And the winner is…

ROBERT GREGORY

The diabetes community has its own equivalents of the Grammys and the Oscars. UK diabetes teams have been recognised for inspirational work to improve care in different categories. ABCD sponsored the *BMJ* Awards Diabetes Team of the Year Award in 2015 and 2016, and supports the Quality in Care awards. There has been a record number of entries for the 2017 Rowan Hillson Insulin Safety Award for 'the best joint pharmacy and diabetes team initiative to improve insulin and prescribing safety in hospital', which will be presented at the ABCD autumn conference.[1] Unlike the makers of movies, healthcare professionals working in the field of diabetes are not motivated by the prospect of winning an award, but by striving to improve the care their service provides to people with diabetes. The benefit of the award transcends that of the trophy to the successful team; the media coverage is an effective method of disseminating innovation and good practice. This is something that needs to be done better in the NHS.

All the nations of the UK have prioritised diabetes in their respective health strategies, and are investing in it in various ways that are expected to result in improvements in outcomes. The Scottish government has announced an additional £10 million for type 1 diabetes.[2] The funding will increase pump provision over the next five years and provide access to continuous glucose monitoring for priority groups of patients. The Diabetes Delivery Plan for Wales refers to variation in the achievement of treatment targets and requires Health Boards to use primary care cluster level working to address variation in care and support practices with improvement tools such as the RCGP's National Quality Improvement Project.[3,4] The full integration of diabetes services will be supported by a project to integrate electronic information across specialist, primary, community and emergency care. This has also been identified as a priority in the Diabetes Strategic Framework for Northern Ireland;[5] a Diabetes Network has been established to implement the framework.

In England the Quality and Outcomes Framework (QoF) incentivised GPs to provide high quality care for their diabetic patients and was successful in increasing the achievement of the selected process and outcome measures. It appeared that the improvement associated with QoF had reached a plateau, and that another lever to raise quality was needed. Enter the Clinical Commissioning Group Improvement and Assessment Framework (CCGIAF).[6] This set out performance metrics in a range of health priorities, including diabetes, by which CCGs would be rated against their peers over the next four years. The diabetes domains had been carefully selected as those for which there was unacceptable variation between CCGs, and therefore opportunities for improvements in care that would be expected to result not only in better outcomes for people with diabetes, but also financial savings for the NHS. The initial focus is on the proportion of people with diabetes who access structured education within a year of diagnosis, and on the proportion who achieve the three treatment targets (HbA_{1c}, cholesterol and blood pressure). In following years, diabetic foot care and inpatient care will be assessed. Assessments will be based on data submitted to the National Diabetes Audit (NDA), so it was important to achieve the highest possible practice participation rates. NDA 2015–16 shows a much improved participation rate compared with 2014–15.[7] An independent expert panel chaired by Chris Askew (Diabetes UK CEO) has been established to analyse the results and identify CCGs where interventions are most needed. This intelligence will feed into the NHS RightCare Programme, the vehicle for encouraging and supporting sustainable improvement in England.[8] In response to the needs identified, NHS RightCare will work in partnership with stakeholders including Diabetes UK and ABCD to encourage and test innovations designed to improve quality of care and reduce unacceptable variation. Any service improvements need to be based on sound principles using the best available evidence. NHS RightCare is producing a catalogue of 'optimal pathways' for various medical conditions including diabetes. We have drawn their attention to documents that should help them to describe good care – the recently updated NICE guidelines, the ABCD position paper 'Standards of care for management of adults with type 1 diabetes'[9] and the type 1 diabetes service specification produced by the London Diabetes Clinical Network.[10]

We recognise that there is no shortage of documents about commissioning models of care for diabetes, most of which are gathering dust on the bookshelves of commissioning managers. When the spotlight is shone onto an organisation to reveal shortcomings, there is an understandable temptation to slash and burn, or to throw everything away and import a model of care that appears to work elsewhere. ABCD often hears from members that commissioners have decided to implement a new model, without discussion with local specialists, that risks throwing the baby out with the bathwater, i.e. dismantling elements of the existing model that work well while pursuing improvements elsewhere. ABCD and Diabetes UK Clinical Champions are ready and willing to assist in

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such situations. Last year I was pleased to be invited to join a Diabetes UK Council of Healthcare Professionals Working Group to design, test and disseminate a commissioning framework for diabetes. We hope this will become the first document that commissioners and providers look at when they feel the need to make improvements to the local diabetes service. It will describe the essential components of successful models to encourage tailored service redesign from first principles, rather than picking an off the shelf solution that may not necessarily be a good fit for their locality.

One important principle is that commissioners and providers have a regular dialogue about diabetes services. It was gratifying to see dialogue starting with CCGs last year when NHS England announced a fund of £44 million per year for two years for sustainable service improvements in each of the four domains in the CCGIAF.[11] In the age of austerity this investment is welcome, and channelling the bids through the STPs should provide an assurance of cooperation between local organisations required to deliver successful projects.

The Carter Report 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' had a different perspective on the impact of variation and claimed that, if this were addressed properly in hospitals, there could be efficiency savings of £5 billion annually.[12] Having tested this claim in a project looking at elective orthopaedic surgery and obtained encouraging results, NHS Improvement is rolling it out across a wide range of specialties, including diabetes and endocrinology. We are waiting to hear who the national Quality & Efficiency Lead for 'Getting it Right First Time' will be, but whoever does it, they will be expected to focus on helping specialist departments to provide best quality cost-effective care for patients, for which they deserve our support.

It does seem as though the NHS is not only talking the talk, but putting some money where its mouth is. I am anxiously waiting to see whether the approaches outlined lead to sustainable improvements on the scale required. Oh, and the winner is … the person with diabetes.

Conflict of interest An abbreviated version of this article appeared in Diabetes Update, Spring 2017

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ERRATUM

"Glucagon like peptide-1 receptor agonist (GLP-1RA) therapy in management of type 2 diabetes: choosing the right agent for individualised care"

ZIN ZIN HTIKE, FRANCESCO ZACCARDI, SUDESNA CHATTERJEE, KAMLESH KHUNTI, MELANIE J DAVIES

(*Br J Diabetes* 2016;**16**:128-137 http://dx.doi.org/10.15277/bjd.2016.091)

In the article listed above, the numbers -0.2 (HbA_{1c}) and -0.9 (body weight) for DURATION 6 study in Table 1 are not correct; the correct numbers are 0.2 and 0.9. The sentence in the second paragraph of "Effect on glycaemic control and body weight" should read as follows: "Compared with liraglutide 1.8 mg, dulaglutide showed marginally greater HbA_{1c} reduction of 0.1% ($p<0.0001$)[55] while once-weekly exenatide showed a marginally lower reduction in HbA_{1c} of 0.2% ($p=0.02$)[32], suggesting that these GLP-1RAs may have similar glycaemic efficacy clinically".