The Super Six diabetes model: Creating a LEGACY?

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Since its inception, the Super Six model, first described in this Journal in 2012, has continued to evolve in response to real-world clinical data. In particular, the importance of achieving early tight glycaemic control in people with recent-onset type 2 diabetes and the negative effects of hypoglycaemia in older people have been highlighted. There are now plans to further evolve the Super Six model. The core of this "LEGACY" (Local Enhanced Glycaemic Action in Critical Years) approach would be to incorporate specialist and generalist healthcare professionals into regional hubs, with particular focus on these two patient groups and on young people with type 2 diabetes. In this article, the authors review the proposed changes and discuss their benefits and drawbacks.

Diabetes is perceived as a complex, multi-system condition. As a result, care has previously been delivered in a specialist setting, which limits the number of people who can access the service and increases care costs. However, in recent years, there has been a very successful drive to shift the focus of diabetes management to primary care, due to the financial and workforce demands faced by the NHS and the sheer number of people with the condition. This shift has required primary, community and specialist care to find collaborative and innovative ways to meet the needs of people with diabetes. This gave birth to the "Super Six" diabetes model in 2010 across the Portsmouth, south-east Hampshire and Fareham/Gosport areas, with the goal of integrating care vertically across the healthcare system, using the strengths of each part of the system to their best effects.

The model's inception, progress and outcomes have been well documented in the past (Kar, 2012; Kar et al, 2013; Nicholson et al, 2016), and the model has been used as a template for the adoption of similar care models across other long-term conditions. The basic principle has been to allow specialists to work across the whole disease spectrum in a supportive, advisory, educative role for both primary and secondary care, in addition to the traditional clinical role for specific groups of patients with high complexity. This has challenged the concept of stand-alone "community" or "hospital" diabetes teams and permitted innovative and more effective working practices. The drive has been to make the pathway simpler for all concerned and to remove barriers so that hospitals are viewed as another aspect of community care rather than siloed entities.

In an era where the trend is moving towards joined-up systems – whether they be Sustainability and Transformation Partnerships (STPs), Vanguards or Accountable Care Systems – stand-alone teams, whether acute or community, may be more of a hindrance than a facilitator for good care.

Over the last 7 years, the NHS has continued to evolve at pace, with a shift from the Clinical Commissioning Group (CCG) as the "unit of planning" towards larger STPs, which may offer economies of scale and expertise but the development of which is not without its own controversy. Vanguard projects, piloting innovative care processes, have been in the mix

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Article points

1. Three CCGs have proposed further changes to the Super Six model of diabetes care to take advantage of opportunities arising from NHS management changes.
2. At the centre of the new "LEGACY" approach would be specialist and generalist healthcare professional hubs, focusing particularly on achieving early tight glycaemic control in people with recent-onset type 2 diabetes, the negative effects of hypoglycaemia in older people and on younger people with type 2 diabetes.
3. The proposals have many attractions. As discussions continue, progress has been made, although it is not yet clear if all the goals will be achieved.

Key words

- Diabetes care model
- Individualised care
- Specialist diabetes care

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1. As NHS management systems have changed, three CCGs have been considering evolving the Super Six model of diabetes care and to use the model for other long-term conditions.
2. The creation of regional hubs would concentrate resources and offer practical educational opportunities that could be taken back into primary care.
3. Hub care would also focus on the patient groups that would benefit most from the approach.

Box 1. The clinical scenarios that receive specialist diabetes care in the Super Six model.

- Inpatient diabetes
- Antenatal diabetes
- Diabetic foot care
- Diabetic nephropathy (individuals on dialysis or with progressive decline of renal function)
- Insulin pumps
- Type 1 diabetes (individuals with poor control or young people)

Individuals targeted in the LEGACY approach

- People diagnosed with type 2 diabetes within the last 5–7 years with HbA_{1c} >58 mmol/mol (7.5%)
- People aged >70 years with HbA_{1c} <42 mmol/mol (6.0%)
- People aged <25 years with type 2 diabetes

too, with organisational change in some areas moving towards "Accountable" Care Systems or organisations. In our local healthcare community, as this wider evolution has taken place, the question has been whether such system changes necessitate a change in the model's approach. Whatever the label of the organisational set-up, there seems to be a push towards joined-up and aligned working, with the goal of cutting across individual Trusts or organisations, and a push towards primary care working at scale but with appropriate support.

Additionally, clinical data collection strategies around diabetes care processes have emerged and evolved, providing a wider and richer evidence base. Such developments have helped locally in shaping amendments to the Super Six model year by year. In particular, the evidence base has highlighted the importance of tightening glycaemic control in the early years of type 2 diabetes and its relevance in maintaining the benefits later on in life. Real-world data have also shown the effects of hypoglycaemia in triggering and prolonging hospital admissions, particularly in older people, and the importance of individualised care rather than a "one-size-fits-all" process. As a result, we have defined different (individualised) targets in frail elderly people, moved towards de-prescribing in the case of potentially hazardous medications and in relevant situations, and adopted more situation-appropriate medication strategies.

The Super Six LEGACY

In our locality, the three CCGs (Portsmouth, South Eastern Hampshire, and Fareham and Gosport) have been given the opportunity to consider evolving the Super Six model further and to look at the options to tie in other long-term conditions with the model. This opens a possibility to create regional hubs, which would amalgamate the locality's specialist and practice nurses, interested GPs and specialist physicians to focus on long-term conditions in sessional activities. The aim of these hubs would not only be to concentrate resources but also to offer practical educational opportunities through shared practice, which can then be taken back into primary care when staff are back at their usual place of work. This offers the promise to focus on areas of maximal benefit in each long-term condition and develop effective regional working arrangements whilst also cascading knowledge through the healthcare system for long-term sustainability.

Based on local discussions and clinical evidence, it appears the group of people who would be suitable for and benefit most from this hub approach initially would be the following:

- People diagnosed with type 2 diabetes within the last 5–7 years with HbA_{1c} >58 mmol/mol (7.5%).
- People aged >70 years with HbA_{1c} <42 mmol/mol (6.0%).
- People aged <25 years with type 2 diabetes.

The idea with the hub care would be to focus time and resources on these patient groups to gain maximal benefit in line with recent evidence, and to aim for an individualised approach in potentially frail patients, in whom over-tight control (based on inappropriate HbA_{1c} targets) might be compromising their wellbeing because of hypoglycaemia. For people not covered by these evidence areas, the pathway would stay as before, with those people outlined in the "Super Six" clinical scenarios (*Box 1*) receiving specialist multidisciplinary care at the hospital and the

remainder being managed in primary care, with advice and virtual support as required.

This would result in a change in the model from specialists visiting each surgery on a regular basis to working collaboratively with primary care teams in the hub. The role of the specialists in the hubs would be to advise and guide the practice nurses and the rest of the multidisciplinary team regarding appropriate management in relevant patient groups. It is important to continue the ethos of the specialist having an advisory role to help facilitate education, as this will ensure such a model of working is sustainable for the future. Other roles would involve advising about appropriate individuals who should be referred to the National Diabetes Prevention Programme and encouraging participation in national audits, whilst also overseeing governance and quality of diabetes care delivered in the community. The emphasis on early-years glycaemic control would become the "LEGACY" (Local Enhanced Glycaemic Action in Critical Years) adaptation of the Super Six model.

The specialist care perspective

The potential benefits of this evolution would be to allow clinicians to focus on those patient groups who have the most to gain, whilst enhancing education and skills among the primary healthcare professionals and maintaining the capacity for access around the Super Six clinical areas inside an acute Trust. This could also thereby help facilitate similar targeted approaches in other long-term conditions. The potential downsides need to be recognised, however, and include the need for negotiated agreement from all relevant GP surgeries, the risk of deskilling GPs who elect not to be involved in hub activities and the challenges of negotiating the financial flow of Quality and Outcomes Framework (QOF) payments.

The primary care perspective

Primary care has adapted itself over the years to facilitate the management of long-term conditions such as diabetes. Practice nurses and lead GPs in diabetes, in most cases, have tirelessly upskilled themselves to be in touch with the latest guidance and management of diabetes. However, with the growing demand of urgent access, appointments get taken up very quickly and most practices face a fire-fight on a daily basis to manage all of their patients' needs. The 10-minute appointment is no longer fit for purpose, in particular for people with multimorbidity. Throw in the workforce crisis and we have a huge problem in primary care. With these challenges in mind, there are several benefits of a centralised hub service:

1. A hub would help mitigate variation in management of diabetes between practices.
2. Education of both staff and patients often becomes a secondary priority as urgent access takes over. Once again, a hub with involvement from consultants, GPwSIs and practice/CCG diabetes leads would aim to deliver a gold-standard way of managing diabetes within localities.
3. Lifestyle advice, weight management, diet, mental health and smoking cessation are key public health facets that are vitally important in the long-term outcomes of people with diabetes. A hub with wellbeing services incorporated within one site would deliver the holistic care and give the time needed to educate patients, and could be delivered in group sessions to best utilise resources.
4. Access. Often practices provide an afternoon or two to deliver diabetes clinics. A hub would give 6-day access, which would fit in with patients' lifestyles and invariably reduce non-attendance rates.
5. QOF and Local Enhanced Services (LES) for primary care bring in important income that helps sustain good care. A hub utilising primary care systems such as SystmOne and EMIS could do a lot of the QOF and LES work for GPs exploiting the potential of interoperability.
6. Medicines management. The hub could serve as a central management tool and deliver on cost savings for inappropriate prescribing.

The potential downfalls for primary care, on the other hand, are loss of control and deskilling of staff. However, most practices train their

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1. One of the main problems for specialist clinicians of a change to a centralised hub service is the need for negotiated agreement from all relevant GP surgeries.
2. As demands grow on primary care practices, there are several potential benefits of a centralised hub service, including less variation in the management of diabetes and a focus on delivering a gold-standard way of managing the condition.
3. Potential pitfalls for primary care of a hub are loss of control and deskilling of staff.

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nurses to deliver care for long-term conditions such as chronic obstructive pulmonary disease and diabetes, and the new model definitely has the potential not only to deliver good holistic care to high-risk individuals but also to be an effective local education hub for all healthcare professionals. Staff could be rotated through from each practice and bring the skills learnt back to their sovereign organisations. To make this work, there has to be vision and an appetite for change, but the benefits are real and plenty.

Summary

This LEGACY approach combines evidence-based clinical practice with creative use of professional resources in a cost-neutral package as regards use of the diabetes specialist team. The focus of the approach is on using time and resources differently – more effectively – rather than trying to add on activity to existing services. The approach allows flexibility to utilise and disseminate evidence-based interventions rapidly, whilst focusing on key areas such as admission avoidance and keeping the ethos of individualised care at its core.

Locally, there has been the creation of an Accountable Care System looking at commissioners and providers working together as one entity. This is, as yet, in its infancy but presents the perfect opportunity for the evolution of the Super Six model as described here. One of the biggest attractions is the potential cost neutrality as regards specialist time, so that whatever investment that is financially possible can be made in primary care, offering the possibility of working with primary care at scale.

Discussions are ongoing and, whilst much progress is being made, it is not clear that we will achieve all the goals described. However, the LEGACY concept has excited many in our health community due to its multiple attractions whilst still holding firm to the core mantra of the original Super Six diabetes model that: "We are one seamless team across multiple organisations with a shared goal of excellence in diabetes care and clear strategy regarding the use of hospitals and hospital staff within a long-term condition programme". Watch this space! ■

The influence of the "Super Six" model of diabetes care in Wales

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It is widely accepted in Wales that diabetes is mostly managed within the primary care setting. The "Super Six" model is slowly being adapted such that specialists are mainly managing patients who have significant complications or risk from the condition. Unlike a hospital-based specialist clinic, primary care clinics often follow a more holistic pattern and deal with all issues, not just glycaemic control. The All Wales Diabetes Implementation Group is working on ways to improve quality of management at all levels as well as supporting a seamless approach between primary and secondary care. A specific group has been established to improve this interface. Wales is a diverse country and one system will not address all of its variations, so some form of local adaptation will be expected.

With secondary care limiting the type of patient that it will see, there is an increased need for more time allocation to primary care clinics and development of experience with injectable therapy initiation, intensification and maintenance. Most primary care physicians are very aware of the need to intensify therapy, but are restricted by time and expertise. It is recognised that we need to invest in a service away from hospital settings – investment to support the availability of time and of skilled practitioners to empower the patient with the management of lifestyle, medication compliance and injections. Recently, an enhanced service agreement has been launched. This is to ensure that primary care has the funding available to improve the upskilling, time commitment and staff recruitment that will be needed owing to the extra demands placed on clinics.

The enhanced services are based around a core module to support the running of clinics, referral to education and the development of agreed management plans. The four voluntary modules are to support practices that wish to invest in the initiation and the maintenance of injection therapies, although these modules are not currently funded by some Health Boards. This may result in patients continuing to be referred to specialist services for the initiation of injectable therapies. It is anticipated that, with the investment in primary care and offering support in quality care, we can ensure that people with diabetes will have the management of their condition undertaken at their local community service, rather than having to be referred into secondary care specialist teams.