

Integrated diabetes care: the Wakefield diabetes service redesign

In this article we describe our approach to modernising diabetes services in Wakefield to support primary care teams delivering high quality diabetes care. The service redesign has been in progress since January 2009 and is led by the specialist diabetes teams and driven by the Diabetes Network.

An interim report on the progress of implementing this model was presented to the Clinical Management Committee in June 2010 with the recommendation that this new way of working become a mainstream service. From April 2011, this service has been fully commissioned from Mid Yorkshire NHS Trust, which hosts specialist diabetes services. A full service specification on this component of the redesign has been agreed with the providers of the service. The objectives were defined as:

- Better clinical outcomes, clinical sustainability, and optimising volume.
- Improving efficiency and productivity for long-term financial viability.
- Integrate primary and specialist care.
- Safe and appropriate care.
- Improve patient experience.
- Duplication to be avoided.
- Up-skilling of GPs and practice nurses.
- Deliver the benefits quickly.
- Reduce variations in the delivery of diabetes care across GP practices.
- Minimal capital spend.
- Maximise existing capacity.

The primary outcome measures were expected to be: delivery of most diabetes care nearer to patients' homes; timely access to specialist services in primary care; up-skilling of practices in delivering diabetes care; and ongoing educational support for patients, GPs and practice nurses.

We made some early decisions during the options appraisal process as to what we did not want to do. Creating an intermediate diabetes service was discarded fairly early as it did not fit with our existing services and was considered unaffordable.

Neither did we wish simply to relocate clinics from specialist centres to primary care or create a model addressing organisational priorities only. We at no stage wanted to lose patient focus.

The focus of the clinical model

The focus of the clinical model was to: reduce health inequalities by providing equitable care to all; provide systematic and structured care; reduce variation in care; engage non-attendees and vulnerable groups; and make the services easily accessible.

We believed that the above could only be addressed by true integration of specialist teams supporting primary care teams and delivering most diabetes care in primary care.

A baseline self-assessment of GP practices was undertaken which was essential to identify the level of service currently provided and the level to which they aspired; this was done by using a model developed by us and adopted nationally as a commissioning tool.

Implementation

The Wakefield model included the allocation of a diabetologist and diabetes specialist nurse (DSN) to a GP practice along with dedicated administrative support. Provision was also made for additional dietetic support. The local enhanced services (LESs) for GPs was reviewed and a new LES was developed for various components of the diabetes service in order to incentivise practices to adopt new models of integrated working. Once the clinical model was finalised, a business case was developed and costed. This was approved by the Financial Review Board of the PCT in October 2008.

In summary, the clinical model to support primary care consisted of:

1. An initial visit to GP practices attended by the diabetologist, DSN, Diabetes Network manager and coordinator, practice nurse(s) and lead GP for diabetes. Discussions focused on the logistics of joined-up working,

an explanation of the model and the new LES for diabetes together with the practices' own aspirations for developing diabetes services further.

2. Case Notes Review (CNR): the patient selection for the CNR was founded on the triage system based on glycaemic control. A pragmatic decision was made to review first those patients with the worst HbA_{1c}. The case discussions not only focused on glycaemic control, but also reviewed cardiovascular risk management and other aspects of the diabetes management. Location of care was agreed for each patient. As the review included those patients seen in specialist diabetes centres, this allowed an opportunity to review the last hospital-based consultation and some view on the appropriateness of the decisions made.

3. Specialist Primary Care Clinics (SPCC): These fell into two categories:

- *A joint clinic attended by both GP and diabetologist:* the consultation was led by the GP despite being a joint clinic. Patients were informed in writing by the practices as to why they had been selected for this clinic. After a joint consultation, based on 'care planning' principles, a care plan was agreed with the patient including priorities for implementation. If these patients were still under follow up by specialist teams, they were discharged from this. The frequency of these clinics was based on the practice level of service (2, 3 or 4) but some degree of flexibility was allowed in the scheduling. The first clinic took place on 15 May 2009 and to date all 40 practices have been involved in running them, including regular clinics in HM high security prison in Wakefield.

- *A joint diabetes nurse and practice nurse clinic:* the main purpose of these was to allow a significant proportion of care to be shifted to practices and giving the opportunity to up-skill practice nurses while working jointly with the DSN. This

allowed us to change radically the time lines for insulin initiation, including aggressive insulin titration, GLP-1 analogue starts and regular follow up of patients already established and stable on insulin treatment. Practice nurses had free access to the DSN attached to the practice (telephone and e-consultation). During the last two years, practice nurses have begun to feel more confident and have acquired skills in the above and are less dependent on the DSN to provide these services.

4. Clinical Case Review: GPs and the practice nurses were allowed clinical freedom to decide which patients (seen in their routine diabetes clinics) they needed to discuss with the specialist teams. In the past and prior to the redesign, these patients may have been referred to the specialist teams. It is recognised by the clinicians that these queries are likely to arise on a daily and weekly basis and, to allow these discussions to occur in a timely manner, a process of e-consultation using SystemOne has been agreed and is being implemented. This allows a GP to raise a 'clinical task' for a diabetologist and permission is given for access to the patient record on SystemOne (a web-based IT system used by GP practices). The diabetologist is then able to review patient records remotely and address the clinical queries raised, and the email is automatically sent to the GP informing them of the review. If the diabetologist feels that (s)he is unable to provide e-consultation, (s)he can request a face-to-face review with the patient.

5. Practice Based Education: an early recognition within the redesign was to address the need for education and training, in addition to what took place during the CNR and joint clinics. Although some *ad-hoc* training has occurred based on practice requests (i.e. insulin regimens, new therapies), 16 modules are being developed for coverage on a wide range of topics in diabetes relevant to daily clinical practices and spanning from prevention of diabetes to early diagnosis, management, and treatment of complications. The responsibility for this lies with specialist teams visiting the practices; the Clinical Champion for the Diabetes Network

Key elements

- A shared vision by all
- Strong clinical leadership and engagement
- Emphasis on patient focus and improving patient experience
- Challenging historical ways of working (dogma)
- Creating a culture of 'yes we can do it'
- True integration of primary and specialist care – embracing teams without walls concept

has been given the responsibility to develop these modules.

Impact

Although it is too early to produce evidence of the success of this model, there are some indirect indicators to support the fact that we are beginning to make a difference.

A recent review shows that the level of services provided by GP practices has changed, with more practices taking on insulin initiation and titration and looking after stable patients on insulin treatment.

Evidence provided by data on the prescribing of new drugs for diabetes shows that, for example, the usage of certain new drugs has escalated. Our interpretation of these data is that, during CNRs of patients in GP practices, a significant unmet need has been identified and the need for new therapies as per NICE guidance is being implemented.

In 2008/09 and 2009/10, the Yorkshire and Humber Public Health Observatory produced Diabetes Community Health Profiles for each PCT where data from PBMA and the Quality and Outcomes Framework were collated. These showed an encouraging shift from the PCT being in the lower end of the 'Low Costs Poor Outcomes' quadrant to almost fully into the 'Low Costs Good Outcomes' quadrant.

We recognise that there are many other aspects of improvement in the quality of diabetes care which are difficult to measure, but qualitative feedback early in the redesign has been very positive.

A completed modular training of GPs and practice nurses will give consistency in the training of GPs. These modules will also include one on

clinical guidelines and pathways for the patient journey. We were surprised that other GPs who do not currently take a lead in the delivery of diabetes services have expressed the desire to attend these modular sessions based in practices and joined with the clinical sessions.

One of the ancillary benefits was the recognition of unmet need as many patients were identified for referral to specialist diabetes teams, and specialist obesity services. In addition, quality assurance of the care provided by the specialist teams was another added benefit and we were able to review all the letters sent to the GPs from diabetes centres during the case note reviews. We believe that the service redesign is addressing and achieving all of the objectives we set out to achieve, and that the redesign is sustainable in the long term.

Summary and conclusions

Our experience during this redesign has been extremely positive and with significant clinical and non-clinical engagement from all stakeholders. Our planning phase, which lasted approximately 12–18 months, appeared fairly long but not so if one considers the service planning cycle in the NHS which can span anywhere between three to five years.

We believe our success in getting the redesign off the ground has been due to a shared vision among all health care professionals. This has led to the start of structured and organised care by the specialist teams to support primary care. We believe the new services have circumvented very circuitous pathways and simplified these to reduce inefficiencies and wastage. Insulin initiation is one example. The specialist services are now accessible more easily and in a timely manner. All this has been possible due to strong clinical leadership and unremitting support from the Diabetes Network.

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The full article is available online at www.practicaldiabetes.com.