'Just do it, 'cos I've got your back!' Diabetes care: the West Cheshire Way

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On behalf of people with diabetes in West Cheshire and all those involved in their care

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This paper is dedicated to the memory of the late Dr Niru Goenka, and was presented as the Niru Goenka lecture at the Autumn 2013 Meeting of the Association of British Clinical Diabetologists held at the Royal College of Physicians in London

Abstract
As the incidence of diabetes reaches epidemic proportions and the NHS is faced with increasingly limited resources, innovation, adaptation and change are essential for the maintenance of excellent care. The energy and strengths of all health and allied health care professionals as well as carers involved in looking after people with diabetes must be harnessed in ways that are optimal for any given population and locality. We believe that the future lies in integrated care – care that is guided by and based upon the needs and preferences of people with diabetes, commissioned by clinical commissioning groups and delivered by specialists, and primary care, community and ambulance services working collaboratively, with a strong focus on research and development. Integrated care must be multi-faceted to encompass the complex needs of people with diabetes in this day and age, and must be based on strong relationships with teams that transcend institutional barriers and on communication that is open, honest and in real time.

There are great examples of innovative care around the country, and the West Cheshire Way of delivering diabetes care described in this article is just one such example, that has worked for us as a community. The imperative, however, is that we continue to share ideas, experiences and good practice to keep improving and enhancing care for people with diabetes.

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Key words
diabetes; integrated care; local enhanced services

The prologue
I became a consultant in August 2009 alongside my colleague and 'partner in crime', Niru Goenka, a man of many talents. He was an excellent physician, a people person, an inspirational teacher, a tireless champion for people with diabetes, and visionary. We realised quickly that the established way of delivering diabetes care was just not delivering! With the increasing numbers of people with diabetes, it was unsustainable to have long-term follow ups in secondary care. The traditional format of an annual review did not allow timely input nor the intensity of intervention required to treat, optimally, those who needed specialist care. There were inefficiencies in the system and significant duplication of interventions; all on a backdrop of an ageing population and patients preferring care closer to home.

Our journey thus began in 2010 when the imperative for change put us on a course to restructuring and revolutionising the way we delivered care for people with diabetes in West Cheshire. From the time we were registrars together, we were dreamers. Niru always joked about the vision: 'today, Chester; tomorrow, the world'. This might come across as unbridled ambition but, coming from Niru, it reflected a much more humble ethos. If it worked for us locally, we would share our experience to spread good practice that could be replicated to benefit people with diabetes elsewhere.

The foundations
There began the laying down of the foundations for what would become the West Cheshire Way for diabetes care. Foundations that were built on the strength of relationships with specialist colleagues, primary care colleagues, hospital management, primary care management, community services, the ambulance service, allied health care professionals and, most importantly, our patients and carers. Foundations that were built on trust, commonality of purpose, shared responsibility and shared success and the very simple motto we lived by: *'Just do it, 'cos I've got your back!'*

We had a population of over 12 500 people with diabetes to care for and, at a time when the NHS was facing some of the greatest challenges it had ever seen, we were

determined to harness the resources of the Countess of Chester Hospital, the West Cheshire Clinical Commissioning Group (CCG), our 37 GP practices, our community provider, Cheshire and Wirral Partnership, the North West Ambulance Service, hospital at home (a local private provider), the Diabetes UK patient group, and partners in the pharmaceutical industry. With a team that crossed institutional barriers, where we all had each other's backs (a phrase we used a lot), we started to build what we saw as our vision of integrated diabetes care, the West Cheshire Way.

The edifice

Components of the West Cheshire Way for diabetes care

True integration of care must encompass all stakeholders and providers – with the patients, their needs and preferences being the focus of services being redesigned. True integration requires simultaneous change in numerous aspects of care with a strategy that looks at the wider picture. Thus, to create the West Cheshire Way for diabetes care a number of different components were developed.

Agreed redistribution of clinical responsibility and clinic restructuring. The first step was to empower our colleagues in primary care to look after the rising number of people with type 2 diabetes and the increasing complexity of their condition and therapeutic options. This was achieved with training, updates and clinical advisory support from the specialist team. Established, hospital-based annual review clinics were disbanded, with a phased handover of all type 2 diabetes patients who had optimal control to their primary care physicians; for those whose control was not optimal, individualised, detailed treatment plans for further optimisation were communicated to their respective primary care practitioners.

Simultaneously, specific hospital-based specialist clinics were developed to cater for the needs of complex patients and those requiring multi-specialty input. These included pregnancy, type 1, renal, foot, young persons and insulin pump clinics, with one new patient clinic per week; a structure similar to that of those who have had similar reconfigurations and have described them variously – such as the 'Super Six' model.[1,2]

- Annual care planning with documented goals and action plans
- Personalised advice on nutrition and physical activity
- Offer of initial and updated structured educational input
- Insulin passports to be issued to all patients on insulin
- Agreed HbA1c targets
- Medication reviews
- Dose titration of insulin if required, with explanation and support from health care professionals. There should be no upper limit, and levels need to be increased as required. Practices should be able to give all insulin advice to patients
- Women of childbearing age should have preconception and contraception advice

Box 1. Level 1 of the local enhanced service included 8 additional quality standards over and above the 9 key care processes that were already part of the Quality and Outcomes Framework

Development and implementation of a diabetes local enhanced service (LES). The shift of resources to manage long-term conditions is moving increasingly into the community and is taking on various forms. The model that best harnessed our strength as a health economy was one which financially supported primary care to take on this added responsibility of devolved care; to ensure delivery of care was to a high standard, two levels of LES were instituted.[3]

Level 1 included providing eight additional quality standards over and above the nine key care processes that were already part of the Quality and Outcomes Framework. These quality standards were agreed in conjunction with primary care colleagues and were based on the NICE quality standards[4] as well as local priorities; all 37 GP practices signed up to delivering these. The eight standards are summarised in Box 1.

Level 2 of the LES included all Level 1 standards and the practices also took on the responsibility of initiating GLP-1 and basal insulin in practice (16 out of 37 practices signed up on the first wave and a further seven in the second wave). It was a pre-requisite that a GP and practice nurse were identified as leads from each practice, working towards a diabetes accreditation and representing the practice at the various meetings and educational events.

Training for implementation of the LES as well as ongoing clinical advisory support were provided by the specialist team. The training included theory and practical implementation around the various quality standards as well as theory and hands-on sessions on initiating injectable therapy tailored around local prescribing practices and guidelines.

Follow-up implementation of in-practice injectable-therapy initiations was set up after the training sessions to reinforce learning. Appropriate patients requiring treatment escalation were identified using patient identification software. Injectable-therapy initiation clinics were then set up during which the practice nurses performed the initiation with the supervision and support of diabetes specialist nurses.

LES meetings are organised quarterly. These are facilitated by the CCG, chaired jointly by the GP lead for diabetes and the specialist lead for integrated diabetes, and attended by GP leads and practice nurses as part of their commitment to the LES. These meetings are a forum to update practitioners on the progress of implementation of the LES, discuss issues surrounding implementation, gather intelligence and feedback, and provide ongoing education and clinical updates.

Structured education: Diabetes Essentials. The role of structured education in diabetes is invaluable,[5] and yet we struggle to deliver structured education consistently and to the majority of our patients. The uptake for already existing commercial structured education programmes had been poor locally. Given that a key quality standard of the Level 1 LES was the offer of initial and updated structured education, the CCG commissioned Diabetes Essentials, a novel modular structured education programme that was tailored to the individual's needs. This was developed by the specialist

team in consultation with primary care and patient representatives. It has been successfully delivered to in excess of 800 people with diabetes a year as well as their carers for the last three years, and the programme has had excellent feedback. The sessions are delivered in convenient community settings such as sports clubs, libraries and even the masonic lodge, with in-depth planning of bus route accessibility and parking to ensure patients find it easy to attend. The sessions are held at various convenient times, including after hours to ensure all patients can attend without too much disruption to their lives.

Working in partnership with the North West Ambulance Service. Historically, an electronic system of alerting the specialist team had been in place, with the hospital patient administration system generating a referral whenever a person attended the emergency department and was coded as having had a hypoglycaemic event.[6] The part of the loop that was not closed was the identification of those patients who had a hypoglycaemic event requiring third-party assistance that was dealt with and corrected by the ambulance service and did not need to attend the emergency department. To overcome this, there is now a system in place such that the specialist team receives daily email notification of any patients who have required paramedic assistance for hypoglycaemia via the Electronic Referral and Information Sharing System used by North West Ambulance Service, if the patient gives consent. These patients are then urgently followed up by the specialist team, by phone or in person, the next day to ensure appropriate change to therapy in order to avoid further hypoglycaemia, and their GP is made aware via written communication.

Working with hospital at home services. A hospital at home service is commissioned locally by the CCG, and the specialist team works closely with them to facilitate the use of intravenous antibiotics for patients from the foot clinic, thus avoiding hospitalisation. The collaboration also facilitates rapid discharge of patients with gastroparesis who are admitted with exacerbations, allowing parenteral analgesia and anti-emetics in the community thus decreasing inpatient stay. Novel ways of community-based care are an integral part of the future development of acute services as laid out in the Future Hospital Commission report,[7] and our experience supports such strategies in people with diabetes-related complications. The feedback from patients themselves on being able to access such treatments at home has been extremely positive.

Working in partnership with the local community services and district nurses. With the increasing complexity of care for patients with diabetes and their increasing age and frailty, the need for a higher level of community and district nursing expertise has become paramount, especially for the care of housebound people with diabetes. We have been working with the district nurses to provide consistent quality care to housebound patients with diabetes. This is being started as a pilot programme, with a comprehensive review of housebound people with diabetes, followed by district nurse-led intervention. Members of the district nurse team have been up-skilled with training provided by the specialist team and have also embarked on a more formal diabetes accreditation. There has been increased collaboration between the district nursing teams and the specialist team, with better communication and the provision of real-time clinical advice and support as required for complex patients.

Development of clinical trials and research. Working in partnership with the comprehensive local research network, primary care research network and GPs, using practices as participant identification centres (PIC) sites, the Countess of Chester has established itself as a clinical trials and research centre. This has allowed West Cheshire patients to participate in research and avail the latest, cutting edge therapies and the additional input that involvement in clinical trials provides. It has also provided additional income streams to primary care and has afforded the specialist team with the opportunity to invest in additional services and provide care using non-traditional NHS resources.

Joint community and hospital diabetes formulary. In recent times, a vast array of new pharmacological therapies for diabetes has been rapidly introduced into clinical practice. This has made it difficult for the processes of formulary groups to keep pace. To try and ensure timely discussions and implementation of new therapies impacting on use in primary care as well as in specialist settings, the specialist team, along with the GP lead and community pharmacy lead, meet to agree and feed into the area prescribing committee to ensure joint decision making in approving and utilising therapies relevant to the model of integrated care in West Cheshire.

In addition to this, there are pressures on medicines management to meet the requirements of various quality agendas. There have been opportunities for primary care and specialist teams to work collaboratively with medicines management to achieve some of these goals to benefit the health economy as a whole, the use of human insulin in appropriate patients being one such area.[8]

An active and strong diabetes network. The direction of travel of diabetes care must be dictated first and foremost by people with diabetes and the role of all health care professionals must be to facilitate this. Although the diabetes network is chaired by the specialist care lead and co-chaired by the GP lead, it has active participation from all stakeholders, specialist nurses, dietitians, pharmacists, community nurses, podiatrists, optometrists, hospital management, CCG management, Diabetes UK and, most importantly, active patient representatives. The engagement and debate at the network meetings underpin the robustness of our processes and ensure that the implementation of changes are in keeping with the decisions of the network as a whole.

The direction of travel

While the transformation so far has allowed significant improvements in providing diabetes care through integration and joint working, there still remain challenges and opportunities to go even further.

Information sharing portal. Real-time access to real-time care information is key and the information technology (IT) systems to facilitate its exchange are a vital component of the future vision. The lack of integrated records is a significant barrier to patient care that involves different institutions, and information sharing, using a portal or platform that pulls together all diabetes-related electronic processes and information from primary and secondary care, is currently being developed. This will improve patient care and also avoid duplication of investigations and processes.

Making care more convenient and taking care out where it is convenient. IT solutions to provide remote consultations are increasingly showing benefit as tools for the management of some patients, especially those young patients who prefer to use such modes of consultation as an alternative to traditional face-to-face consultations.[9] We are currently exploring the use of such consultations for our young people with diabetes.

We are also currently exploring the possibilities of using venues in the community that our patients would frequent for their activities of day-to-day life, e.g. the post office on a Thursday morning for pensioners or the use of a supermarket pharmacy consultation room out-of-hours in order to combine the weekly shop with their diabetes appointment. The concept of providing care closer to home is welcomed by patients and, if there is not a need for multi-specialty care, attempts should be made to try and engage patients in venues other than the hospital. However, it must be recognised that the hospital is a central component of the community and not separate from it.

Specialist in-reach and out-reach. Many hospitals are moving to a model of specialist in-reach to acute medical units for people admitted with diabetic complications requiring hospitalisation. Adopting this model has allowed us to decrease our general medical inpatient bed base and direct our attentions to the right patient at the right time. We also envisage that just as we in-reach, we need to outreach into primary care to provide either virtual or in-practice sessions to facilitate case-based discussions, education and some face-to-face contact with patients identified using the primary care IT systems as needing additional input, e.g. the population manager function in EMIS Web.

- **People matter.** The people – health professionals, carers and people with diabetes – are what define the West Cheshire Way. It is through active consultation and the involvement of all that we draw upon the strengths of people which then defines success
- **Quality matters.** Putting quality as the driver for change, drives change for the right reasons and achieves success
- **Talk more.** Conversations, formal and informal at any opportunity – be it formal or informal – that we can find are what cement relationships and build foundations
- **Talk less money.** If people and quality are at the forefront of change the money will look after itself, especially when times are tough as they are now in the NHS. Always ask: what is the right thing to do? More often than not, the finance facilitates
- **Share.** Share responsibility, share risk, share the burden and eventually you will share the success
- **Look after the next generation.** It is imperative that, at this time of great change in the NHS, we take with us on our journey of change the next generation of trainees in all fields. We must use the experiences of these new ways of working to prepare them for what the future holds and empower them to continue to provide integrated care[10]
- **Don't reinvent the wheel.** While we take credit for the implementation of the West Cheshire Way we must acknowledge that talented, forward thinking people across the country are doing or have done a number of the things we have done and more. We thank them for sharing their ideas and inspiration. For those who are still on their journey, at whatever stage that may be, don't reinvent the wheel: just ask!

Box 2. People and principles: lessons learnt along the way

Modification of LES standards. As with all things, we move upward and onward. We envisage that the LES standards will evolve from service standards to outcomes over the next few years, and will become more refined and discerning. This is essential to ensure that processes translate into outcomes that can be measured.

People and principles

Niru was always sceptical of the 'touchy-feely leadership and reflection stuff'. Not to sound too philosophical, but there are a number of lessons that we learnt along the way (see Box 2). While some of them may seem clichés, there is, as we have learnt first-hand, a great deal of truth in them.

The epilogue

We have had successes, we have had hiccups; but no obstacle was ever too big to overcome as long as we focused on our patients and their care as our goal. Along the way we lost friends and life threw our way obstacles that we never really envisaged, but we persevered to bring to fruition the vision and the dream.

We feel that the West Cheshire Way has encompassed the true meaning of integration, involving and engaging everyone who is involved in the care of people with diabetes in West Cheshire. It uses multiple strategies to provide holistic, multi-faceted care. To make care truly integrated, teams must strive to bring together as many components of care that people with diabetes may require.

We have already started to see the benefits in the form of patient satisfaction. The National Diabetes Audit reports for 2011–12[11] have shown achievement of care processes, treatment targets and outcomes in West Cheshire to be better than the England and Wales average. We hope to show, in the next few years, increasingly improved outcomes from these new ways of working and these joint efforts in improving care for people with diabetes.

Most importantly, we hope that we lived up to Niru's expectations, and continue to dedicate our efforts to an irreplaceable friend and colleague who we all miss dearly.

Declaration of interests

There are no conflicts of interest declared.

References

References are available in *Practical Diabetes* online at www.practicaldiabetes.com.

References

1. Kar P. The 'super six' for the acute trust; all else under primary care? *Pract Diabetes* 2011;28:308–9.
2. Findley H, *et al.* Which patients with type 2 diabetes attend secondary care clinics? *Pract Diabetes* 2013;30:190–3.
3. www.nhsemployers.org/…/Pages/EnhancedServices.aspx [accessed 2 April 2014].
4. http://guidance.nice.org.uk/QS6 [accessed 2 April 2014].
5. www.nice.org.uk/guidance/qualitystandards/diabetesinadults/structurededucation.jsp.
6. Perkins K, *et al.* Impact of a DISN on hypoglycaemia-related hospital admissions. *J Diabetes Nurs* 2010;14:271–7.
7. www.rcplondon.ac.uk/sites/default/files/future-hospital-commission-report.pdf.
8. Holden SE, *et al.* Evaluation of the incremental cost to the National Health Service of prescribing analogue insulin. *BMJ Open* 2011;1:e000258. doi:10.1136/bmjopen-2011-000258.
9. www.health.org.uk/news-and-events/newsletter/trialling-web-based-diabetes-consultations/.
10. www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf.
11. www.hqip.org.uk/assets/NCAPOP-Library/NCAPOP-2013-14/NDA2011-2012Report2ComplicationsMortalityINTERACTIVEPDF26-11-13.pdf.