Commissioning a diabetes service with a GP consortium

Su Down

In 2008, Somerset was faced with an estimated undiagnosed prevalence of diabetes of 21%. With a growing population, inconsistent service delivery models across the county and a high reliance on secondary care clinics to provide routine care, diabetes was identified for a service redesign. This new service model was commissioned by the PCT and GP consortium. The GP consortium was made up of all 75 practices within Somerset. The new service was launched in April 2010 and has just completed a successful, if not challenging, first year. This article outlines the process of redesigning the diabetes service and shares the positive outcomes and challenges at each stage.

Article points

1. In January 2008 a working party was set up to redesign diabetes services in Somerset.
2. The development of the model took from February 2008 to November 2008 and was the result of joint commissioning with the PCT and GP consortium.
3. Implementation, monitoring and evaluation of the new service started in April 2010.
4. The new service model has demonstrated a clear shift of the care of people with diabetes out of secondary care with care delivered closer to home in community clinics.

Key words
- Commissioning
- GP consortia
- Integrated care
- Redesigning services

Somerset is a large rural county with a total population of 535 000. In 2008, there were an estimated 19 200 people diagnosed with diabetes and this was predicted to grow to more than 28 000 by 2017. The cost of continuing to manage these individuals with the same system would have become more challenging at a time when resources would become increasingly scarce (Department of Health [DH], 2008a; 2008b). It became important to see what changes could be made to service delivery to ensure that the services provided were not only cost effective but also offered a more equitable level of care across the county (DH, 2006; 2008c).

Both the PCT and the GP consortium – Wyvern Health, which consisted of all 75 practices within the county – had identified diabetes as a service area that could potentially benefit from a service commissioning review.

A health needs analysis was undertaken in February 2008. At that time, diabetes services were delivered via GP practices, Somerset Community Health and three local acute trusts. The community service employed a nurse consultant for diabetes and a diabetes nurse facilitator. However, their services were not provided universally across the county. Specialist care was provided through multidisciplinary teams based at the NHS acute trusts with outreach services mainly at community hospitals. There was variation between trusts on what specialist services were provided and where.

The health needs analysis showed that, overall, Somerset has good health outcomes for people with diabetes, which were above the national average. Feedback indicated that they were generally happy with the services they received. There was evidence, however, to suggest that levels of undiagnosed diabetes varied considerably across the county. Thirty out of 75 practices were estimated to have more than 30% undiagnosed prevalence rates (compared with an overall county average of 21%). The data further suggested that levels of undiagnosed diabetes were higher in the more rural areas of the county and/or where there were larger numbers of older people.

PCT performance

Table 1 illustrates that Somerset drew heavily on secondary care services. If individuals were

Su Down is a Nurse Consultant for Diabetes and Clinical Lead for the Intermediate Diabetes Service in Somerset.

Table 1. PCT performance.

Description	PCT value	PCT ranking within SHA (highest ranked first)	PCT ranking within England (highest ranked first)	References
QOF indicator DM 20: The number of people with diabetes in whom the last HbA_{1c} level was ≤7.5% (≤58 mmol/mol)	12 477	4 of 14	29 of 151	NHS Information Centre (2011)
Hospital-finished consultant episodes for diabetes 2008/09	931	5 of 14	17 of 151	NHS Information Centre (2011)
Diabetes emergency admissions 2008/09	448	2 of 14	14 of 151	NHS Information Centre (2011)
Diabetes average length of stay 2008/09	4.2	6 of 14	65 of 151	NHS Information Centre (2011)
PCT budget 2009/10 (£000s)	751 518	4 of 14	29 of 151	Flory (2010)
PCT forecast outurn 2009/10 (£000s)	795 880	3 of 14	28 of 151	Flory (2010)
PCT closing distance from target 2010/11	–2.60%	11 of 14	108 of 151	Flory (2010)

identified earlier and treated more appropriately in primary care then outcomes could improve and the costs would therefore be reduced (DH, 2008a).

Service redesign

In January 2008, a working party was set up to redesign diabetes services. The working party was co-chaired by the PCT and the GP consortium. The core group consisted of representation from the acute trusts, the nurse consultant for diabetes, a GP with an interest in diabetes, a member of the primary care executive committee (PEC) and a member of the PCT finance team. Additional representation from public health, Diabetes UK, podiatry and dietetic staff were invited to attend as necessary.

Two stakeholder events were conducted during the development of the model of care and a public engagement process was undertaken during the final development stage. The overall aim of the model of care for adults with diabetes was to increase the capability and capacity of the healthcare system as a whole to meet the needs of growing numbers of people with diabetes, ensuring equity of access and the highest possible standards of care. The objectives of the model are summarised in *Box 1*.

Box 1. Objectives of the model of care for adults with diabetes.

- Improve the care and health outcomes of adults with diabetes in Somerset.
- Promote partnership working and a shared care approach between providers so individuals experience appropriate care, seamlessly, and in a timely manner.
- Provide accessible services as close as possible to people's home or work.
- Improve the knowledge and skills of healthcare professionals and patients to manage diabetes care, through education, training and practice support.

Where this model of care differs from others is that it is underpinned by education. The equivalent of 120 days of education was included in the service specification for the intermediate diabetes specialist nurse (DSN) team to provide education and support to both GP practice staff and community care staff.

The DSN team was commissioned to deliver 40 days of education to GP practices, 40 days to community healthcare professionals, including community hospital staff and community nurses, and 40 days to nursing and care home staff. In addition, the service specification included the delivery of the structured education programmes DESMOND (Diabetes Education for the Self Management of On-going and Newly Diagnosed), a structured education programme for people with type 2 diabetes, and DAFNE (Dose Adjustment For Normal Eating), a structured education programme for people with type 1 diabetes. A minimum of 96 DESMOND courses were to be provided annually in addition

to 15 DAFNE courses. By commissioning the intermediate DSN team to deliver both structured education programmes to people with diabetes and a package of healthcare professional education, it was envisaged that a robust diabetes legacy would be created. This legacy would empower people to take ownership of their diabetes and ensure primary and community care staff were appropriately up-skilled in diabetes to provide effective diabetes care.

New service model development

Development of the model took from February 2008 to November 2008 and was the result of joint commissioning with the PCT and GP consortium. There are a number of positives that resulted from this first phase of the process:

- Somerset was in the unique position where all 75 practices belonged to one consortium – Wyvern Health. This provided a faster sign-up.
- Engagement of people with diabetes and stakeholders was improved through workshops, engagement documents and focus groups. Good support was provided by the PCT, patient and public involvement and Diabetes UK.
- Learning from experience elsewhere.
- Involving the financial department in costing decisions from the outset.
- The public health involvement from the outset with a health needs analysis.
- PEC and PCT kept informed through regular reporting at board level.

The main challenge at this stage was to get diabetes-specific information that was comparable across organisations. This meant that it was difficult to understand the current services and activities across multiple providers and also the associated costs. The NHS Diabetes costing toolkit (NHS Diabetes, 2009) was used but the underlying hospital data were not robust and due to competing demands it was hard to get the PCT support departments to commit to project guidelines.

Service specification, procurement and mobilisation

The development of the service specification, procurement and mobilisation took place from December 2008 until March 2010. Again, a number of positives and a number of challenges came out of this second phase.

The positives included:

- The involvement of commissioners, clinicians and patients in the development of the service specification.
- The commissioning decision to implement the model of care via a strategic alliance of existing providers rather than go to competitive tender – the main aim being that care was integrated.
- The establishment of a pathway management group – comprising clinical leads from each service level and commissioners.
- The communication of Somerset diabetes service developments with sign-up from clinical leads of all contributing providers.

A key factor in the success of this service redesign was felt to be the decision of the PCT to move forward with a strategic alliance approach using current providers.

The main risk to the project at this point was that a potential conflict in commissioner and provider roles meant that if not handled carefully there was potential for a lack of engagement. It was difficult to manage both the competition and partnership models simultaneously. This was evidenced when trying to agree activity targets and resourcing with providers when shifting staff and resources from hospitals to the new intermediate level 2 service; not only was it very protracted because of the impact on the financial health of individual organisations, but also the pressure on maintaining partnership working. The partnership was maintained via the clinical leads in the pathway management group. The lengthy contract negotiations also impacted on releasing funding, which meant that Somerset Community Health could not commence with the new service implementation as soon as they would have liked.

The service specification and a full description of the model of care may be accessed from the WyvernHealth.com Somerset practice-based commissioning consortium – website at http://www.wyvernhealth.com/pathways.htm.

Page points

1. Development of the model took from February 2008 to November 2008 and was the result of joint commissioning with the PCT and GP consortium.
2. A key factor in the success of this service redesign was felt to be the decision of the PCT to move forward with a strategic alliance approach using current providers.
3. The main risk to the project at this point was that a potential conflict in commissioner and provider roles meant that if not handled carefully there was potential for a lack of engagement.

"Increased knowledge and skills in the community and practice setting has been achieved with the delivery of a range of education days and mentorship to healthcare providers."

New service implementation

Implementation, monitoring and evaluation of the new service started in April 2010. To date the positives have included:

- The launch of the Somerset Diabetes Service which had sign-up from the clinical leads across all levels of the service.
- GP referral route to level 2 services is via Choose and Book, including to the structured education programme DESMOND. (This is the only service in the country to use Choose and Book for structured education.)
- Establishment of patient and carer network – the first newsletter was published in September 2010.
- The training and development programmes for healthcare professionals commenced in September 2010.

There were a number of lessons learnt through this process. The IT infrastructure made it difficult to set up the correct data collection system, and coding issues also meant it was hard to produce ongoing activity reports. Variations in knowledge and skills of the new intermediate DSN team meant that the service needed to be phased to ensure success. However, there was immediate pressure for this new service to perform to capacity from the outset.

Service review

Results at the completion of the first year service review suggest that this model is a success.

A focus on opportunistic case finding across the county has seen an increase in diagnosed prevalence of type 2 diabetes. Current numbers are in excess of 25 000 people.

A clear shift in patients from secondary care to the intermediate service has been demonstrated with a reduction in the number of new outpatient appointments attended. This shift has been greater from one acute trust, which as a result has been able to set up more specialist clinics and increase service provision for inpatient care.

The intermediate team consists of 6.8 whole time equivalent (WTE) DSNs with two WTE specialist diabetes dietitians. Clinical leadership is provided by the nurse consultant who is also a member of the pathways management group, which meets monthly. The majority of DSNs are non-medical prescribers and are trained to deliver both DESMOND and DAFNE. The employment and training of this team, while also delivering the service specification, has been a great challenge in the first year of the service.

The delivery and uptake of the professional education packages has been positive. A total of 90 days of education was achieved in the first year with plans to increase this to 120 days in year two.

In the first year there were 2754 face-to-face clinic contacts with the DSN and specialist dietetic team. This comprises 1082 first appointments and 1672 follow-up appointments.

In total, 717 people attended a DESMOND course against a target of 960. However, as only 817 people were referred to DESMOND in year one this was an unachievable target. This represents 36% of newly diagnosed people.

Conclusion

The new model of care for diabetes in Somerset has completed the first year of a 3-year commission. The model of care is unique in both the amount of education commissioned for people with diabetes and healthcare professionals and in having the structured education programme DESMOND accessed via Choose and Book.

The new service model has demonstrated a clear shift of the care of people with diabetes out of secondary care with care delivered closer to home in community clinics. Increased knowledge and skills in the community and practice setting has been achieved with the delivery of a range of education days and mentorship to healthcare providers.

This new service will face continuing challenges over the next 2 years as the current commissioning alliance of the PCT and GP consortia are replaced by newly formed consortia and the emergence of nine GP federations. Somerset Community Health, who provides the intermediate service, is also merging with Somerset partnership and will then become an NHS foundation trust. ■

Department of Health (2006) *Our Care, Our Health, Our Say: A New Direction for Community Services.* DH, London

Department of Health (2008a) *Delivering Care Closer to Home: Meeting the Challenge.* DH, London

Department of Health (2008b) *NHS Next Stage Review: Leading Local Change.* DH, London

Department of Health (2008c) *High Quality Care for All: NHS Next Stage Review Final Report.* DH, London

Flory D (2010) *The Quarter. Quarter 2 2009/10.* NHS Leadership Team, London. Available at: http://bit.ly/prxusB (accessed 10.08.11)

NHS Diabetes (2009) *Commissioning Diabetes Without Walls.* NHS Diabetes. Available at: http://bit.ly/q48g7C (accessed 21.07.11)

NHS Information Centre (2011) *QOF 2009/10 results.* NHS Information Centre, London. Available at: http://bit.ly/peuc9k (accessed 10.08.11)