Potential Vision for Diabetes Care…

Stirling Court Hotel, Stirling
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#improvediabetes2018
Outline

• What is a ‘vision’?
• Developing a ‘vision’ for diabetes care within national priorities?
• What is the potential vision for diabetes care?
• Aim of the workshops

#improvediabetes2018
Vision: Definition

**Noun**

1. the faculty or state of being able to see.  
   "he had defective vision"

2. the ability to think about or plan the future with imagination or wisdom.  
   "the organisation had lost its vision and direction"

3. an experience in which you see things that do not exist physically, when your mind is affected by something such as deep religious thoughts or drugs or mental illness.
Developing a ‘vision’ for diabetes care within national priorities?
National Clinical Strategy

• High level & strategic
• Direction of travel for health and social care
• Attempts to address challenges facing healthcare
• Why we need change?
• Primary & community care
• Secondary & tertiary care
• The need for ‘realistic medicine’
Our vision is that by 2020 everyone is able to live longer healthier lives at home or in a homely setting. We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management.

Main healthcare challenges

Multi-morbidity  Ageing
Multimorbidity

Percentage of patients with the row condition who also have the column condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage who only have the row condition*</th>
<th>Mean No of conditions in people aged &lt;65 years with row condition</th>
<th>Mean No of conditions in people aged ≥65 years with row condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease</td>
<td>8.8</td>
<td>3.4</td>
<td>4.4</td>
</tr>
<tr>
<td>Hypertension</td>
<td>21.9</td>
<td>2.5</td>
<td>3.6</td>
</tr>
<tr>
<td>Heart failure</td>
<td>2.8</td>
<td>3.9</td>
<td>5.6</td>
</tr>
<tr>
<td>Stroke/transient ischaemic attack</td>
<td>6.0</td>
<td>3.6</td>
<td>4.8</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>6.5</td>
<td>3.3</td>
<td>5.0</td>
</tr>
<tr>
<td>Diabetes</td>
<td>17.6</td>
<td>2.9</td>
<td>6.5</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>14.3</td>
<td>2.8</td>
<td>4.5</td>
</tr>
<tr>
<td>Painful condition</td>
<td>12.7</td>
<td>3.1</td>
<td>4.3</td>
</tr>
<tr>
<td>Depression</td>
<td>25.4</td>
<td>2.6</td>
<td>4.9</td>
</tr>
<tr>
<td>Dementia</td>
<td>5.3</td>
<td>4.1</td>
<td>4.6</td>
</tr>
</tbody>
</table>

* Percentage who do not have one of 39 other conditions in the full count
Deprivation & Scotland

Map 17 – Scottish Index of Multiple Deprivation (2012)

Overall Rank - Data zone quintiles
- Red: Most Deprived
- Orange: Intermediate 1
- Yellow: Intermediate 2
- Green: Least Deprived

Deprivation in Scottish Cities

Blue areas are amongst the 20% least deprived in Scotland
Red areas are amongst the 20% most deprived in Scotland

Aberdeen
Dundee
Edinburgh
Glasgow
## Deprivation, Healthy Life & Life Expectancy

<table>
<thead>
<tr>
<th></th>
<th>Males – Least deprived</th>
<th>Males – Most deprived</th>
<th>Female – Least deprived</th>
<th>Female – Most deprived</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life Expectancy (years)</strong></td>
<td>81.7</td>
<td>71.3</td>
<td>84</td>
<td>77.2</td>
</tr>
<tr>
<td><strong>Healthy Life expectancy (years)</strong></td>
<td>69.1</td>
<td>48.3</td>
<td>71.9</td>
<td>51.5</td>
</tr>
<tr>
<td><strong>Expected years of “Ill health”</strong></td>
<td>12.6</td>
<td>23</td>
<td>12.1</td>
<td>25.7</td>
</tr>
</tbody>
</table>
Additional drivers for change...

• Need to balance health and social care
• Workforce development
  – Appropriate skill level
  – Recruitment issues
• Financial considerations
• Developing medicines
• Maximising the use of technology
• Remote and rural
• Reducing waste, avoidable harm and variations in treatment
Primary & Community Care

• **Change the balance of power:** Co-produce health and wellbeing in partnership with individuals, families, and communities.

• **Customise to the individual:** Contextualize care to an individual’s needs, values, and preferences, guided by an understanding of what matters to the person in addition to “What’s the matter?”

• **Promote wellbeing:** Focus on outcomes that matter the most to people, appreciating that their health and happiness may not require healthcare or medication.
Primary & Community Care

- **Anticipate:** Work to develop more comprehensive anticipatory care plans with higher risk patients, to understand their preferences and to plan for challenges that might otherwise result in undesired and avoidable hospital admissions.

- **Support Self-Management:** Using the benefits of longer-term relationships with people, encourage patients to move from being dependent recipients of healthcare, to informed individuals, better able to understand and manage their conditions.

- **Collaborate and cooperate:** Recognize that the health and social care system is embedded in a network that extends beyond traditional boundaries.

- **Use technology to the full:** While there is currently insufficient evidence to support the widespread use of telemonitoring people's health, there is evidence that simple telecare can support patients to manage and remain at home, and appropriate use of technology can help overcome social isolation in house bound patients.

- **Assume abundance:** Use all the assets that can help to optimize the social, economic, and physical environment, especially those brought by individuals, families, and communities. This helps move away from a strictly medical model of health and wellbeing, and recognises the importance of optimising life circumstances.
Secondary & Tertiary Care

Most care will be provided locally with the expansion of primary care avoiding many having to access secondary care at all.

Most local hospitals will be able, as now, to provide emergency services, including accident and emergency services,

Using a network of hospital sites, some specialties will provide inpatient services in a smaller number of hospitals.
Outpatients: many reviews of outpatients can be dealt with by letter, email or telephone instead of clinic appointments. Where there is a need for patient-clinician interaction we should consider, especially for rural patients, the use of tele-consultations using effective video-linking.

Ensure this activity is recognised....
Modernising Out-Patients

A Modern Out-patient -
- Safely managed at home, or close to home
- Manage their own health or supported by HCPs.
- Needs addressed by hospital-based, but not necessarily hospital delivered, services if and when required;
- Ensure that every return appointment is timely, appropriate and effective’
Core Principles

• Strengthening self-management in the community
• Optimising e-Health and digital opportunities
• Reducing widespread variation
• Accessing decision support & care planning
• Emphasising competency-based roles in secondary care, to focus Consultant resource on more complex patients, and recognising the role of the GP as the ‘expert clinical generalist’ and raising the profile and enhancing the role of the wider MDT of community-based practitioners;
A potential ‘vision’ for diabetes care?
National Health Service....

Current

- Disjointed
- Divided
- Silos
- HCP Centred
- Illness Focused
- Reactive
- Rigid
- Process Driven
Here is Edward Bear, coming downstairs now, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think of it.
Co-ordinated approach of ALL 3 improves care & outcomes
How do we improve the situation?

“Sir, I’m helping to put a man on the moon!”

Janitor NASA 1961
NHS utilising idealistic pragmatism.......
Proposed Vision for Diabetes Care

• Individuals with diabetes in Scotland will live longer and healthier lives.
• They will feel confident and able to self manage their diabetes day to day.
• They will have equitable access to timely help and support from across the healthcare system and beyond when required.
Type 1 Diabetes Care

- Increasingly complex
- Specialist centers (hospital?)
- Rapidly evolving area
- Virtual support
Current: Type 1 diabetes care

- Insulin/CHO counting intensification strategy
- Structured education programme
- Continuous subcutaneous Insulin infusion therapy
- Sensor augmented pump therapy
- Islet cell / pancreatic transplantation

Existing cohort with T1DM

Doing well with good control

Be brave and stop doing what isn’t working…
Possible Vision Type 1 Diabetes Care

- Early Insulin/CHO counting intensification strategy
- Structured education programme & technology to improve diabetes care: Remote & automated support, Flash BG monitoring etc
- Continuous subcutaneous Insulin infusion therapy & technologies to improve diabetes care: CGMS/hybrid close loops Bionic Pancreas

Existing diabetes resource

- Doing well with good control
- Islet cell / pancreatic transplantation
Potential Game Changer…!

Introducing the iLet™
At long last, a fully integrated bionic pancreas.
Carry your glucose metabolism in your pocket.

Go Bionic shirts | Watch the TEDx

Home use of a bihormonal bionic pancreas versus insulin pump therapy in adults with type 1 diabetes: a multicentre randomised crossover trial

www.thelancet.com  Published online December 19, 2016  http://dx.doi.org/10.1016/S0140-6736(16)32567-3
Learning from others…

Towards a complication-free future

Type of therapy:
- MDI 2013 (n=560)
- MDI 2014 (n=634)
- CSII 2013 (n=733)
- CSII 2014 (n=749)
- SAP 2013 (n=125)
- SAP 2014 (n=127)

% patients in given HbA1c range

HbA1c level

< 7.5% (58 mmol/mol)  > 10% (86 mmol/mol)
Type 2 Diabetes Care

- Increasingly complex: multiple agents
- Increasing prevalence
- Multi-morbidity; utilising the expert generalist
- Dynamic specialist support; move away from the ‘tag’ approach
- Utilise technology enabled care to risk stratify
- Develop virtual care models
- Community based specialist diabetes services
Type 2 Diabetes Care

Advice from specialist diabetes services

Remote/virtual Multidisciplinary case review

Community based Multidisciplinary clinics

Review by specialist diabetes services

Support of diabetes self management; Structured education My Diabetes My Way House of Care approach

- Clearly defined interventions
- Anticipatory Care Planning
- Individualised care planning
- Utilise IT: SCI-DM
- Dynamic interface

Targeted focused intervention;
Glycaemic control
Weight management
CVS risk reduction
Learning from others...

- Clearly defined clinical pathways
- Finite intervention period
- Focused aggressive individualised Mx plan
Thank you for making an appointment at your Health and Wellbeing Hub.
We look forward to seeing you soon.
Is this a possibility...?
Processes of Care
Health & Wellbeing Hub
Welcome to My Diabetes My Way
The NHS Scotland interactive diabetes website to help support people who have diabetes and their family and friends.

You’ll find leaflets, videos, educational tools and games containing information about diabetes. You can now also use this website to view your own up-to-date diabetes clinic results, to help you manage your condition more effectively.

My Diabetes
Sign up to gain access to your own test results, clinic letters and your treatment plan

My Details
From your diabetes medical record.
If any of them are wrong, please let us know by contacting your diabetes team

My Results
My test results

My Reports
Print these off for discussion with members of your health care team.

My Screening
View at a glance

It is important to know your personal goals and to be aware of the status of your control to stay healthy with diabetes. When you attend for diabetes care a variety of measurements are made e.g. blood pressure, weight and various blood tests. You need to know your values and what they mean.
Information Pre-Appointment

Summary
This chart shows a summary of your latest results (marked as a cross) in relation to national targets for these parameters. Your health care provider may have agreed slightly different targets to suit you needs.

- Informed individual
- Review results prior to consultation
- Consider action plan pre-review
- Meeting of equals
- Joint agenda setting
- Goal setting
Workshops

Delineate a clearly defined diabetes care pathway
What are the key components within each of the steps of the pathway:
  – Prevention
  – Early Detection/Diagnosis
  – Initial Care
  – Consolidation including surveillance
  – Intensification

Defining outcomes and success
What measure (if any) could be used to assess each step of the pathway?
What measurable outcome would define success for this step of the pathway?
What measurable outcomes would define success for the entire pathway?

Care Delivery
Who could/should provide that key component within the pathway?
Where could/should that be delivered?

Go put a person on the moon...
NO MATTER WHAT PEOPLE TELL YOU, WORDS AND IDEAS CAN CHANGE THE WORLD.

ROBIN WILLIAMS (1951-2014)