Structuring diabetes services to support self-management

A report from the Diabetes Education Network steering group

In recent years there has been a huge growth in the development of patient education programmes across the UK. Most of these have focused on teaching appropriate skills and knowledge to encourage self-management of both type 1 and type 2 diabetes. It is estimated that over half of all diabetes services now have some provision for structured education, by running national or local programmes.

It is clear however that self-management education is an ongoing process, of which attendance on a programme may be 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 work out an appropriate insulin to carbohydrate ratio for certain situations, based on his own experience, is instructed during a clinic consultation to do something different. This highlights the difference in approach demanded by a system which 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 as they developed structured education programmes for people with diabetes. In June 2009, the DEN convened a “think tank” to explore the key requirements for structuring diabetes services to support self-management. The event was attended by a multi-disciplinary faculty, representative of services which have developed and delivered patient education programmes, professional organisations such as the Association of British Clinical Diabetologists (ABCD) and the Primary Care Diabetes Society (PCDS), Diabetes UK, NHS Diabetes and people with diabetes. The group included practice nurses, diabetes nurse specialists, paediatric nurse specialists, consultant physicians, psychologists, dietitians and general practitioners, as shown in appendix 1.

The day started with consideration of 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 in order to consider how current services would need to change in order to support self-management and to identify 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. Each discussion was summarised on flipcharts which were later transcribed and categorised into the following five key themes.

Diabetes self-management is supported by:

1. 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 will set 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 delivered by appropriately trained staff, this will require front-line staff (eg practice nurses, specialist nurses and consultants) to be able to help identify and meet educational needs during all patient contacts.

2. Clear and timely access to information and care when needed

By definition, self-management is patient-led and needs to be supported by a structure of care which 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 patient need. This will require 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 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 email, websites and other forms of electronic communication can be very helpful in providing appropriate support, and ensuring adequate communication between the patient and different parts of the diabetes services.

3. Every consultation supporting self care using goal setting

It was recognised that the nature and quality of consultations can have a huge effect on supporting self-management. Key themes which were identified included:

a. Patients having 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.

b. Professionals using behaviour which encourages patients to make self-management decisions using a collaborative process. This might employ goal-setting techniques to help identify educational as well as medical needs. It would require a change in mindset to "how can I help you to help yourself?" and respecting choices made without judgement.

c. Incorporating planned changes and other interventions into an ongoing care-planning process to which patient and professionals contribute as equals.

This will require all diabetes professionals to have competency in promoting self-care using goal-setting, emotion management and interviewing techniques. This will require training in consultation skills, including motivational interviewing and behaviour change, and peer review and support at all levels.

4. A good surveillance system that is enhanced by care planning

It is recognised that not all patients will identify all of their own care needs, and that there is still a place for an "annual review". This should be an educational and care-planning process, which would sign post 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

It is established policy that everyone with diabetes should be offered structured education at diagnosis (DH, NICE); the record of implementation over recent years has been impressive, but some areas are still without such provision. Further development of patient self-management will be supported by explicit commissioning of structured education and of patient-centred systems of care, by the development of a system of accreditation of patient education, and by inclusion of ongoing self-management education in the QoF system.

What should be done now 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 service
- Identify training needs of health care staff in appropriate consultation skills
- Enhance the annual review to include care planning

We encourage commissioners to prioritise these aspects to support self-management in the forthcoming round.

We 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 to be undertaken.

Diabetes Education Network, September 2009

Appendix 1: list of attendees

Jackie Sturt	Associate Professor
Clare Shaban	Consultant Clinical Psychologist
Sue Cradock	Consultant Nurse
David Cavan	Consultant Physician
Chris Kelly	Consultant Physician
Simon Eaton	Consultant Physician
Rob Dyer	Consultant Physician
Dinesh Nagi	Consultant Physician (representing Association of British Clinical Diabetologists)
Sharon Martin	Diabetes Dietitian
Chris Cheyette	Diabetes Dietitian
Helen Loughnane	Diabetes Dietitian
Joan Everett	Diabetes Nurse Specialist
Janet Sumner	Diabetes Nurse Specialist
Francesca Arundel	Diabetes Nurse Specialist (representing Primary Care Diabetes Society)
Nick Kennedy	General Practitioner
Jonathan Roddick	General Practitioner
Bridget Turner	Head of Policy and Care Improvement, Diabetes UK
Suzanne Lucas	Independent consultant
Chris Headland	National Care Advisor for Wales, Diabetes UK
Carole Gelder	Paediatric Diabetes Nurse Specialist
Rebecca Thompson	Paediatric Diabetes Nurse Specialist
Sheridan Waldron	Paediatric Dietitian
Maggie Bodington	Practice Nurse
Stuart Aylward	Person with diabetes
Dave Rusher	Person with diabetes
Henry Bartlett	Person with diabetes
Gill Saunders	Programme Manager, NHS Diabetes
Mark Hannigan	Programme Manager, NHS Diabetes