Integrated Diabetes Care in Bolton. Success in the light of the NSF?

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Bolton Hospitals NHS
NHS Trust

Bolton NHS
Primary Care Trust

Bolton Diabetes Network

"Improving care through partnership and planning"

Diabetes Care in Bolton

- 10,500 people registered with diabetes = 3.5 (1.9-6.3) %
- 9.3% south asian population - Gugerati

- 55 General Practices,
  - 80% of practices structured diabetes care
  - 96% register - district register
  - 75% patients primary care only
- Community based diabetes specialist team
  - Bolton Diabetes Centre - 1995
  - 25% of patients, mainly complex or at transition

Diabetes Care in Bolton

- Integrated diabetes information system (register)
  - Managed by PCT

- Foot screening and education programme - 10 years
- Digital retinal screening - 2 years (70% population 2002/3)

- District wide professional education programmes 12 years
  - 4-6 monthly district education days (3 year curriculum)
  - ENB 928 equivalent 7 + years
  - advanced practitioner course (assistantships) 5 years
  - specific programmes e.g. insulin for practice nurses

Diabetes Care in Bolton

- Specialist clinics
  - Renal, Foot, Antenatal, Erectile dysfunction, Adolescent, post MI, pre-op assessment, childrens service.
- Patient education programmes
  - DSN for patient education, community based sessions, developing programmes and literature.
- 24 hour specialist advice line

Ethos of Specialist Team

To facilitate and provide high quality patient centred diabetes care throughout Bolton, through education and expert practice

External Review - 2000/1

Centre for NHS
Health Care Development

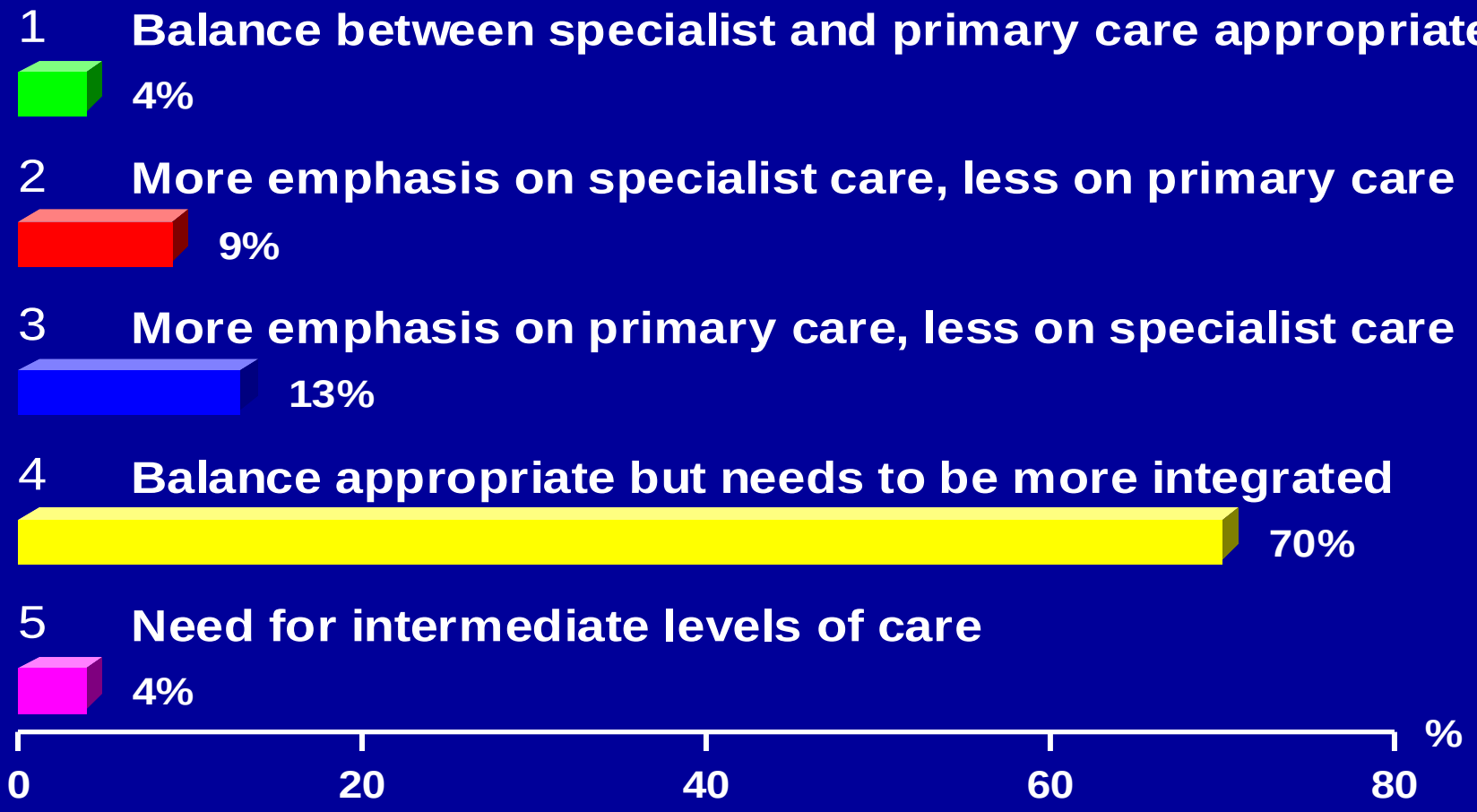
STRENGTHS

- Strong leadership from Diabetes Centre
- The Diabetes Centre team is able to offer multidisciplinary consultations for patients with complex needs
- Many examples of good and innovative practice in specialist, primary and community care
- Practice nurses-extensive training and experience in diabetes (10 yrs)
- Podiatry screening service consistently praised
- Good teamwork in the management of diabetic foot ulcers

RECOMMENDATIONS

- <u>Reduce variation in primary care</u>
- More practice based education is needed
- More specialist interaction with primary care

Bolton Diabetes Care Strategy



Diabetes Care in Bolton

THE VISION:"INTEGRATED DIABETES CARE"

Patient centred not organisation centred

Care should be delivered

- at the appropriate time,
- in the appropriate place,
- by the appropriately trained professional,
- for that patients present needs

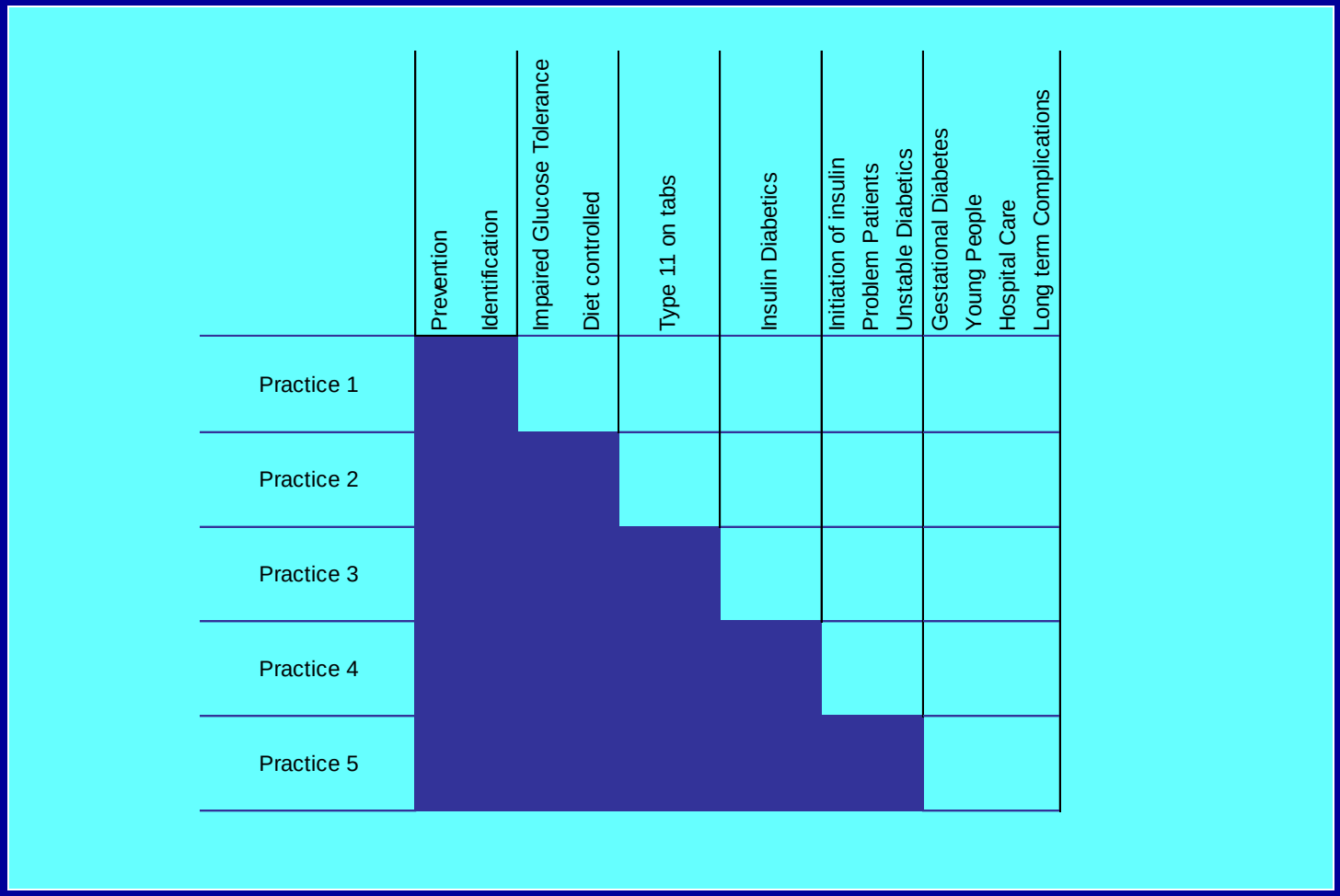
Objectives of Integrated Diabetes Care for Bolton

- fully integrated service
- avoid any gaps or duplication in service
- smooth and quick referral from primary care for advice and management plan
- increased specialist input into primary care settings
- consistent high quality patient centred care

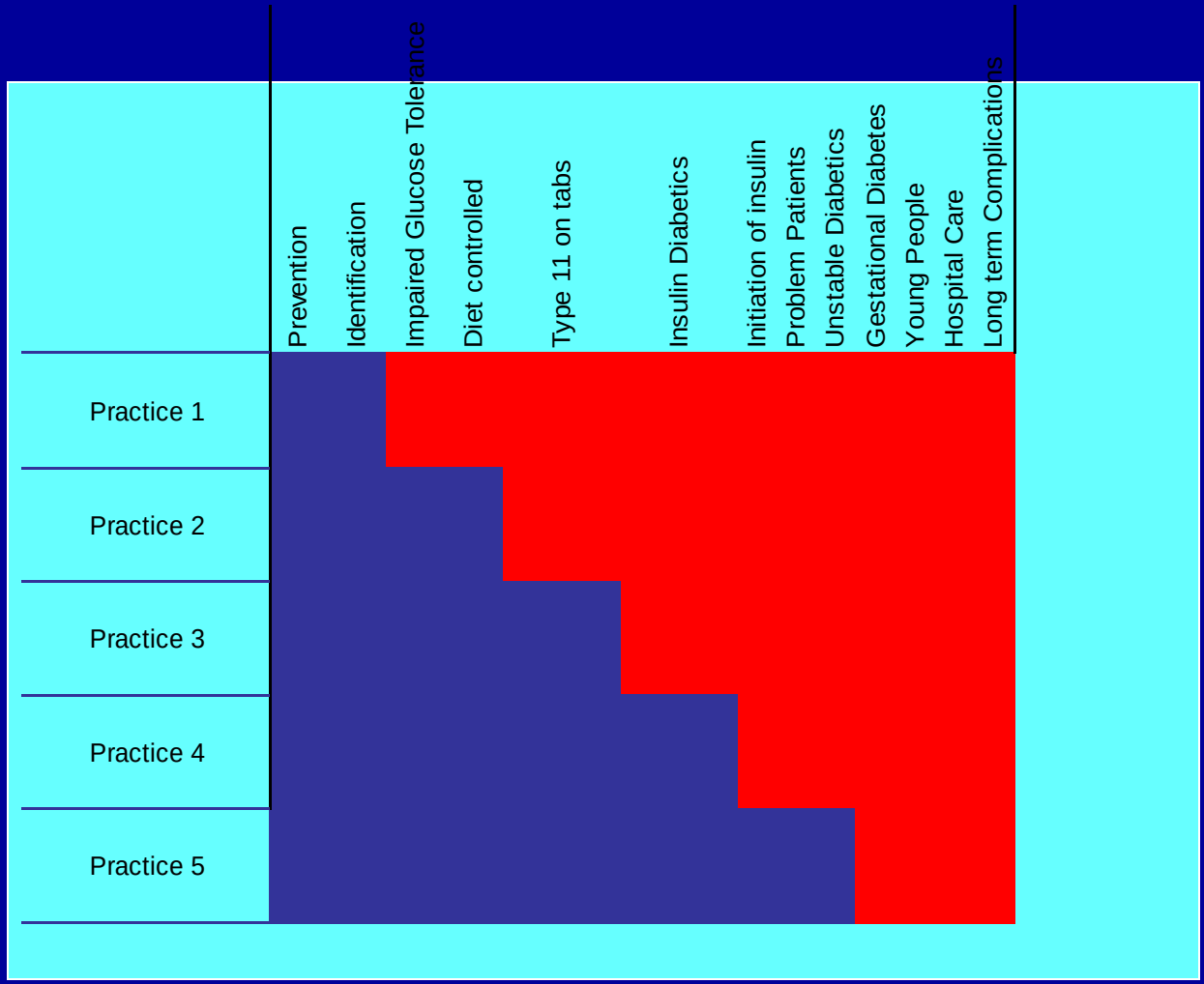
Our Principles for Integrated Care

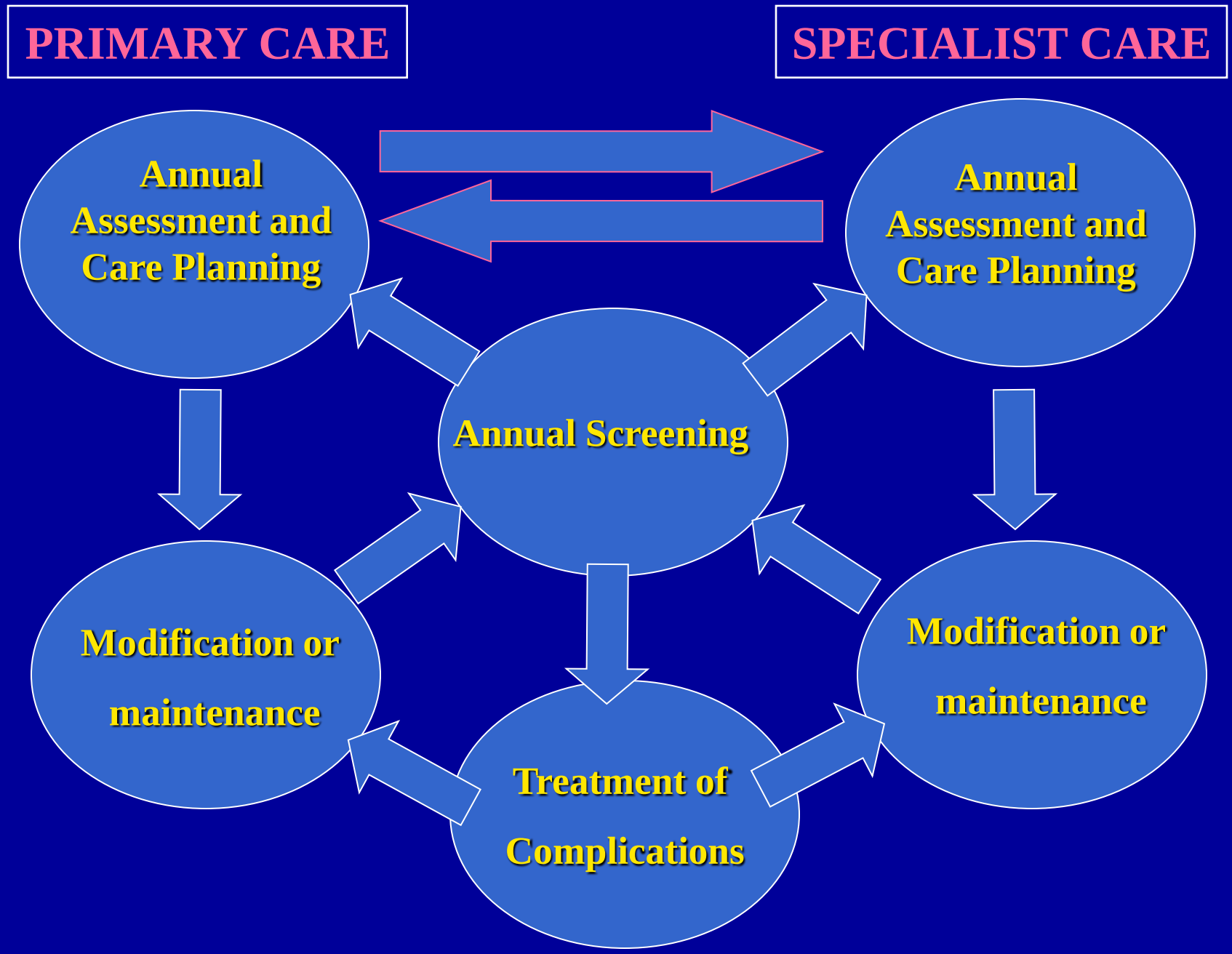
- Some components of care are required for each patient
- Some components of care are most appropriately delivered by primary care
- Some components of care are most appropriately delivered by specialist care
- Location of care must be the best to achieve the objectives of that care for that patient
- All care for patients with diabetes is part of an integrated diabetes service
- Integrated diabetes care requires integrated management

Define level of provision by Practice

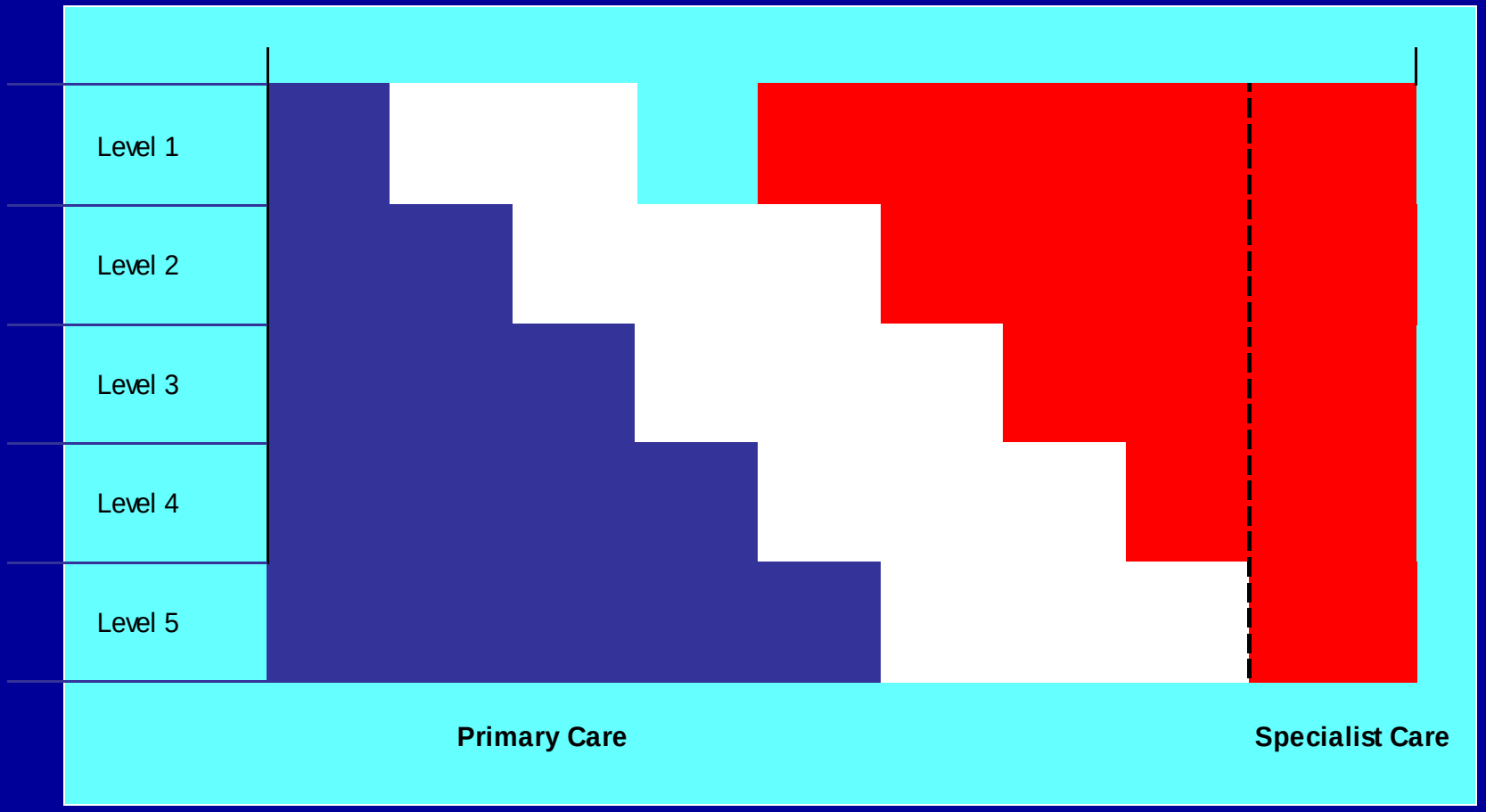


Complemented by the Diabetes Specialist Service

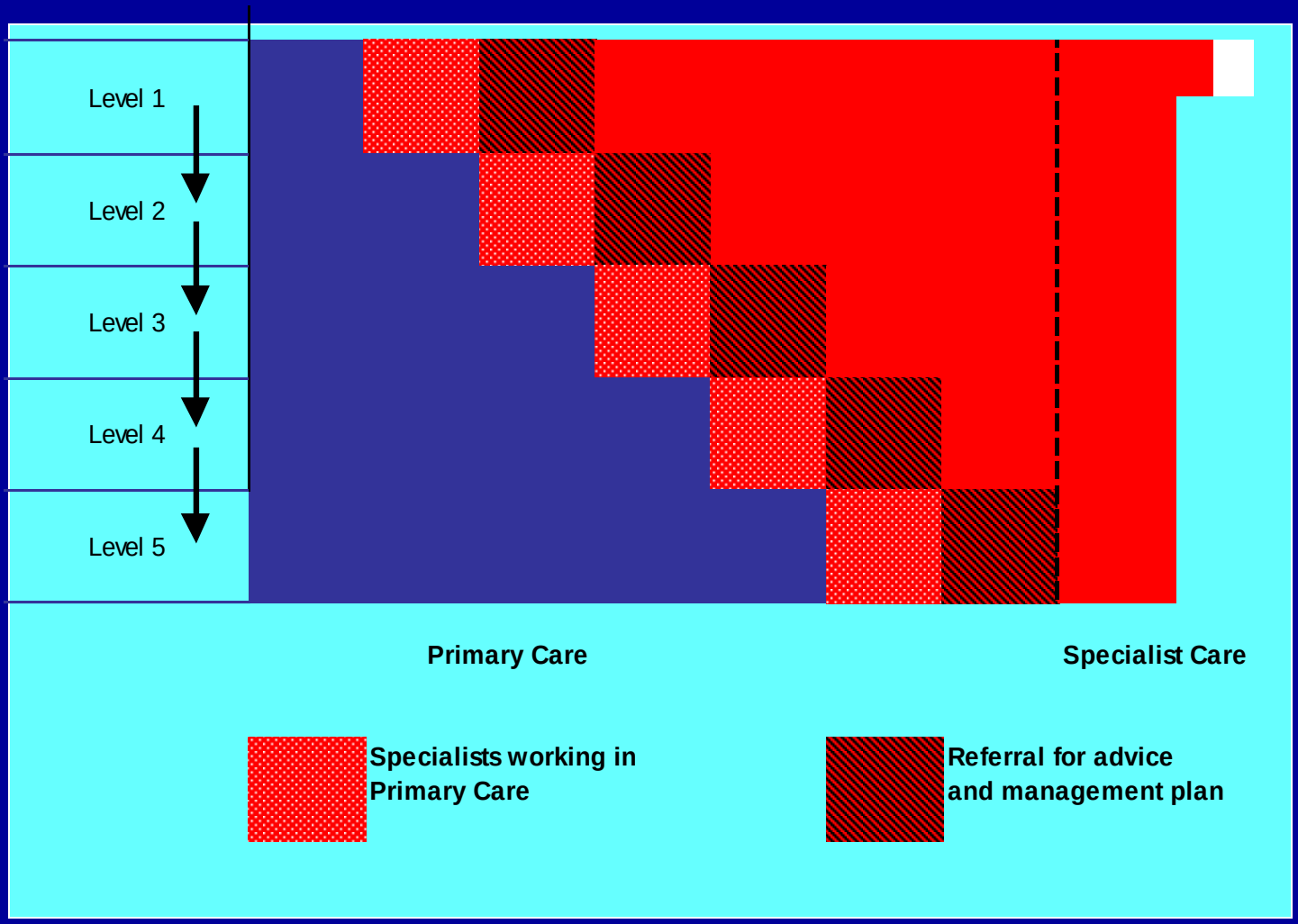



PRIMARY CARE
SPECIALIST CARE
Annual Assessment and Care Planning
Annual Assessment and Care Planning
Annual Screening
Modification or maintenance
Modification or maintenance
Treatment of Complications

Present


Level 1
Level 2
Level 3
Level 4
Level 5
Primary Care
Specialist Care

Integrate


Level 1
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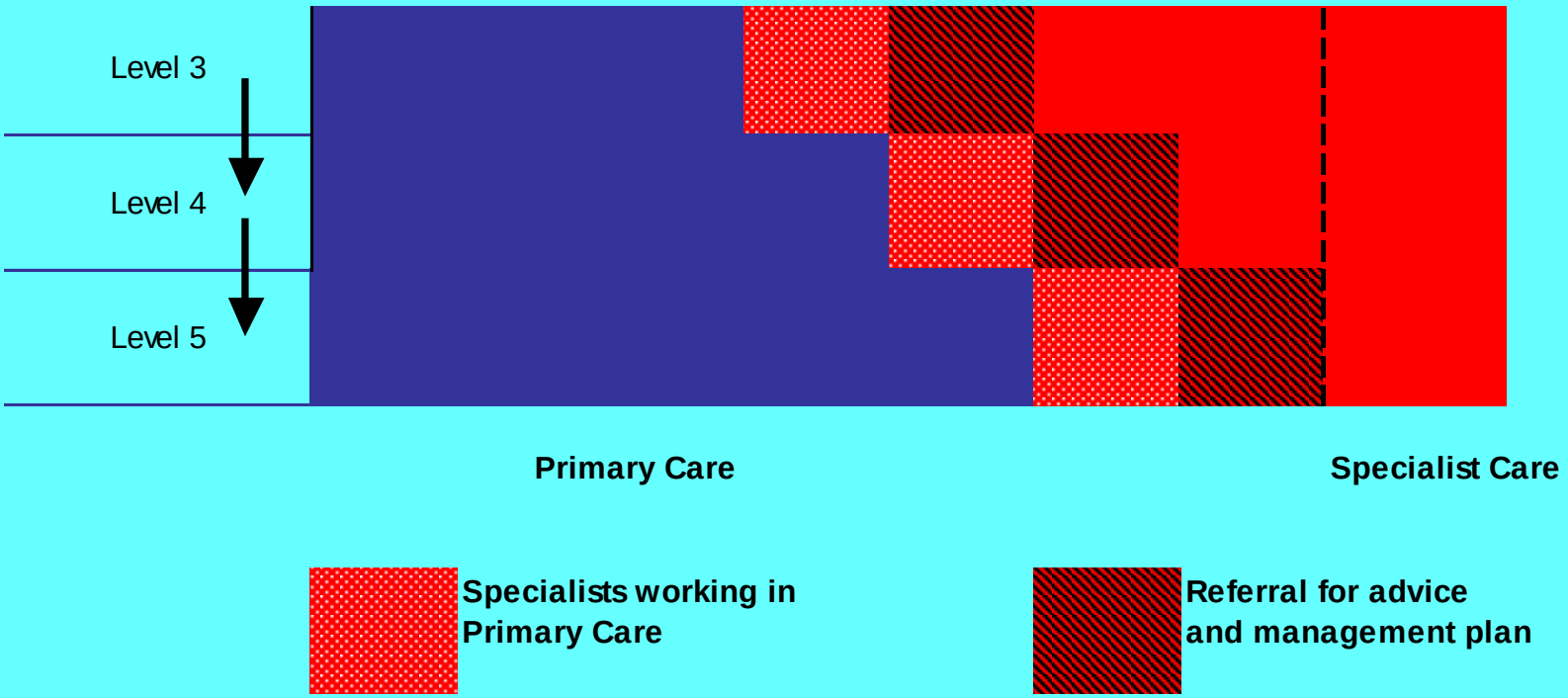
Level 5
Primary Care
Specialist Care
Specialists working in Primary Care
Referral for advice and management plan


Level 3
Level 4
Level 5
Primary Care
Specialist Care
Specialists working in Primary Care
Referral for advice and management plan

Pre requisites for integrating care

- Shared vision
- Clear accountable leadership
- Defined and agreed roles and responsibilities of staff and organisations
- Common Patient Record and Information

Integrated Management

- the local managed diabetes network

Accountability

D.O.H

Strategic Health Authority

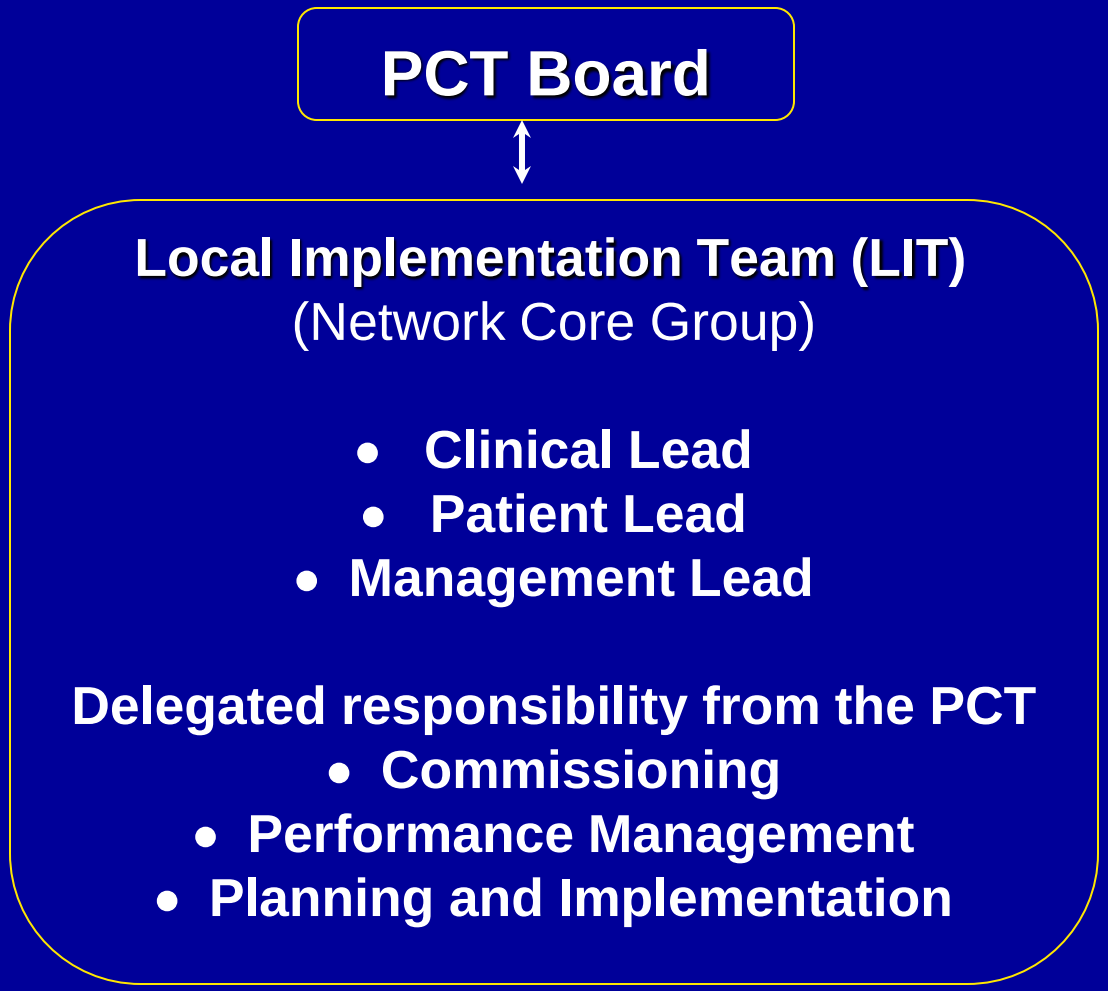
PCT

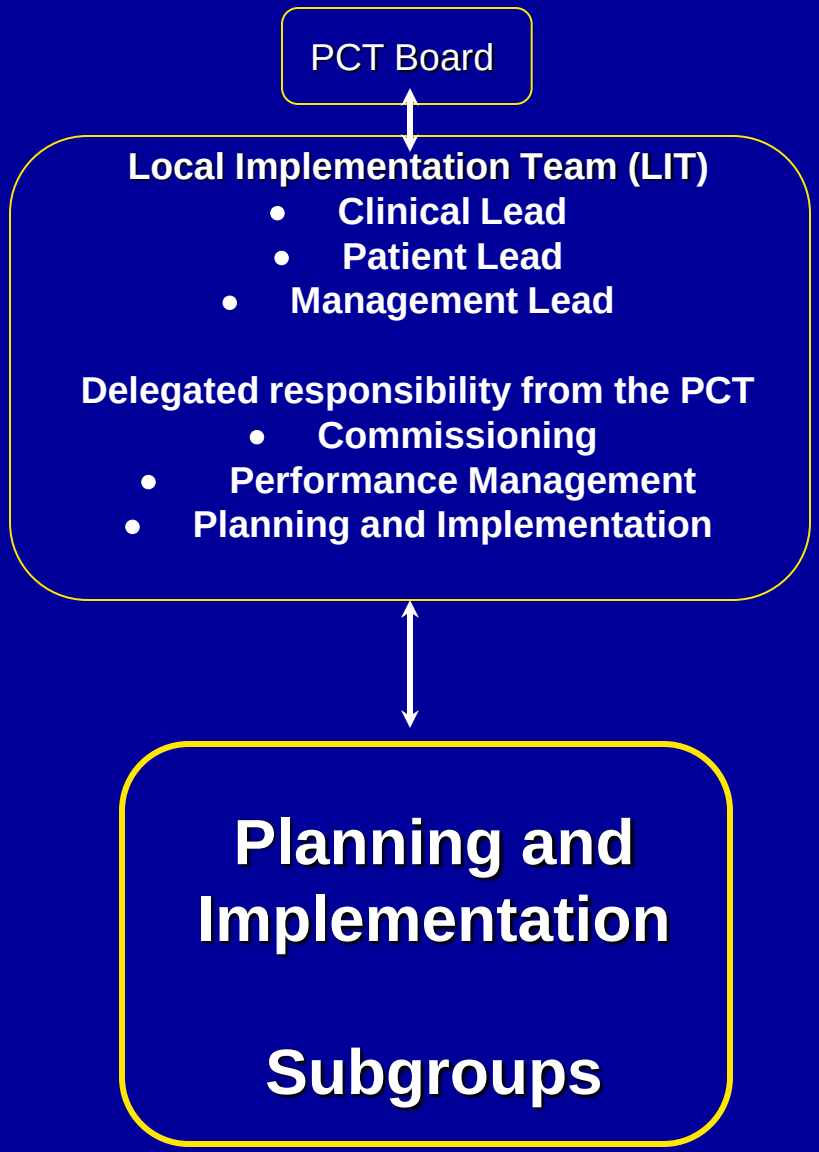
- Planning
- Primary care provision
- Commissioning specialist services
- Partnership working
- Monitoring and performance managing

Hospital Trust Services and staff

Primary Care Services and staff

Voluntary/Social Services and staff


PCT Board
Local Implementation Team (LIT)
(Network Core Group)
• Clinical Lead
• Patient Lead
• Management Lead
Delegated responsibility from the PCT
• Commissioning
• Performance Management
• Planning and Implementation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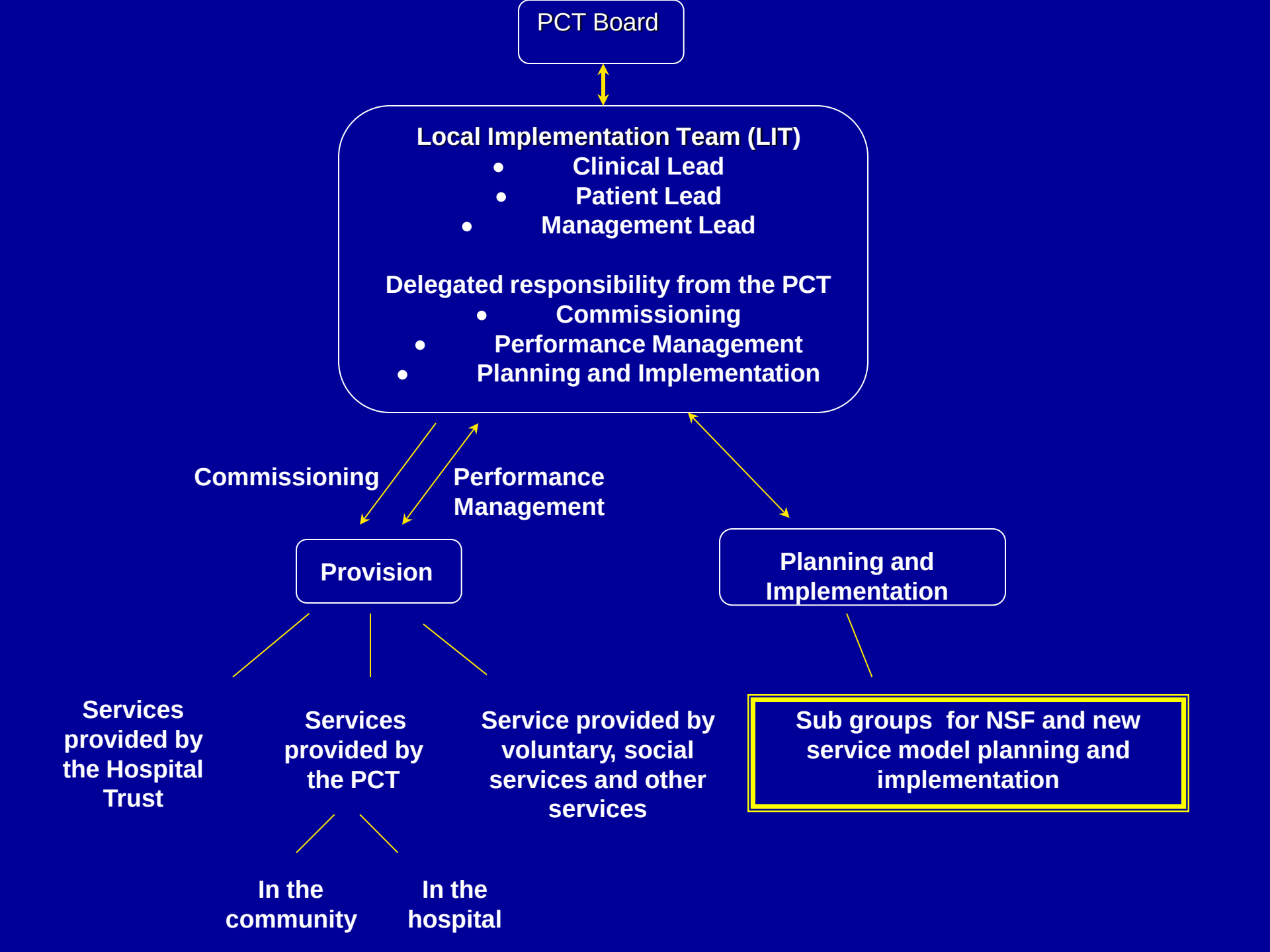
Planning and Implementation
Subgroups


PCT Board
Local Implementation Team (LIT)
• Clinical Lead
• Patient Lead
• Management Lead
Delegated responsibility from the PCT
• Commissioning
• Performance Management
• Planning and Implementation
Commissioning
Performance Management
Provision
Planning and Implementation
Services provided by the Hospital Trust
Services provided by the PCT
Service provided by voluntary, social services and other services
Sub groups for NSF and new service model planning and implementation
In the community
In the hospital

Sub groups

- **Patient experience** (largely service users with a few professionals, to cover patient education, information and empowerment)
- **Diabetes specialty group** (inpatient and emergency care, plus laboratory services)
- **Children and young people**
- **Pregnancy**
- **Foot care**
- **Eye care**
- **Information management** (audit and integrated clinical information system)
- **Workforce** (includes training, education, professional education, workforce planning, appraisal and staff development, etc)

Task groups
(time limited - undertaking a specific task)

- **Adult integrated care** (to cover the development of the local diabetes model including social care)
- **Housebound group**
- **Minority ethnic group**
- **Transfer group**
- **Identification group**
- **Nutrition group**

Link groups (broader remits, but with links to diabetes)

- **Primary prevention** (also to cover CHD, stroke, etc)
- **Chronic disease management group** (largely primary care with links to social services and specialist care)
- **CHD LIT** and associated sub groups
- **Greater Manchester Renal Services Network - Bolton Clinical Management Team**
- **Clinical care group** (for the LIT and subgroups to link to around development of specific protocols/guidelines)
- **Workforce Development Group**

Chapter	Sub Group	Link group	Task group
1. Prevention of type 2 diabetes		Primary prevention	
2. Identification of people with diabetes			Identification
3. Empowering people with diabetes	Patient experience		
4. Clinical care of adults with diabetes		Chronic disease management	Adult integrated care
			Housebound
5 & 6. Clinical care of children and young people with diabetes	Children and young people		
7. Management of diabetes emergencies	Diabetes specialty		
8. Care of people with diabetes during admission to hospital			
9. Diabetes and pregnancy	Pregnancy		
10, 11 & 12. Detection and management of long-term complications	Foot care	CHD LIT and associated sub groups	
	Eye care	Renal	
All chapters	Information management	Clinical care	Minority ethnic
	Workforce		Transfer
			Nutrition

What does this mean for Staff?

PRIMARY CARE STAFF

- Clear remit and managerial support to deliver level of care
- More access, support and education from specialists, to agreed level
- In practice time for education
- More care delivered in primary care

SPECIALIST STAFF

- Clear remit and managerial support
- Time spent in primary care
- Devolving appropriate care to primary care
- More time on education and support and advice for primary care
- More time for intensified care for appropriate patients, Complex needs, Transition.

ALL - Involvement planning integrated care

Closer Working relationship

Specialist staff

Physicians:

- Clear managerial, clinical leadership roles across network
- Job plans: Sessions Primary care education, outpatients, inpatients, general medicine, management.

Specialist Nurses

- Clear roles in relation to other nursing staff across network
- Job plans: Sessions Primary care education, outpatients, inpatients, service development, emergency advice.

Job planning
in line with network objectives
e.g. Sp nurses

Minimum

- 1 primary care session per week
- 1 inpatient session per week
- 2 nurse led clinics per week
- 1-2 speciality clinics per week
- 1 emergency advice session per week
- 1 MDT/ admin session per week
- On call

Job planning
in line with network objectives
e.g. Cons Physicians

3 WTE includes: (34 sessions)

3 sessions for Acute Medicine/on call

1.5 sessions General medical/endocrine outpatients

4 sessions inpatient care

2 sessions primary care

2 sessions network clinical lead

5 sessions general specialist diabetes

3 sessions specialist diabetes clinics

1.5 sessions Research

1 session MDT

Admin/CME/CPD/Audit

Service Level Agreements ensuring integration

PCT provides to Hospital

- Consultant Physician sessions
- Specialist Nursing sessions
- Special dietician/ podiatry sessions
- Access of other specialist services to diabetes specialist team

Hospital Trust provides

- Consultant Physician time
- Telephone/ Computer network
- Appointments system
- Access to hospital records
- Consultant accommodation
- Consultant hospital based secretaries
- Laboratory services
- Estates services

What does this mean for Patients?

- Complete care by adequately trained professionals
- Local care
- Consistent care
- Access to specialist advice
- Seen in most appropriate care setting
- Involvement in planning and monitoring integrated care

Bolton Diabetes Services Evolution.

1992 Multiagency planning group established (LDSAG)
Plans for “town centre” Diabetes Centre for specialist care
Primary Care Education days commenced
1994 Consultant Physician and lead Nurse appointed
Care agreements established with each general practice
1995 Bolton Diabetes Centre opened
1995 -2002 Specialist Clinics developed
2nd Physician appointed
Extension of primary care professional education
Expansion of nursing team through “opportunities”
2001 External Diabetes Services review
2002 Plans for Bolton Diabetes Network and greater integration of care
June 2002 Plans/model for integration agreed at Stakeholder event
Oct 2002 Diabetes Network agreed by PCT and Hospital Trust Boards

Bolton Diabetes Services Evolution

Nov 2002 Network leads appointed

January 2003 Transfer of Bolton Diabetes Centre and Specialist Team to PCT agreed

March 2003 Network LIT first meeting

January 2003- March 2004 Job plans modified to ensure integration of specialist team

SLAs agreed between PCT and Hospital Trust to ensure integration

Additional Consultant Physician appointment to PCT agreed to enable integrated care and clinical management/leadreship

April 2004 **Diabetes Specialist Service transferred to PCT**

May 2004 New consultant appointed

April – November 2004 Primary care education/facilitaion commences

Levels of care agreed with practices

Practice self appraisal with Diabetes e commences

NSF Delivery Strategy

- Build care around the person with diabetes, seeing services from their perspective and enabling staff to work across organisational boundaries to deliver the highest quality care.

- Ensure services for diabetes do not stand in isolation (primary care)

Bolton Hospitals NHS
NHS Trust

B·O·L·T·O·N
M·E·T·R·O

Bolton NHS
Primary Care Trust

Bolton Diabetes Network

Early Successes

- Managed Network established with user involvement
- Model of care for day to day care agreed
- Integration of specialist team
- Agreed local targets and milestones
- Identification protocol
- Agreed Priorities

Enablers and Obstacles

Enablers:

- Defined Community / Network
- Clear Structure of Diabetes Care Delivery
- Defined roles and responsibilities
- Service objectives
- Stakeholder involvement
- Job planning / appraisal
- Service Level Agreements
- Colleagues / Team working
- Geography
- Flexibility?
- **NSF?**

Obstacles:

- Organisational boundaries
- Competing priorities
- No vision
- Inflexibility
- History
- Unclear roles
- Poor understanding by others of role
- No risk taking

Bolton Hospitals NHS
NHS Trust

Bolton NHS
Primary Care Trust

Bolton Diabetes Network

Integrating primary and specialist diabetes care

Improving care through partnership and planning