Diabetes and Integrated Care

What is it?
Does it work?

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Diabetes care in Camden

Fragmented care for patients

Community Specialist Service

Primary Care

Other Services: Mental Health, Social Service, Community Pharmacy

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

The Value Agenda
The strategic agenda for moving to a high-value health care delivery system has six components. They are interdependent and mutually reinforcing. Progress will be greatest if multiple components are advanced together.

1. Organize into integrated practice units (IPUs)
2. Measure outcomes and costs for every patient
3. Move to bundled payments for care cycles
4. Integrate care delivery across separate facilities
5. Expand excellent services across geography
6. Build an enabling information technology platform
What is integrated care?

- Coordinated 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
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
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
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
Diabetes population outcomes

- *Patient Reported Outcome Measures*
- *Avoiding complications*
- *Improving management*
Integrated services for diabetes – service model

This is our service model that is currently in place. We have started to see an improvement in outcomes as a result and are now working to support this model contractually.

Diabetes Integrated service
All patients with a diabetes diagnosis over 18 years registered with a Camden GP

Supporting primary care in management and care planning

Diabetes IPU Specialists
- Diabetes Specialist Nurses
- Podiatry
- Dietetics
- Psychology
- Consultant

*Secondary care - health care services provided by medical specialists, including in hospital

**Community care - provided within the community rather than in hospitals or institutions

***Primary care - the first point of contact in the health care system. In the NHS, mainly general practice
Avoiding complications - diabetes deaths
Population outcomes
Avoiding complications reduction in admissions hyper/hypoglycaemia

63 % reduction in admissions

Under 60s

Mainly hypos
Major Amputations
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
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

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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.
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.

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<tr>
<th>Year</th>
<th>2015</th>
<th>2017</th>
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<tr>
<td>Hba1c</td>
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<td>77</td>
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<tr>
<td>Cholesterol</td>
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<td>7.4</td>
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<tr>
<td>BP</td>
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<td>116/70</td>
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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
Improving diabetes care – patient reported outcomes

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

- 76% found it easy to get the care they needed when they needed it.
- 87% feel confident that they can manage their diabetes.
- 67% have enough support from local services.
Collaborative and Joined Up

Collaborative → Joint Responsibility & Accountability → Population Level Data → Access to Shared Clinical Record
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
Unique Award Winning Service

Collaborative & Joined Up

Patient-centred care

Improve Patient Outcomes
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?