GP commissioning: Shaping diabetes care in Bexley

Bill Cotter, John Grumitt

Redesigning the diabetes service in Bexley involved research from people with diabetes and healthcare professionals, improving access to structured education, regular audit and implementing person-centred care, including care-planning. Bexley was also a Year of Care pilot site and changes to the service have resulted in improvements in HbA_{1c} levels, blood pressure and BMI, and a sense of empowerment among people with diabetes to self-manage their condition successfully. This article outlines the process of redesigning the diabetes service.

Article points

1. There was a need to strategically develop diabetes services in Bexley, engaging with clinicians and people with diabetes alike.
2. The initial goal was to use evidenced-based best practice to provide high-quality, person-centred, integrated care.
3. After implementing changes to the delivery of structured education, patient participation increased dramatically.
4. Many healthcare professionals have completed basic and advanced diabetes training as well as attending general diabetes events.
5. Bexley is not reinventing services but implementing existing services more efficiently.

Key words

- Audit
- Care planning
- Commissioning
- Person-centred care
- Structured education
- Year of Care

Bill Cotter is a GP at Bellegrove Road Surgery in Welling, Kent, and a Clocktower member for Bexley Clinical Cabinet; John Grumitt is Diabetes Programme Manager for Bexley and Vice Chair of Diabetes UK.

About 11 000 people out of a population of around 225 000 in Bexley have diabetes (Information Centre for Health and Social Care, 2011a). Type 2 diabetes is much more common than type 1 – it is estimated that in England, 90% of people with the condition have type 2 and 10% have type 1 diabetes (Department of Health [DH], 2009).

Caring for people with diabetes can be challenging, particularly when they are admitted to hospital. More than 15% of beds at Bexley's local hospital, Queen Mary's Hospital Sidcup, are taken by people with diabetes (NHS Diabetes, 2010). Williams (2005) estimated that the cost of inpatient care for someone with diabetes can be up to five times more than a person without the condition. It is therefore key to ensure that diabetes services offer the tools that people with diabetes need to self-manage their condition successfully and avoid unnecessary hospital admissions.

Initiating the development of the diabetes service in Bexley

Before GPs were involved in the diabetes care pathway in Bexley, basic care was delivered to people in the practice and all specialist care was provided in a hospital setting. There was a need to strategically develop diabetes services, engaging with clinicians and people with diabetes alike. In addition, improving communication between primary and secondary care was paramount.

The Diabetes UK local patient group had met with GPs and staff from Bexley Care Trust to suggest where improvements could be made. Three key areas for improvement were identified:

- Education for people with diabetes.
- Training healthcare professionals.
- Integrating fragmented providers.

The redesign of the diabetes services in Bexley started with research – establishing good practice models from other acute and primary care trusts, working with GPs and examining how recommendations made by NHS Diabetes, Diabetes UK and the International Diabetes Federation could be implemented locally.

In Bexley, research identified that certain services, such as education for people with diabetes, were not being used to best effect –

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1. Bexley GPs were encouraged to be involved by the commitment to implement proven best practice, through the persuasive arguments in research findings and by advice from clinical experts. GPs were also encouraged to engage with service redesigns because of the strong presence and support of patients, which gave credibility to the proposals.
2. A network of healthcare professionals from consultant specialists to practice nurses, patient representatives and Bexley Care Trust staff formed a diabetes redesign team and created a set of values to apply when creating new services.
3. The X-PERT programme had significant benefits but GPs and project workers recognised that the programme had not been implemented in the most efficient way possible.

some services were fragmented, inefficiently organised and incomplete. The redesign was therefore about improving and reshaping existing services so that they cost less, with a better likelihood of success. The initial goal was to use evidenced-based best practice to provide high-quality, person-centred, integrated care.

During the service redesign stage a GP from each of Bexley's three localities – Frognal, Clocktower and North Bexley – played an active role. By regularly attending meetings, GPs have consistently provided advice and relayed their experiences of treating people with diabetes.

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The service redesign was also being driven by Bexley Care Trust's diabetes programme manager, John Grumitt, who is Vice Chair of Diabetes UK and also has type 1 diabetes. With John's background, GPs felt confident in the proposals being made.

A network of healthcare professionals from consultant specialists to practice nurses, patient representatives and Bexley Care Trust staff formed a diabetes redesign team and created a set of values to apply when creating new services. They had to:

- Be person-centred.
- Apply evidence-based best practice.
- Deliver care where it is clinically and economically best to do so and where people with diabetes want it.
- Measure impact.
- Ensure integrated care, including:
  - A universal commitment to deliver best care regardless of where healthcare professionals are employed.
  - Providers communicating and sharing data – it was thought initially that an integrated information system would have to be introduced. The investment and risks of so doing were too great and so alternative "old-fashioned" routes were used. A template was developed for all practices to use for all data extraction, referrals and care planning. A set of reporting requirements for all providers was agreed. These are shared openly.
  - Rapid and clear triage and referrals.
  - Clear and swift feedback from people with diabetes and healthcare professionals.

As services were being developed, they were also evaluated by the diabetes network. Stephen Thomas, author of Healthcare for London's *Diabetes Guide for London* and a specialist diabetes consultant at St Thomas' Hospital, also provided input to the redesign and implementation planning.

Engaging with various networks and specialists ensured that the service was evidence-based, clinically-led and person-centred.

Improving the delivery of structured education

X-PERT

The 5-week education course X-PERT, which includes information about up-to-date treatments and management of diabetes and offers participants the opportunity to explore problems and issues, was available in Bexley.

The X-PERT programme had significant benefits but GPs and project workers recognised that the programme had not been implemented in the most efficient way possible. For example, many people expressed concern about the location of the venues, which were often hard to access via public transport. The times of the courses also proved inconvenient.

The diabetes redesign team consulted with people with diabetes and, as a result, identified a set of suitable venues and held courses on a variety of dates and times to meet demand. Funding for this was secured by producing a business case that included evidence of improved clinical outcomes to support bids for investment. For example, Nicolucci et al (1996) state that "the value of patient education is evident from research demonstrating that patients who never received diabetes education showed a striking four-fold increased risk of a major complication".

The team also identified that people did not always respond well to advice from healthcare professionals and so they decided to "train the trainers" – where patients and carers (who had previously completed the course) were taught how to present the X-PERT course. As a result, more patients who had completed the course and implemented the advice felt empowered to help others. There is now a strong bank of people with diabetes and carers who are all trained to teach the X-PERT course. Such individuals have professional backup – they are taught and supported to ensure that the highest standards of education are being met. One person, Stephen Bickerstaff, who recently completed the 5-week X-PERT programme said:

"I really enjoyed attending the X-PERT course. I learnt a great deal and it has made my life a lot easier. Having been diabetic for 25 years there are still new problems that occur and attending the course has taught me how to deal with them and how to improve my life."

After implementing changes to the delivery of structured education, patient participation increased dramatically. In 2010, over 1000 people completed the 5-week course (compared with 40 in 2009), on average reducing their HbA_{1c} level by 1.3 percentage points (14.2 mmol/mol), from 8.4% to 7.1% (68 to 54 mmol/mol). In the X-PERT Audit Report (Deakin, 2011), this was registered as the highest reduction anywhere in the UK.

DESMOND

More recently, people with diabetes have become ambassadors for a new education programme called DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed): "Walking Away from Diabetes", which trains people at risk of developing type 2 diabetes in techniques for leading healthier and more active lives. Prevention training provides essential support to improve the health of people who are at high risk of developing diabetes.

Regular audit and staff training

The diabetes redesign team also decided to audit each GP practice every 6 months to gain a better insight and understanding of the needs of people with diabetes in Bexley and the services and care available to them. Data were collected on the following areas:

- Health outcomes.
- Medication.
- Experience.
- Training of all those providing care.
- Practice referrals.
- Evaluation of virtual clinics.
- Referrals to structured education.
- Patient survey results.
- Assessment of implementation of care planning.

This process encouraged even more Bexley GPs to be involved in the redesign of services.

Since the first round of audits were conducted, a number of changes have been implemented to ensure care is consistent across Bexley's 28 practices. For example, the audit considered the diabetes skills-set of staff and recommended specialist diabetes training where necessary. Many healthcare professionals have completed basic and advanced diabetes training as well as attending general diabetes events. For example:

- Seventeen healthcare assistants have completed the Diabetes and Annual Review Workshop, coordinated by Bexley's community diabetes team.
- More than 100 people have attended the Foundation course – a 3-day course, developed locally by Anne Goodchild (DSN), with specialist consultant input, to provide an introduction to diabetes, its diagnosis and the essential elements of care, local treatment pathways, and ongoing care and screening for complications.
- More than 100 people have attended the MERIT 2 (Meeting Educational Requirements, Improving Treatment) course, regarding the support of people with type 2 diabetes who are treated with insulin, coordinated by Novo Nordisk.
- Forty-two people attended Warwick University's Intensive Management of

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1. From the audits, a diabetes annual report is produced for each practice, including comparative performance measures as well as a practice development plan. This will help to ensure that diabetes services across the borough are of consistent high quality.
2. GPs and the diabetes redesign team identified a gap in the diabetes annual review. GPs established that by agreeing a set of goals together, patients were more likely to achieve them.
3. To introduce better care planning, Bexley was an early adopter of the Year of Care programme, supported and piloted by Diabetes UK, the Department of Health, The Health Foundation and NHS Diabetes (2011).
4. GPs and project workers have also been keen to monitor and evaluate diabetes services. This analysis has enabled them to create a more comprehensive diabetes care pathway.

Type 2 Diabetes course, which includes education on the initiation of insulin.

- More than 60 healthcare professionals have attended training to introduce the Year of Care and care planning.

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A consultant diabetologist has also visited GPs at their practice to discuss cases and provide on-the-spot training to the practice diabetes team. The meetings were an opportunity to identify individuals receiving care in a hospital setting and how they could be transferred back into primary care. As a result, statistics demonstrate a drop in the number of patients receiving care from a hospital – referral rates have more than halved since January 2010 without any deterioration in recorded HbA_{1c} level – and healthcare professionals feel more confident in dealing with people with complex needs. There has been an overall improvement in the quality of care offered by a Bexley practice (Information Centre for Health and Social Care, 2011b). Clinical outcomes are being measured through patient and GP feedback – in June, a second patient survey was conducted to track qualitative measures.

Annual review

GPs and the diabetes redesign team identified a gap in the diabetes annual review. Less than half of people with diabetes did not have their goals discussed or agree their care plan with a healthcare professional. GPs established that by agreeing a set of goals together, patients were more likely to achieve them.

To introduce better care planning, Bexley was an early adopter of the Year of Care programme, supported and piloted by Diabetes UK, the Department of Health, The Health Foundation and NHS Diabetes (2011). Year of Care is a way of providing care to people with long-term conditions. Since introducing the scheme, more than half of Bexley's GP practices have been actively involved in training and developing IT systems to ensure people with diabetes are engaged in developing their own care goals, and the development plans to achieve them. In collaboration with software companies, a standardised template was developed, which can extract clinical data into a patient-friendly form. This helps the patient and GP identify what areas need development, for example weight, diet and blood pressure. As the individual progresses through the care-planning process, their statistics are regularly recorded and the patient form is updated. The GP and patient both sign the form, agreeing to commit to the decisions taken by both parties, for example to attend an X-PERT course or to undertake more exercise.

This process has been adopted by the care-planning team who are encouraging other healthcare professionals to implement the patient and GP form, which is a testament to its value.

GPs have introduced these changes and previously disengaged people with diabetes are responding well and becoming motivated for the first time to take control of their diabetes. All of Bexley's practices were fully trained in Year of Care practices by summer 2011.

Evaluation of diabetes services

GPs and project workers have also been keen to monitor and evaluate diabetes services. This analysis has enabled them to create a more comprehensive diabetes care pathway. For example, in 2010, Diabetes UK was commissioned to conduct a patient survey. As well as identifying satisfaction and feedback on the services people with diabetes receive, the survey addresses the extent to which needs are being met. Practices have been given a target of more than 75% of people scoring their care as "good" or "better". The results of the 2010/11 survey are expected by the end of the year. GPs hope to achieve better patient outcomes by engaging with patients who use their services.

The 2010 survey provided evidence of unmet demand, for example 62% of people

with diabetes were not offered education, while of those that had attended education sessions, over 70% had said it was easy to understand. There was a clear desire for access to DSNs both in the community and hospital setting. In addition, there was frustration among people with diabetes at providers not being integrated. Such feedback offered powerful evidence to support the redesign and give focus to the team's efforts.

GPs are also keen to monitor feedback by ensuring representation of people with diabetes on the local diabetes network. Commissioners and healthcare professionals attend the Diabetes UK local patient group's monthly meetings, where more than 100 people regularly get together to share experiences, obtain support from peers as well as discuss current performance, development plans and provide feedback on the services being delivered.

The initiatives and service improvements introduced in Bexley also reflect some of the proposals made in the government's White Paper – *Equity and Excellence: Liberating the NHS* (DH, 2010), in particular, person-centred care. People with diabetes are actively encouraged to shape decisions and identify priorities. As a result of such inclusivity, decisions are based on what is best for the individual and not any one provider or commissioning institution.

A document entitled *Bexley GP Commissioning: A Prospectus*, formulated by GPs in the local area, highlights GPs' commissioning intentions, clinical priorities (for example, older people's services, unscheduled care, long-term conditions) and work plan to reach authorisation by March 2013.

Outcomes from the diabetes service redesign

Outcomes from the diabetes service redesign include evidence-based best practice being applied, not reinventing services but implementing existing services more efficiently, and expert advice being sought to create services that work and are effective.

The service is now outcome-focused; for example, when GPs and project workers initiated the education programme X-PERT, they launched a campaign among healthcare professionals to report the clinical impact that education had on the person with diabetes. The data generated demonstrates that the programme had a positive impact on patients' blood glucose, weight, cholesterol and blood pressure, although it is recognised that further improvements still need to be made:

- Mean HbA_{1c} level has fallen from 8.4 to 7.1% (68 to 54 mmol/mol).
- Mean BMI fell by 1.5 kg/m^2.
- Mean systolic blood pressure fell by 3.3 mmHg.
- Mean diastolic blood pressure fell by 1.7 mmHg.

GPs and diabetes project workers ensure that services meet people's needs by attending the Bexley local diabetes group and facilitating the Diabetes UK roadshows and stands at a local festival, attended by over 50 000 visitors. The Bexley diabetes team are working in partnership with Diabetes UK to establish community champions to reach seldom-heard communities.

Lead GPs have encouraged their colleagues to support the changes to care. Project workers have also been able to support GPs who want to play an influential role in diabetes service development. For example, building on the Year of Care pilot, Bexley introduced GP mentors to support the implementation of care planning.

Bexley's shadow consortium board – Bexley Clinical Cabinet – plays a supportive and active role in the development of diabetes services. Dr Bill Cotter, Bexley Clinical Cabinet's Clocktower member, has been an active advocate of diabetes redesign.

He is determined to apply the lessons learned in improving diabetes services to other long-term conditions. In fact, long-term conditions has been identified as one of three key elements in how GPs are to commission services (DH, 2010).

Along with unscheduled care and older people's services, long-term conditions are seen as a vital area of work. Dr Cotter believes that

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2. Outcomes from the diabetes service redesign include evidence-based best practice being applied, not reinventing services but implementing existing services more efficiently and expert advice being sought to create services that work and are effective.
3. Lead GPs have encouraged their colleagues to support the changes to care. Project workers have also been able to support GPs who want to play an influential role in diabetes service development.

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focusing on the success of the work in diabetes services in Bexley – and extending this work to other long-term conditions – would see exponential benefits in terms of health services for local people and in ensuring maximum value for money.

For GPs wanting to reorganise diabetes services in their area, the authors have a few suggestions for establishing key success drivers:

- Encourage independent patient leadership – this provides focus and imagination "without walls".
- Get the support of your Chair and Chief Executive.
- Ensure GPs are supported and are well coordinated.
- Gain momentum quickly.
- Build an effective support team with proven diabetes experience.
- Produce a clear strategy, goals and deliverables: know what you are doing, stay focused, and be honest – build on what works and learn form what does not.

Conclusion

Many lessons have been learnt while redesigning diabetes care. First, never underestimate the importance of communication and always keep stakeholders aware of your plans, while managing their expectations. Second, understand the different perspectives of providers. Finally, changes may take longer than you expect – but aim high! ■

An award-winning service

Bexley Community Diabetes Project was a finalist at the recent HSJ Awards in the *Managing Long Term Conditions* category (see http://bit.ly/tFKyFI for more details). A Bexley GP practice – Lakeside Medical Centre – won *NHS Team of the Year Working in Diabetes* at the recent Quality in Care awards (see http://bit.ly/seQn8q for more details).

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