The Coventry diabetes model: Empowering primary care

Jim McMorran, Juliet Hancox, Aresh Anwar

The face of healthcare delivery is rapidly changing. In many areas around the UK, diabetes care appears to be at the forefront of such change. The models adopted, however, are by no means identical. In this article, the authors describe one such model that has, to date, proven to be successful and popular in Coventry among both the healthcare professionals and the service users.

Coventry city has a population of approximately 305 000, with 11% from an Asian background (National Statistics, 2006). In the *Indices of deprivation 2004*, Coventry was ranked at 64 out of 354 local authorities in England (with number 1 being the most deprived; Department for Communities and Local Government, 2004). The latest survey of people with diabetes suggested that there were just under 12 000 such individuals in Coventry (Health and Social Care Information Centre, 2005), although epidemiological modelling suggests that the figure should be closer to 15 000 (Yorkshire & Humber Public Health Observatory, 2005).

Before the establishment of the GP with a Special Interest (GPwSI) in diabetes service, referrals from primary care went to the local hospital: University Hospitals Coventry and Warwickshire. In common with many other diabetes units, the secondary care team found themselves overwhelmed by 'revolving door' patients (who previously would have been on continual review in the diabetes clinic), with insufficient resources to absorb the growing numbers of referrals and to adequately address diabetes complications.

In 2004/2005, the local diabetes implementation group agreed a new integrated model of care supported by additional investment from the primary care trust (PCT). The GPwSI service was considered an important component of the Coventry diabetes model of care that was to be implemented from 2005.

The Coventry diabetes model

The Coventry diabetes model (see *Figure 1*) is a system of care designed to empower primary care. The whole emphasis of the model is to continue the care of patients in primary care who previously would have been followed up in a secondary care clinic. This process of empowerment is mediated via initiatives such as the two-stop GPwSI clinic model (McMorran et al, 2006) and the various educational processes that have been focused on Coventry primary care clinicians. The educational initiatives include practice-based diabetes meetings and the Coventry diabetes network, which is discussed later.

The GPwSI clinic service is designed to act as a clinical problem-solving resource for

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Article points

1. The Coventry GP with a Special Interest (GPwSI) service has been up and running since May 2005.
2. All primary care referrals to the diabetes service are sent through a city-wide referral service that allows the GPwSIs to triage out appropriate patients to be seen by the service.
3. Up to 80% of such referrals are felt to be suitable to be seen by the GPwSI service.

Key words

- GPwSIs
- Triage
- Care pathway

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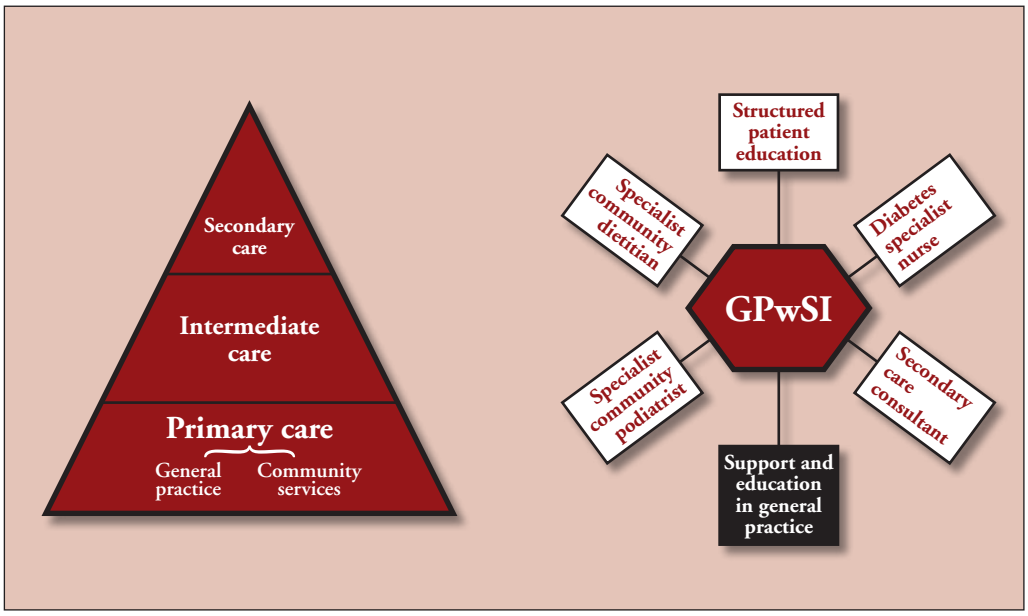

Figure 1. The Coventry diabetes model, signifying the emphasis on primary care, and highlighting the healthcare professionals and services on which GPs with a Special Interest (GPwSIs) can draw (in the white boxes) and the role that they must provide in addition to service delivery (in the black box).

primary care and then to 'hand back' clinical care to the referring primary care team. The focus of continuing care of patients in primary care facilitated by the Coventry diabetes model differentiates it from other GPwSI-based diabetes care services, in our view.

The team

The team consists of three GPwSIs in diabetes working for one session a week each, two part-time community dietitians, one part-time podiatrist and four diabetes specialist nurses (DSNs). In addition to their special interest, experience and expertise in diabetes, each of the three GPwSIs has a particular area of responsibility. The areas covered are obesity, lipids and diabetes in the ethnic population.

Referrals

All primary care referrals to the diabetes service are sent through a city-wide referral service that allows the GPwSIs to triage out appropriate patients to be seen by the service. Currently, up to 80% of such referrals are felt to be suitable to be seen by the GPwSI service. The majority of patients seen in the service have been referred with poor hypoglycaemic control or abnormal lipids. Those felt to fall outside the remit of the GPwSI service are seen in secondary care. (*Figure 2* provides a pictorial representation of the care pathway for people with diabetes in Coventry.)

GPwSI clinic sessions

Sessions are held in three community health clinics, providing easy access for patients. The clinics are multidisciplinary, with a DSN and a dietitian in attendance (the podiatrist is only available at one site at present). Patients are contacted by a booking clerk and asked to telephone to arrange a convenient appointment. Where blood tests are required, a form is sent out to the patient. GPwSIs can access the hospital reporting system to obtain blood test results prior to the clinic.

New patients have a 30-minute joint consultation with the GPwSI and the DSN. Patients are usually seen twice within the service (those needing more than three appointments will probably need to be seen in secondary care). A pro forma is used for the clinic staff to fax back a letter to the referring GP on the day of the clinic. The format follows the Alphabet Strategy (Morrissey et al, 2005; *Table 1*) developed by the team at George Eliot Hospital and adopted and adapted to meet local needs by Coventry. Patients will usually see the dietitian during their consultation and often receive further appointments with the DSN before their follow-up appointment with the service.

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3. Those felt to fall outside the remit of the GPwSI service are seen in secondary care.

The pro forma produced at each clinic visit allows the GPwSI and colleagues to provide a management plan for clinical issues classified using the Alphabet Strategy. This allows the provision of a scenario-based plan. For instance, a person with diabetes who has a total cholesterol level >5 mmol/l might have a plan with a suggested prescription for a particular statin and then an adjusted treatment after 1 month if the total cholesterol level is not yet to target. This provision of plans of care again allows the care of the patient to be managed within the primary care team. An email support service (described later) also supports any ongoing problems that practice staff may have after a patient is discharged from the GPwSI service.

Other roles of team members

The dietitians and the DSN team receive their own specific referrals from both primary and secondary care as well as supporting the GPwSI clinic sessions. These team members are also running the city-wide structured education programmes for patients.

Management support

The need for an alternative model of diabetes care had been discussed at Coventry PCT for 2–3 years. Indeed, a good working model had been drawn up. Critical to the successful implementation was an acceptance by the PCT to move away from locality-based management of health care to a dedicated 'diabetes manager' – now called a 'network manager'. Success without such an individual would have been impossible, and service development continues to depend on having this individual.

Secondary care

The Coventry GPwSI service has been up and running since May 2005, with concomitant changes in secondary care occurring to meet the changing face of diabetes care. Secondary care clinics are now able address the vast majority of issues associated with advanced complications and the needs of people with 'more complex' diabetes, for whom a multidisciplinary approach is required. These include a joint foot and lower limb clinic with a podiatrist, a DSN, an orthotist and a vascular surgeon, soon to be supported by a 12-bed inpatient foot unit. The joint diabetes antenatal and postnatal clinic with an obstetric team has been enhanced, as has the joint renal service. An intensive insulin clinic (for insulin pumps) will commence shortly, along with structured patient education for type 1 diabetes.

Education

While the 'traditional role' of doctors in the UK healthcare system has been service delivery,

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1. The provision of a scenario-based management plan allows the care of the patient to be managed within the primary care team.
2. An email support service also supports any ongoing problems that practice staff may have after a patient is discharged from the service.
3. GPs with a Special Interest in diabetes split their time between service delivery and ongoing educational support of fellow healthcare professionals.

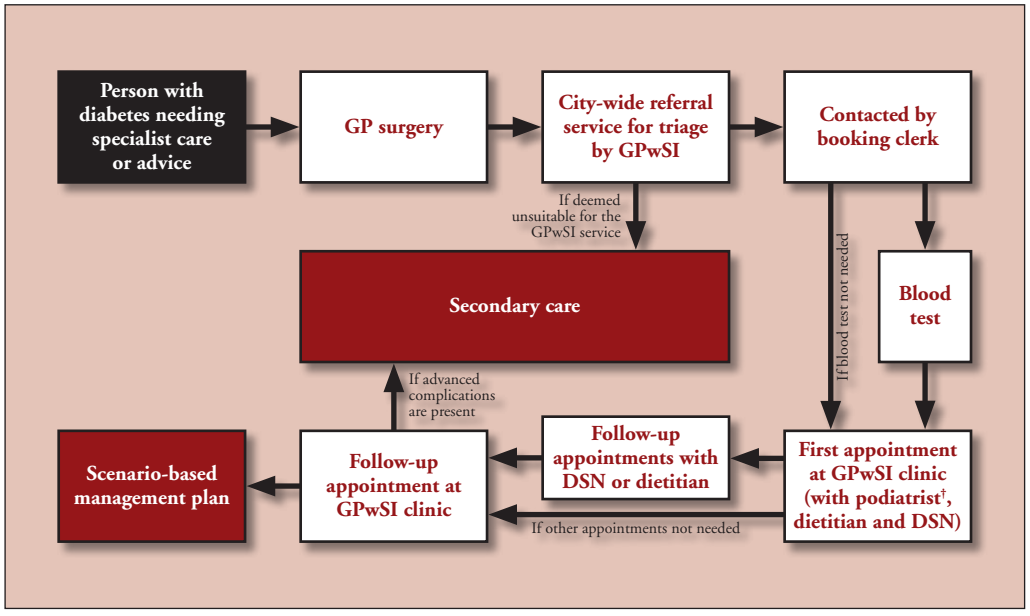

Figure 2. The care pathway for people with diabetes in Coventry (DSN, diabetes specialist nurse; GPwSI, GP with a Special Interest). †The podiatrist is only available at one site at present.

Table 1. The Alphabet Strategy.

Advice (diet, weight loss, smoking cessation, exercise)
Blood pressure lowering
Cholesterol lowering
Diabetes control
Eye examination
Feet examination
Guardian drugs (such as aspirin, angiotensin-converting enzyme inhibitors and statins)

GPwSIs split their time between this and ongoing educational support of fellow healthcare professionals. This occurs through a variety of means and settings.

The most popular format has been a weekly meeting set in local practices, over a lunchtime for example. Practices can use the time to discuss individual cases, to go through an agenda of 'hot topics' or frequently asked questions, or even to ask for support with running a diabetes clinic. The meetings have also provided an opportunity to promote and explain the ethos behind the new service and highlight the new local guidelines for diabetes care.

The team has also established a Coventry diabetes network as an educational forum to bring together interested GPs and practice nurses. These are run three times a year over an afternoon and provide an opportunity to spread good practice and latest clinical information. The same forum is an opportunity for continuing professional development for the GPwSIs.

Information technology

An email address for the team has been set up so that practice staff can get answers for queries relating to the management of their patients. Emails are replied to within 7 days by a member of the team, and the reply includes input from a secondary care consultant.

A website is planned to enable practices to download local guidelines, protocols and pathways. In addition, patient leaflets will be available to be printed off within the practice to suit individual patient needs.

What next?

The clinicians within the service are auditing the clinical outcomes of the first year's work and a patient satisfaction questionnaire is due to go out shortly. We are continuing to analyse the service to get a better appreciation of the training needs of the GPwSIs themselves, and to see whether we can more clearly delineate the types of patients who are being seen in the GPwSI clinics.

Practice-based commissioning (PBC) is seen as an opportunity for the team to support practices in taking back the care of some of their patients who are currently seen in secondary care. This approach has the backing of the secondary care team and a pilot study involving six practices has commenced to work through a process to achieve this. It is envisaged that the GPwSI service will still act as an intermediate care service for the PBC practices.

It is probable that the proportion of referrals triaged to the GPwSI service from the PBC practices will be significantly less than the proportion from the current system (up to 80%). However, the GPwSI service and PBC practices will provide a model of care where the 'revolving door' patients (who previously would have been on continual review in the diabetes clinic) will be based in the PBC practices, and the first stop for solving any problems with the care of these patients will be the GPwSI service.

Adapting to Choose and Book will be the next challenge for the service, and the team is looking at the opportunities and difficulties implicit in the system.

We believe that the success of our service has been an ability to firmly build it around an ethos of local care for local patients where and when appropriate. We believe that the continued support of GPs in helping to care for their own patients, rather than simply translocating secondary care into a community building, has proven to be critical to acceptance of the current model. There is still much to do; however, the foundations appear to be strong and popular. ■

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