NHS
Herts Valleys
Clinical Commissioning Group

A New Integrated Diabetes Service

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Your Care, Your Future

- Nationally – 6% of population have Diabetes growing at about 5% per year. About 10% of people with diagnosed diabetes have type 1 and 90% have type 2 diabetes

- Herts Valleys – 2014/15 5.3% of population had diabetes (24,974) growing at about 0.3% per year

- Your Care, Your Future – Has identified as a priority Long Term Condition area .

  Key themes identified by patients – prevention, joined up care, care closer to home, ongoing education, psychological support.

Diabetes – Case for Change

- Workforce/operational issues in HCT
- Low levels of GP education
- Low up take of structure education sessions,
- Long waits for both services
- Unnecessary duplication of care
- Delay in patients seeing the right clinician at the right time.
- Foot = ‘burning platform’, not meeting NICE standards, poor outcomes NB amputation compared with other similar CCGs.

Diabetes – Case for Change

- Outcomes for diabetes although improving have been identified as poor:

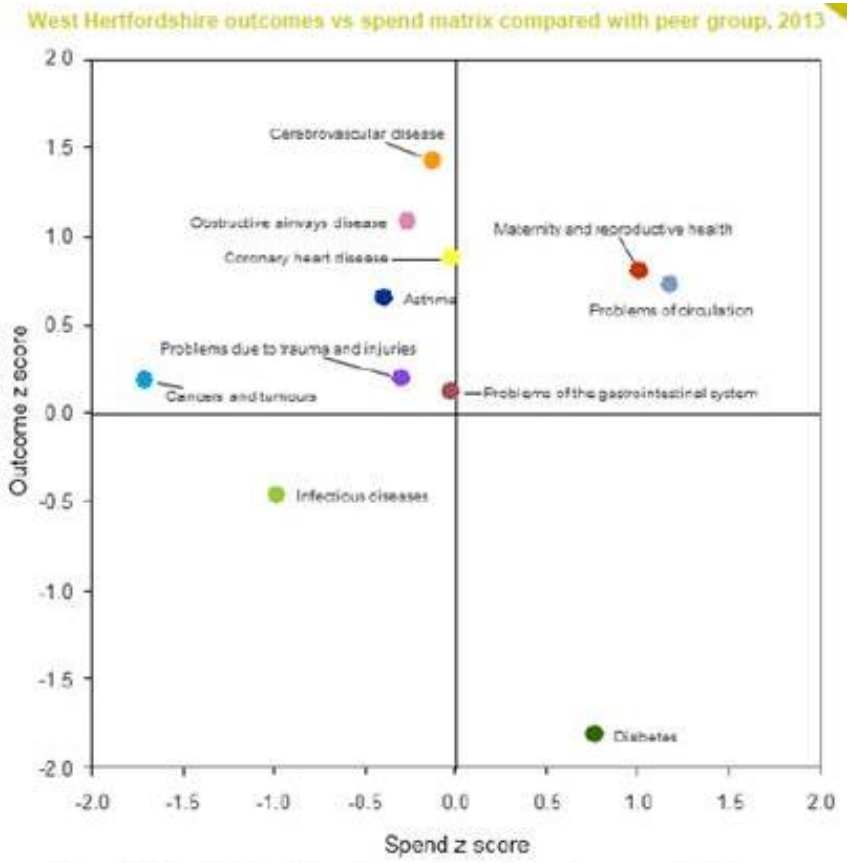

Figure 6: West Hertfordshire outcomes vs spend matrix compared with peer group (2012/13)*

2014 Spend and Outcome Tool produced by Public Health England, and tabled above.

Development of the Model

Herts Valleys Integrated Diabetes Service Model

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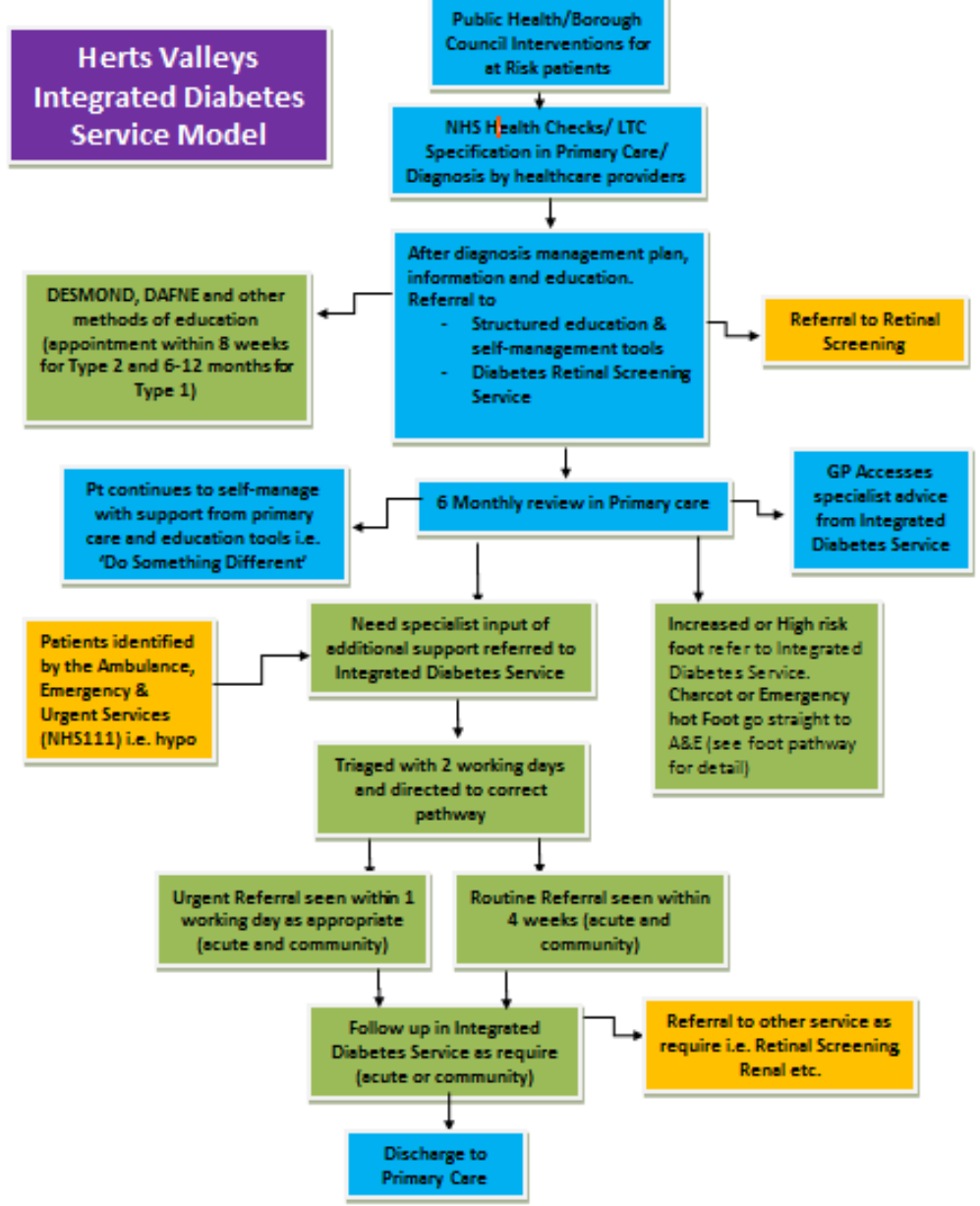

Key	
Pt in Primary Care	
Pt in Integrated Diabetes Service	
Pt in other service	

Interdependencies to other service including: Physical, Mental Health, End of Life Care and Social Care Service

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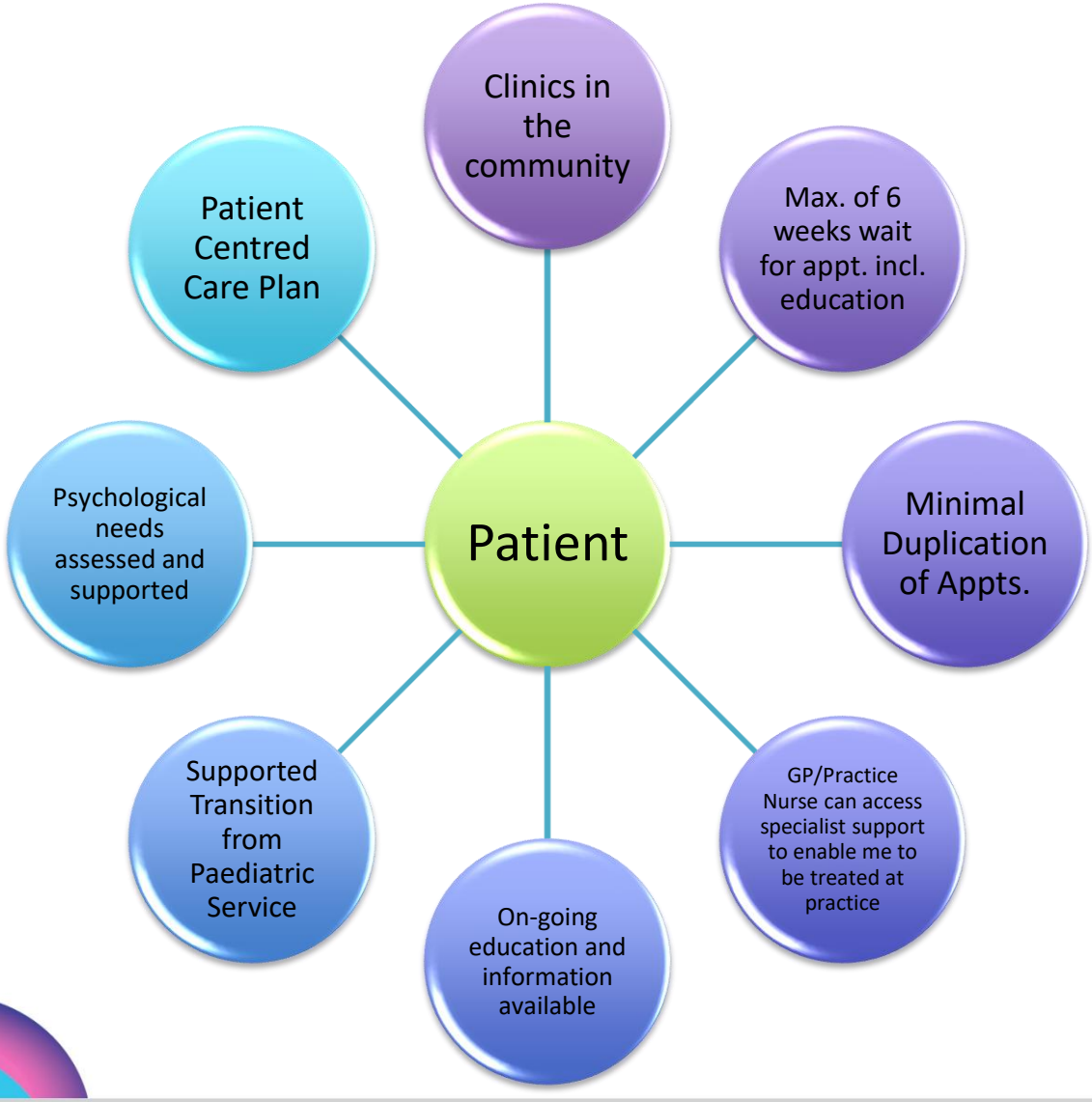
Diabetes New Service



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Diabetes New Service

Children's Services

- Together agree Children not to be included due to the best practice already being followed in Children's

- Developed transition process to ensure robust patient centred service during the move from children's to adult services

Mental Health & LD

- Development of HPFT CQUIN for diabetes

- 3 tiers of service:

  WBS – diabetic patients needing mental health support.

  Psychiatric support for complex patients e.g brittle type 1s.

  Multi-disciplinary team approach to patients with SMI, LD and diabetes or at high metabolic risk.

- Ongoing mutual education.

Next Steps & Implementation

Implementation of the new model through:

- Assurance Framework for most capable provider (incumbent providers) input from all directorates across CCG involved in this process

- Task and finish groups as part of Diabetes Clinical forum to work on the following stages of the pathway :

1. Primary care up-skilling and education of the multi-disciplinary team.
2. Structured patient education and care planning
3. Medicines optimisation & IT

A Skilled Clinical Workforce

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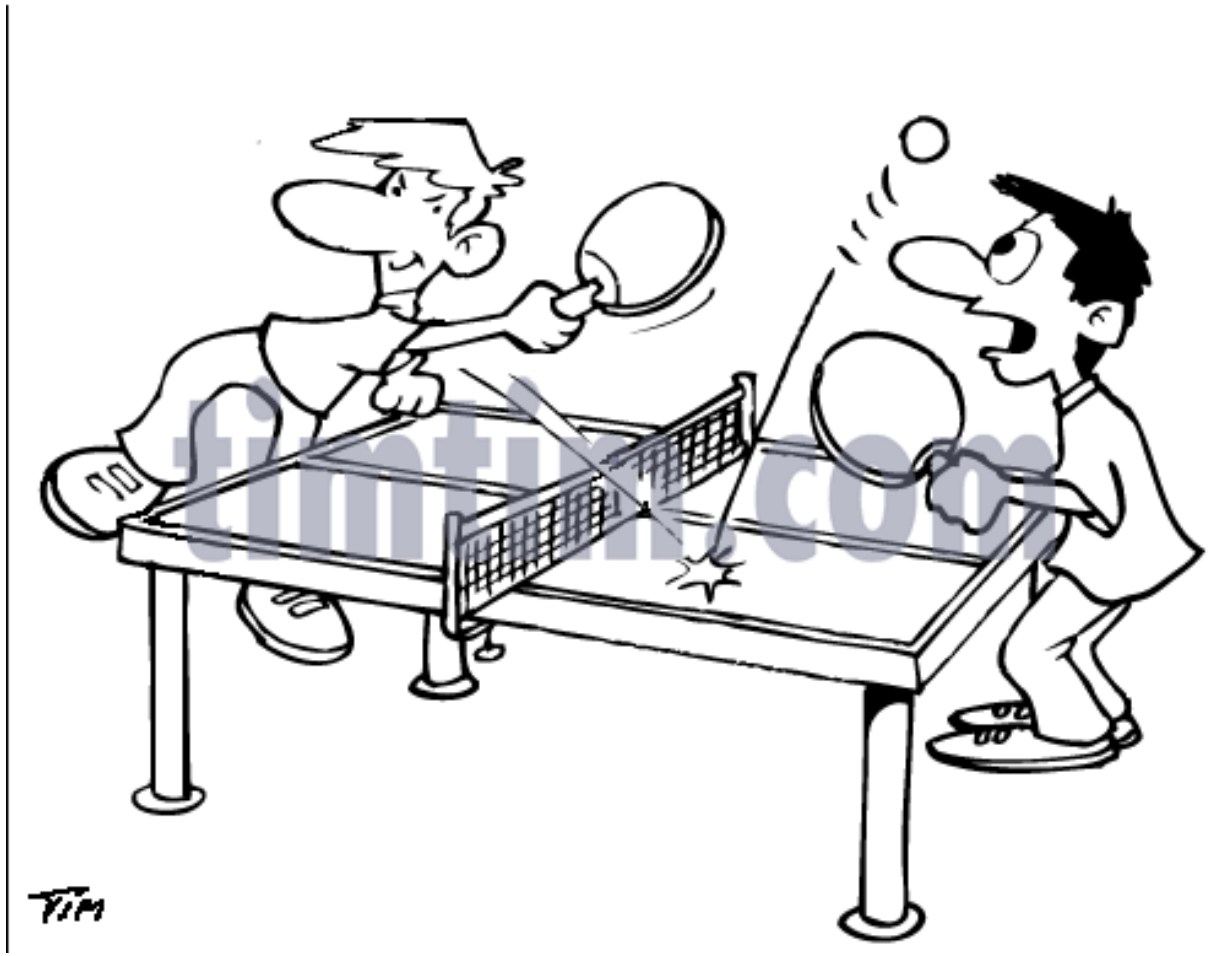
Less 'Ping-Pong' Care



More Collaborative Care

Less of this

More of that

Less Waiting


RIGHT PERSON
RIGHT PLACE
RIGHT TIME

Better outcomes