The exemplar focuses on the development and implementation of a model of enhanced diabetes care within primary care settings, supported by specialist expertise.

Background

A number of key factors influenced the re-design of diabetic services within case study 2 (CS2).

Disease Projections: The number of patients with Type 2 Diabetes (T2DM) within CS2 in 2008 was approximately 21,600; Type 1 (n=1700) – with another estimated 2,000 cases remaining undiagnosed, following diagnosis this group was more likely to present with established complications. Projections suggested that the number of diabetic patients would increase to over 30,000 by 2020 (Public Health Report 2008).

Demands on Secondary Care: Approximately 430 patients per year were admitted to hospital as a direct result of their diabetes, and at any one time, more than 10% of patients in hospital had diabetes (Public Health Report 2008). In 2008, all patients with requirements above routine management were referred to hospital irrespective of need – this was felt to be unsustainable in the future.

Stakeholder Feedback: A number of public consultations also identified the need to review services. A public consultation exercise 'Achieving Balanced Health" (March – June 2007) identified a number of public priorities in relation to diabetes: -

- Improved communication between primary and secondary care
- Care nearer to home and at single location;
- Better engagement with diabetic patients from Black and Minority Ethnic (BME) groups.

Similar issues were highlighted in the Health Commission's National Patient Survey (2008) of people with diabetes (n=800 patient questionnaire).

Key Policy Drives and Service Gaps: Service review identified a lower uptake to retinopathy screening than the national average with an overall rise in admissions (Public Health Report 2008).

Diabetes Service Re-design – Community Diabetes Service (TYPE 2 Diabetes)

Documentation identified a new approach to commissioning diabetes care (Type 2) at four different levels: -

1. Routine
2. Enhanced
3. Specialized
4. Complex

The community service was to ensure that patients were cared for at the most appropriate level and to reduce the burden on the specialist provider. The community service would comprise of a multi-disciplinary team (MDT) of clinicians and health care professionals with relevant skills and competencies. The re-focusing of care would be away from secondary services but would be fully supported by senior consultants – it was expected that Level 1 (Routine) and Level 2 (Enhanced) care should take place within primary care.

This view was also supported by the Integrated Care Vision and Strategy, which highlighted the ambition to transform the way patients and citizens accessed local healthcare – with a greater volume and breadth tailored, personalized services made available in their own homes and/or communities.

Other important aspects of the new service were the identification and targeting of people with diabetes who were at risk of hospital admission or re-admission. This service development also had to be in-line with the Strategic Health Authority (SHA) approach to diabetes service delivery focusing on independence, choice and control.

Key Financial Benefits:

- Reduction in variation in care against 2008-9 Quality and Outcome Framework (QOF) baseline
- Increase in patients transferred out of specialist care (level 3) into routine (Level 1) or enhanced (Level 2) care
- Quality, Innovation, Productivity and Prevention (QIPP) guidelines – linked to financial projections for diabetes care in the community: -
    - Central (service based in one PBC area) expected to deliver net savings of: -
        - Yr 1 £17K,
        - Yr 2 £78K
        - Yr 3 £93K
    - Citywide (roll out of service to all areas) – expected to deliver net savings of: -
        - Yr 1 £95K
        - Yr 2 £111K
        - Yr 3 £113k

The PCT suspended tariff and ring-fencing monies spent on diabetic out patients

Service Specification: Identified that the majority of T2DM patients on oral agents, incretin mimetics and daily insulin regimens would be managed in primary care. The main aim was to assist primary care teams to deliver more complex care, which would require the up skilling of practice nurses and general practitioners (GPs). This would be achieved through: -

- Mentorship
- Joint consulting
- Educational events
- Case-note discussion

Consultants would also provide clinical supervision to the specialist team and primary care personnel. Initially, the community diabetic service would be implemented in one PBC area of the city and a Diabetes Planning and Commissioning Group was established to support the

transition process. This group had lay representation via local representatives of Diabetes UK.

Patient education was seen as key enabler within the service re-design, with patient referral to structured education courses such as DESMOND recommended. Primary care services already offered Expert Patient Programme, health trainers and diabetic support workers.

Specialist nurses would deliver short-term interventions such as insulin initiation with referral back primary care following 3 or 4 contacts, with management plans jointly agree with patients. Care homes would be visited monthly to review patients and deliver education to staff.

Performance Specification:

Main Objectives: -

- To improve the quality of care via: -
    - Clinical effectiveness;
    - Patient safety
    - Patient satisfaction
- To improve clinical outcomes.

Main Outcomes: -

- Patient supported via a care planning approach
- The same if not better clinical outcomes as the previous service
- Good patient experience
- An increased number of patient care provided outside the hospital setting

Specific Diabetes Clinical Target: At least 56.5% of patients will have an HbAlc level at or below 7.5%.

Service Implementation

The service was initiated in a phased way – focusing on one of the PBC groups within the city, service roll out to citywide was implemented in March 2012. The Community Diabetes Service was launched In April 2009. The specialist team is consultant-led and includes community nurses and dieticians. The team provides support and expertise relating to: -

- Self-management
- Diet and Lifestyle
- New Therapies
- Initiation of Insulin Therapy

The team runs community support clinics to help diabetic patients better understand and manage their own condition and live a more independent life. They also provide training for practice nurses so they can offer on-going care for diabetic patients. The team attended final out-patient appointments to highlight and discuss the new service to aid transition to primary care and to allay concerns.

On-going patient feedback on redesigned services is included as a standard in annual evaluation reports (Clinical Commissioning Executive, 2010). Public consultation around successive updates of 'Achieving Balanced Health' public consultation has confirmed the publics' willingness to use alternatives to hospital where services are available – on-going discussion and dialogue is built into the timeline as well as formal Transfer of Undertakings (Protection of Employment) (TUPE) consultation (Clinical Commissioning Executive, 2010).

Service Timeline with Achievements

Year 2009 – 1250 patient follow up appointments for diabetes took place in the community instead of hospital (Annual Report 2009/10).

Year 2010/11 – Diabetes services at hospitals had been re-commissioned using the levels of care set out in the long-term conditions strategic framework - with this service focusing on Level 3 specialist care. Anyone admitted as an emergency with diabetes was placed directly in the care of a consultant diabetes physician. Funding was made available for the national THINK GLUCOSE campaign, which included hospital staff training. Continuing liaison

between the specialist service and Ambulance Authority – ambulance personnel are to inform the Diabetes Specialist Nurses to follow up an emergency call out.

Year 2012 – Community Diabetes Service rolled out citywide in March – the Clinical Director (Diabetes and Endocrinology) described feedback from professionals and patients as very positive, with improvement in HbAlc levels. The re-design reflected a more highly specialized secondary care service, focusing on diabetes in-patients (16%). Almost 3000 patients with Type 2 diabetes have been discharged from secondary care – the money saved has been re-invested into the multi-disciplinary specialist community team.

Highlighted the belief that tariff based services (particularly where there are different tariffs for hospital and community patients) are unhelpful when trying to deliver care across boundaries. - the service remains as a block tariff.