex needs and/or lower health literacy.

Planning change

50 patients, clinicians and managers met to identify local changes needed to support self-management, based on shared agenda setting, action planning and proactive follow-up of agreed goals. 14 teams became involved in quality improvement activities which included: development of an agenda/goal setting tool and a confidence ruler; adapting the electronic patient record diabetes template; sending results prior to appointments; patient group meetings with clinical input; email follow-up; terminal/kiosk to record outcome measures.

Intervention

Clinicians attending CCH consultation skills training were encouraged to undertake service improvement. Training in the Improvement Model (PDSA cycle) was provided to clinicians redesigning their services to support self-management. Test sites collected data on the patient consultation.

Study design

This was observational work, using qualitative data and quality improvement measures.

Strategy for change

Changes were implemented across primary, community and secondary care. A series of workshops involving patients and clinicians were held to identify and develop ideas and nurture innovation. Improvements were shared across sites, through monthly reports/run-charts, at workshops and in a regular newsletter. Implementation and spread of change occurred between June 2008-2010.

Measurement of improvement

We designed and agreed definitions for process and outcome measures. Four process measures around agenda setting, goal setting, action planning and goal follow-up were sampled monthly from ten patient records per site. The outcome measures included patient enablement questions adapted from the Consultation Quality Index and patients measuring their confidence to manage their condition (scale 0–10). A patient survey was used for outcome measures, with some captured on an electronic terminal/kiosk. The monthly results were plotted on a run chart and shared with participating teams.

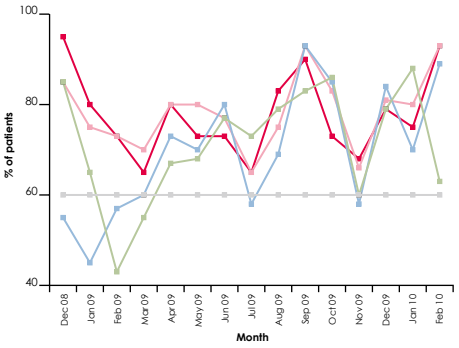
Effects of changes

Once a common definition of measures was clarified in February 2009, there was a steady improvement. Having a shared agenda increased from 43% to 88% (against project target of 60%). Goal setting increased from 45% to 75% (project target 60%). Action planning remained relatively constant at 70% (project target 60%). Goal follow-up increased from 65% to 88% (project target 70%). Overall patient enablement scores showed an improvement of 10%. The patient confidence score for managing their diabetes remained relatively constant at 8-8.5/10.

Lessons learnt

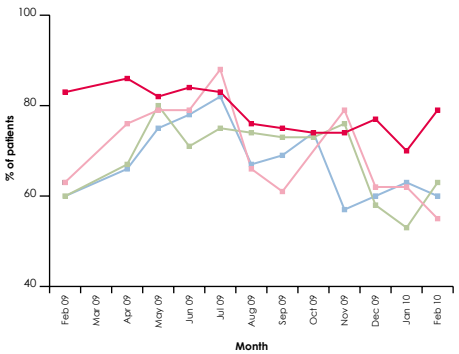
- A 'Core Group' of patients who have completed a Self-Management Programme provide the patient voice, informing service improvement work.
- Training clinicians in communication skills and service improvement methods proved essential to inspire and continue improvements.
- Our improvement measures decreased initially due to definitions not being specific. In the future we would carefully define our measures from the beginning for clarity amongst involved teams.
- Service improvement projects are essential to transform diabetes care locally and are spreading into other long-term conditions.
- Integrating the different elements of CCH, including patient and clinician training, has been fundamentally important to stimulate service improvement and optimise diabetes care.

Co-creating Health – diabetes
Self-management support – overall process measures



Process measures have improved over 15 months since December 2008.

Co-creating Health – diabetes
Self-management support – overall outcome measures



Since August 2009 the outcome measures have shown an overall decrease which is due to the spread of data collection to new testing teams and wider in existing teams through the introduction of a new electronic patient experience survey system.

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