Report of the Chief Officer NHS Bradford City and NHS Bradford Districts CCGs to the meeting of Health and Wellbeing Board to be held on 13th May 2014

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Subject:

Diabetes Update

Summary statement:

This paper presents an update regarding diabetes developments within NHS Bradford Districts CCG, NHS Bradford City CCG and NHS Airedale, Wharfedale and Craven CCG and considers potential next steps for the district.

This paper describes the outcomes of the Diabetes Review commissioned by the three CCGs and initial learning and feedback from the NHS Bradford City CCG 'bradford beating diabetes' programme.

Ultimately we want to achieve better outcomes for our population and improved prevention of conditions such as diabetes is our long term goal. This requires a focus that goes beyond the effectiveness of current services.

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Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

1.1 This paper presents an update regarding diabetes developments within NHS Bradford Districts CCG, NHS Bradford City CCG and NHS Airedale, Wharfedale and Craven CCG and considers potential next steps for the district.

1.2 This paper describes the outcomes of the Diabetes Review commissioned by the three CCGs from West and South Yorkshire and Bassetlaw Commissioning Support Unit (WSYBCSU and initial learning and feedback from the NHS Bradford City CCG 'bradford beating diabetes' programme. Ultimately prevention of conditions such as diabetes is our long term goal. This requires a focus that goes beyond the effectiveness of current services.

1.3 This paper builds on the discussion at the May 14th 2013 Health and Wellbeing Board Meeting to inform the Board, as requested, on the developments which have taken place over the last year.

2. BACKGROUND

Diabetes Overview

2.1 Diabetes is a chronic disease characterised by an inability to regulate blood glucose concentrations. There are two major forms of diabetes. Type 1 diabetes is characterised by a lack of insulin production and type 2 diabetes results from the body's ineffective use of insulin. Type 2 accounts for around 85% of diabetes within the UK. The average prevalence in England is 5.8% and the average prevalence across the Bradford district is 7%.

2.2 Type 2 diabetes is up to six times more common in people of South Asian descent, and in the UK, people of South Asian origin (of Indian, Pakistani and Bangladeshi descent) are the largest ethnic minority who now comprise the majority ethnic group in several urban locations.

2.3 Diabetes can lead to serious complications in the long term. People with diabetes are up to five times more likely to have cardiovascular disease and stroke, compared to those without diabetes. Cardiovascular disease is responsible for between 50% and 80% of deaths in people with diabetes. It is also the most common cause of visual impairment and blindness among people of working age. It is also the most common cause of kidney failure and non-traumatic lower limb amputations.

2.4 In England, people aged between 20 and 79 with type 2 diabetes are 1.6 times as likely to die prematurely than those without the disease. It is estimated that, generally, they die 10 years earlier than average.

2.5 Type 2 diabetes is associated with increased risk of depression and reduced quality of life. The prevalence of depression is approximately twice as high in people with diabetes as it is in the general population.

Independent review of diabetes service within Bradford, Airedale, Wharfedale and Craven

2.6 The West and South Yorkshire and Bassetlaw Commissioning Support Unit (WSYBCSU) was commissioned by Bradford Districts, Bradford City and Airedale, Wharfedale and Craven Clinical Commissioning Groups (CCGs) to undertake an independent review of the current primary care diabetes service which commenced in April 2013. The aim of the review was to produce a series of recommendations to help the CCGs to ensure that public money is spent economically, efficiently and effectively to achieve high-quality local services for the people of Bradford, Airedale, Wharfedale and Craven.

2.7 The community diabetes system in place across the Bradford, Airedale, Wharfedale and Craven district, broadly consists of three levels of service: Level 1 delivered under terms of GP contracts (core services and the Quality and Outcomes Framework), and Levels 2 and 3 enhanced diabetes service which are available to patients of 86 of 91 practices (the 5 practices in Craven do not currently deliver diabetes services in the same way as across the Bradford district). The services reviewed included the community diabetes service, podiatry, psychology and retinal screening services, as well as GP providers of core and enhanced diabetes services. The views of patients, the work of local Voluntary and Community Sector (VCS) and links with secondary care were also explored.

2.8 The review documents and identifies how the current model of care for patients with diabetes across Bradford, Airedale, Wharfedale and Craven district performs. The key areas reviewed were the public health and economic burden of diabetes within the three CCGs, screening and prevention of diabetes and the analysis, comparison and overview of the current system of care for patients with diabetes.

Management of patients by Level 1, 2 and 3 providers and process and outcomes measures of the current system providers were reviewed and a cost effectiveness analysis performed on the system. Identification of costs was undertaken from a commissioning perspective. Detailed analysis of outcomes was undertaken and costs were compared against outcomes for each level of service. Structured interviews were held with all key stakeholders. In addition a stakeholder all day event facilitated by Sir Muir Gray, an expert in public health and value based healthcare and a pioneer in evidence based medicine, was held with a follow up stakeholder workshop. A number of options and accompanying series of recommendations were made regarding future direction of travel for the diabetes system based on the findings of the review.

2.9 The total known costs from a commissioning perspective for the diabetes system for 2012/13 was approximately £13.9 million. The average cost per patient to manage HbA1c control is £264 per annum. (HbA1c refers to glycated haemoglobin. It develops when haemoglobin, a protein within red blood cells that carries oxygen throughout the body, joins with glucose in the blood, becoming 'glycated'. By measuring HbA1c, clinicians are able to get an overall picture of what the average blood sugar levels have been over a period of weeks/months. For people with diabetes this is important as the higher the HbA1c, the greater the risk of developing diabetes-related complications).

The most common complications associated with diabetes care are angina, myocardial Infarction and cardiac failure. This suggests that the focus on care for patients with diabetes should include Cardio Vascular Disease (CVD) risk as well as glycaemic control.

2.10 Confusion regarding the roles and responsibilities of Level 1, 2 and 3 providers was identified. Specifications were unclear, contract monitoring poor and there was a lack of robust data.

2.11 The Level 3 service costs and outcomes analysis revealed high costs with low percentages of patients achieving NICE treatment targets, although it is recognised that this is a more complex cohort of patients, more specialist support is commissioned, and the percentage of patients with improved HbA1c only ranges from 20 –57%.

2.12 The Community Diabetes Nursing Service (CDNS) provides key services for patients with diabetes across the system, and delivers a robust education programme for Level 2 providers, as well as forming part of the monthly multi disciplinary team (MDT) clinics at each Level 2 provider practice. The provision of dedicated Diabetic Specialist Nurse (DSN) time, through these MDTs, was identified by stakeholders at the Muir Gray event as a valuable part of the system. However the current specification has not been monitored effectively and the link to clinical outcomes is weak.

2.13 Limitations were found throughout the review regarding data for costs and clinical outcomes. However, considerable variation in proxy clinical outcomes were identified. Although variation in outcomes is undoubtedly influenced by factors such as case mix, age, and ethnicity which are beyond the control of commissioners, the levels of variation identified suggests that some variation may be due to factors which are controllable. This is where the CCGs have focussed their efforts.

2.14 Improvements in these areas as well as performance of high quality audit, use of education and training should be influential in reducing variation. This will especially be the case when they are underpinned by high quality leadership, and improved commissioning supported by robust data collection and measurement of performance.

2.15 Three options were identified as a result of this review as follows:

• Option A: retain the enhanced services in their current state but improve contract monitoring.

• Option B: amendments to the existing specifications, to focus enhanced services on management of CVD risk as well as glycaemic control, and establish a minimum data set, robust contract monitoring, audit and formal evaluation of the service.

• Option C: system redesign, building on work commenced at the Sir Muir Gray stakeholder event, and the introduction of a whole system approach and consideration of a prime contractor model. Learning to be taken from other models as part of this process.

2.16 All 3 CCGs agreed to take forward Option B in the short term, but aim for Option C at an appropriate point in the future. The CCGs considered that improvements regarding the current service could be implemented whilst establishing a better system in the long

term.

2.17 All 3 CCGs agreed to roll forward the existing Level 2 and Level 3 service specifications for 2014/15. The service delivery content of these specifications has not been altered but they have been updated to allow clarity on responsibilities within each Level.

2.18 Work has started to look at future service models. It has been agreed that initially all 3 CCGs will do the exploratory work together, although future service models may look different due to the differing population needs.

NHS Bradford City CCG bradford beating diabetes programme

2.19 Bradford City CCG agreed that diabetes prevention and improved care of people with diabetes was a key focus for improvement. Their overall programme is called bradford beating diabetes. The programme was launched on the 14th November 2013, National Diabetes Day.

2.20 There are three principal aims:

- to identify people at risk of developing type 2 diabetes and offer a range of lifestyle interventions to prevent or delay the onset of diabetes
- to identify all people currently undiagnosed with diabetes who are registered with GPs in Bradford City CCG
- to improve outcomes for people with type 1 and type 2 diabetes through improved clinical management and self care

2.21 To deliver our aims we are:

- Risk stratifying people at high risk of developing diabetes
- Using the Diabetes UK risk tool to assess people for their level of predicted risk of developing type 2 diabetes
- Offering brief advice to people with low and intermediate risk
- Offering a brief intervention to people at moderate risk
- Offering an intensive lifestyle change programme to people at high risk
- Identifying people who have developed type 2 diabetes
- Working with our member practices, neighbouring CCGs, patients and the public and other stakeholders to identify areas for improvement in services for people who have diabetes.

2.22 The work is being delivered through a local improvement scheme with all 27 City GP practices.

2.23 There is a media campaign to support the programme, the most recent event being ‘Painting the City Purple’ on March 26 2014, where the team spent time in City Park and the fountains and clock tower were lit purple.

2.24 The CCG has commissioned intensive lifestyle change programmes (ILCPs) for people at high risk of developing type 2 diabetes in order to prevent or delay the onset of diabetes in these individuals. The ILCPs are run by 'bradford beating diabetes champions' which have been recruited from local communities and have completed an accredited course. The ILCPs take place over a 9 month period and help equip people with the skills they need to make changes to their lifestyle to reduce their risk of developing diabetes in the future.

2.25 Phase one is currently being delivered and involves persons already known to be at risk, identified through blood results in the last 12 months. The patients are invited to attend an appointment by a letter from their GP practice for further assessment to determine their current level of risk of developing type 2 diabetes or whether type 2 diabetes has developed and then managing interventions and/or care appropriately.

2.26 Phase two is being launched in May 2014. This will invite patients who are deemed of being at increased risk of developing diabetes (based on the NICE Public Health 38 Guidance) to the practice to undertake a risk assessment. Dependent on their risk they will then be placed on the appropriate pathway and be offered managing interventions.

2.27 Any persons newly diagnosed with type 2 diabetes will enter the diabetes management pathway which falls outside of this programme.

2.28 All 27 City CCG practices are taking part in this programme of work. The CCG see this as being a major advantage to the programme, as it is anticipated that this robust engagement will spread to other initiatives, and the quality improvement from this programme of work will also be applied to other areas.

3. IMPROVING THE PREVENTION OF DIABETES

Population and individual focused interventions to prevent type 2 diabetes (public health appraisal)

3.1 There is a strong argument that in relation to managing the rising incidence of diabetes, prevention will be what makes the biggest difference in the future. Within changes to services commissioned by the CCGs, consideration will be given to commissioning preventative services. But to have the impact we believe is required will take more than just the CCGs actions. The CCGs believe that the Health and Well Being Board can provide leadership to increase the focus on prevention across all partners and stakeholders as we believe the overall impact on the health and wellbeing of the population will be significant.

3.2 In order to explore the potential of this approach further, there would need to be a systematic appraisal of the available evidence on the environmental and social influences on behaviour and lifestyle. Such work would need to consider the cost of implementing policies, along with the cost of not implementing policies in terms of future disease burden.

3.3 There are a number of NICE guidelines that are helpful in this area and links to these are listed in the background documents. The recommendations overlap across the different pieces of guidance and there is much common ground. There are some issues

that are not covered in NICE guidance (as there may be limited evidence, or as NICE tends to focus on a “medical paradigm” and thus will not include evidence from other areas of policy).

3.4 Some of the recommendations NICE make are relevant to national policy makers, and some to local policy makers. We have not so far systematically considered whether we are fully addressing all the recommendations made by NICE and other similar bodies. However, there is a range of services, interventions and policy that is within the gift of local organisations.

3.5 Despite the NHS continuing to do what it can to treat patients with diabetes and its complications, while ever we see increasing levels of obesity and physical inactivity, this may negate any advancements being made currently. This is a perspective commonly put forward by clinicians who treat patients with diabetes and cardiovascular disease, and one for which there is increasing evidence in the scientific literature. It is certainly doubtful whether the current set of initiatives, interventions and services are intense enough to reverse the rise of obesity or at least slow its growth.

3.6 In order to make a real difference in preventing diabetes, it will be necessary to address and treat overweight and obesity and promote physical activity across the whole population. Arguably this is best approached through policy interventions that affect whole populations as opposed to service interventions that influence individuals.

3.7 Targeting those with impaired glucose tolerance with lifestyle nutrition and exercise programme is effective in reducing the rate of transition to diabetes, as long as the programme is evidence based, systematic and sufficiently intensive. Local programmes should be rigorously evaluated.

4. FINANCIAL & RESOURCE APPRAISAL

There are no financial issues arising from this report.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

N/A

6. LEGAL APPRAISAL

N/A

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

Any future service developments and changes to the delivery of diabetic services will be subject to an Equality Impact Assessment.

7.2 SUSTAINABILITY IMPLICATIONS

N/A

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

N/A

7.4 COMMUNITY SAFETY IMPLICATIONS

N/A

7.5 HUMAN RIGHTS ACT

N/A

7.6 TRADE UNION

N/A

7.7 WARD IMPLICATIONS

There are no ward implications as all wards are covered by the 3 CCGs and by City of Bradford Metropolitan District Council.

8. NOT FOR PUBLICATION DOCUMENTS

None.

9. RECOMMENDATIONS

Members of the Health and Well Being Board are invited to:

a) Receive the report as assurance that appropriate clinical commissioning arrangements are in place and outcomes are expected to improve as a result.
b) champion and provide leadership to the work that needs to be undertaken to improve the prevention of diabetes
c) Request a report setting out the appraisal of the evidence on diabetes prevention and clear options for the direction of the programme.

10. APPENDICES

N/A

11. BACKGROUND DOCUMENTS

- An independent review of the diabetes service within Bradford, Airedale, Wharfedale and Craven Report. West and South Yorkshire and Bassetlaw Commissioning Support Unit August 2013.
- 'bradford beating diabetes' Local Improvement Scheme
- Preventing type 2 diabetes – risk identification and interventions for individuals at high risk (PH 38) NICE http://guidance.nice.org.uk/PH38
- www.diabetes.org.uk
- Four commonly used methods to increase physical activity (PH2) (partially updated by PH41 and PH44). http://guidance.nice.org.uk/PH2
- Behaviour change: the principles for effective interventions (PH6). http://guidance.nice.org.uk/PH6
- Physical activity and the environment (PH8). http://guidance.nice.org.uk/PH8
- Promoting physical activity in the workplace (PH13). http://guidance.nice.org.uk/PH13
- Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. http://publications.nice.org.uk/obesity-cg43
- Obesity: working with local communities
- http://publications.nice.org.uk/obesity-working-with-local-communities-ph42
- Prevention of cardiovascular disease
- http://publications.nice.org.uk/prevention-of-cardiovascular-disease-ph25/recommendations