MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**25/03/2015**
TYPE	**An open public item**

Report summary table	
Report title	Diabetes Care Pathway Redesign
Report author	Laura Marsh, Commissioning Manager for Long Term Conditions (BaNES CCG)
List of attachments	Appendix 1 – Proposed Diabetes Pathway
Background papers	None
Summary	Diabetes is the long term condition with the fastest rising prevalence and in order to manage the increasing demand, the diabetes care pathway is being redesigned. This work is one of the CCG's strategic priorities for the next 5 years and the purpose of this paper is to inform the B&NES Health and Wellbeing Board on the model and provide an update on project progress.
Recommendations	The Board is asked to: • Note the project work undertaken to date; and • Support the development and delivery of the new pathway.
Rationale for recommendations	The Health and Wellbeing Board is receiving this update because the diabetes care pathway redesign work sits within theme two (Improving the quality of people's lives) of the Joint Health and Wellbeing Strategy, linking to priority five (Improved support for people with long term health conditions).
Resource implications	The delivery of this project requires input from the members of the diabetes pathway redesign group as well as support from other CCG staff including representatives from the finance, informatics, communications and quality teams. Clinicians who deliver diabetes care will also need to be engaged and partake in the new ways of working.
Statutory considerations and basis for proposal	There are no statutory considerations but the project will contribute to the delivery of the following domains of the NHS Outcomes Framework:

	1. Preventing people from dying prematurely 2. Enhancing quality of life for people with long term conditions 3. Helping people to recover from episodes of ill health or injury 4. Ensuring people have a positive experience of care 5. Treating and caring for people in a safe environment and protecting them from avoidable harm.
Consultation	The initial pathway redesign scoping work was undertaken by the Commissioning Manager for Long Term Conditions and CCG Medical Director. However, to develop the pathway further a diabetes care pathway redesign group was formed, whose members include: • Commissioning Manager for Long Term Conditions (CCG) • Medical Director (BaNES CCG) • Consultant in Diabetic Medicine (RUH) • Diabetes Specialist Nurse Team Leader (GWH) • Chief Executive (BEMS+) • GP representative • Practice Nurse representative • Podiatry Professional Lead (Sirona) • Dietetics Professional Lead (GWH) In order to progress the self-care element of the pathway, it is proposed that the membership of the group is expanded to include: • Public Health representative (BaNES Council) • Diabetes Education Lead (Sirona) • Health and Wellbeing College representative (Sirona) • Senior Commissioning Manager for Mental Health (BaNES CCG)
Risk management	This work programme is managed in line with the CCG's risk management guidance.

THE REPORT

Purpose

1. The redesign of the diabetes care pathway is one of the CCG's strategic priorities for the next 5 years and the purpose of this paper is to inform the B&NES Health and Wellbeing Board on the model and provide an update on project progress.

Project Background

2. The Joint Health and Wellbeing Strategy sets out a framework for partnership action to reduce health inequalities and improve health and wellbeing. The strategy comprises three themes and the diabetes care pathway redesign sits within theme two (Improving the quality of people's lives), linking to priority five (Improved support for people with long term health conditions).

3. Long Term Conditions are also a strategic priority for the CCG and initially diabetes is the focus because there are increasing numbers of people, particularly younger adults, developing type 2 diabetes and this is going to have a considerable impact on primary, community and secondary care services in the future unless the pathway is redesigned.

4. The aim of the project is to redesign the diabetes care pathway so that services are delivered by the most appropriately skilled person in the most appropriate setting and the system can manage the increasing demand. This will be done by taking a whole system approach; stressing the prevention and self-care agenda by upskilling primary and community care providers and working in partnership with specialists in diabetes care.

5. The rationale for change is as follows:
    - Fastest rising prevalence of any long term condition – local prevalence is increasing by 5% per year
    - Increasing numbers of people aged 45 and under being diagnosed with type 2 diabetes
    - Referrals to secondary care diabetes services are increasing by 7% each year
    - Up to 20% of all inpatients at the RUH now have diabetes
    - 10% of NHS budget nationally is spent on diabetes. 80% of that is spent on managing complications.

6. The increasing prevalence of diabetes is a national problem and so several CCGs have already reviewed and redesigned their diabetes services. Work undertaken elsewhere shows that integrated care programmes tend to have a positive effect on glycaemic control and other clinical measures in the long term. They have also been proven to particularly benefit patients with poor glycaemic control and patients who live in rural areas. Integrated care is more effective when they enable high quality care to be provided in primary care settings but this requires changing and expanding team roles, particularly in primary care, and ensuring adequate and appropriate support from secondary care specialists.

7. With regard to effective self-management, diabetes education programmes that adopt a psychological/motivational approach, focussing on empowering patients to set goals and solve problems, have been shown to be more effective. There is also evidence to suggest that education programmes which include exercise content are more likely to improve glycaemic control and automated telephone systems for patients to report information have a positive effect on patients' adherence and clinical outcomes. Finally, it has been proven that beliefs about treatment effectiveness, seriousness of diabetes and beliefs about control of the disease are strong indicators of self-management behaviours and in particular beliefs about treatment effectiveness are stronger predictors of behaviour than belief about the disease.

The Model

8. Following a review of the available evidence, including models elsewhere in the country, it has been concluded that a vertical integration model (i.e. integration between primary and secondary care services) with a package of interventions aimed at supporting self-management being an integral part of the initial management of the disease would be most suitable for use in BaNES.

9. A diagram of the model can be seen in Appendix 1 and the two key features of the new model are:
    - Greater support on diagnosis with the aim of improving self-care and therefore reducing the likelihood of complications developing
    - Better integrated continuing care so even with increasing numbers of people with diabetes, patients receive specialist input (when needed) in a timely manner.

Project Update

10. Since the CCG's Operational Leadership Team approved the model and project approach, the following progress has been made:

Mobilisation of the Diabetes Care Pathway Redesign Group

11. This is predominantly a provider group whose members are clinicians providing diabetes services and the purpose of this group is to help develop a patient focussed and evidence based pathway. To date, this group has been involved in the design of the overall pathway and has agreed the detail of the 'Continuing Care' element of the pathway, which is to be tested in one cluster from Spring 2015 before being rolled out across BaNES. It is intended that the membership of this group will expand when the project starts to focus on progressing the self-care element of the pathway.

Connecting Data Work

12. The Council received funding from the Cabinet Office to facilitate a 'Connecting Data' programme and the Council and CCG are working in partnership with the University of Bath to better understand current patient pathways. The work involves using patient NHS numbers to link service use and HbA1c results and the emerging findings show that:
    - 32% of patients with diabetes also have depression
    - 14% more women than men have depression and diabetes (statistically significant)

- Women with diabetes tend to be older than men with diabetes
- Attendance on DESMOND group education courses is positively correlated with improved HbA1C and fewer hospital admissions
- On average over the last 5 years, hospital admissions cost £600 more for patients who haven't attended a DESMOND group education course.

The next stage of this work will include looking at the impact of the Conversation Maps education courses as well as the use of the Diabetes Specialist Nurses. However, this work is more complex than anticipated so it will not be complete by the end of March 2015 as originally hoped.

Patient Survey

13. To complement the 'Connecting Data' work, a survey for all patients with type 2 diabetes has been developed in conjunction with the University of Bath and this was sent out to patients via GP practices at the end of January 2015. The purpose of this survey is to better understand patients' perceptions of their diabetes and their opinions on the care they receive. The survey also seeks to collect a range of demographic information, including NHS number, which will allow the CCG to join up their responses with their use of services and HbA1c. This level of detail has not previously been sought from patients but the necessary Information Governance processes have been followed and providing personal information is optional. It is anticipated that the survey findings will help the CCG understand the needs of different population groups within the population of patients with type 2 diabetes and will therefore ultimately help shape the 'supported self-care' offer to patients.

Continuing Care Element of the Pathway

14. The Pathway Redesign Group has developed the 'Continuing Care' element and helped clarify the roles of primary care, secondary care and the community diabetes team.

15. The main change from the current configuration of services is the creation of the Community Diabetes Team comprising of a Consultant Diabetologist, a Diabetes Nurse Facilitator (specialist nurse) and the practice's lead GP and Practice Nurse for diabetes with input from podiatry and dietetics as required. The Community Diabetes Team will meet regularly to discuss the care of patients with more complex needs. However, the Community Diabetes Team meetings will also provide an opportunity for education updates and audit at a practice and cluster level.

16. As a minimum the Community Diabetes Team for each practice will meet twice per year but the Diabetes Nurse Facilitator will be making additional visits to practices. However, it is anticipated that the practices within each cluster will 'pool' their sessions so they can benefit from more frequent direct contact with the consultant. 'Pooling' sessions should also mean that the most complex patients can be discussed from each practice, removing the inequality to patients of allocating the limited specialist resources to individual practices equally. I.e. Equal allocation would mean that the practices with a larger proportion of patients with diabetes would receive proportionately less time per patient than a practice with a smaller diabetes register. The alternative would be allocating practices a set number of sessions per year based on their population but due to the limited specialist resources available, this would mean some practices would receive such little time that the impact would be extremely limited.

17. It is proposed that the 'Continuing Care' element will be implemented in April/May 2015 (dependent on start date of new Diabetes Nurse Facilitator) in the Bath West cluster initially so that any lessons can be learnt before it is rolled out to the other four clusters. The CCG/Council Joint Commissioning Committee supported the approach and agreed some funding to support the implementation of this new way of working at the committee meeting in December 2014.

Diabetes Specialist Nursing and Dietetics Services

18. BaNES CCG is an associate to Wiltshire CCG's contract with GWH Community, the provider of the Diabetes Specialist Nursing and Dietetics services across BaNES and Wiltshire. This contract is due to end in 2016 and therefore BaNES CCG needs to ensure continuity in service provision after the contract ends. The options for this are currently being explored.

Next Steps

19. The next steps are:
    - Mobilise the 'Continuing Care' element in one cluster initially
    - Complete the 'Connecting Data' work and analyse the results of the patient survey
    - Continue the development of the pathway (i.e. supported self-care)
    - Fully explore the options to ensure continuity in service provision for the Diabetes Specialist Nursing and Dietetics services once the current contract ends.

20. The Health and Wellbeing Board is asked to note the project work undertaken to date and support the development and delivery of the new pathway.

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