The ABCD Debate: This house believes that GP's manage diabetes more cost effectively than Consultant Diabetologists.
For the motion

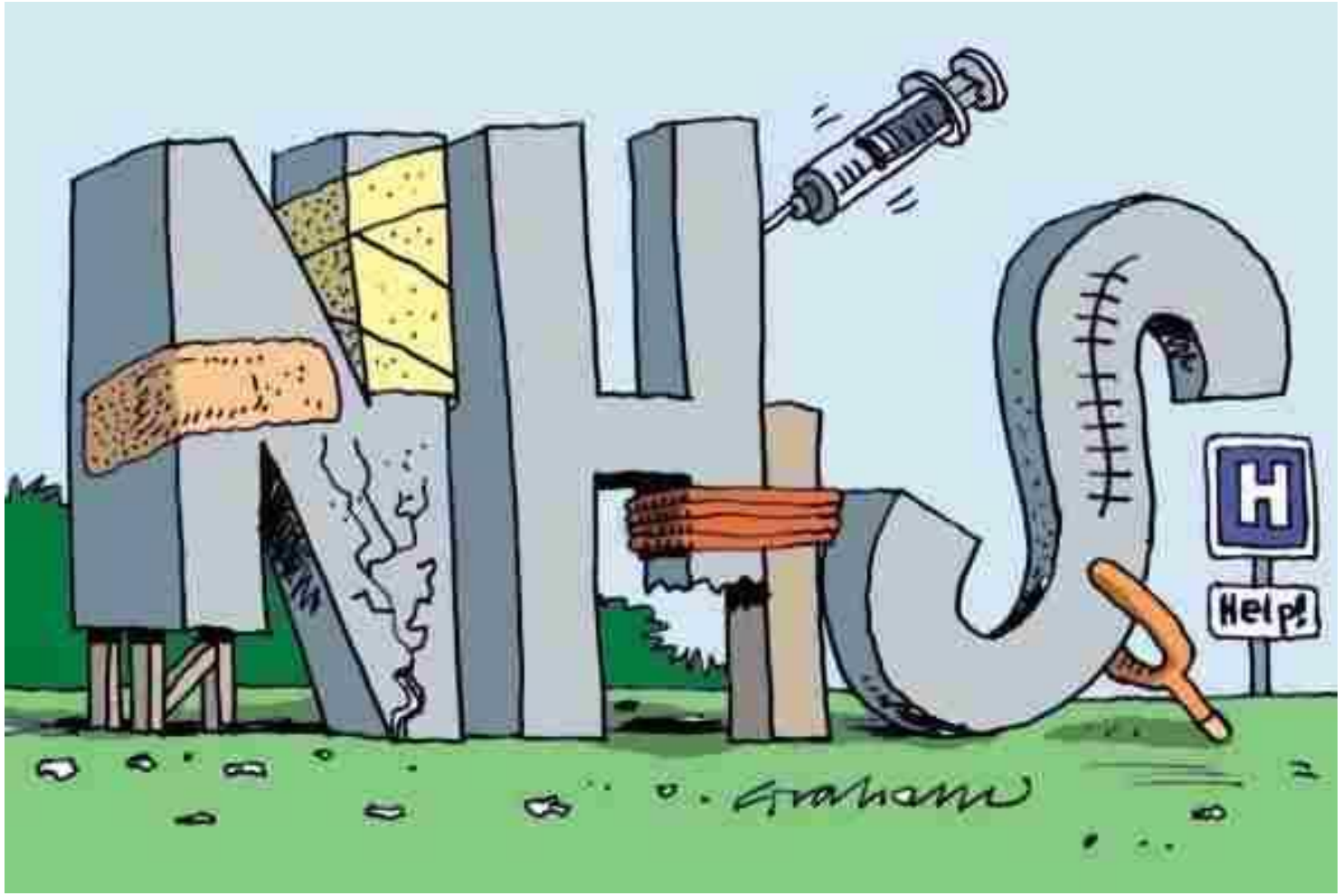
- Dr Stephen Lawrence
- Primary Care Medical Advisor Diabetes UK & RCGP Clinical Lead for Diabetes
- Executive Committee Member PCDS
- GPwSI diabetes

Equity and excellence: Liberating the NHS

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

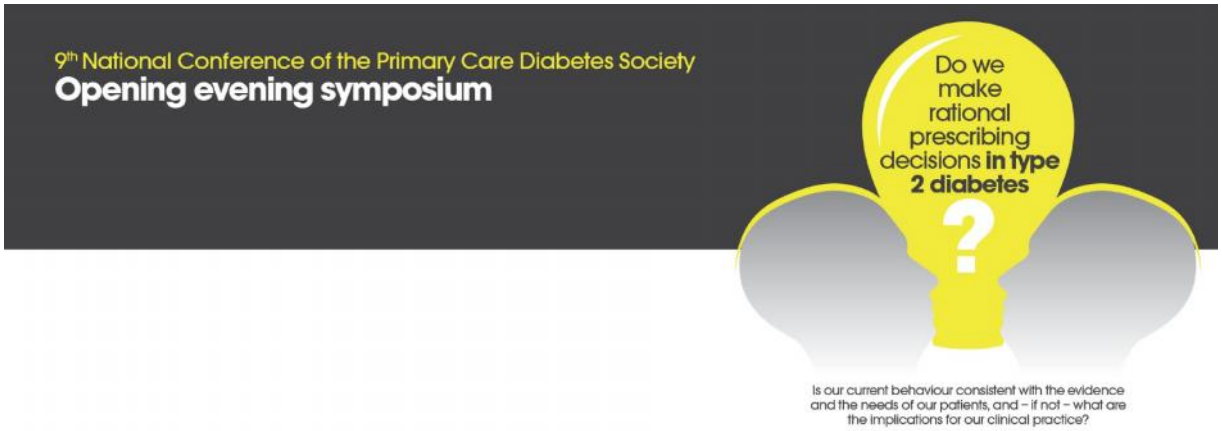
July 2010

The Changing NHS



Cutting bureaucracy and improving efficiency

Discharging more complex cases people with Diabetes from secondary care back to primary care



At what cost?

- £1m an hour, 10% of its yearly budget, treating diabetes and its complications
- The total cost to the NHS equates to £9bn/year
- 850,000 people unknowingly have the condition
- At diagnosis 50% of people have started developing complications

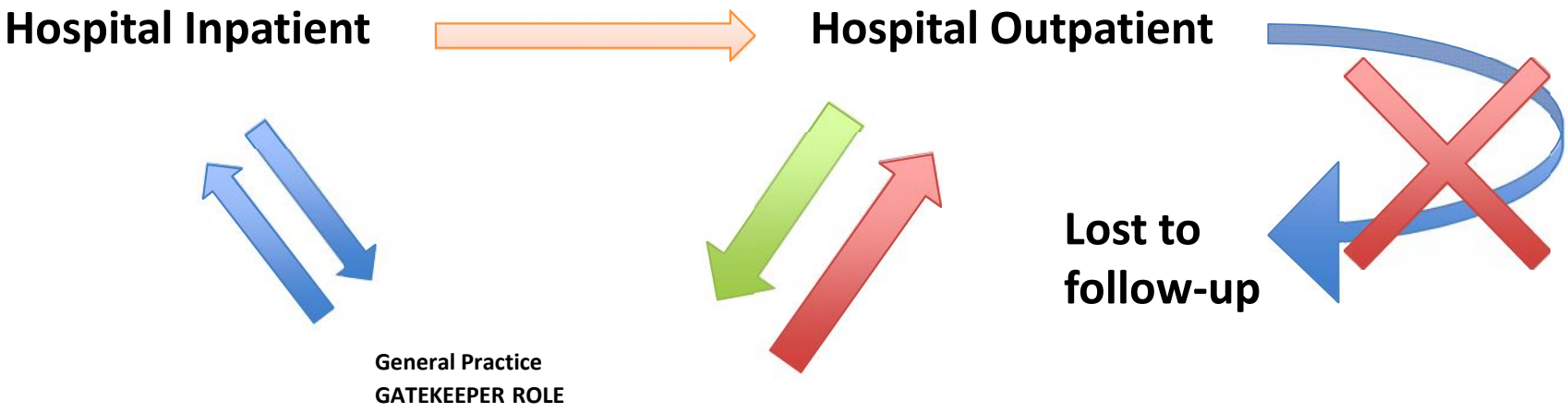
At what cost?

- 10 per cent of all hospital beds are occupied by people with diabetes.
- 1.34 million bed days per annum are attributable to people with diabetes.
- £465.25 million per annum
- Excess bed occupancy as a result of prolonged length of stay for people with diabetes is approximately 80,000 bed days each year in England, for those with a main surgical or medical specialty discharge code

At what cost?

- GP consultation £30
- 3 consultation per annum
- First consultant appointment £280
- Follow up appointment £85

Cost-effective Diabetes Care



Medway PCT – 2003/4

- 248,000 population
- 12, 230 T2DM
- 61 practices – large number smaller practices
- 2 Consultants (+ 1 SpR)
- 2 Clinical assistants – x1 weekly session each
- Community Diabetes Specialist Nurse Team

The lows - problems

- Repeated breaching of 13/52 OPA waiting time
- Large number of “inappropriate” referrals”
- > 50% patients managed in secondary care
- Overflowing clinics
- Large numbers of DNAs
- Insufficient information provided in referral letters
- Poor patient, professionals and PCT satisfaction

The (immediate) reaction

- Clinical assistant (SL) agreed to do extra clinics
- Consultant working beyond allocated times
- Plea to GPs to refer appropriately

The (strategic) reaction

- Meeting with hospital manager, PCT, clinical assistant, consultants
- Agreed minimum referral criteria
- Agreed that the CA posts be converted to GPwSIs
- GPwSI to triage ALL referrals to secondary care.

The triage process - pathway

- Newly established intermediate GPwSI clinic
- Seen in hospital clinic
- Seen by Community DSN
- Holding state; due to insufficient information in referral letter.

The high - results

- One stop intermediate clnics with clear individualised care plan
- Very high patient satisfaction
- GPs who used service happy with guidance
- Fewer, but more complex, patients seen in hospital clinic
- Fewer referrals to the intermediate service over 18/12
- Improved Hba1c control

The lows

- X1 adverse comment from local GP
- Pressure on consultants from managers suggesting lower clinics numbers equate with lower work load
- ? Glycaemic improvement attributable to Qof
- Minimal admin support to GPwSI
- One of the GPwSIs withdrew from arr. early on in the process
- Expense of GPwSI salary little different from that of consultant.
- Progressively fewer referrals to diabetes service made the continuation of IC untenable

The high - progression

- GPwSI I/C model extended to neighbouring struggling PCT
- Targetting of local GP with low diabetes Qof attainment for GPwSI input to discuss case management
- Ongoing GPwSI involvement in local/national education, policy formation, service development, treatment algorithms

The high - progression

- Ongoing weekly ½ sessional hospital diabetes clinic
- Input/advice into CCG

Intermediate Care 2013

- Ongoing weekly ½ sessional hospital diabetes clinic
- Input/advice into CCG

Consultant Diabetes Care

- Type 1 diabetes
- Type 2 diabetes with unstable control
- Type 2 Diabetes with unstable co-morbidities
- MODY, LADA
- Diabetes in pregnancy
- Pump therapy

Nobody Does it better!

- Good models of Primary Care Diabetes service have led to the development of innovative integrated care schemes such as GP Diabetic Mini-Clinics (Wolverhampton, 1971) and Diabetes Shared-Care (Poole, 1976).
- Such schemes are now widespread in the UK.
- The enhanced role of the General Practitioner in diabetes care is not a new concept (see ‘A National Framework for the Provision of Secondary Care within General Practice’, NHSE, Leeds, HSG, 1996)

Nobody Does it better!

- Consultants strongly supports the enhanced role of the General Practice in diabetes care
- Proper training and accreditation programme is essential if we are to avoid the evolution of two different standards of care for our patients.
- Consultants believe close and harmonious relationship between primary and secondary care.
- This will necessitate a clear understanding and agreement of respective roles and responsibilities.

Perception vs Reality

Surely Secondary Care is better!!

NSF Diabetes
Author:
Department of Health
Published date:
8 February 2007
Gateway reference:
2001

Standard 8
All children, young people and adults with diabetes admitted to hospital, for whatever reason, will receive effective care of their diabetes. Wherever possible, they will continue to be involved in decisions concerning the management of their diabetes.

Surely Secondary Care is better!!

- People with diabetes are admitted to hospital twice as often and stay twice as long than those without diabetes.
- They occupy one in ten acute hospital beds.
- They also frequently describe poor experiences of inpatient care, due to;

  - inadequate knowledge of diabetes among hospital staff

  - inappropriate amounts and timings of food and of medication the

  - lack of information provided delays in discharge resulting from their diabetes, especially when diabetes was not the original reason for their admission.

Surely Secondary Care is better!!

Timely liaison with the primary care diabetes team can both prevent the need for diabetes-related admissions

The employment of a specialist nurse to oversee the diabetes management of people with diabetes during their admission to hospital can reduce their length of stay and release bed space.

Surgery in people with diabetes is associated with increased clinical risk – can be reduced by adherence to locally agreed evidence-based guidelines for the management of people with diabetes during surgical procedures

The Inpatient experience

The following quotations from people with diabetes demonstrate some of the issues:

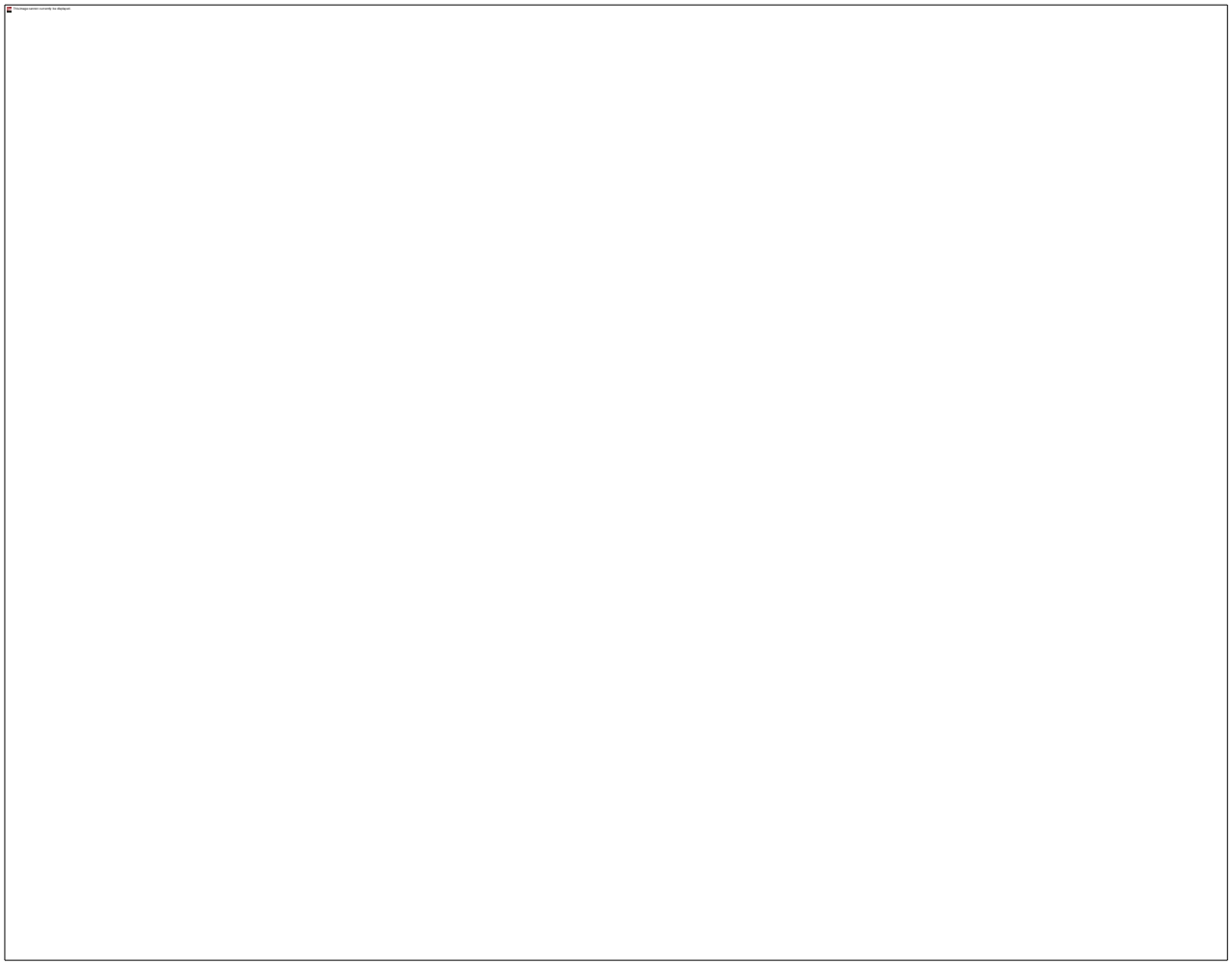
—"I had taken all my medications with me, insulins, blood pressure tablets, statins, aspirin, etc so they would know. These were all taken off me on ward admission. I was traumatized by the whole experience, the loss of my control, the feeling of not being listened to; you are so vulnerable”

—”I suffered avoidably large excursions of blood glucose level, ranging from 2.2mmols/l to over 27mmols”

The Inpatient experience

—"The next day I had a hypo, the nurse was called and did not know what to do.The charge nurse came and said he had nothing to give me. It was left for another patient on my ward to give me a sugary drink and biscuits. The nurses left, came back half an hour later, took my blood sugars, said the result was much better and with that they went. No food was offerede except by the patients on the ward."

What can go wrong?



Competencies

Practice nurse

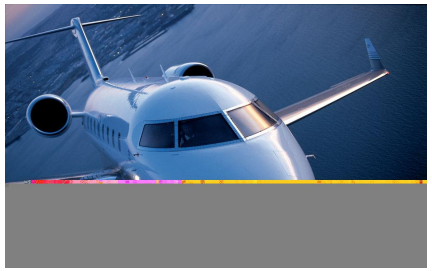
Competencies

Consultant Diabetologist

Competencies

GP

Competencies



GP

In providing care you must:

- keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment
- make records at the same time as the events you are recording or as soon as possible afterwards
- be readily accessible when you are on duty
- consult and take advice from colleagues, when appropriate
- make good use of the resources available to you.

When should GPs refer?

- At the time of the initial diagnosis of diabetes
- Poor control on maximal OHA
- New complications (for example, retinopathy or nephropathy)
- When the patient requests consultation.
- Any child with diabetes - any Type 1
- Loss of hypoglycaemic awareness

Referring to secondary care

Persistently (3 measurements over 6 months) raised (>58mmol/mol) HbA1C, despite established (>3 months) treatment with **maximal tolerated** doses of 2 or 3 oral hypoglycaemic agents, prescribed in accordance with NICE guidelines.

Overt proteinuria (one plus on dipstick, repeated after a month, in the absence of infection).

CKD 4 or worse (eGFR < 30 ml/min/1.73m2)

Referring to secondary care

People with significant Diabetic retinopathy e.g:

Being photographed 6 monthly

Attending ophthalmologist for serious retinopathy

People with severe diabetic neuropathy, especially if painful

Type 1 Diabetes
Foot ulceration

Patients with recurrent hypoglycaemic episodes on oral or insulin treatment

Summary

- The delivery of patient sensitive cost-effective care is a national priority
- Diabetes is an easy condition to treat badly
- Primary have access to and manage the bulk of diabetes care
- There is too much Diabetes out there for consultants to do it all
- PROVISO; working within competency frameworks
- GP's are more cost effective than consultant in the provision of Diabetes care

Cook CB et al. *Endocr Pract*. 2009;15:263-269.