NHS
Liverpool
Clinical Commissioning Group

Creating an Outcomes-Based Community Diabetes Service

Lessons learned from Liverpool Diabetes Partnership

NHS Liverpool Clinical Commissioning Group

September 2016

Liverpool Diabetes Partnership

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Contents

Introduction 3
1. What worked well 4
2. What didn't work well 5
3. Recommendations 6
4. Service improvement ideas 7
5. Live poll survey results 8
Contact Us 10

Introduction

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Since 2013, Liverpool has embarked on an ambitious journey to create an integrated, outcomes-based diabetes service.

NHS Liverpool Clinical Commissioning Group (LCCG) has invested an additional £900k to enable this transformation, which has united three main provider trusts in a partnership arrangement with the result being Liverpool Diabetes Partnership (LDP).

The commissioning approach and subsequent service model adopts a pioneering approach; moving away from traditional activity focused delivery, to 20% of the contract value linked to the achievement of meaningful patient outcomes.

Three years since this work commenced, and 18 months since the service inception, the teams involved have come together to reflect and capture key lessons learned, to inform current and future transformational clinical redesigns, both in Liverpool and beyond.

What we did

In July 2016 LCCG hosted a Lessons Learned Workshop inviting stake-holders from across all components of the service to give their views and opinions through group discussions and a real time voting poll survey. 23 people participated in the workshop including consultants, nurses, commissioners and managerial leads.

This report consolidates the responses during the session, highlighting from both a finance and contracting and service delivery perspective **what worked well, what didn't work well and a series of recommendations and suggested service improvements** that can be considered and applied in the future.

Who should read this report?

This reports is aimed at groups and services involved in diabetes care and clinical transformation such as commissioners, health care providers and frontline staff. It will particularly resonate with organisations exploring, or already implementing, outcomes-based commissioning.

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1. What worked well

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Finance and Contracting	**1.1**	Establishing a partnership approach from the beginning with the focus on what matters most to patients – this helped cement good partnership working between the providers and also with commissioners
	1.2	Consensus from the partnership that this was the right thing to do, driven by strong clinical leadership across the system
	1.3	Shared appetite for risk which was accepted and worked through to reach suitable solutions and compromises
	1.4	Culture of openness and transparency engendered trust between parties, which was needed during times of difficult negotiations
	1.5	Strategic level buy-in to the approach was essential to facilitating the transformation
	1.6	Introduction of secondary payment mechanisms – outcomes based approach is useful but long term; developing shorter term, more measurable objectives which sit under the outcomes helps providers keep track of progress
	1.7	Positive influencing upstream in primary and secondary care to adopt more proactive approaches to diabetes care
	1.8	Two roles were critical to success – experienced business intelligence personnel to lead outcomes development and an operational manager employed at the beginning of development. Their individual buy-in to this approach and leadership was crucial in making it happen
Service Delivery	**1.9**	General consensus from team that the outcomes-based approach has had a positive impact and added value. Cited most as being improved were patient access and the tailored education provision
	1.10	Contract structure enabled the service to develop and grow at pace due to increased flexibility of the partnership
	1.11	Introduction of diabetic specialist nurses (DSNs) working directly in primary care – a massive enabler for this work was the adoption of the EMIS Web system which provided the digital interoperability and interface between the DSNs and local practices
	1.12	Sharing success stories from patients who received positive care motivated the team and reinforced the impact of achieving the right outcomes
	1.13	Establishing working groups developed common pathways that led to more standardised care in the partnership

2. What didn't work well

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Finance and Contracting	**2.1**	Expectations needed to be set out more clearly from the beginning – 20% of the contract value linked to outcomes was a bold step
	2.2	Practical difficulties in aligning CCG contract spend / Trust HRG income to actual service delivery – even when considering directly related HRG's
	2.3	Additional investment didn't always feel tangible to front line staff – possibly because integration of different workforce groups didn't happen quickly enough and so it felt piecemeal
	2.4	Developing the outcomes was extremely complex and difficult at times. However this was to be expected adopting a new contracting approach
Service Delivery	**2.5**	Workforce engagement during mobilisation could have been stronger; divides between community and acute settings continued after the service had been established
	2.6	There was a disconnect between the vision of what an outcomes based service was and what that actually meant in reality– some frontline staff felt they were delivering the same service, only in a community rather than hospital setting
	2.7	'On the outside looking in' - The community diabetes nurses already in post before LDP said their valuable experience was not always acknowledged by managerial teams and felt excluded from the development of the service
	2.8	There were barriers to progress when managerial teams in each partnership provider would not all agree to implement the same service changes. This was frustrating for the operational team and not seen as working to the ethos of the partnership
	2.9	Multidisciplinary meetings (MDT) too administration focused and not encouraging consistent attendance from across the team

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3. Recommendations

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Finance and Contracting	**3.1**	Adopt a simplified approach to developing outcomes where possible
	3.2	Ensure a common understanding and standardisation of language across all parties involved, with transparency around data and process
	3.3	Embed secondary process measures for assurance that the service model is delivering improvements in line with the long term outcomes. Achieving a balance between short and long term goals and incentivising these appropriately and proportionate to the context of the redesign
	3.4	Ensure sign off from clinicians, commissioning, contracts and finance colleagues prior to submission of proposals to Boards/Governing Bodies for formal ratification of decisions
	3.5	Clinicians involved from the very beginning to define the outcomes, their associated trajectory and to lead the teams to deliver against these
	3.6	Stipulate the infrastructure arrangements in the contract required to make this approach work effectively, for example, a date to achieve integration or shared protocols rather than being prescriptive on the number or location of clinics
	3.7	Develop strategy for continued value in the service; keeping track of the benefits and achievements to date and a focus on what these should look like for the future
Service Delivery	**3.8**	Have a robust engagement and communications strategy. Create opportunities to physically bring people together at staff events during mobilisation
	3.9	Build in integrated workforce planning including clearly defined roles and opportunities for colleagues to shadow different roles in the service
	3.10	Hold clinically led multidisciplinary meetings
	3.11	Regularly share success stories and celebrate achievements
	3.12	Support teams to understand how an outcomes service works and is different, for example demonstrating how achieving the outcomes link to wider population health issues

4. Service improvement ideas

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During the workshop groups were also asked to think about what they felt the service need to do to continue to be successful. The ideas below are potential service improvement projects that can be explored and scoped in more detail by LDP.

Service Improvement	**4.1**	Improve alignment of contracts to caseload – podiatry service was used as an example of where this could be improved
	4.2	Develop process to request bloods without GP referral
	4.3	Developing more proactive support for house bound patient
	4.4	Continue to strengthen joint working and innovative service delivery with psychology services, TALK Liverpool, Health Trainers and other health and wellbeing services
	4.5	Further develop podiatry in the community service
	4.6	Increase number of sessions in the community
	4.7	Explore digital solutions for the multidisciplinary meeting such as Skype
	4.8	Deliver another phase of Making Every Contact Counts (MECC) training to staff
	4.9	Host quarterly nurse meetings to share clinical guidance and best practice
	4.10	Conduct exercise to map the current pathway to identify areas for improvement
	4.11	Build LDP presence across media platforms – revisit work to create and website and explore social marketing
	4.12	Improve the quality and accessibility of on health and wellbeing services

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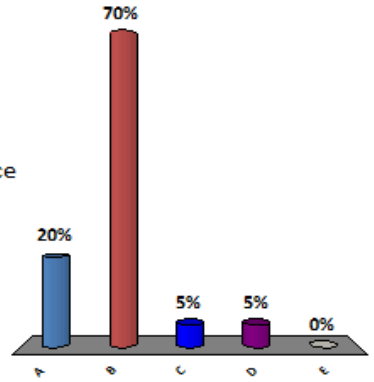
5. Live poll survey results

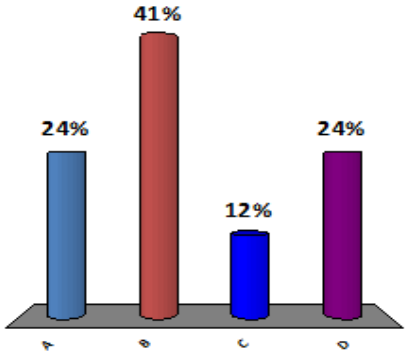
1. Do you feel the LDP approach has improved the quality of care for people with diabetes in Liverpool?

A. Yes & we can produce evidence to support
B. Yes, but not sure if we can provide measureable evidence
C. Probably / partially
D. Unsure / Could not say
E. No



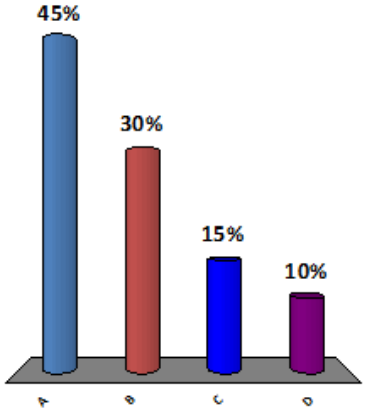
2. Do you feel part of an Integrated Team within the LDP*?

A. Yes, very much so
B. Yes to some extent
C. Not sure
D. No I don't feel part of an integrated team



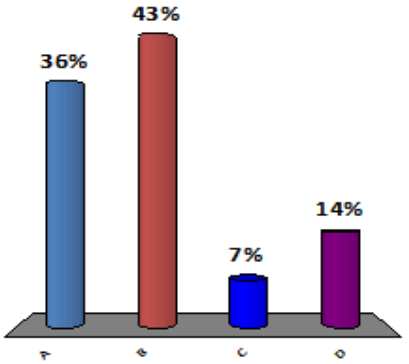
3. Do you feel empowered to influence how the LDP improves its service to best meet the needs of local people?

A. Yes definitely
B. Yes somewhat
C. Not sure
D. No I don't feel empowered to influence



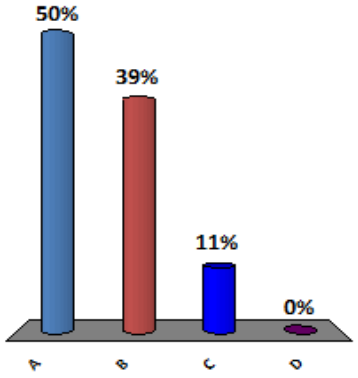
4. Do you feel you have the freedom to use bespoke approaches, tailored to the needs of individual patients*?

A. Yes definitely
B. Yes somewhat
C. Not sure
D. No



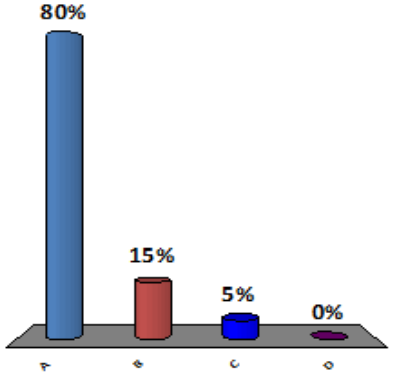
5. Do you feel that the service helps overcome some of the barriers between different settings of care?

A. Yes definitely
B. Yes somewhat
C. Not sure
D. No



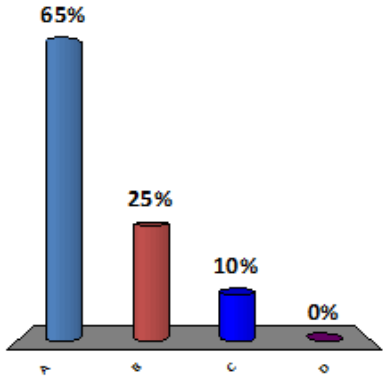
6. Do you feel optimistic that you will help the LDP to continue to improve over the next five years?

A. Yes definitely
B. Yes somewhat
C. Not sure
D. No



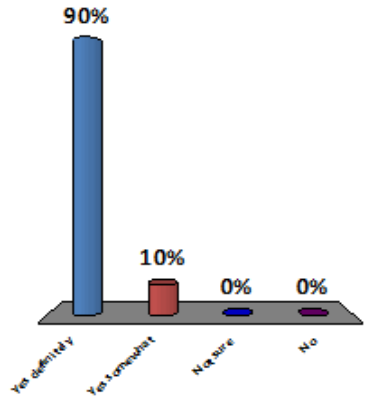
7. Would you recommend the further expansion of outcomes based services?

A. Yes definitely
B. Yes somewhat
C. Not sure
D. No



8. Would you be happy for one of your family members to receive care from the LDP?

A. Yes definitely
B. Yes somewhat
C. Not sure
D. No



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Contact Us

We are happy to answer any questions about this report or provide more information about Liverpool Diabetes Partnership. Please contact **Jane Fradley - Lead Commissioner for Diabetes** on the details below.

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