DIABETES UK
CARE. CONNECT. CAMPAIGN.

SERVICE REDESIGN

CASE STUDY 1: NOVEMBER 2014

Networking for success: A 'burning platform' in Berkshire West

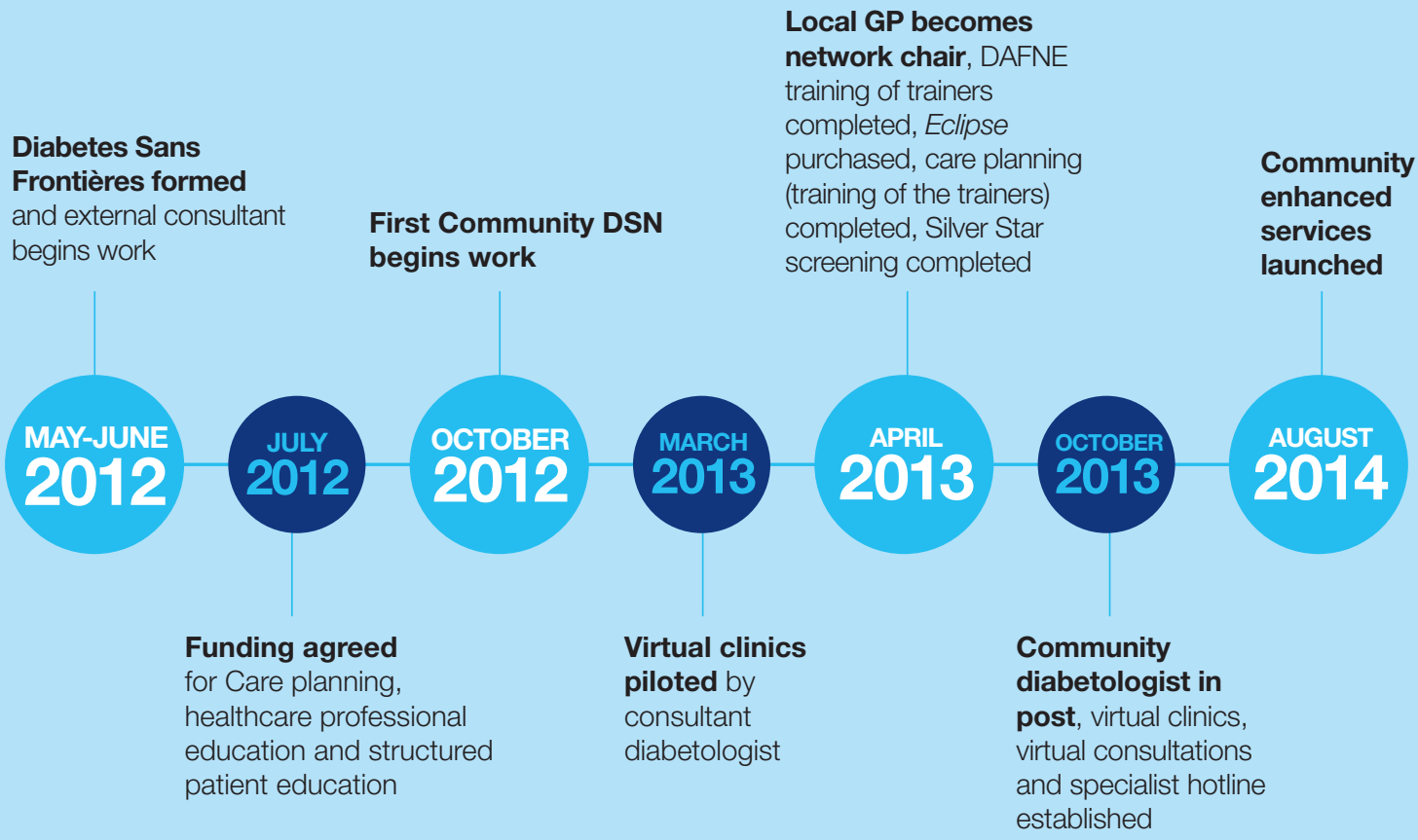
SUMMARY

In 2012, four federated CCGs set up a network to redesign diabetes services in Berkshire West. The 'burning platform' that led to change was the existing service, which was expensive and delivered poor outcomes with only 46.8% of people achieving an HbA1c of below 60mmol/mol in comparison with 56.8% nationally.

An effective and fully representative stakeholder network was established with clear terms of reference that worked across organisational boundaries. Care planning, structured patient education and healthcare professional education were prioritised, as was real time data collection. Effective local clinical leadership forms an integral part of the ongoing project success. Diabetes specialist nurses provide a community service and a diabetes consultant has been appointed to work between the community and the acute trust.[1]

Early data shows improved clinical outcome measures with a significant increase in the proportion of people meeting HbA1c, blood pressure and cholesterol targets. Prescribing savings of around £800,000 have also been achieved.[1]

Timeline



The case for change

Berkshire West comprises Reading, Wokingham and Newbury and District CCGs (a population of approximately 500,000). In 2012, the local diabetes performance measures were below national average[2] despite a relatively high financial expenditure.[3] A local doctor was key in raising awareness of the problem. Services were limited with little structured patient education and no access to an intermediate community diabetes service. This, coupled with the poor QOF and NDA performance provided the 'call to arms',[1] and the agreement was made to urgently prioritise improving diabetes care.

[1]Annual Report 2013 Diabetes Sans Frontières! http://bit.ly/1vMypV5
[2]Health and Social Care Information Centre. National Diabetes Audit (2011-2012). 2013.
[3]National Cardiovascular Intelligence Network: Public Health England diabetes outcomes versus expenditure tool for CCGs (2011-2012) http://www.yhpho.org.uk/default.aspx?RID=88739

Lessons learned[4,5]

1. **Identify the 'burning platform.'** Highlight a problem looking for a solution that is relevant to all stakeholders and that requires urgent intervention. This can provide some of the necessary momentum to generate true investment in a service redesign. Framing the problem and the solution in a way that engages all stakeholders is essential in developing focus and commitment towards a common goal.
2. **Use 'quick wins.'** The agreement from the hospital to train diabetes specialist nurses, thereby providing key members of a community diabetes team and reducing recruitment difficulties, was a quick win that provided early project momentum and support. This decision was made possible by the attendees at the first stakeholder network meeting - the solution was 'in the room.'
3. **Enable local leaders.** Multiple stakeholders described the importance of ongoing local project leadership. An external consultant with experience of successful diabetes service redesigns was employed at the beginning of the project (from July 2012 to April 2013) to lead, empower and mentor local clinical leaders. Project sustainability and success depended on leadership of the network by a local GP who was commissioned by the CCGs to undertake this role and had worked with the external consultant from the beginning. Sponsorship, support and the provision of enough time to do the job properly have been key to his ongoing success.
4. **Invest in real time data collection.** Data collection and monitoring can be used to assess impact and guide further interventions. West Berkshire commissioned the *Eclipse* tool, which enables practice performance monitoring and central data collection as well as closed loop referrals. (In practice, this means that a paper free message or referral can be sent to other healthcare professionals who use ***Eclipse***). Patient information is anonymised and reviewed centrally and at practice level. Algorithms are available for risk stratification. Regularly publishing results also helps generate interest and demonstrates project success.

[4]Annual Report 2013 Diabetes Sans Frontières! http://bit.ly/1vMypV5
[5]Developed following discussions with Richard Croft (Berkshire West Stakeholder Network Chair) and John Grumitt (external consultant).

The model of care

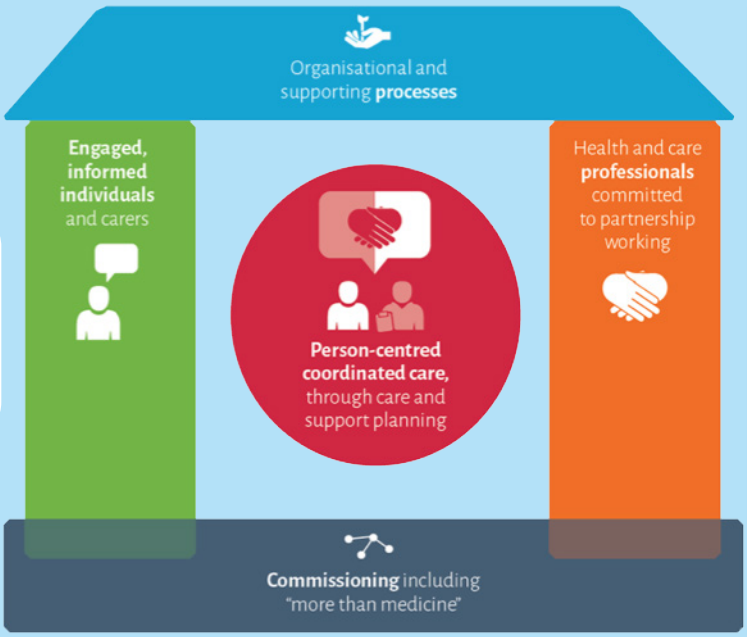
Local networks with multidisciplinary, service user and commissioning representation play a role in developing commitment to partnership working.[6] Diabetes Sans Frontières (DSF) is a network led by a local GP that operates across organisational boundaries including the acute trust, CCGs and the community trust.

A growing body of literature supports the importance of healthcare systems that promote patient-centred, coordinated care.[7] Structured patient education, care planning, healthcare professional education and clinicians commissioned to work across traditional boundaries have all been shown to be valuable components of this model.[8] The Berkshire West service follows key national recommendations from NICE as well as aligning with The House of Care.

Figure 1. Members of DSF: Network chair and local GP, diabetes consultant, care planning lead, local diabetes leads, consultant vascular surgeon, podiatrist, IT support manager, service user, dietician, diabetes specialist nurses, medicines management team, practice nurse.

COMPONENTS OF THE HOUSE OF CARE IN BERKSHIRE WEST:[9]

Metrics and monitoring and *Eclipse* stakeholder network



Care planning, structured patient education (DAFNE, X-PERT, carb awareness course, Talking Health Website)

- Healthcare professional education
- Eye screening
- Dietetics
- Podiatry
- Medicines management
- Community pharmacy
- Virtual clinics
- Diabetes specialist nurses
- Consultant community diabetologist
- Website
- Newsletter
- Link to secondary care

Commissioning and sponsorship of programme elements

Figure 2. The House of Care Framework, Coalition for Collaborative Care

[6]National Diabetes Support Team. Beyond Boundaries: A Guide to Diabetes Networks. (2006).
[7]The King's Fund. Delivering better services for people with long term conditions: Building the house of care. (2013). http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf
[8]Diabetes UK. Improving the delivery of adult services through integration. (2014). http://www.diabetes.org.uk/integrated-diabetes-care
[9]NHS England. Building the House of Care. http://www.england.nhs.uk/house-of-care/

Commissioning and sponsorship of programme elements

Federated (CCGs): The four Federated CCGs involved in the service redesign do not share finances and each remains a responsible statutory body, but the federated model enables services to be jointly commissioned. This offers increased efficiency and influence with large providers as well as the potential for risk sharing.

Organisational and supporting processes

Stakeholder network: The network meetings are positive, providing a forum to identify problems and explore ideas for improvement. There is a sense of enthusiasm and trust amongst members. They always have service user representation. The network receives no direct funding. Individual members are funded individually by their respective bodies.

Metrics and monitoring: *Eclipse* allows regular practice level data interrogation. Monthly performance reports can be generated. In addition, a 'patient passport' enables service users to access their results online, a key component of person-centred care. The passport is currently being piloted in several practices. Real time data is anonymised and can be reviewed centrally across Berkshire West, thereby facilitating trend analysis, central audit and medicines optimisation.[10]

Person-centred care

Care planning: To date, healthcare professionals from 53 out 54 GP practices have attended care planning training. 70% of practices now send results to patients in advance of their annual reviews. An internal audit into the effectiveness of local implementation is underway.[11]

FOCUS POINT

Care planning, lessons from DSF

Integral to the House of Care model, effective care planning is described as "an ongoing process of two-way communication, negotiation and joint decision-making in which both the person… and the health care professionals make an equal contribution to the consultation.[12]" In practice, this requires a long term paradigm shift for both professionals and service users as well as practical administrative support.

Key local enablers[13]

A well-attended GP event at the beginning of the project provided a forum for a motivational presentation.

Impassioned local champions – a local practice nurse had independently been incorporating some of the aspects of care planning into consultations and was achieving positive results. Her experience of local implementation was invaluable. In addition, the GP chair of DSF maintains a strong lead over the whole programme of activities and enables integration and momentum to continue.

Local financial incentives are provided for healthcare professionals to attend training sessions.

Key local challenges

Initial training demand was higher than expected resulting in a delay in some practices attending training.

There is no integrated electronic care plan between primary and secondary care. This is a common problem due to data sharing issues.

[10]Berkshire West Website: So What's Eclipse For? http://bit.ly/1B4IRZX
[11]Information obtained through discussions with Claire Scott, DSF Care Planning Lead
[12]Joint Department of Health and Diabetes UK Care Planning Working Group. Care Planning in Diabetes. (2006). http://bit.ly/1xEhMqc
[13]Local challenges and enablers identified through discussions with team members involved in the project.

Partnership working and clinical engagement

Communication with stakeholders: The GP chair of the stakeholder network is essential for project leadership and stakeholder communication. A regular network newsletter is produced and a website is kept up to date, ensuring that successes are celebrated and providing an accessible forum for the discussion of current issues.

Specialists working across boundaries: Berkshire Healthcare NHS Foundation Trust was engaged to provide an intermediate diabetes service. Diabetes specialist nurses work in the community to provide advice, structured patient education, healthcare professional education and care planning support. An advice line for healthcare professionals is provided on weekdays.

A diabetes consultant works between primary and secondary care. Responsibilities include regular virtual GP clinics (2-3 per week), education and support of community healthcare professionals as well as the development of treatment guidelines.[14]

Healthcare professional education: Two PITstop training sessions were commissioned for healthcare professionals delivering diabetes care in clinical practice. A local foundation training course has been developed, and two courses have been run so far. Further locally designed courses are under development.

Medicines management: An incentive scheme was introduced in 2011 to ensure prescribing of newer diabetes medications was in line with NICE guidance. An industry sponsored 'Enhanced Management of Diabetes' project supported practices to optimise the medications of people with uncontrolled diabetes. A local insulin prescribing guideline was developed to address analogue insulin prescription in people with Type 2 Diabetes. People taking GLP-1 and DPP4 medications were reviewed to ensure that necessary targets for weight loss and HbA1c reduction were being met.

In addition to this, there was a reduction in the cost of glitazone medications due to a change in patent.[15]

Engaged, informed individuals and carers

Regular structured accredited patient education: X-PERT Health and DAFNE (Dose Adjustment for Normal Eating) are currently commissioned. Industry sponsored short carbohydrate awareness courses are also available for people with Type 1 Diabetes. To date, over 1600 people with Type 2 Diabetes have been referred the X-PERT health training sessions and three DAFNE courses have been held. X-PERT sessions are held in different venues on different days in the week with plans to begin running sessions during holidays and on the weekend to improve attendance.

FOCUS POINT

Effective stakeholder networks (lessons from Berkshire West)

1. Establish a common goal such as improving outcomes for people with diabetes.
2. Build relationships with individual stakeholders from the beginning. This offers a valuable insight into individual barriers and motivations.
3. Establish clear terms of reference (including 'house rules'). Establishing, agreeing and reinforcing core values facilitates quick and effective decision making as the process develops.
4. Facilitate, support and gather relevant stakeholder expertise together to deliver and implement the improvement plans.[16]
5. Use several channels of communication to ensure stakeholders are kept up to date with outcomes as they develop. A regular newsletter and an updated website can be used effectively for this.

[14]Annual Report 2013 Diabetes Sans Frontières! http://bit.ly/1vMypV5
[15]Annual Report 2013 Diabetes Sans Frontières! http://bit.ly/1vMypV5
[16]Diabetes UK. Implementing Local Diabetes Networks. (2013).

Outcomes[17]

- **Clinical outcomes between June 2012 and June 2014**

  Mean HbA1c reduction of 5.35mmol/mol (60.49 to 55.14 mmol/mol).

  Increase in the proportion of people achieving HbA1c <60mmol/mol (46.5% to 57.6%). Increase in the proportion of people achieving total cholesterol <5mmol/l (46.3% to 79.2%).

  Increase in the proportion of people achieving a blood pressure of ≤ 140/85 (66.2% to 78.0%).

- **Initial outcomes of structured patient education**

  Initial data shows an average HbA1c reduction of 18% among X-PERT attendees (from 67.5mmol/mol before the course to 55.5mmol/mol 6 months later).

- **Financial savings**

  Prescribing savings of around £800,000 are estimated since 2012. This is due to a reversed trajectory of the cost of diabetes medications: £294 (2009/10), £301 (2010/11), £313 (2011/12), £283 (2012/13), £269 (2013/14).

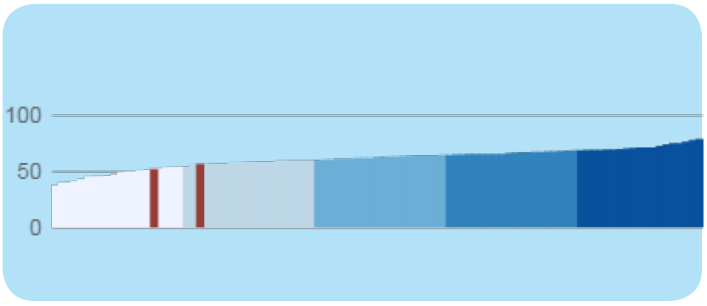


Figure 3a. Percentage of people receiving all care processes in CCGs in England in 2011-2012. CCGs in Berkshire West are highlighted in red. (Data is only available for two CCGs in 2011-2012)

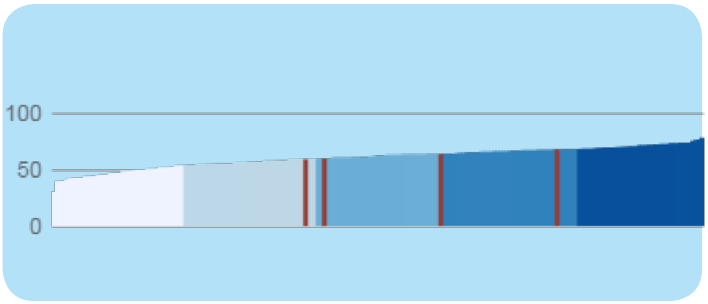


Figure 3b. Percentage of people receiving all care processes in CCGs in England in 2012-2013. CCGs in Berkshire West are highlighted in red.

Figures 3a and 3b are taken from the Diabetes UK Diabetes Watch tool and show the performance of the four CCGs in the National Diabetes Audit.[18] Although the data shows some early improvement, the full impact of the project is expected in the next audit cycle.

[17]Data obtained via network chair.
[18]Diabetes Watch tool. http://diabeteswatch.diabetes.org.uk/

Future plans

The ongoing local leadership of the project means that plans are able to evolve and continue to develop. More work is needed to further embed the changes, in particular care planning but initial outcomes data is promising. Future aims include increasing the capacity for structured patient education and healthcare professional education as well as expanding care planning sessions to include management of other long term conditions. Locally, DSF is being looked to as an example of an effective system redesign and there are plans to replicate the model for other long term conditions such as respiratory care.

Acknowledgements

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Further information

For further information please contact Diabetes UK at **sharedpractice@diabetes.org.uk**

Disclaimer

The information in this case study was obtained via interviews with DSF members as well as from the Berkshire West website, newsletters and annual report. Occasional quotes from team members have been used. The views expressed in this publication do not necessarily reflect the views of Diabetes UK.

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