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Excellence in commissioning diabetes care



NHS Clinical
Commissioners

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of clinical commissioning groups

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Introduction

More people than ever before are living with diabetes. Since 1996, the number of people in the UK with the condition has more than doubled. The situation is such that the NHS is now spending more than £9.8 billion each and every year on treating the condition and its complications.

Clinical commissioners up and down the country know action is needed to reduce costs and improve care. They want to find ways to better manage the health of those with diabetes. They also know there are many people at risk of developing the condition who need support. And they understand they're increasingly being assessed on their performance in this important area – the clinical commissioning group (CCG) improvement and assessment framework now contains specific measures on diabetes, and the National Institute for Health and Care Excellence (NICE) has detailed care processes that every patient with diabetes should receive.

That said, commissioning effective services for diabetes can be complicated. Those with type 1 diabetes, an autoimmune condition

which generally develops in youth or young adulthood, need support over the long term. Type 2 diabetes is often associated with obesity, poor diet and lack of exercise. So just like many other long-term conditions, treatment – and prevention in the case of type 2 diabetes – involves addressing people's lifestyle choices. That necessitates a multi-agency approach. It also starts debates about constructing services which focus on patient outcomes rather than simply recognising activity.

There are commissioners who are leading the way here, and this publication showcases them. It is our hope that sharing best practice will help other CCGs improve care for their population with diabetes. But realistically we know they will face challenges along the way – national obstacles they need to negotiate. That's why this paper also includes actions we believe national bodies should take to assist commissioners in this vital area.

This paper is based on a roundtable event held in March 2017, and subsequent conversations with commissioners working at other CCGs. We thank them all for their contributions.



Top tips on commissioning diabetes services

In March 2017, NHS Clinical Commissioners organised a roundtable to discuss diabetes commissioning. Co-hosted with the Association of the British Pharmaceutical Industry (ABPI), it brought together a group of leaders from top performing CCGs which have commissioned diabetes services that have improved care with flat or reduced funds. Via their discussion – and subsequent conversations with staff at other CCGs that are leading the way in this area – we have identified key points to consider when designing diabetes services.

1 Involve patients in their own care

A common theme was the value of involving patients in their own care, whether through supported self-management or through engagement in the design of services. “It’s really important that is not neglected,” says Adrian Hayter, clinical chair of Windsor, Ascot and Maidenhead CCG and diabetes lead on the NHS Clinical Commissioners board. “It is a fundamental thing we need to take into account.” In his area, they are rolling out the ‘HealthMakers’ concept, originally conceived by Bracknell and Ascot CCG to enable local people with long-term conditions to help improve their own health as well as local healthcare services. “It is empowering them to be patient leaders across a wide range of long-term conditions, from running education sessions to leading the conversations in the CCGs about diabetes commissioning.”

2 Use data to illustrate the issue, and to encourage action

More or less every project we heard about had begun with an examination of the data. Nithya Nanda, diabetes GP lead for Slough CCG, told us diabetes outcomes versus expenditure (DOVE) data showing the area had poor outcomes was enormously helpful “in selling the story both to local GPs and to the senior leadership” that change was needed. In Bradford, data on cardiovascular disease mortality in the under-75s showed the CCG was one of the worst in the country. “When you see that, everybody recognises that you’ve got to do something,” says long-term conditions lead Kath Helliwell. The CCG is using this sort of baseline local performance data, and analysis of national statistics, as the basis for a major new outcomes-based contract on diabetes care.

3 Strong leadership makes a huge difference

Success in diabetes commissioning was often attributed to strong leadership – particularly from GPs. Fin McCaul, long-term conditions lead at Bury CCG, said it was crucial to the area’s integrated community diabetes service. “It’s a CCG-led service, and the CCG is led by GPs and GPs own the CCG. It’s the GPs that provide the leadership, the attitude, the approach. They very much take ownership.” The CCG has one of the best performances on diabetes in the Greater Manchester region.

4 Find champions, and help them to work across organisational divides

We heard from attendees that a key component for performance on commissioning diabetes is strong partnerships across local areas. Where there is a history of commitment from consultant colleagues working in collaboration with primary care and the wider health and social care team success will usually follow. The willingness of individuals working on the ground to do so makes the difference, along with the identification of champions within each sector who can drive improvements when there is little or no extra money available.

5 Consider partnerships with the pharmaceutical industry

Support from the pharmaceutical industry is a common thread in many examples of good practice in diabetes commissioning. Education for paramedics at South East Coast Ambulance Service NHS Foundation Trust helped reduce the number of 999 calls for episodes of hypoglycaemia, and was made possible by pharmaceutical industry support. “We worked with a partner to develop all of the literature and all of the posters publicising the education,” says Stewart Tomlinson, diabetes clinical lead at Surrey Downs CCG. “And we had a project manager at the company who was like a dog with a bone, going round all of the counties and really pushing the education hard. I think that was absolutely crucial in its success.”

6 Collaborate with providers on the move from activity- to outcomes-based approaches

Better diabetes services typically involve a shift away from an activity-based approach and towards an outcomes-based one. In Bradford, the CCGs are working collaboratively with local providers of diabetes care to deliver a diabetes service which includes primary prevention on a large scale. By talking through what was needed with the local providers, including voluntary and community services, a new way of working is being established. “Our providers have stepped up to the mark, and we are jointly developing outcomes over the period of the contract which has been set for ten years,” says Kath Helliwell, head of long-term conditions.



Good practice case studies

Reducing 999 calls and improving communication: Surrey Downs CCG

In 2014, South East Coast Ambulance Service NHS Foundation Trust (SECAMB) took about 400 emergency calls relating to hypoglycaemia in diabetes patients. Such instances of low blood sugar can lead to unpleasant and potentially dangerous symptoms including loss of consciousness and coma.

In 65 per cent of cases, staff from the ambulance trust were able to reverse the episode of hypoglycaemia and there was no need for a patient to go to hospital. But this also meant there was no discharge summary, and so no information for GPs on what had happened. This in turn meant primary care wasn't able to offer support to patients in understanding why they had become hypoglycaemic – and advice on how to stop it from happening in future.

The result was poor experiences for patients, and significant costs for CCGs. “Each ambulance call out at that time was estimated at just shy of £400, and if a patient was admitted to hospital the average cost was about £1,300,” says Stewart Tomlinson, diabetes clinical lead at Surrey Downs CCG.

Commissioners decided action was needed. “Our objectives were to reduce ambulance attendances for hypoglycaemia per se across Surrey, but particularly to target repeat [calls],” explains Dr Tomlinson. “We wanted to reduce the risk of repetitive hypoglycaemia – and obviously from the patient’s perspective improve quality of life, reduce the need to go into hospital, and look at how we were going to improve their knowledge to prevent events in the future.”

The first challenge to overcome: lack of funding. “We started this work back in 2014, and at the time neither SECAMB or the North

West Surrey CCGs had any money to invest in developing this.” The solution: a partnership with pharmaceutical firm, MSD.

One of the immediate priorities was to increase paramedics’ knowledge about hypoglycaemia. “They have fantastic knowledge of reversing an acute episode of hypo, but the reasons why they’re having it, which medications were likely to be greatest risk, and how to try to tackle the risk of a recurrence in the future was poorly understood,” reports Dr Tomlinson.

Four education days were therefore delivered across Surrey and Kent. “We educated about 90 staff – these were key members of SECAMB staff who were responsible for leading ambulance services – and their responsibility after the programme was to roll out the learning to those who hadn’t attended.” That was supported by the creation of an online learning module, using MSD’s education platform.

The next priority was improving communication about hypoglycaemias between ambulance crews and individual GP practices. A form was created to support this. “It’s completed by the ambulance staff and it gives some background of what’s happened and potential factors that might have contributed to the hypo so that follow up can be organised within 24 hours.”

The results have been positive. “In Surrey Downs CCG we launched this in December 2014, and quite quickly the number of hypos requiring 999 calls started to head downwards. That trend has continued, which is great from a commissioning perspective with cost savings and fantastic also from the patient perspective,” says Dr Tomlinson. “One patient had had 15 999 calls in a year, and in the last nine months they’ve had none.”

A multi-pronged approach: Slough CCG

When members of Slough CCG gathered to discuss what the priorities of the newly-formed body should be, there was little doubt diabetes needed to be near the top of the list. “We have 16 practices in a six mile radius that in 2013 had over 8,600 patients with diabetes,” explains Nithya Nanda, diabetes GP lead for the CCG. “That’s a prevalence of over 8 per cent: very few areas in the country have that prevalence.”

In addition, data from Public Health England’s diabetes outcomes versus expenditure (DOVE) tool showed these patients were not always receiving optimum care. “We were in the quadrant with low spend and low outcomes.”

The data was invaluable in making the case that action was needed. “As a clinical lead, the DOVE plot really helped in engaging both the local GPs and the senior leadership team,” reports Dr Nanda. Having looked at the data to determine the scale of the issue, the next item on the to-do list was determining what to target for change.

“We really worked hard with the public health consultants locally and had discussions with the GPs and practice nurses,” recalls Dr Nanda. “We discussed the QOF (Quality and Outcomes Framework) data which showed there was huge variation between the 16 general practices in the area in the prevalence of diagnosed diabetes – ranging between 3 and 12 per cent of registered patients, so about a 120 per cent variation.”

The QOF data also showed a considerable variation in the percentage of patients whose diabetes was well managed, judged in terms of HbA1c measurements (an indication of blood glucose levels for the previous few months); cholesterol levels; and blood pressure rates.

To target this variation, the CCG opted for a multi-pronged approach. Much of the work centred on cultural considerations: nearly 60 per cent of those living in Slough are from a black or minority ethnic (BME) background, with a large number of people hailing from South Asia – an ethnic group with a particularly high risk of developing diabetes.

“We implemented a South Asian lifestyle project where not just the patient but the family came along to the education sessions, because – quite simply – Asian men usually eat what their wives cook for them. So unless we transform the family, we don’t necessarily improve the outcomes. It’s a very non-traditional approach and it really helped.”

As well as providing targeted support to patients, the CCG also directly supported practices to improve performance. It joined with a pharmaceutical company to create a non-promotional programme of education on how to better manage people with diabetes.

Dr Nanda explains: “Specialist nurses came into each of the 16 practices for an initial audit and then myself and the rest of the team did practice visits. For patients whose HbA1c was very high, the specialist nurses sat in on the consultations with GPs. There was also classroom education, sponsored by another pharmaceutical firm.” In addition, pharmacists reviewed GP clinical records to identify patients whose diabetes was particularly poorly controlled. These individuals were then invited in for a consultation.

As a result of all this work, Slough now ranks second best in the country on delivering the eight care processes identified by the National Institute for Health and Care Excellence (NICE) as representing good practice in diabetes care.

From activity to outcomes: Bradford CCG

When Bradford CCG looked at spend and outcomes across the whole of the diabetes pathway, data showed the CCG had one of the country's highest mortality rates for cardiovascular disease – for which diabetes is a recognised risk factor. It was a situation which commissioners knew could not continue, and so work began to fundamentally change the model of care. The aim is to develop an accountable care system, in which providers of care are remunerated not on how many patients they see but on how they improve their health.

“All our providers of diabetes care – from the community right through to secondary care – have developed the Bradford Provider Alliance,” explains Kath Helliwell, the CCG's head of long-term conditions. “We're giving the alliance the budget to work collaboratively to develop a care model which will reduce the number of people at risk of diabetes, and improve the care and management of those who do have diabetes.”

The outcome targets are grounded in analysis of data. “We've taken our baseline from previous years activity, and then we've used the RightCare data and the national data and agreed standards that are challenging but achievable as well. We have seen all our providers sit down and work together to agree a pathway that meets the needs of our population and that has been a huge step in the right direction.”

Partnerships with patients: Aylesbury Vale and Chiltern CCGs

For a clinician, the effectiveness of care for a patient with diabetes will likely be judged by blood sugar levels. But for a patient, the criteria for success might be very different – the desire for a foot problem to heal so that they can play with their grandchildren, for instance.

Adopting a more patient-centred approach in which those aims are put first is not without its challenges. Navigating all the services which could help is traditionally challenging. In Aylesbury Vale and Chiltern CCGs, there has been intensive work to solve that.

Kathy Hoffman, diabetes clinical lead, explains “The CCGs – using the flexibilities of co-commissioning and working with public health within the council – have commissioned a provider as a single point of access. Into that is plugged anything to do with lifestyle intervention, but also anything to do with education of the patient on their condition. In addition, psychology services are involved, because we know that people with long-term conditions have a disproportionate incidence of anxiety and depression.”

It's a matter of reducing the complexity of the system to improve care, suggests Dr Hoffman. “All you have to know is that the patient wants to do something about their lifestyle, they want to learn about their condition, or they have a psychology issue that is preventing them from doing as well as they could with the condition that they have, and that single point of access is your gateway in.”

Delivering community-based care: Bury CCG

Bury CCG performs consistently strongly on a range of performance indicators for diabetes. Ask long-term conditions lead Fin McCaul how they've achieved it and the first thing he points to is the area's integrated community diabetes service (ICDS).

The service was initially set up in 2005, when it was primarily hospital-led. But a refresh in 2013 moved it into the community, with care delivered from two central sites within Bury. Led by a consultant diabetologist, the team includes a GP with a special interest in diabetes (GPwSI), as well as specialist nurses and a community support worker.

The central aim is to offer care closer to home, as well as to reduce the number of hospital admissions for diabetes patients. "They do hospital in-reach, and we've encouraged them to reduce length of stay and our hospital admissions as part of their service." explains Mr McCaul.

Patients are offered help to better manage their own condition, but the team also provides all diabetes education for local healthcare professionals. That's a mission Mr McCaul says is helped by ICDS' status as a 'gatekeeper' to services. "They judge all the referrals that are coming in, and use the referrals as an educational tool to understand where the practice's gaps in education are, and then go and put on education to resolve those gaps," says Mr McCaul.

In the past 12 months alone, 152 professionals have received education to help them better support diabetes patients. "That includes practice visits, nurse forums and GP update sessions. The team has also trained district nurses in managing hypoglycaemias, and gone into care homes to train adult social care teams. So it's about spreading education wider than just diabetes teams."



How national bodies could help even more people receive excellent diabetes care

This document, and the roundtable and conversations which informed it, demonstrate that there are numerous examples of CCGs commissioning excellent diabetes services. Too often, however, commissioners told us they had made progress despite many challenges. It is clear that removing some of these obstacles would enable more CCGs to provide better care for people with diabetes.

In order to support CCGs in this process we call on the national bodies to:

1 Work with CCGs to identify top-priority patient outcome measures

When we asked our roundtable participants what national bodies could most valuably do to help, this was the most popular answer. This document aims to identify some common themes around good practice in diabetes commissioning, but there remains a need for clarity on the top priority patient outcomes that CCGs should take action to address. NHS England and other partners should develop this with input from CCGs as they can provide intelligence on the priorities and needs of patients locally. Commissioners we spoke to also argued there was a need for improved clinical outcomes measures, which gave a more accurate insight into the quality of diabetes care.

2 Promote new contracting mechanisms which better reflect population-based care

In Aylesbury Vale and Chiltern CCGs, an integrated pathway for diabetes care has been developed. It is focused much more on caring for a population than on activity, but implementing it is proving challenging because it necessitates a very different type of contract with providers. Part of the challenge is that hospitals are only used to taking responsibility for the patients who attend or are admitted. “They aren’t under any obligation to look after the population that doesn’t show up, because the national inpatient diabetes audit only deals with the patients they see,” explains Kathy Hoffman, diabetes clinical lead.

“The challenge for me is about how a CCG takes the step to create these innovative new contractual arrangements.” She and many others we spoke to felt national support was needed here. “I think we could do with some help from above,” says Dr Hoffman.

3 Establish clearer rules of engagement on collaborations between pharmaceutical companies and CCGs

Many of the CCGs we spoke to said their innovations in diabetes commissioning would have been impossible without financial and practical assistance from partners in the pharmaceutical industry. Yet the prospect of such ventures can make some commissioners anxious for fear of being seen to involve industry in an inappropriate fashion. While there has been some guidance issued in this area, we suggest that clearer information still is required, and urgent work to remove any obstacles to valuable partnerships being constructed. Nithya Nanda, diabetes clinical lead for Slough CCG, said the organisation had “involved pharma in a big way” in improving local outcomes. “Although if we were going to repeat the work now, there’s so much red tape involved that I may not be able to do it.” It is therefore helpful to note that a new national framework is in development to facilitate and accelerate appropriate collaboration between industry and the NHS in the field of diabetes.

By addressing these issues, national bodies could significantly aid commissioners in their work to provide the best possible care to people with diabetes. With ever-growing spend and prevalence, this is not an issue which we can afford to ignore.

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