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Bright idea

Developing a diabetes education programme to meet local needs in Tower Hamlets

Tower Hamlets has an ethnically diverse, transient population with an increasing number of people with diabetes in need of self-management education. NHS Tower Hamlets CCG have commissioned education and support packages from the local diabetes centre and community based charities. Several innovative techniques have been used in recent years to improve access and make health messages consistent. A new, simplified menu of education options has been introduced.

The case for change

Evidence suggests that group based self-management options such as X-PERT can improve glycaemic control, resulting in fewer complications and improved quality of life.[1] In Tower Hamlets, course attendance rates are excellent (the team won an X-PERT award in 2014 for achieving a 98.1% attendance over the first four sessions) and the average HbA1c reduction is 0.9% (9.3mmol/mol) at one year.[2] Despite the course success, some of those referred do not book onto a course. There are a number of reasons for this. Some are organisational and have been improved with basic interventions from providers and referrers[3] (see focus point). Others may reflect personal choice.

The main ethnic group in Tower Hamlets is Bangladeshi. The Mile End diabetes centre (Barts Health NHS Trust) have two Bengali speaking diabetes educators who provide regular Bengali X-PERT courses. However, despite the high proportion of Bangladeshi residents, people in Tower Hamlets come from more than 200 different countries and over 43% of the population were born outside the UK. The diabetes centre provides one to one or small group education through local translators but there are a number of hard to reach groups for whom poor health literacy and language barriers may prevent them engaging with traditional healthcare services.[4] This highlights the need for different self-management options.

The model of care

Quick facts

The current model of care in Tower Hamlets reflects the three levels of education developed in Scotland[5], a framework endorsed in the Diabetes UK report, **Diabetes education: the big missed opportunity in diabetes care (2015).**

Level one: Information and one to one advice when diabetes is diagnosed.

Level two: Ongoing learning that may be quite informal, perhaps through a peer group.

Level three: Structured education with a clear curriculum and teaching philosophy that is delivered to a group of people, with quality assured teaching standards.

Type 2 diabetes self management education programmes available in Tower Hamlets[6]

Level one education
is provided in general practice with specialist support. Bengali speaking diabetes link workers and translators from the hospital advocacy team are available if necessary.

Patient activation measures (PAM)[7] determine which education or support option is most suitable.[8]

PAM level one/two

Level two education
Course name: Manage My Health
Provider: Women's Health and Family Services
Location: Local centres, linking to existing community groups
Duration: Ten sessions over nine weeks
Content: Short Key Messages (these are short, consistent health messages written by the diabetes centre staff and delivered by a diabetes specialist nurse (DSN) or diabetes educator), Healthy Hearts education, guided group discussions, healthy eating and cooking, exercises, self management support for cardiovascular disease and hypertension. Befriender support scheme also available as part of the programme
Outcomes and quality assessment: PAM and mental wellbeing scales[9] assessed at the start and end of the course.

PAM level two/three

Level two education
Course name: Good Move
Provider: Social Action for Health
Location: Local centres, linking to existing community groups
Duration: Eight sessions over eight weeks
Content: Also available for cardiovascular disease and hypertension. Short Key Messages as above, gentle exercise activities and healthy eating advice. There will be courses specifically targeted for families and pre and post natal women. Peer group support will be run for some courses
Outcomes and quality assessment: PAM and mental wellbeing scales[9] assessed at the start and end of the course.

PAM level three

Level three education
Course name: X-PERT Diabetes Education
Provider: Diabetes centre, Mile End Hospital (Barts Hospital NHS Trust)
Staffing: Four DSNs, two full time Bangladeshi diabetes educators, three dieticians, one diabetes coordinator, one diabetes administrator
Location: Diabetes centre, GP surgeries and community venues
Duration: 48 sessions run over 12 months. Each course is six weeks long
Content: Regular courses in English and Bengali. Other language options are available through translators. One to one sessions can be arranged. The team have developed a video in Bengali.
Outcomes and quality assessment: All instructors are X-PERT accredited and undergo regular internal peer reviews. HbA1c, cholesterol and blood pressure are audited.

Focus point

Staff at the Mile End diabetes centre in 2014

Increasing the uptake of diabetes education

The diabetes centre received referrals for 1,897 people to attend X-PERT courses between April 2014 and April 2015. All those referred were invited to attend the course. 608 attended the first session and 502 (83%) completed the course. The Quality and Outcomes Framework encourages referrals to structured patient education but the quality of primary care referral often influences attendance at education sessions.[3] The diabetes centre has raised awareness of the course in primary care by:

- Using the local GP network structure to present the different education options during network meetings.[10]
- Using established communication pathways with primary care (shared electronic records, regular multidisciplinary meetings and diabetes clinics run in the community) to promote the courses.
- Inviting primary care staff to attend taster education sessions.

Attendance at structured education sessions has been addressed by:

- Advertising. Courses are advertised in local GP surgeries.
- Working across traditional care boundaries. The diabetes centre team are visible in the community, for example they regularly deliver Ramadan education sessions.
- Making it easy to book onto a course. Those referred receive a letter with an appointment date. They then receive a telephone call (with a translator where required) explaining the course. They can either confirm, alter the dates or choose not to attend. If they choose not to attend they are advised on how to attend in the future or signposted to different options.
- Holding sessions at flexible times in convenient locations. Sessions are held on weekdays and early evenings in the local diabetes centre, in GP surgeries and occasionally in community centres. Tea and coffee are provided. An option on the new referral form asks users if they would prefer to have weekend sessions.
- Providing ongoing contact throughout the course. People receive a telephone reminder before each of the first four education sessions. Where needed, people are offered a more convenient time.

Lessons learned

1. Education programmes must be flexible to adapt to the needs of the local population, but health messages must remain consistent (Short Key Messages are short health messages written by the diabetes centre staff and delivered by a DSN or diabetes educator as part of the level two education options).
2. Referrers (usually in primary care) must have a clear understanding of the different self management choices available and a simple referral process to follow.
3. Structured education courses can improve health outcomes in a diverse and transient population. Simple interventions can be used to improve course uptake.

Has this resource helped you to improve diabetes care? You can share your work with others or get more information by emailing **sharedpractice@diabetes.org.uk**

References

1 Deakin, TA et al (2006). Structured patient education: the Diabetes X-PERT Programme makes a difference *Diabetic Medicine*. 23 (9). p 944 – 954

2 Please note that it is assumed that the patients whose GP practices did not provide follow up HbA1c results are comparable to the 70 per cent of patients whose GP practices did provide follow-up data. As a point of comparison, analysis of national-level X-PERT audit data for patients with a full set of clinical data at one year showed a statistically significant reduction in HbA1c of 0.5 per cent points [Deakin, TA et al (2011). The diabetes pandemic – is structured education the solution or an unnecessary expense? *Practical Diabetes*. 28 (8)]

3 Winkley, K et al (2015). Patient explanations for non-attendance at structured diabetes education for newly diagnosed type 2 diabetes: a qualitative study *Diabetes Medicine*. 32 (1). p 120 –128

4 WHFS (2014). Diabetes Patient Experience in Tower Hamlets available at: **http://whfs.org.uk/images/REPORTS/WHFS_Report_Diabetes_Patient_Experience_June_2014.pdf**

5 Diabetes Education Scotland (2013). Available at: **http://www.diabeteseducationscotland.org.uk/Patient.aspx**

6 These options exist as part of a comprehensive education programme including structured Type 1 diabetes education, peer support groups and dietician-led carbohydrate counting courses. Information on Type 1 education options is beyond the scope of this resource

7 Hibbard, J et al (2014). Supporting people to manage their health: An introduction to patient activation *The King's Fund* available at: **http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf**

8 The model will be evaluated at the end of 2015

9 Assessed using the Warwick Edinburgh Mental Wellbeing Scale

10 Hull, S et al (2013). Improving outcomes for patients with type 2 diabetes using general practice networks: a quality improvement project in east London *BMJ Qual Saf* doi:10.1136/bmjqs-2013-002008