NHS

Diabetes

Success Story

Project title	Structure patient education
Topic Area	Self care management

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Aims of the project

The aim of the project was to establish a structured patient education (SPE) programme to address the needs of people with type 2 diabetes. Prior to the initiative, less than 80 people received X-Pert SPE in Bexley in 2008/9.

Why was the project undertaken?

John Grumitt approached Bexley Care Trust in 2009 in a private capacity with a view to establishing high quality patient centred care for people with diabetes. Himself a person with type 1 diabetes, John holds a number of other positions, including that of vice chair of Diabetes UK. In response the chief executive of Bexley Care Trust appointed him as Diabetes Programme Manager. It was clear that SPE presented a gap in the service that could be addressed relatively simply, thereby providing a “quick win” for the overall service redesign .

Demographics and description of the local health community

The registered population of Bexley is 228,339 with 10,500 people diagnosed with diabetes. It is an urban population in the South East of London with 16 percent of people aged over 65 compared to 12 percent for London as a whole. The north of the borough has a much higher concentration of black and minority ethnic (BME) communities and higher deprivation than the rest of the area. While overall the borough has a BME population of 12 percent compared to London’s 29 percent, the highest concentration is at the Thamesmead East ward with 20 percent. As a result all-age, all-cause mortality is

higher in this area too. 20 percent of children in year 6 are either overweight or obese.

How was the project approached?

The diabetes programme manager had discussions with Dr Trudi Deakin the creator the X-Pert Programme and MD of X-Pert Health CIC to obtain learning from around the country. He was referred to Tower Hamlets Primary care Trust (PCT) who had taken on X-Pert and adapted it achieving high volume coverage in a 6 month period in 2008/9.

Using the information gained from this research, a new service started in January 2010. This was developed by Anne Goodchild a local diabetes specialist nurse (DSN) who also crossed referred to Dr Deakin to check the validity of the approach taken by Bexley Care Trust. As the diabetes re-design gathered pace, Suzanne Lucas, a specialist diabetes educator, joined the team.

People with diabetes were offered a taster course, followed by the option to attend four subsequent weekly 2 ½ hour sessions. This was a model applied by Tower Hamlets where they found that 20 percent of people went on to take up the follow on course.

Bexley scheduled their courses to run at a variety of times: mornings, afternoons, evenings and Saturday mornings at six different venues across the borough to eliminate access barriers.

The programme was marketed to GPs to drive referrals and patients could also make bookings directly. Leaflets and posters were distributed to practice surgeries. A variety of people were recruited as trainers, including volunteers from the local Diabetes UK patient group, health trainers, people from the local community, e.g. the local Asian Women's Group, a variety of healthcare professionals, including DSNs, dieticians, practice nurses and assistants as well as enthusiastic patients who had been through the course, to run the education sessions.

To start with, the objective was to get 50% of people diagnosed with type 2 diabetes to attend the training in the first year of diagnosis. An additional aim was to enable 15% of all other people with type 2 diabetes to receive such SPE.

Over time, it was found that offering a variety of times and venues was highly effective. However, it was also clear that people only wanted to travel a short distance and that this, as well as good parking facilities, were the most important barriers to be overcome. For example the importance of car parking spaces was clearly demonstrated one of the main venues lost their car facility and attendance dropped rapidly.

Supporting newly trained educators was critical to build confidence and preserve quality. Experienced mentors attended alongside the educators to facilitate this.

Transporting the teaching materials between venues was also found to be impractical and the decision was taken to buy additional sets for each location.

In addition to the X-Pert programme, the team have also recently launched DESMOND's (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) Walking Away From Diabetes

patient education programme.

Quality, innovation, prevention and productivity outcomes achieved

Since February 2010, the average number of people attending the courses has been 100 a month, i.e. over 1,000 people have completed the course in 2010/2011 The conversion rate from initial taster to full 5 sessions was over 85%percent, much higher than expected.

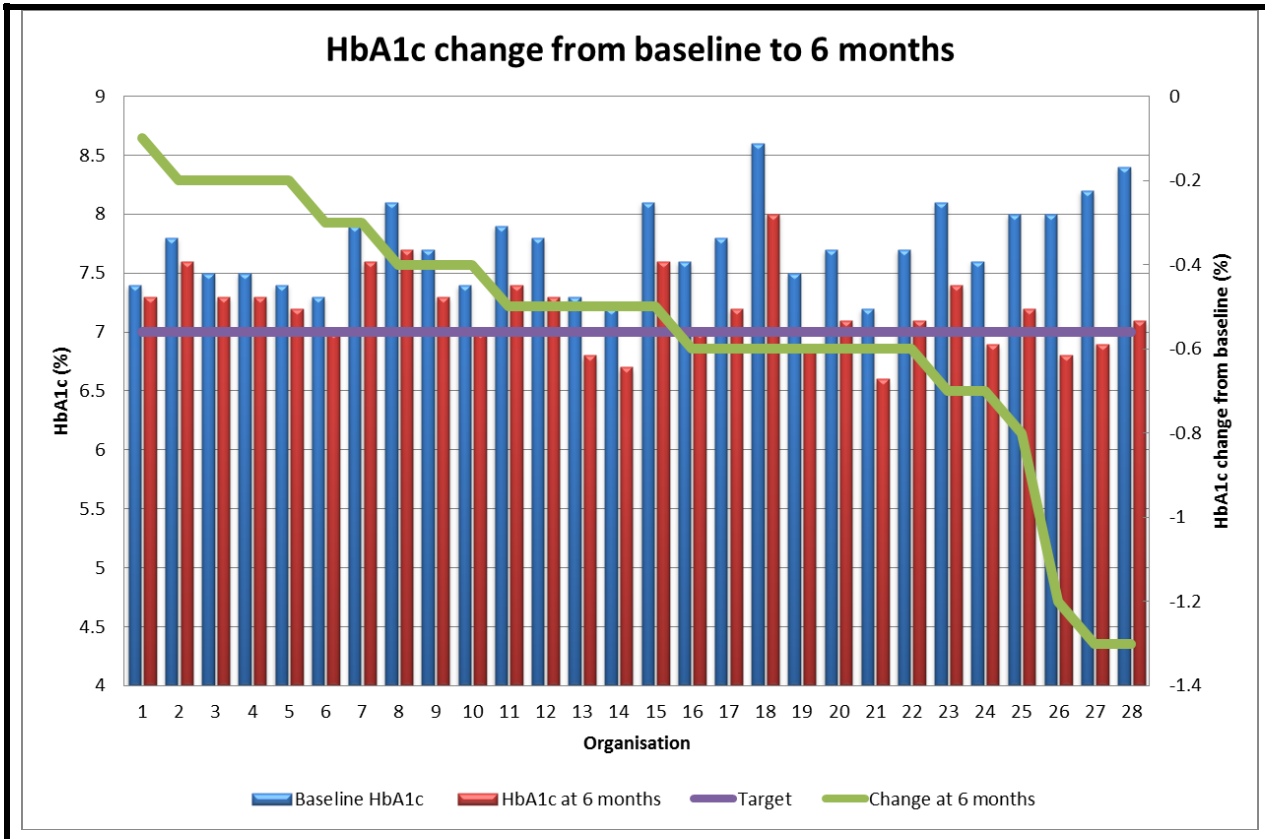
The programme achieved its target of reaching 50 percent of people with Type 2 diabetes who are in the first year of diagnosis.

The most recent outcome data published in the X-Pert Health CIC Audit Report (February 2011) is shown below.

	Bexley			National		
	Baseline	6 months post X-Pert	Overall reduction (percent)	Baseline	6 months post X-Pert	Overall reduction (percent)
Average HbA1c (%):	8.4	7.1	15%	7.7	7.1	8%
Average cholesterol (mmol/l):	5.0	4.3	14%	4.4	4.2	5%
Average BMI (kg/m2 (kg/m2):	31.8	30.3	5%	31.8	30.8	3%

The greatest unintended consequence was the huge demand for the courses plus the high conversion rate from 'taster' to remainder of the course.

The chart below shows patient's HbA1c levels from 28 organisations. The blue line shows HbA1c before undergoing the programme and the red line shows it 6 months later. Bexley is organisation 28 on the chart.



Health economic benefits

It is too early to expand on the data mentioned above, which itself is extremely positive.

These data are recorded as part of the national X-Pert Programme ongoing audit organised by X-Pert Health Community Interest Company.

Measures/metrics were used to assess the success of the project

The measures used to assess the success of the project include number of people with Type 2 diabetes who are in the first year of diagnosis received structured education and average weight, cholesterol and HbA1c (baseline levels), 6 months and one year after the education sessions.

Pathway/ intervention used

Patients with type 2 diabetes in the first year of their diagnosis were referred by their GP for structured patient education. In addition to general publicity in their practices, some proactively looked for patients on their register who might benefit.

Resources/ workforce required to initiate and deliver the project

In the first year £114,000 was allocated to the project to cover, management, bookings, trainers, venues

and equipment. Practices also received LES (locally enhanced services) funding to provide diabetes care. Providing access to SPE was one of the points that subscribers were directed to provide.
Evidence base on which the project is based
Deakin, T. A., Cade, J. E., Williams, R., & Greenwood, D. C. (2006) *Structured Patient Education: The Diabetes X-Pert Program makes a Difference.* Diabetic Medicine: 23; 944-954. [Appendix 1: Abstract]