



IQC/2009/62
Improvement and Quality Committee
24 November 2009

DIABETES COLLABORATIVE COMMISSIONING PLAN

1. PURPOSE OF THE REPORT

The purpose of this report is to update the Improvement and Quality Committee on progress towards the promises set out within the Diabetes Collaborative Commissioning Plan.

NHS Tayside Board agreed seven promises in December 2007 as part of the NHS Tayside Collaborative Commissioning Paper on Diabetes.

2. RECOMMENDATIONS

The Board is asked to note:

- Progress towards achievement of the promises since they were agreed in December 2007.
- NHS Tayside Diabetes Managed Clinical Network will continue to work collaboratively with its partners to deliver on the Diabetes promises.
- The challenges which have been faced in delivering some of the promises.

3. EXECUTIVE SUMMARY

NHS Tayside Diabetes Promises to people with diabetes were:

1. All people newly diagnosed with Type 2 diabetes will have access to quality assured, structured education through the Tayside Diabetes Education Programme (TDEP) within 1 month of diagnosis.
2. At least 75% of people with diabetes will have a foot risk score formally calculated annually.
3. All people with diabetes will have access to appropriate state registered podiatry services as indicated by their foot risk score.
4. All people with diabetes will have appropriate access to state registered dietetic services in line with agreed Tayside-wide standards.
5. All people with diabetes will be managed in line with agreed "Tayside Care Pathway for Patients with Diabetes".
6. All appropriate people with Type 1 diabetes will have access to intensive management instruction via the Tayside Insulin Management Programme (TIM).
7. All people with diabetes will be offered annual eye screening by digital retinal photography.

3.1 Context

Many of the Diabetes Collaborative Commissioning Promises support the delivery of other national and local strategic priorities:

Improving Health and Wellbeing of People with Long Term Conditions in Scotland: A National Action Plan, High Impact Changes (June 2009)

- To commission self management peer support for people living with long term conditions and their carers and provide relevant, accessible information.
- To provide better, local and faster access to healthcare, social care and housing services for long term conditions.
- To strengthen the contribution of Managed Clinical/Care Networks (MCNs) in improving support for people with long term conditions.

Better Health Better Care – Action Plan (December 2007)

- HEAT Target T6 To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/7 to 2010/11.

NHS Tayside Collaborative Commissioning Promises (October 2007)

- To develop a range of relevant education so that you and your carer(s) can gain a better understanding of how to manage it from diagnosis.
- To work in partnership with colleagues from Local Authority and the Voluntary Sector, aiming to provide the most appropriate person, service, and place to suit your needs. This will enable you to stay within your community for care when appropriate.

3.2 Achievements

There have been many achievements since the promises were agreed in December 2007. These include:

- An increase in the number of people with Type 2 diabetes receiving structured education about their condition following diagnosis.
- The percentage of people with a foot risk score recorded doubled to 73%.
- Introduction of a self management education programme to empower suitable people with diabetes with low foot risk to manage their own foot care confidently and competently.
- An additional Specialist Diabetes Dietitian appointed in Perth & Kinross.
- A Local Enhanced Service for Diabetes agreed and implemented from 1 January 2008. This has supported the implementation of the Tayside Diabetes Integrated Care Pathway.
- A further 15 Tayside Insulin Management Programmes were run allowing a further 113 people to attend this education programme on insulin intensification.
- Additional eye screening facilities were introduced in Perth Royal Infirmary and the percentage of people receiving eye checks remained consistently high.
- Two recently published papers have shown that in Tayside there has been a significant reduction in the incidence of amputations in people with diabetes and a reduction in laser treatment for diabetic maculopathy in people with Type 2 diabetes.

3.3 Challenges

Progress towards achievement of the seven promises since they were agreed in December 2007 has been made despite a number of challenges. These include:

- The continuing increasing prevalence of diabetes. There has been an 11% increase from 16,110 in November 2007 to 17,941 in September 2009. It is becoming difficult to deliver improvements to patient care against this increasing challenge.
- Many of the achievements have been delivered through the use of non recurring resources, such as the provision of structured education and a shift in balance of care from specialist diabetes services to general practice for people with Type 2 diabetes.
- The inability to release podiatry staff for training without funding for backfill in order to ensure they are competent and confident to treat people with diabetes.

3.4 Future Priorities

- Complete the roll out of Tayside Diabetes Education Programme, increasing attendance and ensuring compliance with criteria for structured education. Seek solutions for long term funding.
- A long term solution to shifting the balance of care for people with Type 2 diabetes to take forward the outcomes from the Local enhanced Service.
- Audit of podiatry services to ensure people with diabetes are seen by an appropriate podiatrist according to their foot risk score.
- Continuation of training for community podiatry and general practice staff to undertake foot screening and foot care of people with diabetes.
- Ensure patients who require dietetic intervention in line with agreed criteria are seen by appropriate dietician.
- Further develop Tayside Insulin Management Programme to increase availability and ensure meets criteria for structured education.
- Continue to monitor the eye screening service to ensure it meets demands.

4. MEASURES FOR IMPROVEMENT

Measures for improvement have been identified for each Diabetes Collaborative Commissioning Promise. Measures will be routinely monitored and reported through the Long Term conditions programme to the Improvement and Quality Committee, NHS Tayside.

5. FINANCIAL IMPLICATIONS

The financial implications for delivering the promises were set out in the Diabetes Collaborative Commissioning Plan presented to NHS Tayside Board in December 2007. Funding provided by the Scottish Enhanced Services Programme has been used to support a Local Enhanced Service for Diabetes which is enabling delivery of three of the promises. However, this funding is only available until March 2011.

6. DELEGATION LEVEL

Resources are managed across the Diabetes Managed Clinical Network (MCN) by Community Health Partnerships and the Medicine Directorate. The MCN encourages a collaborative approach to decision making about use and distribution of resources.

7. RISK ASSESSMENT

The Diabetes Collaborative Commissioning Promises will ensure that NHS Tayside delivers safe, effective, patient centred, timely, efficient and equitable services and supports the Single Delivery Unit in discharging its duty to deliver single system operational clinical services.

8. IMPLICATIONS FOR HEALTH

The Diabetes Collaborative Commissioning Promises will ensure that NHS Tayside provides high quality care for people with diabetes. By focussing on the prevention of complications of diabetes through provision of education and regular reviews, the life expectancy and quality of health for people with diabetes will be increased.

9. TIMETABLE FOR IMPLEMENTATION AND LEAD OFFICER

The Lead Officer is Mr Gerry Marr, Chief Operating Officer of the Single Delivery Unit. He is supported by the following officers:
Collaborative Commissioning - Caroline Selkirk, Director of Change and Innovation
Diabetes – Dr Alistair Emslie-Smith, GP and Diabetes MCN Lead Clinician and Elaine Wilson, Diabetes MCN Manager.

10. CONSULTATION INFORMING, INVOLVING & CONSULTING WITH PUBLIC & STAFF

The following colleagues were consulted on the original promises in 2007 and/or on progress reporting:

- Dr David Dorward, Lead Clinician, Dundee Community Health Partnership
- David Lynch, General Manager, Dundee Community Health Partnership
- Dr Phil Tipping, Lead Clinician, Perth & Kinross Community Health Partnership
- Bill Nicol, General Manager, Perth & Kinross Community Health Partnership
- Dr Michelle Watts, Lead Clinician, Angus Community Health Partnership
- Susan Wilson, General Manager, Angus Community Health Partnership
- Rhona Guild, Primary Care Development Manager, Angus Community Health Partnership
- Dr Alex Duncan, Lead Diabetes Clinician, Angus Community Health Partnership
- Dr David Johnston, Associate Medical Director, Medicine Directorate
- Carol Goodman, General Manager, Medicine Directorate
- Arlene Wood, Clinical Service Manager, Planned Care, Medicine Directorate
- Diabetes MCN Implementation Group including:
 - Professor Andrew Morris, Professor of Diabetic Medicine
 - Dr Geraldine Brennan, Diabetes Team Leader, Medicine Directorate
 - Andy McQueen, Patient Member

11. EQUALITY & DIVERSITY IMPACT ASSESSMENT

The Diabetes Collaborative Commissioning Plan complies with the principles of Equality and Diversity Impact Assessment.

12. BACKGROUND

Diabetes is a chronic and progressive disease that has an impact upon almost every aspect of life. It is characterised by elevated blood glucose levels as a result of a lack of insulin or resistance to its action and is associated with increased risks of heart attacks, strokes, blindness, amputations and kidney failure.

Diabetes is a major and increasing health problem in Scotland. Over 219,000 people in Scotland have been diagnosed with diabetes and the prevalence continues to rise, particularly for Type 2 diabetes which is often associated with unhealthy body weight. It is possible that within 25 years, one in ten people in Scotland will have diabetes (Scottish Diabetes Action Plan, 2006)

Diabetes is still the leading cause of blindness in the working population. Twenty percent of renal replacement therapy in Scotland is due to diabetes. Patients with diabetes have a 15-20 fold increased risk of lower limb amputation. Life expectancy is reduced by at least fifteen years for someone with Type 1 diabetes and 10 years for Type 2 diabetes.

The number of people with diabetes in Tayside currently stands at 17,941 (September 2009) which represents a prevalence of 4.5%. Around 90% of people with diabetes have Type 2 diabetes. Based on past prevalence and an average increase of 7% each year, we could expect a prevalence of around 23,000 by 2012. This does not take into account demographic changes with an ageing population and the expected increase in obesity that is closely linked to the risk of developing Type 2 diabetes.

As with the management of most long term conditions, the majority of care for people with diabetes could be provided locally within primary care provided that adequate resources in terms of personnel and support services were available. Under this arrangement patients with more complex needs would access specialist services on a clinical needs basis in line with agreed protocols. The aim of modern diabetes management is to target multiple risk factors prospectively to prevent long term complications. This model supports current local and national policies in relation to shifting the balance of care and supporting self management.

Dr A Emslie-Smith
Diabetes MCN Lead Clinician
NHS Tayside

Professor W J Wells
Chief Executive
NHS Tayside

Ms E Wilson
Diabetes MCN Manager
NHS Tayside

Diabetes
Progress Report on Promises agreed in 2007

Measures for Improvement	Status	Supporting information	Future Actions
Promise 1: All people newly diagnosed with Type 2 diabetes will have access to quality assured, structured education through the Tayside Diabetes Education Programme (TDEP) within 1 month of diagnosis.			
Increase in number of general practices able to access TDEP.	Increase achieved – Chart 1	Roll out of TDEP has been supported as part of the funding for a Local Enhanced Service for Diabetes.	Funding for the Diabetes Local Enhanced Service is only available until March 2011.
Increase in number of people newly diagnosed attending TDEP.	Increase achieved – Chart 2	Three new groups have been established in Montrose, North West Perthshire and Crieff/Comrie.	A new group in East Perthshire covering Blairgowrie, Alyth and Coupar Angus is due to start in 2009. This will result in 100% of practices having access to TDEP.
Reduction in waiting time for access to TDEP.	Over 3 months in 2008 Within one month in 2009	A new online TDEP booking system was implemented in June 2009 to support practices in referring people.	Work is ongoing to ensure the programme meets the NICE criteria for structured education.

Chart 1: Percentage of Practices Able to Access TDEP

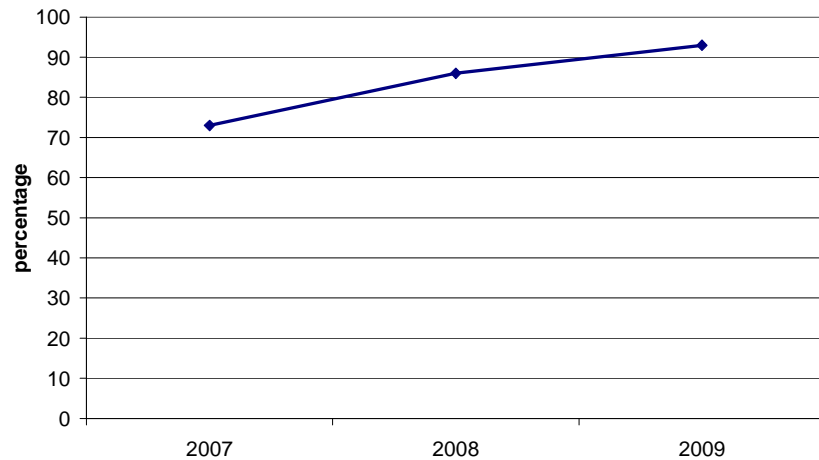
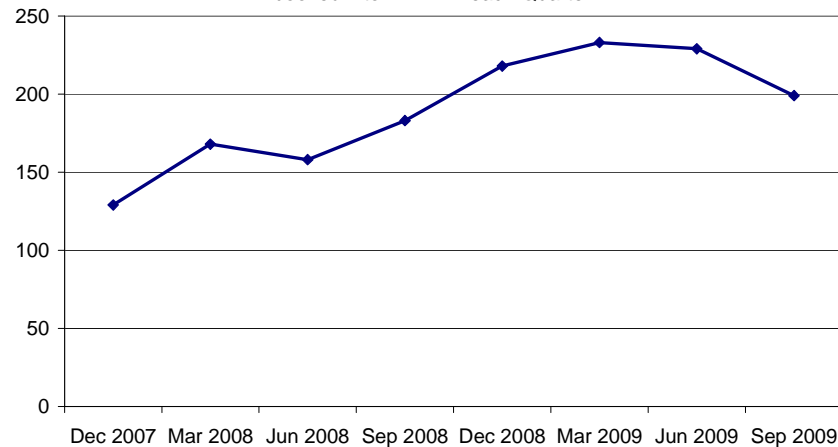


Chart 2: Number of people newly diagnosed with Type 2 Diabetes booked into TDEP in each Quarter



Promise 2: At least 75% of people with diabetes will have a foot risk score formally calculated annually.

Increase in number of people with foot risk formally calculated and recorded annually using SCI-DC foot risk assessment tool.

Increase achieved – Charts 3 and 4

The requirement to ensure foot assessments are undertaken and foot risk score is recorded for all people with Type 2 diabetes is included within the Local Enhanced Service for Diabetes.

Funding for the Diabetes Local Enhanced Service is only available until March 2011.

Chart 3: Number of foot risk scores recorded

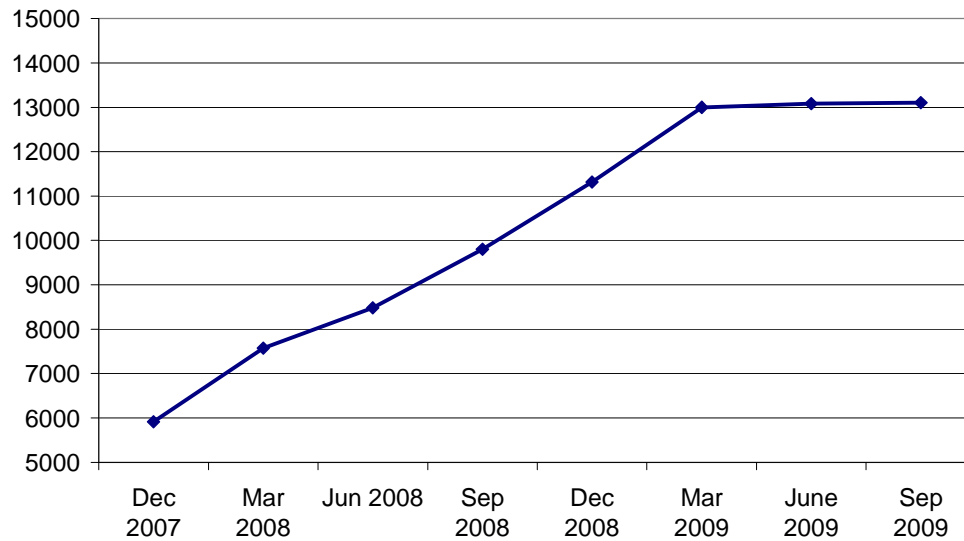
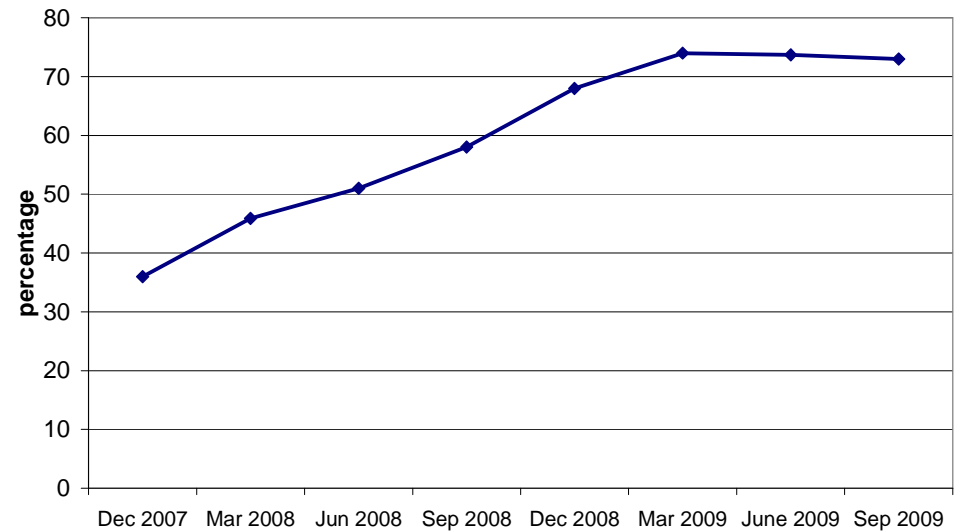


Chart 4: Percentage of People with Diabetes with a Foot Risk Score



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Measures for Improvement	Status	Supporting information	Future Actions
Promise 3: All people with diabetes will have access to appropriate state registered podiatry services as indicated by their foot risk score			
<p>Increase in number of podiatrists who have received training in diabetes foot care.</p> <p>Increase in number of people with diabetes seen by an appropriate podiatrist according to their foot risk score.</p>	<p>No progress</p> <p>Mechanisms to capture this data being explored.</p>	<p>As part of a Podiatry Project, 34 community podiatrists undertook training to increase their skills and confidence in looking after people with diabetes. The funding for this ended in 2007. It has not been possible to continue to support these podiatrists or train more community podiatrists due to the challenges of releasing staff without backfill.</p> <p>Using funding from the Diabetes Local Enhanced Service "Footstep" education programme was developed. It aims to empower people with diabetes with low foot risk (requiring no podiatry intervention) to manage their own foot care.</p> <p>As a result of the above initiative specialist diabetes podiatry services have been able to discharge appropriate patients to community podiatry.</p>	<p>The Scottish Diabetes Group is providing funding to MCNs for two years for two sessions of podiatry time per week to further support community podiatry and develop links between them and specialist services.</p> <p>Funding for the Diabetes Local Enhanced Service is only available until March 2011.</p>
Promise 4: All people with diabetes will have appropriate access to state registered dietetic services in line with agreed standards			
<p>Agreement of Tayside-wide guidance for access to dietetic services.</p> <p>Increase in number of people who require dietetic intervention in line with agreed criteria seen by appropriate dietician.</p>	<p>Agreed and published on website as part of Tayside Diabetes Handbook.</p>	<p>Perth & Kinross CHP approved the establishment of a Diabetes Specialist Dietitian post which commenced in August 2008.</p>	<p>Benchmarking of current provision against guidance to be undertaken during November 2009.</p>

Measures for Improvement	Status	Supporting information	Future Actions
Promise 5: All people with diabetes to be managed in line with agreed "Tayside Care Pathway for Patients with Diabetes"			
<p>Reduction in number of people with diabetes attending specialist clinics for routine review appointments.</p> <p>Agreement and implementation of an local enhanced service for diabetes care</p> <p>Increase in number of people with diabetes managed in line with agreed pathway</p> <p>Development of specialist services.</p>	<p>No progress for review appointments.</p> <p>Decrease in % of people newly diagnosed with Type 2 diabetes referred to specialist clinics – Chart 5</p> <p>Agreed and implemented from 1 January 2008 to 31 March 2011.</p> <p>96% of people newly diagnosed with Type 2 diabetes managed in line with agreed pathway. Number of people cared for within Local enhanced Service in Chart 6.</p> <p>Not possible until progress made on reducing number of people attending specialist clinics.</p>	<p>Local Enhanced Service for Diabetes introduced from 1 January 2008 and extended from April 2009 to March 2011. The Local Enhanced Service covers:</p> <ul style="list-style-type: none"> • Management of patients diagnosed with Type 2 diabetes from 1 January 2007 in line with Diabetes Integrated Care Pathway • Referral to structured education for people newly diagnosed with Type 2 diabetes • Foot risk assessment for all people with Type 2 diabetes • Participation in continuing professional education. <p>Has supported a shift in the balance of care for people with diabetes enabling those patients who do not require specialist intervention to be managed within general practice.</p>	<p>Funding for the Diabetes Local Enhanced Service is only available until March 2011. Long term resourcing needs to be explored and agreed.</p> <p>Audit of appropriateness of referrals being undertaken.</p> <p>Review of specialist service capacity and demand currently being undertaken.</p>

Chart 5: Percentage of People Newly Diagnosed with Type 2 Diabetes Attending Specialist Diabetes Clinics

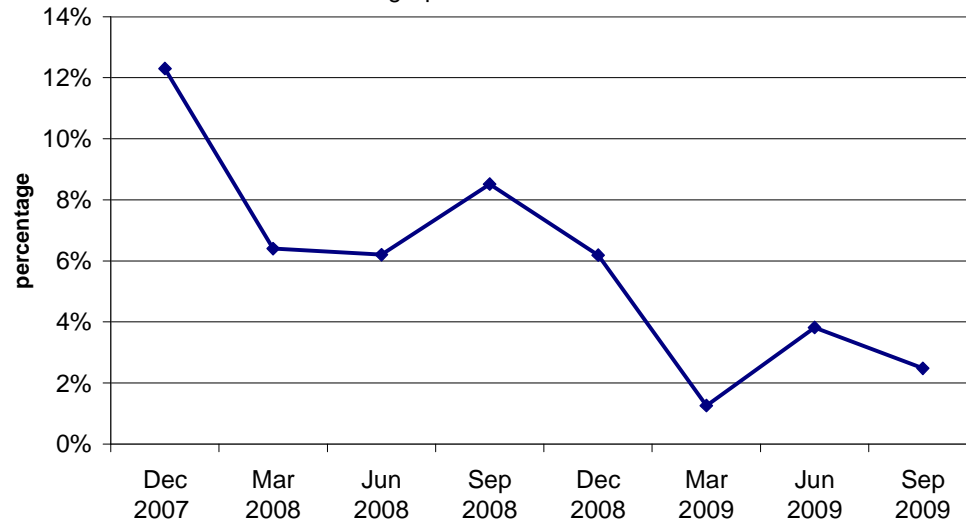
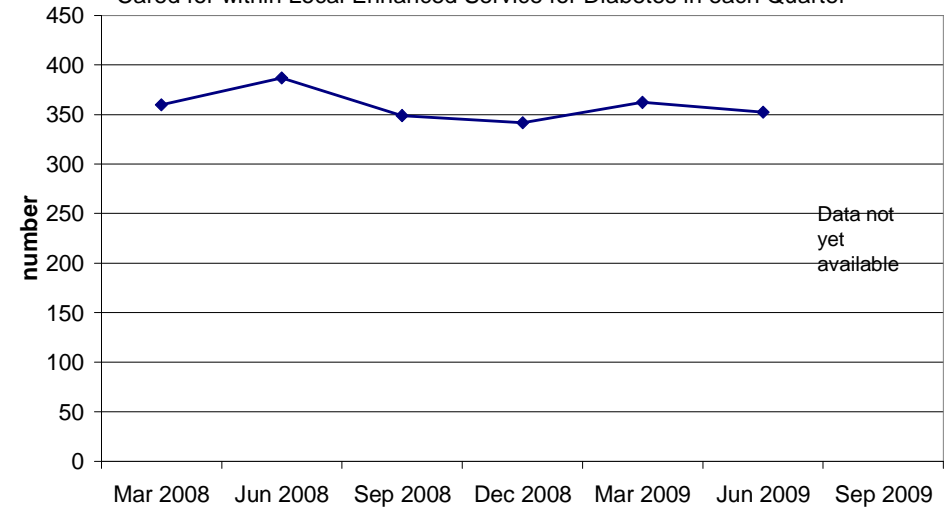


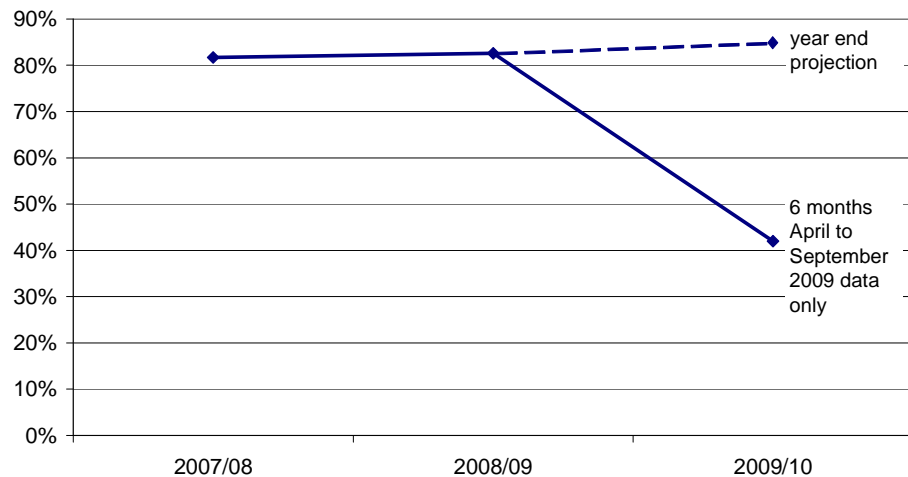
Chart 6: Number of People Newly Diagnosed with Type 2 Diabetes Cared for within Local Enhanced Service for Diabetes in each Quarter



Measures for Improvement	Status	Supporting information	Future Actions
Promise 6: All appropriate people with Type 1 diabetes will have access to intensive management instruction via the Tayside Insulin Management Programme (TIM).			
Increase in number of TIM courses provided	9 courses in 2007 9 courses in 2008 9 courses scheduled in 2009	The Specialist Team continue to provide TIM courses within current resources.	TIM resources are being reviewed and the programme further developed to work towards meeting the NICE criteria for structured education.
Increase in number of people with Type 1 diabetes attending a TIM programme	59 in 2007 64 in 2008 49 in 2009 to date	11 courses were originally planned in 2009 but 2 were cancelled due to lack of uptake. As a result the team are reviewing the referral pathway and course documentation to improve uptake.	

Measures for Improvement	Status	Supporting information	Future Actions
Promise 7: All people with diabetes will be offered annual eye screening by digital retinal photography.			
Redesign eye screening service to maximise current capacity	Achieved	The eye screening service has been re-designed to reduce the number of drop in slots and utilise more fixed appointments to improve the maximise use of resources.	The Diabetes MCN Retinopathy Sub-Group will continue to monitor the service to ensure meets demands.
Map capacity of eye screening programme required to meet rising prevalence of diabetes.	Achieved	An additional fixed camera became operational in Perth Royal Infirmary in July 2008. Slit lamps clinics became operational in April 2009.	
Increase in number of people attending for eye screening.	Increase achieved – Chart 6		

Chart 6: Percentage of eligible population who have had their eyes screened



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