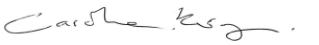
NHS
Bedfordshire
Clinical Commissioning Group

Agenda Item: 13.0

Governing Body *held in public*	***Report*** Date of Meeting: 1 March 2018

Report Title	**Improving Care for Patients with Diabetes across Bedfordshire**	
Report Author	**Presented By**	**Responsible Director**
Dr. Sanhita Chakrabarti Clinical Lead Diabetes Program Wendy Pearson, Interim Project Manager (Diabetes)	Dr. Sanhita Chakrabarti Diabetes Clinical Lead	Caroline Kurzeja, Director of Commissioning **Signature:** 
Purpose for presenting report	This report is to update BCCG Governing body on the improvement program that has been put in place for people diagnosed with Diabetes in Bedfordshire	
Action Required:	For information only	
Approval Route:	Bedfordshire CCG Clinical Reference Group on 07.12.2017 and 08.02.2018	
Further Assurance:		

Which Strategic Objectives does this report provide evidence for?	**Please Tick √**
We will commission high quality, safe and sustainable models of care that deliver effective clinical outcomes and patient experience using evidence based decisions and best practice	√
We will ensure that there is a financially sustainable and affordable healthcare system in Bedfordshire.	√
We will lead, engage and operate as an effective place based and STP wide system partner to achieve greater integration of care delivery.	√
We will support local people and stakeholders to have an influence on services we commission to ensure our decisions are informed and shaped by local views and insights.	√
We will operate and manage our Governing Body to the highest standards of accountability and transparency.	

Implications/Assessments	**Yes**	**No**	**N/A**
Have any financial implications been signed off by the Chief Finance Officer?			√
Have any quality implications been signed off by the Director of Nursing & Quality?			√
Have any privacy implications been signed off by the Head of Information Governance?			√
Have any conflicts of interest implications been signed off by the Corporate Office?			√
Have any public engagement implications been signed off by the			√

Head of Communications & Engagement?			
Has an Equality Impact Assessment been carried out?			√

Key Risks	Bedfordshire, Luton and Milton Keynes STP are collectively close to delivery of targets set out in the service specification for the National Diabetes Prevention Program (NDPP) Diabetes prevention program. Should targets be reached, the STP is likely to suffer from an early cessation of this program in 2018/19. In particular Bedfordshire practices have exceeded the two year allocated quota of 1,740 referrals for people with high risk of Diabetes. The improvement program has been possible due to £418,000 transformational funds for 2017/18 that Bedfordshire CCG was able to secure from NHS England Transformational funds 'NHS Diabetes Treatment and Care Program'. This bid was for a five year program with two year's funding by NHS England in 2017/18 and 2018/19. However CCGs are currently awaiting confirming of funding for Year Two - 2018/19. Should this funding not be forthcoming, the planned delivery of this improvement program will need to be reviewed.
Executive Summary	The purpose of this paper is to provide an update on the Diabetes Transformation Programme for Bedfordshire CCG, providing an overview of the background, case for change and the initiatives that are being mobilised to support Diabetes care improvement. Bedfordshire CCG recognises the opportunities for improvement in Diabetes Care and acknowledges the recent IAF result as 'needs improvement', based on the 2016/17 National Diabetes Audit. With the support of our patients, our system partners and local and national investment, a significant number of new interventions have been initiated within the financial year 2017/18 and we are confident that the interventions will have a significant improvement on the health and wellbeing of our Diabetes patients. A summary of the interventions and benefits are described below: • A two-year NHS Diabetes Prevention Programme providing education and support, over a period of nine-months, for people who are identified as being at risk of diabetes to help prevent or delay the onset of diabetes • Patient participation in care planning as part of their diabetes annual review in general practice, including a jointly agreed care plan with the patient will deliver improved NICE recommended treatment targets

	• Improved access to structured education, provided by the Integrated Diabetes Service, for patients so that they can understand and take responsibility for managing their condition • Improved access to other services including health and well-being services will help patients to get holistic support for managing their diabetes • Early identification of foot problems for people with diabetes and referral to specialist MDFT services, where required, will impact on reduced hospital admissions for people with diabetes, reduced length of stay when admitted and a reduction in foot amputations • Better efficiencies within funded programs for patients with Diabetes will be achieved by reduced emergency admissions for patients with Diabetes. • Investment within the Integrated Community Diabetes Service to support patients who are struggling to optimise control of their diabetes and tailored support to practices where indicated by current outcomes and performance

Improving Care for Patients with Diabetes across Bedfordshire

1. Introduction

The purpose of this paper is to provide an update on the Diabetes Transformation Programme for Bedfordshire CCG, providing an overview of the background, case for change and the initiatives that are being mobilised to support Diabetes care improvement over the next five years.

Governing Body are asked to note the content of the report and support the ongoing work programme for Diabetes improvement as a key clinical priority for Bedfordshire CCG.

2. Background

Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. There are two main types of diabetes:

- **Type 1 diabetes** – where the body's immune system attacks and destroys the cells that produce insulin. This tends to occur in children and young adults and results in a complete dysregulation of sugar control.
- **Type 2 diabetes** – primarily a condition of insulin resistance and evolves to where the body doesn't produce enough insulin. The effects of Type 2 Diabetes has been shown to be reversed or prevented with strict glycemic control, as a result of lifestyle management processes i.e. diet, exercise, weight loss.

Type 2 diabetes is far more common than Type 1 in the UK and around 90% of all adults with diabetes have Type 2 diabetes.

In 2017, 29,874 (8%) of Bedfordshire CCG population, above the age of 16 years, were known to have Diabetes.

The national prevalence for Diabetes in England is 8.7% and this figure is likely to rise. By 2020, it is estimated that a further 8,318 people are likely to develop Diabetes with the prevalence predicted to rise to 9% of the population. However, in certain parts of Bedfordshire, prevalence of Diabetes is higher than national average.

3. Case for Change

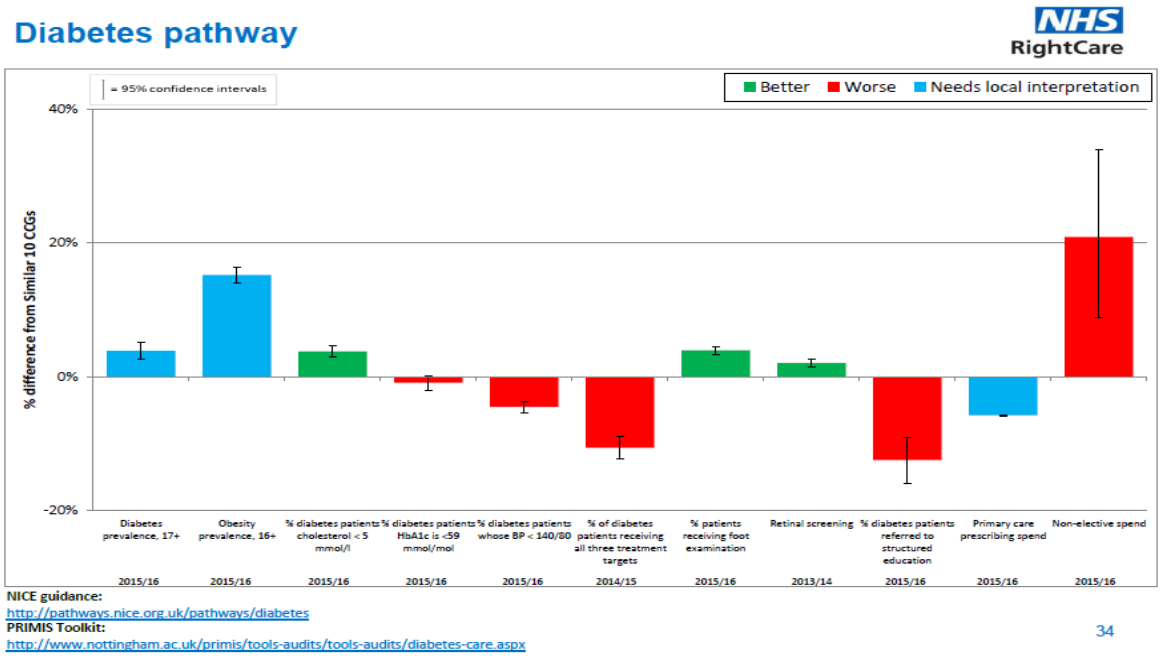
The Bedfordshire CCG Operating Plan 2017-2019 highlighted Diabetes as one of our five Clinical Priorities for review as part of the NHS RightCare and Commissioning for Value programme.

Bedfordshire CCG has a diverse population and there are a number of key issues that need to be addressed. The key points from the NHS RightCare Programme 2015/16 (Table 1), National Diabetes Audit 2016/17 and local intelligence are summarised below:

- Given rising prevalence of Diabetes, there is an increasing need to focus on Diabetes prevention and early identification

- Lower than average number of patients that have offered all 8 care processes
- Below average rate for the number of patients achieving all three treatment targets - Cholesterol, Blood Glucose (HbA1C) and Blood Pressure. In particular, achievement of the target for Blood Pressure is significantly below average.
- High prevalence of Obesity, a key contributor to the development of Type 2 Diabetes
- High rate of activity and expenditure on non-elective Diabetes admissions
- Low number of referrals to Structured Education coupled with low uptake of Structured Education
- Lack of shared care planning with patients as part of their Diabetes Annual Review
- Significant variation in performance across practices
- High rate of amputations and of admissions for people with foot care problems

Table 1. NHS RightCare – Diabetes Pathway Indicators



Based on the 2016/17 National Diabetes Audit, the CCG has been given an Improvement and Assessment Framework rating of 'Needs Improvement'. The remainder of the paper sets out the work that has been initiated to tackle the health improvement and variation indicators for Bedfordshire.

3.1. Nine Care Processes

All patients with diabetes aged 12 years and over should receive all of the nine NICE recommended care processes and attend a structured education programme when

diagnosed. The nine Annual Care Processes for all people with diabetes aged 12 and over are:

1. **HbA1c** - blood test for glucose control
2. **Blood Pressure** - measurement for cardiovascular risk
3. **Serum Cholesterol** - blood test for cardiovascular risk
4. **Serum Creatinine** - blood test for kidney function
5. **Urine Albumin/Creatinine Ratio** - urine test for kidney function
6. **Foot Risk Surveillance** - foot examination for foot ulcer risk
7. **Body Mass Index** - measurement for cardiovascular risk
8. **Smoking History** - question for cardiovascular risk
9. **Digital Retinal Screening** - screening register drawn from practices

In 2016/17, the national diabetes audit reported that 43.2% of patients with Diabetes in Bedfordshire CCG received all eight care processes (excludes digital retinal screening) compared to 47.7% nationally. Appendix 2 summarises the performance against each of the eight care processes, split by Type 1 and Type 2 diabetes.

3.2. Three Treatment Targets

As part of the nine care processes, NICE recommends three key treatment targets for patients with Type 2 Diabetes:

1. Target **HbA1c** reduces the risk of all diabetic complications.
2. Target **blood pressure** reduces the risk of vascular complications and reduces the progression of eye disease and kidney failure.
3. Target **cholesterol** reduces the risk of vascular complications.

In 2016/17, 38.1% of patients achieved all three treatment targets which was an improvement on the previous year (37.6%), however below the national average of 41.1%. Bedfordshire CCG performance is also below the average of its Right Care Commissioning for Value peer group (Table 2) and there is also considerable variation in the level of achievement across practices. The most significant area of poor performance is management of hypertension (blood pressure) for patients with diabetes as presented in Table 3.

Table 2. NHS RightCare: % of patients receiving All Three Treatment Targets

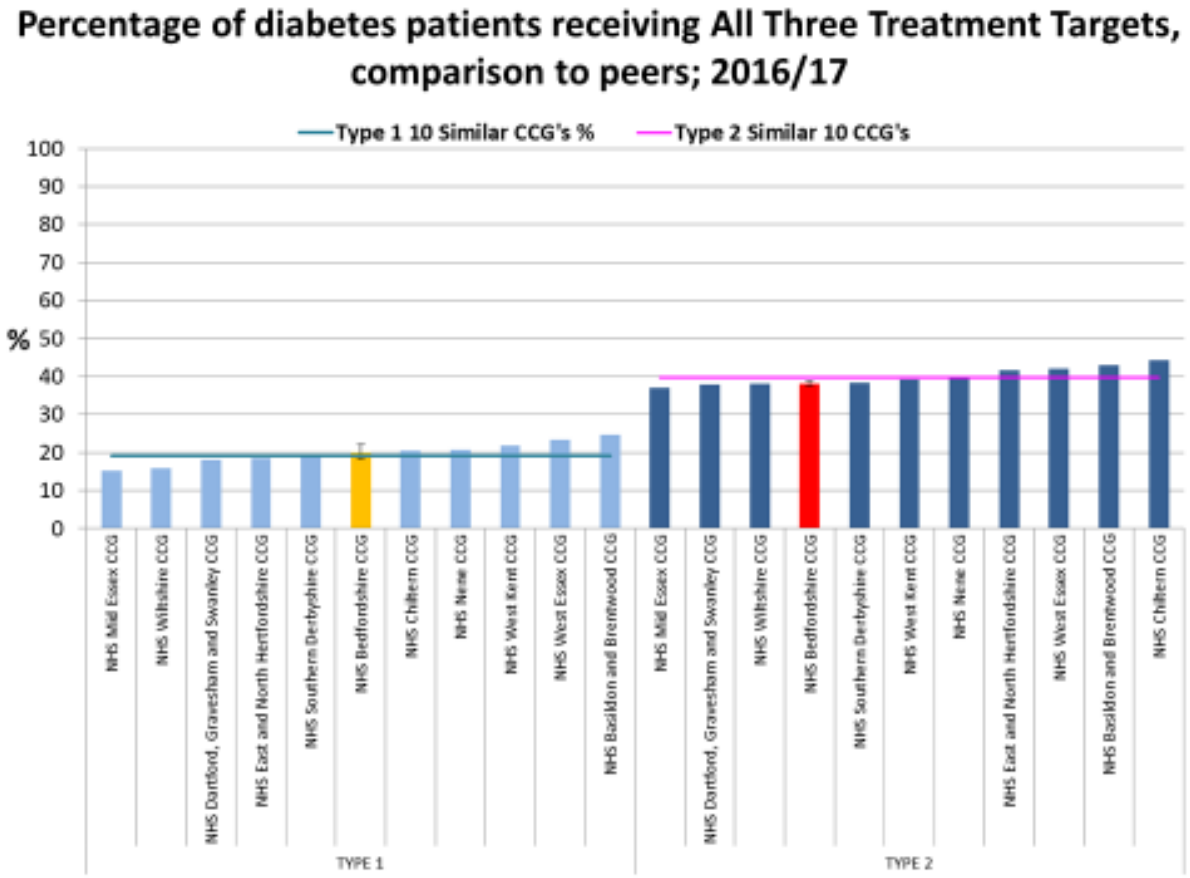


Table 3. NHS RightCare: % of patients receiving All Three Treatment Targets

Type 2 Diabetes Overview	NHS BEDFORDSHIRE CCG (06F)	ENGLAND
	Percentage completed	Percentage completed
HbA1c < 48 mmol/mol (6.5%)	29.5	30.6
HbA1c <= 58 mmol/mol (7.5%)	66.5	67.0
HbA1c <= 86 mmol/mol (10.0%)	93.8	93.3
Blood Pressure <= 140/80	70.2	74.4
Cholesterol < 4 mmol/L	40.3	41.3
Cholesterol < 5 mmol/L	75.4	76.2
All Three Treatment Targets	38.1	41.1

4. Diabetes Transformation

Bedfordshire CCG recognises the opportunities for improvement in Diabetes Care and acknowledges the recent IAF result as 'needs improvement', based on the 2016/17 National Diabetes Audit.

With the support of our patients, our system partners and local and national investment, a significant number of new interventions have been initiated within the financial year 2017/18 and we are confident that the interventions will have a significant improvement on the health and wellbeing of our Diabetes patients and lead to improvement in the IAF assessment for 2017/18, due to be published in Quarter 3 2018/19.

4.1. Multi-partnership Approach to Diabetes Improvement

A Diabetes RightCare Specialty Implementation Group (SIG) was established in late 2016 and is responsible for service review, service redesign and innovation to ensure better outcomes for patients and improved efficiency. This includes all stages of the patient pathway from self-help and Primary Care through to Community, Acute and Specialist Care. The Diabetes SIG and wider Diabetes Improvement Network has representation from the following stakeholders and meets regularly:

- Secondary Care Consultants, Nurse Specialists, Dietitians and Allied Health Professionals
- Community Podiatry Service Clinical Leads
- CCG Clinical Lead, GP Lead, Commissioning/Quality/Locality Leads
- Healthwatch and Diabetes UK
- Contracting and Business Intelligence Leads
- Local Authority, including Public Health Leads

Bedfordshire CCG, alongside its STP partners, Luton CCG and Milton Keynes CCG, was fortunate in securing additional investment to improve care and treatment of diabetes. The Bedfordshire CCG share equates to £418,000 in 2017/18 under all categories for which bids were submitted, as follows:

- Improving Treatment Targets - £170,000
- Expanding Structured Education for people with diabetes - £64,000
- Multi-disciplinary foot care team - £184,000

Luton CCG investment will also provide benefit to Bedfordshire CCG patients due to a high proportion of patients attending Luton & Dunstable NHS Hospital.

The bid was awarded in mid-April 2017 for a five year program with two year's funding by NHS England in 2017/18 and 2018/19. However Bedfordshire CCGs is currently awaiting confirming of funding for Year Two - 2018/19. Should this funding not be forthcoming, the planned delivery of this improvement program will need to be reviewed. We are in regular communication with NHS England regarding Year Two award and have sighted this risk and mitigations within the BCCG Corporate Risk Register.

The bid objectives and expected outcomes are set out in Appendix 1. The following sections provide an overview of the comprehensive Diabetes programme and progress made since initiation.

4.2. Improving Prevention of Type 2 Diabetes

The main risk factors to developing type 2 diabetes are:

- Age – being over the age of 40 (over 25 for people of south Asian, Chinese, African-Caribbean or black African origin, even if born in the UK)
- Genetics – having a close relative with the condition, such as a parent, brother or sister
- Weight – being overweight or obese

- People of south Asian and African-Caribbean origin also have an increased risk of developing complications of diabetes, such as heart disease, at a younger age than the rest of the population

Many cases of Type 2 diabetes are preventable and there is strong international evidence that behavioural interventions can significantly reduce the risk of developing the condition, through reducing weight, increasing physical activity and improving the diet of those at high risk.

The NHS Diabetes Prevention Programme (NDPP) is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver at scale, evidence based behavioural interventions for individuals identified as being at high risk of developing Type 2 diabetes.

NDPP was introduced to Bedfordshire as part of the wave 2 national program. The program supports people who are at risk of Diabetes. Once identified by their GP, people with high risk of Diabetes are referred to a 9 month structured program. To date 2,153 people across Bedfordshire have been referred to the program since commencement in June 2017.

4.3. Improving Treatment Targets and Care Planning

Based on best practice across the country as well as our STP partners, Bedfordshire CCG has introduced a number of schemes to support GP Practices with tools and education to support delivery of the nine care processes, including the achievement of the three treatment targets:

- Improved training for Practice Nurses, Health Care Assistants, GPs and other community staff to use the 'care planning' process, whereby the patient becomes a partner in the planning of their clinical management. Six half day training session on the Introduction of Care Planning have been carried out between October 2017 – January 2017 which the majority of Bedfordshire CCG practices have attended. Further, train the trainer sessions have been held with the Integrated Community Diabetes Service.
- Training updates have been provided for GPs and Practice nurses at Protected Learning Time events and additional weekend educational sessions on best practice Diabetes clinical management. A number of these training sessions have already been delivered since April 2017.
- All Bedfordshire CCG practices were invited to participate in a new Locally Commissioned Service for the delivery of care planning as a key part of diabetes annual review. This scheme incentivised practices to undertake training in order to provide best practice care planning. As of 15th February 2018, 44 of our 51 practices have signed up to this Locally Commissioning Service and we are engaging the remaining practices to encourage participation.

- Quarterly Clinical Dashboards have been developed at GP practice level, Bedford Locality Board level as well as CCG level to identify key opportunities for health improvement and opportunities for optimising patients with Diabetes.
- New SystmOne Long Term Conditions Diabetes template to support delivery of best practice, to provide access to advice, guidance and referral forms and clinical dashboards. This will support local monitoring of improvement on a quarterly basis as opposed the existing annual National Diabetes Audit results.
- Investment within the Integrated Community Diabetes Service to support patients who are struggling to optimise control of their diabetes and tailored support to practices where indicated by current outcomes and performance
- Additional Diabetes nurses to support practices where there is lack of capacity or workforce to adequately deliver care for our patients with Diabetes
- Additional support available to patients from local authority commissioned smoking cessation service as well as excess weight services.
- Adult mental health as well as community podiatry teams have also been expanded to provide support to patients with Diabetes.
- Social care teams from both local authorities are also working to support patients with Diabetes.

4.4. Improving Access and Uptake of Structured Education

Structured education is designed to support patients with diabetes to understand and to support self-management of their condition. The NHS England Diabetes Fund is supporting the expansion of Structured Education for patients with Type 2 diabetes in Bedfordshire, providing increased sessions to patients based on their needs.

The Structured Education offer, provided by the Integrated Community Diabetes Service, is being tailored to provide sessions for Black and Minority Ethnic communities, as well as providing sessions at flexible times and at local venues convenient for patients. From 2017/18 (Quarter 4) the additional capacity to deliver structured education for patients with Type 2 diabetes is increasing. There will be an additional 960 places per annum, increasing the number of places from 990 to 1950 and almost doubling the current capacity.

4.5. Reducing rate of Diabetes Foot Complications and Amputations

Multi-disciplinary Foot Teams (MDFT) are responsible for regularly reviewing patients with diabetes who develop complications with their foot. The NHS England Diabetes Fund has enabled expansion in the capacity and expertise within the Multi-Disciplinary Foot Care team at Bedford Hospital NHS Trust (BHT), including Consultant expertise (diabetes, vascular surgeon, orthopaedics, radiology support) working as a team with specialist podiatrists.

Alongside this, a community based foot protection team will focus on early identification of foot care problems and referral into the MDFT as required.

Taking 2015/16 as the baseline year, by March 2019 the additional investment is aimed to: reduce amputations from diabetes by 6 (11%); reduce admissions for people with active foot disease by 39 per annum (10%); and to reduce length of stay from 11 days to 7.5.

Further reductions in all of these targets are planned for years 2-5 of the programme and early evidence suggests that it is likely that these targets will be exceeded.

Following implementation of the expanded MDFT in September 2017, data extracted for the period October - December 2017, in comparison to the same months in 2016, shows a reduction of approximately 6 non-elective admissions per month for foot related diseases.

5. Conclusion

Bedfordshire CCG recognises the opportunities for improvement in Diabetes Care and acknowledges the recent IAF result as 'needs improvement', based on the 2016/17 National Diabetes Audit.

With the support of our patients, our system partners and local and national investment, a significant number of new interventions have been initiated within the financial year 2017/18 and we are confident that the interventions will have a significant improvement on the health and wellbeing of our Diabetes patients.

A summary of the interventions and benefits are described below:

- A two-year NHS Diabetes Prevention Programme providing education and support, over a period of nine-months, for people who are identified as being at risk of diabetes to help prevent or delay the onset of diabetes
- Patient participation in care planning as part of their diabetes annual review in general practice, including a jointly agreed care plan with the patient will deliver improved NICE recommended treatment targets
- Improved access to structured education, provided by the Integrated Diabetes Service, for patients so that they can understand and take responsibility for managing their condition
- Improved access to other services including health and well-being services will help patients to get holistic support for managing their diabetes
- Early identification of foot problems for people with diabetes and referral to specialist MDFT services, where required, will impact on reduced hospital admissions for people with diabetes, reduced length of stay when admitted and a reduction in foot amputations
- Better efficiencies within funded programs for patients with Diabetes will be achieved by reduced emergency admissions for patients with Diabetes.
- Investment within the Integrated Community Diabetes Service to support patients who are struggling to optimise control of their diabetes and tailored support to practices where indicated by current outcomes and performance

APPENDIX 1 - Bedfordshire National Diabetes Treatment and Care Programme - Objectives and Outcomes

Clinical lead: Dr Sanhita Chakrabarti, Bedfordshire CCG
GP Lead: Dr Shahidar Ponnala

Bid Area: Increasing Attendance at Structured Education

Overview:

- Increased provision of DESMOND with focus on newly diagnosed T2 patients – an increase of 400 places in year 1 (FYE) and a further increase of 560 places in year 2
- Offer choice of days/times of provision e.g. evening and weekend to meet demand
- Offer culturally adapted courses
- Improve coding of referrals to and attendance at Structured Education
- Audit at practice, locality and CCG level

Expected Outcomes:

- Increased referral to structured education
- Increased attendance at structured education
- Improved patient knowledge and confidence to self-manage their condition
- Delay or prevention of long term complications of diabetes through better control
- Courses more accessible to patients
- Improved performance monitoring

Bid Area: Improving Achievement of NICE Recommended Treatment Targets

Overview:

- Work with GP Practice 'clusters' of 30-50,000 patients to improve NICE recommended treatment targets
- Implement a Locally Commissioned Service (primary care incentive scheme) to deliver Care Planning within planned diabetes annual review
- Care planning training for practice nurses
- Additional Diabetes Specialist Nurse focusing on practices with poor achievement of treatment targets
- Part-time psychologist to work with patients who lack motivation
- Work with community weight management, smoking cessation and IAPT services
- Purpose designed SystmOne template supporting diabetes management
- Audit at practice, locality and CCG level

Expected Outcomes:

- Improved achievement of NICE recommended treatment targets
- Raise performance in practices with poor achievement
- Delay or prevention of long term complications of diabetes through better control
- Improve integrated working between primary care, community teams, and secondary care.
- Improved patient knowledge and confidence to self-manage their condition
- Care planning tailored to specific cohorts of patients with diabetes such as those from ethnic background, men and specific age groups

Bid Area: Implementation of Multidisciplinary Footcare Team

Overview:
Implementation of an enhanced service with new multidisciplinary foot care team, that will link the enhanced community foot protection team with the new specialist MDfT at Bedford NHS Trust including:

- MDFT with specialist podiatrist, vascular, tissue viability, diabetes specialist nurses and diabetologist
- consultant led specialist foot clinic and urgent vascular clinic access
- advanced level specialist podiatrists
- podiatry assistant

Expected Outcomes:

- Reduce time from community referral of new acute foot problem to triage by specialist foot team
- Reduction in number of diabetes related emergency admissions through more proactive management of foot ulcers
- Reduction in length of stay for people with where admission cannot be avoided through better control and more proactive management.
- Reduction in major lower limb amputations resulting from diabetes related foot ulceration

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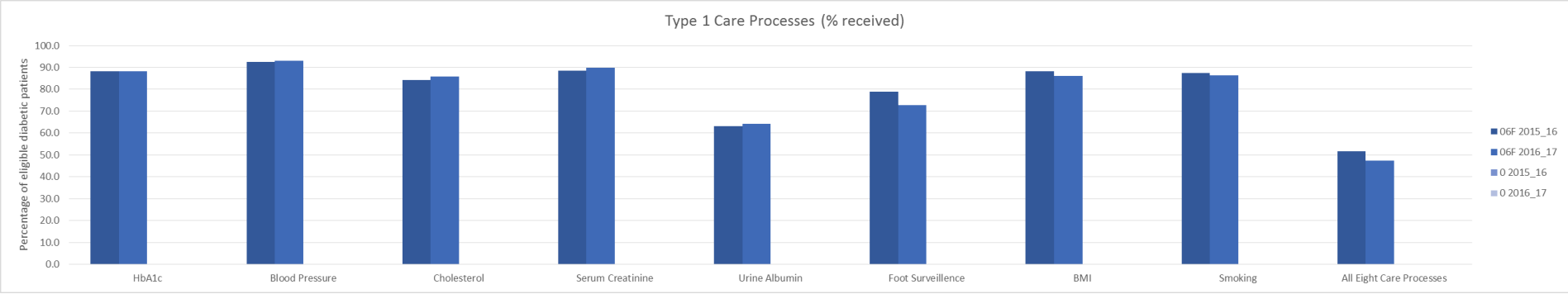
APPENDIX 2 - Bedfordshire CCG Care Processes for patients with Diabetes

Care Processes for people with Type 1 diabetes

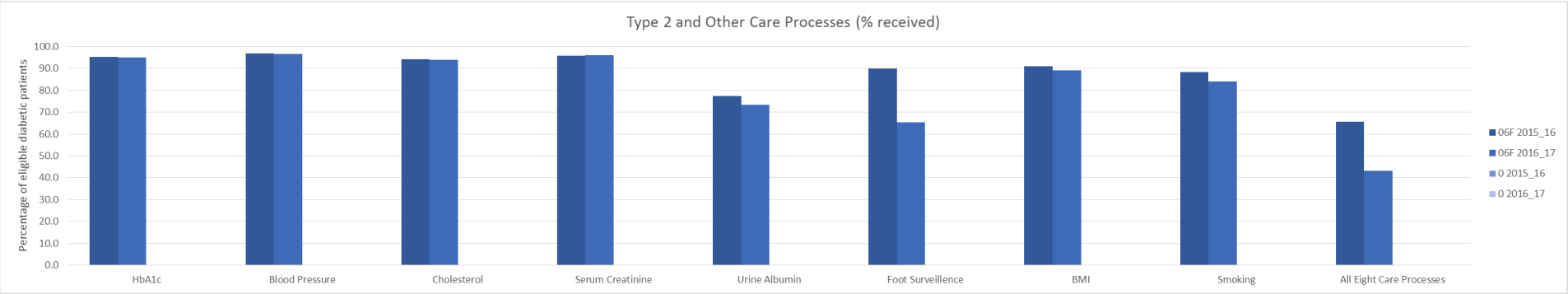
The diagrams below show the % of patients receiving each of 8 care processes and the achievement of all eight care processes in 2015/16 and 2016/17. Whilst achievement of most of the targets is 80% or above foot surveillance and urine albumin pull down performance against all eight care processes.



*The NDA does not include the ninth care process, diabetic retinopathy screening, in its analysis

Care Processes for people with Type 2 and other diabetes

The diagrams below show the % of patients receiving each of 8 care processes and the achievement of all eight care processes in 2015/16 and 2016/17. As in Diagram 4 above, whilst achievement of most of the targets is 80% or above foot surveillance and urine albumin pull down performance against all eight care processes.



*The NDA does not include the ninth care process, diabetic retinopathy screening, in its analysis