Leeds Diabetes Service – Five Year Plan (2019-2024)

OUR AMBITION:
Working together to deliver the best outcomes for people at risk of or living with diabetes

Our diabetes service will achieve the triple aim of reducing inequalities, improving quality and financial sustainability

(As stated in the Leeds Health & Care Plan and Health & Wellbeing Strategy 2016-2021)

Our outcomes	How we will measure impact	Year 1 priorities
Priorities in future years	Key principles	Resources & definitions

Leeds City Council

NHS

The outcomes we want to achieve

Captured through person reported surveys and system data

- An improvement in early identification of diabetes and those at high risk of developing diabetes
- A reduction in the proportion of people at high risk of diabetes progressing to Type 2 diabetes
- Prevention of complications, with the aim of reducing the rate of people of all ages developing avoidable long term conditions
- An improvement in patient outcomes by reducing unwarranted clinical variation between primary care networks and providers
- An improvement in people's experience of the diabetes service
- An increase in people taking an active role in managing their condition and treatment
- An improvement in quality of life
- An increase in people returning to and maintaining their normal activities and functions
- A contribution to a reduction in premature mortality (PYLL) – with highest reduction in poorest areas
- *Outcomes related to obesity will form the basis of work for the Leeds Obesity Network, under development in 2019-2020*

"Mental health is a massive issue with managing diabetes " – person living with T1 diabetes

"There needs to be a mixture of clinically approved online and offline support" - carer

"We want a seamless service for diabetes management across the city" – health care professional

"We want people to notice and feel that the Leeds diabetes service is different and better" – Bryan Power, Clinical Lead

We will measure the impact of change in outcomes during 2019-2024:

Outcome (what we want to achieve)	**Output (what we will measure) -** *we will use Q4 2019-2020 data as a baseline*	**Source of information (how we will know)**
An improvement in early identification of diabetes and those at high risk of developing diabetes	Number of people diagnosed Number of people attending NHS DPP Number of people with gestational diabetes who receive an annual follow up (aspirational)	Leeds Care record NHSE NDPP service data
A reduction in the proportion of people at high risk of diabetes progressing to Type 2 diabetes	Number of people attending NHS DPP Number of people maintaining normal HbA1C 12 months after completion	NHSE NDPP service data
Prevention of complications for diabetes	Reduced amputation rates (minor and major)	National Diabetes Audit; Service level data
	Reduction in the number of people with diabetes experiencing cardiovascular complications (e.g. stroke, heart failure)	Service level data; CVD dashboard *(in development)*
	Reduction in the number of people registered blind or partially sighted or number of new patients needing laser or intravitreal treatments for retinopathy (aspirational)	National data (tbc)
	Reduction in the number of people assessed for renal replacement therapy (late CKD 5)	Service level data
An improvement in patient outcomes by reducing unwarranted clinical variation between primary care networks and providers	Treatment targets and % achievement of all eight care processes for people with diabetes split by area of deprivation, BAME, Learning Disabilities and serious mental illness	GP risk stratification tool (RAIDR); National Diabetes Audit
An improvement in people's experience of the diabetes service	Reduced waiting times	Service level data
	Increased access to advice and guidance	Service level data
	Reduced proportion of hospital-based outpatient provision	Service level data
	The extent to which people are accessing care closer to home	Service level data (single point of access)
	Reduced hospital admissions	Service level data
	Reduced number of steps to the pathway (for patients and for administration process)	Service level data (single point of access)
	The extent to which our diabetes service is working to our principles (aspirational)	People survey (tbc) and other measures (tbc)

We will measure the impact of change in outcomes during 2019-2024:		
Outcome (what we want to achieve)	**Output (what we will measure)** – *we will use Q4 2019-2020 data as a baseline*	**Source of information (how we will know)**
An increase in people taking an active role in managing their condition (this includes carers)	Proportion of people with Type 2 diabetes who return to normal HbA1C within 12 months of diagnosis	Type 2 Diabetes remission service evaluation; Leeds Care Record
	Improve achievement of treatment targets (HbA1C, Cholesterol and Blood Pressure)	National Diabetes Audit (NDA)
	Structured education attendance	Service level data and NDA
	Increased use of digital tools e.g. online learning, Freestyle Libre	Service level data
	Improved patient knowledge & confidence in self management	Patient Activation Measures; Service level data (patient survey)
	Reduction in the proportion of people who are diagnosed with diabetes and have no contact with the diabetes service	National Diabetes Audit (NDA)
An improvement in quality of life (future aspiration)	Improvement in things that matter most to people (link to wellbeing)	Self assessment; Service level data (e.g. Problem Areas in Diabetes - PAID)
	Improved access to psychological support	Self assessment
An increase in people returning to and maintaining their normal activities and functions (future aspiration)	To be defined	To be determined
A contribution to a reduction in premature mortality (PYLL) – with highest reduction in poorest areas (future aspiration)	Reduction in proportion of patients with Type 2 diabetes dying from Cardiovascular Disease (CVD)	To be determined

Year one priorities (2019-2020)

OUR AMBITION: Working together to deliver the best outcomes for people at risk of or living with diabetes
This is underpinned by 10 key principles
Our diabetes service will achieve the triple aim of reducing inequalities, improving quality and financial sustainability (As stated in the Leeds Health & Care Plan and Health & Wellbeing Strategy 2016-2021).

What we will achieve for all groups (those at high risk of and living with diabetes and people working in the diabetes service):

- ✓ Implementation of single point of access for specialist services (adults) – September 2019
- ✓ Ensuring that recommissioned IAPT service is accessible for people living with diabetes (improving access to psychological therapies) – November 2019
- ✓ Standardisation of information for healthcare professionals and people living with or at risk of diabetes – April 2019
- ✓ Workforce – training needs analysis for all healthcare professionals working in the diabetes service – July 2019

What we will achieve for specific groups:

- ✓ Type 1 – mapping data flows across the diabetes service to ensure treatment targets are recorded by any healthcare professional involved in care and shared with the individual – June 2019
- ✓ Type 1 – work to understand and better address the specific needs of people living with the condition who are struggling to engage with services – November 2019
- ✓ Type 2 Diabetes remission service (for people who have BMI over 30 and living with Type 2 diabetes and newly diagnosed in last 6 years) – to help lose weight and place diabetes into remission (testing impact) – July 2019
- ✓ Implement improved pathway for people with hypoglycaemia – May 2019
- ✓ Medicines management – review of blood glucose meters and strips – June 2019
- ✓ Refresh existing Freestyle Libre policy to ensure compliance with national guidance – May 2019

Related strategies: NHS England Long Term Plan, West Yorkshire & Harrogate Health and Care Partnership (ICS), Leeds Health & Care Plan, Leeds Health & Wellbeing Strategy 2016-2021, Leeds Digital Inclusion Strategy, Leeds Carers Strategy (under review)

Diabetes Service – Five Year Priorities (2019-2024)

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This is underpinned by 10 key principles

Our diabetes service will achieve the triple aim of reducing inequalities, improving quality and financial sustainability (As stated in the Leeds Health & Care Plan and Health & Wellbeing Strategy 2016-2021).

What we will achieve - for all groups (those at risk of and living with diabetes and people working in the diabetes service):

- ✓ Training delivered to health and social care professionals and people living with or at risk of diabetes (e.g. diabetic foot screening, NDPP, LEEDS Programme, DAFNE)
- ✓ Reduction in unwarranted variation including access to services and achievement of treatment targets across the city
- ✓ Development of a single diabetes service, including continued consultation with primary care and localities recognising that over 80% of care is delivered there
- ✓ Increased screening and symptom awareness of diabetes
- ✓ Increased use of new technologies (e.g. continuation of access to Freestyle Libre, insulin pumps and sensor augmented pump therapy for appropriate groups of people, and other digital tools to support self management)
- ✓ Expansion of working with community assets e.g. existing peer support networks and individuals

What we will achieve for specific groups:

- ✓ Re-procurement of NHS Diabetes Prevention Programme is tailored to meet needs of Leeds residents
- ✓ Improving the transition of young people into adult services (age 17 – 25 years)
- ✓ Improving our service to ensure that it better meets the needs of people living with a learning disability and/or significant mental ill health
- ✓ Ensuring every woman with gestational diabetes receives appropriate follow up in primary care post delivery

Commitment to review the strategy and identified priorities to ensure they remain relevant and we respond dynamically. Alongside this we need to ensure that we continue to develop relationships; working together, sharing experiences and improving outcomes (Co-production) and review our marketing and communications with people involved in prevention, treatment and care.

Our 10 key principles

We have described a set of 10 principles which are inclusive of all the needs of people at risk or living with, all types of diabetes as well as support for their families and carers. These principles also relate to those working in the Leeds diabetes service:

1.	We will work together with people (at risk or living with, all types of diabetes), their carers and health and care professionals to improve services.
2.	We will put people and carers at the heart of our strategy, focusing on the whole person and not just their condition (diabetes)
3.	We will improve access to services in local communities who are at greatest risk of developing diabetes and do whatever we can to support people who are at risk and identify those who have the condition as early as possible
4.	We will support people with diabetes and their carers to gain the confidence, knowledge and skills to look after their health, tailoring support to meet their needs
5.	We will do whatever we can to treat people with diabetes more effectively to prevent the risk of complications
6.	We will target and support services to tackle inequalities so that no matter where you live in Leeds you can access the best possible care available
7.	We will use information to help us deliver services that are likely to have the greatest impact for patients and their carers
8.	Our staff are important in delivering the best possible services; we will provide them with opportunities to develop their skills and work together across Leeds
9.	We will work differently across the system and adopt appropriate new technology wherever possible
10	We will make sure that we get best value for people living in Leeds within the available resources (staff and money) so that we can commit to delivering the principles of our strategy.

Resources

At high risk of developing diabetes

- Qdiabetes - Know Your Risk
- NHS Diabetes Prevention Programme (NHS DPP)
- Short Patient Feedback Film (NHS DPP)

For children and young people living with diabetes

- Looking after your feet
- How to inject insulin as a child
- Workbook for children and young people living with Type 2 diabetes
- Digibete - Helping young people and families manage Type 1 Diabetes
- Digibete - Helping young people and families manage Type 1 Diabetes Workbook
- JDRF - For Newly Diagnosed Children
- Transitioning from child to adult with Diabetes

For adults living with diabetes

- Diabetes in Pregnancy
- JDRF Pregnancy Toolkit
- Driving with Diabetes (DVLA)
- Safe Driving and DVLA (TREND UK)
- Diabetes UK - The Basics
- My Diabetes Booklet
- Information Leaflets (insulin and blood glucose)

For adults living with diabetes

Foot care:

- Looking after your feet Video
- Looking after your feet
- Foot Screening for Healthcare professionals

For adults living with Type 1 diabetes

- What is Type 1 Diabetes?
- Diabetes UK
- JDRF - Adult Type 1 Toolkit
- Self management and Skills (DAFNE)

For adults living with Type 2 diabetes

- What is Type 2 diabetes?
- Diabetes UK - What is Type 2 Diabetes?
- Self Management and Skills (LEEDS programme)

For adults living with diabetes

Diabetes UK 'How To' Films:

- How to inject insulin
- How to test your blood sugar levels
- How to measure your waist
- How to test your feet for sensitivity
- Information Leaflets (insulin and accurate measurements)
- Northumberland Foundation Trust Self Help Leaflets

Definitions

Diabetes Leeds: the service that cares for people living with or at high risk of diabetes (and their carers) . The service involves Leeds NHS staff whoever their employer is (e.g. GP practice or Leeds Confederation, Leeds Community Healthcare NHS Trust, Leeds Teaching Hospitals NHS Trust, NHS Leeds Clinical Commissioning Group or Leeds City Council. The service also works alongside people at high risk of or living with diabetes. The service also extends to delivering NHS care alongside voluntary and independent sectors e.g. care homes and charities.

Leeds GP Confederation: a 'not for profit social enterprise,' working to improve the health of the people of Leeds by strengthening and sustaining primary care. The Confederation provides a single voice for all the GP practices in the city.

Primary Care Networks: part of the NHS long term to improve the ability of practices to recruit and retain staff; to manage financial and estates pressures; to provide a wider range of services to patients and to more easily integrate with the wider health and care system. GP practices are expected to come together in geographical networks covering populations of approximately 30–50,000 patients.

People at high risk of developing Type 2 diabetes: means those people who are identified in one of two ways:

1) HbA1C 42-47 mmol/mol i.e. blood glucose (sugar) levels intermediate between normal and diabetic.
2) On a screening tool i.e. with a Qdiabetes score greater than 5.6 (https://qdiabetes.org/2018) or the Diabetes UK 'Know your risk' tool score greater than 16 (https://riskscore.diabetes.org.uk/start)

Improving Access to Psychological Therapies (IAPT): an NHS service designed to offer short-term psychological talking therapies to people suffering from anxiety, depression and stress.

Single point of access: we will have a single route for referrals which will help reduce waiting times and enable us to redesign how and where care and support is delivered and accessed.

Premature Years of Life Lost (PYLL) - Years of potential life lost or potential years of life lost, is an estimate of the average years a person would have lived if he or she had not died prematurely. It is, therefore, a measure of premature mortality. As an alternative to death rates, it is a method that gives more weight to deaths that occur among younger people. An alternative is to consider the effects of both disability and premature death using disability adjusted life years.

Alternative formats: if you have special communication needs or would like the Diabetes Summary in another format or in a different language, please contact us or ask a carer or friend to contact us on 0113 8435457 or email leedsccg.comms@nhs.net
More information: the full version of the Leeds Diabetes Strategy is available on the NHS Leeds CCG website - https://www.leedsccg.nhs.uk/