Changing diabetes®

Integration of diabetes care: The Derby model

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In 2009, a novel project was set up in Derby to try and find a solution to issues in the provision of diabetes care (Rea et al, 2011). Up until then there was a traditional hospital-centred diabetes model, resulting in large numbers of people with diabetes attending for routine review. This meant that those with complex needs in primary care were unable to access services in a timely manner. Variations in standards in primary care meant that discharge was difficult and our users felt continuity of care was poor. All those involved in diabetes care wanted to do things differently; the aim was to build an integrated service with seamless pathways around users rather than being based on location. This is not the same as other models, which involve sending out a secondary care team into primary care or setting up an intermediate level of care.

When is care truly integrated?

In the last few years, "integrated care" has become something of a buzzword that we feel we understand. Our experience is that the concept is actually quite difficult to get across, even to those with many years of experience in the health sector. The King's Fund (2011) has defined integrated care as:

> *"An approach that seeks to improve the quality of care for the individual patient, service users and carers by ensuring that services are well organised about their needs."*

Some key benefits of commissioning an integrated service are shown in *Box 1*.

The background

A new model was devised that was not an outpatient service simply "placed" into the community. Two organisations were formed and these are currently working in the Derby City area only, as the service has not yet been implemented across the whole of Southern Derbyshire. These were technically not-for-profit companies with shares held between a group of practices and the hospital. This gave the organisations legal and financial autonomy to deliver services against objectives agreed with the Primary Care Trust at the time, with input from public health.

In 2009, First Diabetes brought five practices together with a collective population of 2500 people with diabetes and in 2010, InterCare Health started with seven practices, which has been subsequently increased to 29 practices with 14 500 people with diabetes in the catchment area. These arrangements had their roots in former practice-based commissioning groupings. Considerable energy and skill in demonstrating leadership across boundaries was needed to get so many independent health units to work together. The Derby Model is the only one to integrate at organisational, clinical, information technology and financial levels.

Box 1. The key benefits of commissioning an integrated service

- Seamless pathway centred around the user.
- User seen in the right place, by the right person and at the right time.
- Improved outcomes and reduced variation.
- Improved user experience.
- Improved communication.

The Model

The revolution was in getting professionals out of their departmental silos and working together in one organisation around the person with diabetes. By doing it this way, it was easier to align the incentives and share responsibility for success. Hospital staff were seconded and GPs were employed sessionally. Premises were rented in community settings, which most people with diabetes liked, although some preferred to be seen at the traditional hospital-based outpatients service. Working from a common budget allows more flexible deployment of resources.

Fortuitously, the majority of practices in Derby and the specialist teams use the same software, SystmOne, and so share one record. The process of referral is, therefore, very easy and notes are held in common. The service has a good understanding of practices' capacities, which helps the joint working and affords educational opportunities. The teams in the two organisations were not only able to provide a collective outpatient service but also to function as a team without walls, working with nurses and doctors in practices and visiting people with diabetes in the community. It was also easier to pull together professional and patient education groups, including work with ethnic minorities. This means that standards are raised in primary care, and care can be

escalated to and de-escalated from the specialist team as needed.

InterCare Health also hosts PROCEED, which is a service for integrated prenatal care for women with diabetes. A few areas remain traditionally funded and are outside integrated care, including antenatal, renal, multidisciplinary foot and pump clinics. The whole process is supported by a single clinical governance structure, and monthly team meetings to maintain standards and reduce risk.

Outcomes

Process

Reduced waiting times, a halving of the "did not attend" rate to 6% and all referrals being triaged and patients contacted within 72 hours are all measures of success. Clinical queries are responded to within two days, rather than the weeks it used to take, which helps practices' staff to feel supported by the service.

Clinical

In the first year, practices demonstrated improvements in the Quality and Outcomes Framework targets for blood pressure and glucose targets, but it is hard to know whether this is a matter of improved documentation rather than quality. Perhaps more meaningful is the impact on our shared decision making with people with diabetes, focusing on their needs and setting mutually agreed targets. For example, in a group of poorly controlled users with diabetes, HbA_{1c} reduced from a mean 83 mmol/mol±4 mmol/mol to 63 mmol/mol ±3 mmol/mol (9.7%±0.4% to 7.9%±0.3%; $P<0.01$) within 6 months of referral to InterCare, compared with no change in the preceding year. In addition, the impact of integrated care in reducing in patient activity is clear. In 2010/11 InterCare users had fewer admissions and mean length of stay was 1.8 days shorter than those under traditional care.

User opinion

Our service users are pleased with the new service, with 85% of users rating InterCare as "excellent" or "very good". They commented on the ease of access and described the service as "first class".

Finance

There have been financial savings for both projects. These, combined with improved service delivery, represent considerable savings compared with the southern part of Derbyshire County, which is supported by the specialist team using a traditional model. The National Diabetes Information Service DOVE tool was used to compare outcomes and costs between the two areas and has demonstrated that relatively better outcomes were achieved, but with a net saving of £54 per patient per year in the city. This equates to an annual saving of £800 000, while quality was being improved.

These savings are from a combination of improved service efficiency, reduction in admissions and improved outcomes, as well as a reduction in prescribing costs. There is evidence of considerable prescribing savings despite the use of more expensive agents, such as analogue insulins.

National recognition

The work undertaken in Derby contributed to the five pillars in the better commissioning document (NHS Diabetes, 2012). First Diabetes received a Quality in Care Award in 2012 and InterCare won a *Health Services Journal* Care Integration Award in 2013.

Conclusion

Both projects have been effective clinically and financially. Both the people with diabetes and healthcare professionals involved appreciate the new way of working and we hope it will form the basis of future service commissioning, as recommended by the Director of NHS Diabetes, Anne Morton, before its closure:

> *"A good example for all long term conditions to present to the NHS Commissioning Board."*

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