knowdiabetes

West London NHS Trust
North West London Clinical Commissioning Groups

NHS

Making mental health a golden thread in North West London Diabetes Care
A model for other long term conditions?

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AIMS

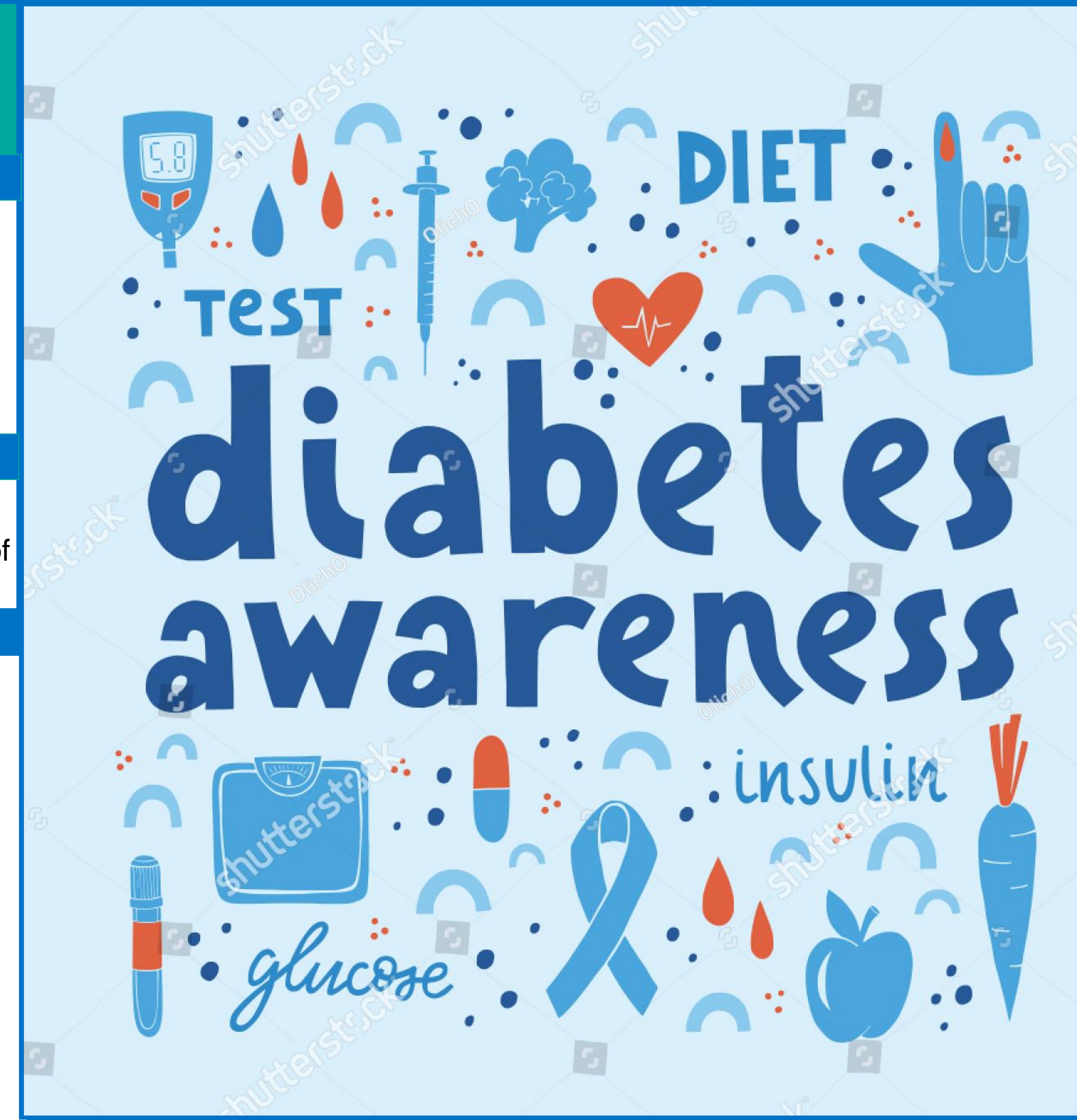
1. To weave mental health (MH), as a golden thread, into all aspects of diabetes care across all of North West London (NWL).
2. To use this to support delivery of the four key deliverables in the NWL Diabetes Transformation Programme (DTP):
   - improved 3 treatment targets (BP, HbA1c, cholesterol),
   - uptake of diabetes self care education
   - reduced variation in foot care
   - improved uptake of the National Diabetes Prevention Programme

HYPOTHESES

- That addressing MH in the context of a large scale diabetes transformation programme, will support the programme to achieve its diabetes outcomes.
- That a small amount of short term funding for MH is better utilised to create system change than to use it for a short term clinical pilot for a small cohort of patients. That this is better value and addresses NHS Long Term Plan goals for reducing variation and improving access.

BACKGROUND

- Self-care is central to diabetes management but it is negatively affected by mental illness. Diabetes UK Report Too Often Missing (2019) found that 70% of People with Diabetes (PWD) struggled with their emotions or their MH and this made it hard for them to manage their diabetes[1].
- There is increasing evidence that MH is a significant part of overall diabetes costs and that addressing MH improves diabetes outcomes[2].
- NWL has 8 Clinical Commissioning Groups (CCGs) and is a diverse area with significant deprivation and a complex commissioning landscape. It has hundreds of stakeholders across primary, community and acute care and huge numbers of differing contacts and key performance indicators (KPIs)
- 41% of all NWL acute hospital admissions were diabetes related. NWL is projected to require 377 more hospital beds by 2028 to accommodate diabetes need.
- In NWL, there were 142,000 PWD. 99,000 of them were estimated to be struggling with MH issues. But there were only 15 WTE staff (mostly part time IAPT and psychology) providing MH input into diabetes for 8 CCGs; there was variation in MH service provision across the 8 CCGs; there was no standard MH screening or data collection across NWL. This made data analysis and compassion impossible..
- NWL was funded by NHSE to deliver an ambitious DTP across four key KPIs (as above) and some minimal funds were allocated for a MH provision.



METHODOLOGY

1. In January 2018, we used small, short term MH funding to build sustainable change rather than deliver a short term clinical service to a small number of PWD.
2. We set up a Task and Finish Group, co-chaired by a PWD.
3. We produced a driver diagram to implement system-wide interventions that were aligned to wider DTP (fig 1)
4. Over 18 months, we engaged a wide stakeholder group, conducted a service mapping exercise, developed a strategy and supported staff to deliver the strategy through intensive ongoing engagement and embedding MH digital systems into wider DTP

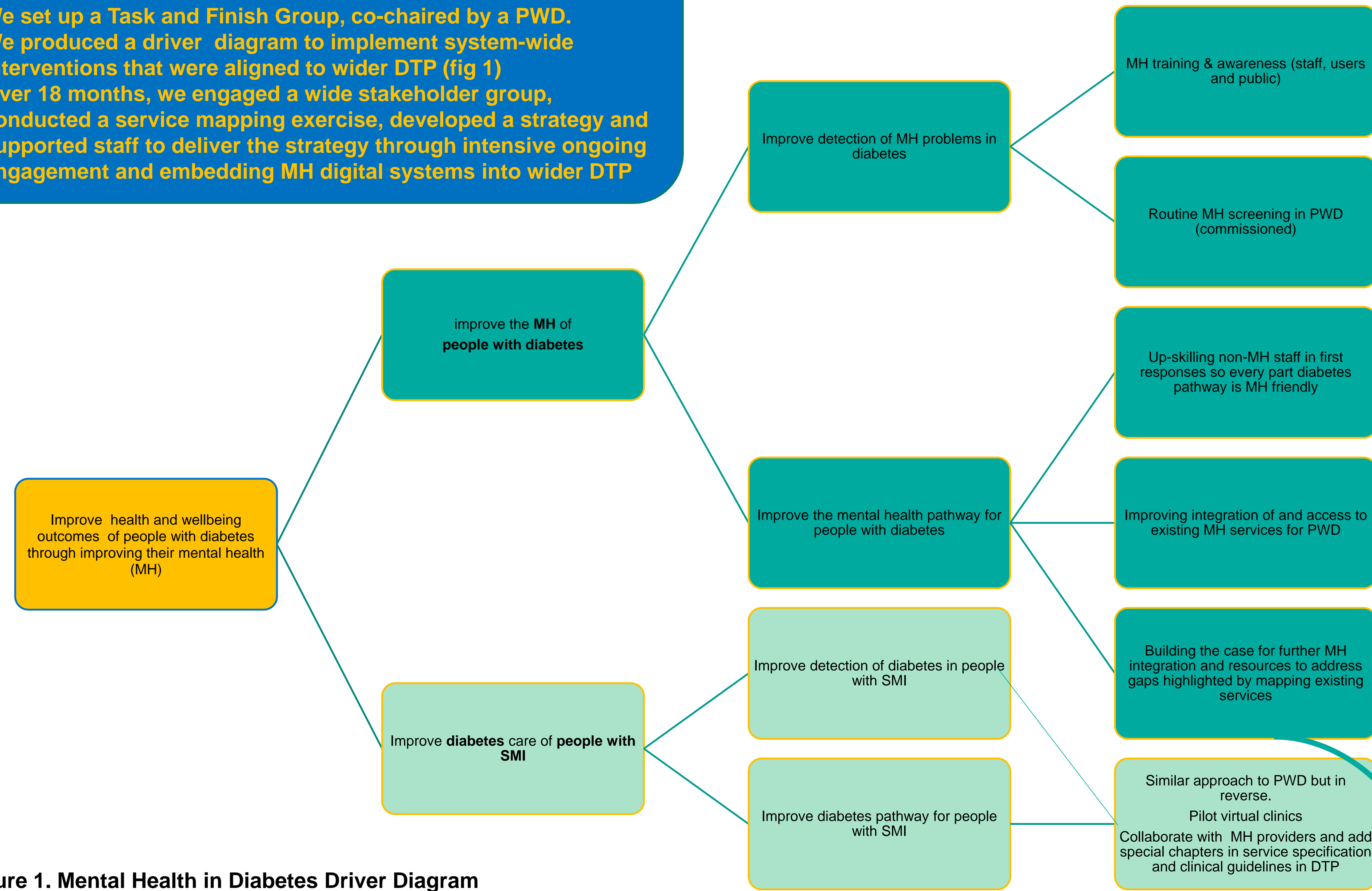


Figure 1. Mental Health in Diabetes Driver Diagram

OUTPUTS AND PRODUCTS

Figure 2. the four legacy products delivered by the NWL Diabetes Transformation Programme with Mental Health woven through all of them

1. Collated Gold standard then compared to "AS IS" in NW London
2. Mapping document of all MH services providing MH care to PWD in 8 CCGs across NWL London (see fig 3).
3. MH woven through FOUR NW London Diabetes Transformation Programme tangible products, as a golden thread (see fib 2)

FINDINGS AND OUTCOMES

Data on whole NWL diabetes population (142,000)

- Mental health screening: 4% to 41%
- Collaborative care planning: 5.5% to 83.4%
- 30% increase in PWD completing diabetes education
- 3 diabetes treatment targets achieved:17.9% to 29.6%
- 9 key diabetes care processes completed: 29.4% to 69.5%
- 12% decrease in admissions for diabetes complications

DEEP DIVE: Data on pilot of 16 MH virtual clinics

ACTIVITY (mid Dec 18-mid March 19)
- **102** patients discussed
- **90** minutes (range 30-120 mins)
- **7=**Ave number of patients discussed/clinic

PRACTICE FEEDBACK
- **100%** agreed/strongly agreed that they would recommend the clinic
- **100%** agreed /strongly agreed that they would be able to use the learning from this discussion for other cases
- Most useful aspects of clinic:
  - Advice about managing people without formal mental health diagnosis
  - Learning about MH in diabetes
  - Case discussion
  - Second opinion
  - Signposting information

Intelligence from these clinics was used to develop 4 clinical protocols for different categories of patients (Eg.SMI, common mental illness, cognitive impairment, not engaging) for GPs to be able to follow them autonomously on the electronic patient record diabetes template. See Figure 2.

63:37 ratio

55 years (average)

Average baseline HbA1c=**89mmol/mol** (range 38-167mmol/mol)

92% not engaging with at least one aspect of care

51% had no previous mental health diagnosis

INTERVENTIONS SUGGESTED
27 %*advised to screen for depression/anxiety
22 %*advised to screen for dementia

14%* advised to review psychiatric medication

10% *advised and trained to do Motivational Interviewing

REFERRALS SUGGESTED
38%* advised refer to SE /Recovery College#
17%* advised refer to IAPT services
17%* advised refer to specialist mental health^

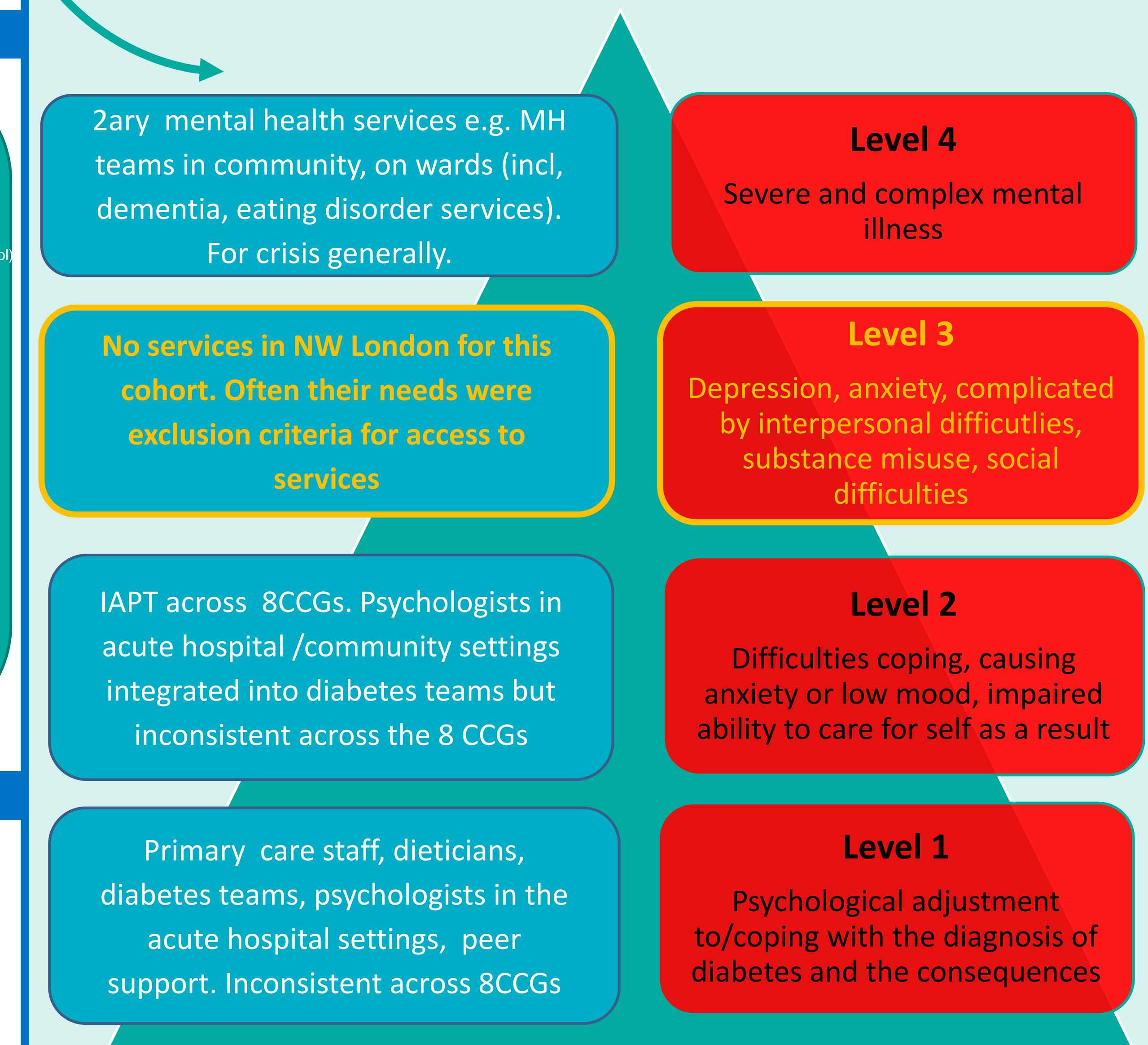


Figure 3. Pyramid of MH need and provision in NWL for PWD

CONCLUSIONS AND NEXT STEPS

1. Sustainable wide spread change is achievable using short term funds to embed system change= better value?
2. Working with all stakeholders around co-producing a simple driver diagram is useful for taking a wide view of the issues and for engaging all parties but it takes time to embed, change culture and see results.
3. The model is generic enough to transfer to other long term conditions (LTCs). The author has used a similar driver diagram for NWL renal care and is now working with Kidney Care UK to create a MH pathway for kidney care using this approach as a starting point influence the NHSE Renal Services Transformation Programme.
4. There is a gap in service provision for people with MH needs that are too complex for IAPT but not severe or acute enough for secondary MH services. This is not just for diabetes but all LTCs. This is an important area that newly emerging trauma informed services may be able to address. Working on multiple LTCs could provide the financial cost savings for addressing the gap that working on one LTC might not.

REFERENCES

1. Too often missing: Making emotional and psychological support routine in diabetes care. Diabetes Uk. 2019
2. Schmidt CB, val Loon BJP, Vergouwen ACM et al (2018) Systematic review and meta-analysis of psychological interventions in people with diabetes and elevated diabetes-distress. Diabetic Medicine 35 (9), 1157 to 1172
3. North West London Diabetes Clinical Guidelines https://www.hounslowccg.nhs.uk/media/116668/diabetes-north-west-london-diabetes-clinical-guidelines.pdf