

Appendix 1

**Better integration between
primary and secondary care:
Examples of good practice**

Introduction to the resource

This resource outlines examples of:

1. Models of integrated care between primary and secondary care
 - Evidence based examples of integrated care
 - Other examples of integrated care
2. Useful links and resources

The selected models of integrated care offer GPs alternatives to straight forward referral onto secondary care and therefore reducing unnecessary referrals.

Examples include:

- Effective models of working between primary and secondary care to support reduced unnecessary referrals and improved outcomes for patients
- Joint management plans held between the consultant and GP
- Access to the clinical record, shared between the consultant and GP
- Virtual clinics
- Integrated IT
- Pooled budgets

Please note: These model case studies were identified following a response to a callout to regions asking for examples of integrated care between primary and secondary care. There will be other good practice models that have not been cited in this document.

How can this help commissioners?

This resource can be used as a guide for commissioners (and providers) in implementing integrated care in their local areas.

Commissioners (and providers) should work together to:

- assess local need and work with providers to review workforce capacity and competency
- define and agree the local model of care and the local pathways to deliver all the services needed to meet local need
- monitor care processes and outcomes to identify improvement programmes and ensure participation in the National Diabetes Audit.

Commissioners should be responsible for driving improvement in their local areas for the benefit of people with diabetes.

Evidence based examples

1. Ipswich: Tackling Diabetes
2. The Diabetes UK report Improving the delivery of adult diabetes care through integration
3. The Super Six model of care: Five years on – Portsmouth
4. Transform the delivery of diabetes care across Leicester, Leicestershire and Rutland (LLR) CCG areas
5. Service redesign in Berkshire West CCGs
6. North East Essex Diabetes Service (NEEDS)

Ipswich: Tackling Diabetes

ISSUE: Diabetes spending was high locally compared to national averages, so the CCG came up with a new way of focusing on preventing and managing the condition.

AIM: Locally, compared to national averages, diabetes spending was high in the acute sector, low in the community sector and low in the area of prevention.

One of the early steps of this programme was to share the data – this was done at the CCG’s newly formed clinical executive. This involved a joint workshop with Diabetes UK and 30 attendees, a meeting with the Ipswich hospital diabetes user group and meetings with grassroots GPs and lead GPs for diabetes across three locations. Also, there was a half-day practice-shutdown event for all GPs. The following four themes were identified:

1. A lack of consistency between different training providers and service providers on how particular patients should be managed – leading to disagreements among GPs and also between different specialists even on basic scenarios, such as the random blood glucose level at which patients might be retested.
2. Differences in attainment between practices.
3. No real ownership of the declining situation. Some pathways were totally outdated, for example glitazones being preferred over gliptins.
4. Poor feedback in the media and politically, including letters from three of the MPs who had constituents in the CCG catchment area.

Solving the problems: Once the scene had been set, the CCG established two groups: An internal task and finish group. A project board with wider membership including patients, hospital and community clinicians, management, CCG GPs and public health representation. For the redesign process, the elements of diabetes care were split into five tiers:

1. Inpatients.
2. Complex specialist care.
3. Specialist care.
4. Enhanced primary care
5. Primary care.

The purpose of the split was not to create divisions or over-engineer the pathway for patients, but to map treatments to the most appropriate professionals and settings. The mapping was significantly aided by Diabetes UK’s Recommendations for the Provision of Services in Primary Care for People with Diabetes, produced in 2005, which included a section on criteria for referral to specialist services.

OUTCOME: The traditional view of hospital services is that it provides outpatient appointments and inpatient admissions. The main shift the CCG and hospital wanted to achieve was the additional focus on the wider management of diabetes across the population. To achieve this, the CCG and the hospital agreed a more flexible view of how the integrated diabetes service would act.

The service was not only responsible for seeing specialised cases, but also for providing structured patient education and developing a quality management function. Clinicians in general practice would benefit from an advice service, electronically or via phone, and professional education. The integrated diabetes service also supports general practice through diabetic specialist nurse review clinics in the community, whether face to face with selected patients or by review of case notes identified by the nurse practitioner or GP.

As of the time of writing, the integrated diabetes service has been provided at over 26 locations of the CCG’s 41 member practices.

These changes to the structure of the service were supported by new processes including pathways agreed jointly by primary and secondary care – with specified entry and exit points.

KEY LEARNING POINTS:

- Block contracts can prove successful
- CCGs need to ensure the best settings are used
- National Diabetes Audit provide’s better evaluation than QOF

The National Diabetes Audit showed that in terms of treatment targets, NHS Ipswich and East Suffolk CCG has a higher proportion of patients who meet all three treatment targets than the England average, and that this is unique to the region according to the Healthier Lives website from Public Health England.

Diabetes UK: Improving the delivery of adult diabetes care through integration

The Diabetes UK report [Improving the delivery of adult diabetes care through integration](#), published in October 2014, explains how diabetes care can be improved to achieve better outcomes for people with diabetes.

The key enablers of integrated diabetes care are identified in 'Best practice for commissioning services: an integrated care framework', which was widely endorsed by the diabetes community. This includes:

- **Integrated IT** so that all providers in a pathway are able to access a patient's data. (Wolverhampton)
- **Aligned finances and responsibility** to align priorities. (Portsmouth and Leicester)
- Collaborative **care planning** where clinicians and patients work together to agree goals, identify support needs and develop and implement action plans.
- Effective **clinical engagement** where commissioners, providers, clinicians and people with diabetes work together in local networks to organise the whole care pathway – from diagnosis to management of complications.
- **Clinical governance** for the whole diabetes pathway to provide a way to make continuous improvement.

* **The challenge for commissioners and healthcare providers locally is to make the system work to support integrated care**

Diabetes UK highlighted **5 local initiatives** to deliver models of integrated diabetes care. These include:

- **Wolverhampton**

Whole system information system, where GPs and specialists can see the same record, can be used to automatically identify and target 'at risk' patients

- **Derby**

All GP practices and the hospital use SystmOne. Once the system was fully established clinicians were able to see a patient's records, regardless of whether their previous appointment was in primary or specialist care, to optimise care and make the referral process more efficient

- **Portsmouth and Leicester**

In Portsmouth and Leicester, the initiatives focused on clarifying the role of the consultant diabetologist in the delivery of diabetes care. This saw the consultants focus on super-specialist areas of diabetes care in the hospital and refer all other care, which it was felt did not need to be managed exclusively by specialists, back to community and primary care

- **North West London**

In 2011 NHS London provided £5.7m for a pilot project to improve the delivery of diabetes care in North West London. The Integrated Care Pilot (ICP) did not introduce any new services but focused on better coordinating good practice to enable clinicians to work efficiently across provider boundaries. Investment was made in IT, leadership of the pilot, coordination of multidisciplinary groups and project management.

Link to the Diabetes UK report is available at: <https://www.diabetes.org.uk/integrated-diabetes-care>

The Super Six model of care: Portsmouth

ISSUE: The model of care for diabetes has traditionally been delivered in a specialist setting due to the perceived requirements of a complex multi-system condition. However, in the modern climate, the financial and workforce demands faced by the NHS has shifted the focus of diabetes management to primary care and required primary, community and specialist care to find collaborative and innovative ways to meet the needs of people with diabetes.

AIM: The “Super Six” model was established in Portsmouth Hospitals NHS Trust to streamline care across the Clinical Commissioning Groups in its catchment area with the aim to improve health outcomes of people with diabetes.

It has been in place for over 5 years with the aim of improving diabetes care in the Portsmouth area by creating uniformity across primary care trusts and providing support for the majority of diabetes management to be in primary care.

The defined areas of specialist diabetes care in the Super Six model

1. Inpatient diabetes
2. Antenatal diabetes
3. Diabetic foot care
4. Diabetic nephropathy (individuals on dialysis or with progressive decline of renal function)
5. Insulin pumps
6. Type 1 diabetes (individuals with poor control or young people)

Options available during GP practice visits in the Super Six model

- Virtual clinics (case-based discussions)
- Database reviews to discuss individuals with regard to achievement of Quality and Outcomes Framework target
- Reviews of audits completed by the GP practice on diabetes care
- Educational sessions on areas of diabetes management of the practice’s choice
- Patient reviews (in conjunction with GPs or practice nurses)

OUTCOMES: The Super Six model has allowed the specialist team to deliver timely, high-quality care in areas where their expertise is better suited within acute trusts, such as concentrating on supporting individuals who fall into the Super Six remit and providing a 7-day diabetes service. There have been improvements to the care of young people with type 1 diabetes, with sessions on alcohol and drugs delivered in university campuses; patient engagement; innovations to improve inpatient foot care, including an ongoing joint vascular and diabetes inpatient audit investigating the development of diabetic foot disease and the possibilities for earlier intervention. The “Hypoglycaemia Hotline” has been a major contributing factor in reducing admissions secondary to hypoglycaemic events. When people with diabetes require paramedic assistance for hypoglycaemia, the diabetes specialist team is informed by the paramedic, allowing direct follow-up by the specialist team (by telephone initially) within one working day

KEY LEARNING POINTS: The reported achievements of the Super Six model have relied on the strong relationships that have been built across primary and secondary care. The basis for success in Portsmouth has been in redefining the role of the consultant to that of a specialist who is also capable as an educator to provide a support framework for primary care.

The Super Six model of care has been recognised in The King’s Fund document “Specialists in out-of-hospital settings 2015” (Robertson et al, 2014) and by Diabetes UK (2014) as an example of integration of diabetes care with the community.

For further information:

http://www.diabetesandprimarycare.co.uk/media/content/_master/4760/files/pdf/dpc18-5-221-6.pdf

Transform the delivery of diabetes care across Leicester, Leicestershire and Rutland CCG areas (LLR)

ISSUE: Funding was provided by the CCGs in 2012/13 to transform the delivery of diabetes care across Leicester, Leicestershire and Rutland CCG areas (LLR Diabetes Transformation Project).

In Leicester, Leicestershire and Rutland (LLR) there are 54,000 patients with diabetes mellitus, with particularly high prevalence rates amongst black and ethnic minority communities and elderly patients. This number is projected to rise to around 100,000 patients by 2030.

For 2012-13, funding was allocated to LLR to undertake a full pathway review for Diabetes. The review was to include an identification of the current pathway including spend and activity as well as review of each of the different elements of the pathway from prevention and early diagnosis, to primary, community and secondary care.

The aim was to identify gaps in current provision and recommendations for future commissioning arrangements to ensure that LLR has a sustainable pathway that ensures high quality of care for patients, in the right setting at the right time.

Proposed Model of Care: With the rising numbers of people with diabetes and with increasing pressure on NHS resources any model should:

- Identify all people with diabetes or at risk of diabetes
- minimise patients who do not access appropriate care and services (including housebound patients),
- ensure that primary care has the necessary skills to manage patients who are suitable to be looked after in the community,
- that care is based on evidence (in particular NICE guidance) in the most cost effective environment, and t
- specialist services are available for those patients who require them. A diabetes service should aim to minimise avoidable hospital admissions.

OUTCOMES: A diabetes care map which described the “what, where, who and how” of diabetes care was developed. The diabetes care map illustrates the ‘what’ or key areas of diabetes care which a service needs to address and highlights high level considerations for a diabetes service. The LLR transformation steering group were involved in the development of this care map which encompass prevention and health promotion and on-going care for those who have a diagnosis of diabetes.

To help underpin the thinking from the steering group other models of care were considered to help create the approach as described. This separates the complexity of diabetes care to that which needs to be provided closer to the patients home i.e. at a GP practice and this elements of care that require specialist input and other personnel to manage this care i.e. the “super 6.” The diabetes care map describes to a degree the ‘what’ in terms of diabetes care. The proposed LLR model of care starts to describe where and by whom this care can be provided. The key elements of this map are provision by primary care (core and enhanced) , community specialist support for patients in primary care (this depends on what practices provide themselves) and specialist care which may need to be provided by specialists in community or hospital settings.

KEY LEARNING POINTS: Who has responsibility for the provision of care across the service has been clearly defined.

- **Routine care** is provided in primary care with the support of a locality based community diabetes specialist team. The following services are provided (Necessary 9 in Primary care): screening, prevention, regular review, prescribing, insulin initiation, patient education, cardiovascular care, care homes, outcomes and audit.
- **Specialist care:** The following services are provided in a secondary and tertiary care setting: inpatient care, insulin pump clinics, renal clinics, foot clinics, pregnancy care, Type 1 and rare diabetes.

For further information:

http://www.leicestershirediabetes.org.uk/827.html?_ga=1.82059231.83913153.1467368305

Service redesign in Berkshire West CCGs

ISSUE: In 2012, four federated CCGs set up a network to redesign diabetes services in Berkshire West. The 'burning platform' that led to change was the NDA and DOVE results (2010/11) demonstrated poor process of care and poor glycaemic control (46.8% vs. 56.8% nationally achieving HbA1c <59mmol/mol) and with high costs. Services for patients were limited with little patient education and no community DSN service

AIM: To redesign, implement and audit diabetes services.

To address these issues, a service redesign was instigated in 2012, at scale and pace. An external consultant was commissioned, a local champion appointed and a stakeholder network (*Diabetes Sans Frontières!*) formed with patient and healthcare professional (HCP) representation. The House of Care was introduced as a model around which services were planned.

A number of new services were introduced including:

- **Structured Patient education** – X-PERT for Type 2, DAFNE for Type 1
- **HCP education** – Foundation course, PITstop (injectable therapies), Enhanced Management of Diabetes mentoring service
- **Care planning** – 3 local HCPs trained to train GPs and practice nurses and implement care planning in primary care in all practices
- **IT** – *Eclipse* introduced, a cloud-based system for audit, risk stratification and patient portal provision
- **Website** - www.berkshirewestdiabetes.org.uk for HCPs and patients
- **Monthly newsletter**
- **Care pathway and treatment guidelines development**
- **New resource/staff** - Community DSNs deployed, Specialist community diabetes consultant appointed; Virtual clinics in GP surgeries providing case review and HCP education
- **Novel strategy** - 3-hour industry-sponsored carbohydrate counting courses ('CarbAware') for Type 1 patients including provision of a bolus calculator glucometer.

OUTCOMES

- improvements in the 3 care processes (BP, HbA1c and Cholesterol management)
- Prescribing savings of £805,000 resulting from medicines optimisation
- The process has created enthusiasm and greater professional satisfaction

KEY LEARNING POINTS:

- Large-scale diabetes redesign at scale and pace, led by a motivated and empowered stakeholder network, is effective.
- For further information:

<http://www.berkshirewestdiabetes.org.uk/professionals/stakeholder-network/presentation-archive/diabetes-networks-work-diabetes-uk-conference-poster-march-2015>

North East Essex Diabetes Service (NEEDS)

ISSUE: To support primary care clinicians to manage more patients in practice/community settings thus reducing the need for hospital visits

AIM: NEEDS is committed to providing high standards of care for ALL patients, with GP practices being supported by a diabetes specialist team which is led by a consultant.

The aim is to provide more care across a range of community settings, reducing the need for hospital visits and providing services closer to home.

NEEDS is a Prime Provider model of integrated diabetes service which uses a community DSN team as the key interface between general practice and secondary care, Consultants support this team in the community setting .

Services provided by NEED include :

Podiatry - GPs will carry out foot checks with the annual diabetes review. If GP has any concerns, then the patient will be referred for an appointment at a podiatry clinic and these will take place locally.

Retinal (eye) screening - continues to be provided by Health Intelligence, which is closely linked to the NEEDS service.
Health In Mind for Diabetes

Emotional and psychological support – for people feeling low or anxious and would like some support then GPs can arrange a referral to Health in Mind, which is part of the NEEDS service.

OUTCOME: GP practices will provide most of the care and will carry out annual reviews with each patient. They will make referrals, where required, to the diabetes specialist team. Once stable, patients will be discharged back to the care of their GP practice.

The diabetes specialist team will run community clinics which are led by a consultant. These will take place on a weekly basis in local areas . Patients will be referred by their GP for these clinics, as and when necessary.

Find out more at:

<http://diabetesneeds.co.uk/our-services/>

Useful resources

Service redesign and integration in diabetes care (Diabetes UK)

Service redesign can be an important enabler for local areas to integrate diabetes care and drive improvement at pace and scale.

Diabetes UK offer the following resources and tools to support service redesign in diabetes care.

- [Prime contracting in North East Essex: commissioning a GP federation to deliver a vertically integrated care pathway, Diabetes UK \(August 2015\) \(PDF, 853 KB\)](#)
 - This case study presents the NEEDS service, a pioneering model of care developed by NHS North East Essex CCG that brings together diabetes providers under the umbrella of a single, integrated service.
- [Networking for success: a 'burning platform' in Berkshire West, Diabetes UK \(November 2014\) \(PDF, 409 KB\)](#)
 - This case study presents Diabetes Sans Frontières, a network of providers, commissioners and people with diabetes setup to redesign diabetes services across four federated CCGs in Berkshire West. [Watch a video about the redesign.](#)
- [Improving the delivery of adult diabetes care through integration, Diabetes UK \(September 2014\) \(PDF, 648 KB\)](#)
 - This report presents the five key enablers for delivering integrated diabetes care. The report also presents learning from five areas across England that have adopted an integrated approach. Find out how [Wolverhampton](#), [Derby](#), [Leicester, Leicestershire and Rutland](#), [North West London](#) and [Portsmouth](#) are delivering integrated care.

Link to resource:

<https://www.diabetes.org.uk/Professionals/Resources/shared-practice/Service-redesign-and-integration/>

Evaluating the impact of an enhanced primary care diabetes service on diabetes outcomes: A before–after study (King’s Fund)

The health care professionals in the team are drawn from both the hospital and the community and include consultants, GPs, specialist nurses, health care assistants and dieticians. The team are able to communicate easily among themselves through a shared electronic patient record and work closely with the practices who are part of the First Diabetes service. As well as providing individual appointments for patients, team members also provide group education along the whole patient pathway, from prevention of diabetes to complex insulin regimes. They also go out to practices to see patients and provide professional training and advice.

Find out more at:

[http://www.primary-care-diabetes.com/article/S1751-9918\(16\)30101-2/abstract](http://www.primary-care-diabetes.com/article/S1751-9918(16)30101-2/abstract)

Useful resources

Integrating diabetes care in Derbyshire

- Health care professionals in the team are drawn from both the hospital and the community and include consultants, GPs, specialist nurses, health care assistants and dieticians. The team are able to communicate easily among themselves through a shared electronic patient record and work closely with the practices who are part of the First Diabetes service. As well as providing individual appointments for patients, team members also provide group education along the whole patient pathway, from prevention of diabetes to complex insulin regimes. They also go out to practices to see patients and provide professional training and advice.
- Find out more at:

<https://www.kingsfund.org.uk/audio-video/rustam-rea-integrating-diabetes-care-derbyshire>

Integrated care for patients and populations : improving outcomes by working together. The King's Fund, 2013

- This paper has been written as a contribution to the work of the NHS Future Forum and in support of the government's espoused aim of placing integrated care at the heart of the programme of NHS reform. Integrated care is essential to meet the needs of the ageing population, transform the way that care is provided for people with long-term conditions and enable people with complex needs to live healthy, fulfilling, independent lives.

Find out more at:

<http://www.kingsfund.org.uk/publications/integrated-care-patients-and-populations-improving-outcomes-working-together>

Useful resources

- The Health Innovation Network Type 1 Consultation Tool <http://hin-south.org/clinical-areas/diabetes>
- ABCD Type 1 standards of care <https://abcd.care/abcd-position-statement-%E2%80%93-type-1-standards-care-0>
- London: Type 1 diabetes commissioning pack <http://www.londonscn.nhs.uk/diabetes>
- Best Practice for Commissioning Diabetes Services: An integrated care framework <https://www.diabetes.org.uk/Documents/Position%20statements/best-practice-commissioning-diabetes-services-integrated-framework-0313.pdf>