Agenda Item No 8

NHS Dudley Clinical Commissioning Group

Report of the Head of Service Improvement, Dudley Clinical Commissioning Group

Update on service improvement plans for patients with diabetes
March 2013

Purpose of report

Diabetes is a major health issue and Clinical Commissioning Groups (CCGs) will play a key role in ensuring people with diabetes and those at risk of diabetes receive the best care and support available.

Dudley Clinical Commissioning Group (DCCG) has identified improving services for people with diabetes as one of their top ten key priorities. The CCG wishes to improve the quality of services, diagnose more people at an early stage and identify those at risk of diabetes to decrease the number going on to develop the disease.

Needs Assessment

Dudley is not atypical to England; however the prevalence in Dudley is slightly higher than the England figure but lower than the West Midlands average. An estimated 15000 people in Dudley (5.7% of the overall population) are known to have diabetes. The data suggests that the recorded cases represent about 75% of the estimated number of prevalent cases. 90% of known cases are type2 diabetes.

Diabetes prevalence is growing, the best evidence we have is the number of people with diabetes in Dudley is likely to grow to 21,000 by 2015; 24,000 by 2015; and to 25, 700 by 2030.

Quality of Current Services

The quality of care delivered in primary care as measured by QoF scores is generally good in Dudley but varies among practices. The extent of the exception reporting for diabetes QoF indicators varies from 7.2% to 13.4%. In the National Diabetes Audit in 2011 Dudley Practices scored in the middle 50% for most indicators, the upper quartile for 9 and the worst for only 1 (urinary albumin). Dudley is in the bottom quartile for screening for kidney disease.
The efficiency with which resources are deployed in Dudley is similar to other comparable district hospitals. Dudley's health services score well overall in the national Diabetes self assessment for almost all indicators of quality services. Dudley and Dudley Group Foundation Trust (DGFT) are in the best 25% of organisations. In the 2011 National Diabetes In-patient audit DGFT compares well with other hospitals.

Standards of Services:

National Diabetes Audit (NDA):

The National Service Framework for Diabetes contains nine standards for the provision of high quality diabetes services:

1. Prevention of Type 2 Diabetes
2. Identification of people with Type 2 Diabetes
3. Empowering people with Diabetes
4. Clinical care of adults with diabetes
5. Clinical care of children and young people with diabetes
6. Management of diabetic emergencies
7. Care of people with diabetes during admission to hospital
8. Diabetes and pregnancy
9. Detection and management of long-term complications

The 9 core processes are measured in both the QoF and NDA. In QoF, for most Primary Care Trust's (PCT), all 9 core processes are recorded at over 90%.The nine core processes are measured using NDA, which is considered to be the largest annual clinical audit in the world. It provides an infrastructure for the collation, analysis, benchmarking and feedback of local clinical data to support effective clinical audit across the NHS. Quality information is vital to the success of organisations implementing the Diabetes National Service Framework (NSF) and improving services.

Dudley CCG National Diabetes Audit 2010 -2011:

The most recent NDA shows that 42 practices (79.2%) from Dudley PCT submitted data to the National Diabetes Audit:

2010 – 2011			**2009 – 2010**		
Number of registered practices	Number of participating practices	PCT participation rate	Number of registered practices	Number of participating practices	PCT participation rate
53	42	79.2%	55	41	74.5%

Quality and Outcomes Framework (QOF):

QoF results 2011 -2012 (June 2012)

The average total on all QoF indicators in diabetes across all practices in Dudley is 86%. This is broken down into 13 practices achieving an average of 90% and above, 34 practices achieving between 80 -89% and 6 practices achieving below 80%.

Diabetes Local Enhanced Service 2011/12:

Total of 40 out of 51 practices signed up to participate in diabetes LES 2012/13
9 practices did not meet criteria to undertake LES this year due to not meeting minimum QoF points of 85% across all indicators. All of these practices received a visit by the clinical and commissioning lead to identify issues and develop a practice action plan for implementation and improvement next year.
Submissions were received from 38 practices covering 85 % of total diabetes population in Dudley

Tier 1

Brief Definition of Tier 1:

- The practice must have two clinicians complete the Dudley PCT Core Competencies for Adult diabetes in primary care Stage 2 training
    - Review annually all patients under the Diabetologist
    - Manage patients in accordance with NICE Guidelines and locally defined diabetes pathways
- Compile a risk register of patients at risk of diabetes defined as impaired glucose tolerance and impaired fasting glycaemia and previous gestational diabetes
    - Undertake an annual review for all patients at risk as above and advise and manage any identified risks
- Undertake personalised care planning on patients with HbA1c>8.5% or those with complication at the time of annual review
    - Care planning should be taken by a qualified nurse or doctor
- Conduct annual and 6 month monthly diabetic review including domiciliary visits where appropriate

All 38 practices were delivering Tier 1, which resulted in

- 78 Patients being discharged back from Secondary Care
- 1281 Patients identified and put on an 'At Risk of diabetes Register'
- Of the 'at risk' 752 (59%) had an annual review
- And 8212 (62%) of diabetes patients had at least an additional 6 month review
- In addition all these practices were undertaking personalised care planning (National priority for all long term conditions) with patients whose control was poor defined as HbA1c >9 and/or complications of diabetes

Tier 2

Brief description of Tier 2 –

The practice must have two clinicians complete "The Dudley PCT Core Competencies for Adult diabetes in primary care Stage 2 training" and at least one doctor must complete "The Dudley Model for Comprehensive Insulin Management Programme Part One"

In addition to Tier 1 the practice will:

- Identify patients suitable for insulin initiation inline with NICE guidelines
- Where appropriate commence patients on insulin and offer continued supervision and support

- Offer Structured education

Results 2011-12
29 practices covering 68.3 % of total diabetes population were undertaking commencement of insulin within the practice setting.

- Across the economy this resulted in 134 insulin commencements (88.2% in these practices) within primary care. Following audit the HbA1c reduced on average by 4.54 (range 0.2-7.54).

Tier 3
The practice must have two clinicians complete "The Dudley PCT Core Competencies for Adult diabetes in primary care Stage 2 training" and at least one doctor must complete "The Dudley Model for Comprehensive Insulin Management Programme Part Two"
In addition to Tier 1 and Tier 2 the practice will:

- Provide specialist management to its diabetes patients that include insulin change
- Where appropriate, commence patients on insulin and offer continued supervision and support
- Offer Structured education
- Enrol in a primary care audit programme

Audit of use of new drugs in primary care
20 practices (covering 52.5% of total diabetes population) were delivering commencement of GLP1 within primary care. Following an audit results produced showed an average HbA1c reduction of 1.51 (range 0.6-3.6) and average weight reduction of 3.56Kg (range -5 to 9.1Kg).

Primary Care Diabetes Community Specialist Team
The CCG also commission a Primary Care Diabetes Specialist Team, the service is designed to support children, young people and adults who have both type 1 and type 2 diabetes. The aim is to deliver a responsive service to meet the needs of the local population as close to home as possible:

- Provide a range of group patient structured patient education initiatives in a variety of local settings including GP surgeries, community centres, health clubs and local supermarkets.
- Provide a full range of treatment options, education and support locally in a variety of settings including GP surgeries, health centres, schools and the home environment
- Offer newly diagnosed patients with diabetes, structured education to include dietary education
- Offer a motivating and empowering approach which encourages confident self care
- Support the needs of General Practice and of the primary health care team
- Strive to offer innovative models of care and clinically effective specialist advice which meets the needs of people with diabetes

- Develop guidelines and protocols together with educational packages to ensure the provision of a highly specialist service.
- Support people whose first language is not English to confidently self manage by developing an understanding of their condition, its treatments and complications
- Ensure competence in practice through continuous personal development, education and training
- Challenge professional barriers to lead change and service redesign as considered appropriate
- Learn from patient experience to make changes and improvements to the service

Dudley Group of Foundation Trust provides higher level services:
All Patients:

- Failure to reach treatment targets despite following guidelines or significant side effects from medication
- Any admission with uncontrolled diabetes
- Hypoglycaemia requiring medical assistance
- New development of microvascular complications
- Nephropathy = CKD 3B - 5
- Retinopathy requiring ophthalmology follow up
- Neuropathy: mononeuritis, amyotrophy, painful neuropathy if not responding to first-line treatment
- Autonomic neuropathy e.g gastroparesis
- Erectile dysfunction not responding to phosphodiesterase inhibitors
- Commencing/titrating insulin (depending on the competencies of individual practices)
- Commencement of GLP - 1 analogue therapy (depending on the competencies of individual practices)

Special Circumstances:

- 'Brittle' diabetes
- Continuous glucose monitoring or insulin pump assessment in Type 1
- People with type 2 diabetes with BMI > 35 on maximum oral therapy / Insulin in combination with GLP-1 analogue therapy which is not currently licensed
- Vocational drivers on insulin or medication that can cause hypoglycaemia
- Children and adolescents
- Type 1 diabetes
- Pre-conception
- Pregnancy
- Foot ulceration foot care pathway
- Osteomyelitis and acute Charcot Joint footcare pathway
- Psychological problems - e.g. fear of hypos, injection-related anxieties, eating disorders

Discharge Criteria:
General specialist discharge will be considered in partnership with individual GP for patients:

- Who have reached their treatment targets without problematic hypoglycaemia

- Where diabetes control is stable or where no further improvement can be achieved and a care plan completed
- If complications are stable and a management plan is in place
- Whose foot condition has resolved and a care plan completed
- At patient or GP request

Please note this list is general and not exhaustive.

Strategic direction:
DCCG recognises that diabetes prevalence is increasing which will lead to an increase in demand for service. The NHS is facing an austere financial climate and the challenge diabetes brings is the need for effective utilisation of resource by service redesign to produce better outcomes within a finite budget. DCCG will aim to implement the following actions with key partners to support this challenge to ensure that patients have access to cost-effective high quality services:

1. Development of a strategic action plan to capture undiagnosed diabetes. To include:-

    - NHS Health checks (40-70 years)
    - Develop a programme which incorporates the >40 and >75 years
    - At risk annual review included in Diabetes LES
    - Update existing pathway to include NICE type 2 at risk guidance
    - Diabetes at risk website and social marketing campaign – launched January 2013
    - Diabetes at risk workbook and posters for GP practices – implemented in January 2013
    - BME worker within Community diabetes Team to work with high risk populations

2. Refresh of Dudley Obesity strategy

    - BMI is part of QoF
    - Include code for referral to lifestyle services in the diabetes LES for both at risk and patients with a diagnosis of diabetes

3. Redesign of Service Model to ensure cost effective high quality patient care

- Primary care, community based specialist care and acute specialist care to have clear roles as part of an integrated Diabetes pathway which is seamless. Including improvement of access/ take-up to the following services; Retinal screening, foot and leg check, renal review.
- Ensure patient education is available to everyone and capture the necessary data to monitor uptake in education programmes.
- Ensure Patient education has been included within the diabetes LES.
- Monitor the outcome of the Diabetes Expert Patient Programme pilot to inform commissioning a long term solution

4. To monitor and reduce exception reporting in Diabetes QoF.
    - Review of QoF data and recommendations produced by NHS diabetes on the National Diabetes audit, to highlight practices to target/focus on.
    - Work to be integrated into GP engagement lead and practice mentorship programme.

5. Continue to monitor and review prescribing to ensure cost effective treatments are implemented.
    - Continue to utilise Quality Innovation Prevention Productivity (QIPP) prescribing data produced by Keele and implementation through the practice based pharmacists to ensure cost effective prescribing is maintained
    - Continue to monitor the impact of blood glucose monitoring guidance and strip utilisation to achieve efficiency savings
    - Monitor impact of recently updated clinical guidelines for Type 2 Diabetes
    - Develop localised guidelines for Type 1 Diabetes based on NICE
    - Prescribing advisor to give regular updates on prescribing issues at local Diabetes Network

6. Work with DGFT to further improve patients access to the joint renal/diabetes multi-disciplinary clinic to improve care of patients with complications

7. Increase early diagnosis, improve access and quality of services for children with diabetes

    - Re-circulation of referral poster previously produced by DGFT to all practices to raise awareness of signs and when to refer
    - Link into Diabetes UK campaign
    - Implementation of Paediatric Diabetes Best Practice Tariff in 2013/14
    - Review of Diabetes in pregnancy NICE guidelines

Key recommendation
That the Overview and Scrutiny Committee are assured that DCCG are working to further develop services for people with diabetes in order to improve outcomes.

Report compiled by:
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