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Executive Summary

Aims: What is the Diabetes Strategy for Slough?

This document presents an approach for improving the management of patients with diabetes in Slough. It focuses on the prevention and early detection of diabetes, as well as on how to improve the management of patients with already-diagnosed diabetes. Our aim is to improve health outcomes in diabetes care through the education of both patients and professionals. This Executive Summary provides a précis of the full report.

Introduction: Why do we need a strategy?

There are approximately 3.75 million people with diagnosed diabetes in the UK. 10% have Type 1 diabetes (T1DM) and 90% have Type 2 diabetes (T2DM). [1] Estimates suggest that a further 850,000 patients remain undiagnosed among the UK population. By 2025, it is estimated that there will be 5 million people in the UK with diabetes. [2] In addition, the average age at which people develop T2DM is falling; the proportion of those under 40 with T2DM has risen from 5% to 12%.

Approximately 75,000 deaths per year are directly related to diabetes or its complications – at least 24,000 of which are estimated to be preventable. Worryingly, the rate of complications is rising [Fig1, Fig 2]. Patients with diabetes account for approximately 19% of all inpatient admissions. [2] NHS spending on diabetes is approximately £14 billion, with 80% directed towards potentially preventable complications. This means that a condition affecting 5% of the population is utilising nearly 14% of the total NHS budget – a clear disparity. [3, 4]

Diabetes poses a particularly major health problem in Slough, due to a significantly higher than national average proportion of people with diagnosed diabetes, and low physical activity rates [Fig 3]. There are currently 7,765 patients in Slough with diagnosed diabetes (7.5% of the population - higher than the national average of 5.5%). In Berkshire East the prevalence of diabetes is expected to increase from a current 18,248 to 32,786 by 2030 - an increase of 80%. For Slough,

this will mean a total population with diabetes of 14,172 by 2030. [5] This burden could be even greater, with Public Health estimates suggesting that there could be over 3,000 people with undiagnosed diabetes in Slough. [5] Consequently, diabetes has been prioritised as a 'high burden' condition (alongside obesity) in the Slough Wellbeing Strategy (2012-2015), representing the highest health priority issue for the local area. [6]

Local gap analysis: Why does Slough have a high prevalence of diabetes?

There are several reasons that account for the higher-than-national average proportion of our population with diabetes. Some of the key reasons are outlined below:

- Slough has a high proportion of BME (Black and Minority Ethnic) patients: 54% of Slough's population is non-White (40% Asian, 9% Black). [7] T2DM is 6x more common in people of South Asian origin and upto 3x more common in people of African and African-Caribbean origin). [8]
- There is likely to be a significant undiagnosed population with diabetes: National estimates suggest 15% of the population with diabetes remain undiagnosed - equivalent to 1,165 undiagnosed patients in Slough. [8, 9] Public Health estimates using more up-to-date 2011 census data (to account for the ethnicity mix of Slough) and recent diabetes prevalence estimates, [8] suggest there should be 10,815 patients with diagnosed diabetes in Slough - i.e. an undiagnosed population of 3,050, representing a more significant 'hidden' burden. [5]
- Lifestyle factors are a major issue, with limited focus on identifying 'at-risk' populations: The prevalence of diabetes, cardiovascular disease and associated deaths can be significantly reduced through physical activity. [8] It is estimated that around 14% of the new diabetes cases in Slough could be prevented if adults are 100% active, and 6% prevented if adults are 50% active. [10] Only 7.6% of adults in Slough participate in moderate-intensity sport and active recreation for >20 days per month - one

of the lowest rates in England (England average 11.2%). [8] Another contributing factor to poor diet, exercise and general health is the high level of deprivation in parts of the borough (the most deprived in the UK are 2.5x more likely to have diabetes). [8]

- Childhood obesity is a growing problem, representing the future patients with diabetes: Slough ranks statistically above the England average for childhood obesity: children in reception year (10.10% prevalence) and year 6 (21.30% prevalence). England average = 29% of all children aged 2-15 years. [Fig 9] [8]
- There is limited patient education and poor uptake of relevant services: There is low awareness and uptake of relevant local services providing behaviour or changes or preventative services such as physical activity and healthy eating, as well as services including diabetic eye screening, structured education programmes and psychological support. 2011 referral data show that out of a total diabetic population of 7,765, only 302 patients in Slough were referred to a structured education programme. [6]
- Prescribing and spend is not in line with national averages, with low use of insulin and higher use of oral anti-diabetic agents, and considerable variation among practices: Slough CCG spends less per patient with diabetes on prescriptions than England average. This is due to a lower use of insulin. Insulin use is 27% less than would be expected given the prevalence. Spend on oral medications is much higher than England average. Additionally, there is huge variation in prescribing rates between practices. For example, prescribing of sulphonylureas is twice as high in some practices compared to others; prescribing of GLP-1s varies by up to 6 times between practices. [11] Lack of confidence, skills in insulin initiation and prescribing, local patient's choice of oral drugs over insulin, some cultural myths and needle phobia were found to be some of the barriers identified through our local JSNA focus groups. Despite this large degree of variation between spend and prescribing practices, there is no discernable relationship between greater practice spend or total prescriptions issued, and better QOF outcomes in Slough. [11, 12]

Current standards: What national frameworks are in place for diabetes care?

A number of commissioning frameworks and standards have been established to ensure a consistent and high standard of care for patients with diabetes. For example, the 2001 National Service Framework for diabetes established 9-standards for the provision of high quality services, which cover the identification, empowerment and care of patients with diabetes. Two main performance measures that are the National Diabetes Audit (NDA) and the GP Quality and Outcomes Framework (QOF):

National Diabetes Audit (NDA):

<http://www.hscic.gov.uk/searchcatalogue?productid=13129&q=%22National+diabetes+audit%22&sort=Relevance&size=10&page=1#top>

This was developed in order to ensure that patients receive the highest level of care. The NDA presents some key checks and measures that should be offered to all patients diagnosed with diabetes, known as the '9 Key Care Processes'. The NDA is this is the largest annual clinical audit in the world. Participation is voluntary, so not all UK GP practices participate (although in 2010/11, 48 of 51 Slough GP practices participated - 94.1%). It takes place on a 15-month cycle, and looks at four key questions:

- Is everyone with diabetes diagnosed and recorded on a practice diabetes register?
- What percentage of people registered with diabetes received the nine NICE key processes of diabetes care?
- What percentage of people registered with diabetes achieved NICE defined treatment targets for glucose control, blood pressure and blood cholesterol?
- For people with registered diabetes what are the rates of acute and long term complications (disease outcomes)?

NDA-derived 9 Key Care Processes: The NDA proposes that all patients with diabetes are expected to receive a planned programme of recommended checks each year:

1. Blood glucose level measurement
2. Blood pressure measurement
3. Cholesterol level measurement

4. Retinal screening
5. Foot and leg check
6. Kidney function testing (urine)
7. Kidney function testing (blood)
8. Weight check
9. Smoking status check

Quality and Outcomes Framework (QOF): This is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results in achieving 8 of the 9 Key Care Processes by a series of proxy measures. As all practices participate, data from this can be used to evaluate performance in a range of areas – such as whether the 9 Key Care Processes are offered to patients and patient outcomes on each of these 9 measures. Note that there are some differences in the methodology used between the QOF and the NDA measures, so their results can differ.

The goal of this and any future local strategy should be to use the NDA as a guide and the QOF results as a performance measure in order to ensure consistency of standards, targets and outcome measures.

Current practice: What is currently being done locally?

In Slough, diabetes continues to be a leading commissioning priority. Care in Slough is provided through several routes:

- **GP practices** are the main providers of diabetes care, offering annual patient reviews, advice, health monitoring and medicines management
- **Diabetes Specialist Nursing and Outpatient Services** provide services including clinical care, structured education, support and advice. Teams include Consultants, Diabetes Specialist Nurses (DSN), GPs, dieticians, podiatrists and administration staff, working from Upton and King Edward Hospital as well as in local venues and health centres
- **In-patient/secondary care** is primarily provided by the local acute trust, Heatherwood and Wexham Park Hospital Foundation Trust (HWPHT), which offers in-patient and emergency care, as well as specialist multi-disciplinary team (MDT) services

- **A diabetic retinopathy screening programme** is provided by Berkshire Healthcare Foundation Trust (BHFT) in GP practices and community venues
- **10 health activists** act as 'Diabetes Community Champions' to educate and raise awareness of diabetes and Diabetes UK to people from BME backgrounds
- **Diabetes networks** are key to ensuring cohesion of the above services and in ensuring clear and consistent communication between teams. The Slough Diabetes Network was established in April 2013 and has the goal of sharing innovation and best practice both within the CCG and across the wider federation

Performance assessment: How is Slough doing?

2010 QOF data suggests that there is considerable variation in the proportion of patients nationally who are offered checks in all 9 Key Care Processes, ranging from 6.4% to 68.9%. In Slough, 55.9% with T2DM are receiving (being offered) all 9 Key Care Processes (2010 England average 49.8%). [2, 13] The 2010/11 NDA reported that 66.5% patients with T2DM were offered all 9 Key Care Processes (national average 57.7%; Slough is ranked in the top quartile nationally). [14]

However, offering patients the recommended checks does not necessarily mean that patients achieve the treatment targets (i.e. the best outcomes). This is confirmed by the NDA, which reported that only 19% patients with T2DM achieved all 9 treatment targets (national average 20.5%). [14] Another report - 2011/2012 Diabetes Outcomes Versus Expenditure Tool (DOVE) – has identified that there are 2,188 patients in the Slough CCG not meeting blood pressure (BP) targets, 1,735 not meeting total cholesterol (TC) targets and 2,494 patients not meeting HbA1C targets. While there is likely to be some overlap of patients, these numbers represent a significant population that are not receiving optimal outcomes. [12]

Of the 9 key care processes, the blood pressure (BP), total cholesterol (TC) and HbA1C targets are particularly important as they are particularly modifiable. For the BP target, Slough is in the top 50% of CCGs, with 71.9% patients achieving a BP <140/80mmHg (England average 70.5%).

However, HbA1C and TC targets are below national average: [12]

- **HbA1C <59mmol/mol:** 66.4% patients (England average 70.2% - Slough in the bottom 50% of CCGs)
- **Total cholesterol <5mmol/l:** 77.2% patients (England average 81.7% - Slough in the bottom 50% of CCGs)

Ultimately, a key goal of good diabetes care is to reduce diabetes-related hospital admissions. The NDA showed that 11.2% patients with diabetes were admitted specifically for the management of their condition, with 48.1% cases having active foot disease. 82.8% were admitted as emergencies (vs. 79.4% emergency admission for those without diabetes). [15] For our local hospital, Wexham Park, some overall figures were better than the national average, with the percentage admitted specifically for the management of their diabetes being 8.6%, with only 8.8% admitted with active foot disease. However, 75.7% were admitted for 'medical reasons other than diabetes - significantly higher than the 66.6% reported nationally, suggesting generally poorer health in these patients.

This is likely secondary to the underlying high physical inactivity and obesity rates which lead to the high prevalence of T2DM in these patients in the first place. Nationally, patients with diabetes have an 8-day median length of stay - compared with 5-days for all other inpatients - so improving overall diabetes care in the community can reduce a significant burden for patients and health services.

Action plan: How can we make a tangible improvement to diabetes care?

In summary, Slough's performance in diabetes care is variable - broadly comparable to national average in some areas, but below average in others. We want to do better - and with motivated healthcare professionals and patients, we know we can.

We have identified four main categories of action for 2013-15. The tables below summarise agreed actions. Slough CCG and Public Health will be periodically review whether these targets are being achieved. Full details can be found in the full strategy:

1. A staged approach is required to improve the identification of patients at risk of developing and with undiagnosed type-2 diabetes

No	Term	Objective	KPI	Responsible action team
1	Short-Medium term	Increase uptake of NHS health checks to increase diabetes screening - currently targets only 10% of Slough's population	Screen 20% eligible Slough population by end 2014/15	Slough CCG/ GPs/ MDT, Public Health
2	Short-Medium term	Establish pre-diabetes registers at Slough GP practices (currently 0%) - [See Appendix for 605 patients already identified as high risk from the ACG tool]	25% practices to have and use a pre-diabetes register by end 2013/14; 50% by end 2014/15	Slough CCG/ GPs/ MDT
3	Long term	Reduce the number of undiagnosed patients with diabetes through targeted screening of high risk groups and via collaboration between the CCG, public health, and other groups (e.g. industry, faith groups, charities)	Reduce diagnosed: undiagnosed ratio	Slough CCG/ GPs/ MDT, Public Health, Slough Borough Council, Groups hosting support services in Berkshire East

2. Those at risk should be offered targeted health promotion, lifestyle interventions and education				
No	Term	Objective	KPI	Responsible action team
1	Short - Medium term	Offer structured education programme to newly diagnosed patients, in order to teach them the skills required to live with their condition and effectively self-manage	50% newly diagnosed patients have documented offer of access to an educational programme by end 2013/14; 85% by end 2014/15	Slough CCG/GPs/MDT, Groups hosting support services in Berkshire East
2	Short - Medium term	Offer stop smoking services to all patients with diabetes who smoke	Offer to 50% patients with diabetes by end 2013/14; 100% by end 2014/15	Slough CCG/GPs/MDT, Groups hosting support services in Berkshire East
3	Short - Medium term	Offer appropriate lifestyle support (e.g. physical activity, diet or weight management) and disease management (e.g. psychological support) programmes to patients with and at risk of developing diabetes [See appendix for courses] (Active Slough Communications Plan)	25% patients with or at risk of diabetes offered access to lifestyle and disease management services by end 2013/14; 50% by end 2014/15	Slough CCG/GPs/Active Communities/MDT, Groups hosting support services in Berkshire East
4	Short - Medium term	Identify diabetes leads from each of the 16 GP practices (GP or practice nurse) to represent and promote the Slough Diabetes network and ensure completion of at least 1 course or training programme [See appendix for incentives and courses]	1 diabetes lead from each Slough GP practice to be identified and to attend once-monthly meeting. Lead to complete at least 1 training course by end 2013/14	Slough CCG/GPs/MDT
5	Short - Medium term	Increase uptake of specialist GP practice-based programmes such as EMD (as part of the Slough CCG QIPP project)	50% practices to have engaged with a programme to identify and manage high risk patients with diabetes, by end 2014/15 [see Appendix - QIPP project]	Slough CCG/GPs/MDT, Groups leading support and educational courses
6	Medium - Long term	Improve patient satisfaction with diabetes care and increase their ability to self-manage their diabetes <u>Active Slough Action Plan</u>	50% practices to complete patient questionnaire by end 2014/15	Slough CCG/GPs/MDT/Active Communities

3. All patients with diabetes should be offered the 9 Key Care Processes, with a particular focus on achieving treatment targets and improved patient outcomes, including through better medicines management				
No	Term	Objective	KPI	Responsible action team
1a	Short - Medium term	Improve offer: Increase the percentage of patients in Slough receiving all 9 NICE recommended care processes	Increase from current 64.2% to 75% by end 2014/2015	Slough CCG/GPs/MDT
1b	Short - Medium term	Improve treatment targets: HbA1C, cholesterol, BP: Achieve top decile performance in the treatment targets for glucose control, blood pressure and blood cholesterol - as per agreed QIPP project goals	Achieve QIPP project targets for these 3 markers [See Appendix - QIPP targets]	Slough CCG/GPs/MDT
1c	Medium - Long term	Other targets (not in QIPP): Eyes: Improve eye screening uptake - as per Slough Wellbeing Strategy	Achieve 80% uptake of eye screening services by end 2013/14	Slough CCG/ GPs/MDT, Berkshire Eye screening teams
1c	Medium - Long term	Other targets (not in QIPP): Renal: Reduction in the percentage of people in the National Diabetes Audit (NDA) with diabetes who received renal replacement therapy from the current 0.63% - as per Slough Wellbeing Strategy	Achieve 10% reduction in use of renal replacement therapy by end 2014/15	Slough CCG/ GPs/MDT, Secondary care teams
1c	Medium - Long term	Other targets (not in QIPP): Amputations: Reduction in the percentage of people in the National Diabetes Audit (NDA) having major lower limb amputations from the current 0.9% - as per Slough Wellbeing Strategy	Offer appropriate podiatry services to 50% diabetic patients by end 2013/14; 100% by end 2014/15. 50% reduction in amputation in patients with diabetes by end 2018/19 (in line with Diabetes UK 'Putting Feet First')	Slough CCG/ GPs/MDT, Secondary care teams
2	Short - term	Increase NDA reporting from practices in Slough (in 2010/11 48 of 51 practices participated - 94.1%)	100% GP practices reporting to NDA by end 2013/14	Slough CCG/ GPs/MDT
3	Short - Medium term	Increase engagement with community pharmacists for management of new patients with diabetes	100% practices to have community pharmacist involvement in care of new patients with diabetes by end 2014/15	Slough CCG/ GPs/MDT, Community Pharmacy teams
4	Short - Medium term	Engagement with Medicines Optimisation Team in Slough CCG in order to improve prescribing and reduce variability at a practice level	100% practices to have had a review of prescribing by Medicines Optimisation	Slough CCG/ GPs/MDT
5	Medium - Long term	Increase insulin prescribing in appropriate patients	5% increase in insulin prescribing by end 2014/15	Slough CCG/ GPs/MDT

4. By improving the offer, uptake and outcomes of the 9 Key Care Processes, both primary and secondary care utilisation should be ultimately reduced as patients have the skills to manage their diabetes more effectively right from diagnosis

No	Term	Objective	KPI	Responsible action team
1	Long term	Reduce demand on primary and secondary care services as an ultimate goal of all of this strategy	To be discussed and agreed by Slough CCG	Slough CCG/GPs/MDT, Secondary care teams/Active Communities
1	Long term - better joined up working	Integrated diabetes Care with investments on IT, education, benchmarking, mentoring and sharing of best practice	To be discussed and agreed by Slough CCG, Acute care consultants, DSNS', BHFT	Slough CCG/GPs/MDT, Secondary care teams

1 Vision

1.1 What is the role of this strategy document?

This document presents a clear and tangible strategy for improving the management of patients with diabetes in Slough. It focuses on both the prevention and early detection of diabetes, as well as on achieving top-decile national performance in the offer and treatment outcomes for the 9 Key Care Processes. This strategy should inform debate around the design, development and offer of sustained policies and services for the identification and management of those with, and at risk of, developing type-2 diabetes (T2DM). Improving the health of these patients has impacts beyond those on diabetes outcomes alone, for example through a reduction in cardiovascular disease-related morbidity and mortality. While many of the lifestyle approaches and interventions discussed in this document are also applicable to patients with type-1 diabetes (T1DM), the nature of this condition means that it not 'preventable' in the same way as T2DM, and is also largely managed by hospital-led services rather than in a GP or community-led approach.

By educating and empowering patients to manage their own condition, the ultimate goal of this strategy is to reduce demand on diabetes services, resulting in a reduction in elective and non-elective diabetes-related admissions.

1.2 How was this strategy put together?

This strategy incorporates recommendations from a number of key national and local sources, including the Slough Wellbeing Strategy 2012-2015, Joint Strategic Needs Assessment (JSNA) for Slough, Medicines Management, Diabetes UK representatives, local diabetes networks and healthcare professionals, Slough CCG and members of Berkshire Public Health teams. It considers the overarching Public Health Strategy and should be read in conjunction with other key local strategies, such as the Slough Physical Activity and Sport Strategy 2012-2015. Wider consultation with patients is now required to gain further strategic engagement from patient groups.

2 Introduction

2.1 Diabetes presents a considerable, growing health burden for the NHS

There are approximately 3.75 million people with diagnosed diabetes in the UK. 10% have Type 1 diabetes (T1DM) and 90% have Type 2 diabetes (T2DM) [1]. Estimates suggest that a further 850,000 patients remain undiagnosed among the UK population. By 2025, it is estimated that there will be 5 million people in the UK with diabetes. [2]. In addition, the average age at which people develop T2DM is falling; the proportion of those under 40 with T2DM has risen from 5% to 12%. [3, 4]

Together with a range of complications and the life-long care needs for each patient with diabetes, the burden on the NHS is considerable; more than twice as many people are diagnosed with diabetes each year than with either colorectal or lung cancer, and the prevalence of diabetes is higher and rising faster than many other long term conditions. [5, 6] Outcomes such as excess mortality are improving; a recent population-based study showed that patients with diabetes in 2009 were 1.5-times more likely to die than those without diabetes, compared to being 2-times more likely to die in 1996. This reduction is, in part, likely due to earlier detection. However, thousands of patients are still reported to be dying prematurely every year. [7, 8]

2.2 Preventing the rising rate of complications can improve outcomes and save money

NHS spending on diabetes is approximately £14 billion, with 80% directed towards treating potentially preventable complications. This means that a condition affecting 5% of the population is utilising nearly 14% of the total NHS budget – a clear disparity. A National Audit Office report (2012) found poor performance against expected levels of care and concluded that diabetes services in England were not providing value for money. [9, 10]

Approximately 75,000 deaths per year are directly related to diabetes or its complications - at least 24,000 of which are estimated to be preventable. Worryingly, the rate of complications is rising [Figure 1, Figure 2]. Patients with diabetes account

for approximately 19% of all inpatient admissions. [2] It is estimated that effective services can considerably reduce the costs associated with diabetes-related care; for example, Trusts employing a specialist diabetes nurse can save an estimated £200,000 per year through reductions in acute admissions. [5]

Figure 1 - Complications of diabetes

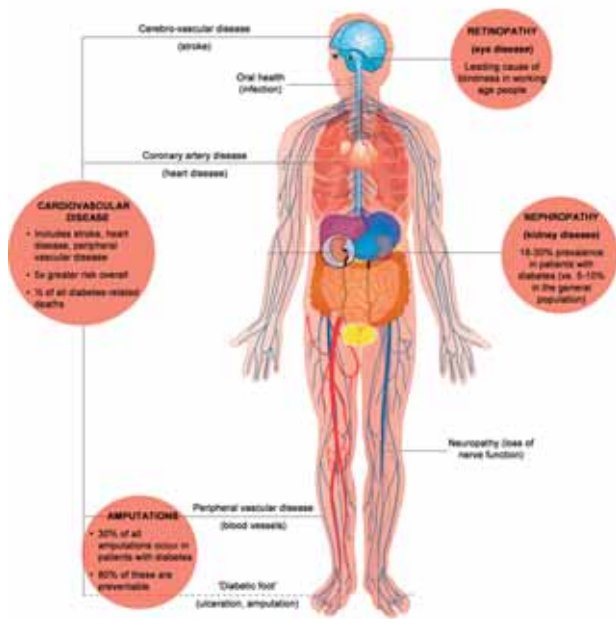
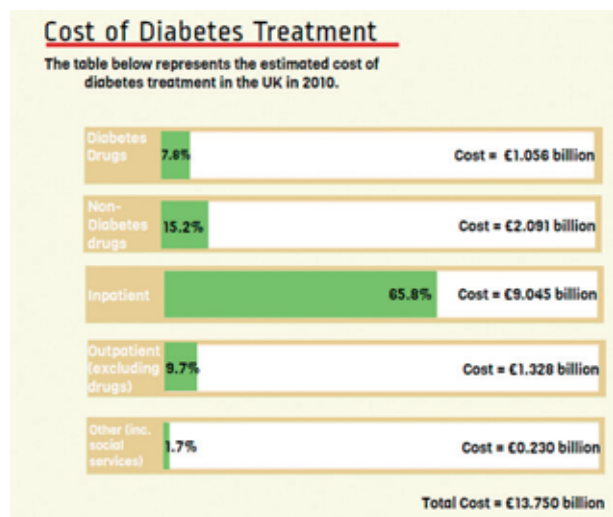


Figure 2 - Costs of diabetes care [9]

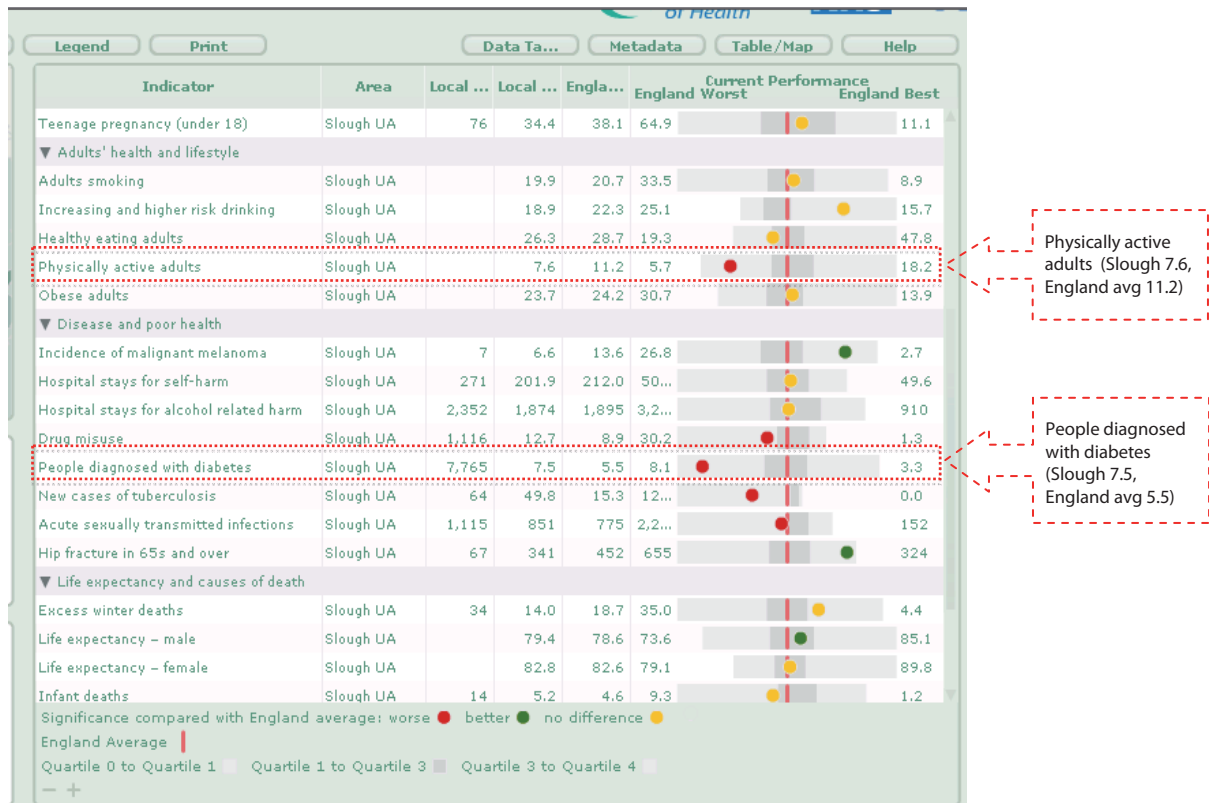


2.3 Slough has a significantly higher than national average prevalence of diabetes

Diabetes poses a particularly major health problem in Slough, due to a significantly higher than national average proportion of people with diagnosed diabetes and low physical activity rates [Figure 3]. There are currently 7,765 patients in Slough with diagnosed diabetes. In Berkshire East the prevalence of diabetes is expected to increase from a current 18,248 to 32,786 by 2030 - an increase of 80%. For Slough, this will mean a total population with diabetes of 14,172 by 2030. [11] This burden could be even greater, with estimates suggesting that there could be over 3,000 people with undiagnosed diabetes in Slough. [11] Consequently, diabetes has been prioritised as a 'high burden' condition (alongside obesity) in the Slough Wellbeing Strategy (2012-2015), representing the highest health priority issue for the local area. [12] This has been reflected in the Slough Quality Premium 2012/13, for which two local targets are:

- 12.5% premium for 'patients with diabetes having all 9 Key Care Processes' (a measure that is part of the Community Outcomes Framework 2 and is consistent with the Joint Strategic Needs Assessment, JSNA, for Slough)
- 12.5% premium for 'patients feeling supported in managing their condition' (a measure in which Slough is currently ranked lowest in the country). [13]

Figure 3 - Public Health England data for Slough (2011) [14]



3 National and local guidance and research

3.1 Standards of care: what national frameworks are in place to improve diabetes care?

A number of commissioning frameworks and standards have been established to ensure a consistent and high standard of care for patients with diabetes. The NICE Quality Standard for diabetes in adults requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole diabetes care pathway. An integrated approach to the provision of services is fundamental to the delivery of high quality care to people with diabetes. In particular, patients with diabetes should receive a structured educational programme, personalised advice on nutrition and physical education from an appropriately trained HCP or as part of a structured educational

programme, and should participate in annual care planning. [15]

National Service Framework (NSF):

The 2001 National Service Framework for diabetes contains 9-standards for the provision of high quality services, which cover:

1. Prevention of Type 2 diabetes
2. Identification of people with 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.

In order to ensure that patients receive the highest level of care the National Diabetes Audit (NDA) presents a guide for what measures should be offered to patients diagnosed with diabetes, through the '9 Key Care Processes'.

National Diabetes Audit (NDA):

This is the largest annual clinical audit in the world. Participation is voluntary, so not all UK practices participate. It takes place on a 15-month cycle, and looks at four key questions:

- Is everyone with diabetes diagnosed and recorded on a practice diabetes register?
- What percentage of people registered with diabetes received the nine NICE key processes of diabetes care?
- What percentage of people registered with diabetes achieved NICE defined treatment targets for glucose control, blood pressure and blood cholesterol?
- For people with registered diabetes what are the rates of acute and long term complications (disease outcomes)?

NDA-derived 9 Key Care Processes:

The NDA proposes that all patients with diabetes are expected to receive a planned programme of recommended checks each year:

10. Blood glucose level measurement
11. Blood pressure measurement
12. Cholesterol level measurement
13. Retinal screening
14. Foot and leg check
15. Kidney function testing (urine)
16. Kidney function testing (blood)
17. Weight check
18. Smoking status check

It is important to note that improving outcomes in the first three of these has a positive impact on reducing morbidity and mortality in patients with other conditions as well, such as cardiovascular disease. In practice, an indicator of success in offering the Key Care Processes and in achieving treatment targets can be obtained through performance in the Quality and Outcomes Framework (QOF).

Quality and Outcomes Framework (QOF):

This is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results in achieving 8 of the 9 Key Care Processes by a series of proxy measures. As all practices participate, data from this can be used to evaluate performance in a range of areas - such as whether the 9 Key Care Processes are offered to patients and patient outcomes on each of these 9 measures. Note that there are some differences in the methodology used between the QOF and the NDA measures so their results can differ. In addition, 'exception reporting' is permitted, which allows certain cases to be excluded from being counted towards QOF attainment, although this is not reported to be a significant issue in Slough. [16] [See appendix]

NHS Health Checks (to screen for diabetes):

These provide an ideal way to bring patients into GP practices for an assessment of their overall health and for diabetes screening. This two-stage strategy has been implemented to assess the risk of patients, usually between the ages of 40-74 years, using a risk assessment tool, following by appropriate blood tests if people are high risk of having or developing conditions such as diabetes (for example, if they are obese – i.e. have a Body Mass Index (BMI) of >30). However, by the end of 2011, only half of the expected tests for 2011/12 had been offered to patients (UK-wide). In Slough, only 7 of 16 GP practices had started offering these checks at the time of writing. [See appendix]

The goal of this and any future local strategy should be to use the NDA as a guide and the QOF results as a performance measure in order to ensure consistency of standards, targets and outcome measures. NHS Health Checks outcomes will be monitored via the Public Health strategy.

4 Market and gap analysis

4.1 There is considerable national variation in performance

QOF data suggests that there is considerable variation in the proportion of patients nationally who are offered checks in all 9 Key Care Processes, ranging from 6% to 69% in 2010. [17] Patient understanding of their condition may be a key issue. A 2006 Diabetes UK survey of 20,000 patients with diabetes found that only 9.6% patients in England reported having access to a structured education course - a significant deviation from the NICE Quality Standard. [15]

4.2 Diabetes is a leading priority for Slough

In Slough, diabetes continues to be a leading commissioning priority. The local diabetes networks (consisting of GPs, public health specialists, commissioners, consultants, patient groups, providers and managers) have made considerable in-roads in improving the offer rates of the 9 Key Care Processes, including providing more specialist nurses, and improving education and strengthening networks. Care in Slough is provided through several routes:

- GP practices are the main providers of diabetes care, offering annual patient reviews, advice, health monitoring and medicines management
- Diabetes Specialist Nursing and Outpatient Services provide services including clinical care, structured education, support and advice. Teams include Consultants, Diabetes Specialist Nurses (DSN), GPs, dieticians, podiatrists and administration staff. The teams assess individual needs, devise management plans, deliver evidence-based patient-centred care and evaluate treatment in a variety of clinical settings including Upton and King Edward Hospital as well as in local venues and health centres
- In-patient/secondary care is primarily provided by the local acute trust, Heatherwood and Wexham Park Foundation Trust (HWPH FT), which offers:

- o In-patient and emergency adult diabetes care
- o Paediatric in- and out-patient services via a consultant paediatrician, DSN and dietician, and Paediatric to adult transition clinics
- o Specialist services: podiatry (foot care), renal (kidney), cardiology (heart)
- o Other specialist Multi-Disciplinary Teams (MDTs): for individuals with complex problems (e.g. gestational diabetes, significant co-morbidities) and significant complications (e.g. renal failure, requiring renal dialysis, foot ulceration, eye disease, peripheral vascular disease)

- A diabetic retinopathy screening programme is provided by Berkshire Healthcare Foundation Trust (BHFT) in GP practices and community venues
- 10 health activists act as 'Diabetes Community Champions' to educate and raise awareness of diabetes and Diabetes UK to people from Black Asian and Minority Ethnic communities (BME)
- Diabetes networks are key to ensuring cohesion of the above services and in ensuring clear and consistent communication between teams. The Slough Diabetes Network was established in April 2013 and has the goal of sharing innovation and best practice both within the CCG and across the wider federation

4.3 How is Slough doing?

38.5% of patients in Berkshire East with T1DM and 55.9% with T2DM are receiving (being offered) all 9 Key Care Processes (England overall average 49.8%, range 6.4% - 68.9%). [2, 18]

Overall, Slough is performing considerably better, with QOF data reporting that 67.5% patients received all 9 Key Care Processes (range 17.5% to 84.1%) However, while Slough is doing reasonably well in offering the 9 Key Care Processes, the region - like the country as a whole - is doing less well on achieving treatment targets. Furthermore, there is significant variation in the standard of care provided across practices in Slough. Only 15.6% patients in Slough achieved all of the treatment targets (range 6.4% to 22.8%). [19] [Figure 4]

Historically, Slough has performed relatively well against QOF indicators for offering all 9 Key Care Processes but has seen relatively poorer outcomes in the NDA due to differences in methodology between the two measures [See appendix]. The 2010/11 NDA reported that while 64.2% patients with diabetes (T1DM and T2DM) and 66.5% (T2DM patients only) were offered all 9 Key Care Processes (national average 55.5% for both T1DM and T2DM; 57.7% for T2DM only; Slough in the top quartile for both), only 18.6% (T1DM and T2DM) and 19% (T2DM only) achieved all 9 treatment targets (national average 19.9% T1DM and T2DM; 20.5%

T2DM only). Note that the NDA awards credit only when ALL 9 Processes are offered, whereas the QOF uses an average of the % patients offered each individual Process. [Figure 4, Figure 5]. [19]

Based upon 2011/2012 Diabetes Outcomes Versus Expenditure Tool (DOVE) data, there are 2,188 patients in the Slough CCG not meeting blood pressure (BP) targets, 1,735 not meeting total cholesterol (TC) targets and 2,494 patients not meeting HbA1C targets. While there is likely to be some overlap of patients, these numbers represent a significant population that are not receiving optimal outcomes. [20]

Figure 4 - QOF: Patients receiving all 9 Key Care Processes vs. patients achieving treatment targets (based on average % patients offered each individual Process) across Berkshire East (2010/11)

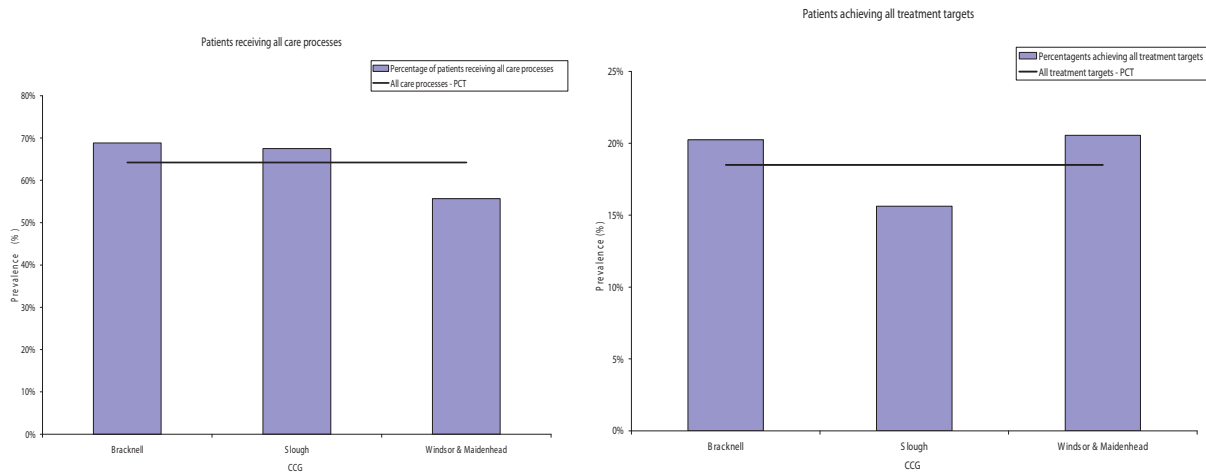


Figure 5 - NDA: Patients in Slough with T2DM a) receiving all 9 Key Care Processes and b) achieving all 9 treatment targets (2010/11)

Care Process recorded	Percentage of registered patients in PCT (including RAG Score)	Percentage point change since 2009-2010	Median score across all PCTs	National quartile ranking
All Care Processes*	66.5%	+10.4%	57.7%	1
Blood Creatinine	94.5%	+0.08%	94.3%	2
Blood Pressure	95.9%	-1.24%	96.0%	3
BMI	91.6%	-0.04%	90.9%	2
Cholesterol	93.2%	+0.10%	93.1%	2
Eye Screening	82.9%	+8.02%	83.4%	3
Foot Exam	87.8%	+0.23%	86.1%	1
HbA1c**	93.2%	+4.05%	93.8%	3
Smoking Review	89.0%	-0.54%	86.4%	2
Urinary Albumin	84.0%	+2.92%	78.7%	1

*People registered with diabetes receiving all nine key processes of care processes
 **For patients under 12 years of ages, 'all care processes' is defined as HbA1c only as other care process are not recommended in the NICE guidelines for this age group.
 RAG (Red-Amber-Green) score key: ■ <70% ■ 70% - 90% ■ >90%

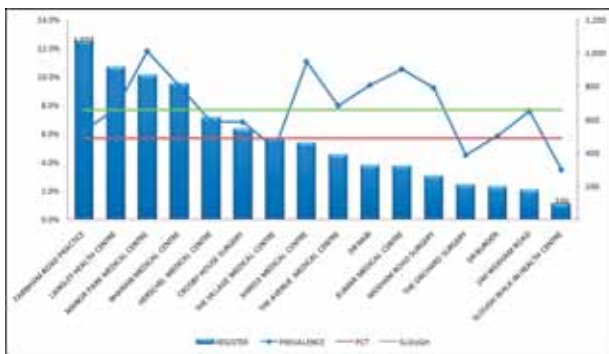
Target	Percentage of registered patients in PCT (including RAG Score)	Percentage point change since 2009-2010	Median score across all PCTs	National quartile ranking
HbA1c < 6.5% (48 mmol/mol)	22.7%	+1.14%	26.5%	4
HbA1c <= 7.5% (58 mmol/mol)	64.3%	+0.71%	66.8%	3
HbA1c <= 10.0% (86 mmol/mol)	91.7%	-0.04%	93.1%	4
Cholesterol < 4 mmol/l	49.7%	+2.51%	42.6%	3
Cholesterol < 5 mmol/l	77.8%	+0.49%	78.2%	3
Target BP*	33.8%	+0.71%	35.2%	3
BP < 140/90	42.5%	+1.63%	43.6%	3
All**	19.0%	+0.02%	20.5%	3

*Blood pressure target of <140/90 applied to those patients without recorded eye, kidney or vascular disease (EKV-) and blood pressure target <130/80 applied to those patients with recorded eye, kidney or vascular disease.
 **Where patients have achieved HbA1c <7.5%, cholesterol <5mmol/l and their relevant blood pressure target.
 RAG (Red-Amber-Green) score key: ■ <70% ■ 70% - 90% ■ >90%

4.4 Local needs assessment and gap analysis: What are the specific challenges that Slough faces?

- Slough has a particularly high prevalence of diabetes
 - o 7,765 of all registered adult patients in Slough have diabetes (7.5% of the Slough population) [Figure 6]. This is higher than the national average of 5.5%, particularly due to the higher proportion of BME patient populations at high risk. 54% of Slough's population is non-White (40% Asian, 9% Black, 5% Other). [21] T2DM is 6x more common in people of South Asian origin and upto 3x more common in people of African and African-Caribbean origin). [14] [Figure 6]
 - o Patients with diabetes in Slough comprise 42.5% of the 17,400 registered patients with diagnosed diabetes in Berkshire East (NB. the former South Central Strategic Health Authority prevalence is 4.9%) [12, 22] [See Appendix re: why NDA & QOF prevalence is different]

Figure 6 - QOF prevalence of diabetes among practices in Slough (2010/11) [12]

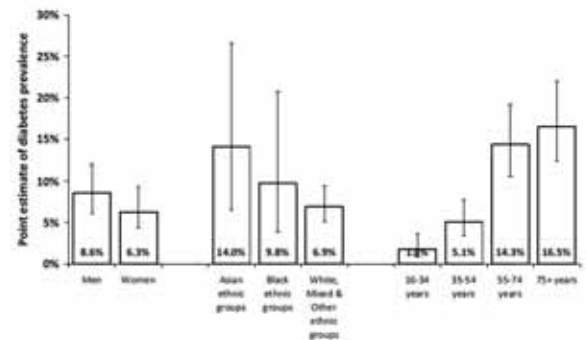


- There is likely to be a significant undiagnosed population with diabetes in Slough
 - o National estimates suggest that 15% of the population with diabetes remain undiagnosed - equivalent to 1,165 undiagnosed patients with diabetes in Slough [14, 23]
 - o Estimating using up-to-date 2011 census data (which accounts for the ethnicity mix of Slough) and current APHO diabetes

prevalence estimates, suggests that there should be 10,815 patients with diagnosed diabetes in Slough - i.e. an undiagnosed population of 3,050 - a much more significant 'hidden' burden. [11] There remains considerable uncertainty over the precise number of 'hidden' patients with diabetes [Figure 7]

- o Data from Berkshire West (an area with a lower prevalence of diabetes) concluded significantly higher rates of approximately 30% of the population being undiagnosed. This suggests that estimates in Berkshire East (and in Slough in particular) may be too low. [24]

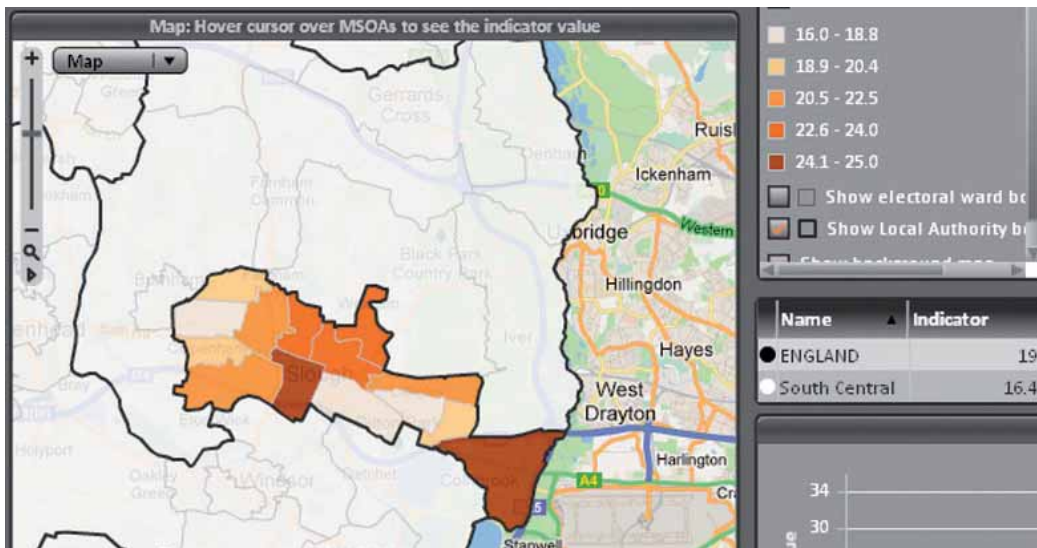
Figure 7 - Variability in estimates of diabetes prevalence between sex, ethnicity and age [11]



- Lifestyle factors are a major issue, with limited focus on identifying 'at-risk' populations
 - o The prevalence of diabetes, cardiovascular disease and associated deaths can be significantly reduced through physical activity. [14]
 - The Health Impact of Physical Inactivity (HIPI) index estimates that Slough has 394 total deaths (in adults aged 40-79 years) through conditions that are preventable through physical activity. 74 of these are estimated to be preventable if adults are '100% active', with this number reduced to 29 if adults are 50% active. While this model is not perfect, it provides some quantification of the impact of physical activity

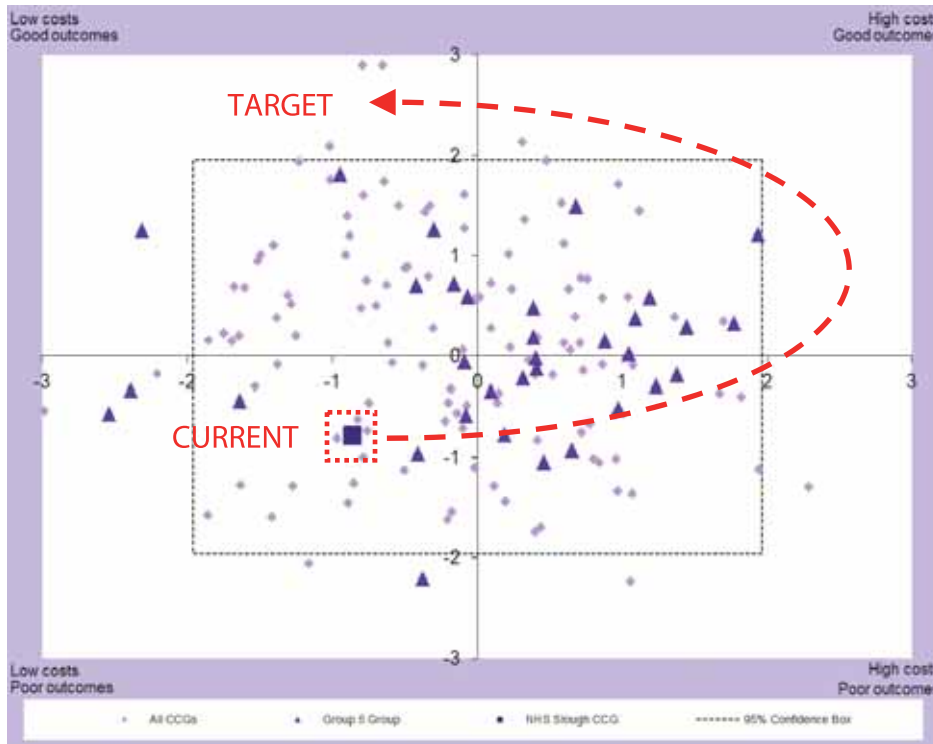
- Furthermore, the model estimates that 14% of the cases of diabetes in Slough can be prevented if adults are 100% active, and 6% prevented if adults are 50% active
- o Very few structures and processes exist to support diabetes risk reduction in a uniformed way across the CCG, with variation between clinicians and practices in approaches to identifying those at risk of developing diabetes or from diabetes-related complications. It is hoped that the recent “Slough Physical Activity and Sport Strategy 2013 - 2015” will be actively promoted and used to help provide advice and resources to patients
- o Only 7.6% of adults in Slough participate in moderate-intensity sport and active recreation for >20 days per month - one of the lowest rates in England (England average 11.2%) [14]
- o Slough ranks statistically above the England average for childhood obesity: children in reception year (10.10% prevalence) and year 6 (21.30% prevalence). England average = 29% of all children aged 2-15 years. [Figure 8] [14] In contrast, the >16 years population has an obesity prevalence that is not significantly above the England average (10.64%, compared to England average of 26%) [22, 25]
- o Another contributing factor to poor diet, exercise and general health is the high level of deprivation in parts of the borough (the most deprived in the UK are 2.5x more likely to have diabetes) [14]

Figure 8 - Percentage of obese children aged 10-11 years in Slough, 2009/10 – 2011/12 [26]



- There is limited patient education and subsequently poor uptake of relevant services
 - o There is low awareness and uptake of relevant local services providing behaviour changes or preventative services such as physical activity and healthy eating, as well as services including diabetic eye screening and structured education programmes
 - o 2011 referral data show that out a total diabetic population of 7,765, only 302 patients (3.9%) in Slough were referred to the structured education programme [12]
 - o There are few mental health professionals in Slough providing diabetes-specific psychological support for either adults or children. The Increasing Access to Psychological Therapies Service (IAPT) offer sessions to patients with long-term conditions such as diabetes, but their reach is not widespread. Children and young people with diabetes may experience psychological disturbances such as anxiety, depression, behavioural and conduct disorders and family conflict. These can impact on the management of diabetes and wellbeing. NICE recommends that diabetes care teams should have appropriate access to mental health professionals to support them in the assessment of psychological dysfunction and the delivery of psychosocial support. NICE also recommends psychological support for type-2 diabetes, particularly for some of the complications such as diabetic neuropathy
- Prescribing and spend is not in line with national averages, with low use of insulin and higher use of oral anti-diabetic agents, and considerable variation among practices
 - o As a CCG, Slough spends less per patient with diabetes on prescriptions than England average. This is due to a lower use of insulin. Insulin use is 27% less than would be expected given the prevalence. Spend on oral medications is much higher than England average. Additionally, there is huge variation in prescribing rates between practices. For example, prescribing of sulphonylureas is twice as high in some practices compared to others; prescribing of GLP-1s varies by up to 6 times between practices [16]
 - o Total spend on prescribing per person on the diabetes QoF register is £384.28 - below the England average of £420.94 (Slough in the lowest quartile of spending CCGs)
 - o Spend on non-insulin anti-diabetic drugs is £183.29 - above the England average of £155.00 (Slough in the highest quartile of spending CCGs), with variation among practices
 - o Insulin prescribing among practices in the Slough CCG is low; spend on insulin items is £121.48 - below the England average of £174.85 (Slough in the lowest quartile of spending CCGs - 5th lowest out of 211 CCGs). Slough practices prescribe an average of 1.79 items per patient with diabetes compared to an England average of 2.44, with considerable variation in prescribing and spend between practices. Anecdotally, it has been reported that the low initiation of insulin in South Asian patients with T2DM may be due to a perception among GPs and patients alike that insulin use can lead to weight gain. Better education of patients and professionals is therefore required in order to highlight that, when appropriately used, this is not the case
 - o Despite a large degree of variation between spend and prescribing practices among practices, there is no discernable relationship between greater practice spend or total prescriptions issued, and better QoF outcomes in Slough. [Figure 9] [16, 20]

Figure 9 - Prescribing in Slough CCG: moving from 'low cost, poor outcomes' to 'low costs, good outcomes' [27]



- Certain areas within Slough have particularly high risk populations
 - o The 2010 JSNA identified certain practices as having the highest number of registered patients with diabetes: Sandhurst (714), Manor Park (768), Langley (829), Bharani (678) and Farnham Road (909). [22] However, there is no targeted intervention for these areas
 - o Diabetes mortality in Bracknell Forest and Windsor and Maidenhead is below the England average but is now above the England average in Slough (2010) [22]
- Children and young people with diabetes have already been identified as a priority group
 - o Slough has a very young population (46% of the population are <35 years old; 20% are <20 years old) [14]
 - o In Berkshire East there are 142 children with diabetes (total <19 population = 40,589), it is expected that the majority of these are be in Slough due to its population mix. Note that the majority of these cases will be T1DM, with only a handful of children with T2DM. [14]
- o The incidence of childhood T1DM is rising, with a large proportion of cases diagnosed before 5 years. 1 in 479 of those aged <18 years in the former South Central SHA has diagnosed diabetes (compared to a national average of 1 in 337). This is likely to increase by 70% over the next 10 years. [22, 28] Again, while this report focuses on T2DM, the lifestyle interventions are still highly relevant to both these patients, and those children that are overweight/obese and therefore at a higher risk of developing T2DM
- A significant number of patients with diabetes are admitted to hospital for the management of diabetes-related or other medical problems
 - o The National Diabetes Inpatient Audit 2011 showed that 11.2% patients with diabetes were admitted specifically for the management of this condition, with 48.1%

- cases having active foot disease. 82.8% were admitted as emergencies (vs. 79.4% emergency admission for those without diabetes). [29]
- o For Wexham Park Hospital, some overall figures were better than the national average, with the percentage admitted specifically for the management of their diabetes being 8.6%, with only 8.8% admitted with active foot disease. However, 75.7% were admitted for 'medical reasons other than diabetes - significantly higher than the 66.6% reported nationally, suggesting generally poorer health in these patients. This is likely secondary to the underlying high physical inactivity and obesity rates which lead to the high prevalence of T2DM in these patients in the first place.
 - o Nationally, patients with diabetes have an 8-day median length of stay - compared with 5-days for all inpatients.
 - o Diabetes is not always well-managed in the hospital setting: 34.2% patients in the audit experienced at least one medication error, with this group of patients more than twice as likely to experience a severe hypoglycaemic episode (17.4%) compared with patients who did not have a medication error (7.5%). Wexham Park data was again better than national average, showed a lower rate of medication errors (27.7%), with only 8.5% experiencing a severe hypoglycaemic episode
 - o These data suggest that a) the overall health of patients needs to be improved to reduce admissions that are both diabetes-related and due to other medical problems, and b) provider education needs to be an area of focus in order to reduce the relatively higher proportion of medical errors experienced by patients with diabetes
 - Control of certain key measures in patients with diabetes is below national average [20]
 - o HbA1C <59mmol/mol: 66.4% patients (England average 70.2%, 2010/11 - Slough is in the bottom 50% of CCGs, ranked 37th of 211 CCGs)
 - o Cholesterol <5mmol/l: 77.2% patients (England average 81.7%, 2010/11 - Slough is in the bottom 50% of CCGs, ranked 6th of 211 CCGs)
 - o Blood pressure <140/80: 71.9% patients (England average 70.5%, 2010/11 - Slough is performing relatively better for this measure and is in the top 50% of CCGs, ranked 142nd of 211 CCGs)
 - o The above findings are reflected a comparison of Slough's performance compared to other similar CCGs [Fig 10]

Fig 10: Comparison of Slough with other similar CCGs

CCG	HbA1C	TC	BP
Slough	66.40%	77.20%	71.90%
Bradford	60.00%	79.30%	69.30%
Ealing	63.00%	79.20%	67.60%
Hillingdon	66.40%	79.30%	69.80%
Luton	71.40%	78.70%	64.30%
South Reading	67.10%	81.20%	69.60%
“Cluster” (South Central)	65.70%	79.20%	68.80%
England	70.20%	81.70%	70.50%

4.5 Note: Other types of diabetes

The data and commentary in this report above largely relate to T2DM. While many patients with T1DM will still benefit from the same surveillance and lifestyle interventions as patients with T2DM, their overall care and management is different. In general, patients with T1DM should have their 'management base' in a secondary/tertiary care setting (i.e. generally in a specialist -led service). As the management of T2DM is very much more community and GP-led, the focus of this report is on T2DM. Similarly, other types of diabetes – such as gestational and maturity onset diabetes of the young (MODY) generally require specialist input for their management. A separate policy document has been developed that discusses the services available for Paediatric Diabetes Services in Berkshire East [see appendix].

5 Design of future provision and monitoring arrangements

5.1 How can we improve outcomes in Slough?

Achieving the gold standard of integrated diabetes care involves the co-ordination of healthcare services around a patient. Integrated care models can respond to the complexities of managing long -terms conditions such as diabetes and, in particular, the increasing prevalence of multiple morbidity and poly-pharmacy, by ensuring the involvement of the MDTs and continuity of care, and minimising fragmentation of service provision. [30] A federated approach would provide a helpful model for cross-locality networking and expertise sharing (as adopted in Berkshire West).

A particular challenge for Slough is to ensure that any strategy sensitively considers the specific cultural needs of Slough's population. It is important to note that many of the interventions proposed below will have an impact on improving the general health of patients in Slough with corresponding benefits on reducing morbidity and mortality from other conditions (e.g. cardiovascular disease, cancers).

5.2 Specific recommendations

Based upon the specific needs of patients with diabetes in Slough, this strategy report makes the following recommendations:

5.2.1 A staged approach is required to improve the identification of patients at risk of developing and with undiagnosed type-2 diabetes

- o **Promoting diabetes awareness:** This should be encouraged, for example by highlighting to patients the free Diabetes UK promotional events and materials - such as the '15 Healthcare Essentials'
- o **Targeted and opportunistic screening of high risk groups is key to achieving this goal:** This will allow clinically appropriate interventions to be targeted to reducing the ongoing risk of those patients who are currently undiagnosed, and to commence lifestyle measures to delay the onset of diabetes in those who are at risk of developing diabetes
- o **High-risk patient groups should be initially targeted:**
 - One way in which those at high-risk of developing T2DM can be identified and followed-up is by increasing the uptake of existing NHS Health Checks.
 - These are recommended to focus on: adults > 40 years (except pregnant women); Adults >25-39 years of South Asian, Chinese, African-Caribbean or Black-African, or other high risk BME groups; adults with conditions that increase the risk of type-2 diabetes, positive family history of diabetes, hard-to-reach or vulnerable groups (e.g. those with mental health, alcohol or drug misuse problems), pregnant women, older people, those in residential or nursing homes. [31]
 - Successful strategies adopted in Berkshire West include the use of community-based programmes, targeted at community centres including faith centres (e.g. churches,

temples, mosques), as well as through engagement with local pharmacies, supermarkets and also employers to offer 'work-based' screening programmes

- o **Risk-registers:** Use of existing registers (e.g. obesity registers), validated risk assessment tools (e.g. Q Diabetes) and appropriate investigations (e.g. fasting glucose or HbA1C blood test) should be used in primary care to either establish 'at-risk' or 'pre-diabetes' patient registers for those that need targeted clinical and lifestyle interventions, and close follow-up
- o **TARGETS:** See *Executive Summary for action tables*. Note that targeted screening will initially detect more cases of diabetes, although it will reduce the diagnosed:undiagnosed ratio, allowing overall outcomes to improve

5.2.2 Those at risk should be offered targeted health promotion, lifestyle interventions and education

- o **Opportunistic screening through NHS Health checks:** These provide an ideal opportunity to identify those at higher risk and a therefore the greatest priority to target with information, education and intervention (see previous section)
- o **Incorporating Slough's Wellbeing Strategy:** This has a focus on prevention in order to increase the early diagnosis of all types of diabetes and to reduce the gap between the expected and recorded prevalence. The aim should be to enable diabetic patients to self-manage their condition, to introduce positive lifestyle behaviours and to and empower patients to become more engaged in their health care decisions
- o **Regular exercise:** For those at risk, lifestyle interventions such as regular, structured exercise, combined with dietary advice, can significantly reduce their risk of developing T2DM by up to 58%. Studies have demonstrated that

even a 12-week structured walking programme can provide significant benefits to health. [14; 32]

- o **Smoking cessation:** Smoking, another key general risk factor, should be targeted through ensuring patient status is checked annually, with appropriate advice and Stop Smoking Service referral made
- o **Personalised care:** For those with diagnosed diabetes, personalised care can reduce complications. Newly diagnosed patients and/or their carers should be offered structured education around the time of diagnosis, with annual reinforcement and review. [31] Good disease control can have positive impacts such as reduced planned and unplanned hospital admissions, and reduced absence from work for patients
- o **Patient education:** A number of programmes already exist in the region. Going forward, it is important for Slough CCG and Public Health teams to ensure that these have clear objectives, tangible outcomes and are offered equally to all patients across the CCG. There should be a particular focus on offering lifestyle interventions to children and BAME groups in order to reverse the rising trends of childhood obesity and T2DM in Slough's significant South Asian population. Good 'Care Planning' should focus on what patients want to achieve. Services currently on offer in Slough include:
 - **Self Management UK** (formerly the Expert Patient Programme) - Locally-run service to provide guidance to patients to help them self-manage their condition. Delivered through group workshops that focus on behavioural change, led by patients with long-term conditions. Other parts of the country have the more structured 'Xpert' programme, which is more focused on T2DM
 - **DEAL and DEAL Plus** - T2DM education - "Education and Awareness for Life".

- Looks at educating patients on aspects of diabetes, including treatment and complications. Deal Plus is catered to patients who have had diabetes for >1 year
- *Gestational Diabetes Education* - designed for pregnant women with diabetes.
- *CHOICE* - T1DM education - Carbohydrate, Insulin Calculation Education (both organised by Senior Diabetes Specialist Nurse Team Lead: Michelle East - 01753 636629 at King Edward VII Hospital, Windsor). Run 4x per year, requiring attendance for 4x consecutive weeks. Some carbohydrate counting knowledge is required
- *Slough Education and Life Style Intervention Programme for Pre diabetic and Obese Diabetic Patients* (hosted at Kumar Medical Centre by Poonam Kumar) - a 7-week program that focuses on diet and weight loss advice, designed for Asian patients
- *Stop Smoking* services in Berkshire East
- *GP Prescription on Referral scheme* - GPs to encourage to provide a formal prescription for physical activity in order to provide patients with a more 'formal' requirement to undertake structured physical activity
- *Diabetes UK* - run national education and marketing programmes in a number of languages, providing patient information and support (e.g. the '15 healthcare essentials' patients with diabetes should receive). They are currently developing an online course for patients with T2DM, and also run the 'Primary Care Network' to disseminate knowledge to GP practices (primarycarenetwork@diabetes.org.uk)
- Cooperation with other relevant strategies and groups is vital in delivering many of the lifestyle services discussed in this report (e.g. the "Slough Physical Activity and Sport Strategy 2013-2015"), the Slough Leisure contract, and IAPT services), which seek to encourage collaboration to encourage healthier lifestyles among Slough's residents [see appendix for physical activity pathway]
- o **Education for healthcare professionals (HCP):** Continued education should also be provided for members of the MDT, as planned through the Slough CCG 'Improving Diabetes Care and Outcomes Framework'. Courses/training opportunities on offer include: [33]
 - Enhanced Management of Diabetes (EMD) in Primary Care - a free, non-promotional programme, sponsored by Lilly, in which practices are mentored and the care of complex patients is discussed. 30 of 56 practices in Berkshire West are now engaged, and medicines management have sat in on sessions to validate that there is no corporate bias. (see appendix)
 - Certificate in Diabetes Care (CIDC) - University of Warwick
 - Diabetes Management in General Practice - University of Surrey
 - MSc Course in Diabetes - University of Leicester
 - Slough Diabetes MERIT Course (aiming for at least 2 Healthcare professionals from each practice – ideally Dr and Practice Nurse)
- o **Diabetes networks:** Local diabetes healthcare professionals should support and promote the Slough Diabetes network), with a view to making this a hub of innovation and best practice that can be shared across the CCG and more widely with other CCGs in the federation. Best practice should be shared across Berkshire, ensuring that the region provides a cohesive set of services to patients, including through the use of diabetes specialist nurse-led clinics. Diabetes UK has a toolkit and best-practice guidance on running such networks [34]

- o **TARGETS:** See Executive Summary for action tables
- 5.2.3 All patients with diabetes should be offered the 9 Key Care Processes, with a particular focus on achieving treatment targets and improved patient outcomes, including through better medicines management
- o **Focus on improving treatment targets:** By improving awareness among GP practices across Slough, we need to continue to increase the proportion of patients both receiving the 9 NICE-recommended Key Care Processes, and in achieving improved treatment targets for BP, HbA1C, and TC in order to achieve top-decile performance in the next DOVE audit. A key goal should be to reduce inequality in outcomes between practices
 - o **Improve GP practice participation in the next NDA:** This should continue to improve to ensure that we achieve 100% data reporting (in 2010/11 48 of 51 practices participated - 94.1%). GPs should ensure that appropriate coding is used to achieve better results, noting the differences in methodology between the NDA and the QOF data collection [See Appendix]
 - o **Recording needs to be optimised at practices across Slough:** In order to achieve maximal outcomes, practices should review their coding of T1 and T2DM in order to ensure compliance with both QOF and the NDA (e.g. NDA picks up Idiabetes and NIdiabetes). A strategy adopted by practices in Berkshire West has been to implement the PRIMIS system, for a small licence fee, to help pick up hidden patients. [See Appendix]
 - o **Focus on follow-up:** Patients are less likely to develop complications when their condition is managed effectively. By increasing the number of patients with diabetes that are followed-up with the appropriate management, we need to aim to improve our achievement in the treatment targets for each of the 9 Key Care Processes. A key area in which Slough can improve performance is through effective and appropriate prescribing, for which support is available through Slough CCG (via Tim Langran and the Medicines Optimisation Team - see next section)
- o **Innovation Fund project:** This is being run by the Medicines Optimisation Team together with the EMD programme, and aims to review practices' performance in each of the 9 Key Care Processes and provide medicines optimisation. This, and other projects aimed at providing support to practices in Slough will help promote a consistent approach to diabetes care
 - o **Specific focus:** In line with the 'Making Every Contact Count' approach, there are some key messages to note for each of the 9 Key Care Process: [See Appendix for specific details]
 - **HbA1C:** This is an area of strategic focus as it is the Key Care Process in which Slough is performing the poorest and for which READ coding has also been inconsistent across practices. It is important that the 42W5 code is used, results recorded as mmol/mol (not as a DCCT %) and that practices note the differences between NDA and QOF targets
 - **Blood pressure:** This is an area in which Slough is performing relatively well - a standard that needs to be maintained and improved. There should be awareness of the more stringent BP criteria used in the NDA audit of <130/80mmHg for patients with eye, kidney or vascular complications
 - **Cholesterol:** Practices should note and aim to meet the NDA target of <4mmol/l - more stringent than the QOF target of 5mmol/l
 - **Eyes:** Diabetic eye screening, commissioned by Berkshire Public Health in line with the National Screening Programme is currently

achieving around 77% uptake. This needs to continue to improve to achieve >80%, in line with national standards. Patients should receive multiple communications (minimum two letters/texts/phone calls) to encourage them to attend. There are also plans for slit-lamp bio-microscopy clinics and outpatient community clinics (vs. hospital eye services) in line with the Common Pathway introduced by the National Screening Programme. A centralisation of services might be helpful in order to help coordinate the system Berkshire-wide.

- **Feet:** Amputation rates for patients with diabetes in Slough are currently 0.9 per 1000 (at UK average), of which BME patients actually have lower than average amputation rates. MDT members need to continue to ensure opportunistic and proactive screening of foot pulses and neuropathy, with appropriate and timely referral to podiatry services, as well as to hospital teams if problems warranting acute care are noted. At present there is variable uptake of podiatry services, which should be addressed. Diabetes UK's 'Putting Feet First' campaign aims to reduce diabetes-related amputations by 50% by 2018 - a target that should also be a local aspiration
- **Kidneys:** Screening for microalbuminuria needs to improve in terms of NDA outcomes, by ensuring a morning sample of urine is sent to secondary care laboratories (the NDA does give credit for in-house urine dip recording) for an albumin:creatinine ratio each year, regardless of the presence of nephropathy. The correct read code '46TC' should be recorded.
- **Weight/Smoking:** See above for targeted lifestyle interventions
- o **Quality, Innovation, Productivity and Prevention (QIPP) & Enhanced Management of Diabetes (EMD):** In order to enhance performance in the poorest faring areas, Slough CCG have chosen HbA1C, blood pressure and total cholesterol as the three key targets for a QIPP project, an EMD service (Enhanced Management of Diabetes) and a series of educational initiatives for healthcare professionals and patients as the vehicles of delivery for this project. It has been agreed that GP practices will be incentivised for achieving this chosen key outcomes in this QIPP initiative that has been approved for roll-out by the CCG. The EMD component of this is an initiative designed to improve diabetes education among practices through a mentoring model, led by Lilly [see Appendix for details]
- o **Medicines optimisation is key to achieving top quartile outcomes:** A key aim for Slough CCG is to provide support and training for prescribers to appropriately use medications for diabetes and insulin to optimise achievement of outcomes. This should reduce variation in both prescribing rates and outcomes and increase use of insulin where appropriate. Additionally, given the lack of correlation between higher prescribing rates and outcome achievement there must be other factors having significant impact on achievement of outcomes e.g. patient adherence to therapy, lifestyle support/patient education. These other factors will also need to be addressed. The following strategies have been proposed by the Slough CCG Medicines Optimisation Team:
 - **Adjusting spend:** Slough spends less per person with Diabetes on prescribing than the national average. This is predominantly due to a lower than expected prescribing rate of insulin. Going forward, Primary Care will need to be supported to have confidence and competence in prescribing insulin. Use of oral medications is at national average or higher depending upon the therapeutic class
 - **Medicines Optimisation Team:** Despite large variation between Slough GP

practices on diabetes drugs spend, there is no relationship between greater spend and QOF target achievement. Patients need to be supported to adhere to their medications through information and a concordant approach, with the continued need to emphasise lifestyle interventions and patient responsibility. This team will therefore work with GP Practices to audit current management of Diabetes and support changes to therapy to improve patient outcomes. Additionally, patients will be directed to sources of education and lifestyle support. The team will also work with local diabetes specialists to develop and implement Prescribing Guidelines to ensure that Slough gets the most effective and safe medications for the resource it has available. Joint education initiatives will also be developed in order to motivate patients and to tailor treatments to individual patients - there is no single solution that fits all patients

- **Community Pharmacy and New Medicines Service:** 66% patients on new medications have a single query; 33% of patients are not taking their new medications as intended by day 10. NHS South Central sees £20 million of wasted medicines every year. Community pharmacies are ideally situated to work with patients to help improve their understanding of their disease, to provide advice on their drug treatments and to provide lifestyle advice to help improve patient health and quality of life. Pharmacists can offer an annual review within their confidential consultation room; they can provide advice on diet, how to minimise side effects and also on how to improve their health through simple changes to lifestyle. They can also provide help with stopping smoking where appropriate. When a patient's medicines change the pharmacist can offer a programme of support over the first 28 days to help the patient with any medicines issues and this support

has been shown to increase patient satisfaction with their treatment. Pharmacists and their teams of trained staff are readily available, often seven days a week, for patients to drop in and discuss their health. Community Pharmacists could also play a role in the identification of undiagnosed diabetics. This could be achieved through a commissioned service for targeted screening of a defined population or as an outcome from a commissioned NHS Healthchecks service. [35]

- **Pharmacy training:** Tesco and Boots pharmacies train their staff in Diabetes Risk Assessment. Further training for other pharmacies should be encouraged, as these are ideal places for health promotion (e.g. being sources of distribution for Diabetes UK educational materials)

- o **TARGETS:** See Executive Summary for action tables

5.2.4 By improving the offer, uptake and outcomes of the 9 Key Care Processes, both primary and secondary care utilisation should be ultimately reduced as patients have the skills to manage their diabetes more effectively right from diagnosis

- o **Optimisation of services:** This may require services need to appropriately re-designed in order to achieve maximal gains in patient outcomes, with a focus on lifestyle and other preventative measures
- o **Reducing service demand:** The ultimate goal should be to reduce demand on both primary care services, and elective/non-elective diabetes-related outpatient clinics and admissions through improved prevention and management of diabetes and its associated complications
- o **Virtual clinics:** One option may be to adopt the cardiology model of 'virtual clinics' to provide a rapid-access fax number for queries from Slough GPs,

direct to consultant diabetologists, in order to assist the management and triage of complex patients with diabetes in the community. Any patients deemed in need of an urgent outpatient appointment could have this directly arranged via the secondary care teams

- o **Improve primary and secondary prevention:** By focusing on associated health risks for patients with diabetes (e.g. cardiovascular disease), at-risk populations can be targeted to reduce overall co-morbidity and therefore, admissions. For example, looking at statins in cardiovascular disease, Slough practices have historically targeted the wrong patient mix (i.e. those at low risk - not those who have already had a cardiac event and are therefore high-risk) and have had poor patient compliance. This is reflected in the fact that spending more on medications to reduce BP and total cholesterol does not necessarily correlate with fewer non-elective admissions [16]
- o **The long term goal should be to reducing non-elective diabetes-related admissions:** Discussion between relevant parties (e.g. the Slough CCG, Public Health, secondary care teams) is ongoing to determine a series of targets that can be put in place to monitor the long-term goals of this strategy

6 Summary

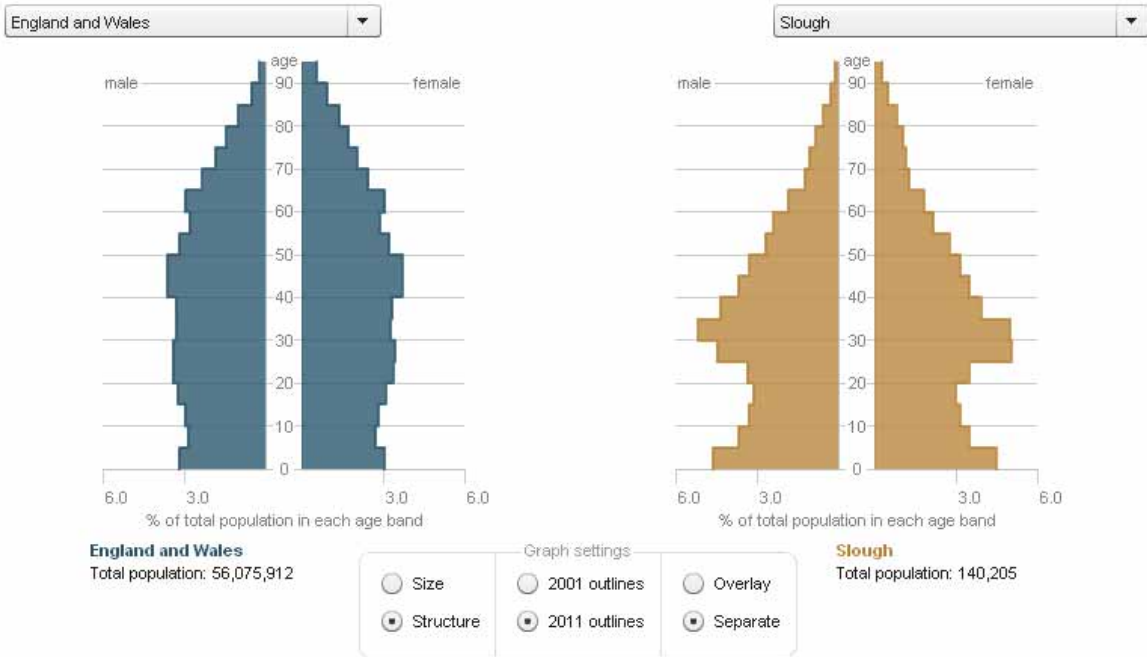
In summary, the role of Slough CCG should be to commission sufficient capacity to cope with the rising trend in diabetes with a focus on paediatric diabetes team, and to ensure that there is consistently high performance across all practices in Slough. Ultimately, overarching changes are required to health strategy in order to place a greater focus on indicators to deal with the major determinants of health that have a significant impact on diabetes, such as reducing obesity through greater physical activity and healthier diets, and encouraging smoking cessation. At a local level, this requires appropriate service re-design in order to ensure services are targeted consistently and effectively in order to achieve the best patient outcomes, with minimal variation.

Primary and secondary care teams, as well as public health and local council/Wellbeing services should continue to offer and develop on-going support to the local diabetes network in Slough. Through adopting the Slough Physical Activity strategy, there should be continued advocacy and support for promoting better local lifestyle interventions promoting healthy eating and active lifestyle and reducing obesity, inactivity and poor lifestyle choices through on-going funding for weight-management interventions such as 'Slimming World' (likely 'Eat4health' in future), 'More Life' (likely 'Let's get going for children' in the future). Existing programmes will be evaluated for quality and performance and appropriate future programmes chosen in partnership with the CCGs and local community needs. Public health initiatives, such as the 'Longer Lives' strategy, which provides peer grouping so local authorities can compare their premature mortality rates with others of similar socioeconomic status, will allow improvements on outcomes to be monitored, helping everyone to build a healthier Slough.

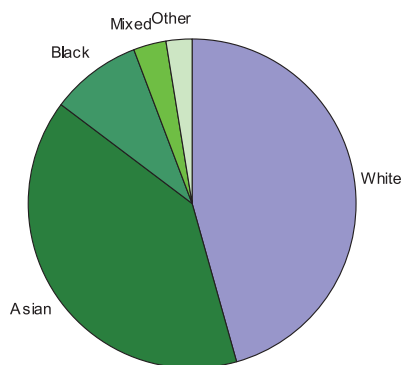
7 Appendices

Appendix 1 - 2011 Slough Census population data (APHO Small area indicators Slough)

2011 Census: population estimates for England and Wales



54.3% of the Slough population is from a BME* background (39.7% Asian; 8.6% Black; 3.4% Mixed; 2.6% Other)



Source: ONS – 2011 census (<http://www.ons.gov.uk>)

Appendix 2 - Quality measures

Quality and Outcomes Framework (QOF)

- What data is collected? All patients >17 years, aggregate data collected annual from primary care, permits exception reporting. For patients <12, 'all care processes' only includes AbA1c (other processes not recommended by NICE).

National diabetes Audit (NDA)

- What data is collected? All patients >12 years, patient-level data collected from primary and secondary care (differently to QOF), picks up read codes (Idiabetes and NI diabetes, not T1 diabetes and T2 diabetes), no exception reporting. Reporting in a 15-month cycle (not matching QoF) submission timelines.

Differences between QOF and NDA methodology

There are some differences between QOF and NDA which can account for differences in performance. The table below summarises some of the differences and recommended targets:

Care Process	Key issue/s	Proposed actions	Difference from DM QoF
HbA1c*	1. Targets differ 2. Coding varied 3. HbA1C units differ (mmol/mol, not % should be used)	1. Note targets in next column 2. The correct read code for IFCC Hba1c is "42W5." 3. No conversion necessary except possibly where non-laboratory point of care Hba1c measurements are recorded (when DCCT % should be changed to mmol/mol (conversion of DCCT %-IFCC mmol/mol: 6%=42, 6.5%=48, 7%=53, 7.5%=59, 8%=64, 9%=75).	NDA targets: HbA1c < 6.5% (48 mmol/mol) HbA1c <= 7.5% (58 mmol/mol) HbA1c <= 10.0% (86 mmol/mol) DM QoF targets: DM 7 = % patients <59mmol/L (equiv. to <7.5%) DM 8 = % patients <64mmol/L (equiv. to <8%) DM 9 = % patients <75mmol/L (equiv. to <9%)
Blood Pressure	1. Targets differ	1. Note differences in targets between NDA and QOF and aim to follow the more stringent NDA criteria	NDA targets: <140/80mmHg for those without recorded eye, kidney or vascular disease (EKV) or <130/80mmHg for those with recorded EKV disease DM QoF targets: Last BP in preceding 12-months DM2 = BP <150/90mmHg DM3 = BP <140/80mmHg

Care Process	Key issue/s	Proposed actions	Difference from DM QoF
Urinary Albumin	<p>1. Coding varied</p> <p>2. Album-Creatinine (ACR) estimation. The question asked is different: is there a record of micro-albuminuria testing? (QOF) vs. is there an ACR record of this process for all diabetic patients?</p> <p>3. Differing targets</p>	<p>1. Use read code 46TC</p> <p>2. Urine ACR should be sent to the lab and both Urine ACR and serum Creatinine (GFR estimation) must be performed 'annually, regardless of the presence of nephropathy'</p> <p>3. Note targets in next column</p>	<p>NDA targets: Urinary albumin [ACR tested in lab]; >2.5mg/mmol is abnormal ACR for men >3.5mg/mmol is abnormal for women Blood/serum Creatinine (GFR estimation) must be performed annually</p> <p>DM QoF targets: DM 5 = % patients with a record of albumin: creatinine ratio in preceding 12-months DM 6 = % patients with diagnosis of nephropathy (clinical proteinurea) who are on ACE inhibitors (or ARBs)</p>
Cholesterol	<p>1. Targets differ</p>	<p>1. Aim to achieving the more stringent target of <4mmol/l which matches the NDA expectation</p>	<p>NDA targets: <4 mmol/l</p> <p>DM QoF targets: DM 4= % of pts with a cholesterol < 5mmol/l</p>
Eye Screening	<p>GP referrals and uptake</p>	<p>All diabetic patients who are eligible are screened annually. This may require additional follow up by GP practices for patients who DNA or DNR when invited for screening.</p>	<p>NDA targets: Screening uptake rates locally</p> <p>DM QoF targets: DM 12= % of pts with a record of retinal screening in preceding 12-months</p>
Foot Exam	<p>Inadequate access to foot care/ referrals</p>	<p>1. Ensure foot pulse and neuropathy testing for all patients with diabetes during each opportune visit by each member of the multi-disciplinary team in primary or secondary care, including the GP, PN, HCA, podiatrist is mandatory.</p> <p>2. The examination recorded appropriately in terms of required notes and read codes. Follow foot care examination tools offered by NHS diabetes & diabetes UK.</p> <p>3. One team member to attend the monthly podiatry educational sessions.</p>	<p>NDA target: % of people who had a foot examination</p> <p>DM QoF target: DM 12 = % of patients with a record of foot examination and risk classification</p>

Source: <https://mqi.ic.nhs.uk/Search.aspx?query=diabetes> [2013/14 QOF v 6]

Differences in reported diabetes prevalence between QOF and NDA

The 2010/11 NDA has a slightly lower (population and missing data adjusted) diabetes prevalence for Slough (6.6%) due to the fact that a) one practice did not submit any data (Farnham Road), b) there are differences in age 17+ population estimates (86,000 NDA vs. 105,000 QoF), with a very young population in Slough, c) the NDA and QOF have different timeframes for data collection

Source: Sid Beachamp - Information Advisor, BHFT

Diabetes QOF guidance - 6th ed 2013-2014

Indicator	Points	Achievement thresholds
Records		
DM001. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed <i>NICE 2011 menu ID: NM41</i>	6	
Ongoing management		
DM002. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less <i>NICE 2010 menu ID: NM01</i>	8	53–93%
DM003. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less <i>NICE 2010 menu ID: NM02</i>	10	38–78%
DM004. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less	6	40–75%
DM005. The percentage of patients with diabetes, on the register, who have a record of an albumin:creatinine ratio test in the preceding 12 months <i>NICE 2012 menu ID: NM59</i>	3	50–90%
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	57–97%
DM007. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months <i>NICE 2010 menu ID: NM14</i>	17	35–75%
DM008. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months	8	43–83%
DM009. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10	52–92%
DM010. The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 September to 31 March	3	55–95%
DM011. The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 12 months	5	50–90%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months <i>NICE 2010 menu ID: NM13</i>	4	50–90%
DM013. The percentage of patients with diabetes, on the register, who have a record of a dietary review by a suitably competent professional in the preceding 12 months <i>NICE 2011 menu ID: NM28</i>	3	40–90%
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register <i>NICE 2011 menu ID: NM27</i>	11	40–90%
DM015. The percentage of male patients with diabetes, on the register, with a record of being asked about erectile dysfunction in the preceding 12 months <i>NICE 2012 menu ID: NM51</i>	4	40–90%
DM016. The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 12 months <i>NICE 2012 menu ID: NM52</i>	6	40–90%

New indicators highlighted in red

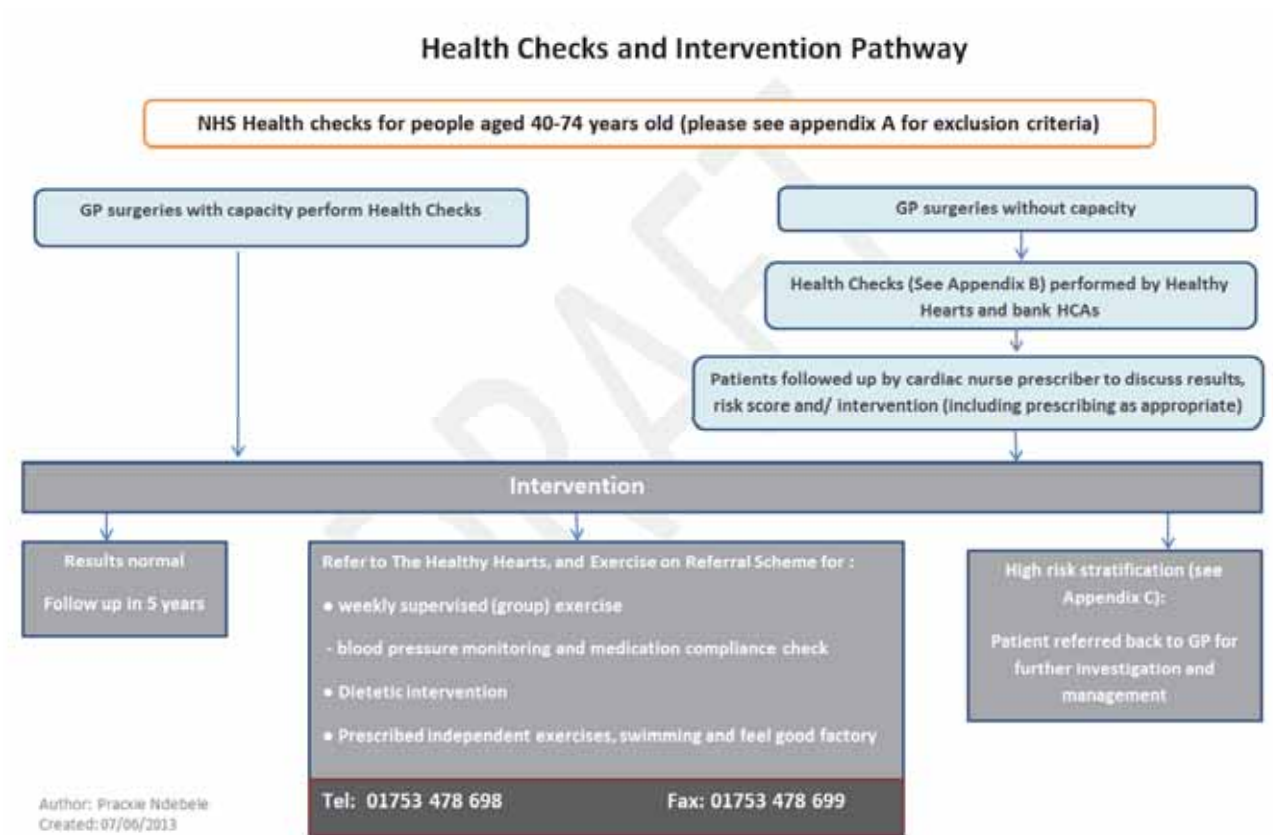
Source: http://www.eguidelines.co.uk/eguidelinesmain/external_guidelines/qof.php

Other tools: DiabetesE

DiabetesE is an online self assessment tool designed to support continuous quality improvement and the implementation of the NICE Quality Standard for Diabetes in Adults. measures and benchmarks the quality of diabetes service provision and is a mechanism for capturing service strengths and gaps in primary, secondary and community care and commissioning in one place. It is one of a suite of complementary information tools that operate under the auspices of the National Diabetes Information Service (NDIS). In addition to identifying the baseline of local services and gaps, it is also an educational tool that can be used for planning and team-building

Source: <http://www.innove.co.uk/Pages/Services/DiabetesE/>

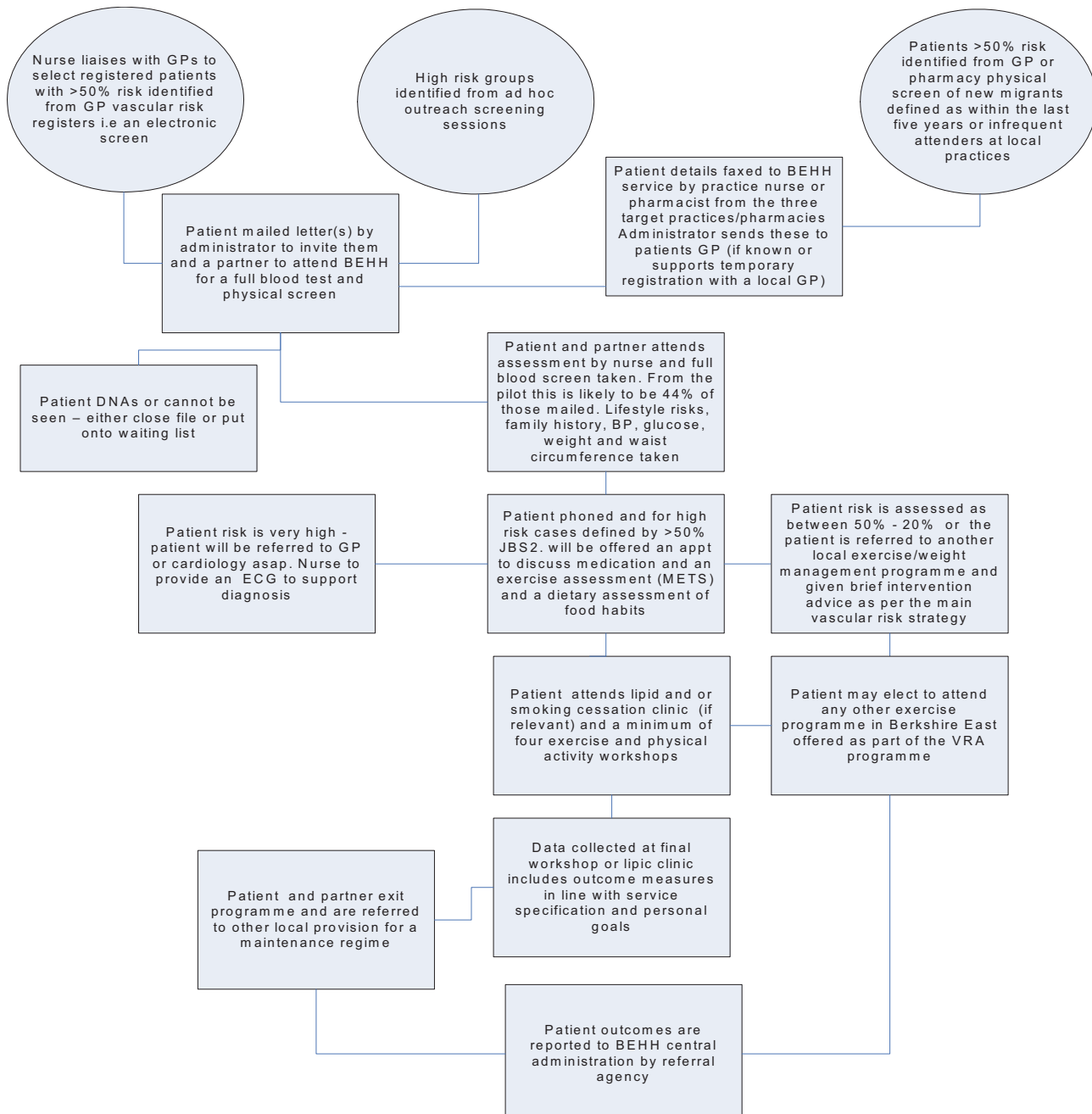
Appendix 3 - NHS Health checks



Source: Praxiedes Ndebele, Specialist Cardiac Nurse Manager, Berkshire Healthcare NHS Foundation Trust

Appendix 4 - Physical Activity pathway

Please see the "Slough Physical Activity and Sport Strategy 2013-2015" for more details. The new Physical Activity Pathway incorporates a triage system for referrals from NHS Health Checks, Healthy Hearts or patients referred as part of the GP Exercise on Referral. Patients are allocated to appropriate interventions/services through this pathway:




Source: Public Health, Slough Borough Council

Appendix 5a - Slough CCG QIPP (Quality, Innovation, Productivity, Prevention) project: Overview

The following slides summarise the diabetes QIPP project:

AT-A-GLANCE INFORMATION




Project name	Improve Quality of Diabetes Care in Slough Enhanced Management Programme		Date	April 2013	9 th April 2013
Project sponsor	Dr Jim O'Donnell	Project lead	Dr Nithya Nanda Rashida Sultana	Clinical champion	Dr Nithya Nanda
Potential Impact on Activity	Increase % of patients receiving all treatment targets: (Clinical Parameters): GP Total Cholesterol and HbA1c Improved health professional performance Reduced hospital emergency admissions	Anticipated Financial Cost	£33,000.00 Approved on 9 th April 2013 £16,412.00 Additional allowance to be approved on 11 th June 2013 Total: £49,419.00		
Finance Manager	Debbie Fraser	Reference (completed by PMO)	Rashida Sultana		

Framework Strategy:
SCCG aims to reduce disparities in diabetes outcomes by supporting:

- Evidence-based, community-focused interventions
- Efforts to ensure that successful programs and services are sustained in policy and practice
- Collaboration with key stakeholders at the national level through local levels to achieve policy and system change that reduces inequities in care and outcomes; Development of service standards;
- Integration of services and resources Implementation; Implement Case Management to ensure efficient use of resources and provision of excellent quality and outcomes for patients.
- Pathway re-designs, to ensure integrated pathways which are safe for patients and improve the quality of care for diabetic patients.
- Effective demand management including monitoring of Key performance indicators (KPI)

VISION OF PROJECT



Patient Intervention

Increase % of patients receiving all treatment targets:

- How patients are identified and receive care according to their needs; Risk stratification tool (i.e. EMD programme, ACG Risk Stratification Tool and Q-Diabetes) and internal practice audits.
- Improve the provision of patient centred integrated shared care and self-care
- How specialist nurses will support people with complex conditions; i.e. Case Management and LTCs
- Identify social and environmental barriers to diabetes self-management
- Identify resources for patients
- Remind patients of appointments for care
- Track patient progress and report to physician
- Conduct patient interviews

Innovative, evidence-based patient education:


- Introducing programs to enable diabetes self-management and empower patients to become more engaged in their health care decisions better at managing their diabetic conditions.
- Adopters of behaviours that help prevent complications
- Effective communicators with physicians and other clinicians
- Patients are identified and receive care according to their needs
- Encourage patients to participate in community health screenings

Front-line, proven health provider training including cultural sensitivity:

- Interventions aimed to enable clinicians to be more effective in working with diverse patients through training in cultural sensitivity and effective communication skills
- Teams of staff will be encouraged to work together with people with LTC and their families
- The Community, High level of involvement with the faith-based community and health ministry model. This would help target the BAME patient groups
- Diabetes navigators: Practice nurses assist patients in communication and interaction in the health care system

Sustainable quality improvements in health care access, and coordination:

- Introducing sustainable changes to how health organizations and providers manage their patients through improvements in information exchange identifying patients at risk of developing diabetes or of complications access to care coordination of services assessment of outcomes, e.g., clinical measures, patient satisfaction with care and health care use and cost. Monitor Key performance indicators; 9 care processes



Visions:
The overall vision of the proposal was to redesign the provision of diabetes care across primary care to provide a service which is accessible, fair and equitable, offers choice and is personalised to individual needs and circumstances, to reduce inequalities and to make best use of the resources available.

Diabetes is a significant health issue in Berkshire East however the severity of the problem varies between the 3 CCGs localities that make up NHS BE. There are more than 18 248 people with diabetes in Berkshire East. Slough has the highest prevalence at 7.6% (n=7765) equivalent to 42.5% of the total diabetic population in BE followed by WAM at 5.5% (5537= 30.4%) and Bracknell and Ascot has the lowest 5.4% (n=6946). The high prevalence in Slough is likely to be attributable to Slough's higher rates of deprivation and larger number of patients from at-risk population groups (particularly South Asian population). Diabetes is more common in people of black and south Asian origin. For instance, the prevalence of diabetes is up to five times higher in Pakistani and Bangladeshi people than in white people. Diabetes tends to present at a younger age in people of black and south Asian descent, and these groups have a higher risk of developing diabetes-related long term complications. It is estimated that a further 3 012 patients registered with a BE GP have either not been diagnosed or have not had their diabetes recorded correctly. These patients comprise 15% of the estimated total diabetic population taking the total number of diabetics in Berkshire East to 23 260


Overview of the model of care:
Diabetes care in Slough is currently provided at 3 levels /tiers:

Tier 1: GP Practices: GP practices are the main providers of diabetes care for the majority of individuals via the Quality Outcomes Framework, including annual reviews, advice, and health monitoring and medicines management. A care pathways is in place to provide support and supplement clinical management for individuals.

Tier 2: Diabetes Specialist Nursing and Specialist Diabetes Outpatient Service (DSNS): This service provides high quality specialist diabetes care through clinical care, structured education, support and advice to achieve the best outcomes for all diabetic patients in Slough and the rest of Berkshire East. It consists of Diabetes Consultants, Diabetes Specialist Nurses (DSN), GP (clinical assistants) Dietitians, podiatrists and admin staff.

Tier 3: Inpatient/secondary care is provided through the local acute trust, Heatherwood and Wexham Park Hospital Trust (HWPHT). The services provided at HWPHT trust include consultant led adult and paediatric inpatient and emergency adult diabetes care. Diabetic patients with complex problems and complications such as renal failure, require renal dialysis, foot ulceration, eye disease, peripheral vascular disease also have access to other consultants at HWPHT.

NEED FOR CHANGE – THREATS & OPPORTUNITIES



Need for Change – Threats if no change is made:

What are the current obstacles to quality diabetes care in Slough?

- Slough's diabetes rate is Statistically significantly above England (E) prevalence rates and this will continue to increase.
- The Diabetes centre location in KE VII is not ideal for Slough patients this has a negative impact on access and outcomes.
- Diabetes Education not tailored to the Slough population- i.e. content, mode of delivery, venues and language
- Lack of a standardised pathway for the management of patients with impaired glucose tolerance in Slough.
- Limited Diabetes education support for primary care clinicians – adequate service not delivered to the patient
- Very few Slough specific Public health campaigns around Diabetes, Obesity and Diet and Nutrition – poor awareness and disadvantage to self-care in Slough population
- No coordinated approach to prevention – very few prevention services and the few that are available are fragmented.
- Eye screening service capacity not enough – also patients are not followed up appropriately
- Diabetic input is limited – due to lack of competence / skills / poor management of diabetes care
- Inpatient care at HWP – evidence long LOS
- Not enough NHS Health Checks – are being carried out

Need for Change – Opportunities if change goes ahead:

What changes can we make that will result in improved outcomes for our patients in Slough?


Interventions

There are variations in the quality of care provided in primary care as measured by QOF indicators. The latest QOF data show significant differences between the practices in Slough for both the 9 NICE recommended care processes and treatment targets e.g. the percentage receiving all the key processes ranges from 17% to 92%. Currently only 61.8%, 39.8% and 43.4% of patients in East Berks are achieving the NICE recommended treatment targets for HbA1c, Cholesterol and BP respectively.

There is little work being explicitly carried out by local diabetes services on diabetes prevention and awareness, although there are other local services providing related preventative activities such as physical activity and healthy eating.

Poor uptake of some services including diabetic eye screening and structured education programmes in Slough.

DESCRIPTION OF CHANGE



Intervention:


The proposed diabetes model is as follows:

- 1 - Scope and agree practice incentive scheme
- 2 - Implement Enhanced management of diabetes programme delivered by Lilly UK across Slough practices.
- 3 - Establish prospective audit process for the 9 care processes in all practices.
- 4 - Ensure co-ordination and implementation of SCCG diabetes innovation project - medicines optimisation alongside EMD project.

Types of outcome measures:
Objectively measured health professional performance or patient outcomes in a clinical setting and self-report measures with known validity and reliability.

1) Health professional performance, including (process outcomes):
Measurement of blood pressure, blood glucose, HbA1c, weight, cholesterol, HDL-Cholesterol, triglycerides, serum creatinine; urinalysis; making a follow-up; referral; examination of the feet; visual acuity and retinal fundi. An increased knowledge within primary care to ensure quality and accessible care
Patients care will be undertaken by one streamlined pathway Specialist Diabetes Team working closely with General Practice to ensure a smooth pathway for the patients to follow
To ensure the provision of an equitable diabetes service across the CCGs

2) Patient outcomes, including:
Glycaemic control: HbA1c, blood glucose
Micro- or macro-vascular complications: nephropathy, retinopathy, neuropathy, cardiovascular diseases, amputations. Cardiovascular risk factors: weight, cholesterol, triglycerides, albumin, serum creatinine, blood pressure, BMI, Hospital admissions and Mortality



Continued...

3) Self report measures with known validity and reliability, including:
Well-being/perceived health/quality of life/functional status/patient satisfaction: scores on validated generic and disease-specific measures, Patient satisfaction and Provider satisfaction

4) Impact on Acute
A reduction in non-elective hospital admission of all people with diabetes from the baseline, where diabetes is a primary or subsequent diagnosis. This will be calculated using a baseline which will be the number of hospital admissions in the preceding financial year at the appropriate acute trust. This figure will be adjusted to account for the anticipated increase in the diabetes population.

For the Pharmaceutical Companies:
The experience and relationships gained from working with the CCGs (and other NHS stakeholders as appropriate) to help shape and deliver the project via membership of a steering group
To provide a resource to clinicians, in the sharing of knowledge and skills and to improve patient care and outcomes through collaborative working practices and the quality of specialist care diabetes services
Improving compliance through access to better information for patients about their condition and the medicines to treat it, and improved communication throughout the pharma-patient chain are key aspects of medicines management that industry is keen to work with PCTs to address.

FINANCIAL APPRAISAL – OPTIONS APPRAISAL



Option A Define Option of Delivery and Rationale:	Option B (if required) Define Option of Delivery and Rationale:	Options C (if required) Define Option of Delivery and Rationale
<p>Implementation of new service provision; Enhanced Management Programme including attendance to Slough Diabetes MERIT Course</p> <p>Advantages:</p> <ul style="list-style-type: none"> - Improve Quality of diabetes care using a more cost effective approach - Increased % of patients receiving all treatment targets - Improvement in achieving 9 care process - Practitioners up skilled to provide a fluent service <p>Disadvantages:</p> <p>None</p>	<p>- Enrolment onto numerous available courses;</p> <ul style="list-style-type: none"> - Certificate in Diabetes Care (CDC) (Warwick) - Diabetes Management in General Practice (Surrey) - MSc Course in Diabetes (Leicester University) <p>Advantages:</p> <ul style="list-style-type: none"> - Enhanced knowledge and improves academic competence <p>Disadvantages:</p> <ul style="list-style-type: none"> - Very costly for Practices - Poor Enrolment rate - Poor track record of candidates completing the courses 	<p>Do Nothing</p> <p>Advantages:</p> <p>None</p> <p>Disadvantages:</p> <ul style="list-style-type: none"> - Slough's diabetes rate is Statistically significantly above England (E) prevalence rates and this will continue to increase. - Increased resources = increased cost - Poor provision of patient care

Agreed with Finance Manager: _____ Name: _____ Date: _____

Finance & Budget Summary – base case



**NOTE : These figures are for management in the primary care ONLY
Invest Only Project**

Costs – Yr 1	Savings – Yr 1	Impact on Activity (POD Code – OPFA/OPFU/OPPROC/Elective/NEL/A&E)	Type of Provider & name of provider (Acute/Community/MH/Tier 2)
£ 49 419.00	£ None	<p>Increase of 5% of patients in each practice achieving IFCC-HbA1c target.</p> <p>NELA: 49 patients Current Cost: £ 65175.00 (53 identified of which 4 cases are related to other primary specialities and NOT diabetes)</p> <p>NEL excess bed days – 20 Current Cost: £541.00 Locally Slough will aim to achieve 5% reduction in NELAs and Excess bed days as an extra 'unrecorded' outcome</p>	<p>Primary Care Tier 2</p> <p>Acute reduction inactivity Community increase in activity</p>

METRICS – LEADING/LAGGING INDICATORS



Leading Indicator	Baseline (Current value)	Target value	How will you measure it?	When will you measure it?	How often / starting when?	Who provides the data?
Primary Care	QOF data 12/13 On DM prevalence scores.	Individual practice target to be agreed using Miquet data	By CCG and Lilly/NHSI	June 2013	June 2013	Information department derived from GP activity data
Primary and Community	Baseline from no. of case mgmt pts. Under care of ICT	Increased number of diabetic patients with a individualised care plan in place – cared by the ICT	By Practice and ICT	June 2013	Six monthly June 2013	Information department derived from GP activity data
Lagging Indicator	Baseline (Current value)	Target value	How will you measure it?	When will you measure it?	How often / starting when?	Who provides the data?
NDA Audit 9 care processes in all practices	2011/2012 2012/2013	Meet all 9 care processes	Central Southern CSU	July 2013	Quarterly July 2013	Information department derived from GP activity
NEL admissions	49 NELAs	5% reduction	By CCG / Informatics Team CSU	Monthly	April 2013	Information department derived from acute activity data
NEL LoS excess bed days	20 days	5% reduction of total NELA excess bed days	By CCG / Informatics Team CSU	Monthly	April 2013	Information department derived from acute activity data

Management targets for people with diabetes



The table below sets out the latest recommended desirable targets for metabolic control and the control of other cardiovascular risk factors in people with diabetes. The overall aim should be for metabolic control to be as near to the non-diabetic state as possible, but targets should be tailored to the individual patient, according to what it is possible and safe to achieve – over ambitious targets can be counterproductive. For example, in those with relatively short life expectancy, it may be inappropriate to impose strict management targets where this may impair quality of life. The impact of other cardiovascular risk factors should also be taken into consideration when agreeing targets. It should also be noted that the achievement of good blood glucose control in patients on insulin therapy may be associated with asymptomatic hypoglycaemia and an increased risk of severe hypoglycaemic events. All targets are based on current NICE guidance apart from those for blood pressure. These are based on Diabetes UK consensus agreement.

Target	Target	Target
HbA1c	HbA1c	HbA1c
LDL cholesterol	LDL cholesterol	LDL cholesterol
Blood pressure	Blood pressure	Blood pressure
Aspirin	Aspirin	Aspirin
Statins	Statins	Statins
ACE inhibitors	ACE inhibitors	ACE inhibitors
Beta blockers	Beta blockers	Beta blockers
Diuretics	Diuretics	Diuretics
Calcium channel blockers	Calcium channel blockers	Calcium channel blockers
Insulin	Insulin	Insulin
Oral hypoglycaemics	Oral hypoglycaemics	Oral hypoglycaemics
Diabetes UK consensus agreement	Diabetes UK consensus agreement	Diabetes UK consensus agreement

RISKS & ISSUES



Risks	Mitigating Actions
Current position of key stakeholders adversely changes to act as barrier to implementation	Continue early engagement activities and involve appropriate stakeholders in co production of localised implementation plans
Education interventions fail to change GP practice management of diabetes	Plan for changes to help practices to identify at risk patients and deliver result in the long term and manage expectation of early results
Step down in acute trusts fails to be implemented and LoS is largely unaffected	Ensure adequate investment to create inpatient specialist nurse capacity to allow step down to happen
Community services for diabetic patients are insufficient leading to continued long staying NELs	Ensure adequate patient management program are in place to include patients with diabetes to be better management in the community. (Active case management/identification of at risk patients/ active crisis management)
Issues	Who needs to do what to resolve?
There is currently insufficient project management capacity to deliver the project	Public Health specialist to allocate PM support and continued support from CCG
Current weaknesses in GP practices in early diagnosis and prevention to avoid hospital attendances & NEL admissions	Education and training mechanisms to up skill the clinicians to manage diabetic patients.

STAKEHOLDER MANAGEMENT



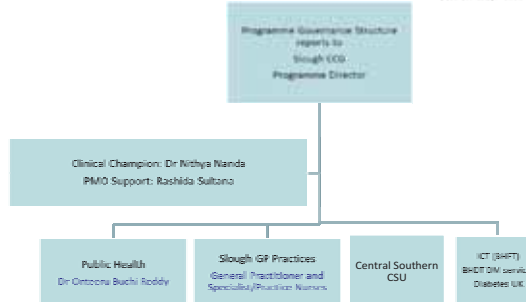
Stakeholder	Impact (H/M/L)	Present mindset	Support needed	Concerns / issues / resistance (with proposed change)	Benefits / what's good about proposed change?	Actions to resolve concerns / responsibility / date
Primary care providers	H	Supportive	PM CCG Public H	Need to agree new service protocols	Better management of patients and identify at risk patients	Early diagnosis and prevention mechanisms encouraged through education and training
Community & MH providers	H	Advocate	PM ICT CCG Public H	Concerned that community services will not be properly resourced	Opportunity to raise profile of diabetes	Co-produce implementation plans with ICT
Acute providers	H	Supportive	PM IP Nurse	Need to agree new service protocols	Enables cost improvements	Continue to engage and agree implementation plans
Unitary authorities	H	Skeptical	CCG Public H	Concerned about 'cost shifting' as LoS reduces	Reduced LoS leads to greater independence and delays admission to care home, thus saving social care costs	Early engagement with all three unitaries to manage impact of change on social care
Carers groups	H	Worried	PM Public H	Worried change may increase burden on carers	Family members able to live at home independently for longer	Engagement activities including co-creation of local implementation plans

COMMUNICATION PLAN



Stakeholder	Message(s)	How communicated	When and how often	Feedback mechanism/ follow-up required	Who Responsible?
Berkshire East DSG CCGs		QIPP highlight Report			Dr Nithya Nanda Rashida Sultana
BHFT – DSN Service		Slough Diabetes Network meeting	Bimonthly	Meeting minutes and Action Log	Jan Durrant
HWPB NHS Foundation Trust		Slough Diabetes Network meeting	Bimonthly	Meeting minutes and Action Log	Dr Heffernan
NHS Diabetes		Slough Diabetes Network meeting	Bimonthly	Meeting minutes and Action Log	Tbc
Diabetes UK		Slough Diabetes Network meeting	Bimonthly	Meeting minutes and Action Log	Jill Steaton

PROJECT TEAM



PROJECT MANAGEMENT



Team Member	Description of role
Dr Nilhya Nanda	SCCG Clinical Lead
Dr Ontseku Buchi Reddy	Public Health Specialist
Rashida Sultana	SCCG Project Manager
Tim Langran	Medicine's Optimisation SCCG
Sarah-Louise Beasley	Healthcare Development Manager Lilly
Jan Durrant	Head of Diabetes Services BHFT
Mike Connolly	Patient rep / SCCG Board Lay Member
Helen Single	Central Southern Commissioning Support
Debi Joyce	Central Southern Commissioning Support
Kim Sergeant	National service for Health Improvement (NHSI) Director

Key Deliverables of Project:
 Intervention strategies to improve the care for patients with diabetes, including organisational, professional and financial interventions.
 1) Increase % of patients receiving all treatment targets
 2) Innovative, evidence-based patient education
 3) Front-line, proven health provider training including cultural sensitivity
 4) Sustainable quality improvements in health care access, and coordination.

WORKFORCE IMPLICATIONS



- Investment in primary care education and training program to up skill primary care providers
- community team integrations will be required in order provide care for those patients whose non-elective admission will be shorter in the future.
- Multidisciplinary engagement involving a mix of qualified nurses, therapists and healthcare assistants.

OTHER COMMENTS

Project rationale:
 •The changes set out in this PID are intended to benefit the entire health and social care system rather than just commissioners or just providers. These benefits will accrue as a result of keeping people out of acute hospitals whether through admission avoidance or length of stay reduction via better management of Diabetic patients.
 •Improved provision of patient care for patient at high risk
 •The project supports the implementation of ICT and shaping the future
Next Steps:
 •Translation of PID to full business case
 •Identification and establishment of appropriate project governance and PMO support
 •Joint collaboration of multidisciplinary teams
 •Detailed implementation plans

ANTICIPATED MILESTONES



Milestone Description	Milestone	Date
1	Develop PID to full business case	Dec – Jan 2012/13
2	Approval from Operational Leads and the Board	Feb 2013
3	Identify/ procure programme team/ set up programme governance/ develop implementation plan	Feb - March 2013
4	Scope and clarify detail of incentive scheme including sign up process/ gain agreement from GPs/ how process will be managed and payments made	May 2013
5	Launch whole diabetes programme at STEPs - Slough	May 2013
6	Gain sign up to EMD programme by 16/ GP practices. Possibly visit all 16 practices	June 2013
7	Agree with Lilly UK/ NHSI KPIs and metrics agreed	June 2013
8	Agree Audit process and timeliness with CICSU GPs to run chart queries on a quarterly basis and return data - CICSU	June - July 2013
9	Co production of service specifications with Providers	Jan 2014
10	Agree changes to contracts	March 2014

Quality standard for diabetes in adults



The quality standard for diabetes in adults requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole diabetes care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to people with diabetes. The diabetes in adults quality standard supports the 'National Service Framework for Diabetes' and locally agreed pathways of care.

No.	Quality Statements
1	People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to on-going education.
2	People with diabetes receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured educational programme.
3	People with diabetes participate in annual care planning which leads to documented agreed goals and an action plan.
4	People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%), and receive an ongoing review of treatment to minimise hypoglycaemia.
5	People with diabetes agree with their healthcare professional to start, review and stop medications to lower blood glucose, blood pressure and blood lipids in accordance with NICE guidance.
6	Trained healthcare professionals initiate and manage therapy with insulin within a structured programme that includes dose titration by the person with diabetes.
7	People with diabetes receive an annual assessment for the risk and presence of the complications of diabetes, and these are managed appropriately.
8	People with diabetes are assessed for psychological problems, which are then managed appropriately.
9	People with diabetes with or at risk of foot ulceration receive regular review by a foot protection team in accordance with NICE guidance, and those with a foot problem requiring urgent medical attention are referred to and treated by a multidisciplinary foot care team within 24 hours.
10	People with diabetes admitted to hospital are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin.
11	People admitted to hospital with diabetic ketoacidosis receive educational and psychological support prior to discharge and are followed up by a specialist diabetes team.
12	People with diabetes who have experienced hypoglycaemia requiring medical attention are referred to a specialist diabetes team.

PID & BUSINESS CASE - BERKSHIRE CLUSTER 12/13



<p>VISION & AIMS</p> <p>Vision (PID/Business Case) Need for Change – Threats & Opportunities (PID/Business Case) Description of Change – Current Process & Future State (Business Case)</p>	<p>RISKS & ISSUES</p> <p>Risks & Issues (PID) Risk Register & Issue Log (Business Case)</p>
<p>FINANCE</p> <p>Finance & Budget Summary (PID) Finance – Options Appraisal (Business Case)</p>	<p>COMMUNICATIONS</p> <p>Stakeholder Management (PID/Business Case) Communication Plan (Business Case)</p>
<p>KEY PERFORMANCE INDICATORS</p> <p>Proposed Performance Measures (PID/Business Case)</p>	<p>PROJECT MANAGEMENT</p> <p>Project Team (PID) Key Deliverables (Business Case) Anticipated Milestones (PID) Milestone Plan (Business Case)</p>
<p>KEY</p> <p></p>	<p>WORKFORCE IMPLICATIONS</p> <p>Workforce Implications (Business Case) Other Comments (PID/Business Case)</p>

EQUALITIES IMPACT ASSESSMENT



All projects BY LAW must consider how services/projects affect equality groups.
 PLEASE REFER TO APPENDIX A IN BUSINESS CASE FOR FLOWCHART & CHECKLIST- slide 21

Standard Screening Tool - PLEASE COMPLETE

Does this project affect any groups more or less favourably than another? (Please refer to check list on flow chart in Appendix A- slide 21) No

Proceeding to detailed screening? No

If yes please state the deadline for completing assessment.

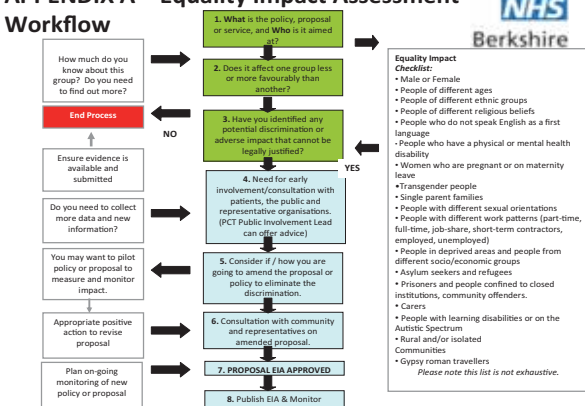
Please copy and paste the LINK to Stage 2 screening .
http://www.berkshirewest-pct.nhs.uk/_store/documents/berkwest_eia_detailed_screening_march_11.doc

If not proceeding to detailed screening, complete the following:

- Assessor's reasons why it is not necessary to do an assessment on this policy (e.g. no adverse equality impacts likely within or between equality groups): * Please attach any evidence which supports your decision not to undergo stage 2 EIA.
- Please provide assurance that there will be continual monitoring of the equality impact of this project on the protected groups.

Date of Q & P committee sign off for the project: _____

APPENDIX A – Equality Impact Assessment



Source: Rashida Sultana, Programme Manager, Slough CCG

Appendix 5b - Slough CCG QIPP: Tools to identify high-risk patients

605 patients have been identified as high-risk in Slough using the CCG's ACG tool:

		Predicted Relative Cost Weight	Difference Between Current & Predicted Cost Weights
Practices		10% above	5% Increase and above
K81005	242 Wexham Rd	11	11
K81024	Langley Health Centre	34	42
K81034	Crosby House	25	7
K81039	The Avenue	36	16
K81043	Herschel Medical Centre	25	20
K81075	Farnham road	42	31
K81083	Bharani Health Centre	34	15
K81085	Shreeji Medical Centre	27	30
K81086	Manor Park Medical Centre	48	29
K81089	Dr Burden	4	4
K81616	Kumar Medical Centre	9	4
K81645	240 Wexham Road	10	7
Y00265	Slough Walk in Centre	5	8
Y00437	The Orchard	10	6
K81608	Dr Nabi	14	21
K81082	Village Medical Centre	9	11
Total		343	262

Source: Rashida Sultana, Programme Manager, Slough CCG

Appendix 5c - Slough CCG QIPP: Patient numbers, by practice, to achieve top decile DOVE performance

Total cholesterol

Practice	Patients not to TC target*	% of CCG uncontrolled TC patients	Share of patients to hit CCG TC target
240 WEXHAM ROAD	76	3.25%	7
BHARANI MEDICAL CENTRE	209	8.95%	20
CROSBY HOUSE SURGERY	129	5.52%	13
DR BURDEN & PARTNERS	97	4.15%	9
DR NABI	94	4.03%	9
FARNHAM ROAD PRACTICE	284	12.16%	28
HERSCHEL MEDICAL CENTRE	217	9.29%	21
KUMAR MEDICAL CENTRE	104	4.45%	10
LANGLEY HEALTH CENTRE	257	11.01%	25
MANOR PARK MEDICAL CENTRE	245	10.49%	24
SHREEJI MEDICAL CENTRE	131	5.61%	13
SLOUGH WALK-IN HEALTH CENTRE	46	1.97%	4
THE AVENUE MEDICAL CENTRE	96	4.11%	9
THE ORCHARD SURGERY	110	4.71%	11
THE VILLAGE MEDICAL CENTRE	174	7.45%	17
WEXHAM ROAD SURGERY	66	2.83%	6
CCG	2335	100.00%	228

Blood pressure

Practice	Patients not to BP target*	% of CCG uncontrolled BP patients	Share of patients to hit CCG BP target
240 WEXHAM ROAD	72	3.02%	9
BHARANI MEDICAL CENTRE	177	7.41%	22
CROSBY HOUSE SURGERY	148	6.20%	19
DR BURDEN & PARTNERS	135	5.65%	17
DR NABI	135	5.65%	17
FARNHAM ROAD PRACTICE	460	19.26%	58
HERSCHEL MEDICAL CENTRE	329	13.78%	41
KUMAR MEDICAL CENTRE	96	4.02%	12
LANGLEY HEALTH CENTRE	221	9.25%	28
MANOR PARK MEDICAL CENTRE	106	4.44%	13
SHREEJI MEDICAL CENTRE	98	4.10%	12
SLOUGH WALK-IN HEALTH CENTRE	36	1.51%	5
THE AVENUE MEDICAL CENTRE	73	3.06%	9
THE ORCHARD SURGERY	76	3.18%	10
THE VILLAGE MEDICAL CENTRE	134	5.61%	17
WEXHAM ROAD SURGERY	92	3.85%	12
CCG	2388	100.00%	300

HbA1C

Practice	Patients not to HbA1C target*	% of CCG uncontrolled HbA1C patients	Share of patients to hit CCG HbA1C target
240 WEXHAM ROAD	93	2.60%	13
BHARANI MEDICAL CENTRE	395	11.04%	57
CROSBY HOUSE SURGERY	168	4.70%	24
DR BURDEN & PARTNERS	114	3.19%	16
DR NABI	195	5.45%	28
FARNHAM ROAD PRACTICE	453	12.66%	65
HERSCHEL MEDICAL CENTRE	304	8.50%	44
KUMAR MEDICAL CENTRE	140	3.91%	20
LANGLEY HEALTH CENTRE	396	11.07%	57
MANOR PARK MEDICAL CENTRE	346	9.67%	50
SHREEJI MEDICAL CENTRE	241	6.74%	35
SLOUGH WALK-IN HEALTH CENTRE	69	1.93%	10
THE AVENUE MEDICAL CENTRE	165	4.61%	24
THE ORCHARD SURGERY	150	4.19%	22
THE VILLAGE MEDICAL CENTRE	254	7.10%	37
WEXHAM ROAD SURGERY	95	2.66%	14
CCG	3578	100.00%	517

Source: Tim Langran – Slough CCG Medicines Optimisation Team

Appendix 5d - Slough CCG QIPP: Enhanced Management of Diabetes (EMD) programme

Aims of the EMD programme

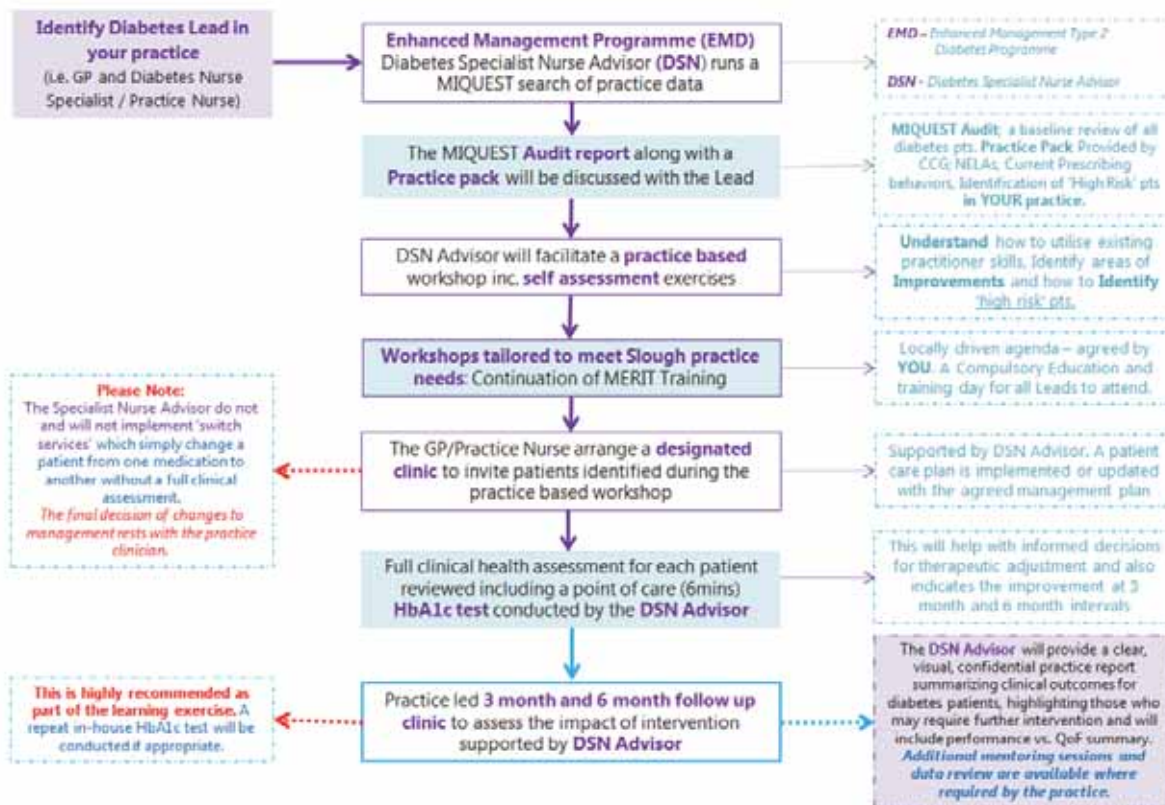
As part of the QIPP project, this is an opportunity to take part in initiative to support and enhance management skills type 2 diabetic patients in primary care across Slough CCG. Slough CCG, in conjunction with Lilly and National Services for Health Improvement (NSHI) also supported by medicines management, CSCSU and Public Health (Slough Borough Council) is offering an opportunity for practices to nominate themselves and take part in the Enhanced Management of Type 2 Diabetes (EMD) project. The service is non-promotional and the practice retains complete control of the service at all times authorising each activity as it is undertaken, any decisions relating to treatment interventions for their patients lies solely with the practice. The objectives of the EMD project are to:

- Improve primary care management of adults with type 2 diabetes and increase confidence and competence of primary care health professionals.
- Reduce overall variability at practice level of diabetes care.
- To increase sustainable support and education for primary care practitioners to strengthen skills in diabetes management.

Contact details

Programme Clinical Lead:	Dr. Nithya Nanda	nithya.nanda@nhs.net	01753 693 535
Project Manager:	Rashida Sultana	rashidasultana@nhs.net	07951 727 654

Bespoke Practice Based Training Programme: Enhanced Management Programme



Source EMD - project guide - Rashida Sultana, Slough CCG, June 2013

QIPP EMD Incentive scheme

As part of the QIPP project, practices will be incentivised for participation in the EMD initiative:

Component 1: Engagement and completion of EMD initiative

You are expected to meet the following criteria's:

- ✓ Sign up to the EMD programme
- ✓ Submission of Diabetes E (Online Survey). This is a mandatory requirement by members of staff participating in the EMD initiative and voluntary for all staff providing diabetes care
- ✓ Completion and submission of a retrospective and four quarterly diabetes chart queries of the 9 Care Process data. (Please note SCCG will support you to collate the reports)
- ✓ Attendance at Slough bespoke MERIT training Course. One of the members of staff should be a staff member participating in the EMD programme (Backfill allowance available for 1 GP and 1 Nurse ONLY)

**Payment of £1,000.00 will be achieved for completion of all criterias detailed above
Payment will be remunerated end of financial year 2013-2014 (Mar 2014)**

Component 2: Achievement of indicated target in the project baseline table

- ✓ Each practice will receive the number of patients within their practice that would need to improve their HbA1c result in order to achieve their target uplift as detailed in the table on page 13.
- ✓ Following the retrospective audit (Charter Query) the new baseline figure will be communicated to the practitioner/diabetes lead in the practice
However this will not change the target value assignment to the practice.
- ✓ Practice performance will be reviewed on Month 9 (December 2013)
Those who have achieved their target will receive payment by end of financial year 2013-2014 (Mar 2014)

It is appreciated that there is a time lag between change in practice and its effect on patient outcomes namely improvement in HbA1c levels therefore practices who have not achieved their targets in Month 9 will be given another 3 months (to give them an opportunity to complete the 12month programme) and those achieve their targets will be remunerated in June 2014.

The Project clinical lead will then review the performance of the ✓ remaining practices to determine levels of reward depending on their overall achievement.

**Payment of £1,000.00 will be achieved for completion of above criteria
The payment will be offered on submission of evidence of achieving individual practice targets
indicated in the table on page 13**

Total offered: £2,000 per practice

[EMD - project guide - Rashida Sultana, Slough CCG, June 2013]

Appendix 6 - Paediatric Diabetes Services in Berkshire East

Introduction

Paediatric diabetes care involves diabetes care for children under the age of 18 years [before their 19th birthday] including new diagnosis, regular follow-ups and the clinic reviews. The majority of them have type 1 diabetes but a minority do have type 2 diabetes or other forms such as CFRD [Cystic Fibrosis Related Diabetes] or MODY (Maturity Related Diabetes in the Young).

What is Type 1 diabetes?

Type 1 diabetes develops when the insulin-producing cells in the body have been destroyed and the body is unable to produce any insulin. Insulin is the key that unlocks the door to the body's cells. Once the door is unlocked glucose can enter the cells where it is used as fuel. In Type 1 diabetes the body is unable to produce any insulin so there is no key to unlock the door and the glucose builds up in the blood.

http://www.diabetes.org.uk/Guide-to-diabetes/Introduction-to-diabetes/What_is_diabetes/What-is-Type-1-diabetes/

Aims of the Service:

- To enable the child or young person with diabetes to lead a full active and healthy life.
- To educate the child and family about diabetes and its management
- To educate those involved with the child at school about diabetes and its management
- To monitor and optimise normal growth and puberty.
- To be aware of, and offer help for, any psychological problems
- To ensure that all hospital staff are aware of current policies
- To be available to families for discussion of problems, and to offer a consistent approach.
- To keep up-to-date with current best practice and to have an active involvement in audit and research

- To participate regularly in local and national audits and be part of the regional paediatric network, share best practice and keep all staff up to date on evidence base

Type of service: They are both in reach and out reach and cover all 3 sites. It includes home visits, school visits and telephone advice.

Our patients: All managed in secondary care. Wide catchment area:

- 170 pts
- 162 with T1DM
- with T2DM
- 2 with other forms

Location/Types of services

- Wexham Park Hospital x 5 children's clinics monthly
- Heatherwood Hospital x 2 children's clinics monthly
- St Mark's Outpatients x 1 outpatient clinic monthly
- King Edward VII Outpatients, Windsor - King Edwards Diabetes Centre (follow on adult centre)

Inpatient service beds: As per need, within Ward 24.

Treatments and Procedures Offered: All aspects of diabetes care.

Support Groups: Parent support group has recently formed and they are setting up a charity fund for the service

Education Sessions: Monthly Education sessions are held in the either the post graduate centre at the hospital or in the seminar Room in the Children's Clinic. Various topics covered include insulin pumps, carbohydrate counting, exercise and travel, sick day management and ketone testing, HbA1C, long term complications, sex, drugs and alcohol, moving on up and transition for beginners etc.

How to contact

<http://www.heatherwoodandwexham.nhs.uk/services/paediatric-diabetesdiabeticchildren@googlemail.com>

Clinical staff

Staff Member	Position
Dr Regan	Lead Diabetes Consultant
Dr Huma	Diabetes Consultant
Helen Timms	Diabetes Nurse Specialist < 12 years
Sarah Witham	Diabetes Nurse Specialist Adolescents
Lucy Jones	Community Nurse with diabetes training
Mandy Choi	Dietician
Alice Martell	Clinical Psychologist

Quality of care and performance monitoring:

What is Best Practice Tariff [BPT] for Paediatric diabetes?

Best Practice Tariff (BPT) for Paediatric Diabetes became mandatory in 12/13 for all providers to achieve the 14 required service standards. The tariff meant that providers are paid a year of care tariff for all non-admitted care rather than the standard new or follow up outpatient appointment tariffs. Achievement of these standards should denote very high quality care provision and this 'best practice' may reduce future care required and therefore health spends. If they were deemed fit, the PCT [now the GP commissioners] would pay the providers a nationally agreed standard tariff ~ £3500 [plus Market forces Factor] per child per year. There are regular scoping/performance monitoring meetings between the commissioning, contracts and the provider organisations to make sure that all the 14 criteria are met and children are offered the best available care locally and close to their homes. The providers [acute care] are also expected to regularly collect patient experience feedbacks and offer guidance on self-management, refer to appropriate patient support groups locally or through the Diabetes UK. The local service provider for children and young people < 19 years of age [acute care] needs to submit data and be able to demonstrate that they can meet each of the 14 individual Best Practice Tariff [BPT] criteria, also taking into account the provider's performance on the National Paediatric Diabetes Audit, their commitment for additional investment to increase

the MDT capacity, IT/software/data collection and collecting qualitative information and patient/carer's feedback. The 14 indicators must be met for at least 90% of children and the BPT is paid on an all or nothing basis.

These criteria are underpinned by:

- (a) DH guidance: Making every young person with diabetes matter⁹³;
- (a) NICE guidance: CG15: Diagnosis and management of type 1 diabetes in children, young people and adults⁹⁴ and TA151 Diabetes - insulin pump therapy⁹⁵ and
- (b) NHS Diabetes guidance: Commissioning services for children and young people with diabetes⁹⁶.

Gaps in the submission of evidence to meet the BPT:

In summary there has been a massive improvement in clinical outcomes, especially in terms of achieving one of the best HbA1C outcomes, fewer complications with good clinical leadership. There are a lot of new policies/protocols which have been brought into effect. There is a commitment of investment for extra staff but with no timelines on when they will actually deliver these additional clinics. In view of our recent anecdotal problems about the provision of a shared care in school settings for a child we are working towards developing a diabetes school care policy, which needs to be agreed with all the local authorities in the East of Berkshire, This is not however a specific requirement of the BPT. The clinical best practice should also be reflected through qualitative data like user/family/carer's surveys /feedback and through robust data systems. The methodology for record keeping, logging clinical visits/conversations, data retrieval and analysis need to be robust. We need to have enhanced communication between the different stakeholders like the CCG's/commissioners, providers/ acute care consultants/ specialist nurses, Voluntary organisations like the Diabetes UK, patient support groups and the children and their families. We need to improve access have a data base on shared care.

References

Executive Summary

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8. Network of Public Health Observatories (APHO) - <http://www.apho.org.uk> and <http://www.yhpho.org.uk/default.aspx?RID=8467> - various data sources utilised, including 2010/11 Diabetes prevalence model, National Diabetes Information Service (<http://www.yhpho.org.uk/resource/view.aspx?RID=102082>), Public Health JSNA datasets (<http://www.apho.org.uk/resource/view.aspx?RID=91736>). Note that APHO datasets have now been replaced by Public Health England data - <https://www.gov.uk/government/organisations/public-health-england>)
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This document can be made available on audio tape, braille or in large print, and is also available on the website where it can easily be viewed in large print.

Diabetes Strategy for Slough

If you would like assistance with the translation of the information in this document, please ask an English speaking person to request this by calling 01753 875288.

यदि आप इस दस्तावेज़ में दी गई जानकारी के अनुवाद किए जाने की सहायता चाहते हैं तो कृपया किसी अंग्रेजी भाषी व्यक्ति से यह अनुरोध करने के लिए 01753 875288 पर बात करके कहें.

ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਵਿਚਲੀ ਜਾਣਕਾਰੀ ਦਾ ਅਨੁਵਾਦ ਕਰਨ ਲਈ ਸਹਾਇਤਾ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਸੇ ਅੰਗਰੇਜ਼ੀ ਬੋਲਣ ਵਾਲੇ ਵਿਅਕਤੀ ਨੂੰ 01753 875288 ਉੱਤੇ ਕਾਲ ਕਰਕੇ ਇਸ ਬਾਰੇ ਬੇਨਤੀ ਕਰਨ ਲਈ ਕਹੋ।

Aby uzyskać pomoc odnośnie tłumaczenia instrukcji zawartych w niniejszym dokumencie, należy zwrócić się do osoby mówiącej po angielsku, aby zadzwoniła w tej sprawie pod numer 01753 875288.

Haddii aad doonayso caawinaad ah in lagu turjibaano warbixinta dukumeentigaan ku qoran, fadlan weydiiso in qof ku hadla Inriis uu ku Waco 01753 875288 si uu kugu codsado.

اگر آپ کو اس دستاویز میں دی گئی معلومات کے ترجمے کے سلسلے میں مدد چاہئے تو، براہ کرم ایک انگریزی بولنے والے شخص سے 01753 875288 پر کال کر کے اس کی درخواست کرنے کے لئے کہیں۔