The Transformation of Diabetes Care in Barnsley

Professor T. Hugh Jones

Clinical scenario

- Don, aged 66 yrs, accountant
- Type 2 diabetes for 2 years
- Non smoker, BP 130/70
- Unable to tolerate metformin
- Taking gliclazide 160mg bd, sitagliptin 100mg od, simvastatin 20mg nocte
- BMI 38 kg/m^2, HbA1c 78 mmol/mol (9.3%)
- Referred to hospital. What next?

Clinical scenario

- No available new patient slots at the hospital – 6 week wait
- Seen by the Specialist Registrar (longstanding mildly abnormal transaminases – hepatitis screen, abdominal ultrasound scan) – all normal
- Reviewed by consultant after another 6 weeks
  - Change DPP4i to GLP1RA. Refer to DSN
- Seen in Community DSN clinic after 6 weeks and started on liraglutide

DPP4i=dipeptidyl peptidase 4 inhibitor; GLP1RA= glucagon-like peptide 1 receptor agonist; DSN= diabetes specialist nurse

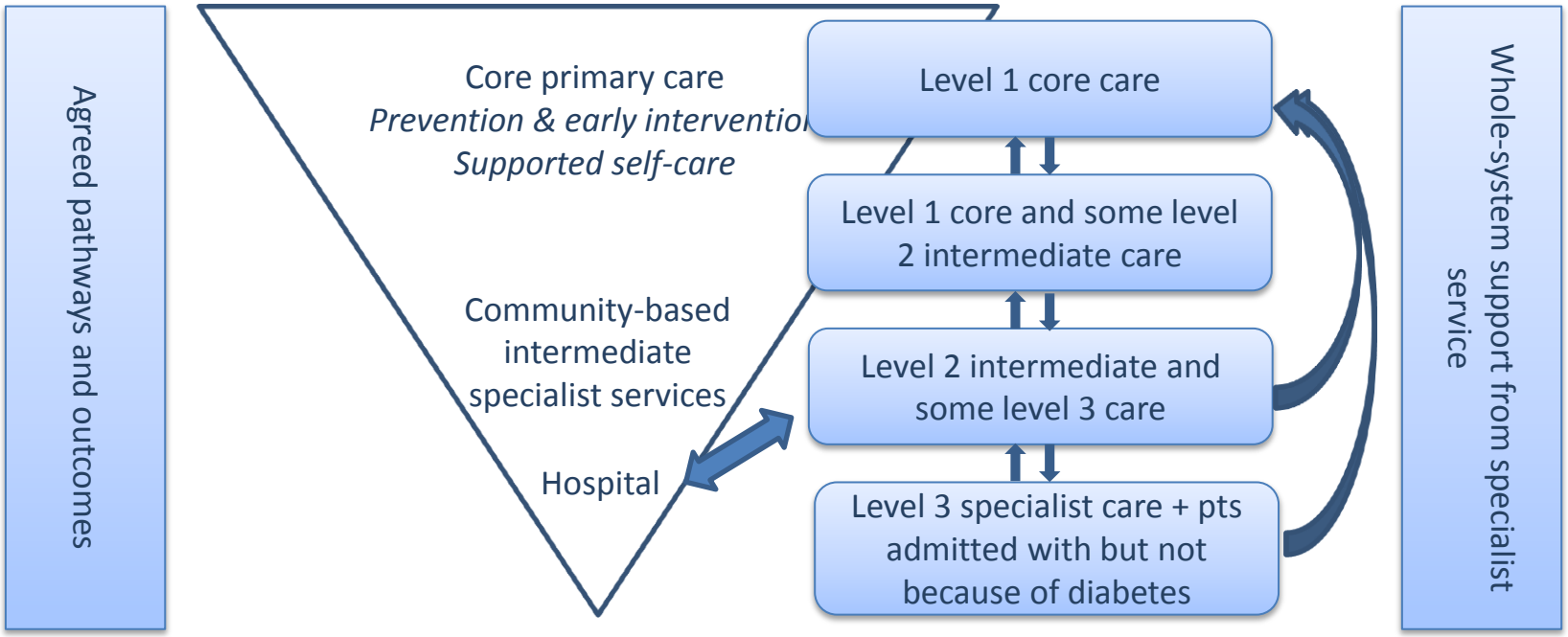
Aim of transformation

To help Barnsley residents to manage their diabetes to the highest standards and in the most cost-effective way by giving them access to the most up-to-date knowledge, support and technology

The drivers for change

- Barnsley local diabetes advisory group
  - Longstanding diabetes improvement plan
  - 2015 – six months' work, with NHS Barnsley CCG, on a new specification
- 2016 January: new specification approved by the Governing Body of the CCG
- Governance structure set up to implement the specification by March 2017

Diabetes model of care



Strong clinical leadership	Education	Good communications and IT	System-wide clinical governance

Improvements to the Service

Responsiveness and ease of access

- Single point of access for all referrals (in place October). Triaged by DSN ± consultant to:
  - Rapid response via advice module on e-referral or by e-consult
  - DSN-led clinic
  - Tele-clinic (future)
  - Specialist clinic
  - New T2D referral for eye screening, education, dietician etc..
- Dedicated hospital numbers and email addresses for People with diabetes and health care professional contact
- Possible manned telephone advice line at nominated times

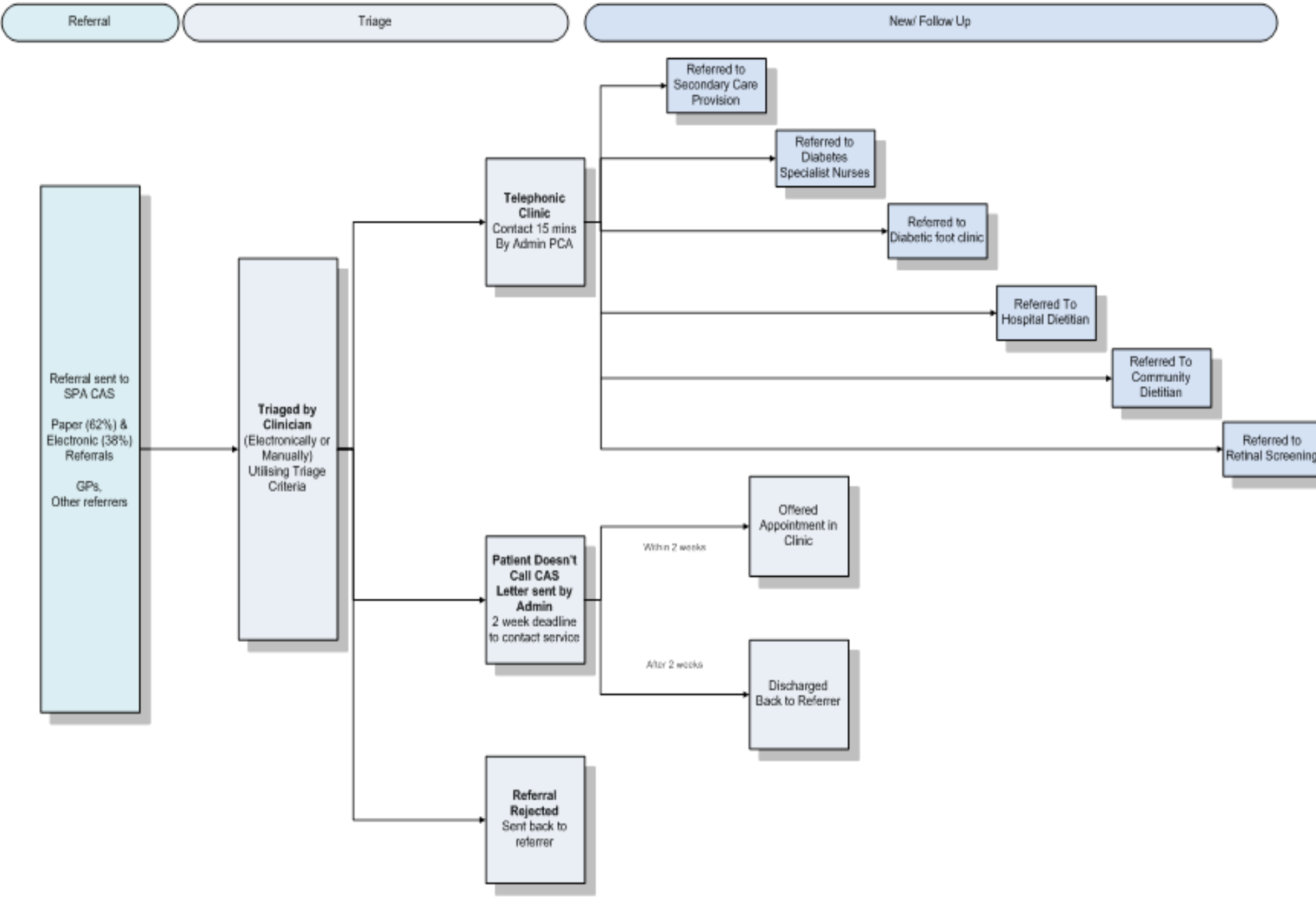
DSN= diabetes specialist nurse; PWD=person with diabetes; HCP=healthcare professional

Single Point of Access (SPA)

- In order to ensure that patients are seen by the most appropriate clinician/team within the MDT, a single point of access (SPA) for referrals is being developed.

- The SPA will collate and triage patient referrals based to agreed criteria and ensure that appointments are booked into the appropriate clinical service element.

SPA - Process


Referral
Triage
New/ Follow Up
Referral sent to SPA CAS
Paper (62%) & Electronic (38%) Referrals
GPs, Other referrers
Triaged by Clinician (Electronically or Manually) Utilising Triage Criteria
Telephonic Clinic
Contact 15 mins By Admin PCA
Referred to Secondary Care Provision
Referred to Diabetes Specialist Nurses
Referred to Diabetic foot clinic
Referred To Hospital Dietitian
Referred To Community Dietitian
Referred to Retinal Screening
Patient Doesn't Call CAS Letter sent by Admin
2 week deadline to contact service
Within 2 weeks
Offered Appointment in Clinic
After 2 weeks
Discharged Back to Referrer
Referral Rejected
Sent back to referrer

Improvements to the Service expected in place by March 2017

Generic

- Guidelines and protocols in place
- Link with other units in South Yorkshire to provide type 1 DAFNE training
- Expand range and appeal of type 2 training programmes
- Business case for psychological support
- All members of specialist team from whatever provider to work as single team within MCP/ACO

DAFNE=Dose adjustment for normal eating; MCP: Multi-specialty community provider; ACO=accountable care organisation

Improvements to the Service

Specialist Care

- ‘Super six’ model – pumps, antenatal, feet, complex care, inpatients, transitional / adolescent
- DSN base in the hospital, with daily nurse-led clinics
- MDT working in all specialist areas – consultant + DSN + dietician ± podiatrist etc…
- Additional consultation time
- Structured discharge of patients not requiring specialist expertise
- Electronic data from blood glucose meters, pumps etc… available in all specialist clinics via Diasend

Criteria for Complex Patients

- Type 1 Diabetes
- Foot Ulcer /Gangrene/Charcot
- Nephropathy
- Painful Neuropathy
- Autonomic Neuropathy
- Insulin Neuritis
- Pregnancy
- Type 2 ?MODY
- Refractory ↑BP
- Refractory Glycaemic Control
- New Drugs
- Insulin Pumps
- Obesity Surgery
- Familial / Difficult Hyperlipidaemia
- ED / Hypogonadism
- Secondary Diabetes
- Diabetes associated with PBC, Coeliac D

Refractory Glycaemic Control and New drugs - Proposal

- Rapid Discharge Clinic
- Already in place allowing patients early discharge then one review by hospital Consultant Endocrinologist and DSN

- One /Two Stop Glycaemic Clinic
- Referral from GP or DSN
- Patients seen assessed decision made
- Then either referred back to GP and/or DSN
- Or a second appointment if

Improvements to the Service

Intermediate Care

- DSNs now working in all specialist services as part of the MDT approach
- Community clinics remodelled but retaining important existing features
- Community clinic focus on problem-solving – on the whole, up to 3-4 visits
- Designated DSN (and possibly consultant) for each neighbourhood
- Use of technology – Diasend, Skype

DSN= diabetes specialist nurse, MDT=multi-disciplinary team

Improvements to the Service

Primary Care

- Improved links with designated DSN ± consultant
- Rapid access to specialist advice
- If desired, regular support sessions with secondary care – you set the Agenda
- Periodic specialist community clinics – sites to be agreed

Don

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Don

- No need for specialist clinic appointment

- Possible
  - Rapid response via e-consultation to provide advice
  - Arrangements for appointment in DSN community clinic within 1-2 weeks for possible initiation of GLP1RA
  - Training of practice nurse by link DSN to initiate GLP1RAs

GLP1RA= glucagon-like peptide 1 receptor agonist; DSN= diabetes specialist nurse

How can you help

- Working with us developing pathways for discharge into community
- Undertaking Training Needs Analysis in practices to establish demand and support for Diabetes education for patients and for Practice staff.
- Testing out new ways of working e.g. specialist community clinics, linked DSN

Thank you