NHS

West Kent
Clinical Commissioning Group

Diabetes Service Review 2015/16

Health Overview & Scrutiny Committee
Friday 4 September 2015

Patient focused
Providing quality,
improving outcomes

NHS West Kent CCG Diabetes Service Review 2015/16

Summary

This report advises the Committee of a proposal under consideration by NHS West Kent CCG to reconfigure/recommission diabetes services. As part of the CCG's Commissioning Intentions 2015/16 and 2016/17, diabetes services and care have been identified as a key priority for improvement to meet the future challenges that will come with the predicted rise in prevalence. The current pathway is fragmented, with services delivered by separate organisations (hospital, community, GP practices) with no overarching care planning across the system. There is scope to deliver more holistic care for patients and to develop a more 'joined-up' pathway between hospital, GP practices, community and mental health support. The successful management of patients with diabetes requires a whole system approach, with support for self-care and care in the community as key elements that can have a major impact on outcomes across all care settings. Through delivering more integrated care, NHS West Kent CCG anticipates that it will improve both the quality of care and also make better use of resources.

The proposal is to decommission the current secondary care level 3 diabetes services for NHS West Kent CCG and to recommission the same in the community under an integrated level 2 and 3 service.

During May and June 15, NHS West Kent CCG has led a joint patient and stakeholder engagement programme to seek views on improvements in diabetes care, covering both local health care professionals and patients. The purpose of this paper is to provide a summary on the results and outcomes of the engagement.

Members of the Kent Health Overview & Scrutiny Committee are asked to note the contents of this report.

Introduction and Background

The current diabetes pathway for NHS West Kent CCG follows a tiered approach, as listed below:

Level 0 is Public Health commissioned prevention and lifestyle services for self-care, underpinning all of the other tiers;

Level 1 is NHS England commissioned core primary care services delivered by health care professionals across the 62 GP practices within NHS West Kent CCG;

Level 2 is enhanced primary care services currently delivered by 28 GP practices. The aim of the level 2 service is to provide enhanced community based services for all adult patients with diabetes, and also manage those who have more complex needs such as injectable therapies (e.g. GLP-1 and insulin) with the view of improving clinical outcomes.

Level 3 is a consultant led specialist multi-disciplinary service, delivered in secondary care/hospital setting and aimed at patients requiring specialist input. Maidstone and Tunbridge Wells NHS Trust (MTW) are the current providers of Level 3 (intermediate) services and employ a multi-disciplinary team of:

- Consultants in Diabetes and Endocrinology
- Diabetes Specialist Nurses
- Diabetes Inpatient Specialist Nurse (DISN)
- Diabetes Specialist Dieticians
- Diabetes Specialist Podiatrist

Level 4 is a consultant led multi-disciplinary service, delivered in secondary care/hospital settings aimed at patients with complex needs and also includes an inpatient service and emergency admissions**.**

NHS West Kent CCG is working to redesign diabetes services for adults with the intention to enable a larger proportion of care to be delivered outside of an acute setting. At present, a significant level of activity takes place as outpatient consultations within MTW by Consultant Diabetologists and Diabetes Specialist Nurses, although Kent Community Healthcare Foundation Trust (KCHFT) provides some community based services. It is recognised that a significant amount of the care for level 3 patients could and should be delivered by a skilled workforce closer to patient's homes i.e. in a community setting and outside of an acute hospital. This in turn would release capacity inside the acute hospital for the treatment of complex level 4 patients, whose care is dependent on a hospital infrastructure.

Predicted levels of local future need

The resident population of NHS West Kent CCG is 467,500 and 86,000 of those people are aged 65 or over, a higher proportion than across England as a whole. In the CCG, 2.5% of people live in the most deprived fifth of areas in England. In 2013/14 a total of **20,485** patients (17 years and over) were recorded to have diabetes which is significantly lower than any other CCGs. There were an estimated **4,800** people who remain undiagnosed suggesting the total number of adults with diabetes in the CCG was around **25,300**. Between 2013/14 and 2019/20, the crude prevalence rate of diabetes in adults is expected to increase from 5.5% to 6.8% and the undetected prevalence rate is expected to increase from 1.3% to 2.6%.

People with diabetes are at a higher risk of having a heart attack or stroke. In this area, people with diabetes are 88.5% more likely than people without diabetes to have a heart attack. This is lower than the figure for England which is 108.6%. People with diabetes are also 103.2% more likely to have a stroke. This is higher than the figure for England where there is an 81.3% greater risk. NHS West Kent CCG spent £320 on prescribing per person with diabetes which is higher than the England average of £285. The total spend on prescribing for anti-diabetic items between April 2013 and March 2014 was £6,550,000. Prescriptions to treat diabetes accounted for 9.1% of the total CCG prescribing budget.

The National Institute for Health and Care Excellence (NICE) recommends nine care processes for diabetes. There are five risk factors (body mass index, blood pressure, smoking, glucose levels (HbA1c) and cholesterol) and three tests to identify early complications (urine microalbumin, creatinine, and foot nerve and circulation examination). Eye screening is recommended but not included in the data presented. Controlling the risk factors helps a person with diabetes reduce his or her future risk of developing diabetic complications. There are also recommended targets for HbA1c, cholesterol and blood pressure. NHS West Kent CCG data for 2012/13 (most recent data available) is listed below:

Indicator	Local	Comparator CCGs	England
People with diabetes who have had 8 recommended care processes	48.6%	56.7%	59.5%
People with diabetes whose last HbA1c was equal to or less than 58mmol/mol	64.2%	68.6%	62.4%
People with diabetes meeting blood glucose, blood pressure and cholesterol targets	35%	34.8%	36%

For West Kent CCG there have been 1,216 episodes of care for diabetic foot disease between 2011/12 and 2013/14, accounting for 10,847 nights in hospital. The annual rate of episodes of care for diabetic foot conditions per 1,000 adults with diabetes is significantly higher than the national average. There were 41 major amputations performed during the three years, giving an annual rate of 0.7 major amputations per 1,000 adults with diabetes, which is not significantly different from the national average. 549 different patients were admitted for foot disease. 51.2% of these had more than one episode of care in the three years, which is significantly lower than the national average. Of the 549 patients, 13.5% had more than four periods of care, which is significantly lower than the national average.

Using national data from 2011, Type 2 diabetes can be estimated to cost NHS West Kent CCG £13 million for treatment and management, as well as £51 million from diabetic complications. For 2019/20, a cost of nearly £21 million to the local health economy is projected using the crude prevalence of diabetes.

It has been shown in studies that good diabetic management in the first 10 years of diagnosis has the maximum impact on morbidity and mortality, hence timely diagnosis and appropriate initial management of the disease is crucial to a patient's clinical outcomes.

Case for change

The current status of service provision and strategy around diabetes prevention and management within west Kent has much scope for improvement, and is ill placed to meet the future challenges that will come with the predicted rising prevalence:

- There is a lack of a comprehensive obesity strategy to slow the rise in the expected number of diabetics in west Kent
- The current programmes (e.g. NHS health checks) for early detection of diabetes has had variable impact with much room for improvement especially in the deprived and 'hard to reach' populations.
- There is a lack of comprehensive local strategy or pathway to deal with patients with 'impaired glucose regulation' in terms of identification, registers and clinical management
- Primary care capability is variable leading to variable standards of care delivered to patients
- Primary care capacity has not risen with the rise in prevalence due to resource constraints which has affected patient care and outcomes
- There has not been any 'workforce planning' for diabetes in west Kent, leading to patchy and variable provision of services based on historical commissioning (e.g. dietetics and podiatry)
- Services like specialist nursing, diabetic podiatry and dietetics are predominantly secondary care based, which is both expensive and fails to reach patients who need their services in the community
- Diabetic related preventable non-elective admissions are on the rise and consuming a significant level of resources
- Most secondary care based diabetic services are based on activity rather than outcomes
- The financial risks to NHS West Kent CCG related to the above points are worsening each year in rising planned, unplanned and prescription costs
- It is estimated that nationally only 15% of diabetic patients meet the 3 'best practice targets' (Hba1c: 6.5% or 48mmol/mol, Cholesterol: <4mmol and BP: <135/80)

NHS West Kent CCG aims to address the current issues facing primary, secondary and community care by developing a Prevention and Obesity Strategy to slow down the expected rise in prevalence. A primary care diabetes prevention programme is in place to support earlier diagnosis of diabetes and improvement in control of the main risks associated with diabetes; namely blood pressure, cholesterol and glycaemic control.

Patient and Stakeholder Engagement

During May and June 15, NHS West Kent CCG led a joint patient and stakeholder engagement programme to seek views on improvements in diabetes care, covering both local health care professionals and patients.

Patient Engagement: An engagement plan was developed and agreed to ensure people with diabetes were asked to provide feedback using an online and paper survey, discussion groups and one-to-one discussions. A total of 210 responses were received to the survey and 39 individuals took part in both the groups and individual discussions. The full report is attached as Appendix 1.

Summary of findings

- The majority of respondents were not aware that they were at risk before they were diagnosed
- Whilst most respondents feel well informed and confident in managing their diabetes, there is mixed feedback as to whether information has been provided. Most answering the online survey indicate information was provided whilst the focus groups and individual discussions highlight a lack of recent and up to date information
- The "location of appointments at the GP" and "quality of care at GP", both receive the highest ratings with a mean score of 3.49 out of 4.
- The "waiting time to get an appointment in community" is rated lowest (a mean score of 2.61 out of 4) as well as "waiting time to get an appointment at hospital" (2.79 out of 4)
- Most respondents had not experienced any problems getting to appointments and the main issue for the remaining respondents included the waiting time for appointments with nurses
- Whilst two thirds of respondents believe that the proposal would improve their experience of diabetic services either a little or a lot, the remainder indicates no improvement, although this is mainly due to respondents indicating they already receive good quality of care, often already delivered in a community setting.

- Respondents highlighted:
    - a need to improve podiatry and dietary services for patients
    - importance of psychological support for new diabetic patients
    - a need for more education on diabetes – possibly in community settings
- The main areas that would help respondents to manage their diabetes more effectively include:
    - More support and help with diet including losing weight, information and education on food groups and support with exercise
    - More regular appointments with diabetic nurses to ensure their levels were stable.

The main fixed risk factors associated with diabetes relate to age, gender and ethnic group. The rate of onset of Type 2 diabetes increases with age, diabetes is more common in men and in certain ethnic groups: it is up to six times more common for people of South Asian ethnicity, and up to three times more common in those of African and African-Caribbean descent. As part of the analysis, it was noted that due to the low response from the BME population, more focussed work is needed to ensure appropriate input and representation. This is due to be completed by the end of August 15 and will further inform the service specification.

GP Membership Stakeholder Engagement: NHS West Kent CCG held two diabetes GP workshops on 25 June 15 at the protected learning time events as follows:

- Tonbridge, Tunbridge Wells and Sevenoaks locality – represented by 90 GPs and 11 community nursing staff
- Invicta, Maidstone & Malling locality – represented by 75 GPs

The workshops were designed to raise awareness, generate discussion about current services, identify gaps and invite feedback on how diabetes services can be improved to inform the service specification. The workshops involved a presentation from the CCG GP chief commissioner and GP diabetes lead outlining the aims for the session, the strategic context for diabetes care as a key priority for NHS West Kent CCG and the outcomes that the CCG hopes to achieve through improving diabetes care. Round table group discussions were held where all GPs were asked to discuss 4 key areas:

- What services should be based in the 'hubs' and what services should be based in the 'spokes?'

- What should be the number of 'hubs' and the number of 'spokes' to meet the service needs of west Kent population (62 practices, 465,000 patients and 21,000 diabetics)? Pease identify the population number that an individual hub and a spoke should service on average respectively?

- What systems of communication (including technological innovations) should be specified for the service to ensure that each practice clinician has a quick and easy, direct and virtual access to Consultant, DSN and Podiatry expertise based at these hubs and spokes?

- Define in your own view what an ideal format for continual education and training for primary care should look like under the redesigned services.

The full summary report detailing outcomes and themes from the discussions is attached as Appendix 2.

The patient and stakeholder engagement plan has provided valuable input relating to current gaps in service provision, together with suggestions of what an improved service may look like to meet future challenges. In summary, NHS West Kent CCG has received no opposition to the principle of redesigning the service and will ensure that suggested areas for improvement are included in the service specification.

The proposal

A diabetes project group has been established to oversee the development of the proposed service with input from both commissioners and clinicians. Work is underway to identify how existing resources can be realigned to support the integrated 'whole system' approach.

The detailed service specification is currently work in progress but is based on the following key principles:

- Improved integration between primary and secondary care
- A single point of access/triage pathway
- Shifting specialist services to the community to reach a larger cohort of complex patients needing multidisciplinary specialist input
- Better skill mix utilisation
- Care closer to home – range of community based clinics 'spokes' across a wider geographical area
- Implementation of new payment structure 'single integrated tariff' that will cover the care of both Type 1 and Type 2 patients as a 'single package of care'. This tariff will be based on activity and outcomes.
- Current level 2 and level 3 services to be commissioned under a singly multisystem community provider (MSCP) contractual model

Based on the outcome of patient and stakeholder engagement, the proposed model of care is outlined in Appendix 3

Next steps:

- An equality impact assessment is being carried out. Given the increased risk factors associated with ethnicity, a targeted patient engagement approach is being undertaken to ensure the needs of BME patients are reflected - final report due end of August 2015
- Finalise service specification / model reflecting outcomes of patient and stakeholder engagement
- The Clinical Strategy Group / Governing Body to meet in November 2015 to consider the business case for the proposed clinical model
- The planned start date for the new service will be 1 July 2016

Recommendation:

Members of the Health and Overview Committee are asked to:

- NOTE the contents of this report

Appendices:

Appendix 1: NHS West Kent CCG Patient Engagement Report – May to June 15
Appendix 2: NHS West Kent CCG GP Membership Engagement Report – June 15
Appendix 3: NHS West Kent CCG Proposed Model of Care

Author and contact: Naz Chauhan
Commissioning Manager
NHS West Kent CCG
n.chauhan@nhs.net

Approved: Dr Sanjay Singh
Chief GP Commissioner
NHS West Kent CCG
Sanjay.singh@nhs.net

Ian Ayres
Accountable Officer
NHS West Kent CCG
i.ayres@nhs.net