Countess of Chester Hospital NHS
NHS Foundation Trust

"Just Do It, 'cos I've Got Your Back!"

Diabetes Care: The West Cheshire Way

our values

we respect each other
we have a can do attitude
we strive for improvement
we take pride in the service we provide
we are welcoming, friendly and caring
we put patients at the heart of everything we do

Frank Joseph & Niru Goenka

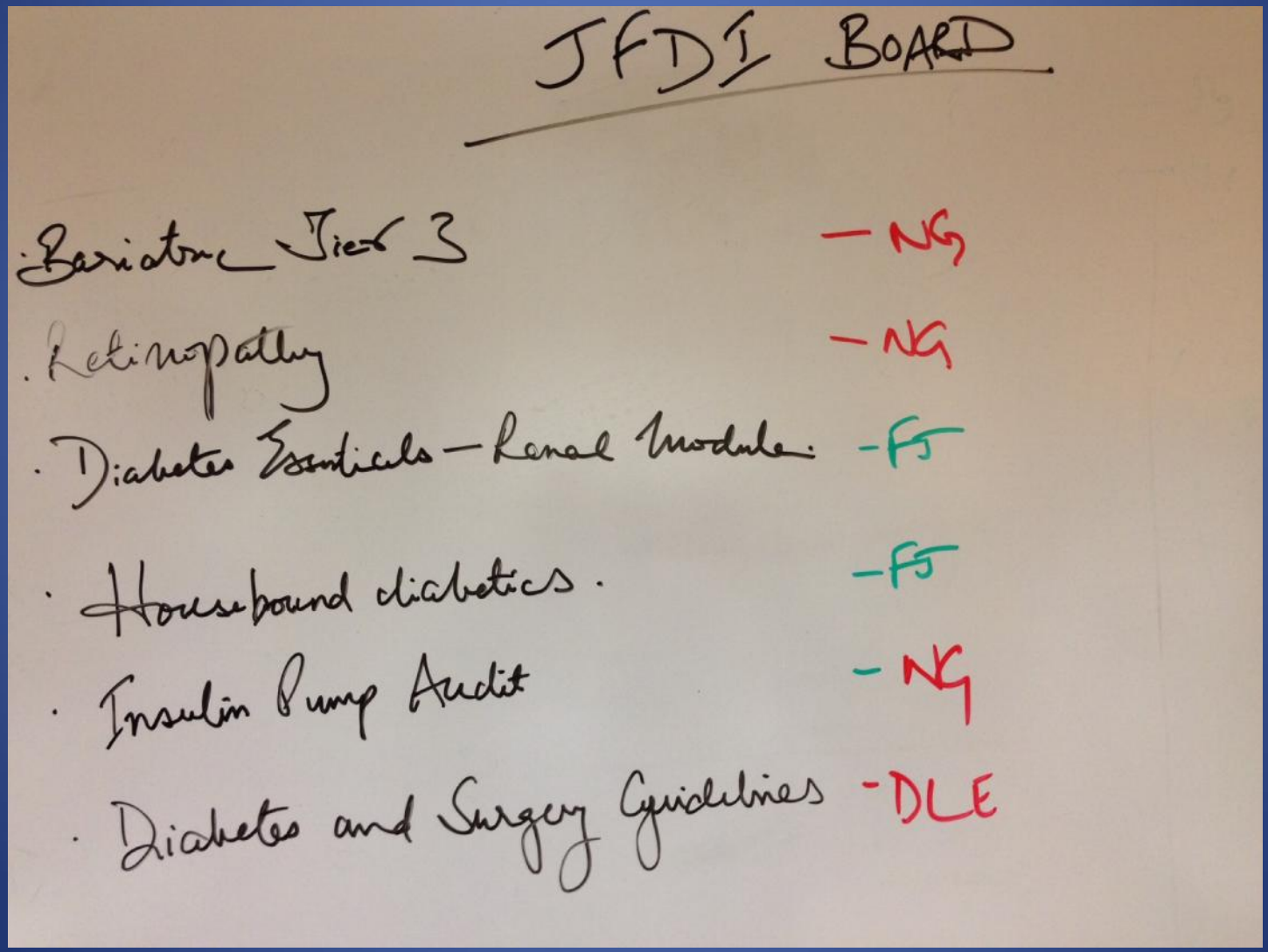
Consultant Physicians

in Diabetes and Endocrinology

The Prologue

- 2003….. The Journey Begins
- August of 2009….. official partners in crime
- Early realisation - established way of working was just not working!
- 2010 ….. change was imperative.
- The vision, ‘today, Chester; tomorrow, the World’.

The "JFDI" Board



The Foundations

- Built on the strength of relationships
  - specialist colleagues
  - primary care colleagues
  - hospital management
  - primary care / CCG management
  - allied health care professionals
  - most importantly our patients and carers
- Built on trust, commonality of purpose, shared success
- Our motto: **“J‘F’DI – Just Do It!”**

The Foundations

- Population of over 12,500 people with diabetes
  - Countess of Chester
  - West Cheshire CCG
  - 37 GP practices
  - Community provider – District Nurses
  - Hospital at Home – Private Provider
  - DUK patient group
  - Industry
- Team that crossed institutional barriers
- Our motto: “**I’ve got your back!**”

“I’ve got your back!”

“of Passengers and Drivers”

Work hard, play harder!

The Edifice

Components of
the West Cheshire Way
of Diabetes Care

Agreed Redistribution of Clinical Responsibility and Clinic Restructuring

- Type 2 diabetes care:
  - devolved to primary care
    - Regular training, updates and clinical advisory support from the specialist team
- Traditional, annual review clinics disbanded:
  - with phased repatriation of all well controlled patients with type 2 diabetes
  - treatment plans for patients requiring further optimisation.
- Hospital based specialist clinics for complex patients and patients requiring multispecialty input:
  - Pregnancy
  - Type 1
  - Renal
  - Foot
  - Young Persons (monthly)
  - Insulin Pump Clinics (2 a month)
  - 1 new patient clinic per week – 'see and sort'

Development and Implementation of a Diabetes Local Enhanced Service (LES)

Level 1: providing 8 additional quality standards over and above the 9 key care processes, were agreed in conjunction: (36 out of 37 practices signed up)

1. **Annual care planning with documented goals and an action plan**
2. **Personalized advice on nutrition and physical activity**
3. **Offer of initial and updated structural educational input**
4. **Insulin passports to be issued to all patients on insulin**
5. **Agreed HbA1c target**
6. **Medication review**
7. **Dose titration of insulin if required, with explanation and support from health care professional. There should be no upper limit and levels need to be increased as required. Practices should be able to give all insulin advice to patients**
8. **Women of childbearing age should have preconception and contraception advice**

Development and Implementation of a Diabetes Local Enhanced Service (LES)

- Level 2: Level 1 plus
  - GLP-1 and basal insulin starts to be done in practice (16 out of 34 practices signed up)
  - Pre-requisite GP and practice nurse leads identified from each practice working towards a diabetes accreditation
- Attendance at Quarterly, LES meetings
  - chaired jointly by the GP lead for diabetes and specialist lead for community diabetes
  - update practitioners on progress of implementation
  - discuss issues surrounding implementation
  - provide education
- A quarterly practice nurse forum supported by the specialist team has also been set up.

Development and Implementation of a Diabetes Local Enhanced Service (LES)

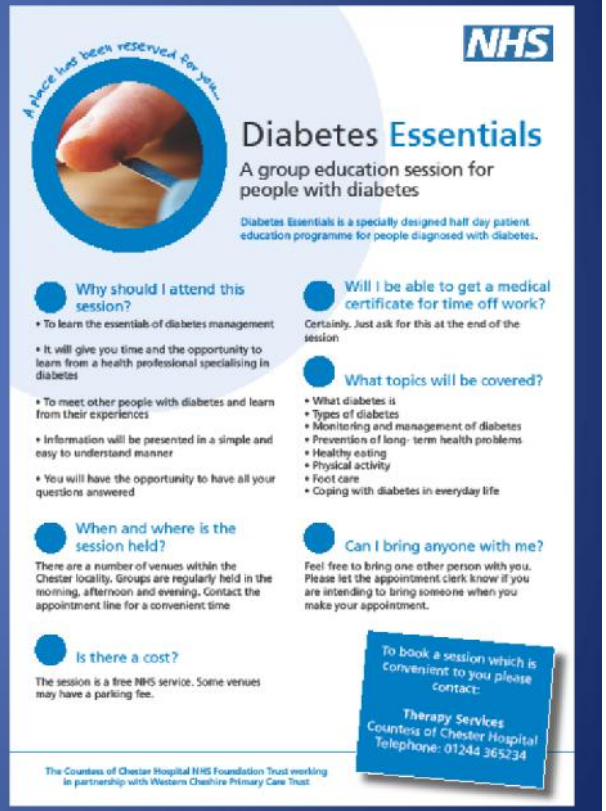
- Training for implementation of the LES
  - provided by the specialist team
  - hands on demonstration of injection devices and theory sessions
- Follow up implementation of in practice initiations
  - identifying appropriate patients requiring treatment escalation using patient identification software
  - injectable therapy initiation clinics were set up where practice nurses performed the initiation to reinforce learning under the supervision of diabetes specialist nurses.

Comms Strategy

Team Building

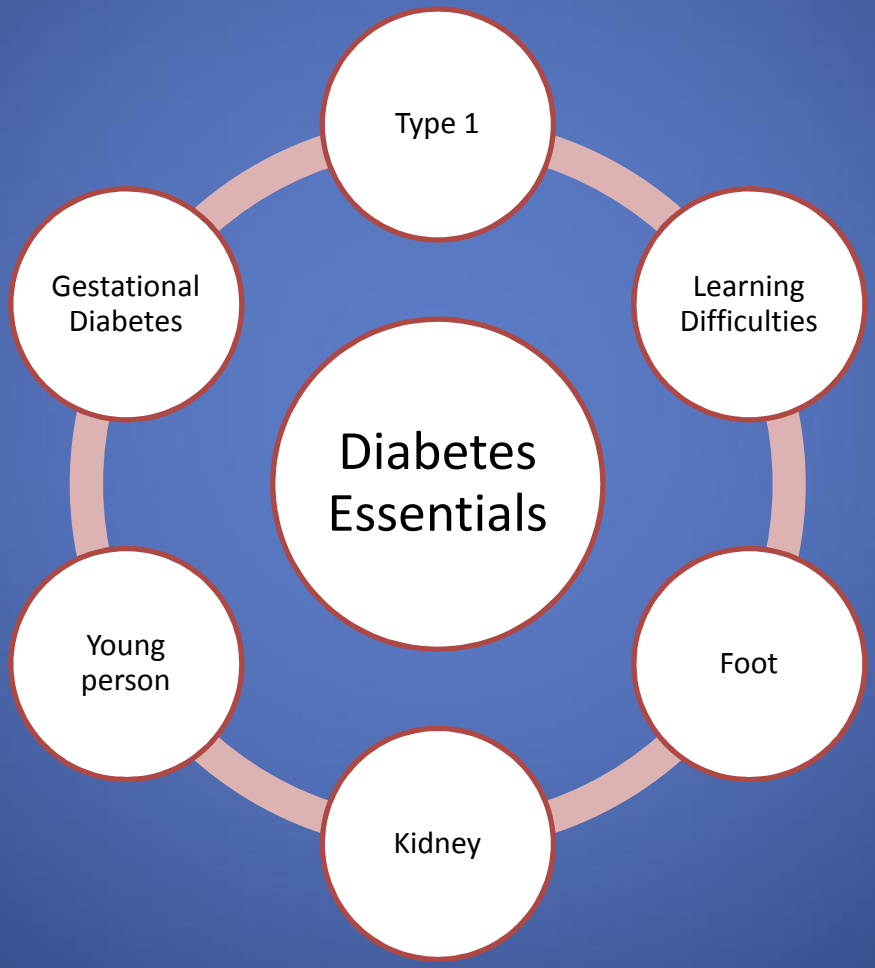
Structured Education
Diabetes Essentials

- Commissioned by primary care
- Delivered by specialist team
- “Modular Diabetes Education”
- Tailored to the individual’s needs.
- Excellent feedback
- Convenient community settings
- Convenient times including after-hours



Diabetes Essentials-

Hub and Spoke Model



Changes in confidence, knowledge and anxiety

Training, education and succession planning!

Development of Clinical Trials and Research – the Chester Boys!

- Successful recruitment – Hands on approach
- Multiple trials
- A great team
- Great relations with CLRN/DRN/PCRN
- University Collaborations

- Reinvest in NHS
- Reinvest in research
- MSc students
- Just appointed our first research fellow

- Benefits for patients in trials
- Benefits for whole health economy

"The PI / Co-I principle"

Joint Community and Hospital Diabetes Formulary Group

- To try and ensure smooth and timely discussions and implementation of new therapies
- impacting on use in primary care as well as in specialist settings
- a diabetes sub-formulary group including the GP lead and community pharmacy lead
- feed into the area prescribing committee
- joint decision making in approving and utilising therapies relevant to the model of care in Western Cheshire.

Working with the Hospital at Home Private Provider

- commissioned locally by the CCG
- facilitate intravenous antibiotics for patients from the foot clinic thus avoiding hospitalisation
- facilitates rapid discharge of gastroparesis patients who are admitted with exacerbations

Working in partnership with North West Ambulance Service

- daily email notification of any patients who have required paramedic assistance for hypoglycaemia
- patients - urgently followed up by the specialist team by phone or in person the next day to institute appropriate change to therapy to avoid further hypoglycaemia
- correspondence to GP to close loop

Working in partnership with district nurses

- consistent and equitable quality care to house bound patients with diabetes
- the district nurses do the appropriate review and act upon findings – not just information gathering
- the specialist team or GP provides clinical support and advice as appropriate

An active and strong diabetes network

- Chaired by the specialist care lead and co-chaired by the GP lead
- Active participation from all stake holders
- DUK and patient representatives
- Engagement and debate at the network meetings, underpins the robustness of our processes and ensures that the changes implemented are in keeping with the decisions of the network as a whole

The Gadget Show!

Information Sharing Portal

- portal that pulls together all diabetes related electronic processes and information from primary and secondary care
- improve patient care
- avoid duplication of investigations and processes
- allow robust data collection

Next Steps

- *Taking care out where it is convenient*
- *Specialist in-reach*
- *Modification of LES standards*

Table 3: Percentage of patients in NHS West Cheshire CCG and England and Wales receiving NICE recommended care processes (excluding eye screening) by care process, diabetes type and audit year

		All diabetes[a]			Type 1			Type 2		
		2009-2010	2010-2011	2011-2012	2009-2010	2010-2011	2011-2012	2009-2010	2010-2011	2011-2012
HbA1c[b]	CCG/LHB	92.8%	94.4%	93.9%	84.4%	87.7%	82.1%	94.1%	95.5%	95.3%
	England & Wales	92.1%	92.5%	90.3%	85.7%	86.0%	83.0%	93.2%	93.5%	91.3%
Blood pressure	CCG/LHB	95.7%	96.2%	95.9%	90.6%	89.1%	89.1%	96.5%	97.0%	96.6%
	England & Wales	95.2%	95.0%	95.0%	88.9%	88.7%	88.4%	96.1%	95.9%	95.8%
Cholesterol	CCG/LHB	93.0%	93.0%	92.3%	79.4%	82.3%	77.4%	94.7%	94.4%	93.9%
	England & Wales	91.7%	91.6%	90.9%	79.1%	78.8%	77.8%	93.2%	93.1%	92.4%
Serum creatinine	CCG/LHB	94.0%	94.4%	94.1%	80.5%	83.3%	79.5%	95.7%	95.8%	95.6%
	England & Wales	92.5%	92.5%	92.5%	81.0%	81.2%	81.1%	93.9%	93.8%	93.8%
Urine albumin[c]	CCG/LHB	75.5%	77.1%	81.1%	53.6%	56.7%	57.2%	78.2%	79.7%	83.8%
	England & Wales	72.3%	75.1%	76.0%	56.2%	58.4%	59.2%	74.3%	77.1%	77.9%
Foot surveillance	CCG/LHB	85.2%	86.6%	87.1%	72.8%	73.5%	71.4%	87.0%	88.3%	89.0%
	England & Wales	84.1%	84.3%	85.3%	71.7%	71.5%	72.8%	85.9%	86.1%	87.0%
BMI	CCG/LHB	90.5%	91.7%	91.7%	81.7%	82.2%	81.7%	91.8%	93.0%	92.9%
	England & Wales	90.1%	89.9%	90.3%	83.6%	83.4%	83.7%	91.1%	90.8%	91.3%
Smoking	CCG/LHB	90.0%	88.1%	89.9%	84.4%	81.0%	81.0%	90.8%	89.1%	90.9%
	England & Wales	86.9%	84.8%	85.1%	80.8%	78.6%	79.0%	87.7%	85.7%	85.9%
Eight care processes[d]	CCG/LHB	65.0%	66.6%	70.7%	42.5%	48.1%	47.2%	67.8%	69.0%	73.5%
	England & Wales	59.4%	60.6%	60.5%	42.4%	43.3%	43.2%	61.6%	62.8%	62.6%

Table 5: Treatment target achievement rate for all patients in NHS West Cheshire CCG and England and Wales by treatment target, diabetes type and audit year

		All diabetes[a]			Type 1			Type 2		
		2009-10	2010-11	2011-12	2009-10	2010-11	2011-12	2009-10	2010-11	2011-12
HbA1c <48mmol/mol (6.5%)[b]	CCG/LHB	25.2%	27.0%	27.2%	6.4%	6.7%	6.7%	26.9%	28.9%	29.0%
	England & Wales	25.0%	24.8%	24.7%	7.1%	6.8%	6.5%	26.7%	26.4%	26.2%
HbA1c ≤58mmol/mol (7.5%)[b]	CCG/LHB	68.1%	69.2%	67.6%	25.1%	28.8%	28.5%	72.2%	73.1%	71.1%
	England & Wales	63.3%	63.3%	62.7%	28.7%	28.1%	27.0%	66.6%	66.5%	65.8%
HbA1c ≤86mmol/mol (10.0%)[b]	CCG/LHB	94.3%	94.0%	93.7%	85.0%	83.0%	83.9%	95.2%	95.1%	94.6%
	England & Wales	92.5%	92.1%	91.9%	83.2%	82.4%	81.9%	93.4%	93.0%	92.8%
Target BP[c]	CCG/LHB	40.7%	41.5%	43.7%	53.4%	58.8%	59.6%	39.4%	39.9%	42.2%
	England & Wales	35.2%	36.2%	38.8%	49.1%	49.9%	51.9%	34.0%	35.0%	37.7%
BP <140/80[d]	CCG/LHB	49.1%	49.5%	53.5%	58.1%	62.8%	66.1%	48.1%	48.2%	52.4%
	England & Wales	43.9%	44.6%	48.1%	54.7%	55.3%	57.9%	42.9%	43.7%	47.3%
Cholesterol <4mmol/L	CCG/LHB	48.0%	46.5%	45.9%	35.4%	35.3%	31.7%	49.2%	47.6%	47.1%
	England & Wales	40.0%	40.7%	40.4%	30.5%	30.4%	29.7%	40.8%	41.6%	41.3%
Cholesterol <5mmol/L	CCG/LHB	81.3%	80.6%	79.6%	77.7%	76.1%	75.1%	81.7%	81.1%	80.1%
	England & Wales	77.7%	77.6%	77.0%	72.6%	72.0%	71.1%	78.3%	78.1%	77.5%
Meet all treatment targets[e]	CCG/LHB	24.3%	25.2%	25.4%	12.9%	14.8%	13.8%	25.3%	26.1%	26.4%
	England & Wales	19.3%	19.7%	20.8%	11.9%	11.8%	11.8%	19.9%	20.3%	21.5%

[a] All diabetes includes maturity onset diabetes of the young (MODY), other specified diabetes and not specified diabetes.

[b] For patients under 12 years of age, 'all treatment targets' is defined as HbA1c only as other treatment targets are not recommended in the NICE guidelines for this age group.

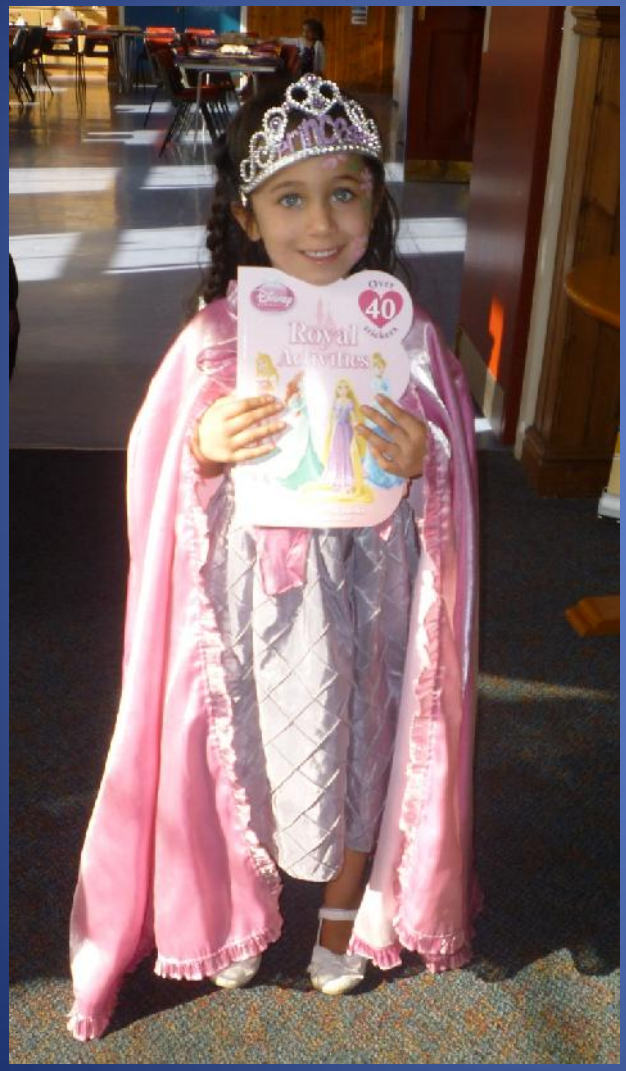
[c] Blood pressure target of <140/80 applied to those patients without recorded eye, kidney or vascular disease (EKV-) and blood pressure target of <130/80 applied to those patients with recorded eye, kidney or vascular disease (EKV+).

[d] BP <140/80 does not take into account whether or not patients have eye, kidney or vascular disease.

[e] Where patients have achieved HbA1c ≤58mmol/mol, cholesterol <5mmol/L and their relevant blood pressure target.

You will never walk alone….

Out of the mouths of babes…



This one’s for you…