Better care at lower cost is the holy grail of healthcare, but there are significant opportunities to deliver both with a more integrated approach to diabetes care. Steve Brown reports

If the NHS wanted a good place to look to add value and transform care services, it could do worse than focus on diabetes. There is a broad consensus that there is significant potential both to improve outcomes and patient experience while reducing overall costs.

There are 2.7 million people in England now with diabetes – 6% of the adult population – with 500,000 more estimated to have type 2 diabetes without knowing it. Some estimates suggest that if nothing changes by 2025, more than four million people in England will have the condition.

NHS England's *Action for diabetes* report last year acknowledged room for improvement. 'While we might be doing well in some areas compared to other countries, we know there is still more opportunity in England to improve patient experience and disease outcomes, as reflected in the unwarranted variation across the country,' the report said. Achieve this and costs should come down.

The direct costs of diabetes, including type 1 and type 2 (see box overleaf), are estimated to be £10bn a year. That's about 10% of the annual NHS budget. And 80% of this spending is estimated to go on managing complications – such as amputations, angina, cardiac failure, stroke, sight loss and kidney failure – which could be prevented if patients were managed differently along the pathway.

A lot of the improvement focus is on ensuring key care processes are delivered to all people with diabetes. The processes, recommended by the National Institute for Health and Care Excellence, cover areas such as checks on blood glucose, blood pressure, cholesterol and kidney function, plus retinal screening and foot examinations.

There are nine tests in total and the presence of all the tests is likely to indicate better management of a patient, which should equate to better outcomes, reduced complications (or at least caught earlier) and a corresponding potential reduction in costs across the system.

However, performance is patchy – contributing to the variation referred to by NHS England. The most recent *National Diabetes Audit* report covering 2012/13, published in October 2014, shows that just 60% of people with diabetes are receiving all eight tests that are monitored. The audit also shows that people with type 1 diabetes routinely receive worse care and treatment than people with type 2 and people of working age are less likely than older people to receive the processes and meet the targets.

While these processes are generally overseen in primary care, the reality is that the diabetes pathway stretches across the whole system, from health promotion, through primary and community services and through to the hospital sector.

Pathway guidance

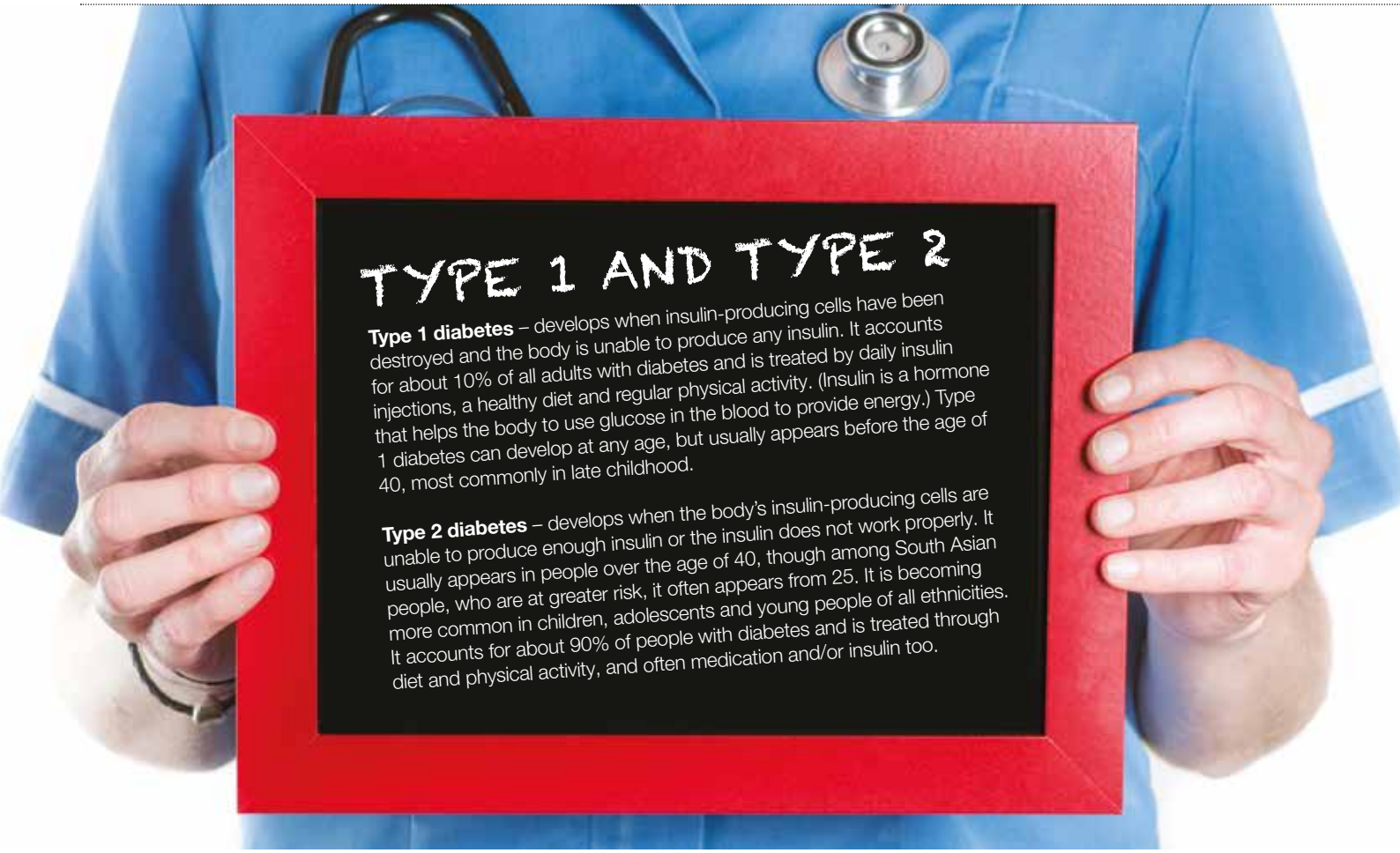
There is plenty of guidance on how the diabetes pathway should operate. 'We have a good idea of what we need to do in terms of the kinds of care and support people need and some good ideas about the organisation of services,' says Robin Hewings, head of policy at the charity Diabetes UK. 'Those places that are doing these things are doing well in terms of outcomes as well.' So the real starting point for improvement is securing greater adherence to these standards and guidelines.

'If you look over 20 to 30 years, you see some big improvements due to changes in technology and the organisation of services,' says Mr Hewings. 'But you still see some gaping holes – well evidenced recommendations by NICE not happening, for example.'

He highlights big opportunities for providers to make short-term savings while improving services. People with diabetes typically make up one in six or seven of all patients on a ward. The presence of diabetes in a patient in hospital for a non-directly related treatment can add three days on average to their stay. So reducing this is a 'really big prize'.

The goal has to be for services to be integrated across the whole pathway. A report from Diabetes UK last year aimed to share experience in delivering this integration, looking at five local models.

It has frequently been argued that the existing tariff system does not incentivise integrated care for long-term conditions – for example with some providers likely to lose out financially from changed pathways, potentially undermining broader service change. The Diabetes UK report found localities had adopted different approaches to local payment systems. In Derby, a new NHS organisation holds a pooled budget to deliver care across the pathway. North West London had



used a pilot budget to compensate providers for time spent working on additional aspects of the new pathway.

These are not the only areas pursuing integrated models across organisational boundaries. In London, Imperial College Healthcare NHS Trust had been working in partnership with Central London Community Healthcare NHS Trust to meet the needs of a population with specific challenges. In addition to high rates of diabetes, many people's first language is not English and there are high levels of deprivation and homelessness.

The joint work has focused on specialised diabetes care and has involved consultants working with community teams, including dieticians and nurses. One area where improvements have been made is podiatry. Dr David Gable, diabetes consultant at Imperial and clinical lead for diabetes at the community trust, says: 'A patient accessing podiatry has access to the whole pyramid of podiatry care, from the multi-disciplinary, high complex care foot clinic at St Mary's – where the patient might see a vascular surgeon, orthopaedic surgeon, microbiologist, diabetes specialist or a podiatrist – through to somebody doing a basic foot assessment in the community.'

He says there has been a fall in amputation rates and a reduction in length of stay more generally. Other work has looked to improve access to services for people with mental health issues and the homeless.

Ipswich and East Suffolk Clinical Commissioning Group, concerned about local outcomes compared with national averages, has sought to take an integrated approach to diabetes care across secondary and primary services. A new integrated diabetes service began in March last year, run in conjunction with The Ipswich Hospital NHS Trust.

As part of this, it wanted to support GPs in increasing the number of people with diabetes receiving all nine of the key processes beyond the 58% they were achieving at the time. But perhaps the biggest change was to introduce a team of specialist diabetes nurses working with the trust's diabetes centre to provide a hub and spoke model. The nurses have been running community-based clinics to supplement the consultant-led care and referrals to the centre. They look for risk factors, keep an eye on glucose levels and on whether people are receiving the key processes.

Underpinning the model is shared IT – the SystmOne GP system. 'We wanted a system that enabled what we had on our screen in the surgery to be seen by consultants in hospital,' says Dr John Flather, local GP and clinical lead for diabetes at the CCG. 'This means referrals can be online and [practitioners] can see a patient's whole past history, including the key care processes and what drugs they've been on.' He adds that tasks – for instance, requested by a consultant to be delivered by a GP – can be performed almost instantly.

Dr Flather says the CCG is still awaiting the first full year's audit data. 'But it looks as if sugar control in Ipswich and the East is getting better and we hope this is reaping dividends and will be reflected in fewer hospital admissions [and complications].'

Meeting rising demand

Liverpool CCG also has ambitious plans to transform diabetes to cope with – and head off – rising demand. Local estimates suggest the city's diabetes prevalence of 4.76% could nearly double (8.3%) by 2030. While the CCG historically commissioned services from two local acutes and a community provider, its ambition has been to have a contractual relationship with one lead provider, with the spend on diabetes-related care placed in a centralised budget with payment linked to outcomes.

Phase one of the new integrated diabetes service plan started in December. The aim is to provide direct specialist patient care outside hospital for everything that can be delivered outside hospital. This should mean a more convenient, seamless service for patients and a reduction in duplication and service gaps.

On top of this, people with diabetes will be supported to achieve

much greater levels of self-care and self-management. In particular, the new model provides a single point of contact for all referrals. All referrals will be seen in a multidisciplinary team clinic with a consultant diabetologist or diabetes specialist nurse. From here, patients may be further referred to specialist nurse-intensive management clinics or dietician-led clinics.

'We need to invest in a preventative model,' says Andrea Astbury, long-term conditions transformational change manager at the CCG. 'This has to be patient-centred and support self-management.'

Patient education will feature heavily with the number of currently run weekly education sessions almost tripled from 10 to 28. 'And we'll be encouraging those who have been diagnosed for a number of years to come back to education. People's conditions change, their ability to take on information at diagnosis isn't always that great. So we'll be looking to reach out into local employers and community settings.'

There will also be monthly support sessions for practice nurses, with specialist nurses helping practices to review diabetes patient lists or support clinics. And there will be a package of consultant support for GPs and a helpline for patients and healthcare professionals.

Perhaps one of the most intriguing aspects of the new service is the plan to move to an outcome-based contract after a transition period that will last until the end of 2015/16. So the link with simple activity and interventions will be broken and block arrangements will encourage providers to move support upstream and avoid complex hospital-based interventions wherever possible.

"It isn't going to be easy but what matters for patients is that they won't lose their sight or have an amputation as a direct result of their diabetes"
Andrea Astbury, Liverpool CCG

Ms Astbury says there is a lot of talk about outcomes-based contracts, but they are often really based on outputs. 'It isn't going to be easy, but from engagement with patients it is clear that this is what is meaningful to them,' she says. 'It wasn't having nine care processes or the time they are seen; what matters for them is that they won't lose their sight or have an amputation as a direct result of their diabetes.'

So outcome measures include metrics covering reductions in the proportion of people with all the key complications, such as circulation problems, impaired vision, stroke or amputations, and those having serious hypoglycaemic episodes. In the transition period, the CCG has agreed to cover the additional costs incurred by the three providers (Aintree Hospitals, the Royal Liverpool and Broadgreen, and Liverpool Community) and to protect the trusts' tariff-based outpatient income against potential drops in activity.

Not all care is currently covered by the new service, but with a total contract value for 2015/16 of £2.3m, it already represents more than 40% of the CCG's total £5.6m spend on diabetes care in acute and community settings. To an extent, outcomes are already being reflected in the funding, with the CCG using the CQUIN mechanism to link 2.5% of the contract value to maintenance of the baseline outcome metrics – a challenge in the context of a growing and increasingly complex cohort of patients. While a similar approach is likely to be used with the main outcome-based contract, the level of the contract value that will be linked to outcomes has yet to be agreed.

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