

Search Title: Models of community based integrated diabetes care

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Date of search: 16/17 April 2014

Databases searched: Medline, HMIC, BNI

Other resources used: NICE, Diabetes UK, Map of Medicine, OJEU

Time taken: 6hrs

Question:

Examples of models of community based integrated diabetes services for consideration by clinicians involved in local service redesign.

Summary of topic:

Examples of existing integrated diabetes services across primary community / acute sectors with supporting information to support discussion around local service redesign.

Excluded – children’s diabetes services.

Summary of findings:

A number of integrated diabetes services have been identified, including case studies from the Quality in Care (QiC) awards for Diabetes care.

(<http://connect.qualityincare.org/diabetes>).

Those which have been extensively evaluated or for which there is evidence to support their effectiveness include

- First Diabetes - Derbyshire (note the OJEU tender currently in process)
- Avon Diabetes
- Integrated Community Diabetes Service (ICDS) Provided by UHL
Diabetes for Leicester CITY
- West Hampshire Community Diabetes Service ‘Reaching and Teaching’
- Integrated Community Diabetes Team (Portsmouth & SE Hampshire)
- Year of Care Pilots - Calderdale and Kirklees PCTs; NHS North of Tyne; and Tower Hamlets PCT.

All links are provided for information only. A link does not imply endorsement of that site. You may be asked to complete an online survey giving your feedback to this report. Please take the time to complete this so that we can make improvements to the search service.

Case studies of local models

Avon

Avon Diabetes

<http://www.avondiabetes.nhs.uk/Default.htm>

Avon Diabetes website gives details of the diabetes service across Avon including workforce, care pathway, development group.

See:

Integrated Care Pathway 2012

<http://www.avondiabetes.nhs.uk/professional/pathway/default.asp>

This Integrated Care Pathway is intended to inform team members and patients of the process of care for adult patients with diabetes and the resources available locally. It aims to provide guidance for health care professionals new to the field or who have recently moved into the area, as well as being a reference document for those already involved in diabetes services both in primary and secondary care

<http://www.avondiabetes.nhs.uk/professional/pathway/>

Bedfordshire

Bedfordshire Integrated Community Diabetes Service

The ICDS is a specialist diabetes team working in the community to support general practice care for patients in Bedfordshire. The service works with primary care and community health care professionals to deliver diabetes care in a seamless way. Patients will have easier access to a specialist diabetes multi-disciplinary team, be offered care closer to home and be further empowered in diabetes self management.

Includes referral guidelines and GP awareness presentation

<http://www.gpref.bedfordshire.nhs.uk/referrals/speciality/diabetes/bedfordshire-integrated-community-diabetes-service.aspx>

Cambridgeshire

Community Diabetes Service (Cambridgeshire Community Services NHS Trust)

Our community diabetes teams operate in Cambridgeshire, Peterborough and Luton.

<http://www.cambscommunityservices.nhs.uk/what-we-do/specialist-services/long-term-conditions/community-diabetes-service>

NHS Cambridge - Integrated Diabetes Care Team

NHS Confederation case study

This model of care involves integration between Community and Secondary care services working alongside Primary Care practices within the East Cambs and Fenland area of Cambridgeshire. The team is a nurse led diabetes team, which includes a specialist dietician, podiatrist, DSN's, a part time Consultant Diabetologist, care technicians and secretaries. The team are funded by NHS Cambridgeshire as an integrated pilot. This specialist integrated service is provided in local community primary care and a domiciliary setting.

A number of factors were key to the successful set-up of this new service: recruiting the right staff; making the case to commissioners that this would be a cost effective service; understanding the local patient needs; developing the links between Primary and Secondary care.

<http://www.nhsconfed.org/priorities/Quality/patient-experience/Pages/cambridge-integrated-diabetes.aspx>

See also; <http://www.cambscommunityservices.nhs.uk/what-we-do/specialist-services/long-term-conditions/community-diabetes-service/community-diabetes-service---cambridgeshire>

Also:

The Joint Cambridgeshire and Peterborough Managed Care Network for Diabetes is a network of a multidisciplinary group of healthcare professionals, patients, commissioners, managers and service providers, who are dedicated to working together to improve care standards and service delivery for people with diabetes, and to work towards the prevention of diabetes complications and the condition itself.

<http://www.cam-pgmc.ac.uk/specialties/diabetes>

Derbyshire

First Diabetes –

First Diabetes is an integrated Diabetes service. This means that the doctors, nurses, dieticians and administrative staff aim to keep the patient at the centre of all that we do. The service is set up in a very novel way in that nearly all the care that a person with Diabetes needs can be delivered in one place, closer to the person's home. This compares to previous traditional services where patients move around a complex system of departments - which can be confusing. We endeavour to link the services to the person with diabetes or simply as possible.

www.firstdiabetes.co.uk

Presentations and case studies of First Diabetes:

First Diabetes – a new clinical integrated diabetes service for patients in Derby

First Diabetes is not-for-profit organisation designed as a unique partnership between Primary and Secondary Care for the delivery of comprehensive, integrated, patient centred care for 2,500 patients with diabetes in Derby.

By bringing diabetes care services under a single budget and single clinical governance structure, it has managed to provide care closer to home in a coordinated and safe manner, resulting in improved quality of care and improved patient experience.

<http://connect.qualityincare.org/diabetes/cross-organisational-partnership-of-the-year/case-studies/first-diabetes-a-new-clinical-integrated-diabetes-service-for-patients-in-derby>

Integrating Diabetes Care in Derbyshire, Kings Fund May 2013

(Presentation by diabetes consultant, including an outline of the model)

<http://www.kingsfund.org.uk/sites/files/kf/media/rustam-rea-integrating-diabetes-care-integrated-care-may13.pdf>

InterCare Diabetes Service : An integrated diabetes service for Derby City commissioned by Southern Derbyshire CCG

(Part of First Diabetes)

An initial Service Evaluation April- December 2012

<http://www.yhpho.org.uk/resource/view.aspx?RID=160575>

Ongoing tender:

NHS Southern Derbyshire Clinical Commissioning Group — Integrated Diabetes Pathway Service.

OJEU tender

Responses by 2.4.2014

“The aim of this procurement process is to implement an integrated service designed to coordinate, promote, embed and provide, via a single point of access, a holistic care pathway that has self-care, preventative care and medical care as the key components to improve the overall quality of life for patients and carers affected by diabetes. The integrated approach shall encompass the whole pathway from prevention through to highly specialist care to streamline services. It shall empower individuals to make informed choices about their health by changing from a traditional medical model to one that is integrative and holistic that not only deals with symptom management but also addresses the root causes of the condition and associated problems. The integrated diabetes service shall be delivered in the community setting across Southern Derbyshire CCG. Through the provision of the service, the lead provider shall ensure that an integrated approach to the management of diabetes is embedded across Southern Derbyshire with all health professionals working in partnership to ensure that patients are seen by the right person, at the right time according to their needs. The lead integrated service provider shall ensure that the following specific service elements are provided:

- Integrated, multidisciplinary diabetes community support
- Single point of access
- Combined clinics in primary care
- Health professional education
- Case finding
- Self-management
- Patient education
- Psychological Support
- Dietetics
- Podiatry
- Pre-conception care
- Culturally appropriate care
- Peer and social support
- Triage of outpatient referrals
- Admission avoidance

— Self-management

This service will be implemented through a phased implementation process from 3.11.2014.

<http://ted.europa.eu/udl?uri=TED:NOTICE:71763-2014:TEXT:EN:HTML&src=0>

Fylde/
Blackpool

Fylde Coast Integrated Diabetes Care Pathway

Presentation:

[http://www.bfwhospitals.nhs.uk/members/docs/presentations%202012/3\)%20Diabetes%20integrated%20%20blackpool%20-%20Presentation.ppt](http://www.bfwhospitals.nhs.uk/members/docs/presentations%202012/3)%20Diabetes%20integrated%20%20blackpool%20-%20Presentation.ppt)

(Cannot find any more substantive information)

Hampshire
West

West Hampshire Community Diabetes Service ‘Reaching and Teaching’

In a redesign of the diabetes treatment pathway, adult patients with diabetes now have a single point of access and are triaged by a diabetes nurse telephoning each patient. The service provides type 1 and 2 education and multidisciplinary clinical appointments throughout West Hampshire, in addition to a nurse-led telephone advice line open Monday to Friday 9-5pm. There is also a primary care education programme in place to support GP and practice nurse initiation and adjustment of insulin and GLP-1 therapies. The infrastructure is built around a remotely accessible IT package. Feedback about the education courses and appointments has been positive, while there have been improvements in the number of patients achieving glycaemic targets and a reduction in hypoglycaemia admission rates.

http://connect.qualityincare.org/diabetes/primary_and_or_community_initiative/case_studies/west_hampshire_community_diabetes_service_reaching_and_teaching

Hampshire
: South
Eastst

The Super Six model: integrating acute and community diabetes care across South East Hampshire

Starting in November 2011, the existing community diabetes team at South East Hampshire was joined by the local hospital diabetes specialist consultant team to provide regular in-depth educational support to GP practices and locality nursing teams, as well as to provide day-to-day advice via email and telephone.

This was influenced by the need to tackle three key issues:

- Pathway inefficiencies involving secondary care follow-up
- Unacceptable variations in quality of care and knowledge of diabetes and management
- The disconnect between care services resulting in fragmentation and duplication.

http://connect.qualityincare.org/diabetes/Network_Care/case_studies/the_super_six_model_integrating_acute_and_community_diabetes_care_a_cross_south_east_hampshire

**Commissioning an integrated Community Diabetes Team,
Portsmouth & SE Hampshire**

In November 2011 the community diabetes team at Portsmouth & South East Hampshire expanded to include consultant diabetologists and formed an integrated community, primary and acute care team. The aim was to increase the knowledge and skills in the management of patients with diabetes among carers and clinicians, as well as to improve communications and relationships across the healthcare community.

The new community diabetes team has gone from strength to strength; feedback from both GPs and patients has been excellent. Following a six-month review the team has met its set targets, which include the numbers of clinicians and patients educated and numbers of patients discharged from acute care.

http://connect.qualityincare.org/diabetes/innovation/case_studies/commi_sioning_an_integrated_community_diabetes_team

Lancashire

Pennine Lancashire Integrated Diabetes Service

We are a committed Multi Disciplinary Team of health care professionals offering a person centered approach to community care.

Our aims are:

- To provide individual person centered care and support to patients and their families
- To act as a resource for all health care professionals
- To offer an accessible service within the local community and surrounding areas
- To provide education and support to patients and other health care professionals

<http://www.elht.nhs.uk/departments-wards-and-services/pennine-lancashire-integrated-diabetes-service.htm>

Leicester

**Integrated Community Diabetes Service (ICDS) Provided by UHL
Diabetes for Leicester CITY**

ICDS multidisciplinary service brings diabetes care closer to home for patients who have poor control of their diabetes through eight community-based clinics.

Our diabetes care service is provided in joint partnership with GPs (doctors). Patients are screened by their doctor and referrals made to our specialist diabetes centres. Patients with diabetes are placed on a diabetes register to ensure that all patients across Leicestershire receive a high level of care.

<http://www.leicestershirediabetes.org.uk/diabetesservices-2.html>

Referral Pathway: <http://www.leicestershirediabetes.org.uk/476.html>

Lincolnshire East **Part of Diabetes Service Review**
Lincolnshire East and Lincolnshire West CCGs are undertaking a review of their Diabetes Service to identify gaps and review current provision.
<http://www.lincolnshireeastccg.nhs.uk/dsr>

Draft Integrated Diabetes Care specification – Lincolnshire East & Lincolnshire West CCGs
http://www.lincolnshireeastccg.nhs.uk/key-documents/doc_download/334-draft-integrated-diabetes-care-specification

London:
North West **NW London Integrated Care Pilot (ICP)**

An initiative to improve integrated care of people with diabetes and those aged over 75, who represent 10 per cent of the population and 28 per cent of budget in North West London.

[http://www.northwestlondon.nhs.uk/publications/?category=1671-Integrated+Care+Pilot+\(ICP\)-d](http://www.northwestlondon.nhs.uk/publications/?category=1671-Integrated+Care+Pilot+(ICP)-d)

Evaluation of the first year of the Inner North West London Integrated Care Pilot (Nuffield Trust May 2013)

The North West London Integrated Care Pilot (ICP) is a large-scale innovative programme designed to improve the coordination of care for people over 75 years of age, and adults living with diabetes.

<http://www.nuffieldtrust.org.uk/our-work/projects/north-west-london-integrated-care-pilot-evaluation>

This work is ongoing see;

Outer North West London Integrated Care Pilot, 2013/ 14: Business Plan Summary

<http://www.ealingccg.nhs.uk/media/2822/Paper%203a%20Short%20version%20ICP%20business%20plan%20Ealing%2020113.pdf>

London:
Tower
Hamlets **Improving outcomes for patients with type 2 diabetes using general practice networks: a quality improvement project in east London, BMJ Qual Saf 2014, 23 (2), pp.171-176.**

35 practices in one inner London PCT were geographically grouped into networks of four to five practices, each supported by a network manager, clerical staff and an educational budget. A MDT developed a 'care package' for type 2 diabetes management, with financial incentives based on network achievement of targets. Completed care plans rose from 10% to 88% and significantly improve BP and cholesterol control. "We found that a key factor for success has been the engagement of clinicians in the planning, implementation and governance of the process, and in contributing to educational support through multidisciplinary team (MDT) meetings."

Abstract: <http://qualitysafety.bmj.com/content/early/2013/09/03/bmjqs-2013-002008> (Full text available using NHS Athens)

London:
Bexley **Bringing care closer to home in Bexley**

Lakeside diabetes team, based in one of Bexley's most deprived communities, has been providing high-quality, innovative, patient-

centred services from the practice with impressive results.

http://connect.qualityincare.org/diabetes/people_team_awards/case_studies/bringing_care_closer_to_home_in_bexley

London: Lambeth	<p>Lambeth Diabetes Community Services</p> <p>This is a community-based diabetes service supporting the management of adults with Type 2 diabetes. The service includes the following interventions: multi-disciplinary diabetes community clinics (referrals from GPs and hospital step-down), patient education, injectable therapy initiation and titration, development and training of primary healthcare teams and diabetes prevention interventions for high-risk people. HSJ Award 2013</p>
Northamptonshire	<p>NHS Northamptonshire - Community Diabetes Service</p> <p>Diabetes Multi-disciplinary team</p> <p>The purpose of the Northamptonshire Diabetes Multi – disciplinary Team (NMDT) is to promote care closer to home, facilitating a seamless service between acute and primary care and avoiding acute hospital admissions and accelerating safe discharge. The delivery of high quality care, efficiently and cost effectively, in accordance with the Northamptonshire Diabetes Care Pathway, is a priority.</p> <p>http://www.nht.nhs.uk/main.cfm?type=DIABETESMULTIDISCI</p>
Somerset	<p>The Somerset diabetes service integrated care pathway clinical guidelines and directory of services for primary care</p> <p>http://www.wyvernhealth.com/somerset_diabetes_service_ICP.htm</p> <p>Includes high level pathway model and lots of other useful information about management and organisation of the service.</p>
Stockport	<p>Delivering specialist diabetes care in a GP practice in Stockport</p> <p>Dr Seabrook and Partners is a GP practice in Stockport. About 530 of its patients have diabetes. Patient stories showed a ‘one-size-fits-all’ approach to diabetes care could lead to poor communication, unmet needs and poor compliance with treatments. Furthermore care needed to be efficient and cost effective.</p> <p>The team wanted to find innovative ways of working and providing high quality specialist care closer to home. Specifically, they wanted to improve the quality of care for hard to reach diabetes patients who had three or more uncontrolled risk factors outside recommended targets.</p> <p>http://connect.qualityincare.org/diabetes/service_redesign/case_studies/delivering_specialist_diabetes_care_in_a_gp_practice_in_stockport</p>
YoC pilots	<p>Year of Care</p> <p>See description here: http://www.diabetes.org.uk/Professionals/Service-improvement/Year-of-Care/</p>

The YoC sets out to demonstrate how routine care can be redesigned and commissioned to provide a personalised approach for people with LTCs and has successfully done this using diabetes as an exemplar in three pilot sites: Calderdale and Kirklees PCTs; NHS North of Tyne; and Tower Hamlets PCT.

Year of Care Pilot case studies (2011)

http://www.diabetes.org.uk/upload/Professionals/Year%20of%20Care/YOC_casestudies_web.pdf

Also – consultancy services available here: <http://www.yearofcare.co.uk/>

Commissioning support and guidance

Nice Diabetes pathways

<http://pathways.nice.org.uk/pathways/diabetes>

The management of adult diabetes services in the NHS, NAO 2012

Considers performance against expected levels of care across England

<https://www.nao.org.uk/report/the-management-of-adult-diabetes-services-in-the-nhs/>

Department of Health: The management of adult diabetes services in the NHS Seventeenth Report of Session 2012–13

House of Commons Committee of Public Accounts

<http://www.publications.parliament.uk/pa/cm201213/cmselect/cmpubacc/289/289.pdf>

Best practice for commissioning diabetes services : An integrated care framework, Diabetes UK, 2013

This document is to help CCGs understand the nature of integrated diabetes care, why it is so important and to provide a signpost to other documents that will be of help in the commissioning process.

Integrated diabetes care is both integration of a health care system and co-ordination of services around a patient.

Essential components:

This diagram summarises the key components of integration. In particular it highlights the need to have five essential pillars of integration in place in order to facilitate the provision of different elements of diabetes care.

Pillars of integration -

1. Integrated IMT systems
2. Aligned finances and responsibility
3. Care planning
4. Clinical engagement and partnership
5. Robust shared clinical governance

<https://www.diabetes.org.uk/Documents/Position%20statements/best-practice->

[commissioning-diabetes-services-integrated-framework-0313.pdf](#)

Admissions avoidance and diabetes: guidance for clinical commissioning groups and clinical teams (JBDS – IP on behalf of Diabetes UK, the Association of British Clinical Diabetologists, and the Diabetes Inpatient Specialist Nurse, in collaboration with NHS Diabetes, and the Primary Care Diabetes Society, 4 December 2013)

http://www.diabetes.org.uk/About_us/News_Landing_Page/Improving-diabetes-services-could-reduce-pressure-on-hospitals/

Care Planning and Diabetes: Knowledge & Information Repository (NHS Diabetes)

A summary of key guidance and evidence. (2012)

<http://www.diabetes.nhs.uk/document.php?o=3188>

“Thanks for the Petunias” A guide to developing and commissioning non-traditional providers to support the self management of people with long term conditions, 2011

This guide, which is a product of the Year of Care Programme, was sponsored by the NHS North East Innovation Fund

<http://www.diabetes.org.uk/upload/Professionals/Year%20of%20Care/thanks-for-the-petunias.pdf>

Integrated Care for the Person with Diabetes A report from the Diabetes UK Integrated Care Task and Finish Group, May 2010

The Integrated Care Task and Finish Group was set up in late 2008 to look specifically at the concept of integrated care and how it can be successfully applied to the provision of diabetes services. The group considered the origins of integrated services, the latest changes to and political context of health service provision and the views of people with diabetes, to determine a definition of Integrated Care for people with diabetes and thoughts on how this could be effectively put into widespread practice.

http://www.diabetes.org.uk/documents/reports/integratedcaretfgroupreport_june%202010.doc
