Diabetes and Integrated Care

What is it ?

Does it work ?

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Strategic Lead
Camden Integrated Practice Unit

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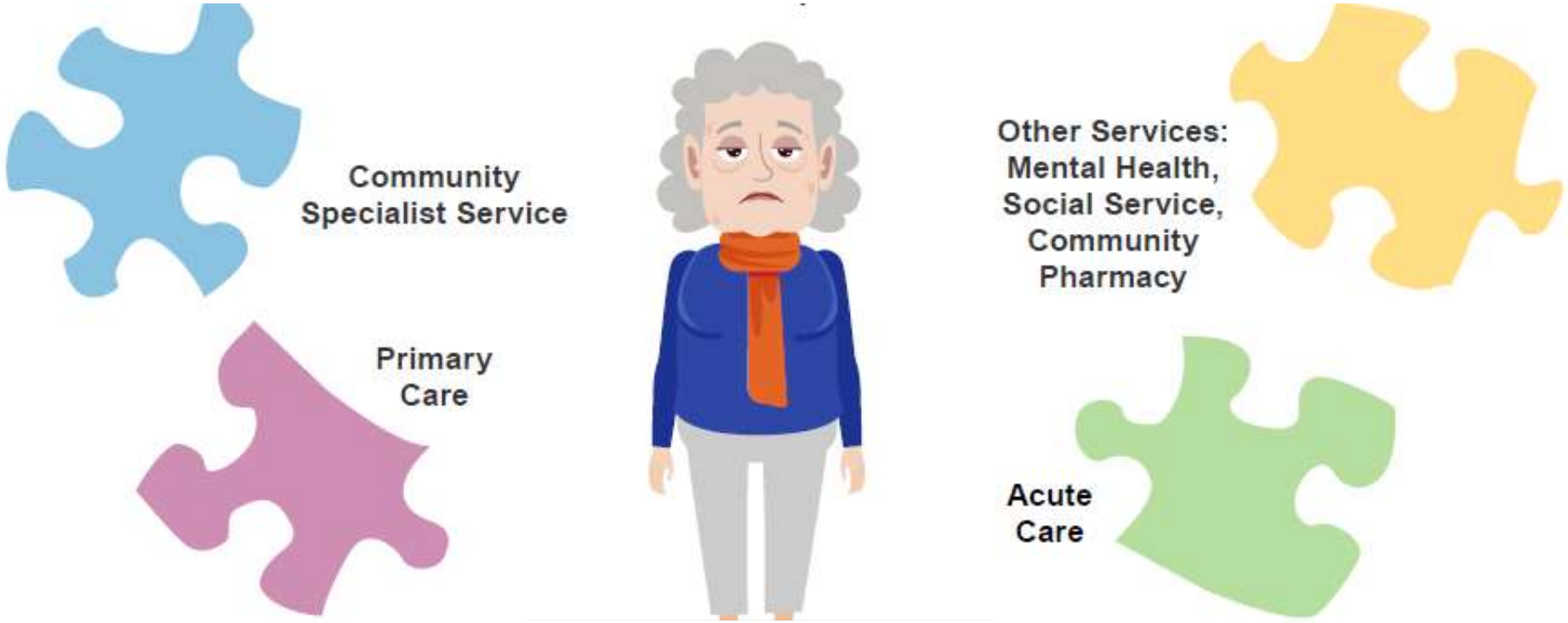
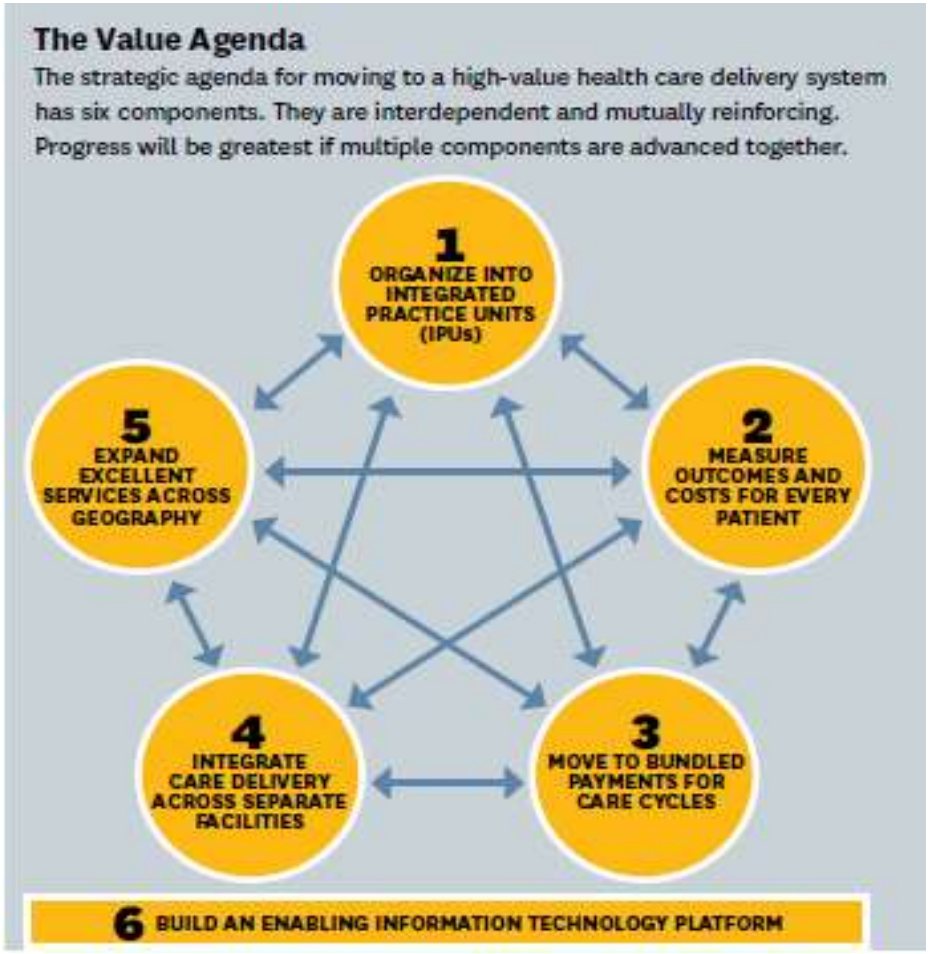
Diabetes care in Camden



Coordinated Care - Why Camden CCG chose an Integrated Practice Unit ?



What is integrated care ?

- Co ordinated care
- Patient centred collaborative care
- Disease management

- Key themes –
  - Purpose to support individuals with chronic care needs , empowering patients and leading to reduction in hospital admissions
  - Address fragmentation of care
  - Vertical (cure and care) vs horizontal integration (within /across sector)

'Imposes the patients perspective as the organising principle of service delivery'

Shaw et al 2011

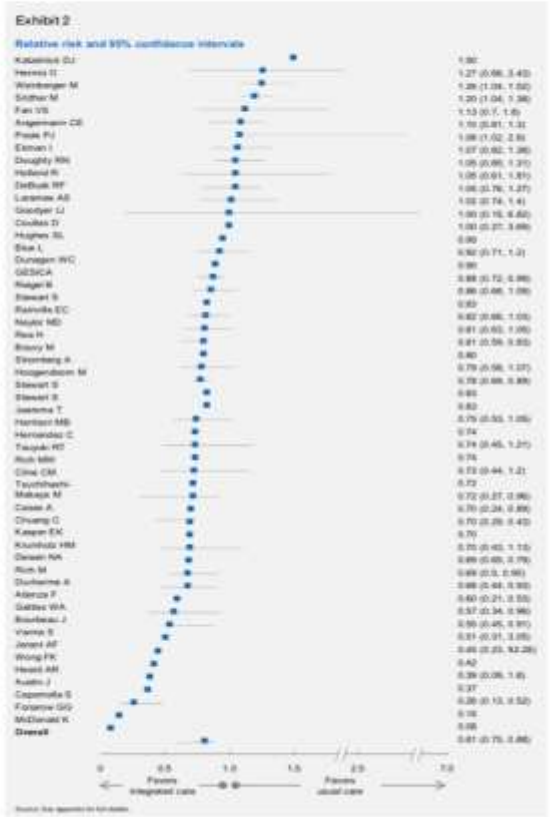
Impact of integrated care

McKinsey&Company

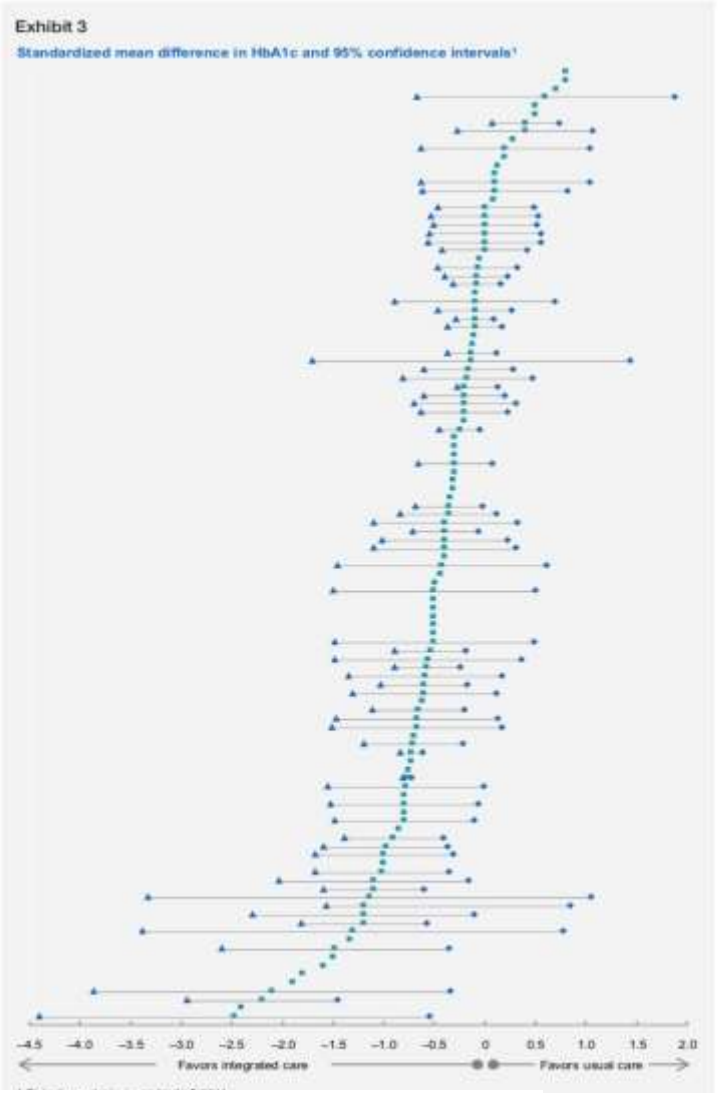
The evidence for integrated care

Authored by:

Hospitalization risk is lower for integrated-care group than for controls



HbA1c declined more in integrated-care group than in controls



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Camden in North London

- Diverse
- Large ethnic minority population
- Gap in life expectancy
- Big differences in wealth and deprivation

Diabetes

Prevalence Gap

High Hba1c

Xs complications and death

Systems

Inconsistent

Poor knowledge in HCP

Multi provider

36 GP Practices

University College London Hospital (UCLH)

Royal Free Hospital (RFH)

Central and North West London NHS Trust (CNWL)

Whittington Health

Haverstock Health Ltd (HH)

‘Requirement for Clinical and service integration’ Value Based Commissioning

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Outcomes

1. Improving the management of Diabetes within the Population

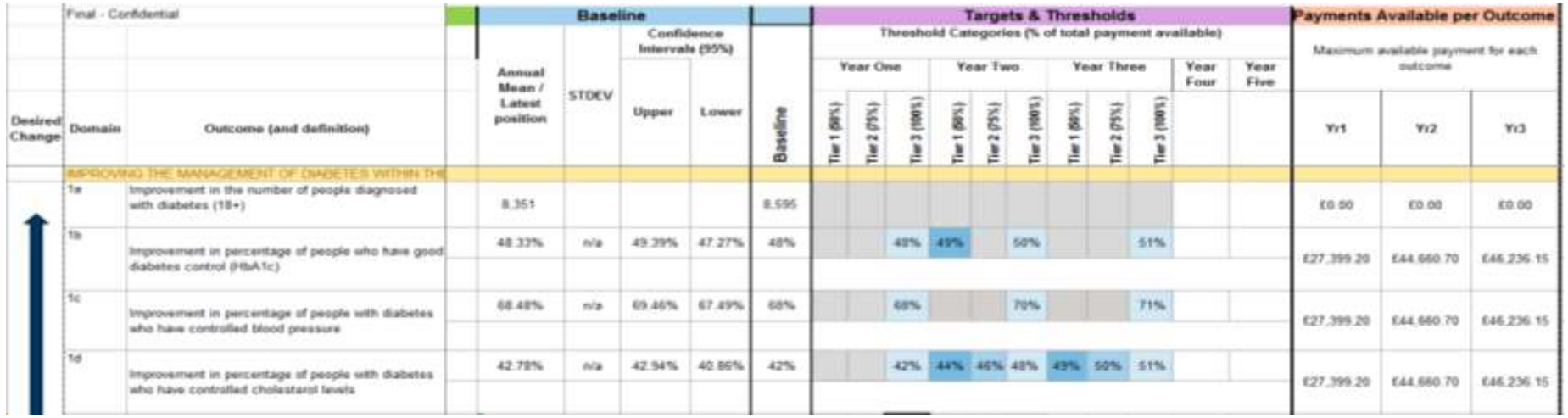
2. Avoiding complications for people diagnosed with Diabetes

3. Patient Reported Outcomes:

- Extend feel care is coordination
- Extend feel have access to right person at right time
- Feel confident manage diabetes
- Feel supported in managing diabetes
- Disruption in life

Value Based Commissioning

- One “pot” for diabetes across community and hospital services
- Investment ~£500,000
- Save on amputations; more podiatrists etc
- Outcome based – risk & reward contract



Final - Confidential

Desired Change	Domain	Outcome (and definition)	Baseline: Annual Mean / Latest position	Baseline: STDEV	Baseline: Confidence Intervals (95%) Upper	Baseline: Confidence Intervals (95%) Lower	Baseline	Targets & Thresholds: Threshold Categories (% of total payment available) Year One Tier 1 (50%)	Year One Tier 2 (75%)	Year One Tier 3 (100%)	Year Two Tier 1 (50%)	Year Two Tier 2 (75%)	Year Two Tier 3 (100%)	Year Three Tier 1 (50%)	Year Three Tier 2 (75%)	Year Three Tier 3 (100%)	Year Four	Year Five	Payments Available per Outcome: Maximum available payment for each outcome Yr1	Yr2	Yr3
		IMPROVING THE MANAGEMENT OF DIABETES WITHIN THE																			
	1a	Improvement in the number of people diagnosed with diabetes (18+)	8,351				8,595												£0.00	£0.00	£0.00
	1b	Improvement in percentage of people who have good diabetes control (HbA1c)	48.33%	n/a	49.39%	47.27%	48%			48%	49%		50%			51%			£27,399.20	£44,660.70	£46,236.15
	1c	Improvement in percentage of people with diabetes who have controlled blood pressure	68.48%	n/a	69.46%	67.49%	68%			68%			70%			71%			£27,399.20	£44,660.70	£46,236.15
	1d	Improvement in percentage of people with diabetes who have controlled cholesterol levels	42.78%	n/a	42.94%	40.86%	42%			42%	44%	46%	48%	49%	50%	51%			£27,399.20	£44,660.70	£46,236.15

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Contract Reference Value

Challenges

- Outcome based –risk
- Short contract
- GPs not contractual partners
- Changes in healthcare structure: STP/GP Neighbourhoods/CHIN
- Multi-partner
- no organisation memory

Total	14/15	15/16	16/17	17/18
Contract parameters				
a Reference contract value	2,743,193	2,743,193	2,743,193	2,743,193
b Performance linked		274,319	447,140	617,218
c % reference contract value		10.00%	16.30%	22.50%
Total contract value				
d Annual investment in baseline contract		2,606,033	2,468,873	2,331,714
e % contract reference value		95.00%	90.00%	85.00%
f Total investment if all 100% thresholds achieved		2,880,352	2,916,014	2,948,932
g % reference value		105.00%	106.30%	107.50%

Diabetes population outcomes

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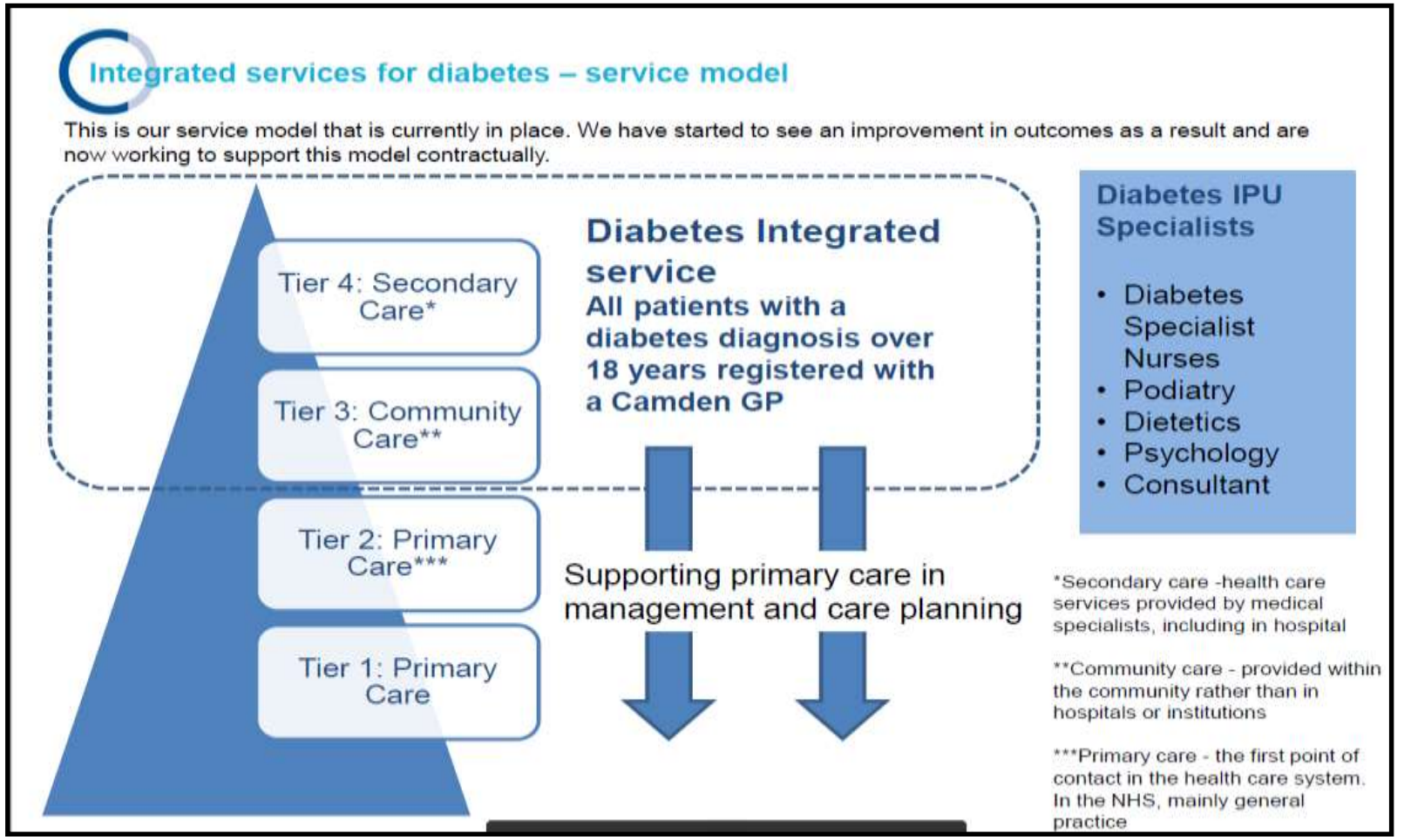
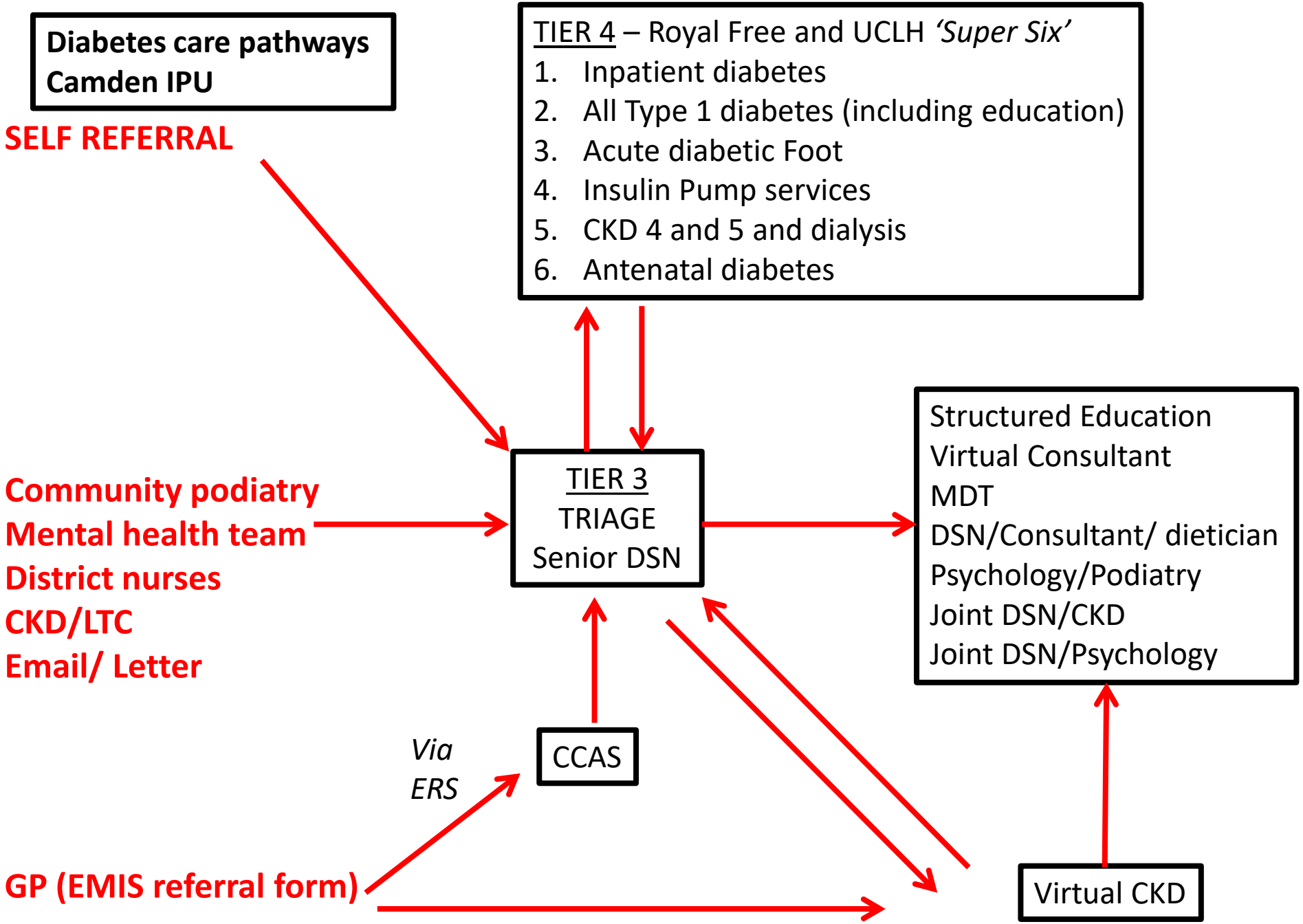
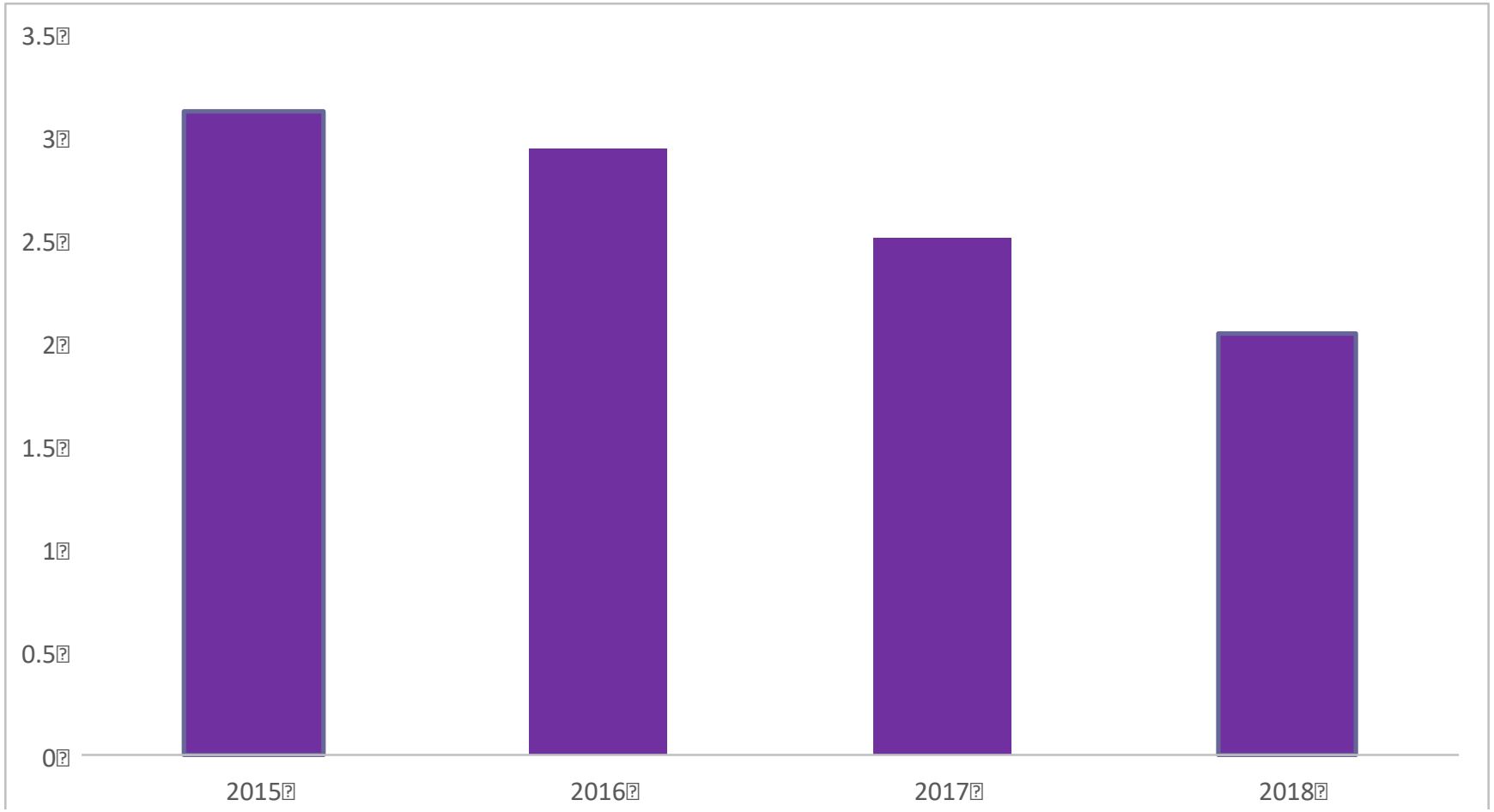
Model of Care




Diabetes care pathways
Camden IPU
SELF REFERRAL
TIER 4 – Royal Free and UCLH 'Super Six'
1. Inpatient diabetes
2. All Type 1 diabetes (including education)
3. Acute diabetic Foot
4. Insulin Pump services
5. CKD 4 and 5 and dialysis
6. Antenatal diabetes
Community podiatry
Mental health team
District nurses
CKD/LTC
Email/ Letter
TIER 3
TRIAGE
Senior DSN
Structured Education
Virtual Consultant
MDT
DSN/Consultant/ dietician
Psychology/Podiatry
Joint DSN/CKD
Joint DSN/Psychology
Via
ERS
CCAS
GP (EMIS referral form)
Virtual CKD

Avoiding complications- diabetes deaths



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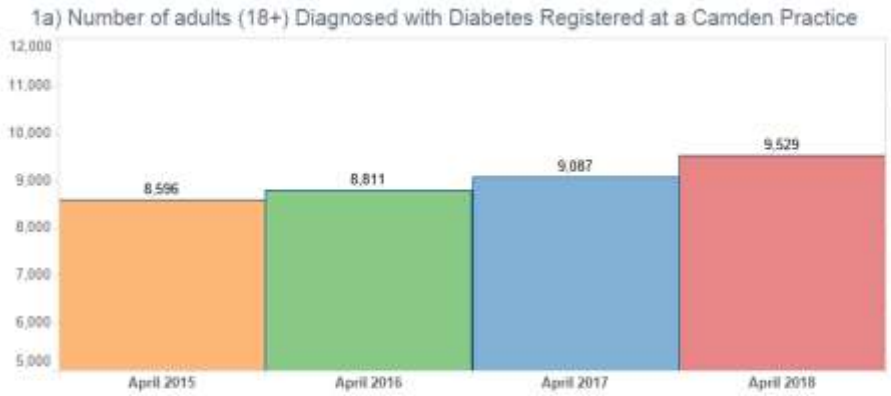
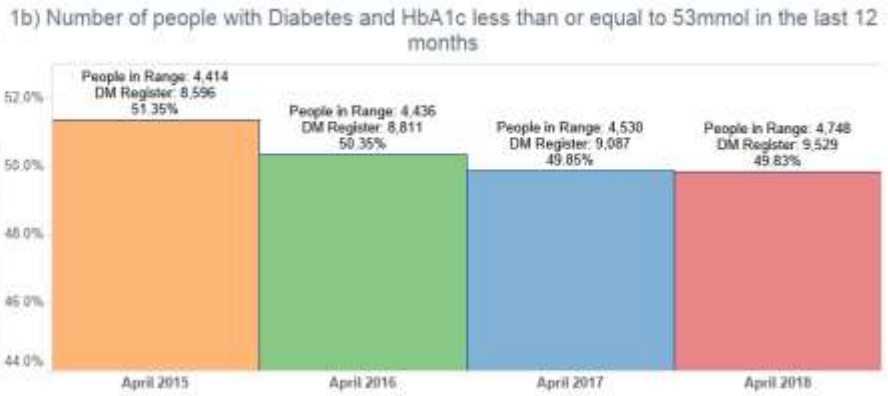
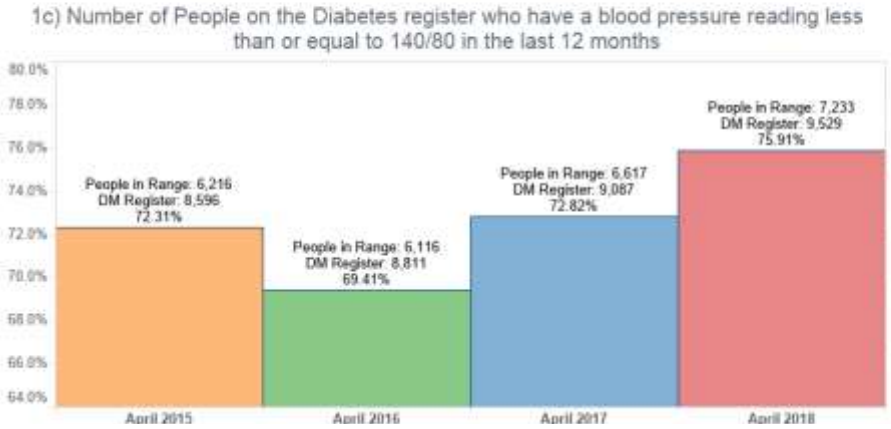
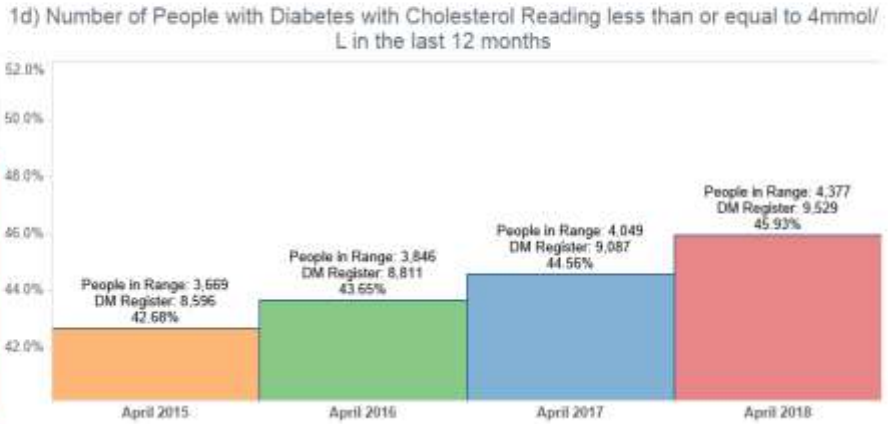
Population outcomes









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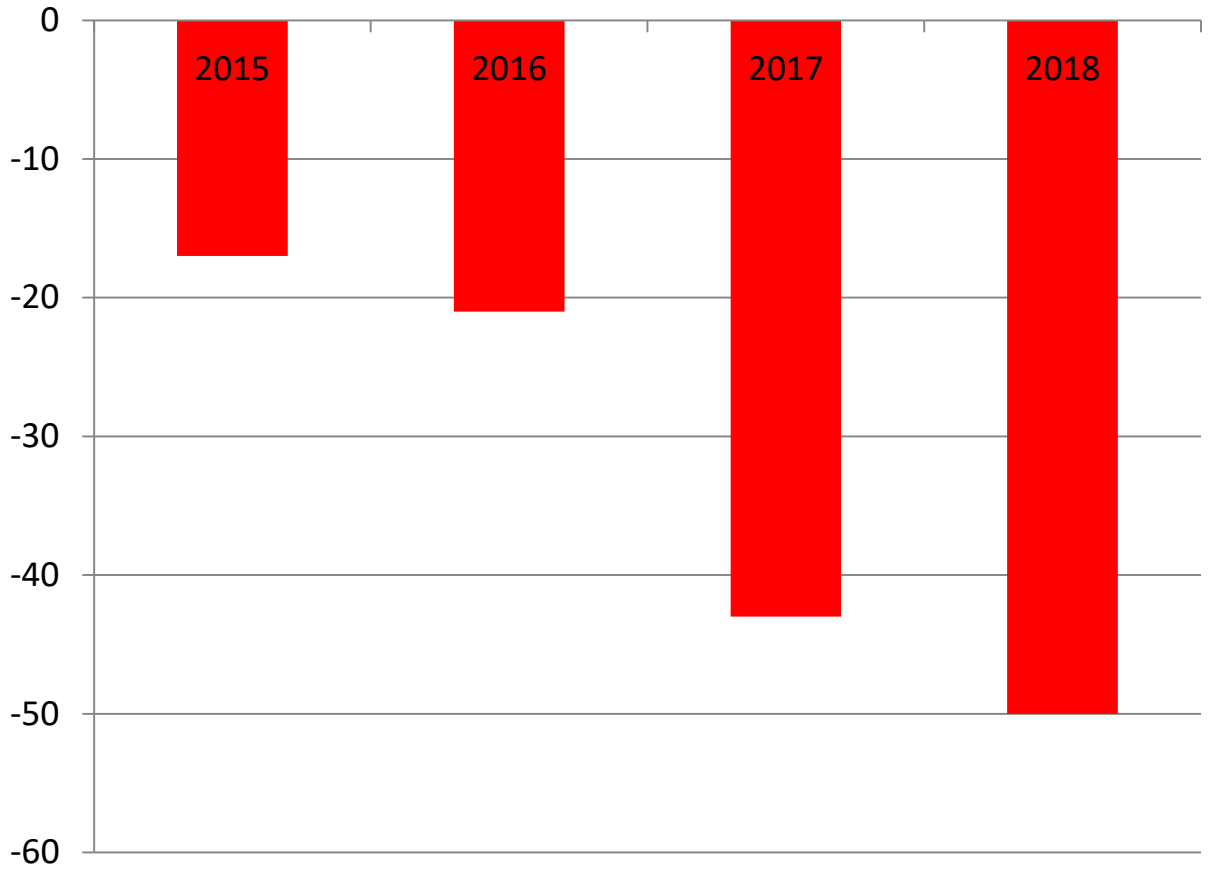
Avoiding complications reduction in admissions hyper /hypoglycaemia

63 % reduction in admissions

Under 60s

Mainly hypos



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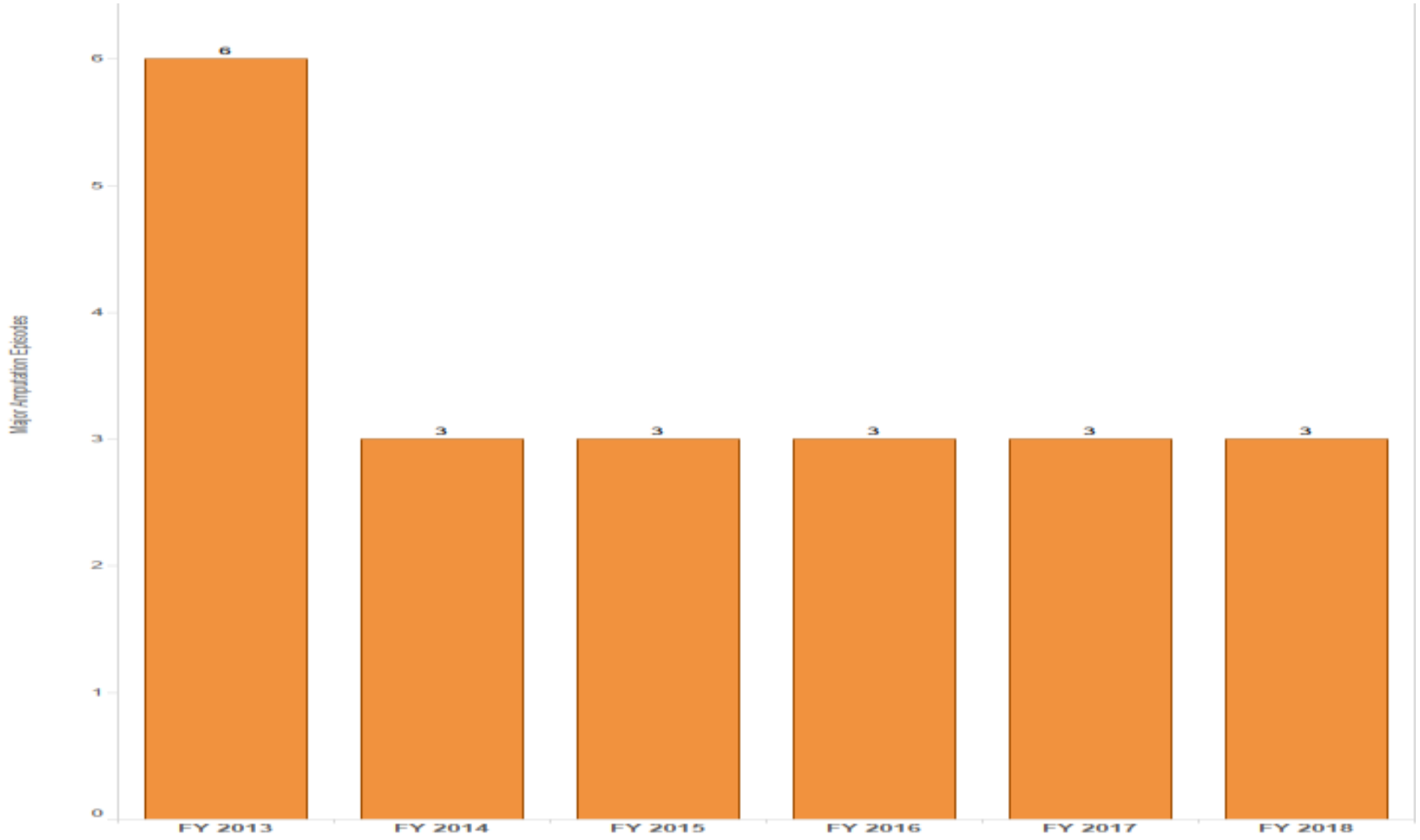
Major Amputations



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Diabetes and SMI

There was a need to improve care for people with dual diagnosis of diabetes and serious mental illness (SMI)

Camden SMI second highest prevalence CCG in England

Whole systems approach – physical health is everyone's responsibility

Joint commissioning and priority setting

Key ingredients for success

- Tackling disengagement head on
- simple care plans

PREVIOUS FRAGMENTED CARE IN CAMDEN:

AIMS OBJECTIVES:

There was a need to improve care for people with dual diagnosis of diabetes and serious mental illness (SMI). Camden has the second highest number of people diagnosed with SMI in England. People with SMI have a 2-fold risk of developing diabetes and their life expectancy can be reduced by 10-15 years.

Whole systems approach

physical health is everyone's responsibility

Joint commissioning & priority setting

Key ingredients for success

- Tackling disengagement head on
- Simple care plans

Collaborative working across a North Central London borough, over a 3-year period, to improve the care for people with diabetes and serious mental illness

Shantell J Naidu*, Dr Paul Chadwick, Dr Miranda Rosenthal, Dr Sarita Naik, Dr Dipesh Patel,
Vanessa Sawmynaden, Susan Cummings, Anthony Jemmott, Manraj Basi, Katie Hacker
Camden Diabetes Integrated Practice Unit, St Pancras Hospital, London, NW1 OPE

CASE STUDY:

62 year old lady SMI T2DM

Polypharmacy and 'Poor insight into physical health, disengaged and reluctant to modify sugar intake. Ran out of medication weeks ago and didn't request more' GP

Betty was discussed in MDT with a member of mental health team

- Agreed joint Diabetes Specialist Nurse and Care Co-Ordinator home visit for a baseline assessment
- Review medication and simply to once day slow release regimes

Initial joint home visits:

- Betty agreed to modify her diet – decrease sugary drinks. To have sugar free squashes instead of fruit juices and milkshakes
- Betty refused blood glucose monitoring and diabetes injections but agreed to change diabetes tablets to slow release once a day in blister pack
- Agreed that co-ordinator will visit regularly and prompt new behaviours.
- She has an engaged GP

Outcome:

- Improved adherence, now taking medication regularly
- Improved psychological well-being 'I feel so much better'
- Improved dietary behaviour – stopped burger and chips, reduced milkshake and changed to flavoured water.

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Current Service – Patient Centred Care

Betty was able to improve her diabetes control:

✓ joint working through MDT

✓ education & support of MHT

✓ reviewed where she is already accessing services.

Year	2015	2017
Hba1c	126	77
Cholesterol	9.4	7.4
BP	114/78	116/70

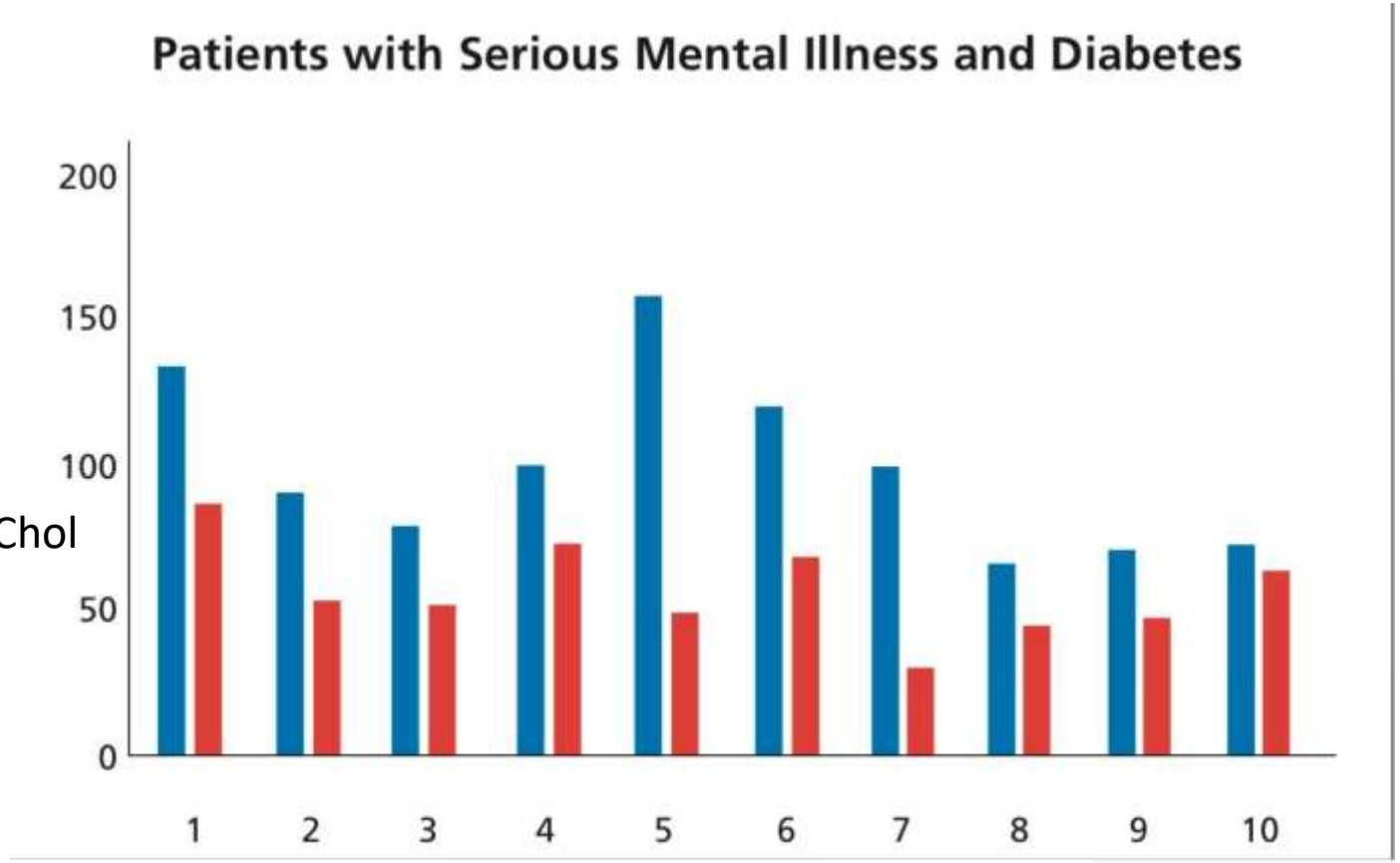
Diabetes and SMI

Average starting Hba1c 98.4mmol/mol

Average Hba1c post intervention 57mmol/mol

Average improvement in Hba1c 41.7 mmol/mol

23 % increase in those with a dual diagnosis
22% those with SMI meet three target BP/HbA1c and Chol



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Improving diabetes care – patient reported outcomes

Feedback from almost 900 people with diabetes
(10% Camden diabetes population)

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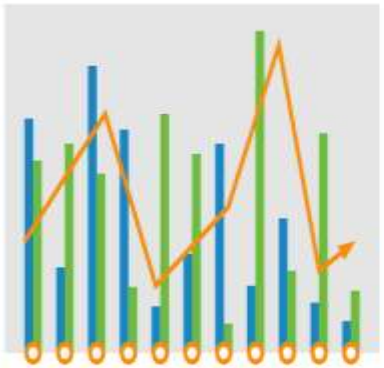
Collaborative and Joined Up

Collaborative → Joint Responsibility & Accountability → Population Level Data → Access to Shared Clinical Record



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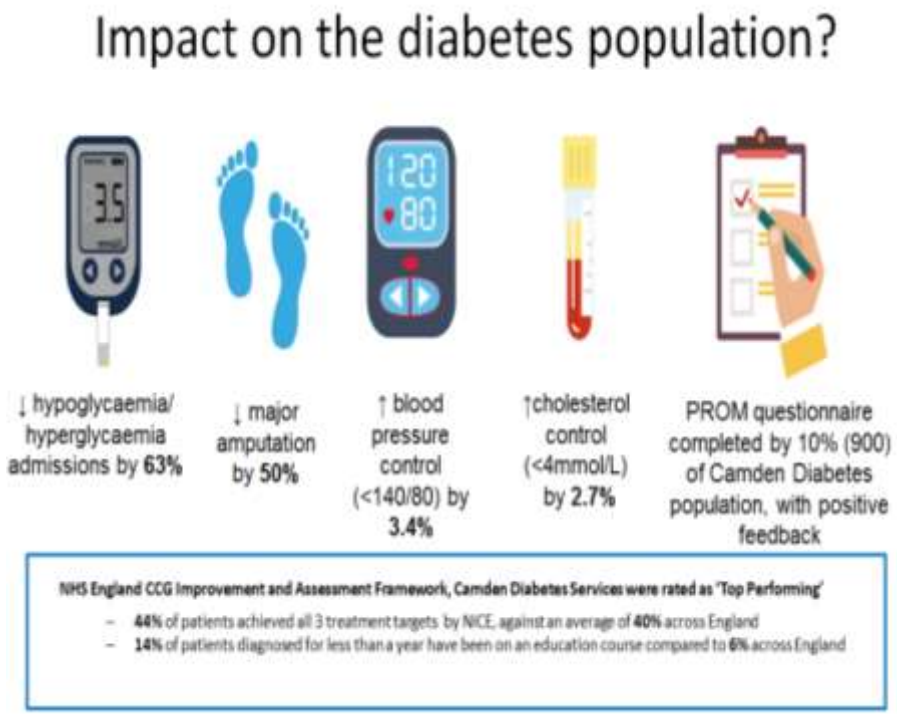
Camden Diabetes IPU (Integrated Practice Unit)

Prior to formation of IPU in 2015 – diabetes care in Camden was fragmented

The Camden Diabetes IPU:

- **One of the FIRST true integrated multi-partner value based contracts in the country**
- **Contracted multi-partner organisation** - 2 acute trusts, a community trust and a GP federation
- **Population Value Based Outcomes** than activities focussed
- **Incentivised** to provide good diabetes care
- Patients stake holders helped develop key priorities



Challenges

- Outcome based – this is a benefit but there is also a risk of not achieving some outcomes and thus financial loss
- Short contract
- GPs not contractual partners, limiting the influence of the IPU on Primary Care
- Changes in healthcare structure: STP/GP Neighbourhoods/CHIN
- Multi-partner organisation – this is both a benefit and a challenge!
- Negotiating extension of contact with no organisation memory from commissionaires and contracts

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Unique Award Winning Service

Collaborative & Joined Up

Patient-centred care

Improve Patient Outcomes

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Key ingredients for successful integrated care

- Investment
- Alignment of goals for all providers with the same outcome measures
- Population health analytics that inform decision making in real time
- Does it pass the Mrs Smith test ?