

Facilitating diabetes care - a community approach

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Abstract

Instigated through the vision of a local GP, the South East Hampshire Community Diabetes Team (CDT) is provided by Southern Health NHS Foundation Trust. Through taking an integrated, multidisciplinary, community based specialist approach, the team works in partnership with colleagues across primary and secondary care. The team support care of both newly diagnosed people with diabetes (PWD), and those requiring ongoing follow up, unless they fall into the 'super six' categories. The key focus of the team is to optimise the knowledge and self management of diabetes through clinician and patient education programmes.

Problem

There were inefficiencies in the traditional pathway of diabetes care, with long term follow ups for PWD being conducted in secondary care clinics. There was an unacceptable variation in the quality of care provided in primary and community care. This was believed to be contributing to higher than expected rates of diabetic emergency admissions and complication rates in the local population. There was a disconnect between care services which resulted in an absence of structured care plans or duplication of effort.

Care quality issues centred on clinician and patient knowledge. Amongst clinicians there was inequitable knowledge of diabetes and insulin management. Further, there was no access to prompt specialist advice regarding diabetes management. Patients were also expressing a preference for care management within primary care.

Background

When the project began there was no known similar examples across the UK that had been published.

The project was designed to tackle a specific local problem with diabetes care, which although reflecting care across the UK, had already been initiated in a small way when the author and others carried out a RCGP/Lilly funded project in 1991 to facilitate structured diabetes care in Portsmouth District - a project that had encouraged and supported practices in the Portsmouth area to formalise their in house diabetes care management.

Baseline measurement

Prior to the project commencing, diabetes management was firmly split between Primary and Secondary care providers.

Patients were managed in either 'silo' with minimal reference to one another and difficulties in communication between one another due to the straight jacket of traditional letters in between both groups.

Previous attempts to use shared care books similar to ante natal care had failed to address the problem.

There was a variation between practices in South East Hampshire (population approximately 500,000) of patients with diabetes attending long term follow up in secondary care from 6% to 25% of the practice diabetes population.

Hospital waiting lists for follow up care had gradually increased over a 10 year period from 6 to 18 months.

There was a systematic failure to discharge patients from secondary care or to support primary care in managing patients, each specialist - either in primary or secondary care - merely providing the best care as an individual they felt able to do.

Design

The GP with a Special Interest in Diabetes who instigated the process was pivotal to success in achieving this engagement. He recognised it was vital to share this vision with key commissioning and clinical stakeholders in ways which would engage them and secure agreement to the development of a new team and care pathway. The vision was challenging for two reasons:

- It directly challenged the secondary care focused status quo
- It would mean a shift of resources within the health economy.

Therefore a strategy, reinforced by persistence and determination, which would appeal to both clinicians and commissioners was needed. Drawing on evidence based on best practice and most efficient use of resources (e.g. NSF for Diabetes) consistent messages were tailored and delivered to both groups to persuade them of the need and benefits of change. This successfully facilitated commissioner and clinician agreement enabled the leap of faith required to instigate the change.

Strategy

There were two phases to implementation. Firstly, in 2007, the Community Diabetes Team was established and a Local Enhanced Service implemented. This allowed appropriate specialist support and education programmes to be in place. The team began to build relationships and a critical mass of upskilled primary care clinicians and PWD through systematic education programmes. Having demonstrated the model could provide the assurance and service quality needed, in 2011, the team moved onto the second phase, changing the secondary care model. Joint baseline assessments by Consultants and GPs identified patients for discharge to primary care and those who were more appropriate to be retained by the secondary care team through the 'Super Six' clinics: Pregnancy, Renal Dialysis, Insulin Pumps, Acute Type 1 Diabetes, Type 1 Education and Adolescents. Subsequently, GP practice meetings were held with a Diabetologist and CDT Specialist Nurse to review patients identified for discharge. These meetings began the support and engagement of practices through identifying care management issues and education requirements of clinicians. Open access via telephone/email also promotes joint problem solving.

Results

The improvements in care have been significant. The initiative has enabled discharge of 666 (85%) of patients from secondary care since November 2011. At a cost per follow-up appointment of around £90 this represents a recurrent saving of £59,940 p.a. Another 108 patients now receive more appropriate secondary based care in a 'Super Six clinic.' New secondary care referrals have fallen from around 15 to 2 per month and 86 GP practice education visits have been undertaken with follow up visits booked.

Since beginning in 2007 it has enhanced the skills and knowledge of PWD and clinicians:

- 2996 PWD have undertaken DESMOND training
- 287 clinicians have undertaken MERIT training
- 2802 individual practice referrals seen
- 30 clinicians have undertaken 'Conversation Map' training

Patient feedback is overwhelmingly positive. PWD report feeling empowered and in control of their diabetes. They report that the training is equally useful for their carers who accompany them.

Relationships with clinicians and other staff are consistently positive. Feedback reflects the value placed on gaining a rapid response to queries and ongoing cross organisational meetings support engagement and relationship management. MERIT training and update sessions are continually oversubscribed.

In cost terms, the service has led to decommissioning of a large proportion of secondary based care, with revenue shifted to support the primary care model. Ongoing running costs for the team cover staffing (including consultant diabetologist input) and training and education costs. These currently stand at £152,100 per annum. The

team remains within budget.

Through discharging 666 patients from secondary care it is estimated that at a cost of around £90 per follow up appointment, this is saving around £59,940 per annum in revenue costs. The fall in new outpatient referrals also represents a reduction of from around 180 referrals p.a. to 24. This represents a reduction in need for provision of around 156 new appointment slots. With a new appointment costing around £200, this represents a recurrent saving of at least £31,200 p.a. The total saved is £91,140 p.a. All savings of course represent released resources that can be used differently to benefit care across the health economy.

Lessons and limitations

Lessons:

1. It is always worth persisting with a good idea
2. All stakeholders need to be engaged with
3. Sometimes a stakeholder is counter productive, other stakeholders have to engage and be involved to shift the balance in favour of change
4. Postive feed back fires the imagination and work productivity

Limitations:

1. Initial enthusiasm for closer working between 1o and 2o care needs fostering, the practice educational sessions between the diabetes community team and GP practices will need ongoing facilitation to encourage enthusiasm and engagement of both parties
2. It is much more difficult to engage doctors, both GPs and consultants, in the process than practice or community nurses. Doctors appear more inherently individualistic and anti team players.
3. Ongoing funding of the scheme will require clear measurable objectives, these are in place but will change with time - this needs managing

Conclusion

The formation of the community diabetes team in 2007 led the way to improving diabetes management skills and education in primary care by supporting GP practices directly in their work place, community nursing teams and patients within their own homes or local environment. The team provided hands on patient and health care professional advice as well as mobile phone advice available throughout the working day. Specifically the team does not carry a patient case load, patients remain with their GP practice and the team provide support to both.

Initial skepticism, fear of job losses and status changes on the part of secondary care specialists were alleviated by observing the resource in practice and enabled the secondary care team to formulate a 'super six' policy in 2011. This led to a structured discharge of patients to their GP practices, setting up super

specialist diabetes clinics for those with specific needs, a robust referral system from primary care and regular twice yearly educational sessions within GP practices by the secondary care consultants and Diabetes Specialist nurses.

Both consultants and GPs have appreciated and enjoyed the fostering of relationships and putting 'faces to names', a step that it is hoped will lead to better diabetes care integration and future improved patient outcomes.

References

Balme M, Goulder T J, Hooper P. "Facilitating Diabetes care in a District - a structured approach" RCGP/Lilly Diabetes Facilitators Project August 1991

Declaration of interests

None to declare

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