

<b>Harrow Clinical Commissioning Group</b> Title of Meeting : CCG Executive Date of meeting: 21 February 2017	Agenda Item	<b>3</b>
	Paper No	<b>3A</b>
	Attachment	<b>3A</b>

**Title: Diabetes Strategy for Harrow**

**Purpose of the report**

To outline the current situation with diabetes in Harrow, the improvement plans in development, and the next steps.

**Executive Summary (to include outcome benefits)**

Diabetes poses a major health problem in Harrow, due to a significantly higher than national average proportion of people with diagnosed diabetes, and low physical activity rates. There are currently 1,872 people with Type 1 diabetes and 16,845 people with Type 2 diabetes diagnosed in Harrow (8.8% of the population - higher than the national average of 6.4%). In Harrow the prevalence of diabetes is expected to increase to approximately 13% by 2030.

The rate of complications is rising. Patients with diabetes account for approximately 19% of all inpatient admissions. NHS spending on diabetes is approximately £14 billion, with 80% directed towards potentially preventable complications. This means that a condition affecting 6.4% of the population is utilising nearly 14% of the total NHS budget – a clear disparity.

The document presents a clear and tangible strategy for improving the prevention of Type 2 diabetes, and for improving diabetes treatment and care, in Harrow. The aim is to reduce the rate of growth of Type 2 diabetes; and to improve the health, wellbeing, safety, and experience of people with diabetes through supported self-care. These improvements will also have a positive impact on other health outcomes, for example through a reduction in cardiovascular disease-related morbidity and mortality.

**Decision required: The Board / Committee is asked to:**

- Recommend that the strategy can go to the March 2017 Governing Body for approval.
- Approve the formation of a Harrow Diabetes Network
- Agree the plan for Prevention of Type 2 Diabetes in Harrow
- Agree the North West London STP Diabetes Transformation Programme Business Case

**Corporate Objectives and Board Assurance Framework:** *(Reference to how the organisation's objectives for year are supported by this paper) Please list BAF and Corporate Risk reference no.)*

- Improve the health and wellbeing of the local residents of Harrow, in line with commissioning plans
- Manage resources effectively
- Implement the Out of Hospital Strategy

**Equality and Diversity considerations and implications from which an Impact Assessment might be made:**

An Equalities Impact Assessment for diabetes transformation was completed in 2016.

**Resource implications:** *(Confirmation that any resource implications have been agreed with Finance)*

A bid has been made to NHS England for Diabetes Treatment and Care Transformation funds, which includes assumptions around reinvestment of savings into services to make them sustainable. Finance has been involved in this process.

**Risks Attached to this initiative (Reference to Corporate Risk Register as appropriate)** *(This could include legal or other statutory implications or drivers)*

- Clinical and organisational buy-in to service review and redesign from provider organisations is limited and effectiveness of review is subsequently reduced
- Review results in short term investment needs for new model implementation before full benefits can be realised
- Previous Integrated Care Pilot – focused on an MDG approach to diabetes care – showed limited scope and outcomes. This may risk clinical buy in to a new programme of service review / enhancement through self-care, prevention and focus on high needs.
- Improvements in clinical outcomes take a longer time to realise than modelled leading to a delay in projected savings
- Losses of trained clinical staff in some areas as services are re-commissioned. Will need to ensure integration of existing resources
- Outcome of NHSE funding bid does not provide requested level of investment in 2017/18 or NHSE funding is not available in subsequent years.

**Patient & Public Engagement Input to and/or Impact of this initiative**

NHS Harrow CCG conducted an extensive programme of stakeholder engagement, including a large stakeholder event attended by 50 people from 15 organisations. This comprised Diabetes UK and other patient representatives, the local diabetes health, social, and voluntary care system, Harrow CCG and members of the Harrow Public Health team.

**Safeguarding Implications:**

NHS Harrow CCG safeguarding colleagues have been included in the engagement activities, and have agreed to monitor and advise on safeguarding implications throughout the implementation phase.

**Communications Strategy:** *(How will this initiative be disseminated)*

Once approved, the strategy will be uploaded to the NHS Harrow CCG website, and a series of stakeholder follow-up activities will be planned with the communication and engagement teams, following a similar structure to those already conducted.

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Job Title: Programme Director for Strategic  
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Job Title: Vice Chair

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## Document Information

<i>Document Name</i>	Diabetes Strategy for Harrow
<i>Version</i>	0.4 14/02/2017
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<i>Author</i>	Jason Parker, Commissioning Manager, NHS Harrow CCG
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## Version Control

<i>Version</i>	<i>Release date</i>	<i>Description of changes</i>
0.1	02/12/2016	N/A Sent to Harrow Diabetes Strategy Development Group for review and feedback
0.2	20/12/2016	Data and charts added; new prescribing section; links to NDA; Action plan amended; new Commissioning section Sent to Harrow Diabetes Strategy Development Group for review and feedback
0.3	18/01/2017	General refresh Sent to over 130 stakeholders, plus all Harrow GPs, for review and feedback
0.3.1		Harrow Diabetes Network Draft ToR added Prevention of Type 2 Diabetes in Harrow paper added NWL STP Diabetes Transformation Programme added Corrections / amendments / additions / deletions

## Revision History

<i>Version</i>	<i>Date</i>	<i>Reviewer name</i>	<i>Organisation</i>
0.1	December 2016	Harrow Diabetes Strategy Development Group	
0.2	December 2016	Harrow Diabetes Strategy Development Group	
0.3	January 2017	Dr Mathi Woodhouse Dr Keith Steer Dr Tony Willis Hassan Khalief  Dr Mushtaqur Rahman Nicky Brownjohn Peter Bullivant Lucy Smith Dr Kevin Baynes Dr Onteeru Buchi B Reddy Rosie Walker Rachael Glover Lis Warren Person with Type 1 Diabetes Person with Type 2 Diabetes David Hiles Robin Hewings Lakhvir Randhawa	NHS Harrow CCG LNWHT NHS NWL Collaboration of CCGs Harrow Association of Somali Voluntary Organisations LNWHT NHS Harrow CCG NHS England NHS NWL Collaboration of CCGs LNWHT Harrow Council Successful Diabetes Diabetes UK Diabetes UK  Diabetes UK Diabetes UK NHS Harrow CCG

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# 1 Introduction

## 1.1 What is the Diabetes Strategy for Harrow?

This document presents a clear and tangible strategy for improving the prevention of Type 2 diabetes, and for improving diabetes treatment and care, in Harrow. The aim is to reduce the rate of growth of Type 2 diabetes; and to improve the health, wellbeing, safety, and experience of people with diabetes through supported self-care. These improvements will also have a positive impact on other health outcomes, for example through a reduction in cardiovascular disease-related morbidity and mortality.

While many of the lifestyle approaches and interventions discussed in this document are also applicable to patients with Type 1 diabetes, the nature of this condition means that it is not 'preventable' in the same way as Type 2 diabetes, and is also largely managed by hospital-led services rather than in a GP or community-led approach.

## 1.2 How was this strategy put together?

Harrow Council's Public Health team published 'Type 2 diabetes: A rapid needs assessment for NHS Harrow CCG' which highlighted the variations in care and need for a diabetes strategy to guide a system change and service transformation. NHS Harrow CCG recognised the need for a strategy, and embarked on an extensive programme of stakeholder engagement, including a large stakeholder event attended by 50 people from 15 organisations. This comprised Diabetes UK and other patient representatives, the local diabetes health, social, and voluntary care system, Harrow CCG and members of the Harrow Public Health team.

This strategy is informed by, and incorporates recommendations from, a number of key national and local sources, including, but not limited to:

- NHS Five Year Forward View
- NHS General Practice Forward View
- NHS Mental Health Five Year Forward View
- NHS Strategic Commissioning Framework for Primary Care Transformation in London
- NHS Improvement and Assessment Framework
- NHS RightCare's 'Commissioning for Value' Programme
- North West London Sustainability and Transformation Plan
- NHS Harrow CCG Commissioning Intentions 2017-19

## 1.3 Why does Harrow need a diabetes strategy?

There are approximately 3.75 million people with diagnosed diabetes in the UK. 10% have Type 1 diabetes and 90% have Type 2 diabetes. Estimates suggest that a further 850,000 patients remain undiagnosed among the UK population. By 2025, it is estimated that there will be 5 million people in the UK with diabetes. In addition, the average age at which people develop Type 2 diabetes is falling; the proportion of those under 40 with Type 2 diabetes has risen from 5% to 12%.

More than twice as many people are diagnosed with diabetes each year than with either colorectal or lung cancer, and the prevalence of diabetes is higher and rising faster than many other long term conditions.

Excess diabetes-related mortality is improving; a population-based study showed that patients with diabetes in 2009 were 1.5-times more likely to die than those without diabetes, compared to being 2-times more likely to die in 1996. This reduction is, in part, likely due to earlier detection. However, thousands of patients are still reported to be dying prematurely every year. Approximately 75,000 deaths per year are directly related to diabetes or its complications – at least 24,000 of which are estimated to be preventable.

The rate of complications is rising. Patients with diabetes account for approximately 19% of all inpatient admissions. NHS spending on diabetes is approximately £14 billion, with 80% directed towards potentially preventable complications. This means that a condition affecting 6.4% of the population is utilising nearly 14% of the total NHS budget – a clear disparity.

A National Audit Office report (2012) found poor performance against expected levels of care and concluded that diabetes services in England were not providing value for money.

It is estimated that effective services can considerably reduce the costs associated with diabetes-related care; for example, Trusts employing a specialist diabetes nurse can save an estimated £200,000 per year through reductions in acute admissions.

Diabetes poses a major health problem in Harrow, due to a significantly higher than national average proportion of people with diagnosed diabetes, and low physical activity rates. There are currently 1,872 people with Type 1 diabetes and 16,845 people with Type 2 diabetes diagnosed in Harrow (8.8% of the population - higher than the national average of 6.4%). In Harrow the prevalence of diabetes is expected to increase to approximately 13% by 2030.

This burden could be even greater, with estimates suggesting that there could be over 4,000 people with undiagnosed diabetes in Harrow. The prevalence of both diagnosed and estimated diabetes in Harrow is higher than in neighbouring boroughs and significantly higher than the London and England average. Harrow has the highest prevalence of diabetes in London and the third highest nationally.

Consequently, diabetes has been prioritised by the Harrow Health and Wellbeing Board.

#### 1.4 Why does Harrow have a high prevalence of diabetes?

There are several reasons that account for the higher-than-national average proportion of our population with diabetes. Some of the key reasons are outlined below:

- Harrow has a high proportion of BME (Black and Minority Ethnic) patients: 54% of Harrow's population is non-White (42% Asian, 7% Black). Type 2 diabetes is six times more common in people of South Asian origin and up to three times more common in people of African and African-Caribbean origin.
- Physical inactivity: Only 76.9% of people in Harrow do any walking at least once a week which is below the England average of 80.6%. Harrow is 2<sup>nd</sup> lowest in London. The prevalence of diabetes, cardiovascular disease and associated



deaths can be significantly reduced through physical activity. It is estimated that around 14.2% of the new Type 2 diabetes cases in Harrow could be prevented if adults were 100% active, and 5.6% prevented if adults were 50% active.

- Poor diet, which can increase the risk of Type 2 diabetes.
- Deprivation: People living in the most deprived parts of the borough are 2.5 times more likely to have Type 2 diabetes than those living in the least deprived areas.
- Childhood obesity is an increasing problem, representing the future patients with Type 2 diabetes. For year 6 children, Harrow ranks statistically above the England average (20.8% Harrow prevalence against the England average of 19.1%). For children in Reception year, Harrow's 9.3% prevalence is similar to the England average of 9.5%.
- There is limited awareness and poor uptake of relevant behaviour change or preventative services such as psychological support, healthy eating, and physical activity.
- There is limited focus on identifying 'at-risk' populations.

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## 2 Diabetes and Pre-diabetes

### 2.1 What is diabetes?

Diabetes is a lifelong condition that causes one'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
- Type 2 diabetes – where the body doesn't produce enough insulin, or the body's cells don't react to insulin

Type 2 diabetes is far more common than type 1. In the UK, around 90% of all adults with diabetes have Type 2. During pregnancy, some women have such high levels of blood glucose that their body is unable to produce enough insulin to absorb it all. This is known as gestational diabetes.

### 2.2 Pre-diabetes

Many more people have blood sugar levels above the normal range, but not high enough to be diagnosed as having diabetes. This is sometimes known as pre-diabetes. If one's blood sugar level is above the normal range, the risk of developing full-blown diabetes is increased. It's very important for diabetes to be diagnosed as early as possible because it will get progressively worse if left untreated.

### 2.3 Symptoms of diabetes

These include:

- feeling very thirsty
- urinating more frequently than usual, particularly at night
- feeling very tired
- weight loss and loss of muscle bulk
- itching around the penis or vagina, or frequent episodes of thrush
- cuts or wounds that heal slowly
- blurred vision

Type 1 diabetes can develop quickly over weeks or even days.

Many people have Type 2 diabetes for years without realising because the early symptoms tend to be general.

## 2.4 Causes of diabetes

The amount of sugar in the blood is controlled by a hormone called insulin, which is produced by the pancreas (a gland behind the stomach). When food is digested and enters the bloodstream, insulin moves glucose out of the blood and into cells, where it's broken down to produce energy. However, if one has diabetes, the body is unable to break down glucose into energy. This is because there's either not enough insulin to move the glucose, or the insulin produced doesn't work properly.

Although there are no lifestyle changes one can make to lower the risk of Type 1 diabetes, Type 2 diabetes is often linked to being overweight.

## 2.5 Reducing the risk of diabetes

Type 2 diabetes is often linked to being overweight. That means there are steps one can take to reduce one's risk of developing it. Around 90% of people with diabetes have Type 2 diabetes. If one maintains a healthy weight, one can reduce the risk of developing the condition. There are no lifestyle changes that can lower one's risk of Type 1 diabetes.

### Diabetes and weight

Overweight or obesity, leads to an increased risk of Type 2 diabetes. A Body Mass Index (BMI) of 25 or above, puts one in the overweight range, while a BMI of 30 or above puts one in the obese range. However, some groups have a higher risk of developing Type 2 diabetes than white populations. These groups are advised to maintain a BMI lower than the standard 25. The advice is:

- Asians with a BMI score of 23 or more are at increased risk of developing Type 2 diabetes.
- Asians with a BMI of 27.5 or more are at high risk of developing Type 2 diabetes.

Although the evidence is less clear-cut, black people and other minority groups are also advised to maintain a BMI below 25, to reduce their risk of Type 2 diabetes.

### Diabetes and waist circumference

BMI isn't the only important measurement when it comes to one's diabetes risk. Waist circumference may also indicate that one is carrying extra body fat, and therefore at risk.

- All women have an increased risk of diabetes if their waist measures more than 80cm (31.5 inches).
- White or black men have an increased risk if their waist measures more than 94cm (37 inches).
- Asian men have an increased risk if their waist measures more than 90cm (35 inches).

A reduction of excess weight, reduces the risk of Type 2 diabetes.

## The healthy way to lose weight

A healthy diet and physical activity are the key to a healthy weight, but that doesn't have to mean going on a strict diet and spending hours at the gym. The NHS advises that the keys to successful weight loss are:

- Making realistic changes to one's diet and physical activity that can become a part of one's regular routine.
- The best way to lose weight is to make long-term changes to diet and physical activity that result in a steady rate of weight loss.
- Aiming to lose weight at around 0.5kg to 1kg a week (1lb to 2lb), until one achieves a healthy BMI.

## Causes of diabetes one cannot control

A number of other risk factors can increase one's risk of developing Type 2 diabetes, most of which can't be controlled.

These include:

- being over 40, or over 25 if one is black or south Asian
- having a close family member (parent, brother or sister) who has Type 2 diabetes
- being south Asian or African-Caribbean; these ethnic groups are five times more likely to get Type 2 diabetes
- having polycystic ovary syndrome (PCOS), especially if one is also overweight
- having had gestational diabetes (diabetes that lasts for the duration of a pregnancy)
- having impaired fasting glycaemia or impaired glucose tolerance, sometimes referred to as pre-diabetes

If one has any of these risk factors, one should maintain a healthy weight to ensure that the risk of diabetes doesn't increase further.

## 2.6 Living with diabetes

If one is diagnosed with diabetes, one needs to eat healthily, take regular exercise and carry out regular blood tests to ensure blood glucose levels stay balanced. People diagnosed with Type 1 diabetes also require regular insulin injections for the rest of their life. As Type 2 diabetes is a progressive condition, medication may eventually be required, usually in the form of tablets, and in some cases insulin may be required.

## 2.7 Complications of diabetes

If diabetes isn't treated, it can lead to a number of other health problems. High glucose levels can damage blood vessels, nerves and organs. Even a mildly raised glucose level that doesn't cause any symptoms can have long-term damaging effects.

### Heart disease and stroke

People with diabetes are up to five times more likely to develop heart disease or have a stroke. Prolonged, poorly controlled blood glucose levels increase the likelihood of atherosclerosis, where the blood vessels become clogged up and narrowed by fatty substances. This may result in poor blood supply to the heart, causing angina, which is a dull, heavy or tight pain in the chest. It also increases the chance that a blood vessel in the heart or brain will become blocked, leading to a heart attack or stroke.

### Nerve damage

High blood glucose levels can damage the tiny blood vessels in the nerves. This can cause a tingling or burning pain that spreads from the fingers and toes up through the limbs. It can also cause numbness, which can lead to ulceration of the feet. Damage to the peripheral nervous system, which includes all parts of the nervous system that lie outside the central nervous system, is known as peripheral neuropathy. If the nerves in the digestive system are affected, one may experience nausea, vomiting, diarrhoea or constipation.

### Diabetic retinopathy

Diabetic retinopathy is when the retina, the light-sensitive layer of tissue at the back of the eye, becomes damaged. Blood vessels in the retina can become blocked or leaky, or can grow haphazardly. This prevents light fully passing through to the retina. If it isn't treated, it can damage vision. Annual eye checks are usually organised by a regional photographic unit. If significant damage is detected, one may be referred to a doctor who specialises in treating eye conditions (ophthalmologist). The better controlled the blood glucose levels, the lower the risk of developing serious eye problems. Diabetic retinopathy can be managed using laser treatment if it's caught early enough. However, this will only preserve the sight one has rather than improving it.

### Kidney disease

If the small blood vessels of the kidney become blocked and leaky, the kidneys will work less efficiently. It's usually associated with high blood pressure, and treating this is a key part of management. In rare, severe cases, kidney disease can lead to kidney failure. This can mean a kidney replacement, treatment with dialysis or sometimes kidney transplantation becomes necessary.

### Foot problems

Damage to the nerves of the foot can mean small nicks and cuts aren't noticed and this, in combination with poor circulation, can lead to a foot ulcer. About 1 in 10 people with

diabetes get a foot ulcer, which can cause a serious infection. People with diabetes should look out for sores and cuts that don't heal, puffiness or swelling, and skin that feels hot to the touch. They should also have their feet examined at least once a year. If poor circulation or nerve damage is detected, feet should be checked every day and any changes reported to a doctor, nurse or podiatrist.

### Sexual dysfunction

In men with diabetes, particularly those who smoke, nerve and blood vessel damage can lead to erection problems. This can usually be treated with medication.

Women with diabetes may experience:

- a reduced sex drive (loss of libido)
- less pleasure from sex
- vaginal dryness
- less ability to orgasm
- pain during sex

### Miscarriage and stillbirth

Pregnant women with diabetes have an increased risk of miscarriage and stillbirth. If the blood glucose level isn't carefully controlled during the early stages of pregnancy, there's also an increased risk of the baby developing a birth defect. Pregnant women with diabetes will usually have their antenatal check-ups in hospital or a diabetic clinic, ideally with a doctor who specialises in pregnancy care (an obstetrician). This will allow the care team to keep a close eye on the blood glucose levels and control the insulin dosage more easily, as well as monitoring the growth and development of the baby.

## 2.8 Co-morbidities of diabetes

It is common for those with diabetes to also have a co-existing mental health issue and another long term condition. In these cases, the use of psychological therapies has been shown to be cost effective. People with both diabetes and depression have also been shown to be at increased risk of dementia.

### 3 What standards and frameworks are in place to improve diabetes care?

A number of standards and commissioning frameworks have been established to ensure a consistent and high standard of care for patients with diabetes, as well as providing mechanisms for service improvement.

#### 3.1 National Institute for Health and Care Excellence (NICE)

The recently updated NICE guidelines for Type 1 and Type 2, and the Quality Standard for Adults with Diabetes, require that services should be commissioned from, and coordinated across, all relevant agencies encompassing the whole diabetes care pathway. An integrated approach to the provision of services is fundamental to the delivery of high quality care to people with diabetes. In particular, people with diabetes should receive a structured educational programme, and personalised advice on nutrition and physical education from an appropriately trained HCP or as part of a structured educational programme.

#### 3.2 National Diabetes Audit (NDA)

This was developed in order to ensure that patients receive the highest level of care. The NDA presents some key checks and measures that should be offered to all patients diagnosed with diabetes. The NDA is the largest annual clinical audit in the world. Participation in England has been voluntary, so not all GP practices have participated. However, from 2017, participation in England has been made mandatory under the GP contract. The audit takes place on a 15-month cycle, and looks at five key questions:

- Is everyone with diabetes diagnosed and recorded on a practice diabetes register?
- What percentage of people registered with diabetes received eight NICE key processes of diabetes care (the ninth, Eye Screening, is not included in this analysis, but is monitored locally)?
- What percentage of people registered with diabetes achieved NICE defined treatment targets for glucose control, blood pressure and blood cholesterol?
- What was the uptake of diabetes structured education?
- For people with registered diabetes what are the rates of acute and long term complications (disease outcomes)?

NDA-derived 8 Key Care Processes: The NDA proposes that all patients with diabetes are expected to receive a planned programme of recommended checks each year:

1. Blood glucose level measurement
2. Blood pressure measurement
3. Cholesterol level measurement
4. Foot and leg check
5. Kidney function testing (urine)
6. Kidney function testing (blood)
7. Weight check

## 8. Smoking status check

### 3.3 Quality and Outcomes Framework (QOF)

This is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement in the Key Care Processes by a series of proxy measures. As all practices participate, data from this can be used to evaluate performance in a range of areas – such as whether the Key Care Processes are offered to patients, and what the outcomes were. Note that there are some differences in the methodology used between the QOF and the NDA measures, so their results can differ. In addition, ‘exception reporting’ is permitted within QOF, which allows certain cases to be excluded from being counted towards QOF attainment.

### 3.4 NHS Five Year Forward View (FYFV)

The FYFV sets out the over-arching case for why the NHS needs to change to address the widening health & wellbeing, care & quality and efficiency gaps as demands on the NHS grow.

The plan puts the upgrade on prevention and Public Health at its heart and describes the new care models which will be needed to deliver the planned objectives. These models will meet other 5YFV priorities to promote more self-care, improve working across organisations, allow local flexibility as well as ensuring more care is delivered in a community and primary care setting.

Strategic development and planning undertaken locally and across London will align with the aims of the FYFV.

### 3.5 NHS General Practice Forward View (GPFV)

The GPFV is a 5 year national programme to provide additional investment and support into primary care. The forward view is a response to a long term lack of investment in primary care and therefore aims to sustain general practice in order to help deliver the prevention agenda, out of hospitals services and enhanced management of long term conditions in a primary care setting.

There are 5 investment areas that the GPFV are committed to:

- **Investment in primary care** - this is the investment into general practice through the primary care funding stream (uplift funding)
- **Workforce** – adopting new incentives for training, recruitment, retention and return to practice
- **Workload** – practice resilience programme and time for care which supports the implementation of the 10 high impact changes to release primary care capacity.
- **Infrastructure** – premises developments and digital roadmap.



- **Care redesign** – support for individual practices and for federations. Direct funding for in hours and out of hours access, including clinical hubs and reformed urgent care; and a new voluntary contract supporting integrated primary and community health services.

### 3.6 NHS Mental Health Five Year Forward View (MHFYFV)

By 2020/21, there will be increased access to psychological therapies, so that at least 25% of people (or 1.5 million) with common mental health conditions access services each year. The majority of new services will be integrated with physical healthcare. As part of this expansion, 3,000 new mental health therapists will be co-located in primary care, as set out in the General Practice Forward View.

### 3.7 NHS Strategic Commissioning Framework for Primary Care Transformation in London (SCF)

Harrow CCG is also committed to developing primary care services under the Strategic Commissioning Framework (SCF) guidance. The SCF main premise is to establish:

- Accessible care
- Coordinated care
- Proactive care

In order to do this general practice needs to be commissioned at scale and GP Federations and Network provision are the key to its implementation.

### 3.8 NHS Improvement and Assessment Framework (IAF)

A new NHS England improvement and assessment framework for CCGs became effective from the beginning of April 2016, replacing the existing CCG assurance framework and CCG performance dashboard.

The assurance framework for the CCG is shown below and the CCG will be measured across these domains.



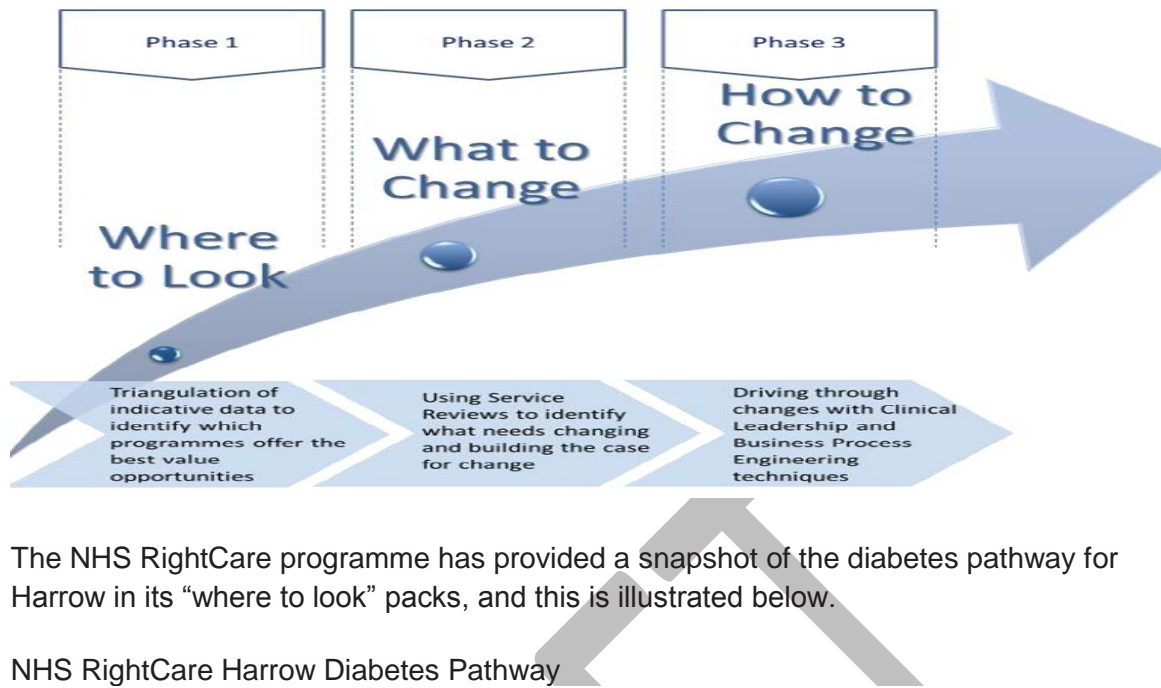
Harrow's 2014/15 diabetes IAF score is as follows:

Overall	3 treatment targets	Structured education
Greatest need for improvement – poor participation	40.9%	Red

### 3.9 NHS RightCare Programme

The RightCare programme has been adopted by Harrow CCG to ensure the optimal development of new diabetes pathways and services. The programme enables the CCG to compare the current service against similar CCGs and identifies areas where the CCG may need to focus on transformation.

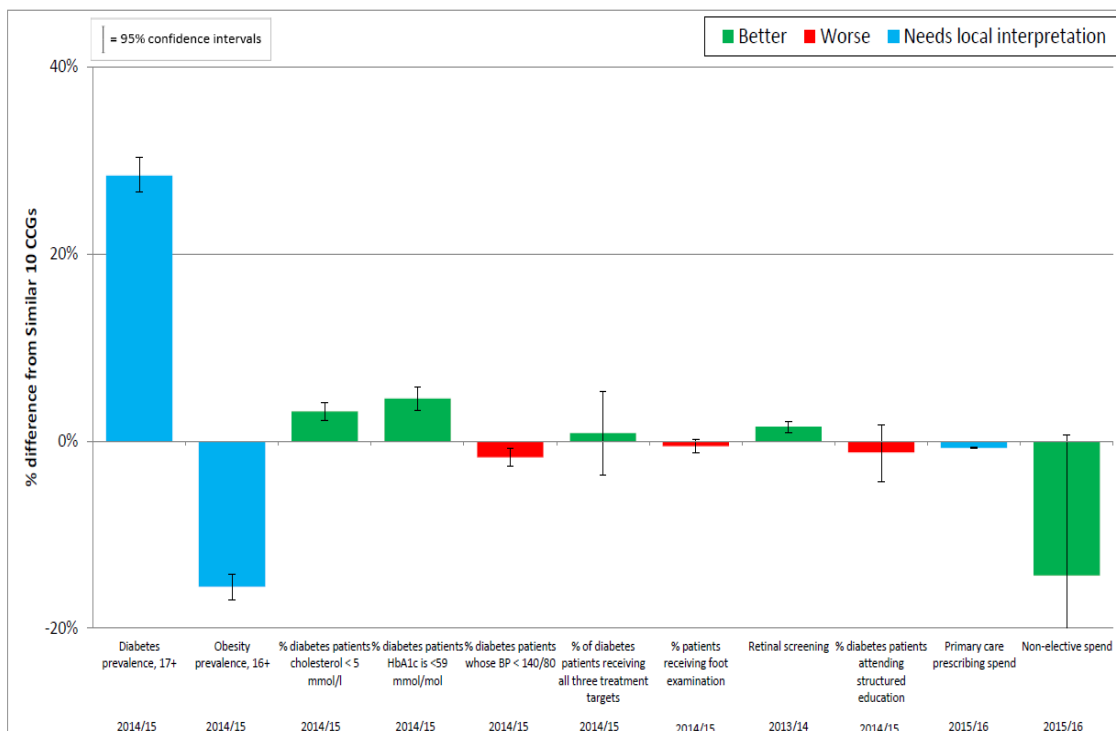
The programme will then support the CCG in the re-design and implementation phases through established quality improvement methodologies.



The NHS RightCare programme has provided a snapshot of the diabetes pathway for Harrow in its “where to look” packs, and this is illustrated below.

NHS RightCare Harrow Diabetes Pathway

## Diabetes pathway



NICE guidance:

<http://pathways.nice.org.uk/pathways/diabetes/>

PRIMIS Toolkit:

<http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/diabetes-care.aspx>

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Source: NHS RightCare Commissioning for Value Where to Look pack – NHS Harrow CCG, October 2016

### 3.10 Developing Accountable Care Partnerships

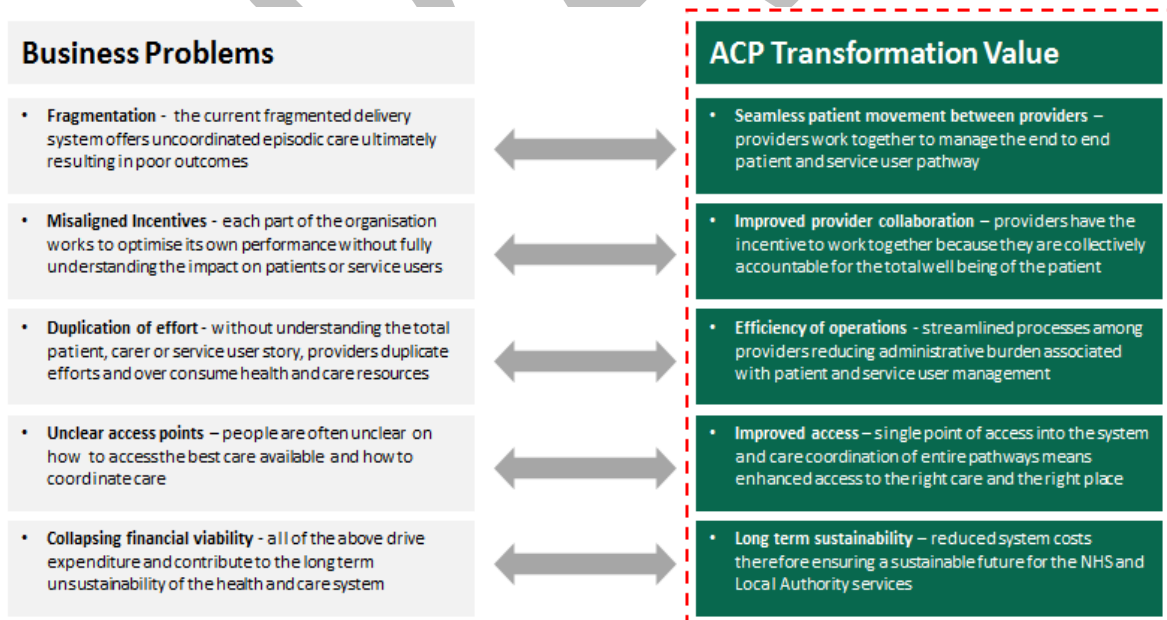
In 2017/18 the CCG will develop a shadow outcome based commissioning model / Accountable Care Partnership (ACP) before implementing an extended range of outcome based commissioning through a formal partnership in April 2018. (Via ACO/MCP)

Any services that are currently commissioned or are procured in future, the outcomes required of those services and associated budgets, might, in future form part of an ACP. The CCG will require current and future providers of services to work closely with any ACP in the delivery of services that provide clinical and financial outcomes that meet the requirements of ACP agreements.

#### How Accountable Care Models Work

- Accountable Care models are globally recognised as one of the most effective ways to bring providers together.
- Shown to advance the joining up of design, management and delivery of care.
- Providers work under a single contract, with a single pooled budget to take joint responsibility for delivering services.
- Outcomes based health and care contracts for a defined patient or resident population.
- Partners are incentivised to continuously improve and to drive delivery out of formal care settings and increasing focus on primary and secondary prevention.
- Gives greater financial security in order to plan and transform care over the longer term.

#### The Value of Accountable Care Models



## 4 Local Spend, Services, and Outcomes

This section will cover the key areas of spend on diabetes, what services are provided locally, and what the key outcomes are.

### 4.1 Local Spend

As mentioned above, NHS spending on diabetes is approximately £14 billion nationally, with 80% directed towards potentially preventable complications. This means that a condition affecting 6.4% of the population is utilising nearly 14% of the total NHS budget – a clear disparity. The largest expenditure on diabetes is prescribing.

#### Diabetes Prescribing in Harrow

Despite Harrow's higher than national average prevalence of diabetes, prescribing and total spend within diabetes is lower than national averages. There is considerable variation in the prescribing of anti-diabetic medication across all practices, with an unbalanced distribution of good and poor glycaemic outcomes.

- Total spend on diabetes prescribing per patient was £205.37 - well below the national average of £288.57; whilst 68.2% of patients achieved an HbA1c of 58mmol/mol - in the bottom 50% of CCGs in the country. [DOVE 13/14]
- Spend per person item on non-insulin anti-diabetic agents is also below the national average, with a wide variation across practices. For example, spend on all gliptin medications is approximately twice as high in some practices relative to others. [ePACT data 2014/15]
- Expenditure on core oral anti diabetic medication (metformin, sulfonylureas, pioglitazone) in Harrow is higher than the national average. Spend per patient item on injectable GLP-1 agonists was in the lowest quartile nationally. [DOVE 13/14]
- Spend per person item on insulin in Harrow was the lowest of all 221 CCGs in England. Spend per patient item of insulin was £71.33, substantially below the national average of £118.29 [DOVE 13/14]. All practices show a low expenditure on insulin, regardless of their QoF HbA1c target outcomes. [DOVE 14/15]
- Total spend on all diabetic diagnostic and monitoring reagents is only 4.2% below the national average spend [ePACT data 2014/15]. This suggests practices in Harrow are inappropriately initiating and issuing excessive quantities compared to their even lower insulin usage.

Several factors may be responsible for this:

- Lack of adherence to national and local guidelines for implementing the use of diabetic diagnostic and monitoring reagents from clinicians, and for medication prescribing and escalating, eg in Type 2 diabetes
- Lack of GP competence and diabetic resources available to initiate and monitor insulin therapy appropriately for Type 2 diabetes (it is not recommended for Type 1 diabetes).

- Low initiation of insulin in Type 2 diabetes patients due to the perception that insulin causes continuous weight gain, which can be a correct assumption. Also, hypoglycaemia fear is a factor.
- Low initiation throughout Harrow of novel anti-diabetic medications for Type 2 diabetes, such as the SGLT-2 inhibitors and GLP-1 agonists (compared with 10 similar CCGs) – [RightCare 2016], as therapeutic options to improve outcomes.

Approximately 70 GPs from Harrow attended the MERIT diabetes course in 2015. However, further investment is required to educate practitioners and patients further. As well as this, recent practice engagement by Harrow CCG's medicines optimisation team is already helping to implement cost-effective medicine strategies. Future plans are to introduce holistic pharmaceutical reviews for people with T2DM. This strategy aims to reduce prescribing costs whilst improving patient outcomes.

### Acute spend

In 2015/16 there were 118 non-elective admissions where diabetes was the primary diagnosis. This equated to £193,588. Non-elective spend is approximately 15% lower than Harrow's similar 10 CCGs.

In the same year, there were 954 outpatient first attendances, equating to £220,581; and 4,008 outpatient follow ups, equating to £462,626.

## 4.2 Local Services

Harrow CCG currently commissions diabetes services through a number of primary, community and acute providers supported through a number of local public health and voluntary sector programmes and initiatives:

- GP practices are the main providers of diabetes care, offering annual patient reviews, advice, health monitoring and medicines management
- The Community Diabetes Team of Central London Community Healthcare NHS Trust (CLCH), provides services including clinical care, structured education for those with Type 2 diabetes (in conjunction with Dieticians from London North West Healthcare NHS Trust (LNWHT). X-pert is the structured education course offered. A brief session on Type 2 diabetes is also offered), support and advice. The team currently consists of 3.8 WTE Diabetes Specialist Nurses (DSN) (against an establishment of 5.0 WTE), with 0.1 WTE Consultant support.
- CLCH generalist and specialist community teams also provide services for people with diabetes, including District Nurses, Podiatrists, Tissue Viability Nurses, and Cardiac Nurses.
- LNWHT provides a small number of GPwSI and Consultant Community sessions. The Consultant sessions take place at Northwick Park Hospital.
- LNWHT provides the DAFNE structured education course for people with Type 1 diabetes



- LNWHT Dieticians, based at Northwick Park Hospital, provide weight management services for people with diabetes at GP practices; and LNWHT provides a Tier 3-type weight management service for people with diabetes at Central Middlesex Hospital.
- Out-patient, in-patient, and emergency care is primarily provided by LNWHT, at Northwick Park Hospital.
- A diabetic retinopathy screening programme is provided by the North West London Diabetic Eye Screening Programme at six venues across Harrow.
- 11 volunteer Diabetes Peer Educators were trained in the X-PERT structured education programme in order that they could participate in the sessions delivered to people with diabetes. Some have also been involved in diabetes awareness raising activities with BME groups.
- People with diabetes can access talking therapies through the IAPT service, but there is no specific 'diabetes wellbeing' service on offer.
- Harrow Council provides a diabetes-specific Expert Patient Programme

### 4.3 Local Outcomes

#### National Diabetes Audit – 2015-2016

The first part of the 2015-2016 National Diabetes Audit was published at the end of January 2017. These covered Care Process Completion, Treatment Target Achievement, and Structured Education. Harrow's participation rate of 79.4% was markedly up on the previous year's rate of 17.1%, but was just below the national participation rate of 81.4%.

Below is an initial summary of results. A comparison with Harrow's 10 similar CCGs will follow.

#### *Care Process Completion*

**Table 1: 2015-16 Care process completion for people with Type 1 diabetes**

	NHS HARROW CCG (08E)		ENGLAND
	Percentage completed	Banding*	Percentage completed
HbA1C	85.4	As expected	84.5
Blood Pressure	91.0	As expected	89.4
Cholesterol	81.1	As expected	80.0
Serum Creatinine	84.1	As expected	82.1
Urine Albumin	58.8	Higher than expected	51.0
Foot Surveillance	72.8	As expected	73.7
BMI	76.8	As expected	75.8
Smoking	63.4	Lower than expected	79.0
<b>All Eight Care Processes</b>	<b>35.8</b>	<b>As expected</b>	<b>37.3</b>

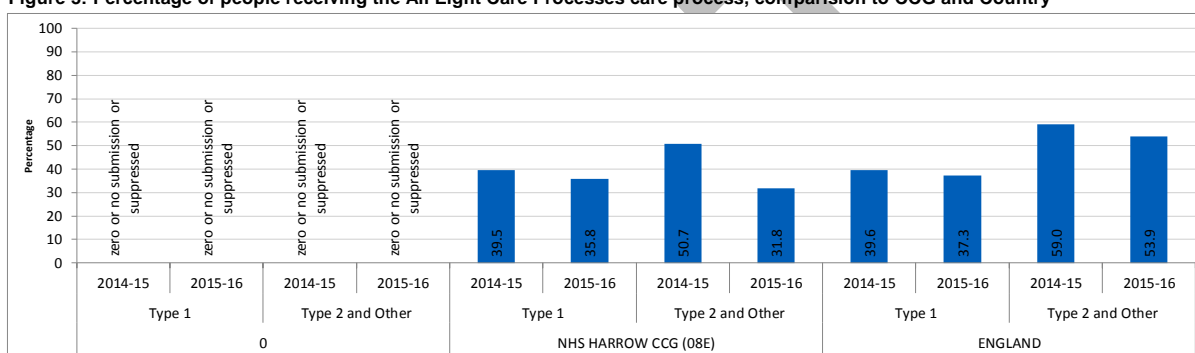
\*The banding should not be treated as an absolute assessment of performance, but rather as a tool to aid local investigation

**Table 2: 2015-16 Care process completion for people with Type 2 or other diabetes**

	NHS HARROW CCG (08E)		ENGLAND
	Percentage completed	Banding*	Percentage completed
HbA1C	94.6	Higher than expected	95.1
Blood Pressure	95.1	Higher than expected	95.8
Cholesterol	93.3	Higher than expected	93.1
Serum Creatinine	93.3	Higher than expected	94.8
Urine Albumin	51.8	Lower than expected	66.8
Foot Surveillance	86.2	Higher than expected	87.1
BMI	66.8	Lower than expected	82.8
Smoking	68.1	Lower than expected	85.4
<b>All Eight Care Processes</b>	31.8	Lower than expected	53.9

\*The banding should not be treated as an absolute assessment of performance, but rather as a tool to aid local investigation

**Figure 3: Percentage of people receiving the All Eight Care Processes care process, comparison to CCG and Country**



There was a wide variation amongst GP practices for people receiving all eight care processes:

- Type 1 diabetes: 10.5% to 66.7%
- Type 2 or other diabetes: 4.7% to 60.6%

### Treatment Target Achievement

**Table 1: 2015-16 Treatment target achievement for people with Type 1 diabetes**

	NHS HARROW CCG (08E)	ENGLAND
	Percentage completed	Percentage completed
HbA1c < 48 mmol/mol (6.5%)	7.5	8.5
HbA1c <= 58 mmol/mol (7.5%)	33.0	29.6
HbA1c <= 86 mmol/mol (10.0%)	83.1	84.4
Blood Pressure <= 140/80	70.5	75.7
Cholesterol < 4 mmol/L	31.0	30.0
Cholesterol < 5 mmol/L	70.9	70.9
<b>All Three Treatment Targets</b>	20.5	18.3



**Table 2: 2015-16 Treatment target achievement for people with Type 2 or other diabetes**

	<b>NHS HARROW CCG (08E)</b>	<b>ENGLAND</b>
	<b>Percentage completed</b>	<b>Percentage completed</b>
HbA1c < 48 mmol/mol (6.5%)	24.8	28.2
HbA1c <= 58 mmol/mol (7.5%)	67.5	65.9
HbA1c <= 86 mmol/mol (10.0%)	94.3	93.4
Blood Pressure <= 140/80	72.8	73.7
Cholesterol < 4 mmol/L	42.4	42.3
Cholesterol < 5 mmol/L	78.1	77.2
<b>All Three Treatment Targets</b>	41.1	40.4

There was a wide variation amongst practices for people achieving all three treatment targets:

- Type 1 diabetes: 10.0% to 50.0%
- Type 2 or other diabetes: 28.0% to 50.9%

### *Structured Education*

The percentage of newly diagnosed people with Type 1 diabetes recorded as being 'offered' or 'attended' a structured education programme (diagnosed in 2014):

	<b>Harrow</b>	<b>England</b>
Offered	23.8	35.8
Attended	4.8	4.2

The percentage of newly diagnosed people with Type 2 or other diabetes recorded as being 'offered' or 'attended' a structured education programme (diagnosed in 2014):

	<b>Harrow</b>	<b>England</b>
Offered	75.1	80.6
Attended	0.4	7.6

### 2016 Harrow Non-elective Admissions Audit

A 2016 audit amongst GP practices in Harrow of 76 non-elective admissions analysed reasons for Emergency Department attendance where diabetes was the primary diagnosis. These were: hyperglycaemia (33%), hypoglycaemia (26%), foot infections (21%), DKA (17%) and other (3%) with over 80% representing patients with Type 2 diabetes. Key characteristics of the hyperglycaemia group were as follows:

Medication review within the previous 12 months	94%
HbA1c < 64 mmol/mol	32%
Number of visits to GP in previous 6 months	6.96
People attending with hypoglycaemia NOT on insulin	55%

What was clear from subsequent discussion following this analysis was that many non-elective admissions for diabetes are potentially preventable through better glycaemic management, more effective MDT working, patient empowerment and information (including better information about sick day rules) and avoiding overtreatment especially of frail/elderly patients with sulphonylureas through monitoring for symptoms of hypoglycaemia.

## 5 In which areas could Harrow improve?

NHS Harrow CCG has identified the following key areas for improvement, through its Local Out of Hospitals Strategy, and Commissioning Intentions for 2017-19:

- Reduction in the prevalence gap for key conditions including Hypertension and Diabetes
- Reducing follow ups at secondary care and shifting those appropriately into the community
- Reduction in the costs of managing people with LTCs
- Participation in the NHS Diabetes Prevention Programme. This programme targets weight loss support at people with pre-diabetes.
- Redesign the obesity pathway, in collaboration with partners, to ensure increased effectiveness and efficiency of weight management services.
- Enhance support for health and social care professionals, in order to increase their knowledge of, and expertise in, diabetes. Commission education at scale in primary care.
- Enhance support for patients and carers, in order to increase their knowledge of, and expertise in, diabetes.
- Improve the partnership between professionals and patients / carers, in order to enhance co-creation of care / self-care.
- Improve value, coordination, and communication within the diabetes care pathway. Follow Right Care principles.
- Integrated community service.
- Improve communication of the diabetes care pathway for health and social care professionals, patient, carers, and the general population.
- Increase uptake of IAPT amongst people with diabetes.
- Review of insulin pumps, in collaboration with Medicines Management.
- Alignment with overall Long Term Conditions management, including cardiology, CKD, and ophthalmology.

## 6 How does Harrow plan to improve the prevention of Type 2 diabetes and to improve diabetes treatment and care?

### 6.1 Overview

There are three main strands to Harrow's strategic programme of work for diabetes:

1. Creation of a Harrow Diabetes Network
2. Prevention of Type 2 Diabetes in Harrow
3. Local implementation of the NWL STP Diabetes Transformation Programme

Each of these is covered in detail in the appendices to this strategy, but a summary can be found below.

### 6.2 Creation of a Harrow Diabetes Network

The purpose of the Harrow Diabetes Network is to:

- Provide direction and leadership as it endeavours to enhance outcomes for people with diabetes, and at risk of Type 2 diabetes, in Harrow
- Provide expertise and advice to the NHS Harrow CCG Executive in relation to diabetes
- Contribute to the development and implementation of the Harrow Diabetes Strategy and action plans

Membership will comprise people with Type 1 and Type 2 diabetes, as well as professionals from across the health care, social care, and third sectors.

Diabetes UK has offered its support in developing the Network

### 6.3 Prevention of Type 2 Diabetes in Harrow

This programme of work has been scoped out by the Public Health department of Harrow Council.

Diabetes prevention needs to be a joint collaboration in Harrow with Health, social care, LA and public health, third sector working closely with the Diabetes UK and the patient groups and the carers. In view of the ever diminishing public sector resources, we need to rely on creativity, innovation, pooled budgets, technology, digital solutions, adopting methodologies like Rightcare, following good practice from NICE, NHS DPP, digital diabetes pilots and good practice across the NWL and Pan-London level. We need to look at system level change through service transformation; ACPs, TCPs and outcome based commissioning approaches. A joint collaboration and commissioning plans need to be agreed at a HWBB level in delivering lifestyle interventions (physical activity, weight management, stop smoking, alcohol, substance misuse services, mental health & EPP), complex cases with

health & social care challenges, licensing and legislation on fast food outlets, oral health, housing, regeneration and health, workplace health, MH, employment & wellbeing.

The vision is to radically upgrade prevention and wellbeing.

The objectives are:

1. At every opportunity, pro-actively raise awareness, signpost to services and empower residents to maintain a healthy weight, stop smoking, be active and eat healthily to reduce the risk of type 2 DM & its complications
2. Improve the early detection of pre-DM (Intermediate hyperglycaemia) through risk scoring in primary care & the community. (CCG) and by raising awareness of signs and symptoms of T2DM
3. Reduce variation in quality of care, offer, access & treatment targets for all Harrow residents, irrespective of their age, gender and where they live.

Key actions will include:

1. NHS Diabetes Prevention Programme Preparedness:
  - a) IT/Primary care data systems & pre-diabetes registers in primary care.
  - b) Collaborative work and referral pathway agreed on NHS Health checks.
  - c) A joint PH /NHS tier 1/2/3 weight management pathway, a joint approach on physical activity and active lifestyle- (To be ready for the next wave of the NDPP by September 2017.
  - d) Promoting data quality by 100% NDA participation, appropriate coding of UA, foot checks and BMI,
2. Mental health and diabetes integration:

Tackle stigma and promote awareness, wider participation and motivation in schools, further education centres, colleges and workplaces:

  - a) Early access to emotional and psychological support at workplace, primary care and the community, including schools and further educational institutions- Mental Health awareness and training, Expert Patient Programme (EPP) specific for diabetes. (PH offering these through a time limited external funding).
  - b) Integrated IAPT services (NWL MH Transformation)
  - c) Diabetes specific IAPT (as in Diabetes wellbeing programme- IAPT, Berkshire).
3. Self-care, care planning and PAM:

Self-care is the cornerstone for diabetes management. Self-care and appropriate education should be offered to families of people with diabetes, carers, all those at high risk and pre-diabetes. Better aligned to the Care Act, NHSE care planning & WSIC/Self-care.

  - a) Clear lifestyle referral routes for people at high risk and pre-diabetes.
  - b) Clear care plans for people with diabetes: rolling out care planning in each GP sx.
  - c) PAM scores for self-care, CMHD, vital signs (UNIVERSAL adoption).
  - d) NHSE/Digital- data inter-operability for better coordinated work.
  - e) Family, friends and carer's input in the person's care plans.
  - f) Consistent training for health & care frontline staff including how to consult for confidence & self-care rather than traditional acute model.

4. Elderly people with diabetes (including care homes, homecare):
  - a) The Harrow Diabetes Network needs a clear protocol on lifestyle advice, routine management and medicines management for elderly people with diabetes in care homes, homes and home care setting.
  
5. Clear focus on secondary & tertiary prevention of CVD & Renal complications, avoidance of blindness, foot amputations of diabetes- complex cases with health & social care needs:
  - a) Identifying the cohort of people with diabetes and multi-morbidities, complex needs and poor control, DNAs at the foot clinics, eye screening, those regularly missing OP/IP appointments (Frequent visitors to the A & E and walk-in).
  - b) Early & prompt detection, appropriate coding and referral to a range of options including structured education, dietetic advice, IAPT; promote self-care, diabetes care plans.
  - c) Close liaison with social care in reducing bed days/bed blocking, home based care, carers strategy and support. Explaining how personal budgets and e- purse could help.
  - d) Focus on 9 key care processes (NWL model-including data collection), focus on foot checks and eye screening- work closely with foot care teams, Diabetes eye screening team to match the data, provide checks at common points.
  
6. Methodologies/Tools for risk assessment and as core part of a population health management system that an ACP would deliver:
  - a) End to end solutions for the diabetes pathway, from prevention to complications, NHS Right care, PAM & read codes, QDiabetes software, Leicester/DUK risk assessment tools, psychological measures of confidence/self-efficacy, activation measures etc
  
7. Population level approaches:
  - a) Opportunistic risk scoring using DUK/Leicester online/paper based tools without the need for POC testing in workplaces, places of worship, culture, schools and colleges.
  - b) Enhanced and clear focus on care homes nad homecare settings.
  - c) NHS health checks commissioners to target practices with higher diabetes prevalence in areas of need and also the right population groups.
  - d) Close collaboration with community pharmacy- on risk scoring, awareness and early detection POC testing. Pharmacy assistants & specialists (including compulsory medication reviews and specialist reviews on diabetes)
  - e) DSNs and dietitians support community volunteers, patient champions, care navigators, peer educators and faith leaders, work with 0-19 team (HVs and school nurses), PNs and district matrons.
  - f) Some of the community DSNs, dietitians not to have caseloads but promote diabetes education, support GPs, nurses, HCPs, community; share this work with the acute care DSNs, who would spend 1 day in the community
  - g) People with strong family history, at high risk-offered risk scoring and blood tests. Those with pre-diabetes registered and offered lifestyle interventions, at the earliest opportunity. Improve opportunistic diabetes awareness and risk scoring events in the community and workplace.
  
8. Technology, Digital /Web/App based approach diabetes prevention:

- a) Offer of technology, digital solutions, including skype consultations, texts, emails and apps on diabetes prevention and management to an appropriate audience
- b) Adoption of local best practice Ex: Infinity/ePurse (Personal budgets and personal health budgets).

9. Other Harrow focussed actions:

a: Community outreach education, supported by the DSNs/dietitians through community connectors or navigators or champions who can train and support people around cultural context. This can also work as prevention in that those at high risk ie pre-diabetes are supported with lifestyle changes. (Needs to start)

b: Encouraging provision of greater physical activity, creating health champions (including GP champions), walk leader training, especially looking for those community members who will lead walking or other groups, like yoga/mindfulness or MH awareness sessions at weekend. This will target the critical age group of 25 to 65 year olds who are working. (Started, needs closer collaboration with primary care)

c: After feedback from professionals public health is working with our dietetics department to develop ethnically specific Eat Well resources that will support people working with residents to offer appropriate advice on healthier foods and portion size. (on-going)  
 Harrow Public Health is working in partnership with Environmental Health to support fast food outlets close to schools to offer healthier foods, lower sugar drinks, and less salt and also supporting schools to reinforce this message. (on-going)

#### 6.4 North West London STP Diabetes Transformation Programme

Harrow is a member of the North West London Sustainability and Transformation Plan, and at the end of 2016 / beginning of 2017, a detailed business case was developed for a diabetes transformation programme across North West London; alongside a funding bid to NHS England's National Diabetes Treatment and Care Programme. The funding decision is expected in early March 2017.

This transformation encompasses an at-scale, proactive, coordinated, integrated, outcomes-based approach, pioneering digital technology and innovative approaches to self-management and supported self-care, fleshing out a model for long term conditions management in line with the strategy laid out for the Sustainability and Transformation Plan.

Four main areas of work have been identified:

North West London STP Diabetes Transformation Programme			
Improving uptake of structured education	Improving the achievement of the NICE recommended treatment targets	Expanded multi-disciplinary footcare teams (MDFTs)	Expanded diabetes inpatient specialist nursing services (DISNs)
<ul style="list-style-type: none"> <li>• Offer a menu of structured</li> </ul>	<ul style="list-style-type: none"> <li>• Training of health and social care</li> </ul>	<ul style="list-style-type: none"> <li>• To avoid / reduce the human and</li> </ul>	<ul style="list-style-type: none"> <li>• To improve the experience and</li> </ul>

North West London STP Diabetes Transformation Programme			
<p>education to people with diabetes, in order to provide them with the skills required to live with their condition and effectively self-manage</p> <ul style="list-style-type: none"> <li>• Remove barriers to access</li> <li>• To include emotional health aspects</li> <li>• Joint work with IAPT teams and VCS support to signpost to activities around the 'five ways to wellbeing'</li> </ul>	<p>professionals, including ensuring that appropriate support is available to children and people transitioning to adult services, as well as to adults</p> <ul style="list-style-type: none"> <li>• Proactive management and monitoring, offering all key care processes</li> <li>• Virtualised MDT</li> <li>• Federated working, bridging the gap between primary, community and hospital based diabetes care. Aiming for a fluid care pathway involving all these three zones of care.</li> <li>• More systematic self care and mental health input</li> </ul>	<p>financial costs associated with diabetes related foot disease and amputations</p>	<p>outcomes of people with diabetes in in-patient settings</p> <ul style="list-style-type: none"> <li>• To reduce the length of stay and medication errors of people with diabetes</li> </ul>

What inputs will be required?

- Current expenditure on diabetes services / programme support
- Additional clinical, management, and admin support:
  - Strategic clinical leadership
  - CCG GP leadership
  - Programme Director
  - Programme Support
  - Admin Support
  - Operational Clinical Leads (Diabetes Consultants)
  - Additional DSN's
  - Consultant Psychologist
  - Clinical Psychologists



- Foot Protection Podiatrists
- Additional DISNs
- Finance, BI, Contracting
- Additional IT infrastructure
- Additional funding for primary care provision

What will be the outputs?

- Readiness of CCG and public health to roll out wave 3 of the National Diabetes Prevention Programme
- Increased referrals to structured education
- Increased attendance at structured education
- Prioritisation of improvements based on need
- Dashboard of care
- Staff education
- Correct skill mix
- Implementation of Type 1 service specification
- Weekend MDfT clinics at vascular hubs
- Weekend virtual MDfT access to local vascular spoke hospitals
- Single point of advice and referral
- Improved patient flow
- Better communication with community, primary care and social care colleagues to improve discharge
- Improved patient experience and safety
- Reduction in length of stay, medication errors, hypos

What will be the outcomes?

- Prevention of Type 2 diabetes and prevention of complications arising from diabetes
- Increased data on primary care support to people with diabetes through the NDA
- Increase in patients receiving all key care processes
- Decrease in variation between practices in care and outcomes
- Increase in patients who are better controlling their blood sugar levels and other treatment targets
- Reduction in non-elective attendances and admissions resulting from poorly managed diabetes
- Appropriate transfer of care of stable patients from hospital to services in the community



## Timescales

### **Phase 1: Establishing the programme (Jan – April 2017)**

- ✓ Diabetes services stock take – resources/ staffing / project support already in place in each CCG
- ✓ Agreements on shared vision and narrative that will be used to bring the system of stakeholders to a shared vision and understanding of the end state – reflected in a Diabetes Transformation Case for Change
- ✓ Agreement on the programme plan and critical path that will set timeline expectations for Providers and Partners
- ✓ Completion and sign-off of a Programme Initiation Document (PID) outlining programme plans, delivery strategy, critical path, governance arrangements, resource requirements, and key risks and processes
- ✓ Establishment of a stakeholder and communication strategy
- ✓ Establishment of a patient engagement strategy and plan
- ✓ Establishment of programme governance and decision making arrangements
- ✓ Mobilisation of programme resources and work-streams
- ✓ First draft Diabetes Strategy
- ✓ Plan for Phase 2

### **Phase 2a: Commissioning, Contracting and Governance (April – Sept 2017)**

- ✓ Define contracting for shadow year April 2017- March 2018
- ✓ Completion of a Definition Framework that will set procurement specifications for Providers and Partners this will include
  - Target population and health need/priority
  - Scope of services scope
  - Outcomes framework
  - Diabetes footprint
  - Budget outline
  - Contract arrangements – including risk/gain share model
- ✓ Establishment of capitation methodology / procurement strategy / implementation and locality delivery strategy
- ✓ Contract award of the integrated outcomes-based contract
- ✓ Refresh of programme governance arrangements
- ✓ Design of provider governance
- ✓ Design of commissioner organisation
- ✓ Design benefits realisation and outcomes accountability model and dashboard
- ✓ Provider and Commissioner capability assessment and change management strategy
- ✓ Monitoring of all provider mobilisation and transformation
- ✓ Detailed implementation plans for transformed business operations – e.g.

<p>workforce, finance, etc.</p> <p>✓ Implementation plans assurance gateway</p>
<p><b>Phase 2b: Clinical Transformation - Improving Treatment Targets Project (April 17 – April 2018)</b></p>
<p><b>Phase 2c: Clinical Transformation - Diabetes Foot Project (April 17 – April 2018)</b></p>
<p><b>Phase 2d: Clinical Transformation - Diabetes Hospital Care Project (April 17 – April 2018)</b></p>
<p><b>Phase 2e: Diabetes, IT, Analytics, Clinical Audit, Research and Reporting (April 17 – April 2018)</b></p>

What will be the Harrow community delivery model?

NHS Harrow CCG will explore the Diabetes Neighbourhood Support Model. The model would deliver improved diabetes care in the community by having three Hub-based teams across the six Peer Groups.

Each of the three teams would include:

1. Diabetes Consultant mentorship
2. GPwSI in diabetes
3. Community-based Diabetes Specialist Nurses
4. Community Dieticians
5. Podiatrists
6. Mental health professionals
7. Diabetes UK mentorship

## Appendices

DRAFT

**Harrow Diabetes Network**  
**Terms of Reference**  
**Version 0.1**

Harrow has a major need for a cohesive programme of care for its rising population of people with diabetes and at risk of diabetes. The Harrow Diabetes Network evolved from the drive to improve the quality of care in the short, medium, and longer term. NHS Harrow CCG is in the process of developing a strategy for diabetes in Harrow modelled on an integrated service. The centre of this work will be based on collaborative work across all systems with the best interests of the patient at its core.

**1. Purpose**

The purpose of the Harrow Diabetes Network is to:

- Provide direction and leadership as it endeavours to enhance outcomes for people with diabetes, and at risk of Type 2 diabetes, in Harrow
- Provide expertise and advice to the NHS Harrow CCG Executive in relation to diabetes
- Contribute to the development and implementation of the Harrow Diabetes Strategy and action plans

**2. Functions**

The principle functions of the Harrow Diabetes Network are to:

- Develop, review, and endorse, evidence based standards of care, guidelines and pathways to promote standardisation of best care practices and principles across Harrow
- Review unjustified variation in clinical outcomes or other aspects of service quality or efficiency, define targets for improvements, choose appropriate clinical indicators for monitoring and develop strategies to achieve such improvement
- Review and provide advice on the implementation of service improvement initiatives
- Assist in the development of Harrow service plans and monitor implementation of such plans
- Facilitate sharing of lessons from audit processes between clinicians
- Develop and agree a model of integrated diabetes care
- Upon mobilisation of the agreed model, troubleshoot and work through any issues
- Enhance and build new relationships between clinicians and other professionals working with diabetes in Harrow

- Understand the pressures on primary care, community care and acute care for diabetes in Harrow
- Start to develop and build on ideas from within the Network, recent data, and the input of the wider stakeholder group, and hone an integrated diabetes service. Use best practice, affordability and increased positive patient outcomes and experience
- Implementation of smaller projects / subgroups

### 3. Reporting responsibilities

The Senior Responsible Officer for Diabetes in Harrow is XXXXX.

Any working groups established will report into the Harrow Diabetes Network.

The Harrow Diabetes Network will report into the CCG Executive Committee.

### 4. Membership

#### Chair

The Harrow Diabetes Network will be Chaired by Dr Kaushik Karia, the Vice Chair of NHS Harrow CCG. The Deputy Chair of the Harrow Diabetes Network will be Dr Mathi Woodhouse.

The membership of the Harrow Diabetes Network will be as follows:

Name	Title	Organisation
Dr Kaushik Karia	Chair of the Harrow Diabetes Network / Vice Chair of NHS Harrow CCG	NHS Harrow CCG
Dr Mathi Woodhouse	Deputy Chair of the Harrow Diabetes Network / GP	NHS Harrow CCG
XXXXX	Senior Responsible Officer for Diabetes	NHS Harrow CCG
Jason Parker	Diabetes Project Manager	NHS Harrow CCG
Zinat Rajan	Medicines Management	NHS Harrow CCG
Dr Onteeru Buchi B Reddy	Public Health Strategist	Harrow Council
Chris Greenway	Head of Quality and Safeguarding	Harrow Council
Rachael Glover	Influencing Manager (London)	Diabetes UK
Ms Lis Warren	Person with Type 1 Diabetes	Diabetes UK
XXXXX	Person with Type 2 Diabetes	Diabetes UK
Mariesa Kielty	General Manager	LNWHT
Dr Kevin Baynes	Diabetes Clinical Lead	LNWHT
Dr Keith Steer	Diabetes Consultant	LNWHT
Dr Elaine Hui	Diabetes Consultant	LNWHT
Dr Asiya Ali	Paediatric Endocrinology	LNWHT
Dr Ken Walton	GPwSI Diabetes	LNWHT
XXXXX	Diabetes Specialist Nurse	LNWHT
Tazmin Wisudha-Edwards	Diabetes Specialist Dietitian	LNWHT
Norma Jeremiah	Community Dietetic Manager	LNWHT
Patrick Laffey	Clinical Business Unit	CLCH

	Manager - Long Term Conditions, North Division	
Nadia Arthur	Community Diabetes Team Leader	CLCH
Dierdre Moroney	General Manager	CNWL
Renuka Jena	Principal Clinical Psychologist	CNWL

In addition the CCG will invite the following personnel as required and when appropriate:

- Avni Amlani, Specialist Podiatrist, LNWHT
- Bindya Thanki, Podiatry Lead, CLCH
- Stella Ward, Commissioning Manager, NWL Adult Screening, NHS England (London Region)

## 5. Meetings

The Harrow Diabetes Network will initially meet every six weeks.

After the first six meetings, the Harrow Diabetes Network will take place quarterly.

The CCG will aim to provide a minimum of six weeks' notice for each meeting. The Harrow Diabetes Network will discuss whether the frequency of its meetings is appropriate within the first three meetings.

Attendance can be face to face or by telephone/video conferencing.

If a member is unable to attend the meeting they can nominate a deputy to attend on their behalf.

A quorum is achieved when X out of the X members are present. This must include at least one representative from each of the stakeholder organisations.

A decision put to a vote at the meeting will be determined by a majority of the votes of the members present and who have voting rights. In the case of an equal vote, the Chair of the Harrow Diabetes Network shall have a second and casting vote.

During the first meeting of the Harrow Diabetes Network, the group shall discuss whether all members shall be voting members.

## 6. Secretariat

The secretariat functions for the Harrow Diabetes Network will be provided by the CCG Diabetes Project Manager, to include setting up of meetings, minuting meetings, following up actions and organising subsequent discussions.

# Prevention of Type 2 Diabetes in Harrow

Dr Onteeru Buchi B Reddy, PH strategist,

Harrow Council, February 2017

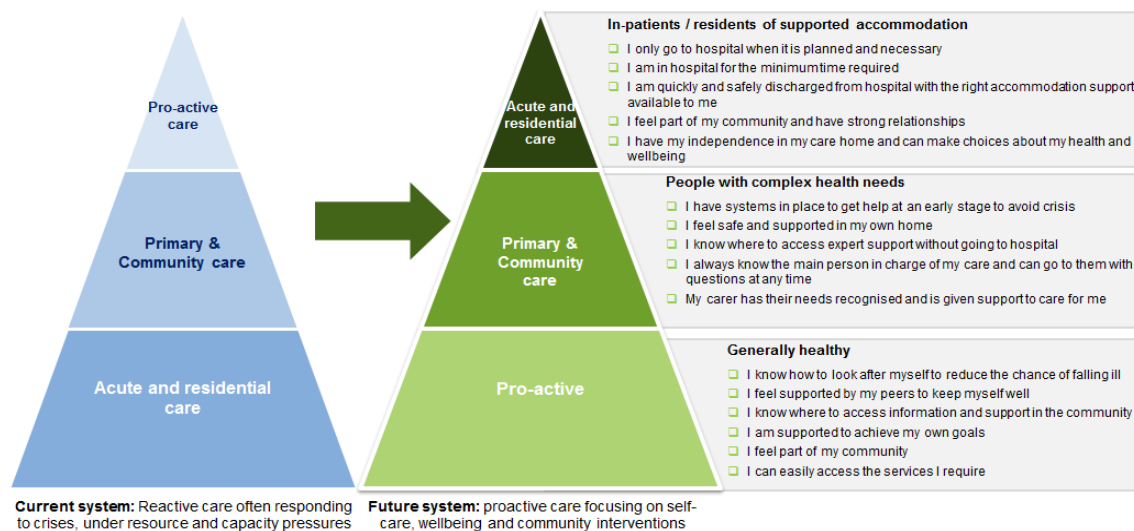
Diabetes epidemic is one of the biggest public health challenges of our times and linked to the massively increased rates of obesity. Inactivity, lifestyle factors, especially obesity when not addressed will lead to metabolic syndrome and pre-diabetes. Around 22,000 people with diabetes dies early every year. Type 2 diabetes is one of the leading causes of preventable sight loss in people of working age and is a major contributor to kidney failure, heart attack and stroke. (NHS DPP). 11.9 million people in the UK are at increased risk of developing type 2 diabetes. We don't have adequate evidence in preventing type 1 diabetes but around 3 in 5 cases of type 2 diabetes can be prevented or delayed through behavioural interventions which support people to maintain a healthy weight, eat well and be more active. (Diabetes UK, 2017)

## Vision: (Diabetes 2020/21):

### Refer DA 1- Radically upgrading prevention and wellbeing

Take action to prevent type 2 diabetes, enable early detection and reduce complications by empowering residents to care for themselves and by providing consistently high quality clinical care across the borough. The plan is to turn a reactive, increasingly acute- based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care in areas close to people's homes, wherever possible. This will improve health & wellbeing and care & quality for patients.

### Our vision of how the system will change and how patients will experience care by 2020/21



## Objectives:

1. At every opportunity, pro-actively raise awareness, signpost to services and empower residents to maintain a healthy weight, stop smoking, be active and eat healthily to reduce the risk of type 2 DM & its complications

2. Improve the early detection of pre-DM (Intermediate hyperglycaemia) through risk scoring in primary care & the community. (CCG) and by raising awareness of signs and symptoms of T2DM
3. Reduce variation in quality of care, offer, access & treatment targets for all Harrow residents, irrespective of their age, gender and where they live.

## National evidence

### A. Screening for and preventing type 2 diabetes in high risk populations

*NICE (2012) Preventing type 2 diabetes: risk identification and interventions for individuals at high risk. Available at: [www.nice.org.uk/ph38](http://www.nice.org.uk/ph38) (accessed 10.02.2017)*

NICE has published guidance on the prevention of type 2 diabetes, which provides details of populations that might be at increased risk of developing the condition and should therefore be considered for risk assessment. These include South Asian individuals aged between 25 and 39 years. Furthermore, NICE recommends that a blood test for either fasting plasma glucose (FPG) or HbA1c is considered for all South Asian people aged  $\geq 25$  years with a BMI  $> 23$  kg/m<sup>2</sup>.

#### **A note on Pre-diabetes or Non- diabetic Hyperglycaemia:**

HbA1c is much more of a gold standard now – 42-47 denotes Non-Diabetic Hyperglycaemia and is used for the National Diabetes Prevention Programme and is what is recommended by the London Diabetes SCN. It also allows for point of care testing and gets round the issue of whether someone was fasting or not. All of the “Pre-diabetes” elements (other than a current status of previous gestational diabetes) should now be called NDH and recorded in the pre-diabetes registers in primary care.

Cultural barriers are still prevalent and include challenges surrounding dietary management, exercise and physical activity, body image and the social stigma attached to having diabetes. If the blood test indicates that the individual is at moderate risk of developing type 2 diabetes (FPG  $< 5.5$  mmol/L or HbA1c  $< 42$  mmol/mol [ $< 6.0\%$ ]), it is recommended that culturally appropriate lifestyle advice is provided and tailored support services offered. If the individual is at high risk of developing type 2 diabetes (FPG 5.5–6.9 mmol/L or HbA1c 42–47 mmol/mol [ $6.0$ – $6.4\%$ ]), an intensive lifestyle change programme should be offered..

Some culturally appropriate educational resources:

- Apnee Sehat ([www.apneesehat.net](http://www.apneesehat.net))
- DESMOND BME (<http://www.desmond-project.org.uk/bmefoundationnewlydiagnosed-279.html>)
- Diabetes UK ([www.diabetes.org.uk](http://www.diabetes.org.uk))
- Facts About Fasting ([www.factsaboutfasting.com](http://www.factsaboutfasting.com))
- South Asian Health Foundation ([www.sahf.org.uk](http://www.sahf.org.uk))

### Population level approaches

**Programmes & Campaigns**-The Healthier You- NHS Diabetes Prevention Programme, One You, Change4life Following best practice guidance from NICE/WHO/IDF/EASD/ABCD/DUK

Community DSNs, dietitians not to have caseloads but promote diabetes education, support GPs, nurses, HCPs, community, care navigators, peer educators and faith leaders, work with 0-19 team, PNs and district matrons, PH to promote diabetes awareness, prevention, pre-diabetes; share this work with the acute care DSNs, who would spend 1 day in the community. Include IAPT team, too and close collaboration/work sharing between these professionals



## **B. Diabetes & Obesity Prevention- Commissioning for Prevention**

### ***(Optimity for PHE, 2016)***

There is a strong evidence for the effectiveness of lifestyle change programmes creating reductions in Type 2 diabetes incidence. Similarly, there is evidence for the cost saving and cost effectiveness of risk assessment and screening in pre-diabetes populations and those at high risk of developing diabetes. There is significant evidence for the importance of including lifestyle interventions into any obesity intervention in order for it to be effective.

There is significant evidence for the cost saving of obesity interventions over a lifetime time frame but there is limited evidence for savings over a five year setting. There is however a clear opportunity for a joint commissioning between the CCG, PH, patient gr support groups and the third sector.

**A Note on Workplace Health**– A reminder that NHS, the local council and business workforce is a key group to apply this to, as well as other employer situations (ethnicity/risk among some workers very prominent, especially in care home/home care settings).

There are some potential benefits of workplace interventions to improve health and care, and provide savings.

**Smoking** – compared with no intervention, most interventions (e.g. brief advice, self-help and nicotine replacement) generated a net financial benefit (value of reduced absenteeism minus intervention cost) over the lifetime and most did so over five years.

**Obesity, inactivity and pro-active Physical Activity** - Counselling/walking programmes are estimated to generate health gains and NHS cost savings and may be broadly beneficial to the employer in terms of reduced absenteeism.

Joint commissioning for prevention- obesity, a clear standardised pathway for physical activity promotion and tier 1 obesity interventions promoted among all professionals with one clear message for inactive groups on physical ctivity and lifestyle.

**Mental Wellbeing** - Worksite interventions to improve the mental wellbeing of employees can save employers between £495 and £5,160 per affected employee per year.

### A Final Note...

While Optimity do state that the potential contribution to savings to 2020/21 are extremely substantial (£430m in public health and £555m in the health and care system), they note that to achieve these savings the health and care system would need to drastically change to focus on **patient engagement, prevention and integration**.

This would require greater collaborative working and the aligning of incentives between local government and health and between primary and secondary care, with a rate of improvement not currently achieved by the system.

### **C. Diabesity- A note on non-hunger eating:**

Dealing with emotional issues and emotional eating/non-hunger eating: This in particular needs to be a priority, alongside psychological assessment and treatment where needed. People do not attend prevention programmes if their motivation/confidence is low or their self-esteem is poor. The best programmes won't deliver unless people attend them!

Add a note on prevention aspects of Rightcare

## Local evidence in Harrow

### A. Diabetes Needs Assessment (2015-16)

From the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies, the two biggest causes of premature death in Harrow are **CVD, cancer and respiratory disease**. According to the report, Harrow has a higher prevalence of the following (in comparison to London as a whole):

- Physically inactive population;
- Childhood obesity (Especially year 6 children)
- Increasing risk drinkers;
- Atrial Fibrillation;
- Hypertensive population; and
- Diabetes

According to the report, Harrow has a lower prevalence of the following (in comparison to London as a whole): Smoking; and Adult Obesity (modelled estimates- not accurate).

- Harrow has among the highest rates of diabetes and intermediate hyperglycaemia in the country and these are rising
  - The major risk factors contributing to the local disease trends are age, ethnicity and overweight/obesity
  - Major investment in controlling overweight/obesity is needed if we are to offset even just the predicted increase in disease burden due to demographic trends
  - There are no local public sector community-based weight management programmes
  - We hear often that primary care teams do not know about the physical activity opportunities in the borough and we do not have a grasp on how many promote physical activity options
- There are geographical, inter-practice variations in the diagnosis of diabetes as well as accessing services.
- Intermediate clinical outcomes and associated process outcomes are broadly in keeping with national outcomes (better than average in some areas), but there is scope for improvement and considerable variation by practice
- Cardiac, renal complications and amputation rates are in keeping with or slightly higher than average, but clear opportunity to prevent
- Minimal local data or services related to mental health or social care appear to be available for those with diabetes

### B. Local best practice

#### 1. Public health:

##### a) Physical Activity

Harrow Physical Activity Strategy 2016-2020 focuses on supporting people who are physical inactive in the borough to do more exercise and reap the health benefits. To implement the strategy, a Physical Activity and Sports Strategy Dashboard has been developed which includes a wide range of actions and corresponding outcomes against the strategy indicators. Public health is proud to have a representation from such a range of partners including, parks user groups, care homes, schools, Harrow Leisure centre. The dashboard also includes some borough wide initiatives such as the launch of the [harrow.gov.uk/get active](http://harrow.gov.uk/get-active) logo and webpage as a main source of information about physical activity opportunities in Harrow and also the planned communications campaign to re enforce

national TV advertising in March to promote 10 minutes walking a day in those people who are currently not doing any exercise. The improvements to outdoors facilities have also shown a coordinated progress to encourage and support inactive people to do exercise.

A group of Harrow organisations including Harrow Council, Harrow Youth Foundation, Voluntary Action Harrow, Watford FC Community Sports and Education Trust are planning to put in a partnership bid to Sport England in the Spring to increase physical activity in the borough – targeted at the areas where people get little exercise. The proposed plan includes a focus on areas in Harrow where there is a concentration of people who do less than 30 minutes moderate activity a week. It is not a coincidence that these areas also have high rates of obesity and Type 2 diabetes as well as social issues such as anti-social behaviour and fear of crime – key barriers to physical activity. Hence the public health priority is to reduce inactivity but through this place based approach we will also seek to bring communities together and collaboratively solve health and social issues in a sustainable way to address the five outcomes.

Gaps: There is a huge amount of work to make physical activity everyone's business in Harrow and support all areas to empower people to do exercise through seeing and feeling the benefits. However public health needs support and championing from all the professionals working with residents – including the GPs, nurses and HCPs in primary care, council services and voluntary sector to have the information at their fingertips and the skills and impetus to promote exercise as normal part of peoples day in their travel, their working and home lives.

## **b) Obesity**

The local evidence shows that two thirds of Harrow adult population are overweight or obese and public health is committed to a system wide approach to reduce the increase in obesity as pledged in the Harrow Obesity Strategy 2014. It has been identified that there is a prominent gap in Harrow obesity pathway for tier 2 and potentially tier 3 weight management support, and this has identified potential opportunity for joint commissioning especially with the transfer of tier 4 services to the CCGs (Clinical Commissioning Groups) in the next financial year (2017/18). Public health hopes to have this joint tiered approach in place in 2017/18 a targeted weight management service for people from vulnerable groups such as those with diabetes, pre diabetes, from ethnic groups with a higher risk of weight issues, and from low incomes areas, but the funding for this service is unlikely to be sustained from Public Health budgets into 2018/19. After feedback from professionals public health is working with the dietetics department in Northwick Park hospital to develop ethnically specific Eat Well resources that will support people working with residents to offer appropriate advice on healthier foods and portion size. Harrow Public Health is working in partnership with Environmental Health to support fast food outlets close to schools to offer healthier foods, lower sugar drinks, and less salt and also supporting schools to reinforce this message.

## **2. Diabetes UK, Harrow: <http://harrow.diabetesukgroup.org/>**

The local group continues to raise awareness of type 1 and type 2 diabetes, organise road shows, meetings, focus groups and educational opportunities for people and their families in a safe, congenial and social environment. They also support the London Diabetes CLG (refer to <http://londonscn.nhs.uk/> and *Understanding diabetes in London*) and the local diabetes strategy group in implementing the action plans.

## **4. Building community capital /Personal budgets & health budgets**

Harrow Council teams (Adult social care, public health, policy) are supporting to build community capital, through technical help with the external funding bids, opening access to a range of small and big voluntary and community sectors in Harrow as providers in a competitive market through the Project infinity. Some service users have cash personal

budgets to access the community and this may involve to support them to attend gyms / with walking / other exercise– particularly where a GP / physiotherapist has recommended this as a preventative measure. This is for all ages.

### **5. Adult social care**

Harrow Adult social care has developed project infinity and co-developing our personalisation tool (MyCommunity ePurse, MCEP\*) within IBM Watson Health's care manager technology. They are exploring the synergies with the health app to enhance health and social care integration. \*MCEP has the capability to list a range of providers both costed and uncosted providers which could include preventative services. Neighbourhood Resource Centres (NRC's) run sessions promoting health living, health eating, running exercise classes etc.

Adult social care promotes wellbeing and where service users are diagnosed with diabetes, their support is organised around their need to eat / have medication at certain times, and care managers work with the carers, and district nurses (where they are involved) to get this right. In terms of our Safeguarding Assurance and Quality Services Team, they have been running diabetes awareness training over the last year for Harrow care homes and Home Care agencies. The course is run by a diabetes specialist nurse. In 2016 we had 250 attendees at the diabetes awareness days we ran. We have two more dates for diabetes awareness on the 15th February and 16th March 2017 for care homes and home care staff and we are expecting around 100 for the two days. They have secured charitable funding from the Jean and Derek King Trust for on-going diabetes awareness training sessions to up-skill care home and home care staff and to maintain a good level of knowledge and skill in this area with an ever changing workforce.

They have included diabetes as part of our monitoring form for all services in Harrow to determine what homes and home care agencies have in place for diabetes care. This includes monitoring of eye and chiropody checks, diabetes policies, blood sugar monitoring and what actions to take when a diabetic is unwell. They also employ a very experienced registered nurse within the SAQS team who brings a wealth of clinical experience and who is instrumental in monitoring the training and who has kindly supplied me with the above information.

### **6. NHS Harrow (Please add a note about what you are doing with reference to prevention)**

#### **Key areas and outstanding actions**

**1. NHS DPP Preparedness:** The NHS Diabetes prevention programme, comprises of assessment of those at high risk of diabetes and referral to a programme that combines physical activity and diet-focussed behavioural modification. There is a need to demonstrate active collaboration with public health, patient charities (Harrow DUK) and support groups- identified risk assessment methodology/tools, mechanisms for lifestyle change, especially for obesity (Tiers 2/3/4 of WM). Well-developed data systems, inter-operability, evaluation and digital maturity mechanisms are required if implemented.

To develop audit standards to assess the quality of current services in identifying patients at high risk of diabetes. To ensure patients identified at increased risk of diabetes at the NHS Health Check receive appropriate assessment and management.

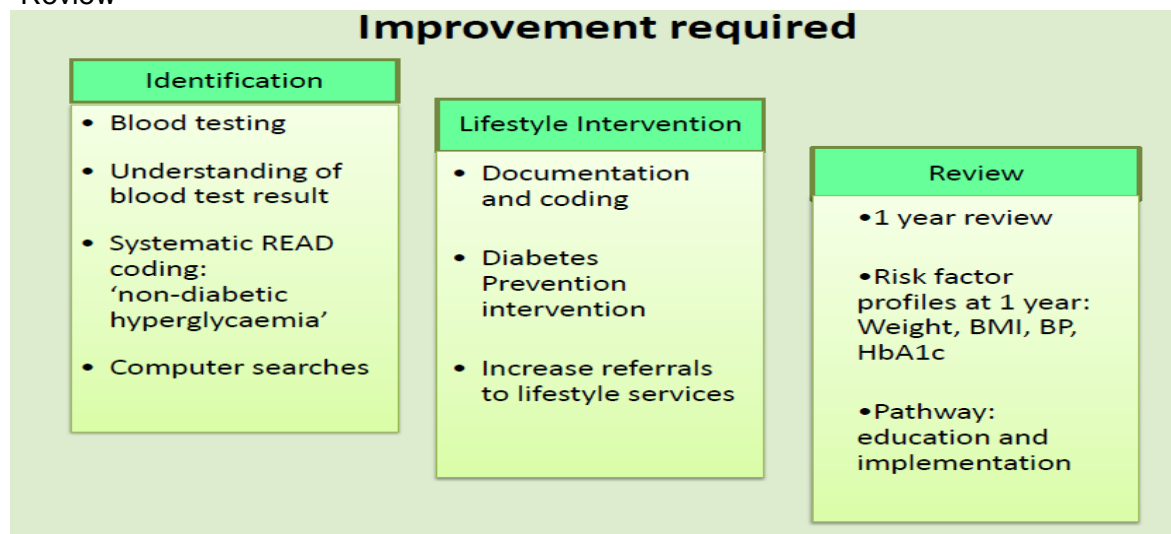
#### **NHS Health Checks Diabetes Filter**

Body Mass Index  $\geq 30$  (or  $\geq 27.5$  if South Asian or Chinese)

Blood Pressure  $\geq 140$  mmHg Systolic and/or  $\geq 90$  mmHg Diastolic

**Create a NHS Health Checks Diabetes Filter Pathway (Bromley Model)**

- Identification of risk
- Provision of intensive lifestyle programme
- Review



#### **Actions:**

- IT/Primary care data systems & pre-diabetes registers in primary care.
- Collaborative work and referral pathway agreed on NHS Health checks.
- A joint PH /NHS tier 1/2/3 weight management pathway, a joint approach on physical activity and active lifestyle- (To be ready for the next wave of the NDPP by September 2017).
- Promoting data quality by 100% NDA participation, appropriate coding of UA, foot checks and BMI,

#### **2. Mental health and diabetes integration:**

Depression & anxiety & CMHDs are quite common in people with type 2 DM but there is very little in terms of support at a tier 1 level; also limited access to IAPT, since they are no disease specific wellbeing groups (Best practice: Diabetes wellbeing groups in Slough/Berkshire); MH offer/training needs to be bespoke, more culture specific, to be able to tackle stigma (PH work in council 16/17).

#### **Actions:**

Tackle stigma and promote awareness, wider participation and motivation in schools, further education centres, colleges and workplaces:

- Early access to emotional and psychological support at workplace, primary care and the community, including schools and further educational institutions- Mental Health awareness and training, Expert Patient Programme (EPP) specific for diabetes. (PH offering these through a time limited external funding).
- Integrated IAPT services (NWL MH Transformation) (Check with Deirdre/Renuka)
- Diabetes specific IAPT (as in Diabetes wellbeing programme- IAPT, Berkshire).

#### **3. Self-care, care planning and PAM:**

Self-care is the cornerstone for diabetes management. Self-care and appropriate education should be offered to families of people with diabetes, carers, all those at high risk and pre-diabetes. Better aligned to the Care Act, NHSE care planning & WSIC/Self-care.

#### **Actions:**

- Clear lifestyle referral routes for people at high risk and pre-diabetes.
- Clear care plans for people with diabetes: rolling out care planning in each GP sx.
- PAM scores for self-care, CMHD, vital signs (UNIVERSAL adoption).
- NHSE/Digital- data inter-operability for better coordinated work.
- Family, friends and carer's input in the person's care plans.
- Consistent training for health & care frontline staff including how to consult for confidence & self-care rather than traditional acute model.

#### **4. Elderly people with diabetes (including care homes, homecare)**

The needs of elderly people with diabetes are quite different. There could be other co-morbidities like HTN, CVD and renal disease, alongside the effects of medication, hydration, could have significant impact on the gait, balance and self-care, with significant impact on the future wellbeing. Issues affecting gait, balance, hydration, including an occasional hypoglycaemia which could lead to falls.

The Department of Health estimates that the number of falls in elderly patients could be reduced by 15 - 30% through the use of successful falls prevention strategies. With the new NICE Falls Quality Standards due to be published in January 2017, it is now essential for health and social care professionals to understand the new guidelines and implement procedures to reduce the number of falls in elderly patients.

##### **Action:**

- The Harrow diabetes strategy groups needs a clear protocol on lifestyle advice, routine management and medicines management for elderly people with diabetes in care homes, homes and home care setting.

#### **5. Clear focus on secondary & tertiary prevention of CVD & Renal complications, avoidance of blindness, foot amputations of diabetes- complex cases with health & social care needs-**

##### **Actions:**

- Identifying the cohort of people with diabetes and multi-morbidities, complex needs and poor control, DNAs at the foot clinics, eye screening, those regularly missing OP/IP appointments (Frequent visitors to the A & E and walk-in).
- Early & prompt detection, appropriate coding and referral to a range of options including structured education, dietetic advice, IAPT; promote self-care, diabetes care plans.
- Close liaison with social care in reducing bed days/bed blocking, home based care, carers strategy and support. Explaining how personal budgets and e- purse could help.
- Focus on 9 key care processes (NWL model-including data collection), focus on foot checks and eye screening- work closely with foot care teams, Diabetes eye screening team to match the data, provide checks at common points.

#### **6. Methodologies/Tools for risk assessment and as core part of a population health management system that an ACP would deliver:**

Across NWL there is a move towards using whole practice screening tools i.e in CWHHE there is a diabetes risk calculator dashboard which runs the Leicester Diabetes Risk

Calculator across the whole practice. I think in Harrow you'd have access to the QDiabetes tool, which could serve as a screening tool on the Whole Systems Integrated Care Dashboard for proactive identification of patients. This would replace many of the primary care boxes.

**Action:**

- End to end solutions for the diabetes pathway, from prevention to complications, NHS Right care, PAM & read codes, QDiabetes software, Leicester/DUK risk assessment tools, psychological measures of confidence/self-efficacy, activation measures etc

## **7. Population level approaches**

Specified focus on Harrow local BAME population, especially culturally specific targeted interventions to target the South Asian population groups, through cultural, faith groups, local inter-faith forums, voluntary and community sectors, carers, MH charities schools, colleges and workplaces. Road shows, an example being successful Diabetes UK and public health road show in 2016 at the Harrow town centre reached out and risk scored around 220 people in two days. Public health continues to reach out to schools, workplaces, Harrow inter-faith groups, carers and other voluntary & community sectors through diabetes awareness talks.

**Actions:**

- Opportunistic risk scoring using DUK/Leicester online/paper based tools without the need for POC testing in workplaces, places of worship, culture, schools and colleges.
- Enhanced and clear focus on care homes and homecare settings.
- NHS health checks commissioners to target practices with higher diabetes prevalence in areas of need and also the right population groups.
- Close collaboration with community pharmacy- on risk scoring, awareness and early detection POC testing. Pharmacy assistants & specialists (including compulsory medication reviews and specialist reviews on diabetes)
- DSNs and dietitians support community volunteers, patient champions, care navigators, peer educators and faith leaders, work with 0-19 team (HVs and school nurses), PNs and district matrons.
- Some of the community DSNs, dietitians not to have caseloads but promote diabetes education, support GPs, nurses, HCPs, community; share this work with the acute care DSNs, who would spend 1 day in the community
- People with strong family history, at high risk-offered risk scoring and blood tests. Those with pre-diabetes registered and offered lifestyle interventions, at the earliest opportunity. Improve opportunistic diabetes awareness and risk scoring events in the community and workplace.

## **8. Technology, Digital /Web/App based approach diabetes prevention:**

Children and young people in schools, places of further education, especially students and new entrants into University and young working adults are very receptive to technology. We need to offer a range of options including skype, apps, emails, texting and other web/online platforms. There's also some funding that's gone into the NWL STP business case around

digital prevention – this is assuming a successful initial pilot of a digital solution in CWHHE and one or two other areas nationally with a potential for return on investment within 3-4 years (i.e. within the STP timeline). The idea would be to upscale rapidly to around 10,000 interventions per year across NWL, including Harrow.

Prof Jonathan Valabhji, National Clinical Director for diabetes and obesity recently envisaged his vision for the digital diabetes prevention.

1. Digital diabetes prevention- how the type 2 DM is affecting younger onset BAME population group and how we need to think about suitable prevention strategies.
2. Tailored offer to younger people on insulin or type 1 DM (through their life-course)– including information on transition.
3. Digital/online structured education.

#### **Actions:**

- Offer of technology, digital solutions, including skype consultations, texts, emails and apps on diabetes prevention and management to an appropriate audience
- Adoption of local best practice Ex: Infinity/ePurse (Personal budgets and personal health budgets).

#### **Other Harrow focussed actions**

Action 1: Community outreach education, supported by the DSNs/dietitians through community connectors or navigators or champions who can train and support people around cultural context. This can also work as prevention in that those at high risk ie pre-diabetes are supported with lifestyle changes. (Needs to start)

Action 2: Encouraging provision of greater physical activity, creating health champions (including GP champions), walk leader training, especially looking for those community members who will lead walking or other groups, like yoga/mindfulness or MH awareness sessions at weekend. This will target the critical age group of 25 to 65 year olds who are working. (Started, needs closer collaboration with primary care)

Action 3: After feedback from professionals public health is working with our dietetics department to develop ethnically specific Eat Well resources that will support people working with residents to offer appropriate advice on healthier foods and portion size. (on-going)

Harrow Public Health is working in partnership with Environmental Health to support fast food outlets close to schools to offer healthier foods, lower sugar drinks, and less salt and also supporting schools to reinforce this message. (on-going)

#### **Conclusion:**

Diabetes prevention needs to be a joint collaboration in Harrow with Health, social care, LA and public health, third sector working closely with the Diabetes UK and the patient groups and the carers. In view of the ever diminishing public sector resources, we need to rely on creativity, innovation, pooled budgets, technology, digital solutions, adopting methodologies like Rightcare, following good practice from NICE, NHS DPP, digital diabetes pilots and good practice across the NWL and Pan-London level. We need to look at system level change



through service transformation; ACPs, TCPs and outcome based commissioning approaches. A joint collaboration and commissioning plans need to be agreed at a HWBB level in delivering lifestyle interventions (physical activity, weight management, stop smoking, alcohol, substance misuse services, mental health & EPP), complex cases with health & social care challenges, licensing and legislation on fast food outlets, oral health, housing, regeneration and health, workplace health, MH, employment & wellbeing.

# STP Business Case

<i>Project name</i>	<b>NWL DIABETES TRANSFORMATION PROGRAMME</b>
<i>Unique reference</i>	NWL D /1216
<i>Clinical lead</i>	Dr Tony Willis
<i>Implementation lead</i>	Lesley Roberts

<i>Date approved</i>	
<i>Signature</i>	
<i>Name</i>	
<i>Role</i>	

*Counter signature (if applicable under detailed scheme of delegation)*

<i>Date</i>	
<i>Signature</i>	
<i>Name</i>	
<i>Role</i>	

## Document Information

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<i>Version</i>	<i>Release date</i>	<i>Description of changes</i>
v.0.1	23 <sup>rd</sup> Dec 16	Outline business case for NWL Diabetes Transformation Programme
V0.3		Sent to Dr Tony Willis
V0.4	24 Dec 16	Updated, tidied up and saved to one drive by Tony Willis
V0.5	29 Dec 16	Updated with some email comments and circulated for final comments by Lesley Roberts
V 0.6	05 Jan 17	Updated by Jess Simpson
V 0.7	06 Jan 17	Updated by Lesley Roberts
V0.9		Suggested updates by Emily Horn
V0.12	29 Jan 17	Updates by Tony Willis
V0.13	30 Jan 17	Updates by Jess Simpson
V0.14	30 Jan 17	Suggested updates by Emily Horn
V0.15	30 Jan 17	Updates by Tony Willis
V0.16	31 Jan 17	Hounslow and prevention figures updated by Emily Horn
V0.17	1 Feb 17	Updates by Tony Willis

## Revision History

<i>Version</i>	<i>Date</i>	<i>Reviewer name</i>	<i>Role</i>

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## Strategic Objectives and Drivers for Change

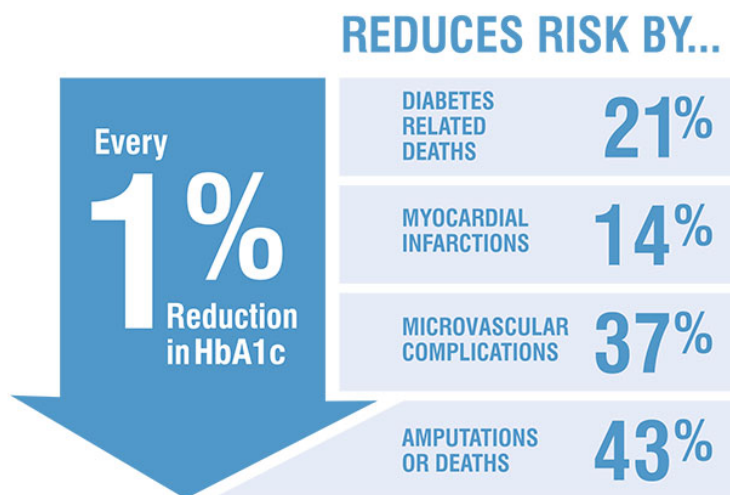
Outline the strategic objectives and the drivers for change.

### Strategic Objectives for diabetes transformation across NWL STP

Diabetes is a leading cause of mortality and morbidity. Data for North West London demonstrate the scale of the problem:

- Approximately 1,000 premature deaths annually
- 6.8% (134,200) of the population
- ~ 30,000 as yet undiagnosed
- 191,906 (nearly 20%) predicted prevalence of non-diabetic hyperglycaemia (NDH)
- Diabetes prevalence expected to rise to around 10% by 2022
- At least £350m (around 10% of health spend) on diabetes care with an additional as yet unquantified amount in lost productivity and social care costs
- 80% of costs are related to treating diabetes complications
- 29.4% of emergency admissions
- 28.3% of bed days for diabetes complications
- 25,000 people living with poorly controlled diabetes (HbA1c > 64), 55% of these under the age of 60
- Survival rates post-amputation are worse than for cancer

Effective diabetes care through reduction in HbA1c (a measure of average blood glucose levels) reduces complication rates significantly, increases survival and reduces costs (UKPDS study).



Economic modelling (IMPACT 2) suggests that similar achievable improvements in HbA1c alone would lead to around £10m cost savings at 5 years from avoided complications, approximately 2 years mean increase in life expectancy and 30,000 avoided complications at 25 years.

Other intervention and population health studies looking at multifactorial risk reduction have demonstrated further additive benefits through achievement of the 3 NICE treatment targets

(HbA1c, blood pressure and cholesterol). These have demonstrated significantly greater impact on cardiovascular mortality and morbidity at 5-7 years:

- 75% reduction in coronary heart disease (equivalent to 2806 fewer patients per year in NWL)
- 56-63% reduction in mortality

Both nationally and locally, there is huge unwarranted variability in both the measurement and the achievement of key care processes and targets across all settings of care as demonstrated by the data below showing variability between different GP practices in North West London:

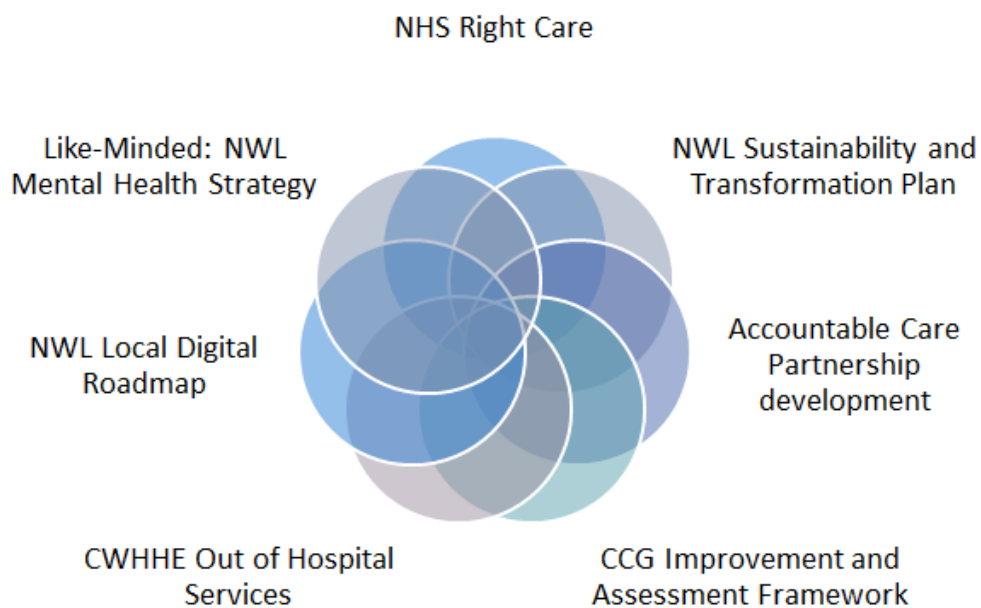
List size	Diabetes register	% Diabetes prevalence	% 9 key care processes in 15m	% HbA1c, BP, Lipids to target	% HbA1c ≤ 58	% BP ≤ 140/80	% Chol ≤ 4
2227	234	10.5	45.3	27.4	53.0	70.1	60.7
1587	96	6.0	68.8	24.0	64.6	58.3	45.8
2476	188	7.6	61.2	23.9	57.4	77.7	40.4
4802	234	4.9	73.1	23.1	62.8	65.4	49.1
2385	97	4.1	54.6	22.7	60.8	72.2	42.3
5077	413	8.1	61.0	21.8	59.6	70.2	46.0
3546	273	7.7	43.2	21.6	59.3	70.7	40.7
2841	285	10.0	61.8	21.1	54.4	83.2	37.5
9727	489	5.0	49.1	20.2	62.0	71.6	39.3
2452	117	4.8	60.7	18.8	45.3	69.2	54.7
2873	277	9.6	54.5	18.1	59.6	67.5	35.4
10045	504	5.0	54.0	17.7	58.5	60.1	38.5
3980	244	6.1	37.3	17.2	52.0	66.4	34.8
4428	296	6.7	43.2	15.2	54.1	52.7	40.2
5159	198	3.8	19.7	11.6	50.0	59.1	31.3

As a result of similar huge unwarranted variation nationally, diabetes has become one of only 6 NHS England national clinical priority areas, and is now included on the CCG Improvement and Assessment Framework. There is a clear drive to:

- Maximise National Diabetes Audit (NDA) participation
- Maximise diabetes prevention through the national diabetes prevention programme (NDPP)
- Tackle unwarranted variation in achievement of the NICE recommended treatment targets for blood pressure, HbA1c and cholesterol in order to reduce the burden of unnecessary complications – our aim is to increase the percentage of patients achieving these targets from 40.2% currently to 62% (95th centile nationally) by 2021
- Improve structured education uptake in order to improve self-care
- Reduce amputation rates through improvements in foot care pathways
- Improve in-patient care and reduce length of stay in acute hospitals through increased provision of diabetes specialist nurses

Diabetes is both a national priority and a local priority outlined within the NWL STP, particularly within Delivery Area 2: Eliminating unwarranted variation and improving Long

Term Condition (LTC) management, and also fits in with a number of other local and national priorities:



Diabetes is one of only two clinical pathways (along with cardiovascular disease) chosen for early transformation within the STP, but in doing so we expect the transformation process to have a catalytic effect on care delivery in North West London and be a blueprint for transformation of other long term condition management and care.

In brief, this transformation encompasses an at-scale, proactive, coordinated, integrated, outcomes-based approach, pioneering digital technology and innovative approaches to self-management and supported self-care, fleshing out a model for long term conditions management in line with the strategy laid out for Delivery Area 2 of the STP.

- **DA2: Eliminating unwarranted variation and improving LTC management**

- **DA2a: Delivering the Strategic Commissioning Framework and Five Year Forward View for Primary Care**

- Using diabetes as a catalyst, we intend to work with GP federations and localities in the development of key components of the model in 2017 with a view to commissioning a new model in 2018:

- Care at scale through development of digitally enabled proactive care management teams working across a population, maximising clinical system functionality and further developing the population-based integrated care record
    - Virtual multidisciplinary team working including mental health and specialist input, care coordinators, health coaches and case managers
    - Segmentation based on key parameters such as health needs, mental health issues, frailty, patient engagement and disease control in order to tailor care and support appropriately

**DA2c: Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions**

There will be close partnership with the NWL Like Minded team to embed mental health and wellbeing support within the diabetes pathway, including learning from the Diabetes Wellbeing Pilot in Hillingdon and the Diabetes Psychological Medicine Service (DPMS) in Hammersmith and Fulham.

- **Case study:** The DPMS was commissioned to address the needs of diabetes patients at the more severe end of the mental health spectrum (including stable psychosis and personality disorder) and showed substantial improvements in HbA1c (average 22mmol/mol reduction at 12-18 months) and reduction in service utilisation resulting in cost savings of £1980 per patient.

The North West London diabetes transformation programme will ensure that mental health support is an integral part of care delivery for both adults and children and young people as it impacts significantly on various outcomes including achievement of NICE targets, development of foot complications, risk of acute admission and length of stay.

The costs and savings associated with providing psychological therapies for people with diabetes are captured in the DA2c business case- the outcomes however are analogous to those described in this business case.

**DA2d: Reducing variation by focussing on Right Care priority areas**

Diabetes is a top focus area for Right Care across NWL, and the transformation principles, structures, commissioning framework and informatics requirements are readily transferrable across multiple long term conditions including cardiovascular disease (hypertension, AF, CHD, heart failure), respiratory (COPD and asthma) and renal allowing a rapid extension of this work to the much broader population with one or more LTCs with relatively less resource and project management requirement. The understanding of diabetes as a priority focus has allowed for initial commitment of a Programme Director leading this work from 24<sup>th</sup> November – until end March 2017.

Across North West London, a significant amount of work has already been initiated to begin to address unwarranted variation in diabetes, for example through the CWHHE Out of Hospital Services, however more needs to be done and with a particular focus on hard to reach cohorts.

**DA2e: Improve self-management and patient activation**

Work has begun in partnership with digitalhealth.London and Imperial College Health Partners (the NWL Academic Health Science Network) to identify and then pilot a selection of self-management and supported self-care apps including approaches such as eLearning courses, use of wearable technology, telephone coaching and behaviour change techniques. These, along with more widely available apps will be assessed in conjunction with Patient Activation Measure assessment in order to help understand appropriateness of different self-care approaches.

Care planning was established initially through the North West London Integrated Care Pilot (ICP) and this learning has been built upon since, with a year of care approach now adopted in the majority of CCGs and care planning now an integral part of the CWHHE Out of Hospital diabetes contract.



### **Long Term Conditions Prevention**

We aim to use diabetes prevention as a paradigm for LTC case finding, digital intervention and lifestyle change approaches. The CWHHE CCG collaborative is one of the most successful delivery sites nationally for the National Diabetes Prevention Programme (NDPP) with around 2500 patients already having accepted initial assessment, and has now been selected as one of only a few national diabetes digital programme sites for piloting digital prevention approaches. We will be sharing our learning from the NDPP and digital diabetes prevention with the BHH CCGs which were not part of the wave 2 NDPP sites, supporting them to take on the next wave of NDPP and digital diabetes bids.

- **DA3: Achieving better outcomes and experiences for older people**

Includes the implementation of accountable care partnerships, improvements in rapid response and intermediate care services and improvements in care in the last phase of life. Whilst the implementation of accountable care partnerships based on outcomes based contracts is clearly a priority for elderly care, the accountable care model is also highly relevant to diabetes and other long term conditions, and we are keen to explore this approach for commissioning an integrated diabetes care system across North West London.

- **DA4: Improving outcomes for children and adults with mental health needs**

We will be working closely with the NWL mental health strategy team to ensure that diabetes prevention and care specifically targets and reaches those with SMI (DA4a) and learning disability (DA4b).

- **DA5: Ensuring we have safe, high quality sustainable acute services**

Improvements in transitional care are essential if we are to ensure continued lifelong engagement with services and improvements in targets across the life course.

A 2015 South East Coast and London wide survey found:

- Teenagers comprise 30% of secondary care clinics
- Teenagers have higher HbA1c
- Multiple models exist, and most involve co-location/co-working with adults and paediatrics
- Teams struggle with:
  - Overcoming the traditional adult/paediatric divide
  - Lack of resources
  - Lack of teenage-focused training courses/resources

### **Digital Enabler**

Transforming diabetes care is both dependent on digital transformation within North West London, but also because of the availability of key measurables, acts as a powerful catalyst to digital transformation along the entire pathway. There are a number of key digital capabilities needed, which are being worked on:

- 1) **A shared record viewable to all clinicians involved in diabetes care.**

Within North West London, the CCGs have been working with GPs and community providers to consolidate on two shared records: SystmOne (CWHHE CCGs and some of our community providers) and EMISweb (BHH CCGs and one of the other community providers). In the acute trusts, Imperial College Healthcare NHS Trust

(ICHT) and Chelsea and Westminster trusts are now sharing a common Cerner Millennium EPR, with other PAS systems used in London North West and Hillingdon trusts.

Work is already underway to integrate these systems via the North West London Care Information Exchange and the North West London diagnostics cloud – this will be significantly enhanced with the arrival in 2017 of GP Connect and FHIR interoperability standards allowing real-time viewing of GP records in other systems.

Furthermore, NWS NW London has recently been awarded (Estates and Technology Transformation Funding (ETTF) to develop interoperable care planning standards in conjunction with NHS Digital. This builds on extensive work done over the last few years in conjunction with lay members and other patient groups to define the core components of a care plan.

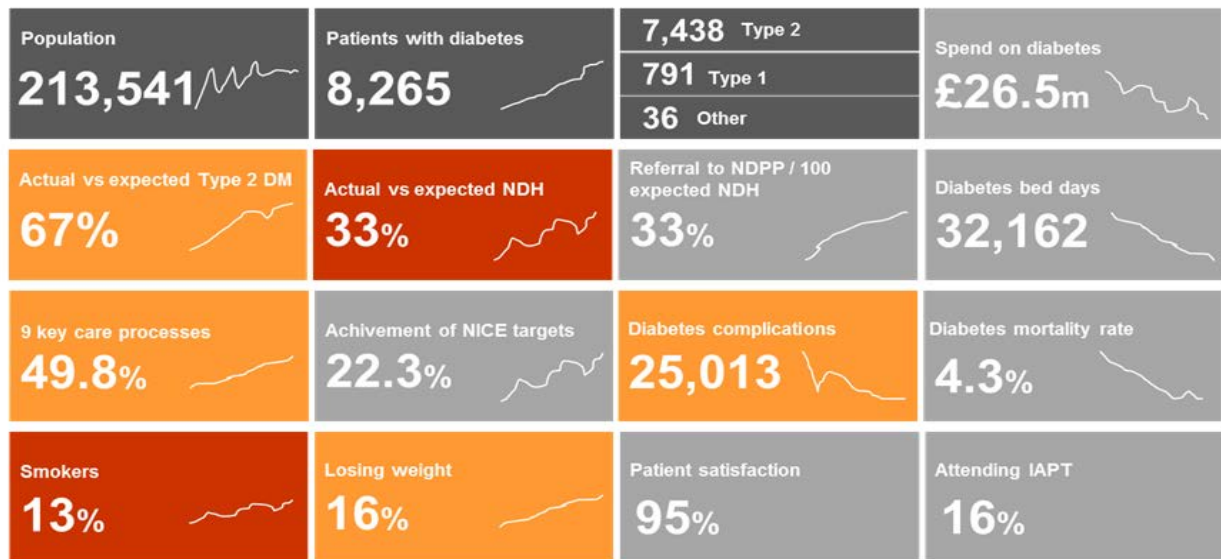
Within CCGs, we are already using common shared records (SystemOne and EMIS) across GP Federations where patients are being seen in other GP practices or by community specialists for insulin initiation or other input, and we will be working closely with clinicians to ensure consistency in coding for key diabetes parameters in clinical templates across the different systems.

2) **Population health and analytics.** There are some key informatics requirements for effective management of diabetes patients across the system using linked primary, community, acute and social care datasets as well as public health intelligence. The benefits of this include:

- Comparing of actual vs estimated disease prevalence
- Identification of at risk groups of patients using prediction tools such as the Leicester Diabetes Risk Tool run across a target population
- Disease management – comparison across providers (including GP practices) in order to understand where variability exists and what may be the cause
- Per patient costing across a population or pathway
- Proactive care management – identification and safety netting of people with out of range results, those who may have been lost to follow up or those not actively engaging in care. This would allow focussed targeting of highest risk patients e.g. those with HbA1c > 75 and end-organ damage or recently diagnosed patients with HbA1c > 48.
- Trend analysis – to understand whether care and outcomes are improving
- Predictive / actuarial modelling – for diabetes this would include an analysis of the cost and outcome implications if treatment was improved e.g. if all providers improved to the 95% centile for NICE treatment targets
- Intelligence gathering – understanding over time the real implications of differences in achievement of treatment targets within the population (the Scottish and Swedish Diabetes Registries are prime example of this)
- Support for further development of population health capability was included in the successful joint ICHT and Chelsea and Westminster Global Digital Exemplar bid
- We are already working with the NWL Informatics team on the development of population health dashboards within the innovative Whole Systems Integrated Care system to allow integrated outcomes based commissioning. A concept view of this is shown below:



Select a practice and metric to view breakdown by patient cohorts



### 3) Patient facing records. The aspiration is for the patient to be able to achieve the following:

- View their own GP clinical record (Patient Online)
- View their diabetes record in context using the latest data from multiple systems where needed (*Care Information Exchange*)
- Interact with the wider care team digitally (including care navigators and health coaches)
- Access information about their own condition (including diabetes), ideally in their own language and with culturally appropriate changes
- Upload glucometer data where needed
- Use apps to help manage their health and wellbeing including integration with activity trackers and smart scales.
- View and interact with eLearning information, such as educational video courses

Much of this we are already on track to pilot within 2017/8

**Where are we now?** There is currently considerable variation in outcomes between CCGs and indeed in individual practices – our aim with this programme is to standardise systems and processes and support GP practices to all achieve what the best local practices are achieving and for the best practices to achieve better than the best GP practice in England.

**What do we want to change?** At our NWL Diabetes Stakeholders workshop on Thursday 24<sup>th</sup> November 2016, there was a strong push, supported by formal post-workshop evaluation, for a NWL Diabetes Transformation Programme. Currently (within CWHHE) we have already made great progress through our Clinical Lead (0.3 WTE) and now our newly appointed Programme Director for Diabetes. We now aim to extend these roles to include Brent, Harrow and Hillingdon CCGs (BHH).

**How do we plan to do this?:** We aim to have all 8 CCGs working to the same systems, processes, workforce deliverables, commissioning guidance and contracts, and ultimately vastly improve our diabetes clinical outcomes. This will include case management of those most in need, flexible specialist diabetes clinician support, high quality integrated specialist diabetes hubs seeing patients where the competencies are not available in the practice and the right incentives to make this embedded and sustainable.

The time is now right to harness this work for diabetes (and then other LTCs) with a common over-arching NWL Diabetes Transformation Programme to be more resource efficient, reduce duplication, and have a common strategy across NWL for diabetes, resulting in a reduction in the cost and burden of diabetes complications (around 80% of diabetes spend) and improvement in patient experience.

The NWL Diabetes Transformation Programme will include a review of current service provision and a re-design of an end to end pathway across primary, community and acute diabetes care.

This will support NHS Right Care, improve CCG IAF diabetes outcomes, build on the OOH service and embed NWL MH Strategy in order to improve quality of care provision and reduce complications for people with diabetes. We are embedded in the NWL local digital roadmap, with our diabetes clinical lead being a key driver for this.

We expect that diabetes will be an exemplar for integrated outcomes-based commissioning - diabetes has frequently been chosen world-wide as the first step to embedding ACPs in health economies.

We know that incentives and support through a programme approach work internationally, nationally and locally: we have increased the numbers of patients achieving target HbA1c of  $\leq 58$  mmol/mol by 4.8% since August 2015 with the largest single improvement in GP network achievement of 15.5% - our aim now is to do this at scale across the 8 CCGs of NW London.

## Proposed change (business option / solution)

Outline what the proposed project would deliver i.e. what would be done to fix the problem and deliver the change.

### Proposed change - NWL DIABETES TRANSFORMATION PROGRAMME

To begin to address these issues, a NWL Diabetes Stakeholders Workshop took place on 24<sup>th</sup> November 2016. In attendance were around 100 clinical, managerial and commissioning representatives from all 8 CCGs, consultants, patients, Diabetes UK, NHSE, Public Health and medicines management.

The event was highly successful with a clear mandate that all 8 CCGs wanted us to develop a NWL wide level Diabetes Strategy Group with a common project and clinical team to drive forward and implement the NWL Diabetes Programme Plan and Strategy (in development).

#### FEEDBACK FROM NWL DIABETES STAKEHOLDERS WORKSHOP (24.11.2016)

- 1 *Greater focus on IT integration to allow for data sharing, analytics etc.*
- 2 *Reduce variability across primary care and build a primary care plan to increase more appropriate interventions*
- 3 *Better training for staff across healthcare – up-skill practice nurses, GPs, care home staff, pharmacists, etc.*
- 4 *Investment in identification and intervention in people with non-diabetic hyperglycaemia (NDH).*
- 5 *Reduce the number of admissions to secondary care and patients in secondary care*
- 6 *Greater collaboration between sectors to involve social prescribing, third sector, etc as core members of the multi-disciplinary team.*
- 7 *Identify individualised treatment targets*
- 8 *Involve patients to keep them engaged in their healthcare*
- 9 *Early education for patients and use of expert patients*

To achieve optimum diabetes outcomes, save patients from diabetes complications, and reduce health economy cost (diabetes complications in NWL STP cost around £270m) we have begun this work with the support of the CWHHE Diabetes Clinical Lead (0.3 WTE) and newly appointed at Programme Director (0.4WTE) until 31<sup>st</sup> March 2017.

These resources are limited and will need to be added to in order to deliver this programme across 8 CCGs to cover the whole of NWL STP. This offers great economies of scale and savings to reinvest in preventing complications – so becomes sustainable.

Investing in diabetes transformation has achieved some results so far:

- Across the UK, the highest National Diabetes Audit achievers and those with highest CCG Improvement and Assessment Framework ratings have engaged in significant diabetes transformation programmes
- North West London:
  - Primary care workforce development (PITStop, MERIT and TOPICAL training courses)

- Significant increase in NDA participation with some CCGs at 100% participation
- CWHHE: Outcomes-based primary care contracts (Out of Hospital Services) have achieved some significant improvements:
  - % of patients receiving all 9 key care processes from 29% to 47%, with some practices now achieving rates in excess of 70%
  - 4.8% increase in patients achieving NICE recommended HbA1c target
  - 52% increase in patients receiving collaboratively developed care plans
  - Over 50,000 on Non-diabetic hyperglycaemia (NDH) register and successful roll out of National Diabetes Prevention Programme
  - Comprehensive clinical guidelines linked from SystmOne
- Brent:
  - Integrated diabetes team using MDTs, virtual clinics and GP-based clinics
  - Local clinical guidelines
  - Successful structured education programme with highest attendance rates in NWL
- Hillingdon:
  - Outcomes-based primary care contracts has improved NDA participation, enabled early identification of NDH patients and shifted the setting of care for newly diagnosed patients
  - Local clinical guidelines
  - Integrated diabetes team using MDTs, virtual clinics and GP-based clinics
  - Specific foot clinics and single point of access with clinical advice helpline
- Harrow:
  - Significant local engagement in 2016, including a stakeholder event with over 50 people representing 15 organisations
  - Map of Medicine accessed via single sign on with EMIS, implemented across all GP practices in Harrow, with over 500 practice users set up. Access to over 250 clinical pathways, including several on diabetes
  - Audits of unplanned admissions in diabetes patients and of NDH

However, this work has been relatively unsupported and piecemeal. We aim to learn from our strengths together and share best practice across the whole STP footprint.

#### Next steps:

Continue to drive the NWL group on the ultimate goal of re-designing the pathway end to end; from prevention to inpatient care

- Focus this work on the 4 identified national priorities plus a focus on diabetes in the integrated IAPT work across NWL:
  1. *Improvements in foot care*
  2. *Improve the uptake of structured education (this will include prevention and NDPP for patients at high risk of diabetes)*
  3. *Improve performance against the 3 NICE treatment targets (building on existing work done on OOHS contracts)*
  4. *Improvement in inpatient care*

The ambition would be to re-procure services across the whole pathway according to priorities listed above using an integrated outcomes-based commissioning model.

## **Learning from National and International Models – some examples of integrated outcomes based commissioning**

### **1) Camden, London**

#### Description

- Integrated Practice Unit that covers Camden CCG with single budget for GP federation, community and acute providers – 6 provider units, one team
- Staff education including sharing/discussion of results per practice
- Virtual clinics, practice improvement plans
- Care planning

#### Innovations

- Diabetes Foundation Course for primary care clinicians to increase knowledge and skills
- “Practices of Excellence” in each locality
- Coaching and facilitation clinics throughout general practice
- Single point of referral for all diabetes services
- Consultant-led multi-disciplinary intermediate care team (Tier 3)
- Uptake of structured education - Bengali diabetes patient education
- Multi-disciplinary team in patients’ homes

#### Impact

- Increase in case finding and new diagnosis of Type 2 DM
- Increase in numbers of patients receiving all 9 care processes
- Increase in numbers with controlled HbA1c and blood pressure
- Increase in numbers attending structured education in Camden.
- Decrease in number of emergency admissions due to diabetes
- Decrease in number of people developing diabetes complications

### **2) Rio Grande Valley, USA**

#### Description

- Accountable Care Organisation that covers 8,500 65+ patient population spread across 18 doctors and 20 mid-level providers
- Proactive management strategy for patients with an HbA1c > 64mmol/mol with a target to reach 80%
- Initiatives aim to support patients to understand their disease, undergo lifestyle changes, and systematically employ diabetes management approaches

#### Innovations

- Daily calls from care coordinators for patients with uncontrolled diabetes
- Larger practices have a once a week “uncontrolled diabetes mellitus clinic” for patient with HbA1c > 64mmol/mol
- Nutritionist available before or after appointment
- Mobile phone program to ensure patients can contact their care team
- Central Diabetes Education Centre that provides additional support to practices and their patients.
- Two-sided risk model – Gain sharing – providers share in savings dependent on quality outcomes
- Uses an “All-or-Nothing” method of scoring: If a patient fails to be compliant with one quality measure, the ACO is deemed to have failed in all five measures for that patient

## Impact

- Acute admissions down 12% in first year of ACO formation
- Showed improvement above the national average in 32 of 33 quality measures coming in \$20 million below its Medicare baseline and receiving reimbursements totalling over \$11 million while also achieving better health outcomes for its patient population.

### 3) North West London

We have a number of examples of practices and small networks of GPs where diabetes care has been transformed over a period of 6 months through intensive focus, active case management and multi-disciplinary working, resulting in huge improvements in percentage of patients achieving key targets. There are also a number of examples of mentoring programmes and other lifestyle change programme achieving significant impact on weight and other lifestyle change.

## KEY ACTIONS WITHIN THE NWL DIABETES TRANSFORMATION PROGRAMME

### **PROGRAMME**

- Develop a NWL Diabetes Transformation Programme – with appropriate clinical, managerial and administrative support.
- Work across all 8 CCGS to develop NWL Diabetes Strategy Group - this will include representation from CCG diabetes clinical and commissioning leads, acute and community provider clinicians, medicines management, public health, Diabetes UK, NHSE and people with diabetes.
- Links will also be made with the local councils to ensure any strategic overlaps are noted and explored, particularly regarding lifestyle change / structured education courses for people at risk of cardiovascular issues including diabetes

Develop common projects within the programme projects with supporting work streams – see structure at appendix 1

### **OVERVIEW**

The NWL Diabetes Service will include primary care, secondary care and community care to support the delivery of population improvements in diabetes detection and control as well as leading the education and training of patients, carers and healthcare professionals including social care, in this area.

#### **Increase detection and diagnosis of diabetes**

- Utilise practice systems / dashboards across all providers to case find people at risk of developing diabetes and invite for screening
- Partnership with public health and local authorities: improve targeted and



opportunistic detection of diabetes in primary care and the community

- Work with diabetes champions and existing community groups to raise diabetes awareness particularly in high risk and BME groups.

#### **Diabetes prevention:**

- Develop and maintain registers of patients with Non-Diabetic Hyperglycaemia and/or previous gestational diabetes
- Maximise uptake of National Diabetes Prevention Programme locally (CWHHE as Wave 1, BHH likely Wave 3)
- Pilot digital diabetes prevention solutions in conjunction with NHSE and Public Health England
- Assuming successful local piloting of digital prevention expand local implementation beyond national targets to offer digital intervention to at least 100% of eligible population by 2021 with potential for 10% uptake (10,000 people) per year

#### **Effectively manage patients with diabetes in primary, secondary and community care:**

- Provide a service for patients with diabetes to support improvements in diabetes related health outcomes, reducing the burden of complications
- Provide an integrated NWL diabetes service based on best evidence for patients with 'challenging' management problems requiring MDT input.
- Ensure that all patients have a personalised HbA1c target appropriate to their condition (higher threshold for elderly/frail/patients with significant comorbidity) with regular monitoring to detect deterioration from that target.
- Work in partnership with patients with diabetes to support self-management, including emotional health and greater awareness and support for those with depression (which is currently under detected).
- Meaningful care planning consultations, based on agreement of self-management goals, action plans and clarity around how the plan will be followed up and formal education sessions where appropriate
- Patient access to their electronic records.
- Maximise use of patient activation measure (PAM) scoring among people with diabetes in order to stratify and tailor self-care and supported care options. We have already obtained 43,920 PAM Licences to use across NWL in 2016/7, increasing to 428,700 by the end of 2020/21

#### **Workforce skills mapping, training and development of:**

##### **Primary care**

- Facilitate better management of diabetes in primary care by supporting GP practices with mentorship, education and skills training.
- Work with clinical leads to promote best practice management of diabetes to prevent complications from these conditions, including greater awareness of co-morbidity with mental health needs.
- Undertake a skills audit and education needs assessment for primary care.

##### **Community care**

- Support Community Matrons and District Nursing services in providing case management to patients with diabetes who are at high risk of unplanned hospital admission and facilitate timely discharge from hospital.

- Support better integration between community teams, hospital teams and primary care, ensuring IT systems are in place to enable this
- Provide advice and support to social services / residential and nursing homes.

### **Secondary care**

- In secondary care ensure staff skills are developed within all settings to ensure patients with diabetes receive high quality evidence based care, including psychological support.
- These skills need to also ensure appropriate support is available to children and people transitioning to adult services
- Ensure all staff working in secondary care (inpatients and outpatients) are able to manage patients with diabetes effectively and meet their needs; for example DAFNE training for those who manage Type 1 patients.

### **Provide structured education for people with diabetes**

- Empower patients and carers to enable self-management through on-going provision of structured education, and support health and emotional wellbeing and behaviour modification

### **Effectively utilise practice system data to case find and monitor quality of care**

- Facilitate extraction and presentation of information on quality of care that can be regularly reviewed and used to monitor progress in improving diabetes care and identifying barriers to progress
- Implement with practices and providers targeted locality-based screening of people to identify unidentified cases of diabetes and those who may also have mental health needs.
- Continually seek to improve the diabetes service by evaluating, auditing and monitoring the delivery of the Service, including quality outcomes.
- Work to reduce unwarranted variation in performance and clinical indicators of care between highest-scoring and lowest-scoring practices in diabetes key performance indicators particularly the three NICE treatment targets as well as type, rates and quality of referrals by targeting and supporting poorer performing practices.
- Work with diabetes networks / federations to ensure all practices are working together to reach the same high level of quality care.

### **Support commissioners in planning services for people with diabetes**

- Carry out continuous review of and pathways leading to recommendations for commissioners on additional services/improvements in pathways based on evidence and patient feedback and experience. We would expect evidence based changes in practice to be rolled out and implemented early, driven by the NWL diabetes transformation team.
- Work clinically across the health system to support best practice in primary, community and specialist settings for people with diabetes including people in nursing and residential care
- An important element of this work will be continuous evaluation and audit, ensuring any development of best practice is shared with the national programmes
- Promote awareness of integrated care pathways (including mental health) and act as liaison between primary, secondary and community care services for people with diabetes
- Develop the clinical aspects of the diabetes integrated outcomes-based

commissioning model

- Support greater joint working between commissioners planning services for people with diabetes and mental health commissioners.

## **PROJECT 1 – DIABETES CLINICAL TRANSFORMATION**

- Work streams: proactive care management and monitoring - case management and care management for patients not at target
- Investment in treatment and prevention of non-diabetic hyperglycaemia – we have begun this with our NDPP work and have applied to pilot the digital NDPP offering in CWHHE, this will be further developed in BHH including a register for NDH
- Where variations in outcomes are mapped, work will be done to ensure that CCGs, networks and practices are supported to move to the best achieved baseline
- Single Point of Access for clinicians where there is not one in place already.
- Improve outcomes for women with type 1 and type 2 diabetes of childbearing age and gestational diabetes
- Reduce the number of avoidable admissions to secondary care and patients in secondary care out-patient clinics, continue to move patients to the appropriate tier of care\* and support greater self-care. ( Diabetes Guide for London)

### **More systematic self-care and mental health input**

- Digital self-care support provision of digital tools to those that can self-care (including online therapies developed for people with diabetes).
- Encourage take up of free resources and apps e.g. the free [www.diabetes.co.uk](http://www.diabetes.co.uk) Low Carb Programme (*which shows a 9cm waist reduction, 10kg weight loss, 20% reducing or stopping medication*), MyFitnessPal, Google Fit, Apple health, etc.
- The Harrow 'Health Help Now' app is being rolled out across most of the rest of NWL. Increasing functionality, including recording of individual health stats will be explored.
- Psychological support – partly through the community health workers at a basic level but increasing referral into IAPT (as per ambitions of the Mental Health Five Year Forward View) if/when needed i.e. mental health as a key component of care rather than as an added afterthought. IAPT workers integrated into diabetes teams as part of integrated IAPT service development work, providing disease specific support.
- Enhanced training in psychological support for patients including those with more severe mental health problems including personality disorder and stable psychotic illness
- Work to ensure the Patient Activation Measure supports case finding of depression and anxiety Maximise prevention and lifestyle change opportunities
- Identify individualised treatment targets and ensure patient is “aware of their numbers” through care planning (*36,123 patients already have collaboratively developed care plans – we want these to be electronically available to patients to increase ownership and engagement.*)
- Structured education embedded in clinical transformation –part of treatment
- Early education for patients
- Use of expert patients for peer support / buddy system
- Community champions and mentors integrated within the integrated care team
- Increased support for those with mental health and diabetes through structured

tiered approach to IAPT and Clinical Psychologists, and an improved self-care offer.

- Improved physical health checks for those with serious and long term mental health needs.
- Secondary care diabetes service transformation – to achieve improved clinical outcomes.

### **Clinical transformation of adults with Type 1 diabetes - BP, Chol and HbA1c**

#### **The NDA data for type 1 PWD re BP/Chol and Hba1c is worse than those for type 2**

- Utilising the document (<http://www.londonscn.nhs.uk/publication/report-living-with-diabetes-what-support-is-needed/>) we have surveyed our patients to see what care they want– using this and the document developed by several of our STP members (including representation of people with diabetes) we will implement the London Type 1 Commissioning pack (<http://www.londonscn.nhs.uk/publication/diabetes-commissioning-pack/>)
- **Improving HbA1c achievement in children – Diabeter model**
- We will scope the implementation of the Netherlands Diabeter model in NWL STP ([www.diabeter.nl](http://www.diabeter.nl))

### **PROJECT 2 – DIABETES WORKFORCE DEVELOPMENT**

Work streams:

- Using federated model, improve competency, capability and capacity
- Closer integration of workforce / potential of one team for diabetes across the 8 CCGs
- Improved training for staff across healthcare
- Ensure competencies of Secondary care staff delivering care to people with type 1 diabetes (through clearly commissioned NICE accredited programmes e.g. DAFNE, BERTIE or other quality assured programme.
- Up-skill practice nurses, GPs, clinical pharmacists, care home staff etc. through education programmes including TOPICAL, MERIT, pre-PITstop and PITStop etc.
- Flexible specialist support driven by the right incentives: high quality integrated specialist diabetes hubs seeing patients where the competencies are not available in the practice
- Use Diabetes Specialists Clinicians more effectively as they mentor and coach other HCPs (e.g. GPs, Practice Nurses, Community Nurses, Tier 3 Diabetes staff in the community, and others such as diabetes specialist pharmacists) –, for example through virtual clinics, video consultations, etc.
- Build on existing care navigator and diabetes mentor models to develop trained community health workers (mentors, educators, coaches) as a key (and accountable) part of the wider MDT team to work with higher risk/higher dependency patients on self-management and lifestyle change. *(Use of IT off loads some non-clinical tasks and provides clinicians with increased capacity)*

Workforce development for health care professionals and community health workers on having a conversation about mental wellbeing (eg. RSPH level 2 mental wellbeing), signposting to IAPT and screening for common mental health needs as part of Making Every Contact Count (MECC) developments.

## **PROJECT 3 – STRUCTURED EDUCATION**

**Structured education should be embedded in clinical transformation as a part of treatment – we will systematically evaluate current NWL SE programmes in terms of both uptake and outcomes to encourage sharing of best practice. Work with local authority Public Health teams to pilot the use of behaviour change techniques in promotional material and invites to increase uptake into structured education.**

Our approach supports the findings of *Taking Control: Supporting people to self-manage their diabetes* (All Party Parliamentary Group for Diabetes, 2015). We have conducted stakeholder engagement to advise and inform our proposals.

The National Diabetes Audit data informs us there is variation in referral rates both across and within the North West London STP footprint. Attendance rates for Type 1 education are largely unavailable. Type 2 education referral rates are generally in line with or slightly above the national average but with attendance rates showing marked variation from less than 5% to just below 25% at a practice level. We are currently not providing the appropriate skills to enable self-management to at least 70 per cent of people with Type 1 and Type 2 diabetes.

Evidence shows that structured patient education can stabilise blood glucose levels, reduce the risk of diabetes-related complications, improve quality of life for patients and their families, and reduce the burden of healthcare costs on the NHS. Where diabetes education is signposted, people affected by the condition are often given little information or explanation about the aims and benefits of attending and consequently many people reported doubts about the usefulness of the programmes available. The X-PERT Diabetes programme found that when people are offered education in a positive manner, up to 75 per cent choose to attend. (All Party Parliamentary Group on Diabetes, 2015).

Based on these findings, this structured education bid is composed of two interrelated elements to meet the needs of both newly diagnosed and prevalent diabetes population for adults and young people in transition (note a phased approach would be taken to meet the needs of the prevalent population).

Three project elements:

1. Improve the knowledge and understanding of GP practice staff of diabetes and the benefits of structured education
2. Design, commission and implement a **North West London Structured Education Hub**

**Workstream 1** seeks to improve referrals to structured education by designing, commissioning and delivering an eLearning tool that will be used to educate primary care clinicians. It is anticipated that the increased understanding of GP practices of the importance of Structured Education will result in more referrals translating to actual attendance.

This education will focus on:

- Patient Stories
- Carers Stories
- General information about Type 1 and Type 2 diabetes
- Reducing stigma around diabetes

- General information about the content of a structured education course
- Outcomes associated with completing a structured education course
- How to motivate and encourage people with diabetes to attend a structured education course (i.e. meaningful referrals more likely to convert to attendance)
- The importance of using standardised read codes and submitting data for the NDA
- The importance of recall, patient reminders, refresher courses and appropriate use of social media
- Understanding options available for people with diabetes to meet cultural needs and whose first language is not English, for patients with additional needs (e.g. learning disability, dementia, mental health), and considering age specific options (links with **Element 2**)
- Knowledge of the referral mechanism to the Structured Education Hub (links with **Element 2**)
- Using a structured education eLearning tool

#### Incentives and/or payment for primary care

We intend that GP practices will be incentivised as part of existing schemes / new contract model:

- To complete the e learning module
- To case find patients who have not attended structured education
- To refer into the Structured Education Hub

Incentivisation will be time limited as an initial fund to enable the change in learning and referral practice which is then embedded and becomes business as normal. If investment for this is only available on a short-term basis, consideration will be given as to how this is sustainable moving forwards across all providers, ensuring that learnt skills are maintained and staff turnover does not affect outcomes.

After this time the responsibility to maintain referral and completion standards will be with the commissioned Structured Education Hub provider.

#### Outcome measures

- % of GP practice staff completing eLearning
- % of GP practices with diabetes champion
- % Increase in SE referral rates
- % Increase in SE attendance
- % Increase in SE completion rates

Development of the eLearning resource would include engagement with the following:

- Patient participation groups
- Community champions/ Health watch
- Voluntary organisations
- Self-management initiatives
- University health and social care courses / Any other relevant organisation.

### **Workstream 2 – commission a structured education booking hub**

The purpose of this element is to maximise choice and information for people with diabetes to attend a structured education course at a time, place and location that meets and reflects their personal needs. This would be achieved by commissioning a **North West London Structured Education Hub** in partnership with the lead CCG, to enable adults and young people with diabetes to attend the right course at the right time with language and cultural options. Building on the existing Bexley Health model in South London the Hub will provide

a single point of referral and centralised booking system for structured education in North West London.

The model builds on the current commissioned Hub service by Bexley GP Federation that has increased referrals and attendance. This centralised Hub model draws on the learning of the success of this model which included adapting the days and times of courses to meet patients preferred choices, providing language options and the model of education e.g. The diabetes manual.

The North West London Structured Education Hub will be commissioned to:

- Provide a single point of electronic referral for the existing Structured Education courses that meet NICE guidance offered by CCGs for Type 1 and Type 2 diabetes for all south London CCGs
- Will remove any boundaries to attending Structured Education i.e. all courses will be available to all NW London CCG registered patients with diabetes with access available to patients' results.
- To include self-referral
- To include completed Patient Activation Measure
- To be responsible for maintaining and increasing year on year referral and attendance at Structured Education e.g. through proactive patient finding with low referring GPs, ensuring sufficient capacity to deliver this is commissioned.
- To provide a service that includes digital and telephone engagement with people with diabetes to:
  - Promote the benefits of Structured Education to individuals
  - Identify a Structured Education course that meets the needs of individuals, including delivery of courses across NWL in different languages.
  - Offer peer to peer support (online and by phone)
  - Offer information and advice including how to secure time off work to attend
  - Reduce stigma
  - Actively contact people from the diabetes register who have not attended Structured education in an agreed phased approach
  - Work with the IAPT services to facilitate referrals for mental health therapies
  - Signpost to relevant services to include Diabetes UK
  - Use social media to promote the site (Facebook, Twitter)
  - Be digital ready (for future digital Structured Education options)
  - Inform GP practices on referral attendance and completion
  - Collect data by GP practice on referral attendance and completion
  - Inform GPs of attendance and completion of Structured Education using relevant read codes
  - Monitor uptake of Structured Education by course e.g. (Desmond, X-PERT, BERTIE, DAFNE etc.)
  - Monitor and flag demand and unmet need with STP diabetes leads and CCG Commissioners
  - Actively suggest / innovate solutions to meet unmet need
  - Signpost people with diabetes to local research opportunities
  - Host Structured eLearning tool
  - Develop a North West London Structured Education Hub Advisory board led by people with diabetes to inform and develop existing and future initiatives

Improving the capacity of current diabetes specialist staff:

A North West London Structured Education Hub will provide an additional resource to manage referrals for all North West London CCGs. The Hub will remove the current requirement by diabetes specialist nurses to chase missing referral information, arrange dates and venues, invite and motivate people with diabetes to attend Structured Education and following up on non-attenders, as all of this activity will be managed by the proposed Structured Education Hub. Self-referral will also be available. Freeing up this time will enable diabetes specialist nurses to focus on their key duties. The sustainability of the Hub will be met by CCGs using the return on investment made.

#### **PROJECT 4 – DIABETES IT, ANALYTICS CLINICAL AUDIT, RESEARCH AND REPORTING**

Work streams:

- Agree consistent data set for recording diabetes related activity using existing NDA standards with local supplementation where needed
- Care planning – work with NWL Digital team and NHS Digital to develop interoperable care planning standards (based on successful ETTF bid)
- Population health – inform and engage with development / procurement of population health system, allowing real time monitoring of cost and outcomes, proactive case management, risk stratification using predictive algorithms and ensuring that there is safety netting of high risk / non-engaging patients
- Interoperability – use of equivalent structured data entry templates and views across different clinical systems and providers. Real time viewing of all pertinent clinical data, messaging, appointment viewing / creation and virtual consultation across care settings.
- Potential use of Map of Medicine, learning from its roll out in Harrow.

Patient facing view of diabetes record and care plan, ability to upload home measurements: weight, activity, glucometer, CGM and insulin pump data. The Harrow based 'Health Help Now' app could enable this; work will be done to build on functionality to support this capability.

#### **PROJECT 5 – COMMISSIONING, CONTRACTING and GOVERNANCE**

Work streams;

- Contract via an integrated outcomes-based commissioning model
- Commission diabetes care at scale across all 8 CCGs but may require some initial early adopter partnerships
- Commission to build in support to primary and community care to reduce variability across the health economy
- Greater collaboration between sectors to involve social prescribing and third sector
- Embed the governance within the programme as an exemplar across NWL STP
- Data driven active case management and intervention. Alignment of outcomes based incentives is crucial in order to drive the system - focus all providers on the three treatments targets

Further work on integrating pathway, ACP / VBC / CoBic approach (still perverse incentives)

NW London STP ACP team are working to try and mobilise the development of ACPs with a 10 yr contracting time frame. We will look at how we can bring diabetes into this model, as there is substantial alignment of required endpoints.



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## **Economic Case**

This section must be completed in conjunction with the project/Delivery Area Finance Lead.

Some projects will have benefits that are not cash releasing but are never-the-less an important consideration in the decision to make an investment.

In this section list and, as far as possible, quantify all of the non-cash releasing benefits for the options that you have considered. The option that has the greatest economic benefit should be strongly considered to be the preferred option, although other factors can be taken into consideration in the next section. Detailed calculations should be shown as an appendix to this document.

A number of attempts have been made to understand potential economic impact of improvements in diabetes care, a baseline and trajectory would be decided as part of Phase One. Below outlines a number of the data sources available and suggested broader impact and savings:

### **NHS Rightcare**

NHS Rightcare data for NWL CCGs in 2015/6 show significantly higher levels of activity for endocrine, nutritional and metabolic complications (largely diabetes) compared with the 5 highest performing CCG comparators, with diabetes identified as a significant spend and outcomes opportunity for the STP. This shows **4,118** more endocrine bed days than comparators (data for 2013 in-patient stays with diabetes related complications are provided below and amount to 76,978 bed days annually)

## Diabetes bed days in NWL for complications (2013)



**10,419**

for diabetes patients with angina



**9,242**

for patients with a myocardial infarction



**32,162**

for patients with heart failure



**10,967**

for patients with a stroke



**11,679**

for patients needing renal replacement therapy



**2,509**

for patients undergoing amputations

The following domains are identified as needing improvement in order to drive this change:

- % diabetes patients whose cholesterol < 5 mmol/l
- % diabetes patients whose HbA1c is <59 mmol/mol
- % diabetes patients whose blood pressure is <140/80
- % of diabetes patients achieving all three treatment targets
- % patients receiving foot examination
- % patients attending retinal screening
- % diabetes patients attending structured education

The programme outlined in this business case addresses all of the above.

### **IMPACT 2**

IMPACT 2 (modelling commissioned jointly by Diabetes UK, JDRF and Sanofi) modelled the savings that could be realised by following best practice, appropriate escalation of purely the glycaemic control element of diabetes care following NICE guidelines.

The savings modelled for NWL (4% of the UK diabetes population) amount to £11m over 5 years, increasing to £46.8m by 10 years.

Of note: Optimised blood pressure and lipid control are potentially more important for cardiovascular disease risk reduction and weren't factored into this evaluation, so further economic and disease impact benefits would be expected if these were factored in.

### **Health London Partnership**

The Healthy London Partnership prevention pack models the economic effects over 5 years of reducing diabetes complications by instituting best practice.

Savings are estimated as between £10.5m and £20.9m over five years, based on a 10-20% reduction in the risk of complications.

### **Portsmouth Super 6**

Portsmouth introduced a care model which focuses on co-ordinated treatment within a primary and community care setting. Specialist consultants were redefined to work as educators as well as continuing as specialists for necessary activities. Part of the model proposed for NWL incorporates a redefining of specialist roles in this manner.

Importantly, they were able to demonstrate a reduction in cardiovascular complications (stroke, myocardial infarction and amputation) compared with baseline even at 4 years:

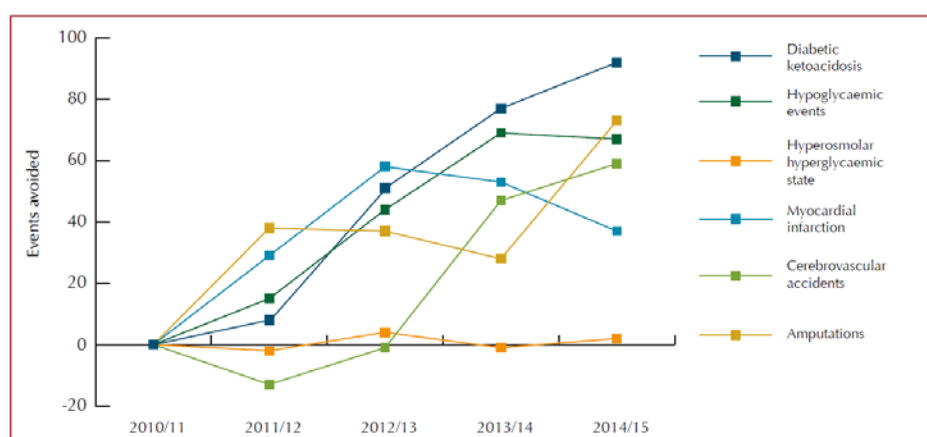


Figure 1. The estimated number of events avoided each year following the implementation of the Super Six model in 2010.

The above graph outlines the ‘events missed’ based on the trajectories from the baseline year. This translated into savings of £1.9m at the end of the fifth year as shown in the table below. Economic modelling for the innovative “Super 6” model in Portsmouth extrapolated to the NWL diabetes population suggest a total annual saving of £8m:

Local Area (SPG/CCG)	Portsmouth	Extrapolated to NWL
Diabetes population	31,253	128,992
Diabetic ketoacidosis admissions	£82,800	£343,000
Hypoglycaemia admissions	£25,551	£105,525
Myocardial infarction	£685,789	£2,832,308
Cardiovascular accidents	£246,292	£1,017,185
Amputations	£887,886	£3,666,969
<b>Total annual saving</b>	<b>£1,929,318</b>	<b>£7,968,083</b>

This suggests that NHSE's estimates for savings are conservative and that greater benefits can be realised. More information is being sought on how NHSE derived their calculations.

### **Swedish Diabetes Registry**






Comparative cohort analysis of patients with well controlled vs less well controlled diabetes (achievable improvements in HbA1c, blood pressure and cholesterol)

- 75% reduction in coronary heart disease at 6.5 years
- 63% reduction in fatal CVD at 6.5 years
- 55% reduction in mortality at 6.5 years

### **Summary for NWL**

Taken together, the above data suggest savings in the region of £2-8m annually by year 5 of the programme and a possible 14,400-24,300 annual reduction in bed days by year 7 through reduction in cardiovascular, foot and renal complications distributed as follows:

#### Estimated reduction in annual diabetes bed days in NWL

	<b>1400 - 3100</b>	angina
	<b>1300 - 2700</b>	myocardial infarction
	<b>5100 - 9600</b>	heart failure
	<b>1300 - 3200</b>	stroke
	<b>4300 - 4500</b>	renal replacement therapy
	<b>1000 - 1200</b>	amputation

Lower limit modelled on effects of 11mmol/mol reduction in HbA1c on risk of complications after 10 years (UKPDS study). Multifactorial risk reduction through lifestyle change and medication could have a significantly bigger reduction. Note that the baseline numbers of people with diabetes are likely to grow significantly over the next 10 years without any large scale preventative intervention.

As part of phase 1 with development of the Whole Systems Integrated Care platform, we expect to be able to obtain further health economics data, including total health spend per patient and further intelligence about social care spending.

Due to a transformation in NWL Diabetes Care Outcomes and Experiences from the investment we should realise the following economic benefits;

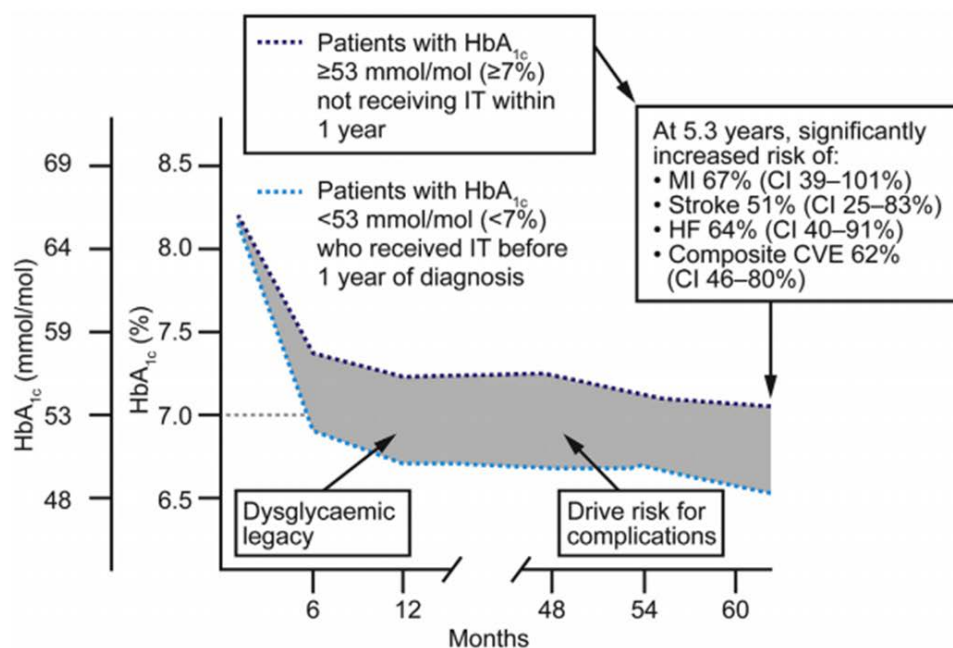
- Reduced Mortality
- Reduced Morbidity
- Reduction in Unplanned Acute Episodes [ Admissions/A&E attendances],
- Improved DM Outcomes and Experiences
- Reduction in volume of patients accessing NHS resources by improved self-management,
- Reduction in Healthcare Costs due to more Efficient Integrated Collaborative In Team working across NWL.

### Reduced mortality

We should see a further reduction in diabetes related premature mortality due to reduced cardiovascular, renal and foot disease over a 5-10 year period of 20-50% based on the various models. We will be using this as one of the key metrics of success.

### Reduced morbidity

Prospective studies demonstrate optimal management (via treatment/on-going access to structured education) of newly diagnosed T2DM Patients leads to a significant “Legacy Effect”. This investment enables many more T2DM Patients to benefit from a legacy effect, which reduces or prevents the onset of Diabetes related complications.



Similar principles apply to patients with existing diabetes. Our estimate would be for a 20-50% reduction in complication rates over a 5-10 year period.

### Reduction in unplanned acute episodes

Improvement management of DM will lead to reduced episodes of hypoglycaemia, hyperglycaemia, micro and macro vascular complications and hence a reduction in unplanned admissions and A&E attendances.

A paper by the Joint British Diabetes Societies for Inpatient Care in 2013 has many important learning points which if implemented as part of the management programme would have an early impact on unplanned admissions and readmission

rates: [http://www.diabetologists-abcd.org.uk/JBDS/JBDS\\_IP\\_Admissions\\_Avoidance\\_Diabetes.pdf](http://www.diabetologists-abcd.org.uk/JBDS/JBDS_IP_Admissions_Avoidance_Diabetes.pdf)

#### Improved outcomes and experiences by improved self-management

Patients empowered to manage their DM may lead to a reduction in accessing Primary, Community/Integrated Care and contribute to improved outcomes and experiences. The key enablers to this are improving patient motivation and access to self-management resources; this investment leads to improved access to self-management tools/resources.

Pilots of supported self-care systems have in some cases demonstrated encouraging early results: e.g. Vitrucare in Bradford demonstrated reductions in healthcare utilisation whilst improving key clinical parameters (mean 2.2kg weight reduction, 6mmHg average blood pressure reduction, mean 16mmol/mol HbA1c reduction). The free [www.diabetes.co.uk/lowcarb](http://www.diabetes.co.uk/lowcarb) programme has also demonstrated significant changes (mean 10kg weight reduction, 12mmol/mol HbA1c reduction) in over 16,000 participants.

#### Reduction in healthcare costs due to more efficient integrated collaborative working

There is significant variation in Diabetes healthcare spend across NWL and we need to evaluate the current costs in relation to outcomes better, commissioning with a focus on outcomes as opposed to activity and a focus on shared/joint working between Teams with new outcomes aligned incentives will lead to a reduction in costs. Again some modelling could demonstrate this.

The Portsmouth Super 6 and Camden models provide encouraging data for improving healthcare parameters and reducing admissions and complications costs.

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## Options Appraisal

In this section please describe the options that are available for achieving the desired outcome. This should include: a summary of the economic assessment of the various options (as above), details on how the options were evaluated, why they were discounted and the process by which the selection process was followed. This should include factors such as financial; legal or reputational risk criteria that impacted these decisions.

**It must evidence that alternative approaches were considered, evaluated and dismissed for sound reasons.**

The options appraisal should include the formal evaluation of “doing nothing”.

### **DO NOTHING**

- Overwhelmed GP practices – capacity, competency and capability issues within primary care
- Poorer outcomes, any improvements dependent on primary care delivering against the OOHS contracts. This will not address system wide problems across the whole pathway, and will lead to an inequitable delivery of care across the STP footprint as the Out of Hospital contracts are only delivered in CWHHE, not BHH.
- Contracts across NWL will need to become outcomes focussed.
- Focus on treating complications rather than preventing them (patient and health economy costs)
- Costs continue to rise as prevalence increases and the rate of complications is not positively affected.
- Fail to pick up on common mental health needs, some of which may be affecting self-management
- Poor patient experience
- Continued high mortality and morbidity rates for diabetes
- Care not coordinated and delivered in a standardised and structured way across NWL so unwarranted variation continues

### **USING THIS MODEL:**

- The model has been collaboratively developed with all key NWL STP stakeholders
- Potential savings have been highlighted in the economic case section above
- Further savings would be achieved through evidence based, cost-effective prescribing in line with NICE guidance (over £4m opportunity for endocrine, nutritional and metabolic prescribing – mainly diabetes - identified in NHS Rightcare STP pack)
- Moving to a 10 year integrated outcomes-based contract would hope to achieve the following (exact numbers will need further work and modelling)

Metric	2017	2021
Actual vs expected non-diabetic hyperglycaemia (NDH) prevalence	44%	90%+
% NDH to diabetes annual progression	TBD	TBD
Actual vs expected diabetes prevalence	75%	90%+
Patient access to digital diabetes care record	0%	100%
Confidence to manage long term condition	85%	95%
% patients receiving 9 key care processes	47%	>90%
% patients achieving positive lifestyle change (e.g. BMI, smoking cessation)	?	>50% ?
% patients achieving NICE 3 treatment targets	40%	62%
% patients attending structured education in last 5 years	<10%	50%+
Reduction in cardiovascular complications	0	? 10%
Reduction in renal complications	0	? 10%
Reduction in amputation rates	0	? 10%
Reduction in average length of stay for diabetes	0	>0.8 days
Reduction in diabetes unplanned admission rates	0	? 20%



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## Commercial Considerations

Outline all of the commercial considerations in taking forward this project. This should include any anticipated impact on:

- Procurement
- TUPE implications
- Premises
- Contracting mechanisms (including proposed payment mechanism)
- Length of contract
- Exit strategy
- Legal implications

These commercial aspects will be an integral consideration as this work moves forwards. As outlined in the 'Proposed Change' section of this business case, the overall programme of work will be split into projects. One of these is specifically to address these aspects –

### ***PROJECT 5 – COMMISSIONING, CONTRACTING and GOVERNANCE***

Please see pages 16 and 17 for details of this project. Diabetes costs are currently covered by a variety of contracts including Out of Hospitals contracts (1 year rolling in CWHHE), acute provider contracts (2 year contracts 2017-19) and GP commissioning. (any others?)

As outlined in the financial case below, this business case is requiring investment in people to deliver the project including subject matter experts in finance, business intelligence and contracting. These individuals will be key to ensuring that the proper amount of consideration is given to these areas, and the links already made with the ACP development team are maintained. It is envisaged that this work will be an exemplar for this work.

## Financial Case

**This section must be completed by the project/Delivery Area Finance Lead.**

Outline and summarises the financial impact of the project.

**For a service redesign programme** set out what the current cost of the service is. Using standard activity growth assumptions forecast what the service will cost over STP period (i.e. up to and including 2020/21).

Set out how the recurrent service cost will change as a result of the project, stating the recurrent cost of the new service, the recurrent cost any residual elements of the old service and any recurrent savings. Underpin all financial assumptions with activity flows.

Present a financial model which includes the non-recurrent set up costs to demonstrate financial viability of the overall investment plan for the STP period.

For all types of project or investment:

- 1) Provide a Return on Investment calculation.
- 2) Include detailed financial costings and workings in an appendix to this document.

Due to the complexity of calculating the diabetes system cost, detailed work in this area is part of Phase 1 of the plan and is not yet complete. Below outlines the anticipated investment need based on an initial gap analysis of the current offering in NWL. This was used within a bid for NHSE funding and as such outlines the national and CCG investments requested. Savings have been estimated by NHSE calculations and will be revisited as part of Phase 1. Details of the programme costs and activity can be found in Appendices 1 and 2

Below are the estimated incremental costs and savings for the STP period. This demonstrates a net saving to the system from 2018/19 which grows year on year.

£000s	National Bid <sup>(1)</sup>				CCG funding				Savings <sup>(2)</sup>				Net cost to CCG			
	17/18	18/19	19/20	20/21	17/18	18/19	19/20	20/21	17/18	18/19	19/20	20/21	17/18	18/19	19/20	20/21
Structured education	1,000	750	750	750	404	1,161	1,347	1,433	-	135	431	774	404	1,026	916	659
Treatment targets	1,750	1,500	1,500	1,500	635	1,153	1,010	1,384	-	291	1,036	1,770	635	862	(25)	(386)
MDFT	397	371	371	371	75	71	38	38	319	1,255	1,171	1,105	(243)	(1,184)	(1,132)	(1,067)
DISN	411	548	548	548	32	32	-	-	305	1,596	1,507	1,507	(272)	(1,564)	(1,507)	(1,507)
<b>Total</b>	<b>3,558</b>	<b>3,169</b>	<b>3,169</b>	<b>3,169</b>	<b>1,146</b>	<b>2,418</b>	<b>2,396</b>	<b>2,856</b>	<b>624</b>	<b>3,277</b>	<b>4,145</b>	<b>5,156</b>	<b>523</b>	<b>(860)</b>	<b>(1,749)</b>	<b>(2,300)</b>
Prevention <sup>(3)</sup>	-	-	-	-	-	672	672	672	-	260	445	634	-	412	226	38
<b>Total</b>	<b>3,558</b>	<b>3,169</b>	<b>3,169</b>	<b>3,169</b>	<b>1,146</b>	<b>3,089</b>	<b>3,067</b>	<b>3,528</b>	<b>624</b>	<b>3,537</b>	<b>4,590</b>	<b>5,790</b>	<b>523</b>	<b>(447)</b>	<b>(1,523)</b>	<b>(2,262)</b>

**Note 1** Diabetes national bid is based on national bid funding available for 17/18, likely funding for 18/19 and provisional funding until 20/21.

**Note 2** Diabetes savings are estimated by NHSE models used within the bid documents.

For clarity there has been no assumption of reinvestment of savings.

**Note 3** The National Diabetes Prevention Programme is currently funding 5,700 places across CWHHE over a two year period to 17/18.

This equates to approximately £1.5m over the two year period. Neither the costs nor the savings have been included above.

Due to the nature of diabetes as a long term conditions and the interventions, NHSE model the savings over a longer period than the STP which demonstrate the continued return post 2021 as follows:

£000s	Additional savings					
	21/22	22/23	23/24	24/25	25/26	26/27
<b>Structured education</b>	1,117	2,034	2,597	2,490	2,414	2,279
<b>Treatment targets</b>	2,564	2,843	3,045	3,220	3,328	3,409
<b>MDFT</b>	276					
<b>DISN</b>						
<b>Total</b>	<b>3,958</b>	<b>4,877</b>	<b>5,642</b>	<b>5,710</b>	<b>5,742</b>	<b>5,688</b>
<b>Prevention <sup>(3)</sup></b>	813	1,014	1,257	1,435	1,633	1,850
<b>Total</b>	<b>4,771</b>	<b>5,891</b>	<b>6,900</b>	<b>7,145</b>	<b>7,374</b>	<b>7,537</b>

Prevention continues to deliver savings over a 20 year period for each cohort, generating cumulative savings of £3m for each cohort.. Please see Appendix 2 and 3 for details. Savings have been modelled using the NDPP ROI calculator. Appendix 3 outlines further health economy savings from the investment.

Total system redesign and move towards capitated commissioning and long term outcomes will enable the sustainability of the approach. These costs are to set up new ways of working whilst new commissioning structures are developed.

## Funding source

Outline all sources of funding for the project (non-recurrent and recurrent).

Consider the application route for sources of funding that are outside CCG allocations, for example, central support for specific initiatives.

Recurrent funding is in place for community diabetes services across the CCGs. There is significant variation in current levels of funding dependent on individual CCG plans in recent years. Over time this funding will be combined with the STP funding to create a new business as usual.

The 16/17 community contract values for these services are as follows:

Central	£1,078,656
Brent	£1,036,405
Hillingdon	£822,493
West London	£652,061
H&F	£494,847
Hounslow	£1,282,386
Ealing	£1,040,000
Harrow	£359,000
<b>Total</b>	<b>£6,765,848</b>

Business Intelligence colleagues are currently working on disaggregating the acute spend on diabetes care across the footprint, unfortunately this will be worked up as part of Phase

1 of the programme and is therefore not yet complete.

There is additional funding available to support integrated IAPT. The Like Minded Programme has £111k from HENWL to assist with e-learning for psychological wellbeing practitioners. There is also a bid for transformation funds for integrated IAPT being submitted to NHSE, of which a focus will be on diabetes as well as other LTCs.

As outlined in the financial case a bid has been submitted to NHSE requesting £3.6m funding in 17/18. Funding is highly likely to be available in the second year (18/19) and £3.1m has been requested. Funding in 19/20 and 20/21 was sought provisionally. If national funding is not received to the level expected then the project plans and STP investment request will need to be revisited.

Additional funding has been received by CWHHE for the National Diabetes Prevention Programme to fund 5,700 places and to invest in digital NDPP.

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## Overall Plans for Implementation

This section must be completed in conjunction with the project/Delivery Area Finance Lead, if necessary.

This section builds on the resources and cost of delivery section included in the project mandate.

Outline the costs to deliver all phases of the project, to include both planning and delivery (phases A-D). Consider procurement cost, legal costs, project management time, stakeholder engagement, equipment and overheads. These costs should also be included in the non-recurrent costs in the financial case.

Also consider the cost of slippage in delivery of the project and the inclusion of a contingency.

The timescales for this programme of work are outlined in the section below. This will be a large scale change that should lead to the development of a 10 year contract and will deliver huge improvements in patient care and savings based on primary and secondary prevention of diabetes and associated complications, optimisation of pathways and improvements in system-wide efficiency.

As outlined in the programme plan and the funding requirements, the programme will require experts in finance, BI and contracting to help develop project documentation including a PID and latterly a full business case. Full consideration to all of the potential costs highlighted above will be detailed in these documents, which will be subject to individual CCG governance processes.

The role of the Programme Director to 31<sup>st</sup> March 2017 will be to complete Phase 1 with a priority on IT development to enable a clear picture of diabetes in NWL. Phase 1 staff costs are not included in the business case as these are already committed as are IT costs for

Whole Systems development.

Costs based on staffing have been included in the financial case above.

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## Timescales

### Phase 1: Establishing the programme (Jan – April 2017)

- ✓ Diabetes services stock take – resources/ staffing / project support already in place in each CCG
- ✓ Agreements on shared vision and narrative that will be used to bring the system of stakeholders to a shared vision and understanding of the end state – reflected in a Diabetes Transformation Case for Change
- ✓ Agreement on the programme plan and critical path that will set timeline expectations for Providers and Partners
- ✓ Completion and sign-off of a Programme Initiation Document (PID) outlining programme plans, delivery strategy, critical path, governance arrangements, resource requirements, and key risks and processes
- ✓ Establishment of a stakeholder and communication strategy
- ✓ Establishment of a patient engagement strategy and plan
- ✓ Establishment of programme governance and decision making arrangements
- ✓ Mobilisation of programme resources and work-streams
- ✓ First draft Diabetes Strategy
- ✓ Plan for Phase 2

### Phase 2a: Commissioning, Contracting and Governance (April – Sept 2017)

- ✓ Define contracting for shadow year April 2017- March 2018
- ✓ Completion of a Definition Framework that will set procurement specifications for Providers and Partners this will include
  - Target population and health need/priority
  - Scope of services scope
  - Outcomes framework
  - Diabetes footprint
  - Budget outline
  - Contract arrangements – including risk/gain share model
- ✓ Establishment of capitation methodology / procurement strategy / implementation and locality delivery strategy
- ✓ Contract award of the integrated outcomes-based contract
- ✓ Refresh of programme governance arrangements
- ✓ Design of provider governance
- ✓ Design of commissioner organisation

- ✓ Design benefits realisation and outcomes accountability model and dashboard
- ✓ Provider and Commissioner capability assessment and change management strategy
- ✓ Monitoring of all provider mobilisation and transformation
- ✓ Detailed implementation plans for transformed business operations – e.g. workforce, finance, etc.
- ✓ Implementation plans assurance gateway

**Phase 2b: Clinical Transformation - Improving Treatment Targets Project (April 17 – April 2018)**

**Phase 2c: Clinical Transformation - Diabetes Foot Project (April 17 – April 2018)**

**Phase 2d: Clinical Transformation - Diabetes Hospital Care Project (April 17 – April 2018)**

**Phase 2e: Diabetes, IT, Analytics, Clinical Audit, Research and Reporting (April 17 – April 2018)**

## Risks

Build on the key risks identified in the project plan to provide an initial risk register to be used at the commencement of the project. This will become the live risk register and will form a separate document. Include a detailed list of risks, scores and mitigations in the appendix of this document.

<b>Description of risk</b>	<b>L</b>	<b>C</b>	<b>Score</b>	<b>Mitigations</b>
Clinical and organisational buy-in to service review and redesign from provider organisations is limited and effectiveness of review is subsequently reduced	2	3	6	Existing relationships with stakeholders will be utilised, further engagement has begun as detailed in the section below. NWL strategy meetings to begin in March
Review results in short term investment needs for new model implementation before full benefits can be realised.	3	2	6	A strengths and weaknesses analysis has begun across all 8 CCGs. Once investments for the programme have been secured, allocation to areas that need short term investment will be modelled and agreed according to the programme governance shown in appendix 1.
Previous Integrated Care Pilot – focused on an MDG approach to diabetes care – showed limited scope and outcomes. This may risk clinical buy in to a new programme of service review / enhancement through self-care, prevention and focus on high needs.	1	3	4	There are a number of strategic objectives that identify diabetes as a priority area. The Right Care programme has identified that 6 CCGs are outliers in terms of spend and outcomes, giving diabetes more focus for service transformation than for previous schemes. We have a large amount of local evidence to support the work that is presented above, the initial NWL workshop in November 2016 showed a clear level of investment from local clinicians, some of whom have already been involved in local service changes.
Improvements in clinical outcomes take a longer time to realise than modelled leading to a delay in projected savings	3	3	9	Savings have been modelled based on the evidence available which includes local data to give a higher level of confidence. Once the programme has begun, performance and realisation of

				modelled savings will be monitored closely
Losses of trained clinical staff in some areas as services are re-commissioned. Will need to ensure integration of existing resources	3	3	9	This programme of work is supported across the geography of NWL and this integration will ensure that areas are not looked at in isolation; workforce training and planning is a large component of the wider programme and will be monitored.
Outcome of NHSE funding bid does not provide requested level of investment in 2017/18 or NHSE funding is not available in subsequent years.	3	4	12	We are not in control of this outcome. If required, the Programme Director will carry out a prioritisation programme using evidence on outcomes and cost and, if required, a new business case will be presented for CCG investment.



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## Stakeholder Engagement

Include here a summary of the stakeholder engagement plan, highlighting particular interdependencies. This should be a summary of the communication plan to support project delivery.

Through the existing CWHHE Strategy group and other strategic groups in BHH links have already been made with a number of stakeholders including;

- Commissioners – clinical, communication and engagement, medicines management and management leads
- Clinicians from all local providers; acute, community and mental health
- Patients and carers– with strong links into the tri-borough Diabetes User Group
- Diabetes UK
- Public Health
- NHSE (Diabetes SCN)

An initial workshop held on the 24<sup>th</sup> November had additional wider representation in the above areas from across Brent, Harrow and Hillingdon and there has been a commitment from these 3 CCGs to support this work and include stakeholders across the wider geography of NW London.

Significant local engagement took place in 2016 in Harrow, including a stakeholder event with over 50 people representing 15 organisations. This included Diabetes UK and other patient representatives; the local diabetes health, social, and voluntary care system; Harrow CCG; and members of the Harrow Public Health team. Networking enabled more joined up working and improved patient outcomes.

As part of the overall programme plan that is being developed communications and engagement will be a key enabler to ensuring on-going buy-in to the work. This will be developed with CCG engagement leads and will be a key component of the programme.

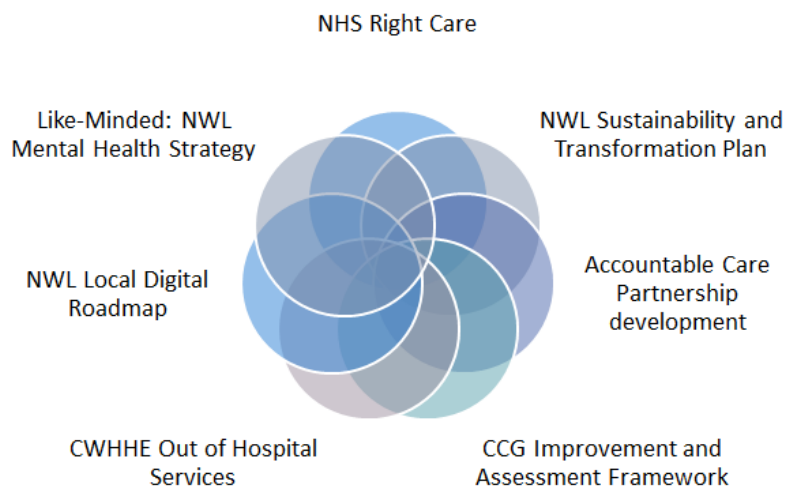
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## Recommendation

Include here an outline of the key decisions that the reviewer (s) of this business case are required to make.

### Key decisions required:

1. Approve outline business case as detailed
2. Ensure that the NWL Diabetes Transformation Programme has strategic support so that we can optimally work together with partners below to avoid duplication, and improve communication by delivering a common message out to busy clinicians and wider stakeholders.



***Table: Complexity of Transformation work in NWL – all driving diabetes improvements***

Appendix 1: Governance Structure –

