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NWL Diabetes- A Transformational Learning

Dr Buchi Reddy, Deputy Programme Director

NWL Diabetes Transformation Programme

know diabetes

- Background
- The North West London Diabetes Transformation Programme
- Digital Initiatives
- Case Studies
- Results North West London
- Learning & Insights

Background

Background: North West London – a complex landscape

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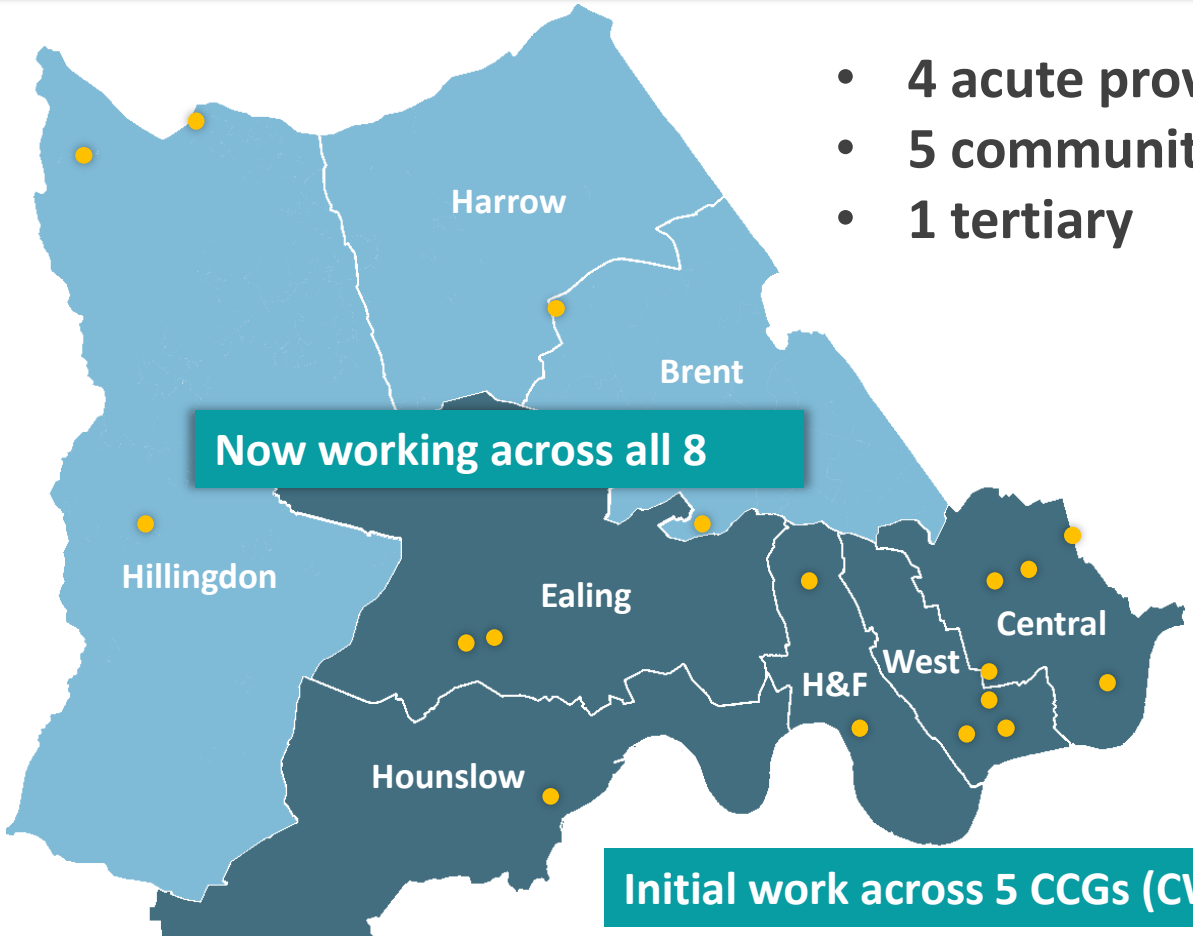

- 4 acute providers (3 on multiple sites)
- 5 community providers
- 1 tertiary

Initial work across 5 CCGs (CWHHE)

Background: NWL data

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148000 patients in NWL with diabetes

41% of all NWL admissions

63% of bed days (36% have a coded complication)

£598m NWL spend on diabetes patients (~22%)

377 additional beds by 2028 – a medium size hospital

Hospital admissions for diabetes patients

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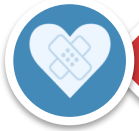
6,623 admissions with angina

25,111 admissions with ischaemic heart disease



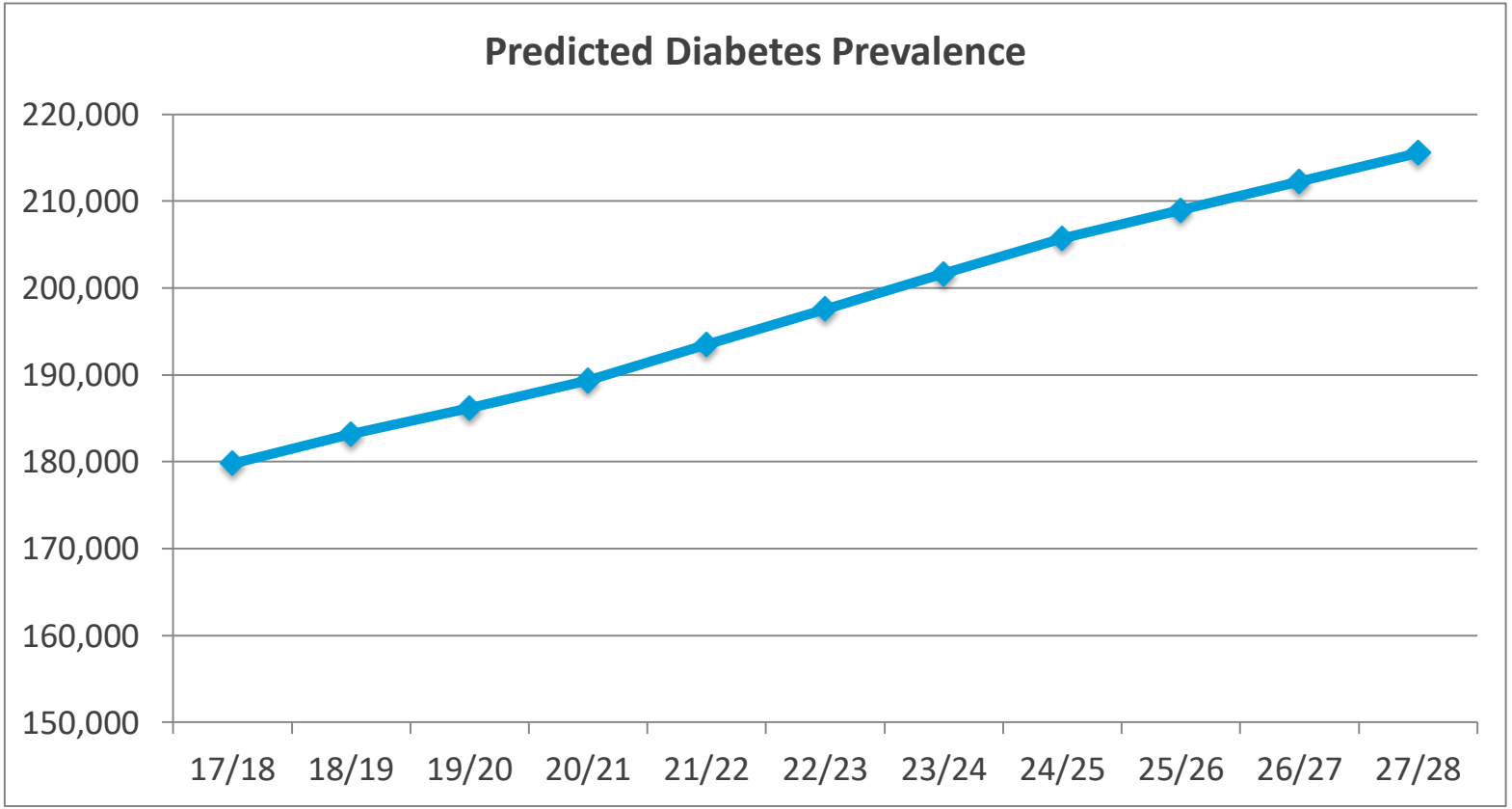
13,644 admissions with heart failure

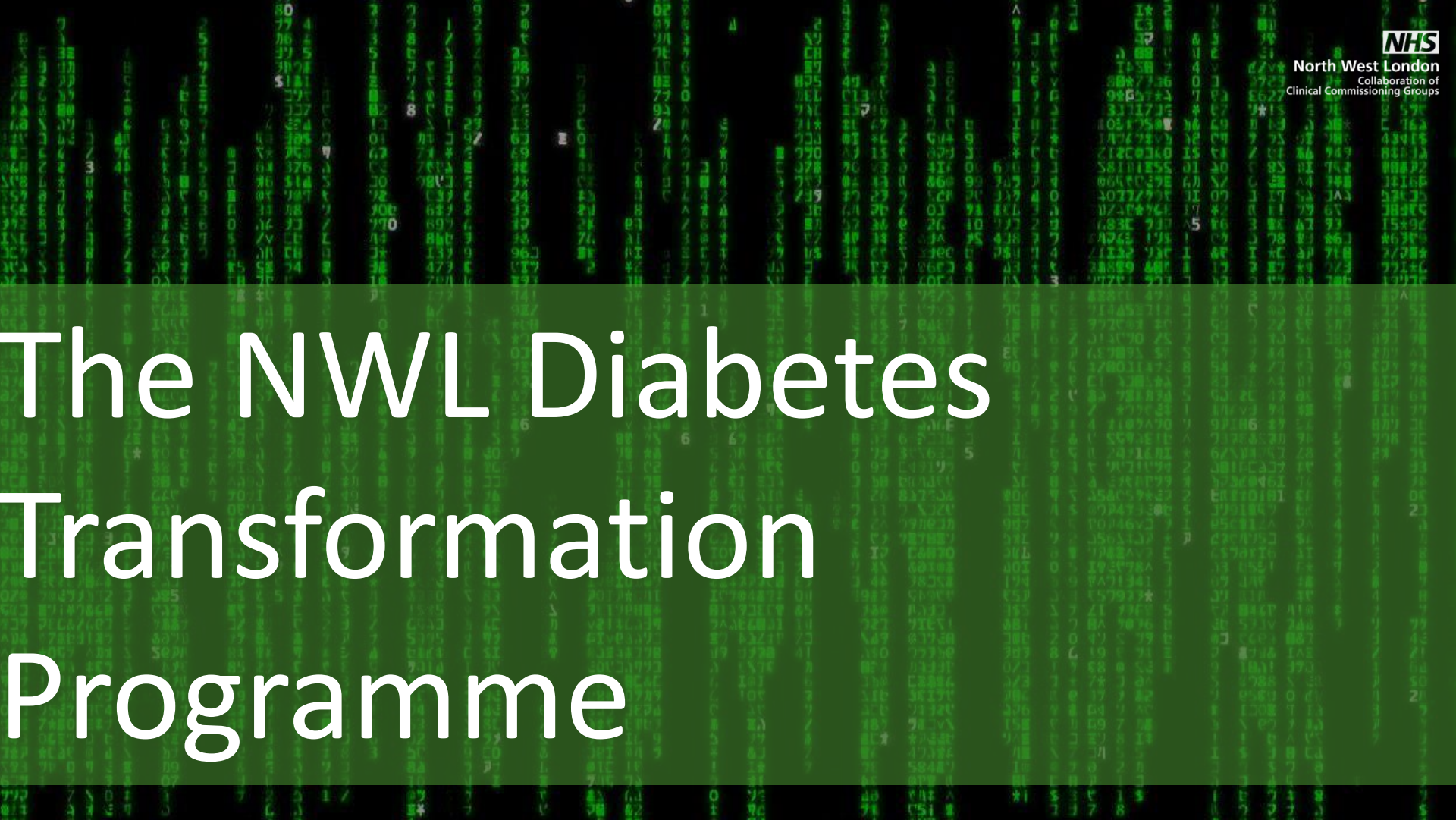
1,606 admissions with a stroke

10,745 admissions with acute kidney injury

9,405 admissions with foot complications

Future state modelling

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The NWL Diabetes
Transformation
Programme

Mission Statement

Our mission is:

- to create a patient-centred seamless diabetes service in which patients are seen by the right person at the right time in the right place.
- to achieve better patient experience, better outcomes, better value and better staff satisfaction.
- to drive innovation, using a “digital first” approach to encourage self-care through information and education and to support new ways of communicating with patients.
- to maximise support for lifestyle change, prevention of type 2 diabetes and achievement of type 2 diabetes remission.

Principles

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- Patient empowerment: collaborative care planning
- Clinician education
- Networks and MDTs
- Dashboards
- Contracts
- Clinical system optimisation
- Clinical guidelines

Programme Management *through* Products (deliverables)

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1. Pathway *(face-to-face and digital) / website / contact centre / Behaviour change apps / ↑options of SE*
2. **Clinical transformation / staff education (PITSTOP / D10pt) →Virtual clinics→eConsultations →**Dashboards →Unified Service Specification
3. Network→ MDfT Podiatrists→Pathway →Weekend MDFT Clinics→Dashboard→NHS E metrics / surveillance
4. NDH register→ Annual reviews→ referral NDPP→ Uptake →reduce number NDH to type 2 diabetes

Learning

MEASURE IMPROVEMENT

DEVELOP DIGITAL CAPABILITY

WRITE THE BUSINESS CASE

BUILD THE TEAM

ENGAGE STAKEHOLDERS

Acknowledgement to Dr Tony Willis

Local incentive scheme existed in 5 of the NWL CCGs since 2016

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Key standards included:

- 9 key care processes
- NICE 3 treatment targets (cholesterol ≤ 4)
- Care planning
- Structured education
- Hypoglycaemia monitoring
- Non-diabetic hyperglycaemia

		% Diabetes prevalence	% 9 key care processes in 15m	% HbA1c, BP, Lipids to target	% HbA1c ≤ 58	% BP ≤ 140/80	% Chol ≤ 4	% patients on Atorvastatin 20mg+	% Care planning in 15m	% Hypoglycaemia monitoring	% Structured education in newly diagnosed
		4.0	85.4	33.3	70.8	88.5	49.0	41.7	90.6	93.5	60.0
		10.8	74.1	30.5	57.7	69.5	63.2	64.9	76.6	79.8	100.0
		7.7	64.8	30.1	60.1	77.7	46.6	70.5	72.0	87.8	100.0
		8.2	74.9	24.8	62.8	73.3	47.3	70.6	79.7	94.7	100.0
		4.8	78.2	24.5	64.2	68.1	51.1	51.5	93.9	97.1	100.0
9791	483	4.9	64.0	23.8	61.1	77.0	41.6	46.2	76.8	86.3	100.0
2837	280	9.9	56.8	23.2	57.1	84.3	40.0	27.5	17.9	57.7	63.2
2532	122	4.9	72.4	21.1	47.2	78.9	56.1	72.4	82.1	95.9	91.7

NICE 3 Treatment Targets

HbA1c ≤58 mmol/mol, Cholesterol ≤5 mmol/L, BP ≤ 140/80

For every 3-4% annual improvement in the 3 Treatment Targets, there is a reduction in the complications of Diabetes Mellitus which releases financial savings

CCG	Network	es register	y care processes in 15m	trolled NICE targets (HbA1c, BP, lipids)	1c ≤ 53 in newly diagnosed	1c ≤ 58	140/80	≤ 4	planning in 15m	oglycaemia monitoring	ctured education in newly diagnosed	abetic hyperglycaemia register	diabetes ratio	% NDH annual review	% NDH referral to NDPP
Central	Cen													.00	40.2	45.2
	Nor													.84	46.0	54.8
	Sou													.06	58.8	58.3
Central Total														.89	38.8	39.0
Ealing	Sou													.94	46.4	49.7
	Acto													.87	57.0	59.7
	Cen													.08	65.0	57.8
	Nor													.01	48.1	44.6
	Sou													.77	44.2	41.7
	Sou													.92	23.7	34.4
	Nor													.93	41.2	45.9
Ealing Total														.14	56.5	60.3
H&F	Cen													.94	49.8	50.7
	Nor													.92	44.3	47.4
	South	2381	38.3	18.3	68.0	59.8	58.5	40.3	58.2	78.8	54.0	1868	0.78	33.5		
H&F Total		8638	47.0	19.4	69.2	58.1	61.1	41.6	66.7	82.7	55.7	6092	0.71	35.3		
Hounslow	HoH	5602	65.7	21.3	68.6	60.2	66.8	43.9	77.7	94.5	79.5	5919	1.06	47.6		
	Brentford	3258	55.8	19.7	70.9	63.0	59.5	40.6	71.9	82.1	73.0	3283	1.01	43.3		
	Feltham	4373	64.1	21.2	65.3	58.4	69.3	40.6	79.9	90.2	79.1	3086	0.71	33.6		
	Chiswick	1624	63.4	23.4	71.7	63.5	70.7	41.4	77.6	90.7	77.1	1833	1.13	38.4		
	Great West	4838	57.7	17.8	63.2	57.4	63.1	39.2	69.4	85.8	69.9	4376	0.90	31.2		
Hounslow Total		19695	61.6	20.3	66.8	59.8	65.6	41.3	75.2	89.1	75.8	18497	0.94	39.7		
West London2	North	4085	59.4	20.3	68.3	57.8	65.4	42.4	70.6	83.9	74.4	3261	0.80	42.7		
	North Central	2429	49.5	18.9	63.9	58.6	66.6	38.9	70.2	84.3	67.2	1056	0.43	35.7		
	South East	1402	50.1	20.8	73.4	64.7	62.5	41.2	62.8	84.4	65.2	762	0.54	29.3		
	South West	2448	52.3	20.4	64.3	57.3	65.6	38.9	71.5	87.1	63.1	1648	0.67	40.2		
West London2 Total		10364	54.1	20.1	67.2	58.8	65.3	40.6	69.7	84.7	68.6	6727	0.65	39.5		
Grand Total		75417	54.6	20.0	66.7	58.9	64.7	41.3	70.8	83.5	70.3	58879	0.78	34.3		

	North	2522	47.8	17.2	62.8	56.0	61.2	38.7	69.7	89.7	51.9	1753	0.70	56.5	68.2	
	South	2592	51.1	19.3	66.5	60.1	59.0	39.9	72.8	86.9	67.2	2442	0.94	40.9	42.3	
H&F Total		9000	53.3	20.4	68.0	59.9	61.2	42.2	72.4	89.1	64.6	7768	0.86	46.0	50.5	
Hounslow	HoH	5948	69.7	29.9	68.9	61.1	72.7	55.1	83.7	96.8	86.9	6899	1.16	62.1	63.6	
	Brentford	3334	54.9	23.4	73.8	62.2	62.5	46.3	73.7	90.8	76.1	3493	1.05	45.3	49.8	
	Feltham	4715	59.6	25.8	70.9	57.8	69.4	49.9	79.4	94.9	83.9	3697	0.78	52.9	52.7	
	Chiswick	1616	61.6	26.9	74.0	64.8	69.6	49.4	76.6	93.7	78.9	1975	1.22	49.0	45.8	
	Great West	5076	62.4	21.3	63.6	57.8	64.5	44.5	77.1	93.7	77.4	4892	0.96	44.7	44.8	
Hounslow Total		20689	62.6	25.6	69.0	60.0	68.1	49.5	78.9	94.4	82.0	20956	1.01	52.4	53.3	
West London2	North	4437	59.1	22.8	69.8	59.8	65.9	44.6	74.2	91.9	68.5	4486	1.01	50.6	55.6	
	North Central	2149	56.4	19.5	66.8	59.0	62.8	40.8	74.1	92.3	72.2	2170	1.01	34.4	38.9	
	South East	1422	51.6	22.6	71.3	62.9	63.1	42.7	71.2	94.1	72.5	1019	0.72	47.3	49.2	
	South West	2539	61.8	22.8	67.5	58.4	68.4	42.0	75.0	92.5	65.3	2371	0.93	51.4	62.0	
West London2 Total		10547	58.2	22.1	68.9	59.7	65.5	43.0	73.9	92.4	68.9	10046	0.95	46.9	52.9	
Grand Total		78479	60.2	22.9	68.7	60.1	66.1	45.5	77.4	91.9	76.1	74540	0.95	49.4	51.6	

GP's view: Individual and population dashboards

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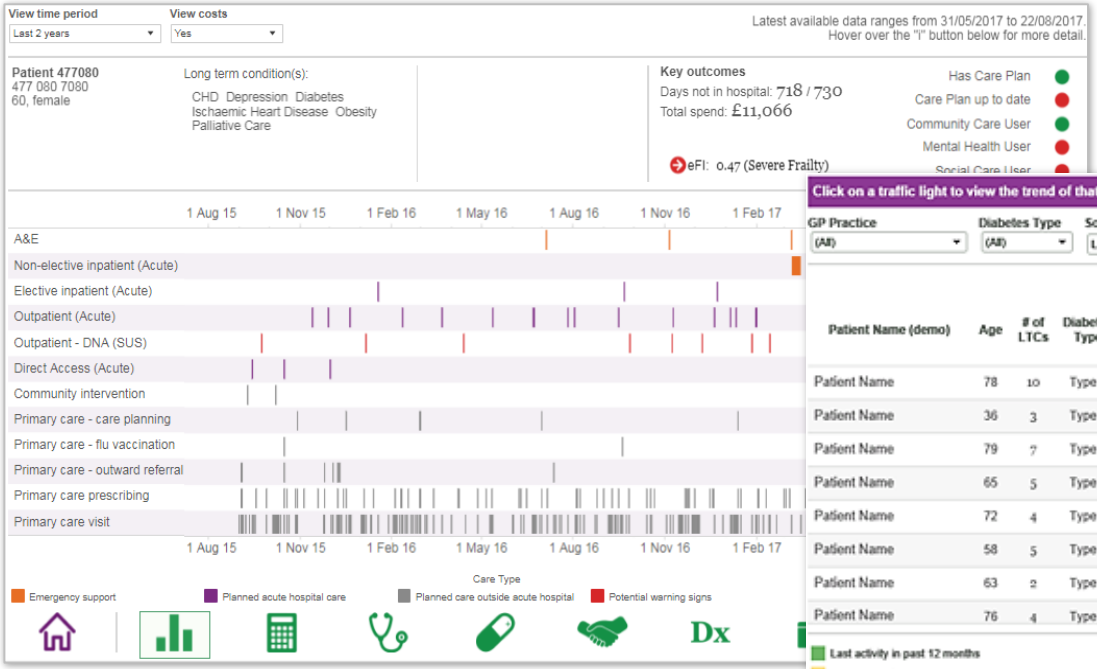

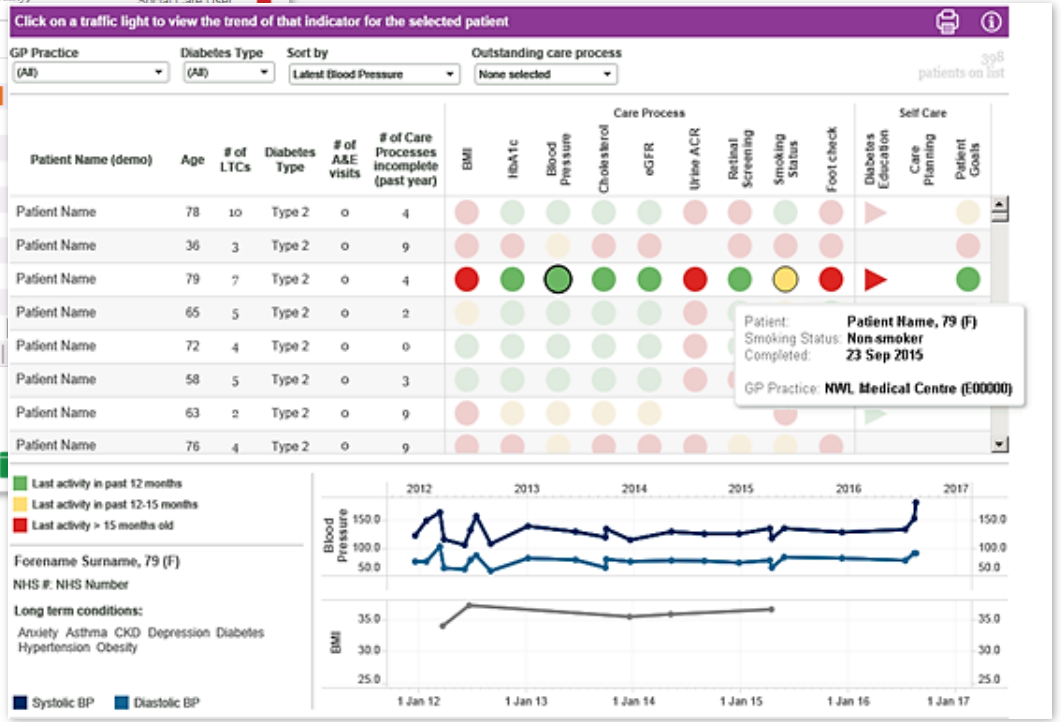

Integrated Service Specification

Service Specification

Care Pathway/Service	**North West London Integrated Diabetes Service** For people at high risk of type 2 diabetes or with a diagnosis of diabetes mellitus
Commissioner Leads	Lesley Robertson / Tony Willis (I CCGs) Jonathan McInerny / Charis Cro Ben Smith (NHS Central London Raj Chandok (NHS Ealing CCG) Angela Caulder (NHS Hammersr Jason Parker (NHS Harrow CCG) Katrina Watson (NHS Hillingdon

Key Performance Indicators

I am told about services that are available to someone in my circumstances	
1.1 Effort is put in to identify patients early and minimise any prevalence gaps, both for Non-Diabetic Hyperglycaemia and Diabetes	a) Non-Diabetic Hyperglycaemia prevalence vs diabetes prevalence b) Diabetes actual prevalence vs expected
I have the information and support I need in order to make decisions and choices	
2.1. Patients are referred to appropriate health promotion, support and education services	a) % Patients with NDH offered referral to NDPP b) % Patients with existing diabetes attending structured education in last 5 years c) % Patients with NDH or diabetes referred to NWL Know Diabetes information hub d) % Patients achieving remission from Type 2 diabetes e) % Patients provided with peer support, coaching or mentoring
er worker, a	% Patients with newly diagnosed diabetes attending structured education within 1 year of diagnosis
treat my physical and emotional health separately. My contacts with professionals should be opportunities to identify other mental	
essed for	1. % Patients with PHQ-4 / DDS-2 and PAM score
mplications and live a life that's normal for me	
ld work in	a) 9 key care processes b) HbA1c ≤86 c) HbA1c ≤53 in newly diagnosed (first 2 years) d) Achieving all 3 NDA Treatment Targets (HbA1c ≤58, BP ≤140/80, Cholesterol ≤5) e) Achieving all 3 Treatment Targets (HbA1c ≤58, BP ≤140/80, Cholesterol ≤4)
hospital data)	a) Reduction in cardiovascular complications (MI, Angina, Ischaemic heart disease, Heart failure, Stroke, TIA) b) Reduction in foot amputation rates

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Integrated Diabetes Care Pathway Service Specification

July 2018

Programme support for

- **Commissioning intentions**
- **Diabetes Structured Education Contracting Options**

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Stakeholder mapping, vigilance and analysis- Get them on board!

1. Improve patient experience
2. Improve patient outcomes (9 key care processes, NICE treatment targets)
3. Support patient self management
4. Reduce hypoglycaemia episodes
5. Reduce complications
6. Prevention of T2DM (and now remission)
7. Upskill the workforce and improving their experience
8. Save costs


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Digital Initiatives

Digital Initiatives

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Clinical System Optimisation

Integrated Records

Digital Structured Education - apps

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Digital Programme Alignment - Activities

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Strategic Programme Vision & Delivery Activity

- Single unified approach to diabetes treatment across the NWL STP
- Specify and Realign models of commissioning and provision
- Redefining good practice, educating staff, changing health professional focus
- Changing population behaviours, achieving at-scale Diabetes avoidance/remission
- Embedding evaluation at programme, population and patient levels

Digital Transformation Activity

- Building a portfolio of enabling projects
- Influencing NWL Informatics & BI decision making
- Collaborating with internal and external stakeholders
- Directing virtual teams to build/adapt service infrastructure and systems
- Building strong and transparent integrated project controls & governance

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Diabetes Information and Support Service will drive scale

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… Receive referrals from across NWL

… Triage patients to most appropriate intervention

Proactive life-long personalised support

myway digital health · Dynamic Health Systems · Microsoft · THE BEHAVIOURAL INSIGHTS TEAM

… Drives at scale engagement and on-boarding, bypassing need for individual referral by primary care. Similar to retinal screening

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Contact Centre Concept

- Single point of referral for all lifestyle change interventions in patients with diabetes and non-diabetic hyperglycaemia

- Assess suitability and refer for different options including face to face, digital behaviour change interventions, mentoring / coaching, eLearning

- Entry onto health focused “customer” relationship management system (CRM) – this may be automated via GP system as part of the original referral

- Tracking of patient progress and activity with semi-automated messaging to patient

Team working: Relational Marketing, CRM and Internal Marketing

Creating a sense of urgency for change
Clarity of vision, Mission & Goals
Listen to stakeholders-they are your critical friends!
Listen to team members- they are trying to help you!
Regular team feedback- quality circles, TQM, lean philosophy

Integrated records

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North West London Whole Systems Integrated Care

An integrated care record including primary, secondary and social care data: NHS-owned

Sources

- Primary care
- Secondary care
- Community
- Mental health
- Social care

Integrated Record

Capabilities

- Clinical record
- Risk stratification
- Per patient costing
- LTC dashboards
- Population health

Over 2 million patient records: linked by NHS number

Clinical model: Intelligent proactive case management and MDT working

Proactive disease management capability through upscaled primary care

Risk stratification and monitoring of patients at ACS, locality or federation level based on:

1) Current health status (e.g. poor diabetes control)
2) Engagement (attendance at clinics, PAM score)
3) Mental health barriers
4) Social barriers to health

Generalism

Continuity of care

Registered population

Holistic

Virtual MDT

- Coaching / Care navigators
- Social prescribing
- Mental health
- Specialist support
- Pharmacy

Patient	Care model
On diabetes register Good diabetes control Engaging with services	**Routine care**
Off target (dependent on disease duration, frailty, etc) **AND/OR** Not seen in last 3-6 months **AND/OR** At least one diabetes related admission **AND/OR** Psychological / social issues interfering with ability to cope	**Active case management:** Care coordinator Regular phone support Health coaching Psychological support Virtual Multi Disciplinary Team review

Programme Management *through* Products (deliverables)

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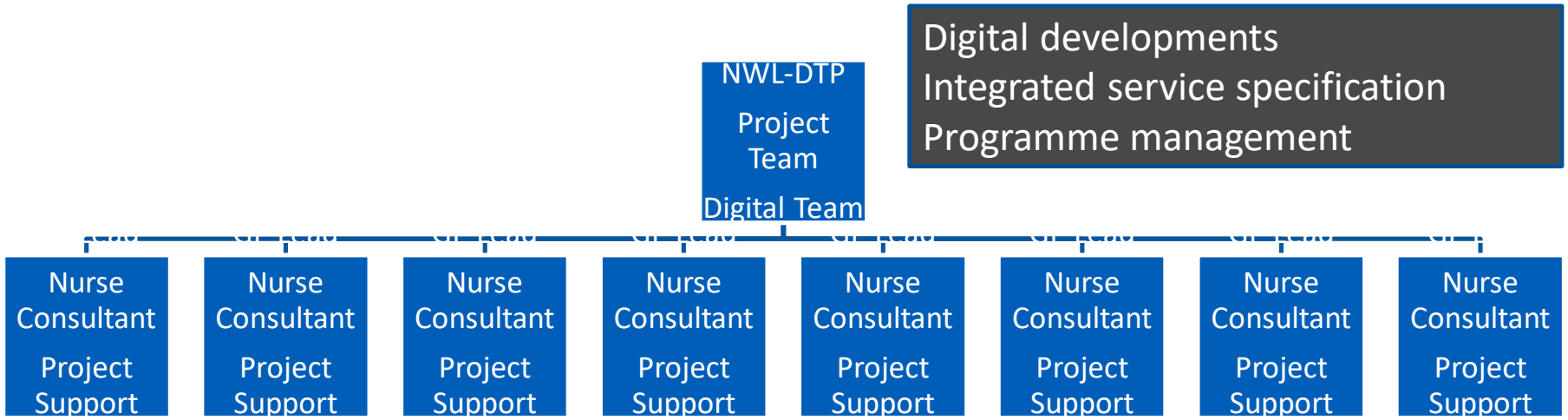
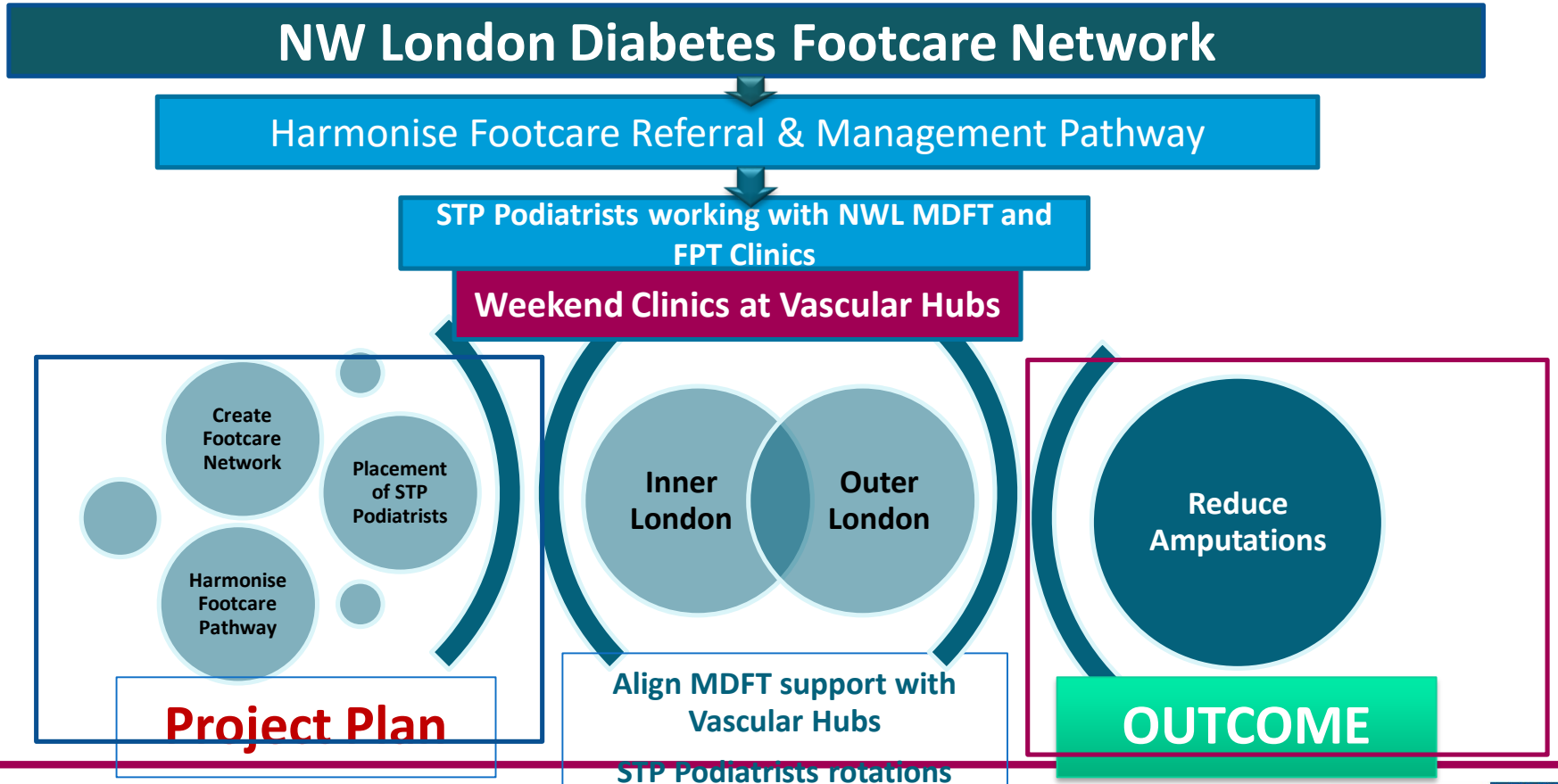
1. Pathway *(face-to-face and digital) / website / contact centre / Behaviour change apps / ↑options of SE*
2. **Clinical transformation / staff education (PITSTOP / D10pt) →Virtual clinics→eConsultations →**Dashboards →Unified Service Specification
3. Network→ MDfT Podiatrists→Pathway →Weekend MDFT Clinics→Dashboard→NHS E metrics / surveillance
4. NDH register→ Annual reviews→ referral NDPP→ Uptake →reduce number NDH to type 2 diabetes

Big team- A Bigger Responsibility



Support primary care improvement
Focus on practices achieving lowest scores on dashboards

NWL MDFT - MODEL OF CARE



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THE TEAM: NWL Multidisciplinary Foot team

- **Diabetes Specialist Podiatrists recruited**
  - Band 8A x 1 – Lead podiatrist
  - Band 7 x 4 – Specialist Podiatrists
  - Band 6 x 1 – Podiatrist
- **Placements / Rotation across NW London**

  Outer NWL
  - Central London Community Care (community)
  - Central Middlesex Hospital
  - Hillingdon hospital
  - Ealing hospital (& community)
  - Northwick Park Hospital – Outer NWL Vascular hub
  - Central North West London Health Care (Community)

  Inner NWL
  - Imperial College hospitals – St. Mary's & Hammersmith hospital
  - Central London Community Care (inner NWL)
  - Chelsea and Westminster Hospital
  - Hounslow and Richmond Community Trust
  - West Middlesex hospital

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Case studies

Case study 1: Southall, Ealing

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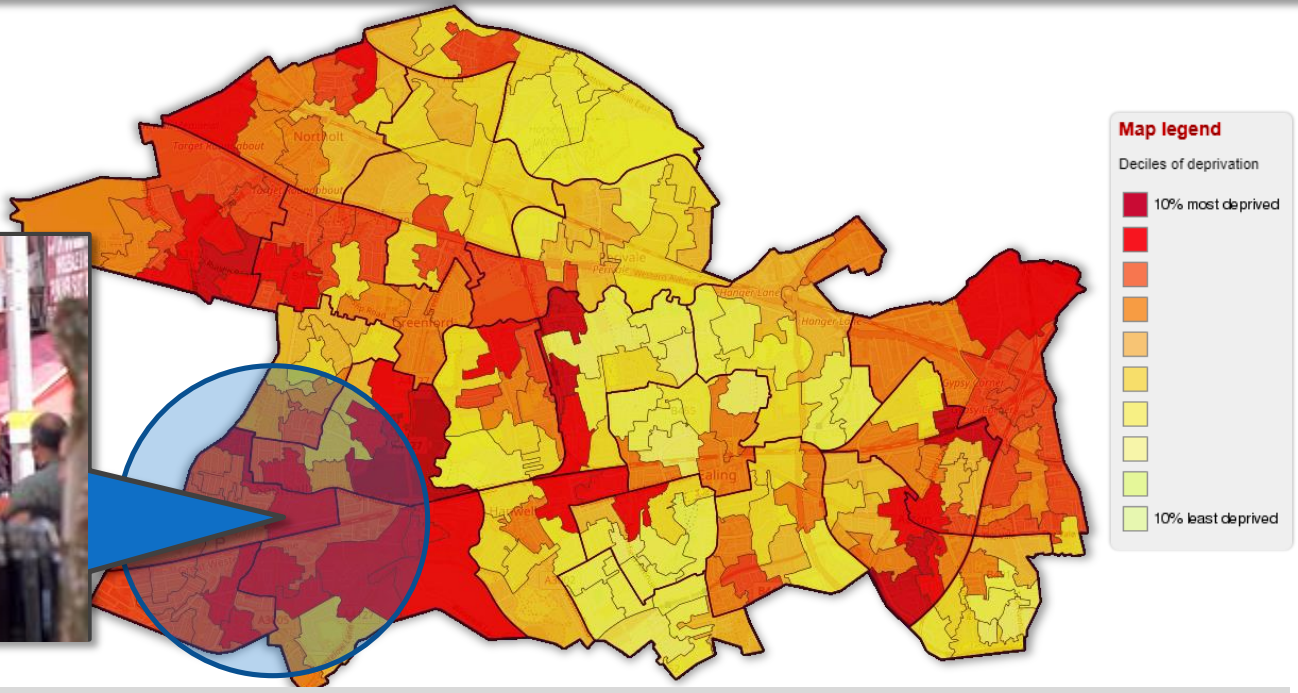

12,077 patients with diabetes

43% born outside UK, **48%** Asian

Support from community diabetes team and federation

Case study 1: Community team and GP federation, Southall

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January 2017

Network	List size	Diabetes register	% Diabetes prevalence	% 9 key care processes in 15m	% HbA1c, BP, Lipids to target	% NDA 3 Treatment Targets	% HbA1c ≤ 58	% BP ≤ 140/80	% Chol ≤ 4	% patients on Atorvastatin 20m	% Care planning in 15m	% Hypoglycaemia monitoring
North Southall	2452	209	8.5	79.9	41.6	53.5	65.6	87.6	67.0	81.3	61.7	96.6
North Southall Total	66											
South Southall	3											
	8132	554	6.8	47.3	13.0	26.3	40.4	63.2	32.9	40.1	28.7	50.9
South Southall Total	50760	4709	9.3	43.1	15.5	32.6	49.3	65.3	36.5	38.4	62.6	68.0
	117653	11493	9.8	42.2	16.2	33.2	52.5	64.1	36.8	39.1	56.4	64.9

March 2018

Network	Diabetes register	% Diabetes prevalence	% 9 key care processes in 15m	% HbA1c, BP, Lipids to target	% NDA 3 Treatment Targets	% HbA1c ≤ 58	% BP ≤ 140/80	% Chol ≤ 4	% patients on Atorvastatin 20m	% Care planning in 15m	% Hypoglycaemia monitoring
North Southall	222	9.9	70.7	50.0	62.6	70.7	89.6	68.5	79.3	93.2	98.9
				27.4	42.9	60.9	79.7	50.0	41.0	83.5	94.4
				26.6	43.3	58.5	74.7	49.1	56.1	9.3	90.3
				25.5	43.5	63.5	75.9	42.8	60.8	92.3	95.5
				21.8	36.3	60.4	72.7	46.7	50.1	86.9	99.2
				21.7	39.8	66.8	66.1	43.0	37.2	96.7	99.3
				21.3	35.4	55.7	70.4	44.1	50.0	34.5	50.0
				21.1	36.9	52.4	73.8	44.1	45.9	78.7	85.6
				20.4	39.0	56.9	81.4	40.9	56.1	81.3	90.8
				19.8	46.8	59.4	75.6	38.6	34.5	91.4	97.7
				19.3	35.5	61.8	57.2	43.2	40.7	81.1	94.4
				18.5	35.8	56.2	66.9	41.5	40.4	82.3	95.5
				15.8	34.0	55.3	60.1	34.8	42.0	84.8	95.4
North Southall Total				13.4	31.0	47.8	54.0	32.1	35.7	76.3	96.1
South Southall				22.1	39.3	58.9	71.3	43.3	48.1	78.7	90.6
				0	42.4	53.7	74.1	43.4	38.1	86.0	98.3
					39.9	52.3	74.5	43.9	46.1	79.4	91.5
					6	51.4	66.7	42.5	36.0	77.3	89.3
						57.6	63.1	46.7	61.2	89.8	94.2
				20.0		5.4	69.5	38.2	38.4	83.7	96.8
				17.2	27.7	55.3	58.3	44.3	52.0	96.3	97.7
				16.6	34.2	54.4	63.7	40.7	45.0	91.5	98.4
	444	9.4	37.4	14.9	31.9	53.4	60.8	36.3	36.0	65.8	83.0
South Southall Total	4905	9.6	60.9	19.0	36.2	54.5	65.7	41.8	44.8	85.5	94.7
	12052	10.1	60.8	20.8	38.0	57.2	69.0	42.7	46.8	81.5	92.2

4.8% increase in NICE 3TT.

For every 3-4% annual improvement in the 3 Treatment Targets, there is a reduction in the complications of Diabetes Mellitus which releases financial savings

Case study 2: Hounslow

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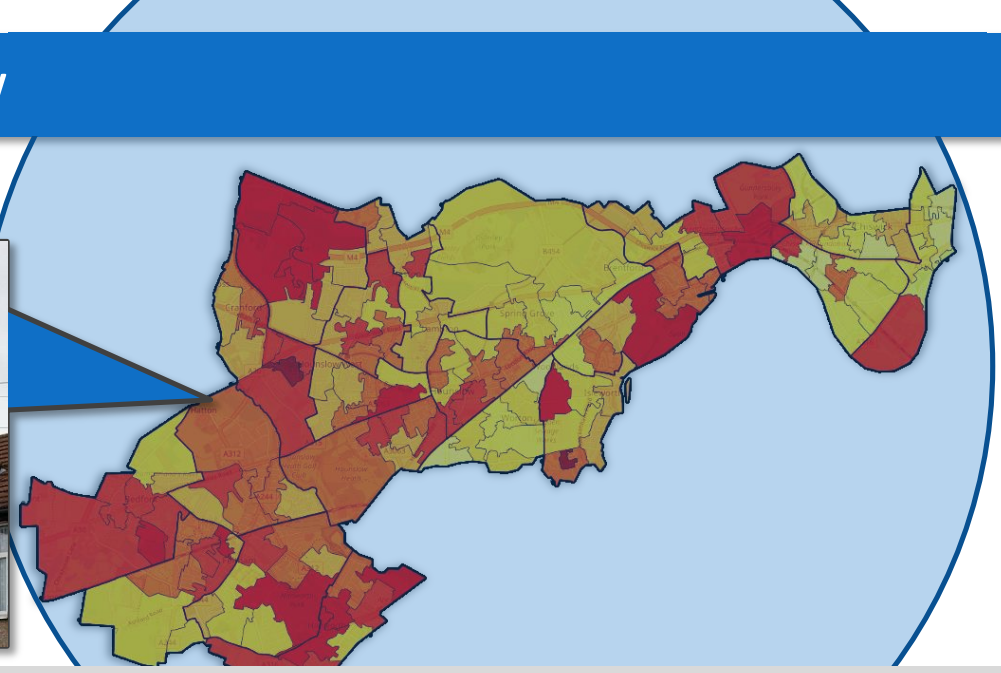
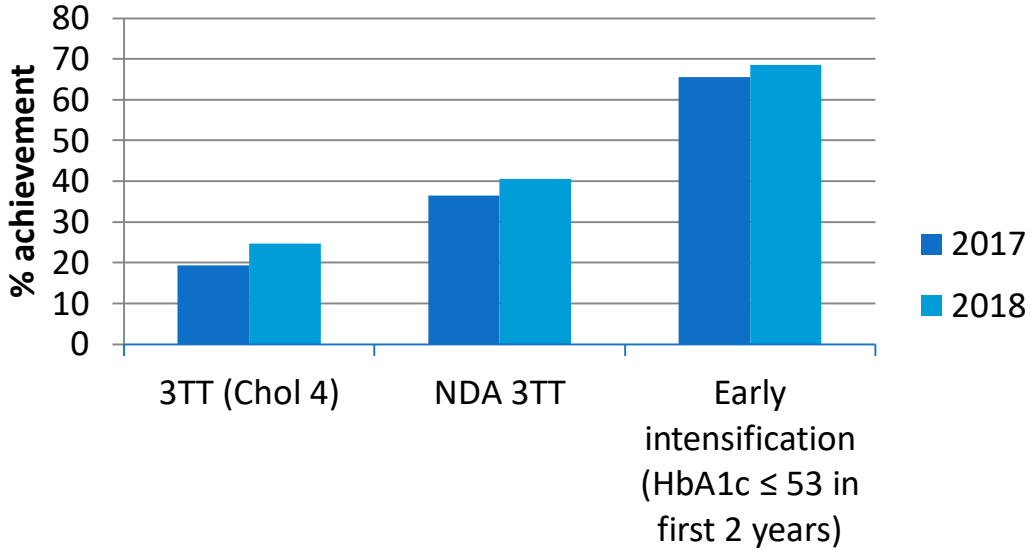


20,612 people with diabetes

46.7% from BME backgrounds

What happened? Locality meetings, whole CCG learning events, use of patient-level dashboards, large increase in structured education uptake

Case study 2: Whole CCG transformation, Hounslow



4% improvement in NICE (NDA) 3TT

For every 3-4% annual improvement in the 3 Treatment Targets, there is a reduction in the complications of Diabetes Mellitus which releases financial savings

NHS
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Collaboration of
Clinical Commissioning Groups

Results NWL

Impact: Significant improvements since November 2016

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28,905 more receiving 9 key care processes

4,884 more with HbA1c ≤ 58

3,790 more achieving 3TT

11,148 more on NICE recommended statin

26,171 more monitored for hypoglycaemia

> 55,000 more with collaborative care plan

Impact: Improvements in key parameters

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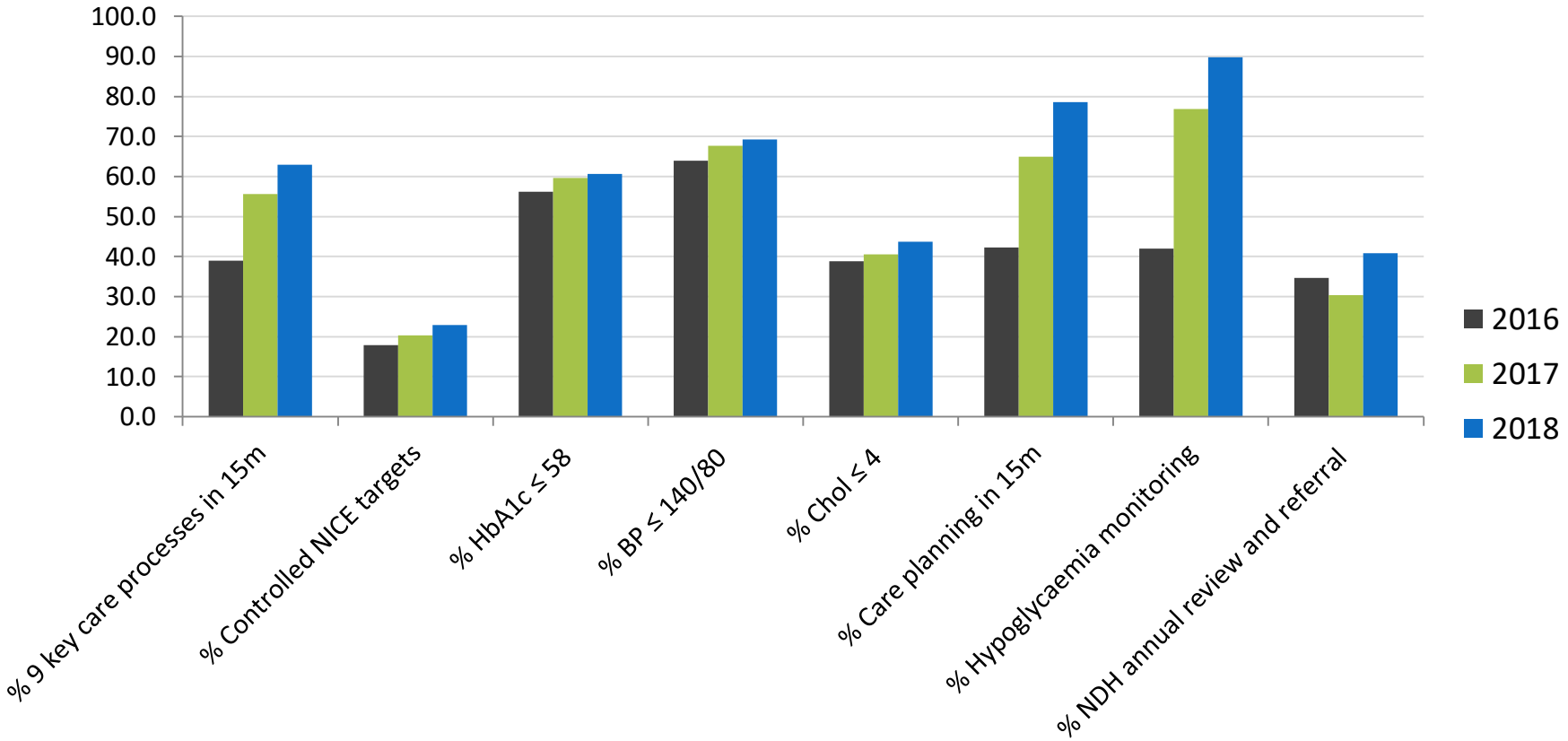

Strategic case

- Scale of problem
- Impact of transformation vs do nothing on health economy
- Impact of transformation vs do nothing on people's lives

Impact on new diabetes diagnoses

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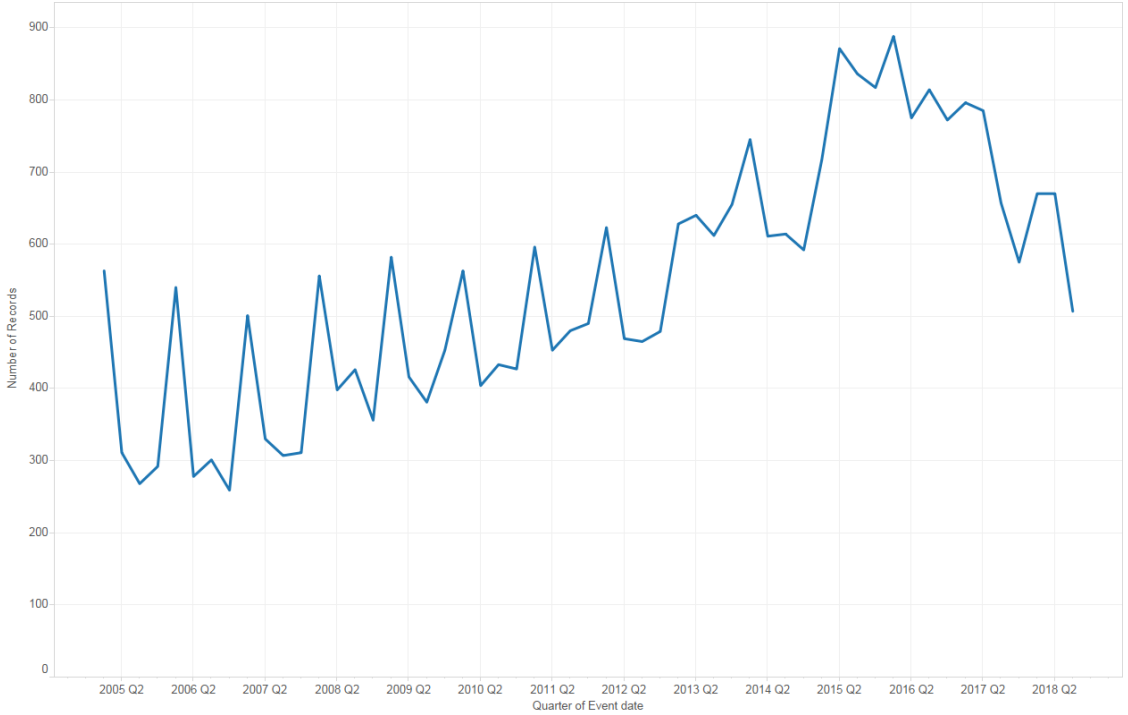
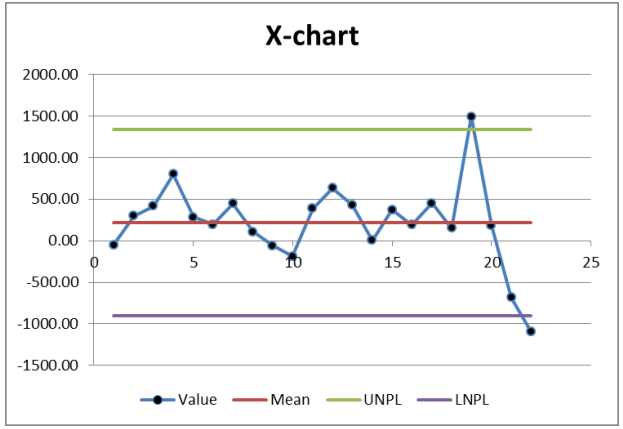
Numbers of new diagnoses per quarter since 2005 had been steadily rising until end of 2015. Peak at the point primary care diabetes contract introduced in 5 CCGs followed by National Diabetes Prevention Programme

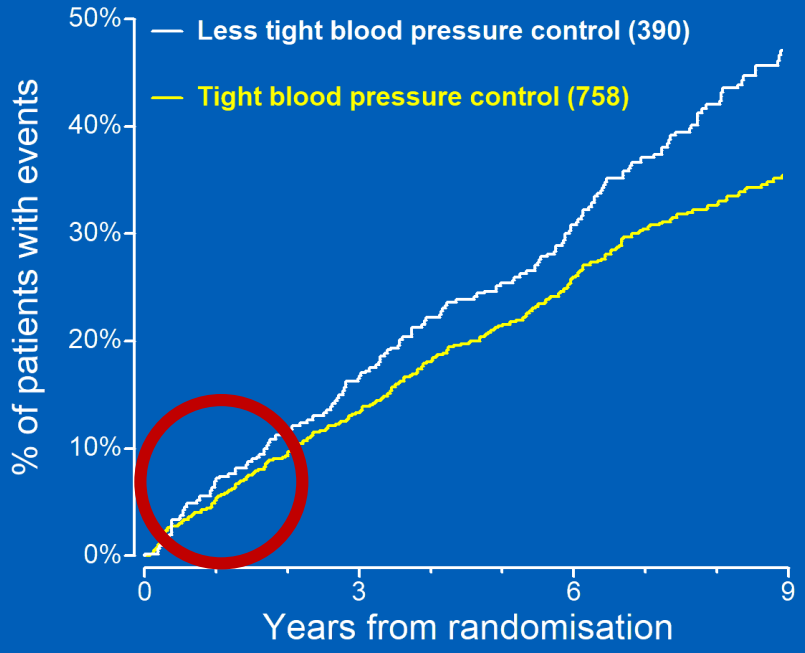




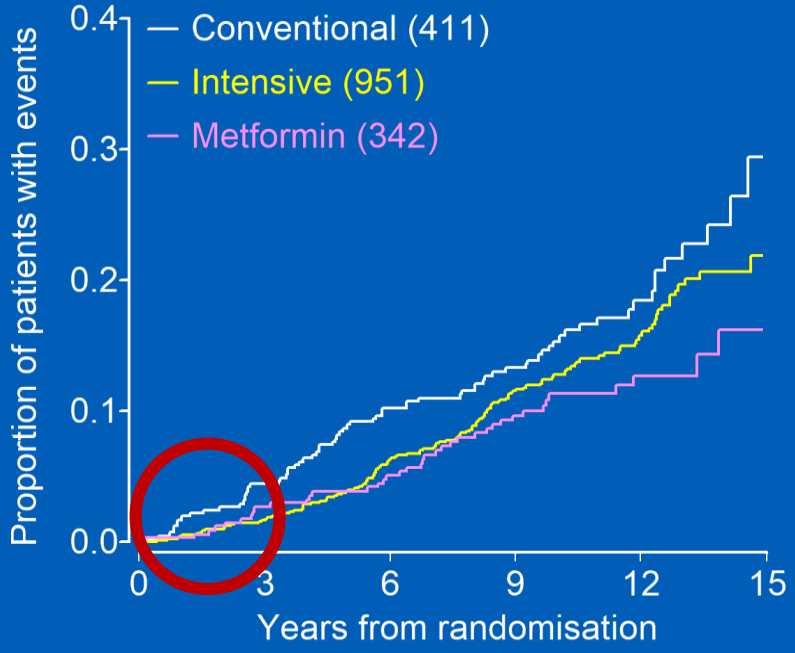
Statistical process control chart shows that reduction in new diagnoses hit statistical significance this year

UKPDS

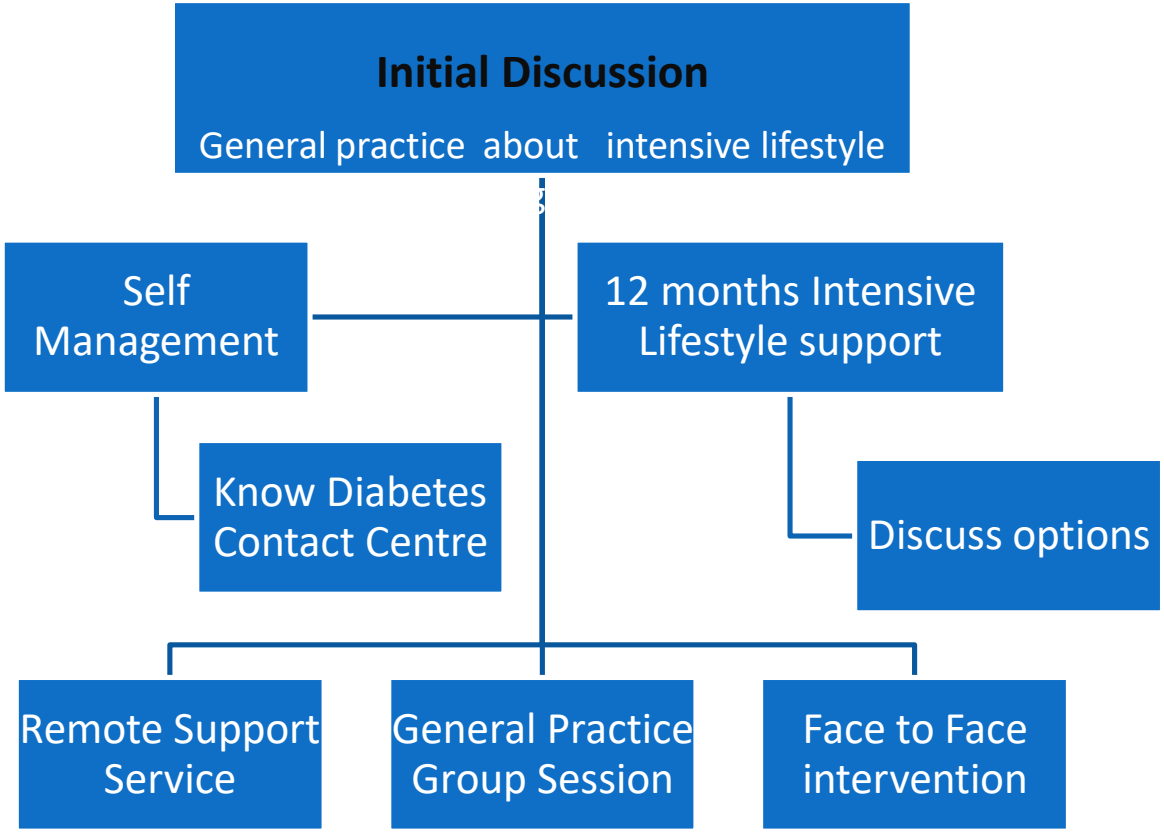
Impact of more intensive blood pressure achievement on all diabetes-related end points



Impact of metformin or more intensive glycaemia reduction on risk of myocardial infarction



Patient Journey to Lifestyle management and Support



NWL REWIND Type 2 Diabetes Pathway

PRIMARY CARE informs Patient by Text

Patient confirms diet start date and informed to make deprescribing appointment with GP

GP Notified

TOTAL DIET REPLACEMENT	LOW CARB DIET
Primary care team contact patient, issue glucometer and stop repeat **diabetes and BP** medication on clinical system according to guidelines, arrange	Primary care team contact patient, issue glucometer and stop repeat **diabetes** medication on clinical system according to guidelines, arrange

PRIMARY CARE Monitoring

1 & 2 week; 1 and 2 month primary care follow up:
Blood pressure, Check glucometer reading

3, 6, 12month primary care follow up:
HbA1c, Blood pressure, Body mass index

Provider Notified

TOTAL DIET REPLACEMENT	LOW CARB DIET

Primary care notified if patient drops out or does not lose weight in order to restart medication.
Patient is communicated to by ICS as a reminder to notify GP of this. ICS will send quarterly GP reports with patients at different stages.

Weeks 1 Initial Assessment

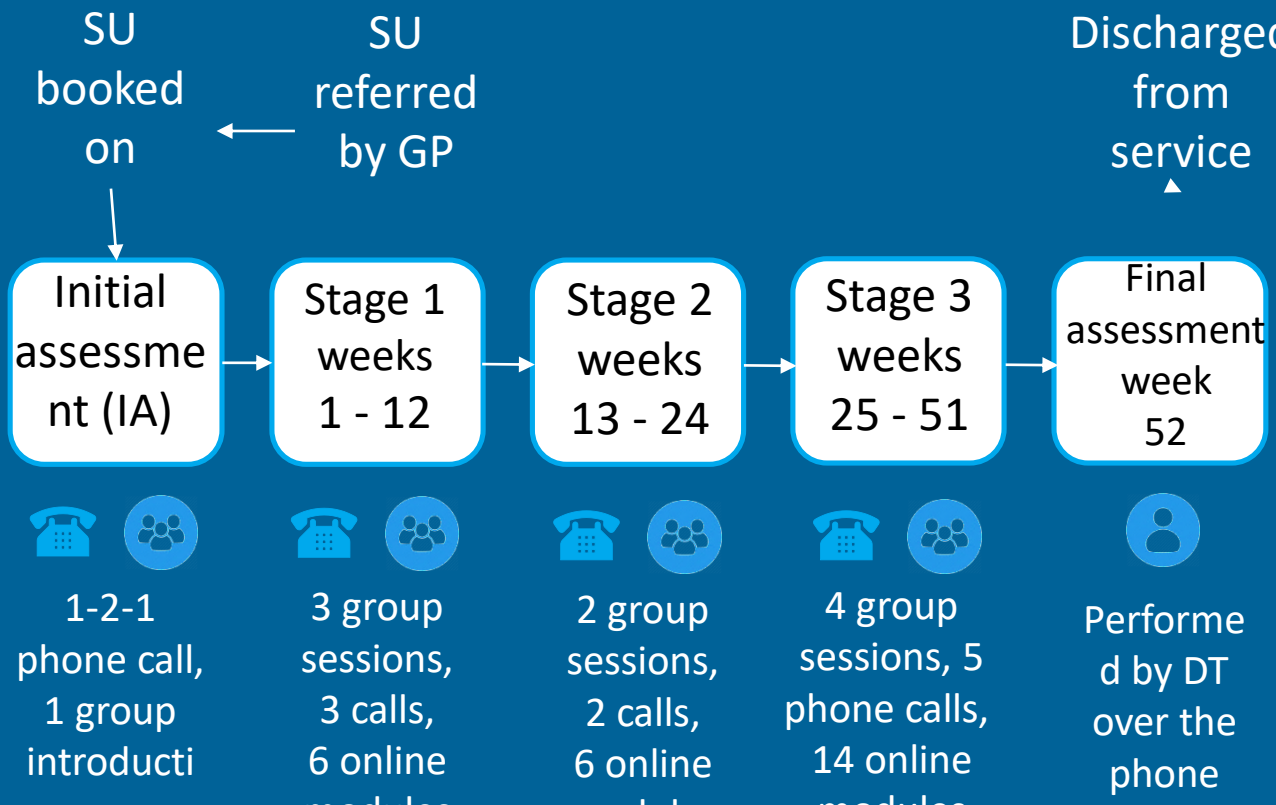
Week 2-12

Weeks 13-24

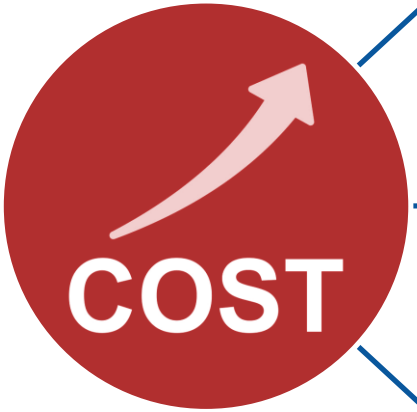
Weeks 25-52

DRAFT

NWL REWIND Programme Service Model



Impact



Finance

- Unsustainable budget
- Reduction in services
- Rationing of resources

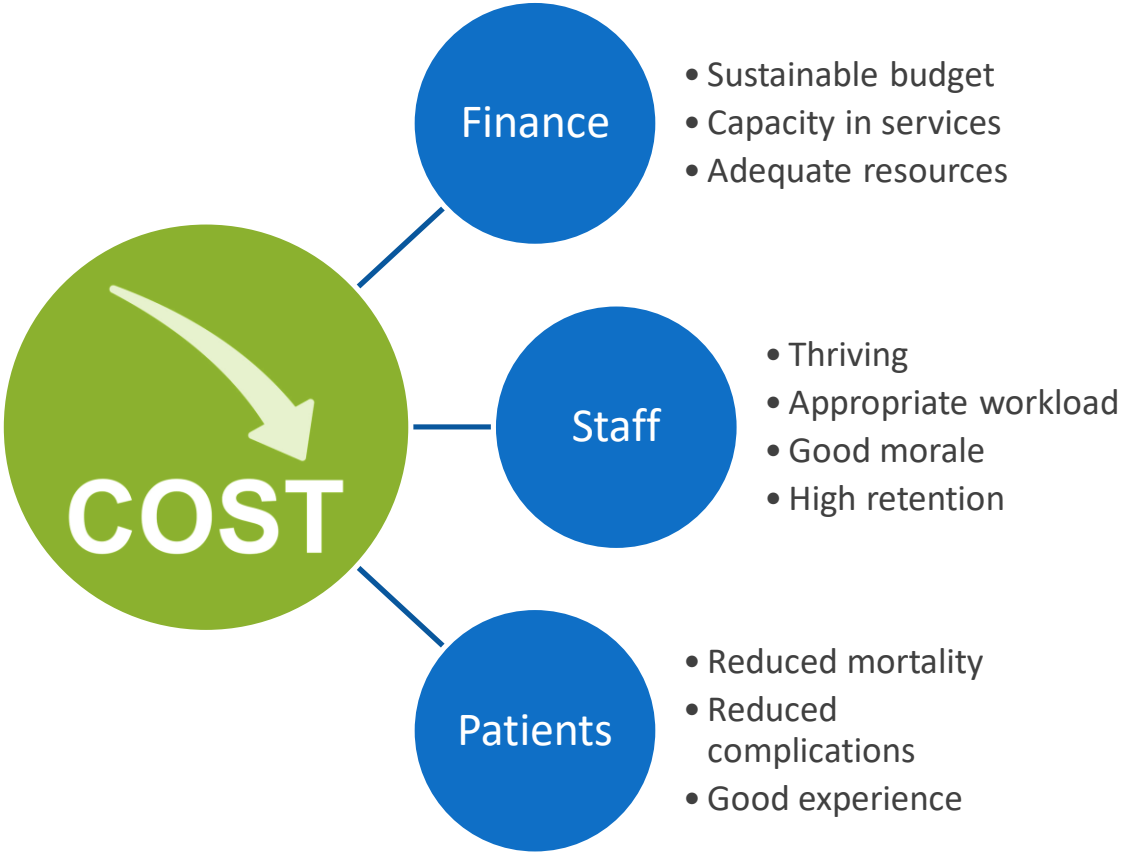
Staff

- Overwhelmed
- Overworked
- Poor morale
- Low retention

Patients

- Increased mortality
- Increased complications
- Bad experience

Investment opportunity



Gain share total diabetes patient costs

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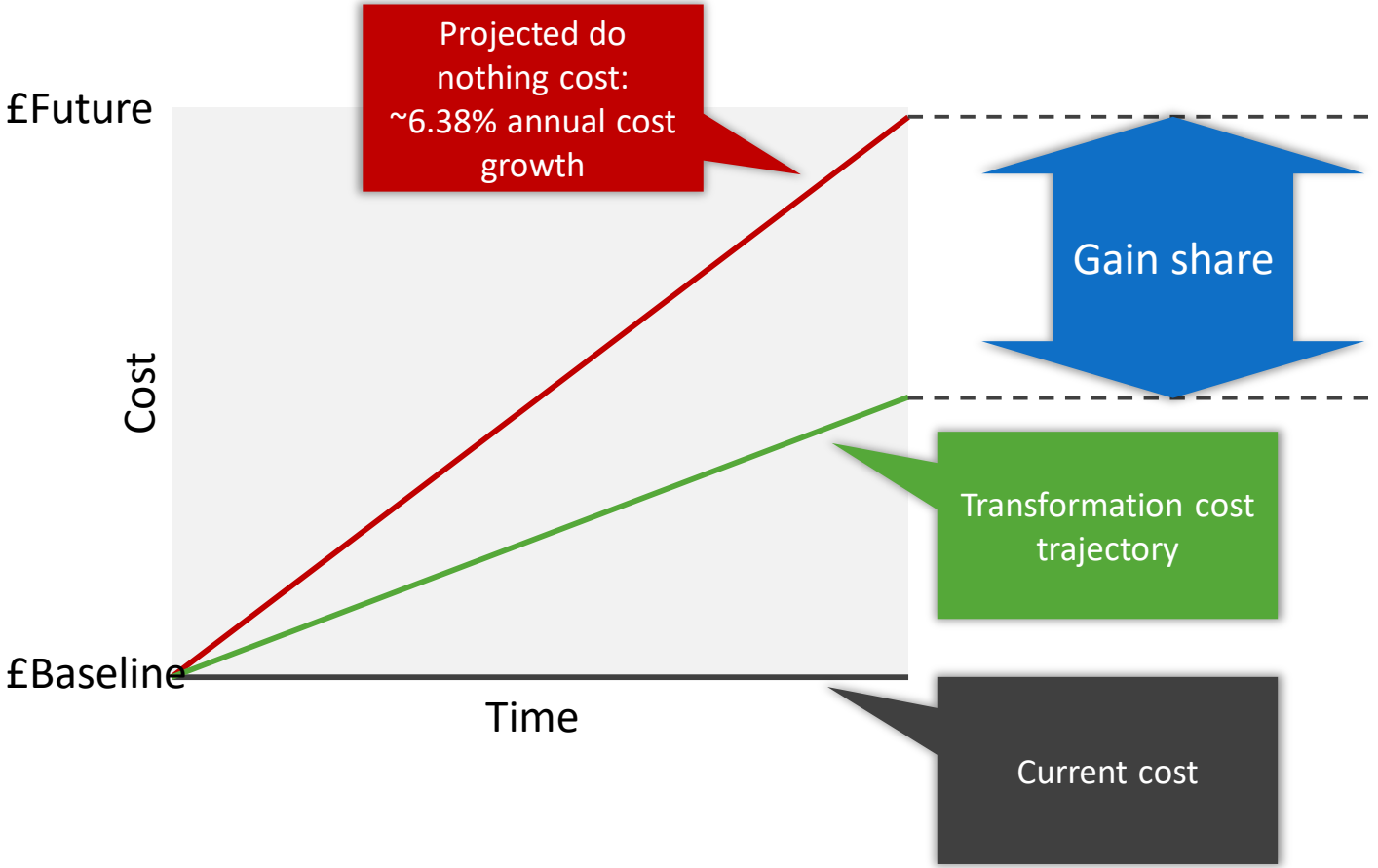

EXAMPLE

50-60-50% share to providers dependent on achieving quality measures

50-40-50% share to CCG

Prof Ed Greggs, Look Ahead Trial & his experience

Any questions ?