

Slough CCG

Improving the Value of Diabetes Care: One year On

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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 NHS Slough CCG case study- *Improving the value of diabetes care in Slough (October 2014)* described how the CCG had adopted the NHS Right Care methodology (where to look, what to change, how to change) into their commissioning processes for diabetes care.

The CCG identified diabetes as a strategic priority. National and local data comparing Slough CCG with comparator organisations had demonstrated that there were opportunities to improve both quality of care and value for money.

In summary, in comparison with similar organisations, Slough CCG:

- Had higher numbers of non-elective admissions associated with diabetes
- Spent more on prescribing costs for conditions resulting from complications in cases of diabetes that were not well controlled
- Spent less on prescribing anti-diabetic items
- Control of diabetes was less effective in terms of HbA1c, blood glucose, blood pressure and cholesterol levels

In addition, locally gathered data and soft intelligence indicated 3 specific areas where diabetes care should be improved:

1. There was a gap in services for the South Asian population (60% of Slough CCG's resident population). This is a group where the incidence of type 2 diabetes is significantly more common than in the whole British population
2. There was a wide variation in the prevalence of diagnosed diabetes between the 16 practices in the CCG area (3% - 12%)
3. There was marked variation between general practices in the measurements of HbA1c in people with diabetes as well as in the percentage of people whose diabetes was well managed in terms of HbA1c, cholesterol and blood pressure

What was decided?

The CCG focused on two key objectives to enhance the quality and value of the diabetes service:

- To up-skill healthcare professionals in all the general practices in Slough to improve the management of people with diabetes
- To identify and engage with the local South Asian population who had type 2 diabetes or were at risk of developing diabetes

- To engage with clinical pharmacist to review patients and advise on compliance as well as recommend medication regime changes to optimise care

What happened?

This casebook describes progress in Slough as at January 2016.

Outcomes of Delivery- One Year On

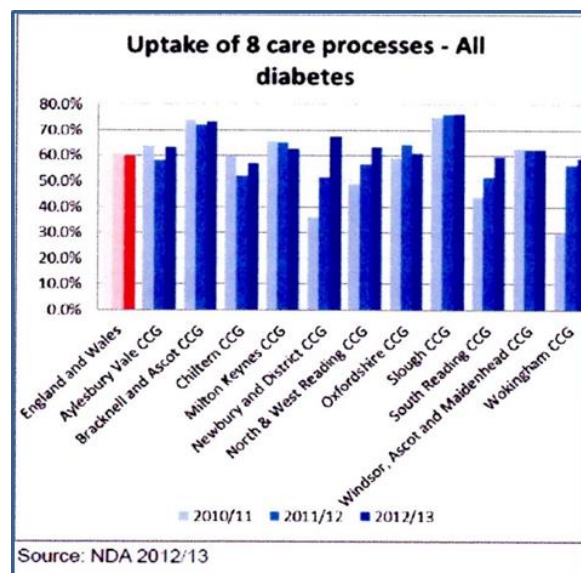
Healthcare professionals in all 16 GP practices in Slough were educated in the identification and management of people with diabetes and those at high risk of developing diabetes. The clinical pharmacists were engaged and each practice list was reviewed and changes made to medication regimes. Innovation Fund monies supported the identification of, and contact with, patients from all 16 GP practices who were at risk of developing type 2 diabetes. The South Asian Lifestyle Intervention Programme has been delivered to appropriate “at risk” patients from all 16 GP practices in the Slough CCG area.

There has been significant improvement in Slough CCG’s identification and management of patients with type 2 diabetes, as described below.

Outcomes from the Enhanced Management of Diabetes Programme (EMD)

- Healthcare professionals from all 16 practices have been trained using the EMD and are key contacts for advice and guidance
- There is reduced variation between the practices in terms of their identification of people with diabetes and those at risk of developing diabetes. In March 2015 the prevalence of diabetes varied between 3.6% and 13.1%ⁱ
- All 16 GP practices are now meeting national targets for delivering the 8 careⁱⁱ processes and Slough ranks second best in England (Figure 1)

Figure 1: Uptake of 8 key care processes as recommended by NICE



- All practices also meet the target for delivery of retinal screening
- Slough GP practices have improved performance in terms of control of diabetes
 - Hba1c target (<59) 58.41% → 64.48%
 - BP target (<140/80) 72.5% → 80.06%
 - Cholesterol (<5) 72.86% → 76.48%ⁱⁱⁱ
- The number of people with diabetes who are meeting blood glucose, blood pressure and cholesterol targets has increased from 16.6% to 39%
- There has been more cost-effective prescribing - the Diabetes Outcome versus Expenditure (DOVE) charts demonstrate that NHS Slough CCG has moved from being a low expenditure/poor outcomes organisation (2011-12) to being a low expenditure/good outcomes organisation (2013-2014) (Figures 2 & 3)

Figure 2: Diabetes Outcome Versus Expenditure Tool: Diabetes Quadrant Chart for NHS Slough 2011/12

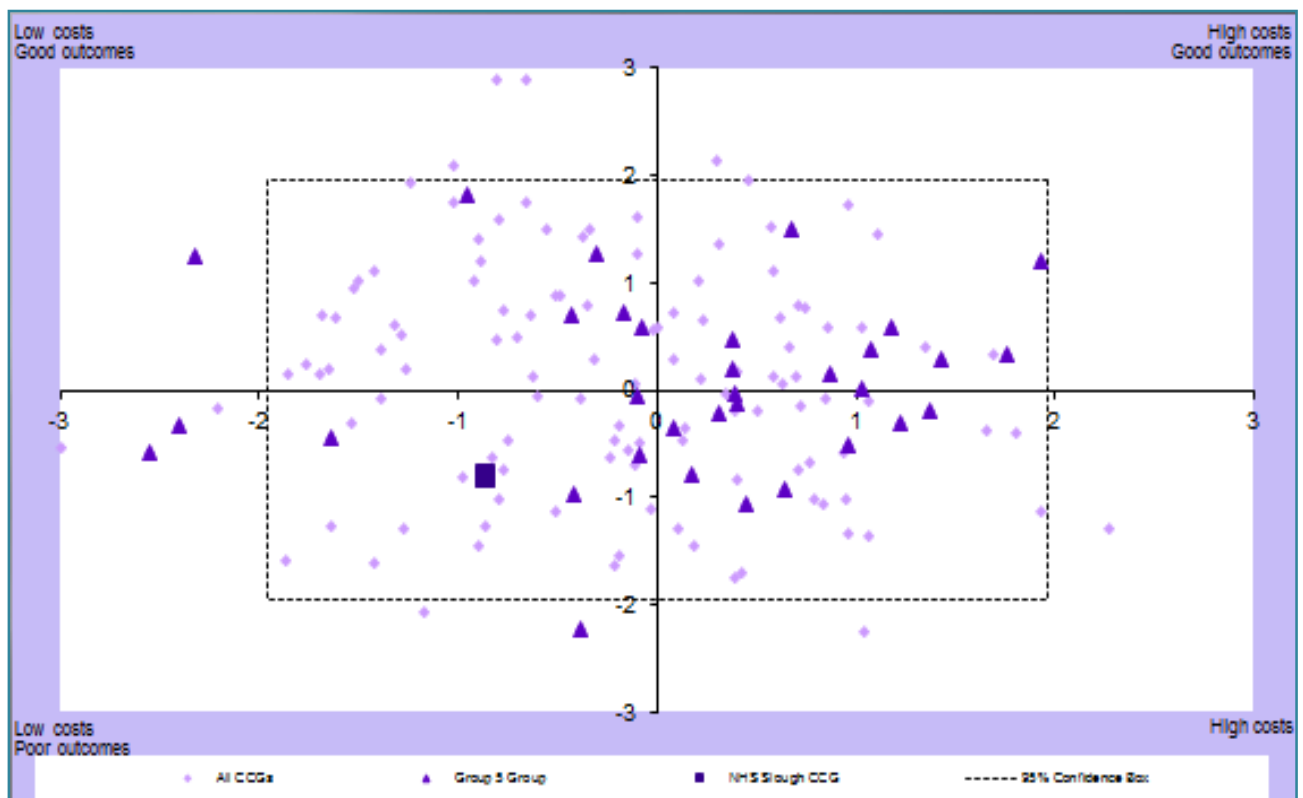
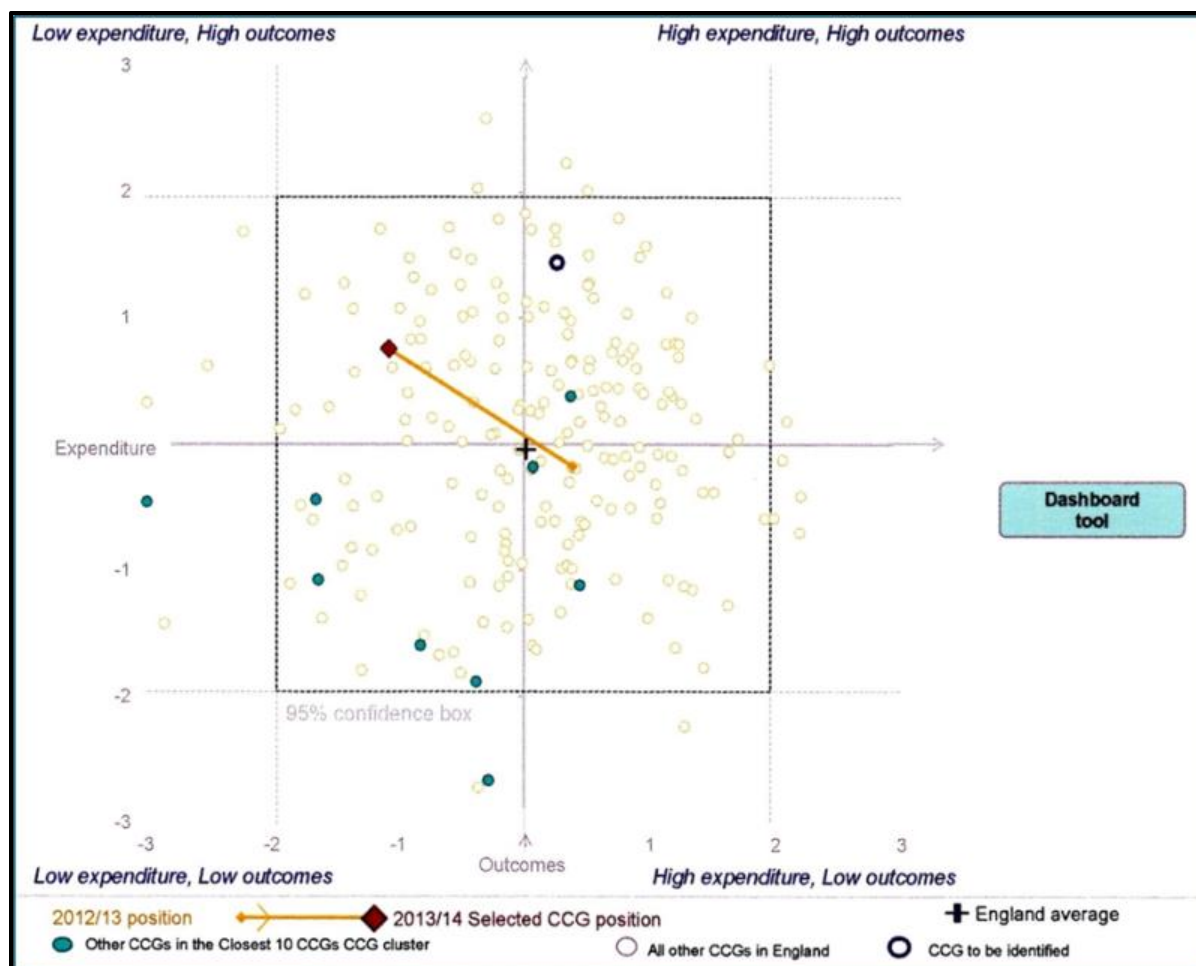


Figure 3: Diabetes Outcome Versus Expenditure Tool: Diabetes Quadrant Chart for NHS Slough 2013/2014



Outcomes from the South Asian Lifestyle Intervention Programme

This programme was initially funded using Innovation Fund resources for one year and was shown to be highly effective in engaging with individuals from the south Asian population whose GP records indicated that they were at risk of developing diabetes due to BMI of 30kg/m² or greater.

- There has been an increase in the number of people diagnosed with type 2 diabetes (8996 in March 2015 compared with 8604 in August 2014¹)
- Individuals who are shown to be at risk of developing diabetes have been given the tools to manage their weight and thus reduce their HbA1c levels. They are now being recalled annually for review
- The CCG has partnered with the Silver Star Charity and the Local Authority to screen members of the public in a variety of places including mosques, schools and festivals.

- Free screening is funded by the CCG as part of its diabetes strategy. Initial results demonstrate that 88% of those screened are of black and minority ethnic (BME) origin. Of those, 38% were overweight, 8% were morbidly obese and 11% were diagnosed with diabetes

What Happens Next?

- Education for health care professionals is being further developed to incorporate two accredited classroom based education programmes:
 - MERIT-diabetes education and management foundation course (annual basis)
 - PITSTOP-insulin initiation and management programme
 - Advanced Management of Diabetes
- There will be increased focus on the education and management of people identified with raised HbA1c levels
- The learning and processes of the South Asian Lifestyle Intervention Programme will be embedded in the NHS Diabetes Prevention Programme
- As a result of the partnership with the Silver Star Charity a further 1,500 patients will be invited to join the South Asian Lifestyle intervention programme
- Every year those identified as being at risk of developing diabetes will be invited back for re-testing.

What was the learning as a result of this experience?

- Change takes time to realise its outcomes
- The NHS Right Care approach supports improvement
- Clinical and managerial buy in is essential
- The NHS Right Care approach can provide the evidence that an organisation is focused on the right areas and provides value to the organisation in the following ways:
 - Resources are focused on priority areas that can make the biggest difference in terms of quality and outcomes
 - Organisational effort – in terms of clinical and managerial time - is focused on the right areas
 - The CCG is enabled to maximise the value of every pound spent

ⁱ Public Health England (March 2015) Cardiovascular disease profile, Diabetes. NHS Slough CCG

ⁱⁱ NICE guideline NG28 (December 2015) Type 2 diabetes in adults: management

ⁱⁱⁱ QOF data 2013/2014 compared with 2012/2013