

Diabetes care planning/self management project

Output 3: Networks report by Paul Corrigan

How can good networks help to implement care planning?

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Lessons from Bexley and Croydon

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1. Acknowledgements

We would like to acknowledge the contribution of the following organisations in the production of this report:

- Bexley Care Trust
- NHS Croydon
- Diabetes UK
- NHS Diabetes
- NHS London

2. Background

In early 2010, the London Strategic Health authority ran a competition for innovation projects. The idea behind this competition was not just to come up with good original ideas but to demonstrate how these ideas could be diffused within the NHS. CSL won one of those grants to support this project.

From March 2010 to March 2011, the CSL grant supported the rapid diffusion of care planning in diabetes services across London. They have been working with five test site PCTs.

Care planning can be defined as a structured process of collaborative working between an engaged and empowered patient and a proactive system – including clinicians. Care planning forms one component of a wider self management support system.

What is clear from previous attempts to implement care planning is that to succeed it needs a large scale cultural and attitudinal shift among both healthcare professionals and patients. This marks a considerable shift from current practice. Implemented correctly, it will support patients to take a more active role in making decisions about how to manage their care and thus achieve more consistent, better health outcomes.

As part of this project CSL wanted to test different mechanisms that might support effective implementation of care planning. An obvious area to investigate was the role of diabetes networks and how a good network might support implementation of care planning.

Diabetes care needs strong pathway development work as much of patient care is provided across a range of organisations. CSL therefore felt that a closer understanding of how networks might work to support implementation of care planning would be useful to both better understand the power of networks but also to see if they were of specific use in the spreading of care planning as a vehicle for empowerment.

3. The importance of networks

Managed care networks have been a part of the NHS architecture for some time. They have been created and developed when care needs to take place across a range of institutions and are an attempt to create some form of integrated approach to health care across those institutions. This brings clinicians from the different parts of the pathway together and also provides the opportunity for patient voice.

Traditionally the role of a network has been to:

- Advise commissioners in respect of service redesign
- Support the coordination of services across the pathway
- Monitor services through a review of performance data

During the current climate of changing commissioning structures, it is particularly important that any organised group performing the functions listed above continues to do so to ensure continuity through the period of change and those improvements to services are maintained.

One of the consistent aims of NHS reforms has been the development of a clear distinction between those who commission healthcare and those who provide the commissioned health care. This has taken some time to develop and the current round of reforms is making that split even clearer. Networks operate on both sides of this divide which is acceptable providing they do not operate in such a way as to preclude competitive behaviour. To ensure this, they need to be clearly separate for the brief period when contracts are being let. Networks will be a valuable part of the new architecture.

In fact networks may become even more important since they will provide an organised way for those who are hoping to commission new and innovative services to work alongside those who might provide them. As long as they are open to new ideas and membership, networks present both commissioners and providers with an opportunity to discuss and develop best practice.

Given that diabetes networks are for the main part hosted and paid for by PCTs, who will be abolished from 2013, they will need to find a new way of managing their work in the future. The role of GPs will change from being solely the main providers of services to also being the main commissioner of those services. As of spring 2011, no one can be sure that the management of networks will be picked up by the new GP commissioning consortia. This will be a matter for the consortia to decide how they want to work with such organisations.

This report draws from interviews with two networks in Bexley and Croydon. It tries to draw out what makes a good network and to see how they might support the implementation of care planning.

4. The two networks

4.1 The Bexley Network

The network in Bexley is managed and resourced by the PCT – the budget for the network is included in the budget for the service cost.

The network membership includes:

Bexley NHS
Care Trust

Bexley Diabetes Network

Bexley NHS
Care Trust

- Clinical Director
- Programme Manager
- PEC Chair
- Finance
- Pharmacist

 **GP**
Commissioning consortia

Oxleas NHS
NHS Foundation Trust

- DSNs
- Podiatry

Diabetes UK

- Bexley Local Group
- Young Diabetic Group
- DUK Regional Manager

South London Healthcare NHS
NHS Trust

- Diabetes Specialists
(Hospital and Community based)
- Dieticians

Diabetes Practice Development Team

- Project Managers
- GPWSi x 3
- DSNs
- Expert Patients

4

The ground rules of the network are as follows:

Bexley NHS
Care Trust

Our Vision

➤ High quality care for people with diabetes

Our Values

- The patient shall be at the centre of everything we do
- We shall apply evidence based best practice
- Care will be delivered where it is clinically and economically best to do so, and where patients want it
- We shall measure our impact
- Care will be integrated:
 - A universal commitment to deliver best patient care regardless of where they are employed
 - Providers will talk to each other and share data
 - Triage and referrals will be rapid and clear
 - Patient and HCP feedback will be rapid and clear

4.2 The Croydon Network

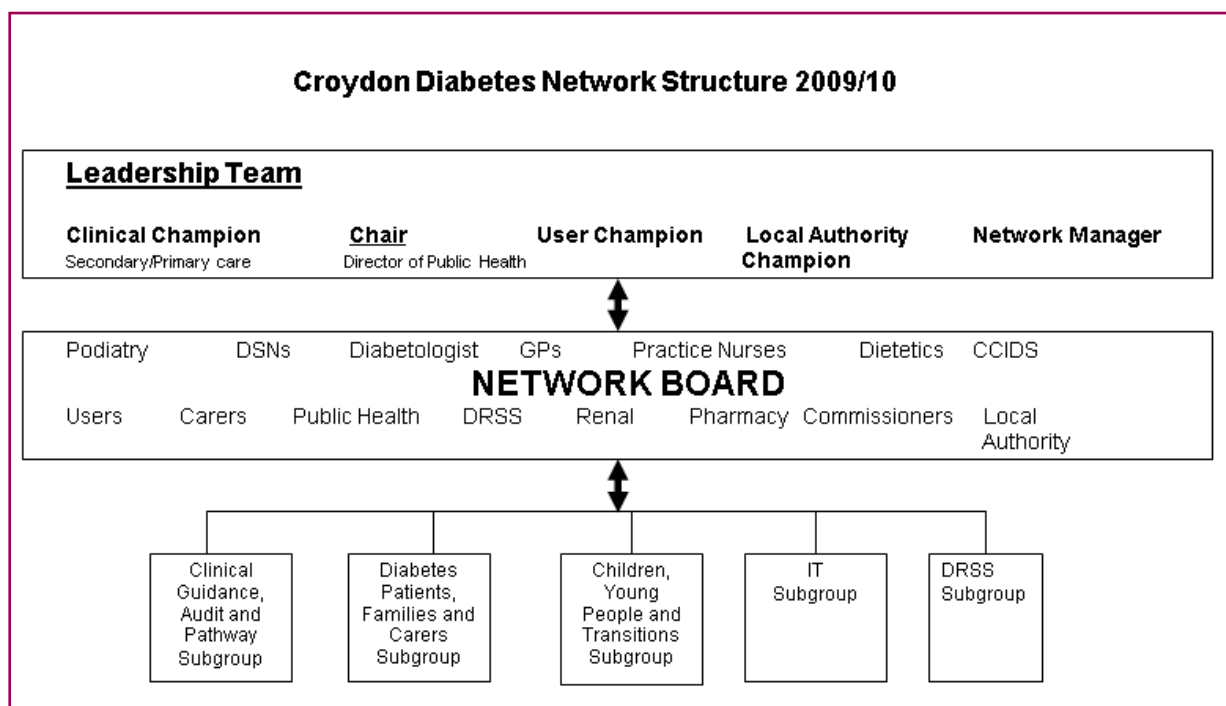
Croydon Diabetes Network is funded by Croydon PCT and is based in Croydon PCT's Public Health Department. It is coordinated by a dedicated 0.6FTE manager. It has a Network Board which meets four times a year at which all members of the network come together. The leadership team has representation from primary and secondary care, local government and people with diabetes. The Network has a range of subgroups carrying out work on current priorities for Croydon diabetes services that report into the Network. At the moment these are:

- Clinical guidance
- Patients, families and carers
- Diabetic retinopathy screening service
- Eye screening

Network activities have included:

- Publishing a newsletter and maintaining a diabetes microsite
- Authoring Croydon's 2010/11 JSNA Diabetes Chapter
- Coordinating the revision of the guidelines for the management of diabetes in primary care
- Developing a care planning checklist for local schools
- Running events to increase awareness of diabetes issues

Network organisational structure



5. Purpose of this paper

Whilst this is a report on the way in which diabetes networks can help to drive a particular form of care improvement – care planning – it is important to recognise that the network operates within a wider organisational culture and structure. For a network to work well, it needs to exist within an overall structure that experiences and expects consistent change. If this is not the case then the network needs to not only organise the specific changes around services for people with diabetes but also the case for change itself. Making the whole case, rather than the specific case for change, places a very large burden on a network.

This report comments on two very different sets of reasons why some networks work better in the NHS than others:

- The first are intrinsic lessons from the experience within the diabetes network. What are the characteristics of the experience of a ‘working network’ that is better than others?
- The second are extrinsic lessons that are experiences of the wider health economy and how that interacts with the network. Why do some organisations engage with a network as a change agency and others do not?

The report is organised this way because it would be misleading for people who wanted to use a good network to support implementation of care planning and not to recognise the extent to which the context it operates in that empowers it.

The ideas in this report spring from the experience of the people we talked to from the Bexley and Croydon networks. This report is about the small details of how you make networks work rather than the wider bureaucratic structures.

This report is small in scale and has been developed by the qualitative research methods of talking to individuals involved in two networks in London. We chose to review the Bexley and Croydon networks because both NHS Bexley and NHS Croydon were test sites in the CSL diabetes Regional Innovation Fund project for diffusing care planning in diabetes services. We were therefore talking with them about how networks could assist in the development of care planning.

Obviously, there are other ways in which care planning can be implemented. Equally obviously, there are other parts of NHS services that networks can be useful in developing.

6. What aspects of a good network support implementation of care planning?

6.1 Intrinsic reasons for the success of networks

Managed clinical networks are an important part of the NHS across the UK. There has been substantial work on this issue of and it has been researched for some time. See Appendix 1 for an example from Scotland.

In answering the question what makes a good network, our interviews identified nine key themes.

6.1.1 Coherent and focussed purpose together with pace

Both networks were based upon groups that had been a part of the local diabetes infrastructure in these localities for a very long time. The recent reworking of them into managed networks marked a change in activity which both locations talked favourably about as being much more concerned with having an impact rather than being a 'talking shop'.

Two patients we talked to had been involved for between 10 and 20 years. They felt that in its latest manifestation it had a much better focus and was achieving progress supported by the more active involvement of patients.

One network met monthly, the other quarterly, and it did seem difficult for the latter to maintain the same level of focus as the former. All the respondents in the monthly meeting felt that the meetings were really worthwhile because they not only were listened to but learnt something at every meeting. It is worth exploring why these network meetings seemed to work so well.

The network emphasised pace which meant that people expected issues to be tackled and to move forward between meetings. If people had tasks assigned to them it was expected that they would follow up on them and report back at the next meeting.

The reality of change is that implementing something such as care planning for patients with diabetes takes consistent work over time. If a network is to succeed in helping this happen it needs to both be able to work with pace but also to maintain its focus over the long term.

6.1.2 Common ground rules

In one location, during the first few meetings the chair, in his own words, "went on and on" about the ground rules of the network. This seems to have focussed not just the network as an organisation but the meetings themselves. The ground rules are not unusual: everyone is listened to; no jargon and no experts putting others down etc, but critically because they had been iterated over and over again, they had real ownership and therefore impact.

The meetings contained a range of different stakeholders with differing perspectives but they seemed to achieve things because of the single most important focus of improving patient outcomes. People felt these were very worthwhile meetings and agreed that this was not usually the case in their experience of other meetings.

Patients and staff both commented on the importance of setting these ground rules as a means of encouraging people to listen to each other and to value the contribution that everyone made.

The chair of the other network stressed that the principles of trust and respect were essential to the meeting and everyone we talked to felt that their voice was given as much weight as everyone else's.

Since the point of a network is to hear different voices from different parts of the health care system this seems important. Given that care planning needs a change in the practice of many professionals and patients, the people within the network need to be able to know that their voice will be heard in those meetings to carry this change forward.

6.1.3 Managed networks need to be managed if they are to work

To be effective, networks need to be managed properly. Both networks reviewed in this report had dedicated managers and there are some common roles/functions that this person performs including: organising meetings, ensuring minutes are circulated, key areas of work are agreed and progresses between meetings, actions are followed up etc.

Whilst both networks were experienced as a democratic set of relationships, everyone was clear that it was being managed and driven. The manager of the network needs to be able to take executive actions on behalf of the network between meetings and they need the status and the authority to complete these tasks.

6.1.4 The process remains fluid

A good network has to learn new ways of working and adapt to the changing landscape in which it operates.

In one of the networks where GP practices were rolling out care planning, it had become clear that the administrative staff in the practices specifically appointed to develop and implement care planning were not only playing a crucial role in each site, but were interested in developing their own network to discuss how to maintain momentum.

Similarly in the other network, additional 'sub-groups' to the main network are set up as and when they are needed, tasked with supporting changes in specific areas, such as the Children and Young People's subgroup. Having groups like this allow a smaller number of experts to focus on addressing specific issues.

Any network needs to keep responding to changing needs.

To carry care planning forward will need the active involvement of a large number of very different staff and patients. For the different groups of staff to carry this forward and to be assisted by a network, they all need to feel that they can use the network for this task and enable the network to develop.

This will become increasingly important as the NHS moves to GP led commissioning. Diabetes networks will have GP champions on them. In one network, the GP will become the joint lead for the GP commissioning for one of the local consortium. The

alignment with this role could ensure that commissioning activities are influenced to support care planning in the future.

6.1.5 Sponsorship from the top

Every organisation that is trying to implement change has stressed that it is important to have sponsorship from the CEO or an equivalent on the Board. This is equally true in looking at what makes a network work well.

In one of the locations, all the interviewees (including two patients) not only commented on the backing of the CEO but could give concrete examples where the individual had stepped in to make a big difference. Indeed in this network, the start of the new way of working had commenced with the patients making a complaint about the level and nature of the service they were receiving. The CEO not only took that seriously but was seen by the patients and the rest of the organisation to take that seriously. The spontaneous mention of the CEO as sponsor gave the network great clout.

The other network had strong sponsorship from the public health department. Chaired both in the past and present by the director of public health, the drive for the network stemmed from the recognition of the very rapid increase in incidence of diabetes that came from a piece of population health analysis.

The leadership of these sponsoring organisations is important since they will recognise how important the development of care planning is to the future of NHS delivery for people with long term conditions. Nearly all commissioning organisations recognise the importance of involving patients in their conditions. The leadership of commissioning organisations therefore recognise the importance of changing the economics of NHS healthcare. Sponsorship from the top for networks that develop care planning for people with long term conditions can provide the drive to help the networks create better self management.

6.1.6 Active GPs

Given the importance of the GP in the diagnosis and treatment of diabetes, GPs can play a lead role in an effective network and in developing care planning locally.

In both networks, GPs played a strong role; in one, the objective of the network was the consistent transformation of GP practice of which care planning became a core part. In this case, the GPs in the network and the other network members used levers outside the network to drive change in GP practices. The GPs also play a leadership role in the implementation of care planning and the development of a mentoring programme for new care planning practices; in one of the sites, GPs have become involved as mentors. This means that the process of passing on skills to new parts of the system has high status and is given credibility by new practice leads.

GPs in the present and even more so in the future with their new commissioning responsibilities will need to lead these changes. The networks need to be able to influence GP practice to bring about change. Networks should start to think through how GPs as commissioners could play a bigger role in developing care planning as a part of their commissioned care.

Care planning needs the GPs and other medical professions to change their practice in how they work with patients. The main way in which GPs can be persuaded to

change their behaviour is through discussion with their fellow GPs. Without the active involvement of GPs in the network, it is difficult to see how any progress would have been made.

6.1.7 Patient engagement

Both networks had very strong involvement of patients and carers. This is much more than tokenism. Since the fundamental philosophy of care planning is such that it requires the active involvement of patients in their own care management, it is important that patients play an active part in the design of new services and the discussion of this at the network meetings.

In both networks there was a strong feeling from all of the patients that they were listened to and their concerns became the concerns of the network. All the patients we talked to had concrete examples of things they had achieved through the network. Of equal importance, they could recount times in the network when they had learnt from other people.

6.1.8 Constancy is required in an NHS where change is expected to come and go

In the NHS there is an expectation that change, however difficult, will come and go and will not be seen through to completion. This encourages people to 'hide' from having to carry out change in the hope that it will go away. Having a stable network in place with responsibility for ensuring continual service improvement can ensure that initiatives such as care planning are implemented properly.

In one network, several people commented on the fact that this set of changes had persuaded people that they were here to stay and that this was important. This constancy of purpose with a timetable to roll out the change made an impact.

Given the changes that will happen in the NHS over the next two years, it will be important that networks continue with their task whilst taking these important environmental changes into account and perhaps changing membership to reflect the changes.

6.2 Extrinsic issues in the organisation that hosts the network

6.2.1 The organisation has to have had a history of learning and valuing training

A lot of this developmental process depends upon clinicians, other staff and patients learning new ways of carrying out their work and their healthcare.

In one network that had engaged a large number of GPs, they reported a long term experience of the PCT demonstrating how important it felt that professional development and training was. This meant that when the case was being made for the implementation of care planning and it was obvious that this would change the way in which clinical and administrative staff worked, the network felt that it would need an extensive training programme. This training programme fitted in with the culture of the PCT. Primary care staff were used to taking part in training and learning important aspects of new care through such training.

Training for the staff and patients consisted of quality assured, national programmes. Time and effort went in to understanding how these courses worked and in ensuring that the standard of the training was high.

6.2.2 The leadership of this change has to have been a part of the local leadership for some time

Most change involves some difficult movement in people's practices. It may initially mean new and hard work. This is made easier if the people that are helping to drive that change are known by staff who are going to have to do new things or more hard work. If staff have to get used to new people pushing new change, then there is a double problem. In one network, the fact that the year of care project manager had been working in the locality for a long time meant that the experience of the change that she was developing had some long term recognition from everyone involved.

7. Conclusions

7.1 Can networks develop values which transcend the purchaser provider split?

Both networks had providers and commissioners as members. This did not cause a problem; in fact, it was seen as positive. These had been set up by the PCT that was both a commissioner and a provider of care. Over the networks' existence the roles of the PCT had become clearer as a commissioning organisation.

Since the network itself is neither a commissioning nor a providing organisation, and it does not offer or accept contracts, there is no conflict of interests. Most markets operate with aspects of the buying and selling operating across the divide and networks will be such organisations in healthcare.

There will now be a further change which most diabetes networks will be in a position to exploit – GPs are on most diabetes networks and the network can influence commissioners' decisions of new consortia. GPs as commissioners could, for example, specify the nature of care planning as a part of the diabetes care that they expect to buy.

7.2 Is it important to have a function, like the network, that provides oversight of the wider diabetes service redesign programme to ensure things remain aligned?

For some time, most of the providers of healthcare will be separate institutions – some in primary, some in community and some in acute care settings. Therefore there is great danger of these providers simply providing episodic care in an isolated fashion. It is therefore necessary for some organisations such as the network to work across these different providers to ensure there is knowledge and understanding of what each of them are doing. Both networks had a great deal of discussion from the different providers which was enhanced by patient input.

7.3 Can networks maintain oversight of the performance of the whole system?

Given the split between purchaser and provider, networks are not currently empowered to run the system of healthcare. Primacy will be given to the commissioners who buy the healthcare that they want delivered. An effective network – with commissioner representation and membership from across the whole care pathway – has the potential to bridge this divide and can inform how standards should be set, how they could be provided and the outcomes that should be expected.

During a time of change and fragmentation of commissioning structures, having an organisation that maintains oversight of the whole care pathway is beneficial for patients. The power of a managed clinical network lies in the fact that it includes participating parties from across the whole pathway. When a local network has representation from all providers and where they are all signed up to an agreed diabetes pathway, the network has the potential to influence and improve the outcomes of services across the full spectrum of that pathway.

Crucially they must do so with a strong patient voice.

8. Appendix 1

There are a range of good analyses of what makes a network work. One we were advised of by a Bexley Network member was from where she had worked in Scotland.

In 2003, the Scottish Health Department carried out a review of managed clinical networks. It found the following key principles essential for the success of a managed clinical network:

- **They must be managed with** clear structures and responsibilities
- **They should have a clear purpose to improve patient care.** Whilst many of their actions will involve improving internal processes, unless there is a clear patient outcome, they may drift
- **Work must be evidence based** using existing guidelines or supporting future research
- **Outcome must be measured** with audits playing an integral part of the network and an open review of results
- **There must be a quality assurance programme**
- **There must be an annual report**
- **They must be genuinely multidisciplinary**
- **Patients must be involved in shaping the network**