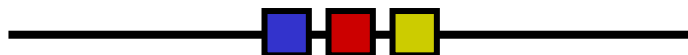


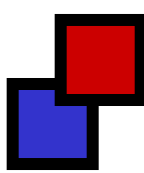
# Prescribing & Performance of Diabetes Care in Brent -why some practices perform well



A GPs perspective  
Dr Joan St John & Dr Encarna Fernandez  
GPwsi Diabetes Brent

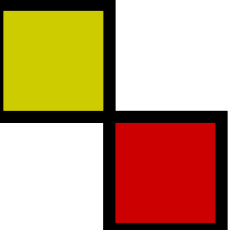
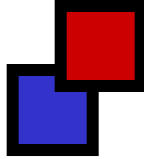


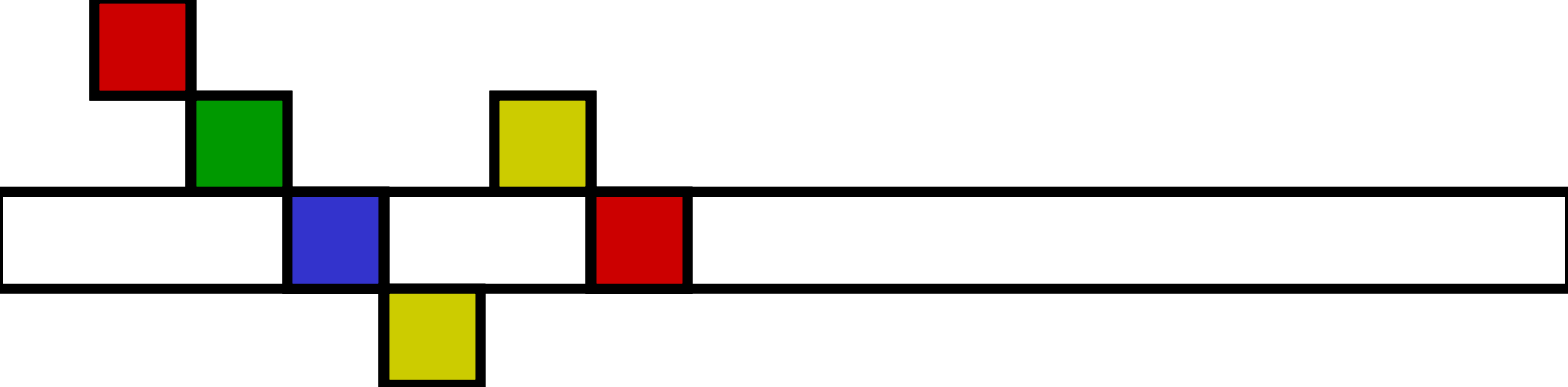
# To improve the care given to diabetic patients in Brent

- To enhance the care given to diabetic patients in Brent
  - To disseminate best practice
  - To work together in an integrated way to improve the standards of care given
- 

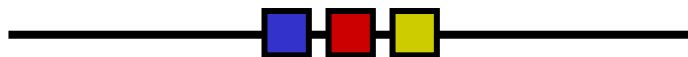


# Goal and Objective

- 
- GOAL- Greater percentage of Practices achieving DM20 (HbA1c 7.4%) for greater percentage of their diabetic population
  - OBJECTIVE- Better quality of care for diabetic patients in Brent
- 



# SITUATION in Brent 06-07

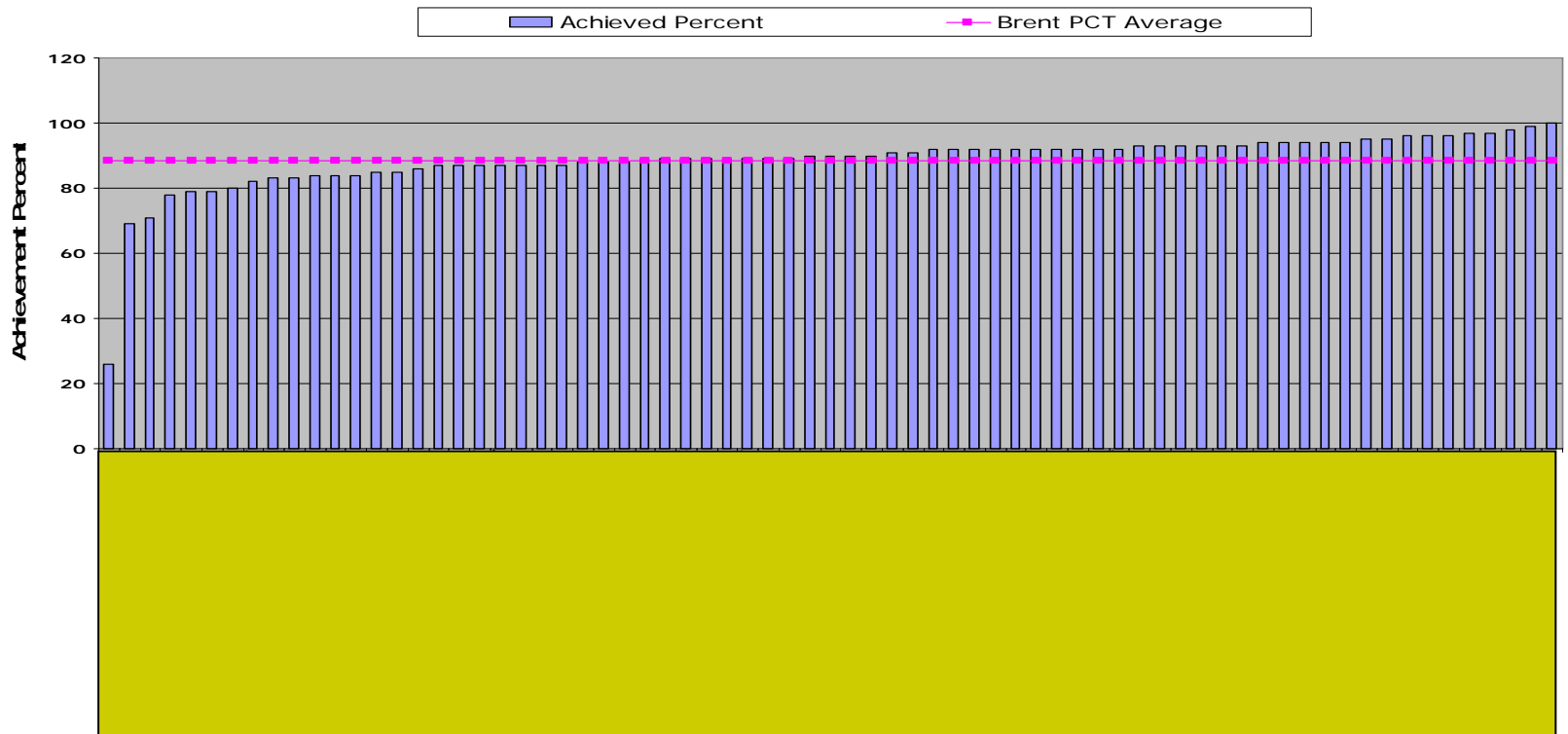


Qof figs 06-07 circulated to all Practices

Indicator DM 7. The percentage of patients with diabetes of whom the last HbA1C is 10 or less (or equivalent test/reference range depending on local laboratory) in the last 15 months.

A maximum of 11 points may be awarded for DM 7, with pay stages falling between 40-90%. Virtually all practices achieved at least 40% attainment except for one. The average PCT attainment for DM 7 is approximately 88.48%.

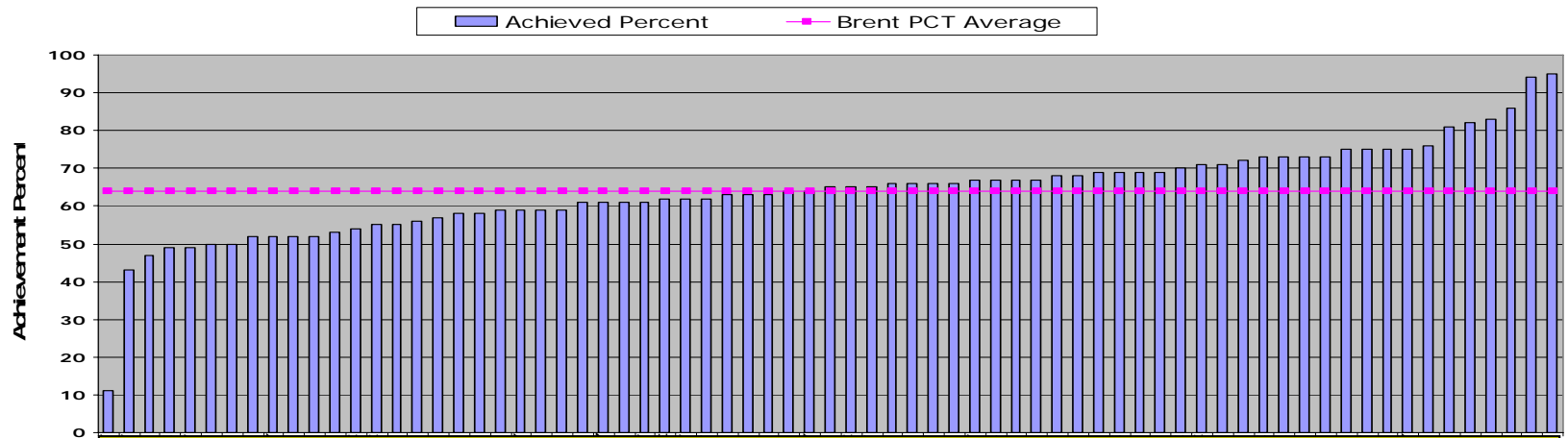
**Brent PCT - DM7 Practice Breakdown of Achievement Percent as at March 2007**



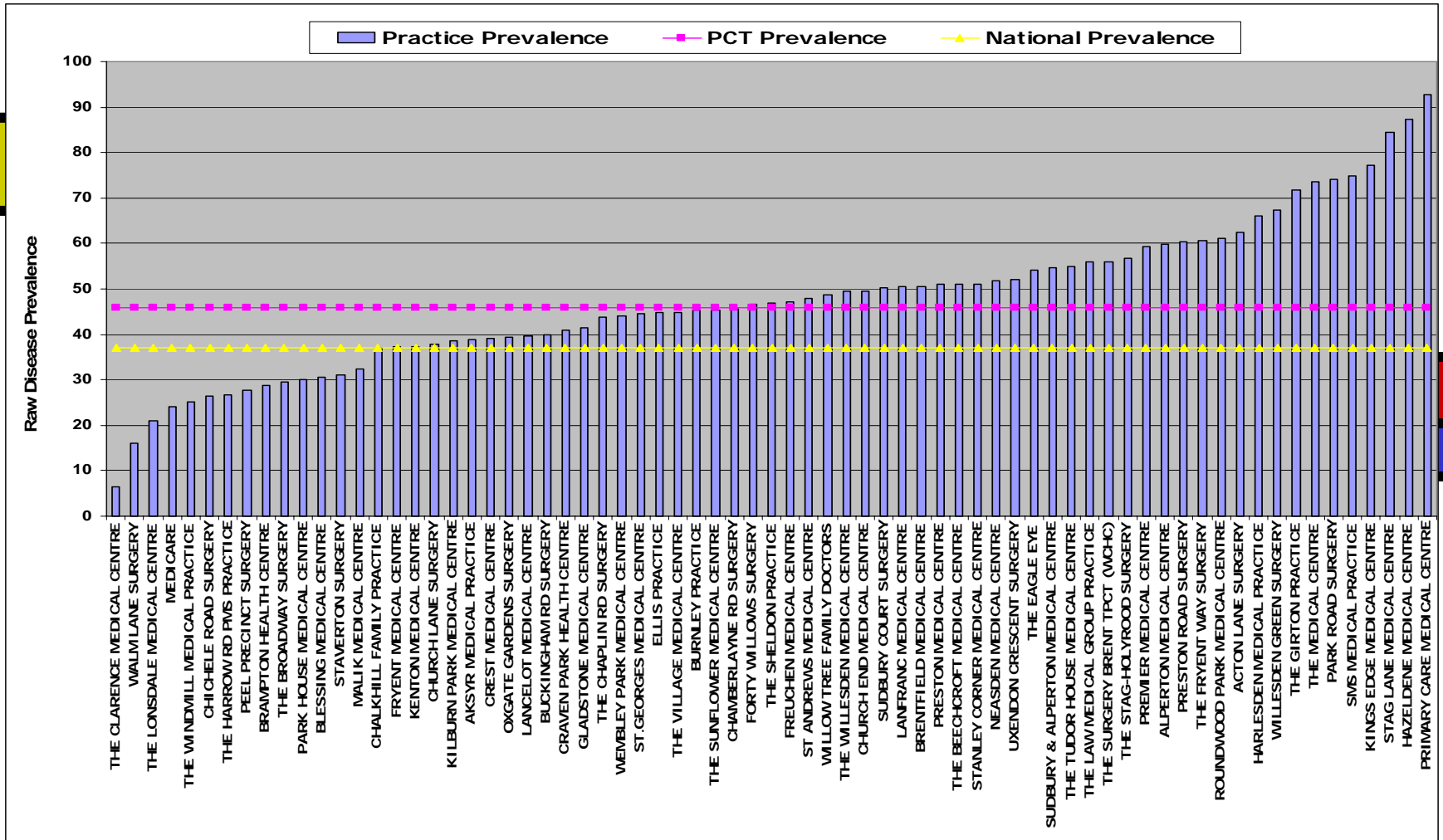
**Indicator DM 20.** The percentage of patients with diabetes of whom the last HbA1C is 7.4 or less (or equivalent test/reference range depending on local laboratory) in the last 15 months.

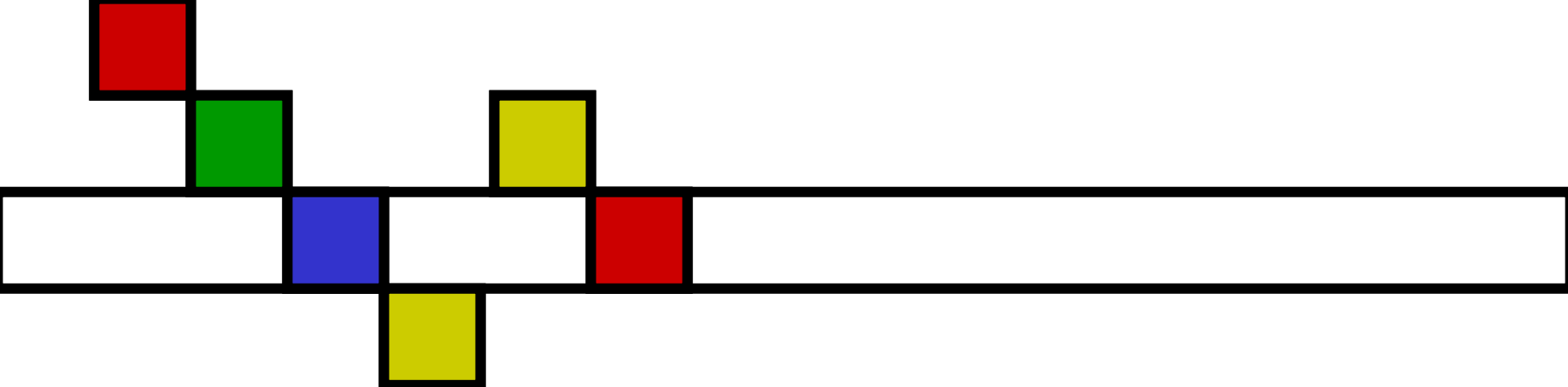
A maximum of 17 points may be awarded for DM 20, with pay stages falling between 40-50%. Virtually all practices except for one achieved at least 25% attainment. The average PCT attainment for DM 20 is approximately 64.09%.

**Brent PCT - DM20 Practice Breakdown of Achievement Percent as at March 2007**

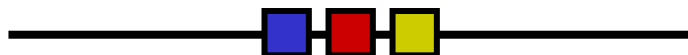


# Diabetes prevalence figs.



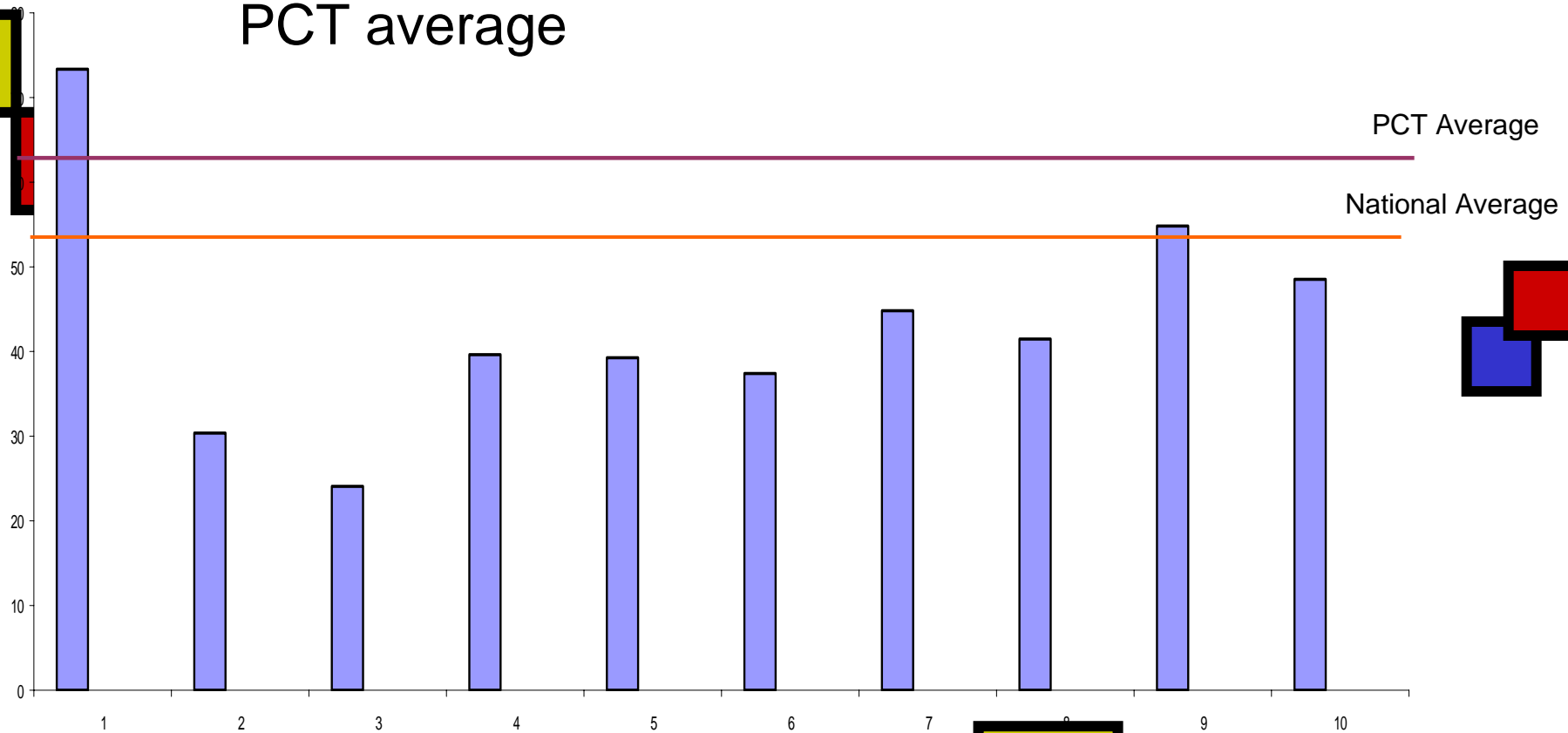


# Situation in identified Practices

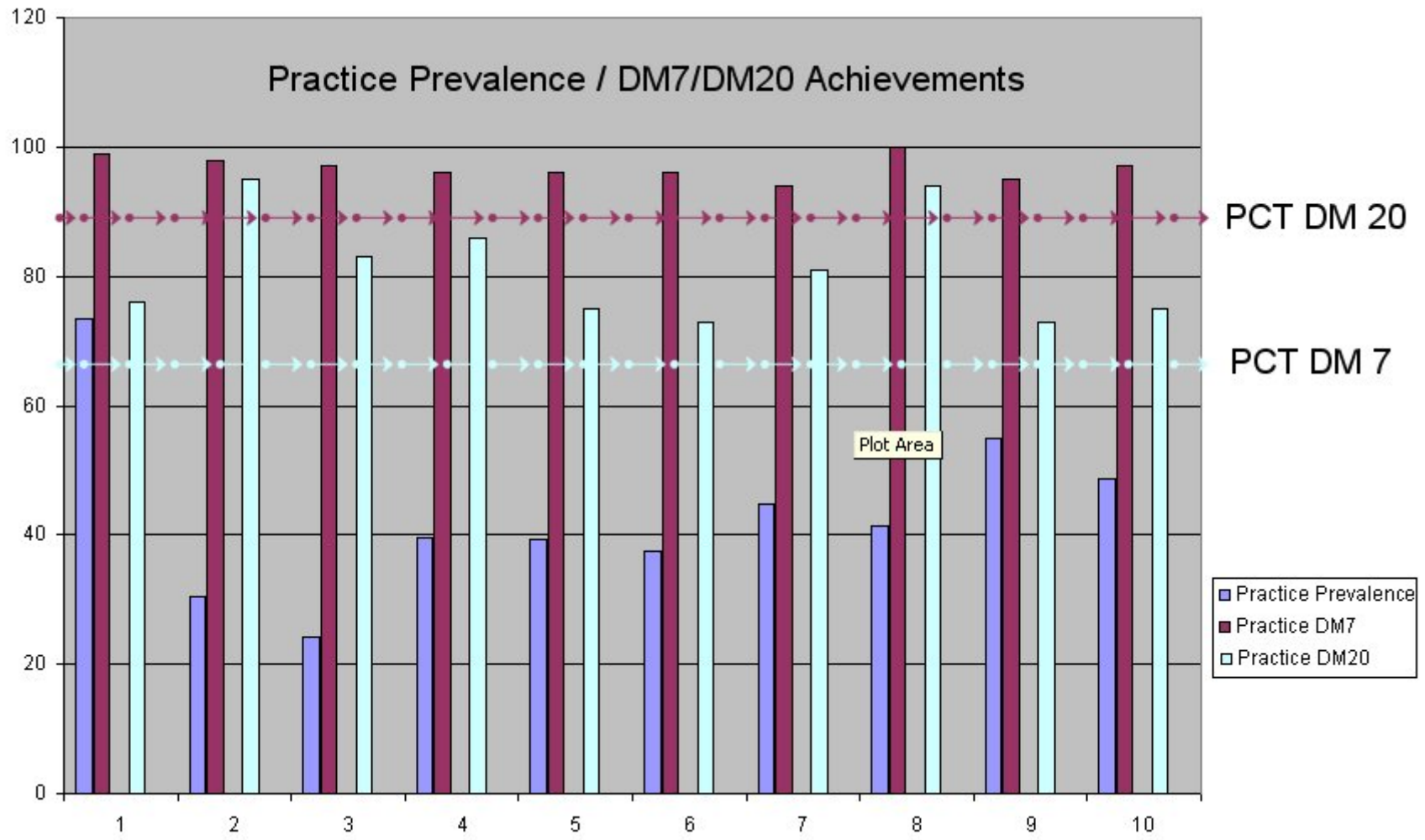


Qof figs. 06-07 for identified Practices

10 of the top performing practices prevalence compared with national & PCT average

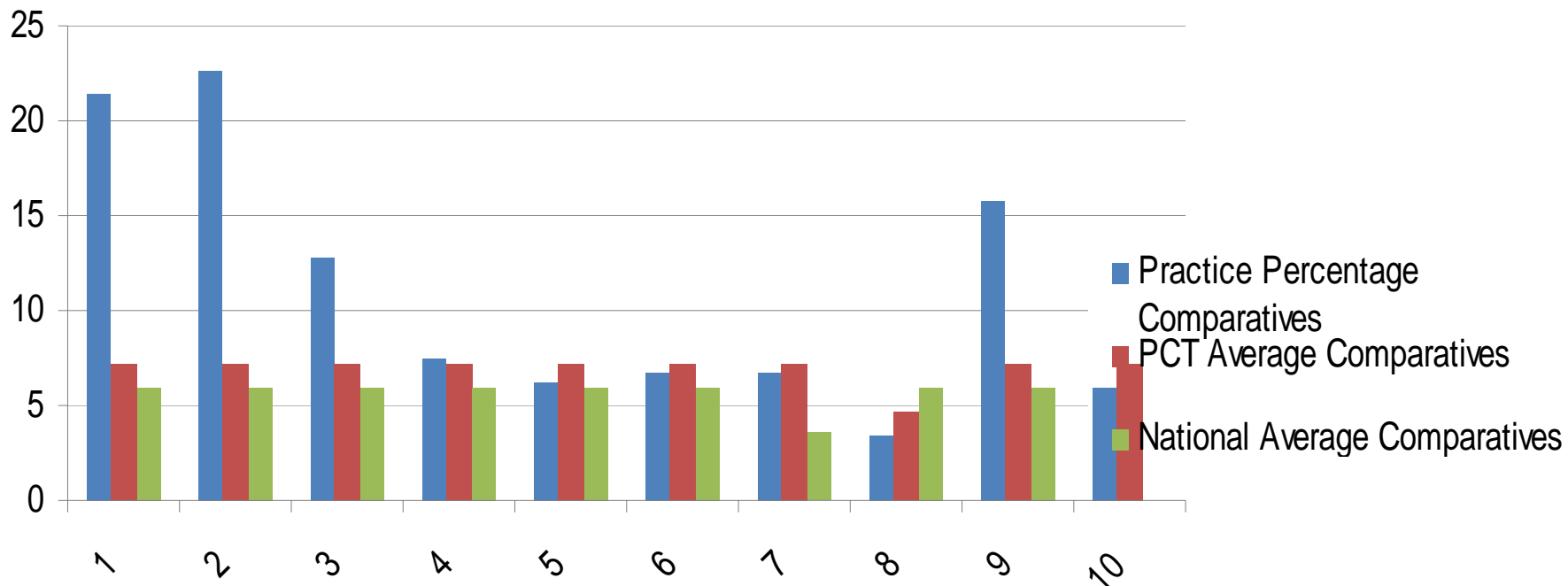


9



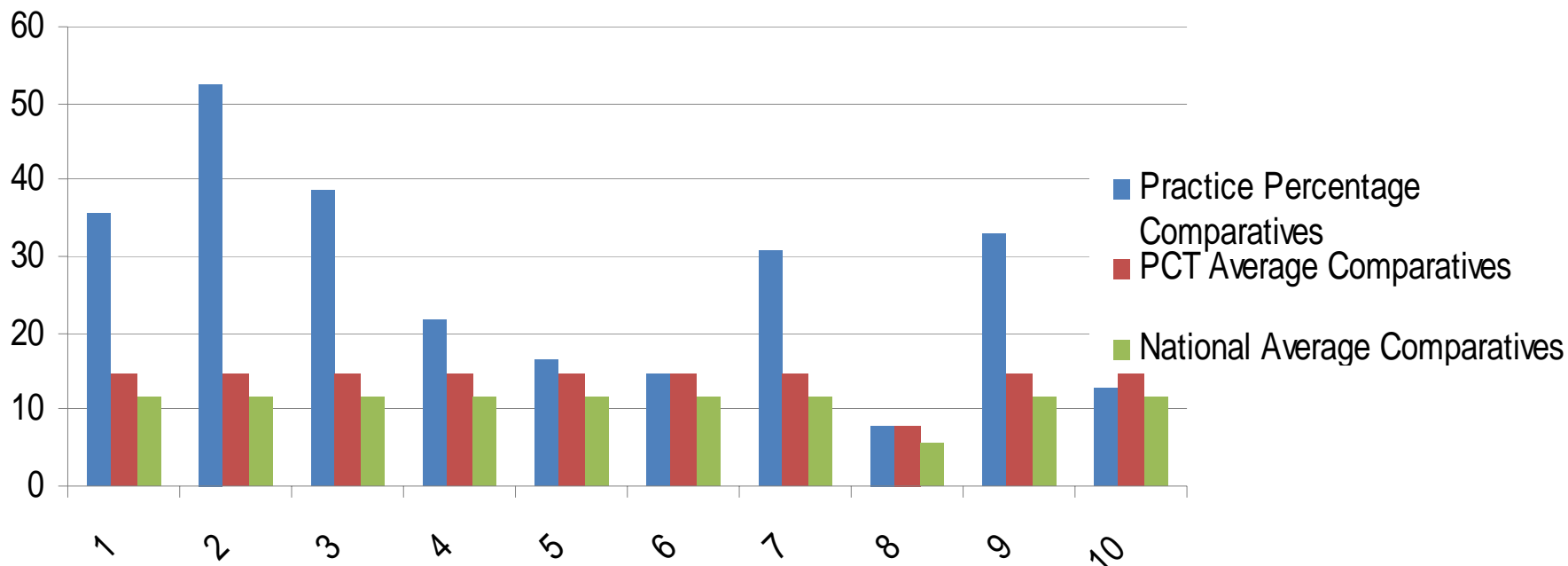
# Level of exception reporting identified practices DM7

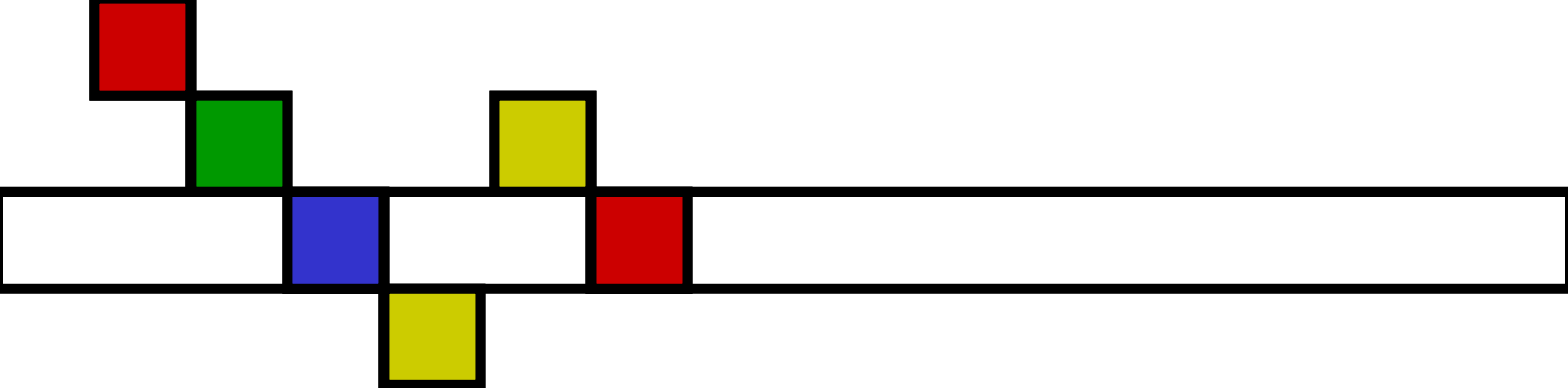
## Exceptions report Diabetes 7



# Level Exception reporting identified Practices DM20

## Exceptions Report Diabetes 20





# WHAT DID THE PRACTICE DO WELL

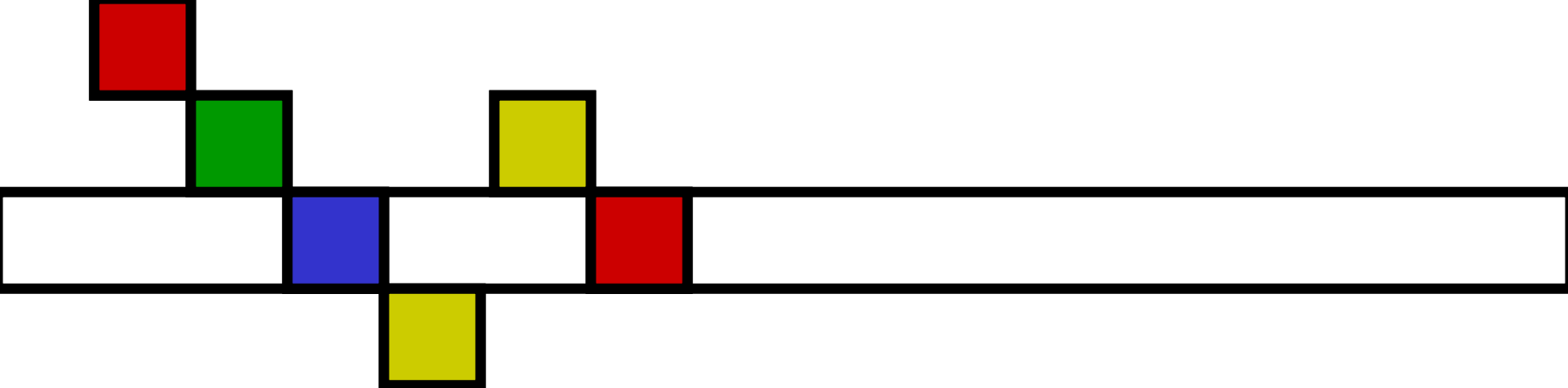


Performance enhancers



# Practices performance enhancers/innovations

- Text messages to patients
- Saturday morning Surgeries for Diabetic clinic
- Phlebotomy in-house
- Involvement of entire practice team.  
Receptionists to recall/scripts as recall tool/  
HCA/ nurses actively involved
- Enthusiatic staff/incentivising staff
- Very regular practice meetings/communications regarding achievements
- Champion within the Practice

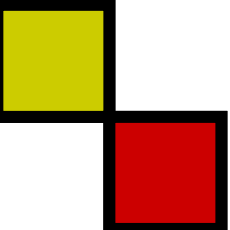
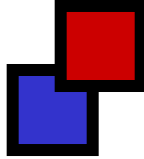


WHAT ARE THE PRACTICES NEEDS?





# Practice needs

- 
- Diabetes updates and training for staff
  - Awareness of local intermediary care clinics
  - Assistance with difficult to manage patients eg mental health probs./housebound
  - Insulin management and initiation
- 



(Extracts from) **EXPECTED STANDARD OF CARE IN DIABETES**

Newly diagnosed **refer to education programme**

Young adults with **type 1 and type 2 diabetes** : refer to **LTCC**

**Weight reduction** – refer to weight management programme once patient has attended education programme : refer to **LTCC**

**Cardiovascular risks** must be addressed - Weight/Waist Circumference, cholesterol, BP, anti-platelet therapy

**Testing for microalbuminuria** must be performed annually, if persistently positive must address CV risk factors as above

**CKD stage 3** ( all patients with Creatinine >150 or eGFR 30-60) refer to **LTCC**

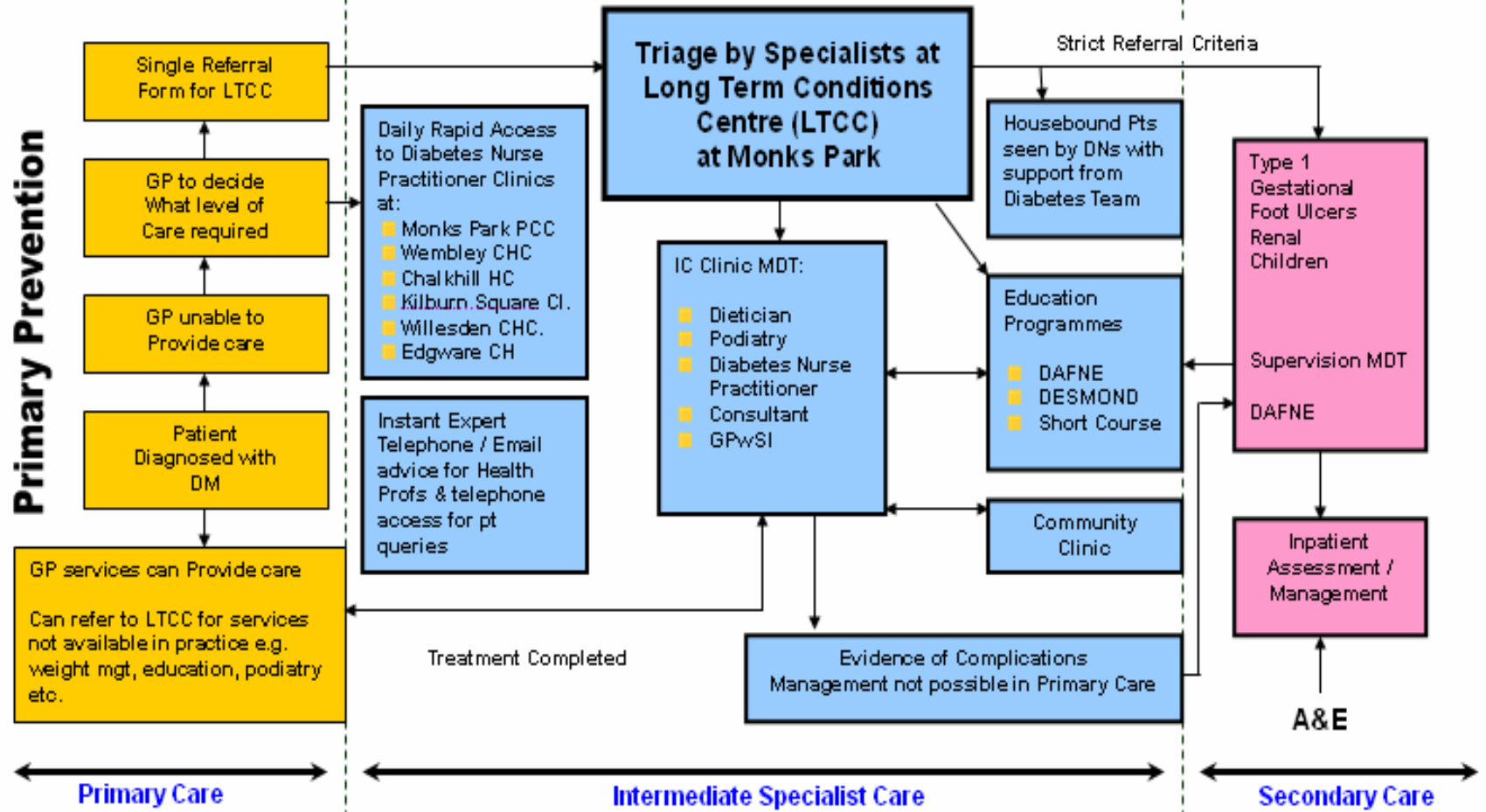
**BP target in type 2 diabetics** should be <140/80mmHg for individuals without microalbuminuria and <135/75mmHg for individuals with microalbuminuria (all patients with creatinine > 150 or eGFR<40, refer to **LTCC**)

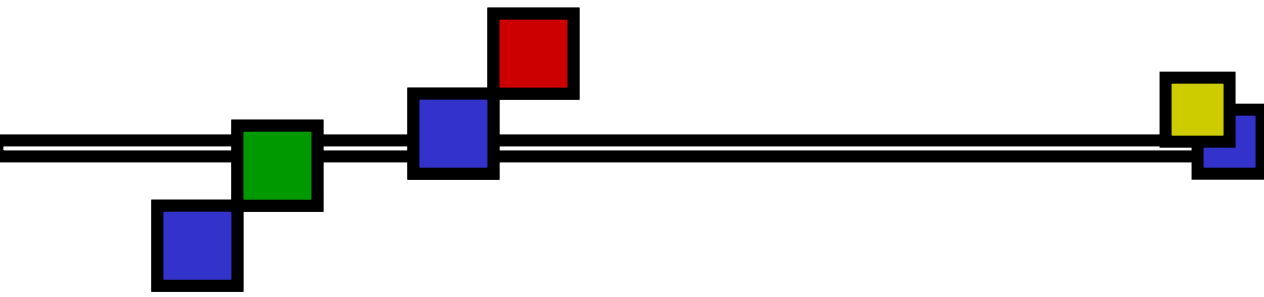
All patients with **grade 2 foot ulcer** – refer to **LTCC** or **grade 3 foot ulcer** – refer to **JKC**

All patients must be referred to the **retinal eye screening programme**

help available at the LTCC centre Monks Park

**Brent Specialist Services For People With Diabetes**



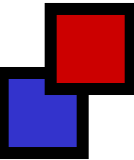


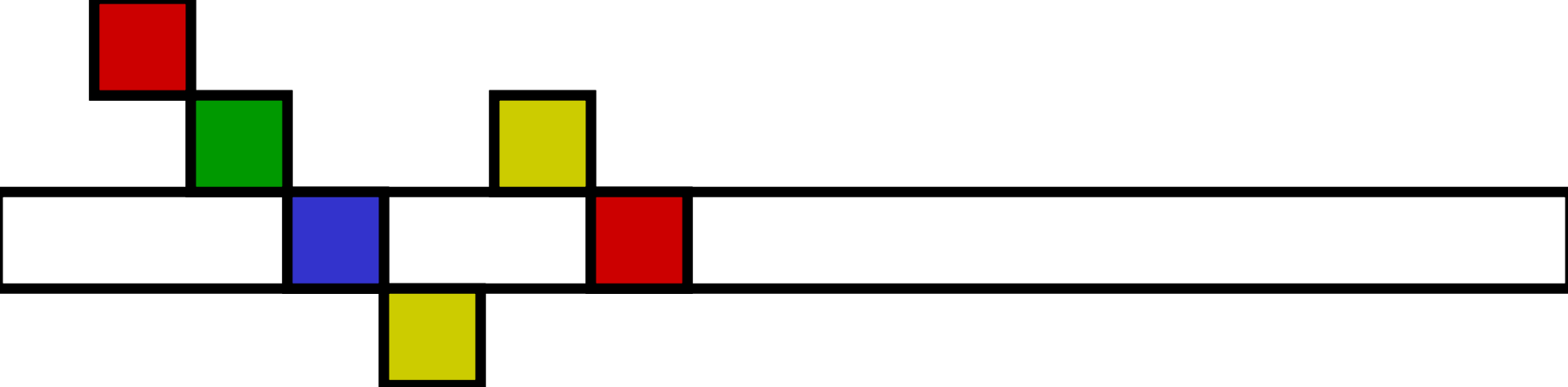
# REFERRALS TO LTCC

■ MOST COMMON REASON

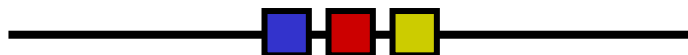
■ POOR GLYCAEMIC CONTROL 7/10

■ 3/10 DID NOT REF





# TOP TEN TIPS FOR IMPROVING PERFORMANCE





# Recommendations

## top ten tips for improving PERFORMANCE

- FLEXIBILITY OF APPROACH.
- CONVENIENCE TO PATIENT
- CHAMPION WITHIN THE PRACTICE
- CHECK FIGS REGULARLY
- HAVE A SYSTEM and monitor system
- COMMITTED STAFF
- WHOLE TEAM APPROACH
- GOOD ONE TO ONE RELATIONSHIP WITH PATIENTS
- KNOW YOUR CAPABILITES/STRENGTHS AND LIMITS
- ONGOING TRAINING UPDATES WITHIN THE PRACTICE TEAM