Collaborating for improving diabetes care in Ealing, London: a time for cautious optimism, years 2011 to 2018

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Received: 24 May 2019
Accepted in revised form: 5 August 2019

Abstract
In 2011, providers and commissioners met to review diabetes care in Ealing, London, UK. The needs assessment showed that there was: a high prevalence of diagnosed and undiagnosed people with diabetes; a projected 50% increase in diagnosed people with diabetes during the ensuing decade; a lack of resources deployed in meeting the needs of people with diabetes; a necessity to involve people with diabetes to shape local diabetes care; and, worryingly, outcomes were poor.

This paper describes how to integrate different contributions to health and care at community level – community-oriented integrated care – as has been advocated worldwide for many years. Community-oriented integrated care is complicated because it requires a whole system approach, involving collaboration between commissioners and providers, specialists and generalists, and a range of local organisations, patients and citizens.

Commissioners and providers in Ealing collaborated with its neighbouring clinical commissioning groups between 2011 and 2018, in a significant number of initiatives, in improving diabetes care that enabled the achievement of certain initiatives more cost-effectively, and at scale and pace. Copyright © 2019 John Wiley & Sons.

Practical Diabetes 2019; 36(6): 212–218

Key words
integrated care; community care; diabetes; three treatment targets

Introduction
This paper describes a way to plan and deliver a system for improving diabetes care using Ealing’s redesign of diabetes services as an exemplar.

In 2011, providers and commissioners met to review diabetes care in Ealing, North West London. The needs assessment showed that there was: a high prevalence of diagnosed and undiagnosed people with diabetes; a projected 50% increase in diagnosed people with diabetes during the ensuing decade; a lack of resources deployed in meeting the needs of people with diabetes; a necessity to involve people with diabetes to shape local diabetes care; and, worryingly, outcomes were poor.

In the 2009/10 National Diabetes Audit, Ealing Primary Care Trust (PCT) was below the England and Wales average in a significant number of diabetes care metrics – in particular, only 59% of patients with type 2 diabetes had an HbA1c <58mmol/mol vs 66.6% for the England and Wales average.1

Previous PCT strategies had not resulted in significant clinical behaviour change in either primary or secondary care teams, nor had they addressed the underlying need for investment and innovation in the delivery of diabetes care.

Methodology for service development changes
In 2011, a series of workshops were held in Ealing – facilitated by Diabetes UK – to establish the views of the local residents, people with diabetes and carers of people with diabetes about diabetes care, and to understand what they would like to see from a future new model of diabetes care. The outcomes of these workshops directly influenced the diabetes strategy that was developed.

In late 2011, a number of innovative initiatives were developed and commissioned; this holistic approach would yield the improvements that people with diabetes, providers and commissioners in Ealing were seeking.

The London Borough of Ealing is the third largest in population size, and 11th largest in geographical area, of the 33 London boroughs. It is located in the outer part of North West London. Ealing is ethnically
diverse – in 2011, 49% gave their ethnicity as white, 30% as Asian, 15% as black and 4.5% as of mixed or multiple ethnicity, the remaining identifying as Arab or of other ethnicity. NHS Ealing Clinical Commissioning Group (CCG) was formed on 1 April 2013 and is a clinically-led membership organisation. NHS Ealing CCG commissions health services for its GP registered population – its geographical boundary is co-terminus with that of the London Borough of Ealing. As at 1 April 2019, NHS Ealing CCG has 75 member general practices, working in seven GP networks ranging in population sizes from 55,287 to 77,752 with a combined registered population of 444,574.

Prior to 2012, all people with diabetes were seen either in general practice or in secondary care clinics. Using the Healthcare for London model as a base, the clinical pathway was fundamentally revised such that six new community clinic sites were established within Ealing so that people with diabetes moved along a continuum from general practice, to community clinics to secondary care clinics in relation to their disease complexity. This model also allowed shared care with specialists inputting into the care of patients along this continuum. This led to the Ealing ‘Three Tier System’ to take diabetes care out of hospital into the community. Between April and October 2012, 1903 patients were transferred from hospital (Tier 3) to community (Tier 2) clinics and 517 to general practice (Tier 1) clinics.

From 2012–2014, Ealing joined the North West London Integrated Care Pilot, which was a collaboration of the eight CCGs in North West London, coordinated approach to key initiatives. The years 2015 onwards therefore saw further innovative initiatives in improving diabetes care in Ealing as part of this collaboration. In mid-2018, Ealing joined the North West London Diabetes Transformation Programme, a collaboration of the eight CCGs in North West London to optimise diabetes care.

This paper describes how to integrate different contributions to health and care at community level – community-oriented integrated care – as has been advocated worldwide for many years. Community-oriented integrated care is complicated because it requires a whole-system approach, involving collaboration between commissioners and providers, specialists and generalists, and a range of local organisations, patients and citizens.

Key initiatives

**Investment in community specialist diabetes staff**
To lead clinical services, a consultant diabetes nurse, three additional community diabetes specialist nurses, one whole-time equivalent community diabetes consultant, a community diabetes specialist podiatrist and a community diabetes specialist dietitian were commissioned and employed by the local integrated care organisation which provided both acute and community services within Ealing. The community diabetes consultant role was split across three consultant job plans to ensure that there was engagement from all consultant diabetes staff and to create vertical integration.

**Creation of six community diabetes clinics across Ealing**
This was linked to other community services – e.g. podiatry, dietetics – with diabetes specialist nurse-led clinics and diabetes consultant advice and clinical supervision. This resulted in having capacity for over 6000 new patient clinical contacts per year. With the creation of this Tier 3 service, patients attending hospital clinics were reviewed virtually using the hospital clinical database and offered follow up in the new community diabetes service if they met the agreed clinical criteria. A new system architecture was developed such that seven geographic areas of GP registered population cohorts, of between 50,000 and 70,000 patients, were formed into seven GP networks. Strong collaborative relationships between practices and community services developed during this time.

**Allocation of resources**
Southall is a large suburban district within Ealing which has an ethnically diverse population – the majority are of South Asian origin; there are high levels of social deprivation and below average health literacy. While Southall houses 27% of the population of Ealing, it has a high prevalence of diabetes, such that 42% of the total number of people with diabetes in Ealing live in Southall. To achieve an equitable approach in the provision of community diabetes services in Southall, 40% of the total newly-commissioned community diabetes services were deployed in Southall, hence the new model ensured clinical resources were allocated commensurate with population needs.

**Agreement of clinical criteria for location of care**
This was based on the Portsmouth Super Six model for hospital diabetes services with some local modification. As specialist expertise is finite, these were the groups of patients who were thought most likely to benefit from specialist hospital diabetes services, therefore allowing specialists to focus on the most complex patients: those at greatest risk of the complications of diabetes. The cohort for hospital clinics was defined as follows: type 1 diabetes, young adults, preconception diabetes care, antenatal diabetes, diabetes and foot ulcers, advanced renal disease, advanced liver disease, and diabetes with significant other comorbidities.

**Diabetes enhanced services delivered by primary care**
Since 2015, NHS Ealing CCG, in collaboration with four other neighbouring CCGs in North West London,
commissioned a population-based Diabetes Specification which incentivised practices to improve the percentage of patients receiving all nine key care processes annually for achieving NICE recommended treatment targets, and in further years of the contract a stretch to higher thresholds for achievement of these treatment targets. The contract was paid against diabetes prevalence in practice, ensuring that the payment was fair, and remunerated practices where the diabetes prevalence was particularly high. Sixty percent of the payment was linked to the performance of the local GP network which added peer-to-peer sharing of learning and a push to reduce unwarranted variation in networks. Care planning, initiated as part of the integrated care pilot, was developed further with adequate time modelled within the primary care contract to support collaborative discussion with people with diabetes and the use of motivational interviewing principles. Key enablers of quality improvement include the use of diabetes dashboards, clinical system optimisation and multidisciplinary group discussions.6

Support for primary care diabetes teams

- Education for primary care staff in managing people with type 2 diabetes was provided by regular teaching days with a structured programme for practice nurses and GPs. At least six teaching days per year were provided, covering both oral and injectable therapies. Multi-professional groups from single practices were encouraged to embed the learning across a practice.
- Access to quick clinical advice for primary care teams during the week, from 9am to 5pm, was provided by a mobile telephone help line staffed by the community diabetes nurses.
- Specific GP practices with poorer outcomes in the National Diabetes Audit were targeted for more focused input from community diabetes nurses with practice visits, virtual clinics and clinical advice.
- Treatment guidelines for diabetes were made available; these clear guidelines aimed to standardise diabetes care across the five CCGs and provide accessible recommendations via hyperlinks from GP clinical IT systems. These guidelines were evidence-based and developed by the diabetes leads of the five CCGs; they are available online and updated regularly.7
- Further developments in the diabetes service specification include the provision for quarterly multidisciplinary group meetings to review primary care network achievement and monthly practice multidisciplinary team meetings/virtual clinics to provide specialist support for patients off target or with more complex diabetes.

Support for people with diabetes

- Structured education for people with type 2 diabetes – Public Health modelled data suggested that there were 100 people newly-diagnosed with diabetes every month, yet the structured education programme only had capacity for 40 of these patients. The commissioners therefore funded increased capacity for structured education for both all the newly-diagnosed people with type 2 and for 5% of the prevalent population to be able to receive structured education annually.
- Structured education for people with type 1 diabetes – the type 1 structured education programme based on the Bournemouth BERTIE course, which had halted due to lack of funding prior to 2011, was re-started and was routinely offered to all people with type 1 diabetes at the next appointment.
- A Diabetes Re-design Board with people with diabetes, Diabetes UK and community group representatives met every two months of the first two years to oversee the implementation of the service changes.

<table>
<thead>
<tr>
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<th>2013/14</th>
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<td>47.3%</td>
<td>40.7%**</td>
<td>49.4%</td>
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<td>37.3%</td>
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<td>47.4%**</td>
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<td>59.0%</td>
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<td>58.8%</td>
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*In 2014/15 there was a data quality issue with extracting urine albumin:creatinine ratio results from practice software. **In 2016/17 there was a data quality issue with extracting foot surveillance data from practice software.

New community diabetes specialist podiatrist

- To lead the foot protection team and liaise with the secondary care based multidisciplinary foot care team.
- Facilitated the development of an integrated diabetes foot care service so that patients can be easily stepped between secondary care and community diabetic foot clinics depending on their needs.
- Regular attendance by members of both teams at biannual London Diabetic Foot Network Meetings.
allowed the sharing of best practice and local implementation of this.

- Establishment of a simple referral form and clear referral pathway allowed patients with diabetic foot problems rapid access to the multidisciplinary foot team.

- Development of local antibiotic guidelines with the microbiology team, dissemination of these guidelines to primary care through education sessions for GPs and practice nurses, and work with the outpatient parenteral antibiotic therapy team have allowed more patients with diabetic foot infections to be managed as outpatients rather than needing hospitalisation.

- Weekly diabetic foot multidisciplinary team meetings with attendance from an appropriate mix of clinical professionals allowed the discussion of complex cases, shared decision making and shared learning.

**Results**

The National Diabetes Audit (NDA) is the principal national database of diabetes care metrics and is published annually. The NDA data for the year 2017/18, ending March 2018 which is the final year period examined by this paper, were published in December 2018. The Secondary Uses Service (SUS) is a single comprehensive repository for health care data in England which enables a range of reporting and analyses to support the NHS in the delivery of health care services; the SUS data were the principal database for our results evaluation of emergency admissions for a range of diabetes-related conditions.

### Table 1: Results for NHS Ealing CCG

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<tr>
<td>HbA1c &lt;48mmol/mol</td>
<td>71.0%</td>
<td>5.5%</td>
<td>7.9%</td>
<td>8.7%</td>
<td>10.4%</td>
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<td>28.0%</td>
<td>27.5%</td>
<td>28.5%</td>
<td>34.5%</td>
<td>32.1%</td>
<td>34.6%</td>
<td>34.7%</td>
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<tr>
<td>HbA1c &lt;86mmol/mol</td>
<td>78.5%</td>
<td>78.4%</td>
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<td>85.5%</td>
<td>85.5%</td>
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<td>85.5%</td>
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<tr>
<td>BP &lt;140/80mmHg</td>
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<td>78.1%</td>
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<tr>
<td>Cholesterol &lt;5mmol/L</td>
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<td>72.6%</td>
<td>75.6%</td>
<td>74.7%</td>
<td>73.6%</td>
<td>72.4%</td>
<td>69.4%</td>
<td>73.6%</td>
</tr>
<tr>
<td>NHS Ealing CCG: all 3 targets</td>
<td>11.9%</td>
<td>16.5%</td>
<td>16.2%</td>
<td>16.2%</td>
<td>18.9%</td>
<td>19.3%</td>
<td>18.1%</td>
<td>18.9%</td>
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Table 2. Type 1 diabetes: NHS Ealing CCG attainment (%) of National Diabetes Audit 3 treatment targets for HbA1c, blood pressure, and cholesterol, and % attainment of all 3 treatment targets vs England and Wales

### Diabetes prevalence in NHS Ealing CCG

Between 2012 and 2018 there has been a considerable increase in the absolute numbers of people diagnosed with diabetes. Over this period there was an increase of 9184 cases representing a 45% increase. Taking into account the total GP registered population in Ealing, the prevalence of diabetes increased from 5.4% to 6.8% over this time period. At the same time the undiagnosed cohort has decreased considerably such that, at March 2018, 1104 cases were thought to be undiagnosed. The undiagnosed cohort has decreased even further a year later and, as at March 2019, 690 cases were thought to be undiagnosed. Public Health modelling data from 2012 estimated the undiagnosed cohort at 6000 cases. As at 1 April 2019, NHS Ealing CCG has 30,571 people with diagnosed diabetes and a diabetes prevalence of 6.9%.

### Key care processes

Table 1 shows the percentage of patients completing all eight key care processes compared to England and Wales 2013–2018. For type 1 diabetes the percentage of patients in NHS Ealing completing all eight key care processes was above the England and Wales average for all years except 2014. For type 2 diabetes the percentage of patients in NHS Ealing completing all eight key care processes was above the England and Wales average in 2015 and 2017, but below this in the other years. These figures represent a proxy measure for patient annual reviews and opportunities to optimise patient care outcomes, e.g. cardiovascular risk reduction, detection of end-organ damage and care planning. These improvements in the percentage of patients completing all eight key care processes arise during years of progressively increasing prevalence of diabetes cases.

### NDA's three treatment target achievement

**Type 1 diabetes.** Table 2 shows the historical change in attainment of the NDA's three treatment targets (3TTs) for type 1 diabetes. There is a progressive increase in attainment which becomes better than the England and Wales average in 2015/14 and continues. In 2017/18 the 3TTs (HbA1c <58mmol/mol, BP <140/80mmHg and total cholesterol <5.0mmol/L) was achieved in 23% of type 1 patients vs 18.6% in England and Wales. We hope that this has been the result of more focused secondary care clinics and enhanced structured education courses for our patients with type 1 diabetes. For the individual HbA1c metrics the number of very poorly controlled type 1 diabetes patients with HbA1c >86mmol/mol has reduced significantly since 2009 and is now below the England and Wales average. Patients with HbA1c...
Collaborating for improving diabetes care in Ealing, London

**Table 3.** Type 2 diabetes: NHS Ealing CCG attainment (%) of National Diabetes Audit 3 treatment targets for HbA1c, blood pressure, and cholesterol, and % attainment of all 3 treatment targets vs England and Wales.

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<tbody>
<tr>
<td><strong>HbA1c &lt;48mmol/mol</strong></td>
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<td>21.7%</td>
<td>21.0%</td>
<td>22.2%</td>
<td>24.1%</td>
<td>23.0%</td>
<td>24.9%</td>
<td>27.0%</td>
<td>28.4%</td>
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<tr>
<td><strong>HbA1c &lt;58mmol/mol</strong></td>
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<td>59.0%</td>
<td>62.5%</td>
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<tr>
<td><strong>HbA1c &lt;86mmol/mol</strong></td>
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<td>93.0%</td>
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<tr>
<td><strong>BP &lt;140/80mmHg</strong></td>
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<tr>
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<td>78.3%</td>
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<tr>
<td><strong>NHS Ealing CCG: all 3 targets</strong></td>
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<td><strong>England &amp; Wales: all 3 targets</strong></td>
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<td>35.9%</td>
<td>41.4%</td>
<td>41.0%</td>
<td>40.4%</td>
<td>40.8%</td>
<td>40.1%</td>
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<58mmol/mol in Ealing CCG showed a 7.6% absolute increase vs 1.3% absolute increase in England and Wales between 2009 and 2018.

**Type 2 diabetes.** Table 3 shows the historical change in attainment of the 3TTs for type 2 diabetes. From a low baseline there is a progressive increase in attainment which becomes better than the England and Wales average in 2017/18. In 2017/18, 41.7% of Ealing patients with type 2 diabetes achieved the 3TTs (HbA1c <58mmol/mol, BP <140/80mmHg and total cholesterol <5.0mmol/L) vs England and Wales average of 40.1%. For the individual HbA1c metrics there was a 6.6% absolute increase in HbA1c <58mmol/mol and a 8.1% absolute increase in HbA1c <48mmol/mol between 2009/10 and 2017/18. We believe that due to the low initial baseline in 2009/10, poor skill mix and the large numbers involved it took longer for the performance to improve considerably.

**Comparison to local CCGs.** It is interesting to compare the longitudinal trends in 3TTs between England and Wales, Ealing CCG and local CCGs. For type 2 diabetes in England and Wales there has been a 6.4% absolute increase in 3TT achievement vs 12.5% in Ealing, 10.2% in Hounslow and 3.6% in Hammersmith and Fulham in the time period 2010/11 to 2017/18. It is noticeable that the 3TT performance for England and Wales has plateaued since 2013/14. The larger increase in Ealing is partly due to the lower baseline starting position. Examining the individual 3TT components the increase is being driven by better performance in both HbA1c <58mmol/mol and BP <140/80mmHg. For type 1 diabetes in England and Wales there has been a 2.1% absolute increase in 3TT achievement vs 6.3% in Ealing, 5.5% in Hounslow and -0.5% in Hammersmith and Fulham in the time period 2010/11 to 2017/18. Examining the individual 3TT components the increase is again being driven by better performance in both HbA1c <58mmol/mol and BP <140/80mmHg with static performance on cholesterol <5.0mmol/L. The sustained improvement in performance for both type 1 and type 2 diabetes care metrics suggests that there is a system-wide change.

**Foot care activity metrics**

Data collected from Hospital Episode Statistics (HES) are collated by Public Health England to produce diabetes foot care activity profiles for CCGs in England. The most recent profiles show activity data between 2012/13 and 2017/18. NHS Ealing CCG, in common with many London CCGs, has a lower than average rate of amputations for people with diabetes. In 2012/13 major amputations were 5.7 per 10,000 population years of diabetes (age and ethnicity corrected) vs 8.3 per 10,000 population years of diabetes in England. In 2017/18 the rates were similar at 5.8 per 10,000 population years of diabetes in NHS Ealing CCG vs 8.2 in England per 10,000 population years of diabetes. Due to the low event rates it is not possible to show that these rates are statistically different from the England mean, although the trend is consistent. For minor amputations the rate has increased in NHS Ealing CCG from 9.4 vs 20.4 in England in 2012/13 to 16.8 vs 21.4 in England in 2017/18 per 10,000 population years. The cause for the increase in minor amputations is unclear. In line with national trends, the number of inpatient episodes for diabetic foot disease has increased in NHS Ealing CCG from 799 in 2012/13 to 1119 in 2017/18, although the mean length of stay has decreased from eight to seven days over that time period.

**Diabetes clinical pathways**

To assure the CCG that patient flows were changing, an audit of patients seen in hospital clinics at Ealing Hospital was undertaken in 2016 and showed that only 9.9% of patients were not meeting the agreed clinical criteria for hospital clinics.

**Avoided emergency admissions**

Using a similar methodology to that of Kar et al., we modelled the likely impact of the changes in diabetes care on avoided emergency admissions. Table 4 presents estimated avoided emergency admissions for a range of diabetes-related conditions. Estimated admissions avoided were calculated by comparing observed and expected...
admissions for patients with diabetes. The admission rate for each condition (emergency admissions/number of patients on GP practice registers in Ealing) in 2012/13 was applied to the diagnosed prevalence annually until 2017/18 to determine expected admissions. These were subtracted from actual admissions to estimate admission avoidance. Admissions data were sourced from SUS and diagnosed prevalence from published Quality and Outcomes Framework statistics for 2012/13 to 2016/17 and local GP practice systems for 2017/18. Despite annual increases in the prevalence of diabetes and sustained or increasing numbers of emergency admissions for the study conditions, there is evidence from this analysis of a reduction in emergency admission rates and admission avoidance. These were most notable for diabetes mellitus, diabetic ketoacidosis and myocardial infarction.

Emergency admissions for diabetes mellitus ranged between 315 and 333 from 2012/13 to 2017/18 but the estimated admissions avoided increased annually to 101 during 2017/18. This was mirrored for diabetic ketoacidosis until 2015/16, although this was followed by an annual reduction to a level where for the first time during the focus period there were theoretically avoidable admissions during 2017/18. The number of admissions for myocardial infarction reduced annually between 2013/14 and 2015/16 then increased in 2016/17 and 2017/18 to the same level as that in 2013/14. However, admission rates reduced substantially despite increases in 2016/17 and 2017/18, and there were still a substantial number of estimated avoided admissions. From basic hypothesis testing, the changes in admission rates for these conditions between 2012/13 and 2015/16 in particular are highly statistically significant (p<0.01) and remained so for diabetes mellitus up to and including 2017/18.

Table 5 presents an estimate of the value of avoided emergency admissions during 2013/14 to 2017/18. The number of admissions for myocardial infarction increased annually to 101 during 2017/18. Estimated savings were £357,132 in 2016/17 and £273,342 for diabetes mellitus. The number of admissions for diabetes mellitus increased annually from £32,517 during 2013/14 to £200,184 in 2017/18. Estimated savings were sustained for myocardial infarction over the period but varied annually for the other conditions.

**Discussion**

While diabetes care metrics (including NICE recommended treatment targets) as evidenced by the NDA have been improving across England and Wales over the last 10 years, in NHS Ealing CCG the improvement appears to be greater than the national trend. There is evidence of a statistically significant change in the emergency admission rates for people with diabetes; and associated estimated avoided admissions for primary diagnoses of diabetes mellitus, diabetic ketoacidosis and myocardial infarction subsequent to NHS Ealing CCG commissioning a new innovative diabetes model of care in 2012.

It is likely that these improvements in the achievement of NICE recommended treatment targets and a reduction in diabetes complications have been achieved by skilled, engaged and motivated primary care, community and specialist teams working collaboratively and being enabled by key initiatives during the years of these improvements; key initiatives include improving access to specialists for the most complex people with diabetes and enabling people with diabetes to access appropriate structured education.

While it is not possible to draw a distinction on which investment and innovation of the new diabetes

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<th>Primary diagnosis / procedure</th>
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<td>£77,651</td>
<td>£156,553</td>
<td>£161,099</td>
<td>£200,184</td>
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<td>(of which diabetic ketoacidosis)</td>
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<td>Myocardial infarction</td>
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<td>£266,902</td>
<td>£242,705</td>
<td>£138,049</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-£84,775</td>
<td>£172,407</td>
<td>£261,539</td>
<td>£357,132</td>
<td>£273,342</td>
</tr>
</tbody>
</table>

Table 4. Estimated number of avoided emergency admissions for NHS Ealing CCG patients by selected diabetes-related diagnoses and procedures, 2013/14 to 2017/18

<table>
<thead>
<tr>
<th>Primary diagnosis / procedure</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebrovascular accident</td>
<td>8</td>
<td>-8</td>
<td>8</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>17</td>
<td>40</td>
<td>75</td>
<td>92</td>
<td>101</td>
</tr>
<tr>
<td>(of which diabetic ketoacidosis)</td>
<td>(16)</td>
<td>(11)</td>
<td>(50)</td>
<td>(32)</td>
<td>(-2)</td>
</tr>
<tr>
<td>Hypoglycaemia</td>
<td>12</td>
<td>15</td>
<td>-12</td>
<td>-1</td>
<td>17</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>-21</td>
<td>23</td>
<td>56</td>
<td>54</td>
<td>26</td>
</tr>
<tr>
<td>Amputations</td>
<td>-10</td>
<td>1</td>
<td>-16</td>
<td>-12</td>
<td>-9</td>
</tr>
</tbody>
</table>

Table 5. Estimated value (£) of avoided emergency admissions for NHS Ealing CCG patients by selected diabetes-related diagnoses and procedures, 2013/14 to 2017/18
Collaborating for improving diabetes care in Ealing, London

KEY POINTS

- In CCGs, where there is a failure to achieve high levels of diabetes care metrics, including NICE recommended treatment targets, there is a need to re-evaluate their approaches to commissioning and providing diabetes care and the work in Ealing provides transferable principles that can be adopted.
- People with diabetes are engaged to design a new model of diabetes care at the beginning of the process. There is a collaborative and shared care ethos of working between all providers in a new model of diabetes care.
- Providers’ resources are deployed commensurate with population need.
- Commissioners to ensure investment at critical moments to address population need, thereby ensuring sufficient capacity and capability of providers of diabetes services.
- Focus on quality improvement and reducing unwarranted variation in diabetes care through peer review of data.
- Commissioners and providers have strong clinical leadership and work collaboratively.

Additionally, there are clear synergies with the developing NHS England Primary Care Network agenda, which will provide further support for bigger teams of health professionals working together in local communities. Ealing is already progressing well on this journey of improving diabetes care, and the additional resources and incentives will provide further support for the system-wide transformation.

In Ealing over the last seven years more people with diabetes have achieved the NICE recommended targets for blood pressure, cholesterol and HbA1c. Pivotal to these improvements have been the collaborative working between primary, community and secondary care providers, the collaborative approach between commissioners and providers of diabetes services, and the collaboration between Ealing and neighbouring CCGs.

Over time, these improvements in blood pressure control, lipid management and improved glycaemic control in people with diabetes in Ealing will lead to a reduction in the premature mortality and morbidity associated with the complications of diabetes: it is a time for cautious optimism.

Acknowledgements

We wish to thank Diabetes Nurse Consultant Grace Vanterpool MBE, members of the Ealing Diabetes Re-design Board, Ealing primary care teams and Ealing community and specialist diabetes services, Dr Sanjeev Mehta, Dr Varunika Lecamwasam, Delia O’Rouke, Melody Dhinra, Dr Mohini Parmar, Tessa Sandall, and Professor Paul Thomas.

Declaration of interests

Dr Kevin Baynes has received educational bursaries from Novo Nordisk, Lilly, Sanofi, and AstraZeneca.

There are no conflicts of interest declared for Dr Raj Chandok, Dr Tony Willis, Maurice Birnbaum, and Neha Unadkat.

References