Integrated Care: Wakefield Diabetes Service Redesign

DPC 2019

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Chairman ABCD

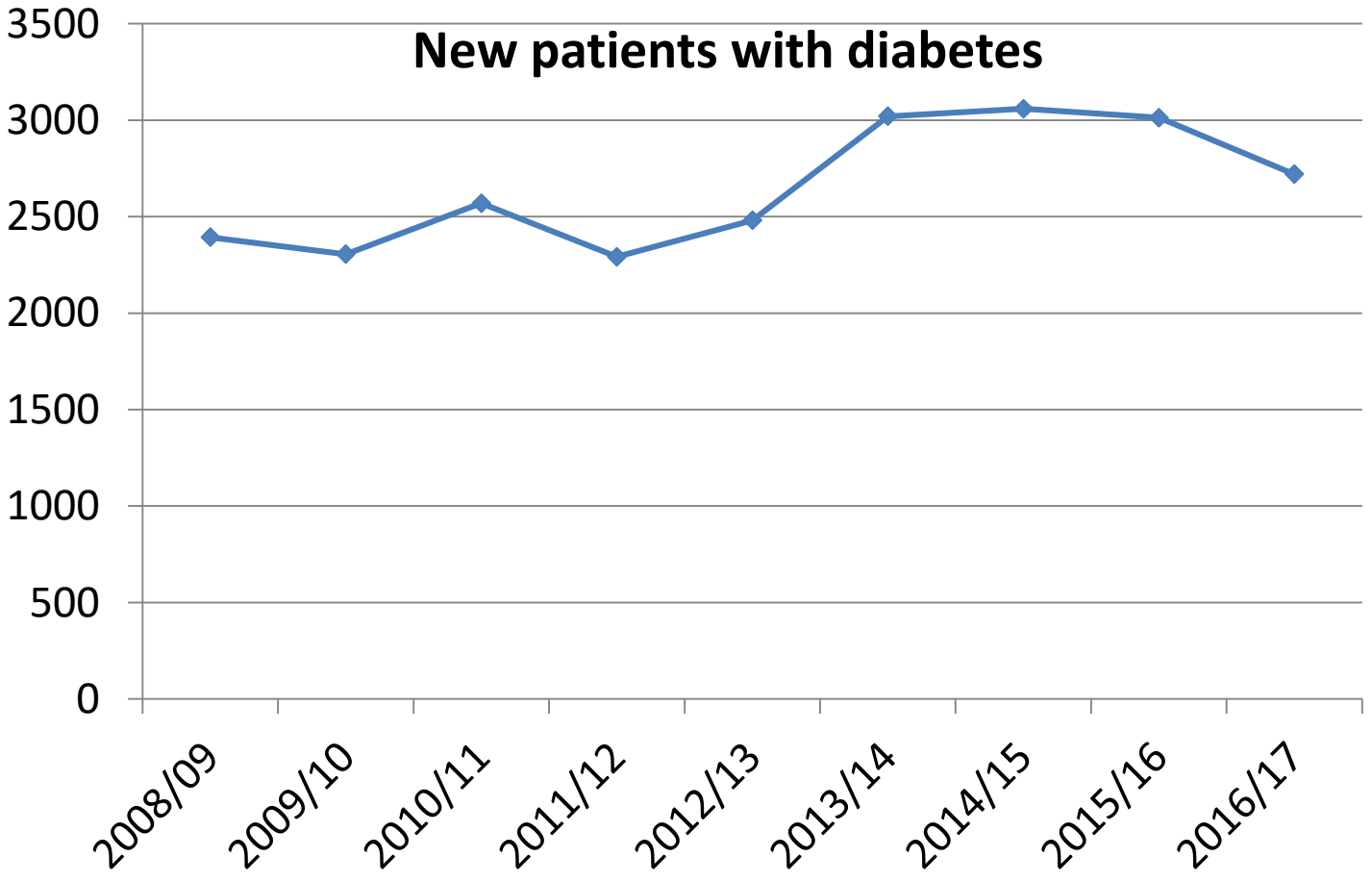
Outline !

- Introduction to start of our Journey
- Initial Planning Phase
- BC including an Options appraisal
- Developing a Model fit for purpose
- Implementation and consolidation
- Long term Sustainability
- Lessons learnt

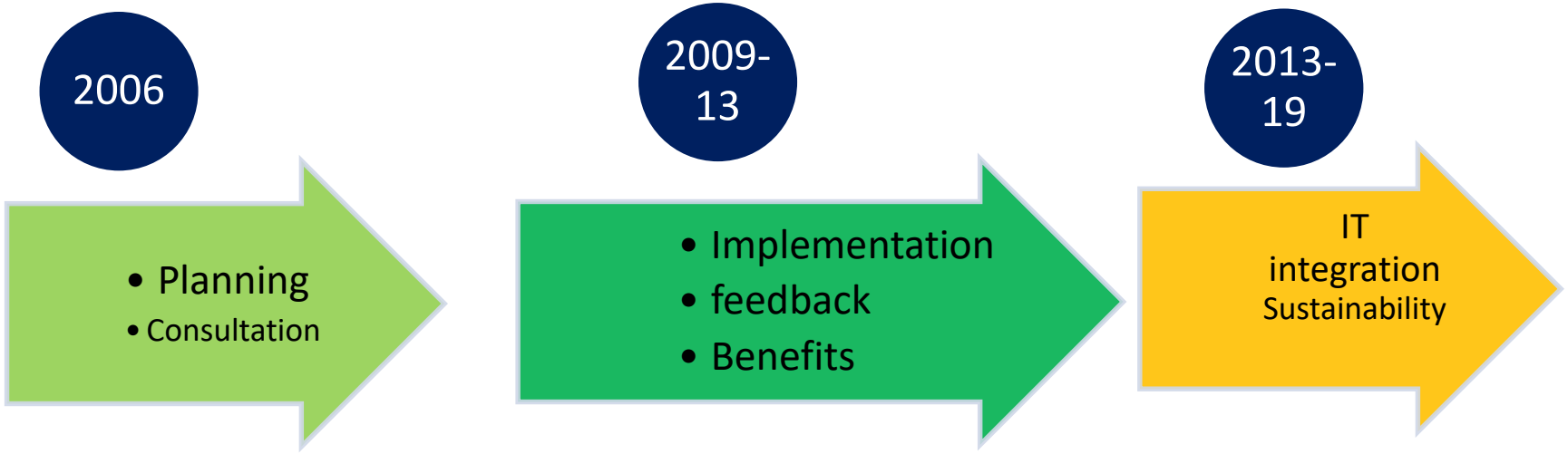
Case for Change!

- ***Burden of Diabetes***
  - Increasing tide of newly diagnosed T2DM
  - Cumbersome pathways of care dependent on a process- which created waiting lists and
  - Untimely and patchy access to specialist diabetes care
- **Workforce Issues**
  - Variable expertise in Primary Care: creating
    - Inequalities of care
    - Primary Care working in isolation at times
- ***A Broken system***
  - A system of Care with duplication and inefficiency
  - No clear cut accountability framework
  - A shared Care system- which became a shared neglect!
- ***No Joint Planning:*** ***to act proactively***
- ***Personal Philosophy***
  - High Quality Care for some or good care for all
  - Specialist as Leaders in Diabetes Care

Number of newly registered patients in Eye Screening Programme



Our Journey Timelines



A Shared Vision…..

- Structured and organised care
- Services easily accessible
- Improving the quality of diabetes care
- Addressing health inequalities
- Reducing variation across practices
- **Integrating clinical care for diabetes across primary care and specialist care**

LEADER

‘Commissioning Specialist Diabetes Services for Adults with Diabetes’

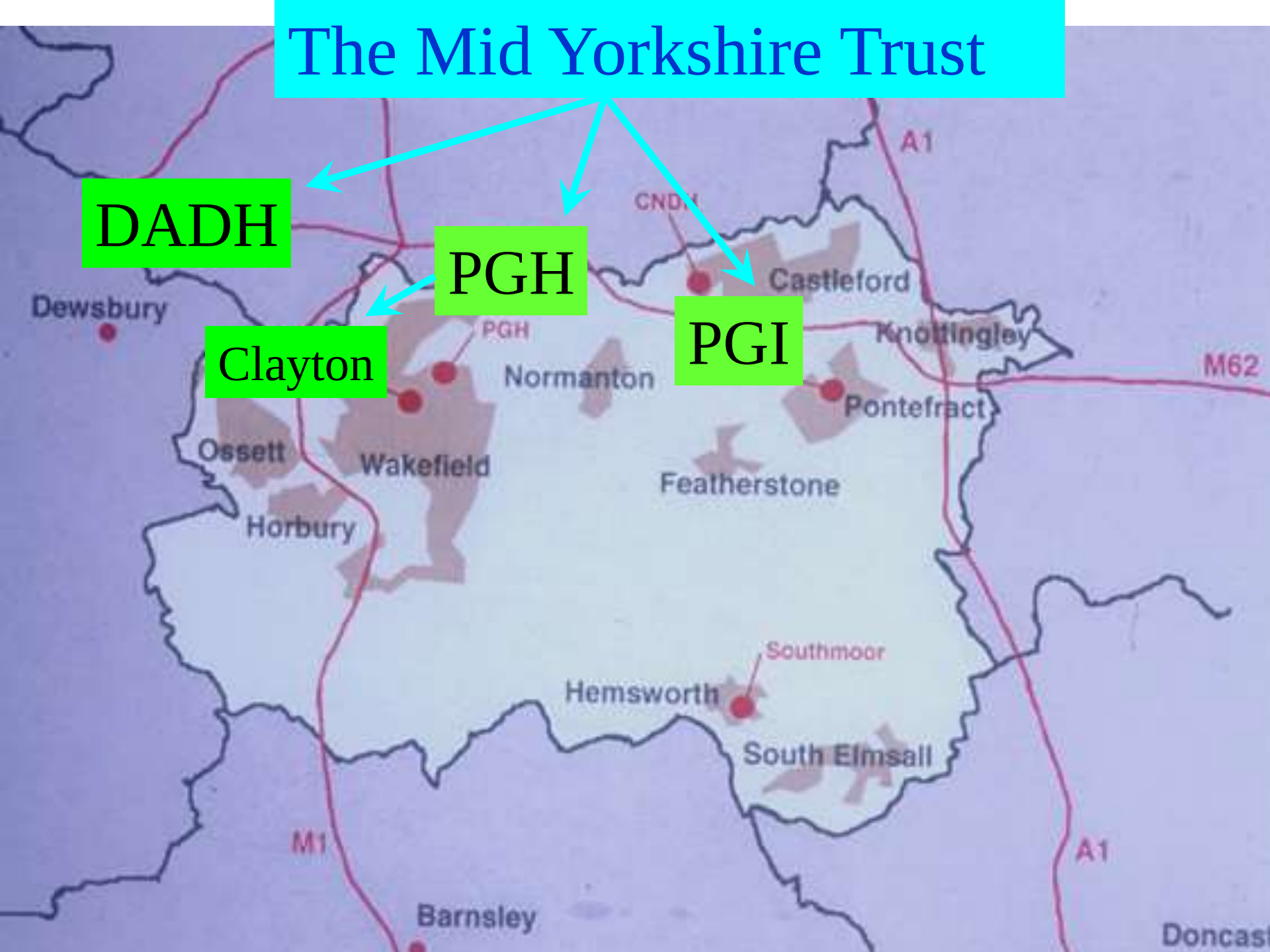
….There is a recognition that specialist teams may need to provide services in a range of health care settings consistent with the ethos espoused in…

“Teams without Walls philosophy”

Lt Niru Goenka and Jiten Vora

Wakefield CCG Demographics

- Population 295,000
- Diabetes 21,000
- 40 GP surgeries
- High Security HMP
- 1 Acute Trust
- 2 Diabetes Centres


The Mid Yorkshire Trust
DADH
PGH
Clayton
PGI
Dewsbury
PGH
Normanton
Castleford
Knottingley
Pontefract
M62
A1
Ossett
Wakefield
Featherstone
Horbury
Southmoor
Hemsworth
South Elmsall
M1
A1
Barnsley

A Solid Foundation
(Existing Service and infrastructure)

- Retinal Screening Programme (2003)
- Insulin Pump Service (2005)
- Structured Education Programmes
  - DESMOND
  - DAFNE
- Revised Diabetes Guidelines (2005, 2009, 2011)
- Active Patient Involvement (Diabetes Network)
- Integrated Care Pathways
- A ***resilient and strong*** Specialist Diabetes Team
- ***Excellent relationship with PCTs and Local GPs***
- ***Diabetes Managed Clinical Network (2003)***

What we did not wish to do?

- Loose patient focus
- Create Intermediate diabetes Services
- Physical translocation of clinics from specialist centers to Primary care
- Create a model addressing organisational priorities
- Create a Model with huge/extra drain on resources

A New Model !

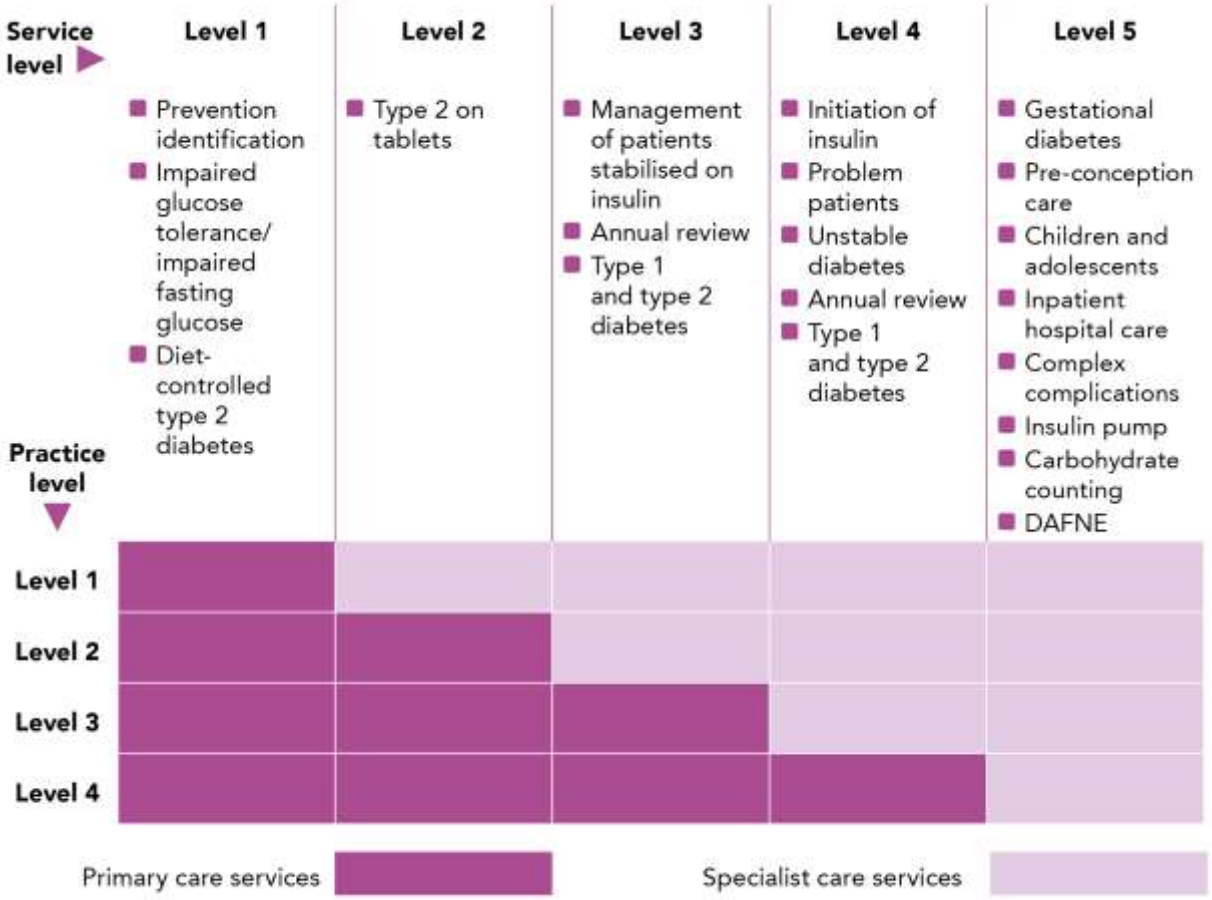
Presented to both PBC consortia-
May-June 2008

And PEC in July 2008

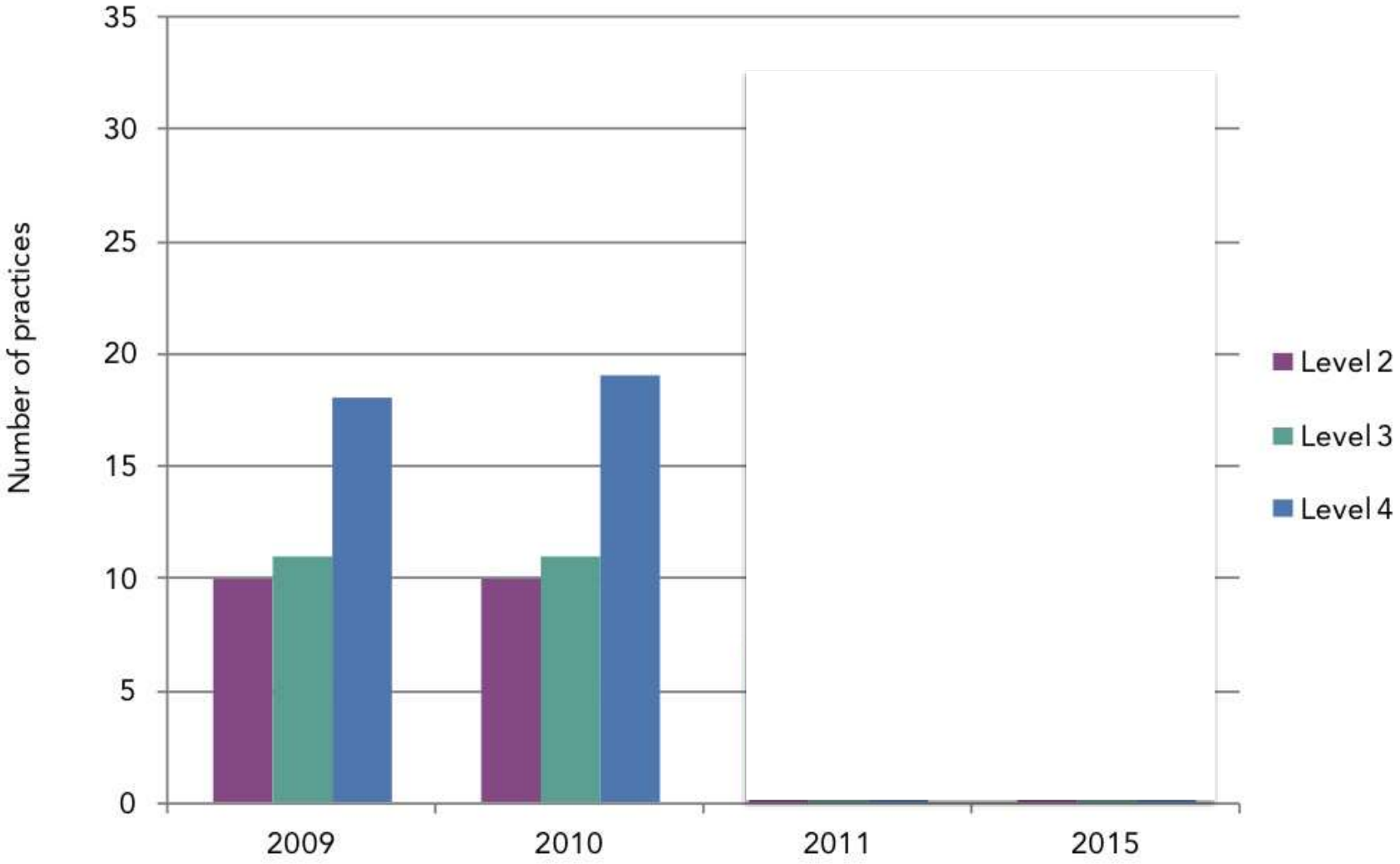
A new Model-fit for purpose?

- Baseline assessment of Practices (self assessment)
- Diabetologist and DSN attached to a practice
- Practice visits and joint working – dependent on the level of service and their aspirations
  - Discuss the organisation of the current diabetes services at the practice
  - Review and agree an appropriate location of care for all patients
  - Case note review (CNR) of patients
  - Joint Clinics (Clear referral Criteria)
- Practice Based Educational sessions

Baseline Self Assessment of GP Practices



Baseline assessment of GP Practices



Practice Visits by Specialist team

Level 2

monthly sessions

Level 3

2 monthly sessions

Level 4

3 monthly

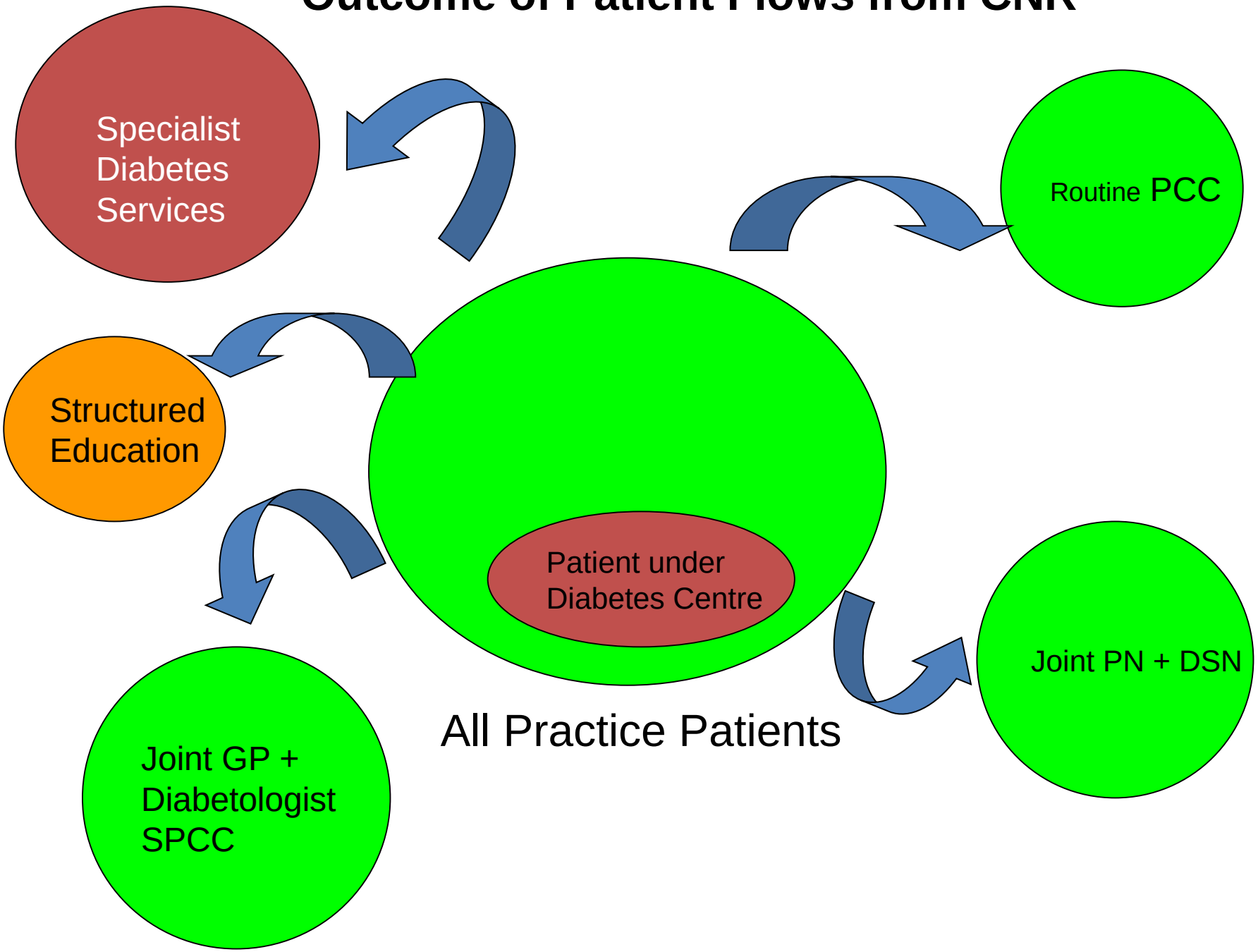
Initial Practice Visit

- GP with Interest in Diabetes
- Practice Nurse/s
- Practice manager
- Diabetes Network Manager
- Network Co-coordinator
- A Diabetologist
- DSN

Model in Operation

1. **Initial visit**:
   - Review the practice list of people with diabetes
   - Review baseline assessment
   - Agree the Practice priorities
   - Discuss the proposed Model
2. **Case note review**:
   - to agree a management plan including location/transfer of care for all patients
3. **Joint Clinics**:
   - Specialist Primary Care Clinic (SPCC)
   - Joint PN and DSN clinics

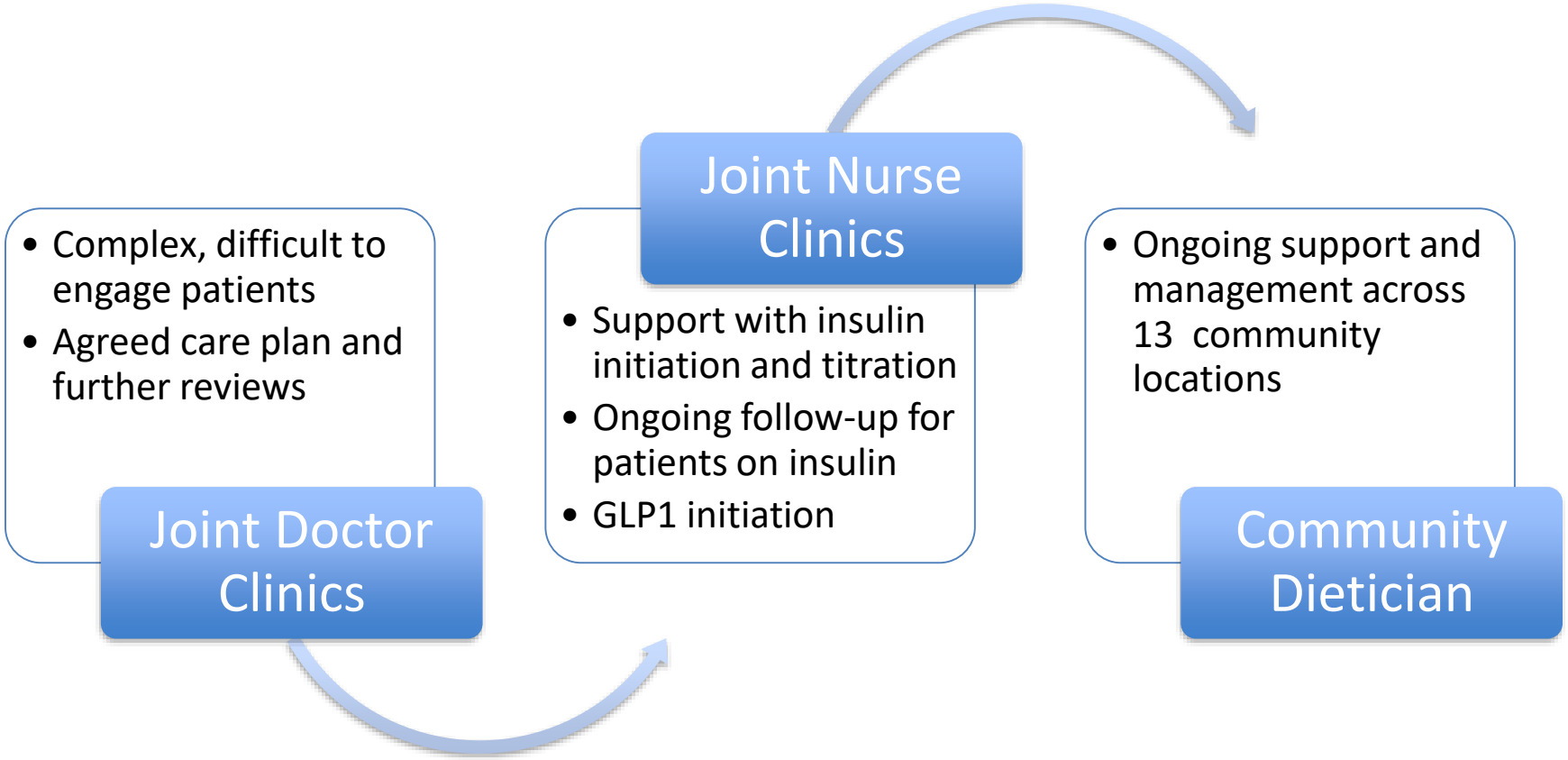
Outcome of Patient Flows from CNR



Specialist Primary Care Clinic (SPCC)

- GP + Diabetologist together
- Consultation led by GP
- An explanation for the reason for this visit
- Patient “in charge”
- Clear agreed plan of action (documented)
- Further Review Plans

Specialist Primary Care Sessions



Development of a new LES (Insulin, Byetta)

Capacity for DESMOND

IT integration (2013)
E-consultations

- Common integrated IT system across primary and secondary care
- Advice given remotely by consultant/DSN having been granted temporary access to the patient record
- Agreed response time within 48-72 hours
- Auditable and advice embedded in the patient record

Education of GPs and Practice Nurses

- Individualized based on practice needs
- Educational Modules were developed and delivered at a practice level
- Regular updates provided on an ad-hoc basis and on going case based discussions
- District wide Themed Educational Events (LES)

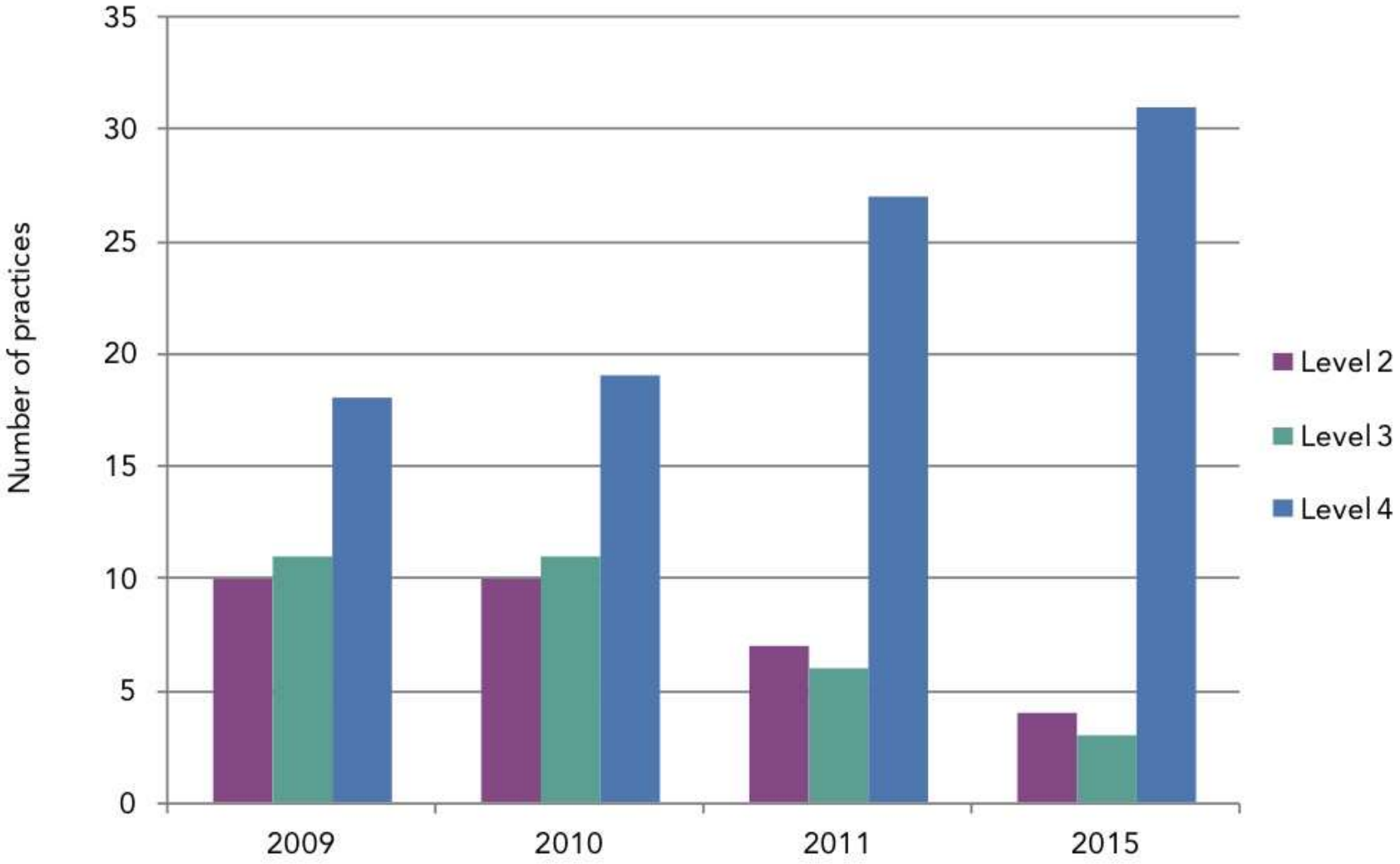
Benefit for People with Diabetes

- Care closer to home
- Access to the right health care professional at the right time
- Consistency of advice/information
- Improved access/ Swift referral to specialist team
- More time allowed for a dedicated consultation
- Reduction in waiting times for appointments/intervention

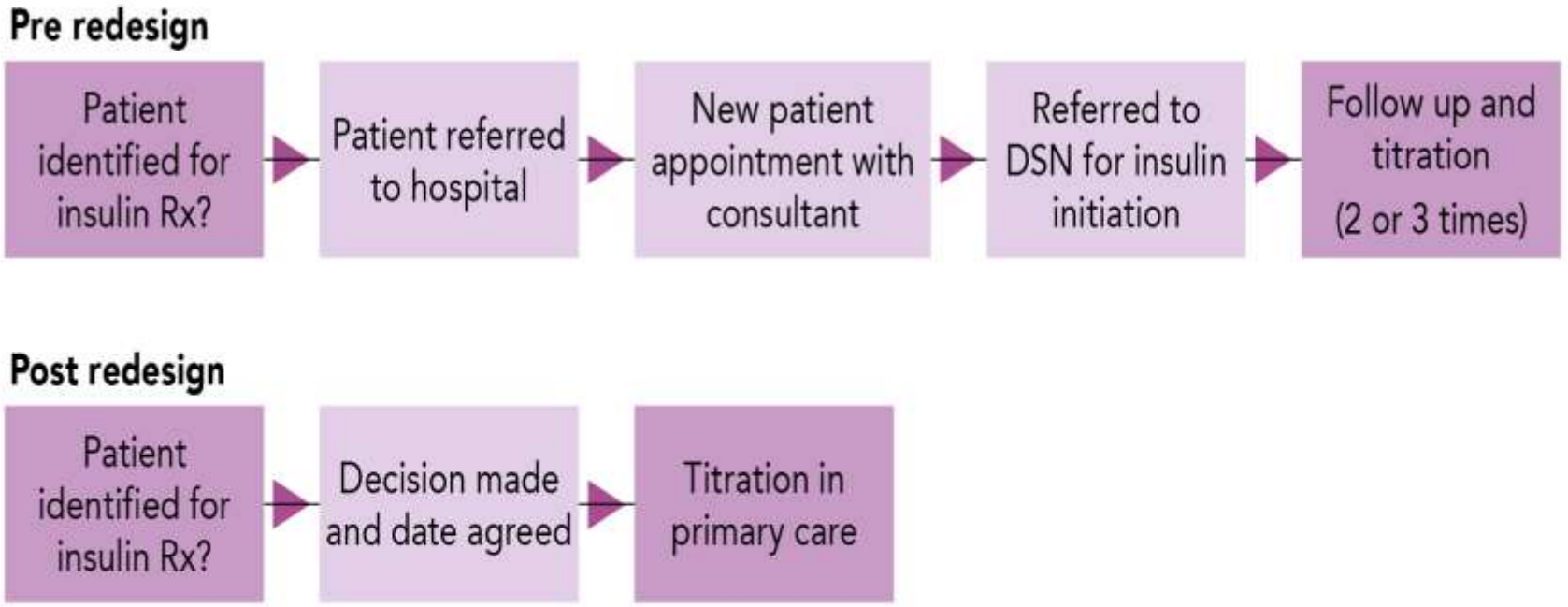
Benefits for GPs/PN

- Up-skilling through education and support
- Access to expertise depending on need
- Access to structured education (eg DESMOND)
- Access to community diabetes dietician on a 1:1 basis
- Improved management of diabetes including an increase in achieving QOF indicators

Up-skilling of Primary Care



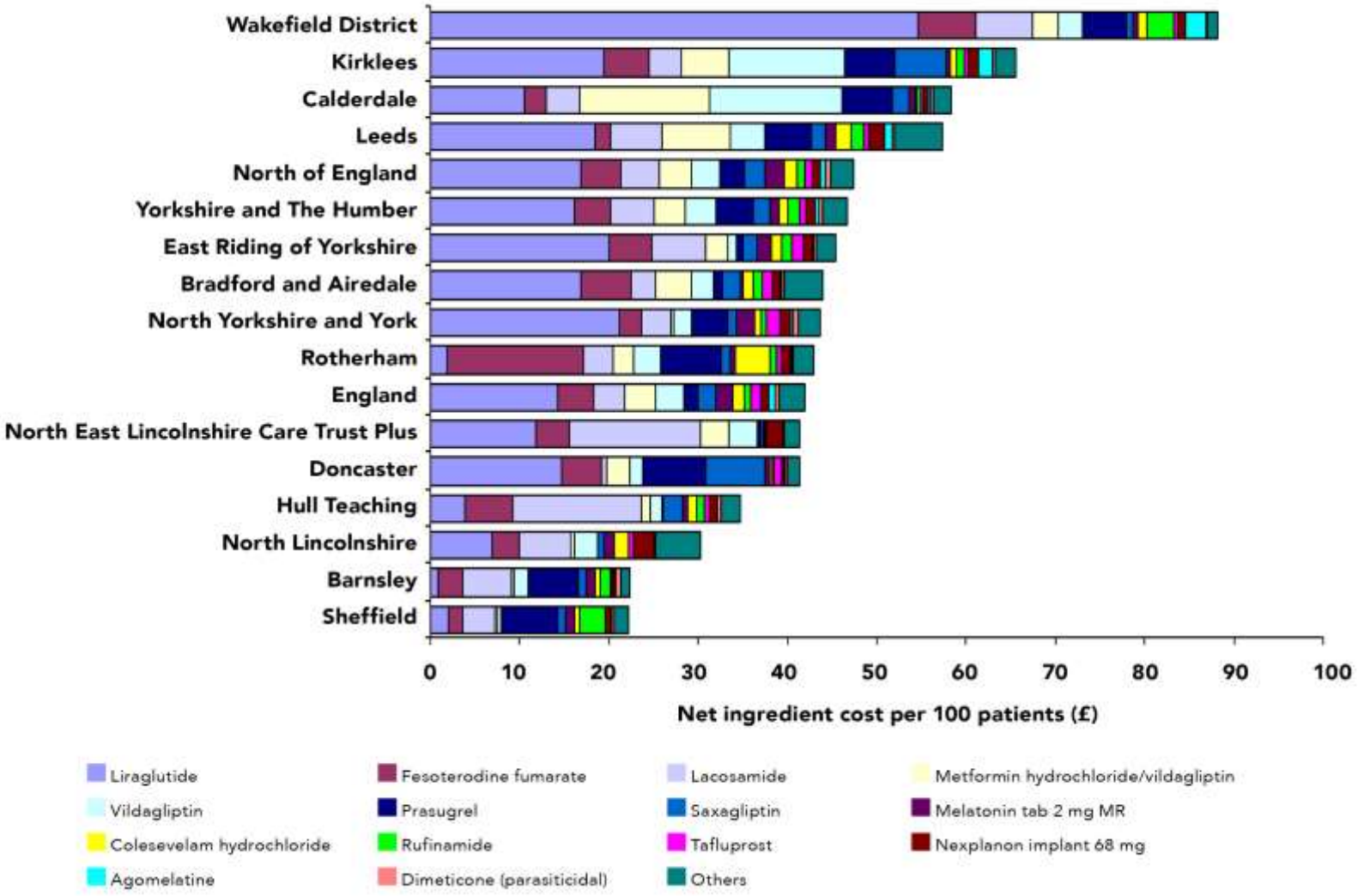
Impact on Insulin Initiation Pathway



Insulin initiation pathway before and after the redesign, which led to a radical change in the pathway and a significant reduction in resources and time wastage. Pre redesign it could take several weeks even to get through the first three steps to the decision-making consultation.

Impact on local prescribing

April- December 2010



Benefits for the prison

- Care provided in prison
- Removed need to attend hospital diabetes clinics – significant financial implication
- Reduction in hospital admissions from HMP for diabetes related issues

Feedback on the Model

- **Local**
  - GPs
  - Practice Nurses
  - Specialist Teams
- **External**
  - DOH Health Inequality Team (Feb 2010)
  - Community Diabetologists (March 2010)
  - Belfast Commissioning Meeting
  - PCTs (Kirklees, Sheffield, Lancashire)
  - Professional Colleagues through ABCD
  - QiC Award Highly commended 2013

Health care professionals…..

"We have always worked very closely with the DSN in diabetes care and always found their input invaluable. The extra support and guidance with the case reviews has only improved this working relationship. It helps to confirm what we are currently doing is correct and gives us confidence to continue and develop further. It is an excellent system for review and I hope it will continue".
Nurse Practitioner

"Fantastic learning opportunity to be able to discuss individual cases with the specialist team at the surgery" ***GP***

"Seeing patients jointly with a hospital specialist was a novel experience which I found very educational. Combining the different strengths of primary and secondary care clinicians clearly benefited both of us, and more importantly, our patients." ***GP***

"I have learned more this morning on diabetes working with the Consultant than I ever did in the 5 years at Medical School! Very enjoyable!" ***GP***

Diabetes Specialist Nurses Views

Improvements in the quality and consistency of care across the patch

Clinical engagement with primary and specialist care, improving the patient journey

Personal job satisfaction – development of relationships, increasing confidence of primary care teams and a stronger working ethos

Service Users feedback…

"Less worrying than hospital atmosphere, less anxiety, a hospital appointment is a "big" appointment"

"Smashing appointment!!"

"Excellent experience seeing everyone together in own practice"

"Brilliant service!"

"Hope we're lucky enough for this new service to continue!"

"Wouldn't have wanted to go to a hospital even though I knew my control was worsening"

Consultant Views

“In the 30 years that I have worked as a diabetes specialist at Pontefract General Infirmary, there has been a gradual and continuous improvement in diabetes treatment and care, but this is the most important and exciting development I have been involved in.

I am confident that this new co-operation between the specialist hospital diabetes centres and GP surgeries will result in much better care for people with diabetes across the district”.

-Colin White
Consultant Diabetologist

Surprises!

- Chance to review (QA) specialist care
- Identifying gaps in care, both in organisational terms and clinical care
- Identification of patients who have ‘slipped through the net’
- Major educational need for PN and GPs
- Original baseline self assessment versus specialist teams assessment differences
- Other specialities adopting similar model

Challenges

- Changing mind set and culture
- Re-organizing traditional ways of working
- Staff movement /retirement/ changing priorities
- High % of DNA for dietician
- Continuous adaptation, feedback and re-assessment of population needs

Key to Our Success

- Pre-existing Infrastructure (key)
- Shared vision, leadership and purpose!
- Changing your own mindset! And those of others..
- Multi-agency planning including Patient involvement
- Meticulous implementation
- Structured and organised admin support

- *Planning takes time!*
- *Swimming with the tide*
- *Endurance (Marathon not a sprint)*