# The Y&H service Innovation and Improvement Collaborative – 23rd November 2017:

## Summary of Table Discussions.

The Yorkshire and Humber Clinical Network for Diabetes hosted a Service Innovation and Improvement Collaborative in Wakefield on 23rd November 2017. The overarching aims of the collaborative were to:

1. Promote and support collaboration across the region in the identification, adoption and diffusion of innovative ideas and technologies,
2. Spread and sustain good practice in diabetes care,
3. Build networks and partnerships across the region, enabling diabetes professionals to share and develop solutions to improve diabetes outcomes across the region.

The first part of the collaborative took the form of table discussions between colleagues from across the region working in a range of diabetes-related roles ranging including Consultants, Diabetes Specialist Nurses, Podiatrists, Dietitians and Commissioners. The table discussions were focussed around the following six 'hot topics':

1. Multi-Disciplinary Footcare Teams,
2. Diabetes Inpatient Specialist Nursing,
3. Structured Patient Education,
4. Treatment Targets,
5. Hypoglycaemia,
6. Technology in Type 1 Diabetes.

This document summarises the key themes discussed around each of the six hot topics.

### Multi-Disciplinary Footcare Teams

The **key challenges** discussed can be categorised as: **logistical** (getting the right people around the table, access to rooms etc.), **staffing** (staff shortages, training, capacity etc.), and **integration** (involvement of multiple organisations, coding and communication between primary and secondary care, quality assurance etc.).

To overcome these common challenges, many of the implemented **solutions and ideas** revolved around **communication**:

- A platform to share tools and resources
- Phone/Voicemail/Email/Consultant Connect/Foot Hotline to answer queries

- Filming examples of good practice nursing
- Face to face – sending a team to all GP Practices
- Steering Groups/joint-working groups to focus on the whole patient journey and not just part of it
- Utilisation of existing databases and information
- Time limited virtual responses for clinicians who cannot attend
- Honorary contracts between organisations to have access to the service

Other solutions included enabling support workers to conduct foot checks and enabling direct referrals into the Foot Protection Team dependent on severity.

Diabetes Inpatient Specialist Nursing

The **key challenges** discussed can be categorised as: **not enough sharing** (policies, forms, dashboards), **consistency of education and knowledge across wards**, and **creating cases for change for beyond 2019.**

Potential **solutions and ideas** that were discussed include enabling **inpatient teams to visit each other and share learning** as this would facilitate co-creation of solutions to common problems. This would require protected time for service development. Three good practice examples for **sharing and improving knowledge across wards** were identified:

1) The 'virtual diabetes service' in Hull and East Yorkshire. Ward staff can now easily refer a patient to the inpatient diabetes service by clicking on a button in the Trust's IT system.
2) The 'Ultracare' online portal which allows patients to enter test results, supporting virtual monitoring by clinicians.
3) Sheffield foot clinic. Patients who attend the foot clinic are logged onto the system. If they attend another clinic e.g. stroke, the podiatrist gets an email notifying them of the patient's attendance.

To **create cases for change for beyond 2019**, it was suggested that Inpatient teams could focus on developing simple dashboards that are used regularly by the whole team to monitor performance and identify areas for improvement.

Structured Patient Education

The **key challenges** discussed can be categorised as: **patient access/attendance** (DNAs, awareness of what is available, reaching everyone, methods of access, quality of referrals etc.), **system integration** (conflicting advice, follow up, highly controlled DAFNE course, etc.) and **patient commitment** (time-constraints impacting attendance, other illness priorities, etc.).

To overcome these common challenges, the implemented **solutions and ideas** included: **primary care involvement/integration** (encouraging practices to attend courses, named specialist nurse for each practice, nurse and consultant helplines, scripts for GPs and DNS, practice nurses to deliver courses), **reviewing course structure** (educating patients earlier – DAFNE 'honeymoon period', hourly slots rather than half days, residential courses for T1 and family, opt out not opt in) and **communications** (work in the community to promote to patients, link together primary and secondary care to provide consistent dietary advice, NDPP promoting courses, nurses talking to employers for Type 1 to encourage attendance, intro to SPE to encourage attendance).

Treatment Targets

The **key challenges** discussed can be categorised as **recruitment** (for staff to deliver TT in the community, fixed term posts, financial restrictions due to 2nd year funding delay), **different primary care contexts/capacity** (mix of individual/federations/super practices and stage of transition – impacts on how to engage primary care, and capacity of primary care to engage), **psychological support** (social issues/financial problems/psychological needs/depression, convincing CCGs to provide funding), **HCP education** and **demonstrating improvements/impact over relatively short time period.**

Each of these common challenges had potential **solutions and ideas** that were discussed. To overcome barriers to **recruitment,** suggested solutions include: incorporating the staffing for TT as part of an integrated service, offering developmental posts on fix-term contracts, utilising adhoc support from pharmacist, practice nurses and using existing teams, and upskilling other related roles. To overcome challenges around **psychological support,** one suggested solution was to provide **motivational behaviour change courses for staff**. To overcome challenges associated with **HCP education**, ideas and solutions **include increasing collaborative working** across community, primary and secondary care, identifying diabetes champions, and providing clear, concise communications to primary care. In some areas DSN's linked with groups of practices to help build relationships and support systems – this was reported to work really well. In some areas a telephone advice line was in place which again reportedly worked well. One solution to **demonstrating improvements** was to take a **targeted/focused approach** e.g. using data/searches to identify practices or patients (hospital admissions, DNA's, very high hba1c etc.) that could then be targeted for TT work. Some areas highlighted a staged approach ("can't do it all at once") to targeting practices and rolling out the programme.

Hypoglycaemia

The **key challenges** discussed for hypoglycaemia were **inpatient care** (non-specialist staff viewing hypos as an 'occupational hazard', good provision for identifying hypos but not as good for preventing hypos, point of care get hypo info but this is not communicated wider

across diabetes teams), **community care** (inappropriate training e.g. 'treated with bread and jam', moving more care into the community resulting in an increase in hypos, QOF targets may not be appropriate for all patients e.g. elderly patients) and **ambulatory care** (consultants not being informed about every ambulance call out).

**Solutions and ideas** to challenges in **inpatient care** include: placing a sticker in patient notes alerting medics that the patient has had a hypo, education around bedtime snacks, Abbott integrated system to communicate hypos across diabetes team, present ward reports on hypos to the wards, assess every patient on the acute medical unit, explore ways of giving patients more control over their food – access, type and timings. Solutions to **community care** challenges include: promoting higher targets for those at risk within primary care, exploring how we can use technology to avoid hypos, some areas run a hypo clinic, and provision of a DISN post-discharge clinic. Solutions to challenges in **ambulatory care** appear to be in development region-wide and include:

1) The east-midlands ambulatory hypo study in which the Inpatient DSNs are informed about each hypo
2) The Y&H AHSN Avoiding Hypoglycaemia Toolkit which helps primary care to identify risk of hypoglycaemia and take appropriate action.

Technology in Type 1 Diabetes

The key challenges for technology in type 1 are **culture change** (still running traditional clinics, patients – early adopters and laggards)**, staff skills** (supporting primary care to manage patients with devices, knowledge and skills concentrated in too few individuals, consultants struggling to stay abreast of new technologies) and **systems not allowing technology enablers for patient led consultations.**

**Solutions** and ideas for/around these challenges largely involved looking at **large scale approaches or very small scale approaches**. One area has used virtual consultations in pilot services (telemedicine in prisons). At the other end of the spectrum, there is the opportunity to look at bigger issues on STP footprints, regional training and S1 is facilitating shared records and allowing specialist services to educate community.

## Online Portal for Sharing Resources and Information

An immense amount of sharing and learning took place in a short space of time at the Service Innovation and Improvement Collaborative, of which I am sure we have not managed to capture all in this document.

The Yorkshire and Humber clinical Network has an online Diabetes portal/forum for sharing resources and collaborating, which we hope all participants will find useful for continuing discussions around service innovation and improvement.

To use the online portal, please follow this link http://www.yhscn.nhs.uk/forum.php. You will need to register and select 'Diabetes' from the interested network drop down box. Instructions on how to use the forum are available on our website or by clicking here.

You can add additional topics and this will allow you to share any resources or information that you have.