

**Improving the management of diabetes care:
A toolkit for London clinical commissioning groups**



London
Strategic Clinical Networks



May 2015

ACKNOWLEDGEMENTS

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FOREWORD | DR STEPHEN THOMAS

The majority of care for diabetes in the NHS is carried out in primary care, and this is set to increase as the prevalence increases. Therefore, it is vital that primary care is able to provide the right care for people with diabetes. In London the system is ripe for improvement as highlighted within the *Better health for London*¹ report and will be facilitated through NHS England's *Transforming primary care in London: A strategic commissioning framework*².



Indeed, primary care is changing from a service which provided care *to* and *for* patients to an organisation which supports patients to self manage their care. As they become the experts in managing their long term conditions with healthcare professionals alongside them, they collaboratively goal set and discuss the complex, clinical aspects of their disease management that will enable them to live better for longer.

This toolkit is a timely collection of learning from areas of London that have recently made some radical changes and improvements in the management of care in primary care. We have highlighted themes that run throughout which were key to making the improvements successful. We hope that you find this a useful collection of 'tips and tricks' which can be implemented locally to enable you to transform the way care is provided for people with diabetes. The key to ensuring that improvements have the greatest impact is to deliver care in a way that will be sustainable after changes are implemented.

This toolkit has been prepared by the London Diabetes Strategic Clinical Network as a subsection of its programme of work. Additional resources are available on the SCN website, www.londonscn.nhs.uk, which can be used alongside this toolkit for maximum impact and transformation of diabetes care to improve the health of Londoners.

Dr Stephen Thomas

Clinical Director, London Diabetes Strategic Clinical Network
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FOREWORD | DR MARK CHAMLEY

Providing diabetes care in London is a challenge, but a challenge well worth doing.

Our culturally, socially diverse and mobile population means that there is no “one size fits all” approach. This is exemplified when planning approaches to structured education where poor uptake remains an issue. How can we best engage with diverse groups? How can we make structured education culturally sensitive? Where or how do people want to learn more about their diabetes?

Variation in the quality of diabetes care in primary care is another challenge. We need to ensure that our workforce is trained and able to deliver consistent and good quality care. Where a person with diabetes lives should not be an issue.

This guide brings together some examples of good work being done across the capital. The aim is not to benchmark or set standards for CCGs, but rather to highlight things which can make a difference. In working on this guide I have been impressed by the range of work being done and by the enthusiasm of diabetes teams and commissioners across London. I would like to thank them for sharing their work with us.



Dr Mark Chamley

Clinical Lead for *Management of care* work stream
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EXECUTIVE SUMMARY

With increasing numbers of people with diabetes in London primary care teams need to rise to the challenge of providing more and even better care.

All people with diabetes should receive the nine care processes as originally defined in the *National service framework for diabetes*¹ and NICE guidance for diabetes² every year. However, there is considerable variation in the number of people receiving the recommended care processes across London clinical commissioning groups (CCGs). Data from the National Diabetes Audit has shown that 40 per cent of people with diabetes in London are not receiving the annual care processes³. This puts these people at increased risk of developing diabetes complications in the future.

This document highlights approaches taken -- and which continue -- to improve diabetes care.

In looking at the work which delivers better care for people with diabetes, common themes emerged. These have been highlighted throughout this document. We have also used these themes to design a “toolkit matrix” (page 19), which summarises which approaches were used in each of the CCG case studies we describe.

Common themes in change initiatives to improve diabetes care processes in London CCGs

- » Leadership and local clinical champions to facilitate improvement
- » Prioritisation of self-management and collaborative care planning for people with diabetes
- » Professional education, care pathways and management guidelines
- » Utilising information technology in patient care and data to monitor performance and promote change

By sharing these case studies and the common themes in change initiatives, we can together make positive improvements to the care given to people with diabetes in London. We hope that this will be a useful guide for CCG commissioners and clinical leads across the capital.

1. *National service framework for diabetes: Standards*, Department of Health.

2. Clinical guidance on diabetes CG15: *Type 1 diabetes: diagnosis and management in children, young people and adults* and CG66, *Type 2 diabetes: the management of type 2 diabetes* (update), National Institute for Health and Clinical Excellence.

3. National Diabetes Audit 2011/2012. *Report 2: Complications and mortality*. HSCIC.

Background

Prevalence of diabetes in London

Currently there are 475,000 people living with diabetes in London. It is estimated that there will be a further 200,000 people diagnosed with the condition by 2025¹.

The increasing number of people with diabetes relates to people diagnosed with type 2 diabetes. In London a variety of factors are contributing to this increase.

More than 20 per cent of men and women in London are obese, and a further 39 per cent of men and 30 per cent of women are overweight².

Being obese or overweight are the main risk factors for developing type 2 diabetes.

London has a large black, Asian and minority ethnic (BAME) population. People of African Caribbean and south Asian descent are much more likely to develop type 2 diabetes and also do so at a younger age.

The prevalence of diabetes in London CCGs ranges between 3.5 to 8.2 per cent, related to differences in age and ethnicity of the local population (*Figure 1, below*).

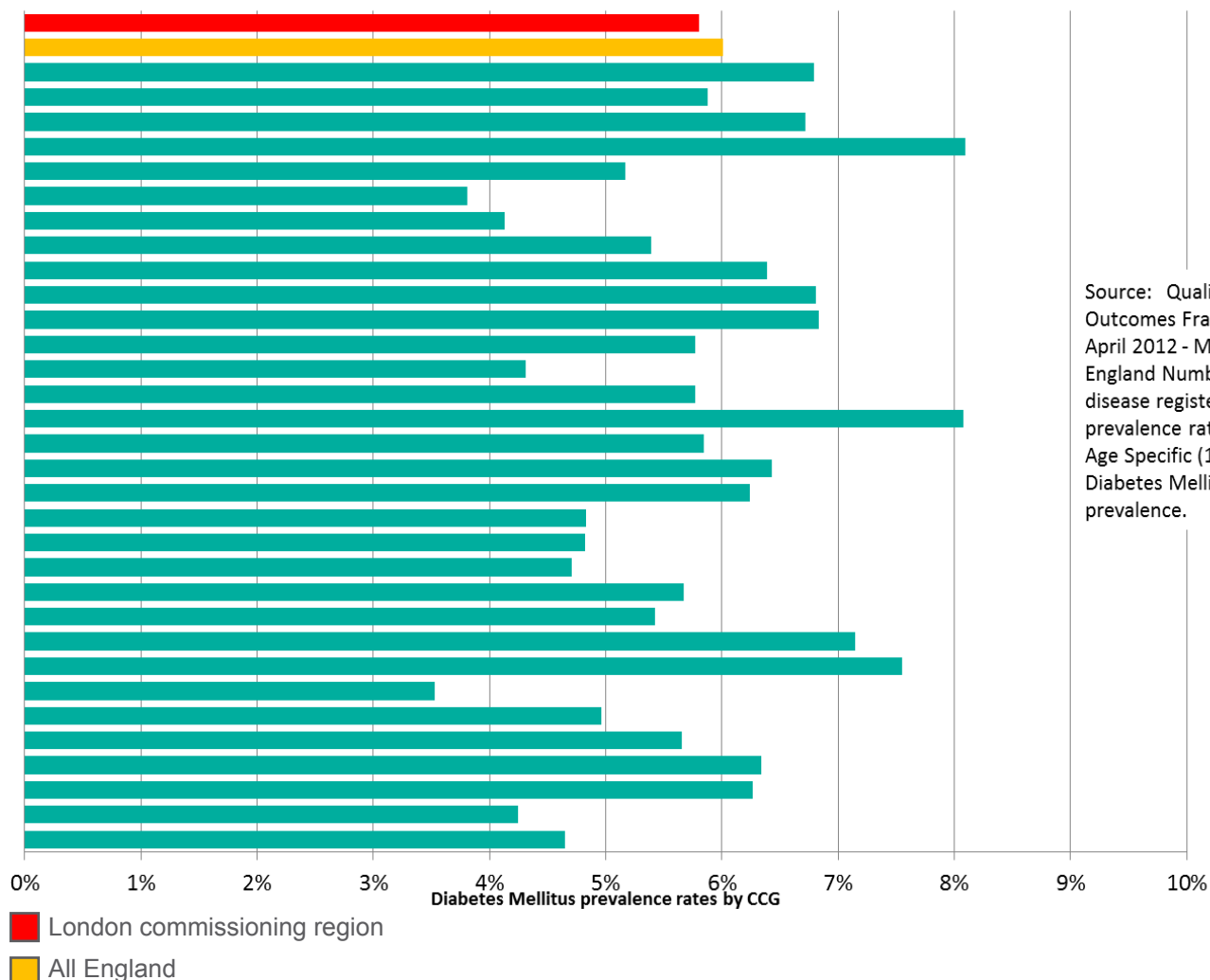
Cost of diabetes in London

Diabetes accounts for 10 per cent of the annual NHS budget in England and the financial cost in London is estimated to be proportional³. The majority of this cost relates to the treatment of diabetes complications⁴. With better diabetes care, most of these complications can be prevented.

The complications of diabetes have a devastating cost to the health of people with the condition. In the UK, around 20,000 people with diabetes die early⁵. Diabetes is the most common reason for limb amputation, blindness and kidney failure in the UK.

Figure 1: Prevalence of diabetes within each London CCG

Age Specific (17 years +) Diabetes Mellitus Prevalence March 2013.



Source: Quality and Outcomes Framework for April 2012 - March 2013, England Numbers on QOF disease registers and raw prevalence rates by CCG. Age Specific (17 years +) Diabetes Mellitus prevalence.

3. Blood sugar rush: Diabetes time bomb in London, London Assembly Health Committee (2014).
 4. State of the nation report for England: Challenges for 2015 and beyond, Diabetes UK (2014).
 5. National diabetes audit 2011-2012 report 2: Complications and mortality, HSCIC (2013).

Nine care processes

All people with diabetes should be receiving the nine care processes recommended by NICE.

Good blood glucose control and management of cardiovascular risk factors (blood pressure, cholesterol, smoking and weight) reduce the risk of developing diabetes complications over time.

Annual foot examinations and kidney checks can pick up complications at an early stage and prevent or delay disease progression.

In 2014 retinal screening was retired as a Quality and Outcomes Framework (QOF) indicator, but it is still vital for primary care teams to promote the importance of regular eye screening to people with diabetes.

Nine care processes

1. HbA1c
2. Blood pressure
3. Cholesterol
4. Smoking status
5. Body mass index
6. Foot check for circulation and neuropathy
7. Kidney function
8. Urine albumin-creatinine ratio
9. Retinal screening

National Diabetes Audit
The National Diabetes Audit collects data on the number of people receiving the recommended care processes for all CCGs in England⁵. Retinal screening data was not included in the audit report in 2011/12. It will be included in reports for 2013/14 and 2014/15.

Key messages from the National Diabetes Audit:

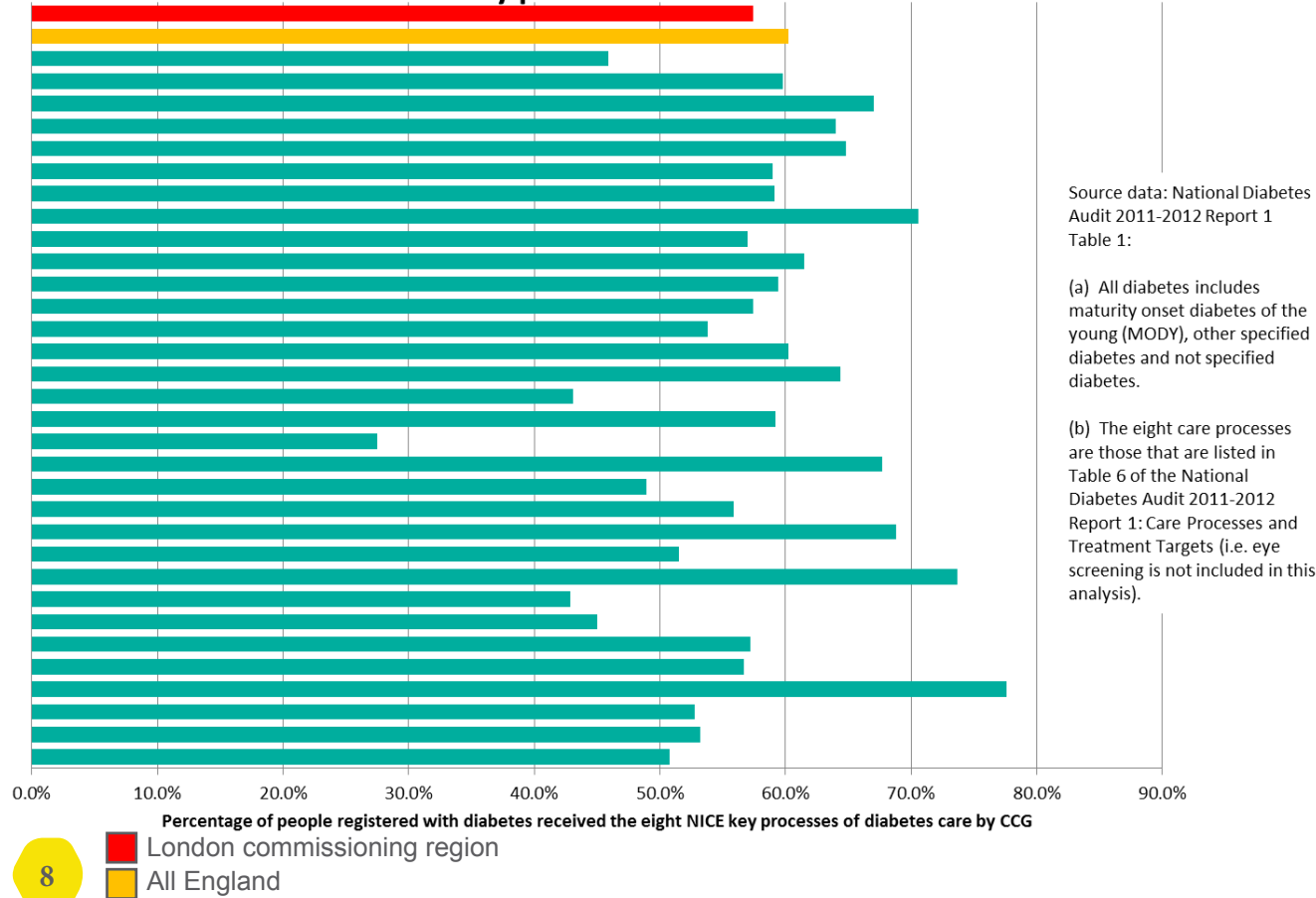
- » There is considerable variation between CCGs.
- » People with type 1 diabetes and people of working age are less likely to have received all nine care processes.
- » Annual completion rates for the care processes have plateaued since 2010.

Results for London 2011/2012

The data from London shows considerable variation between London CCGs in the care for people with diabetes (*Figure 2, below*).

For people with diabetes in London the average number receiving all the nine care processes is less than 60 per cent. This means that more than 40 per cent of people with diabetes in London are not receiving the care they need to prevent complications in the future.

Figure 2: People receiving eight NICE key processes within each London CCG
Percentage of people registered with all diabetes types %^(a) receiving eight NICE key processes of diabetes care^(b).



Improving the management of diabetes care in London

Common themes

There is considerable variation in achievement between London CCGs for the number of people with diabetes receiving all nine care processes.

This variation cannot be explained by differences in demographics. CCGs with similar populations have different outcomes. Some CCGs with the most diverse populations, in terms of ethnicity and deprivation, are achieving the best results.

Some CCGs have implemented the model of diabetes care recommended in the *Diabetes guide for London*. The model includes four tiers of diabetes care:

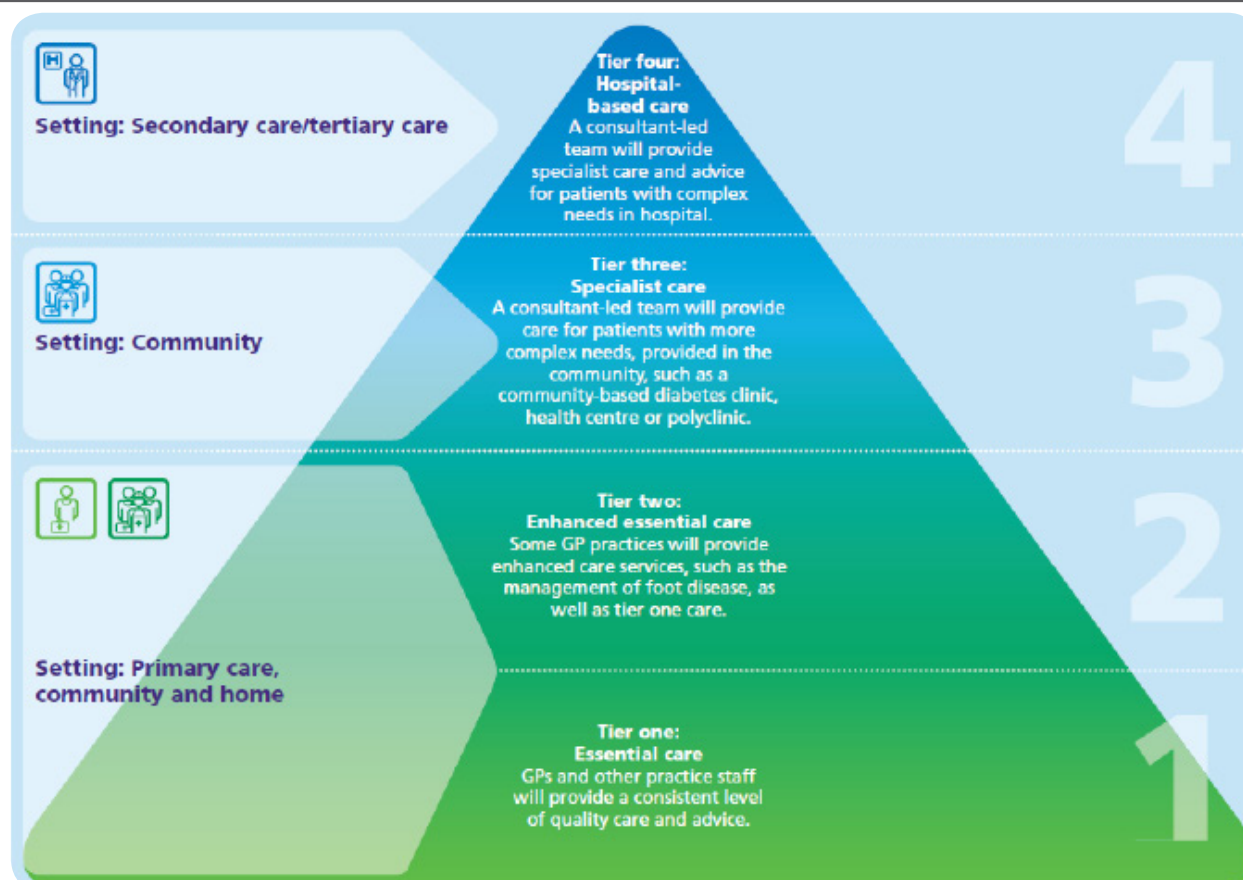
- » **Tier one** - essential care (provided by all general practice);
- » **Tier two** - enhanced essential care (provided by general practice with additional expertise);
- » **Tier three** - intermediate care (provided in the community)
- » **Tier four** - hospital care.

Sustainability

Of course any initiative to improve diabetes care outcomes is only truly successful if the improvements achieved are sustained over time. This requires the change to become “business as usual” with ongoing support from local commissioners and health-care providers.

Common themes in change initiatives to improve diabetes care processes in London CCGs

- » Leadership and local clinical champions to facilitate improvement.
- » Prioritisation of self-management and collaborative care planning for people with diabetes.
- » Professional education, care pathways and management guidelines.
- » Utilising information technology in patient care and data to monitor performance and promote change.



CASE STUDY: Tower Hamlets | Year of Care programme

Tower Hamlets has a population of 260,000, with high levels of deprivation and a large Bengali population. There are large numbers of people with type 2 diabetes (14,000 as of December 2014).

In 2008, Tower Hamlets became one of three national “Year of Care” pilot sites. The then-primary care trust (PCT) had applied to become a pilot site having recognised that diabetes care needed to be improved locally, as there were 12,000 people with type 2 diabetes at that time. There 36 general practices in the patch which varied in terms of size, patient mix and diabetes outcomes.

In 2009 Tower Hamlets Clinical Commissioning Group commissioned groups of 4 to 5 practices to each deliver an enhanced diabetes care package in networks attracting additional funding.

What was done?

- » Strong clinical leadership came from the medical director, the GP diabetes lead and a project manager. Local clinical leads were also identified to work with individual practice teams.
- » Primary care clinicians and support staff were trained in collaborative care planning.
- » People with diabetes were seen by a healthcare assistant for checks prior to diabetes review with a GP or practice nurse in a care planning consultation, focusing on the individual’s goals and priorities.
- » Patients were provided with “colour-coded” test results a week before their consultation with GP or practice nurse to maximize the potential for reflection on these results.
- » A new range of structured education activities were commissioned, driven by what local people with diabetes said they wanted. This was provided by information on a new “Make a Change” website.
- » Multi disciplinary team meetings were held in each network which included a diabetes consultant to discuss cases.

What was achieved?

- » 150 practice nurses and GPs were trained in collaborative care planning.
- » High levels of patient satisfaction with diabetes care were reported.
- » 60 per cent of the local diabetes population attended education sessions.
- » Improved levels of HbA1c, blood pressure and cholesterol control in local population were achieved.

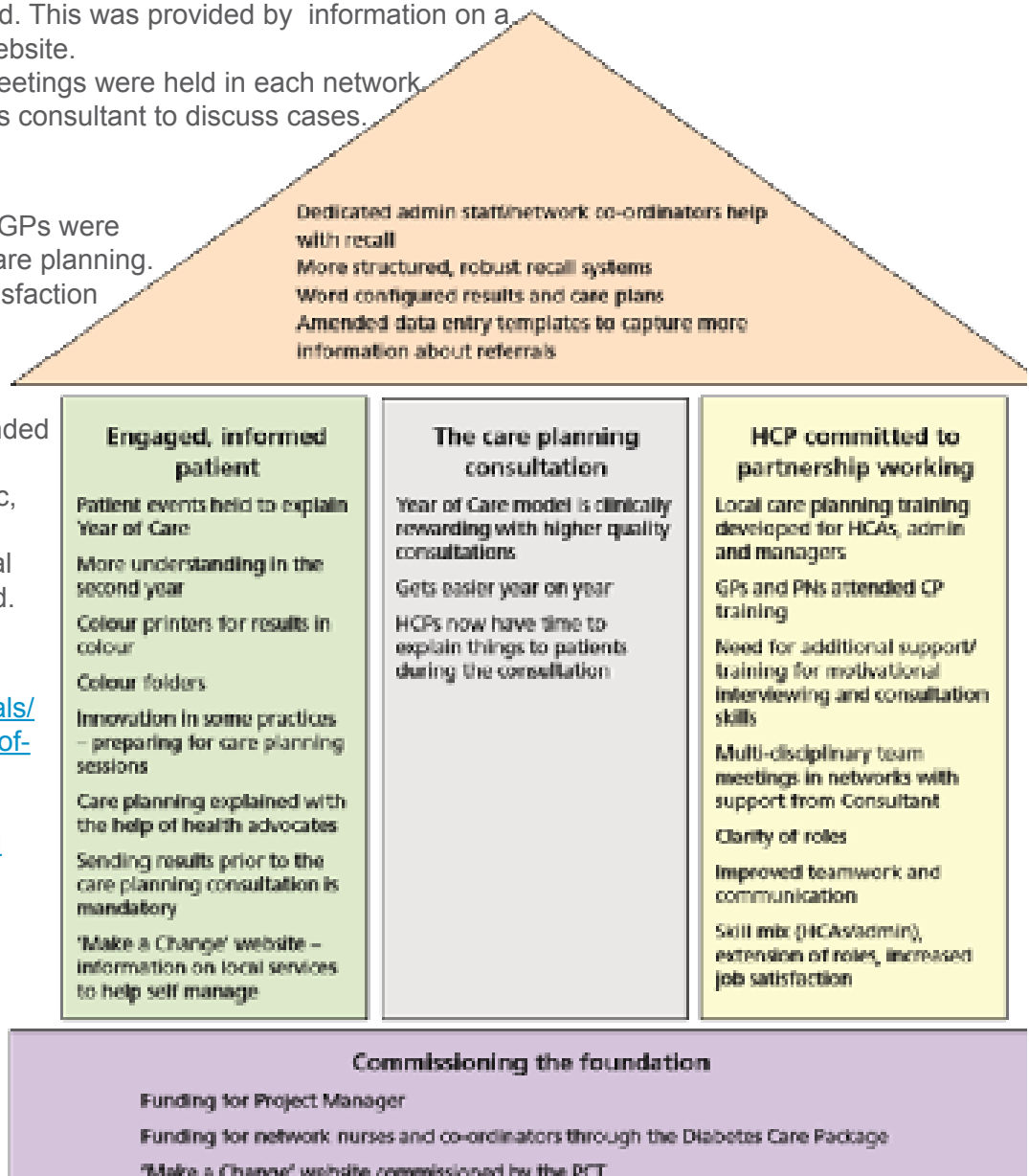
Resources

diabetes.org.uk/Professionals/Service-improvement/Year-of-Care

diabetesintowerhamlets.org

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CASE STUDY: *Bexley | GP led, integrated diabetes care*

Bexley is situated in outer south east London and has a population of 232,000. There are 28 GP practices in Bexley CCG. Bexley has the largest number of people aged over 65 in London. There are more than 12,000 people with diabetes living in the borough.

In 2009, a new integrated diabetes service was commissioned in the borough. Diabetes outcomes are now amongst the best in London.

What was done?

- » Local people with diabetes were actively involved in the service redesign and were represented in the Bexley Diabetes Stakeholder Network.
- » Structured education for people with diabetes was a priority. The X-PERT programme for type 2 diabetes was offered at different times and venues to make it more convenient to attend. A “taster” programme was established for those reluctant to commit to six sessions.
- » Patient champions were developed to ensure that harder to reach communities received information about diabetes.
- » Local enhanced service (LES) for GP practices provided either tier 1 or tier 2 diabetes care services.
- » GP practices undertook annual audits and develop a diabetes action plan.
- » GP practices were supported by a community diabetes consultant and diabetes specialist nurses with regular virtual diabetes clinics.
- » Care planning was successfully introduced across primary care.

What was achieved?

- » People with diabetes in Bexley have consistently achieved the highest HbA1c QOF scores in London (eg in 2012/13, DM26 was 74.6 per cent, the fifth best rate in England).
- » Since January 2010, more than 7,800 (or 67 per cent) of people with type 2 diabetes have been referred to X-PERT. DAFNE is also run for those with type 1.
- » Those attending the X-PERT education programme in 2010/11 achieved the largest reduction in HbA1c in the UK (16 per cent) and the second largest in UK in 2011/12 and 2012/13.
- » They also achieved the greatest reduction in cardiovascular disease risk factors in the UK in 2011/12 and 2012/13.
- » 40 per cent of people attending hospital diabetes clinics successfully transferred to primary care.
- » Secondary care referrals halved in 15 months.
- » 91 per cent of patients rated their care as excellent or good.
- » There was an increased awareness and education of diabetes care within primary care teams.
- » Strong patient engagement, supporting the development of the Diabetes UK patient group, resulted in a current membership of 700 people.

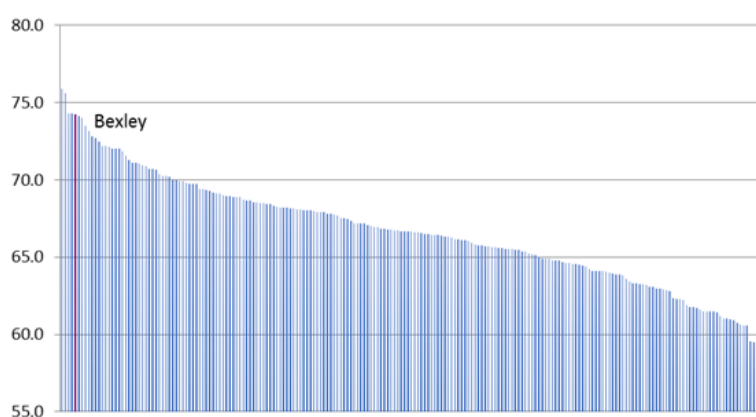
Resources

- » Right Care Casebook: Integrated GP led diabetes care in Bexley | <http://bit.ly/1dMbKSf>
- » Bexley Diabetes | www.diabetesbexley.org.uk
- » GP commissioning: shaping diabetes care in Bexley, Dr W. Cotter and J. Grumitt, Diabetes & Primary Care Vol 13 No 6 2011.
- » Improving quality of care in general practice, Prof R. Gadsby and J. Grumitt, Diabetes & Primary Care Vol 16 No 1 2014.

Contact

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CCG Performance in QOF DM26 2012/13



CASE STUDY: *Lambeth and Southwark* | DMI

There are 29,000 people living with diabetes in Lambeth and Southwark. Of concern was the considerable variation in the diabetes care outcomes across the 93 practices in the boroughs. Average blood glucose control was in the bottom national quartile and amongst the worst in London.

The Guy's and St Thomas' Charity funded a large scale service improvement programme which ran between 2010 and 2014.

What was done?

- » A large diabetes patient forum was established.
- » A clinical reference group was established to lead and champion change.
- » “Seven pillars” of primary care were implemented to reduce variation in the care and outcomes for local general practices.
- » New community-based specialist diabetes services were established in both boroughs.
- » New pathways were developed for the detection and management of diabetic foot complications.
- » A formal alliance, Young Diabetes Connections, between King's College, Guy's and St Thomas' and Lewisham hospitals provided a better service for children and young people with diabetes.

What was achieved?

- » Both boroughs significantly improved HbA1c control. (In comparison to London CCGs, Lambeth moved from 24th to 9th place, and Southwark from 19th to 8th place.)
- » 20 per cent reduction in hospital diabetes outpatient attendances.
- » 4,000 more people received all care processes.
- » 4,000 more people had a collaborative care plan.
- » Detection rate for diabetes increased by 16 per cent.

Resources

dmi-diabetes.org.uk

Contact

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CASE STUDY: Lambeth and Southwark | DMI



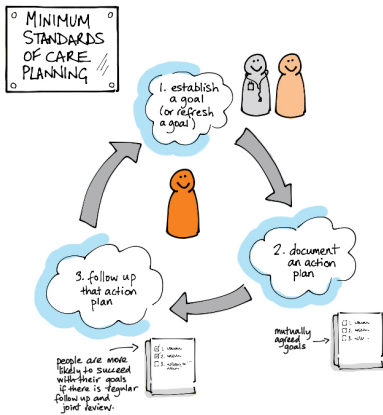
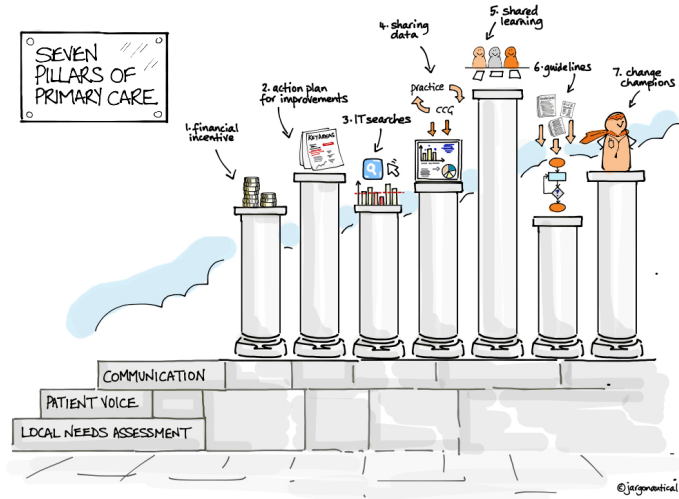
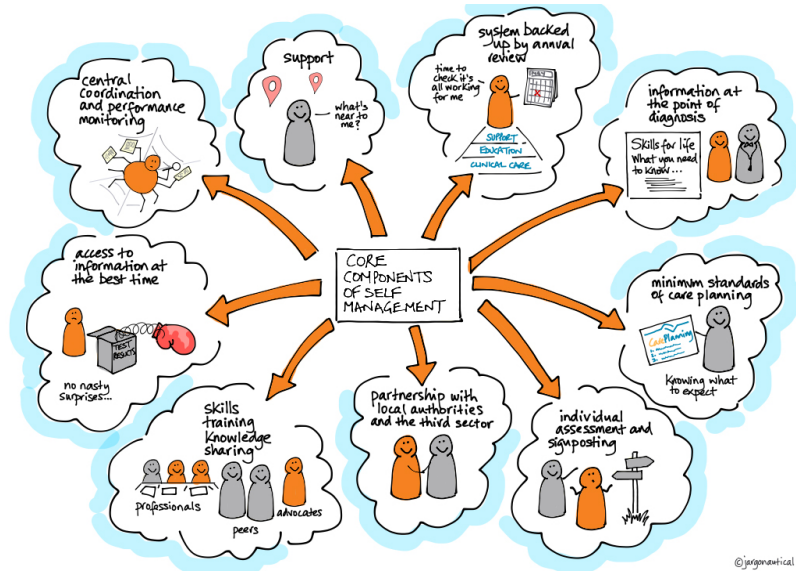
A system of excellence

The Diabetes Modernisation Initiative (DMI) has worked with NHS partners in Lambeth and Southwark to transform services for people living with diabetes. The key learnings of the programme are applicable in other places, and for other long term conditions.

The DMI's system of excellence, adapted from the chronic care model developed by Ed Wagner at the MacColl Institute, describes the programme's philosophy of transformation. Recognising the importance of self care in long term conditions, the core components of self management describe a systematic approach to improvement, of which the minimum standards of care planning are an important element. Key to sustaining that improvement are local practices; the seven pillars of primary care describe how that change can be achieved.

All the DMI's resources, including training materials, toolkits and templates, are available to download at dmi-diabetes.org.uk

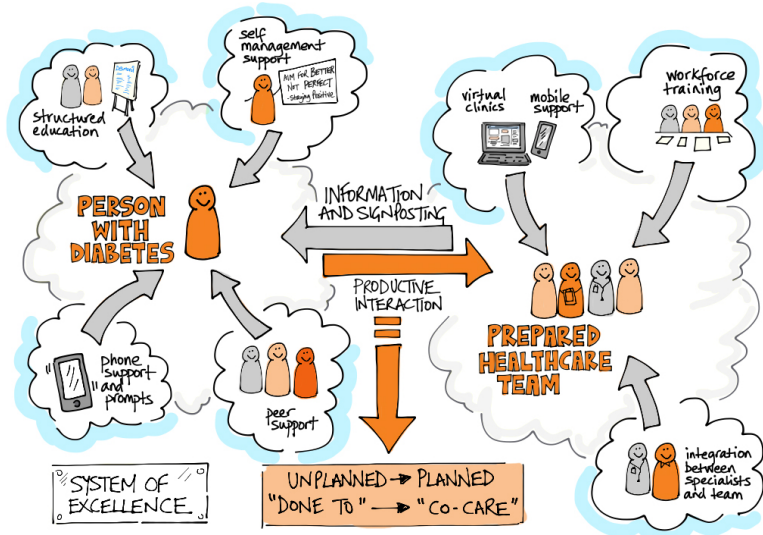
Please take them, use them, adapt them and share them.



Most care is SELF CARE

most people see health professionals for only a few hours per year, so it's the person LIVING WITH THE CONDITION who is in charge of the day to day management of their health.

that's ME



CASE STUDY: *Islington | Diabetes locally commissioned service*

Islington has a registered population of 228,000, and is the fourth most deprived borough in London with high levels of associated ill health. There are 9,986 people diagnosed with diabetes in Islington and a further 6,000 undiagnosed, which equates to almost 1 in 14 of the local population.

Islington has the highest levels of smoking in the capital; obesity and poor diet is a major problem. Although general QOF performance has been good, there has been variable delivery of the nine care processes provided in primary care. Clearly there was a need to improve management of diagnosed patients and address the issue of people who are at high risk of developing diabetes.

What was done?

Between February and April 2012, a series of workshops was delivered by City University London so that Islington CCG could better understand current service provision, identify gaps and encourage ideas for proactive care planning. The workshops resulted in the CCG taking a radical, whole system approach to care planning. A diabetes steering group has been created to lead and champion change. Membership includes consultants, specialist nurses, patients, and pharmacists from both local trusts (Whittington and UCLH), plus commissioners and representatives from Diabetes UK. The group is chaired by a local GP who is the CCG diabetes lead.

To date, the group has driven several innovative initiatives and is currently engaged in pushing forward the value based commissioning approach to local diabetes service provision. However, its initial project - and the drive for setting up the group - was the development of a diabetes locally commissioned service (LCS).

The LCS was launched in February 2013. The aim was to provide every person with diabetes an enhanced care plan, created through an extended collaborative consultation with their clinician, who has been trained in motivational interviewing, coaching and behavioural change.

The LCS offered:

- » Identification of patients at high risk of developing diabetes with proactive follow up and recall for annual review.
- » Regular review of patients with history of gestational diabetes.
- » Implementation of enhanced care planning with a “Year of Care” approach to all patients with diagnosed diabetes.
- » A medicines management audit around metformin prescribing.

What was achieved?

Within the first 18 months of the LCS launch:

- » More than 3500 patients received enhanced care plans.
- » More than 120 clinicians received training, and local trainers are now providing a rolling programme which, by April 2016, will have provided every GP and practice nurse in Islington with Year of Care (YOC) training.

Year of Care Partners estimate that the impact of this change for both clinicians and patients will be seen three years after implementation. Islington CCG has commissioned an external evaluation of the programme to provide baseline data on the early impact that YOC is having on clinicians and patients. It will also highlight any barriers that certain practices may be experiencing on implementation so that they can be addressed at an early stage. The diabetes LCS has now been absorbed into a larger long term conditions (LTC) LCS, and the YOC approach is being offered to all patients with an LTC.

Resources

networks.nhs.uk/nhs-networks/national-pbc-clinical-leaders-network/resources-1/year-of-care

Contact

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CASE STUDY: *Newham | Diabetes appointments via webcam*

Newham has one of the highest prevalence's of diabetes in London at 7.2 per cent, with 17,000 people on the specialist care diabetes register. More than 66 per cent of the population is from black, Asian and minority ethnic (BAME) groups with high levels of socio-economic deprivation. Yet Newham has amongst the best diabetes care outcomes in London.

With rising demand on services and limited resources, Newham exemplifies challenges faced throughout the NHS. High did not attend (DNA) rates (approximately 30 to 50 per cent for diabetes, depending on age) reflect the access challenges and conflicting demands made on patients with a long term condition such as diabetes.

The Diabetes Appointments via Webcam (DAWN) project was started in 2011. It aimed to provide more accessible and cost effective diabetes care by replacing routine follow up for patients not requiring physical examination with web-based consultations. The project was evaluated using qualitative and quantitative methods. Improvements included greater efficiency of the outpatient process, improved patient experience, enhanced patient self management skills and cost effective care.

Uniquely, this project utilised everyday technology available in people's homes (rather than expensive pieces of kit), included patients of all ages and those from ethnically diverse communities and was conducted in an urban environment where face to face care remained a viable option.

The work has been funded by research grants from The Health Foundation.

What was done?

- » Patients attending diabetes follow up appointments under the care of one consultant were offered a web-based consultation via Skype for their next review if a physical examination was not required.
- » All patients attending the Young Adult Diabetes Service were routinely offered Skype-based access with the specialist nurse and consultant diabetologist. This was offered when the young person preferred to be in contact with a clinician, rather than having a fixed appointment slot.

What was achieved?

- » 62 per cent uptake when people were offered web-based consultations; 82 per cent under the age of 50 years.
- » 1644 appointments (doctor and nurse) with 104 patients.
- » DNA rates are 13 per cent for patients using Skype for follow-up (baseline DNA for the same patients 25 per cent). The service is particularly popular in the young adult clinic, which had the highest DNA rate pre-intervention.
- » Average Hba1c reduction is 5 mmol/mol in those who repeatedly use Skype, which suggests greater compliance with treatment / self-management.

Qualitative data from five patient focus groups and questionnaire surveys highlight four main themes:

- » Ease of access.
- » Change in dynamics of the clinician-patient during a web-based interaction.
- » Greater ownership of health.
- » Reduced anxiety.

Patient comments:

- » "Skype is great for diabetes. Previously it meant taking a day off from university to come to the clinic."
- » "I don't think the consultant or the nurses actually realise that their whole attitude changes when they are in the consultation clinic. They have got their papers in front of them; they are fiddling with that, they are reading through it. But when they are on Skype, they just look straight at you and they talk at you."
- » "Skype has helped to change my mind set in terms of management. There's no excuse for missing appointments now."
- » "I feel better controlled since using Skype and less anxious."

Resources

Quality in Care, <http://bit.ly/1csjgk4>

Contact

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CASE STUDY: CWHHE | *Clinical commissioning for better diabetes outcomes*

In 2014/15 five London CCGs, Central London, West London, Hammersmith and Fulham, Hounslow and Ealing, began working together to improve diabetes care outcomes. They had identified a number of issues which required improvement, including variation in the quality of primary care provision, low uptake of structured education, high cost prescribing with poor outcomes and a need for unified guidance for diabetes management.

What was done?

- » Three contracts were developed for GP practices (working as networks to improve diabetes care for a minimum population of 30,000), which attract payment according to the level and quality of care provided.
- » Each GP practice has a lead GP and nurse for diabetes care who are appropriately trained in diabetes management. Each contract has a range of key performance indicators (KPIs). One contract is to provide annual monitoring for people at high risk of developing type 2 diabetes and referral to intensive lifestyle management or structured education courses.
- » The Level one contract includes payment-related KPIs for the number of people with diabetes receiving all nine care processes, reaching NICE targets for glycaemic control, blood pressure and lipids, having a written care plan and being monitored for symptoms of hypoglycaemia if they are on sulphonylureas and/or insulin.
- » The Level two contract is for practices trained to provide injectable therapy initiation and optimisation with requirements for recording of an individualised HbA1c target and a sufficient improvement in glycaemic control following initiation.
- » All practices are on a single IT system (SystemOne), and are supported by local diabetes management guidelines, clinical templates and a diabetes dashboard showing performance at practice, network and CCG level. Practices need to attend locally organised diabetes training and network meetings.
- » The community service contracts have been changed to support this work and to align their performance indicators with the same improvements in the population's diabetes care.

What was achieved?

The go-live date for all five CCGs is summer 2015.

Resources

<http://www.hammersmithfulhamccg.nhs.uk/about-us/our-plans/improving-diabetes-care.aspx>

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CASE STUDY: Camden | Diabetes integrated practice unit (IPU)

Camden has a population of 225,140 people. Of those, 7,830 have been diagnosed with diabetes. It is estimated that a further 7,824 people have undiagnosed type 2 diabetes.

It was recognised that many people with diabetes were not receiving all nine care processes. It was not clear how much of this related to the quality of care provided or poor patient engagement with local services. There was also considerable variation in the proportion of patients receiving the care processes between practices, ranging from 20 to 80 per cent in the 2010/11 National Diabetes Audit.

In 2014, Camden made changes to the way diabetes care was commissioned. The main objective was to create one diabetes team; the Camden Diabetes Integrated Practice Unit (IPU), which is already delivering a population change in results of HbA1c and the nine care processes. From April 2015 this is a value based commissioning contract of pooled budgets across the six partnership organisations* rewarding outcomes rather than process.

What was done?

- » Staff from six provider organisations* are working as one team based at the diabetes centre at St Pancras Hospital.
- » Outcome measures and training needs analysis has been carried out in each Camden GP practice to allow targeted support from the Integrated Practice Unit (IPU) for poorly performing practices.
- » Diabetes Foundation course for primary care clinicians to increase knowledge and skills.
- » “Practices of Excellence” identified in each of three localities with GPs and practice nurses trained to an enhanced level in diabetes care.
- » Single referral form and single point of referral to all diabetes specialist services.
- » Consultant-led multi disciplinary intermediate care team (Tier 3) established.
- » Pathway and criteria for referral to different diabetes specialist services.
- » Focus on care planning and uptake of structured education for people with diabetes.
- » Novel services such as multi disciplinary team in patients’ homes, coaching and facilitation clinics throughout general practice.

What was achieved?

Outcome measures for the IPU include:

- » An increase in the number of people diagnosed with type 2 diabetes in Camden.
- » More people with diabetes receiving all nine care processes.
- » More people with diabetes who have controlled HbA1c and blood pressure.
- » More people attending structured education in the borough.
- » Reduction in the number of emergency admissions due to diabetes.
- » Reduction in the number of people developing diabetes complications.



Resources

www.camdenccg.nhs.uk/gps/diabetes-integrated-care-service

Contact

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* Royal Free London NHS Foundation Trust, University College London Hospitals NHS Foundation Trust, Central and North West London NHS Foundation Trust, Camden and Islington NHS Foundation Trust, Whittington Health, as well as all GP practices now organised into a federation under Haverstock Healthcare.

CASE STUDY: Sutton and Merton | *Diabetic eye screening/serial non attenders*

Patients with diabetes should receive annual screening for a condition known as diabetic retinopathy. Diabetic retinopathy is a leading cause of blindness in the working age population, but has few symptoms until the disease is quite advanced. Screening can detect the condition in its early stages where treatment is much more effective. Patients who do not attend screening are at a much greater risk of sight loss.

The project was funded by NHS England via a Commissioning for Quality and Innovation (CQUIN) scheme.

What was done?

- » The screening programme ran a query against its database to look for patients who had never received screening due to multiple missed appointments.
- » The list of patients was cross checked with other community and primary care databases to verify accuracy and look for opportunities to work with clinicians that may already be caring for each patient.
- » The screening programme assigned a small dedicated team to contact patients and their clinicians to establish any barriers to attendance and develop solutions using a methodology developed specifically for the project.
- » A qualitative analysis of the project was undertaken to identify patient or system factors which were associated with serial non attendance.

What was achieved?

- » 296 patients were identified as having never received screening despite being offered multiple invitations over a maximum period of eight years.
- » 56 patients attended screening during the audit period (with a further two attending thereafter).
- » The proportion of patients with sight-threatening retinopathy was 15 per cent of patients screened -- approximately four times higher than the average for the programme. These patients were referred to an ophthalmologist for treatment.
- » As well as referring a number of patients for treatment, the project provided valuable evidence about reasons for non attendance in this group, which is traditionally very hard to reach or survey. This will be used to inform future service design.
- » Findings were presented to the programme board and are shortly to be published in a peer reviewed journal.

Resources

www.ncbi.nlm.nih.gov/pubmed/23793717

Contact

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TOOLKIT MATRIX

	Leadership and change champions	Self-management and collaborative care planning	Professional education, pathways and guidelines	Information technology and using data to facilitate change
Tower Hamlets: <i>Year of care programme</i>		✓		✓
Bexley: <i>GP led, integrated diabetes care</i>	✓	✓		✓
Lambeth and Southwark: <i>Diabetes Modernisation Initiative</i>	✓	✓	✓	✓
Islington: <i>Diabetes locally commissioned service</i>	✓	✓	✓	
Newham: <i>DAWN project</i>				✓
CWHHE: <i>Clinical commissioning for better diabetes outcomes</i>	✓	✓	✓	✓
Camden: <i>Diabetes integrated practice unit</i>	✓	✓	✓	✓
Sutton and Merton: <i>Diabetic eye screening</i>				✓

About the Strategic Clinical Networks

The London Strategic Clinical Networks bring stakeholders -- providers, commissioners and patients -- together to create alignment around programmes of transformational work that will improve care.

The networks play a key role in the new commissioning system by providing clinical advice and leadership to support local decision making. Working across the boundaries of commissioning and provision, they provide a vehicle for improvement where a single organisation, team or solution could not.

Established in 2013, the networks serve in key areas of major healthcare challenge where a whole system, integrated approach is required: Cardiovascular (including cardiac, stroke, renal and diabetes); Maternity and Children's Services; and Mental Health, Dementia and Neuroscience.