

# **Integrated GP led diabetes care in Bexley.**

## **The role of ‘an active integrator’ in developing integration in NHS services**

**By Paul Corrigan, John Grumitt and Suzanne Lucas.**

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# Table of Contents

- 1. Methodological points about case studies**
- 2. Integrated GP led diabetes care in Bexley – the narrative**
- 3. What is the case for change?**
- 4. What is different about the new diabetes care in Bexley**
  - 4.1. Built on strong patient involvement to ensure that care met their needs.
  - 4.2. Used the service specification to manage performance of all providers.
  - 4.3. Had recognised experts providing clinical leadership.
  - 4.4. Continually improved the service with initiatives such as care planning.
- 5. Outcomes**
- 6. Lessons from the case study for others**
  - 6.1. *The integrator*
  - 6.2. *The need for an early success*
  - 6.3. *Patients and the role of the diabetes network*
  - 6.4. *GP champions who see their role as developing their colleagues*
  - 6.5. *Health Care professionals who recognise the need to create a new service*
  - 6.6. *Developing patient self-management as key*
  - 6.7. *GPs as commissioners who recognise that the present service fails*
  - 6.8. *Capacity to move the secondary provider Clinical leadership from the tertiary provider*

# 1 Methodological points about case studies

The NHS knows that it needs to learn from best practice.

The NHS knows that across the whole service there are a number of different good examples of best practice which the rest of the service should learn from. The writing and publication of these case studies is one method of trying to diffuse best practice.

It's worth noting that however good the exemplar case study is, the description of a case study on its own very rarely impacts upon the speedy diffusion of best practice. This lack of speed in diffusion is partly because the drivers for organisations that leave them with no alternative but going through the pain of change are not strong enough. Without very strong drivers for change, even a very good case study becomes just an interesting example of how they do things differently and in a different place from here.

We need to try and rethink how to write a case study to make it more likely that the example will be followed by others. In terms of the diffusion of innovation writing a case study is a further attempt to PUSH innovation into other parts of the NHS. To diffuse innovation properly there needs to be some more pull drivers.

This case study as with all others will contain a narrative about what changes the main innovator made in order to create the innovation. It is a story of change and how it is led. However as with all successful innovation there are a number of resources that were organic to this particular example of change which proved to be vital to its success. Every case study has these organic resources that are a crucial part of their success. However, while they are organic to this case study they are rarely organic to the locality that is trying to copy the case study. This means that it is much more difficult for the copier than for the original.

Therefore after the narrative about the case study we want to outline what the important organic resources were in the case study and try and explain how these resources might be obtained non organically from those that may want to replicate the case study.

## Case studies and integrated care

At the moment there is a great deal of discussion about integrated care in the NHS.

This case study is a specific example of how care can be integrated through the role of an integrator with clinical leadership as a major part of the process. As with most successful integration a single point has to take the responsibility for integrating what are very fragmented NHS organisations.

We are exploring this example because it provides a strong example of how if you want the patient to experience care that is genuinely integrated then you need an organisational focus for that integration which will ensure that real integration takes place.

## 2 Integrated GP led diabetes care in Bexley

### 2.1 What was the case for change?

In any change programme it is important to have a compelling narrative. Everyone must really believe that something is wrong before they will go through the pain of change. The national and local case for investment in properly treating people with, and at risk of, diabetes is overwhelming on clinical, economic and moral grounds.

A significant proportion of the complications arising from diabetes are preventable. In April this year's Diabetes UK State of the Nation Report<sup>1</sup> estimated that 79% of the resources spent on diabetes were spent on complications. For patients these complications may lead to emergency spells in hospital with the high anxiety that such an experience provides.

- People with diabetes have about twice the risk of developing a range of cardio vascular disease, compared with those without diabetes
- It is the most common cause of end stage renal disease
- People with diabetes are 10-20 times more likely to go blind
- Diabetes is the most common cause of lower limb amputation, accounting for about half of call cases. Tragically, up to 70% of those who lose a lower limb as a result of their diabetes die within 5 years

Medically, we know that the vast proportion of the expenditure on these complications is avoidable. We know that with effective interventions, healthcare resources may be released and quality of life for patients improved<sup>2</sup>.

Equally, we know that the prevalence of diabetes is increasing at about 5% per annum<sup>3</sup>. In Bexley this equates to 500 new cases a year. If we treat these new cases in the old way of acute first and follow up appointments, this will annually increase expenditure by £221,000<sup>4</sup>. This is a straightforward example of how the annual new demand for health care will lead to a bankrupt NHS, unless radical change in treatment patterns takes place.

Whilst the number of people with diabetes in the population of Bexley will make this case for change larger and more compelling, because the care for people with diabetes is failing patients so often the unnecessary expenditure on complications will, with the increased prevalence of the disease use up a considerable amount of resources that the NHS does not have.

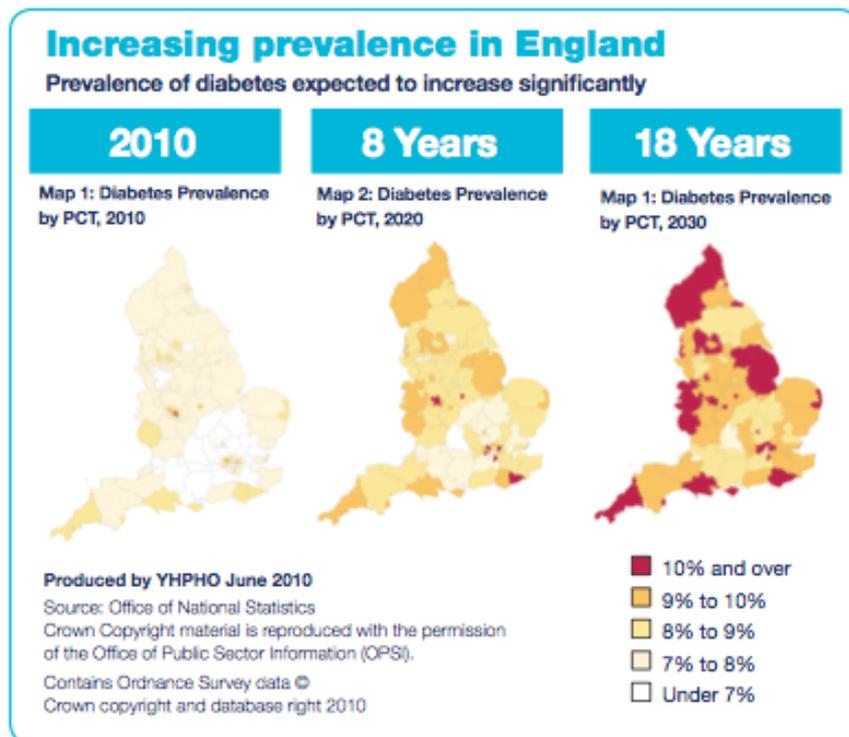
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<sup>1</sup> State of the Nation Report Diabetes UK April 2012

<sup>2</sup> Estimating the current and future costs of Type 1 and Type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs.

<sup>3</sup> [National Diabetes Audit 2009/12](#) p.7

<sup>4</sup> The Yorkshire and Humber Public Health Observatory's most recent estimates have added that there may be a further 2,856 people in Bexley with Type 2 diabetes currently undiagnosed on top of the 10,540 registered on QOF. The number of both is expected to rise at a rate of at least 5% a year to 15,000 by 2025.

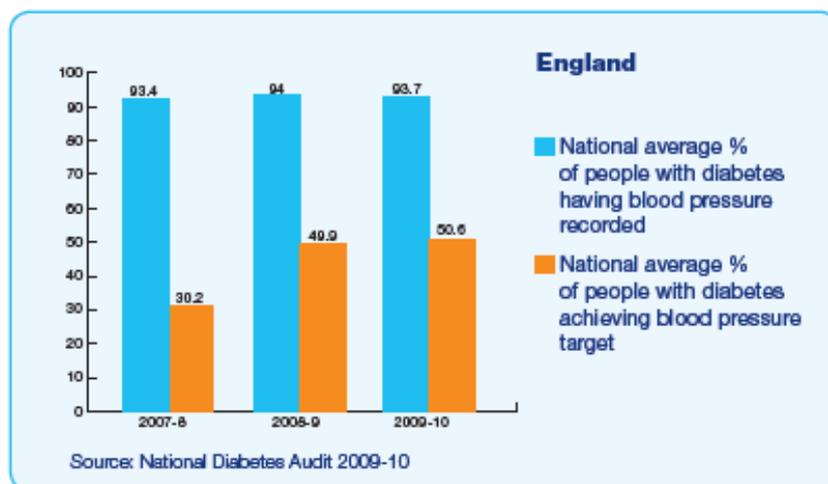
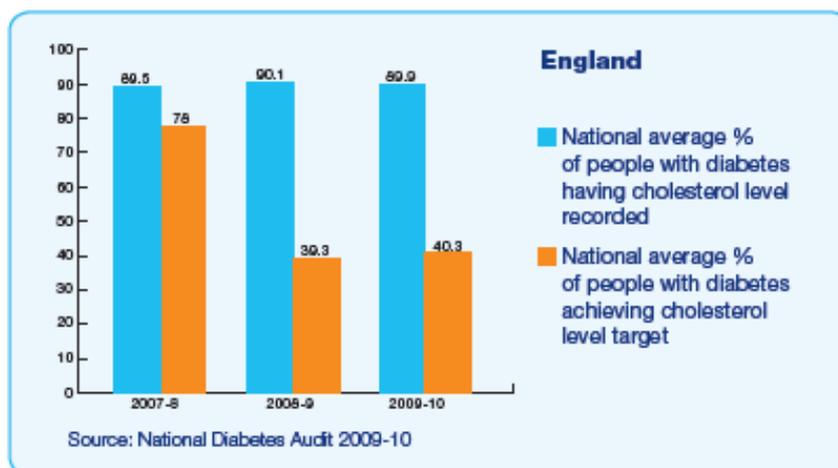
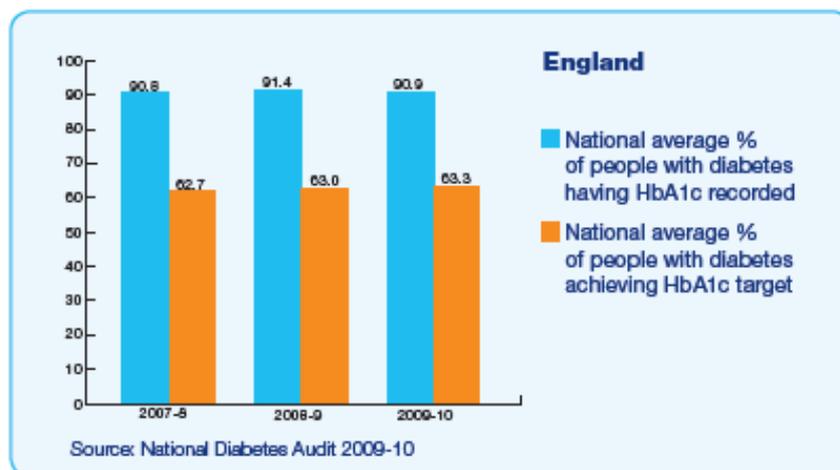


We know that on diagnosis, half of those with Type 2 diabetes already have complications<sup>5</sup>. Complications may begin five to six years before diagnosis and the actual onset of diabetes may be ten years or more before clinical diagnosis. Most are preventable with good self management together with effective support from healthcare professionals. High quality care in conjunction with effective prevention measures is therefore a necessity. Failure to act will continue to fuel patient volumes requiring additional treatment.

Intellectually the NHS knows it has a very large scale problem which needs strong integrated pathways as a solution. Practically few locations are providing that strong integrated and preventative care model.

The State of the Nation report demonstrated, as do the charts below that we are very good at developing the diagnosis based upon test results but a lot less efficacious at doing anything about those results. It is shocking that the NHS has improved its diagnostic testing for individuals with diabetes but that a significant proportion of those individuals who have their tests recorded are not helped to meet the safe level that their tests advise them to meet.

<sup>5</sup> UK PDS Group: UK Prospective Study VIII Diabetologia (1991)



We are left therefore with an overwhelming case for change which most people agree with. We have gone so far as to carry out millions of tests that prove this case. The NHS however has not found it easy to go through the pain of change that would be necessary to bring about an integrated care approach. The Bexley experience is one way of achieving this.

## 2.2 What was different about the new diabetes care in Bexley

There are three themes that run through this new service:

It is a *GP led integrated service* for diabetes and is delivered through primary care. It underlines the importance of and improves the *efficacy of enhanced self management*. This includes more investment in the delivery of primary care and self management than other services.

The different aspects of NHS service, education nurse, practice GP and secondary care led services work together because there is *an active integrator* ensuring that these very different services work together in a common pathway.

To create this new service it has been built around four major changes:

- Built strong patient involvement to ensure that care meets their needs
- Used the service specification to manage performance of all providers
- Recognised experts providing clinical leadership right across the pathway
- Continually improved the service with initiatives such as care planning

## 2.3 Built strong patient involvement to ensure that care met their needs

Beyond rhetoric, patients are at the centre of diabetes care in Bexley. Their views on the design, quality of care and experience are shaping decisions. At the core of this is the Bexley Diabetes Stakeholder Network, to which all service providers are accountable, and includes representation from the local volunteer group of Diabetes UK<sup>6</sup> and the Bexley Young Diabetics group<sup>7</sup> as well as commissioners.

Patient Champions are also represented on the Diabetes Practice Development Team which coordinates support for primary care providers and patients are involved in delivering X-PERT structured patient education<sup>8</sup>.

This core patient group has developed over a period of more than 20 years in Bexley but prior to this initiative, its day to day impact on the nature of care could be characterised by it being 'outside the system'. It felt that like to both the patients and to the providers of care. Bringing the group into the system as a part of the Network took time and effort but was essential to any transformation of the service. While the new Bexley Diabetes service was fortunate to have such a well developed local patient group, ensuring that the input from this group was brought into the centre of service design was new and required a cultural shift for the system.

This essential activity requires adequate resourcing in just the same way as any other key driver of success. Most patients will not, of their own accord, involve themselves in their care or in creation of their service. Far from being a novelty, patients are integral to ensuring service providers and commissioners are aware of and appreciate the impact of their decisions.

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<sup>6</sup> [www.bexley.diabetesukgroup.org](http://www.bexley.diabetesukgroup.org)

<sup>7</sup> [www.youngdiabetic.org](http://www.youngdiabetic.org)

<sup>8</sup> <http://www.xperthealth.org.uk/>

Moreover, this new approach was led by a highly committed expert service redesign team, which itself was led by John Grumitt, himself a person with Type 1 diabetes, and which established a common goal supported by core values which were applied by the network and thus, to decision making.

While there has been so much structural change to both providers and commissioners, sustaining integrated service improvement has not been without its challenges. In common with most health care environments some providers faced greater internal pressures than others.

South London Healthcare Trust, which is currently in administration, had provided a large proportion of the specialist care for people with diabetes in Bexley. Prior to this significant change, many clinicians, over an extended period, felt intense pressure and a great degree of uncertainty. Both these factors contributed to a delay in establishing new community based services.

Likewise, the implementation of new commissioning structures together with increasingly tight resources also contributed to delays and at times represented a distraction to establishing new integrated care processes to deliver high quality patient centred care.

At such a time, the continued development and importance of this network provided an ongoing dialogue with all providers across the pathway, and commissioners, from their patients. However, consistent focus towards publically declared goals supported by evidence gathered to measure impact helped re-enforce the approach. Nevertheless these pressures do remain and, without doubt, the network and proven value generated by the work done to date, has strengthened the service during times of such uncertainty and change in the environment in which the service operates.

While the involvement of patients in the development of the service is very important, it is the patient's involvement in their own care that is transformational. In 2010/11, the number of people with diabetes receiving structured education increased ten-fold, making courses available to well over 1,000 patients. This exceptional volume is still being maintained in its third a year of operation. Critically, nearly half the people providing the training are patients or carers, with the remainder being healthcare professionals.

Ensuring such large numbers of people took up this opportunity required detailed planning. This is managed by Suzanne Lucas who is nationally recognised in the education field who ensured that the patient centric approach was preserved throughout.

Again the development of this programme of diabetes education required resources in the same way that all the other aspects of care do. The national education programme X-PERT is offered six days a week: in the morning, afternoon and evening and in eight different venues. This variety of times and venues has ensured a much greater take up. If a patient felt that a six week course was too onerous, they were offered a one week taster programme to introduce them to the idea. 80% of those then took the rest of the programme. Organising such educational courses around the lives of the patient has proven crucial to an improved take up.

Such an investment in education and learning can take some time to have an impact through the return of improved self management. Bexley has already seen an improvement in control and wellbeing as well as a reduction in individuals' risk profiles. On average, after 6 months patients have achieved a 16.2% reduction in HbA1c (from 8.5 to 7.1) and have almost entirely sustained the

improvement over a 12 month period. This reduction compares to 3% nationally and has been achieved alongside simultaneous falls in both cholesterol and weight. The service was recognised in 2012 as having achieved the greatest reduction in HbA1c in the country for the last two years.

### **Seldom heard groups with Diabetes in Bexley**

Standard 1 of the diabetes National Service Framework is primarily concerned with raising awareness and providing specific targeted support for people at risk of developing the disease.

Within the locality of Bexley there is a five year difference in life expectancy between the most and least deprived wards. Studies have shown that:

- The most deprived are 2.5 times more likely to have diabetes
- Those of South Asian origin are 6 times more likely
- African and Afro Caribbean people are 3 times more likely to have the disease and have more complications on diagnosis too

The rise in childhood obesity is leading to unprecedented and rapidly increasing numbers of young people with Type 2 diabetes<sup>9</sup>.

Working together with specialist advisors from Diabetes UK, Bexley Diabetes initiated, a “Diabetes Champions Project” which identified relevant Key Opinion Leaders to champion diabetes in their communities. Through this, key “champions” were chosen and developed to spread the message of diabetes within their communities. This gives people from hard to reach groups training and support to connect effectively with their communities and convey the key messages on the risks of diabetes, promoting access to care and relaying the essential components of diabetes care. In so doing it, placed the service in front of many thousands of people from Black and Minority Ethnic communities through their places of worship and other community organisations. Diabetes Champions, as local community experts continue provide such leadership.

One example of success in working with hard to reach groups was shown by Lakeside, a practice in Thamesmead, the centre of Bexley’s area of highest deprivation, being awarded the 2011 Diabetes Team of the Year in the Quality in Care awards.

### **Effective internal and external communications were essential**

In developing a service which is genuinely integrated it is important that all stakeholders communicate well with each other:

- The web site [www.diabetesbexley.org.uk](http://www.diabetesbexley.org.uk) has become a central point of reference
- The monthly diabetes network meeting where all stakeholders participate offered a reliable forum for views, evidence to be reviewed and plans to be developed and agreed upon
- A quarterly newsletter was created and distributed to all practices and other key stakeholders to relay key messages, celebrating success as well as driving focus on areas where continued improvement was required

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<sup>9</sup> <http://www.diabetes.org.uk/Documents/Reports/Diabetes-in-the-UK-2012.pdf> p.7

- The patient group produced a newsletter which is distributed to over 800 people. Their monthly meetings can attract as many as 200 people
- Effort was made to ensure relevant patient information is displayed at relevant points in the community including places where care is delivered such as GP practices, pharmacies and public libraries and places of worship
- The diabetes redesign team published a monthly report to internal commissioning stakeholders highlighting what had been delivered, highlighting any new challenges and objectives for the following month
- Timely reporting was provided to the CCG board and its sub committees. A detailed integrated service specification was developed some time ago and received widespread recognition when put out for consultation and benchmarking across the country. It formed the basis for the service narrative and performance metrics

While all of these channels of communication may take some resource to develop and deliver, without them it is neither possible to really involve patients or to create integrated care.

## **2.4 Used the service specification to manage performance of all providers**

The service specification was approved originally when the Care Trust was running commissioning by the PEC and has been more recently approved by the Clinical Cabinet of the shadow GP led commissioning group. It embodied the key principles underlying the Healthcare For London: Guide for Diabetes which is as relevant today as it was when it was published in March 2009. After considerable dialogue, particularly with secondary care clinicians, these were approved by each provider.

The key issue for the secondary care provider was the development of the new form of oversight of the secondary care providers by the local specialist tertiary service. Less than six miles from the sites operated by South London Healthcare Trust there were several internationally recognised specialists in the field of diabetes based at King's College Hospital. To achieve excellence, their input was sought to support the care delivered by the secondary care provider. For example, Professor Mike Edmonds and his team provided input to the design and management of the foot service. While this was not easy to initiate eventually the benefit was recognised by all: providers, commissioners and service users.

This is much more than a formal process both within the old Care Trust and the new CCG. The new service only becomes real if medical staff change the way in which they work with patients in a variety of different ways. Just as this needs real buy in from patients, so it also needs real buy in from all staff. Therefore, the more detailed agreement that there is from leading clinicians then the more likely it is that this change of behaviour will take place.

The evaluation of performance with strong quality assurance continued to be provided by the Diabetes Practice Development Team. This team was responsible for the collation and supporting the interpretation of data extracted from practice systems, referral patterns, national audits, including the National Diabetes Audit and Diabetes E as well as patient surveys. The team provided a comprehensive report for the practice to consider as they developed their Annual Diabetes Action Plan together with the support of the team and the named Diabetes Specialist Nurse (DSN) in particular. The Diabetes Practice Development Team, led by Diabetes Specialist Nurse Anne

Goodchild, was central in raising standards of care provided by GP teams. Rather than a one size fits all approach they tailored the support provided according to need. We outline the role of the practice audit in section 2.6 below.

The service started in 2010/11 with a Locally Enhanced Service agreement (LES) which offered an important motivator for change. Since then, the LES has been substantially modified incorporating learning to ensure that it is both simple and effective. Modifications in 2011/12 changed the overall incentive scheme to include a basic benchmark which had to be exceeded for any payments to be made.

Tier 3 services where specialist care is provided outwith the hospital setting included a number of efficient and valued elements of care. Among these were virtual clinics, where individual cases were discussed by diabetes specialists together with the practice team with the on-going patient relationship remaining with the practice team. These were initially piloted with a locum consultant diabetologist who had just completed a period providing interim cover at the local hospital. This pilot provided important information critical to establishing an effective service. GP teams greatly valued these clinics and after the pilot, they were extended to be run by DSNs. As a result, referrals fell and outcomes improved.

Coordinated working also facilitated the ongoing transfer of care for a large number of patients from the hospital back to the community. As well as detailed examination of the patient's needs, added confidence of the capability of the practice team helped ensure that this process was reliable and standards were not only maintained but outcomes, including patient satisfaction and clinical measurement, improved.

## **2.5 Recognised experts providing clinical leadership right across the pathway**

### **Diabetes (Non Emergency) Accurate Referral and Triage Process (DART)**

To manage the allocation of resources between settings the service has developed a closed loop triage service. DART was developed by the diabetes team who worked with a local GP to make the form available electronically to the majority of the local practices.

As discussed above, the patient-led Bexley diabetes network met regularly ensuring that all providers and patients were represented when performance issues and service developments were discussed and agreed. While all services face considerable economic pressure, the stakeholder network had established core values which included that care would be delivered in the most clinically appropriate and economically efficient setting. True to this, we were not willing to transfer patients without confidence that care standards would be preserved or enhanced. DART was the referral vehicle that ensured this would happen.

There is no doubt that transferring care to a community setting can be a traumatic process for many involved (patients as well as clinicians). Great effort was made in the communication to all those involved in the process to ensure that the service continued to improve.

Annual audits demonstrated that the outcomes achieved by patients consistently improved year on year, are still the best in London and amongst the best in the country.

Each practice had a named Diabetes specialist Nurse supporting them, in line with proven best practice. Goals of this project were to improve: prescribing, management of complex cases and development of practice teams.

In terms of GP practice the outcomes of this process of incremental year on year audit and improvement were impressive. The 2011 QOF figures placed Bexley GP activity as the best in London and the ninth best in England. As yet unpublished figures for 2012 show evidence of further considerable improvement in outcomes.

### **eHealth, IT and diabetes registers**

Initially the service thought it would implement an integrated IT solution from Prowellness that has been used in Westminster and is being introduced in Hammersmith. At the time we recognised the high risk associated with such a large IT project, as well as the considerable investment suggested and the lack of expertise available locally.

Having investigated further, the service developed a more pragmatic and lower risk approach by building on the systems that were already there. Much time has been invested and value obtained from developing practice templates. For example, all practice referrals are now communicated using a template embedded in the DART process that ensures consistent data is provided and the pathway is followed. Likewise, care planning templates were developed to guide Health Care Practitioners through the new way of working towards jointly agreed care plans. The use of templates proved to be popular with clinicians in both primary and secondary care. Nevertheless, integrated IT remains of keen interest but demonstrable evidence of return on investment of schemes adopted elsewhere has remained elusive, despite the clear potential benefits of such an approach. Furthermore, resource constraints have meant that investment in such projects has been hard to come by.

On behalf of the National Year of Care project the Bexley service developed the Vision VE form for automatic reporting and information sharing to support care planning. A solution for the EMIS practices and the one iSoft practice was also developed. This gave the service the opportunity to continually monitor the quality of care in Bexley and further focus support and interventions to specific high risk patients, thereby making best use of resources and improving diabetes care.

### **Tier 2 provision**

Bexley's Diabetes service specification follows the Healthcare for London model's four tiered approach to service provision for people with diabetes<sup>10</sup>. General practice teams are expected to meet the minimum standard of service provision defined within Tier 1. By providing both formal training and in-house clinical support and facilitation many Practices now provide Tier 2 services or are working towards becoming a Tier 2 practice.

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<sup>10</sup> <http://www.londonprogrammes.nhs.uk/wp-content/uploads/2011/03/Diabetes-Guide.pdf>

## What is a Tier 2 practice?

Providing enhanced diabetes care within the practice

In addition to all Tier 1 requirements, Tier 2 practices must have:

- GP and nurse completed certification from an accredited insulin initiation course
- Strong treatment escalation competencies e.g. for people with Type 2 diabetes: initiation of insulin; insulin titration and regimen changes; initiation of GLP-1 Receptor Agonists

Key Outcome Measures - All Tier 1 measures plus:

- Nos managed in practice, showing a reduction in HbA1c of 1% after 6 months on insulin
- Nos achieving a weight loss of 3% and a reduction in HbA1c of 1%, in 6 months on GLP-1 Receptor Agonists

### Outcomes submitted during 2011/12

<b>Total number of insulin conversions</b>	<b>45</b>	<b>£10,600</b>
Number achieving 1% reduction in HbA1c	27	£7,000
Number not achieving 1% reduction in HbA1c	18	£3,600
Cost of referring to Specialist Centers for insulin conversion (Based on 1 new and 5 F/U appointments)		<b>£33,120</b>
<b>Cost saving</b>		<b>£22,520</b>
Mean HbA1c reduction achieved		1.4%
Mean weight gain		1.8kg
<b>Total number of GLP-1 Receptor Agonist</b>	<b>34</b>	<b>£4,650</b>
Number achieving 1% reduction in HbA1c	25	£3,750
Number not achieving 1% reduction in HbA1c (One stopped due to side effects)	9	£900
Referral to specialist centre for GLP-1 Receptor Agonist conversion (Based on 1 new and 2 F/U appointments)		£15,096
<b>Cost saving</b>		<b>£10,446</b>
Mean HbA1c reduction		1.3%
Mean weight loss	5kg (excluding 1 patient - lost 50kg)	

Converting patients with type 2 diabetes onto insulin and GLP-1 receptor analogues in Bexley GP practices by competent practice teams has been shown to be both clinically and cost effective. Ten of the eleven registered Tier 2 practices submitted claims during 2011/12.

Bexley plan to continue to work with Practices to develop their competencies for Tier 2 status. An update training day is planned for September 2012 and community DSNs are currently supporting Practitioners to gain their accreditation after completing injectables training. This may lead to a further five practices gaining Tier 2 status.

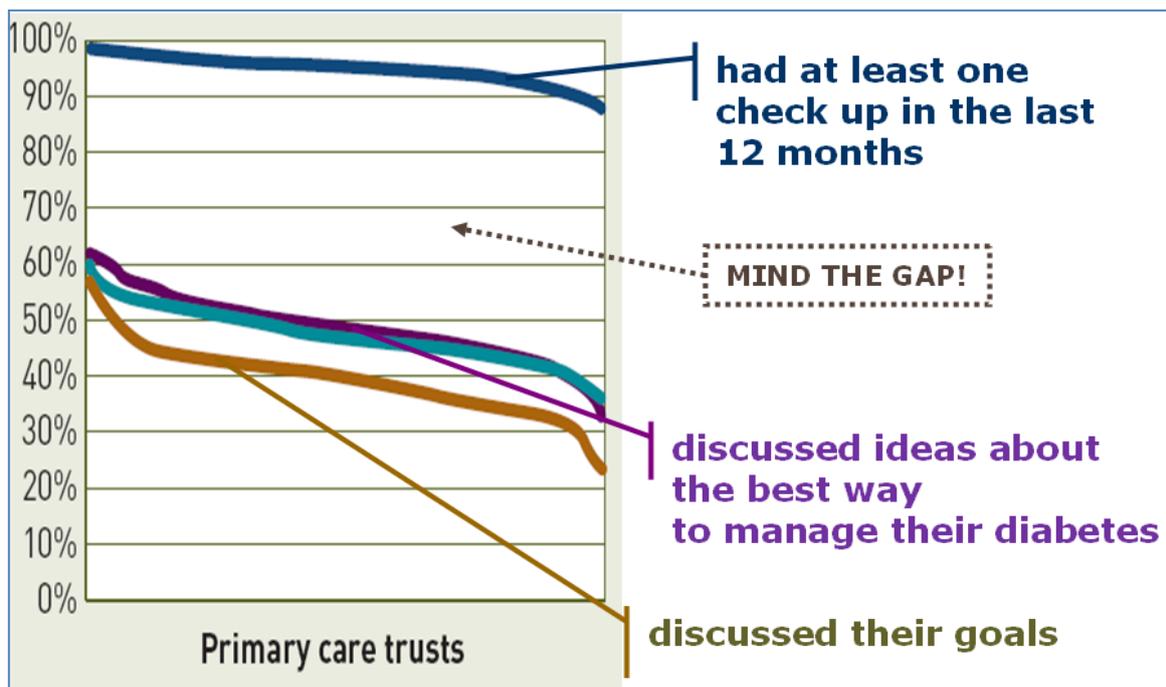
The need to encourage practitioners to prescribe in line with local and national guidelines is a key priority. By altering the claims process and endorse payment in line with the local guidelines will improve prescribing practice. Practitioners will have to justify if alternative insulins are used using local and NICE criteria.

## 2.6 Continually improved the service with initiatives such as care planning and the practice audit

### Care Planning

On average, each year a person with diabetes spends 8,757 hours managing their own long term condition and three hours with a Health Care Professional. If we are to transform the diabetes care for patients we need to fully recognise that the 8,757 hours are nearly 3,000 times more significant than the three hours. The opportunity remains to use this time more effectively. For example, while almost all patients have an annual review, evidence from the Healthcare Commission has shown that only half have discussed ideas about the way to best manage their diabetes or established a jointly agreed plan to manage their condition. This means that for half of the patients who leave their annual check-up there is very little or no investment to create improvement in how they spend the remainder of the year looking after themselves.

The graph below illustrates how far the NHS falls short by failing to value the time and effort that the patient could put into better self management of their diabetes.



Healthcare Commission Healthcare Commission (2007) *Managing diabetes: improving services for people with diabetes* (PDF 2.28MB). London: Healthcare Commission.

Considerable investment was made by Bexley to provide training and support for healthcare professionals to embrace new ways of working and ensure that underlying processes were adapted accordingly. Perhaps the most important of these was found to be collecting and making available clinical results to patients in advance of their consultation. As well as making them available, guidance was developed to aid their interpretation thereby converting the data into valuable information.

## The use of regular practice audit and improvements that resulted from the audit.

The audit of GP practices has been very important. Every practice in Bexley is audited each year and followed up by an assessment visit from the Diabetes Practice Development team (DPDT). At the time of writing, this is the third year of the audit cycle which has shown consistent year-on-year improvements in diabetes related outcomes.



Every practice was audited and the findings used as a basis for bespoke development plan. When aggregated, these plans also provided a basis for the HCP training programme for Bexley as a whole. Critically the plans were originated by the practices themselves, supported by the Development Team, which incidentally included patient champion representation.

The data from the audits was also used in further analyses to evaluate performance right across the pathway.

This included benchmarking, assessment against targets, integrated working objectives, and use of healthcare resources compared to outcomes achieved.

## The audits going forward

The team plan to continue to use the audit cycle format and monitor performance and the satisfaction of practice teams and service users. QIPP work streams will continue to encourage particular projects

- The named diabetes nurse initiative will focus on further improvement on medicine management issues
- Whilst work was started on developing foot protection initiatives and a secondary care multi-disciplinary foot team, this has yet to be completed
- A care pathway around diabetes prevention for people with impaired glucose regulation using registers held by practices has yet to be development and implemented

By involving all stakeholders and developing specific pathways around patients needs we will end up with a truly integrated model.

## 3 Outcomes

### Known outcomes from the audit

The regularity of the audit and the improvement follow up has had an impact.

- Understanding of every practice and their level of ability to deliver diabetes care
- Diabetes is now a priority within practices
- Completion of local treatment guidelines and a Bexley medicines formulary for diabetes
- Achieving a consistent message to patients through educating practice teams and providing patient literature,
- Best diabetes control in London (taken from QOF 2010/11) with further improvements shown in 2011/12 but comparatives for that period as yet unavailable.
- Lowest rate of hypoglycaemia admissions to hospital in London (taken from HES data 2010/11)
- High patient satisfaction in their practice diabetic team (Annual patient surveys)
- Diabetes has become the focus for introducing care planning to long term conditions
- High referral rates to X-PERT structured education programme continue to be sustained and continuing to receive 30-40 referrals a week
- An effective financial model using expensive Consultant time effectively
- Tackling four of the QIPP work streams

### The service has delivered a step change in improved care for people with diabetes in Bexley

Over 40% of people who had received their routine care in the acute hospital now do so at their GP practice.

Over 1,000 people a year have engaged with the X-PERT structured patient education programme. The impact after six months of completing the course shows a substantial improvement in health:

- 16.2% reduction in HbA1c (the 3 month average blood glucose level), the highest in the country, which also significantly reduces the risk of diabetes complications; and
- 15.5% reduction in cholesterol
- 1.4% reduction in weight

The service has substantially improved the level of diabetes awareness among healthcare professionals. 100 people have attended the foundation course, 75 attended Merit (complex type 2 diabetes) and 49 attended Warwick (insulin initiation). Previously, insulin regimes were only initiated in a hospital setting. Now, 5 practices are already starting patients and 3 of these are accepting referrals from other practices. 6 practices more will join in September.

The service is diagnosing over 100 new cases a month. Diabetes UK estimates that 50% of those found to have Type 2 have complications at diagnosis. Early detection significantly reduces the risk of such complications which develop during the early stages of having the condition.

The community based consultant diabetologist had attended every practice:

- Reviewing complex cases and making treatment recommendations to reduce risk of outliers
- Reviewing cases that might be transferred from the hospital to the practice
- Educating HCPs
- This service was also expanded with the support of Diabetes Specialist Nurses

Patient referrals all go electronically on a clearly defined pathway and are triaged by the community diabetes team. Together with the virtual clinics, early intervention is avoiding unnecessary referrals.

The Year of Care was launched locally in 2010. This is the process whereby the care a person receives is personalised thereby aligning it with their goals and individual needs. By so doing, provision should be more effective and care more efficiently delivered. As well as training healthcare professionals, it has required changes to both processes and established working practices. It is not for the faint hearted, but we knew it made sense.

## 4 Lessons from the case study for others

### 4.1 The integrator

This model of integration depends upon a strong individual integrator to make it work. In this case the integrator had no formal role delivering any of the medical services but was recognised by all of those delivering services as vital to the development of an integrated service.

Within this model the integrator had to achieve changes in the work of all of the service providers without the formal power of holding the contract for all the very different service providers. His role as change agent depended upon his skill to carry sufficient medical staff with him to begin to move all of the organisations to provide different services.

In Bexley the integrator clearly had the support of leading GPs through the PEC and the Clinical Cabinet but these were primarily GPs as providers of healthcare. The Care Trust agreed with leading GPs that this was the correct method of diabetes care delivery but did not channel all of the services contracts through the integrator.

In other organisational formulations it would be useful to ensure that the integrator has greater formal contractual power.

An important influencing power, amongst other leadership aspects that the integrator possessed was the fact he chaired the stakeholder network and developed the patient group. The time invested in developing patient input ensured that the most was made of their valuable contribution, something that was central to service design and delivery.

The team regularly returned to the patient group meetings to keep them informed of developments and obtain feedback. They were honest at all times about success, challenges and opportunities to do better. They produced and published a lot more data than was usual in such a process and this gained credibility with the public and clinicians. This has been published at the 2012 Diabetes UK Professional Conference and in professional journals.

### 4.2 The need for an early success

In order to gain momentum the initiative needed to demonstrate that it was taking meaningful action. Recognising the strong pent up demand for structured patient education from patients and GPs, the team ensured this was addressed as a priority. The response surpassed everyone's expectations. Careful, detailed planning together with focused attention to meeting the needs of patients and trainers paid off. A commitment to gather evidence meant that the project could also demonstrate the impact of its actions.

An early success in any turnaround gives you credibility, allowing you to demonstrate that you practice what you preach (and thus re-enforces the messages in favour of change).

### **4.3 Patients and the role of the diabetes network**

The diabetes patient group in Bexley has a long history. They had been engaged in channel specific and pathway complaints to the service providers and commissioners.

The role of the integrator recognised the potential influence and value that the patient group offered and sought to engage with them via the network and thus all elements of service design and performance evaluation. This needed a strong cultural change to the nature and content of the diabetes network meeting. Over several months the purpose and rules for the conduct of these meetings were re-enforced so that all attendees (providers, commissioners and service users) came to recognise the relevance and importance of what others said.

Changing behaviour this way needed a lot of iterations. It did not simply happen in the first, second or even the third meeting.

As a consequence attendance at the meeting was recognised as essential by patients, clinicians and commissioners.

The patient group strengthened too. The main group grew to over 800 strong. A second group was created in the north of the borough where deprivation levels are higher and health outcomes poorer to focus on the needs of the local community. A youth group was also established.

### **4.4 GP champions who saw their role as developing their colleagues**

People with long term conditions come into contact with healthcare providers in a variety of settings. For the most part, care is delivered in a community setting and the majority of that, via the GP team. If care is to be centred on the service user and to be efficiently delivered, all healthcare professionals must commit to an integrated approach.

This means that the GP is both the subject and the object of much the changes in the practice and policy. They need to actively work with the patient to construct a new pathway but to achieve that they also need to quite radically change the way in which they practice themselves.

This dual role as a major change agent and as a part of the required changes means that it is essential that there are a number of GP champions who will not just change their own practice because they believe in it, but will work with their colleagues as peers to support the change process, not least, leading by example. Mentorship became a key tool by which new ways of working were established.

Overall the GP practices in Bexley changed in a series of waves – over a period of more than a year. In some cases early adopters were incentivised to create initial momentum.

## **4.5 Health Care professionals who recognised the need to create a new service**

This new service has a strong centre, the diabetes team which meets weekly and has practicing diabetes healthcare professionals at its core. Armed with their technical expertise, supported by evidence of success locally and beyond Bexley, they became a persuasive force bringing about significant change. This degree of change in practice can only be achieved through medical leadership. Clinical leadership can only work if the individual professional who is changing their practice gives allegiance and credibility to that leadership. Clinical leadership does not start or finish with a specialist consultant, but rather extends to all healthcare professionals working right across the diabetes pathway.

Without it very little change in the health service actually happens.

This group not only provided that leadership but recognised that the new service was aimed at developing the behaviour of thousands of patients and well over a hundred healthcare professionals. This can only happen if there is a form of change and intervention which recognises that change must take place within this distributed system not just within the core of the service.

A clearly articulated goal supported by well understood principles or values, provides the basis for decision making and communication.

Changing distributed systems needs behaviour change in the distributed places where practice actually happens and not just at the centre. But it also needs a centre to understand and tweak the way in which those changes are happening.

## **4.6 Developed patient self-management as key**

This new service will create more value because it is aimed at investing more NHS resource in working with the patient to increase the efficacy of their self-management. Patients with diabetes self manage themselves for over 8000 hours a year. They either self manage well or they self manage badly, but they self manage.

The nature of care planning if carried out in the way in which it does in this service increases the efficacy of that self management as a major object of policy. If the care planning is carried out by the healthcare professional and delivered to the patient very little change happens for the rest of the patient's self management. If healthcare professionals recognise that the care planning has to take place in a relationship with the patient, and the patient feels involved then there is a significant increase in the efficacy of self management.

The X-PERT<sup>11</sup> courses for Type 2 diabetes and the DAFNE<sup>12</sup> course for Type 1 have all been developed not just by professional medical staff but by professional educators to ensure that the patients can use a curricular and knowledge that will give them more power over their experience of the condition.

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<sup>11</sup> <http://www.xperthealth.org.uk/>

<sup>12</sup> <http://www.dafne.uk.com/>

## **4.7 GPs as commissioners who recognised that the present service failed**

The initial service was commissioned as a result of GPs in Bexley PEC recognising that the current service was not working. Whilst this was not a pure commissioning by GPs as will happen in the future with GP led commissioning, there was an important direct line between some leading GPs recognising that the service was not working and their relationship with a commissioning organisation that they felt should develop a new service.

For the future this is an important aspect for the development of new services. If GPs can directly experience the failure of the old, then there is a very direct and powerful case for change that can be made from that experience to the core of commissioning new services.

To move to outcome based commissions will need new and better commissioning tools such as contracts than those that commissioners have to hand at the moment.

## **4.8 Capacity to move the secondary provider with clinical leadership from the tertiary provider**

The secondary provider is a key part of the process of change and also of the delivery of the pathway. It is vital that they recognise both the case for change and the necessity to deliver something very different.

This is not always an easy process of change.

It was very useful to develop good relationships with the tertiary provider of care since that provided what was a GP led change with specialist authenticity.

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