Diabetes Specialists outside of the Hospital

Diabetes Care for You

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Declarations of Interest

- Optimising use of Public money

Introduction and Context

- National sample service specification for Diabetes 2014
- SE SCN Diabetes Integrated Care for Adults Commissioning Information Pack
- NDA results

National sample service specification

- This service specification outlines the provision of high quality care for all those with diabetes, and differentiates the care needs of those with Type 1 diabetes mellitus (T1DM) from those with Type 2 diabetes mellitus (T2DM) where those care needs differ

Generalist Care

An individual's practice MDT will include their GP, practice nurse, and in many cases a community nurse and/or community podiatrist. Some may also include a sessional increased-access-to-psychological-therapies (IAPT) therapist

Annual care planning cycle (Quality Standard (QS) 3)

In some areas service provision may be provided by a community based multidisciplinary team

Community based multidisciplinary team (MDT) may provide:

- Patient education programmes (QS1)
- Pregnancy advice for women of childbearing age (QS7)
- Foot protection team (QS10)
- Clinical psychology support
- Additional support for those with Type 2 diabetes and poor glycaemic control

Community multidisciplinary team (MDT) to include a Physician (Consultant Diabetologist, but may additionally include GPwSI), Diabetes Specialist Nurse, Diabetes Specialist Dietician, Diabetes Specialist Podiatrist, Clinical Psychologist with a special expertise in diabetes

Specialist care

Specialist care services will be multidisciplinary, with membership of the MDT varying according to the specialty service. Specialist services will include:

Transition service
Diabetic foot service
Diabetic antenatal service
T1DM service, including insulin pump service
Diabetic inpatient service
Diabetic mental health service
Diabetic kidney disease service
Diagnostic service where there is doubt as to type of diabetes

There should be clear referral pathways for specialist care outside of the services detailed in this specification

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How much time do Diabetes Consultants spend doing Diabetes in A typical Hospital based service ?

- Previous surveys have shown that on average per whole time equivalent Diabetes Consultant spends only 12 hours / week on Diabetes specific clinical activity.

The Story So Far

KEY STAGES	
Stakeholder consultation held	November 2013
Clinical model agreed by the LMG	January 2014
Governing Body approve the Business Case	May 2014
High Weald Lewes Havens CCG agree to procure jointly	October 2014
Service specification approved	March 2015
Formal tender process initiated	March 2015
Contract awarded to Sussex Community Trust (SCT)	October 2015

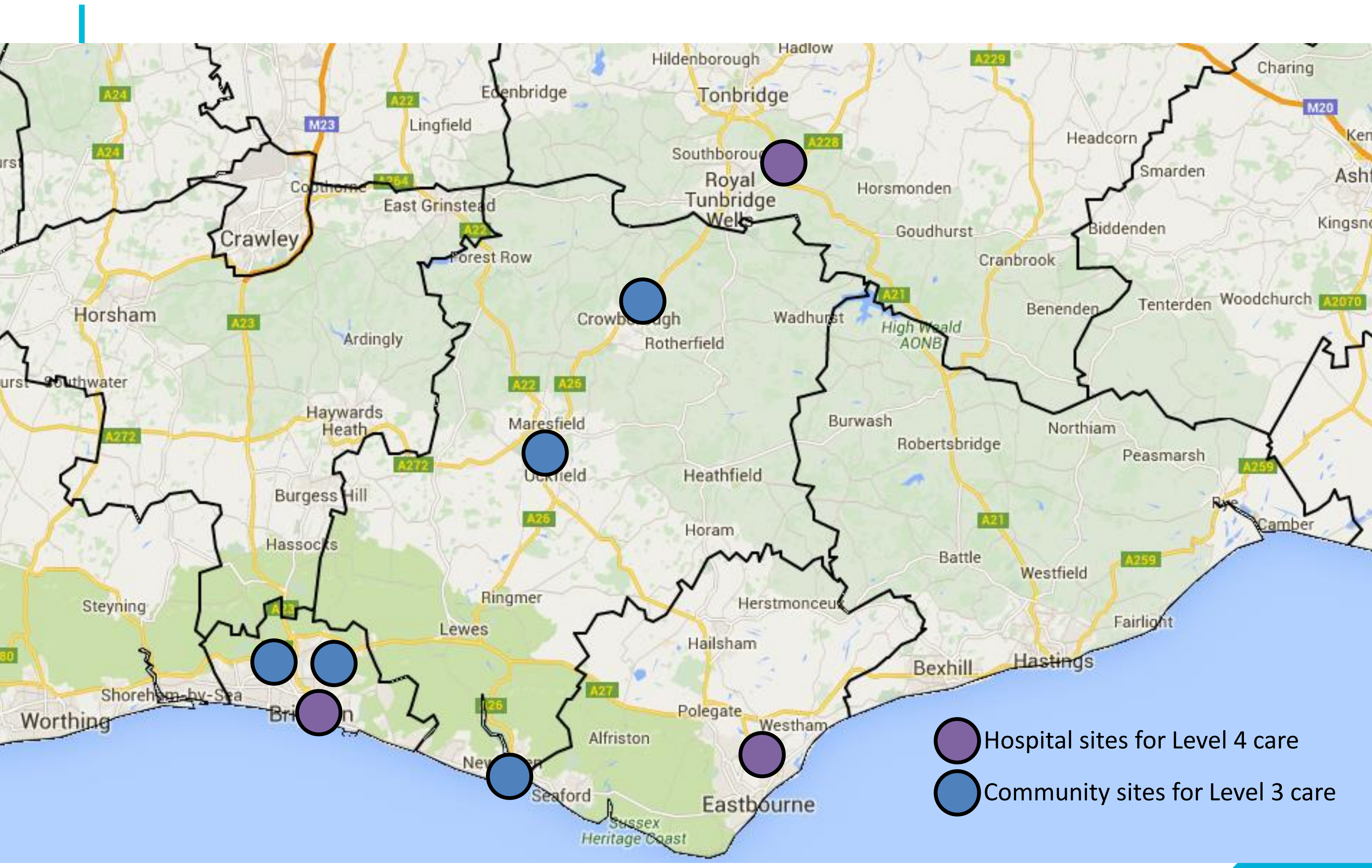
Evidence & Findings

- Not all patients were receiving a full annual review including the nine key care processes
- Significant variation in the knowledge and skills of primary care
- Higher than national average amputation rates in Brighton and Hove and not enough information about foot care
- Disjointed communication and duplication across the pathway

Evidence & Findings

- Patients were not being discharged back to primary care from secondary care
- Care interventions for young people were not tailored to the needs of this age group
- No IT mechanism for sharing information and knowledge across the pathway
- Not enough psychological support and not available within Diabetic clinics
- Patient structured education not always accessible

Concept of the service



Hospital sites for Level 4 care
Community sites for Level 3 care
Hildenborough
Hadlow
Tonbridge
Edenbridge
Lingfield
Charing
Headcorn
Smarden
Horsmonden
Royal Tunbridge Wells
East Grinstead
Crawley
Forest Row
Goudhurst
Cranbrook
Biddenden
Horsham
Ardingly
Rotherfield
Wadhurst
Benenden
Tenterden
Woodchurch
High Weald AONB
Southwater
Haywards Heath
Maresfield
Burwash
Robertsbridge
Northiam
Peasmarsh
Heathfield
Burgess Hill
Horam
Hassocks
Battle
Westfield
Camber
Steyning
Ringmer
Lewes
Herstmonceux
Fairlight
Hailsham
Bexhill
Hastings
Shoreham-by-Sea
Worthing
Polegate
Westham
Alfriston
Seaford
Eastbourne
Sussex Heritage Coast

Level 4: hospital care

- Diabetic emergencies and inpatient care
- Insulin pump service
- Paediatrics
- Complex diabetes requiring joint management including HIV, obstetrics, renal, complex active foot and vascular.

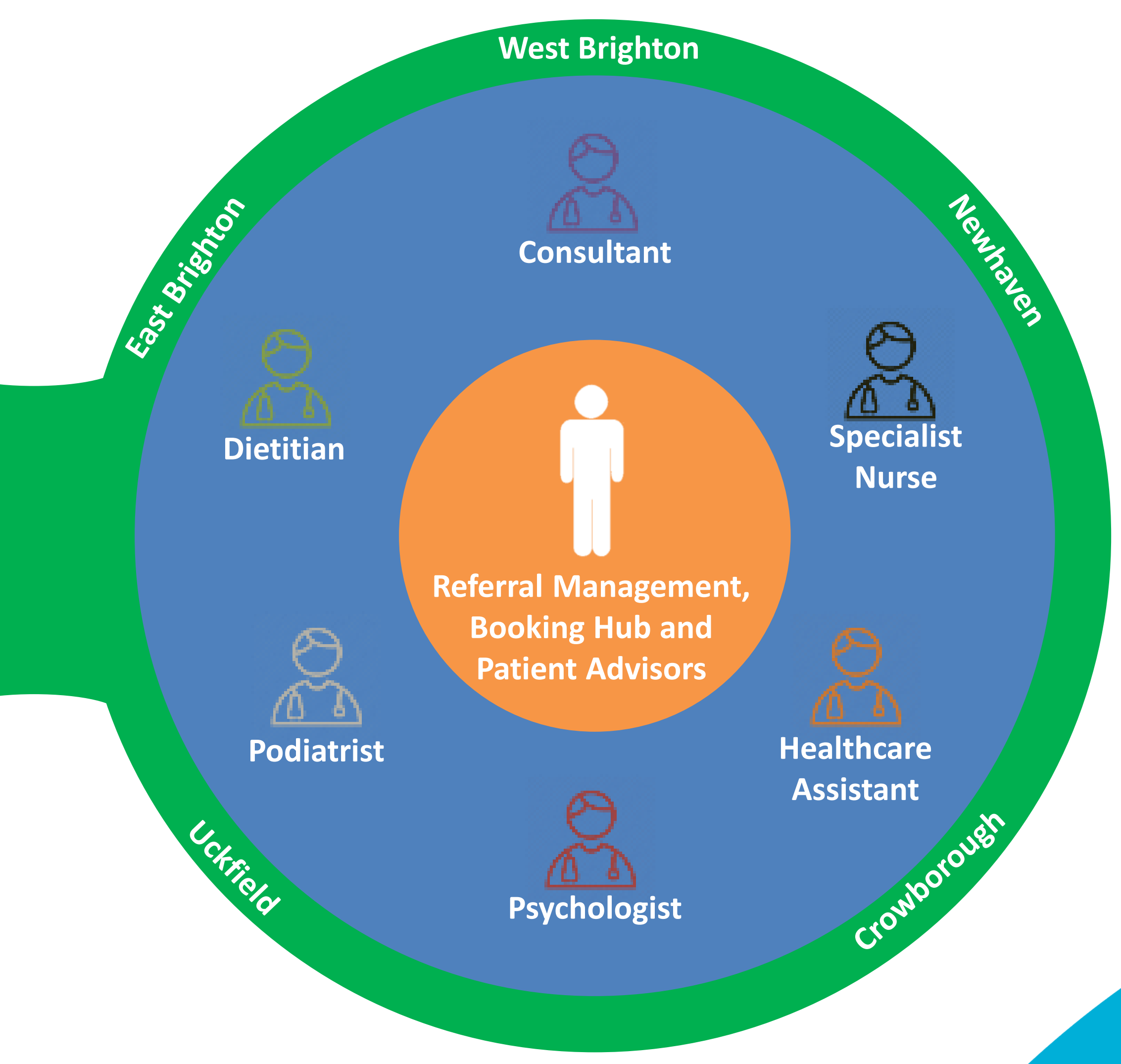
Level 3: community care

- T1 annual review
- Management of unstable/complicated T1 & T2 patients including insulin/GLP-1 initiation, management of diabetic foot, psychological support and dietetic advice.
- Structured education programmes for T1 & T2 patients
- Preconception advice for T1 & T2 patients and those who have suffered from gestational diabetes
- Supporting transition to adult services
- Advice and support to primary care

Level 2: primary care

- T2 annual review & ongoing management
- Monitoring post-gestational diabetes

Level 1: self-care



- **For patients**
  - Choice of 5 locations of where to have appointments across Brighton & Hove and High Weald, Lewes and Havens
  - Multi-disciplinary care from a Consultant-led team including Diabetes Specialist Nurses, Podiatrists, Psychologists and Dieticians
  - Some appointments will be with multiple professionals offering a one-stop approach; for example, management of diabetic foot
  - Far more access to Podiatry, Dietetic and Psychological teams to support diabetes control and care
  - One electronic patient record across the service so all professionals know your diabetes ‘story’
  - Focussed on supporting patients to meet their personalised goals

- **For professionals and referrers**
  - Every GP practice will have a named Diabetes Specialist Nurse
  - There will be a named Lead Transition Diabetes Specialist Nurse
  - Offer of an annual Virtual MDT session with every GP Practice for learning and development of Practice teams
  - Single point of referral supported by clinical triage ensuring patients access <u>all</u> the pathways and professionals they need including Level 4 (hospital) care
  - Regular written/electronic feedback (including clinical markers) from the service to ensure accurate patient records, alignment to care plans and other care eg. other long-term conditions, can be managed effectively.

Practicialities

How our service differs from those I have worked in.

- It is truly multidisciplinary
- It is specific and focused
- It is outcome driven
- It is not funded by PBR
- It is hosted within an organisation whose business is complex chronic disease management

How our service differs from those I have worked in (2)

- Monthly contract meeting with commissioners and clinical leads from both CCGs and DCFY
- Systm1 – Paperless, auditable
- Power BI -
- A focus on innovation and the use of IT eg Libreview, Diasend etc
- A change in role

What does this create ?

- A shared vision with the means to carry it out
- A constant focus on improvement
- The ability to try new things and take controlled risks

Who are we ?

- 1 WTE Service Manager
- 1 WTE Deputy service Manager
- 5 WTE Patient Care Advisors
- 1 WTE Consultant PA
- 1 WTE IT Analyst
- 4 WTE Dietitians
- 9 WTE DSNs (Band 6,7)
- 1 WTE Lead DSN
- 1 WTE Nurse Consultant
- 2 WTE Medical Consultants
- 2 Psychotherapists
- 1 PWP
- 2 HCAs
- 7 WTE Podiatrists
- 1 GP Lead 1PA / week

NEW DIABETES CARE MODEL - CLINICAL ACTIVITY AT EACH LEVEL OF CARE- *Care is delivered Levels 2,3, 4*

LEVEL 1 – PREVENTION SELF CARE

- **Promoting healthy lifestyle** for all patients, e.g. giving patients support, advice, information and sign-posting as necessary.
- **NHS health checks** /screening patients at risk of diabetes – improving prevalence as per LCS.

** Diabetes **Annual review to include:**
- Screening for complications
- Medication review
- Onward referral as appropriate
- Care plan standardised across level s
- Annual review to be recorded using same template across levels
- Patient information & advice
- Referral for further education
- Arranging follow up where appropriate

  All patients to have diabetic eye screening as per national standard
- Basic preconception advice for all women of child bearing age

LEVEL 2 – PRIMARY CARE

Delivered in Primary care by General Practice

- **Maintenance of diabetic disease register and patient recall for annual review for all Type II** including care planning and supporting patients to set realistic targets.
- **Type I to be referred to level 3** unless there are exceptional circumstances.
- **Annual review ****, including medication reviews, of all type II diabetic patients on GP list, including housebound & those in care homes (with or without nursing).
- Disease register for patients at risk of diabetes (IFG/IGT) and recall for annual monitoring
- **On-going management of type II** patients. Liaising with and collaborating with level 3 and 4 where appropriate.
- **Register, recall & annual monitoring of post-gestational** diabetes (LCS).
- **Management** of **low *risk* foot problems** (as per podiatry pathway). Refer to level 3as appropriate.
- **Referral for educational programme** at diagnosis (& later if deemed appropriate). Pre-diabetes (IFG/IGT) , newly diagnosed diabetes or those who are willing would benefit from an update.
- Referral of type 2 newly diagnosed patients to level 4 assessments for under 30's with a BMI under 35
- **Collaborating with integrated team** on health professional education (e.g. virtual clinics).
- Attending **diabetic training for** health care professional as per LCS.
- **Low level psychological support** relating specifically to diabetes **refer to level 3**

LEVEL 3 – COMMUNITY DIABETES HUB

Consultant led multidisciplinary team. Delivery care in community & primary care setting.

- **Triage** of GP referrals where appropriate (some referrals will be direct)
- **Providing clinical leadership** by bringing together stakeholders from across the clinical pathway to improve clinical outcomes, patient care, patient satisfaction and pathway resilience.
- **Onward referral** of type I and II to level 4 if require they meet the criteria or required joint clinics
- **Coordinating care** of patients moving appropriately between levels 2, 3 & 4.
- Ensure patients moving back to level 2 have an appropriate **management plan**.
- **Written notification & information pertaining** to all contacts with the integrated team to be sent to the GP.
- **Maintenance of disease register & patient recall** for all type I diabetics
- **Annual review of all type I** ** (including targeting of hard to reach patients) ensure completed in level 3 or 4
- **Standard review template to be completed** (same as LCS) & shared with primary care
- **Care plan to be agreed** with & given to the patient.
- **Management of unstable &/or complicated* type** II patients & timely referral of those patients back to level 2 with clear & comprehensive management plan.
- **Insulin initiation**.
- Assessment for insulin pumps and referral to Tier 4

Education:
- Patient structured education –evidence based Diabetes education for Type I and II and for people at risk
- Providing educational support to practices including virtual clinics
- Support and clinical advice to member practices & telephone advice.
- Contribute to formal education updates

- **Diabetic foot protection** (NG19) of those at who are at moderate and high risk of a diabetic foot and those with active foot disease that can be safely managed in the community (non-infected neuropathic ulcers, neuropathic ulcers with local infection, patients with osteomyelitis who have been reviewed by the MDT etc.)
- **Specialist dietetic support** & advice for level 2 & diabetes hub service.
- **Specialist psychological support**, including assessment & intervention.
- **Supporting transition** through proactive case management of 18-25 yr olds when clinically appropriate by close liaison with level 4
- **Preconception** advice for diabetic patients & those who have previously being diagnosed with gestational diabetes.
- Referral of type 2 newly diagnosed patients to level 4 assessments for under 30's with a BMI under 35
- Young Adult Diabetes (18-25 yrs)

LEVEL 4 – SECONDARY CARE

Delivered in a secondary care setting by specialist services not provided by the integrated service.

- **Diabetic emergencies** . Newly diagnosed type 1 initiation, HONK,DKA, hypoglycaemia, diabetic foot emergencies
- **In-patient care** – all diabetics regardless of reason for admission
- HIV and Diabetes.

Dietetic support & advice to patients seen in level 4

Active **complex podiatry**, Charcot foot, active ulceration requiring joint liaison (vascular/diabetic and podiatry).

Paediatrics – including young adults 15-19, liaising with level 3 as appropriate

People eligible for **insulin pump therapy** referred via Tier 3

Type I annual reviews **as deemed necessary by level 3.

Management of women with diabetes who have a confirmed pregnancy and up to 4 weeks post-partum.

Complex patients requiring management **in joint clinics** that necessarily have to be situated in a secondary care setting – obstetrics, renal, vascular. **As follows:**
- Medical Obstetric
- Diabetic Foot/Vascular
- Renal Diabetes

Diagnosis of suspected monogenic diabetes

Discharge back to level 2/3 as appropriate

PARTNERSHIP WORKING
Shared Information and Communication
Effective care planning
Shared clinical governance Engagement of clinicians and service users
Joint outcomes

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***Complicated –** unstable/poor glycaemic control, active neuropathy, active renal, active vascular, other co-morbidities, ophthalmology

Key achievements

- Development of internal and external care pathways
- Sharing of leadership and development of structures
- Relationship building with acute providers
- Recruitment, retention and expansion of staff and estates
- Implementation and agreement of Libre pathway
- Hosting STP diabetes work programme
- Pyschotherapist invited lecturer at Diabetes UK

How are we measured ?

- 19 KPIs
- Both clinical and non- clinical including outcomes, processes and patient feedback

Last month -

- 76.9 % of Type 1 patients undergoing annual review had all 8 care processes completed
- 52 % of Type 1 patients were within agreed personalised targets for HbA1c, BP and Lipids
- 87.5 % of patients who have had who have the support of the service following a reported urgent diabetic episode have not had a further reported episode within 12 months

NDA 2017 for our 2 CCGS Type 1–

- HWLH -
- HbA1c – 37%
- BP- 76 %
- Chol – 75 %
- All 3 – 25 %
- Ed (T1 and 2) - 9.2 %

- B & H -
- HbA1c – 36 %
- BP – 72 %
- Chol – 70 %
- All 3 – 22%
- Ed (T1 and 2) – 18 %

Future challenges and plans

- Further integration with GP systems – EDSM
- Further integration with Level 4 Specialists – eg Renal, Opthalmology
- Increase number of prescribers
- Cluster NDA reviews
- Specialist Trainee
- Increase research output
- Further HCP education

Thank you for your attention