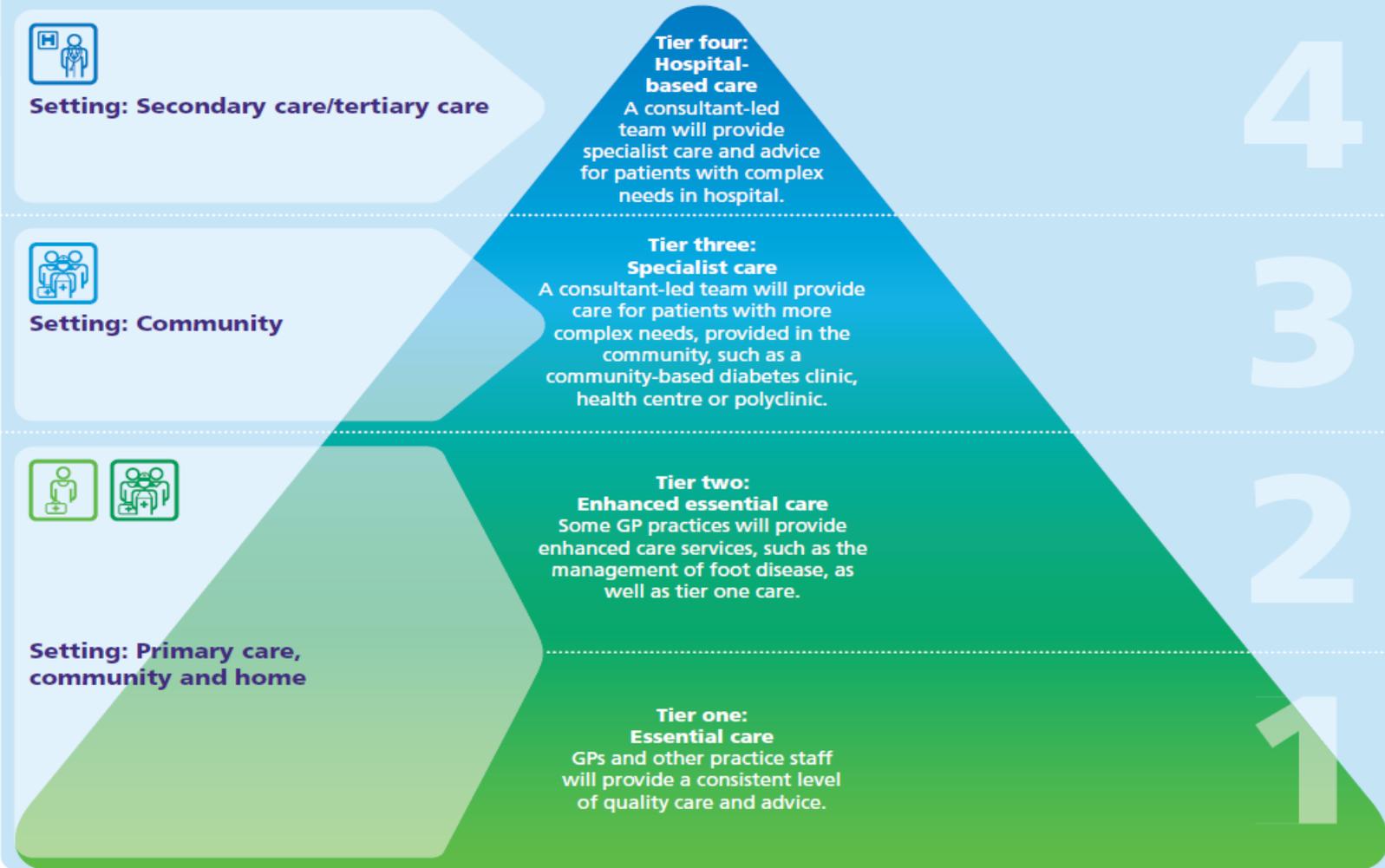


## Memorandum of Information – Integrated Diabetes Care Model

- ❖ Hillingdon CCG is considering the procurement of an Integrated Diabetes Service as part of the CCG’s Transformation Agenda and the NHS’s Out of Hospital Agenda.
- ❖ Our vision for Diabetes Care in Hillingdon is that we will work with Public Health and Primary Care to reduce the prevalence of diabetes whilst supporting those patients diagnosed with diabetes to remain at home or in their chosen care setting with less need for secondary care support (either planned or unplanned).
- ❖ We expect secondary care services to transition to a position where they are supporting the “Super Six” diabetic conditions defined as:
  - Inpatient Diabetes
  - Antenatal Diabetes
  - Diabetic Foot Care
  - Diabetic Nephropathy
  - Insulin Pumps
  - Type 1 Diabetes (specifically young people or individuals with poor control)
- ❖ Outside of the “Super Six” and any patients requiring complex care we anticipate all care being provided in a Community or Primary Care setting.
- ❖ We are also working towards all providers having access to a single IT system to share records.
- ❖ The service aims to provide the best fit between the needs of patients, the capabilities of providers and the financial envelope that HCCG has to work with.
- ❖ The focus of the proposed service model is on four key areas:
  - Increasing focus on Prevention and Patient Empowerment
  - Empowering Primary Care to manage the majority of patient care
  - Bridging the skill mix gap required to shift care out of hospital and into primary/community care
  - Focusing acute care on the “Super Six” conditions and complex patients

Figure 10: Settings of care



## Whole System Integrated Diabetes Care Model HCCG

### Prevention & Patient Empowerment programme

- validated risk-assessment tool
- Self-Management Education Programmes
- provision of Lifestyle change programmes
- Streamline Health Champions Programme
- Patient & Carer Information Hub
- NHS Health Checks

### Empower Primary care to manage majority of care

1. Core
    - Screening
    - Prevention
    - Regular reviews
    - Prescribing
    - Audit
  2. Enhanced
    - Insulin
    - Patient Education
    - Cardiovascular
    - Housebound/care homes
- .....
- Network based model
  - Dashboards with KPIs

### Bridge Skill Mix via Intermediate

- DSN aligned to each practice/network/locality
- Support shift acute activity into primary care
- DSN led Triage
- Support Network dashboard of KPIs
- Patient/practice telephone /web/home visit support

### Super Six Acute

1. Insulin pumps
2. Antenatal Diabetes
3. Foot care
4. Renal – low/low GFR/dialysis
5. Paediatric, adolescent
6. Inpatient

**Prevalence of patients with Diabetes Mellitus (ages 17) in 2013/14**

