Structuring diabetes services to support self-management

A report from the Diabetes Education Network steering group

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Introduction

In recent years there has been a huge growth in the development of patient education programmes for diabetes across the UK. Most of these programmes have focused on teaching appropriate skills and knowledge that will encourage self-management of both type 1 and type 2 diabetes.

It is estimated that over half of all diabetes services have some provision for structured education. It is clear, however, that self-management education is an ongoing process, of which attendance on a programme is just the start.

Diabetes services, therefore, need to ensure that they develop the infrastructure to provide ongoing education. Equally, if not more, important is the need to ensure that learned skills and confidence in self-management are not undermined by professional or systemic attitudes elsewhere within the primary or specialist diabetes care system. This may arise, for example, if someone who has been encouraged to devise an appropriate insulin-to-carbohydrate ratio for certain situations, based on their own experience, is instructed during a clinic consultation to do something different. This highlights the difference in approach demanded by a system that encourages self-management compared with one which follows a traditional medical model.

Since 2003, the Diabetes Education Network (DEN) has supported diabetes teams across the UK in the development of structured education programmes for people with diabetes. In June 2009, DEN convened a 'think tank' to explore the key requirements for structuring diabetes services to support self-management.

The meeting was attended by a multi-disciplinary faculty, representative of services that have developed and delivered patient education programmes. These specialist groups included professional organisations such as the Association of British Clinical Diabetologists (ABCD), the Primary Care Diabetes Society (PCDS), Diabetes UK, and NHS Diabetes, together with people with diabetes. In addition the group included a number of practice nurses, diabetes nurse specialists, paediatric nurse specialists, consultant physicians, psychologists, dietitians and general practitioners.

The first task was to consider the components necessary to ensure that diabetes services supported self-management. There was then discussion about how current services may inhibit self-management skills. Finally, the group split into single discipline groups that considered how current services would need to change in order to support self-management, and identified key commissioning priorities to deliver such changes.

Clear themes emerged as the day progressed, including ensuring appropriate training in consultation skills for all staff, effective communication between elements of care services, availability of information for patients, and prioritising self-management through commissioning processes and the quality and outcomes framework (QoF). Each discussion was summarised and later transcribed and categorised into five key themes.

Details of the five themes

1. Patients should have easy access to effective self-management education at diagnosis and at key times thereafter

A strong emphasis was placed on the need for education at diagnosis. This requires appropriate importance and priority to be placed on education by the person making the diagnosis, by explaining that such education is an essential part of the treatment of their condition.

This in turn sets up the expectation in the patient that they need to learn how to manage their condition, and that they will need to problem solve and learn different self-management skills as time progresses.

In addition to good quality structured education programmes

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delivered by appropriately trained staff, patients will also need ongoing help and support. This will require front-line staff (such as practice nurses, specialist nurses and consultants) to be able to help identify and meet educational needs during all patient contacts.

2. Patients should have clear and timely access to information and care

By definition, self-management is patient-led and needs to be supported by a structure of care that can be accessed as and when needed.

Rather than focusing on well-defined care pathways, diabetes services should allow for access to specific services according to the individual patient's need. This requires a degree of flexibility in provision and may be facilitated by a web-based guide to services and how to access them, possibly with a practice nurse or specialist nurse as the first point of contact. The key is to ensure timely access to the right expertise, information, support, treatment or equipment to meet the current need.

In addition to face-to-face consultations, the use of e-mail, websites and other electronic communication can be very helpful in providing support, and in ensuring adequate communication between the patient and different parts of the diabetes services network.

3. Every consultation should support self-care using goal setting

The nature and quality of consultations can have a huge effect on supporting self-management. Several key themes were identified.

Patients should have access to their results before the consultation: This would enable them to reflect on the results, identify any self-management changes they wish to adopt, and also think about specific questions they would like to ask during the consultation.

Professionals should use behaviour that encourages patients to make self-management decisions using a collaborative process: This might employ goal setting techniques to help identify educational and medical needs. It would require a change in mindset to 'How can I help you to help yourself?' and respecting choices made by patients without judgement.

Changes and other interventions should be incorporated into an ongoing care planning process to which patients and professionals contribute as equals: This requires all diabetes professionals to have competency in promoting self-care using goal setting, emotion management and interviewing techniques. Therefore, training in consultation skills (including motivational interviewing), behaviour change, peer review and support at all levels are necessary.

4. There should be a good surveillance system, enhanced by care planning

Not all patients will identify all of their own care needs so there is still a place for an 'annual review'. This should be an educational and care planning process, which would signpost to other services as required. It is also the 'safety net' by which patients can be re-engaged with their diabetes management.

5. An appropriate policy framework should be in place

It is established policy in the UK that everyone with diabetes should be offered structured education at diagnosis; the record of implementation over recent years has been impressive, but some areas of the UK are still without such services. The development of a system whereby patient education can be accredited, and by the inclusion of ongoing self-management education in the QoF system may lead to explicit commissioning of structured education and patient-centred systems of care thus supporting further development of patient self-management.

What should be done to support self-management?

We encourage diabetes services to respond to these themes by the following initial actions:

- Review availability and encourage uptake of structured education at diagnosis of diabetes
- Identify and publicise how people with diabetes can access their local services
- Identify training needs of healthcare staff in appropriate consultation skills
- Enhance the annual review to include care planning.

We encourage commissioners to prioritise these aspects to support self-management. We also encourage NHS Diabetes and the Department of Health to support the development of an accreditation body for self-management education and promotion of self-management in all relevant policy initiatives.

The DEN steering group will work closely with Diabetes UK and with national NHS organisations, to support progress in these areas and plan the next steps that should be undertaken.