# Developing an integrated diabetes service: Lessons learnt from Worthing

Sara Da Costa

**A change in service organisation may be necessary if it brings improvement in patient care and earlier access to clinicians. The service change in Worthing involved review before investment and then ongoing review to ensure efficiency and effectiveness. This article discusses how a traditional, secondary care specialist diabetes service was changed into an integrated specialist diabetes service, working across both primary and secondary care. It highlights the central roles of diabetes specialist nurses, who provided the framework that enabled this change.**

Stakeholder engagement and support, agreement on shared vision, leadership, and additional funding was required to begin the redesign of the Worthing diabetes service, and to sustain and develop it. The service change involved three stages, which are described below.

Stage 1 began in 2002–03, when the specialist diabetes nursing service that is based in the diabetes centre in Worthing Hospital was struggling to cope with demand and was unable to increase diabetes specialist nurse (DSN) resources. The service was reviewed to identify gaps and duplications, and the need for additional funding was recognised. This was achieved from West Sussex PCT and, during 2004–05, three additional DSNs were employed to provide specialist care in primary care clinics.

Stage 2 was the implementation of this in primary care services across 32 practices, and integration and reorganisation of secondary care diabetes services. Cost savings under payment by results (PBR) tariff were reinvested into additional administrative and specialist nurse posts in 2010, and the service increased into nursing, rest and residential homes, the local hospice, and four additional general practices.

Stage 3 brings the service change to 2011, 2 years after two trusts were merged to form Western Sussex Hospitals NHS Trust, bringing the opportunity to work with specialist diabetes colleagues in primary and secondary care in Chichester, and build on their current services, and develop this model of integration across our combined healthcare system.

## Stage 1: In the beginning

The Worthing diabetes service, based in the acute hospital, serves a population of approximately 280 000, with a high proportion of people over the age of 75 years, and despite being a rural and urban mix, West Sussex has significant areas of deprivation (West Sussex County Council, 2006). In 1999, the first diabetes centre was opened in the hospital, and by 2002, housed two diabetologists, three DSNs, secretaries, a receptionist and the author

**Article points**

1. The service was reviewed to identify gaps and duplications, and the need for additional funding was recognised.
2. In 2010, two more diabetes specialist nurses (DSNs) were employed to resource four primary care clinics in an additional locality, set up education and clinical visits to the nursing, rest and residential homes, targeting those with high emergency admissions and/or those with adult protection issues.
3. In the first full year of this integrated service, by moving the DSN clinics out of the diabetes centre and into the practices, payment by results savings were £130 000.

**Key words**
- Diabetes specialist nurse
- Integrated service
- Stakeholders

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1. The specialist diabetes team has always worked collaboratively with the GPs and practice nurses, and fostered a team approach, recognising what each person contributes to care.
2. Concerns were initially discussed informally and then three team days were set aside to discuss what good diabetes care looked like, which then became the shared vision of diabetes care and services.
3. An educational grant was obtained and a diabetes specialist nurse clinic was piloted in a local general practice, evaluating the patient, practice and clinician experience and satisfaction. All were overwhelmingly positive – patients were confident in the practice staff, enjoyed the collaborative consultation as well as easier and earlier access to specialist services.

as nurse consultant. The specialist service provided outpatient and inpatient services, but despite trying to be more efficient (for example, changing individual appointments to group clinics), it was struggling to cope and meet trust targets as the waiting lists were increasing. This was causing both frustration and stress within the team, so potential solutions were explored.

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An educational grant was obtained and a DSN clinic was piloted in a local general practice, evaluating the patient, practice and clinician experience and satisfaction. All were overwhelmingly positive – patients were confident in the practice staff, enjoyed the collaborative consultation as well as easier and earlier access to specialist services. This was demonstrated by negligible "did not attend" rates, as it was much easier to park at the practice than drive 6 miles to the hospital. The practice nurse was key to the success of these clinics – she was essentially the gate-keeper of the new service. She implemented the referral criteria, so that only appropriate patients were invited, and the practice provided administration, rooms, and ensured that people with diabetes had 30-minute appointments.

Based on this pilot, with the estimated PBR savings from moving DSN one-to-one clinics into all practices, the West Sussex PCT agreed to fund three whole time equivalent primary care DSNs on substantive contracts. This enabled the launch of this new service to GPs and practice nurses in August 2005, and over 2 years all of the 32 practices signed up to this service and agreed to follow the mandatory requirements. These included the referral criteria, the need for protected space and time, the presence of the practice nurse to run the clinic (otherwise the clinic is cancelled) and the attendance of the practice nurse to the Royal College of Nursing diabetes course before the clinics can commence. This process ensured that diabetes knowledge was improved formally via the course, the skills were improved and applied by collaborative clinics with the practice nurse, and ongoing clinical supervision was provided. The intention was, and is, to leave a legacy of knowledge in the practice, which is why the DSNs do not do clinics on their own.

It was important that all stakeholders were informed and involved in this service change, so the author worked with managers within the acute trust, reassuring them that the service would remain for inpatients but its organisation would need to change to enable the achievement of trust targets for reducing avoidable admissions, length of stay and planning discharge. When the one-to-one DSN clinics were moved out into the practices, it released time that could be allocated to inpatient services as well as outpatient clinics. It was important to ensure that the latter was still being provided in terms of skill maintenance and PBR income generation.

Daily visits to the medical admissions unit (MAU) were piloted with positive outcomes for patients (reduced length of stay of 1.8 days) and staff (increased confidence in diabetes care). This success enabled the secondary care-funded DSN service to be moved into all the admission areas – accident and emergency, elderly, medical and surgical admissions units – as a daily priority. Ward visits are scheduled after these admission area visits. Patients are reviewed in accident and emergency and the DSNs can

often discharge them before admission, with a plan of care and follow-up in a practice DSN clinic. Or the DSNs can liaise with other agencies, such as community matrons, district nurses and GPs, to establish a plan of care. By identifying the frequent visitors to accident and emergency and implementing these plans, attendances were reduced from 21 to seven in 1 month (team audit data).

When people with diabetes are seen on these admission areas or wards, it is easy for the secondary care-funded DSNs to liaise with the primary care DSNs because they are all based in the diabetes centre and a nurse consultant is the line manager for both. This DSN structure is the key to the integrated service – concerns and progress can be passed on, discharge to one of the collaborative clinics can be planned, and liaison with other agencies can take place. The whole team have easy access to the diabetologists and can discuss queries from clinics promptly, thus improving patient care and outcomes.

Each primary care DSN is responsible for a locality, and all its practices, so he/she is an identifiable and accountable point of contact for the clinicians in primary and secondary care. As such, they are responsible for leading on team initiatives and education within their localities. They also organise a quarterly practice nurse forum, which is well attended and an evening for networking and updating from conferences, research, and changes in service or practice.

### Audit data

In the first full year of this integrated service, by moving the DSN clinics out of the diabetes centre and into the practices, PBR savings were £130 000.

Length of stay for people with diabetes was reduced by 1.8 days if the individual was seen by a DSN.

DSN activity in all settings is captured to demonstrate the breadth of the role and the necessity for early specialist nurse intervention to improve patient outcomes, reduce clinical risk and highlight the complex needs of the growing number of people with diabetes. Between April 2010 and March 2011, 1142 face-to-face reviews took place in the 38 collaborative clinics in primary care, with additional discussions and meetings with primary care clinicians to plan care.

## Stage 2: Reality of change

All stakeholders in primary and secondary care had been informed of the improvements in patient and clinician satisfaction and care via meetings. They were generally happy because the service was delivered as promised and the resources were used effectively and efficiently. The practice and ward nurses were incredibly supportive of these roles and benefitted from the clinical supervision.

Despite these efficiencies, the number of people with diabetes was rising and the lack of equitable access to the diabetes service across the area (for example, by nursing, rest and residential home residents and people in the hospice) was concerning. After reviewing the service again to ensure more resources were needed rather than changes in processes or organisation, a negotiation began for some of the previous year's PBR cost savings to be reinvested into the diabetes service. This took 2 years to obtain as the PCT and colleagues involved in these negotiations changed several times, and much time was spent revisiting the concerns for these patients. The author is convinced that the economics of the business case (to do nothing was not cost neutral) combined with the history of the successful collaboration and pan-community support enabled the investment, despite the financial constraints that existed.

In 2010, two more DSNs were employed to resource four primary care clinics in an additional locality, set up education and clinical visits to the nursing, rest and residential homes, targeting those with high emergency admissions and/or those with adult protection issues. These DSNs also set up weekly visits to the local hospice and now provide educational programmes for the staff. These links mean that it is less likely that there will be inappropriate admissions from the hospice, and more likely to be involvement in joint care-planning as patients' needs change.

**Page points**

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2. After reviewing the service again to ensure more resources were needed rather than changes in processes or organisation, a negotiation began for some of the previous years' payment by results cost savings to be reinvested into the diabetes service.
3. In 2010, two more DSNs were employed to resource four primary care clinics in an additional locality, set up education and clinical visits to the nursing, rest and residential homes, targeting those with high emergency admissions and/or those with adult protection issues.

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An administrator was also employed to liaise with the practices in scheduling the collaborative clinics, and organise DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) education, in the diabetes centre and in the localities.

Over the past year there have been staff changes, which have helped to review and explain the service. These discussions highlight the considerable changes to the service and the need for engagement with stakeholders, clear leadership and time to make such change happen. It also serves as a reminder that this change is not static, but dynamic, and as such, needs ongoing nurturing and ownership.

Leadership style is critical in enabling change – a transformational style is recommended for such a service change because it inspires a shared vision, it models the way, challenges the process, encourages the heart (to keep going despite setbacks) and enables others to act (Kouzes and Posner, 2007). These fundamentals are evident through this discussion.

Legitimacy of the leader is also key. In the role of nurse consultant, the author had the authority to act and lead this change, the time to do so, and having gained an Masters of Business Administration (MBA), the commercial understanding required for the business discussions. However, in simple terms, the patient remains at the heart of our care.

## Stage 3: Where we are now, and where we are going

Diabetes is not immune to political changes and imperatives and when GP commissioning began, a diabetes board was set up including GPs, practice nurses, managers and clinicians representing both diabetes teams from the acute trust and with a person with diabetes as the Chair. Thus, the stakeholders could continue to be liaised with to ensure the diabetes services and resources were commissioned. The merger between Worthing Hospital and St Richard's Hospital in Chichester, has highlighted the need to organise equitable care across this new and larger health community. The author has been asked to lead the service review and work with the teams to achieve this. Some restructuring within the DSN service is likely as is a more general review of clinician responsibilities, and there is also a great opportunity to collaborate and to build on the considerable strengths and local expertise of both teams.

The principles that underpin the diabetes service change can be applied to this third phase:

- People – encouraging them to lead aspects of the change, while being supported.
- Communication – within and outside of our teams, and finding the best way to ensure it is safe and effective, and that may be different on either site.
- Patients – that is why we are employed, and they are the focus of our care, and need to inform us how we are doing and what we could change.

## Conclusion

A service change, as with any other project, needs a plan. This article has highlighted the key principles of the plan, which are:

- Identification of key stakeholders and what they want from the project/plan.
- Development of a shared vision.
- Identification of a person to lead who has time to do so.
- Transformational style by leader which is an Inclusive approach to promote ownership of the project.
- Regular communication and review against targets and timescales.

These past 9 years have had many delights and some disappointments, and there remains more to do. The achievements of the team have been recognised in publications, presentations and awards. The experience has been tremendous, and has cemented the author's belief that however hard the task and however many people needed for support, if you believe in what you want for your patients, you can succeed. Additionally, as a leader, you cannot lead a service change of this scale on your own, you need followers who can lead too. This is the story of their success, as much as mine. ■

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