NHS
Bromley
Clinical Commissioning Group

Integrated Diabetes Service

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Project Update for the Health & Well Being Board

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helping the people of Bromley live longer, healthier, happier lives

1. Background

Diabetes care is fragmented and quality of care and outcomes are poor across Bromley. To address these issues a new model of care was proposed and agreed across Bromley, Bexley and Greenwich (BBG) CCGs at the BBG Clinical Strategy Group in February 2013. The next step was for individual CCGs to further develop this for local implementation. The agreed model of care is an integrated specialist service which merges Tier 3 and 4 (hospital and community) into ONE Specialist team. This has been adapted from Portsmouth and Derby which have evidenced significant savings from reduced admissions and outpatient activity.

Evidence from these models has shown that we could achieve 40% reduction in outpatient activity and 50% reduction in emergency admissions year on year. This was achieved by clearly identifying categories of patients with Diabetes which the specialist service will manage. This is known as the Super Six: Insulin pumps, Adolescents/ uncontrolled Type 1, Inpatients, Antenatal care, complex foot care and Dialysis/ CKD>5. In order for us to achieve these new standards of service, new investment is required in primary care to up skill the workforce to manage a larger proportion of Type 1 and Type 2 diabetics. Locally we have set inspirational target of 90% reduction in acute out-patient activity when the model if fully implemented in year 3.

Additionally, it is planned that primary care professionals will have greater direct access to specialist advice and support for complex care which is intended to be more flexible and responsive to people's needs. This is a critical interdependency in order to ensure this model effective. GP practice staff will be offered a programme of training followed by supervision for initiation and ongoing management of patients requiring insulin as well as better management of uncomplicated foot care and renal. Patients will be able access the

right level of care in the most appropriate setting through the advice and support provided to GP Practices by diabetes specialists nurses and Consultants. The model of care is illustrated in Appendix A. The objectives and outcomes to be achieved are detailed in Appendix B.

2. Where are we now?

BCCG approved the new model of care for local implementation at the Clinical Executive in April 2013. Current services will be redesigned and developed over a six month period (April – September 2013) with our current provider, Bromley Healthcare against a challenging set of milestones. If there is insufficient evidence of achievement of the milestones, BCCG will move to its next step procure the service externally.

A joint project team has been established with Bromley Healthcare working in conjunction with the Kings Diabetes Service to develop a mobilisation plan and the requirement for resources and potential impact of acute savings. In addition, there is active engagement and support from the LMC with respect to support from GP practices. Patient engagement is being strengthened through working with Diabetes UK. Aspects of primary prevention are being consulted with the Public health team.

The CCG is working towards approval of the mobilisation plan by the end of August, so that implementation can commence.

For further information, please contact:

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Appendix A: The New Integrated Diabetes Model of Care

Specification of the diabetes integrated specialist service model[1] in Bromley		
Now	**Future : Proposed model**	**Future provision (fully operational)**
Tier 1 – routine diabetes management. Delivery based on QOF • **Tier 2 – enhanced diabetes care.** Type 2 Diabetics requiring initiation of insulin and injectables. 15 GP practices delivering this level of service • **Tier 3 – BHC delivering specialist diabetes management** Type 1, adults 18+ and young people 16-18, gestational, Type 2 (insulin initiation), DESMOND and DAFNE (patient education), complex diabetes with neuropathy, Nephropathy, foot care, retinal screening, Primary care education • **Tier 4 – complex specialist care.** Inpatient and out-patient (predominately multiple co-morbidities and pathology, paediatrics, diabetic foot care, nephropathy	**Integrated Specialist Service Model - effectively merging tiers 1&2 and merging tiers 3&4.** Diabetes service model across BBG "Super Six" * Insulin pumps, Antenatal diabetes, Diabetic foot care, Low eGFR/dialysis patients, Uncontrolled type 1/adolescent diabetes, Inpatient diabetes Integrated Tier 3+4 Specialist care *Daily telephone contact to GPs, daily email access for queries, annual/ biannual visits to discuss and review patients, education ** Training and Education to upskill primary care linked to core competency accreditation Integrated Tier 1+2 * Adapted from the Portsmouth Model ** Derby Model	**Fully Integrated 3 & 4 to form ONE Specialist Team** Reduce PBR activity – IP and OP (A&E admissions/ readmissions, follow ups) Highly specialised service Community service acts a gatekeeper to acute care Structured & accredited Education and Training – primary care staff DAFNE and DESMOND for patients Specialist Advisory service – email, telephone and visits for complex care delivered by DSN/ consultant Diabetolgists Paediatrics Super six – Uncontrolled Type I / Adolescent, antenatal, insulin pumps, complex foot care, Dialysis/ Renal CKD>5, inpatient Allocated DSN support 1wte/50,000 resident population **Integrated 1& 2** GP Practices Sole responsibility of diabetic care for at least 85% of Type 2 and shared care of 75% of Type 1 diabetics (stable) Primary care skilled to initiate, manage and monitor Type 2 diabetics who require insulin and injectables Access to specialist support through visits, telephone or email Delivering on NICE treatment outcomes as part of enhanced service

[1] Arora.A (2012). Draft Diabetes Service commissioning Strategy. Proposed solution and model.

Appendix B: Service Objectives

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Primary Outcomes

Service benefits:

- Timely, responsive and seamless care across care settings delivered by an integrated care model
- More effective use of specialist services through clear identifies categories of patients which require complex care
- Upskilled primary care workforce with the confidence to provide greater level of routine care, supported by timely access to specialist advice and support when required

Patient benefits:

- Local access to a full range of services closer to patients home
- Responsive and timely service for patients with no delays in accessing care in emergency care when required.
- Access to specialist support if and when required
- Improved access to patient education

Financial benefits:

- QIPP savings achieved through reduced acute activity (inpatient and out-patient attendances) - £855K full year savings after year three.

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SMART Objectives

Patient Safety:

- To reduce the number of emergency admissions with primary diagnoses of diabetes by 50% and secondary diagnosis by 10% using 2012-13 as a baseline
- To reduce outpatient appointments by 90% using 2012-13 as baseline
- To reduce non-emergency admissions with secondary diagnoses by 10% using 2013-14 as a baseline
- Reduce renal diabetic outpatient appointments by 70% using 2012-13 as baseline

Clinical Effectiveness:

- To increase the number of patients achieving the four treatment standards to 80% by the end of 14/15
- Achievement of clinical outcomes to NICE guidance – KPIs set within GP enhanced service
- To enhance primary care capability to manage people 85% of Type 2 diabetics and 25% of Type 1 diabetics with 100% achieving the required standard to initiate, manage and provide ongoing monitoring of patients requiring conversion to insulin and injectables.

Patient Satisfaction:

- To achieve a high level of patient satisfaction measured regularly via a patient survey which aligns to the National OPD and In-patient surveys

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Secondary Outcomes as a result of clinical effectiveness

Overall health gains

- Improvement in health benefits e.g. reduction in incidence of blindness, amputations and renal failure and overall life expectancy

Address health inequalities

- Improved access to services closer to patients home and delivered in a manner which targets the hard to reach will address inequalities to health

Effective prescribing of insulin and injectables

- Non analogue (long and intermediate acting) insulin as a % of all insulin (long and intermediate acting) for newly initiated patients *(TA053)
- Adherence to NICE guidelines for exenatide (CG087), prolonged release exenatide (TA248) and liraglutide (GLP-1) (TA203) and long acting insulin analogues insulin detemir and insulin glargine

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