What would a "gold standard" diabetes service look like?

Roger Gadsby

In an ideal world, the best features of each diabetes service could be combined to give a view of what a "gold standard" diabetes service for a PCT might look like. This article seeks to describe such a service. It has been developed by an ad-hoc group of healthcare professionals from the West Midlands who have a special interest in diabetes. The group has met quarterly for several years to share ideas and good practice and to support each other. The theme of the ideal service has occupied the group's thinking on a number of occasions, and a draft of the opinion of the group on the ideal diabetes service was written down and circulated for comment.

There have been a number of policy initiatives that have been introduced in England in the past few years that have impacted on diabetes service provision.

First, the Government is encouraging more care for long-term conditions to be delivered in primary care, nearer to the individual's home by the local primary care team, and to reduce the use of expensive hospital-based services. These health policy changes have been outlined in the Government White Paper "*Our Health, Our Care, Our Say: A New Direction for Community Services*" (Department of Health [DH], 2006a). In 2006, for example, the aim was for an extra one million outpatient appointments to take place in primary care rather than in hospital.

Second, the Quality and Outcomes Framework (QOF) of the GP contract begun in 2004 has given financial encouragement for the provision of good-quality clinical care. The clinical indicators for diabetes have encouraged the recording of processes and intermediate outcome measures in diabetes and the achievement of these has increased year on year (NHS Information Centre, 2009).

Third, the introduction of practice-based commissioning (PBC) has provided the opportunity for the development of innovative services to deliver diabetes care. A toolkit for PBC in diabetes has been produced to help commissioners in this process (DH, 2006b). The impact of PBC on the development of diabetes services seems to vary in different parts of the UK. In some areas it has proved to be a tool for change in diabetes care delivery, in other PCTs it appears that PBC has hardly taken off at all.

Fourth, some areas have introduced local enhanced service payments for diabetes, which

Article points

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2. The group of healthcare professionals with an interest in diabetes felt that a gold standard diabetes service for a PCT would have three well developed elements of primary, intermediate and secondary care, with excellent cooperation and working arrangements between them.
3. Each element will take on the work that is appropriate for their expertise and together they can deliver high-quality, cost-effective care across a whole PCT.

Key words
- GPSI in diabetes
- Intermediate care
- Cost effective
- Gold standard

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1. Significant changes in the delivery of diabetes care have encouraged the development of innovative new posts. One new development is that a full-time GP may take up to 1 day a week to work as a GP with a special interest (GPSI) in a specific clinical field.
2. GPSIs in diabetes can fulfill a purely management function, for example overseeing a diabetes network, or a clinical function such as running diabetes clinics in the community for people with diabetes whose problems have not been successfully managed in their general practice.
3. The group felt that primary care should provide high-quality diabetes care, and as a demonstration of this, would obtain maximal or near-maximal QOF points for diabetes.
4. The group felt that it was key to have high-quality supportive secondary diabetes care for each PCT.

have enabled PCTs to incentivise participating GP practices to deliver high-quality diabetes care, beyond that measured in QOF. Practices are then audited to ensure that the contracted standards are being delivered.

These significant changes in the delivery of care in a relatively short period of time have encouraged the development of innovative new posts. One new development is that a full-time GP may take up to 1 day a week to work as a GP with a special interest (GPSI) in a specific clinical field. Framework documents for the work of GPSIs have been published (DH, 2007). GPSIs in diabetes can fulfill a purely management function, for example overseeing a diabetes network, or a clinical function such as running diabetes clinics in the community for people with diabetes whose problems have not been successfully managed in their general practice.

The GPSI role has been a factor in the development of intermediate care services in some PCTs. In others, medical support for intermediate care has been provided by community consultant diabetologists or secondary care diabetologists.

These policy initiatives have been implemented in different PCTs in different ways. As a result, there are quite a variety of new diabetes service provision initiatives across the country, some of which have worked well, others of which have been less successful.

The gold standard diabetes service

The group of healthcare professionals (named at the end of the article) felt that the gold standard diabetes service for a PCT would have three well developed elements of primary, intermediate and secondary care with excellent cooperation and working arrangements between them.

Primary diabetes care

The group felt that primary care should provide high-quality diabetes care, and as a demonstration of this, would obtain maximal or near-maximal QOF points for diabetes. As a result of providing high-quality care, primary care would exclusively look after around 75% of people with diabetes registered in practices. Excellent diabetes care would be delivered in the practice by nurses who had successfully completed post-registration training in primary diabetes care and would be managed by one or a number of GPs with training and expertise in diabetes management.

As well as delivering high-quality diabetes care, as defined by high scores for the QOF clinical indicators, practices would also provide the initial management and prescribing of oral phosphodiesterase type–5 inhibitors for the treatment of erectile dysfunction in people with diabetes. Practices would also carry out the initial diagnosis, assessment and management of painful diabetic neuropathy and would prescribe appropriate analgesia and amitriptyline as indicated. Referral to appropriate specialist care would be indicated if further assessment and management of both erectile dysfunction and painful diabetic neuropathy were needed.

Secondary diabetes care

The group felt that it was key to have high-quality supportive secondary diabetes care for each PCT. At this level, care would be provided for children with diabetes, women with diabetes who are pregnant or contemplating pregnancy, and for people requiring admission for acute conditions. Secondary care could also provide expertise, support, advice and education for the whole diabetes service.

There would be an insulin pump service provided by secondary care to initiate insulin pump therapy in those who fulfill the NICE guideline recommendations for it (NICE, 2008). People already using insulin pumps would usually receive most of their care at this level.

A multidisciplinary team to manage diabetic foot ulcers is best located at this level, providing a rapid assessment and admission service for people newly presenting with a foot ulcer or cellulitis or both, following NICE diabetes foot care guidelines (NICE, 2004)

The group felt that nephrology assessment and management services for people with stage 4 and 5 chronic kidney disease (CKD) and a dialysis service need to be provided at a secondary care level. Retinopathy treatment

services for people with diabetes will also need to be provided at a secondary care level. It was recognised that some of these services may not be found at every district general hospital, but that some would be located at sub-regional "tertiary care centres". The importance of good transport links to such centres is then of paramount importance.

The group felt that around 10% of people registered with diabetes in the PCT would receive most of their care from secondary or tertiary care.

Intermediate specialist diabetes care

The group felt that an intermediate care service was important. It could provide specialist care in the community, nearer people with diabetes, for those who might have been referred to secondary care because the expertise was not available in their practice. Typical situations might include:

- Consideration of further glucose-lowering therapy when the person is not well controlled on two or three oral agents.
- Consideration of further blood pressure lowering therapy when the person is not well controlled on two or three blood pressure lowering agents.
- Consideration of further lipid-lowering therapy when the person is not well controlled on the maximum tolerated dose of statin.

An intermediate care service could run an insulin initiation clinic for those practices not undertaking this procedure themselves. It could also provide support for people who need alteration or intensification of their insulin regimen as well as specialist weight management clinics for morbidly obese people who might benefit from referral for bariatric surgery.

Psychological support services for people suffering from anxiety and depression complicating diabetes should be provided at this level.

Group education programmes for newly diagnosed people with type 2 diabetes

The group felt that these are best provided in the community and could be taught and administered by the intermediate specialist diabetes team. Ongoing education could also be provided in a similar way.

Group education for people with type 1 diabetes

The group felt that Dose Adjustment for Normal Eating (DAFNE) courses need to be provided. These could be made available either in secondary or intermediate care.

Staff in intermediate diabetes clinics

The group felt that the main healthcare resources would be either a consultant community diabetologist or a GPSI plus an experienced diabetes specialist nurse (DSN). Input will also be required from a diabetes dietitian and a podiatrist with special interest in diabetes.

Practice nurses from the PCT area could have an "educational attachment" and visit the clinic as part of their continuing professional development.

Practicalities of intermediate diabetes clinics

The group saw the intermediate specialist diabetes clinic as a "short episode clinic", seeing people for a maximum of around three visits before discharging back to primary care.

It was felt that 30-minute appointments should be given for the first visit, and 10-minute appointments for follow-up. It should be possible to see around 12 patients in a 3-hour clinic.

People with diabetes could see either a doctor or DSN, or both if this was felt necessary. Satellite clinics for group insulin starts would be run by the DSN and for weight management by the dietitian.

Note recording would be electronic, and written at the time of the consultation. Ideally this information would be electronically transferred to the GP record, but if this is not possible, a paper copy should be sent on the day of the clinic. The person with diabetes should also be given a copy of the note.

Ideally, the intermediate clinic should have access to the GP and hospital records as well as pathology laboratory records for test results.

The clinic should have the facility to prescribe when necessary.

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1. The two main models of diabetic retinopathy screening service provision are either by a mobile digital retinal camera service visiting practices, or by using digital cameras based in optometry practices.
2. Results from retinal screening need to be fed back to practices and integrated with the practice clinical computing system.
3. A gold standard diabetes service will, in the group's view, be made up of high-quality primary, intermediate and secondary care services that all work together and support each other.

Diabetic retinopathy screening services

Services providing diabetic retinopathy screening are currently being provided in the community. The two main models of service provision are either by a mobile digital retinal camera service visiting practices, or by using digital cameras based in optometry practices. Schemes often cover more than one PCT, as the ideal number for a retinopathy screening service to cover is felt to be between 12 000 and 25 000 people with diabetes (UK National Screening Committee, 2007). Such services are commissioned by the PCT and are a key part of "gold standard" care.

Results from retinal screening need to be fed back to practices and integrated with the practice clinical computing system. Arrangements need to be made to ensure that all people with diabetes who are housebound or who are residents of care homes are able to be offered screening where appropriate. This may mean ensuring that suitable transport is available to transfer them to the screening location.

Conclusion

A gold standard diabetes service will, in the group's view, be made up of high-quality primary, intermediate and secondary care services that all work together and support each other. Each service will take on the work that is appropriate for it's expertise and together they can deliver high-quality, cost-effective care across a whole PCT. ■

Group members

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