Diabetes networks work!

service redesign in Berkshire West CCGs

Dr Richard Croft, Primary care diabetes lead

Background

The 4 federated CCGs of Berkshire West (N&W Reading, S Reading, Newbury & District and Wokingham) have a population of c.500,000 with a diabetes prevalence of 3.7%.

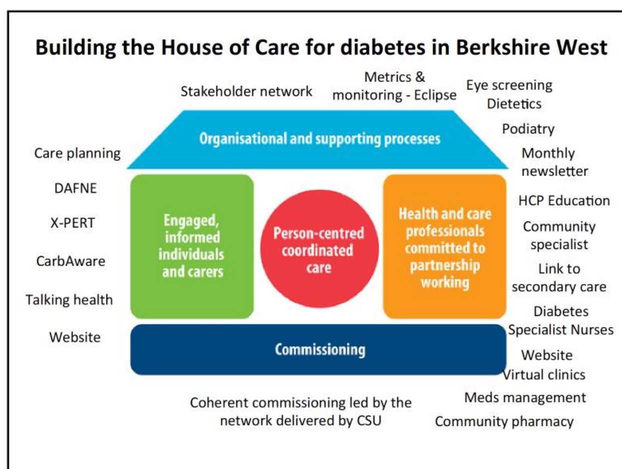
NDA and DOVE results (2010/11) demonstrated poor process of care and poor glycaemic control (46.8% vs. 56.8% nationally achieving HbA1c <59mmol/mol) and with high costs. Services for patients were limited with little patient education and no community DSN service.

Objectives

To redesign, implement and audit diabetes services.

Methods

To address these issues, we instigated service redesign, starting in 2012, at scale and pace. An external consultant was commissioned, a local champion appointed and a stakeholder network *(Diabetes Sans Frontières!)* formed with patient and healthcare professional (HCP) representation. The House of Care was introduced as a model around which services were planned.



Services introduced

Structured Patient education – X-PERT for Type 2, DAFNE for Type 1

HCP education – Foundation course, PITstop (injectable therapies), Enhanced Management of Diabetes mentoring service

Care planning – 3 local HCPs trained to train GPs and practice nurses and implement care planning in primary care in all practices

IT – *Eclipse* introduced, a cloud-based system for audit, risk stratification and patient portal provision

Website - www.berkshirewestdiabetes.org.uk for HCPs and patients

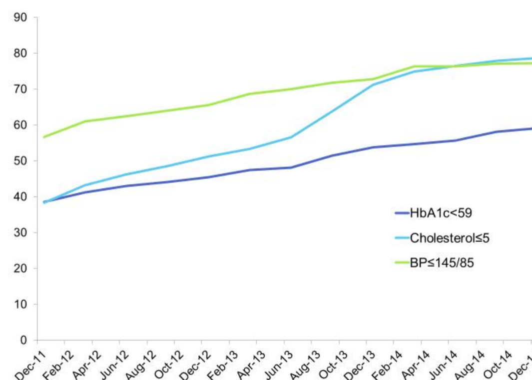
Monthly newsletter

Care pathway and treatment guidelines development

New resource/staff - Community DSNs deployed, Specialist community diabetes consultant appointed; Virtual clinics in GP surgeries providing case review and HCP education

Novel strategy - 3-hour industry-sponsored carbohydrate counting courses ('CarbAware') for Type 1 patients including provision of a bolus calculator glucometer.

Results



Graph showing proportion of patients attaining 3 key metrics December 2011 - December 2014

- Between June 2012 and June 2014, mean HbA1c reduced from 60.49 to 55.14mmol/mol
- Proportion achieving HbA1c <59mmol/mol increased from 46.5% to 57.6%
- HbA1c reduced among X-PERT attendees: 67.5 to 55.5mmol/mol 6 months after course
- Mean HbA1c reduced from 80.5 to 69.4 mmol/mol (-11.1) among the first 56 people attending the CarbAware course who had data at 6 months.
- Mean HbA1c reduced from 88.9 to 81.3mmol/mol (-7.6) among 500 patients reviewed at Virtual Clinics after 6 months
- Proportion achieving cholesterol <5mmol/l increased from 46.3% to 79.2%
- Proportion achieving BP≤140/85 increased from 66.2% to 78.0%;
- Prescribing savings of £805,000 resulting from medicines optimization: £313/patient (2011/12), £283 (2012/13), £269 (2013/14)
- The process has created enthusiasm and greater professional satisfaction

Conclusion

Large-scale diabetes redesign at scale and pace, led by a motivated and empowered stakeholder network, is effective.

Acnowledgement

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