

# IMPROVING THE DELIVERY OF ADULT DIABETES CARE THROUGH INTEGRATION

SHARING EXPERIENCE  
AND LEARNING

**DiABETES UK**  
CARE. CONNECT. CAMPAIGN.

## ACKNOWLEDGEMENTS

The impetus for Diabetes UK's work on integrated diabetes care is the enthusiasm of providers, commissioners and people with diabetes for improving the delivery of diabetes care in their area.

We are therefore thankful to all the people working in those areas that have made significant progress towards improving the delivery of diabetes care through integration. We would particularly like to thank the following clinicians for their time and advice: Mo Roshan, Baldev Singh, Partha Kar, Paru King, Rustam Rea and Stephen Lawrence.

In addition, we are grateful to members of the Diabetes UK Council of People with Diabetes and Council of Healthcare Professionals, the Association of British Clinical Diabetologists (ABCD) and the RCGP who have shared their personal experiences and knowledge, to provide clarity and context for the report.

## FURTHER INFORMATION

Further information on the areas looked at and the opportunity to tell us about other areas is available on the Diabetes UK website at [www.diabetes.org.uk/integrated-diabetes-care](http://www.diabetes.org.uk/integrated-diabetes-care)

**This report is endorsed by:**



# CONTENTS

<b>Executive Summary</b>	<b>4</b>
<b>Introduction</b>	<b>5</b>
<b>What integrated adult diabetes care looks like</b>	<b>6</b>
<b>How to implement the key enablers of integrated diabetes care</b>	
Integrated IT	<b>10</b>
Aligned finances and responsibility	<b>11</b>
Care planning	<b>13</b>
Clinical engagement and leadership	<b>14</b>
Robust clinical governance	<b>15</b>
<b>Local initiatives to deliver models of integrated diabetes care</b>	
Wolverhampton	<b>17</b>
Derby	<b>18</b>
Leicester	<b>19</b>
North West London	<b>20</b>
Portsmouth	<b>21</b>
<b>Conclusion</b>	<b>22</b>

# EXECUTIVE SUMMARY

Diabetes is a growing challenge to the NHS. Over three million people are diagnosed with the condition and rising numbers experience devastating complications. These are responsible for 80 per cent of the £10 billion cost of diabetes. New thinking is needed to improve care and avoid complications.

This report is for commissioners and providers to support the delivery of best practice and to help by sharing lessons learnt from people trying to improve diabetes care through integration.

## The value of integrated diabetes services

Each person with diabetes is constantly managing their condition. They need an NHS focused on supporting their self-management – by delivering care and support centred and coordinated around their needs. They need access to a comprehensive service that delivers care across the whole diabetes pathway, from diagnosis to management of complications. Therefore, the local model of care should ensure all parts of the system work together to deliver all the components of the care pathway.

## The key enablers of integrated diabetes care

Bringing together examples from some of the places that have made progress helps demonstrate what needs to be done.

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

**Integrated IT** can mean all providers in a pathway are able to access a patient's data. As well as the obvious efficiency and convenience, it means that referrals can be triaged to the right healthcare professionals and that 'at risk' patients can be identified.

**Aligned finances and responsibility** help a system work together. A common first step is being clear about who does what. Subsequent training and support for general practice mean that more people are given high quality care in the community while specialists focus on the most complex or unusual cases. Areas have overcome the rigid financial divide between primary and specialist care by pooling budgets or having defined protocols for when people with diabetes are treated in a particular part of the system.

Collaborative **care planning** is where clinicians and patients work together to agree goals, identify support needs and develop and implement action plans. It is the centre of the 'house of care' analogy for care that has an engaged and empowered patient at the centre. It relies on the other organisational enablers of integrated diabetes care.

To make progress, effective **clinical engagement** has been central in all areas. Commissioners, providers, clinicians and people with diabetes work together in local networks to organise the whole care pathway – from diagnosis to management of complications.

**Clinical governance** for the whole diabetes pathway has helped to align the ambitions of different clinicians, commissioners and people with diabetes as people have responsibility for a single goal. It provides a way to make continuous improvement.

# INTRODUCTION

## The importance of integrated care for people with diabetes

People living with diabetes face daily challenges managing their condition. These can include diet and exercise, treatment-taking, psychological stress, education, illness and disability. The input and skills of healthcare professionals across primary, community and specialist care is essential to provide high quality care for people with diabetes, which meets their individual needs and enables them to be engaged in their own care.

The traditional diabetes service delivery model too rigidly distinguishes between primary and secondary care. The aim of integrating diabetes care is to refocus services around the individual, removing barriers between specialties and organisations and introducing an approach that achieves outcomes for individuals and value for the system.

“An approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring that services are well coordinated around their needs”

**Kings Fund and Nuffield Trust (2011)**

## The national focus on integrated care and need for change

The need to join up health services to centre around patients rather than the needs of the system is increasingly recognised in national policy. The NHS Mandate challenges the NHS to improve the provision of care to ensure it is coordinated around the needs, convenience and choices of patients, rather than the interests of organisations that provide care<sup>1</sup>.

The current strain on NHS finances, workload challenges faced by healthcare staff, the complexity of the healthcare system and the national drive for cost reduction makes initiating change difficult, but the rising demand for diabetes care increases the need to move to an integrated care approach to improve the quality and efficiency of care and contain longer term costs<sup>2</sup>. There is strong national and international evidence that demonstrates the potential to improve both the quality of diabetes care and the financial position through integration<sup>3,4</sup>.

“If we want to deliver care which meets the needs of the patient, if we truly want person-centred care, if we truly want to protect our NHS for the future, new coordinated ways of working are the only answer”

**Norman Lamb, Care and Support Minister (2013)**

## Making change locally

Many areas in England, as well as in Wales, Scotland and Northern Ireland, are taking the initiative to improve the delivery of diabetes care through integration. This report shares the work of a sample of those areas. This is a process of continuous improvement and it is hoped that sharing these examples may provide next steps for those areas already prioritising this. For areas yet to initiate change, this report highlights the need to prioritise this form of service reconfiguration.

1 The Mandate. A mandate from the government to NHS England: 2014 to 2015

2 North West London Integrated Care Pilot: business case

3 Porter M & Lee T (2013) The strategy that will fix healthcare. Providers must lead the way in making value the overarching goal. Harvard business review

4 Diabetes UK (2013). The cost of diabetes report

# WHAT INTEGRATED ADULT DIABETES CARE LOOKS LIKE

## Defining integrated diabetes care

Integrated care is about designing a system that focuses on the patient's perspective of care. The delivery of integrated care is facilitated by integration of the processes, methods and tools which enable patients to move between services according to need<sup>1</sup>. Integrated diabetes care means vertical integration between primary, community and specialist care. This is distinct from the wider agenda of horizontally integrated health and social care.

## What is a model of care

A 'model of care' is a multifaceted concept, which broadly describes the way health services are configured<sup>2</sup>. It can be applied to health services delivered in a provider or organisation, within a team or across a whole local system of care. For diabetes, it will need to set out the care to be commissioned and delivered by provider organisations - defining who does what, where and how.

## The importance of the house of care

The house of care framework<sup>3</sup> describes the key elements of delivering care and support centred and coordinated around the needs of the person with diabetes and their circumstances to enable self-management. As members of the Coalition for Collaborative Care, Diabetes UK strongly support this approach.

Delivering the philosophy of the house of care requires localities to define and agree their model of care and approach to delivery. The local model of integrated diabetes care will be commissioned to ensure delivery of all the components of the care pathway. The delivery of specialist training and education for healthcare professionals must be fully integrated into the model of care. Training and education to assure wider staff competency in diabetes and the skills to work in partnership with people with diabetes through care planning should also be included. The key enablers to delivering co-ordinated care, as explained in the section below, are central to facilitating care within the local system.

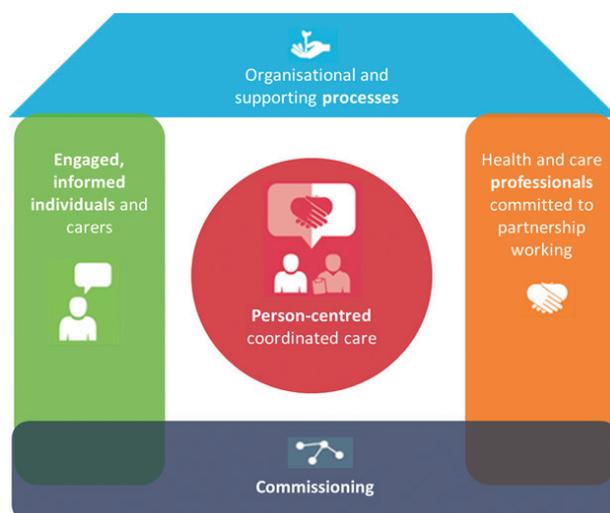


Figure 1: The house of care framework, Coalition for Collaborative Care, [www.coalitionforcollaborativecare.org.uk/house-of-care](http://www.coalitionforcollaborativecare.org.uk/house-of-care)

1 Nuffield Trust (2011). What is integrated care?

2 Queensland Health, Queensland Government (2000). Changing models of care framework

3 [www.england.nhs.uk/house-of-care](http://www.england.nhs.uk/house-of-care). Enhancing the quality of care for people with long term conditions – the house of care

## The diabetes care pathway

Within an integrated diabetes pathway local services will have clear protocols for who does what and what services are provided where. The care pathways and referral pathways will be defined to enable delivery of the ‘right care, in the right place and at the right time’. Figure 2 illustrates the care pathway for diabetes.

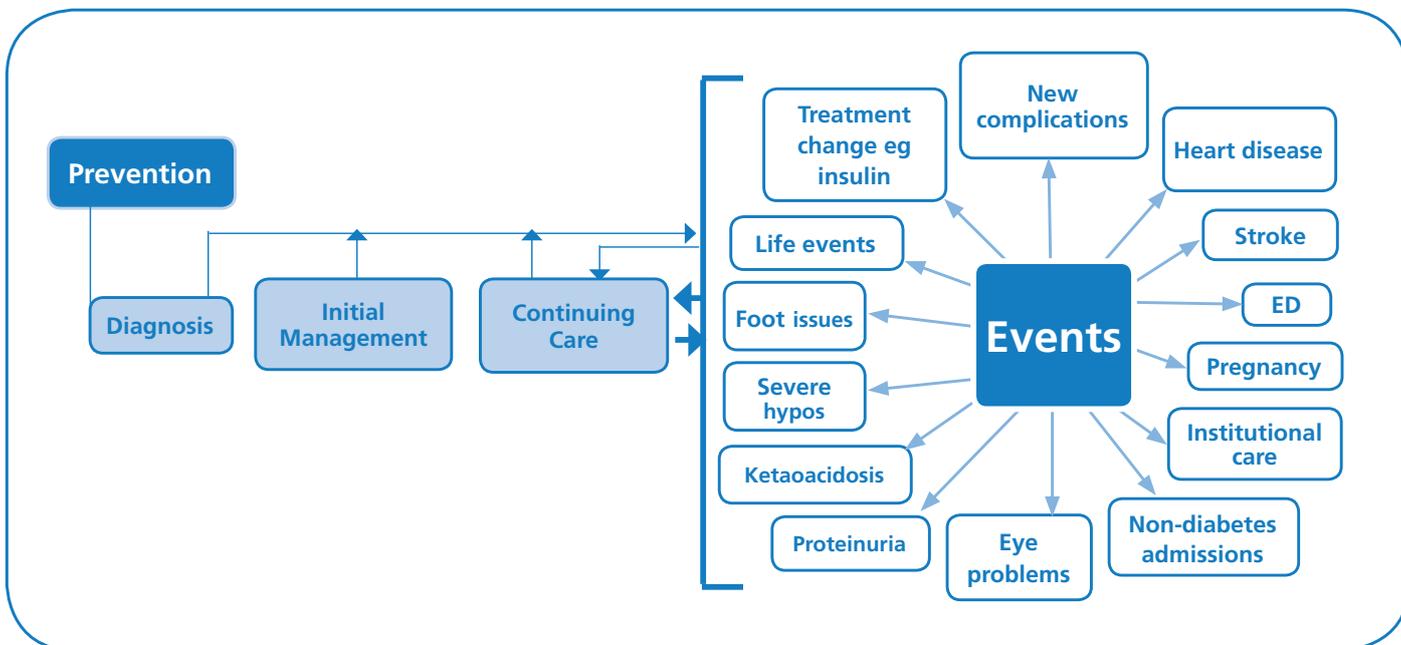


Figure 2: the diabetes care pathway

How this is provided in each locality should be explained in the model of care. It must be underpinned by multidisciplinary team working between generalists and specialists, whether the care is provided in a general practice, in a community centre or in the hospital. Specialists should not only provide care in hospitals. An example of such a service configuration is described in the Diabetes Service Specification, as shown in Figure 3<sup>5</sup>.

## The service specification – configuring the delivery of care

The diabetes service specification<sup>6</sup> outlines the provision of high quality care for all those with diabetes and, as appropriate, differentiates the care needs of adults with Type 1 diabetes (T1DM) and those with Type 2 diabetes (T2DM). It describes all the services needed to provide a complete care pathway for people with diabetes, including those with the long-term complications of diabetes and meets the NICE quality standard for diabetes(QS6)<sup>7</sup>.

5 NHS England (2014). Sample service specification: diabetes

6 NHS England (2014). Sample service specification: diabetes

7 Nice.org.uk. Diabetes in adults quality standard

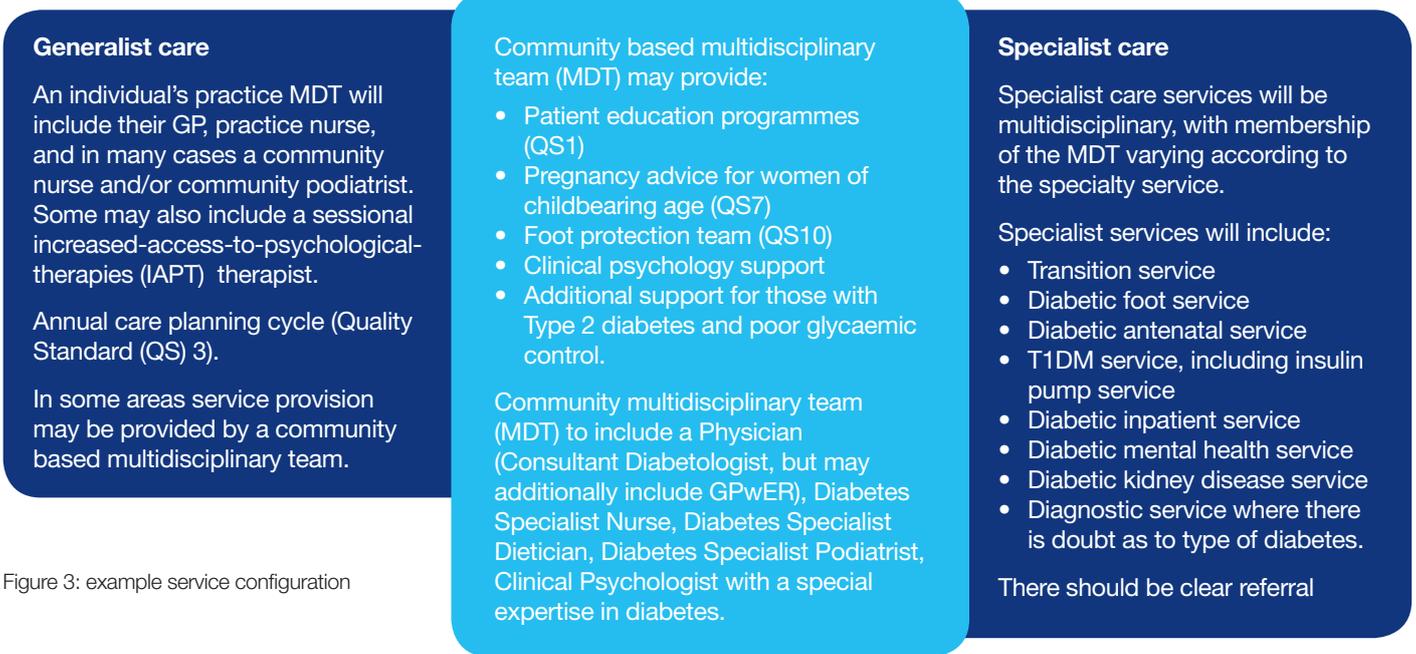


Figure 3: example service configuration

## The key enablers of integration

The key enablers of integration, which underpin the delivery of person centred coordinated diabetes care are identified in 'Best practice for commissioning diabetes services: An integrated care framework'. Widely endorsed by the diabetes community, including Diabetes UK, these distinct but mutually reinforcing integration enablers are:

1. Integrated IT
2. Aligned finances and responsibility
3. Care planning
4. Clinical engagement and leadership
5. Robust clinical governance

The house of care frames how these components and enablers should be implemented to support the clinical pathway and achieve person centred and coordinated care, putting the needs of people with diabetes at the centre of care.



Best Practice for commissioning diabetes services – An integrated care framework

## Responsibility for driving action

Commissioners and providers in England need to work together, with people with diabetes through well managed local networks, to translate policy aspirations into practice. This joint working is the only way to address the real needs of the diabetes community and deliver, measure and continually improve local diabetes outcomes. This requires areas to overcome historical organisational barriers, join services together and provide people with diabetes with access to an integrated diabetes service.

### Calls to actions

#### Commissioners and providers need to work together to:

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

#### Commissioners:

- need to be responsible for holding services to account to drive improvement for the benefit of people with diabetes.

# HOW TO IMPLEMENT THE KEY ENABLERS OF INTEGRATED DIABETES CARE

The delivery of integrated care is facilitated by the integration of processes, methods and tools<sup>8</sup>. This section looks at the 5 key integration enablers which must be in place to facilitate integrated diabetes care. Wherever possible, localities should make sure all the enablers are in place. Although the enablers can be introduced independently to affect change they are mutually reinforcing so each is optimised to the benefit of the model of care where they are developed concurrently.

Evidence shows that where these enablers are in place to support the delivery of integrated diabetes care, patient experience is improved and the cost efficiency of the service increased. Evaluation of the Derby model found that unplanned admissions fell from 43 in 2009-10 to 34 in 2010-11 with an almost 50% reduction in the total number of bed days for patients with a primary diagnosis of diabetes in that period. The model has saved £800,000 per year through increased service efficiency, reduction in admissions and improved outcomes. In response to a patient satisfaction questionnaire (2010), 63% of patients rated the diabetes care as excellent, 22% as very good and 15% as good<sup>9</sup>.

## 1. INTEGRATED IT SYSTEMS

### Why integrated IT is important

To understand what integrated care looks like from a patient perspective National Voices have developed a narrative of integrated care and support. Described through a series of “I” statements, patients stressed the importance of being able to tell their story once, without needing to repeat themselves across the system<sup>10</sup>. A culture change to remove boundaries between organisations and encourage meetings and dialogue between clinicians goes some way to facilitate this. However, optimal information sharing should be underpinned by an information system that provides clinicians across primary, community and specialist care with a patient’s clinical record regardless of setting.

### Integrated IT – in practice

The ideal is for all providers in a pathway to use the same system. For example, in the Derby model all GP practices and the hospital use SystemOne. There can be initial frustrations with this, as clinicians must get consent from patients to share their data and the necessary data sharing and governance structures need to be introduced. However, once the system is fully established clinicians can see a patient’s records, regardless of whether their previous appointment was in primary or specialist care, to optimise care and make the referral process more efficient.

A whole system information system, where GPs and specialists can see the same record, can be used to automatically identify and target ‘at risk’ patients<sup>11</sup>. This is the approach being used in Wolverhampton. A central portal (Graphnet’s Care Centric Portal) is used to extract data from 49 GP practices. These data are fed into the trust’s Diabeta3 system and a locally developed algorithm stratifies patients according to risk. Patients are rated against the nine diabetes care processes and based on their risk status for micro and macro vascular complications of diabetes they are flagged as red, amber or green. The results are then used to decide where care should be provided to that patient along the pathway and what should

8 Nuffield Trust (2011). What is integrated care?

9 Rea R et al (2011) Integrated diabetes care in Derby: new NHS organisations for new NHS challenges. *Practical diabetes* 28, 7: 312–313.

10 Department of Health (2013). Integrated care and support: our shared commitment (2013)

11 The King’s Fund (2011) Where next for the NHS reforms? Making the case for integrated care

be done to improve care for that particular person<sup>12</sup>. Using data in this way allows the clinicians to lift patients above the system to enable treatment at an early point and in the right setting, removing delays in referral and looking to reduce emergency admissions.

## **2. ALIGNED FINANCES AND RESPONSIBILITY**

### **Defining who does what**

Clear responsibility for service delivery is essential in a financially efficient integrated pathway. The pathway should be clearly defined in the model of care, and the infrastructure supporting the delivery of care should ensure that all clinicians are able to deliver against national standards. In general, support for people with Type 1 should be coordinated by specialists. This is because managing Type 1 diabetes is complex and requires significant expertise, and there can be serious consequences if things go wrong. At the same time people with complex Type 2 diabetes will need timely access to specialist care. The ongoing care of people with Type 2 diabetes is generally provided by GPs with clear systems in place for call and recall, regular review and referral when necessary.

In all the areas we looked at unacceptable variation in the quality of care (particularly across primary and community care) and a lack of consistency in the delivery of services preceded reconfiguration. Addressing this was a focus in all the redesigns.

### **Defining who does what in practice**

In Portsmouth and Leicester, for example, the initiatives focused on clarifying the role of the consultant diabetologist in the delivery of diabetes care. This saw the consultants focus on super-specialist areas of diabetes care in the hospital and refer all other care, which it was felt did not need to be managed exclusively by specialists, back to community and primary care. For this approach to work it is essential that all healthcare professionals have the skills, clinical support and infrastructure necessary to be able to provide high quality diabetes care. Under the new alignment the diabetologists in Portsmouth were given two functions: to continue in their role as deliverers of specialist care; and a new function as healthcare professional educators<sup>13</sup>. All the GP practices involved in the 'super six' initiative have virtual access to consultant support (telephone and email) and each practice is visited by a diabetes specialist nurse and consultant biannually to deliver training and support as needed. This is accompanied by a programme of accredited training<sup>14</sup>.

In North West London there has been no formal training offered to GP practices, but the model of care introduced a stratification process which segments people with Type 2 diabetes according to need and refers them to the appropriate part of the system. 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.

### **The role of payment systems in supporting the delivery of care**

The payment system must support the responsibility for service delivery as explained in the local model of care. In a traditional model of diabetes care the rigid divide between primary and specialist care is exacerbated by the provision of funding. For example the tariff system, to pay for activity in specialist care, can create incentives for one part of the system to 'hold on' to patients who might be better treated elsewhere.

---

12 Wolverhampton shares info on diabetics. E-health insider, 24 February 2014. [www.ehi.co.uk/news/EHI/9246/wolverhampton-shares-info-on-diabetics](http://www.ehi.co.uk/news/EHI/9246/wolverhampton-shares-info-on-diabetics)

13 Kar P (2013) The Super Six model of diabetes care: Two years on. *Diabetes & Primary Care* 15: 211–5

14 Porthosp.nhs.uk. Professional education programme. [www.porthosp.nhs.uk/departments/Diabetes-and-Endocrinology/professional-education-programme.htm](http://www.porthosp.nhs.uk/departments/Diabetes-and-Endocrinology/professional-education-programme.htm)

All of the areas looked at the use of funding to support the delivery of care according to the model of care introduced. Notably, there is an acceptance that providers involved need to focus on the needs of the whole health economy rather than their own organisation. In North West London for example, it was explicitly recognised that a more integrated approach might not be in the immediate financial interest of the acute trust.

## Using payment systems to support integrated care – in practice

- Derby introduced a new NHS organisation, which holds a pooled budget to deliver diabetes care based on historical prices across the care pathway.
- North West London used the pilot budget to compensate providers for the time spent working on additional features of the pilot. For example, GPs were paid for the time spent attending multidisciplinary group meetings and putting together care plans. Savings generated by the pilot are shared out between providers.
- Leicester, Portsmouth, Derby and Wolverhampton have introduced a locally enhanced service payment to incentivise primary care attendance at diabetes training courses and interaction with the diabetes specialist team to attain endorsement as a GP practice with an interest, and high level of competency, in the delivery of diabetes care.
- Leicester and Portsmouth have clarified responsibility for care delivery across the pathway and as such have defined the areas of care that must be delivered in a hospital setting. In Portsmouth, each of these areas has now been commissioned to a distinct service specification – allowing financial alignment with outcomes.

## 3. CARE PLANNING

### What is care planning

Care planning is a continuous process, in which clinicians and patients work together to agree goals, identify support needs, develop and implement action plans and monitor progress<sup>15</sup>. People with diabetes should have active involvement in the care planning process of deciding, agreeing and owning how their diabetes will be managed<sup>16</sup>. Care planning should replace traditional routine care and is at the centre of the ‘house of care’ framework. Effective care planning can only happen where an engaged and empowered patient is able to work with healthcare professionals committed to partnership working. This better uses the expertise of both parties to optimise the time spent in consultation. This makes sure people with diabetes are given the information they need to take action to prevent the development of complications and improve overall outcomes. As illustrated by the house of care framework, this partnership working relies on the presence of the necessary organisational components – a comprehensive care pathway and the enablers of integrated diabetes care. If one element of the house of care framework is missing the continuous process of care planning cannot happen.

### Care planning in practice

The potential of the care planning process has most effectively been demonstrated through the Year of Care pilot, which used diabetes as an exemplar and introduced care planning as routine practice, including in Tower Hamlets where:

- The indices for diabetes care were amongst the worst 10% of PCTs in 2005. By March 2012, Tower Hamlets reported the best in England<sup>17</sup>;

---

15 The King's Fund (2013). Delivering better services for people with long term conditions. Building the house of care

16 Year of Care (2011). Report of findings from the pilot programme

17 Year of Care (2011). Report of findings from the pilot programme

- Improvements in patient experience, job satisfaction, and practice organisation were directly observed. Positive answers to the question, 'I have had about the right amount of involvement in my care' rose from 52% in 2006 to 82% in 2009<sup>18</sup>.

## The difference between care planning and 'a care plan'

Collaborative working in a care planning process is distinct from developing a care plan for people with diabetes. In North West London, as part of the process of stratifying patients with Type 2 diabetes, the multidisciplinary group (with input from the person with diabetes through discussion with a practice nurse) has responsibility for developing a care plan for each patient which varies according to individual need. This will determine the care to be delivered but it stops short of facilitating ongoing collaborative working for people with diabetes with the healthcare professional.

For care planning to be truly collaborative, the person with diabetes must be engaged in the process and allowed time to think about their own priorities. In Wolverhampton the care planning process is initiated through a questionnaire sent to patients prior to their annual review appointment, which includes a list of questions for them to consider and identify their priorities<sup>19</sup>. This is discussed at their consultation and an action plan based on this is designed in collaboration with the clinician to inform their ongoing care.

## 4. CLINICAL ENGAGEMENT AND LEADERSHIP

### Engaging the right people in designing a model of care

To maximise the chances of the model of diabetes care meeting the needs of people with diabetes and healthcare professionals all relevant stakeholders – as listed – should be engaged collaboratively in discussion at an early point. The North West London ICP clearly illustrates both the difficulties and central importance of this. The meeting to develop the ICP was attended by the Chief Executive of Imperial Hospitals NHS Trust, diabetologists, diabetes leads, commissioners, representatives of Central London Community Healthcare Trust, GP leads, psychiatrists, Diabetes UK and Age UK. Chief executives and senior managers gave the ICP their backing from an early point, giving clinicians the financial and managerial support necessary to enable them to better focus the model of diabetes care on the needs of people with diabetes. The trust chief executives were particularly supportive of the diabetologists spending time away from the hospital to work more closely with colleagues across the pathway.

### Getting clinicians support

One of the most significant challenges for North West London was getting clinicians from all providers involved and supportive of the pilot. Initially, clinicians were concerned about the challenges the pilot posed to their position and current way of working. These concerns were gradually overcome as an external chair was appointed to lead the pilot and bring people together on equal terms. The number of clinicians attending the meetings to develop the pilot steadily grew as people got to know one another and unite behind the aim of improving the service for people with diabetes<sup>20</sup>.

18 Year of Care (2011). Report of findings from the pilot programme

19 Wdconline.org.uk. My Diabetes Plan. <http://www.wdconline.org.uk/downloads/education/MyDiabetesMyPlan.pdf>

20 Vize R (2012) Integrated care: a story of hard won success. *BMJ* 2012; 344:e3529

## Initiating change – who to involve

### Local diabetes network, to include:

- people with diabetes and groups representing them
- healthcare professionals from the full range of relevant specialties from primary, specialist and community care
- CCG clinical lead
- area team representative

### Additionally:

- senior managers (inc. hospital chief execs)
- trust finance managers
- trust IT leads
- medicines management
- existing network (e.g. SCN) representatives.

For further information on local diabetes networks go to [www.diabetes.org.uk](http://www.diabetes.org.uk)

## Engaging people with diabetes

In the initial developmental discussions about the ICP, people with diabetes were represented by Diabetes UK. As the pilot developed it was agreed that people with diabetes should have a direct role to help determine priorities such as education and training needs. People with diabetes were therefore included on all the groups and an additional patient and users committee was established to discuss the progress of the pilot as a whole<sup>21</sup>.

“Patient involvement in establishing an integrated service is essential. In a traditional model of service delivery the only people to cross organisational boundaries are patients, giving them a unique perspective to contribute to the process of reorganising care”.

**Integrated care: a story of hard won success (BMJ 2012), Richard Vize**

21 Vize R (2012) Integrated care: a story of hard won success. BMJ 2012; 344:e3529

## 5. CLINICAL GOVERNANCE

### What is clinical governance and why it is important

Clinical governance is a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish<sup>22</sup>.

Implementing a clear and effective clinical governance structure helps to align the ambitions of clinicians with those of commissioners and most importantly with people with diabetes. An integrated system which removes barriers between care providers and overcomes perverse financial incentives allows services and the people involved to align and take shared responsibility for a single goal<sup>23</sup>.

### Implementing clinical governance

In Derby and North West London establishing a structure of clinical governance for their respective initiatives was core in their drive to improve. They took different approaches to this, reflecting the scale and complexity of the project.

The Derby model has a single clinical governance structure. The service is jointly led by a GP and consultant and supported by management staff seconded from secondary care. The multidisciplinary clinical team of primary and secondary care clinicians meet monthly to review safety, refine pathways and ensure quality of service delivery. This group is accountable to the board of the joint venture organisations (JVOs), which are not for profit organisations with 50% of shares held by the acute trust and 50% by primary care by a group of GPs. The JVOs have responsibility for holding the clinical leads to account for the delivery of the commissioned service specification and the financial state of the company. Patient participation groups meet on alternate months to contribute to service development.

---

22 Gabriel Scally (1998) Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ* 1998;317:61

23 Gabriel Scally (1998) Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ* 1998;317:61

# LOCAL INITIATIVES TO DELIVER MODELS OF INTEGRATED DIABETES CARE

The models of care described have been developed within the geographical, financial and structural constraints of that location. What unifies these areas is the local determination to take action to improve their service to move towards a high performing integrated diabetes service.

## Further Information

Further information on each of these models of care and commentary from the clinicians involved is available on the Diabetes UK website. We are also seeking further examples from England, Scotland, Wales and Northern Ireland, so please get in touch via the website – we know these examples are out there!

[www.diabetes.org.uk/integrated-diabetes-care](http://www.diabetes.org.uk/integrated-diabetes-care)

## WOLVERHAMPTON

### Organisations involved

The Royal Wolverhampton Hospitals NHS Trust (delivering community and hospital services), Wolverhampton CCG (formerly PCT). GP practices within the CCG area.

### The model of diabetes care

Wolverhampton has been delivering an integrated diabetes model of care for many years, which supports the development of primary care led diabetes services. Specialist care is delivered in partnership with primary care to meet the clinical needs of the patient. The model of care is based on self-care through education, patient centredness and empowerment.

### The care pathway

All service providers across primary, community and specialist care have agreed to work within a model of care which emphasises an increasing proportion of service delivery in primary care. Specialist care is delivered in partnership with primary care, in the community or hospital as appropriate according to the clinical need of the patient.

### Developed enablers in place

- **IT:** The CCG has introduced the CareCentric patient portal, which extracts data from GP practices and feeds it into the trust's system, giving clinicians a complete record across care settings. In addition, an algorithm is in place which stratifies patients according to their risk status, for referral to the appropriate clinicians.
- **Aligned finances and responsibility:** The single trust for hospital and community services removes boundaries between specialists and community based teams. Specialists have a key role contributing to education and training for primary care staff (through enhanced service training events). In addition GPs are incentivised to deliver care planning, working in a multidisciplinary team structure with specialists.
- **Care planning:** Care planning is facilitated by an initial questionnaire sent to patients prior to their annual review appointment, which includes a list of questions for them to consider and identify their priorities. This is discussed at their consultation and an action plan designed in collaboration with the clinician informs their ongoing care.
- **Clinical engagement and leadership:** The Wolverhampton diabetes network is well established. In addition to the clinical network board there are groups for specific workstreams including user involvement, care pathways and education and training. Membership of the groups is multidisciplinary from across the service. All decisions are reported to the clinical network board.
- **Clinical governance:** The network is overseen by 'The Diabetes Programme Board' which includes representatives from across the service. The role of the programme board is to oversee the work of the network in driving improvement and maintaining quality in service delivery. The programme board will take issues, themes and commissioning priorities to the CCG.

## DERBY

### Organisations involved

Derby Hospitals NHS Foundation Trust, Derby City PCT (currently commissioned by Southern Derbyshire CCG) and Derby City GP practices.

### The model of diabetes care

Derby introduced a new model of delivering diabetes care in 2009 – commissioned by the then PCT. The basis of the new model was the creation of a new NHS organisation: a not for profit joint venture with shares held by the hospital and a group of GP practices. This allowed clinicians to work together to introduce the enablers of integration that mean clinical pathways can be developed around the user, and care seamlessly escalated to and from the specialist team as needed.

### The care pathway

- **Routine care:** This is provided by primary care, according to training (this is ongoing and participation is incentivised) and supported by satellite visits by the specialist team.
- **More complex care:** Joint clinics are held in the community with input from consultants (diabetologists and ophthalmologist) DSNs, dietitians and GPs. There is provision for retinal screening to be undertaken at the same time as other appointments, and resources for structured education. The majority of people are referred to the joint clinic with specific problems, such as GLP initiation or insulin management. Care is de-escalated to primary care once the problem is addressed. These clinics are also used to support people with well controlled Type 1 diabetes, including those on pumps.
- **Specialist care:** Those requiring support from other specialties are seen in the traditional hospital setting including those requiring antenatal care, input from the renal team, MDT foot care, and transition. They are contractually outside integrated care.

### Developed enablers in place

- **IT:** Diabetes specialists and 85 per cent of GP practices use the IT system SystmOne. This allows rapid communication and appropriate referral and holistic care as specialists and primary care teams are able to see each other's consultations.
- **Aligned finances and responsibility:** A single budget allows care delivery without competition. Nobody is employed directly by the new organisation – GPs are paid at an hourly rate and the trust receives an income for the time specialists spend in joint clinics. The provision of training to primary care by specialists, supported by an enhanced services payment to reward higher level training and associated competencies, ensures consistency of care delivery across GP practices.
- **Clinical engagement and leadership:** The redesign of the model of diabetes care delivered in Derby was driven by mutual enthusiasm from GPs and the hospital diabetologists. The service is jointly led by a GP and a consultant.
- **Clinical governance:** There is a single clinical governance structure, the multidisciplinary clinical team meet monthly to review safety, refine pathways and ensure quality of service delivery. The group is accountable to the board of the joint venture organisations. Patient participation groups contribute to service development.

## LEICESTER, LEICESTERSHIRE AND RUTLAND (LLR)

### Organisations involved

West Leicestershire, East Leicestershire and Rutland and Leicester City CCG, Leicester City and County Council, University Hospitals of Leicester, Leicestershire Partnership Trust.

### The model of diabetes care

Funding was provided by the CCGs in 2012/13 to transform the delivery of diabetes care across Leicester, Leicestershire and Rutland CCG areas (LLR Diabetes Transformation Project). Who has responsibility for the provision of care across the service has been clearly defined. Core services are provided by all GP practices and an enhanced payment and ongoing training made available to support the delivery of more complex care in primary care. This is supported by the introduction of specialist community based teams, which includes consultant sessions, as well as improved access to patient and professional education.

### The care pathway

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

### Developed enablers in place

- **IT:** Data sharing agreements are in place across all GP practices. Data is reported to CCG level.
- **Aligned finances and responsibility:** The project prioritised investment in training. This is provided to primary care by specialists. Attendance at training is supported by an enhanced services payment to reward higher level training and associated competence. This ensures consistency of care delivery across GP practices. Areas of care that must be delivered in a hospital setting have been defined. Each of these areas has now been commissioned to a distinct service specification – allowing financial alignment with outcomes.
- **Clinical engagement and leadership:** The project was overseen by the operational group which shaped the model of diabetes care in LLR. Alongside representatives from all CCGs, representatives from the hospital trust, community trust and the public were involved in determining the model of care. Working groups on specific areas – such as Type 1 diabetes and primary care – reported directly to the operational group.

### Want to know more?

Further information on all of these models of care is available on the Diabetes UK website at

[www.diabetes.org.uk/integrated-diabetes-care](http://www.diabetes.org.uk/integrated-diabetes-care)

## NORTH WEST LONDON

### Organisations involved

The pilot expanded as it progressed to cover three acute hospitals, two community hospitals and 104 GP practices.

### The model of diabetes care

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

### The care pathway

It was agreed that all people with Type 1 would remain under the care of consultant diabetologists. People with Type 2 were segmented into three groups and then stratified and provided with a care package determined by their wider care needs. This was underpinned by the introduction of multidisciplinary groups (MDGs) which were each chaired by a GP and brought together clinicians from primary, community and specialist care in multidisciplinary case conference to support the delivery of more complex care in primary care.

### Developed enablers in place

- **IT:** The ICP introduced an IT tool (a secure web based portal), intended to inform decisions about care delivery and patient pathways. This was designed to be used in conjunction with existing IT systems, so does require duplication of data entry and explicit consent from people with diabetes to share information across the system.
- **Aligned finances and responsibility:** The model of care introduced a system, through multidisciplinary group working and the IT tool, to stratify people with Type 2 diabetes (on the register in the MDG areas) according to risk. People are then referred to the appropriate part of the system for their care. Attendance at the multidisciplinary group meeting is paid for out of the ICP budget, so GPs are not financially disadvantaged. The MDG is an opportunity to discuss complex patients between specialists and generalists.
- **Clinical engagement and leadership:** A working group (equivalent to a diabetes network) was established and attended by NHS managers, diabetes specialists, GP leads and Diabetes UK. The working group determined the model of care, clinical pathways and governance structure for the pilot. Clinician engagement has been maintained through involvement in MDGs, which are an ongoing opportunity to discuss and identify ways to work more collaboratively and efficiently across the organisations. In addition, committees were established with responsibility for reviewing and improving the delivery of the ICP with specific remits – such as clinical care and IT. Clinicians from across the pathway were able to feed their experience into the discussion at these committees.
- **Clinical governance:** An integrated management board was established to sit above the committee structure. The board was given overall accountability for the pilot with responsibility for driving the strategic agenda and being the main decision making body. The Chair was external (formerly the London Deanery Director) and all the providers in the pilot are represented, with voting rights to a pre-determined split.

## PORTSMOUTH

### Organisations involved

SE Hampshire, Fareham & Gosport and Portsmouth CCG; Portsmouth Hospitals NHS Trust; Southern Health Foundation Trust and Solent NHS Trust (community trusts), South Central Ambulance Services, all GP practices within the CCG area.

### The model of diabetes care

In 2010 the diabetes clinical lead at Portsmouth Hospital, a GP with special interest in diabetes and commissioning managers developed a proposal for change. The model of care defines who does what within the system and is widely known as the 'super six'. The 'super six' are the areas of diabetes care that it was agreed must be managed by consultant specialists. The model of care is based on an increased role for primary care in the delivery of diabetes care. This is supported by the introduction of specialist community based teams, with consultant input, and improved access to professional education and support.

### The care pathway

- **Routine and more complex routine care:** This is provided in primary care with the support of a locality based community diabetes specialist team.
- **Specialist care:** The following services are provided in a secondary and tertiary care setting: inpatient care, insulin pump clinics, antenatal diabetes, footcare clinics, renal clinics, foot clinics and uncontrolled and adolescent Type 1.

### Developed enablers in place

- **Aligned finances and responsibility:** The changes to the model of care centred on defining the areas of care to be delivered in specialist care. To make the payment system support primary care's responsibility to deliver an increased proportion and complexity of care the following have been introduced:
  - Access to training and ongoing support from diabetes specialists.
  - A locally enhanced service payment to incentivise primary care attendance at diabetes training courses and interaction with the diabetes specialist team (through biannual practice visits) to attain endorsement as a GP practice with an interest, and high level of competency, in the delivery of diabetes care.
  - Areas of care that must be delivered in a hospital setting have been defined. Each of these areas has now been commissioned to a distinct service specification – allowing financial alignment with outcomes.
- **Clinical engagement and leadership:** The process of defining the care pathway was led by a group that comprised of members of the hospital team, a GP with special interest in diabetes and CCG leads (clinical and non-clinical). Local focus groups were held to seek the opinion of people with diabetes and GP engagement was recognised as crucial and sought early in the process.
- **Clinical governance:** Regular visits to GP practices by consultant diabetologists are followed up by individual feedback and review of primary care and patient satisfaction surveys.

# CONCLUSION

Delivering joined up, coordinated care for people with long term conditions is the national policy challenge posed to all commissioners and providers. To deliver this for diabetes, commissioners and providers must take responsibility for reconfiguring services to deliver a whole system model of care, which provides excellent ongoing management and rapid access to specialist services when required. The clinical pathway must include all the components of good diabetes care and be configured according to local need. To operate effectively, it should be underpinned by the structural integration enablers of shared information systems; aligned finances and responsibility; care planning; clinical engagement and leadership and robust clinical governance.

The focus in any drive for change must be for providers and commissioners to align the system and themselves behind the goal of delivering better care for people with diabetes.



**Get in touch**

**Call 0345 123 2399\***

**Email [info@diabetes.org.uk](mailto:info@diabetes.org.uk)**

**Go to [www.diabetes.org.uk](http://www.diabetes.org.uk)**

**Address Macleod House,  
10 Parkway,  
London NW1 7AA**

**DiABETES UK**  
**CARE. CONNECT. CAMPAIGN.**

\*Calls may be recorded for quality and training purposes.

A charity registered in England and Wales (215199) and in Scotland (SC039136). © Diabetes UK 2014 0323A