NHS
Harrow
Clinical Commissioning Group

Transforming diabetes in Harrow

Dr Mathi Woodhouse, Clinical Lead for Diabetes

Where are we now in Harrow?

- Since June 2016 as a team we have worked hard to study and understand the baseline of diabetes care in Harrow.
- **Diabetes is a major issue in Harrow**
  - QOF registers for 14/15 report 8.8% diagnosed diabetics,
  - Modelled prevalence about 10-13%
  - (London average is 6.4% and England 6.1%)
- Rates have been and are expected to continue rising
  - 3% increase since 2010/11
  - Large projected increase to approx. 13%

  by 2030!
- Health Survey for England data, estimates in 2015, Harrow has the highest rate of non-diabetic hyperglycaemia **(pre-diabetes)** in the country at 27,935 (14%).
- Harrow spends 10 % of its current budget on diabetes care.

Scoping steps taken so far…

- September 2016 Diabetes workshop
  - Extensive local stakeholder engagement in the latter part of 2016, including an event attended by over 50 people from 15 organisations.
- National Diabetes Audit – 27/34 participation rate.
- NDPP bid
  - Harrow was unsuccessful in its recent bid to join Wave 2 of the National Diabetes Prevention Programme. In 2017/18 Harrow will implement the changes required to be ready for Wave 3.

- NWL transformation bid (NHS England funding)
  - Harrow is a member of the North West London STP
  - Dec 16/Jan 17 - a detailed business case was developed for diabetes transformation across NWL
  - Pot of £44m nationally
  - £3.6m requested across the 8 NWL CCGs, of which Harrow's share was £0.5m
  - Decision is expected in early March 2017

Local Harrow diabetes issues at baseline

- 1 Wide variation in quality / model of 1°care delivery
- 2 Low uptake and completion of structured education
- 3 Little patient involvement in decisions about own care
- 4 No unified diabetes guidance for clinicians
- 5 No register of patients at high risk of diabetes
- 6 High levels of prescribing expenditure
- 7 Fragmented community and primary care

The Harrow Strategic Wish List

1. 9 key care processes
2. NICE targets
3. Care planning
4. Reduction in hypoglycaemia episodes
5. Collaborative across primary, community and secondary care, and also across the NWL STP
6. Improve accessibility and quality of patient education
7. Improve primary care skills
8. Intervention for patients at high risk of diabetes

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Collaborative working

- Lack of funds and isolated working mean we can often miss ideas and opportunities
- Collaborative working has been shown to improve outcomes and reduce operating costs.
- Higher level: North West London STP
- Local level: 15 local organisations, inc primary care, CLCH, LNWHT, CNWL

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Harrow's Diabetes Strategy

- The four Treatment and Care programme areas are:

-Improving uptake of **structured education** by both the prevalent and newly diagnosed population

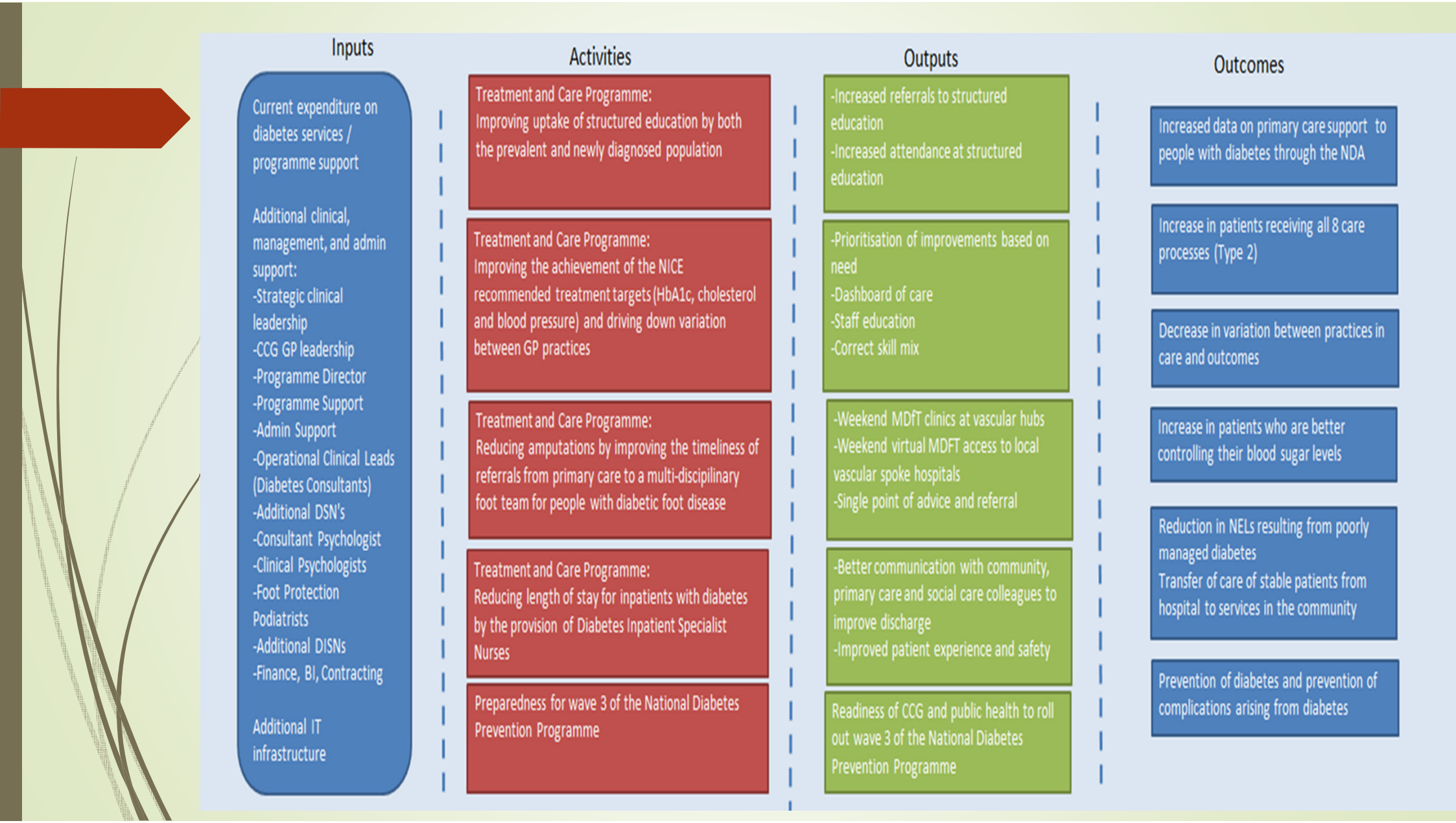
-Improving the **achievement of the NICE recommended treatment targets** (HbA1c, cholesterol and blood pressure) and driving down variation between GP practices

-**Reducing amputations** by improving the timeliness of referrals from primary care to a multi-disciplinary foot team for people with diabetic foot disease

-**Reducing length of stay for inpatients with diabetes** by the provision of Diabetes Inpatient Specialist Nurses

Formation of Diabetes Clinical Steering Group

- 1 CCG Diabetes clinical leads
- 2 CCG management
- 3 Hospital / community team clinicians & nursing
- 4 Medicines management
- 5 Public health team
- 6 Mental health
- 7 Diabetes UK
- 8 Patient representatives


Inputs
Current expenditure on diabetes services / programme support
Additional clinical, management, and admin support:
-Strategic clinical leadership
-CCG GP leadership
-Programme Director
-Programme Support
-Admin Support
-Operational Clinical Leads (Diabetes Consultants)
-Additional DSN's
-Consultant Psychologist
-Clinical Psychologists
-Foot Protection Podiatrists
-Additional DISNs
-Finance, BI, Contracting
Additional IT infrastructure
Activities
Treatment and Care Programme: Improving uptake of structured education by both the prevalent and newly diagnosed population
Treatment and Care Programme: Improving the achievement of the NICE recommended treatment targets (HbA1c, cholesterol and blood pressure) and driving down variation between GP practices
Treatment and Care Programme: Reducing amputations by improving the timeliness of referrals from primary care to a multi-discipilinary foot team for people with diabetic foot disease
Treatment and Care Programme: Reducing length of stay for inpatients with diabetes by the provision of Diabetes Inpatient Specialist Nurses
Preparedness for wave 3 of the National Diabetes Prevention Programme
Outputs
-Increased referrals to structured education
-Increased attendance at structured education
-Prioritisation of improvements based on need
-Dashboard of care
-Staff education
-Correct skill mix
-Weekend MDfT clinics at vascular hubs
-Weekend virtual MDFT access to local vascular spoke hospitals
-Single point of advice and referral
-Better communication with community, primary care and social care colleagues to improve discharge
-Improved patient experience and safety
Readiness of CCG and public health to roll out wave 3 of the National Diabetes Prevention Programme
Outcomes
Increased data on primary care support to people with diabetes through the NDA
Increase in patients receiving all 8 care processes (Type 2)
Decrease in variation between practices in care and outcomes
Increase in patients who are better controlling their blood sugar levels
Reduction in NELs resulting from poorly managed diabetes
Transfer of care of stable patients from hospital to services in the community
Prevention of diabetes and prevention of complications arising from diabetes