PRIMARY CARE HOME (PCH)
DIABETES RAPID TEST SITE

Cambridgeshire Community Services NHS Trust and
Kingsway GP Cluster

PILOT EVALUATION REPORT

Author	**Penny Gazeley, PCH Operational Project Lead**
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1.1	Attached appendices, populated patient satisfaction survey and staff feedback
1.2	Added narrative to all sections
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EXECUTIVE SUMMARY

As part of the NAPC Primary Care Home Rapid Test Site CCS and Kingsway cluster of GP's in Luton worked together to test a pathway to improve the uptake of structured education to diabetic patients who were identified as not engaging with health professionals and to test if intensive support through a 6 week programme improved patients motivation to manage their own condition.

Patients needed to be registered with a Luton GP and meet the following criteria:

- Evidence of non-engagement with diabetic reviews and other checks (consecutive DNAs)
- Type 2 Diabetes diagnosed within the last 5 years
- Hba1c > 80

Pilot objective:

To develop and test a pathway to engage and support patients that are struggling to self-manage their diabetes condition which identifies each patient's motivation in engaging and participating in managing their condition and creates an individual management plan for each patient.

The pathway developed provided a 6 week programme for each patient of intensive support using a coaching approach and tailoring the agreed management plan to the individual patient's motivation level, measured by using the PAM (Patient Activation Measure) tool and prioritising the patient's needs. This meant clinical improvements might not be seen during the test but motivation levels should increase.

The programme of support was delivered by CCS Luton Community Diabetic Service using the skills of the Diabetic Support Workers.

- 19 patients in 2 cohorts participated – attending group sessions and having telephone support.
- Patients who were identified as needing support from other services had direct referrals made
- Post pilot results:
  - 75% of patients achieved a lower Hba1c level
  - 80% of patients had an increase in their PAM score
  - Patient satisfaction feedback was very positive
  - Staff feedback was also positive

The outcomes of the test were that intensive support, with structured education does have positive outcomes. The coaching approach works and patients value time to explore their condition and other related issues, indicating a holistic approach is needed. Support needs to be individualised taking account of patient's lifestyle and commitments.

The test demanded a high level of administrative resource to achieve the results which needs to be factored into future plans.

1. INTRODUCTION

Kingsway Cluster in Luton comprises 7 GP practices providing Primary Health Care Services to a population of patients where a high percentage of patients are of South East Asian origin. Research suggests (Diabetes.org.uk 2016) that people from South East Asia and black communities are 2-4 times more likely to develop Type 2 Diabetes than those from a Caucasian background. The cluster has been aware of the burden of diabetes on their practices, their patients and the wider health system and has struggled to manage this group of patients with low uptake of structured education and attendance at other diabetic checks. Discussions took place with Luton Clinical Commissioning Group (LCCG), Cambridge Community Services (CCS) and the Kingsway cluster to look at how a Primary Care Home approach might be tested in a pathway to improve patient engagement, self-management and motivation to ultimately lead to improvements in health now and on-going. The level of diabetic complications was increasing and the future quality of life for these patients was assessed to be decreasing. 10% of the NHS budget is spent on Diabetes (Diabetes UK 2016) and as Diabetes nationally is the fastest growing health threat and an urgent public health issue, for Luton this will be a major problem which is recognised by all the stakeholders as a joint problem needing an integrated approach to resolve. The opportunity to work together and test a pathway was seen as a step towards creating a plan of action.

A pathway was developed to test a more intensive approach to contacting these patients and encouraging them to attend structured education and make changes to their lifestyle. A programme of diabetes education was already provided by Luton Community Diabetes Team but attendance was low from these practices. NICE Guidance (NICE Guidance 28, 2017) recommends that an important part of Type 2 diabetes management is to offer group education programmes that meet cultural, linguistic, cognitive and literacy needs of the patients or an alternative equal standard of education if patients are unable to attend. The programmes offered by the diabetic team met these requirements.

For 3 months LCCG, CCS, and the Kingsway worked together to undertake the test.

2. PILOT OBJECTIVES

The pilot objective was to develop and test a pathway to engage and support patients that are struggling to self-manage their diabetes condition which identifies each patient's motivation in engaging and participating in managing their condition and creates an individual management plan for each patient

Specific objectives:

- To Increase motivation to self-manage condition
- To improve quality of life
- To improve clinical outcome – including sustained improvement in HbA1c levels

3. PILOT OVERVIEW

3.1. SCOPING/PLANNING/PRE TEST STAGE

Three separate workshops of 2.5 hours were held at a central location to scope, plan and develop tools and documentation to be used in the test.

The workshops had representatives from all cluster GP practices – including GP's, Practice Managers, and administrative colleagues. Attendance from Cambridgeshire Community Services (CCS) included Service Delivery Manager, Project Operational Lead, Diabetes Specialist team, Community Matron, MDT co-coordinator.

The patient cohort was agreed with consideration to which groups of patients would potentially benefit in taking part.

The Diabetes review pathway was scoped and agreed with roles and responsibilities identified - Appendix A

A Standard Operational Procedure (SOP) was drafted and then finalised as a working document for the test – Appendix B

Documentation created for this pilot included - pilot pathway, patient invite letter and patient information leaflet.

The project team attended the patient participation group held monthly at Luton Treatment Centre. The views of the patients were listened to and knowledge of what patients needed was gained. They talked about having diabetes and the impact on their lives and their families. The patients gave feedback which was included in the pilot about what would help them to manage their diabetes.

Patients who had been newly diagnosed may not have had the opportunity to discuss their condition in detail. Participating in the pilot would allow the time and the environment to explore these issues. Attending the group sessions would be encouraged both as a method of providing information but also providing an opportunity to talk to other people with diabetes. In this hard to reach group it was agreed that during the pilot there administration support would be provided by CCS to allow continual communication with the patient. It was recognised that GP practices did not have this resource. The administrator would contact patients throughout the pilot to ensure they made every effort to attend appointments, group sessions and 1:1 calls.

Issues discussed and agreed were:

Information Governance (IG) – practices gave access to their clinical systems and patients were advised when contacted that they were participating in a test and consent was sought.

Clinic Schedules – Room availability at each surgery was matched to Diabetes Support Worker (CCS) capacity and a schedule was agreed, with each practice having initial patient consultations in the practices and final patient consultations at the practice. Support sessions were held at the Luton Treatment Centre for all practice patients.

How/what to measure – outcome measures were discussed and agreed – it was agreed that clinical changes may not be seen during the pilot and monitoring of patient progress needed to be continued at the practices – this included HbA1c, weight and blood pressure.

Use of the PAM tool to measure patient motivation was agreed – the Diabetes team were familiar with using this tool and discussion around any language issues resulted in agreement that CCS administration who were proficient in other languages would make contact with the patients and complete the PAM tool.

Scope:

- Patients registered with Kingsway GP cluster, practices detailed below, and living in Luton.

Kingsway Cluster GP practice	Practice population
Conway	8,000
Kingsway HC	8,915
Medina	6,000
Neville Road	3,000
Pastures Way	4,700
Wenlock	3,207
Total	**33,822**

- Target Group:
  Type 2 Diabetes diagnosis within last 5 years
  HbA1c > 80
  Evidence of non-attendance – at least 3 DNA's to diabetes monitoring checks including Retinopathy
  Invitation to Educational programmes not accepted or DNA'd when arranged
- Patients authorised by their GP as suitable to take part in the test.
- Patients must have consented to sharing data with CCS to participate in the test.

Out of Scope:

- Patients on Insulin or other injectable
- Patients residing in a care home or on a palliative care pathway
- Test length was 3 months only and should not be seen as permanent pathway.
- Patients who were involved in the pilot would continue to have their diabetic reviews after the pilot in line with their GP practice policy and Luton CCG guidelines.

Identifying Cohort of patients

Extensive searches and data cleansing resulted in 40 potential patients across the cluster being identified to be invited to take part in the pilot – this resulted in 12 patients participating in the pilot – Cohort 1. During the first stages of the pilot with this group it was decided to run a second search and try to identify a further cohort of patients to be included in the pilot as Cohort 2. This search resulted in 72 patients being identified and 7 patients finally took part in the pilot.

A total of 19 patients took part in the pilot

During the planning stage one GP practice declined to continue with the pilot as the management of diabetes within their practice was not seen as a problem, searches of patients found very low numbers who met the criteria and subsequently the practice contacted these patients themselves and arranged review appointments which were attended by the patient

3.2. IMPLEMENTATION

The pilot commenced with Cohort 1 in May 2017 and Cohort 2 in June 2017. The patient phase of the pilot was completed in July 2017 – with 19 patients taking part in the programme.

Patients who were identified were contacted by telephone by the project team and invited to take part. They had already been sent a letter which detailed the pilot and advised they would be contacted. Contacting patients was very time consuming, with

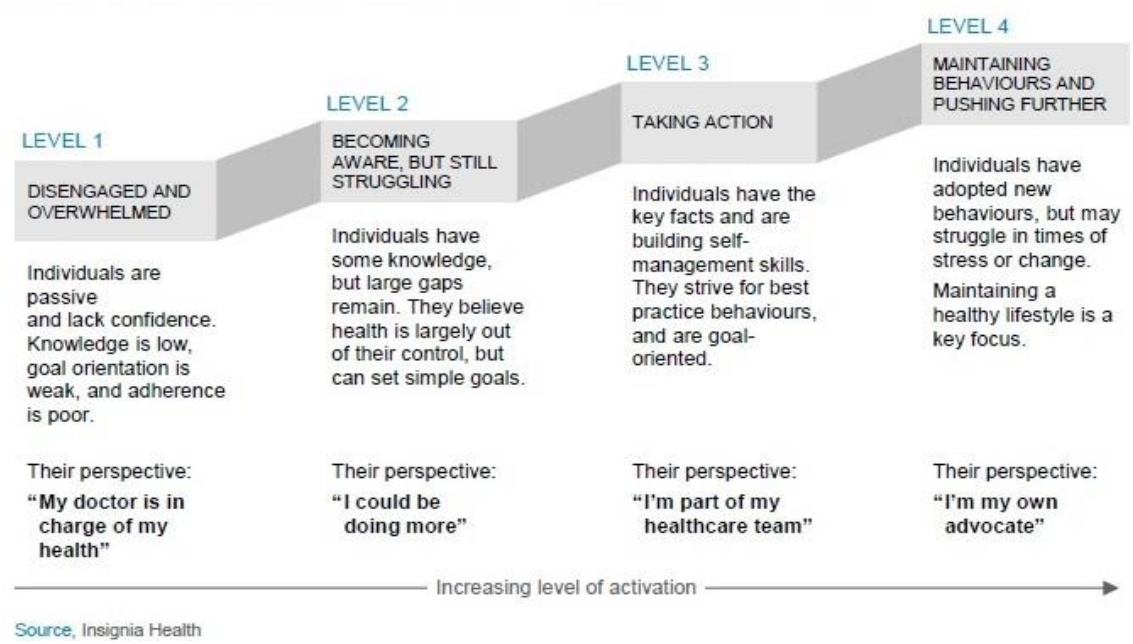
most patients being called several times before contact was made. A high number of calls resulted in the telephone number being incorrect for the patient and following checks with the practice no other numbers were on record.

Additional administration time was allocated to the pilot to facilitate the recruitment of patients. When a patient responded a surgery appointment was scheduled. Patients were asked to bring along all their medication to the appointment and were advised they could be accompanied by a relative or carer – they were also asked to think about any questions or queries they might have and could discuss with the Diabetes Support worker.

Patients were contacted prior to the appointment to complete the Patient Activiation Tool (PAM tool) – Appendix D and obtain a pre-pilot score. Some patients declined and others were not contactable prior to the appointment. The PAM tool is a questionnaire developed by Insignia, used by the NHS. A series of 13 questions are scored according to the patient response. A final score is calculated by Insignia and returned to the submitting person. There are 4 levels of activation – defined as people's ability to manage their health and healthcare needs, a single point change in a patients score is meaningful e.g. each point increase correlates to a 2% decrease in possible hospitalisation. It is recognised moving through the levels may take time and goals should be set to meet individual patient needs.

The PAM score level is also used to guide the clinician in managing the patient's consultation – it helps clinician and patient set goals which are achievable. Using the PAM tool allows effective support of each patient identifying what skills and knowledge they need to become activated.

The graphic below shows each level:



Source, Insignia Health

Appointments at practices were 1 hour for initial and final consultations. Each attendance at the group sessions was 2 hours. The appointments, group sessions and telephone support were all provided by CCS Diabetic team – the Diabetic Support workers (DSW) were identified as having the coaching and language skills to support patients.

Standardised documentation was used for the consultation. A written management plan was agreed with the patient and given at time of consultation or sent within 24 hours of the appointment.

The DSW used the PAM score if available to support the consultation content and tailor the information and advice given to individual patients at their level of identified motivation. The DSW would explore what the patients concerns were and how they felt about their condition – this would also guide the goals being set with the patient. Patients were invited to a programme of 4 weekly group sessions held on a Monday morning or individual face to face appointments or telephone support. This was the patient's choice but the information given was universal and any literature used at group sessions was sent to patients who were not participating in the group. Outcomes were recorded in the patients' records.

Data for the test was captured on a tracker at the project site; patients were identified by their practice, a project code and NHS number.

Regular monitoring of the progress was completed by the project team and patients who had not responded/DNA'd were contacted by telephone to encourage continued participation.

Prior to each appointment or group session patients were contacted by phone as a reminder of the date and time, sent a letter and then a text message.

On completion of the 4 week educational/support patients were contacted and asked to arrange a follow up appointment at the surgery. This was to monitor progress with any changes, repeat PAM tool and develop the process with patients of self-management encouraging patients to continue with attending diabetic checks and maintaining any lifestyle changes made.

Feedback and discussion on the test progress was captured at the monthly GP cluster meeting and by project team contact with the GP practice.

The project group reported monthly to the CCS Executive Programme Board.

It is planned to provide an outcomes newsletter to all Luton GP's, LCCG, CCS, community pharmacists, Health watch and Hospital.

3.3. COSTS

Funding to support this pilot was provided by NAPC; however, the pilot did also rely on CCS colleagues being released to support this work.

NAPC FUNDING	**£**	**70,000**

PILOT COSTS		
OPERATIONAL LEAD (ALLOCATED TO THIS PILOT)	£	20,888
MEETING ROOM HIRE (COST SPLIT BETWEEN TWO PILOTS)	£	112
PROJECT SUPPORT ASSISTANT (80% OF TIME)	£	7,135
	£	**28,135**

CCS STAFF RELEASED FROM CLINICAL DUTIES TO SUPPORT THE PILOT
NO PCH FUNDING USED FOR THIS

Diabetes Support Workers (16 weeks)	£	9,100.08
Dietician (8 weeks)	£	288.16
	£	**9,388.24**

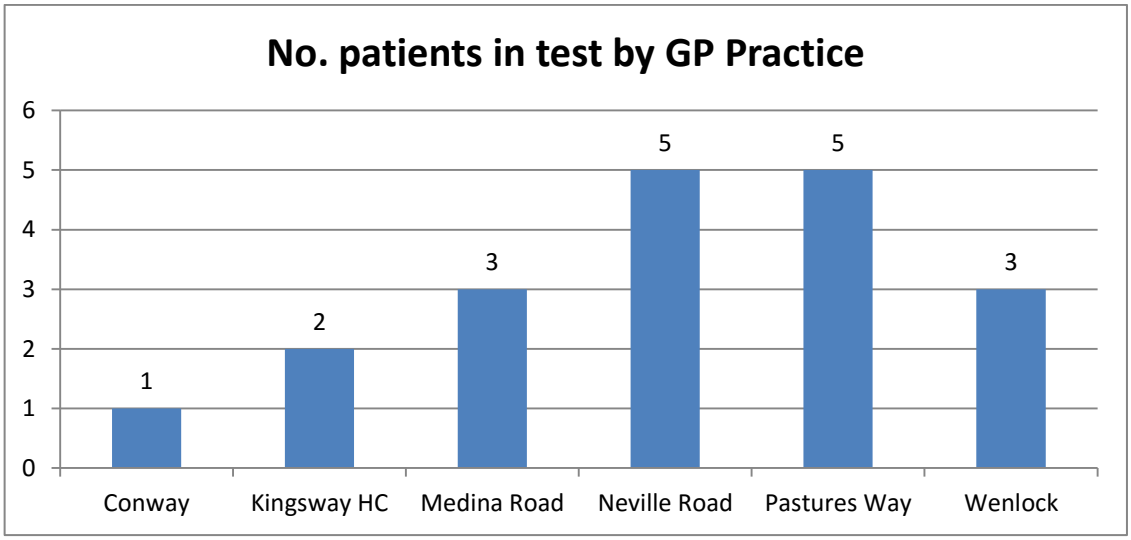
OTHER STAFF SUPPORTING BUT NOT COSTED:
Assistant Director of Business Development, Contracts and Strategy
Service Redesign Delivery Manager
Service Director (Strategic and Operational Leadership and Management)
Diabetes Lead Nurse (Operational Management, supporting workshops etc.)
Service Management Accountant (Financial support, cost benefit analysis)
GPs (attending workshops, co-designing the pathway, sharing updates with practice etc.)
Practice Managers (attending workshops, assisting with the setting up of clinics, extracting data, patient contact etc.)

4. OUTCOMES

4.1. PATIENT COHORT

- **112** patients were identified as meeting the criteria to participate in the test.
- Following extensive attempts to recruit patients **19** (17%) patients participated in the test. Many patients were not contactable and others declined to take part. Feedback from some patients that declined to participate advised that they were not available at the time allocated for both the consultations and the group sessions.

4.2 CLUSTER DATA



All practice searches identified many patients who were put forward to be invited – during the data cleansing process patients were excluded if they did not meet the criteria.

4.3 PATIENT DATA

4.3.1. PAM TOOL DATA

Cohort 1

Practice	Patient ID *	Initial PAM score Level 1-4	Final PAM score Level 1-4	Change
Medina Road	ME1	3	Not completed	N/A
Medina Road	ME2	3	Not completed	N/A
Pastures Way	PA 1	2	Not completed	N/A
Pastures Way	PA 2	2	2	No change*
Pastures Way	PA 3	Not completed	2	N/A
Pastures Way	PA 4	4	Not completed	N/A
Neville Road	NEV 1	1	Not completed	N/A
Neville Road	NEV 5	2	Not completed	N/A
Kingsway HC	KW 2	Not completed	1	N/A
Kingsway HC	KW 3	Not completed	Not completed	N/A
Wenlock	WE 3	Declined	Declined	N/A
Wenlock	WE 7	2	Not completed	N/A

Unable to make a full comparison of PAM scores in this cohort as only 1 patient completed an initial and final PAM tool and this patient's score remained the same level, however patients can stay in the same level but have an increase in their activation which as mentioned previously is still significant.

Feedback from the staff managing the PAM tool process advised that where the tool had not been done this was due to being unable to contact the patient on many occasions, however it was re-iterated that the PAM tool was an important part of the test and that if it could not be completed prior to the patient's appointment the DSW should complete at the beginning of the first consultation. This resulted in Cohort 2 having a higher success rate in obtaining PAM scores.

The completed PAM tools feedback showed there were no language problems using the tool but many patients found the questions difficult to answer

Cohort 2

Practice	Patient ID*	Initial PAM score Level 1-4	Final PAM score Level 1-4	Change
Pastures Way	PA 2	Not completed	2	N/A
Neville Road	NEV 1	2	3	increase
Neville Road	NEV 2	3	4	increase
Neville Road	NEV 3	1	3	increase
Wenlock	WE 1	1	4	increase
Conway	CO 1	Not completed	3	N/A
Medina Road	ME 2	3	1	decrease

*Please note that cohort ID's were used for cohort 1 and cohort 2, it was identified after allocating the ID's that same ID's were used, it is important to add each cohort data was kept separate.

Five (71%) of the seven patients in cohort 2 completed an initial and final PAM tool – of these 4 patients (80%) had an increase in their PAM tool score. This indicates that their motivation to manage their own condition had increased and that a change in their behaviour could be expected. Patients as they move from level 1 to level 4 are also expected to show an increase in confidence to manage their own condition.

4.3.2. HBA1c DATA

HBA1C is a measurement of average blood sugar levels over a period of weeks/months. Good control of blood sugar is known to lower risk of diabetic complications (Diabetes UK 2017). Improving HBA1c by 11 mmol cuts the risk of micro vascular complications by 25%, these include retinopathy, neuropathy and nephropathy, it also results in patients' risk of cataracts being reduced by 19%, Heart failure risk by 16% and amputation risk by 43%.

COHORT1

PRACTICE	PATIENT ID	INITIAL HBA1C	FINAL HBA1C
Kingsway	KW 2	104 mmol	86 mmol
Kingsway	KW 3	96 mmol	Not available
Medina Road	ME 1	91 mmol	78 mmol
Medina Road	ME 2	88 mmol	70 mmol
Neville Road	NEV 2	68 mmol	57 mmol
Neville Road	NEV 5	100 mmol	62 mmol
Pastures Way	PA 1	77 mmol	99 mmol
Pastures Way	PA 2	112 mmol	Not available
Pastures Way	PA 3	83 mmol	80 mmol
Pastures Way	PA 4	80 mmol	62 mmol
Wenlock	WE 3	96 mmol	Not available
Wenlock	WE 7	99 mmol	88 mmol

Seven patients (58%) in Cohort 1 reduced their HBA1c level by 11mmol or greater

COHORT 2

PRACTICE	PATIENT ID	INITIAL HBA1C	FINAL HBA1C
Medina Road	ME2	74 mmol	98 mmol
Neville Road	NEV1	90 mmol	Not available
Neville Road	NEV 2	76 mmol	72 mmol
Neville Road	NEV 3	62 mmol	98 mmol
Pastures Way	PW 2	73 mmol	68 mmol
Conway	CO1	66mmol	70 mmol
Wenlock	WE 1	68 mmol	53 mmol

Two patients (28%) in cohort 2 achieved a reduction in their HBA1c level by 11mmol or greater

Patient cohort:	19 patients
Bloods taken both before and after the pilot	16 patients *(3 patients did not attend a face to face final review, they have been advised to attend their surgery and have a review).*
Lower HbA1c result: (positive result)	12 (75%) - 9 achieved a reduction of 11 mmol or greater
Higher HbA1c result:	4 (25%)

4.3.3. GROUP SESSIONS/1:1 SUPPORT

All patients were invited to attend a programme of 4 group education/support sessions held weekly for 2 hours, patients who declined this invite were sent a reminder each week that

they could still attend and telephone support was given. During these calls the DSW explored how the patients were doing with their goals as set.

Topics in the group sessions were:

What is diabetes, Diet, Exercise, Diabetic monitoring and regular checks, wellbeing, Long Term effects, Foot care, Medication, How to live with Type 2 diabetes, and complications of Type 2 Diabetes

Patients who did not attend the sessions were sent all the patient information.

COHORT 1

3 patients attended the group sessions, none of these patients attended all 4 sessions. 2 attended once and 1 attended 3 sessions.

9 patients received telephone support; this was offered weekly only 2 patients were contactable for the 4 sessions

COHORT 2

2 patients attended the group sessions, 1 attended 3 sessions and 1 attended once

4 patients had telephone support – none were contactable for all 4 sessions, 3 patients had 1 contact with the DSW, and 1 patient had 2 contacts, 1 patient was not contactable

4.3.4 REFERRALS INTO OTHER SERVICES

During the test patients were able to be referred to other services for any specific problems which were impacting on their health and life. Prior to the start of the test Live Well Luton and other providers were informed of the pilot and agreed that patients who were part of the pilot and referred would be seen during the 12 week RTS period.

Service	No. referrals
Stop Smoking support	1
Living with Diabetes – Urdu	1
Podiatrist	1
Khidmat/depression	1
Women's Exercise	1

It is recognised that patients with Long Term Conditions may have other problems that will impact on their life and health. Working closely together with other providers is essential to ensure access and provision is available. It is also important

that patients have time to discuss with their professionals what might be blocking their recognition that their health condition needs managing to improve current and long term outcomes

4.3.5 PATIENT SATISFACTION SURVEY RESULTS

15 responses were returned.

Question 1 – Fully understanding your concerns-communicating that they had accurately understood your concerns, not overlooking or **dismissing** anything

	Patient Response				
GP Practice	**Poor**	**Fair**	**Satisfactory**	**Good**	**Excellent**
Conway	0	0	0	0	1
Medina Road	0	0	0	0	1
Neville Road	0	0	0	1	3
Pastures Way	0	0	1	1	1
Kingsway HC	0	0	0	1	1
Wenlock	0	0	0	0	2
Total	0	0	1	3	9

13 responses received - 92% of responses were good or excellent indicating patients concerns were explored and understood by the clinician – patients are more likely to make changes and increase motivation to self-manage if their concerns are discussed. The coaching model used by the Diabetic Support worker explores what issues patients have which may be preventing them from managing or recognising the need to look after themselves and their health. Changes to clinical measures are not seen as important to patients if they have other issues in their life which are their priority – the holistic approach is beneficial to outcomes for the patient and the clinician.

Question 2 – Explaining things clearly – Fully answering your questions, giving you adequate information, not being vague

	Patient Response				
GP Practice	**Poor**	**Fair**	**Satisfactory**	**Good**	**Excellent**
Conway	0	0	0	0	1
Medina Road	0	0	0	0	1

Neville Road	0	0	0	2	4
Pastures Way	0	0	0	2	1
Kingsway HC	0	0	0	2	0
Wenlock	0	0	0	0	2
Total	0	0	0	6	9

100% of responses were good or excellent indicating all the patients felt they had received clear information and their questions had been answered – sharing knowledge and giving patient specific information is important to help patients be motivated in self-management of their condition.

Question 3 – Helping you to take control – Exploring with you what you can do to improve your health yourself, encouraging rather than lecturing you

	Patient Response				
GP Practice	**Poor**	**Fair**	**Satisfactory**	**Good**	**Excellent**
Conway	0	0	0	0	1
Medina Road	0	0	0	0	1
Neville Road	0	0	0	2	4
Pastures Way	0	0	0	2	1
Kingsway HC	0	0	0	1	1
Wenlock	0	0	0	0	2
Total	0	0	0	5	10

100% of responses were good or excellent indicating that patients received supportive advice which will enable them to be more motivated to self-manage their condition – giving patient specific advice and including the patient in discussing ways they can improve their health encourages ownership of their condition and setting goals which are more likely to be achieved.

Question 4 – Making a plan of action with you – Discussion the options, involving you in decisions as much as you want to be involved, not ignoring your views

	Patient Response

GP Practice	Poor	Fair	Satisfactory	Good	Excellent
Conway	0	0	0	0	1
Medina Road	0	0	0	0	1
Neville Road	0	0	0	2	4
Pastures Way	0	0	1	0	0
Kingsway HC	0	0	0	1	1
Wenlock	0	0	0	0	2
Total	0	0	1	3	11

93% of responses were good or excellent – this indicates the plan of action agreed with the patient was patient centred and more likely to be achieved

Question 5 – Overall how would you rate your appointments with the diabetic team

	Patient Response				
GP Practice	**Poor**	**Fair**	**Satisfactory**	**Good**	**Excellent**
Conway	0	0	0	0	1
Medina Road	0	0	0	0	1
Neville Road	0	0	2	0	4
Pastures Way	0	0	0	2	1
Kingsway HC	0	0	0	1	1
Wenlock	0	0	0	0	2
Total	0	0	2	3	10

86% of patients responded good or excellent to this question – indicating a high level of patient satisfaction with the clinician

Question 6 – The appointments helped me to understand my diabetes and self-management

	Patient Response				
GP Practice	**Poor**	**Fair**	**Satisfactory**	**Good**	**Excellent**
Conway	0	0	0	0	0
Medina Road	0	0	0	0	1

Neville Road	0	0	0	2	4
Pastures Way	0	0	0	2	0
Kingsway HC	0	0	1	1	0
Wenlock	0	0	0	0	2
Total	0	0	1	5	8

14 patients responded - 92% of patients responded good or excellent – indicating the information given about diabetes had helped them to understand their condition – this will encourage self-management.

Question 7 – Coming to the sessions has helped me feel more motivated to look after my diabetes

	Patient Response				
GP Practice	**Poor**	**Fair**	**Satisfactory**	**Good**	**Excellent**
Conway	0	0	0	0	0
Medina Road	0	0	0	0	1
Neville Road	0	0	0	1	4
Pastures Way	0	0	0	2	0
Kingsway HC	0	0	0	1	1
Wenlock	0	0	0	0	2
Total	0	0	0	4	8

12 patients responded - 100% of patients responded good or excellent to this question – indicating all the patients who responded now felt motivated to look after their diabetes.

5. STAFF FEEDBACK

All staff involved in the pilot were asked to complete a feedback form – all the responses are shown below

Question 1 – What were the project highlights and which activities and processes worked well?

- Group education session worked well.
- When enough people in a group setting then they were able to help each other as peers.

- They shared common misconceptions about food, what fruit they can eat and discussed portions sizes.
- They identified common problems about weight, being hungry and what they should be eating.
- First assessment with patients- one to one consultation.
- Patient engaged and followed up the Diabetes management plan very well who attended at the initial assessment.
- Primary Health Care GP project lead and admin support was good.
- Communication was effective between Lead, Diabetes Support Worker and admin.
- Response from patient's GP surgery was in timely manner.
- Active engagement with patients from team members to support self-management in diabetes related goals.
- The administrative process worked well as seen from the effort put in by Aisha.
- Appointment slots- Patients who DNA'd at first initial appointment were then offered another appointment at a later date; the outcome was good for this.
- Have DESMOND service brought 'in house' for the patients
- Poorly controlled diabetics with challenging circumstances and attitude to their disease were identified and earmarked for this project.
- Very well prepared and good communication between the administration and our surgery.
- Easy email contact in case of any queries.
- It left us with almost no work; everything was done by your team, which was very helpful.
- Patients with HBA1C >80 with pilot scheme their HBA1C came down.
- Apart from usual cluster meeting updates during the planning of this project, I don't remember any phone calls/letter updates or patient feedback about this project so I am unable to comment.

Question 2 – Lessons Learnt: which activities and processes could be improved?

- Group session to have one 3hrly session instead weekly attendance as patients have work commitments to attend every week.
- To have specially allocated admin time rather than shared admin time.
- To review the pathway and to follow the pathway effectively as described.
- A substantial amount of resources were used related to engagement of patients.
- Despite this a high proportion of patients contact by the project team patients did not engage.
- It may be useful, to contact patients who did not engage to look at the reasons why?
- Patient summaries from GP practices- contact details were not updated and some of the patients referred were unable to take part because of this.
- DSW carrying out the assessment with patients in accordance to the pathway.
- Not much change in outcomes noted for most patients in the project.
- Unfortunately there were not many patients eligible for the service; therefore we had not a lot of activity.
- Group session should be in different languages.

Question 3 – Recommendations: If this pathway was to be rolled out to other GP Clusters

- This may mean multiple telephone calls and reminders or a face to face to encourage attendance.
- In terms of delivery and planning to discuss what days and what time would best suit patient.
- GP to have staff trained in this subject, and for that member to have regular clinics.
- Where the team can provide support on regular bases. Like mentorship.
- Ideally in hind sight employing a full time Diabetes support Worker may help to improve patient care at GP surgeries and by promoting patients to attend structured education i.e. at the Desmond, Living with Diabetes in Bengali or Urdu.
- Develop an audit on patients that are at high risk and do not engage in GP practice.
- Patient to carry out a simple questionnaire in order to look at the reasons why?
- Once this has been evaluated – do a root cause analyse in order to identify core factors that may influence engagement.
- These are hard to reach patients so may need one to one either by having a personal assistant or a personal trainer or even home visits (if at all possible) to encourage to them to look after their health.
- Group sessions and educational programmes are the key in motivating these patients to make the small changes as they are given information in depth as well as given demonstration as to how to manage their diabetes.
- Giving these patients one to one telephone consultation is beneficial as these patients aren't as engaging with attending appointments.
- Diabetic specialist nurse sessions from DESMOND should be made available at the surgery-some of our patients who we refer to DESMOND input can be seen at surgery with the practice nurse of doctor.

Question 4 – Any other comments/suggestions/feedback

- Evidence shows group sessions are productive and can be lighter way of learning about managing their diabetes.
- As from the evaluation giving time and listening, patients gained more knowledge and actually made changes as advised. By also understanding their condition they realised it is serious and need to do something about it.
- Unfortunately a lot of patients did not attend at the appointments despite sending appointment letters and reminder telephone calls.
- GP practices needs to research on DNA patients and find different but effective

approach to engage these outreach patients according to their individual need.

- We need to think about the high levels of resource used in this project; despite this only a small amount of patient's activity engaged .We need to look at the reason why and how we can improve this further.
- These patients could benefit from having home visits if hard to attend appointment at their GP practice.
- Practice managers were very friendly and welcoming towards admin staff member.
- Project had 'challenging' patients so outcomes of hba1c improvement may not be good in the timeframe of the project but improved processes to help such patients may have been identified.
- We had very helpful and friendly staff coming in!
- Aisha was very co-operative.

6. POSITIVES

The rapid test provided an opportunity for whole system working to try a different way of working to improve attendance of diabetic patients to educational programmes and to find reasons why education and other diabetic checks are not accessed by patients.

Joint working on pathways etc. was agreed with everyone's input.

19 patients participated and this may feel like a lot of resource for a few patients but this is an achievement in this group of difficult to reach patients.

The test has shown that through structured education tailored to the patients' needs, group sessions and/or telephone support, changes can be achieved. There are positive changes in the clinical outcomes and the patient satisfaction scores were very high.

Staff feedback mostly positive outcomes – support given to the practices by the project team was particularly highlighted which indicates that the high level of administration resource needed would require factoring in to any future programmes as this may not be readily available in the GP practices.

7. CHALLENGES

Roles and Responsibilities needed definition from the outset with a clearer estimate of the time needed for the pilot, it was felt there was a huge underestimate of the time, resources and work involved in the pilot for practices and their staff.

IT issues were resolved but it was evident that using different IT systems added work and caused problems with sharing information

IG issues needed close monitoring and expert help was needed to ensure there were no breaches.

Collecting data – practices were often unable to provide data and this was collected by the project team. The time needed for this was not available from the GP practices.

Contacting patients was very time consuming and many patients were contacted numerous times before a conversation was able to take place.

The group sessions were poorly attended and this could have been due to the time/day and/or venue scheduled for this activity. Those who attended gave positive feedback.

8. RECOMMENDATIONS/ CONCLUSION

The test was to use an intensive approach to initial contacting and maintaining contact throughout a monitoring of their condition. Would this approach provide change to patients attending educational sessions and to the outcomes both clinically and in patient satisfaction?

The test was also looking at patient's level of motivation and could intensive support and education specific to each patient's current level of motivation be increased?

The learning from this test has shown that it takes a very structured approach and a significant time resource to make initial contact with these patients. Practice records need constant updating at every opportunity to maintain current contact details for each patient. Once contact is made reminders by letter and text are helpful and successful to encourage/improve attendance.

The test has shown structured education does work and initial outcomes show changes can be made quickly and substantially. The education can be in groups or 1:1 and can include telephone support; the important factor is to provide the support specific to the patient's needs. Dates, times, and venues all need to be tailored to the patient. Language did not cause any exclusion in this test, but should remain an important consideration. Provision of education therefore needs to be flexible and creative. One provider cannot achieve the required amount of input into this area, a whole system approach needs to be planned and implemented. The DSW's in this pilot were able to give intensive support to a small group of patients, if this was to be replicated in larger groups of patients (which is what is needed) the labour resource would be huge and not achievable. New ways need to be explored and tested, more patient groups, education in different venues, use of social media increased, session times/days tailored to patients lifestyles. Public health input for prevention and maximising opportunity for education in schools, religious venues, etc. needs to be integrated across all sectors.

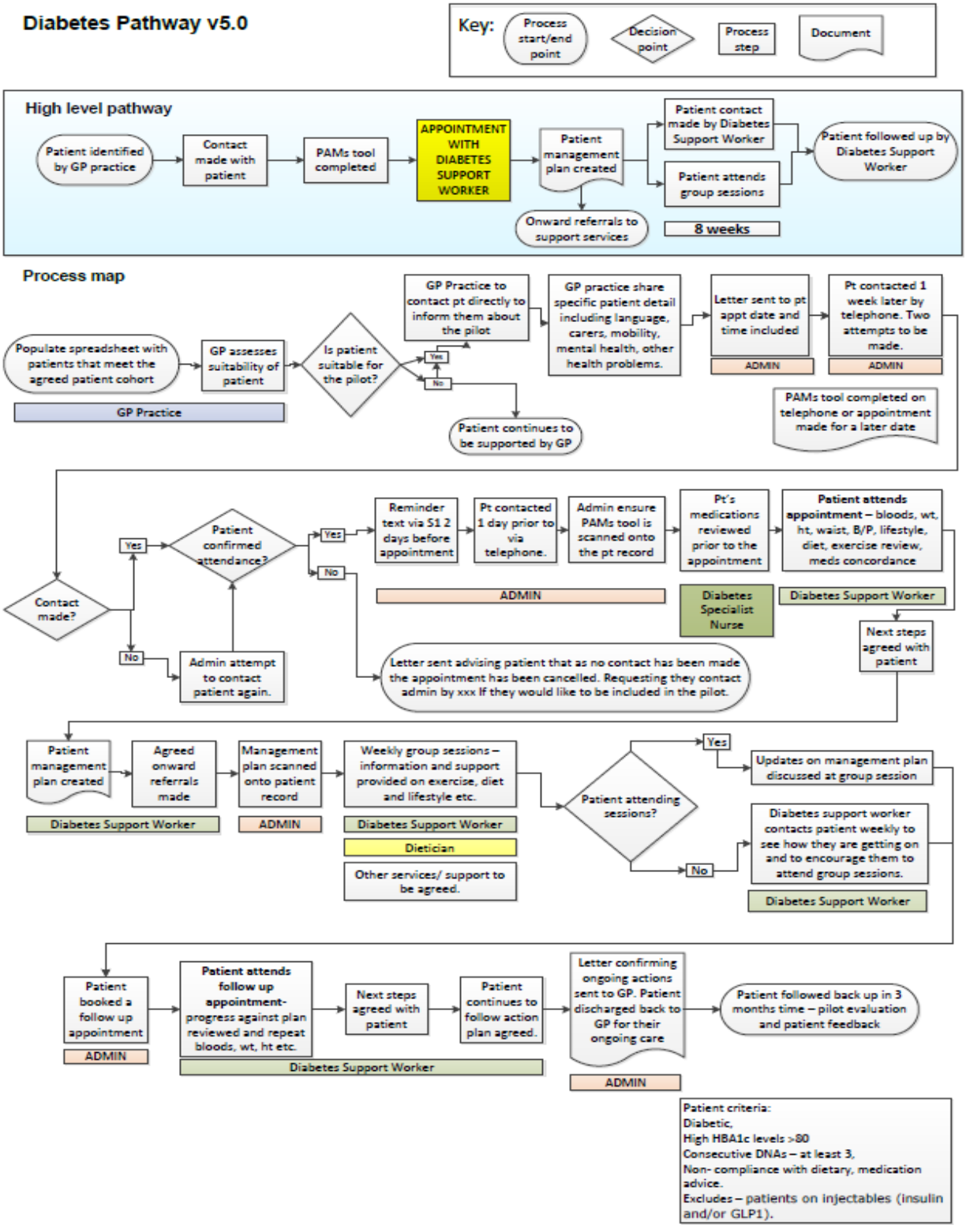
Patient satisfaction was high and motivation levels increased in many patients. If this was to be maintained patients would become more confident in managing their own conditions and self-management would increase releasing some of the burden on provider services and increasing health outcomes.

As patients continued to live with their condition it was noted they had 'normalised' their diabetes and were unaware in some cases of the serious potential future outcomes. The patients in this test had a diabetes diagnosis for some time but had not accessed education or monitoring appointments. In order to start the process of self-management and achieve improved health outcomes, an intervention needs to happen at diagnosis and a process put in place to support this.

These patients need to be reviewed again within the practice and assessed for sustained change and level of motivation. An audit of those who did not accept the invite to participate and the reasons why collated and results acted on. As the test has been completed these recommendations will be given to the GP practices along with a summary of their patients data/outcomes.

9. APPENDICES

9.1 APPENDIX A – PATHWAY



9.2 APPENDIX B – STANDARD OPERATING PROCEDURE (SOP)

STANDARD OPERATING PROCEDURE

Primary Care Home Diabetes Project			
Document no:	TBC		
Version:	V1.3		
Document owner:	Penny Gazeley/Amy Edwards		
Originating service:	Luton Adult Community Health Services		
Purpose of document:	This Standard Operating Procedure (SOP) outlines the process to be followed for arranging, preparing, undertaking and recording outcomes of the diabetes pilot pathway for Primary Care Home Project. This is a joint project with Kingsway GP Cluster in Luton.		
Scope:	Luton Integrated Community Diabetes Services (ICDS) and GP practice staff.		
Standards & legislation:	National institute of Clinical Excellence Type 2 diabetes pathway https://pathways.nice.org.uk/pathways/type-2-diabetes-in-adults		
Approved by:	TBC		
Date approved:		Review date:	
Key related documents:			
Equality & Diversity Impact (EDIA): (Attached)	• An EDIA has been completed and is attached. No negative impacts have been identified.		
Financial implications:	N/A		
Key word search:	Diabetes, Self-Management, Peer Support		

VERSION CONTROL SUMMARY

Version	Page No.	Description of change	Date approved
1.0		First issue	
1.1	multiple	Minor changes/updates	
1.2	Front page, 5	Front page Front page update to title – Diabetic review Page 5 Handling of outcome data – Sundon Park removed from table – change to ID code allocation	
1.3	4, 5,7	Updated attached file to version 5.0, updated process section and duties section.	

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7.0 Audit 8

8.0 EDIA Form 8

1. INTRODUCTION

As part of the National Association for Primary Care (NAPC) Primary Care Home model Cambridge Community Services (CCS) together with Kingsway GP Cluster have been working on a project to improve the care for patients with type 2 diabetes, by piloting a pathway which provides intensive support for a short period of time to help patients understand and self-manage their condition. This will involve empowering the patient to identify actions and lifestyle changes that can help improve or make managing their diabetes condition easier. This is a 3 month pilot and as detailed in this Standard Operating Procedure (SOP) will involve the joint working of both organisations.

2. OBJECTIVES & AIMS

The project has been designed and will now test and evaluate a service/pathway to support patients who are struggling to self-manage their diabetes condition. Patients need to have the skills and confidence to effectively manage the condition on their own. Researchers have described three categories of tasks that patients with chronic conditions perform, managing the illness, carrying on with normal roles and activities and managing the emotional impact of the illness. Enabling patients to make good choices and sustain healthy behaviours requires a collaborative relationship, a new health partnership between health care providers and teams.

This project aims to develop a pathway to engage and support patients who are struggling to self-manage their diabetes condition (criteria for patient cohort outlined below), which identifies each patient's motivation in engaging and participating in managing their condition and creates an individual management plan with each patient. Detailing agreed actions and support required.

This SOP details the process for this pathway, criteria for inclusion in the pilot is listed below.

- Patients registered with Kingsway GP Cluster in Luton only.
- Type 2 Diabetes diagnosis
- High HBA1c levels >80mmol
- Consecutive DNAs – at least 3,
- Non- concordance with dietary, lifestyle and medication advice.
- Patients authorised by their GP as suitable to be part of the pilot.
- Patients consent to sharing data with CCS to participate in the pilot.

Excludes:

- Patients on injectable (insulin and/or GLP1).
- Patients that meet the above criteria and who either reside in a care home or are on a palliative care pathway.

3. PROCESS

Attachment 1 – Primary Care Home Diabetes Pathway v5.0

3.1. PRIOR TO THE APPOINTMENT

Booking Appointments

- Patients will be contacted by their GP practice to inform them about the pilot.
- Invitation letter sent out to patients by the project team administrator, with information leaflet about the project and surgery contact telephone number to book appointment.
- Patient to contact surgery to make an appointment - appointments allocated to slots available on each practice schedule, with available languages. Practice schedule supplied by CCS.
- All appointments will be booked as 60 minute slots.
- If no response from patient after 7 days – a member of the project team will call the patient and ask for a response yes accepting invite/no does not want to accept invite and record the outcome for audit.

PAMs Tool

The PAMs tool will be completed with the patient over the telephone by a member of the project team prior to their face to face appointment with a Diabetes Support Worker. The outcome of the tool will be uploaded onto the patient's record in preparation for the appointment.

Reviewing patient records

Patient records will be reviewed by a Diabetes Specialist Nurse to confirm what medication the patient is taking and that patient meets referral criteria. The ICDS SystmOne Diabetes template will be accessed through Mobile working or at the GP practice who is using S1. All practices and ICDS must ensure that open records sharing has been initiated for patients that have booked an appointment.

3.2 DURING THE APPOINTMENT

- Patients' current measurements will be taken – including: height, weight, waist measurement, blood pressure.
- HbA1c blood test will be repeated if more than 3 months since last taken
- The Diabetes Support Worker will discuss the patients' lifestyle, diet and exercise and their concordance with their medications.
  A patient management plan will be agreed with patient and created during the appointment.

Attachment 2 – Patient Management Plan Template

3.3 AFTER THE APPOINTMENT

Outcomes

- If GP practice is on S1 and record shares activated, consultation notes and patients diabetes self-management plan will be visible immediately to GP practice. If not on S1 report will be printed off and scanned into GP surgeries electronic patient record system by next working day.
- Outcomes from the review documented on data capture spreadsheet
- All data recorded in S1 will be recognised read codes
- Any outstanding work not completed needs to be reported to project team.

3.4 FOLLOW UP APPOINTMENTS

- A reminder for follow up appointment will ticked on SystmOne and Vision to enable GP practices to search for these patients.
- Patients will be advised that they will be followed up within 3 months by the Diabetes Support Worker.

4.0 INFORMATION GOVERNANCE

Consent to data sharing

Information about consent for data sharing has been included in the patient invitation letter. By booking an appointment patients are advised that they are consenting to sharing data with ICDS for the project.

Appointments and patient information

All information relating to the appointment will be stored electronically.
Trust policy re. Patient Identifiable Data/Records will be adhered to – all staff involved in the project are up to date with all mandatory training and will use a red bag according to trust policy in exceptional circumstances

Handling of outcome data

To anonymise patient information, each patient will be given a 'Patient ID code', examples below. Patient ID codes will be allocated by the Diabetes Support Worker based on the order the patient was seen.

Conway	CO1, CO2,CO3
Kingsway	KW1, KW2, KW3
Medina	ME1, ME2, ME3
Neville Road	NE1, NE2, NE3

Pastures Way	PA1, PA2, PA3
Wenlock	WE1, WE2, WE3

A reference table spread sheet (separate document from the data capture spread sheet) will list the patient ID code against their NHS number to enable the project team to follow up with the patient at a later date.

5.0 RISKS AND SAFEGUARDING

Any clinical or non-clinical risks identified through the process will be recorded onto Datix in line with the Trust policy.

Any safeguarding issues identified will be actioned following Trust policy guidelines/policies.

6.0 DUTIES, ROLES & RESPONSIBILITIES

Project Support Assistant

- To ensure data captured from the Diabetes review is anonymised and all patient identifiable information removed before being shared.
- To contact identified patients encouraging them to participate in the pilot, ensuring that the clinics are fully utilised.
- To manage the PAMs tool use with patients, send completed tools for analysis, upload PAMs tool outcomes to patient records
- Liaise with GP practices about patients and booking of clinic rooms.
- To communicate any changes to the appointment schedule promptly to GP practices to ensure patients are kept informed.

GP Practices

- To send and schedule appointments to all patients that meet the criteria and have been approved as suitable to participate in this pilot by their GP.
- To provide patient summaries for all identified patient for the project, summary to include, Type 2 diabetes diagnosis, patients spoken language, HbA1c result, anti-diabetic medication prescribed.
- To liaise with the CCS Project Team regarding any changes to clinic room availability.
- To scan all review documentation into the patients electronic records

Diabetes Support Worker

- To ensure that patient's records have been reviewed and any preparatory tasks completed prior to each appointment.
- To conduct and record consultation using the agreed tools and templates outlined in this SOP.
- To use an empowerment approach throughout consultation to maximise patients likelihood to engage in self-management of their diabetes.
- To ensure outcomes of any appointments are accurately recorded on the patient's electronic record within the timescales specified in this SOP and communicated to their GP.

- To ensure that patient information is managed in accordance with CCS policy and as detailed in this SOP.
- To report any clinical or non-clinical risks regarding patients to the patient's GP and PCH Operational Project Lead. Safeguarding concerns must be reported immediately following the Trust's policy.

Diabetes Specialist Nurses

- To review patient medications prior to the appointment and provide any information or guidance to the Diabetes Support Worker on conversations needed with the patient regarding this.
- To provide clinical advice and support for any queries regarding a patient's condition.
- If required support the Diabetes Support Workers at group sessions.

7.0 AUDIT

The following information will be obtained from through the appointments and will be used to support the analysis of the pilot.

- Patients' assessment of their knowledge on diabetes and quality of life living with the condition.
- Biomedical and lifestyle outcomes

8.0 COMPLETED EDIA FORM

STANDARD OPERATING PROCEDURE (SOP) Diabetes Primary Care Home Project	
Objective	To set-out the process steps to follow for the Diabetes Primary Care Home Project.
Scope	Diabetes Support Worker, Primary Care Home Project team including administrator, GP Practice staff, and patients identified as fitting the consultation criteria.
Responsibility	The individual performing the diabetes review is professionally accountable for ensuring that they have undertaken the appropriate training and supervised practice to demonstrate individual competency and confidence. All involved in project are responsible for following the process.
Equipment	• Computer – with access to SystmOne • SystmOne card with access rights to Integrated Community Diabetes Services and Kingsway Cluster S1 practices. • Printer, paper and postage facilities • Patient summary from GP surgery (including current medication, medical history and allergies). • Latest ICE results • Phlebotomy equipment – *bottles, needles and forms* • Blood Glucose Meter – *which must be up-to-date with quality assurance* • Weighing scales • Electronic blood pressure machine • Tape measure – suitable for waist measurement • Metal Tape measure – suitable for measuring height • Hand washing facilities – *Alcohol gel for in between assessments, or hand washing kit in car.* • Gloves – in accordance with risk assessment and local policies • Patient to bring all of their medication with them to appointment and blood glucose results
Abbreviations	Primary Care Home – PCH, Diabetes Support Worker - DSW DSN – Diabetes Specialist Nurse ICDS – Integrated Community Diabetes Services

PROCESS STAGES	**RATIONALE**
<u>STEP 1:</u> Patient identified **GP Practice** Patients identified by GP practice who fit the following criteria: • Patient is registered with Kingsway GP Cluster, Luton	To ensure only patients who fit the referral criteria are

• Type 2 Diabetes diagnosis • High HBA1c levels >80mmol • Consecutive DNAs – at least 3 • History of non- concordance with dietary, lifestyle and medication advice • Patients authorised by their GP as suitable to be part of the pilot. • Patients consent to sharing data with CCS to participate in the pilot.	invited to take part.
<u>Excludes:</u> • Patients on injectables (insulin and/or GLP1). • Patients that meet the above criteria and who either reside in a care home or are on a palliative care pathway. • Patients who are not able to self-manage their diabetes Patient contacted and invited to take part in Diabetes Primary Care Home Project. Patient summary printed from patients electronic records Patient declines taking part: See alternative pathway ***'Patient declines'***	
<u>STEP 2:</u> Review of patient summary DSN • Patient summary reviewed against referral criteria and clinical decision made about suitability of patient taking part. Patient identified as not suitable: See alternative pathway ***'Patient identified as not suitable by DSN'***	*Second check to ensure only patients who are suitable for project are included.*
<u>STEP 4:</u> Invite letter and information to patient ADMIN • Letter inviting patient to make an appointment and information leaflet about project sent to patient • Letter scanned into patient electronic record	*So patient understands what to expect from their appointment.* *So that it can been seen that a letter has been sent to patient.*

STEP 5: Follow-up phone call to offer appointment **ADMIN** • Telephone patient to check if they have received information about the project • Offer to book them an appointment at their GP surgery • Send confirmation letter Patient declines appointment: See alternative pathway ***'Patient declines offer of appointment'***	*To check information is received by patient and to offer an appointment as early as possible at the start of the project.*
STEP 6: S1 Record Share **ADMIN** Ensure S1 record share has been set-up by GP practice and record on tracker.	*So all clinical staff involved in project have access.*

STEP 7: Register patient on ICDS S1 Unit **ADMIN**
 	
• Register patient on S1 following usual process for registering patients.
  ○ Service offered: 'Primary Care Home Project'
  ○ Caseload: 'Primary Care Home Project'
• Scan *'Patient Summary'* into patients S1 record. Shred summary.
	To ensure patient is registered and information is available for booked appointment.

STEP 8: Complete PAMS tool with patient **ADMIN** ▪ At least 2 days before appointment telephone patient to complete PAMS tool ▪ Follow process for getting PAMS score online, adding to tracker and adding to Patients S1 record.	*Tool used to identify where patient is in relation to understanding and self-management. Score needs to be available at start of consultation.*
STEP 9: Remind patient about appointment **ADMIN** **2 working days before appointment** - send a Text message reminder to patient from S1 **1 working day before appointment** – telephone patient reminding them to attend appointment and bring all of their medication and blood glucose meter and results. Log that you telephoned in patients S1 record. If no answer leave a message saying: *'this call is to remind you about your surgery appointment tomorrow at …., please attend and bring all your medication with you'* also send a text message reminder from S1. **Day of afternoon appointment** – send a Text message reminder to patient from	*Reminding patient means they are more likely to attend their appointment.* *Recording telephone call made on S1 give an audit trail.* *Text messages*

S1 in the morning.	*are automatically recorded in S1.*
STEP 10: Clinic List **ADMIN** Two working days before clinic. Email S1 clinic list to DSW using NHS Mail. Send text message to DSW to remind them to check their email for list. Fida Hussain Tel: 07881 2126455 fida.hussain@nhs.net Syeda-Tasmia Chowdury (Taz) Tel: 07795 122104 syeda.chowdhury@nhs.net	*To ensure list is available for clinic.*
STEP 11: Reviewing clinic list **DSW** One working day before scheduled clinic, review email with clinic list. Following information governance process regarding paper and electronic Patient Identifiable material.	*To prepare for clinic in a timely manner.*
Step 12: Day of appointment **DSW** Arrives at GP surgery minimum 15minutes before start of clinic Introduce yourself to GP reception staff and ask to be directed to your room. Switch on computer or Laptop and access S1 ICDS Review clinic list sent via NHS Mail. Log onto first patient Call patient into appointment – keeping to appointment time	*To allow enough time to prepare prior to start of clinic.*
Step 13: Consultation 60 minutes **DSW** Introduce yourself and explain project and what they can expect from consultation. Ask patient what they would like you to call them. Record consultation in ICDS S1 Diabetes template: • Open record share from ICDS if this has not been activated. Patient has already given consent. • **WEIGHT, HEIGHT, BMI, WAIST MEASUREMENT** – Accurately record and document (BMI can be calculated on S1). • Ask patient if they have any concerns about their diabetes and record on S1 Assess patients diabetes knowledge and self-management at all times focus on using an empowerment approach	*So patient knows who you are and what to expect* *To keep an accurate record of diabetes review.* *To record baseline measurements.*

• **DIET** – review eating pattern and diet, record in detail on S1 template, discuss areas they might like to improve. [See Diabetes Diet Competences]. Make a note of any concerns. • **PHYSICAL ACTIVITY** – review physical activity levels, as discussed in annual review. *Make a note if any concerns.* • **LIFESTYLE AND SOCIAL SITUATION** – Check previous report and review any issues raised then. *Note if any concerns.* • **BLOOD PRESSURE** – measure with patient sitting down using the correct technique and correct cuff size for taking a blood pressure. *Note if out of normal range.* **Target ≤130/80** • **HbA1c –** Discuss results and what they mean. Use graph on ICE to show results and ideal target range. If HbA1c was taken more than 3 months ago, repeat. • **MEDICATION CONCORDANCE** – Ask to see medication that they are taking and check with patient against list the GP has provided. **Tick master list if concordant, if not make a note.** If patient is having difficulty taking medication correctly, especially if polypharmacy, request that a Pharmacy Technician visit patient. • **DIABETES SELF-MANAGEMENT PLAN** – agree with patient what areas they would like to focus on improving. Record this on S1 template *'Diabetes Management Plan'* **If** facilities allow print-out plan and give to patient after discussing, if they don't ensure plan is sent to patient within 24 hours of consultation. • **FOLLOW-UP** – Advise patient that their process will be reviewed in clinic in 3 months' time, when HbA1c will be repeated. They will also receive regular telephone contact to see how they are progressing and encourage them to attend weekly support sessions at Luton Treatment Centre.	*To raise awareness of the importance of having a healthy diet and keeping physically active.* *To detect if blood pressure is in the normal parameters recommended for people with diabetes.* *Medication concordance for people with diabetes is known to be a problem. Therefore it is important to identify that what patient is taking correlates with prescribed medication. If it does not this should be discussed with patient and recorded on management plan.* *To produce a clear plan that the patient has agreed* *It is essential that patient received a copy of plan in a*

	timely manner, to keep them motivated. *To support motivation to change.*
<u>Step 14:</u> Diabetes Self-management Plan DSW/ADMIN • If it has not been possible to complete and send self-managmeent plan on day of consultation, ensure this is sent within 24 hours. • If patient is registered with Medina Surgery via S1 email Self-management plan to Aisha Khan Aisha.khan26@nhs.net who will arrange for report to be scanned into patient electronic record.	*Ensuring there is no delay in information getting to patient and GP*
<u>Step 15:</u> Ongoing motivational support DSW • Follow weekly project schedule to telephone patients to review progress and support motivation. • Focus support on patients who do not attend weekly support session • Record telephone consultation on S1 record. • Update tracker that contact made with patient – email Aisha.khan26@nhs.net who will update tracker	*Patient is likely to be more successful if they receive ongoing support*
<u>Step 16</u>: Weekly support session DSW/Dietician • Deliver One hour Diabetes support session weeks 3 to 11 (excluding bank holiday 1/5/17). Follow Plan.	
<u>Step 17</u> : Book follow-up clinic consultation ADMIN ADMIN • Week 9 of Project schedule telephone patients and offer follow-up clinic session • Follow Step 5 • Advise patient that they will need to have a repeat HbA1c blood test before their appointment • Send repeat blood form request with appointment letter	
<u>Step 18 :</u> Repeat PAMS tool ADMIN Follow Step 8	
<u>Step 19:</u> Remind patient about appointment ADMIN Follow Step 9	
<u>Step 20:</u> Preparing and Consultation ADMIN/DSW ADMIN **Follow steps 10 to 14 to complete project**	

Alternative Pathways:	***'Patient declines'*** **Step one:** Standard Diabetes care maintained by GP surgery.
	'Patient identified as not suitable by DSN' **Step one:** Admin notifies GP surgery **Step two:** Standard Diabetes care maintained by GP surgery
	Patient declines offer of appointment **Step one:** Admin notifies GP surgery **Step two:** Standard Diabetes care maintained by GP surgery
References:	**NICE Pathway – Managing Type 2 Diabetes** https://pathways.nice.org.uk/pathways/type-2-diabetes-in-adults [accessed 16th February 2017] **15 healthcare essentials** https://www.diabetes.org.uk/Documents/15-healthcare-essentials/15-healthcare-essentials-checklist-0714.pdf [accessed 16th February 2017] **NICE Guidelines type 2 diabetes in adults (2015)** https://www.nice.org.uk/guidance/ng28/resources/type-2-diabetes-in-adults-management-1837338615493 [accessed 16th February 2017] **DIABETES COMPETENCIE** ○ Assessing and advising on Healthy Eating and Diabetes ○ Hypoglycaemia Management ○ Capillary Blood Glucose Monitoring
Review period	
Date of implementation	February 2017
Validation date	February 2017
Author	Lyn Murphy – Service Manager Specialist Nursing - Lead Diabetes Specialist Nurse

9.3 APPENDIX C – PATIENT INFORMATION LEAFLET

Luton Children & Adults Community Health Services

NHS

Primary Care Home Pilot

Diabetes Support Service
February - May 2017

Cambridgeshire Community Services NHS Trust: delivering excellence in children and adults' community health services across Luton

PCH Diabetes Evaluation\PCH Diabetes Pilot information leaflet.pdf

9.4 APPENDIX D – PAM TOOL QUESTIONNAIRE

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by circling your answer. There is no right or wrong answers, just what is true for you. If the statement does not apply to you, circle N/A.

1. I am the person who is responsible for taking care of my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
2. Taking an active role in my own healthcare is the most important thing that affects my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
3. I am confident I can help prevent or reduce problems associated with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
4. I know what each of my prescribed medications do	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
5. I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
6. I am confident that I can tell a doctor or nurse concerns I have even when he or she does not ask	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
7. I am confident that I can carry out medical treatments I may need to do at home	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
8. I understand my health problems and what causes them	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
9. I know what treatments are available for my health problems	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
10. I have been able to maintain lifestyle changes, like healthy eating or exercising	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
11. I know how to prevent problems with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
12. I am confident I can work out solutions when new problems arise with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
13. I am confident that I can maintain lifestyle changes, like healthy eating and exercising, even during times of stress	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

9.5 APPENDIX E – PATIENT SATISFACTION SURVEY

Luton Children & Adults Community Health Services

NHS

PATIENT SATISFACTION SURVEY – DIABETES

		1 Poor	2 Fair	3 Satisfactory	4 Good	5 Excellent
1.	Fully understanding your concerns… (communicating that he/she had accurately understood your concerns, not overlooking or dismissing anything)					
2.	Explaining things clearly… (fully answering your questions, giving you adequate information, not being vague).					
3.	Helping you to take control… (exploring with you what you can do to improve your health yourself, encouraging rather than 'lecturing' you).					
4.	Making a plan of action with you… (discussing the options, involving you in decisions as much as you want to be involved, not ignoring your views).					
5.	Overall, how would you rate your sessions with the Diabetic team					
6.	The sessions helped me to understand my Diabetes, and self- management					
7.	Coming to these sessions has helped me feel more motivated to look after my Diabetes					

9.6 APPENDIX F – STAFF FEEDBACK FORM

Primary Care Home Diabetes Pilot Questionnaire

Question 1.Project Highlights: Which activities and processes worked well?

Question 2.Lessons Learned: Which activities and processes could have been improved?

Question 3.Recommendations: If this pathway was to be rolled out to all GP Clusters

Question 4.Any other comments, suggestions and feedback

9.7 APPENDIX G – GROUP SESSION PLAN & POSTER

PRIMARY CARE HOME PILOT

Diabetes Weekly Group Sessions

WHAT WE COVER IN SESSIONS

What will the sessions cover and what will I learn?

Our 4 week programme will cover the following topics:

- What is diabetes
- Diet and how to choose foods to improve your glucose levels
- Importance of exercise
- Diabetes monitoring
- Wellbeing
- Long term effects of diabetes
- Looking after your feet
- Diabetes regular checks
- Medication
- How to live with Type 2 diabetes
- Complications from Type 2 diabetes and how to reduce them

How do we cover the above topics to help you learn?
We use group activities to help people learn through joint learning. The workshop sessions are guided by clinician's with diabetes experience.

If I miss the session, where else can I get this advice form?
The Diabetes UK web site has all this information in it. On their web site there is guidance on how to learn about all of the above areas. Using this web site will allow you to learn at your own pace and we would recommend you to do so if you miss any sessions.

Where is the Diabetes UK website?
This site can be reached by going to the following web address address using the internet:
https://www.diabetes.org.uk/Guide-to-diabetes/Managing-your-diabetes/Education/Type-2-diabetes-and-me/

PRIMARY CARE HOME PILOT

Diabetes Weekly Group Sessions

An exciting opportunity for you to be supported to self-manage your diabetes and to learn about living with a lifelong condition. As well as share experiences and information, receive and give support to other local people and make new friends.

Weekly sessions are at:
Luton Treatment Centre, Vestry Close, Luton LU1 1AR
9:30am to 10.30am

- **Monday 8th May 2017**
- **Monday 15th May 2017**
- **Monday 22nd May 2017**
- **Monday 5th June 2017**

Please arrive promptly

Our 4 week programme will cover the following topics:

- **What is diabetes?**
- **Diet and how to choose foods to improve your glucose levels**
- **Importance of exercise**
- **Diabetes monitoring**
- **Wellbeing**
- **Long term effects of diabetes**
- **Looking after your feet**
- **Diabetes regular checks**