# Transforming Chronic Disease Management Pathways across a Primary Care Network

## 1. The Challenge

GP Health Connect (GPHC), a GP Federation in Halton, Cheshire, embarked on an ambitious programme of transformational change in Autumn 2018 as a forerunner to the creation of the Primary Care Network in Runcorn; R-Health. The Federation bid for and received funding from NHS England as part of General Practice sustainability programme across Cheshire & Merseyside. The aim of the programme was to support real transformational change with particular focus on quality, outcomes and sustainability.

GPHC recognised that the current approach to General Practice is unsustainable, coupled with variation in services and outcomes across practices. In common with many GP practices, the practices in Runcorn are experiencing increasing demand from patients with ever increasing complexity and need. The increase in demand is from patients with both chronic and acute need, as well as mental health needs and social needs.

Health and Social Care services are too fragmented causing confusion to both practices and patients as to how to navigate through to achieve the best outcomes for patients. All of these factors are contributing to reducing morale across the work force and as a result, it makes retention of staff more challenging.

## 2. The Vision

*"We want to work together as practices to offer a standardised approach across Runcorn. We want to work in a much more integrated way with our partners, including social care, mental health, community services, the third sector and our acute colleagues. We know we can do more to support prevention and self-care. We want to increase the capacity available using the same resources and assets but in a different, more efficient way. We want patients seeing the right professional and right service every time and that doesn't always mean General Practice or a GP. We want to invest in our staff and maximise the skills that we have available in Runcorn. We want to make Runcorn a great place to work in General Practice".*

### What does this mean for patients?

- We want to *improve the health of our population*
- We want *care continuity for patients* who need it and to ensure that patients *access the right services quickly*
- We want to *improve the experience of our population* accessing local services
- We want to *spend more time with patients who need it* and *reduce the number of times a patient needs to tell their story*

## What does this mean for our provider colleagues and workforce?

- We want to *work as an integrated team* with our statutory and non-statutory partners
- We want to *maximise everyone's skills* and *increase morale*
- We want to be *co-located with partners* (where it's appropriate) to *offer 'one stop' services*
- We want to *develop portfolio careers*, offering *choice and variety* and *opportunities to continue to learn and develop* (where people want to)
- We want to *make Runcorn a great place to work*

Investing in our staff is a key ambition of the local primary care strategy in Halton. Upskilling members of our teams in change management tools and techniques creates a sustainable and positive impact that will deliver benefits for years to come.
**David Wilson, GP and Chair of GP Health Connect, Halton**

# 3. Designing the Programme

The aim of the project was to spend longer with patients who need more support and intervention and to ensure that every Runcorn resident receives the same level of care, and that resources and skills can be better shared across the town. The focus included both prevention and self-care based on feedback and engagement with patients and their families.

As part of its visioning as to how this work could be undertaken, GPHC wanted to ensure a sustainable approach to the transformational change programme by enabling its workforce to have the tools and knowledge to drive forward the changes, and create the necessary behaviours to ensure learning could be applied to all areas of work.

Both the GP Federation and emerging Primary Care Network saw the opportunity as a key enabler to the Runcorn GP practices working together as an effective Primary Care Network.

The aim of the programme has been to **create a standardised town-based approach** for each **Chronic Disease Management group** that will both **reduce and remove** elements of **variation** and **improve patient outcomes**.

*The Rapid Improvement Cycles have created an environment for everyone to come together with a focus on standardising our chronic disease pathways to improve the quality for our patients. Through working together across the town, it's helped in building new relationships across our MDTs.*
**Dr Harjinder Sandhu, GP, Runcorn**

Integral Health Solutions (I.H.S) were commissioned to lead a Rapid Improvement Cycle (RIC) for the Hypertension pathway. Key to the approach was the development of closer integrated working with partners across all sectors – community staff, social care, third sector providers, acute and mental health colleagues, and supporting multi-disciplinary teams to enact the changes needed.

The approach involved working across the healthcare system, including Halton Public Health team, the local Acute NHS providers, the British Heart Foundation, Local Authority, and Halton CCG.

I.H.S designed and delivered a programme of support that would result in a core group of staff being trained in the tools and techniques and be involved from the outset in the development of the change approaches.

> Applying a structured approach has been very helpful; we've been focused on the needs of our patients throughout each session, and it's enabled all practices to engage in the process.
> **Dr Rhian Thomas, GP, Runcorn**

The programme of work consisted of 4 stages of work:-

i) Stage 1 – Training the Core Team in change management principles and RIC methodology

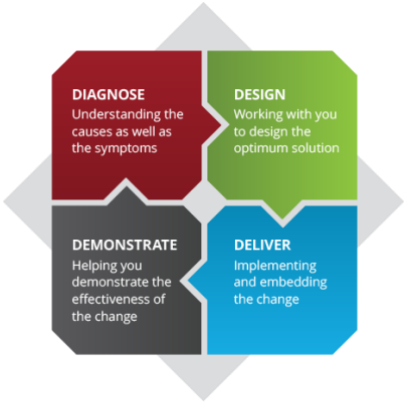
ii) Stage 2 – Leading and facilitating the first end-to-end RIC focused on Hypertension. This stage consisted of diagnosing the current pathway, building the blueprint for change, and leading the Report Out on the changes to a wider primary care network stakeholder group.

**iii)** Stage 3 – Coaching members of the Core Team to undertake the future Rapid Improvement Cycles, and production of a RIC manual as an aid to on-going learning.

**iv)** Stage 4 – Supporting the new KPIs to be used to monitor and measure progress against the new Hypertension Pathway.

## 4. Methodology

Utilising our Diamond Approach methodology which we applied to the whole programme of work, I.H.S worked closely with the Clinical Transformation Lead and senior management team at GPHC to design a programme utilising RIC methodology that would deliver focused change quickly. Whilst RIC approaches have been used in secondary health care, their use in primary care has been less documented, and therefore the design of the overall programme to minimise disruption to primary care services, was carefully considered.




Prior to the initial diagnostic workshop, a data collection exercise, in partnership with the local Public Health team, was undertaken across the 6 GP practices to understand what key performance indicators were in place, and the relative performance of different metrics along the Hypertension pathway. Data capture was undertaken at practice level; however, the data from the different practices proved to be inconsistent with significant variation in coding. This meant that there was a lack of meaningful insight to provide a true picture of the hypertension pathway across the practices.

> We've been able to use the learning from the rapid improvement cycles to look at other important areas of work for us, including some of the back-office function work in our practices.
> **Ms Sarah Sandhu, Practice Manager, Runcorn**

The Federation had articulated from the outset that they wished to instill a culture of learning throughout the process, and therefore the lack of insightful data provided a key learning opportunity for future RIC events, and an opportunity to explore the current process in more detail at the diagnostic workshops.

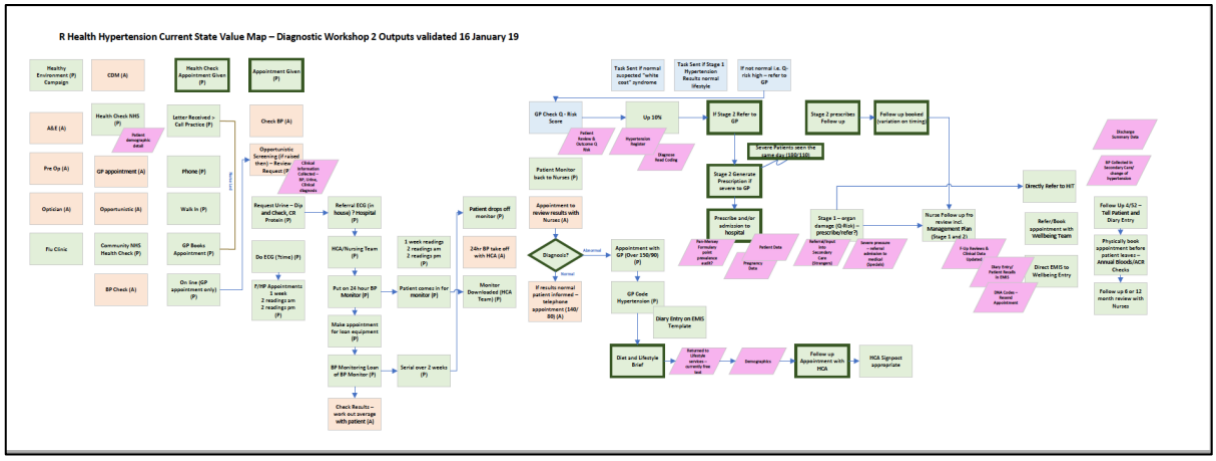
The RIC for Hypertension comprised of a series of workshops, working with a multi-disciplinary group of staff from across the 6 GP Practices, including colleagues from

Public Health, local acute NHS Trust, patient groups, Local Authority, Halton CCG, and The British Heart Foundation. The workshops were designed with a short period of time between each to encourage momentum and build action.

The first diagnostic workshop focused on identifying the current pathway and variation in process and pathway management for hypertension. A value stream map (figure 1 below) was created to provide a visual aid for staff.

Throughout this event, communication broadened between colleagues and amongst workforce groupings of the 6 practices, who started sharing their experiences about how they worked differently and how they might work together to transform the pathway. In particular, the Practice Nurse staff established their own network in sharing clinical protocols and policies to support the diagnostic phase.

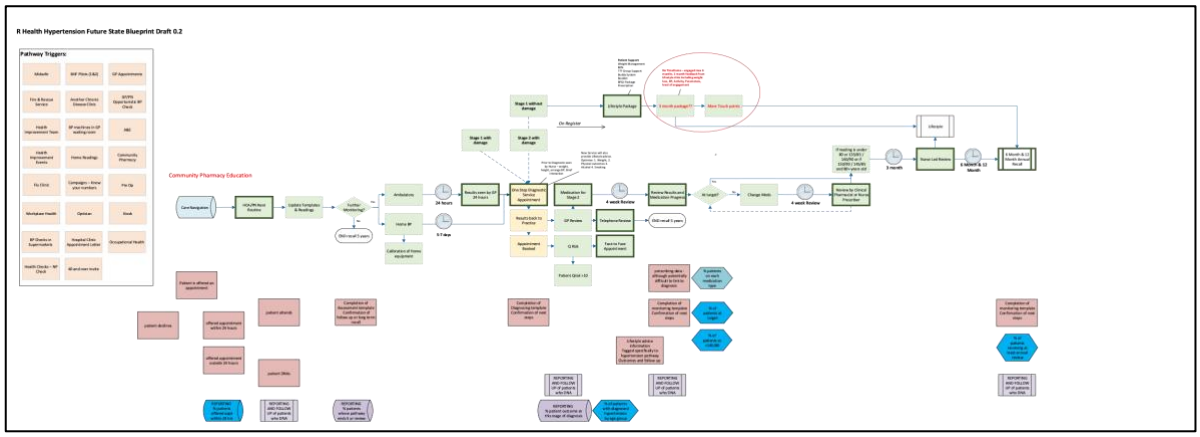
**Figure 1 – Hypertension Current State Value Map**




On completion of documenting the current process, an audit was undertaken of the different hypertension clinical guidelines in place across the practices, and their alignment with NICE guidance and best practice. This audit process allowed a stock-take to be undertaken to determine the areas of good practice in existence, and those areas where future development was indicated.

A workshop approach was also used to shape the development of the future blueprint for the Hypertension Pathway (figure 2 below).

**Figure 2 – Future State Blueprint - Hypertension**



Building on the outputs from the two diagnostic workshop sessions, I.H.S facilitated discussion to create the ***Outline Future State*** for the service. This included: Keep; Introduce; Develop; and Stop activities; visioning events; developing PDSA approaches to change; and creating the new value stream map. In creating the Blueprint, the following was considered:

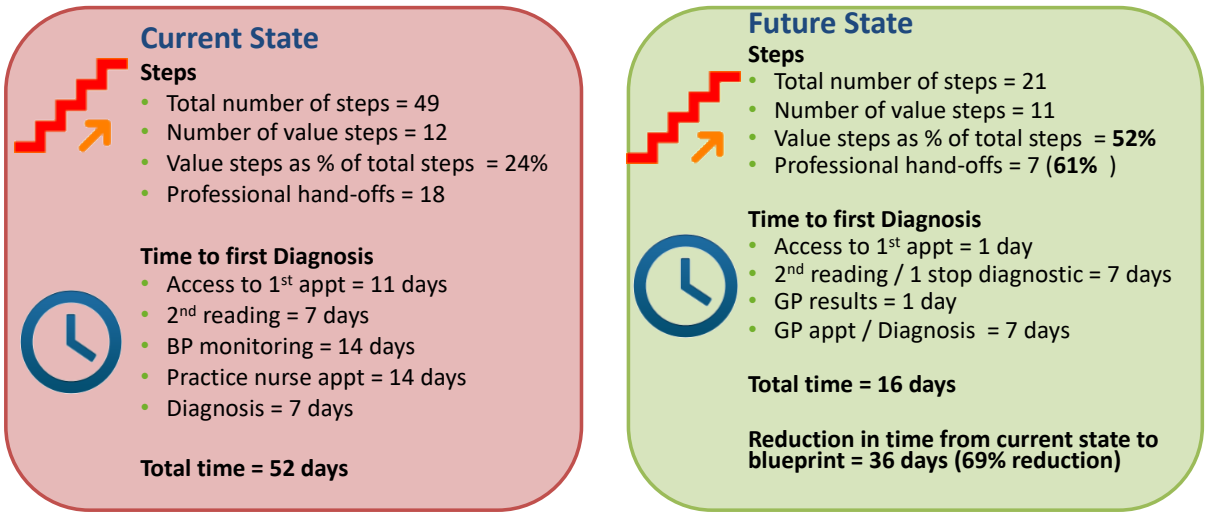
- What the change will mean for key stakeholders including patients, carers and staff;
- How people work and the way in which they integrate across the practices;
- How we can ensure consistency in approach across the 6 GP practices to ensure best practice guidance is followed, and patients receive the optimum care;
- How technology can be used to enable access and visibility of data;
- How limited workforce resources can be pooled to better meet patient needs;
- How clinical governance and safeguarding are assured; and
- Identification of the key milestones and timeline for implementation.

## 5. Impact

Through the value stream mapping of the Hypertension pathway, we were able to identify the total number of steps, hand-offs between healthcare professionals, and the value to patients in the current state pathway.

Improving the value to patients was the over-riding objective and on finalisation of the blueprint, the total number of value steps had improved by over 50%. The total number of steps had reduced from 49 down to 21, and total number of hand-offs reduced from 18 to 7. Both the current state and future state analysis summary can be seen in figure 3 below).

**Figure 3 – Current State versus Future State (Hypertension Pathway)**




**The establishment of a one-stop diagnostic approach, and 24-hour access to the first appointment for patients with a potential diagnosis of hypertension, within the future state process has created a reduction of 69% in time across the total pathway.**

Further achievements within the hypertension pathway included the following:-

- A new clinical protocol was developed by a group of GPs from across the practices and further developed so that it integrated into the EMIS system. In collaboration with the community pharmacist, the protocol recommends the medicines to be used at each stage of the pathway.

- The Local Authority Lifestyles Team, who provide a holistic dietary and activity support service, re-designed the access points into their service to ensure more equitable access for all patients, and provided guidance and support to GP practices to encourage more patients to commit to this important element of care.

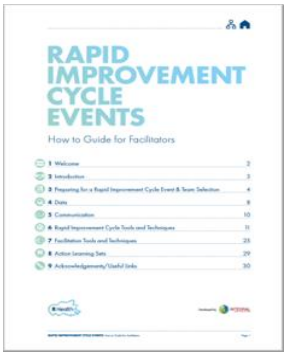
- Focus on the back office supporting functions for the recall of patients on the Hypertension pathway has resulted in all practices agreeing to consistently using the MJog texting service as the primary contact mechanism (unless different preferences are requested by the patient), given that patients can be contacted in real time. This will improve timely communication with the patient population. In addition, agreement has been reached across the 6 GP practices to standardise the codes used for monitoring this cohort of patients, in accordance with the Quality Outcome Framework (QOF).

- A group of Practice Nurses looked at how they can manage their surgery commitments to ensure that patients referred with a potential diagnosis of Hypertension can be reviewed on the same day, if they wish. This was challenging given the paucity of Practice Nurse resource across the town; however, it has been successfully achieved.

## 6. Additional Benefits

At the outset, it was important to GPHC that the new approaches and methodology for RICs could be shared with a wider workforce to enable sustainable change and upskilling of staff so that the work can continue beyond the remit of this commission. Coaching in the facilitation of RICs, and the passing on of knowledge in Lean Methodology and its application was therefore an important part of the learning process.

To support this, I.H.S developed a training manual with supporting narrative for each of the tools and when they are best applied.




The training manual also provides facilitator guides to running each workshop. The training manual can be viewed online via the Network's intranet site and has been a useful aid to the core team who have committed to continue to run the RICs.

Since the work programme completed, the GP Federation have continued to roll-out the approach on Diabetes, Respiratory, Cancer and Acute Mental Health Illness pathways, under the facilitation of the newly recruited Project Manager. The Project Manager has been key in their role in engaging staff from practices to attend and participate in both the training and RICs. In addition, new clinical leaders have emerged through the process, and a number of GP's have now stepped into facilitation of each of these cycles.

I've enjoyed being a part of each rapid improvement cycle; we've seen tangible improvements in a short timeframe, and it's kept us motivated to change. Having a structured approach has enabled us to keep momentum.
**Sr Jane Hodson, Practice Nurse, Runcorn**

Practice nurses have embraced the methodology and approach and presented on behalf of the project at regional events. This has been achieved through a belief in the methodology and observation of what can be achieved.

The management team of the GP Federation estimate that over 60% of staff have engaged in the process in some way, forming a new set of relationships, and instilling change behaviours into every day working.

As the Clinical Director for the newly formed Primary Care Network, the focus on chronic disease management through Rapid Improvement methodology has been timely; it has supported the foundation for working as a whole clinical network and enabled further building of relationships amongst the practice teams. Focusing on clinical pathways has garnered fantastic engagement across our clinical community, the benefits of which are being realised across other strands of our transformation programme.
**Gary O'Hare, Clinical Director, Runcorn Primary Care Network**

The impact of the RIC approach cannot be underestimated in the development of the new Primary Care Network. The energy, passion, and focus demonstrated the new leaders that have emerged through the process, and the creativity applied to the new blueprint pathways which are all testament to the ambition that GPHC set out on commencing their transformation programme.

As a clinically driven transformation programme, building early momentum and adding value were critical factors in engaging our staff as we launched R-Health. Starting with a focus on clinical practice and patient care was the hook. Integral Health Solutions (IHS) have been essential partners in helping create a series of projects that have extensively engaged all staff – clinical and non-clinical – who have developed standardised and local care pathways. We are extremely confident that the results of our partnership with IHS will deliver improved outcomes for our local population and we have trained staff with core change management skills to ensure that the funding made available by NHS England will have a sustainable impact in Halton.
**Rob Foster, Chief Officer, GP Health Connect, Halton**