Diabetes Care within Primary Care Services in Great Yarmouth and Waveney

Suggested approach from Maureen Orr, Democratic Support and Scrutiny Team Manager

A report on primary care services including prevention, diagnosis, early intervention and long term care for people with diabetes in Great Yarmouth and Waveney.

1. Background

1.1 On 26 February 2015 Norfolk Health Overview and Scrutiny Committee (NHOSC) received a report about diabetes care delivered by primary care services across Norfolk. Based on the information it received, NHOSC suggested that Great Yarmouth and Waveney Joint Health Scrutiny Committee may wish to look in more detail at whether people with diabetes living in the area were receiving the recommended care processes and treatments. There was some doubt on this question due to the low levels of participation by GP practices in the Great Yarmouth and Waveney area in the National Diabetes Audit 2012-13 (eastern region).

1.2 On 22 July 2015 the Joint Committee received an information bulletin from the Clinical Commissioning Group's (CCG) Director of Clinical Transformation, who was also a GP at a local surgery:- GY&W Joint Health Scrutiny Committee 22 July 2015 (see item 9(c), page 70)

1.3 The bulletin acknowledged that the CCG area was not performing well against diabetes national targets (e.g. achieving target readings in blood pressure, cholesterol and HbA1C) and that analysis of diabetes outcomes data and secondary care activity patterns within the CCG area suggested considerable variability in the standards of diabetes management at both a locality and individual practice level. Similar variation could be seen across all of the Diabetes Mellitus Quality Outcomes Framework (QOF) indicators relating to the nine key care processes that every patient with diabetes should have access to on a yearly basis. There were also significant variations between GP practices in regard to efficiency and financial factors as well as in the indicators of the quality of diabetes management. There were, for example, significant variances in the numbers of patients from each GP practice regularly managed in hospital.

1.4 At the time of the information bulletin, a new primary care based service managed by Diabetic Specialist Nurses (DSNs) had been running for a year. This was the Diabetes Intermediate Care Service (ICS). There was 100% sign up to the service from GP practices in Great Yarmouth and

Waveney and the DSNs were running clinics in every practice. The aim was for this service to improve clinical knowledge and confidence so that primary care was supported to manage complicated diabetes cases. The new service also covered prevention of the onset of type 2 diabetes, management of diabetes and prevention of complications.

1.5 The CCG's next step was to commission and Integrated Model of Diabetes care. This was to create an integrated diabetes care service across primary care, community and acute hospital settings, which would also include specialist foot clinics, integrated working with pharmacists in the community, recruitment from the voluntary sector to take the pressure off primary care, and pro-active use of 'Apps' technology to support patient self-management, confidence and education.

1.6 The new model of care required adequate support from a number of sources, which potentially included:-

- Diabetic Podiatry
- Public Health
- Community services e.g. district nursing.
- Specialist Diabetes Dietetics
- Patient Education Programmes
- Pharmacists
- PPGs and Diabetes UK.

During 2015-16 the CCG intended to look at services already available in the Great Yarmouth and Waveney area, assess the quality and develop plans for improvement where necessary.

2. Purpose of today's meeting

2.1 The CCG has been invited to update the Joint Committee in respect of:-

- Progress of the Diabetes Intermediate Care Service
- Commissioning of an Integrated Model of Diabetes Care
- Current performance of diabetes care within primary care in Great Yarmouth & Waveney in terms of:-
  - Delivery of the recommended care processes and treatment targets
  - The extent to which patients with diabetes are managed in a primary care setting rather than in secondary care.

The CCG's report is attached at Appendix A and representatives will attend to answer Members' questions.

3. Suggested approach

3.1 After receiving the CCG's report the joint committee may wish to discuss the following areas with the representatives:-

(a) How much progress has there been since July 2015 towards delivering the standard treatments and care processes to all patients with diabetes in Great Yarmouth and Waveney?

(b) How much progress has there been since July 2015 towards managing more patients with diabetes in a primary care setting rather than in secondary care?

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Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

Briefing for Great Yarmouth and Waveney Health Scrutiny Committee:

Delivering a diabetes strategy for Great Yarmouth and Waveney

Background

As one of the UKs' most common chronic conditions, diabetes is high on the national agenda. The prevalence of diabetes increases by approximately 10% per annum and treatment of the conditions encompasses 10% of the overall NHS budget.

Diabetes is associated with high levels of mortality and morbidity, in particular:

- The life expectancy of a patient with diabetes is reduced by approximately 10 years
- 50% of newly diagnosed diabetics already have complications at the time of diagnosis
- 80% of diabetes patients will die of cardiovascular disease
- The risk of stroke for a patient with diabetes is tripled
- Diabetes is the UK's leading cause of blindness and one of the leading causes of limb amputation

The management and treatment of diabetes has received significant strategic attention across the country, beginning with the National Service Framework for Diabetes (2004) which sets clear guidance for the prevention, diagnosis and clinical management of diabetes.

The CCG has over 14,000 patients on Diabetes registers. NHS Great Yarmouth.

One of the 10 'top tips' for commissioners from the paper 'Best Practice for Commissioning Diabetes Services – March 2013' includes 'Enhancing capacity and competency in primary and community care'. It states that 'For integrated care to provide maximum clinical efficiency and avoid duplication in care of complex cases, there will be a need to strengthen community and primary care services so the focus of care can be on co-ordination, prevention, structured chronic disease management and care planning with the aim of reducing wastage, unnecessary medication errors and, most of all, inappropriate hospital admissions'. An additional recommendation is that a key principle should be that all commissioned diabetes services should be as close to where people with diabetes live as possible.

In July 2015 the CCG reported that they had commissioned a Diabetes nurse specialist to deliver clinics in GP practices. The aim was that this service would improve local clinical knowledge and confidence and subsequently provide a better service to patients. The more that Primary Care is supported to manage complicated diabetes cases then over time this will up-skill the workforce. The service covers prevention of the onset of type 2 diabetes, management of diabetes and prevention of complications.

Delivering the strategy

Since July 2015 the CCG has been working to develop and deliver a Diabetes strategy to build on the existing Diabetes specialist nurse service. A common theme in successful models of diabetes care across the country is the presence of distinct tiers of care, which enable patients to be managed as close to home as possible and integrated care across hospital and GP care.

This tiered structure involves three levels of care across three settings; primary care, the community and acute hospitals. The model is designed to enable patients to access the right level of care according to their clinical need.

This expanded service which will include 4 nurses delivering clinics to patients in GP practices and education to patients and clinicians went live on 1st August 2016. The aim is to work with practices to identify patients who require specialist advice and to improve local clinical knowledge of diabetes management. The activity in this service will rise in subsequent months as the team reaches full staffing levels.

Historical activity – average 184 contacts per month

	Number of new referrals	Planned Follow Up (From April 2016)	Unplanned Follow Up	Total Follow up's	DNA's	CNA Patient	Unallocated Slots	Non face to face consultations	Email	Total Contacts (New, FUP's, Non Face to Face)
Apr-15	139			61	13		20	59		**198**
May-15	93			51	14		20	69		**162**
Jun-15	123			58	13		19	31		**154**
Jul-15	142			70	17		19	56		**198**
Aug-15	112			65	18		9	51		**163**

Sep-15	57	51	4	55	10	0	13	35	0	**147**
Oct-15	63	48	0	48	12	5	6	36	11	**147**
Nov-15	117	89	1	90	15	8	18	39	29	**246**
Dec-15	94	49	0	49	15	1	28	39	36	**182**
Jan-16	121	41	1	42	17	1	29	31	22	**194**
Feb-16	103	26	0	26	11	6	8	33	0	**162**
Mar-16	103	52	0	52	10	3	15	51	0	**206**
Apr-16	106	70	0	70	15	1	34	89	0	**265**
May-16	84	40	0	40	10	5	10	33	11	**157**
Jun-16	104	64	0	64	20	5	27	39	0	**207**
Jul-16	76	62	0	62	12	1	16	23	0	**161**

New service activity, launch 1st August

	Number of new referrals	**Planned Follow Up**	**Unplanned Follow Up**	**DNA's**	**CNA Patient**	**Unallocated Slots**	**Non face to face consultations**	**Total Contacts**
Aug-15	95	62	0	7	11	25	67	**224**
Sep-15	0	0	0	0	0	0	0	**0**
								224

The CCG has also been working with Diabetes UK on a foot care pathway review. A second workshop in July 2016 has identified several areas for improvement including a multidisciplinary care Diabetic foot clinic. Another output was the creation of a local clinical network. This is under development.

Working with Diabetes UK, there was a Living with Diabetes day in May 2016.

The day was a great success with 112 delegates attending the event to learn more about Type 2 diabetes. We have already received some amazing feedback with 98% of people rating the day overall as good or excellent!

22% of people said they were aware of all 15 Health Care Essential checks before the event
78% of people said they were aware of all 15 after the event.
46% of people said they knew quite a bit or a lot about diabetes before the event – 91% of people said they knew quite a bit or a lot after the event.
61% said they were either very or fairly confident before the event – 98% of people said they were either fairly or very confident after the event

The CCG is also involved in the Rightcare programme. Right Care is an established programme of NHS England and its main objective is to maximise value across the health system:

- the value that the patient derives from their own care and treatment.
- the value the whole population derives from the investment in their healthcare.

The Right Care approach has three key phases: Where to look, What to change and How to change.

The approach begins with a review of indicative data to highlight the top priorities or opportunities for transformation and improvement. Each CCG is clustered with 10 CCGs who have the most similar population. This comparator group is used to identify realistic opportunities to improve health and healthcare for the CCG population.

Lastly the CCG will be submitting a bid to participate in wave 2 of the Diabetes prevention programme. This programme is nationally funded and will provide 100,000 patients with pre-diabetes access to lifestyle education in an attempt to prevent Diabetes. The CCG is working with Norfolk public health on this initiative.

Next steps

As part of the development of diabetes services the following vital next steps are required:

- Right care workshop to develop action plan for next priority areas – Autumn 2016.
- Continued implementation of the Diabetes Intermediate care team.
- Submission of wave 2 Diabetes prevention programme and if successful, roll out of the service in conjunction with Public health.
- Development of a local Diabetes clinical network.
- Development and implementation of a service model for foot care services.

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