

The Bermuda triangle of diabetes

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Abstract

Achieving better patient outcomes is something that often eludes us. We sail together with our patients through the rough seas of diabetes and its complications. As in the Bermuda triangle, both patient and health care professional can get lost at times; however, this process of being lost and finding our way back again can provide us with valuable lessons to become better at what we do and thus improve outcomes for the person with diabetes. This paper addresses the key elements of effective treatments for diabetes, the qualities needed to be a clinical champion, and the components needed to deliver high quality care. The paper delves into issues around leadership, passion and vision. It also addresses effective service delivery models, structured self-management education and health care professional training.
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Key words

clinical champion; leadership; service delivery; self-management education; health care professional training

Introduction

We would all agree that achieving good glycaemic control, blood pressure and cholesterol targets along with reducing cardiovascular risk is essential in the care of people with diabetes. Achieving these outcomes is based on effectively managing the three cornerstones of diabetes management: diet, activity and medication (Figure 1). This may sound simple; however, positive outcomes with this familiar treatment triad all too often elude us and many of us, patient and health care professional (HCP), get lost along the way. Just like the Bermuda triangle, it is easy to get lost when navigating the complicated world of diabetes. People with diabetes and their health care providers have to sail together, navigating the journey between their personal world, primary care providers and secondary care providers. Throughout that journey they often have to ride the rough seas of diabetes complications.

What will help us successfully navigate these difficult seas and avoid mutiny by either crew? Could building to our familiar treatment triad strengthen our ability to achieve better patient outcomes?

Throughout this paper, the argument is presented for placing importance on two further triads that need to be considered to ultimately improve outcomes for patients: a triad to represent the clinical champion and a triad to represent high quality services.

The clinical champion

The clinical champion triad (Figure 1) consists of passion, leadership and vision: all essential qualities of becoming an effective clinical champion.

Passion

Passion drives our behaviour and ultimately it makes us want to do a good job; however, sometimes it can be misguided and burn out.

'If passion drives you, let reason hold the reins' – Benjamin Franklin.

Passion is something within us, but seeing passionate role models when being new to a clinical area can spark your vision. Janet Kinson was someone who I saw was passionate about diabetes. She transformed training for nurses working within diabetes care by developing the original ENB 928 in Diabetes. Her passion drove her to influence the diabetes nursing agenda. This training for diabetes nursing had a major influence on the care that people with diabetes received at that time.

To be a clinical champion you have to be passionate about wanting to make a difference for people with diabetes. During my early career, volunteering at the British Diabetic Association holiday camps for children sparked my passion. Here I learnt what it was like to live with diabetes for 24 hours a day, and about the challenges faced not only by the children and parents but also by the leaders who often had diabetes themselves. I was inspired early in my

career by the determination of individuals to overcome the adversity of being diagnosed with diabetes.

People who are passionate are often also explorers. If you have passion and ideas that you believe will work, you need to give them a go and venture onto new territory. Mentors in my early career made me believe in my ability to make things happen and they encouraged me to try new things. Sometimes our ideas stayed afloat and sometimes they sank, but the important thing was that we learnt something new and we maintained our passion about making a difference. At times, passion can be misinterpreted as mutiny but I believe passion challenges the status quo and brings about necessary change. Suggesting change is not always popular and requires change management skills. Having a go and doing something new started initiatives like group patient education, and from these initial ideas great things have developed. At the time, these small initiatives may have seemed insignificant; however, it is these ideas that are the important first stages of research which can lead to bigger things. Major work such as the DESMOND (Diabetes Self-Management for Ongoing and Newly Diagnosed) project¹ and the DAFNE (Dose Adjustment For Normal Eating) project² have been born through people with passion trying something new.

Leadership

Good leadership can really make a difference and learning the skills to be a good leader can often be a steep learning curve. An effective leader is aware of their leadership style and can work within a team to coach people, see the best in them and develop their potential. Adopting an effective leadership style can result in increased quality of work life, job satisfaction and psychological well-being for employees, which results in greater work engagement allowing everyone to work together towards collective goals.³ They also learn from those with whom they work.

'He who cannot be a good follower cannot be a good leader' – Aristotle.

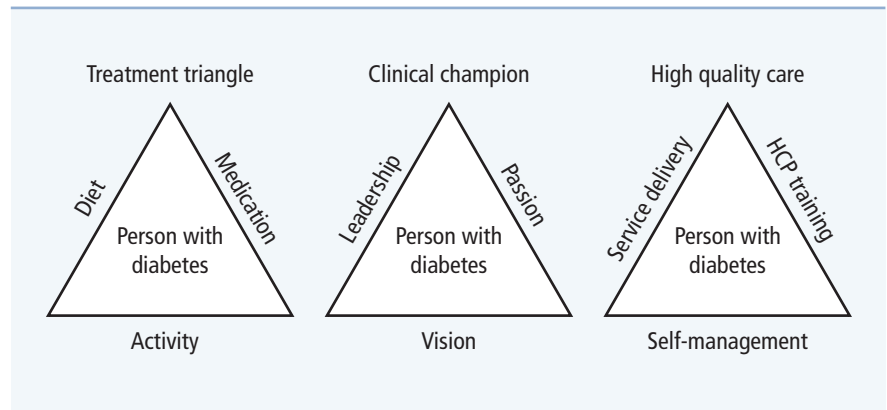


Figure 1. Triads for successful diabetes management

Many things can influence leadership style and this is something that can be developed, learnt and shaped through effective mentorship and training. People often confuse management with leadership. Most of the time, within a role, an individual will have to be both a manager and a leader; these are distinct roles and it is important to recognise the differences. Managers organise, delegate and plan, while leaders inspire and motivate. The diabetes nurse consultant role gives an ideal opportunity to progress clinical and leadership roles without the responsibilities of management and, if implemented in the right way, can make a real and lasting difference to diabetes services and their delivery.

Clinical champions are effective leaders and drive forward improvements in care and services with the help of the people that work around them whom they inspire and motivate.

Vision

Not everyone has the ability to be visionary.

'Vision is the art of seeing what is invisible to others' – Jonathan Swift.

My time as Nurse Consultant in Leicester allowed me to be visionary. I worked with others developing shared guidelines across primary and secondary care⁴ and we also developed the Leicestershire website.⁵

Things happen quickly if people share vision and this happened during my time in Leicester when a group of people came together to establish a research project looking into self-management education for people with type 2 diabetes. This group of people formed the

DESMOND steering committee and the work they did went on to see the largest-cluster randomised controlled trial in group education published in the *British Medical Journal*.¹ This piece of work went on to receive the *Health Service Journal* Award in 2007 for its quality assurance and training. The vision held by the DESMOND steering group has led to unprecedented and positive changes in the way people with diabetes learn to self-manage their condition. Vision ultimately promotes necessary change.

If clinical champions possess all the skills we have talked about, they can influence the diabetes agenda and positively influence the outcome for people with diabetes. Clinical champions are leaders, they have passion and they have vision; however, they also have to be a bit devilish at times. So how can they use their influence to achieve high quality care? This brings us on to our third triad.

High quality diabetes care

To achieve high quality care that has good outcomes we need the three elements of this final triad working together (Figure 1): effective self-management, an effective service delivery model and effective HCP training. At times the emphasis on them may change, but they are all reliant on each other for their strengths and success. Miss one out and the triangle collapses.

Self-management

Prior to 2003 we have had very little evidence for structured self-management education; however, this is no longer the case. Over the last 10 years there have been numerous

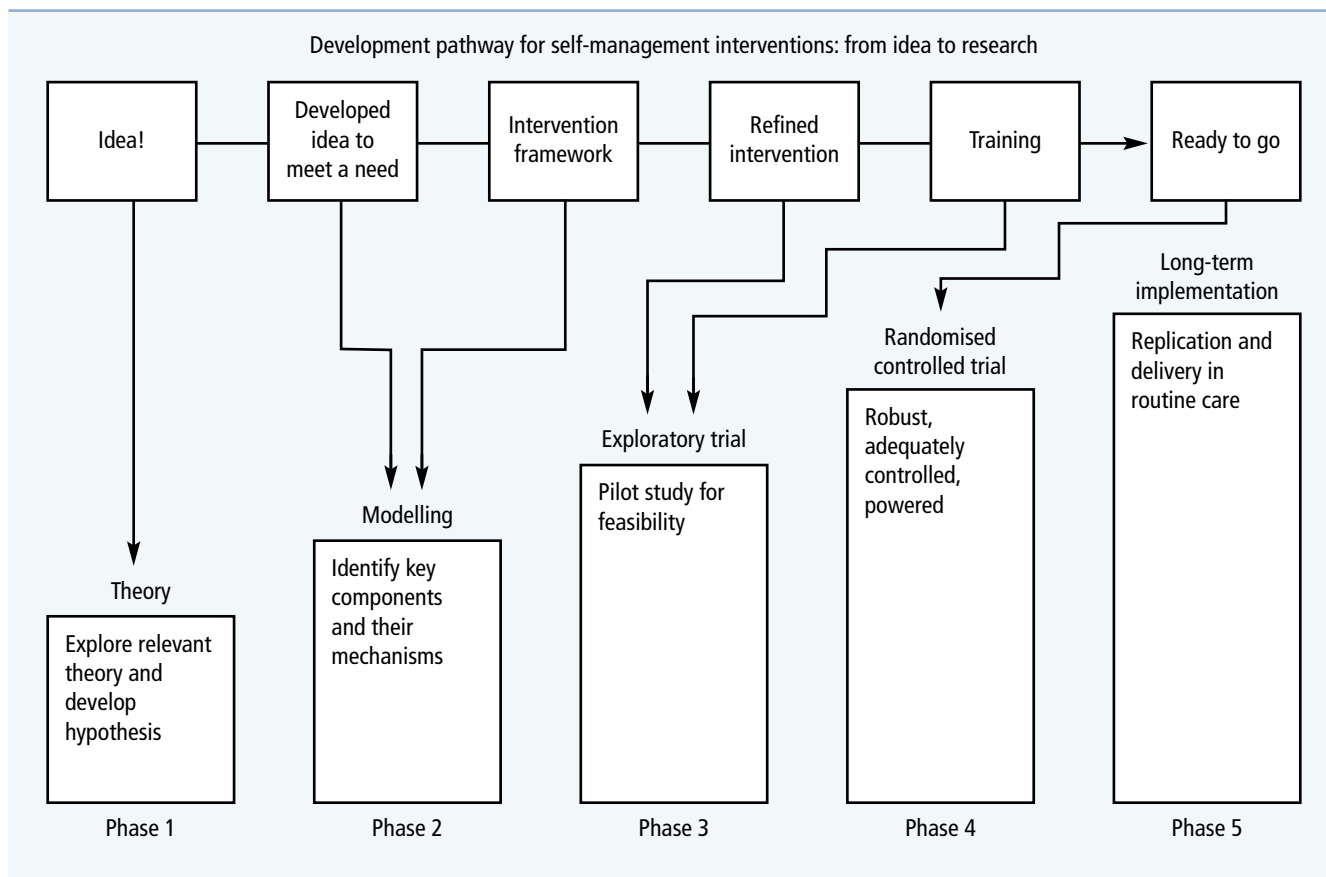


Figure 2. Medical Research Council framework for complex interventions: from research to the real world. (Adapted from MRC Framework for Complex Interventions website: www.mrc.ac.uk/documents/pdf/rcts-for-complex-interventions-to-improve-health/)

publications detailing the trial evidence^{6,7} behind such interventions. Although such evidence shows us that self-management education improves outcomes in many different ways and is cost effective, the reality is that overall only below 9% of people are offered structured education and less than half of those actually attend, meaning few have access to the potential benefit.⁸ This is because, despite being pushed onto the diabetes agenda by our clinical champions, it is still considered by many as an optional area. In many areas of the country it is not commissioned as part of integrated care and, where implemented, the quality is sometimes lacking despite national guidance.⁹ Structured self-management interventions are complex and thus trialling them is also complex. The Medical Research Council has addressed quality in the design and delivery of these trials by providing a framework for trials with complex interventions (Figure 2).¹⁰ This framework ensures that these interventions are subject to the same

kind of rigour as other interventions, ensuring that all stages of the process are researched in a rigorous manner. The pathway itself is complicated and there is extensive work involved from having an idea for a self-management intervention to undertaking a full randomised controlled trial.

The DESMOND programme has used this pathway in the development of its programmes. From the initial research in 2000 for people with newly diagnosed diabetes, the DESMOND family has grown to include programmes for ongoing diabetes, prevention, injectable therapies, young type 2 diabetes, mental health, sleep apnoea and polycystic ovary syndrome (Figure 3).

Despite all of this work there is still more work to do on raising the profile of and access to structured self-management education to achieve those sought-after high quality outcomes. One barrier to overcome is successfully implementing these programmes and their results into the 'real world'. Funding for the

post-research stage needs to be seen as a critical part of getting the message out there to both HCPs and people with diabetes. The Leicestershire Diabetes Centre has done some great work on the process of how we can make this happen (Figure 2).

While the Quality and Outcomes Framework has achieved a step in the right direction in awarding points for referral to diabetes self-management education, a more effective approach would be to award points for attendance as this would positively influence the perceived value to HCPs.

The barrier of dissemination may be for many why structured self-management education is still seen as a relatively new concept. As new trial evidence emerges, it will be seen as more common; however, we still have to overcome the concept of inertia. We know there is inertia in prescribing medications,¹¹ often taking years to optimise medication to achieve targets. The same inertia exists in the

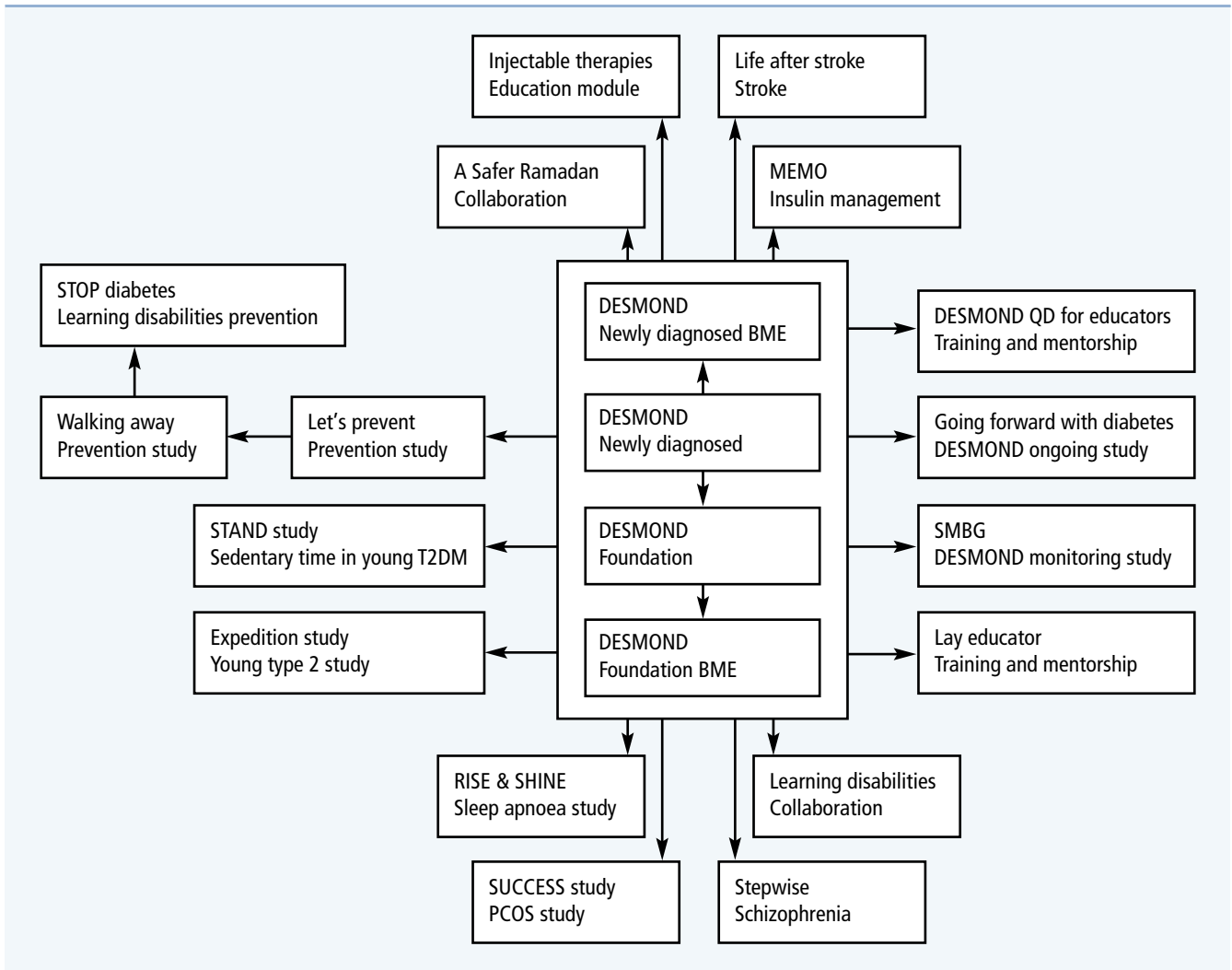


Figure 3. The DESMOND Family of Interventions (reproduced from: www.desmond-project.org.uk/whatisthedesmondprogramme-271.html)

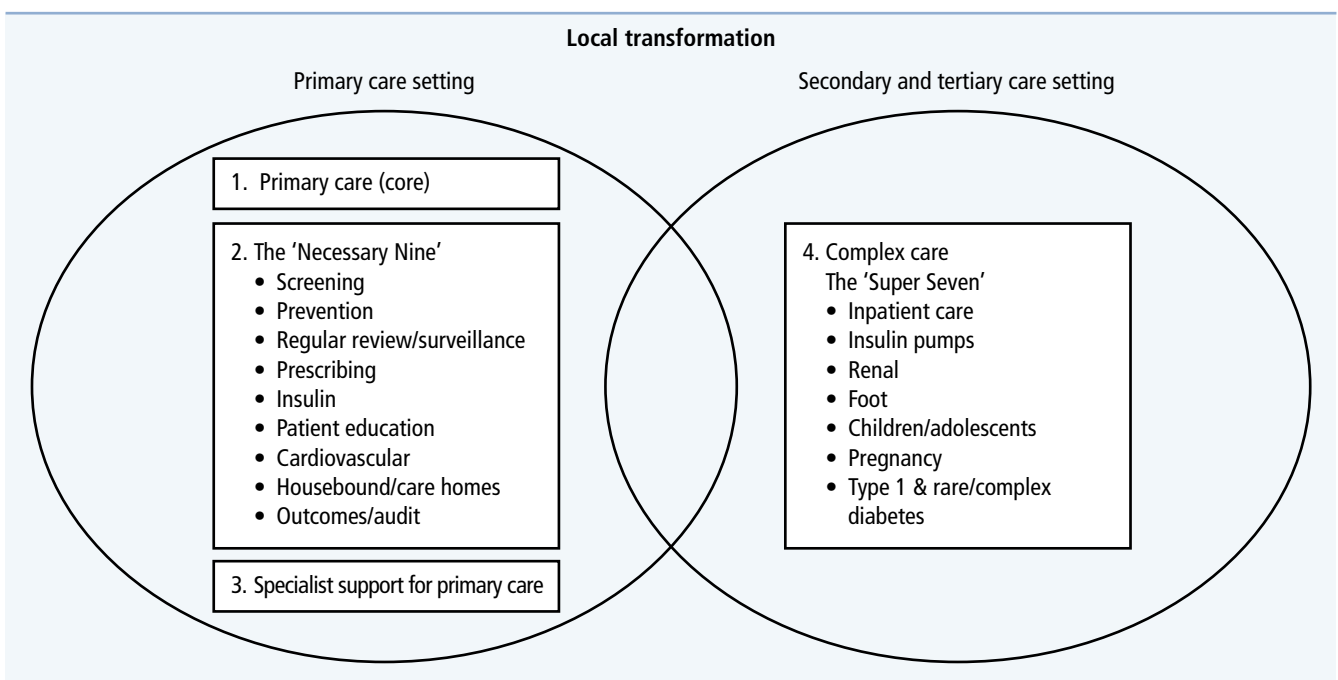


Figure 4. The Leicester transformation project. (Reproduced with permission of University Hospitals of Leicester)

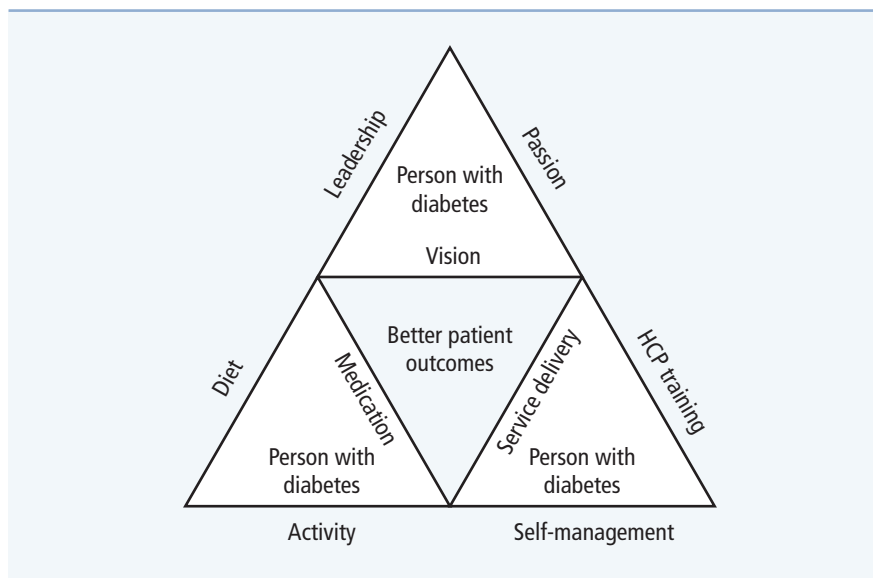


Figure 5. The ultimate diabetes triad

prescribing of structured education and, as it is not a medication, it can be argued that the inertia may be worse. If self-management education could be prescribed on an FP10, it would be madness not to prescribe a relatively inexpensive treatment that you know would be effective for a minimum of 12 months.

Until we see a time when every person with diabetes has access to high quality structured self-management education and this becomes as common and habitual as prescribing metformin, there will be patients who are lost along the way in the rough seas of this Bermuda triangle. The DAWN2 study¹² highlighted that 50% of HCPs did not ask patients what impact diabetes has on their lives, and approximately the same number requested training in this area. These results show we have a long way to go.

Service delivery

Service delivery is not about the building where the service is delivered but about the agreed pathways of care. This side of the triangle is an important one not only for HCPs but also for the person with diabetes and their carers to enable us to audit the standard of care provided. All of these players, especially people with diabetes, should be involved in shaping the way we develop and deliver services.

All clinical areas across the country will have their own pathways and models of care. However, one of my experiences in re-designing service delivery is from a transformation project within Leicestershire which totally re-designed the model of care. Throughout this project we worked together involving commissioners, patients and users to develop the service re-design (outlined in Figure 4). The transformation group highlighted services that would be delivered in primary care, dubbed the 'Necessary Nine', and those that would be delivered in the secondary and tertiary care setting, dubbed the 'Super Seven'. This model provided a framework on which to build these services, supporting the delivery of diabetes care wherever it is best for the person with diabetes. Patient and public user involvement was invaluable in this process, and their presence ensured we had the person with diabetes at the centre at all times.

One of the key and essential recommendations that came out of this piece of work was the importance of HCP training. No one can argue the fact that to ensure high quality diabetes care at the point of contact you require a highly skilled, knowledgeable and competent workforce to deliver that care at different levels. This leads to a discussion about what constitutes effective HCP training, the last side of our final triangle.

Health care professional training

We know HCP training is effective because we can measure knowledge, skills and competency in a variety of ways. However, do we know if HCP training is cost effective and, more importantly, who is going to pay for it? For many HCPs, funded training opportunities other than mandatory training are scarce in the current climate of budget cuts and restrictions on industry sponsorship. In Leicester, as part of the service delivery re-design, a focus on HCP training to deliver the service effectively was not left behind. The local clinical commissioning group (CCG) commissioned a three-year project called EDEN (Effective Diabetes Education Now).¹³ This project supports the transformation of care to ensure GPs, practice nurses and health care assistants all have the necessary skills to support the 'Necessary Nine' components of the new model of care.

This programme is competency based and supports core care skills, but also provides mentorship to those practices aspiring to deliver enhanced care ultimately to attract additional funding. A database of training and mentorship has been designed and an audit trail links this to clinical outcomes at practice level. EDEN has developed its own brand and can be easily recognised for its high quality and diverse approach to training. Projects such as these are often very clinically based and, for some wishing to specialise further, accredited courses are advantageous to enhance both clinical and academic skills.

Nationally we have many post-graduate accredited courses which can provide a higher level of study for those wishing to take their studies to a Masters level.¹⁴ All provide higher awards and continuous professional development (CPD) modules on a variety of topics covering all aspects of diabetes care. Funding can often be a challenge but local clinical champions can incorporate sourcing this into their agenda around service delivery. As part of the Leicester transformation project, monies were allocated to support local primary care staff to undertake Masters modules as well as the EDEN training.

Key points

- Patients and health care professionals have to sail together the rough seas of diabetes
- Clinical champions, effective treatments and high quality care are all needed to provide the best opportunities for people with diabetes to manage their condition effectively
- Leadership, passion and vision are all qualities essential to being an effective clinical champion
- An effective service delivery model, effective health care professional training and excellent self-management education for patients are essential in ensuring that high quality care is available for people with diabetes
- Diet, medication and activity need to work together to provide optimum treatment for people with diabetes

Gaining clinical knowledge is often put to the forefront by HCPs; however, often the all-important skills to empower and counsel people with diabetes are left behind. The Knuston Hall Empowerment and Counselling Skills course for Diabetes¹⁵ is a course I feel should be mandatory for everyone working within the field of diabetes. It is currently part of the University of Leicester MSc programme¹⁴ but can be taken as a stand-alone course. It gives delegates the skills to place the person with diabetes at the centre and will shape consultation skills forever.

As an HCP who has undergone a lot of training, my most valuable lessons have not come from textbooks or courses. Most of my learning about diabetes has come from the people with diabetes, and for that I am eternally grateful. My advice would be: whatever you do, ask yourself where the representation and the voice of the person with diabetes is, because without their voice it will not be fit for purpose. The person with diabetes is at the centre of all of these triangles and they should be involved with all aspects of diabetes care through patient/user involvement.

Putting it all together

As we re-visit the three Bermuda triangles of diabetes care, I conclude that it is only when these three triangles come together that we can achieve improved patient outcomes (Figure 5). Miss out any of the elements and our structure loses its collective strength and is at risk of collapse.

We will all undoubtedly get lost in these Bermuda triangles at times; however, the process of finding our way back again is the one from which we learn and ultimately helps us become better at what we do. The key is being prepared when our ships set sail.

With this in mind, as I wish you luck at the start your journey, I leave you with three gifts: a pair of binoculars to see what is coming ahead, a compass to navigate your way, and a rope to hold you all together when the seas get rough.

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