Development of the Gestational Diabetes (GDM) pathway

"Ensure all women with Gestational Diabetes are offered follow up care throughout Greater Nottinghamshire."

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Summary

- We did not have an accurate register of women with gestational diabetes
- There was no agreed pathway within Greater Nottingham
- Decide who needs to be involved and engage with key stakeholders including GPs, Primary Care, Community and Secondary Care
- Implement an aligned pathway
- Communication confirming diagnoses
- Reviewing letters (advising, designing and keeping it simple)
- Consistent coding (read codes)
- Liaising with IT for consistent data extraction and utilisation
- Case for change and prevention - client, exercise, stop smoking, diabetes, education, NDPP

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Case for change

Why was there a need to change the pathway?

- 4% of pregnant women have gestational diabetes (nationally)
- Implement 1x single aligned pathway across Greater Nottingham
- Ensure consistency of follow up for patients with gestational diabetes in Primary Care
- Ensure clarity of responsibility to determine where care should be delivered at different stages of pregnancy
- All women with gestational diabetes are supported pre and post pregnancy (understand the risks)
- Treatment plans
- Healthy lifestyle

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Model of care

- Clear patient pathway
- Prevention advice – offered diet, exercise and preventions re risks of diabetes
- Delivery system design – designed by clinicians
- Support in making decisions
- Clinical information systems
- Follow up of annual screening and self management advice

Key Objectives:

- Optimise provider and consistent team behaviour with aligning pathways
- Support patient self management
- Change the care system for screening diabetes

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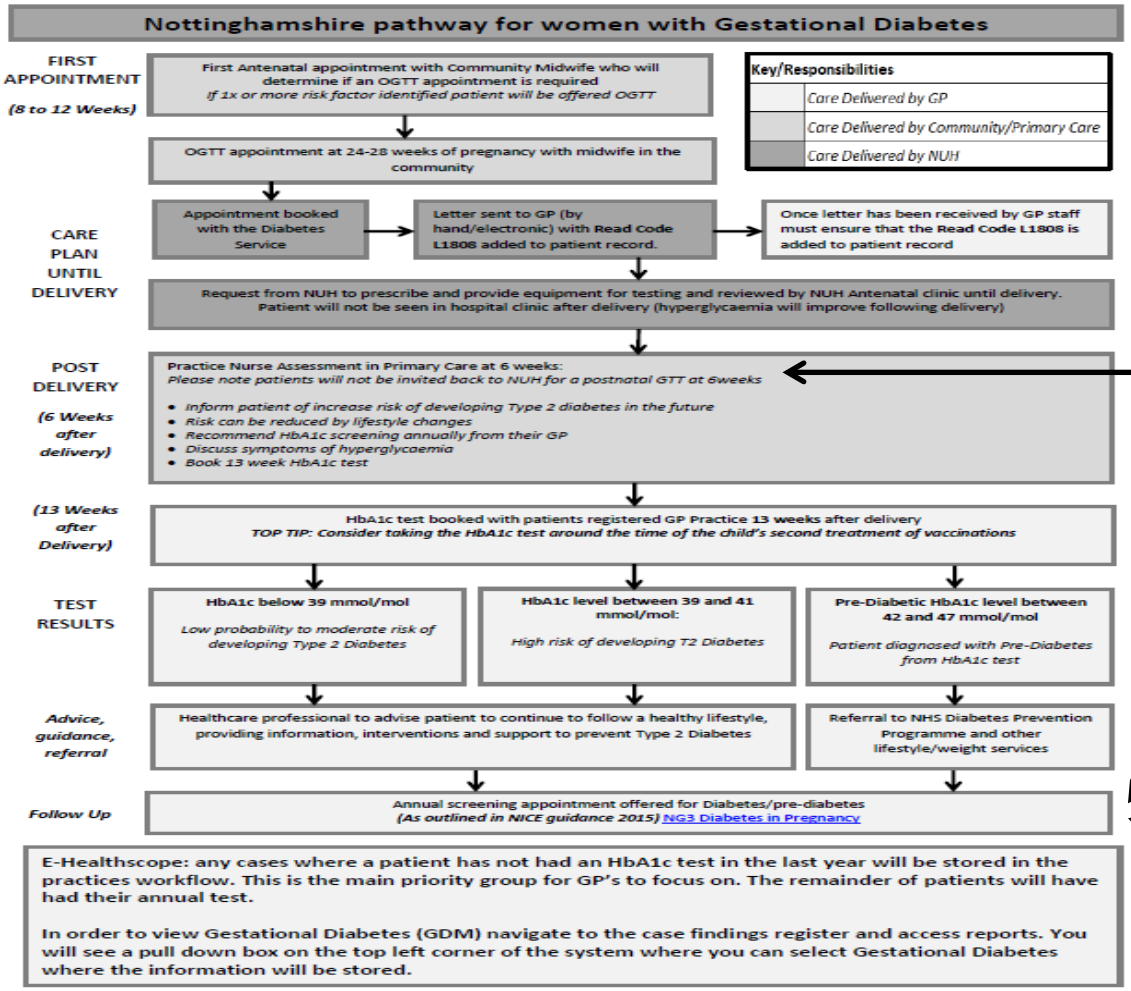
New Pathway



Patient would be referred to NHS DPP before the development of non-diabetic hyperglycaemia (NDH).

NICE Guidance: NG3 Diabetes in Pregnancy

Pathway is a cyclical process. Continuous annual review of patients to ensure they are not lost throughout follow up/pathway and preventing developing of Type 2 Diabetes.

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How to put a pathway in place

- How was the service/pathway delivered previously? (i.e. Were patients falling through gaps and consideration of their need?)
- Was there a known service/pathway? (Identified any gaps or missing links within the pathway)
- Explore elements of what works/does not work or what needs improvement (e.g. letters and communications)
- Getting the right people involved within the process to identify how the pathway will work (i.e. clinicians from acute, primary care and community services) to influence changes within the pathway, promoting a joined up and integrated approach
- Setting objectives and ensuring outcomes are achievable (measuring success from the changes made
- Following a framework and project management principles including a logic model to ensure all areas are explored (i.e. looking at overall outcomes for patients, and rationale behind the pathway)
- Exploring the improvement of information flow across systems (i.e. transfer of care from acute, community and primary care)

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Discharge letter template

Dear

Your patient (please see the above information) attended the Antenatal Diabetes Clinic today having been diagnosed with **gestational diabetes (Read Code L1808).** It is very important that until delivery, monitoring of blood glucose levels pre and post meals are completed.

Management targets in the NICE guidelines (2015) are for capillary (finger prick) blood glucose levels to be less than 5.5mmols before meals 7.8mmols one hour after meals and, 7.0 mmols at bedtime. This equates to a minimum of 7 blood glucose tests a day.

Please would you prescribe until the end of pregnancy:

Glucomen Areo Glucose Test Strips: Pip code 386-7405.
(There are 50 strips in each box so the patient will need one per week)

Glucoject Lancets PLUS 33G: 1 Box (200) Pip code 385-1755

1 litre sharps bin for safe disposal of sharps.

We will keep your patient under review throughout pregnancy and will inform you if there are further changes in diabetes management e.g. starting metformin or insulin.

We will NOT see your patient in the hospital clinic after delivery. Most women who have an episode of gestational diabetes will potentially benefit from life-style advice as they are at high risk of developing type 2 diabetes. Post-natal screening is required to identify those women who already have undiagnosed Type 2 diabetes or impaired glucose tolerance and also those who subsequently develop diabetes. Your patient will therefore require an HbA1c test at least 13 weeks after birth (NICE 2015) and an annual HbA1c indefinitely thereafter.

Thank you

Yours sincerely

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Outcomes

Since the new GDM pathway launched on 3 October 2017:

- 3,311 (increased to 3,598 Oct 2018) females with GDM read codes recorded on the system in Greater Nottingham with an annual recall for diabetic screening
- 300 (increased to 507 Oct 2018) women with a new diagnosis of GDM since the new pathway began to the end of March 2018 (Greater Nottingham)
- 1,063 (increased to 1,291 Oct 2018) had an annual recall recorded in the last year including annual screening and HbA1c tested
- 109 (increased to 143 Oct 2018) women found to be having pre-diabetes and referred to Diabetes Prevention Programme (DPP)

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Lessons learnt

- Development of communication, letters and pathways
- Involvement of stakeholders throughout the design process
- Test the pathway
- Simplified detail within the pathway
- Clearly outline the responsibility of care (acute, GP and community) throughout the pathway
- Clear understanding across Primary Care of how to align pathways
- Available IT tools to have databases which are able to support practices with annual recalls
- Ensure there is a consistent approach to support 97 practices across Greater Nottingham in the future

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Future plans

Rolling out the pathway across Nottinghamshire STP

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Further information

Disclaimer

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