RightCare CASEBOOK

Slough CCG

Improving the value of diabetes care in Slough

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The setting

NHS Slough Clinical Commissioning Group (the CCG) is a group of 16 GP practices with branch practices in the Borough of Slough, Berkshire. Slough CCG is responsible for commissioning (buying-in) and managing most of your hospital and community health care services. The CCG has a responsibility for 143,343 registered patients and an allocated budget of £150m to commission health services in 2013/14

The situation or problem

The prevalence of type 2 diabetes in the UK is rising due to increasing levels of obesity and an ageing population. It is a condition that costs the NHS over £10 billion a year, yet 80% of these costs are spent on avoidable complications including heart attacks, stroke, renal disease, blindness and amputations.

The prevalence of diagnosed cases of type 2 diabetes in the UK is approximately 6%. However, in 2013, there were over 8600 people in the Slough with a diagnosis of type 2 diabetes - a prevalence of 8% - and approximately 1400 more people with undiagnosed diabetes as estimated using the Diabetes Prevalence Model. Type 2 diabetes is significantly more common in people of South Asian and African-Caribbean descent, and Slough's resident population includes 40% of South Asian descent and 9% of African Caribbean descent.

What action was taken?

Diabetes has long been recognised as a priority for the Slough health economy, as demonstrated by earlier campaigns including "Action Diabetes" in 2004. That campaign targeted the large Black and Minority Ethnic (BME) populations of Slough who were at greater risk of diabetes and also less likely to access healthcare services.

Slough CCG's commissioning approach for the improved management of type 2 diabetes was based on evidence with a clear emphasis on outcomes. It was consistent with the three-stage Right Care methodology (Where to look, What to change, How to change) and supported by a designated leadership team.

Where to Look

Data comparing Slough CCG with national data, comparator CCGs and the Thames Valley strategic clinical network demonstrated that there were opportunities to improve both quality of care and value for money.

- The Commissioning for Value Insight pack for Slough CCG identified that diabetes presented an opportunity for both quality improvement and financial savings. These opportunities were indicated by higher numbers of non-elective admissions compared with similar CCGs and also higher prescribing costs for conditions resulting from complications in cases of diabetes that were not well controlled.
- The National Diabetes Audit 2011/2012 demonstrated that, whilst the CCG performed well in terms of the percentage of people with diabetes who had received the 8 care processes

recommended by NICE, the control of their diabetes was less effective than the comparator groups as measured by HbA1c, blood glucose, blood pressure and cholesterol levels.

- The Health and Social Care Information Centre analysis in 2012/2013 demonstrated that Slough CCG spent less on prescribing for anti-diabetic items compared to the English average, and their outcome measures were poor compared to all comparators. These outcome measures were the percentage of patients with diabetes in whom the last HbA1c was less than 59mmol/mol (59.5% compared with 65.6%) and those meeting blood glucose, blood pressure and cholesterol targets (16.6% compared with 20.8%). Effectively Slough CCG's profile was one of "low costs and poor outcomes"

What to Change

In response to the information gathered from national information sources, NHS Slough CCG triangulated the evidence with locally gathered data and "soft" intelligence.

- Local Public Health intelligence indicated that there was a significant gap in services for the South Asian population and that there was a need to engage this population in a culturally sensitive way for the purposes of diagnosis, management and prevention of diabetes.
- QOF data (2012/2013) demonstrated wide variation in the prevalence of diagnosed diabetes between the 16 general practices in the CCG area, ranging between 3% and 12% of registered patients.
- QOF data also demonstrated marked variation between general practices in the measurement of HbA1c in patients with diagnosed diabetes, as well as in the percentage of patients whose diabetes was well managed in terms of HbA1c (<59mml/mol) cholesterol (5mmol/l or less) and blood pressure (140/80 or less)

How to Change

The outcome of the analysis of data and local intelligence alongside national evidence on "what works where" suggested that there were two main areas for action to enhance the quality and value of the diabetes service:

1. Direct engagement with the local South Asian population who either had type 2 diabetes or had risk factors for developing it
2. A programme of education to up-skill the healthcare professionals in the 16 general practices in Slough and improve the management of people with diabetes.

What happened as a result?

The South Asian Lifestyle Intervention Programme was launched, delivering interactive group education sessions over 7 weeks. The sessions place emphasis on various exercise, lifestyle and behavioural changes specific to the South Asian population and are delivered by a nutritional advisor and nurse with support available in Urdu and Punjabi languages. Referral to the programme is made by GPs for individuals with a body mass index (BMI) of 30 or greater.

- At the initial assessment all participants had their weight, blood pressure and HbA1c measured and were given a target weight loss
- Weight checks were performed on the 3rd, 5th and 7th week
- Individual food and activity diaries were discussed at the 2nd, 4th and 6th week
- Quizzes helped to monitor the participants' levels of understanding
- Behavioural questionnaires assessed their changes in behaviour after the programme

The outcomes of the South Asian Lifestyle Intervention Programme between June 2013 and November 2013 demonstrated significant successes:

- Of 106 individuals who were invited to attend the programme 75 accepted and another 7 expressed an interest in enrolling on a subsequent course.
- Of the 75 participants 61% attended 6 or 7 sessions, 27% attended 2-5 sessions and 12% attended only one session
- 86% of attenders lost weight. The remaining 14% either lost no weight or gained weight
- Of participants with pre-diabetes whose results are available for evaluation, 100% saw a reduction in their HbA1c levels ranging between 1 and 9 mmol/mol. There was a direct correlation between the numbers of sessions attended and the reduction in Hb1Ac level
- Of the participants with type 2 diabetes, 89% saw a reduction in their HbA1c levels. These reductions ranged from between 1 and >17mmol/mol

NHS Slough CCG is now working in partnership with Slough Borough Council and Community Health groups to provide lifestyle support and information to 50% of patients with diabetes or those identified as being at risk of developing diabetes by 2014/2015. The next phase of the programme will include cooking demonstrations.

The Enhanced Management of Diabetes (EMD) Programme, a clinical mentorship programme to support and up-skill health care professionals in general practices, was established in 2013/2014 and run in partnership with external agencies including National Services for Health Improvement. The objectives of the programme were to:

- Improve primary care management of adults with type 2 diabetes and increase the confidence and competence of primary care health professionals
- Reduce overall variability of diabetes care at practice level
- Increase sustainable support and education for primary care practitioners to strengthen their skills in diabetes management

The outcomes of the EMD programme between June 2013 and November 2013 have been positive:

- Patients in each of the 16 general practices in Slough now have a key contact for advice and guidance on managing their diabetes

- There are clear pathways / referral criteria for patients and also primary care health care professionals
- Patient Participation Groups have been established to provide support and encourage self-management of the condition
- There has been demonstrable improvement in the control of diabetes resulting from EMD:

    - With one exception each of the 16 practices showed an increase in the number of patients whose diabetes was controlled, as measured by Hb1Ac <59mmol/mol. The total increase was 6.1% from 58.4% to 64.5% of patients
    - Again, in all but one practice, there was an increase in the percentage of patients whose blood pressure was <140/80. The overall increase was from 72.25% to 80.06%
    - Increased numbers of patients in 14 of the 16 practices had total cholesterol levels of <5. The overall increase in patient numbers across the 16 practices was from 72.86% to 76.42%.

NHS Slough CCG now plans to build on the improvements resulting from the delivery of the EMD programme, and hopes to deliver an Advanced Management of Diabetes (AMD) programme as delivered by PITstop Diabetes. The aim of the AMD programme is to improve outcomes of hard-to-engage patients whose diabetes is uncontrolled (HbA1c higher than 75mmol/mol).

What was the learning as a result of this experience?

- The Right Care methodology (Where to look, What to change, How to change) has been successfully applied to the management of diabetes in a population
- Right care methodology led to improved engagement with internal and external agencies
- An integrated service is now provided with the community Diabetes service providers
- CCG leadership and focus on specific disease groups is essential
- Engagement of all stakeholders in a system of care is required

Right Care Resource Centre

Right Care has a new resource centre where CCGs can find supporting materials describing the Commissioning for Value approach:

- Online learning videos
- “how to” guides
- Theme based Webinars
- Casebooks showing learning from early adopters
- Essential reading lists and glossary
- Tried and tested process templates to support taking the approach forward

www.rightcare.nhs.uk/resourcecentre