City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the NHS Bradford City CCG and NHS Bradford Districts CCG to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 8th February 2018

AC

Subject: Diabetes services in Bradford

Summary statement: This report gives an overview of the development of the diabetes services in Bradford. This includes an update on the development of the new model of care, primary prevention services and national diabetes transformation funds.

Portfolio: Diabetes

Health and Wellbeing

Report Contact: Kath Helliwell
Phone: (01274) 237735
E-mail: kath.helliwell@bradford.nhs.uk

1. Summary

1.1 This report gives an overview of the development of the diabetes services in Bradford. This includes an update on the development of the new model of care, primary prevention services and national diabetes transformation funds.

2. Background

2.1 In 2016 the Bradford CCGs, as part of the wider health and social care system, agreed that the development of a new model of care for diabetes would be the first step Bradford would take on its journey towards the integration of health and social care.

On the back of this decision, the providers of health and social care came together to form Bradford Provider Alliance (BPA). BPA includes Bradford Teaching Hospitals NHS Foundation Trust (BTHFT), Bradford District Care Foundation Trust (BDCFT), Bradford Care Alliance CIC (BCA) (representative organisation of GP providers), Bradford Metropolitan District Council (BMDC) and the Bradford Voluntary and Community Services Alliance (BVCSA). The formation of BPA would allow the providers to work together to deliver diabetes services to the population of Bradford.

2.2 There is a strong history of diabetes innovation within Bradford, and most recently this was seen through the development of Bradford Beating Diabetes (BBD). BBD was a programme of work that focussed on diabetes prevention. GP practices identified patients that were at high risk of developing diabetes (e.g. due to lifestyle or demographic information). These patients were invited into the practice to assess their risk levels and were either given advice or referred onto a lifestyle intervention programme. This work was included as part of a national pilot which has since developed into the national Diabetes Prevention Programme (DPP).

2.3 Although Bradford has been innovative in relation to diabetes, there are still issues with both diabetes prevalence and clinical outcomes. National data sets have highlighted high levels of spend but poor outcomes against key clinical indicators. Therefore, the choice of diabetes as the first step towards integration of care aims to reverse this trend.

2.4 Nationally there has also been a focus on diabetes. To support local areas to make improvements national transformation monies have been made available. In 2017 a bid was submitted to NHS England to improve access and increase capacity across four areas: Structured Education; improved management and achievement of the three NICE treatment targets (Blood Pressure, Hypertension and Cholesterol); Multi-disciplinary foot teams; and diabetes inpatient specialist nurses. Bradford City and Bradford Districts CCGs and Airedale, Wharfedale and Craven CCG submitted a joint bid totalling £1.5 million pounds.

Bradford City and Bradford Districts CCGs bid was for two of the four areas; Structured education and the three NICE Treatment targets. In Bradford we have a robust Multi-disciplinary foot team and diabetes inpatient specialist nurses and therefore we agreed that these areas should not be our focus. Airedale Wharfedale and Craven CCG bid for all four areas.

We wanted to focus on these two areas as according to the CCG Improvement and Assessment Framework (IAF) report Bradford CCGs performance in structured education needs improvement. National data suggests that only 3% of people within Bradford attends an education programme within 12 months of their diagnosis. The CCG is working with BTHFT, the education provider in order to improve this outcome. One of the issues is around recording and sharing the data within GP Systmone (GP clinical system) because if correct codes are not used it won't be shown in the national data searches. We are working with the CCG IAF team to identify correct read codes to be used across the system. We also recognise the challenges of demographics, ethnic and cultural variance and various languages used in Bradford and are working through the BPA to raise awareness of structured education. We have taster sessions for the practice clinical staff and for patients to attend and get a feel of the education programme. This helps practice staff to encourage people to attend the education programmes and also allows patients to better understand what will be gained by attending the full education sessions. We are also working towards providing more education sessions within GP surgeries and community centres, in different languages, women only sessions and different times including weekends so that people have more choice and can attend the programme closer to home and in a familiar environment.

The CCGs were successful in their bid and Bradford's share of the bid was £948,553. This was year one of a two year bid submitted. To date we still have no confirmation of year two funding.

Working collaboratively with our Bradford Provider Alliance we agreed a 12 month delivery plan. Implementation has proved challenging due to the lack of confirmation of year 2 funding and late release of the funds from NHS England. Much of the plan for improvement is based on additional recruitment and providers are understandably reluctant to go out at risk to recruit into posts.

As we approach the final few months of the funded period, we have not been able to fulfil the improvements that we had outlined in our plan. Therefore the CCGs in conjunction with BPA made the decision to seek approval from NHS England to revise our delivery plan, focusing on the last quarter of the financial year, reviewing activity and achievability. This revised plan was approved by NHS England and work is now underway to deliver this plan.

The structured education sessions will be developed locally in practices to increase capacity, working to deliver a sustainable model for the future.

Achievement of the NICE treatment targets will be undertaken by primary care. All practices have clinical reports showing which patients are not achieving all three of the targets. The focus will be on working with these individuals to improve management.

3. Report issues

3.1 Bradford CCGs have been proactive in regards to diabetes prevention. As BBD informed the development of the national DPP initiative, we were one of the first areas to roll out this work. As part of this national programme of work we have

commissioned a provider called Ingeus to provide a diabetes prevention programme to our population.

This programme rolled out in 2017 and is linked to the national Healthier You programme. It is a free service for people who are at high risk of developing Type 2 diabetes, delivered by Ingeus in partnership with Leicester Diabetes Centre. Participants attend a series of group sessions where they are supported to make lifestyle changes that are proven to significantly reduce their chances of developing diabetes.

To date there have been issues with the number of patients being referred into the programme, as they have been much lower than expected. The programme is being rolled out across the CCGs in a phased approach but despite regular engagement with practices numbers have been slow to pick up. However, following more intense engagement throughout December the referrals have improved and we hope to be back on track by the end of the financial year.

3.2 As detailed in section 3.1, the importance placed on diabetes prevention is high. However, there is also a key focus on supporting patients who have already been diagnosed with diabetes to better manage their condition. This has been at the centre of the national diabetes transformation fund and BPA were successful (as detailed in section 2.4) in being awarded funding to support this work.

There have been two key areas of focus locally for this national funding; structured education and the achievement of three clinical targets.

Access to structured education for patients diagnosed with diabetes is seen to be very important as people with diabetes spend around three hours a year with a healthcare professional and on average, the remaining 8,757 hours they manage their diabetes themselves. Diabetes is a complex and challenging condition. People need skills and confidence to manage the daily demands of self-management and avoid devastating complications.

Diabetes education is key to successful day-to-day diabetes management and can be life-changing for people with diabetes. Structured education courses are an opportunity to offer information and advice and give individuals these much needed skills to reduce their risk of developing complications. Locally, BPA have focussed on increasing the capacity of the service to allow for a greater number of patients to be seen and have discharged the responsibility of this indicator to BTHFT as well as the action detailed within section 2.4.

Great emphasis is also placed on the achievement of three clinical areas which have specific measures set against them: blood pressure; HbA1c; and cholesterol. The importance here is placed upon the fact that all three must be achieved to feel the greatest benefit medically. This was originally allocated to BTHFT to deliver against, but this responsibility has recently been moved to BCA to deliver within primary care.

3.3 In 2017 the CCGs in conjunction with BPA agreed a diabetes outcomes framework. The purpose of developing this framework was to move away from commissioning ‘parts’ of the system, to commissioning outcomes that providers would work

together and support each other to achieve. This is a key step towards integration and system working.

To encourage partnership working and to reduce risks to individual providers, the first two years of delivery will involve collecting baseline information and agreeing stretch targets over a further 8 years. This will encourage a 'left shift' in care and resources. (Currently, the majority of resources go into the acute end of the pathway but with increased provision around prevention and self care, the aim is to reduce complications relating to diabetes and 'shift' resources away from the acute services into primary care, community and preventative services).

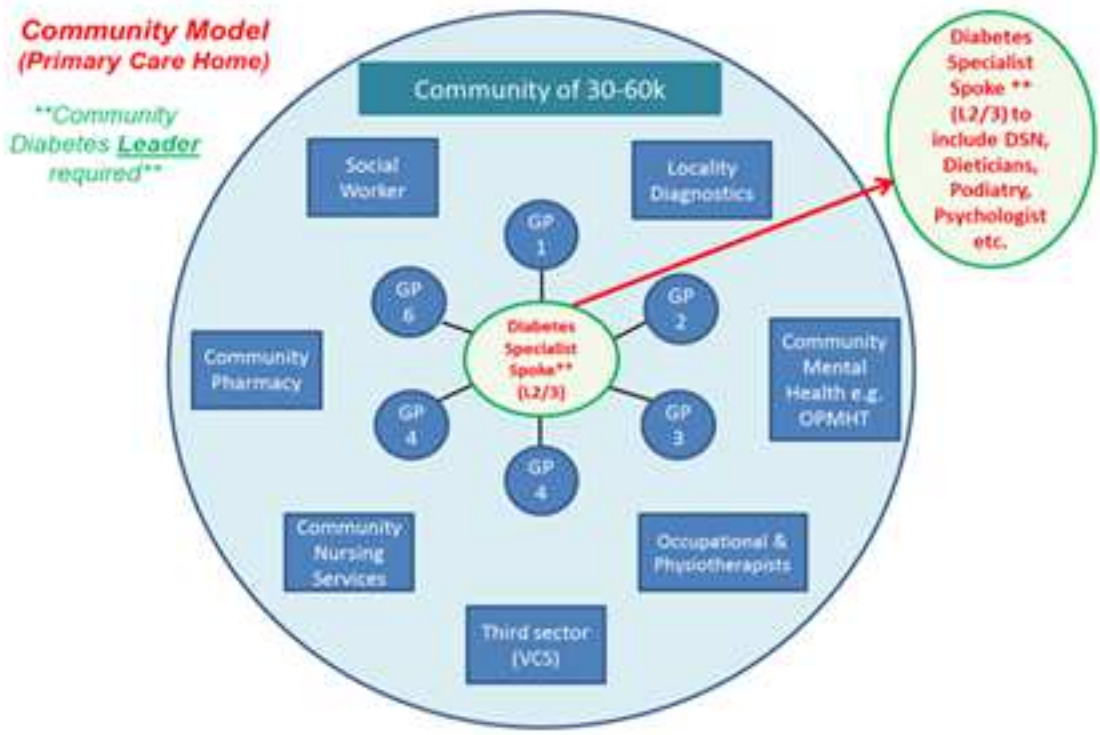
3.4 BPA in conjunction with the CCGs are leading the development of a new model of delivery for diabetes care which will deliver the outcomes set out within the framework over the next 10 years. There are two key elements to this work; primary prevention work which is being led by BVCSA and development of a community specialist diabetes service which is being led by BCA (both projects in conjunction with commissioners and other providers).

3.4.1 Our Primary prevention work will have a very specific focus on reducing the incidence of people developing Type 2 diabetes in the high risk population. Generally lifestyle, unhealthy diet and lack of exercise are the risk factors associated with the development of Type 2 diabetes. The primary prevention work will complement the national diabetes prevention programme and will be able to offer a range of interventions from local walking groups to exercise classes to suit all abilities and interests. This will be suited to people who do not wish to participate in group sessions delivered by Ingeus.

Nationally work is underway to evaluate an on-line option. This will allow for the development of a personal programme, will allow individuals to enter their achievements and will calculate improvements against their set goals. Again this recognises that different approaches suit different people.

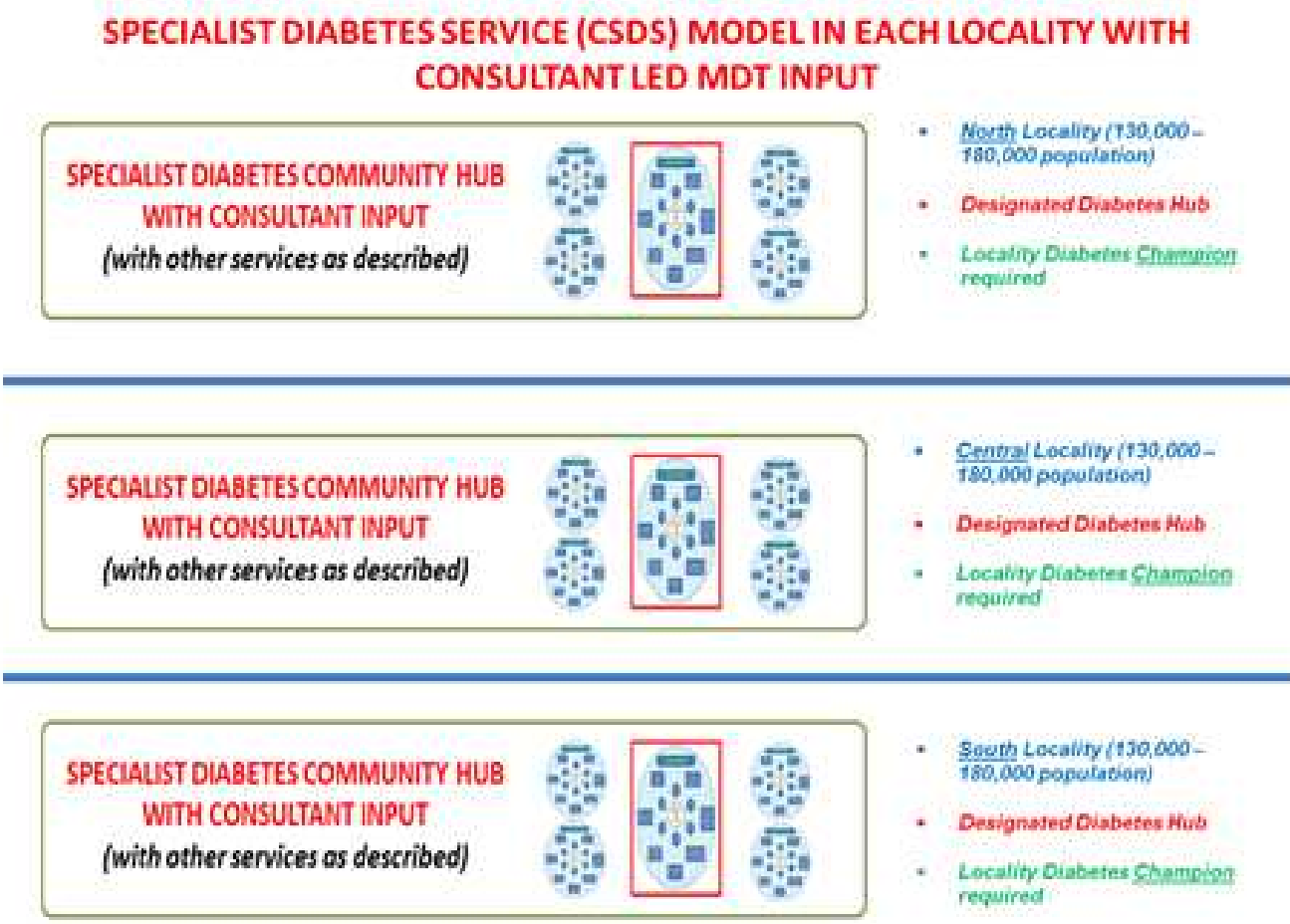
3.4.2 The development of a community specialist diabetes service (CSDS) retains the good practice that is already in place (e.g. multidisciplinary working) and builds upon the wider transformation work which is taking place locally. In regards to the latter point, the framework for the CSDS will be the primary care home (PCH) footprints. These are communities of between 30-60k population, which make geographic sense, that are structured around GP practice lists. The majority of clinical input will be delivered at this community level by multidisciplinary teams, as depicted in Diagram 1 below.

Diagram 1: Diabetes Community Primary Care Home



For patients who need additional specialist input that cannot be provided at individual community level they will receive their care via a locality hub. Within Bradford three localities are being developed; North, Central and South. Each of these localities will cover a population of 130-180k and each will cover either three or four PCHC's. This will include input from secondary care clinicians and practitioners with special interests for example. Diagram 2 below depicts this level of the new model of care.

Diagram 2: Diabetes Localities



Patients with highly specialised needs (e.g. gestational diabetes) will remain under the care of the secondary care consultants as part of the new model.

The main advantage for patients and providers is that under the new model the services will be delivering to patients at the same time as one service. The aim is to wrap care around the patient, with each PCHC taking responsibility for the quality of care delivered to their population. This way of working supports each provider to work towards the same outcomes and gives them the ability to hold the whole system to account on the quality of care delivered.

4. Options

➢ Not applicable

5. Contribution to corporate priorities

Contributes to the CCGs priorities of:

- Promoting self care
- Reducing variation in care
- Eight care processes for diabetes

6. Recommendations

The Health and Social Care Overview and Scrutiny Committee is asked to:

6.1 Receive and note the CCGs' commitment and actions taken to improve diabetes services and increase the focus on prevention of diabetes.

6.2 Receive and note initiatives that are being developed that will impact the diabetes service offer to residents.

7. Background documents

None

8. Not for publication documents

None

9. Appendices

None