The Health Foundation
Inspiring Improvement

Case study: Guy's and St Thomas NHS Trust

Creating a tool for patients to set their agenda and goals

The challenge

Early in the work to develop self management support within Guy's and St Thomas' we held a workshop bringing together a wide range of participants including patients, clinicians and managers. with an interest in Diabetes and Self Management.

The objectives of the workshop were to:

- share experience locally and elsewhere in developing self management tools/enablers which will support people to self manage
- explore where the opportunities are for change and service improvement
- develop a list of possible service changes that could be made to help patients self manage their diabetes
- provide an overview of how changes will be tested and implemented.

One of the most popular suggestions for how we could support self management was to develop a form that patients could use to support them in planning what they wanted to talk about at the appointment and setting themselves some goals, as a way of making appointments with their health professional more collaborative.

What we did

How we developed the tool

Initially a group of people who had been trained in running the Patient Skills Programme (which promotes people's ability to manage their own condition) and the Practitioner Development Programme (which builds practitioners' skills and techniques to proactively support self management), worked with a small team of patients to design a simple A4 'Agenda Setting Sheet' which could be sent out to patients with their appointment letters.

The Diabetes team at Guy's Hospital trialled this, but we found that it was not very successful, as the majority of the patients either did not notice the sheet in with their appointment letter or did not complete it prior to their appointment. We continued to use the Sheet, but with Clinic Staff using it during the consultation.

Over time, we made small changes to the sheet, which we evaluated each time we made them, and added 'Goal Setting'. Patients were then offered the form at reception when they arrived in the clinic to complete while they waited to be seen.

How we promoted use of the tool

Initially we tried to spread the use of the 'My Health Plan' to the whole of the Diabetes Department (Guy's & St Thomas'), but a number of the clinicians in the team (particularly registrars) had not attended the Practitioner Development Programme and found it difficult to grasp the concept. When the team re-launched the use of the form with briefing sessions for all staff this proved very successful, demonstrating that it is possible to get clinicians to test and adopt Self Management Support tools even if they have not attended a full Practitioner Development Programme.

In order to spread the use of the form to Primary Care, we created a generic 'My Health Plan' leaflet which included the same information and could be used for all Long Term Conditions. The 'My Health Plan' leaflet was presented at the weekly team meeting to embed its use by all diabetes staff across both the Guy's and St Thomas sites. Posters are displayed and 'My Health Plan' is available in waiting areas in the Diabetes Departments at Guy's and St Thomas'.

The leaflet is also used during our Practitioner Development programme, and given to practitioners as a tool to use between training sessions.

Practices who have attended the Practitioner Development Programme also support the use of 'My Health Plan' by ensuring it is available in the waiting area. Some surgeries have also tried posting the leaflet to patients prior to their review appointments but again have found this unsuccessful.

We also provide 'My Health Plan' to people attending the Patient Skills Programme during the course, so they can use them at future appointments. This also

spreads awareness of the leaflet to clinicians who have not taken part in Practitioner Development Programme.

The Diabetes Modernisation Initiative at Guy's and St Thomas' have designed an information pack for newly diagnosed diabetes patients (type 1 & 2) which signposts them to the care they should expect to receive, including what structured education is available locally for them, and 'My Health Plan' has been included in this pack.

Community Clinics have recently been set up in Lambeth. As this is a new service it was seen as an ideal opportunity to implement the use of 'My Health Plan' as normal practice. A patient is referred to the Community Clinic by their GP and is then seen by a GP, a Diabetes Consultant, a Diabetes Specialist Nurse and a Dietitian during one session. When the patient arrives they are given a pack of information which includes 'My Health Plan', a 'My Health Plan' evaluation and a clinic evaluation form.

As the majority of patients are not familiar with a more collaborative approach to their appointment with their health professional, 'My Health Plan' is used during the consultation (usually led by the DSN and Dietitian) and given to them at the end of the appointment as a record of what was discussed and the agreed next steps.

Another 'My Health Plan' is given to the patient at the end of the session for them to complete before their next appointment. It is still early days but this approach seems to be working extremely well and will hopefully be duplicated by Southwark when their Community Clinics commence.

Impact

- Patient feedback: The diabetes team reports that 'We have had great feedback from patients with 100% either 'strongly agreeing' or 'agreeing' that their Health Care Professional discussed what was important to them during their consultation'.
- Clinician feedback: Clinicians agree that although the leaflet can take some time to get used to and some patients need this to be explained to them, on the whole they enjoy the collaborative approach and feel that they and the patients benefit from this. Clinics seem much more patient focused and there are more opportunities to promote self management. The team have reported that language has changed during weekly staff meetings, staff now refer to Agenda Setting and Goal Setting as routine. This has helped new staff, who have not attended the Practitioner Development Programme, become accustomed to the patient centred approach.

Our learning

- Health professionals are more likely to use self management support tools such as 'My Health Plan', when they are introduced through a briefing, which explains the philosophy and what you are trying to achieve.
- Patients are similarly unlikely to start using tools such as 'My Health Plan' when they are included in appointment letters, but are more likely to if they are introduced in the appointment by the health professional in the first instance.
- Nurses, dieticians and junior doctors are more likely to document the use of the self management support tools in the notes in comparison to hospital consultants, which may be related to the types of patients the consultants are seeing.
- The hospital consultants run a number specialised clinics, where patients are usually acutely ill and the majority of the consultation is dedicated to medical assessment run by hospital consultants. It has been difficult to introduce the Self Management Support tools in these clinics. It may therefore be that self management support tools are most usefully used when patients are not acutely ill.