West Hampshire Community Diabetes Service: re-commissioning a sustainable model of care

Kate Fayers1
MBBS, BSc, FRCP, Consultant Diabetologist

Hermione Price1
MB ChB, MRCP, DPhil, Consultant Diabetologist

Sarah Woodman1
BSc (Hons), RD, Dietitian, Service Manager

1West Hampshire Community Diabetes Service, Long Term Conditions Centre, Lyndhurst, UK

Correspondence to:
Kate Fayers, West Hampshire Community Diabetes Service, Long Term Conditions Centre, Fenwick 2, Pikes Hill, Lyndhurst SO43 7NG, UK; email: kate.fayers@southernhealth.nhs.uk

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The West Hampshire Community Diabetes Service was established in 2010. The service replaced traditional hospital-based specialist clinics and relocated care in a community setting – GP surgeries and community hospitals. The service has received a number of national awards for its innovation and leadership.1,2 In 2015, the service was re-commissioned and remains one of the few services to undergo a complete commissioning cycle and successfully re-emerge.

This article outlines the broad economic, cultural and quality drivers that led to the changes that were made in West Hampshire (the 'WHY'), identifies the vital (often overlooked) link between leading change and developing new models of care (the ‘HOW’) and, finally, describes our service model and an evidence-based approach to service redesign (the ‘WHAT’).

This paper was originally presented at the 2016 Diabetes UK Annual Professional Conference as the Mary MacKinnon lecture. Mary sadly passed away in 2013 and the primary author is indebted to Ewen MacKinnon, Mary’s husband, for his encouragement – particularly, Ewen’s suggestion that Mary would have wanted the presenter to ‘Be bold’!

Change is required: the WHY

Traditional hospital-based models of diabetes care have changed little since the inception of the NHS. There can be no doubt that housing specialist expertise under one roof leads to productive relationships with differing medical specialities, trainees and multidisciplinary staff. That this, in turn, leads to a robust culture of intellectual challenge, research and education is also worthy of recognition.

Diabetes and endocrinology have been co-associated for many years and it is interesting to reflect that the ratio of the caseloads of these two specialties must have changed dramatically. Numbers of type 2 diabetes patients have risen considerably in response to the global obesity epidemic, and at the same time there is a trend towards diagnosis of type 2 diabetes at a much earlier age. Diabetes, both types 1 and 2, are now long-term conditions that have a significant and lasting impact over a person’s lifetime – and we are living longer than ever before.

There are three fundamental drivers – economic, cultural and quality drivers – which make a change in the way we deliver diabetes services both inevitable and long overdue.

Economic drivers

In 2002, the Wanless review3 outlined the likely need for investment in the NHS to the year 2022 and demonstrated that, even with a fully-engaged, hi-tech system, funding requirements were set to escalate dramatically (in the context of a multi-comorbid and ageing society). After the economic downturn in 2008, the King’s Fund projected the likely funding gap to 2017.4 That these graphs appear to take a nose dive is no trick of the eye. The very real (and growing) funding crisis affecting NHS provider organisations is testament to the current challenges we are experiencing and are likely to experience for some time. We need to find a way to deliver more for less.

Cultural drivers

While society in 2016 bears little resemblance to the society of the 1940s, the NHS has been slow to adapt to the pace of change. Health care professionals engaging in social media are still seen as entrepreneurs rather than the norm.5 Care planning (i.e. placing a patient’s goals at the heart of their health care) is patchy and often seen as time consuming.6 Psychological support for people with a life-long and life-changing medical condition such as diabetes is frequently seen as an unnecessary extravagance.7

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Quality drivers: a toxic triad of stagnation, variation and complication

All NHS data sources point to rising complications in the face of stagnating outcome measures and often inexplicable variation between individual localities.8,9 Our knowledge of the complexity of the underlying health system that generates these outcomes is often poor or piecemeal. There is no current mechanism for mapping differences in expertise, investment and staffing levels between providers, without which it is difficult to draw conclusions and compare best practice.

Making it happen: the HOW

As a community service, we have faced a number of challenges around service redesign. Initially, in 2010 the service was tendered for five years (including two optional one-year extensions awarded at the discretion of commissioners). In 2015, we set about meeting the challenge of re-commissioning the community service in West Hampshire.

The commissioning process is complex and sometimes slow, as different commissioning priorities compete for attention from the CSU (Commissioning Support Unit). Under the 2012 reforms and AQP (Any Qualified Provider), these bids are competitive and open to the wider market. Most NHS front-line staff who contribute to bid writing have not had formal training and may have little knowledge of the process. However, in our experience, this clinical expertise is a vital component of a coherent bid.

During the tender period, in order to ensure fairness to all parties, formal channels of communication are provided. These record and respond to questions from potential providers which are anonymised. Neighbouring providers therefore become possible competition, which seems contrary to the creation of seamless care that patients desire and from which they benefit. We estimated that approximately 100 hours of consultant time and 100 hours of clinical manager time went into the development of our bid over the six-month period to January 2015. Our vision for a re-tendered service came in no small part from the energy and support of the wider clinical team, who also juggled these demands with their business as usual.

After successfully obtaining a new five-year contract, commencing April 2015, we reflected on why we had been successful when other, national well-recognised services have not managed to cross the hurdle of re-commissioning.

Perhaps unsurprisingly, letting go of old systems and replacing them with new ways of working has been likened to the stages of the grief model initially proposed by Kübler-Ross.11 Many of us can recognise our own shock, denial, anger, depression, acceptance and final integration when faced with imposed change. The adoption of an innovation curve has been likened to a normal curve with outliers both front and back (innovators and laggards respectively)!

Nationally, we might reflect that service improvement in diabetes (or any medical specialty) seems to be personality dependent and that these personalities demonstrate vision, communication and influence. Such skills are vital in supporting teams to move through the stages of change and encouraging the adoption of new ideas. These skills are not rigid and are present to some degree in all of us. They directly affect our ability to lead. Leadership can be learnt.

Our service has been fortunate to have access to an award-winning, trust-wide programme of leadership development.12 Our senior team leaders (diabetes specialist nurses, consultants and a dietitian) were each given access to an eight-day leadership programme. By identifying four underlying themes – Working together; Integration; Innovation; and Releasing ambition – we are able to change behaviour and develop a culture that embraces service improvement.

“However beautiful the strategy, you should occasionally look at the results”  
Winston Churchill

“Culture eats strategy for breakfast”  
Peter Drucker

Working together as a team and gaining a sense of self-awareness and the relative strengths of other team members meant that we were able to work cohesively as a team during the bid process.

Early on in the re-tendering process we identified the need for a shared vision across the team. This exercise identified some areas where the team was conflicted about the overall sense of direction and it was useful to expose these and avoid internal conflict. We used the method of Simon Sinek13 to understand why we work in a community diabetes team, and we deliberately decided to communicate this vision to our stakeholders, rather than what we do. Identifying our desire to give patients access to excellent skills and knowledge, help patients achieve individualised targets and support patient activation has given team members permission to be creative and innovate using their own ideas.

We understand that, for many, this level of reflection and team working may be seen as an indulgence. However, our experience supports industry research that these interventions improve efficiency, provide innovative solutions to difficult problems and attract/retain the best talent.

Many health care professionals will remain unpersuaded by these arguments, and it is worth exploring some of this reasoning. We have heard three common blocks: ‘I don’t need leadership development, I just do it’; ‘We are overwhelmed and we don’t have time’; and ‘They won’t let us.’

These statements reveal much about self-awareness, personal ownership and organisational culture. All three issues are readily mirrored in real-world examples of the benefits of culture change in health and industry. Patrick Lencioni’s book ‘Five dysfunctions of a team’14 identifies five factors responsible for poor team dynamics (inattention of results, avoidance of accountability, lack of commitment, fear of conflict and absence of trust) that we can all identify in the many health care settings in which we have previously (or currently) worked. In this respect, we have reflected that perhaps the
failure to progress diabetes outcomes nationally may, in part, be due to dysfunctional team dynamics, rather than simply just a lack of resource. Certainly, teams requesting investment, or competing for bids, are well placed to demonstrate their ability to lead effectively.

**Evidence-based service redesign: the WHAT**

Service redesign is not always well understood by front-line clinical staff. A lack of knowledge of the importance of stakeholder engagement, influencing skills and evidence-based improvement methodology can create a paradox in which expert clinicians with exemplar clinical skills and academic knowledge may struggle to put into place practical strategies that improve care delivery.

West Hampshire Clinical Commissioning Group (CCG) \(^{15}\) is a large CCG in the south of England that encompasses two acute trusts and a mix of rural and urban geographies. The wholesale relocation of clinical care, patient education (type 1 and type 2) and health care practitioner education (e.g. injectables training) into a community setting was prompted by a desire to shift local diabetes pathways closer to patients and primary care and build a culture of patient empowerment.

Our challenges in the first years of service were significant but mainly predictable. IT was a significant hurdle that was under-recognised at the start of our project. The local CCG supported the new community service with a Locally Enhanced Service payment at local practices (an LES). This included the option of signing up to level one (engagement with local priorities) or level two (injectable initiation).

Our service is managed with a block contract and has not increased with a rising incidence of diabetes. This immediately shifts the focus of the community diabetes service to manage the wider diabetes care delivery system. In order to stand any chance of operating effectively, the service relies on its ability to empower patients and primary care staff effectively. The ability to engage the whole diabetes community has been key and we have looked to assess this by mapping the outcomes of local surgeries against their sign up to the LES. We can demonstrate a difference in clinical outcomes according to ‘how engaged’ surgeries are (indirectly measured by zero, partial or complete LES sign up, i.e. LES 0, LES 1 and LES 2 respectively).

The West Hampshire model takes into account the need for sustainability across the wider system, especially within primary care. We believe our approach is particularly effective in a setting which incorporates multiple acute providers, such as ours, and helped reduce inequity in provision across our locality where care was previously delivered in two acute trusts.

Measures of service redesign are fraught with difficulty. The temptation to claim success for metrics which are influenced by multiple (some uncounted) interventions is a risk.

**Key clinical outcomes**

- We have demonstrated that practice engagement with a new model of diabetes care is associated with less exemption reporting (HbA1c, BP and cholesterol), statistically higher HbA1c and cholesterol measures and a reduction in contacts with specialist consultant time.
- Between 2012 and 2015 we have reduced admissions for diabetic ketoacidosis (43% reduction) and amputations (56% reduction). These are significant reductions and compare very favourably with reported Super Six outcomes.
- Participation in the National Diabetes Audit is high at 88%, validating our local data.
- Patient experience is high quality – 97% of our service users would recommend our services to friends and family.
- Services cost less per head of the diabetes population – an initial 30% reduction compared with tariff in 2010 which has fallen further as the diabetes population has grown from 17,500 in 2008 to 22,500 in 2015 (a 28% increase in the diabetes register over seven years). Unlike a tariff-based system of payment, a fixed block contract does not increase in response to demand.

**Box 1. Key clinical outcomes of service redesign at West Hampshire**

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**Practice makes perfect: a primary care tool kit**

A key component of our re-commissioned strategy has been the development of a practice tool kit: ‘Practice Makes Perfect’. Each practice is offered a visit to review their practice level data and is encouraged to identify areas they wish to improve. Importantly, our visiting consultant and diabetes nurse listen to the surgery team and offer bespoke support for clinical and educational requirements. In this way, we can wrap support around the practice and respond to the variability that we know exists. We do not police local outcomes, but celebrate local success and share best practice where possible. Each surgery generates a ‘Diabetes Action Plan’ which they own. Uniquely, we have asked that surgeries hold us to account for our ability to support them in achieving their desired clinical outcomes.

The tool kit is a folder containing local pathways, tools such as Diabetes UK’s Information Prescriptions, the local formulary, and a prospectus of education for patients and health care practitioners. Much of this information is also available as an app which can be accessed through separate portals for patients and health care practitioners.

**Chatty plan: a different conversation**

Included in the folder is our ‘Chatty Plan’ care plan which encourages all health care professionals looking after people with diabetes to think about how we help patients achieve their personal targets. We have distilled the complex nine key care processes to four key areas for discussion:

- Understanding glucose.
- Keeping well.
- Preventing complications.
- Feeling supported.

A 7-minute educational DVD supports the care plan. Currently, we are devising motivational interviewing training based on this template. In this way we hope patients will be
better oriented in their conversations with health care professionals and start to find some consistency in approach, regardless of where patients are in their care pathway.

Patient engagement has been key to our success. Patients have been consulted at all stages of service development. We have supported the development of ‘Sugar Buddies’, an award-winning peer support programme. Annually, we hold very popular type 1 and type 2 conferences. Awareness of the patient and health care professional conferences is also triggered within our app as a push to notification.

**Thinking ahead: next steps and new models of care**

The Five Year Forward View set the scene for national vanguards which would trial newer models of care delivery. An example of this would include the ‘Better local care vanguard in South Hampshire’ which is following a multi-clinical specialty provider (MCP) model, but other vanguards have responded in different ways, according to their unique setting and the surrounding communities of care. Examples include PACS (primary acute care systems) and the nursing homes partnership projects. The vanguards are united by a desire to align objectives, integrate care and deliver real improvements in the quality of patient care.

Key themes have emerged which include: (1) Prevention of disease; (2) Increased primary care capacity; (3) Patient activation and self-care; and (4) Delayering specialist care.

It is this last theme that opens up an important opportunity for specialist consultants, but also a number of direct challenges to the historical way in which specialist care is currently delivered.

**Changing the rules of thumb: heuristics of care delivery**

The current structure of specialist care has changed little since Aneurin Bevan’s inception of the NHS (and perhaps some time before). Specialist care is restricted through the cost of both care delivery and expertise. This restriction is also frequently extended to the site in which care is delivered.

Specialist services often comprise both inpatient and outpatient care.

<table>
<thead>
<tr>
<th>Time heuristic</th>
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<tbody>
<tr>
<td>My time is limited to those with greatest need</td>
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<tr>
<td>My time is restricted and expensive</td>
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<tr>
<td>Influencing others and managing systems is an effective use of my time</td>
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<tr>
<td>I use my time to reach out to others</td>
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<td>Culture</td>
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<td>Behaviour</td>
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<th>Knowledge heuristic</th>
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<tbody>
<tr>
<td>I am a guardian of specialist knowledge</td>
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<tr>
<td>I retain specialist knowledge</td>
</tr>
<tr>
<td>I spread my knowledge to a diaspora of specialists</td>
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<tr>
<td>I release my knowledge</td>
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<td>Culture</td>
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<thead>
<tr>
<th>Leadership heuristic</th>
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<td>I lead a specialist team in my organisation</td>
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<tr>
<td>I collaborate with others across organisations</td>
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<tr>
<td>I am responsible for excellent results in my unit</td>
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<tr>
<td>I am responsible for managing a pooled collective resource</td>
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<td>Culture</td>
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This has enabled specialist consultants to contribute to the wider provision of care within an acute trust, namely the acute take. This added dimension – the ability to deliver both specialist and more generalist medicine – has been highly prized by specialists and preserved consistently, despite the introduction of a ‘new’ specialty – acute medicine. Hospital medicine has been seen by specialists as a safe contract and career, highly prized and competitive to access. The links with research, education and senior managerial positions should not be underestimated. Many of these opportunities have been almost intrinsically linked to the employing institution. The definition of the specialist therefore also defines the role of the non-specialist or general practitioner. The desire to alter the divide between specialist and generalist led, in part, to the 2010 reforms.

Setting this aside, we have identified three heuristics (rules of thumb) that may perpetuate some decision making between specialist and primary care. These relate to: specialist time, specialist knowledge, and specialist leadership. These ‘rules of thumb’ may influence the culture of care delivery and, in turn, the behaviours of health care professionals. (See Figure 1 for examples of time, knowledge and leadership heuristics.)

**Figure 1. Examples of time, knowledge and leadership heuristics**

Time heuristic. Specialist time is certainly limited. Indeed, all resources are finite. However, changing the
culture to one in which a specialist’s role is to use part of their time allowance to influence others and manage wider systems may alter behaviour from introspection to effective external engagement.

Knowledge heuristic. Changing a culture which promotes retention of specialist knowledge to one that promotes a wider knowledge ‘economy’ may alter specialist behaviour in a way that releases knowledge (and trust) to a network of interested parties, who in turn release their skills and knowledge to patients, so improving access and reducing inequity.

Leadership heuristic. Specialists, committed to their work and career development, are capable of delivering strong leadership. Currently, that leadership is all too often limited to one unit or institution. In order to work effectively with others and thereby deliver farther reaching influence, specialists would benefit from a collaborative approach across boundaries, ultimately ensuring the effective management of shared (limited) resources.

Summary
The pace of change in the delivery of health care will accelerate over the coming years. Specialist consultants must remain at the forefront of reforms. The largest challenge facing diabetes care (specialist and generalist) comes from the need to redefine the current paradigms of care in a bid to change outdated culture. A determined, resourceful and innovative group of specialist professionals, equipped for the challenges ahead, would expedite this journey and work effectively in partnership with primary care colleagues. In order for this to happen, the challenges must become personal.

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Call for diabetes vignettes
Do you have an interesting clinical diabetes case that could be written up as a short story in Practical Diabetes? Diabetes vignettes should contain a case history and discussion of the implications for practice; articles should be a maximum of 800 words.

We welcome submissions from the whole multidisciplinary team; for further information please email the Managing Editor, Helen Tuppsy: email htupsy@wiley.com.