**ELR GP Federation / Latham House Medical Practice Partnership to provide Diabetes Specialist Nurses for the LLR STP Diabetes Transformation Project – Update & Governance Arrangements**

1. **Background**

The Leicester, Leicestershire and Rutland STP was awarded transformation funding for Diabetes treatment and prevention, of which a substantial element was to specifically help improve the achievement of the NICE recommended treatment targets, and to help reduce the variation in achievement across general practice in all 3 CCGs. There were two main arms to this project;

1. **Targeted programme: Diabetes Care and Treatment Multi-Disciplinary Team**

A Multidisciplinary team (DSN, GP/Diabetic Mentor, HCA and Consultant time) from across primary care and secondary care was commissioned to;

* + Undertake a diagnostic in each practice to identify the causes of under achievement, and to establish the infrastructure with the practice;
	+ Support primary care healthcare professionals in treating complex cases, reduce variations in care provision and inappropriate referrals to secondary care. This included identifying hard to reach patients such as housebound, care homes and nursing homes.

The Multi-Disciplinary Team has been supported by EDEN (Effective Diabetes Education Now) to provide a package of education, upskilling and mentorship tailored to the needs of the practice based on;

* a training needs analysis of the practices involved in the programme to establish a baseline and
* The diagnostic review undertaken by the MDT.
1. **Improve Blood Pressure Control across LLR**

Supported by the EDEN team; a Primary Care Nurse with a specialism in Diabetes /or a Community Diabetic Specialist Nurse was recruited to improve Blood Pressure control to all identified practices across LLR.

The ELR GP Federation and Latham House Medical Practice, working in partnership, were commissioned to provide the specialist diabetic nursing element of this programme.

The project ran during FY18/19 but was extended into FY19/20.

1. **Governance arrangements**

Our Expression of Interest (EOI) stated;

*As a provider of General Medical Services, LHMP is registered with the CQC which ensures compliance with all Key Lines of Enquiry which encompass good clinical governance. At their most recent inspection LHMP were rated GOOD in all areas and their report shows exceptionality on leadership within the organisation. LHMP’s leadership chart is attached at appendix 1 and embedded below which diagrammatically shows how the practice is structured and governed by our clinical leaders. Should there be the opportunity we will provide our clinical governance policies and procedures at a later stage.*

*The Clinical Lead within LHMP will take the lead on ensuring effective safe and evidence based practice.*

*LHMP already employ specialist diabetic nurses who are embedded within the organisation and can;*

* *Effectively facilitate joint clinical protocols for use in primary care,*
* *Provide clinical oversight of the specialist nurses,*
* *Undertake clinical peer reviews, ongoing CPD and annual appraisals.*

*Specific KPIs will be introduced through the clinical lead, and disseminated. By expanding the remit of the team across a wider area with these LLR specialist nurses, we will be able to further develop, enhance and support the specialist diabetic nurses through the hosting arrangements. We will be able to bring the nurses under the umbrella of primary care service provision, with closer working arrangements and support structures, whilst retaining vital links to secondary care colleagues, through current PRISM pathways and advice and guidance clinics.*

*The ELR GP Federation Board will provide oversight to ensure the specialist nurses are deployed and managed effectively.*

Dr Kate Berry was identified as the clinical lead for the project.

We clarified in the EOI that LHMP hold appropriate indemnity and insurance. This will be updated as required to include the specialist nurses.

1. **Implementation**
2. The Specialist Nurses were recruited by a panel which included LHMP, Federation and EDEN team representatives.
3. The Federation (James Watkins) has provided management oversight to the project with professional nursing support from the EDEN team. LHMP have provided HR, payroll and finance support and are available for clinical support if required. LHMP’s policies apply to the Specialist Nurses, who are employees of LHMP.
4. The EDEN team have provided professional nursing advice to the project.
5. We have held regular ‘huddle’ meetings between the specialist nurses, EDEN team members and West Leicestershire CCG (host commissioner) to feedback on progress, provide advice and support to the nurses, which included peer support.
6. The Specialist Nurses have been provided with training / development – see training log @ **Appendix 1**.
7. A full review meeting was held at the end of the first year to review progress, lessons learnt and arrangements for the second year.
8. All support activity has been recorded on a database devised by the EDEN team which provided the data for the report that was conducted at the end of the first year **(see Appendix 2)**. A further report will be devised with the EDEN team to provide feedback to the Board.
9. The lessons learnt from the Project Review in May 2019 are shown @ **Appendix 3.**
10. James Watkins will conduct appraisals of the specialist nurses with Mary Harrison from the EDEN team.
11. The project risks have been assessed – see **appendix 4.**
12. **Other factors to consider**
* Governance structure – Board used as the forum for discussion
* Professional nursing advice to the Board – via the EDEN team?
* Monitoring & reporting arrangements for the Board – to include patient / practice satisfaction, numbers of patients / clinics, quality schedule
* Policies and processes - (Latham House’s)
* Serious incident reporting – via LHMP’s policy

**Appendix 1 – Training Log**

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| **TRAINING** |
| **Maggie Bodington** | **Lyndsey Robinson** | **Marilyn Frost** |
| **Course** | **Date** | **Course**  | **Date** | **Course**  | **Date** |
| Obesity | 10/07/18 | Footcare | 25/02/13 | D. Update | 25/06/12 |
| Prevention | 25/03/13 | HYPE | 22/05/18 |  | 3/11/15 |
| Diabetes Update | 27/02/14 | Obesity | 10/07/18 |  | 25/2/16 |
|  | 21/02/19 | Clin. Mgtment | 17/11/14 |  | 08/09/16 |
|  | 06/06/19 | D. Update | 21/02/19 |  |  |
| Launch | 25/06/19 | 3TS | 23/05/19 |  |  |
| GP Clin. Mtgs | 16/08/18 | GP Clin. Mtgs | 21/03/19 |  |  |
|  | 18/10/18 |  | 17/01/19 |  |  |
|  | 15/11/18 |  |  |  |  |
|  | 17/01/19 |  |  |  |  |
|  | 21/03/19 |  |  |  |  |
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**Appendix 2 – Report on the Diabetes Transformation Project**

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| Diabetes Transformation Funding Case StudyImprove achievement of the three treatment targetsLeicester, Leicestershire and Rutland STP

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| CONTEXT |

The LLR Sustainability and Transformation Plan (STP) identifies a need to reduce the variation in health outcomes noting the considerable difference in health outcomes across the STP footprint. For example 43.8% of diabetes patients in Leicester city have all three of the NICE recommended treatments targets compared to 41.9% of patients in East Leicestershire and Rutland. People feeling supported with a long term condition to manage their condition is 66.4% in West Leicestershire and Leicester city at 58.5%. The aim of this bid to support the STP in reducing the variation that exists across general practices in achievement of the 3 treatment targets and to bring LLR in line with the national average on controlling a diabetic patients blood pressure.

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| WHAT WE DID |

Data analysis of the National Diabetes Audit 2015/16 data was undertaken to identify practices that would benefit from a targeted programme of work to improve achievement of 3TT. The project focused on two areas: 1. Provide targeted support, education and mentoring to practices achieving below the England average for three treatment targets. 2. Improving blood pressure control for all practices below England average**Improving three treatment targets Programme includes:*** Undertake a diagnostic in each practice to identify the causes of under achievement, and to establish the infrastructure with the practice
* Support primary care healthcare professionals in treating complex cases; reduce variations in care provision and to reduce inappropriate referrals onto secondary care. To include identifying hard to reach patients such as housebound, care homes and nursing homes.
* GP Mentor session following diagnostic to pull together a practice development plan
* Diabetes Specialist Nurse to support practices in implementing their PDP; this includes clinics/virtual clinics to discuss complex patients
* EDEN (Effective Diabetes Education Now) to provide a package of education, upskilling and mentorship tailored to the needs of the practice based on
1. Training needs analysis of the practices involved in the programme to establish a baseline and
2. The diagnostic review undertaken by the MDT.
* Strong links with secondary care will be established to offer advice and assistance – email and complex case reviews for all the 3 CCGs, this will include clinical governance.

**Blood Pressure Improvement Programme*** Diabetes Specialist Nurse will deliver: 2 visits per practice, the nurse will review the patient register and undertake an audit and case finding to identify the issues contributing to the under achievement of the blood pressure control. This could potentially be carried out by using GRASP Diabetes tool.
* Mentoring and upskilling of practice staff to embed the skills for continued achievement of the treatment target.
* Develop an action plan for the practice which will include a case study based on 5-10 patients whose BP control is not at target.
* EDEN (Effective Diabetes Education Now) to provide:
	+ 3 day training programme for HCAs in practices (priority for target practices)
	+ Blood Pressure Protected Learning Time events for target practices (one per CCG area)

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| RESULTS – Clinical Improvement Programme |

Acquiring outcomes from patients receiving one visit, and re-testing parameters on the second visit, was always going to present a challenge for us to be able to demonstrate improvements so quickly:* Diabetes is often progressive in nature, any improvements in HbA1c take time, effort and often behaviour change on the patient’s part. The same is true for lipid measurements.
* Blood pressure is a variable haemodynamic phenomenon; NICE gold standard for diagnosing hypertension is ambulatory blood pressure readings where averages of day and night readings are complied. Taking one clinic measurement and retesting again on another clinic visit is unlikely to provide reliable evidence to the success/failure of any BP intervention.

However, this is not a research project and as such a level of pragmatism must be shown, therefore the results are more muddied by additional variables outside of the team’s control. The effort put in by the clinical staff is obvious when looking at the number of surgeries visited and the amount of patients that have been physically seen or their records reviewed. The qualitative feedback from the staff about the project also speaks powerfully of the success of the DSN team in providing support and education clinically while staff care for people with diabetes.**Results:****3TT arm:**Number of patients seen in clinics or reviewed with staff: 347 (until end March 2019)* HbA1c result: **-2.3mmol/mol** Although this is a small improvement, for a progressive disease and only one clinic visit this level of improvement is a real achievement
* BP result:
	+ Systolic BP= **-9.8mmHg**
	+ Diastolic BP= **-3mmHg**

These BP results are impressive, however there was only a small number of patients [n= 7] that had a BP recorded on both visit one and two to make a comparison* Total Cholesterol (TC) result: **-0.007 [n=91 patients TC from both visits]**
* Triglycerides result: **-0.03 [n=67 triglycerides from both visits]**

**Qualitative feedback from staff:***“Very supportive in being able to look more closely at patient’s blood sugars to interpret them and offer advice”* Burbage staff*“We discussed ways of having conversations with patients, helpful when meeting resistance from them when control is not good. Learnt to consider more implications of tight control.”* Anstey staff“I have been more confident about commencing patients on insulin and injectables…”“Useful to have “outside” advice…”“[I] feel more confident now to change/alter medication…”**\*\*\*\*\*\*****BP arm:**Number of patients reviewed: 399 (until end March 2019)* BP result: as the visits were audits, no patients were physically present. Dates varied for BP measurement; to be pragmatic we averaged the BP recordings from both visits to assess general outcomes for individual patients over a time period, including the audit.
* Any patients reviewed that didn’t have any BP recorded on the second visit were removed before analysis.

 * (n= 113: patients that had 2 reviews and BP recorded on both)
* **Systolic BP=  -9.911504425**
* **Diastolic BP= -6.132743363**

**Qualitative feedback from staff:***"Please highlight in this audit patients with raised BP in the acute setting will need to be booked for a re check ". Nurse Comment**"Blood pressure is mainly controlled at clinical level, therefore a proactive approach when seeing patients for review is necessary." GP comment.* *Discussion with nurse regarding increasing medication to control BP reiterated how lower BP lowers risk of macro vascular events.*  *"It would be such a help to have a support within the clinic as I need more confidence to look at blood pressure medication changes" - Practice nurse in post for 3 months.* RESULTS – EDEN Training Programme**LLR STP and EDEN Training Delivery 2017-2019**LLR successfully bid for NHSE funding to improve diabetes treatment across primary care. The aim of the funding as outlined by NHSE is to reduce the variation that exists across the area in the achievement of the NICE recommended Three treatment targets (HbA1c, cholesterol and blood pressure) which will ultimately lead to better patient outcomes.**LLR STP Dedicated Training:**28 Training events were delivered during April 2018-March 2019:**Improving Patient Outcomes Launch**Information presented on the role of the projects, and the opportunity to meet the diabetes specialist nurses who will work with the selected practice teams.**Three Treatment Targets**Enhance the knowledge and skills of HCPs in the management of blood pressure, cholesterol and HbA1c for people living with diabetes. The programme included the latest national guidelines and evidence base in respect of treatment options and recommendations for application into clinical work.**Improving Clinical Practice to achieve the Three Treatment Targets - Training for Healthcare Assistants** Health Care Assistants working in primary care learnt about diabetes pathophysiology, complications and treatment and how to support patients in aspects of care including the three treatment targets and the annual review.**Annual Review included*** Assessing Risk of Cardiovascular Disease and Diabetes
* Preventing Diabetes: How and Why?
* The Annual Review - What it involves and Why?
* HCA Role in the Annual Review
* Accountability and Delegate - RCN guidelines

**Hypertension:*** Medication guidelines
* practice protocols and targets
* Best practice guide on how to take blood pressure
* Case studies and putting learning in practice
* Useful resources available to take back to practice

**Engagement:**49 practices were selected as part of the STP project. Of those selected practices 69% attended LLR STP specific training.Across the whole LLR (147 practices) 49% of practices attended LLR STP specific training events.Attendance:247 Health Care Professionals attended specific STP TrainingKnowledge & Confidence:66% Strongly Agreed34% Agreedthat their Knowledge and Confidence had increased after attending EDEN training.**Testimonials: What are you going to put into practice?***Inform and advise patient on healthy lifestyle. Open question when performing reviews. Refer patients. Reduce risk of long-term health problems**Have the 15 Healthcare essentials up on a wall so that all points are covered during the annual review**Explain to the HCA the importance of using right cuff and timing of BP**More focused practice, less treatment inertia**Holistic care, look at everything to do with patient and discuss lots to help the DSN get to bottom of things e.g. medication, diet, lifestyle, external factors e.g. stress, diagnosis date and foot check**Educating patients on the importance of exercise and diet control**Guide patients on where to get information from. Advise patients on risks and understanding how they can manage their risks.*

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| KEY LEARNING POINTS |

Some of the comments from the staff feedback noted that as they had a DSN working with them they were allowed 30minutes per patient. This added time meant they were more able to discuss issues with the patients, build rapport and understand the patient’s needs better. This is a confounding variable to our results.The nurses have also provided additional support at surgery level that has been more challenging to report in a tangible way. For example, initiating practice policy and protocols for BP management, providing infographics and teaching aids to surgeries. This will have impacted on results.

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| CONTACT DETAILS |

Nisha Patel, Project Lead, West Leicestershire CCG – Nisha.Patel@westleicestershireccg.nhs.ukMary Harrison, 3TT Clinical Lead, Leicester Diabetes Centre - mary.harrison@uhl-tr.nhs.uk Lisa Heggs, Education Support Manager, EDEN - lisa.heggs@uhl-tr.nhs.ukDr YB Shah – GP Clinical Lead for 3TT, West Leicestershire CCG - YB.Shah@gp-c82627.nhs.uk Julie Stone, LLR Diabetes Lead, West Leicestershire CCG – Julie.Stone@westleicestershireccg.nhs.uk  |

**Appendix 3 – Diabetes Project Review**

**LLR STP Diabetes Transformation Project – Review of FY18/19 – 2nd May 2019**

1. **Background;**
* £75K has been identified to continue the DSN input to LLR Practices during FY19/20
* Primary Care Networks (PCN) are being developed across LLR
1. **Themes identified;**
* Practices ‘getting by’ but only just
* Education is critical
* GPs are de-skilled; reliance on DSNs who don’t have adequate consultation time
* Holistic approach is missing
* Concerns re capacity
* Inequity of access to DSN support
* HCAs / DNs are taking too much responsibility
* GPs’ PDPs have not been completed (not needed)
* It has been challenging to get access to Practices but when the DSNs get in they have welcomed and staff have been grateful for the support
* Redcap has been an excellent template
* Marilyn BP arm has reviewed 10 patients per visit and picked up on broader issues – including cases of mis-diagnosed diabetes
* The support of the EDEN team has been essential
* GP education is needed
* Not all issues are quantifiable
* Importance of early detection
* New dietary advice – manage weight & obesity
* Training;
	+ 28 STP events
	+ 247 attendees
	+ Attendees have reported an increase in knowledge and confidence after 3 months
1. **Next steps;**
* Allocate the remaining Practices between the DSNs
* Carry out additional visits for existing Practices
* Develop a suite of options that can be deployed flexibly depending on the needs of the Practices – to be used by all 3 DSNs – to include;
	+ Joint clinics
	+ Practice meetings
	+ Case studies
	+ Education programme (?on a Hub / PCN basis); include Q&A and Case Study presentation and discussion, on tx and managing complex patients, how to deal with diabetes emergencies and avoid hospital admissions
	+ Mentoring Practice Nurses & staff
	+ Dietary guidelines
	+ Consultation skills
	+ Identify PCN Leads / Link Nurses
	+ Empower patients to be self-reliant requires good input and education at the onset
* Consider Diplomas for key lead DSNs / link nurses; perhaps on a PCN basis?
1. **Clarity to be determined regarding the respective roles of;**
* Eden team
* LLR STP DSNs
* Community DSNs

**Appendix 4 – Risk register**

