Improving Standards in Diabetes Care: Putting Learning into Practice
Wednesday, 7th September 2016
17:00 – 18:00
Committee Room 18, House of Commons

This was the fourth and final meeting in the year-long investigation into diabetes care conducted by the APPG for Diabetes. The Group heard from a range of professionals involved in CCG delivery of diabetes care. Challenges include a lack of staff, a lack of training, and a high degree of complexity in CCG commissioning.

George Howarth MP (GH) chaired the meeting.
GH announced that Keith Vaz would be absent, and that this is the fourth and final meeting into standards of care in diabetes. GH introduced Abigail Kitt (AK) as an independent consultant, and David Lipscombe (DL) as a diabetologist and South East Diabetes clinical lead.

Abigail Kitt, Independent Consultant in the Healthcare Sector and Diabetes Support for South East Coast Strategic Clinical Network, and Dr David Lipscomb, Consultant in Diabetes and Endocrinology East Sussex Healthcare NHS Trust.
Abigail began by explaining that in April 2013 a strategic clinical network was established covering 20 CCGs, 11 trusts, 6 local authorities, and 5.5 million people. There are just 3 staff to run this network. The role of clinical networks is non statutory regulation, and relationship building to improve care and efficiency.

In Sept 2013 they developed a priority plan across the CCGs, focusing on education, foot care, supporting commissioning and prevention of diabetes.

There are 3 key areas that are a challenge across diabetes care:

- CCG management and engagement.
- Clinical leadership.
- Complexity of commissioning pathway.

CCG management and engagement:

- Transport links are poor so engagement with patients online helps.
- All 20 CCGs working together is essential.

Clinical leadership:

- Several areas have posts we cannot fill – some brain drain to London, but mostly a lack of skilled people.
- There is a swift turnover of managers, which can mean starting from the beginning with a new manager each time.
- Clinicians find it hard to understand this complex NHS organisation.
- The 24/7 agenda is drawing attention away from diabetes, to managing 24/7 care for everyone.
They developed a consultants forum to meet and discuss these problems and combined health education across Kent, Surry and Sussex. Focus was put on patient education—including local education initiatives with independent quality assessment. But healthcare professional education has less rigour than patient education.

Complexity of commissioning process:

- Long term nature of diabetes is at odds with short term targets asked of commissioning groups.
- The whole process needs to be simplified.

The team produced a briefing paper to explain issues with foot surgery and gap analysis were conducted really to find problems and highlight issues. They wanted to share learning between physicians. They also found payments for items of service vary between regions: “transparency in payments system would be good and we would like to see guidance”, said Abigail Kitt.

George Howarth MP commented on the difficulty of working collaboratively, inclusively and across different profession. He noted the presentation was a useful prompt to show what can be done, but what a long time it takes to do it.

George Howarth MP introduced Kate Fayers, who became a diabetologist in the community in 2010, has gone through two commissioning cycles, and is now working in West Hampshire which has urban and rural communities.

**Dr Kate Fayers, Lead consultant for the new West Hampshire Community Diabetes Service (WHCDS).**

Kate said there are three drivers for change in west Hampshire community diabetes service: economics, cultural (NHS and diabetes patients have changed over the years) and quality (there are three problems here: stagnation, complication and variation).

Her team made change by leadership development: It’s difficult to find well equipped clinicians so they found occupational psychologists who have worked with clinicians to enhance the skills of their clinicians.

They created a vision for change that included access for patients to excellent skills and knowledge, allowed the achievement of patients’ individual goals, and allowed patients to activate self-care where possible.

They devised evidence based intervention, using a chronic care model. To do this required collaborative working, and data sharing: data was evidence for change. They were able to go to GPs with data to ask about where their priorities should be.

“In clinics, we only measure clinical effectiveness, but we should be measuring influence. This data fuels conversations with clinics”, said Kate.

Kate developed a model called Practice Makes Perfect. This emphasises the relationship between patients and their healthcare practitioner. De-layering specialist care allows for autonomy in different regions, but Kate and her team encouraged working between practices.
There remains, though, three barriers to better working: time, knowledge and leadership.

George Howarth MP commented that data is very valuable and we need to look at the care model much more closely. He liked the idea of diabetes services not being the diabetes police—telling people how to live their lives creates a lopsided relationship between patients and GPs.

George Howarth MP introduced Carole Metcalfe, paediatric diabetes nurse specialist

Carol Metcalfe, Lead Paediatric Diabetes Specialist Nurse at Macclesfield District General Hospital

Carol noted that there are some common themes already raised. She did not present a case study, but instead spoke generically. Carole has spent 22 years as a diabetes nurse for children. There has been improvement in developing services, but challenges remain. There are currently 28,000 young people in diabetes care, just over 500 are type 2, and so most remain type 1.

There is variation in care across the country (e.g. varying HbA1c outcomes). The tariff for young people has improved things, as groups can go to commissioners with data to get more money. But, things that still need work:

- We need to ensure all children have regular contact with healthcare professionals, not just those with the loudest parents.
- We need to train nurses as educators.
- We need programs for nurses: we have many PDSNs but don’t have the resources to support them (also the case with doctors and dietitians).
- Best practices tariff has allowed for hiring more psychologists, but there aren’t the people to hire.
- Dietetic resources are limited, education is really needed.

Carol and her team have run residential events for kids which have proved successful, but we need to keep building on education as children grow an age—“we need to grow our education with them. We need skills and facilities to allow this”, said Carol.

Relationships between families and paediatric care team is also vital: “there is currently no one to transfer young people to when they reach 17 or 18, as nurses have been taken on to other priorities in care. The audit has been helpful but need to improve transition and upskill nurses, dietitians, and doctors”, explained Carol.

George Howarth MP commented on the need consistent messaging—it can be easy to get contradictory advice. We should reinforce messages and keep education as children grow. Transition is an issue, as is support for people with psychological or psychiatric care. Young people with diabetes and eating disorders is a particular issue of interest.

George Howarth MP introduces David Hiles, Medical care consultant.
David Hiles, Consultant, Diabetes Service Redesign and Improvement Consultancy

David started by saying that people don’t realise what they are doing to support diabetes. He provides hands on practical help for people with diabetes, and supports CCGs in improving systems and processes. He said we need to facilitate variation in primary care for patients’ varying needs.

David has used best practice modelling – working out what is being done in successful practices and spreading these ideas. They use data to work out who is doing well, and then work with practices to get real time data – who is achieving good glycaemic control, for example. David and his team go into clinics to collect this data, getting a walkthrough of the process of a new diabetes diagnosis or new patient in the area.

Successful processes can be built into CCG care pathways to implement across CCG practices. Simple things can make the biggest difference – such as nimble use of available resources, e.g. who can work in the evening to make calls to patients.

Continuity of care is important, and where possible people should see the same practitioner. This allows for the development of a good rapport, and a good relationship can allow patients to open up about what they may be doing that is less healthy.

For example, at diagnosis, there is variation in consultant time. In the first four weeks of diagnosis we found best practice was 1 hr with patients, split over two sessions. And it is important to not shy away from the hard truths. That way, patients can ask questions in their second consultation.

The answers to providing better care can be local answers, and can be easy and replicable. There is a greater willingness to adopt when ideas come from other practices, and not from ‘on high’. CCGs hold the answer to reducing variation in care provision. The best Practice Care model could be the answer to variation and bad care.

George Howarth MP commented that Identifying best practice from data sounds like all scientific investigation; you find out what and why something works.

George Howarth MP asked the floor for questions.

Discussion points

Implementation

We know easy ways of improving care – how do we actually implement these ideas? Will there be learning from international groups where there is no UK precedent, and how do we ensure implementation? Approaching better practices in sharing good ideas is good, but how do we get from learning good practice to implementing it widely? Currently, we do look for evidence beyond the UK, and look at evidence across the world. But we can’t just transplant ideas from one region to another. We must ask what works/doesn’t work as a practice, then look at similarities across the country and marry the two ideas. People like to talk about what they do well so we should ask practices for their good ideas. It is a challenge to implement, but workshops with DSNs and with CCGs, and an evaluation process, has worked. This should work in secondary care as well as primary, but need buy-in from people in the system.
Education
Education is very important for people with diabetes. How can consistent piece of education be possible when each diabetes patient is different? Each team should say the same thing as a basic ‘textbook’ and people can live around this information.

In terms of educating professionals, all diabetes practitioners have certification, but all diabetes care should be certified to provide diabetes specifically. But, time is limited, which results in thinned down training. Training MUST be robust. We should ring-fence budgets for training. There is foot care pathway advice for commissions, and a training guide online for primary care.

Patients are, and should continue to be, involved in service design
Young people can be engaged via focus groups. We can’t just use patient satisfaction surveys, we need to meet patients and ask what works/what doesn’t work for patients and carers. Understanding patient quality of life is very important, and carers are essential to understanding the whole story with a patient. There is not much qualitative data, we need more. The National Paediatric Audit has online reports from 6 months of data collection (over 14,000 responses). Reports have been produced for units that attained the required minimum number of responses.

South London AHSN ran an experience based co-design project with the mission of improving pump access and it increased uptake by 21% across 10 clinics. It can be so helpful to take ring-fenced time to talk about good practice. It can bring big changes across type 1 clinics. Involving patients meant we could learn what is actually important to patients.

MPs should be given the opportunity to learn and engage
Setting up events for MPs to attend could engage them. Many MPs won’t know much at all about diabetes – they need support. Healthcare professionals and clinics should put ourselves out there and reach out to MPs