NHS Rotherham Clinical Commissioning Governing Body

Operational Executive – 13th March 2017

Strategic Clinical Executive – 15th March 2017

GP Members – 29th March 2017

CCG Governing Body – 5th April 2017

Diabetes - Strategic Update

Lead Executive:	**Ian Atkinson**
Lead Officers:	**Janet Sinclair-Pinder, Jacqui Tuffnell**
Lead GP:	**Anand Barmade**

Purpose:

To update Governing Body in relation to the proposed changes to the Diabetes pathway to improve outcomes and reduce cost.

Background:

Work commenced in September 2015 to look at ways to improve Diabetes care across Rotherham. This was in response to national reports and local data sets highlighting that Rotherham was an outlier for Diabetes care both in term of cost and outcomes. The annual cost of diabetes in Rotherham is around £10.5 million pounds (excluding associated complications) and this figure is projected to increase to £12 million over the next 5 years.

Working closely with TRFT, the CCG has agreed a new model of secondary care for Diabetes in Rotherham, with full implementation by April 2017. This model is based on the Portsmouth "Super 6" model.

- Inpatient diabetes
- Foot diabetes (with predefined criteria)
- Poorly controlled Type 1 diabetes, including adolescents
- Insulin Pump services
- Low eGFR or patients on renal dialysis
- Antenatal diabetes

Under this model 95% of patients who have a diagnosis of diabetes will be cared for in the Community by General Practitioners, Practice Nurses and Community Diabetes Specialist Nurses (DSN) and with significant emphasis placed on self care by appropriately educated patients.

Portsmouth have recently published a 5 year report following implementation of the Super 6 model. The report noted high rates of patient and clinician satisfaction; a 29.5% reduction in rates of admission from diabetic ketoacidosis; a 42% reduction in rates of admission from hypoglycaemic events and a 30% reduction in rates of admission from hypermolar hyperglycaemic events. The report also estimates a reduction in Myocardial Infarction of 22%, reduction in stroke of 22% and a reduction in rates of major amputation of 39%. In addition to the obvious increase in quality of life and health improvement, in monetary terms this equates to a total saving of £1.9 million over the five years.

TRFT clinicians have identified that they already consider that they are working to the principles of the Super 6 model

Patients and carers will be equal partners in decisions about their care and have more control in the management of their own health, care and treatment. It is intended that joint care planning should identify interventions and programmes aimed at helping individuals to achieve their personal goals.

GPs and Practice staff will be supported in managing the vast majority of patients with Diabetes in the community, with education and advice provided by Secondary Care clinicians via virtual clinics and MDTs and by the Diabetes Specialist Nurse Service. Improving Diabetes care is a priority for the CCG and the primary care changes required have been put into the Quality contract with practices implementing the new model of care from April 2017.

There is currently variation within practices in respect of Diabetes treatment and care. The new model will address this variation in several ways and includes:

- Delivery of the requirements as set out in the Primary Care Quality Contract
- Sharing best practice, including DSN input to practices.
- Utilising the Integrated Locality Team (ILT) -currently a pilot only
- Via multidisciplinary team (MDT) meetings.
- Nominating a key-worker for patients.
- Utilising direct-access diagnostics available in primary care.
- Workforce education.
- Systematic delivery of the 9* care processes, bringing the CCG's QOF average in line with national targets.

**Diabetic retinopathy sits with NHS England and is not the responsibility of general practice*.

Under the new model all Rotherham GPs will undertake:

- Holistic assessment for people with diabetes to check for the existence and/ or risk of associated co-morbidities.
- Increased identification of hypertension and high cholesterol through annual Long Term Condition (LTC) checks, and the prescribing of medication to control both conditions.
- Opportunistic case finding, for example, when patients attend for LTC management, flu clinics etc.

Rotherham GPs will improve the management of patients with Diabetes by:

- Identifying patients and adding them to the appropriate practice disease register.
- Early referral to lifestyle services, e.g. smoking cessation, weight management and self-management programmes.
- Greater acknowledgement of the impact of a long term condition(s) on a person's mental health. Access to mental health services is available via the ILT or a mental health referral.
- Applying the NICE Quality Standards, specifically:

    1. People with diabetes and/or their carers will receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to on-going education.(e.g. DAFNE/DESMOND courses)
    2. People with diabetes will receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional (HCP) or as part of a structured educational programme. (referral to DAFNE/DESMOND courses)
    3. People with diabetes participate in annual care planning leading to documented agreed goals and an action plan.
    4. People with diabetes agree with their HCP a documented personalised HbA_{1c} target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%), and receive an on going review of treatment to minimise hypoglycaemia.

5. People with diabetes agree with their HCP to start, review and stop medications to lower blood glucose, blood pressure and blood lipids in accordance with NICE guidance.

Working up to the implementation date of April 2017, several initiatives have already been implemented. This includes referral back to the GP of all Type II patients who are not on triple therapy maximized dose. In November 2016 a Diabetes Information and Advice Line (DIAL) for GPs and other healthcare professionals was commenced with the aim of improving Diabetes care in the Community and prevention of unnecessary admissions to hospital. A recent report has indicated that Rotherham is an outlier for significantly more hospital admissions for severe hypoglycaemia.

Guidance on GLP1 initiation in Primary Care has been written and at PLT on the 11 January, GPs and Practice Nurses were educated in respect of this guidance, along with tips on managing insulin patients and diabetes and obesity.

The Diabetic Specialist Nurses (DSN) are in the process of developing a competency framework for Practice Nurses and educational packages for practices. Starting in April 2017 it is envisaged that all patients with Type II diabetes will be managed in primary care, with DSN support to practices for managing Insulin titration.

The DSNs have also developed a shared care pathway to manage movement of patients between the different levels of care. This includes Patient Management Plans.

A bid has been submitted in respect of improving Diabetes Care in Rotherham. The bid is through the National Diabetes Treatment and Care Programme to improve the 3 treatment targets for which Rotherham is currently an outlier. The bid consists of additional non recurrent resources to ensure the new pathway is delivered at improved pace and also incorporates release time for GP Practices to be trained. We believe we will know the outcome of this bid by April. Rotherham was also part of a collective bid with Barnsley, Doncaster and Bassetlaw to be a second wave pilot for the National Diabetes Prevention Programme. This bid was successful and we are working towards roll out of the programme in early Summer 2017. Recruitment for a project manager and provider are currently under way.

Analysis of key issues and of risks

A service specification has been developed which encompasses the principles of the Super 6 model and outlining the roles and responsibilities of the DSN Service and Primary Care. This draft specification has been shared with TRFT managers and clinicians for comment. The DSN Service/managers have approved the specification in principle.

Whilst some practices in Rotherham are already up to speed in respect of Diabetes care, other practices will require training and support to enable appropriate management, care and monitoring of patients. The DSN service has identified those practices which require the most assistance in terms of support and education and targeted training and education for five practices will be starting imminently. There will be some delay in providing all of practices with the education and this will therefore need to happen in year. Patients will not therefore be discharged back to a GP practice until this training has been undertaken Should the bid for funding from NHS England be successful, this should assist in accelerating the education and support programme by allowing back filling for Practice Nurses, DSNs and Dieticians, freeing staff up in order to attend/provide the education and training.

Patient, Public and Stakeholder Involvement:
The new model has been discussed at the bi monthly Diabetes Network Meeting. Present at these meetings is a member of Diabetes UK and a Rotherham patient representative. These representatives were also invited to the PLT on the 11 January.
Equality Impact:
Engaging the BME community with Diabetes Care has traditionally proved challenging, it is expected that with further support being provider across primary care it will allow the BME community to access additional support and education.
Financial Implications:
The approach to implementation of the new Integrated Diabetes Service has been cost neutral in terms of expenditure. When the model was introduced in Plymouth, savings of around £90k were made by transferring patients to Primary and Community care. Because Rotherham Foundation Trust consider that they are already operating to the Super 6 model, and Rotherham already has an established Community Diabetes Nursing service, it is not expected that any savings will be realised from secondary care to the Community/Primary care. NHSE have estimated that by improving three care processes, Rotherham can save around £2 million. By implementing the new model, any projected savings will be in the long term and cannot always be directly measured. Improvements in Diabetes care will affect other conditions, such as reduction in MI and stroke and need for amputation. Although it is difficult to compare Rotherham with Portsmouth, as the demographics are different, it is expected that improvement in monitoring and treatment of Diabetes will culminate in savings for Rotherham along the same lines as mentioned above following the Portsmouth 5 year report, as well as a reduction in prescribing costs.
Human Resource Implications:
NA
Procurement:
NA.
Approval history:
CRMC/SCE/OE/LMC
Recommendations:
Governing Body are asked to note the progress with regard to improving Diabetes Care and to support the continued direction of travel to implement an Integrated Diabetes Model across the borough.