NHS
East Lancashire
Clinical Commissioning Group

An integrated service for diabetes in East Lancashire – Ribble Valley Diabetes Group

Diabetes Integrated Service Redesign

Identify Need

1. Variation in commissioning activity
2. Variation in outcomes
3. Inequities in service delivery
4. Variation in resource allocation

Clinical Engagement & Ownership

1. Protected Learning Event
2. Sharing Information on resources and outcomes
3. Agreement on a case for change
4. Diabetes Task and finish Group

Delivery

1. Delivery Plan
2. Detailed, robust Service Specifications
3. Workforce, education and training
4. Ongoing system resilience

Prevalence; Need & Resources

1. Diabetes prevalence across all localities
2. Establish workforce and skill mix to deliver agreed clinical model according to agreed specifications
3. Cost out workforce required to deliver agreed clinical model

Activity Data; Costs & Accommodation

1. Review all activity data in relation to diabetes activity.
2. Establish elements that should be provided in community setting.
3. Re-allocate resources according to findings
4. Explore accommodation options to ensure care delivered closer to home .

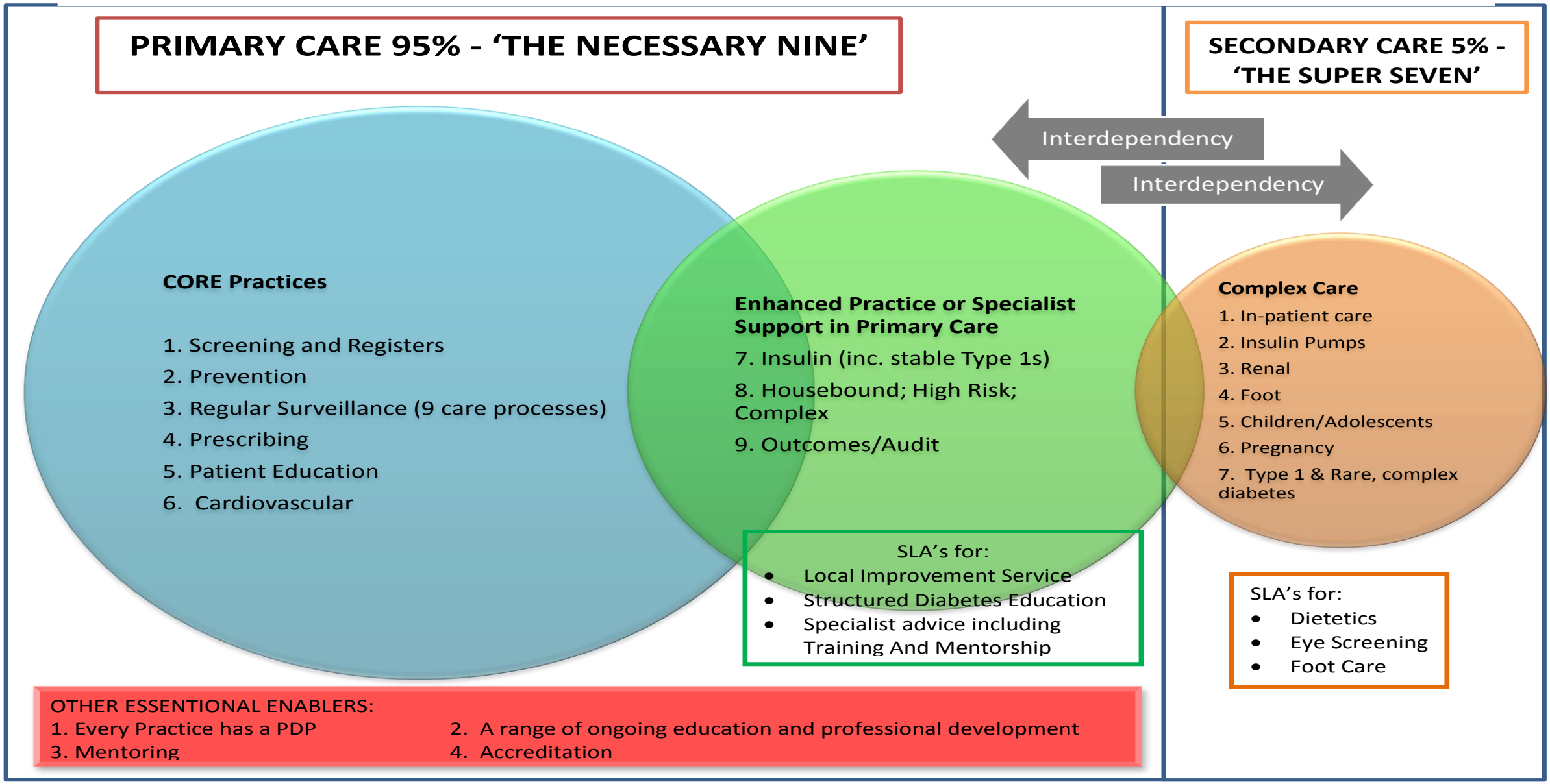
Performance; Quality and Outcomes

1. KPIs included in each specification
2. Quarterly monitoring of KPIs
3. Submission of outcome data prior to payment
4. Ongoing performance review tracked over time to monitor improvement.

Identifying the Need

- Inequity in commissioning arrangements
- Variation in outcomes and Exception Coding compared to England Av:
  - HbA1c [18.6 vs. 12.1]
  - BP [6.32 vs.4.78]
  - Cholesterol [13.85 vs.11.4]
  - Proteinuria [12.8 vs.10.9]
- Inequitable allocation of resources: £2.37 per diabetic in Pendle - £123.86 in Hyndburn with other implications
- Variation in service delivery across primary and secondary care
- Variation in knowledge, skills and capacity

East Lancashire Diabetes Service Model



Service Specifications

Integrated and Seamless Care close links with podiatry, dietetics , renal and eyes

Primary Care – Enhanced Diabetes Care

- Excludes core diabetes care
- Training, education and hands on mentorship via specialist team

Community Specialist Diabetes Care

- Management of more complex patients only
- Training and mentorship to primary care
- Excludes core diabetes care

Structured Diabetes Education

- To be delivered through either primary care, specialist team or other provider
- Standardised outcome data must be submitted from any provider

Primary Care - core service

- Registers: Building and validating accurate diabetes registers against nationally expected prevalence rates
- Screening and prevention: Screening all patients at risk of diabetes . Pre-diabetes risk register.
- **At least annual** surveillance of patients with diabetes including the 9 key care processes:
  - HbA1c measured and managed according to NICE guidelines
  - Blood pressure measured
  - Cholesterol measured
  - Creatinine measured
  - Micro-albuminuria measured
  - Body Mass Index and waist circumference recorded
  - Eyes examined (including access to retinal screening programme)
  - Feet examined. This should include a first level diabetic foot screen (appendix 2)
  - Smoking status recorded
- Cardiovascular risk reduction.
- Prescribing: Evidence based prescribing including insulin, other injectable treatments, oral agents and home glucose monitoring.
- Referral of newly diagnosed patients and patients with established diabetes to structured diabetes education programs.
- Annual audit of the above measures.
- Referrals into the specialist team must meet referral criteria.

Primary Care enhanced

- Manage patients on insulin (and other injectable agents), including initiation and titration for type 2 patients
- Initiation and management of all treatments in line with NICE Guidance, locally approved guidance and the Health Economy Joint Formulary.
- Standardized patient education to enhance self-management.
- Practice Nurses and/or GPs should attend regular meetings with the specialist team to build knowledge and expertise within the primary care workforce.
- Provide proactive care for all patients, especially complex patients at high risk of acute hospital admission including the use of risk assessment and stratification tools.
- Review of patients post discharge as clinically appropriate.
- Timely management of more complex patients including those with poorly controlled HbA1c, those with co-morbidities.
- Support high quality care for housebound patients (including those in Nursing/Residential homes). This includes home visits where appropriate especially for those patients on insulin.

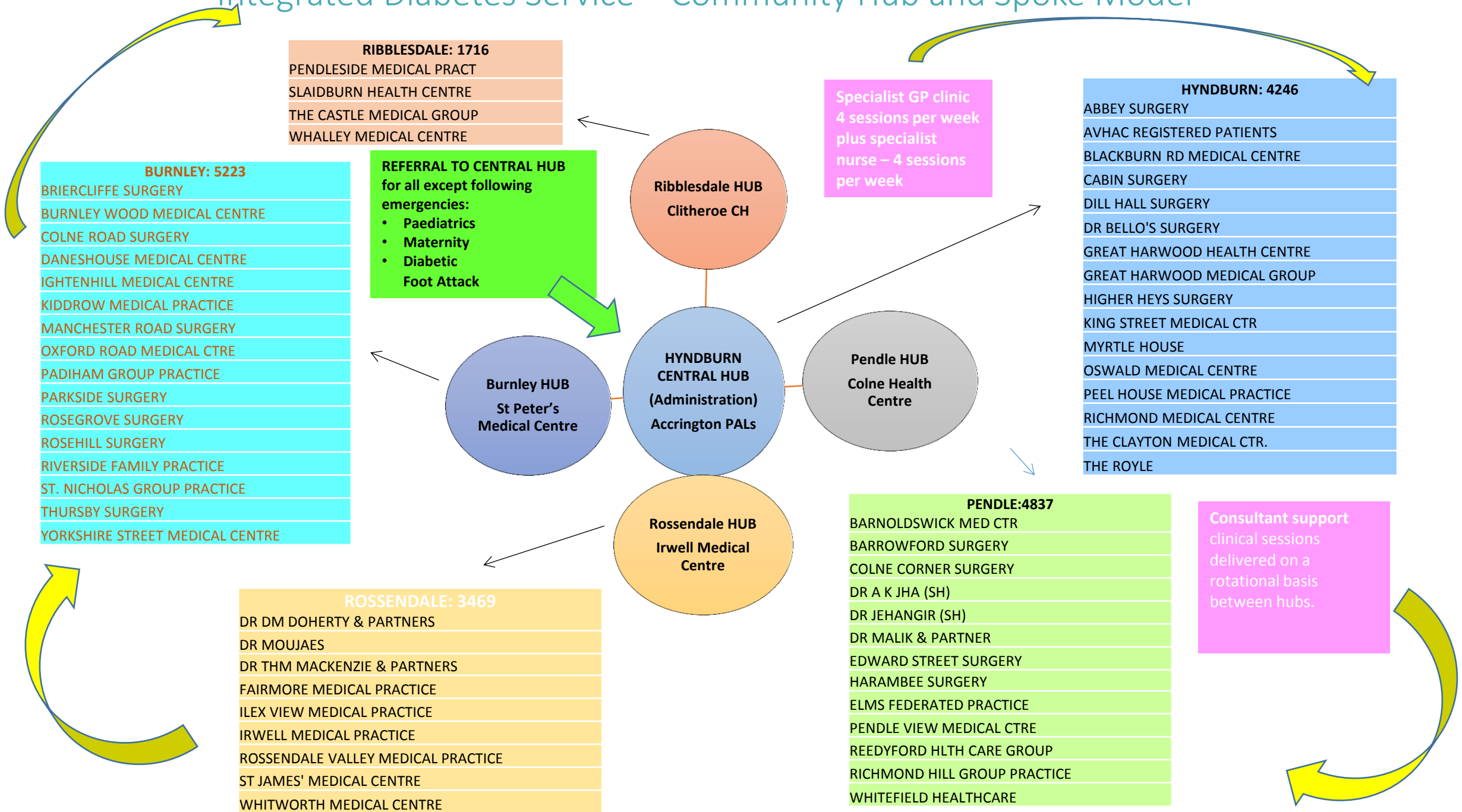
Specialist Service

- Support appropriate secondary to primary care shift of activity creating care closer to home.
- Provide expert advice and mentorship to primary care clinicians to enable practices to deliver a high quality, enhanced level of diabetes care to all patients in a primary care setting.
- Ensure all patients across East Lancashire have access to an enhanced level of diabetes care including insulin start-ups and other injectable treatments with on-going monitoring.
- Reduce variations in the delivery of diabetes care across GP practices creating consistency of practice, measured through regular clinical audit.
- Encourage structured annual reviews for patients ensuring standardized care plans are in place.
- Increase the quality and accessibility of diabetes services at locality level.
- Maintain a high level of training in general practice, increasing skills confidence and competence.
- Promote an open culture of audit, education and clinical updates.
- Provision and facilitation of structured education programs to ensure primary care clinicians have annual updates and re-accreditation.
- Encourage close working relationships with podiatry, ophthalmology, dietetic and other specialists and secondary care consultant advice.
- Support practices in training and education to deliver the core and enhanced elements of the service and provide assurance to the commissioners of delivery from primary care providers. **The specialist service will not directly provide the core or enhanced level of diabetes care on behalf of practices.**

Diabetes Prevalence across East Lancashire

Diabetes Prevalence in East Lancs			
Locality	**Locality Population/k**	**Diabetic Population**	**Prevalence/%**
Hyndburn	76	4246	5.5
Ribblesdale	37	1716	4.6
Burnley	96	5223	5.4
Pendle	92	4837	5.3
Rossendale	69	3469	5
TOTAL	370	19,491	

Integrated Diabetes Service – Community Hub and Spoke Model



Workforce development

- Delivery of diabetes clinical diploma (in conjunction with Bradford University) locally to our GPs and PNs
- Delivery of diabetes updates sessions for those clinicians already undertaken diploma but requires a refresh
- Delivery of diabetes session for HCAs.
- Delivery of insulin start-up courses for those practices delivering enhanced level of care.
- More sessions also planned to deliver the above.