Potential Vision for Diabetes Care…

Stirling Court Hotel, Stirling

2nd February 2018

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NHS SCOTLAND

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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

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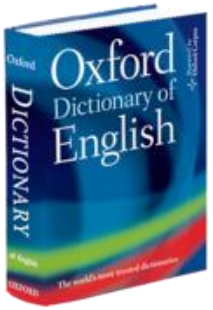
Vision: Definition



Noun

1. the faculty or state of being able to see.

   "he had defective vision“

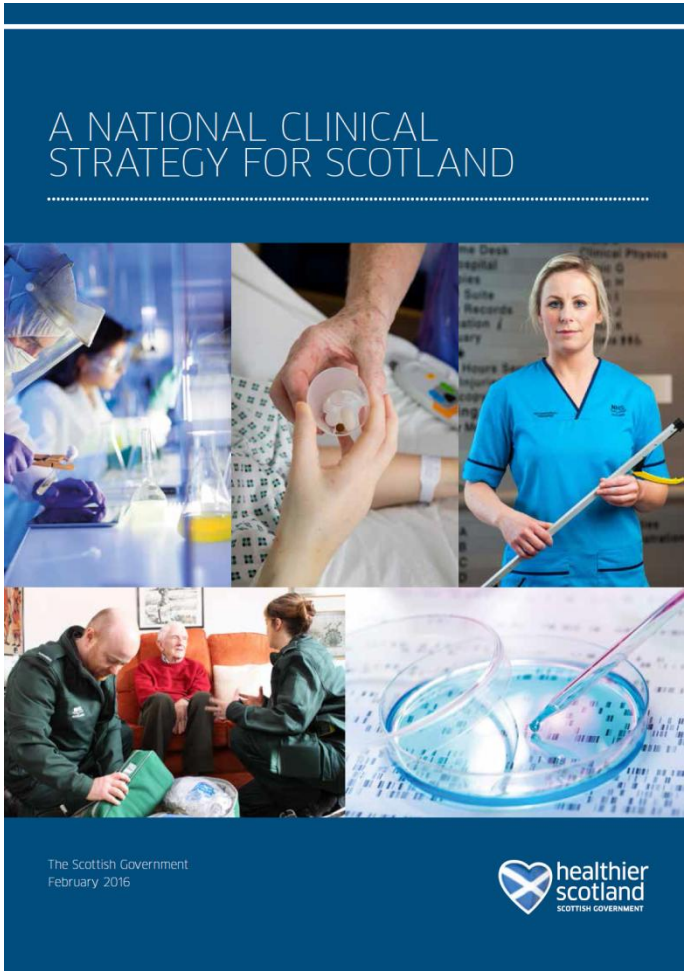
2. the ability to think about or plan the future with imagination or wisdom.

   "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.

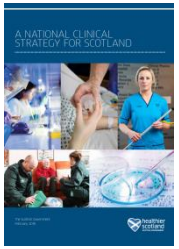
Developing a 'vision' for diabetes care within national priorities?

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’

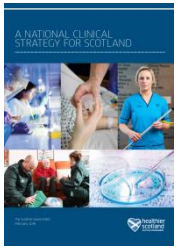
National Clinical Strategy

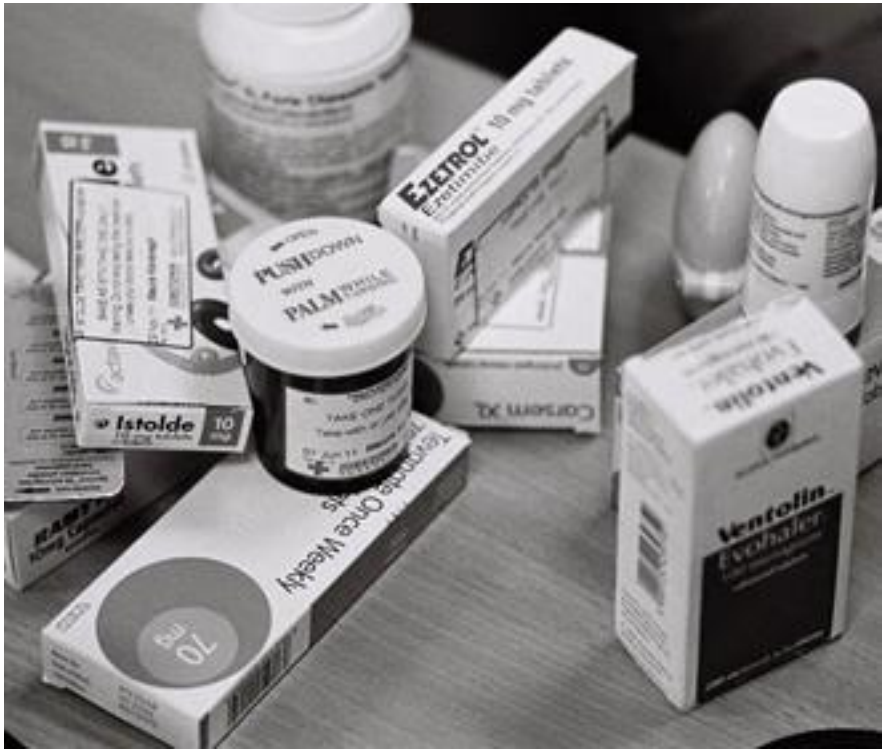


Our vision is that by 2020 everyone is able to live longer healthier lives at home or in a homely setting. We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management.

"The 2020 Vision." Scottish Government 2010

Main healthcare challenges

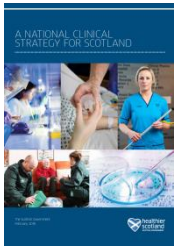




Multi-morbidity

Ageing

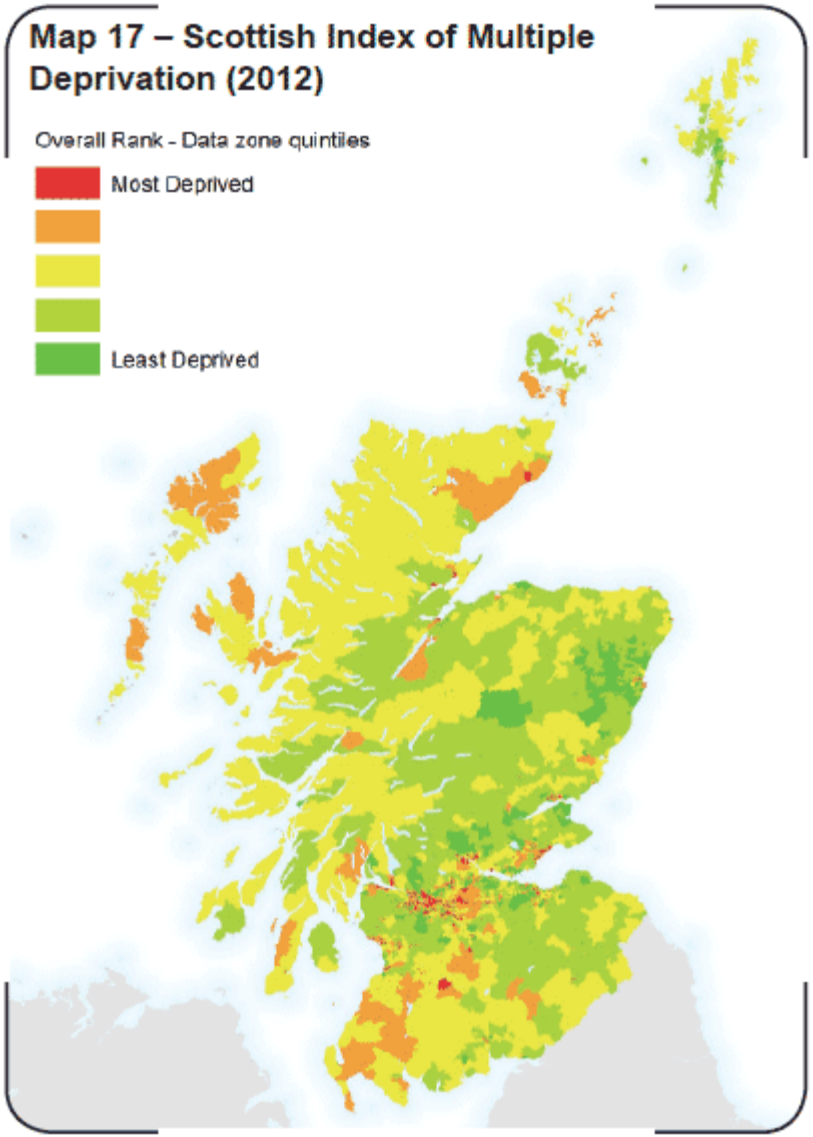
Multimorbidity



Percentage of patients with the row condition who also have the column condition	Coronary heart disease	Hypertension	Heart failure	Stroke/transient ischaemic attack	Atrial fibrillation	Diabetes	Chronic obstructive pulmonary disease	Painful condition	Depression	Dementia	Percentage who only have the row condition*	Mean No of conditions in people aged <65 years with row condition	Mean No of conditions in people aged ≥65 years with row condition
Coronary heart disease	52	14	13	11	22	13	24	17	3		8.8	3.4	4.4
Hypertension	18	5	10	6	18	8	19	14	2		21.9	2.5	3.6
Heart failure	59	57	16	26	23	18	23	17	4		2.8	3.9	5.6
Stroke/transient ischaemic attack	29	61	8	13	19	13	22	21	5		6.0	3.6	4.8
Atrial fibrillation	37	55	21	20	19	13	18	14	5		6.5	3.3	5.0
Diabetes	23	54	6	9	6	8	21	18	2		17.6	2.9	6.5
Chronic obstructive pulmonary disease	19	33	6	8	6	11	23	18	2		14.3	2.8	4.5
Painful condition	16	36	3	6	3	13	10	31	3		12.7	3.1	4.3
Depression	10	23	2	5	2	9	7	27	3		25.4	2.6	4.9
Dementia	21	41	6	18	10	13	9	17	32		5.3	4.1	4.6

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

Deprivation & Scotland

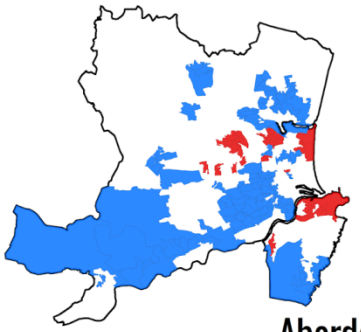


Deprivation in Scottish Cities

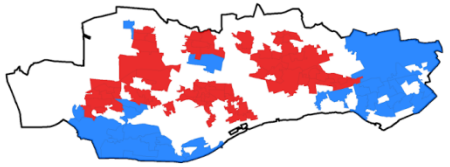
Source: Scottish Index of Multiple Deprivation 2012

Blue areas are amongst the 20% least deprived in Scotland

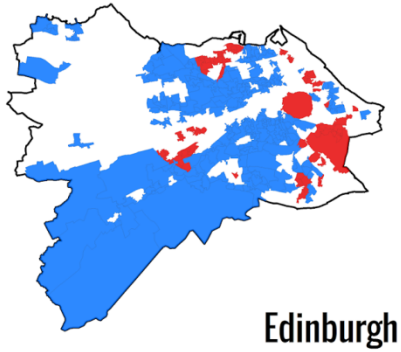
Red areas are amongst the 20% most deprived in Scotland



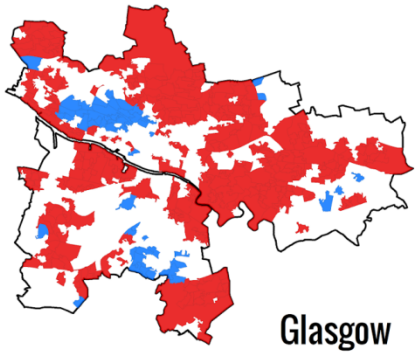
Aberdeen



Dundee

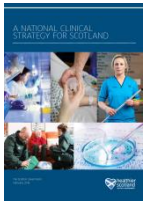


Edinburgh



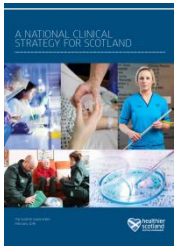
Glasgow

Deprivation, Healthy Life & Life Expectancy



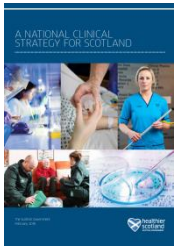
	Males – Least deprived	Males – Most deprived	Female – Least deprived	Female – Most deprived
Life Expectancy (years)	81.7	71.3	84	77.2
Healthy Life expectancy (years)	69.1	48.3	71.9	51.5
Expected years of "Ill health"	12.6	23	12.1	25.7

Additional drivers for change…



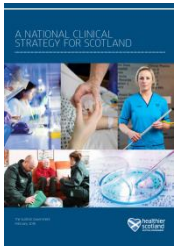
- Need to balance health and social care
- Workforce development
  - Appropriate skill level - Recruitment issues
- Financial considerations
- Developing medicines
- Maximising the use of technology
- Remote and rural
- Reducing waste, avoidable harm and variations in treatment

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.

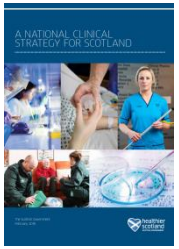
- **Support Self-Management:** Using the benefits of longer-term relationships with people, encourage patients to move from being dependent recipients of healthcare, to informed individuals, better able to understand and manage their conditions.

- **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

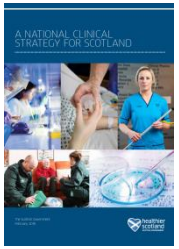


Most care will be provided locally with the expansion of primary care avoiding many having to access secondary care at all.

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.

Secondary & Tertiary Care



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 -

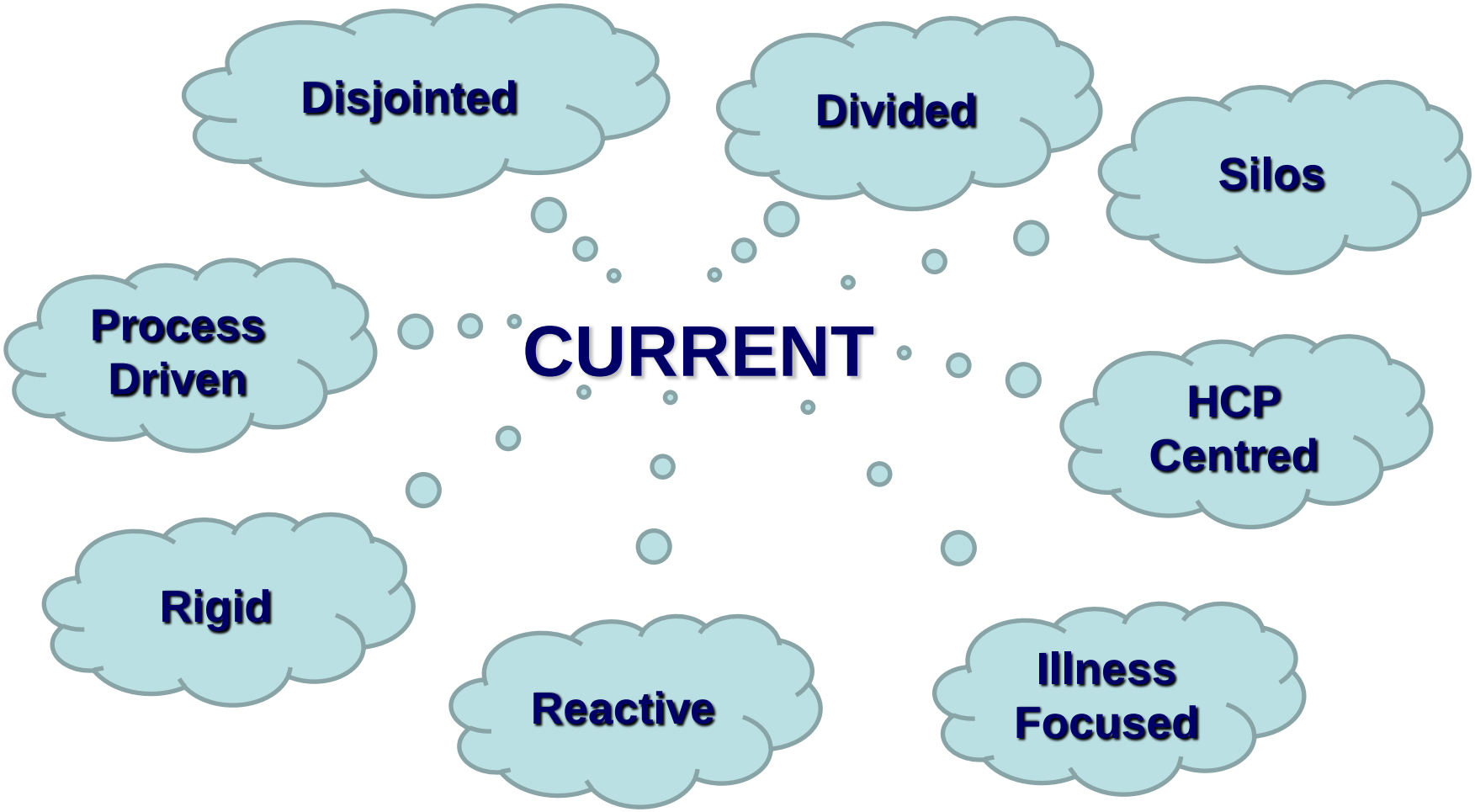
- Safely managed at home, or close to home
- Manage their own health or supported by HCPs.
- Needs addressed by hospital-based, but not necessarily hospital delivered, services if and when required;
- Ensure that every return appointment is timely, appropriate and effective’

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?

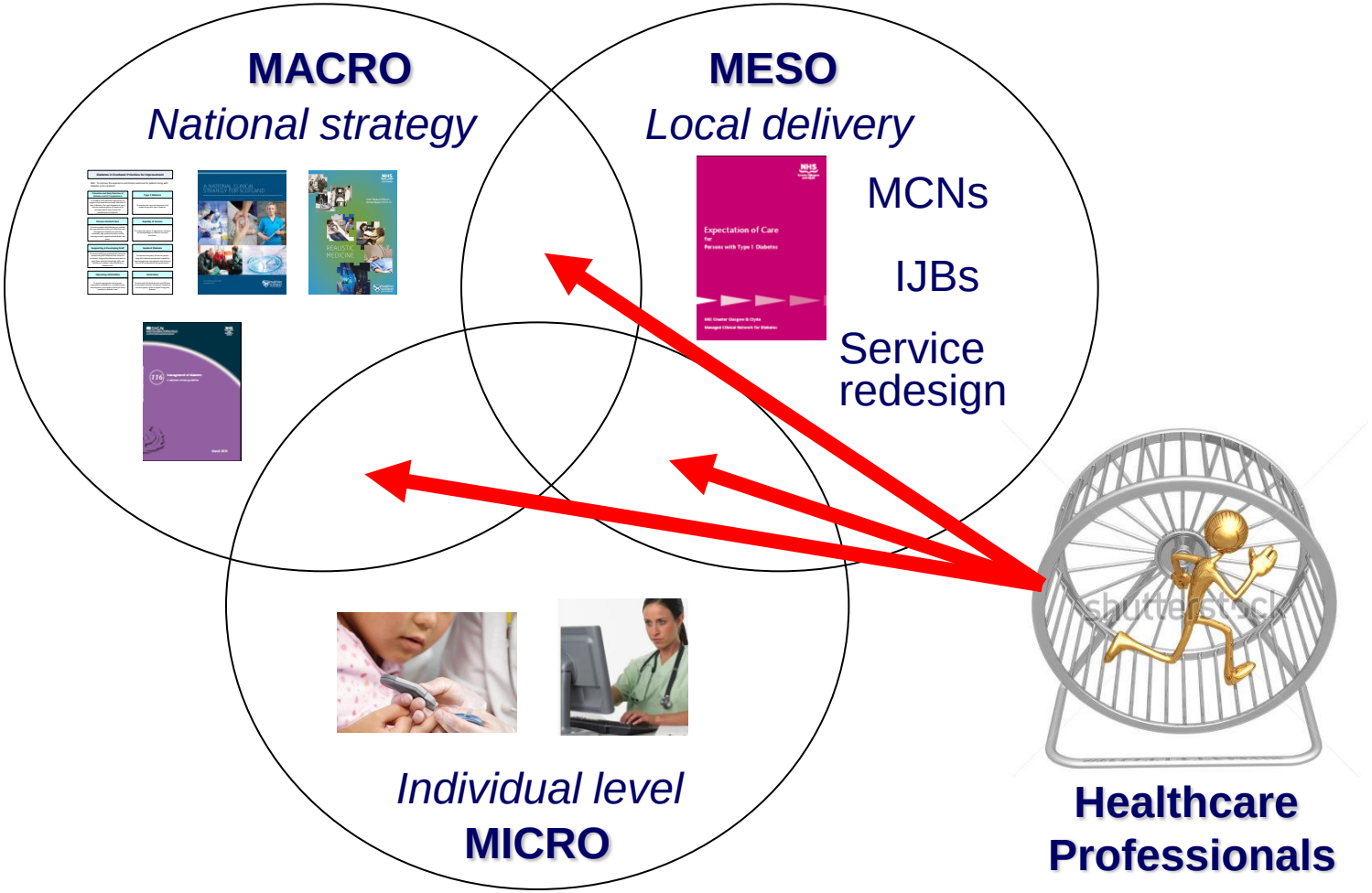
National Health Service….



Current Perception…?

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.

Healthcare Delivery & Chronic Disease



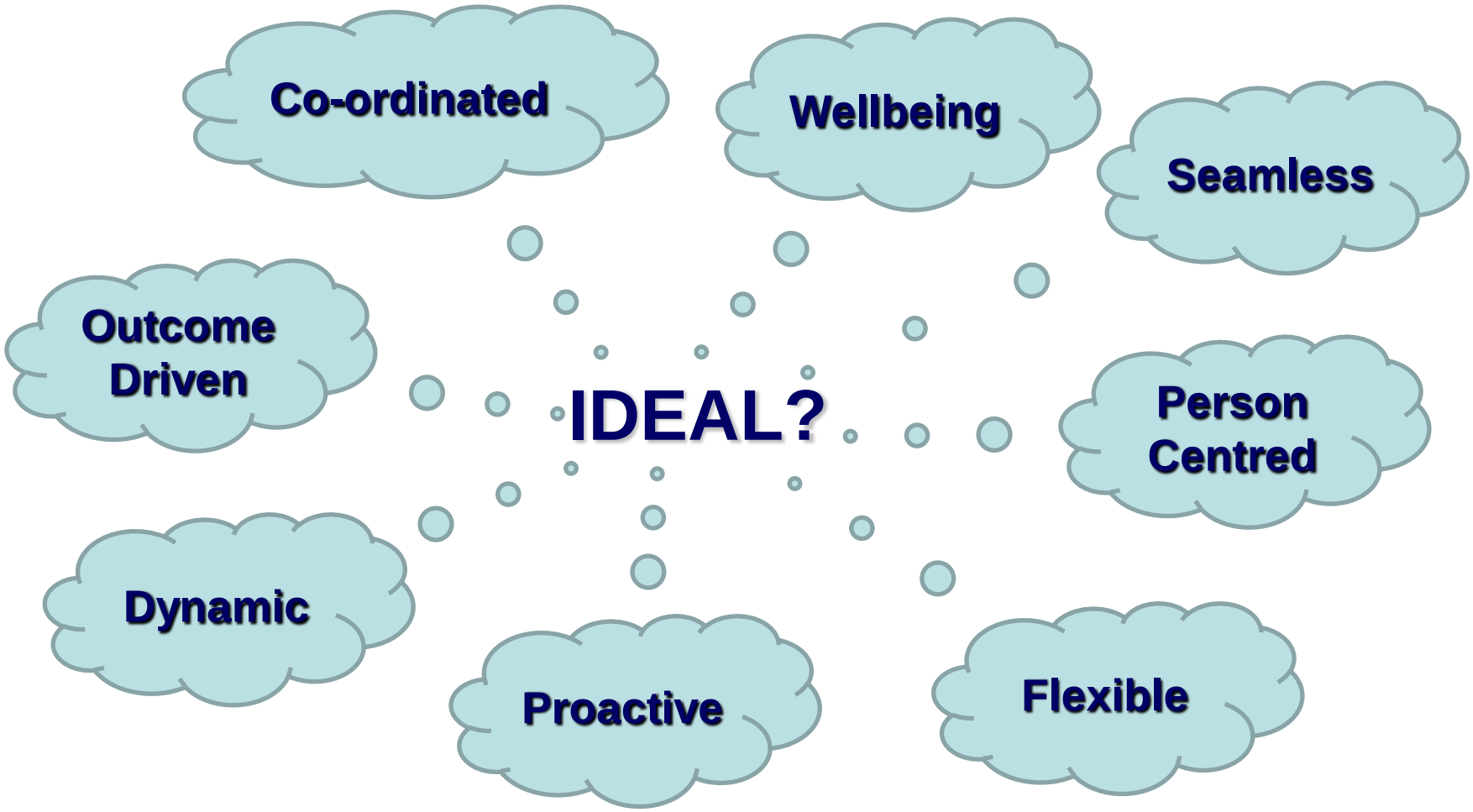
Co-ordinated approach of ALL 3 improves care & outcomes

How do we improve the situation?

"Sir, I'm helping to put a man on the moon!"

Janitor NASA 1961

NHS utilising idealistic pragmatism.....



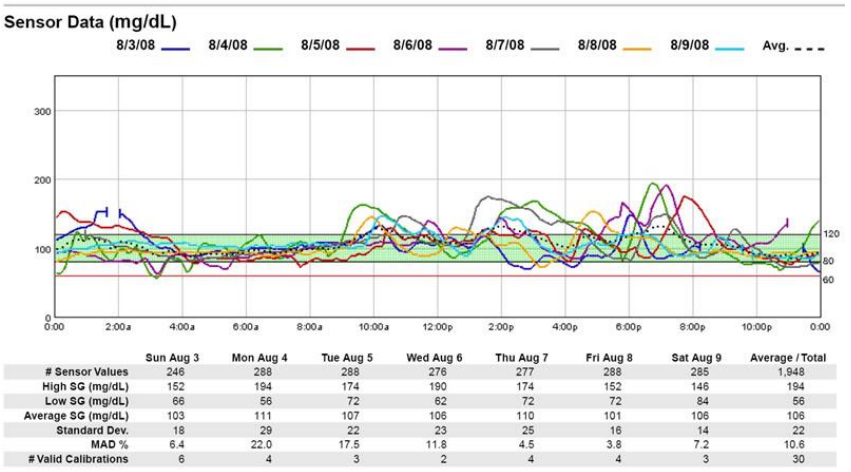
National Wellbeing Partnership

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



	Sun Aug 3	Mon Aug 4	Tue Aug 5	Wed Aug 6	Thu Aug 7	Fri Aug 8	Sat Aug 9	Average / Total
# Sensor Values	246	288	288	276	277	288	285	1,948
High SG (mg/dL)	152	194	174	190	174	152	146	194
Low SG (mg/dL)	66	56	72	62	72	72	84	56
Average SG (mg/dL)	103	111	107	106	110	101	106	106
Standard Dev.	18	29	22	23	25	16	14	22
MAD %	6.4	22.0	17.5	11.8	4.5	3.8	7.2	10.6
# Valid Calibrations	6	4	3	2	4	4	3	30

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

Existing diabetes resource

Structured education programme & technology to improve diabetes care: Remote & automated support, Flash BG monitoring etc

Doing well with good control

Continuous subcutaneous Insulin infusion therapy & technologies to improve diabetes care: CGMS/hybrid close loops Bionic Pancreas

Islet cell / pancreatic transplantation

Potential Game Changer…!

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Introducing the iLet™

At long last, a fully integrated bionic pancreas.

Carry your glucose metabolism in your pocket.

Go Bionic shirts | Watch the TEDx

Articles

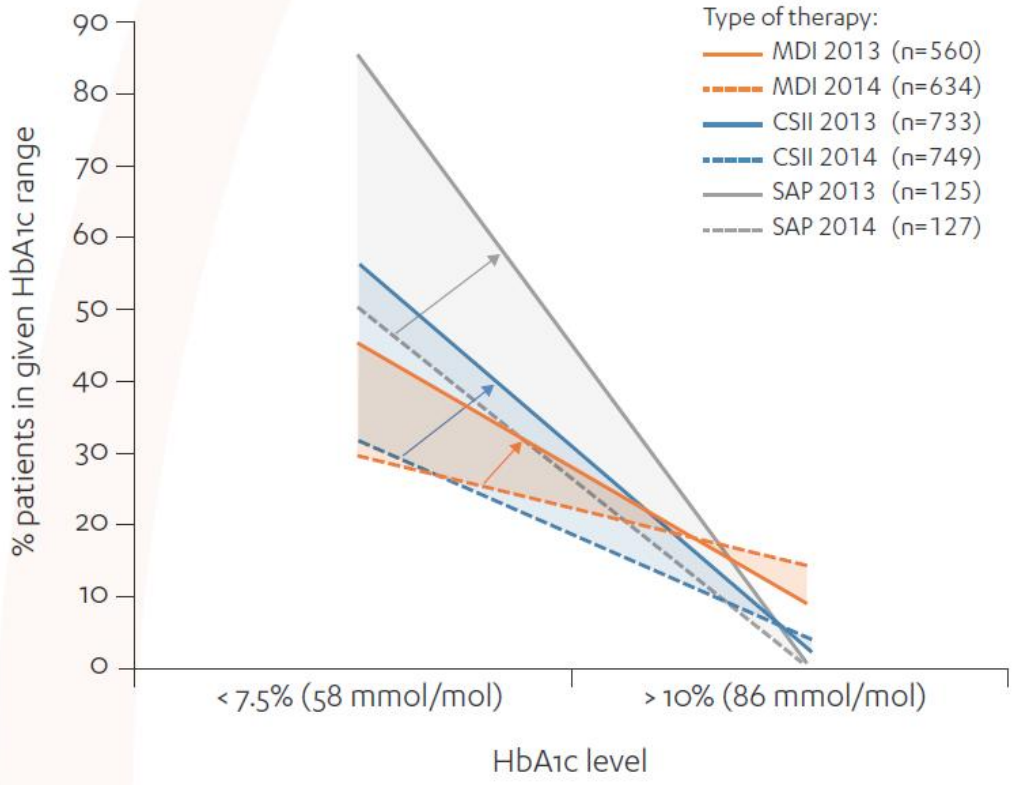
Home use of a bihormonal bionic pancreas versus insulin pump therapy in adults with type 1 diabetes: a multicentre randomised crossover trial

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

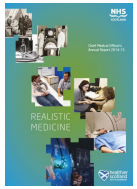
Learning from others…

Diabeter

Towards a complication-free future

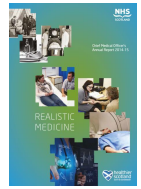


Type 2 Diabetes Care



- 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 clincis

Review by specialist diabetes services

Targeted focused intervention;
Glycaemic control
Weight management
CVS risk reduction

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

Learning from others…

- Clearly defined clinical pathways
- Finite intervention period
- Focused aggressive individualised Mx plan

Vision for Diabetes Care?

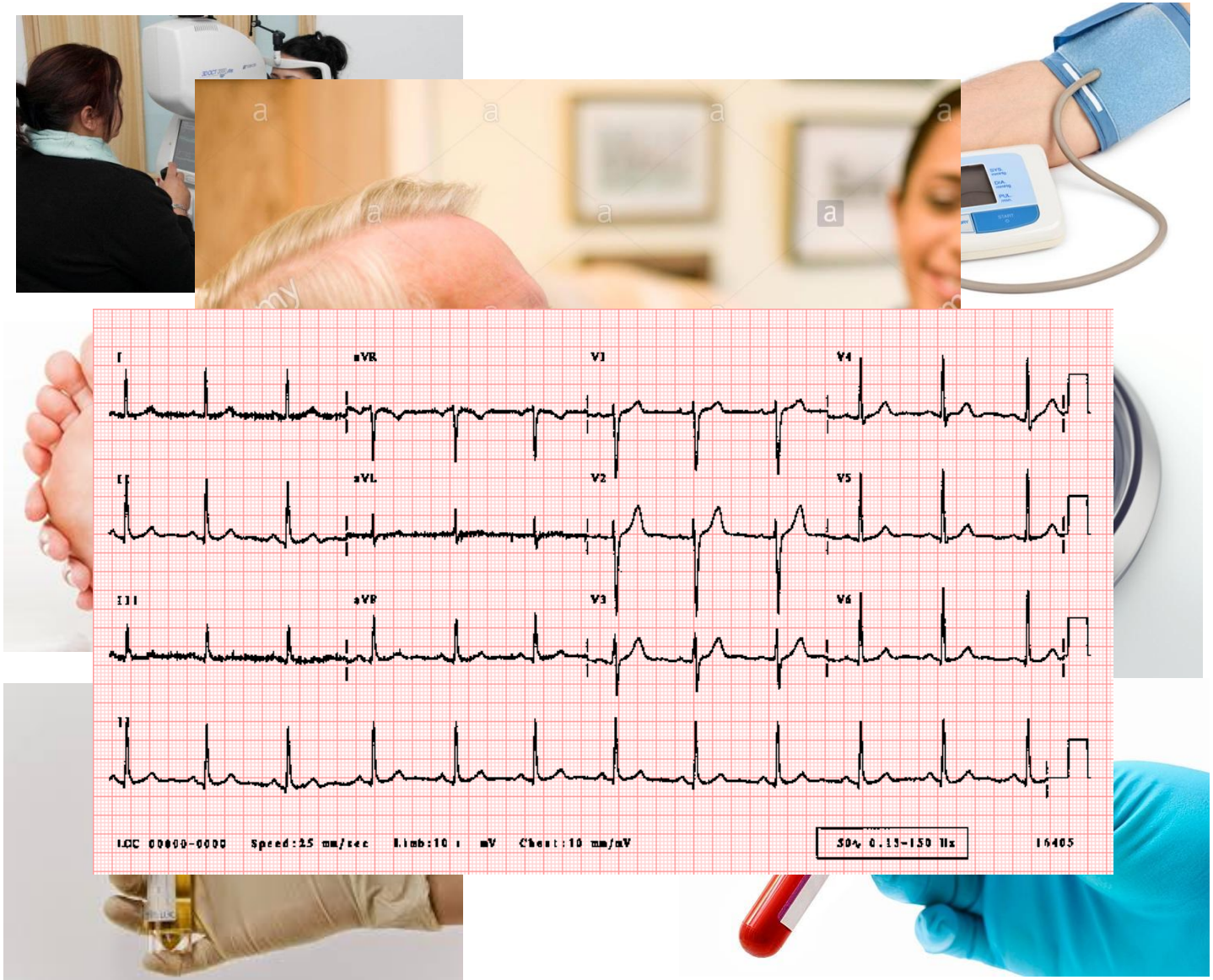
BOOK ONLINE

Thank you for making an appointment at your **Health and Wellbeing Hub.**

We look forward to seeing you soon.

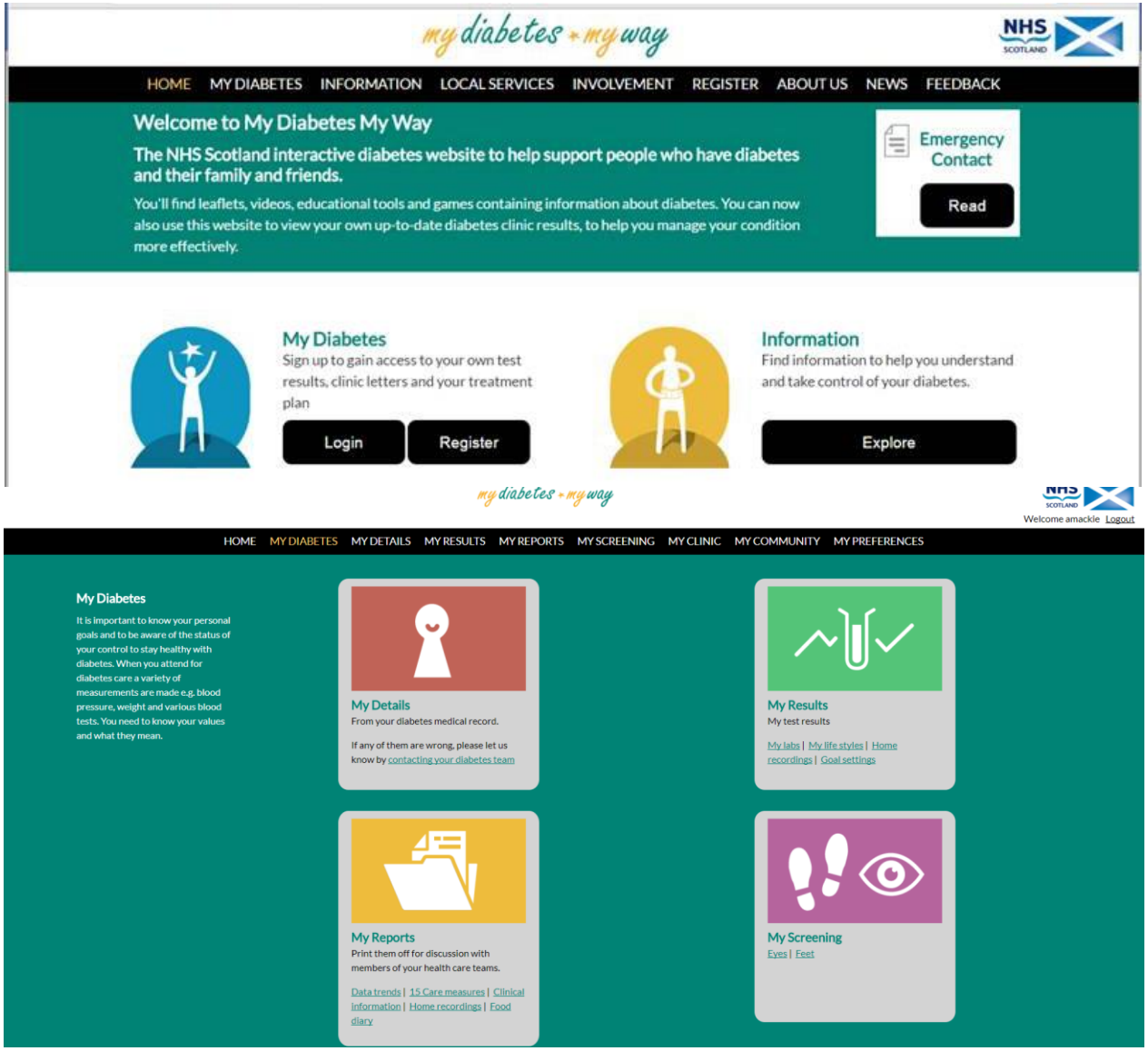
Is this a possibility…?

Processes of Care

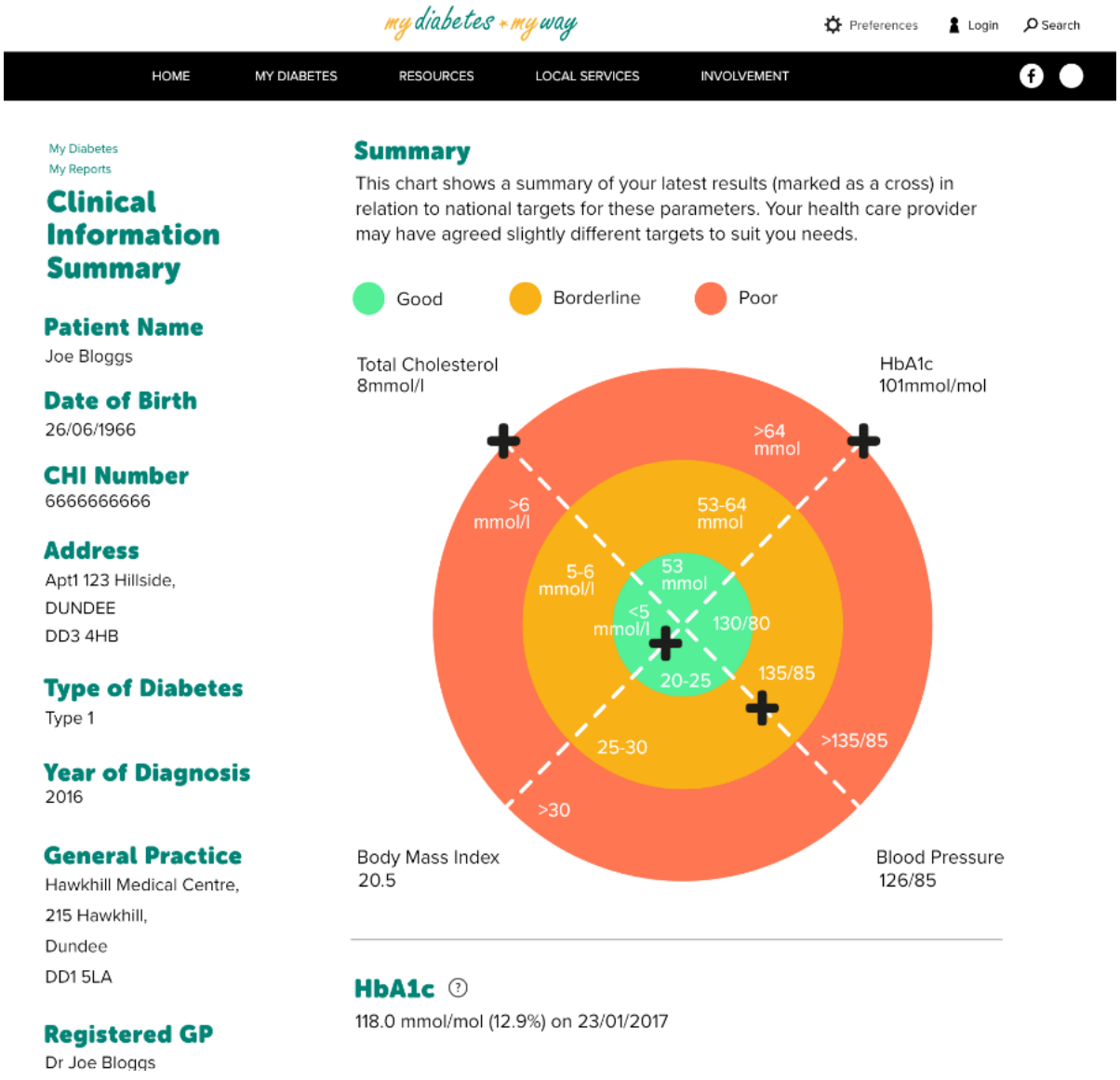


Health & Wellbeing Hub

Patient Portal – Access to results



Information Pre-Appointment



- 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)