Diabetes Strategic Initiative 2008-2013
Summary

1. Introduction
This report sets out the NHS Leicester City Diabetes strategic initiatives for 2008 to 2013 to improve the health of people with diabetes. It covers the care pathway, services and self management programmes for adults with diabetes and links to the Healthy Life Styles, Cardio Vascular Disease, Children’s and Community Service strategic initiatives.

A key plank of the strategy will be ‘Decommission existing community diabetes services and 50% of new and 20% of follow up diabetes general outpatient activity and reinvest in an Integrated Community Diabetes Service (ICDS) that is responsive to locality need’. This service would provide a consistent pathway of care and support to primary care to develop their skills. It will be provided from different locations in the community to enable choice, improve access, care closer to home and meet the needs of different communities to address health inequalities. A Diabetes Centre of Excellence facility is being planned as a base for the service and other complementary diabetes services.

2. Context
Diabetes is a priority in the Local Area Agreement with Leicester City Council and the Annual Report of the Director of Public Health and Health Improvement.

The strategy is consistent with
• The National Service Framework for Diabetes and related NICE guidance
• The NHS Diabetes Commissioning Framework

Diabetes prevalence (5%) is one of the highest in the country and this will increase to 6.7% by 2014 and with a population growth (4.3%) this equates to a rise from 17000 patients (March 2008) to around 22,368 patients with diabetes by 2013. Prevalence of type 2 diabetes is 4 times greater in South Asian groups and occurs at a younger age. Patients with diabetes are more susceptible to serious complications such as heart attack, stroke, blindness, renal failure, loss of limbs and a general reduction in life expectancy. In addition, premature mortality from diabetes and hospital admission rates is high compared to the national and regional average. Complications are largely preventable through control of blood sugar and a healthy life style.

There are health inequalities with higher diabetes mortality and hospital admission rates for people from areas of deprivation and poorer South Asian groups.

3. Current Performance
59.1% (10,166) of patients have had an HbA1c of 7.5 or less in March 2008. To achieve the target of 70.5% by 2013 15,770 patients would need an HbA1c of 7.5% or less.

Compared to peer NHS authorities Leicester City’s investment in diabetes services is consistent with the high diabetes prevalence rate but health outcomes are worse, e.g. diabetes death rates are twice the national average and diabetes hospital admission rates are high in populations of deprivation

A Health Care Commission survey of patients found their knowledge of their condition, self management and involvement in care planning was worse than the national average. Patient self management training programmes are not available for people with pre
diabetes and training places for programmes for patients with type 2 diabetes are insufficient.

Professional and user views have helped evaluate current provision. Provision of community specialist diabetes services is patchy, uncoordinated and pathways inconsistent across the City to respond to locality needs to improve health outcomes. There is little targeted support for primary care for patients with poor diabetes health. There is large variation in diabetes health between practices and the reason is not understood. 15 practices do not meet the current QOF target of 58.9% of patients have an HbA1c of 7.5 or less. Many patients with complications and type 1 diabetes who could be managed in the community are managed in diabetes general outpatients in hospital settings. Evidence in the UK indicates that intensive clinics in the community reduce hospital activity by 25% (50% new and 20% follow up).

4. Clinical vision

The vision is for integrated services provided in appropriate settings by staff with the right skills, that patients are involved in planning their care and trained in self management to promote healthy life styles and improve diabetes control and increase their life expectancy. The new pathway provides support to up skill primary and community care staff and provides expert support for practices with populations with the worst diabetes health to help address capacity issues and population differences.

The new care pathway is illustrated in appendix 1 and includes:

Patient self management
- Provide a pre-diabetes patient education programme to help patients achieve healthy life styles and reverse pre-diabetes.
- Increased uptake of the diabetes type 2 patient training programme
- Provide patient training in locations, at times and in different ways to respond to the needs of different localities and population groups.
- Provide support for locality patient/peer support groups for people from BME and disadvantaged communities.

Primary care
- Primary care will have robust, registers, recall and review processes to ensure an exclusion rate of 8.7% or less for the QOF HbA1c indicator.
- Provide expert nurse and prescribing support for practices targeting those with the poorest diabetes control and practices that make inappropriate referrals to an Integrated Community Diabetes Service.

Integrated Community Diabetes Service (ICDS)
- Provide an Integrated Community Diabetes Service from 2010 in a range of community settings to meet locality needs for core elements of care identified in the Leicester City Diabetes Care Model Framework at level 2 e.g. insulin titration that does not require hospital care
- Provide training and advice for primary and community care staff;
- Provide telephone advice and follow up for patients and telecare to support/motivate behavioural change for self management in patients with poor health;
- Provide triage to hospital based diabetes general outpatients except for emergencies;

Modern facilities
- Develop a modern facility to be a Diabetes Centre for Excellence and a hub to accommodate complementary community services from 2011/12 including: the ICDS; Patient self management training programme services; Voluntary sector enabling service for patient support groups; Staff training; Diabetes community researchers; promotion and patient education resources.
5. Links to strategic goals

The Diabetes initiative supports the NHS Leicester City strategic goals by promoting partnership working between primary, community and secondary care health services, the voluntary sector and patients. It supports increasing life expectancy and reducing health inequalities by tackling one of the major causes of premature death and by providing services that are responsive to the diverse needs of the population in Leicester. It develops expertise and services in the community to enable care to be provided closer to home and modern facilities that are fit for purpose.

6. Commissioning priorities

The commissioning priorities by year of implementation are

2009/2010

- Commission a patient survey of outcomes and experience to evaluate progress.
- Support the development of promotion material and diabetes awareness raising initiatives amongst BME groups
- Support the Leicestershire Diabetes web site
- Tender for a voluntary sector enabling service to initiate and support patient support groups and peer educators to ensure uptake by BME and other disadvantaged groups
- Appoint a prescribing pharmacist to support primary care medication reviews, provide training and advice, review the Leicester prescribing formulary and provide clinical care integrated with Community Diabetes Services.
- Review outlying practice’s
  - QOF HbA1c patient exclusions to achieve an average rate of 8.7% or less.
  - referral rates to patient support services to try and better understand variation in outcomes
  - arrangements for early detection of diabetes to better understand reasons in difference in practice prevalence from anticipated prevalence.
  - staff training needs and if appropriate provide back file to release staff for training.
- Quality agreements for hospital care include national guidance on ‘The Care of People with Diabetes In Hospital’
- Develop specifications for services with a focus on outcomes and patient experience
- Through service level agreements achieve 91% of patients with diabetes are offered retinal screening of which 85% are screened and monitor the proportion of people who are screened who were newly diagnosed in the last 12 months, in whom diabetes retinopathy is already established.

2010/11

- 1500 places on the diabetes Type 2 patient self management training programme to enable 50% of newly diagnosed patients and 12.5% of patients with poorly controlled diabetes to attend.
- Commission a pilot pre-diabetes patient self management training programme and its evaluation.
- Decommission existing community diabetes services and 50% of new and 20% of follow up diabetes general outpatient activity and reinvest in an Integrated Community Diabetes Service (ICDS) that is responsive to locality need.
• Provide 126 diabetes specialist nurse sessions for practices with >35% of patients with HbA1C >7.5 and those with high inappropriate referrals for ICDS care.

2011/12
• Relocate the base for complementary diabetes services in a modern purpose built Diabetes Centre of Excellence.
• ICDS pilot and evaluate telecare in supporting patients behavioural change for health life styles and the management of their diabetes

2012/13
• Evaluate the pre-diabetes patient self management training programme
• Role out the pre-diabetes patient self management training programme
• Commission a patient survey of outcomes and experience to evaluate progress

7. Performance indicators
The proposed performance indicators to assess overall progress in improving diabetes outcomes will be monitored by the NHS Leicester City Board and cover
• By 2013, 70.5% of patients have an HbA1c 7.5 or less in the previous 15 months (trajectory attached)
• Diabetes Hospital admission rates – target to be considered for 2010 subsequent to a hospital admission audit.
• Diabetes death rates – target under consideration.
• By 2013 patient experience will be 3% above the national average for key indicators in the Health Care Commission patient survey of 2006/07. key indicators where Leicester City was below the national average relate to diagnosis, health checks, patient training programmes, hospital care and patient management of diabetes.

Individual service specifications, service level agreements and practice reviews will include outcome related performance measures including the patient experience and prevention of Cardio Vascular Disease complications.

8. Sustainability
Sustainability of the care pathway and delivery of the targets is supported by
• The Healthy Life styles and Cardio Vascular Disease Strategic Initiatives which will help prevent type 2 diabetes by addressing some of the causes
• Integrated work, training and advice across primary, community and secondary care services to ensure staff have appropriate skills and are capable of providing care in different settings at the right time and
• Patient involvement in care planning, education by professionals and patient structured training programmes to enable patient self management and prevention of complications from diabetes

9. Identified risks to implementation
Potential risks to achieving targets for improved health include:
• There are unexplained differences in diabetes health between practices. The reason for variation in outcomes (diabetes control) is not fully understood e.g. there may be segments of the population who have blood sugar that is inherently resistant to control through behavioural and treatment programmes.
• A significant financial recession with increased unemployment and poverty would increase the risk of more people developing type 2 diabetes.
APPENDIX 1

Diabetes Care Pathway

Pre diabetes

Diagnosis

Type 2 diabetes

PC management

Type 1 diabetes

ICDS
- Telephone advice
- Clinics
- PC/CH staff training
- Type 1 insulin initiation
- Support IC
- Telenedicine 2012
- Research

Type 2 pt Education programme

Type 1 pt Education programme

Hospital specialist diabetes service
See level 3 elements of care
Training ICDS

Shared care

Improved health

Level 3 core elements of care

Emergency

Diabetes Target

Diabetes controlled sugar (HbA1c <=7.5 in previous 15 months)

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