

Press Release

Suffolk GP Federation commended for innovative model of diabetes care

26 August 2015

A pioneering initiative from Suffolk GP Federation to improve services for the 18,400 people living with diabetes in North East Essex has been commended by charity Diabetes UK after achieving impressive results in its first year.

The Federation, which delivers primary care services in Suffolk and the surrounding areas, was commissioned by the North East Essex Clinical Commissioning Group (CCG) in 2013 to provide an integrated approach which brings together the majority of diabetes care under the umbrella of one service.

One year on from the launch of the North East Essex Diabetes service (NEEDS), the Suffolk GP Federation has increased the number of patients receiving all eight care processes, which includes blood glucose levels and kidney function, from 40.1% to 60.3%.

Blood pressure and cholesterol outcomes have also improved and hospital readmissions due to diabetic ketoacidosis (DKA) and hypo/hyperglycaemia have decreased by 31.6%.

To support the rapidly rising number of people diagnosed with diabetes in North East Essex, patient education and involvement has also been a key focus, with 95% of patients newly diagnosed with Type 1 diabetes and 96% of patients newly diagnosed with Type 2 diabetes being offered structured education.

Dr Karunakaran Vithian, Community Diabetologist for NEEDS and Clinical Lead for Diabetes at Colchester Hospital University Foundation Trust, said: "Ensuring patients receive all eight care processes is one of the most important measures of a diabetes service. This is a real achievement, reflecting the hard work of the diabetes team, primary care colleagues and of course, people with diabetes. To have achieved these results in the first year of the new model of diabetes care is fantastic and bodes well for the future."

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Ben Ellis, Shared Practice and Innovation Manager at Diabetes UK, who has developed a case study on the Suffolk GP Federation's model of diabetes care, said: "This is a great example of what can be achieved when healthcare professionals come together across the care pathway to deliver more joined up care. Through expanding the role of primary care, the NEEDS service has achieved fantastic first-year results, which are already making a big difference to the lives of people with diabetes."

A UK first in diabetes care for a GP federation, Suffolk GP Federation has a single, five year contract with the CCG to both provide care, including secondary care services and a community-based diabetes specialist team, and organise other providers across the care pathway through subcontracting arrangements.

The full case study is available on the NEEDS website: www.diabetesneeds.org.uk

Top line findings

- A 5.3% increase in the diagnosed population (from 17,470 in 2013/2014 to 18,400 in 2015/2016)
- An increase in the percentage of people receiving all eight care processes from 40.1% in April 2014 to 60.3% in March 2015
- A 31.6% decrease in readmissions for patients with diabetic ketoacidosis (DKA) or hypo/hyperglycaemia
- 95% of patients newly diagnosed with Type 1 diabetes and 96% of patients newly diagnosed with Type 2 diabetes offered structured education
- 66% of outpatients previously under the care of the acute hospital were discharged and are now being treated in primary care
- 96% of patients stated they were 'likely' or 'extremely likely' to recommend the new service (of 85 patients surveyed)

ENDS

CAPTION: The NEEDS service has significantly increased patient involvement through a number of engagement events

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NOTES TO EDITORS

NEEDS

1. The North East Essex model of care is based on learning from Bexley's GP led model of care developed in 2010/11. The model aims to improve outcomes for adults with diabetes by providing a single point of access to, and continuity of care across, an integrated care pathway.
2. The NEEDS service provides a diabetes specialist team that supports GP practices to provide more services in a local community setting, reducing the need for hospital visits.
3. The diabetes specialist team is led by a consultant and community clinics are held in Clacton, Colchester and Harwich. Podiatry and other specialist clinics take place in a variety of GP practices locally on a weekly, fortnightly or monthly basis.
4. Patient education and involvement are very important to the NEEDS service and aim to improve patients' long term health and reduce the number of complications requiring hospital visits. To achieve this patients are encouraged to develop their diabetes awareness and feel more in control of their condition. A wide range of education courses and less formal ways to learn are on offer and patient 'Buddies' and 'Experts' are being trained to help others with the condition.

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Suffolk GP Federation

1. Suffolk GP Federation was commissioned by North East Essex Clinical Commissioning Group to deliver the integrated diabetes service for North East Essex from April 2014. Details of the service were shaped with input from a wide range of stakeholders including Diabetes UK.
2. The not-for-profit Suffolk GP Federation has 61 independent GP practices covering 580,000 patients and is growing quickly. Its objectives are to improve the range and quality of local healthcare. Members remain independent GP organisations whilst collaborating in the further development of local primary care and the delivery of improved services for patients.
3. Current contracts include services for lymphoedema and community based ultrasound. The Federation also runs innovative community based intermediate clinics for cardiology and urology. These involve patients being seen at GP practices by a team consisting of a consultant, one or more clinical assistants (who are GPs who have had additional training) and specialist nurses.
4. Suffolk GP Federation is a Community Interest Company. Address is Riverside Clinic, 2 Landseer Road, Ipswich IP3 0AZ. See www.suffolkfed.org.uk

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