North of England
Commissioning Support

County Durham and Darlington Integrated Diabetes Model

June 2016

NHS
Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

NHS
North Durham
Clinical Commissioning Group

NHS
Darlington
Clinical Commissioning Group

Partners in improving local health

Why we are redesigning diabetes care

- Diabetes is a national and international problem, but the number of people developing diabetes is rising faster in County Durham than the UK average.
- We want to improve the quality of care for people living with diabetes, and to support them to manage their condition so they can stay healthy.
- At the moment specialist clinicians are having to focus on managing the complications from Diabetes, instead of preventing complications occurring.
- There is not enough joined up working between Primary (GPs), Community (District nursing) and Secondary (Acute) care settings. This is frustrating for patients and clinicians.
- 10% of the NHS budget is spent on Diabetes, 1% of the whole NHS budget is spent on drugs to control blood sugar. Spend on Diabetes drugs per patient is higher in County Durham & Darlington (CD&D) than the North East and is rising faster.
- Costs will continue to rise, becoming unaffordable if we do not change how we support people both at risk of diabetes and those who already have the condition.

What people have told us

Diabetes Patients in County Durham and Darlington have told us:

They want more support to self-manage their condition

- *I want more support to pick myself up and take control on Diagnosis*
- *I want to feel like a true partner in decision making and planning*
- *I want to understand how I can avoid the long term effects (feet / eyes)*
- *I want more support to stay healthy, to diet and to exercise*
- *I want the doctors and nurses to understand what it is like to live with Diabetes*
- *I want clinicians to really listen to my concerns*

They want a more flexible and joined up Diabetes service

- *I want a more flexible service that is easy to access for those who work (out of hours)*
- *I want easy access to specialists when I need it*
- *I want to be able to access care close to home*
- *I want all parts of the service to be 'joined-up' and to speak to each other*
- *I want a service with more ways to access: telephone access, one stop shop*

Consultants, GPs and Nurses caring for Diabetes have told us:

They want patients to take more responsibility for their condition

- *I want to be able to direct patients to a range of non-medical support*
- *I want to be able to direct patients to Education courses, at diagnosis and as a refresher*
- *I want to build improved trusted relationships with patients*
- *I want better integration with Mental Health Services*
- *I want better access to Dietetics & Nutrition*
- *I want a more integrated Podiatry service*
- *I want to improve Diabetes monitoring and management in Care and Residential homes*
- *I want more professional education for Primary Care staff*

What we have done

- A new model of care has been developed with input from patients, primary and secondary care clinicians and this will see GPs and local hospitals working more closely together to give patients care closer to home.
- The new model will see a shift from acute to primary and community services to support people with Type 2 Diabetes.
- Our aim is for the new service to be:

- The new model promotes a keen focus on prevention, individualised care planning and patient self-management.
- Named specialist resources (Consultants and Diabetes Specialist Nurses) will collaborate with groups of GP practices (based on local GP Federations) in newly formed ‘diabetes groups’ to upskill primary care and improve the level of care provided in practices.
- The aim is to pursue savings for reinvestment in diabetes care to ensure a financially sustainable service whilst also delivering quality care to our patients.
- We have developed a training curriculum for primary care clinicians to ensure GPs and Practice Nurses are suitably qualified in diabetes care.

What is happening now

- In County Durham and Darlington a transition to the new model of diabetes care will commence from July 2016 and continue throughout 2016/17
- In future the majority of patients will be seen by their GP and practice nurse who can call upon the expertise of Consultants and Diabetic Specialist Nurses who will be fully supporting primary care throughout the transition.
- Patients will start to see changes throughout the summer of 2016. Some will continue to see their Diabetes Specialist (Consultant or Diabetes Specialist Nurse) in hospital, but others will begin to see their Specialist in clinics at their local GP practice.
- GPs and Practice Nurses will be receiving training to manage more complex diabetes needs throughout the year.
- There will be an increased focus on patient education and prevention to help people live healthy lives.
- In the future, as the model matures, we anticipate that all patients will have an individualised care plan where each patient will be partner to decision making and planning regarding their diabetes health.

Living Well, Taking Control

County Durham Diabetes Prevention Programme

- There are currently 2.8 million people with Type 2 diabetes in England with around 200,000 new diagnoses every year. While Type 1 diabetes cannot be prevented and is not linked to lifestyle, Type 2 diabetes is largely preventable through lifestyle changes.
- In the north east, around one in ten people are estimated to be at risk of developing Type 2 diabetes, which can lead to an increased risk of health problems, including heart disease, kidney disease and serious eye problems.
- People at high risk of Type 2 diabetes in County Durham will start to benefit from the first ever national NHS diabetes prevention programme in the next few weeks.
- The local programme “Living Well, Taking Control” is expected to be rolled out across County Durham during this summer. Initially it will focus on areas where need is greatest (maybe due to deprivation or higher numbers of patients identified as being at high risk of diabetes), and we expect the first localised programme to start in early August.
- Those referred will get tailored, personalised support to reduce their risk of Type 2 diabetes, including education on healthy eating and lifestyle, help to lose weight and bespoke exercise programmes, all of which together have been proven to reduce the risk of developing the disease.