NHS
Wandsworth
Clinical Commissioning Group

REPORT TO BOARD

11th March 2015

Agenda No. 6.1

Title of Document:	Diabetes Clinical Reference Group Annual Board Report
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Summary:
The Diabetes CRG built upon the work of previous years and focused upon three areas; Primary Care, Self-management and Specialist Service Provision.

Reducing and sustaining optimal HbA1c levels is key to improving clinical outcomes, reducing the number of diabetes related complications, increasing the quality of life and thus reducing the level of spend. In the August 2014, the National Cardiovascular Intelligence Network profile of Wandsworth noted that 61.69% of people with diabetes in Wandsworth had optimal levels of HbA1c against 63.7% by comparative CCGs.

All of the activities of the DCRG ultimately aim to improve the management of HbA1c through high quality clinical intervention in primary care or specialist centre and self-management. This work will be continued in 2015/16 with a focus on early diagnosis and prevention by looking at ways to identify more undiagnosed people and raising awareness. Diabetes UK will be supporting this by training some of the Community Champions in using their Risk Assessment Tool and then holding community events which they have found much success with in the past.

Key sections for particular note (paragraph/page), areas of concern etc:
Whole report

Recommendations:
The CCG Board are asked to review the information contained in this report and continue to support the work of the Wandsworth Diabetes Clinical Reference Group.

Attach 2

Equality Analysis

Has an Equality Analysis been carried out? YES (for individual activities described in the report)

Key issues from assessment None to note

Which of the following Assurance Domains does this work relate to:

- Are patients receiving clinically commissioned, high quality services? All activities apply
- Are patients and the public actively engaged and involved? DCRG has patient representation. Room for growth in this area
- Are CCG plans delivering better outcomes for patients? All activities apply
- Does the CCG have robust governance arrangements? Activities are managed via CCG policy
- Are CCGs working in partnership with others? Working with Diabetes UK, St George's University Hospitals NHS Foundation Trust, Wandsworth Local Authority (Public Health)
- Does the CCG have strong and robust leadership? Joint clinical leadership with individual strengths

Risks:

Have any potential risks been identified on the Risk Register: No

Financial Implications:

Reviewed by:

Committees that have previously agreed the report:

No committees but report has been agreed by both Joint Clinical Leads

Wandsworth Diabetes Clinical Reference Group

Annual Board Report

11th March 2015

1.0 Background

This year Dr Seth Rankin joined the Diabetes Clinical Reference Group (DCRG) as Joint Chair and Clinical Lead and strengthens the management input to the group whilst Dr Neil Bamford continues to provide his clinical expertise.

The DCRG built upon the work of previous years and focused upon three areas; Primary Care, Self-management and Specialist Service Provision. Clinical members of the CRG have also been working with Public Health colleagues to develop an Obesity Strategy for the borough and review the pathways and access to lifestyle services.

This paper will describe the work of 2014/15, discuss the outcomes and provide an overview of the direction of flow in 2015/16.

2.0 Overview of Diabetes in Wandsworth

The DCRG have been working with the CCG Business Intelligence team to develop a dashboard to demonstrate how their work is affecting areas of productivity and clinical outcomes. It is be difficult to access data relating to diabetes but some of the metrics that will be included are:

- Planned and unplanned admissions
- Outpatient attendance
- Structured education uptake and completion
- Number of emergency admissions for amputations or emergency care for foot problems that are diabetes related complications
- Number of elective admissions for amputations or emergency care for foot problems that are diabetes related complications
- 30 day readmission rate due to diabetes complications

The aim is to be able to use the dashboard in 2015/16 though there are two other sources that the DCRG currently use to inform its decision making.

2.1 National Cardiovascular Intelligence Network Profile 2014

Each year, the National Cardiovascular Intelligence Network (NCVIN) publishes a Diabetes Profile for each CCG. The latest version was published in August 2014 and reviews data up to 2013. The key highlights of the Wandsworth report are:

- In NHS Wandsworth CCG (2012/13), the prevalence of diabetes varied between the 44 practices from 0.6% to 22.3%. The diagnosed prevalence rate for diabetes in NHS Wandsworth CCG was 4.2%, the estimated total diabetes prevalence was 6.0%

- In 2013 there were 12,638 people over 17 years of age who had been diagnosed with diabetes in NHS Wandsworth CCG. There were an estimated further 4,900 people who remain undiagnosed suggesting the total number of adults with diabetes in the CCG was around 17,500

- People with diabetes are at a higher risk of having a heart attack or stroke. In Wandsworth, people with diabetes are 29.6% more likely than the general population to have a heart attack. This is lower than the figure for England which is 55.4%. People with diabetes are also 45.0% more likely to have a stroke. This is higher than the figure for England where there is a 34.3% greater risk

- Type 2 diabetes is a key cause of sight loss among the working age population and the diabetic retinal screening programme in Wandsworth has increased consistently in recent years, with uptake in 2011/12 of 83% (slightly tapering in 2012/13- 80.6%). Analysis of programme data has found that there was variation in uptake of screening by GP practice but that there was little variation in uptake by ethnic group

- NHS Wandsworth CCG spent £285.66 on prescribing per person with diabetes. The total spend on prescribing for anti-diabetic items between April 2012 and March 2013 was £3,610,000. This accounted for 10.0% of the total CCG prescribing budget.

The profile table below also uses data taken from the NCVIN report and, through this benchmarking, the DCRG is able to identify priority areas.

	Wandsworth	**Comparator CCGs**	**Strategic Clinical Network (London)**	**England**
Diagnosed diabetes prevalence in adults (2012/13)	4.2%	5.6%	5.8%	6.0%
Estimated total diabetes prevalence in adults (2012/13)	6.0% (1.8% gap)	7.6% (2.0% gap)	7.8% (2.0% gap)	7.3% (1.3% gap)
People with diabetes who have had the eight recommended care processes (excluding diabetic eye screening) (2011/12)	53.2%	55.3%	57.7%	60.2%
People with diabetes whose last HbA1c was equal to or less than 58mmol/mol (2012/13)	61.9%	63.7%	62.3%	62.8%
People with diabetes meeting blood glucose, blood pressure and cholesterol targets (2012/13)	22.7%	20.6%	21.2%	20.9%
Inpatient episodes for diabetic foot disease per 1,000 people with diabetes (2010 to 2013)	15.1	16.6	16.1	18.6

	Some improvement required
	Wandsworth is better than all comparators

The full NCVIN report can be accessed via this web link

http://www.yhpho.org.uk/ncvincvd/Default.aspx

2.2 NHS Outcomes Framework 2014/15

The NHS Outcomes Framework sits at the heart of the health and care system alongside the Social Care and Public Health outcomes frameworks. The NHS Outcomes Framework provides an overview of how the NHS is performing and aims to drive up quality by encouraging a change in culture and behaviour focused on health outcomes rather than process. Some of the targets are diabetes specific and some are multi-speciality. This year, the Business Intelligence team provided a report that shows how the CCG is performing against each of the indicators (Appendix one). Some of the data appear to be outdated and this is due to the original source that they come from. The report is due to be updated at the end of March.

The table below demonstrates the key areas where the CCG is working well and the areas that require improvement

Areas working well	Areas for Improvement
The percentage of people with diabetes diagnosed less than one year who are referred to structured education	People feeling supported to manage their condition
Unplanned hospital admissions for under 19s Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
Emergency readmissions within 30 days of discharge from hospital	Potential years of life lost from causes considered amenable to healthcare: adults, children and young people

3.0 Activities 2014/15

The DCRG activities of 2014/15 centred around three areas; Primary Care, Self-management and Specialist Service Provision. The full list of activities with the current progress can be seen in Appendix two. This section of the report will summarise the context of this work and how it seeks to improve diabetes care in Wandsworth.

3.1 Primary Care

Most people who have been diagnosed with diabetes are cared for in the primary care setting, therefore, improvements here should have the greatest impact on the measures described in section 2 of this report.

The DCRG have been focussed on identifying the key messages that health professionals need to be aware of and developing training to ensure these messages are disseminated. This includes a Medicines Optimisation Protocol and the need to increase usage of human insulin, for which Wandsworth had a poor uptake. There has been work undertaken to redesign the Diabetes pages on the CCG website that is also a main source of local and national information for clinicians as well as patients. Finally, an audit aimed at closing the gap between the actual and expected prevalence has been undertaken.

3.1.1 Training

In 2013/14, 60 Primary Care health professionals completed Diploma level training in the Management of Diabetes. Although this created much needed specialist knowledge in primary care, it was agreed that there was a need for a widespread minimum level of knowledge and skill to ensure that every patient received a minimum standard level of care. The three steps were identified to achieve this was:

I. The development of a Medicines Optimisation Protocol from which health professionals would be able to competently titrate oral medication for adults with type 2 diabetes

II. The development of a referral pathway that would explain how, when and where patients should be referred to

III. Delivery of a Primary Care Core Competency Training session to be attended by 100% of GPs and Practice Nurses that would cover the Medicines Optimisation Protocol and the Referral Pathway. It is envisaged that this will be adopted as a mandatory training session for all new joiners

Parts I and II were in place when, in January 2015, NICE published a draft guideline in the diagnosis and management of Type 2 diabetes. The final version is expected in August 2015. The DCRG had planned to launch the Primary Care Core Competency Training in March/April 2015 but due to the significant difference between the local guidelines and those from NICE, it was thought that it would be confusing to clinicians who will subsequently need to change prescribing choices just a few months later. However, the NICE guidelines have created much national discussion and there is a real feeling that the recommendations that it contains may be changed which will delay the final publication date. This has prompted clinical members of the DCRG to go ahead with implementing local guidance and so training is being planned for May 2015.

The Primary Care Core Competency Training is training is seen as the foundation stone of diabetes knowledge for health professionals in Wandsworth and other training will be built around this. The DCRG is currently identifying those needs and will develop a programme of workshops which individual clinicians will be able to access in any order that suits their needs and at their own pace.

3.1.2 CCG Website

A further source of information for clinicians, as well as for patients, is the CCG website and Dr Neil Bamford has been working with one of the CCGs informatics experts to redesign the diabetes pages. The aim is to make it easier for all stakeholders, not least the public, to find information that they are looking for. The new pages will be launched by the end of March following consultation with service users and clinicians to ensure that it meets their needs.

3.1.2 Human Insulin Uptake

In line with NICE guidance for patients with type 2 diabetes, a target in London was set to increase the use of human insulin from 14% to 17%. Wandsworth CCG exceeded this target by August 2014 and has since regularly reached around 20%. This is a credit to the

collaborative working between the pharmacists in the CCG Medicines Management Team and the Community Diabetes Specialist Nursing Team.

3.1.3 Undiagnosed Patient Audit

In 2013 there were 12,638 people over 17 years of age who had been diagnosed with diabetes in NHS Wandsworth CCG. The APHO Diabetes Prediction Model found there were an estimated further 4,900 people who remain undiagnosed suggesting the total number of adults with diabetes in the CCG was around 17,500.

The DCRG commissioned an audit that used risk stratification to in an attempt to identify those undiagnosed or at risk of having diabetes. The risk stratification was in line with NICE guidance using the following criteria:

- Patients with abnormal glucose results with no diagnosis or follow-up
- Patients with IGT/IFG with no glucose check in the last year
- Patients on diabetes medication with no diagnosis
- Patients with codes indicative of diabetes or IGT/IFG with no diagnosis
- Patients whose diabetes has resolved with no annual follow-up
- Patients with a generic C10 code not classified

Thirteen GP practices participated in the audit and the DCRG is sourcing EMIS specialist support to enable an analysis of the audit to take place. However, one practice did produce their own report and the conclusion is reproduced below:

> At the Heritage Medical Practice 85 patients were identified as potential undiagnosed diabetic patients. Of these patients, diabetes was excluded in 42 patients, a new diagnosis of Type 2 diabetes was given in 32 patients, 3 patients were newly diagnosed with IFG[1] and 8 patients were given a diabetes screening invitation (9Oy0). All patients have subsequently been managed according to their revised diagnosis and will be coded accurately with the new results on EMIS.
> The results of the 8 patients invited for diabetic screening will be followed up and they will be managed coded appropriately according to their results.
> The importance of accurate diagnosis, management and coding of potential diabetic patients has been highlighted to all clinical staff at the Heritage Medical Practice.
> I advise a re-audit of these criteria to be conducted in 1 year to ensure the above standard is met and maintained.

3.1.4 National Diabetes Audit

The National Diabetes Audit takes place annually in January. The CRG set itself a task to encourage GP practices to participate as traditionally there is only about a 25% response rate. The results are widely scrutinised by national and local groups as well as individual members of the public. The data is also used to inform other reports such as the NCVIN profile but are not necessarily a true reflection of the work and outcomes in Wandsworth due to the low response rate. It is hoped that more GP practices will have participated the 2014 audit but this will not be clear until the report is published at the end of 2015.

4.0 Self-management

Self-management aims to empower patients to improve their health. The basis of this is to inform them and this year the DCRG focused on three areas; structured education, visual/audible information and the recruitment of volunteer champions.

4.1 Structured Education

The CCG commission three diabetes structured education programmes; DESMOND, DAFNE and BERTIE. The current funding arrangements do not provide value for money and the standard mechanisms were not in place to effectively measure the successful delivery of the programmes. This year, a service specification was developed to address these issues and this is being discussed as part of the annual contracting arrangements. This will form a basis from which the DCRG can identify other means of providing structured self-management information.

4.2 Visual Information

A review of local information and availability was led by Dr Rankin and, other than that produced by St George's University Hospitals NHS Foundation Trust (SGUH), there is only a leaflet produced by the CCG concerning glucose monitoring. In 2015/16, the DCRG will work with patients to develop local information that sign-posts patients and clinicians to local services. In the meantime, information will be posted in the redesigned web pages and the CCG has just launched the Wandsworth Well Being Hub. Patients directed to the hub are assisted by a navigator to access services that will help them manage and optimise their health and well-being.

Dr Rankin has also been working on the development of a library of video clips. Each short video aims to answer a specific diabetes related question. Although patients will be able to access all of the videos by visiting the website, GPs will also be able to send them a link via text message or email so that they can access a cluster of videos that will be of particular relevance to them. Filming has taken place and the clips are in the production phase. The videos will be available for distribution by end of March.

4.3 Volunteer Champions

The recruitment of volunteer diabetes champions has been successfully implemented in several London boroughs and has helped the CCGs and Public Health departments to:

- promote key messages about diabetes in the local community
- increase knowledge of the risks and symptoms of diabetes, particularly amongst Black, Asian, Middle Eastern and other minority ethnic groups and those living in deprived areas
- promote lifestyle changes in diet and exercise to reduce the risk of developing diabetes or to improve control for those who have it
- signpost people to testing for diabetes, group education and other services for those with the condition

Wandsworth CCG is working with Diabetes UK and Wandsworth Public Health to implement this scheme and recruitment is underway. Various forms of social marketing have been used such as Facebook and Twitter as well sending out the poster in Appendix three to GP practices. Diabetes UK are also actively recruiting by contacting local community and religious groups.

Champions do not need any formal qualifications, but rather first-hand experience of diabetes, good communication skills and a passion for the project. It's also an advantage if they already have links within the community which will enable them to ease into the role much more easily.

So far, 11 members of the public have volunteered and training for them is being planned for April 2015. Some Champions will also be offered training in the Diabetes UK Risk Assessment Tool and the intention is to hold some street events inviting members of the public to be assessed throughout the year.

Diabetes UK have informed us that they wish to make this an exemplar project and will be making funds available to help support it.

Once established, some of the champions will be invited to participate in further training to become peer educators and/or mentors.

5.0 Specialist Service Provision

5.1 Tier 2

As part of the Tier 2 service, Community Diabetes Specialist Nurses have been reviewing patients in GP practices whose diabetes is not well controlled, demonstrated by their HbA1c being >7.5% (59mmol/mol). This also included a review of any medication to ensure that it was at an optimal level. It is clear that there could be a significant number of patients who could benefit from this review and so, in 2015/16, the DCRG plan to build on this work.

Funding has been applied for to support a project that will recruit a Diabetes Specialist Nurse (DSN) who will be responsible for delivering the following milestones:

- Development and delivery of training to Primary Care health professionals
- Identifying patients and assisting GPs and Practice Nurses to review patients
- Provide recommendations for the practice to implement as part of the care planning for each patient

- If needed, advise practices in how to produce a care plan with the patient – i.e. a set of mutually agreed goals between patient and clinician
- Promote guidelines for diagnosis, prescribing and treatment pathway
- Review project outcomes using clinical data and patient experience feed back

5.2 Tier 3

In September 2013, SGUH began a pilot tier 3 clinic which was held weekly at St John's Therapy Centre. In March 2014, the project management presented the CCG with an evaluation report that covered the five month period until January 2014 (inclusive). Following many discussions between clinical commissioners and providers, it was decided that, although there was much learning to be taken from the pilot, the service model still needed some adjustment. This year some further review and redesign work will take place and this will look at the whole pathway from pre-diagnosis onwards and also encapsulate support areas such as self-management support and health professional networking and education. This will be a fully consultative process ensuring that stakeholders across the care delivery spectrum, including patients and carers, are able to access and participate in the process that aims to develop an evidence based, costed service proposal.

In the meantime, SGUH have submitted a business proposal to the CCG to continue providing the Tier 3 clinic and this is currently under discussion.

6.0 Future Plans for 2015/16

Reducing and sustaining optimal HbA1c levels is key to improving clinical outcomes, reducing the number of diabetes related complications, increasing the quality of life and thus reducing the level of spend.

In 2015/16, the DCRG will continue to work on this firstly by reviewing patients with sub-optimal HbA1c levels and agreeing a new care plan with them that will include optimisation of medication and enabling access to information and support that is available in the community.

Alongside this, the delivery of the Primary Care Core Competency Training and the development of other training for health professionals will ensure that the skills and knowledge is available to sustain improvements.

It is just as important that there is continued development in the information resources available to patients including a more varied offer of different forms of structured education. A more informed patient is empowered to take control of their own health and the DCRG will research other opportunities.

Early diagnosis and prevention are also key to improving outcomes and the DCRG will be looking at ways to identify more of the undiagnosed and raise awareness of the risk factors. In 2015/16, the DCRG will focus as much on prevention as it does on treatment.

All of the above will also factor in as part of the end to end redesign of diabetes services which is the major project that the DCRG will undertake in 2015/16.

To underpin all of the work, the DCRG will need to monitor agreed metrics and a priority before the end of 2014/15 must be the final agreement and development of the benefits realisation dashboard

7.0 Recommendations

The CCG Board are asked to review the information contained in this report and continue to support the work of the Wandsworth Diabetes Clinical Reference Group.

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Attach 2

Appendix one

Indicator Description	Current Indicator Value	Current Reporting Period	Previous Indicator Value	Previous Reporting Period	Change	National Average	London Average	National Quartile
The percentage of people with diabetes diagnosed less than one year who are referred to structured education	19.5%	2011/12	Not Available	Not Available	N/A	14.1%	13.8%	1
Indirectly age and sex standardised rate of complications associated with diabetes, per 100 people with diabetes	6.08	2011/12	Not Available	Not Available	N/A	7.14	6.25	2
People feeling supported to manage their condition	63.2%	July 2013 to March 2014	60.7%	July 2012 to March 2013	0.025	65.1%	59.7%	3
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	842.7	2013/14	898.3	2012/13	-55.6	820.5	821	3
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	256.5	2012/13	176.9	2011/12	79.6	340.6	288.6	1 (Top)
Directly standardised average health status score (EQ-5DTM) for individuals aged 18 and over who identify themselves as having a long-term condition	0.77	July 2013 to March 2014	0.76	July 2012 to March 2013	0.01	0.743	0.746	1 (Top)
Emergency readmissions within 30 days of discharge from hospital	11.7	2011/12	12.9	2010/11	-1.2	11.78	12.14	3
Potential years of life lost from causes considered amenable to healthcare: adults, children and young people	2056	2013	1871.2	2012	184.8	2027.4	1907.8	3

Attach 2

Appendix two

ACTIVITY MILESTONES 2014/15	OVERALL RAG	COMMENTS
Develop a peer mentoring support network based upon the case study from Hammersmith and Fulham called the Diabetes Improvement through Mentoring and Peer-led Education	A	11 volunteers have contacted the CCG so far and training is planned for April. Criteria is to be established to identify those who in the future will be invited to train to become peer educators and/or mentors
Review the current library of local patient information resources, make necessary updates and upload onto the CCG website	G	Review complete. Little local information available. In 2015/16 will need to work with patients to address this. Ensure web redesign includes availability of local information
Develop Medicines Optimisation Protocol - 1st core basics competency; ability to titrate oral medication	G	Completed
Develop referral pathways document explaining when, how and where to refer to - 2nd core basic competency	G	Completed
Use Medicines Optimisation Protocol and referral pathways document to develop and deliver core basics training to be attended by 100% of GPs and PNs	A	Launch and training planned for May 2015 - later than originally planned
Identify and develop additional training packages that are above and beyond the core basic competencies that HCPs could access if they wish to learn more about diabetes	R	Still on-going. Will be completed in 2015/16 as part of HbA1c project (see below)
CDSNs to review all patients in tier 2 who have a HbA1c of >7.5% (59mmol/mol) and are on optimised oral medication	G	Community Diabetes Specialist Nurses untook this work. Clearly needs continued focus. Business case submitted for funding to continue via a dedicated specialist nurse who will also provide insight into training needs as they work alongside Primary Care health professionals
Redesign the diabetes pages on the CCG website to ensure they are user friendly, contain all local information and guidelines and links to national information and data	G	New pages will be launched by the end of March following consultation with service users and clinicians to ensure that it meets their needs
Increase use of human insulin in line with NICE guidance to the agreed 2014/15 London target of 17% from a baseline of 14%	G	Taget reached in August 2014. Continues to report at around 20%
Conduct Undiagnosed Patient audit and report findings to the CRG	G	Audit complete. Sourcing EMIS specialist to access results and provide analysis
Each GP locality lead to promote the completion of the National Diabetes Audit using the EMIS Web solution provided	G	Will not know if there has been an increase in participation until report published later in 2015

Attach 2

Appendix three

NHS
Wandsworth
Clinical Commissioning Group

Have you got some SPARE TIME?

Do you want to become a WANDSWORTH DIABETES CHAMPION?

ARE YOU PASSIONATE about health?
WELL CONNECTED with Black, Asian and minority ethnic communities?
MOTIVATED to help others?
Do you want to build CONFIDENCE and SKILLS?

Then we'd like to train you to raise AWARENESS of DIABETES.
We're holding TRAINING WORKSHOPS across the borough.

TO FIND OUT MORE please phone 020 8812 6732
or email Janice.Obrien@wandsworthccg.nhs.uk

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