NHS Rotherham Clinical Commissioning Governing Body

Governing Body 4th October 2017

Diabetes Update

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

Purpose:

To update Governing Body in relation to the implementation of the new Diabetes Model

Background:

The new Diabetes model commenced on the 1 April 2017.

Planning for the introduction of the new model began in September 2015 to look at ways to improve Diabetes care across Rotherham. This was in response to national reports indicating 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.

The model is based on the Portsmouth "Super 6" model. 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.

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 DSN service. 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.
- Via multidisciplinary team (MDT) meetings.
- Nominating a key-worker for patients.
- 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*.

The Diabetes Service Specification and KPIs has now been signed off by both the CCG and TRFT.

The process of referring back to Primary care all Type II patients with Diabetes not on triple therapy began prior to the implementation date of the new model. The Diabetes Information and Advice Line (DIAL) for GPs and other healthcare professionals was commenced in

November 2016 with the aim of improving Diabetes care in the Community and prevention of unnecessary admissions to hospital and GPs and Practice Nurses have undergone education and training in respect of GLP1 initiation, and managing patients on Insulin. A competency framework for Practice Nurses, and educational packages for practices is now in place and being utilised. Primary Care Diabetes leads have also been identified to enable better communication and dissemination of education and information between Primary Care, Secondary Care and the Diabetes Specialist Nursing Service. A shared care pathway has been produced and is awaiting sign off by medicines management.

National Diabetes Treatment and Care Programme(NDTCP)

To support the implementation of the new diabetes pathway, Rotherham CCG applied for transformation and care funding from NHS England to improve the delivery of the three treatment targets (HBa1C, cholesterol and blood pressure). RCCG was successful in this bid and has been allocated £154,000 for this financial year, subject to the achievement of agreed milestones. The funding is primarily being utilised to increase capacity in the Diabetes Specialist Nursing and Dietetic teams to increase the support to practices with implementation of the new specification which is expected to improve the three treatment targets. Staff have now been recruited to these posts.

National Diabetes Prevention Programme (NDPP)

Rotherham, as part of a South Yorkshire and Bassetlaw Waive 2 bid (excluding Sheffield who were undertaking the programme as part of Waive 1) were successful in securing the NDPP and commenced planning for delivery of the programme in early 2017. Rotherham referrals to the service commenced in July for central practices and all remaining practices from 18 September 2017. The programme will be delivered as close to the population as possible using where feasible community facilities and are arranged once 25 referrals are received from the locality. An initial session has been organised to take place at the New York Stadium. Clifton is looking to trial using MJOG to notify patients of their eligibility to undertake the programme, there are over 800 patients within the practice who meet the criteria.

Analysis of key issues and of risks

The successful bid for transformation funding has meant that the targeted support to practices has been accelerated. The Diabetes Service is able to offer 2 educational sessions to practices per month plus shorter sessions on particular subjects tailored to suit the individual needs of the practice. There has been positive engagement from the vast majority of GP practices and a recent targeted education session in one practice attracted participation from 9 GPs and 6 Practice Nurses.

With the exception of the Consultant led clinics in Primary Care, all the milestones for the Transformational Funding are on target.

Agreement was reached with TRFT that Consultants would be made available to attend clinics at least once a year in Primary Care. Despite this being a milestone in the funding for Diabetes Transformation and an integral part of the model and service specification, the current timetable provided by TRFT means that it will take 3 years for all practices to have received support by way of a Primary Care Clinic. The Diabetes Consultants and GPs who have already taken part in the clinics so far have agreed how valuable these clinics have been both in terms of education and in preventing referral to secondary care. This issue has been discussed with Rebecca Chadburn and Sarah Lever who will be raising this as a contracting concern with TRFT.

At the last update there had been an issue in respect of annual foot checks for complex Type 1 Diabetes. As part of the Super 6 model patients with Type I Diabetes would receive all of their care by secondary care clinicians, including foot checks. TRFT had expressed concerns

regarding the capacity to undertake these annual foot reviews. This has now been resolved and patients with Type 1 Diabetes are now receiving holistic care, including foot checks as per the Super 6 model.

One of the aims of the new model was to ensure systematic delivery of the 9 care processes, bringing the CCG's QOF average in line with national targets. A key measure of the transformation and care funding is improvement in the delivery of the three treatment targets. The IT team are currently working to develop a dashboard to monitor these key service metrics and provide data for business case development to secure on going funding. There have been problems following the recent cyber attack in respect of the necessity for required permissions having to be sought on each individual member of staff's laptop to enable this work to be done. The Data Quality Manager has assured the Diabetes Steering Group that this work will be achieved by the end of September in line with the agreed milestone.

We have also identified a gap in provision of care for housebound patients and it has been agreed that the district nursing team will be trained to provide diabetic support to meet this gap.

Patient, Public and Stakeholder Involvement:

The bi monthly Diabetes Network Meeting has now been incorporated into a monthly Diabetes Steering Group. Membership of this group includes a Rotherham patient and Diabetes UK representative.

Equality Impact:

Work is ongoing to improve the uptake of Diabetes Education and engagement with the BME Community. The Diabetes Dieticians have developed a plan to increase dietetic support to practices particularly focussing on ethnic minority groups. This includes identification of GP practices with high ethnic minority groups and patient advocates from different ethnic minorities in order to support tailored focussed advice in appropriate settings. These settings include GP practices, the Unity Centre and Mosques.

An officer from the CCG and a member of staff from the Diabetes team will also be attending a structured patient education workshop in Leeds which is developing a translated education programme for BME patients.

Financial Implications:

The approach to implementation of the new Integrated Diabetes Service has been cost neutral to the CCG in terms of expenditure. Funding has been secured through the NDPP NDTCP which will assist in delivery of the Diabetes model

Human Resource Implications:

NA

Procurement:

NA.

Approval history:

OE 15 September 2017
SCE 20 September 2017
GPMC 27 September 2017

Recommendations:

It is recommended that Governing Body members continue to support the Diabetes Steering Group in the ongoing implementation of the new Integrated Diabetes Model and achievement of the milestones for funding under the NDPP and NDTCP.