Integrated Diabetes Service in North Devon

Project Brief

A model for managing long-term conditions by the right team, at the right time in the right place

Final 24.01.17

Vision

Integrated diabetes care that keeps people with diabetes in the best possible health by making best use of the knowledge and experience of everyone in the team which includes themselves, their family, peers, specialists, family doctor and nurses.

Aim

Person-centred diabetes care integrated across primary and secondary care and delivered consistently across North Devon. Where clinically required this will be in hospital, whilst all other diabetes care will be delivered nearer to home enabling a more holistic service where people with diabetes and their families are empowered to manage their health more effectively and reduce the likelihood of further complications by receiving the advice, support and care that they need when they need it.

Project objectives

- An Integrated Diabetes Team bringing together the roles of: the specialist diabetes team, the primary care team and diabetes education
- Clear, patient-centred pathways that are easily navigable and developed in partnership with patients and their families
- Diabetes management guidelines that reduce variation and allow standardised, consistent and high quality diabetes care across North Devon
- Specialist support and education to primary care where the majority of patients will be cared for
- Education, advice & support readily available to people with diabetes and those supporting them so that they can get into the right habits early and then maintain them.
- Collaborative care planning, with patients and clinicians working as partners to agree goals, identify support needs and implement action plans.

What needs to change for this to happen?

- The diabetes specialist team become educators dedicating part of their programmed activity to supporting primary care colleagues rather than delivering care directly to individual patients within the acute setting only.
- Collaboration with the community and voluntary sector to develop innovative place-based programmes of supported self-care
- Identification and removal of any perverse incentives or obstructions to maximise the opportunities for the whole health economy of North Devon.
- Blurring of organisational lines so that the best person at the time is able to support people when they need it

Who agrees?

NHS England Five Year Forward View recommends:

- Empowering people with long-term conditions to manage their own conditions more effectively
- Breaking down the barriers in how care is provided between family doctors and hospitals

NHS Planning guidance 16/17:

- Take into account the expertise and resources of people with long term conditions and their communities to help them achieve the best outcomes
- Patients and professionals are partners in agreeing goals and developing care

NHS England House of Care framework:

- Long term condition management - teamwork between professional specialists & generalists which puts the individual central to endeavours.

Devon Sustainability & Transformation Plan:

- Integrated care: Locality-based care model design & implementation; shift resources from hospital to community; promote health through integration

NDHT strategic objectives:

- We will work in partnership with stakeholders to promote independence and well-being**.**

Local in-principle support:

- Integrated Diabetes Care for North Devon (Appendix 1) sets out the broad case for change and recommendations. It has been shared with commissioners and primary care colleagues across North Devon and there has been a great deal of support for the concept.

What problems will the project address?

System issues

- Variation in service received by patients across North Devon, no diabetes patient care plan shared across primary & secondary care
- Services not currently designed around the patient but divided around traditional boundaries between primary and secondary care
- Uptake of available patient education is low, many miss the key first stage in understanding their condition & addressing behavioural risk factors
- System disincentives to patients accessing available clinical skills and competencies
- Current pathways contain inefficiencies, duplications & missed opportunities for learning and communication between primary and secondary care
- The specialist diabetes team currently have limited opportunity to influence diabetes care for the wider diabetes population
- Referral process to secondary care is laborious and lengthy resulting in patients not getting specialised advice early enough

Issues identified by patients

We carried out a survey with the North Devon Diabetes Group on 5th & 19th December with 28 people with diabetes. Whilst some people described excellent care and clear points of contact, when we asked 'What 3 aspects of your current diabetes care would you change to improve it?' the most popular responses were:

- More frequent appointments with more time to ask questions and checks such as footcare (9 responses)
- Better information and education, sometimes given varying advice (7 responses)
- Easier access and knowing who to approach to help with specific advice such as diet, feet (7 responses)

When asked what 3 aspects of your current diabetes care would you keep because it works well?

- Six monthly review (14 responses)
- Retinal screening and eye check (4 responses)
- Annual appt with consultant at NDDH
- GP contact (2 responses)
- A good practice nurse (2 responses)
- Diabetes group

The results of the patient questionnaire can be found in Appendix 1.

Diabetes outcomes

- 7% of North Devon population has diabetes with prevalence estimated to increase substantially over the next 10 years
- Spending on diabetes and its complications accounts for 10% of the total NHS budget
- North Devon continues to have an excess of major lower limb amputations [1]

Anticipated outcomes, theory of change and deliverables

Benefit	Why	Delivered through
People with diabetes will be better informed about what they can do to improve their health	There will be a greater emphasis and increased clinical capacity for educational activities	**The diabetes education team** who will provide a structured education programme to patients such as: • Educational activities (often in groups) at diagnosis and ongoing on specific diabetes topics. **Outcomes:** • Better glycaemic control measured by XXX
People with diabetes will be more in control of their own health planning	Patients will have greater involvement in their own care and management as they work as partners with clinicians to agree personal goals, identify support needs and implement action plans.	**Joint care planning programme** • Primary care team will work with all patients to agree a personal care plan – in line with NHS England's "Personalised care and support planning handbook: The journey to person-centred care") [3] • The infographics pilot will be rolled out with ongoing patient involvement.
People with diabetes will have timely access to advice and support	People's need for advice and support arises as and when questions or issues arise, which is not always when appointments are scheduled. Advice and guidance will additionally be made available by alternative means to clinical support.	**Place-based supported self-care programme** • The innovation and capacity within the community and voluntary sector will be best utilised to provide a range of support for people with diabetes that will not necessarily involve primary or secondary care, such as: o Peer support groups o Expert patients o Community Connectors • The diabetes education team will train and support those carrying out such roles • Technology to support advice, guidance and self-care will be promoted
Earlier identification & treatment/prevention of complications such as foot problems, renal failure	The confidence and skillset in primary care will be enhanced and there will be specialist support and advice more readily available for primary care clinicians.	**The primary care team (GPs and practice nurses) who will:** ▪ Create a personal diabetes care plan with individual patients including what to look out for. ▪ Referral for diabetes education ▪ Management of the patient according to NICE & locally agreed guidelines & within limits of individual competencies ▪ Annual surveillance of patient & early recognition of diabetes specific complications ▪ Early referral to specialist team according to need, i.e. the 'Super Six'

		▪ Clear plan from specialist team for management of patients no longer requiring specialist care & follow up with easy access to ongoing advice. **Community-based podiatrists will:** • Be linked to individual GP practices and work as part of a team with the practice nurses • Be easily accessible for rapid response for GPs and practice nurses who are not certain whether a referral is needed • Provide a step-up and step-down service into the Multidisciplinary Footcare Team
Greater impact on wider diabetes population, not just the small percentage being currently managed by specialists	Specialist education and support for primary care where the majority of patients receive their care.	**The diabetes education team** who will provide a range of educational activities to GP practices such as: ▪ The virtual clinic – case based discussions where specialists can provide advice and GPs can provide the wider knowledge and understanding of the patient's individual health and circumstances ▪ Jointly run patient face-to-face review (specialist team alongside primary care) ▪ Comprehensive multidisciplinary diabetes education care programme for primary care including updates such as new NICE guidelines **Wider dissemination of specialist knowledge with primary care** • E.g. initiating and monitoring insulin and other injected medicine for diabetes • Prescribing newer medications
Improved patient experience of diabetes care	• Closer to home so easier access • More holistic care -GPs know family & other health & social conditions which might impact on patient's diabetes management	**The primary care team (GPs and practice nurses)** who will Manage the patient's diabetes as well as other health conditions reducing fragmentation of care
Patients will receive the same high standard of care	The same diabetes pathways will be used wherever in North Devon the patient lives	**Single combined diabetes care plan** shared across primary & secondary care, easily accessible and shared with the patient **Practice level audits** enabling specialist support to be effectively targeted.
Patients will only need to attend hospital when absolutely necessary	Only patients requiring high levels of diabetes expertise will be seen by the specialist diabetes team in the most appropriate setting	**The specialist diabetes team** who will: (Diabetes consultant, diabetes specialist nurses, diabetes podiatrist, diabetes specialist dietitian) ▪ Be responsible for patients requiring high levels of diabetes expertise or multi-disciplinary input, such as the 'Super 6' ▪ Discharge patients under routine follow-up in specialist care back to primary care using traffic light system to enable appropriate support ▪ Provide specialist advice via phone or email (to the primary care team)

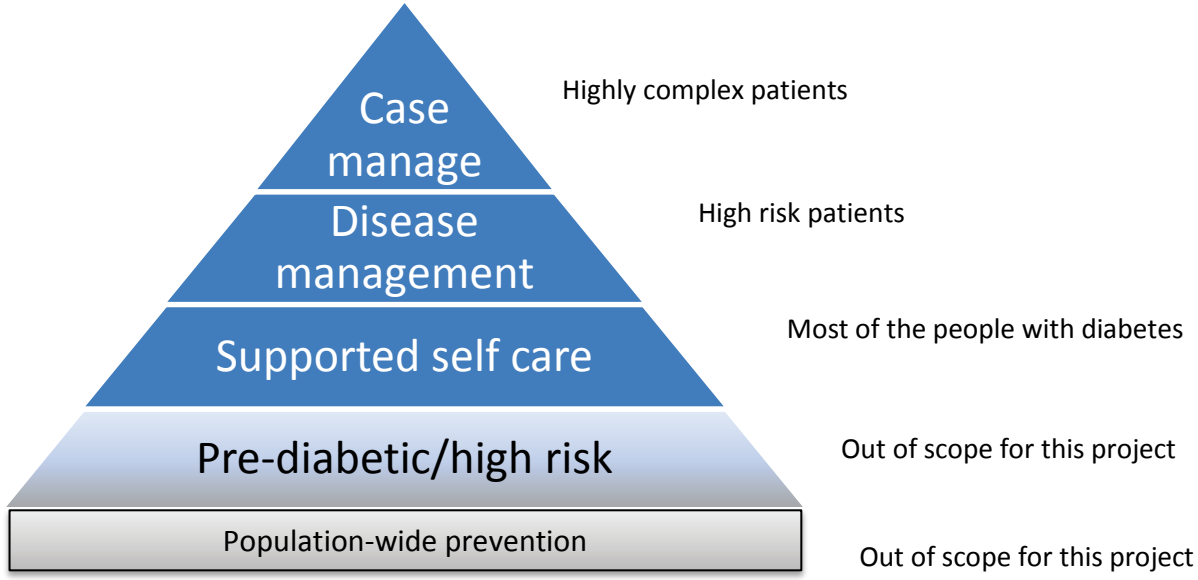
Patients will experience joined up care	All integrated diabetes team members will have direct access to patient's clinical record and the communication between all those responsible for a patient's care will be improved.	**Shared clinical record** There are a spectrum of options for achieving this as described by the pioneer sites, from a bespoke IT package to data sharing protocols **Communication mechanism between primary and secondary care** Primary care teams will have opportunity to consult members of the IDS in relation to individual patients in a timely manner **Joint clinics with renal physicians and ophthalmologists**
A collective strategy and joint objectives which could act as a model for LTC	Implementing clear and effective clinical governance structures will align the ambitions of clinicians with those of commissioners and, most importantly, the patient.	**Clinical governance structure for the integrated service** Regular review of safety, pathways, referrals, outcomes and quality input from both primary and secondary care clinicians. Patients should be able to contribute to the development of the service.

Scope

The project dovetails and overlaps with a number of current and anticipated workstreams across Devon. The project should have sight of, be influenced by and influence these workstreams but not be dictated or led by them.

The scope of this project is:

- Geography: North Devon
- Funding: no additional funding but opportunity to redistribute resources
- Prevention: Preventing further complications in those with a diabetes diagnosis
- Prevention: Supporting people with diabetes to make the necessary lifestyle changes & self-management decisions
- Patients: With Type 1 & Type 2 Diabetes (although it is felt that the greatest impact will be on patients with Type 2 diabetes)



Out of scope but with potential to develop after IDS is implemented

- Addressing mental health needs of diabetes patients
- Addressing physical health needs of mental health patients
- Identification of those at high risk of diabetes and work towards reducing that risk
- Providing more patient choice – greater convenience through access closer to work for example

Related workstreams that the project should align with

Figure 1 illustrates the range of work being undertaken that links to the project but that the project is not dependent on for its success and should not dictate the timescales for the core project implementation. For example, the national funding that is available for improving diabetes care would be a huge enabler for the work we intend to do, however, whilst we will work with and sometimes within these workstreams, their timescales, successes and failures will not be determinants of the project's success.

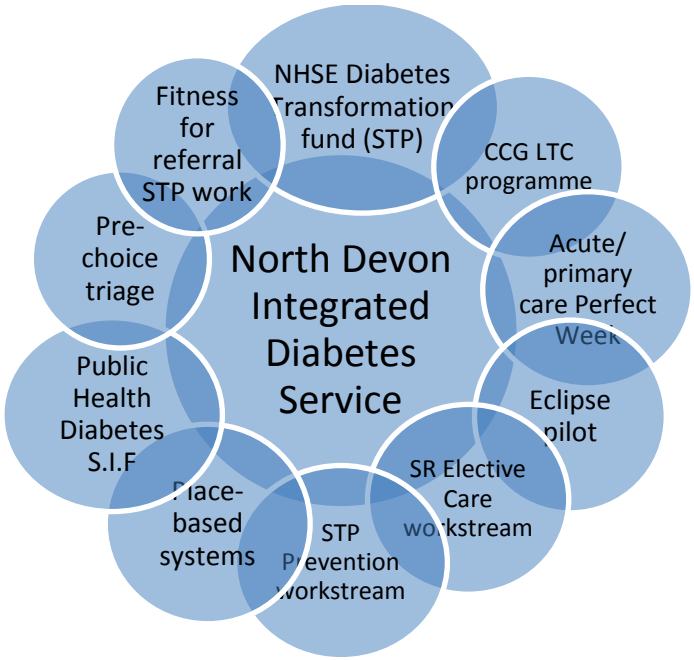


Figure 1: Workstreams linked but independent to the IDS project

Main stakeholders

The main stakeholders have been identified as people with diabetes, secondary diabetes care, primary care & commissioners. The project will co-produced, steered and managed by representatives of these stakeholders (Northern Devon Healthcare Trust, North Devon GP Forum, NEW Devon CCG northern locality and Diabetes UK or similar appropriate representatives of patient groups).

Project sponsors

In order to co-design an IDS service that meets the needs of patients, providers and commissioners overall direction and assurance should come jointly from project sponsors representing each stakeholder group. It is suggested that NDHT's Medical Director takes the role of Senior Responsible Owner.

Project sponsors		**Role and responsibility**
Dr George Thomson	NDHT, SRO/Project Executive	• Accountable to corporate governance (boards/exec directors as defined) of partner organisations for success of project • Confirm project tolerances with corporate management • Overall guidance & direction ensuring project remains viable & within specified constraints • Communications between project team & corporate management • Authorise management stage plans • Approve exception plans • Receive assurance that risks are being tracked and managed effectively and that stakeholder engagement is effective
Caroline Dawe	NEW Devon CCG Northern Locality	
Dr Sebastian Mogge	North Devon GP Forum	
Annika Palmer (tbc)	Devon Diabetes UK rep	

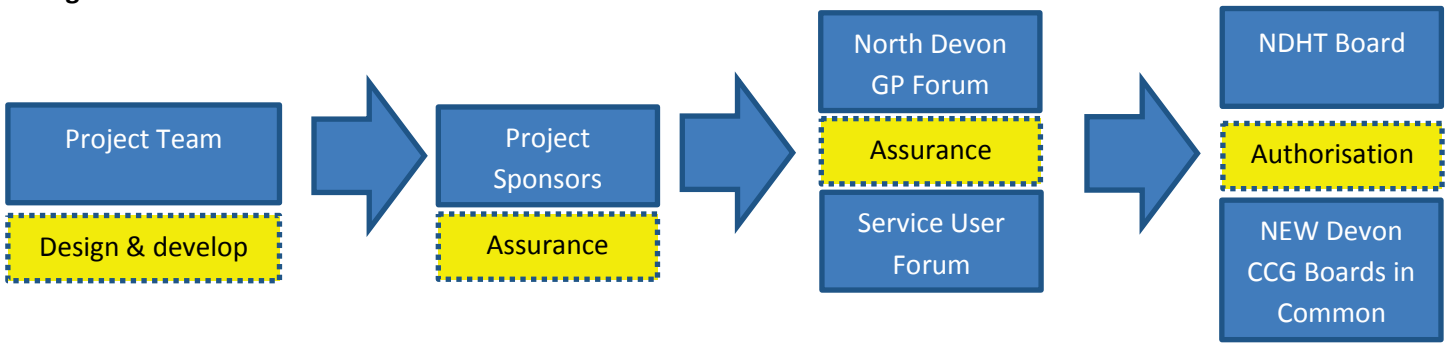
Project team

Clinical, commissioning, service & project management areas of expertise are required within the project team.

Project team			**Role and responsibility**
Clinical Leads	Dr Alistair Watt	NDHT Diabetes Consultant	• Manage the project • Prepare the business case • Impact analysis on new issues or risks that affect the project's desirability, viability or achievability • Assess and update business case at end of each management stage • Create project plan to deliver the agreed deliverables • Report on project performance in relation to plan to project board • Responsible for carrying out the work detailed in the project plan. • Carry out robust engagement & involvement with stakeholder groups • Identify learning opportunities and ensure learning from project is captured and made available • Highlight reports to project board
	Gayle Richards	NDHT Lead DSN	
	Dr Glen Allaway	CCG LTC commissioning lead	
	Dr James Szymankiewicz	GP Forum representative	
Other roles	Andrea Beacham	Project Manager	
	Patrick Doran	Patient Representative	
	Kerry Burton	Commissioning Manager long term conditions	
	Lindsay Stanbury	NDHT Diabetes service manager	
	Lyndon White	NDHT Podiatrist	
	Ellie Williams	NDHT Diabetes Specialist Dietitian	

	Tom Lewis	NDHT Medical Management	
	tbc	Practice Nurse rep	
	tbc	Practice Manager rep	

Reporting and communication lines



Other project stakeholders to be kept informed and involved as appropriate
Jill Canning & Liam Kevern – keep informed of progress
Vascular surgeons – as appropriate
Neil McNeil – keep informed of progress

Communications and engagement plan
See Appendix

Resource implications
Pre-implementation stage:

- Patient representatives on the project board and project teams should be reimbursed for any expenses incurred. The project board should consider whether payments should be made for the time that specified team members spend on the project to a pre-determined level.
- Primary care representatives on the project board and project teams should have their back-fill costs paid for.
- Participation events usually incur some costs
- Project team members will need to have time allocated to the project
- Learning from previous experience – a visit to those areas who have implemented a diabetes integration programme is recommended

Role	Non/Recurring	Existing in-kind allocation	Additional DFT funding request to meet DTF timeline	Mid point	Total 1 YEAR £
Project Manager	Non- recurring to support service set-up Apr 17 – Mar 19	0.35	0.35	£45,317	£31,722

Project Support Officer	Non- recurring to support service set-up Apr 17 – Mar 19		0.7	£31,288	£21,902
Clinical Lead Diabetes Consultant	Non- recurring to support service set-up Apr 17 – Mar 19	0.1	0.3	£120,000	£48,000
GP Lead	Non- recurring to support service set-up Apr 17 – Mar 19	52 hrs	0.2	£100,000	£20,000
Lead Diabetes Specialist Nurse	Non- recurring to support service set-up Apr 17 – Mar 19	0.1	0.4	£56,146	£22,458
Co-production	Non-recurring primary care engagement, pathway mapping and needs analysis		22 x ½ day practice shut-down sessions		
	Non-recurring primary care engagement -root cause analysis. Learning from amputations.		22 x ½ day practice shut-down sessions		
	Non-recurring primary care training needs assessment & practice education to standardise education level.		Kerry to include GP costs		
	Non-recurring primary care Eclipse training				
	Recurring primary care allocation for Eclipse data mining				
Total non-recurring costs					**£144,082**

Performance Measures / Success Criteria

These will be agreed as part of the project development to ensure the validity of each measure but could include

Indicator:	Measured by:
Short-term	
Reduction in hospital out-patient follow up (Aim: discharge of 50% of patients with diabetes from general diabetes clinics with saving of £X per pt)	HES, service contract
Patient experience/satisfaction	Patient surveys
Healthcare professional satisfaction	Staff surveys
Completion of core diabetes care processes	National Diabetes Audit; QOF
Quality of treatment in primary care	Diabetes QOF targets
Improved delivery of diabetes care	NDA care processes, NICE quality standards
Individual practice and skills	Competency and skills assessment
Patient involvement in own health management	Patient activation measures
More cost-effective use of diabetes medications, tests	Costs (Medicines Management, Pathology)
Outpatient activity at secondary care	Clinic activity (PAS or EHR)
Long-term	
Reduction in rates of hypoglycaemia	Admission rates for hypoglycaemia, HES
Diabetes identification, control & overall management	• Admission rates for DKA and/or HHS • Admission rates for other diabetes specific complications, HES • Rates of MI/ Stroke/Dialysis, HES, amputation
Vascular events	NDDH activity (PAS or HER)
Diabetes-related hospital admissions	Clinical coding data

Learning from experience

Integrated care models have been implemented in other parts of the country for a number of years and have received successful evaluation.

- Internal expertise
    - Dr George Thomson introduced a new model of diabetes care in Nottingham and has been involved in national developments
        - Podiatrists and dieticians as core members of project team, they have much to contribute
- External expertise
    - Early discussions have taken place with leaders of successful integration models – Partha Kar and Kate Fayers recommend a visit as the models are fundamentally different
    - Early discussions with clinicians and commissioners implementing Plymouth Integrated Diabetes Service model
    - SWCN Peer review re foot complications
    - Cambridge Uni – learning package for primary care

Risks

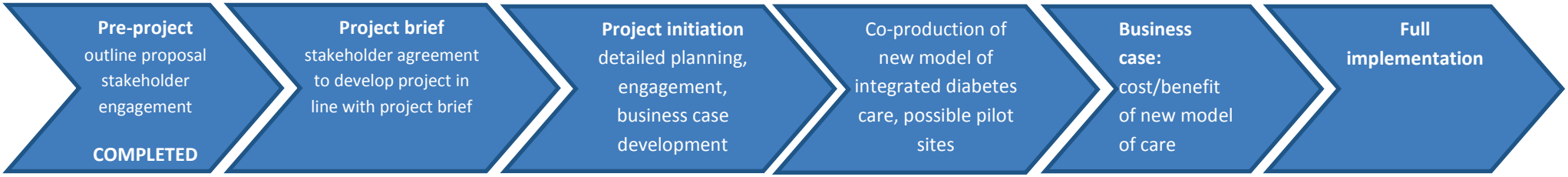
1. Potential for 'mission creep' if not disciplined
2. Impact on medical service if current consultant job role changes as a result of the project
3. Discharge of patients who do not require "super Six" specialist follow up, and reduction in new referrals should be anticipated. It is anticipated that there will be a need for hospital clinicians to spend more time in primary care and community settings. There is no indication at this stage that the change in role and responsibilities will result in a net increase in work for either primary or secondary care clinicians.
4. IT supporting integration – need to understand if project is dependent on no-cost solutions or the diabetes funding bid.

Mitigation

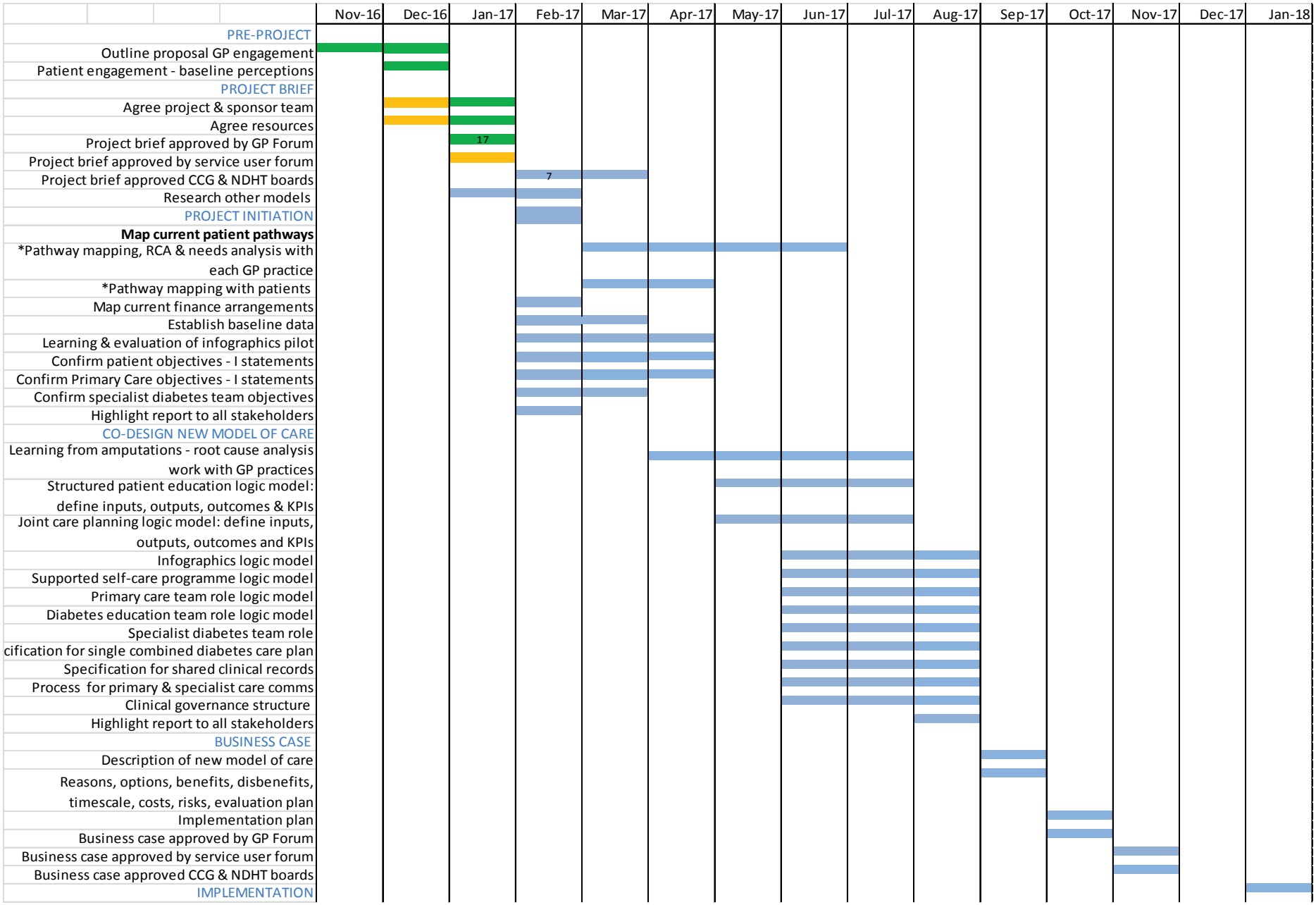
1. Be clear what is the core project, have sight of and be sighted with these other projects and include where appropriate but not to the detriment of implementing the core project. Any scope expansion request to be agreed by Project Board.
2. Lindsay Stanbury on project team and Liam Kevern and Jill Canning kept informed
3. Workload distribution will be evaluated throughout the development of the model and commissioner involvement is vital to ensure all sectors are sufficiently funded for the activity they will be expected to deliver. No stakeholder should be financially worse off as a result of the integrated service.

Outline timeline

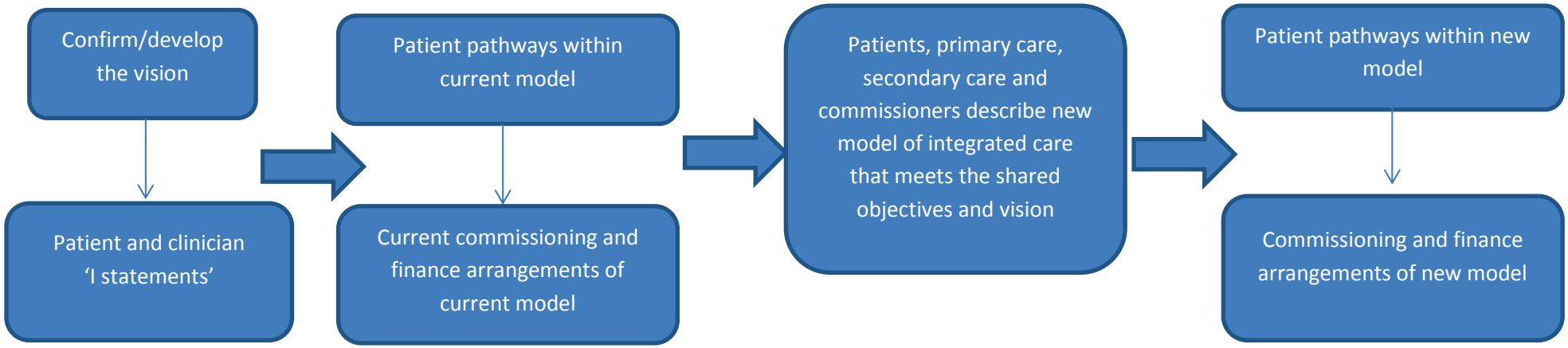
Mar – Nov 2016	Dec – Jan 2017	Jan 2017	Mar 2017	June 2017	Jan 2018



Draft detailed timeline



Business case to describe



To be attached:

Appendix 1 – Integrated Diabetes Care proposal – Feb 2016

Appendix 2 – Pre-project Patient Engagement

Appendix 3 – Pre-project GP engagement

Appendix 4 – Engagement Plan (to follow once project plan confirmed)

Appendix 5 – Communications Plan (to follow once project plan confirmed)

Supporting documents

1. www.scpod.org/_resources/assets/attachment/full/0/32290.pdf
2. http://www.kingsfund.org.uk/sites/files/kf/media/portsmouth-and-south-east-hampshire-diabetes-service-kingsfund-oct14.pdf
3. https://www.england.nhs.uk/ourwork/patient-participation/patient-centred/planning/
4. https://www.mrc.ac.uk/documents/pdf/diabetes-uk-facts-and-stats-june-2015/