Barnsley Integrated Diabetes Service

Barnsley Hospital FT and

Barnsley Healthcare Federation

Barnsley Hospital

NHS Foundation Trust

Barnsley Healthcare Federation

Better Health, Better Care, for a Better Barnsley

View from Primary Care

* Closer collaboration
* Increased support to improve the consistency of care
* Improved skills and training for Primary Care staff
* Rapid access to advice and guidance
* Care closer to home for all Barnsley patients

Drivers for change

- Rising prevalence of diabetes across Barnsley
- Increasing hospitalisation and hospital care for patients with diabetes
- Need to help empower patients to manage their own condition
- Need to increase skills within Primary Care teams
- Limited availability of specialist staff and the need to focus their skills on developing and delivering specialist services i.e. insulin pump service, specialist foot clinic, renal services
- The need to reduce inappropriate referrals to specialist teams so that specialist teams are not overloaded with routine work, which can take place in Primary Care.

Our Vision

- To implement a truly accessible, streamlined diabetes service across Barnsley
- We will facilitate direct integration between Primary Care and Barnsley Hospital
- Improve awareness and diagnosis across the wider healthcare economy, and upskill colleagues to enhance patient access
- Empower patient through education to effectively manage their own condition
- To support the transition of Patient care from the Hospital to Primary Care

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The Integrated Team

Barnsley Hospital FT

Barnsley Healthcare Federation

Consultant Lead

Dr Elizabeth Uchegbu

Diabetes Lead Nurse

Diabetes In-Patient

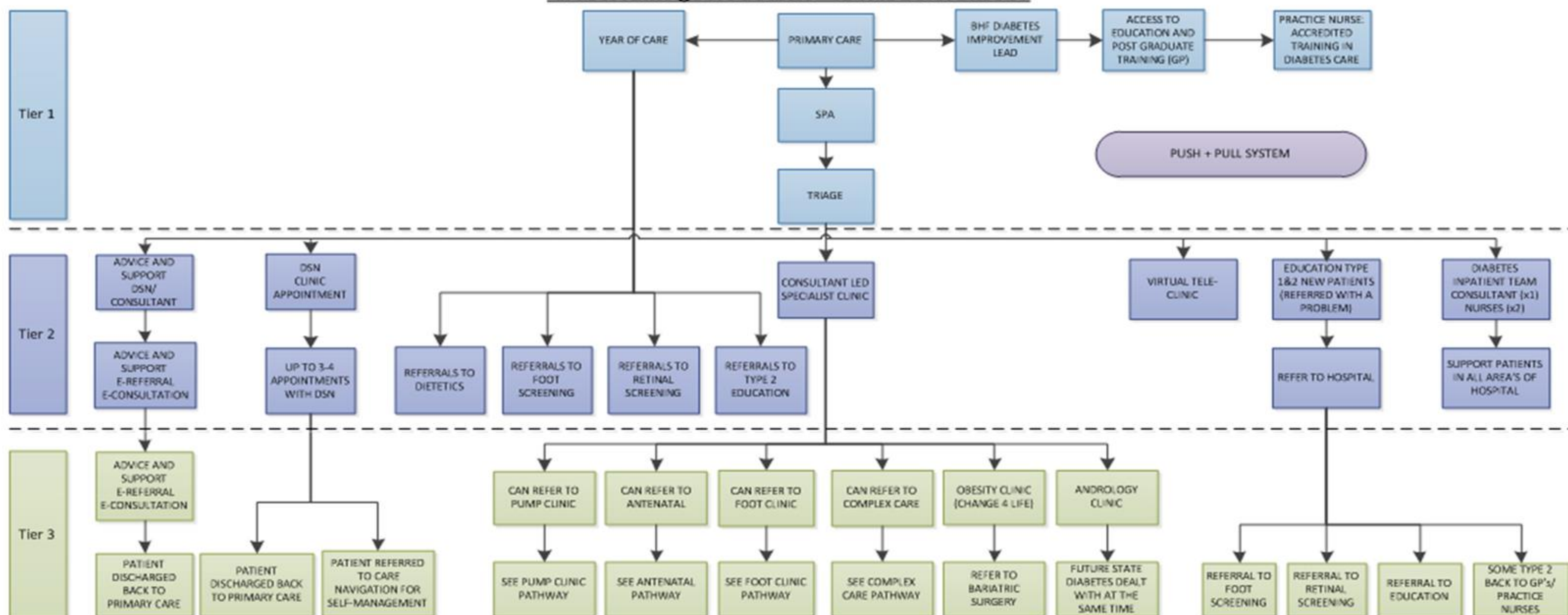
Locality DSNs

Single Point of Access

Patient Education

Practice Support

Diabetes Integrated Service - Future State Model



Patient Benefits

- Joined up timely care minimising duplication whilst maximising cost efficiencies.
- Outpatients, inpatient, rehabilitation, support services, patient engagement and education all included.
- Patients feel fully empowered about their care making them less reliant of health services and with the ability to self manager their condition/s.
- Personalised care delivered in an integrated way.
- Deliver the right care in the right place at the right time, with the aim of avoiding hospital admission.
- Better communication both to patients and between staff i.e. patient/s tell their story once.
- E-consultations via: Phone, Skype.
- Ability to Self-Manage supported by Telehealth as appropriate.
- Increase ease of access to advice and services, for patients.

Professional/s Benefits

- Create a far more cost efficient and clinically effective model of care.
- A fully integrated care model across all sectors of local health care providers.
- Removes traditional demarcation and care boundaries.
- Target resources more effectively (task designated by skill) based on detailed understanding of population need and the ability to deliver care in the appropriate environment.
- Use of technology to deliver new services using E-consultations that can dramatically reduce the cost of caring for diabetes patients whilst providing a high quality and more convenient service for patients.
- Providing an integrated IT system across all providers will not only allow access to full patient record but also permit direct clinical entry to the primary clinical record.
- Improved access to consultation and diagnostics.
- Through Practice based MDT's ensure that a comprehensive package of care and support is agreed with, and delivered by all providers.

Commissioners Benefits

- Population health improvements.
- Overall quality of care improves in Barnsley.
- Greater patient satisfaction.
- Improved patient experience.
- Reduction in Hospital admissions and A&E attendance.
- Financial accountability.
- Clearer accountability across providers.
- Integrated care model delivering Value for Money (VFM).
- Collaborative care model appropriate for 21st Century.
- Flagship integrated models of care.

Primary Care Benefits

- Regular Support sessions for individual/groups of Practices – This replicates Diabetes Clinics In Practice Can Be Done Remotely.
- Specialist Clinics in the Community.
- Dedicated Specialist Advice Line (Timing and duration TBC) Can Be Delivered Using: Skype, Lync, Phone.
- Access to Multi-Skilled professionals in Community and Secondary care.
- Reduced timescales for patient treatment.
- One stop shop referrals.
- Patient management through MDT's.
- Increased ease of access to advice and services, for primary care teams.

What will be different?

- Partnership between Primary Care and the Hospital
- Integrated single clinical team
- Joint clinics delivered in Practice
- Named Consultant and Diabetes Specialist Nurse for each locality and Practice
- Menu of support tailored Practice need
- Consultant lead support and upskilling for Primary Care Colleagues
- Move to 7 days service

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Accessing Barnsley Integrated Diabetes Service

- All access is through a single point of access
  - New service telephone number 01226 240086
  - Referrals triaged within 48 hours
- Referrals made through NHS e-Referral Service
- Extended opening for patients to access SPA
  - Move toward 8am-6:30pm Monday to Friday
  - New Diabetes website for information and questions
- E-consultation for Primary Care Advice and Guidance

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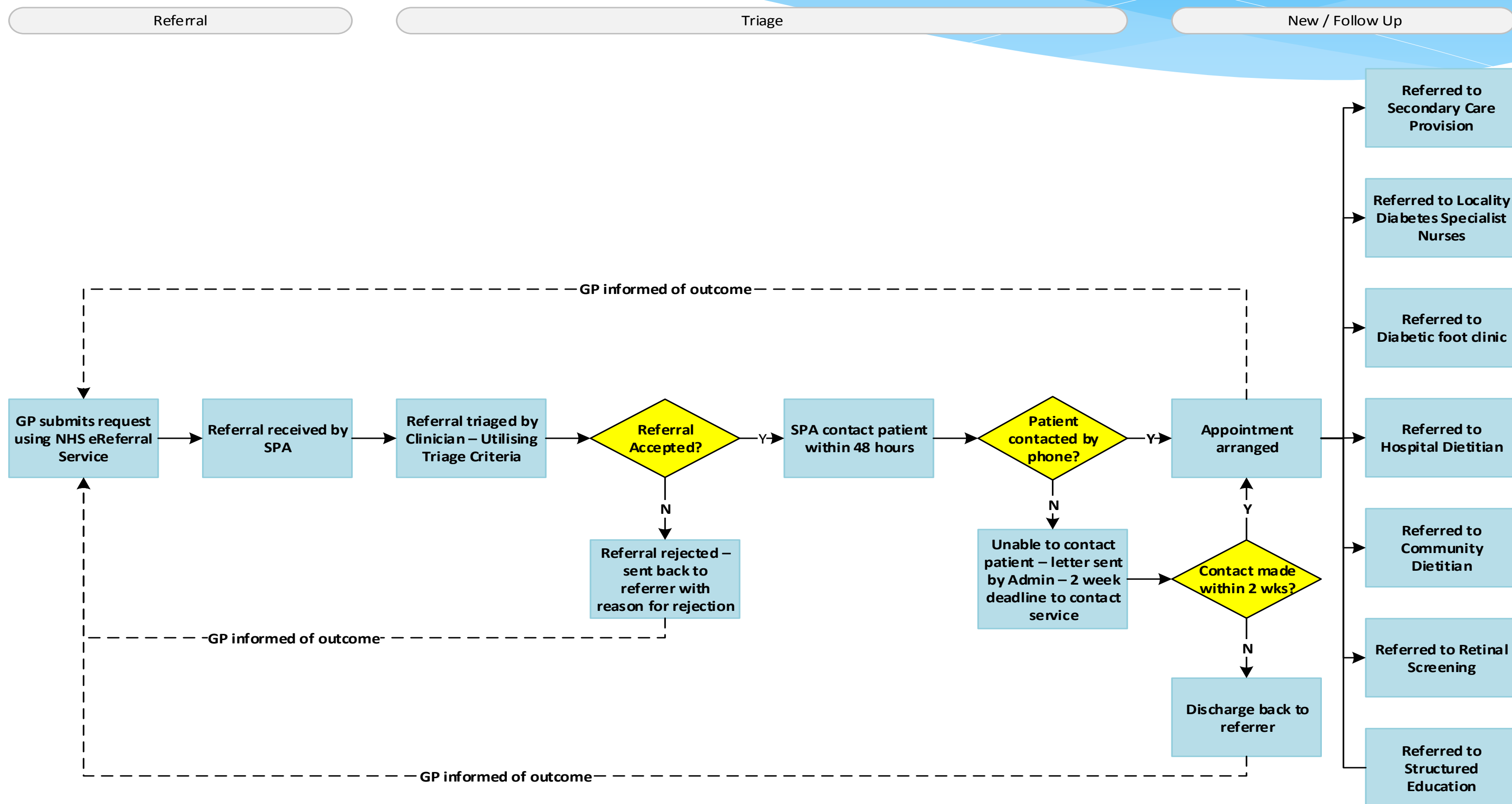
Barnsley Integrated Diabetes Service

Single Point of Access (SPA)



Appendix B – Treatment Options

Menu For Gp – Treatment options

Menu 1	Target audience	Expected characteristics	Key support activities	Success Criteria and evidence
	Surgeries with established Diabetes care	• register reflects expected numbers, • cohort of either complex patients or with severe disease or both • competent in performance and interpretation of spirometry • prescribing trends in line with agreed standards • Practice self assessment adjustments	• Doctor clinic/case note review • Nurse/nurse case note review • Specialist nurse input to complex cases • Specialist nurse case management in a minority of complex cases • Additional consultant input into complex cases • Joint clinics; consultant/GP, practice nurse/specialist nurse or variations dependent on practice requirements. (Minimum of one consultant and one specialist nurse joint clinic per practice per year in first year) This will be adjsuted dependent on number of referrals into SPA and number of referrals into secondary care • Best events and Medicines Optimisation Forum focus on Diabetes medication.	• Evidence of best practice being followed • Measures of confidence of patients to self-manage • QOF results

Menu 2	Target audience	Expected characteristics	Key support activities	Success Criteria and evidence
	Surgeries who have identified in their training needs analysis the need for clinical support in Diabetes management	• register over/under estimates Diabetes population • limited expertise in performing/interpreting blood glucose and Ketones • higher levels of Diabetes prescribing Therapy treatment • higher admission rates	**As for Menu 1 plus:** • Review of Diabetes therapy technique supervision and test validity • Doctor/doctor clinic • Nurse/nurse clinic • Support and education to practice Nurse clinics for Diabetes.	**As for Menu 1 plus:** • Measure of confidence of Primary Care staff to make accurate diagnoses • Reductions in hospital admissions • Reduction in ED attendances with a Daibetes issue.
Menu 3	**Target audience**	**Expected characteristics**	**Key support activities**	**Success Criteria and evidence**
	Surgeries with very limited/no Diabetes expertise (e.g. Diabetes practice nurse left and not been replaced)	**As menu 2 but lower experience and potentially lower resourcing levels.**	**As for Menu 2 plus:** • recording of history and support with development of treatment plan.	**As for Menu 2 plus:** • improvements in accuracy of Diabetes register • improved prescribing of Diabetes therapy.

What Practices will need to do

* Inform the team of their Practice requirements
* Engage with the team to build and deliver joint clinics
* Follow new referral guidance
* Support the new clinical steering group
* Provider feedback and suggest areas for improvement

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Wider Service Transformation

- Patient education
  - Continuation of X-PERT programme (Type 2)
  - Commencement of the DAFNE programme (Type 1)
- Primary Care training
  - Warwick course for Practice Nurse
- Practice Support
  - Primary Care Improvement Lead for Diabetes

Future Communication

* Each Practice will receive a service introduction letter
* Monthly communication on the progress of implementation and changes for the following month
* Communication to Patients outlining changes and transformation progress

Twitter
@BarnsDiabetes

Website

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Diabetes Service

WARWICK Training opportunity

Are you a GP, Practice Nurse or Community Nurse working to support people with Diabetes in Barnsley

THE UNIVERSITY OF WARWICK

Certificate in Diabetes Care (CIDC)

The Warwick Certificate in Diabetes Care (CIDC) provides the practical knowledge and skills necessary for healthcare professionals to deliver an effective and efficient service for people with diabetes. This certificate course will be delivered locally in Barnsley by Clinicians from the Barnsley Intergrated Diabetes Service. There is also backfill monies that are available to support practices to enable staff to attend this course which is delivered once a month over a 6 months period.

Day 1
- Overview of course
- Living with diabetes
- Making the Diagnosis

Day 2
- Behaviour change (motivational interviewing and cognitive behaviour therapy)
- Nutrition
- Lifestyle and physical activity

Day 3
- Oral therapies in diabetes
- Cardiovascular disease and diabetes
- Preparation for audit assignment

Day 4
- Insulin therapy
- Overview of insulin pump therapy
- Blood glucose monitoring
- Acute complications of diabetes

Day 5
- Foot disease and diabetes
- Neuropathy
- Sexual health in diabetes
- Peer review of audit assignment
- Preparation for the CIDC project

Day 6
- Nephropathy
- Children and diabetes
- Older people and diabetes
- Pregnancy/Gestational diabetes
- Learning disabilities
- Eye disease

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rmation visit: https://warwick.ac.uk/fac/med/study/cpd/diabetes/cidc/

arren Howlett darren.howlett@nhs.net
ice manager
1 Barnsley Hospital

are expected to undertake all pieces of work
that you can attend all 6 days of the course

The closing date for applications is 30th April 2018
ompleted applications (see attached form) should be returned to:
Mr Darren Howlett darren.howlett@nhs.net