

Integrating Care for Patients with Diabetes, examples of developments Nationally, and across the South West.



South West
Clinical Networks

VIRTUAL CLINICS – A GUIDE

A Virtual Clinic (VC) involves case discussions between diabetes specialist(s) and the primary care clinicians, with the aim of improving outcomes for patients with diabetes. The focus should therefore be on patients identified with poor glycaemic control and complications of diabetes. However, it is also an opportunity to discuss more complex cases that the practice has identified.

VCS can also provide time for teaching, practices can have specific topics covered, examples include:

- Achieving good HbA1c in type 2 diabetes
- Basic insulin management and titration
- Oral hypoglycaemic agents
- Renal disease in diabetes
- Obesity management
- Home blood glucose monitoring & hypoglycaemia
- Pregnancy and antenatal care
- Hypertension / lipid control (reducing cardio-vascular risk)

As well as the consultant endocrinologist/diabetologist, and GP, participants of the VC could include any of the following;

- Practice nurse
- Nurse practitioners
- GP trainees
- Health coaches/keyworkers
- Practice manager

In preparation for the VC, the practice will run a series of searches, and select the patients to be discussed. Examples of searches include:

- Patients with poor glycaemic control and on suboptimal therapy
- Patients with foot risk classification of active, high or moderate
- Patients with diabetic retinopathy
- Housebound patients with diabetes
- 8 or 9 care processes

During the clinic the specialist(s) will review the patients that have been identified and have had their details prepared for discussion. If it is not the first session, time will also be allocated to review the patient progress from the last clinic held in the practice. A clear action plan for each patient discussed will be outlined for the practice team and documented in the patient's record. The next session date(s) and educational topics for discussion are agreed.

SOUTH WEST EXAMPLES

Cornwall

An Integrated virtual care service was first launched in September 2015 with specialist diabetes clinicians at RCHT being able to access primary care records. A series of education events are held with participating practices.

A local tariff was agreed in autumn 2016 and full rollout for the RCHT catchment area in autumn 2017. Initial results show a potential saving of approximately £200K when fully rolled out.

80% of patients report that the new service has had a good or excellent benefit to their care.

As part of the transformation programme a tool to support the use of Eclipse was rolled out – Pro-active register management (PARM). The PARM tool is used to support practices in the following ways;

- Support understanding in variation in local QOF data
- Support Understanding of local National Diabetes Audit (NDA) data for HbA1c treatment target
- Medicines management - to supply the diabetes spend per head
- Support understanding of the 8 care processes achievement
- Understand the context of the patient populations, to allow appropriate resourcing of the diabetes funds

If you would like any further information, please contact lorrainelong@nhs.net



Integrated Diabetes
Virtual Care may 17.p

Somerset

A pilot project of running VCs formed part of the South Somerset Vanguard Programme. A 6 monthly session was held with GP practice staff, consultant diabetologist and diabetes nurse consultant. Attendees also included; GP trainees, practice nurses, nurse practitioners, health coaches, practice managers, IT leads, and anyone else with an interest.

Pre-clinic:

- GP practices identify 15-20 appropriate patients during “huddle” / general practice
- Practice runs PRIMIS Diabetes Care Quality Improvement or other audit prior to the clinic.

The Clinic (whole session)

- Case discussion with outcomes documented
- Education / Other discussions - informal, either based around case discussions or based around a theme identified by practice (ideally in advance).

Post-clinic

- Summary of case discussions shared
- Next clinic arranged

Please contact Alex Bickerton, Consultant, Diabetes and Endocrinology, Diabetes UK Clinical Champion, Yeovil District Hospital NHS Foundation Trust, alex.bickerton@ydh.nhs.uk

Torbay and South Devon

Primary care teams in Torbay have been initiating insulin and other injectable treatments for at least 15 yrs. This has allowed the specialist service to concentrate on the more complicated patients i.e. Portsmouth 'super 6 type model' with a diabetes support service / virtual clinic model formally being implemented in 2012.

This service supports general practices in managing patients close to home and has avoided an increase in referrals, despite the exponential increase in numbers. It also supports practices in cost effective prescribing and has enabled savings to be made by reducing prescribing costs for diabetes as well as contributing to good outcomes for patients.

The model involves an annual visit to each practice by a diabetes consultant, diabetes specialist nurse and dietician when cases are discussed and educational issues covered. The service is currently looking to develop a more robust audit tool to support these practice visits and possibly an IT solution eg Eclipse to make the process more effective and comprehensive.

For further information please contact Jamie Smith, Consultant, Diabetes & Endocrinology jamie.smith2@nhs.net or Heidi Clarke lead DSN heidi.clarke@nhs.net Torbay and South Devon Foundation Trust

Bath and North East Somerset (BaNES)

In 2014 BaNES CCG proposed to take a whole system approach to improving diabetes care, emphasising the prevention and self-care agenda by up-skilling primary and community care providers working in partnership with specialists in diabetes care. The rationale for change included the following:

- Fastest rising prevalence of any long term condition - local prevalence is increasing by 5% a year
- Increasing numbers of people aged 45 and under being diagnosed with type 2 diabetes
- Referrals to secondary care diabetes services are increasing by 7% year on year
- Up to 20% of all inpatients in the Royal United Hospital, Bath, now have diabetes

VCs have now been embedded across the CCG with clinics being held every 6 months at each GP practice. A one hour education session is held before each clinic, GPs and nurses from other practices in a 5 or 6 practice cluster attend. GP practices are proactive between sessions and increasingly managing the more complex patients as confidence has improved.

The service is now being expanded to increase support to practices by including the role of a diabetes specialist nurse working as a diabetes nurse facilitator (DNF). The DNF does not have a case load but attends virtual clinics, provides pragmatic support and holds joint clinics with practice nurses but no solo clinics. This has been vital to improving outcomes, underlining the importance of primary care engagement, development and staffing. This model is now being expanded to neighbouring Wiltshire CCG.

A range of support materials have been developed including a protocol re treatment, frailty assessment and impact on diabetes targets.

To demonstrate the impact of the new care pathway, a robust data collection has been developed using a read code for everyone discussed in a VC providing the capability to follow up on patient outcomes.

If you would like any further information, please contact Mark Atkin, Consultant, Diabetes and Endocrinology, RUH Bath, marc.atkin@nhs.net

NATIONAL EXAMPLES

North East Essex

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



North East Essex
(August 2015).pdf

Derbyshire

In Derby, GPs and hospital-based clinicians have collaborated in an innovative way to form new NHS organisations which provide integrated diabetes care for their local population.



Derby
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Berkshire

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.



Berkshire West
(November 2014).pdf

Diabetes UK- Improving the delivery of adult diabetes care through Integration.



Integrated diabetes
care DUK summary (P

The Portsmouth model

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

Five years on, the authors have surveyed patient and practitioner satisfaction of the service provided, and calculated the estimated clinical events avoided as a result of the Super Six model. Patient and practitioner satisfaction is high and there have been reductions in diabetes-related hospital admissions and vascular events. Several articles can be obtained from Diabetes on the Net [Here](#): (search for Portsmouth in the content search)

Smethwick Community Pathfinder Diabetes Project: Right care, Right here (RCRH) initiative Objectives

The project had a long list of goals, among them: to upskill GPs and practice nurses (PNs); to reduce 'do not attends' (DNAs); to increase patient satisfaction; and to improve diabetes control by reducing HbA1c. It also aimed to provide care without financial boundaries, to build capacity within primary care, to improve appropriate referrals to secondary care and to improve communication between GPs/PNs and specialists.

Finally, the project hoped to improve formulary compliance and value for money prescribing, reduce hospital and A&E admissions with hypos and Diabetic Ketoacidosis (DKA), and to increase the uptake of structured education programmes.

The model centres on providing joint diabetes clinics within GP practices for a one-off advice and creation of management plan by the consultant/diabetes specialist nurse, who run a parallel clinic. The primary care team takes this plan forward and puts it into action. Referral criteria depended on locally agreed pathways, frequency of clinics and methods of dealing with interim queries.

All local GP and primary care clinicians now have access to clinical support and practice diabetes teams on an ongoing basis.

Results

Diabetes management skills in primary care have improved significantly. Patients like this service which is closer to their homes, as shown by good attendance rates and satisfaction surveys. Routine new hospital referrals have decreased significantly, and surveys of GPs and patients have shown that primary care value this service enormously. The service has helped achieve cost savings and attain RCRH model of care by devolving care into community care, leading to increased hospital clinic capacity. People with diabetes have benefited from improved self-empowerment and ownership, along with increased awareness of when to seek help. They are seeing fewer complications and hospital visits.

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