Diabetes Update

DATE - GROUP

Frimley Health & Care STP

Health & Wellbeing

Care & Quality

Finance & Efficiency

Effective Workforce

The Background

Although 84% of newly diagnosed patients are offered a structured education course, in line with NICE guidance, only 3% are recorded as having completed a course;

Although consistently better than the national average, across East Berkshire, fewer than 50% of patients with diabetes are achieving the three treatment target goals for blood sugar, blood pressure and cholesterol;

Every year across East Berkshire, approximately 6 people have a lower limb amputation due to poor diabetic control

The National Diabetic Inpatient Audit shows lower than average levels of specialist inpatient nursing input across all Frimley sites.

Transformation Funding

To improve uptake of structured education	£298,000
To improve achievement of the NICE recommended treatment targets for HbA1c, cholesterol and blood pressure	£189,000
To reduce amputations by improving the timeliness of referrals from primary care to a multi-disciplinary foot team (MDFT) for people with diabetic foot disease	£288,000
To reduce length of stay for inpatients with diabetes by the provision of Diabetes Inpatient Specialist Nurses (DISNs)	£233,000
Total	£1,008,000

Structured Education

A central hub has been introduced to manage all referrals for structured education;

Tailored First Language and culturally sensitive programmes are being developed and will soon be introduced;

Improved reporting standards will improve the level of recording for all course attendances;

The range of times and locations for delivering the structured education will be expanded

We have engaged with Diabetes UK to help equip some of our patients to lead patient support programmes in their community.

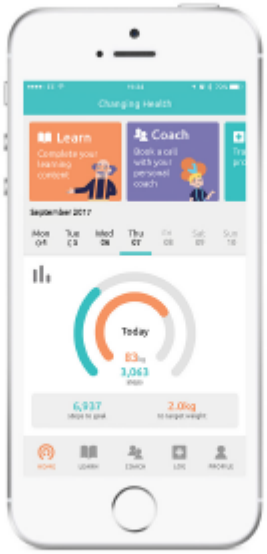
Structured Education

Digital Offer

BOOK A COACH SESSION
Your personal coach will help you create and achieve goals

ACTIVITY TRACKING
Use your smartphone to find out how active you are

GOAL SETTING
Changing Health supports you in setting realistic goals for your activity, weight loss & food intake



WEIGHT TRACKING
Keep an accurate record of your weight loss journey

SIMPLE & FUN CONTENT
Articles and videos chosen for you and updated regularly in response to your changing lifestyle needs

FOOD DIARY
Spot trends in your eating habits using a simple visual food diary

Advice with Motivational Interviewing to support uptake

Direct contact with a health professional to support patient to choose best options for them

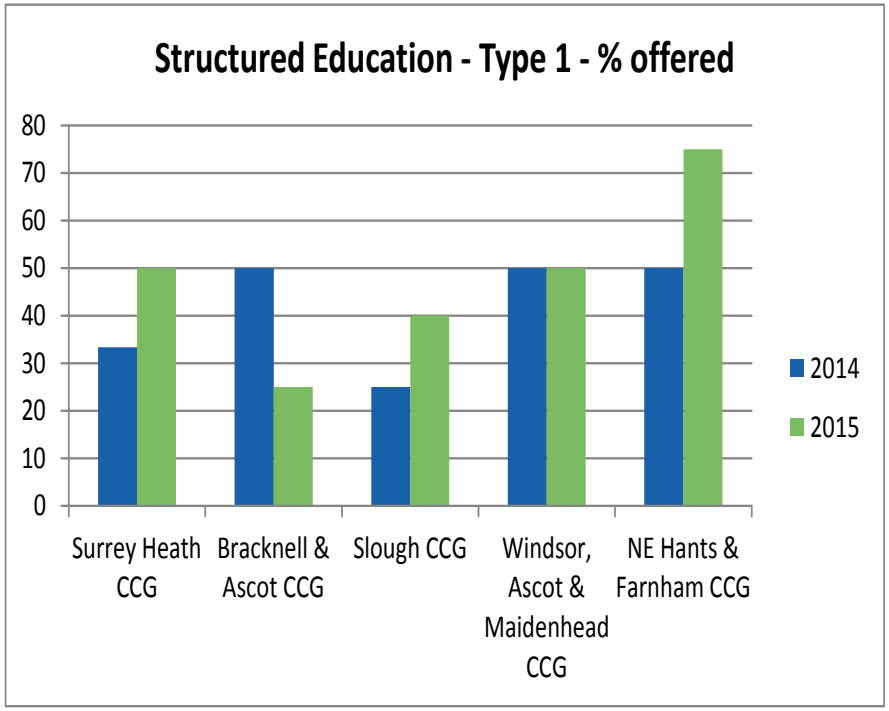
Enhanced Evening and weekend courses

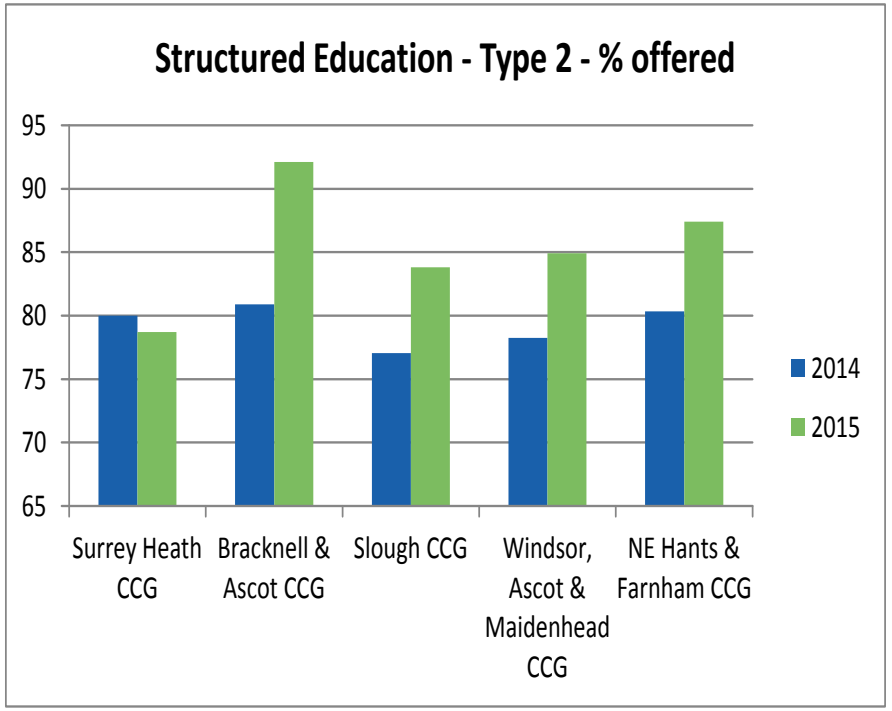
Direct contact with a health professional to support patient to choose best options for them

Bespoke South Asian Lifestyle Programmes to encourage uptake in our ethnic communities

Diabetes Community Champions – Diabetes UK

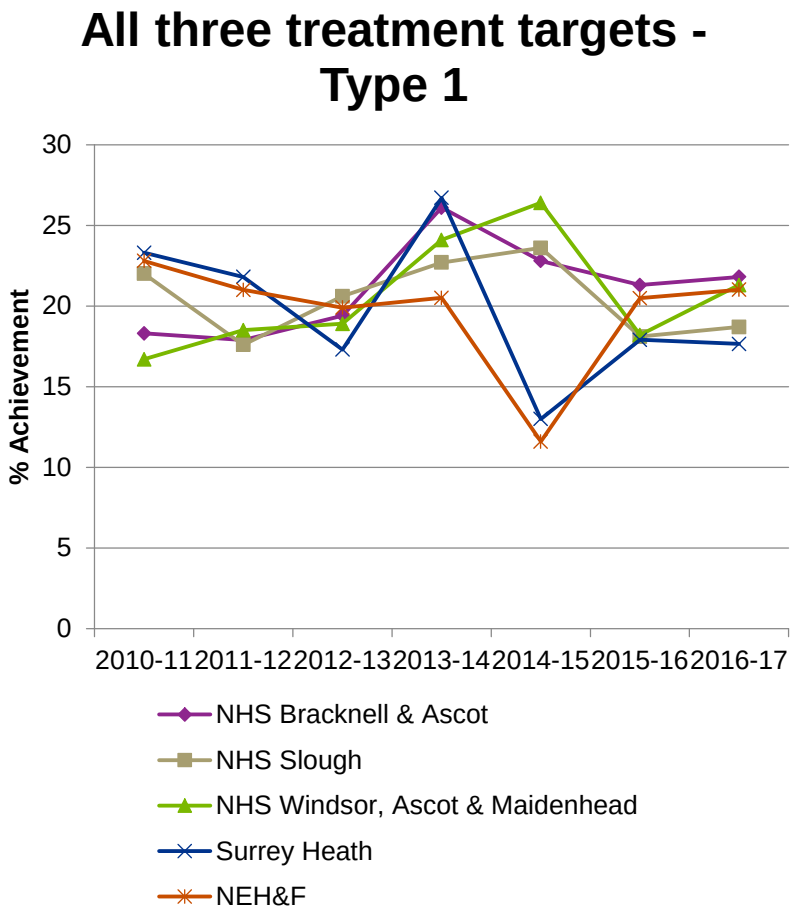
Structured Education - % Offered

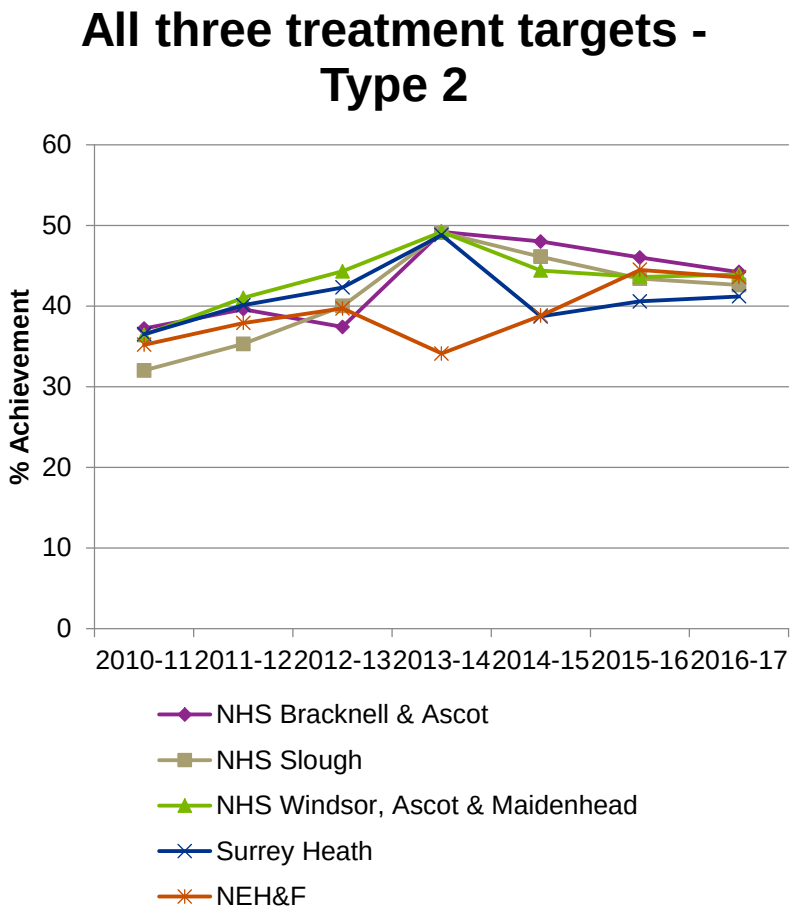




The percentage offered SE has, in general, increased

Treatment Targets





Treatment Targets

We have implemented a locally commissioned service model to support a person-centred approach to diabetes care (known as the House of Care model). In alignment with this model, practices will provide Lifestyle Management Support to their patients;

Training in this methodology has been rolled out to all practices and its delivery is being supported through a locally agreed payment with each practice. The practices with poorest results in achieving treatment targets are being supported through peer review and sharing of best practice.

Our ambition is to improve treatment control by 5% over the next 2 years.

We are also working to provide reports from EMIS Enterprise that provide up to date data at practice level on the three treatment control targets.

Treatment Targets

Most practices have been on the Care and Support planning training.

Quotes from practices – I have changed the way I run my clinics for diabetes – GP in Maidenhead

Practice Nurse in Bracknell-
‘ *So many patients having had their results beforehand , adjust their lifestyle , adjust their medications and access self support . They do not await their appointment to manage the condition’*

Bracknell uptake of Eight Care processes has improved as a result of adopting care and support planning

Multidisciplinary Foot care Team- MDFT

The Thames Valley Foot Pathway has been developed in conjunction with Frimley Healthcare Trust and formally adopted in East Berkshire;

Following a review of workforce gaps, we have implemented a redesign and expansion of the existing East Berkshire Multi Disciplinary Foot-care Team (MDFT), including fully integrating the provision of Podiatry services to provide better outcomes across the pathway;

We have introduced a 'Hot Foot' clinic phone line for direct referrals into the service where a healthcare professional is concerned about a patient's foot condition;

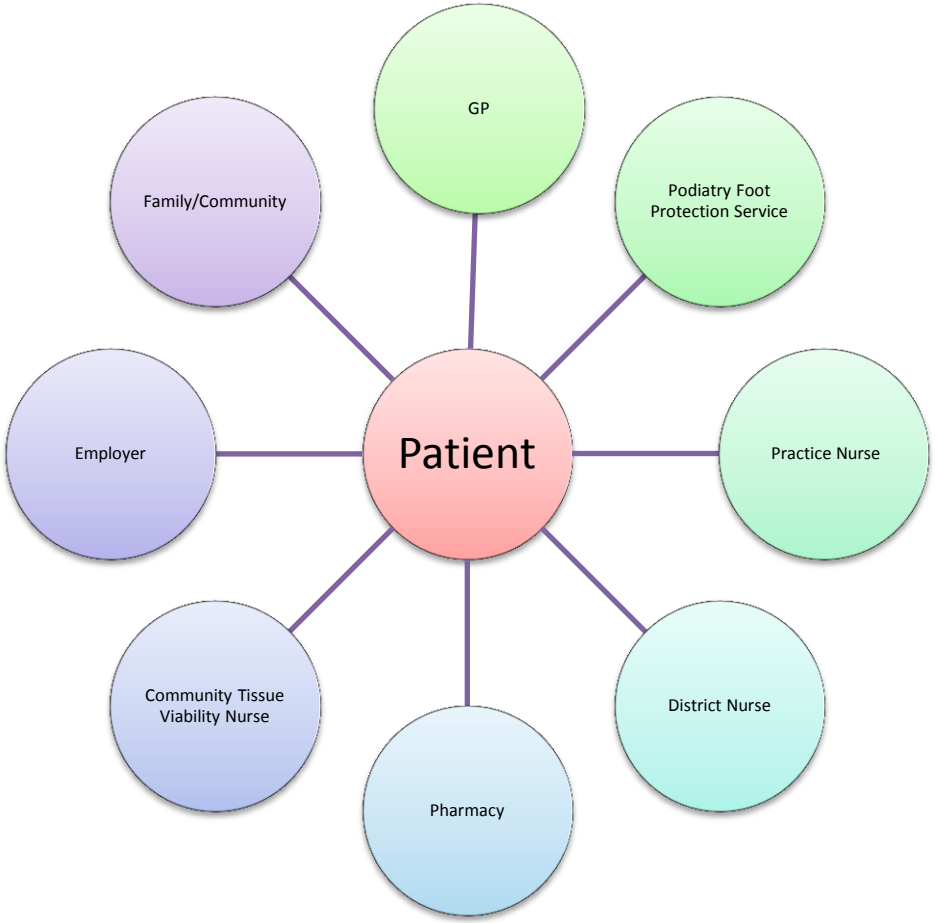
We are looking to expand these services from 5 days to 7 days where demand suggests it is needed.

MDFT- What it means for patients

Practice nurses are now accessing the clinic for advice. Rather than refer a patient in to hospital, they can access information in a timely manner and are able to manage with dressings, as well as to access appliances where appropriate.

East Berkshire Diabetes Footcare Pathway

'Average to excellent….'



Diabetes Inpatient Nursing Service

We have supported Frimley Healthcare Trust to expand the current DISN service at both Wexham Park and Frimley Park Hospitals;

The trust have been successful in recruiting to 3.5 of the 4 nurses posts funded to provide a 7 day service.

We will look to continue to expand to deliver a 7 day service where there is demand;

This service will continue to provide specialist diabetic care to patients in hospital and facilitate earlier discharge and reduced readmissions.

DISN

What it means for patients….

When you have to go into hospital as an emergency, and you have Diabetes the hospital will have access to specialist nurses whose role would be to support you in the hospital and ensure your care is planned as you return home

This means you reduce the length of your stay in hospital, the diabetes teams in and out of hospital

Stay connected via the Diabetes Specialist nurse

Workshop

We have several new and different approaches to supporting our patients with Diabetes-

How can you help us engage with our communities to

- **Raise awareness of Diabetes as a condition?**
- **Raise profile of these new or improved services?**
- **Support our communities to manage the condition?**

Diabetes Transformation Programme

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