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Right person, right place, first time

Transforming elective care services **diabetes**

Learning from the Elective Care Development Collaborative

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Introduction

This handbook describes what local health and care systems can do to transform diabetes elective care services at pace, why this is necessary and how the impact of this transformation can be measured. Practical guidance for implementing and adopting a range of interventions locally is included to help ensure patients see the **right person, in the right place, first time**.

Interventions and case studies are grouped by theme within this handbook. 'How-to' guides and suggested metrics are included.

The list of interventions is not exhaustive and reflects those tested in the second wave of the Elective Care Development Collaborative, along with further relevant information.

The success of interventions designed to transform local elective care services should be measured by changes in local activity following implementation of the intervention and performance against the Referral to Treatment (RTT) standard. Patient and professional outcome and satisfaction should also be measured (NHS Improvement, 2018).

The second wave of the Elective Care Development Collaborative included rapid testing in dermatology, diabetes and ophthalmology. This handbook is just one of the resources to be produced following this wave. Further handbooks, case studies, resources and discussion can also be found on the **Elective Care Community of Practice** pages.

You can learn about the interventions tested in previous waves (**MSK** and **gastroenterology**) and find all the handbooks and case studies on our webpages.

1. The national context and challenges facing elective care services in England

The NHS is experiencing significant pressure and unprecedented levels of demand for elective care.

Around 1.7 million patients are referred for elective consultant-led treatment each month. Between 2011/12 and 2016/17, referrals rose annually by an average of 3.7% per year and since 2005/06, total outpatient appointments have nearly doubled from 60.6 million to 118.6 million.

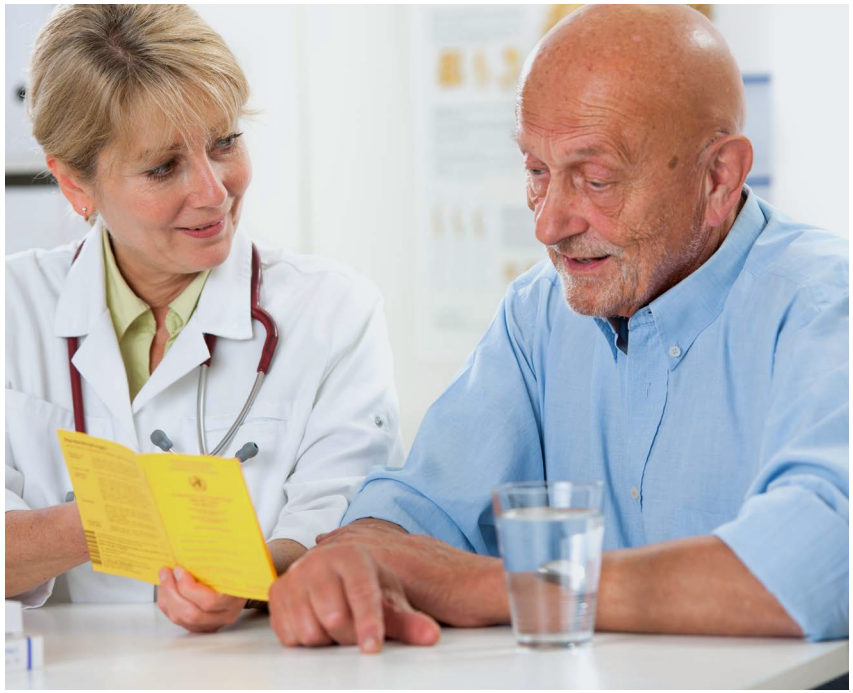
At the end of October 2018 only 87.1% of patients were waiting less than 18 weeks to start treatment (thus not meeting the 92% Constitutional Standard for referral to treatment). 4.2 million patients were waiting to start treatment and of those, 2816 patlents were waiting more than 52 weeks.

Timely access to high quality elective care is a key priority under the NHS Constitution.

Two key documents: Next Steps on the Five Year Forward View and the NHS Operational Planning and Contracting Guidance 2017-19, make the redesign of elective care services a must-do for every local system. They call for better demand management that improves patient care while improving efficiency.

The NHS Long Term Plan clarifies the direction for health and care over the next ten years, including the importance of transforming outpatient services.

The friends and family test results for October 2018 show that overall satisfaction with outpatient services is high, with 94% of 1,401,736 respondents saying that they would recommend the service to a friend or family member; 3% said they would not recommend the service, with the remaining 3% saying 'neither' or 'don't know'. It is important to take steps to ensure that patient satisfaction remains high.



2. The national diabetes challenge

Some 2.7 million people are diagnosed with diabetes in England and this figure is increasing yearly by 5%. With rising obesity levels, this will be an estimated 5 million in 2025. It is also estimated that around 630,000 people are already living with diabetes but are yet to be diagnosed. Diabetes accounts for around 10% of total NHS spending. Some 80% of this cost is incurred in treating potentially avoidable complications. Prescription costs alone reached £764 million in 2012/13.

Diabetes doubles the risk of cardiovascular disease and is a major cause of premature mortality. Up to 100 people per week have a limb amputated because of diabetes – often this is avoidable. Many people with diabetes have at least one other long-term condition – with this group forecast to grow by 250% by 2050 (NHS England, 2014).

The rise in type 2 diabetes is thought to be related to lifestyle factors and is a major challenge.

There are many opportunities to improve diabetes services. Supporting patient management in primary care through advice and guidance (Healthy London Partnership NHS, 2017) means the majority of outpatient appointments could take place in the community. The role of the consultant can be redefined to include peer education that provides a support framework for primary care (NHS England, 2017). Ensuring optimal use of skills and capabilities across primary and secondary care (including specialist diabetes nurses and pharmacists) to help people manage their condition can also assist with improving diabetes services. Diabetes self-management education helps people to stay healthy, yet difficulties accessing education mean that fewer than half of patients receive structured education within 12 months of diagnosis (NHS RightCare Pathway, 2017).

Table 2: Percentage of people with diabetes receiving NICE recommended care processes by care process, diabetes type and year audit.

England and Wales

	Type 1						Type 2 and other					
	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
BhA1C	83.0	79.8	80.9	83.2	83.7	84.3	90.9	93.1	93.5	94.8	95.0	95.1
Blood Pressure	88.4	87.7	87.0	89.0	89.1	90.3	95.6	95.4	94.9	96.1	95.7	96.2
Cholesterol	77.8	77.3	77.4	78.7	79.1	79.9	92.1	91.9	92.4	92.8	92.7	92.7
Serum creatinine	81.1	80.3	78.8	80.5	81.5	82.7	93.5	93.2	93.4	94.5	94.7	95.0
Urine albumin	59.2	56.5	63.9	55.9	50.2	50.1	77.5	74.7	84.4	74.6	66.7	65.2
Foot surveliance	72.8	71.5	70.7	72.4	72.9	69.5	86.4	85.8	86.2	86.7	86.7	79.4
BMI	83.7	83.3	76.8	74.9	75.2	75.3	90.9	90.9	85.7	83.1	82.7	83.1
Smoking	79.1	79.2	77.4	77.9	78.5	79.2	85.7	86.3	85.5	85.2	85.2	85.5
Eight care processes	**43.2**	**40.8**	**44.5**	**38.7**	**36.5**	**33.7**	**62.1**	**61.2**	**67.6**	**58.7**	**53.1**	**47.6**

National Diabetes Audit (NHS Digital, 2017)

3. The Elective Care Development Collaborative

NHS England's Elective Care Transformation Programme supports local health and care systems to work together to:

- Better manage rising demand for elective care services.
- Improve patient experience and access to care.
- Provide more integrated, person-centred care.

As part of this programme, the Elective Care Development Collaborative has been established to support rapid change led by frontline teams. In Wave 2 of the Elective Care Development Collaborative, local health and care systems in Dorset, Stockport, Norfolk and Lincolnshire formed teams to develop, test and spread innovation in delivering elective care services in just 100 days (the 100 Day Challenge). You can find more about the methodology used here.

The teams used an intervention framework to structure their ideas around three strategic themes:

Rethinking referrals

Rethinking referral processes to ensure they are as efficient and effective as possible means that from the first time a patient presents in primary care, patients should always receive the assessment, treatment and care they need from the right person, in the right place, first time.

Shared decision making and self-management support

An all age, whole population approach to personalised care means that:

- People are supported to stay well and are enabled to make informed decisions and choices when their health changes.
- People with long term physical and mental health conditions are supported to build knowledge, skills and confidence to live well.
- People with complex needs are empowered to manage their own condition and the services they use.

This should be considered at every stage of the patient pathway and can be achieved through shared decision making, personalised care and support planning, social prescribing, patient choice, patient activation and personal health budgets.

Transforming outpatients

Transforming outpatients means considering how patient pathways and clinic arrangements (including processes) ensure that patients always receive assessment, treatment and care from the right person, in the right place, first time. This may not be in secondary care. Virtual clinics, technological solutions and treatment closer to home are all possibilities.

4. Overview of ideas included in this handbook

Theme	Intervention	The opportunity
Rethinking Referrals	Advice and guidance	If access to specialist advice and guidance is available through tools such as e-Referral Service, email or telephone more patients should receive effective treatment and advice in primary care. Primary care practitioners should have improved and more responsive access to specialist support. This should reduce the number of referrals into secondary care and improve the quality of referrals made.
	Shared learning opportunities	If learning and knowledge around the appropriate treatment of diabetes is shared between practitioners, then patients should receive effective and holistic treatment and advice earlier. Primary care practitioners should gain increased knowledge, confidence and expertise. The quality of information accompanying referrals to secondary care should improve and the number of unnecessary referrals should decrease.
Shared Decision Making	Patient education	If education sessions are attended by patients, they should feel more confident to manage their diabetes with support from primary and community practitioners and be more likely to improve their health outcomes. This should reduce the number of referrals made to secondary care.
	Integrating pharmacy into the diabetes pathway	If pharmacy is integrated into the diabetes pathway medicines should be optimised so patients have the best possible outcomes. Primary care practitioners should feel more confident to make decisions with patients about medicine management through pharmacists sharing their decision-making processes. This should reduce the number of referrals to secondary care whilst connecting patients to appropriate support in the wider system.
Transforming Outpatients	Multidisciplinary team clinics in GP practices	If patients are seen in multidisciplinary team clinics in GP practices they should receive holistic support to effectively manage their diabetes. Primary care practitioners should have more confidence and knowledge to manage patients in primary care, through support from specialist colleagues. This should reduce the number of referrals to outpatient waiting lists and also a reduction in the number of follow-up appointments/ re-referrals required.

a. Advice and guidance

What is an advice and guidance service?

An advice and guidance service enables one clinician to seek advice from another, usually a specialist. For example, this could be about a patient's diagnosis, treatment plan and ongoing management; or it could be for clarification of test results and referral pathways.

There are several methods of obtaining advice and guidance. For example, the NHS e-Referral Service enables GPs to actively request advice from identified specialists. Clinicians in primary care can also use email or telephone services using 'chase' systems, which call secondary care clinicians in turn until the call is picked up.

Why implement advice and guidance?

Patients should receive the care and treatment they need in primary care wherever possible. Unnecessary hospital visits should be avoided and they should feel more confident and supported to manage their condition.

Primary care clinicians should be able to manage patients more effectively and avoid unnecessary referrals into secondary care. Where a referral does need to be made, advice and guidance can improve the quality of information that accompanies the referral. This means that specialist expertise can be directed to those patients who need it most. Advice and guidance is a great opportunity for shared learning. As practitioners' confidence and proficiency increases, the overall number of referrals made may reduce, along with waiting times for specialist input.

A national CQUIN (2017-19) supports local systems to offer advice and guidance for non-urgent GP referrals. Advice and guidance services can form an effective part of a suite of interventions that transform the way referrals are managed, complementing standardised referral pathways and referral forms.

We know it works:

- Utilisation of the NHS e-Referral Service has steadily increased across England from 55% in January 2017 to 73% in May 2018.
- Patient satisfaction with the e-Referral Service was 80% overall (NHS Digital 2018).
- 72% of advice and guidance calls regarding diabetes and endocrinology avoided an unnecessary hospital visit. This compares to an average of 66% across other high volume elective specialties (Consultant Connect, 2018).

Since the start of the one hundred days in Dorset:

- All requests were responded to within 48 hours (meeting the national CQUIN target).
- 50 requests were received during the hundred days (compared to only 105 requests in the previous 10 months).

Since the start of the one hundred days in Stockport:

- The advice and guidance service has been automated and 100% of all new referrals have been reviewed by consultants. They have provided feedback to referrers via the e-Referral Service.

a. Advice and guidance

How to achieve success: implementing advice and guidance

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Involve people from across your local system

- **Engage clinicians from the beginning**. Explain the opportunities and potential benefits before launching the advice and guidance service. Effective engagement with those who will use the service is crucial, as it is unlikely to be used widely without successful buy-in across primary and secondary care.
- **Seek input and feedback at every opportunity**. It is important to communicate regularly with key stakeholders and enable potentially difficult conversations to take place in a 'safe' environment. This means feedback can to be used constructively.

Design your advice and guidance service

- **Review current services and usage** (if advice and guidance services are already available locally). Use this review to understand local need and potential areas for development.
- **Explore examples from elsewhere and refer to national guidance.** The 2017-19 Advice and Guidance CQUIN (NHS England, 2017) is a good starting point from which to agree a local standard and ensure that your service meets the necessary requirements. Use the Elective Care Community of Practice to find case studies and ask questions of others who may be using advice and guidance services effectively.
- **Make use of available resources.** Don't get held up by technical concerns. Testing a simple, low tech solution (such as using email and phone) is an easy way to generate interest and buy-in. This gives opportunities to understand what is needed, what will work locally and any potential issues or challenges.
- **Seek specialist advice on procurement, IT and telephony.** Ensure that the chosen advice and guidance system can meet local need and integrate with existing systems. A more high tech system will work better once any technical glitches have been addressed and users are comfortable with the system.
- **Integrate existing standardised referral templates into the advice and guidance process** to help referrers consistently capture the necessary information. It is important to co-design and review these templates where necessary, to ensure the right level of detail is included. Consider how to include feedback on referrals, clinical decision support tools and specialist case review in primary care.

a. Advice and guidance

How to achieve success: implementing advice and guidance (continued)

- **Start small and scale up.** Invite consultants to join the advice and guidance rota on a trial basis. People may prefer to take part in a trial first before committing long term. This also allows initial benefits to be observed and helps to make the case for scaling up the service. Ensure job planning implications are worked through to secure ongoing involvement. Build dedicated time into schedules and ensure there is capacity to provide the service consistently.
- **Agree activity and impact metrics** to demonstrate the success of the advice and guidance service against local priorities, even in the earliest trial stages. This is to ensure that evidence is there to prove the case for sustainability. Ascertain the current baseline and ensure there are processes in place to capture any necessary data as the service develops.
- **Install and test the chosen advice and guidance system**. Ensure there are opportunities for continual feedback and refinement from users at all stages of implementation.

People you may wish to involve from the start:

- diabetes specialist nurses
- consultants
- GPs
- practice nurses
- practice managers
- primary care relationship managers
- business manager (diabetes)
- booking team
- finance team (if purchasing a new solution)
- IT support (including app developers, if applicable)
- NHS Digital (for e-Referral Service support)
- Administrative support in secondary care to help review and monitor advice and guidance requests and responses.

a. Advice and guidance

How to achieve success: implementing advice and guidance (continued)

Promote your advice and guidance service

- **Promote the service and available resources to GPs and practice managers.** Using various means (face-to-face, email communication, flyers, etc.) is most effective. Link in with practice education sessions and use local networks where possible.
- **Provide information and training for clinicians.** Consider developing a quick reference guide for consultants and GPs to refer to. This is useful as they start to use the service.
- **Consider developing an information video to promote and explain the service.** Liaise with your local communications leads to gain support and advice on filming and editing. Invite clinicians and patients to take part and share their positive experiences.

Develop the possibilities for ongoing education

- **Advice and guidance should not just be an answer.** Responses should include the rationale and reasoning behind decision making to optimise learning.
- **Collate common themes and use these to inform local educational programmes for primary care (protected learning events, learning bulletin etc).** An optimally effective advice and guidance service should upskill all those with the same learning need as the GP seeking advice, whether or not they are aware of their own needs or whether they would have asked for the same advice themselves.

The following standards and guidance may be useful:

Offering Advice and Guidance: Supplementary Guidance for CQUIN Indicator 6 (NHS England, 2017)

NHS e-Referral Service: guidance for managing referrals (NHS Digital, 2018)

Resources required:

- Email and telephone access for referrers.
- Access to an agreed and integrated advice and guidance service.
- Specialists who can answer advice and guidance requests.
- Promotional resources (e.g. flyers/leaflets).
- Links to local opportunities to promote the service e.g. locality/neighbourhood meetings.

a. Advice and guidance

Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

Quantitative

- Length of time between referral and appointment in secondary care.
- Number of consultant to consultant referrals.
- Number of practitioners using the service (broken down by where they work).
- Number of advice and guidance requests.
- Outcome of advice and guidance – e.g. refer to secondary care/rejected/advice and guidance to enable patient to remain under primary care.
- Length of time taken for a response to be received.

Qualitative

- Feedback from referrers:
  - Knowledge, ability and confidence to manage patients in primary care with support from the advice and guidance service (self-reported).
  - Effectiveness of communication and relationships with colleagues providing advice and guidance.
- Feedback from secondary care:
  - Quality of referrals and accompanying information received.
- Feedback from patients and the public:
  - What was their experience? (case studies).

Intended benefits:

- Earlier access to specialist advice and reduced patient waiting times.
- Increase in quality of referrals to secondary care.
- Reduction in unnecessary referrals to secondary care.

a. Advice and guidance: Dorset case study

The challenge – why here and why now?

Nationally a growing number of people are being diagnosed with diabetes. In Dorset the numbers reached their highest level (42,000) in 2017.

This intervention aimed to contribute to Dorset's overarching goal of reducing waiting times for appointments in secondary care to two weeks by reducing the number of unnecessary referrals wherever possible.

Dorset already had an email advice and guidance system in place at the start of the 100 Day Challenge. Clinicians could request approved advice about any diabetes or endocrine problem from a consultant at Dorset County Hospital via a dedicated email address. However, the system was not being used to its maximum potential.

The intervention – what did they do and how did they do it?

The team took a whole-system approach and involved GPs, practice nurses, diabetes specialist nurses, practice managers, CCG representatives and IT team support. They undertook the following:

- **Reviewed the current advice and guidance service.** Obtained feedback from GPs and consultants already using the service. This helped to inform their planning.
- **Gathered data to demonstrate effectiveness and impact.** Metrics included the numbers of advice and guidance requests, average time to respond and satisfaction with the service. The team was working with IT to automate a feedback mechanism regarding GP satisfaction with the responses received.
- **Clarified guidance on how to use the service.** The advice and contact details were moved from the bottom to the top of clinic letters.
- **Built greater awareness of the advice and guidance service.** This included all Dorset localities and in particular Bridport, West Dorset and Weymouth and Portland. They created flyers to advertise the service and encourage greater uptake. The flyers included positive quotes from users to highlight the value of the service, along with data on response time to set expectations. They promoted the service via word of mouth and email to GPs, practice nurses, diabetes specialist nurses and consultant oncologists. They also went along to three GP locality meetings which were attended by at least one representative from ten GP practices.

a. Advice and guidance: Dorset case study

Lessons learned

- Consulting key stakeholders including current users of the service to understand current benefits and limitations of the system proved invaluable. It helped the team make changes that non-users may not have thought of, for example, changing the location of the contact email address to make it more visible.
- Using various means of communication (face-to-face, email, paper flyers, meetings, word of mouth) to promote advice and guidance was more effective than just focusing on a single channel.
- Working with IT to automate the feedback process could save time in the long run and create a feedback mechanism that would improve the service in the future.

Headline achievements in 100 days:

- Received 50 advice and guidance requests during the 100 Day Challenge. This was a notable increase from the 105 requests received in the 10 months prior to the 100 Day Challenge, before additional promotion.
- Responded to all 50 advice and guidance requests within 48 hours.
- Avoided at least one referral due to advice and guidance.

What did people say?

"I'm very impressed with the service – I contacted the advice and guidance email at 7pm on a Monday night and had a reply by 9am the next day."

GP, Dorset.

You can find further information about this work, as well as other case studies on the Elective Care Community of Practice pages. For more information, please email: england.electivecare@nhs.net

b. Shared learning opportunities

What is a shared learning opportunity?

Shared learning means general practitioners and primary care staff can learn from diabetes specialists and others with essential skills and experience. Individuals can ask questions and check their own understanding. Opportunities may include formal training or peer mentoring and continuing professional development shared learning sessions or events. Other possibilities include: optimising advice and guidance services to ensure feedback on referrals is comprehensive and shared to help others wherever possible, multidisciplinary team virtual review meetings and triage of referrals by specialists.

Why implement shared learning opportunities?

Shared learning opportunities build capacity and expertise in primary care. If learning and knowledge about the appropriate treatment of diabetes is shared:

Patients should benefit from improved assessment and support in primary care, along with more integrated care and comprehensive and effective treatment plans. Treatment outcomes (including control of HbA1c, blood pressure and cholesterol) should improve.

Practitioners in primary care should benefit from increased knowledge, confidence and expertise in diabetes. As effective communication increases, relationships with specialists will be strengthened and trust will be built.

Collaboration and integration across the system should improve and the quality of referrals made should improve as primary care clinicians become more confident managing complex cases (Diabetes UK, 2014).

We know it works:

- In Tower Hamlets a care package for type 2 diabetes management was developed and implemented across all 35 GP practices which were grouped into eight local networks. Over three years completed care plans rose from 10% to 88%. Patients achieving both blood pressure and cholesterol targets rose from 35.3% to 46.1% (Hull et al., 2013).

Since the start of the one hundred days in Dorset:

- Seven virtual MDT review meetings have taken place, each session with five to 10 patients.
- Participants say the meetings are a good opportunity to share knowledge and practice.

Since the start of the one hundred days in Lincolnshire:

- Only two of 40 new patient referrals triaged by diabetes specialist nurses required onward referral to secondary care. The rest were supported in primary care, with six of these cases reviewed in the virtual MDT meeting.
- The current specialist consultant led diabetes clinic caseload was audited and 50% of patients were moved either to nurse led care or another more appropriate clinic.
- 25 patients were reviewed over two virtual MDT review meetings. 23 of the 25 were managed in the community. Previously, all would have been referred to secondary care.
- All attendees found the review useful and reported an increased ability to manage diabetes patients in primary care.

Since the start of the one hundred days in Stockport:

- 20 GPs and nurses attended the first day of a three-day training course (scheduled over three months).

Since the start of the hundred days in Norfolk:

- 40 nurses attended a shared learning forum. Positive informal feedback from 12 attendees.
- 41 practices registered for consultant mentoring, with seven consultants registered and six initial meetings held.

b. Shared learning opportunities

How to achieve success: implementing shared learning opportunities

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Plan for learning opportunities across your local system

- **Establish where there are gaps in learning.** Ask primary care practitioners which areas of diabetes care they would like to explore and where they think there are areas for development. Ask secondary care clinicians where they think learning should be directed. The wider the range of people involved in setting up the learning opportunities, the broader participation will be, which adds a range of perspectives. This is particularly important in diabetes care, where patients are managing complex conditions that benefit from support across multiple care and community settings.
- **Identify where there are skills and expertise that can be utilised.** It is important to engage local specialists across both primary and secondary care from the beginning and to ensure that the mutual benefits of shared learning are explained and understood so that people are willing to give their time and knowledge.
- **Involve people with lived experience.** Hearing the stories and perspectives of patients is a powerful way to influence change. It also means the patient perspective is embedded into new ways of working.
- **Explore examples, resources and training from elsewhere and refer to national guidance.** Diabetes UK signpost to a range of useful training courses and resources, including e-learning. Use the Elective Care Community of Practice to find case studies and ask questions of others who may have developed successful shared learning opportunities.

Decide upon the approach you will take

- **Virtual multidisciplinary team review meetings** allow a team of professionals from across both primary and secondary care to gain holistic oversight of complex patients. Patients are not present but professionals meet regularly to ensure that care pathways and treatment plans are integrated and aligned across the multidisciplinary team. They allow for learning and expertise to be shared and for questions to be asked. They also strengthen relationships and ways of working across organisational boundaries. Meetings could take place face to face in primary care or virtually, with team members joining via webinar.
- **Clinical triage of new referrals** allows appropriate next steps to be identified and ensures that patients are referred into the most appropriate service. It also allows any unnecessary referrals to be identified and a plan put in place for treatment in primary or community care, if possible. This feedback can then be discussed with referrers to ensure future referrals are successful and upskill the referrer. Triage may be undertaken by consultants via the e-Referral Service (see advice and guidance) or by diabetes specialist nurses (see Lincolnshire case study). Patient satisfaction should also increase, as patients are seen in the right place, first time.

b. Shared learning opportunities

How to achieve success: implementing shared learning opportunities (continued)

- **Training and peer mentoring in primary care.** Specialists in both primary and secondary care can deliver structured training and become peer mentors for clinicians who do not have the same level of specialist knowledge. Mentors can come from a range of backgrounds, including consultants, diabetes specialist nurses and pharmacists.
- **Shared learning events and forums.** Shared learning events can count towards continuing professional development (CPD). They usually have a specific focus and bring together individuals with similar interests and learning needs.

Plan ahead

- **Get dates into diaries as far in advance as possible.** Any event or meeting that brings individuals together needs to be scheduled as far in advance as possible so that people can ensure they can attend. This will improve engagement and reach.
- **Identify suitable venues and dates.** Any meetings or events will need to be held in a convenient place that can accommodate the right number of participants and the requirements of the event. Local GP practices may have space available that is appropriate for virtual MDT meetings. It may be useful to identify administrative support to help co-ordinate venues and invites for speakers and participants. Consider which day and time of the week will work for most attendees.
- **Decide on themes or cohorts for virtual multidisciplinary team review meetings.** This needs to be done in advance of the meetings and communicated to practitioners in good time to enable them to prepare cases for discussion. For particularly complex patient cohorts, all practitioners in contact with the cohort across both primary and secondary care should be invited. This gives the opportunity to share learning and to develop integrated care plans. Alternatively, inviting attendees to bring along cases on a certain theme can lead to a more focussed and in-depth discussion (e.g. diabetes and renal issues or gestational diabetes). This can enrich the learning experience for participants, enabling them to attend specific meetings on topics on which they want to broaden their understanding.
- **Schedule and cost events in a way that meets people's needs.**
- **Engage and connect people from your local system even before developing formal learning opportunities.** This enables different conversations and shared learning to develop and take place organically.
- **Create and disseminate promotional material.** Ensure it is clear who the intended participants are and how people can get involved.
- **Setting up triage within GP practices takes time.** It relies on buy-in from the practice and from clinicians. Focus on a small number of cases to begin with and maintain regular contact with the practice to ensure feedback can be incorporated.

People you may wish to involve from the start:

- consultants
- GPs
- practice nurses
- diabetes specialist nurses
- podiatrists
- dietitians
- psychologists
- business intelligence team
- practice manager
- Administrative support to identify patients.

b. Shared learning opportunities

How to achieve success: implementing shared learning opportunities (continued)

Share learning and resources as you scale

- **Share any resources you develop.** Resources such as agendas can be invaluable when planning subsequent meetings and events. Acknowledge that these may never be completely standardised because each locality is different but they will be a helpful starting point.
- **Develop a 'read code' for patients whose cases have been reviewed at virtual multidisciplinary team meetings.** This allows those who are unable to join the meetings to review any notes or plans relating to the patient and benefit from the discussion that took place at the meeting. It also facilitates automated data collection.
- **Film events and speakers to share learning more widely.** If speakers are happy to be filmed and participants are willing to share feedback, then their experiences and perspectives can be shared widely online which can reduce future costs and increase reach.

The following standards and guidance may be useful:

Integrated care - taking specialist medical care beyond the hospital ward (Royal College of Physicians, 2016)

Improving the delivery of adult diabetes care through integration: shared experience and learning (Diabetes UK, 2014)

Make the most of available data to enrich the discussion

- **Track the impact of any shared learning opportunities.** Think about how you can track the impact on participant practice and health outcomes for the cohorts and conditions that are the focus. Consider developing a brief questionnaire to record reflections from participants at the end of sessions and work with the local business intelligence team to design a means of capturing and analysing impact data from the sessions. This will help with the design and development of future learning opportunities.

b. Shared learning opportunities

Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

Quantitative

- Number and type of shared learning sessions held.
- Number of patients reviewed.
- Number of professionals involved.
- Time spent participating.
- Number of avoided referrals.
- Number of referrals made into secondary care.
- Rate for patients who did not attend (DNA) appointments.
- Waiting time for patients.
- Longer-term health of patients (e.g. blood pressure, HbA1c, cholesterol).

Qualitative

- Participant feedback on the level of communication and trust between different practitioners as well as level of shared learning (e.g. development of knowledge and skills).
- Roles of professionals involved.
- Patient feedback on their experience of primary care support, including ability to self-manage.

Intended benefits:

- Increase in confidence to manage patients in primary care.
- Reduction in referrals to secondary care.
- Improvement in HbA1c, blood pressure and cholesterol outcomes.

b. Shared learning opportunities: Lincolnshire case study

The challenge – why here and why now?

The diabetes register in Lincolnshire contains 49,386 people (7.7% of the Lincolnshire adult population, compared to the UK average of 6.7%) and the number is increasing at approximately 5% a year. It is estimated that 12.4% (75,506) of the adult population in Lincolnshire have non-diabetic hyperglycaemia (pre-diabetes) and are at risk of developing type 2 diabetes.

The team were keen to see more patients managed in the community for three reasons: firstly, in a rural county, where many patients live around one hour away from the nearest hospital and where 57% of people with type 2 diabetes are over the age of 65, there is a clear advantage for patients being able to receive the care they need close to home. This is particularly true for a number of house-bound patients. Secondly, with high levels of diabetes and a growing number of people living with the condition, the current demand for specialist support for diabetes is unsustainable. Lastly, the team believed there was significant capacity to manage patients currently looked after in specialist care in the community if there was a small increase in the guidance and education offered to primary care practitioners.

Multidisciplinary team virtual review meetings offered the two-fold benefit of proactively moving patients from specialist care to community care and of creating a space for discussion, guidance and education for GPs and other primary care practitioners. The team believed this would have a knock-on effect on future referral decisions.

The intervention – what did they do and how did they do it?

The team took a whole-system approach and involved a core group of GPs, consultant and diabetes specialist nurses (hospital and community), alongside involvement from a practice nurse. It was decided that pharmacists, dietitians and podiatrists could be invited for meetings of particular relevance to them. They undertook the following:

- **Attended Clinical Commissioning Group (CCG) meeting** to discuss opportunities and ideas for virtual review.
- **Referred patient cases** from the triage process to a multidisciplinary team virtual review meeting (see triage case study).
- **Tested virtual review meetings and triaging** in three GP practices serviced by a district general hospital and an Intermediate Community Diabetes Service. This meant that the multidisciplinary team were able to discuss a common cohort of patients.
- **Identified practitioners to attend each virtual review**. All reviews involved a consultant, GPs and diabetes specialist nurses. The reviews were thematic, so other healthcare professionals were invited along as relevant (e.g. a clinic focused on renal issues and diabetes would include a renal consultant). The multidisciplinary team virtual review meetings needed to be planned well in advance to adhere to the six week rule.

b. Shared learning opportunities: Lincolnshire case study

The intervention – what did they do and how did they do it? (continued)

- **Held multidisciplinary team virtual review meetings on a monthly basis** at a local GP practice for two hours. This included a review of ten to 15 patients brought by the attending GPs, focusing on a theme identified by the consultant
- **Followed up with patients afterwards** to communicate decisions made and next steps.
- **Accounting for staff travel time** to practices for any multidisciplinary team virtual review meeting was important.
- **Discovering that it took on average ten minutes to discuss an individual patient in appropriate detail** was helpful in planning for future sessions.

Lessons learned

- **Building good relationships with practitioners** early in the process was an important part of the success of the intervention.
- **Ensure clinicians have enough time to work on the project is important.** This needs to be agreed at the beginning of the programme.
- **Gaining support of senior leaders** was helpful in breaking through initial resistance and getting everyone's schedules lined up.
- There was some resistance to the idea initially as there were concerns about the value of releasing clinical time to join and some of the clinics took place in clinicians' own time. **The results achieved at the first two clinics changed this mindset significantly**.

b. Shared learning opportunities: Lincolnshire case study

Headline achievements in 100 days:

- 25 patients were reviewed over two virtual MDT review meetings. For 23 out of 25 new referrals reviewed in virtual MDT meetings, it was decided that their care would best be managed in the community. Prior to the introduction of these meetings, all would have been referred to secondary care.
- All five attendees found the review useful and all attendees reported an increased ability to manage diabetes patients in primary care.

You can find further information about this work, as well as other case studies on the Elective Care Community of Practice pages. For more information, please email: england.electivecare@nhs.net

a. Patient education events

What is a patient education event?

Patient education can be delivered via community-based events to provide information, advice and access to clinical and non-clinical support for patients with diabetes (NHS RightCare, 2017), or via a number of one-to-one or smaller group education sessions held in either a community or secondary care setting (National Voices, 2014). The CCG Improvement and Assessment Framework includes the number of people with diabetes diagnosed less than a year who attend a structured education course as one of the key indicators.

Why implement patient education events?

Many areas already offer some form of structured education. However, improving uptake and attendance has to be a focus to ensure that as many people as possible receive the information and education necessary to help them manage their own condition.

Patients should build their knowledge and confidence so they can manage their diabetes better, leading to a reduction in HbA1c and better control of cholesterol and blood pressure. This should also reduce complications such as amputations, strokes and blindness. It should also help reduce anxiety about their condition, increase self-efficacy/empowerment and patient satisfaction.

Practitioners should all use their expertise to educate patients so there are fewer appointments with clinicians in primary care and secondary care.

There should be fewer referrals to secondary care and attendances at primary care for this cohort of patients, while networks across the system should be strengthened. Significant cost savings should be anticipated if self-management education is made available to everyone with type 1 diabetes. If patients manage their own condition better, then they are more likely to meet the NICE recommended treatment targets. Attendance at a structured education course by people with diabetes diagnosed less than a year is also one of the indicators in the CCG Improvement and Assessment Framework.

We know it works:

Smaller group sessions can enable people to build relationships and confidence in a peer to peer setting, while also receiving specialist support and advice from the event lead – typically a specialist nurse (The Health Foundation, 2015).

Since the start of the one hundred day challenge in Dorset:

- Average drop of 10 mmol in HbA1c level (from 55 to 45 mmol) between the first and second patient education group session for the eight patients who attended.

Since the start of the one hundred days in Lincolnshire:

- Four people living with diabetes designed and ran a high profile patient engagement event with 61 attendees.

a. Patient education events

How to achieve success: implementing patient education events

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Engage people with lived experience to lead on the design and delivery of the event or sessions, with support from a wider cross-system team

- **Don't assume you know what people want.**
- **Involve your target audience in the session design and delivery** to understand what people want from the sessions and build engagement.

Agree patient cohort and focus of event(s)

- **Using diabetes prevalence data (e.g. drawn from PRIMIS) is a helpful way of identifying where sessions should be offered.** Data may highlight, for example, that two practices with differing numbers of diabetic patients need different levels of support/number of education sessions offered.
- **Ensure that separate sessions are available for adults with type 1 and type 2 diabetes,** recognising that there are differences in the self-management needs of these populations.
- **Consider how to reach those people who are newly diagnosed with diabetes** so that they have the opportunity to attend a structured education course within a year. (Diabetes UK, 2016) (CCG Improvement and Assessment Framework).
- **Consider how to reach the working age population and those who find it difficult to attend at set times.**

People you may wish to involve from the start:

- Diabetes specialist nurse
- People with lived experience as part of the project team (ideally at least two).
- Patients, carers and other family members.
- GP
- Dietitian
- Practice nurse
- Podiatrist
- Voluntary sector representatives, e.g. Diabetes UK/local diabetes support services.
- CCG support with promotion and engagement across primary care.
- Acute Trust team support with promotion and engagement across secondary care.
- Communications team support to help with coordination and promotional material, including posters and emails.
- Administrative support (1.5 hours per event).
- Source support to engage multiple agencies to participate in event, book the room, food, etc. and identify patients to invite.

a. Patient education events

How to achieve success: implementing patient education events (continued)

Plan your events

- **Identify the target audience and focus or theme for your events.** Using diabetes prevalence data (e.g. drawn from PRIMIS) is a helpful way of identifying where and what type of education sessions should be offered.
- **Don't assume you know what people want or need.** Involve your target audience in design and delivery of the sessions to build engagement and gain a patient perspective.
- **Schedule the events to optimise attendance.** Consider people of working age and those who may find it difficult to attend at set times, along with how to reach anyone newly diagnosed with diabetes. Ensure there are a range of methods by which people can access diabetes education. This means considering online and virtual options as well as face to face sessions.
- **Choose a convenient location.** Consider accessibility and aspects such as parking to make it as easy as possible for people to attend.
- **Agree the focus and agenda for the events.** Ensure that separate sessions are available for adults with type 1 and type 2 diabetes, as these two cohorts have different self-management needs.
- **Consider the wider determinants of health.** It is important to offer people the right advice and support at the right time. This could mean signposting people to help address social circumstances before focusing on diabetes, e.g. via wellbeing navigators or voluntary sector organisations. Ensure that the benefits of healthy dietary and lifestyle choices are promoted and understood in terms of their ability to improve specific health outcomes and overall wellbeing.

Invite attendees

- **Agree referral/invitation process.**
- **Draw on your local networks to engage speakers to develop and deliver a holistic programme, which will attract a broad range of participants.** Use the resources that you have available locally to build confidence and capacity in professionals across the system to deliver events.
- **Involve the voluntary sector.** This can be a good way of complementing clinical involvement and can increase turnout.

a. Patient education events

How to achieve success: implementing patient education events (continued)

- **Promote events and sessions via networks across primary and secondary care.** Design and produce promotional materials. Aim these at professionals and participants, outlining the education offer and the purpose of event/sessions, along with the intended audience. Produce posters and advertise in local pharmacies, GP practices, shops and community centres to reach participants. Use existing networks and email to send invites via staff.

Build on available resources to ensure quality

- **Review existing self-management and diabetes education materials and ensure that they are promoted to staff and to patients.** A wealth of educational information and resources (such as self-management apps, course curricula and materials, leaflets, e-learning and websites) are available for clinicians and patients but are often always used. Many options have supporting evidence from randomised controlled trials. The Quality Institute for Self-Management Education and Training (QISMET) quality standard may be helpful to check for certified resources. This covers all structured self-management interventions, including those using multimedia platforms and is endorsed by NHS Digital. Make sure that resources are accessible and promoted as this can help ensure that advice is consistent. Building on existing resources can help ensure that self-management education is of high quality and relevant to the needs of patients within the local area.

a. Patient education events

How to achieve success: implementing patient education events (continued)

Evaluate your events

- **Develop some key metrics to measure the impact of your education sessions.** Work with your local business intelligence team to plan how best to measure this impact.
- **Develop an evaluation form for participants and professionals to complete.** Consider how you will use this feedback to shape future sessions.

Resources required:

- room for event or education sessions
- refreshments
- booking/registration system
- promotional materials

The following standards and guidance may be useful:

Diabetes in Adults Quality Standard [QS6] (NICE, 2016)

NICE Guidance NG17- covers the care and treatment of adults (aged 18 and over) with type 1 diabetes

NHS Diabetes Prevention Programme

NICE GUIDANCE NG28 Type 2 Diabetes in Adults - Management (NICE, 2017)

My Diabetes, My Care (CQC, 2016)

Diabetes Education: The Big Missed Opportunity in Diabetes Care (Diabetes UK, 2016)

DAFNE (dose-adjustment for normal eating) Programme

National Diabetes Audit (NHS Digital, 2018)

CCG Improvement and Assessment Framework (NHS England, 2018)

A Guide to Quality Improvement in Specialist Diabetes Services from the National Diabetes Audit

Type 1 Diabetes in Adults: Diagnosis and Management : NICE guideline [NG17]

Diabetes Self-Management Education Quality Standard (QISMET, 2016)

Self-Management Education Quality Standard

Person-Centred Care in 2017 – Evidence from Service Users

Supporting Self-Management: A Summary of the Evidence (National Voices, 2014)

Realising the Value: Ten Actions to put People and Communities at the Heart of Health and Wellbeing (Nesta, 2016)

A Practical Guide to Self-Management Support – Key Components for Successful Implementation (The Health Foundation, 2015)

QoF Indicators: DMO14

Putting feet first (Diabetes UK)

a. Patient education events

Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

There is guidance to help you record and measure patient attendance accurately: National Diabetes Audit, 2016.

Quantitative

- Changes in health outcomes for patients (e.g. body mass index, HbA1c scores).
- Number of diabetes-related complications in patients.
- Number of patients who participated.
- Number of patients who attended who have been diagnosed less than a year.
- Number of sessions held.
- Number of attendances for the cohort of patients in primary care.
- Number of referrals to secondary care.
- Number of patients completing appropriate treatment plans.
- Number of attendances in primary care.
- Professional time spent coordinating/delivering activities.
- DNA rates
- Patient waiting time to see a secondary care specialist.

Qualitative

- Patient feedback on the value of the education events and the impact on their confidence to make healthy lifestyle choices.
- Practitioner feedback (in primary care and community settings) on their confidence to provide support and ability to help patients self-manage.
- Progress made against patient-led goals.

Intended benefits:

- Improvement in health outcomes (e.g. HbA1c).
- Reduction in diabetes-related complications.
- Increased patient confidence to manage their condition and make healthy lifestyle choices.

a. Patient education events: Dorset case study

The challenge – why here and why now?

Before the 100 Day Challenge, patient education sessions were being held within Dorset County Hospital and often had low attendance rates. The team believed that this was often due to patients being expected to travel out of the area to attend. The aim of this intervention was to deliver local patient education sessions and increase engagement with knowledge-building and capability for self-management of diabetes outside Dorchester.

The team felt that all patients in west Dorset should have the same access to education opportunities, regardless of their location and the resources of local clinics.

By offering more education sessions outside Dorchester (in Bridport, for example) and basing those offerings on population need, they aimed to improve attendance and increase the number of patients with the information and skills to self-manage their diabetes in other parts of west Dorset. These sessions also had the benefit of engaging more professionals and the local population in understanding how to manage diabetes, for example, through multidisciplinary teaching and attendance of patients' spouses or other supporters at the education sessions.

The intervention – what did they do and how did they do it?

The team took a whole-system approach involving diabetes specialist nurses, practice nurses, dietitians, GPs and consultants in delivery and promotion, supported by a CCG support officer, patient representative and administration staff. They:

- **Analysed and used data around diabetes prevalence rates throughout west Dorset** to identify where sessions should be offered.
- **Worked with GP practices and colleagues from the trust** to book in a date and arrange the logistics (e.g. rooms and patient invitations to the education sessions).
- **Communicated and advertised the sessions to patients** through GPs and the foundation trust.
- **Coordinated a mix of diabetes specialist nurses, practice nurses and dietitians to measure initial clinical data** (e.g. HbA1c levels), deliver the sessions and collect a follow-up comparison of relevant clinical data.
- **Collected and analysed feedback from the patients and practitioners** who participated.
- **Planned to offer two three-hour sessions on a monthly basis** in rotating areas (based on population need) after the 100 Day Challenge ended.

a. Patient education events: Dorset case study

Lessons learned

- Holding education sessions within the community closer to people's homes means more people are likely to join.
- Assessing the demand across different areas helps to tailor the support provided and ensure that resources can be used most effectively. Having sight of population data around diabetes prevalence helps to inform this.
- Sharing resources across areas to support with administration and coordination can reduce the time it takes to track health outcomes.
- Providing patient education in a more flexible and creative way can help with uptake, engagement and outcomes. For example, running sessions out of hours and with new mixes of clinical expertise.
- Providing protected time for the right people to be involved in the delivery of these sessions is important.

You can find further information about this work, as well as other case studies on the Elective Care Community of Practice pages. For more information, please email: england.electivecare@nhs.net

What did people say?

Feedback from patients who attended the Bridport course:

"It was so useful to clear up food myths!"

"Really informative."

"Trustworthy information about diabetes!"

"It was really great to meet other people with diabetes, having similar problems."

"I have a better understanding of what I can eat now."

"I never realised how much diabetes affected every part of the body."

"I had no idea what diabetes really was before coming."

Headline achievements in 100 days:

- One patient education course delivered, consisting of two three-hour sessions.
- 14 participants attended the course (eight patients, plus six partners/others).
- From first to second education session, there was an average reduction in HbA1c level by 10 mmol (55 to 45 mmol).
- One additional course (two three-hour sessions) planned in Weymouth and Portland.

b. Integrating pharmacy into the diabetes pathway

What is integrating pharmacy into the diabetes pathway?

The role of community pharmacists can be enhanced to support the management of diabetes patients. Pharmacists can help raise awareness of local services or new platforms by encouraging patients to attend self-management and education or supporting them to adopt new technology such as telephone advice and apps. Pharmacists can also undertake medication reviews before patients attend multidisciplinary team clinics. This helps practitioners and patients better understand the medication that has been prescribed and where to make changes to support self-management.

Why integrate pharmacy into the diabetes pathway?

The General Practice Forward View (NHS England, 2016) calls for greater integration of pharmacy into patient pathways and primary care.

Pharmacists' clinical expertise in medicines management supports both patients and primary care practitioners. If community pharmacists spend time with patients talking about their diabetes they can signpost patients to available resources to help them manage their own condition and their medication (Langran et al., 2016) along with healthy lifestyle advice. This leads to more patients achieving the three NICE-recommended treatment targets (CCG IAF) and improved health outcomes (Van Eikenhorst, 2017). Co-morbidities should also reduce and patient satisfaction should increase (Ali et al., 2012).

Integrating pharmacists into the diabetes pathway and ensuring that they are part of the multidisciplinary team means that GP workload is decreased, as pharmacists can undertake medication reviews, prescription requests and discharge. GPs and primary care practitioners can draw on the expertise of pharmacy colleagues as and when it is needed, with benefits for medicines optimisation and safety (Mann et al., 2018).

There should be fewer appointments in primary and secondary care as increased support is given by pharmacists to help patients self-manage. Pharmacists should also connect patients to appropriate support in the wider system, including developing pathways for integrated care (The King's Fund, 2016).

We know it works:

NHS England proposed enabling a greater role for community pharmacists and technicians within the local NHS in new, integrated local care models (NHS England, 2016).

The Clinical Pharmacists in General Practice Pilot reports decreased GP workload, improved capacity and improved medicines optimisation and safety, with one site reporting an hour of GP time being saved each day. Satisfaction was reported as high (Mann et al., 2018).

During the one hundred days in Stockport:

- Medication review of 30 patients' diabetic medication in line with NICE key therapeutic topics.

b. Integrating pharmacy into the diabetes pathway

How to achieve success: implementing integrated pharmacy in the diabetes pathway

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Invite pharmacists to be part of your work

- **Pharmacists can be members of the mutidisciplinary team.** Their role here can be to provide expert insight and guidance, particularly for people with complex co-morbidities.
- **Pharmacists may be able to provide education opportunities for other primary care staff.** This could be in the form of shared learning or sessions within specific continuing professional development events.

Support pharmacists to provide patient medication reviews

- **Build in time in primary care clinics for the pharmacist to conduct patient medication reviews.** These were found to be valuable for practice teams but very time-intensive for the pharmacist. A less time-intensive approach could be explored, such as developing a toolkit and automating some aspects of the review process.
- **Plan for the pharmacist to share medication optimisation decisions with primary care practitioners.** This can be done in clinics as an opportunity to increase shared learning.

People you may wish to involve from the start:

- people with lived experience
- pharmacist (community or CCG)
- GP
- practice nurse

Resources required:

- Pharmacists' time to support with the promotion of services or to deliver medication reviews as part of multidisciplinary teams.

The following standards and guidance may be useful:

Specialist Diabetes Team: Role and Members (Diabetes UK, 2010)

Diabetes Multi-Disciplinary Team (MDT) Pilot Evaluation (NHS Northamptonshire, 2012)

Community Pharmacy Clinical Services Review, 2016

b. Integrating pharmacy into the diabetes pathway

Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

Quantitative

- Number of referrals to secondary care avoided from pharmacy input.
- Number of clinics held.
- Attendance rate at clinics.
- Number of pharmacist interventions accepted by clinicians.
- Time spent on medication reviews.
- Number of attendances in primary care.
- Number of patients supported by the pharmacists, e.g. referrals and signposts made.
- Waiting time for secondary care appointment.
- Waiting list for secondary care appointment.
- Non-referral impact of pharmacist involvement, e.g. changes made in medication reviews and new diagnoses made.
- Patient compliance with medication (can be crudely measured through ordering frequency and waste).
- Patient diabetes control.

Qualitative

- Feedback from patients on knowledge and confidence to self-manage.
- Feedback from patients on the value of the support received from pharmacists.
- Feedback from primary care practitioners on the value of pharmacy involvement.
- Feedback from pharmacists on the value of their involvement.
- Case studies recording outcomes for patients.

Intended benefits:

- Improved patient experience and ability to manage their condition and medication.
- Improved health outcomes for patients.
- Increased understanding for clinicians of patients' current medications.

a. Multidisciplinary diabetes clinics in GP practices

What is this idea?

A multidisciplinary team clinic is typically led by either a GP with a special interest, a consultant or diabetes specialist nurse. They allow patients to access specialist practitioners (including pharmacist, podiatrist and dietician) in a community setting (i.e. their own GP practice) rather than in secondary care. GPs and practice nurses also join the clinics and can learn by watching the specialist engage with the patients and listening to the advice and guidance given.

Why implement an MDT diabetes clinic in a GP practice?

Patients should receive more joined up services offering comprehensive and effective treatment plans and access to the help that they need closer to home. Patients gain confidence in managing their own diabetes.

GPs should gain an understanding of holistic needs and develop their confidence, knowledge and skills. Better communication helps to build trust between practitioners in different settings and this helps to improve the management of patients across the pathway (Royal College of General Practitioners, 2016).

There should be a reduction in referrals to GPs and secondary care due to benefits of working across the system with the wider primary care team.

We know it works:

Since the start of the one hundred days in Stockport:

- 18 out of 20 patients invited attended their MDT appointments.
- Seven referrals (out of nine) were avoided from just one GP. The decision was made to manage their treatment in primary care instead as a direct result of the clinic.
- Patient feedback was positive, with 67% saying that they are more aware of how to manage their condition following the MDT clinic.

Since the start of the one hundred days in Dorset:

- 74 out of 83 GP practices have implemented multidisciplinary team meetings.

a. Multidisciplinary diabetes clinics in GP practices

How to achieve success: implementing a multidisciplinary diabetes clinic in a GP practice

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Design the format and approach of your clinic

- **Agree target cohort for the multidisciplinary clinic.** Many patients can be managed safely and effectively in primary care. However, where it is evident that patient outcomes are better when cared for by a specialist team or when MDT review might delay treatment, this should be taken into consideration. For example, 67% of ulcers heal within six months if reviewed within two days. If it takes more than two months for hospital MDT review, then healing rates are only 54% at six months (National Diabetes Footcare Audit, 2018).
- **Book date and secure room for multidisciplinary clinics.** You may wish to have a combined clinic across one or more practices. In that case, it is important to consider the best location to increase attendance.

Set up the clinic

- **Invite patients and clinicians to join the multidisciplinary clinics.** Send letters to patients explaining the benefits of the clinics and the multidisciplinary approach. Approach clinicians and send diary invitations to ensure the dates are in their diaries well in advance.
- **Take a flexible approach and work with the resources available.** It may not always be possible to have secondary care representation at every multidisciplinary team due to capacity within services. Specialist involvement from specialist nurses or GPs with special interest in diabetes can prove equally valuable and increase the confidence and expertise of practice staff.
- **Enable pharmacist review of medication, HbA1C score and body mass index (BMI) of each patient in line with NICE key therapeutic guidance.** Reviews are invaluable for practice teams and providing them in advance means that a treatment plan can be discussed with practitioners and the patient as part of the clinic. Involving pharmacists in this way increases the opportunity for GP and practice nurses to learn more about medicine optimisation so they can manage a targeted cohort of patients in primary care, rather than refer them on to secondary care.

People you may wish to involve from the start:

- Administrative support to identify patient cohort by searching clinical records on GP IT systems; coordinate pharmacy and GP review of patients and send invitations to patients.
- GP
- practice nurse
- specialists (e.g. consultant/ specialist nurse/GP with special interest in diabetes)
- healthcare assistant
- pharmacist

a. Multidisciplinary diabetes clinics in GP practices

How to achieve success: implementing an MDT diabetes clinic in a GP practice (continued)

Prepare patients for the clinic

- **Follow-up phone call to targeted patients explaining purpose and process of the multidisciplinary team clinic.** You may wish to secure administrative support for this task.
- **Book patients in for initial HbA1c measure/blood test** before multidisciplinary team clinic.
- **Design pre and post-clinic patient and practitioner questionnaires to gather feedback.** It can be helpful to work with public health and with your local communications team to develop these resources.

Running the MDT clinic

- **Incorporate patient-led goal setting.** This gives patients an opportunity to have a different conversation about their diabetes management and to set lifestyle goals.
- **See multidisciplinary teams as a shared learning opportunity**. Primary care practitioners benefit from seeing the decision making process of their colleagues (particularly around medication) and may be able to apply this learning to other patients.
- **Involve the whole practice in supporting patients**. Lifestyle goals may prove harder to set and measure with patients than anticipated. More whole-practice involvement and communication can help provide follow-up support for patients making lifestyle changes and help to track multidisciplinary team impact on patients more consistently.
- **Consider running the multidisciplinary team clinics in areas with less specialist knowledge already available**. Variations in expertise in diabetes at different primary care practices can affect the impact of the multidisciplinary team clinics.
- **Include reflective time after the patients have been seen.** This provides an opportunity for practitioners to discuss any questions or concerns that may have come up.

Resources required:

- Room at health centre for multidisciplinary team.
- Practitioner time.

The following standards and guidance may be useful:

Diabetes in Adults Quality Standard [QS6] (NICE, 2016)

NICE Guidance NG17- Covers the care and treatment of adults (aged 18 and over) with type 1 diabetes

NHS Diabetes Prevention Programme

NHS RightCare Pathway: Diabetes (NHS RightCare, 2017)

Specialist Diabetes Team: Role and Members (Diabetes UK, 2017)

Diabetes MDT Pilot Evaluation (NICE, 2012)

Examples of Better Integration Between Primary and Secondary Care (NHS RightCare, 2017)

a. Multidisciplinary diabetes clinics in GP practices

Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

Quantitative

- Number of referrals made to secondary care for the cohorts discussed as part of the multidisciplinary team clinics.
- Number of multidisciplinary team outpatient clinics.
- Participants in multidisciplinary team clinics (patients and professionals).
- Number of patients attending multidisciplinary team clinics.
- Outcomes of multidisciplinary teams: medications reviews/ referrals to secondary care/other services.
- Waiting time for secondary care appointment.
- Waiting list for secondary care appointment.
- Number of primary care attendances (for cohorts discussed/involved).
- Time spent coordinating and participating in multidisciplinary team clinics.

Qualitative

- Survey feedback from patients on their experience and knowledge and confidence to self-manage their conditions.
- Survey feedback from staff on knowledge and confidence to deliver care.
- Case studies recording outcomes for patients.

Intended benefits:

- Improved access to specialist care.
- Reduction in referrals to secondary care.
- Improved diabetes health outcomes.

You can find further information about this work, as well as other case studies on the Elective Care Community of Practice pages. For more information, please email: england.electivecare@nhs.net

a. Multidisciplinary diabetes clinics in GP practices: Stockport case study

The challenge – why here and why now?

It is estimated that 27,000 people in Stockport are at risk of developing diabetes and there are 14,600 people who are diagnosed with the condition. There is a variation in the confidence and expertise of practitioners within primary care, leading to variation in who is referred to secondary care. The wait for outpatient appointments is growing even though many patients could be safely managed in primary care if expertise within this part of the system increased.

The team saw the multidisciplinary team clinics as part of a wider model that aims to standardise the quality of care in general practice (using advice and guidance, training and mentoring and patient education).

The intervention – what did they do and how did they do it?

The team took a whole-system approach to create multidisciplinary teams with a broad range of expertise:

- **Worked with GP practice managers and GPs to identify patient cohort** (based on 'poorly controlled' definition: patient on more than two medications, HbA1c > 65 (<80), BMI >32) and agree multidisciplinary team clinic dates.
- **Rang patient cohort and booked appointments for pre-clinic HbA1c/blood test**: 60% of patients contacted by the first multidisciplinary team clinic engaged and came in for blood test/HbA1c.
- **Approached clinicians and secured their involvement**:
  - First multidisciplinary team clinic: GP, diabetes specialist nurse (DSN), GPwER, consultant, podiatrist, dietitian and pharmacist.
  - Second multidisciplinary team clinic: GP and GP with a special interest in diabetes, alongside practice nurse, healthcare assistant and pharmacist.
- **Held two multidisciplinary team clinics in different GP practices** for targeted patients.
- **Completed a pharmacist-led review of 30 patients invited to the multidisciplinary team clinics**. Recommendations to optimise pharmaceutical treatments of patients.
- **Created a toolkit for pharmacy reviews** and identified which parts of the medication review could be automated.
- **Worked with GPs with a special interest in diabetes to design a template for nurses** outlining questions to ask patients before they are seen in the clinic by a GP.
- **Followed up call/appointment with patients four to six weeks after the clinic** to measure progress against patient-led goals and any HbA1c/BMI changes.

a. Multidisciplinary diabetes clinics in GP practices: Stockport case study

Lessons learned

- Involving specialists in patient clinics in primary care offered a valuable opportunity for primary care practitioners to see and learn from their colleagues' decision making processes, particularly around medications. This also offered a different experience of care for patients.
- Taking a flexible approach to participation and using available expertise can help to overcome the challenge of secondary care availability for clinics due to capacity and seasonal pressures. For example, developing a model that uses GPs with a special interest as specialists sharing their expertise in the multidisciplinary team.
- Learning for practitioners involved in multidisciplinary team clinics has longer-term benefits. Practitioners reported feeling more confident in managing cases that they would normally refer to secondary care as they were able to apply their learning to other patients.
- Involving pharmacy to complete medication reviews as part of the multidisciplinary teams was extremely valuable. Scaling this up would require input to be less time-intensive, for example, through using templates to guide pharmacists and automating some parts of the medication review process.
- Making sure that all practitioners involved know how to support people to set SMART (Specific, Measurable, Achievable, Relevant, Timely) goals is vital if patient-led goal-setting is included in the multidisciplinary team clinics. This is so that the impact can be measured effectively.
- Following up with patients is really important; this does not necessarily need to be carried out by a practitioner involved in the clinics if there is good communication and involvement within the practice.
- There is a potential for multidisciplinary team clinics to have greater impact in practices where primary care practitioners have less diabetes expertise at the outset.

What did people say?

"In one morning you can teach an awful lot."
GP with special interest in diabetes, Stockport.

"The multidisciplinary team clinics created a different environment for patients where they were more comfortable discussing their diabetes management. One patient opened up and told the nurse how she wasn't taking her insulin reliably. She has been referred to the district nurses for them to administer her insulin."
GP practice team member, Stockport.

8. Common factors in transforming diabetes elective care

All diabetes teams made significant progress during Wave 2 of the Elective Care Development Collaborative. The case studies in this handbook show what can be achieved locally in just one hundred days. The ideas reached different stages of implementation but the 100 Day Challenge has proved a catalyst for wider collaborative transformation in diabetes across the participating local health and care systems.

There is learning from across the second wave that will be useful for other areas who are transforming diabetes elective care services. Useful considerations include:

1. Don't assume that you know what is needed or what people actually want

- **Be prepared for initial plans to change.** Transformation is an iterative process and rapid cycles of testing mean that ideas can improve continuously. Feedback is crucial at all stages.
- **Involve people with experience of living with diabetes in the design and delivery of local services.** This can be time consuming but is extremely valuable, as you gain the perspective of people who actually use the services.
- **Involve staff from across the system.** Again, this brings different perspectives and can help you to identify and understand the potential unintended or unexpected outcomes and impact of your plans. It will also help you to think differently about what the best solution may be. Pressures and priorities elsewhere in the local system can affect progress and adoption, so engaging effectively with individuals (including clinicians, managers, administrative staff and commissioners) is crucial to success.
- **Explore similar work in other areas.** Many areas will be facing similar challenges. Talk to others and share resources or templates where possible.

2. Develop and maintain relationships with system leaders

- **Engage with senior leaders** to open new lines of communication and create an environment where front line staff know they have permission to test their ideas. Foster the development of relationships among all members of the team and be honest about challenges so that system leaders are aware of what is happening and can help to unblock barriers as they arise.

3. Tell your story and illustrate the impact your transformation is having

- **Measure your impact.** Data is hugely influential when convincing others to commit to your idea. It is important to consider not only activity metrics (for example, the number of people seen in a new service) but also impact metrics that illustrate what has changed for them as a result. Even small changes can be hugely informative.
- **Share your learning.** Think broadly and creatively about how you are going to tell your story and show the journey travelled. Share your work and progress as part of the Elective Care Community of Practice. This will enable you to share your learning and gain feedback and useful input.

9. Key resources

NHS England Treatment and Care Programme webpages: https://www.england.nhs.uk/diabetes/treatment-care/

A variety of case studies from the national diabetes programme are available here: https://www.england.nhs.uk/diabetes/

There is also an email address for specific diabetes queries: england.diabetestreatment@nhs.net

NHS RightCare diabetes pathway: https://www.england.nhs.uk/rightcare/products/pathways/diabetes-pathway/

National Diabetes Audit: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-audit

NICE guidance for diabetes: https://www.nice.org.uk/Guidance/conditions-and-diseases/diabetes-and-other-endocrinal--nutritional-and-metabolic-conditions/diabetes

Quality Institute for Self Management Education & Training: http://www.qismet.org.uk/certification/dsme-certification/

Diabetes UK shared practice library: https://www.diabetes.org.uk/professionals/resources/shared-practice

Other useful Diabetes UK links: https://www.diabetes.org.uk/professionals, https://www.diabetes.org.uk/professionals/resources, https://www.diabetes.org.uk/professionals/resources/clinical-champions-and-networks

Sign up to receive the NHS Diabetes Programme bulletin

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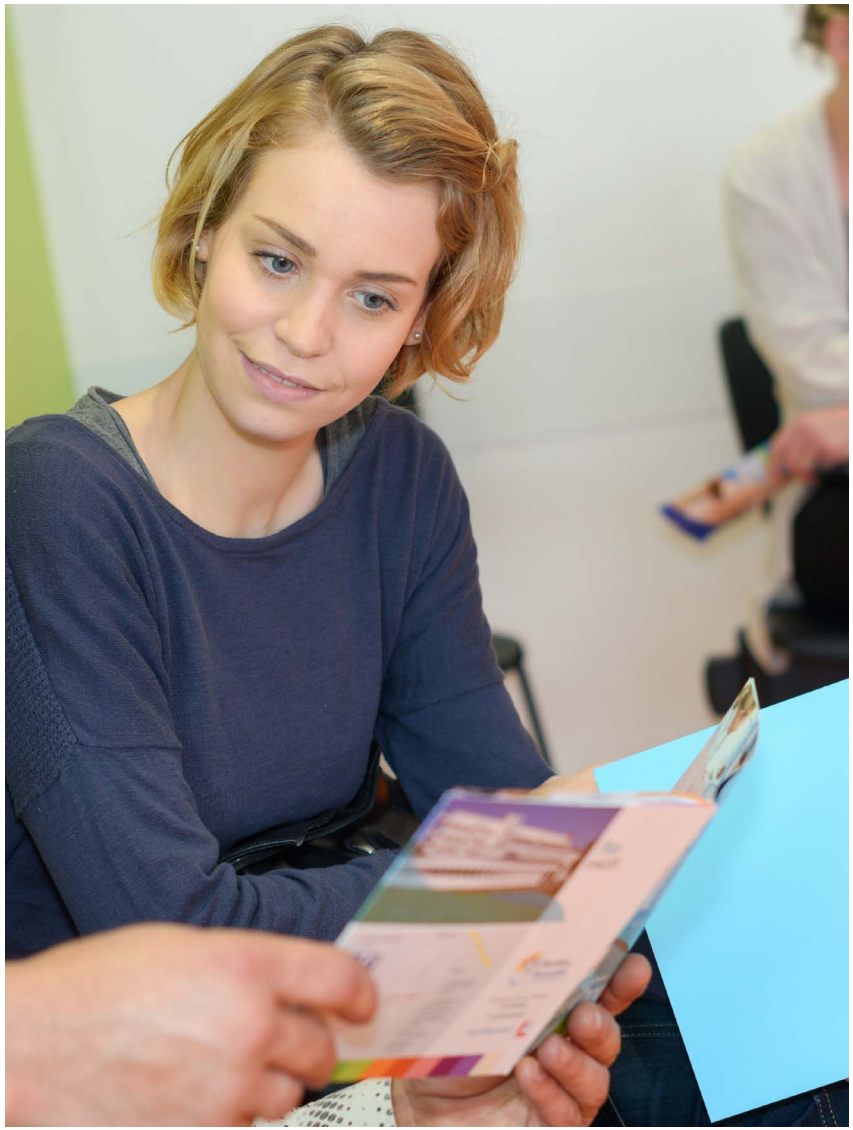

10. Case studies and further evidence

Some interventions tested out within the 100 days can be supported by evidence generated from other initiatives and localities. The table below is a summary of which diabetes interventions, and more specifically their outcomes and impacts, can be supported by this evidence.

Intervention	Impact	Link	Description	Location within source
Shared learning opportunities	Patients having access to the care they need.	Better integration between primary and secondary care: Examples of good practice (NHS England, 2017)	A good-practice document highlighting a Portsmouth model of care, demonstrating the impact of timely, high-quality care. This was enabled by the consultant working as an educator to primary care.	Section: The Super Six model of care: Portsmouth
	Improved clinical outcomes and shared learning/ access to specialist advice.	Virtual clinic review (Cambridge and Peterborough CCG, 2017)	Virtual clinic review frequently asked questions discussing what it entails and outcomes. The frequently asked questions note that the aim is to improve patient outcomes and collaborative care.	Section: What is a virtual clinic review?
	Improved learning and skills development of primary care clinicians.	Improving the delivery of adult diabetes care through integration: Sharing Experience and Learning (Diabetes UK, 2014)	A Diabetes UK service improvement report concluding that "The multidisciplinary group structure provides GPs with direct access to specialist knowledge – links which had previously not been made – to discuss complex cases and develop their skills."	Page 11: Defining who does what in practice

10. Case studies and further evidence

Intervention	Impact	Link	Description	Location within source
Shared learning opportunities	Improved collaborative care across settings.	My diabetes, my care (Care Quality Commission, 2016)	Care Quality Commission (CQC) report around diabetes care including a case study of South Reading CCG stating that a specialist diabetes team, including a consultant, worked with the practice to manage complex patients by sharing best practice with the GP. This resulted in the same advice and guidance given to everyone.	Page 26: Working effectively across services
Advice and guidance	More patients managed in primary care.	Improving the management of diabetes care: A toolkit for London clinical commissioning groups (London SCN, 2015)	London Strategic Clinical Network report on improving the management of diabetes care. An intervention including GPs being supported by diabetes specialists concluded with 40% of patients attending outpatient clinics moving to primary care.	Page 11: What was achieved?
	GPs access advice and guidance prior to making referrals.	Offering Advice and Guidance: Supplementary Guidance for CQUIN Indicator 6 (NHS England, 2017)	NHS England supplementary guidance for advice and guidance. It states: "The CQUIN requires secondary care providers to establish advice and guidance for non-urgent services so that GPs can access consultant advice prior to referring patients."	Section: Supporting implementation of CQUIN 6 - scope of advice and guidance

10. Case studies and further evidence

Intervention	Impact	Link	Description	Location within source
Advice and guidance	Reduced referrals to secondary care.	Economic Evaluation of a Digital NHS in North Central London STP (i5 Health, 2017)	Healthy London Partnership evaluation of digital healthcare interventions. The 'online educational support' was shown to save a referral per half advice request.	Page: 11 intervention 11 'GP support from secondary care consultants'
	Timely responses for advice and guidance.	NHS England Demand Management Good Practice Guide (NHS England, 2016)	Barts Health NHS Trust offers GPs access to clinical advice in many specialties via dedicated specialty email addresses. Responses are expected within five days.	
Patient education	Improved diabetes management.	CCG improvement and assessment framework 2017/18 (NHS England, 2017)	A CCG improvement and assessment framework. One of the frameworks is around diabetes patients achieving NICE recommended clinical targets and how achieving this can be influenced by patient self-management.	Technical annex: Page 5
	Reduced diabetes complications.	Diabetes self-management education (Diabetes UK, 2018)	Diabetes UK page and report around the benefits of self-management education. This concludes that diabetes education courses can reduce diabetes complications.	Section: Level 3 education: What is the evidence base? Including link to report within this section

10. Case studies and further evidence

Intervention	Impact	Link	Description	Location within source
Patient education	Reduced referrals to secondary care.	Helping people help themselves: A review of the evidence considering whether it is worthwhile to support self-management (The Health Foundation, 2011)	A report from The Health Foundation on the benefits of self-managements for patients. One of the impacts on behaviour was that patients spent fewer days in hospital.	Section: Impact on self-care behaviour
	Cost saving.	My diabetes, my care (Care Quality Commission, 2016)	A CQC 'my diabetes, my care' report indicating "in the next 25 years almost a million serious medical complications, such as blindness, amputation and kidney failure could be avoided and save the NHS £5.5 billion." Furthermore, it concluded that lay educators were a "cost-effective part of the extended diabetes team."	Section: Introduction and Page 19: use of lay educators
Integrating pharmacy into the diabetes pathway	Improved medication understanding by patients.	Supporting the management of type 2 diabetes with pharmacist-led reviews: an observational analysis (Langran et al., 2017)	Improved achievement of NICE nine key care processes and diabetic control during the year of programme delivery. This was through pharmacist-led review involving CCG, GP teams and clinical and information technology skills of an experienced pharmacist team.	Whole report

10. Case studies and further evidence

Intervention	Impact	Link	Description	Location within source
Integrating pharmacy into the diabetes pathway	Reduced co-morbidities and increased patient satisfaction.	Impact of community pharmacy diabetes monitoring and education programme on diabetes management: a randomized controlled study (Schifano et al., 2012)	A study of enhanced pharmacist input in type 2 diabetes management in the community. This study concluded that patient acceptance/satisfaction with the intervention was high.	Section: study outcomes
	Improved health outcomes.	Pharmacist-Led Self-management Interventions to Improve Diabetes Outcomes. A Systematic Literature Review and Meta-Analysis (van Eikenhorst et al., 2017)	A study of pharmacist-led self-management interventions in diabetes patients. This study concluded that the intervention significantly improved HbA1c values.	Section: introduction and Page 19: use of lay educators
	Increased support and connecting to appropriate pathways to integrate care for patients and reduce pressure on primary and secondary care.	Community Pharmacy Clinical Services Review The King's Fund, 2016)	A community pharmacy clinical services review concluding that pharmacy must be integrated into any new models of care as they enhance the support to people with long-term conditions. The report speaks about pharmacists alleviating pressure from other parts of the NHS, including GPs and A&E.	Section: recommendations and current service pressures

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