Fit for the Future
Working together to keep people well

Report to STP Board: 18 July 2019

Agenda item:	3.3
Title:	Pathways for radical redesign – an update
Lead:	Alex Gimson, Chair, Clinical Communities Forum, Sustainability and Transformation Partnership (STP)
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Report purpose *(Please mark one in bold)*			
APPROVAL	DECISION	ASSURE	**INFORM**

Link to STP Priorities *(Please mark all applicable in bold)*			
AT HOME IS BEST	SAFE & EFFECTIVE HOSPITAL CARE, WHEN NEEDED	**WE'RE ONLY SUSTAINABLE TOGETHER**	SUPPORTED DELIVERY

Committees/groups where this has been presented to before *(including date)*

N/A

Purpose of the paper

To update Sustainability and Transformation Partnership (STP) Board on progress on Clinical Transformation projects within Cambridgeshire and Peterborough STP and in particular Diabetes.

The STP Board is invited to:

The STP Board is asked to:

Note the progress and support prioritising clinical transformation personnel from within the system.

1. INTRODUCTION / BACKGROUND

The three areas of radical clinical transformation within the STP are Cardiovascular Disease (CVD), Respiratory Medicine, Prevention & Health Inequalities starting with Obesity and Diabetes.

The focus of this report is around Diabetes in particular and below we have set out the headline points from the emergent Diabetes and Obesity Clinical strategy.

2. BODY OF REPORT

Transformation Structure and process

These transformation initiatives are being designed within relevant Clinical Communities, which include clinicians, patient representatives, voluntary organisations / specialty charities as well as commissioning and operational staff. Each clinical area identified for radical transformation has:

- Identified their project team; Senior Responsible Officer (SRO) and Health and Care Executive (HCE) sponsor. Clinical lead, project lead, finance lead, health analytics contact; (Not yet organised for Respiratory Medicine)
- Identified representatives from primary, community, secondary care, public health and social care, specialist societies, voluntary sector and patient representatives. A core working group in addition to the whole ensemble have been formed;
- Identify metrics/outcomes to be addressed by the project;
- Consider generic recommended Transformation themes; and
- Priorities, both short and medium term.

Diabetes & Obesity Clinical strategy (draft 8 July 2019)

The System has agreed to undertake three major clinical transformation projects starting in 2019/20, in Cardiovascular Disease, Respiratory Medicine and "Prevention and Health Inequalities - Diabetes and Obesity". Together these Long-term Conditions (LTCs) are major drivers of health inequalities and costs within our local health system.

The Diabetes Clinical Community have identified in this strategy short term priorities; medium and longer term issues will be addressed in subsequent documents. Where relevant we have distinguished recommendations for type 1 and type 2 diabetes separately.

Address prevalence and rising risk over a number of years.

Nationally the prevalence of diabetes is rising, with increasing complexity of patients and accounting for >12% of NHS spending. Locally the prevalence is high in some areas and C&P STP outcomes on National Diabetes Audits and RightCare data are poor and not improving:

- Cambridgeshire and Peterborough (C&P) Clinical Commissioning Group (CCG) has poor diabetes outcomes for type 2 Diabetes Mellitus (DM) with only 35% of patients achieving all three National Diabetes Audit (NDA) treatment targets (lipids, blood pressure, HbA1c). (Annex 1);
- In two of the proposed new Primary Care Networks (PCN) < 30% of patient achieve this target, and in only four is it above the NHSE average;
- Type 1 diabetes, three treatment targets (TT) is comparable to the NHSE average. (Annex 2);
- RightCare data shows cardiovascular outcomes for diabetic patients are poor. (Annex 3); and
- The CCG has one of the highest spends on Diabetes in NHSE (£306.99 per DM Patient), but also the second lowest % cases achieving their three TTs.

To address this will require concerted action over many years at System, Alliance, Integrated Neighbourhood (IN) and GP practice levels. Change will be required at scale and at pace.

An Ambition for Remission for Type 2 Diabetes Mellitus.

The System with all partners will sign up to a system-wide challenge to action, an *Ambition for Remission,* for all new cases with Type 2 diabetes and Pre-Diabetes, through life-style changes.

Invest in prevention strategies.

The System will work closely with Public Health and Local Authorities to prioritise enhanced interventions for weight management in diabetes and obesity. These will include:

- A single point of contact (SPOC) for weight reduction/management services, with an expansion of tier 1 and 2 capacity;
- Weight management services devolved to the level of Integrated Neighbourhoods;
- Use of behavioural change apps for weight management (e.g. Counterpoint);
- Coordination of weight management offers across third sector, private providers (Slimming World, Weight Watchers etc), community dietetics, national DPP and secondary care to increase the range of offers available to overweight individuals; and
- All weight management strategies for diabetes will be aligned within a wider obesity strategy from pre-school children through to adulthood.

Re-design, simplify and harmonise clinical pathways.

We have re-designed and standardised recommended system-wide pathways for Type 2 diabetes, including:

- Initial diagnosis and management;
- Annual Reviews; and
- Management pathways for complications.

These pathways will stratify patients by degree of patient activation and complexity.

Introduce better monitoring, intervention and evaluation.

The Diabetes Clinical Community strongly recommends the use of Eclipse IT platform across the System, allowing practices, Integrated Neighbourhood MDTs and System to monitor diabetes outcomes, costs and components of NDA audits. It allows real-time feedback of individual patient alerts to practice/network teams. It has proven benefit in other health systems. The primary monitoring targets will include:

- Percentage remission and weight reduction 12 months after diagnosis of type 2 diabetes;
- Percentage cases meeting all three diabetes treatment targets (bp, lipids, HBA1c.);
- Outcomes for 5 other National Diabetes Audit metrics;
- Major cardiovascular event rates;
- Diabetes non-elective costs and prescription costs; and
- Introduction of total Diabetes system budget.

We have recommended to the CCG the introduction of a Diabetes Quality and Engagement Framework (QEF) to financially incentivise Integrated Neighbourhoods (INs) and Primary Care Networks.

Alliances and Integrated Neighbourhoods.

Diabetes care will be devolved to, and a primary focus of, Alliances, Primary care Networks and Integrated Neighbourhoods:

- Diabetes care will be part of the universal personalised care agenda, based in INs, including social prescribing, health coaching, addressing multimorbidity and what matters to the patient. Their feedback will inform and help improve delivery of diabetes services;
- Each IN will have a Diabetes Clinical Lead from their PCN and 1 health care person (Diabetes Specialist Nurse (DSN), Diabetes Care Technician (DCT) or Health Care Assistant (HCA)) per 500 DM patients;
- Each IN will manage a Multi-Disciplinary Team (MDT) virtual clinic of patients identified by an IT system, jointly within Alliances. MDT care will be directed at those cases not achieving three TTs and other high risk groups;
- Intensive support will be offered to INs, with worst outcomes, which are commonly those with highest deprivation index. This will help address health inequalities driven by diabetes; and
- It is expected that some pathways will be managed successfully by Healthcare Assistants with protocolised care.

Health inequalities

Diabetes is a major driver of health inequalities. Some of the areas with the highest Index of Multiple Deprivation (IMD) have the worst outcomes on the National Diabetes Audit. These areas also have high proportion of ethnic minorities who require a specific tailored approach to education and delivery of diabetes care. To address this:

- The Diabetes Clinical Community recommends identifying the five areas with the worst diabetes outcomes and working with their Integrated Neighbourhood / Primary Care Network to develop services in those areas. The possibility of linking to other areas where outcomes are in the top 20%, to share information and approaches will be explored; and
- The Accessibility Information Standard, introduced in 2016, will be used as it can improve acceptance by those with learning disabilities and for groups for whom English is not their first language.

The Diabetes Clinical Community also recommends identifying the system Diabetes ‘budget’. Improvement in diabetes care will require re-investment from within this budget, but also allow rationalisation and savings to be identified. Specific opportunities arising might include:

- We envisage switching from secondary care outpatient follow up to that led by IN / PCN multi-disciplinary team follow up for many diabetes patients;
- Introduction of low carb diets have been demonstrated to dramatically reduce diabetes drug costs;
- Supporting primary care to secure quality related income associated with improving care for patients with diabetes, for example additional QOF points have been allocated to diabetes for 2019/20; and
- Currently our CCG spends £11 m on 1,000 patients with diabetic foot conditions – there is a large opportunity to prevent progression to severe foot disease.

Future areas to be addressed

The Diabetes Clinical Community will introduce further recommendations in the second phase of this project (2020-22) which will include:

- Type 1 Diabetes
- Pregnancy and diabetes
- Diabetes in special patient groups (Serious mental illness, learning disorders, travellers, rough sleepers)
- Tier three obesity services for diabetes

Next steps

- Draft to Clinical Communities Forum and JCG - July
- Draft to North and South Alliances - July
- Submission to NHSE; September 2019
- Discussion with FPPG on Diabetes System Budget

3. RECOMMENDATIONS

The STP Board is asked to:

- **Note** the progress and support prioritising clinical transformation personnel from within the system.

July 2019

Appendices: ***Annex 1 - National Diabetes Audit Outcomes - Type 2 diabetes***
Annex 2 - National Diabetes Audit Outcomes - Type 1 diabetes
Annex 3 - RightCare data; outcomes and costs.

Annex 1 - National Diabetes Audit Outcomes - Type 2 diabetes

Table 1: Cambridgeshire & Peterborough STP National Diabetes Audit – T2DM 2017-18

17/18 data for Type 2 diabetic patients by CPFT Neighbourhood team (source NDA data 2017 - 18)

					8 care processes	HbA1c <= 58 mmol/mol (7.5%)	Blood Pressure <= 140/80	Cholesterol < 5 mmol/L	All three treatment targets
					% of patients	% of patients	% of patients	% of patients	% of patients
		England	2017 - 2018		58.8	65.8	73.8	76.6	40.1
		CCG	2017 - 2018		61	63.9	68.4	74.3	35.3

Rag Rating

	Better than England and CCG average
	Between England and CCG average
	Worse than England and CCG average

negative change from 16/17 to 17/18

					2017 - 2018					2016/17	Change	2016 / 17	Change
	N. Team	Registrations 16/17	Registrations 17/18	Change	8 care processes	HbA1c <= 58 mmol/mol (7.5%)	Blood Pressure <= 140/80	Cholesterol < 5 mmol/L	All three treatment targets	All three treatement targets		8 Care Processes	
		Number of patients	Number of patients	Number of patients	% of patients	% of patients	% of patients	% of patients	% of patients	% of patients		% of patients	
Summary	Peterborough City 1	**4,050**	**4,295**	**245**	**55.5**	**62.6**	**65.5**	**75.0**	**33.2**	**33.1**	**0.0**	**41.6**	**13.8**
Summary	Peterborough City 2	**3,630**	**3,895**	**265**	**60.2**	**62.6**	**62.6**	**75.1**	**32.0**	**31.6**	**0.3**	**44.6**	**15.5**
Summary	Borderline	**2,715**	**2,900**	**185**	**66.0**	**66.6**	**62.0**	**75.2**	**33.6**	**34.6**	**-0.9**	**52.3**	**13.8**
Summary	Borderline Central	**2,655**	**2,875**	**220**	**61.7**	**64.4**	**64.6**	**74.5**	**35.1**	**36.1**	**-1.1**	**48.6**	**13.1**
Summary	Cambridge City North	**2,285**	**2,355**	**70**	**58.7**	**63.4**	**70.1**	**72.2**	**37.7**	**39.7**	**-2.0**	**51.2**	**7.5**
Summary	Cambridge City South	**2,655**	**2,785**	**130**	**62.6**	**67.3**	**66.3**	**74.2**	**36.5**	**35.8**	**0.7**	**50.9**	**11.7**
Summary	Cambridge East	**2,570**	**2,930**	**125**	**56.1**	**68.9**	**71.5**	**76.8**	**41.0**	**41.0**	**-1.3**	**39.4**	**17.7**
Summary	Cambridge Villages No	**2,355**	**2,475**	**120**	**65.1**	**68.5**	**69.0**	**74.6**	**38.8**	**38.3**	**0.4**	**56.1**	**9.0**
Summary	Ely	**3,855**	**3,920**	**65**	**62.0**	**64.6**	**78.0**	**74.3**	**38.9**	**38.5**	**0.4**	**50.0**	**11.9**
Summary	Fenland	**2,840**	**2,940**	**450**	**53.3**	**61.0**	**69.1**	**76.0**	**33.9**	**34.1**	**-0.2**	**40.2**	**13.1**
Summary	Huntingdon	**2,665**	**2,940**	**110**	**60.9**	**61.4**	**68.3**	**69.4**	**33.7**	**33.3**	**1.0**	**48.8**	**10.1**
Summary	St Ives	**2,650**	**2,880**	**95**	**60.0**	**62.7**	**70.0**	**70.5**	**33.0**	**34.7**	**-2.0**	**49.5**	**16.3**
Summary	St Neots	**2,320**	**2,380**	**60.0**	**60.6**	**60.5**	**63.7**	**75.2**	**32.0**	**32.7**	**-0.7**	**41.9**	**18.7**
Summary	Wisbech	**2,955**	**3,070**	**115**	**51.6**	**61.0**	**67.2**	**73.4**	**32.5**	**32.8**	**-0.3**	**38.4**	**13.3**

Table 2: 2016/17-2017/18 Comparison T2DM

16/17 and 17/18 comparisons for Type 2 diabetic patients (source NDA data 2017 - 18)

Type 2 comparison between 16-17 and 17-18 Data from NDA for C & P CCG

		Registrations	8 care processes	HbA1c <= 58 mmol/mol (7.5%)	Blood Pressure <= 140/80	Cholesterol < 5 mmol/L	All three treatment targets
		Number of pa	% of patients	% of patients	% of patients	% of patients	% of patients
CCG	16/17	40195	47.3	63.7	69	73.6	35.3
CCG	17/18	42625	61	63.9	68.4	74.3	35.3
	Change	2430	13.7	0.2	-0.6	0.7	0

Type 2 comparison between England and CCG 2017 - 2018

			8 care processes	HbA1c <= 58 mmol/mol (7.5%)	Blood Pressure <= 140/80	Cholesterol < 5 mmol/L	All three treatment targets
			% of patients	% of patients	% of patients	% of patients	% of patients
England	17/18		58.8	65.8	73.8	76.6	40.1
CCG	17/18		61	63.9	68.4	74.3	35.3
Difference			2.2	-1.9	-5.4	-2.3	-4.8
England	16/17		47.7	67	74.4	76.2	41.1
CCG	16/17		47.3	63.7	69	73.6	35.3

Annex 2 - National Diabetes Audit Outcomes - Type 1 diabetes

Table 3: Cambridgeshire & Peterborough STP National Diabetes Audit – T1DM 2017-18

17/18 data for Type 1 diabetic patients by CPFT Neighbourhood team (source NDA data 2017 - 18)

			8 care processes	HbA1c <= 58 mmol/mol (7.5%)	Blood Pressure <= 140/80	Cholesterol < 5 mmol/L	All three treatment targets
			% of patients	% of patients	% of patients	% of patients	% of patients
England	2017 - 2018		42.9	29.9	74.8	70.3	18.6
CCG	2017 - 2018		47.7	32.4	70.3	68.6	18.7

Rag Rating

Better than England and CCG average
Between England and CCG average
Worse than England and CCG average

negative change

Please note that number of patients is rounded to the nearest five patients

				2017 - 2018					2016/17	Change	2016 / 17	Change
N. Team	Registrations 16/17	Registrations 17/18	Change	8 care processes	HbA1c <= 58 mmol/mol (7.5%)	Blood Pressure <= 140/80	Cholesterol < 5 mmol/L	All three treatment targets	All three treatment targets		8 Care processes	
	Number of patients	Number of patients	Number of patients	% of patients	% of patients	% of patients	% of patients	% of patients	% of patients		% of patients	
Borderline	**230**	**235**	**5**	**46.3**	**31.1**	**59.4**	**78.1**	**20.0**	**19.2**	**0.8**	**36.9**	**9.4**
Borderline Central	**280**	**280**	**0**	**35.9**	**31.1**	**64.6**	**74.6**	**21.5**	**22.6**	**-1.1**	**32.2**	**3.6**
Peterborough City 1	**340**	**345**	**5**	**43.5**	**33.2**	**76.1**	**70.0**	**30.4**	**32.9**	**-2.5**	**38.0**	**5.5**
Peterborough City 2	**250**	**260**	**10**	**50.9**	**24.5**	**76.4**	**73.0**	**16.4**	**20.3**	**-3.9**	**45.4**	**5.5**
Cambridge City North	**310**	**315**	**5**	**46.0**	**50.8**	**73.0**	**70.5**	**37.7**	**30.1**	**7.6**	**49.4**	**-3.4**
Cambridge City South	**350**	**365**	**15**	**52.6**	**39.2**	**63.4**	**68.0**	**22.2**	**25.2**	**-3.0**	**37.4**	**15.3**
Cambridge East	**300**	**345**	**45**	**56.2**	**39.5**	**65.8**	**66.4**	**20.2**	**24.5**	**-4.3**	**38.2**	**13.2**
Cambridge Villages North	**295**	**300**	**5**	**55.7**	**40.9**	**71.3**	**72.2**	**35.8**	**37.8**	**-2.0**	**41.7**	**14.0**
St Ives	**260**	**275**	**15**	**53.3**	**34.4**	**76.8**	**62.7**	**30.3**	**29.4**	**-1.3**	**43.3**	**15.8**
St Neots	**230**	**220**	**-10**	**49.9**	**39.2**	**71.5**	**65.6**	**23.8**	**20.4**	**3.4**	**35.6**	**14.2**
Huntingdon	**255**	**285**	**30**	**50.9**	**35.9**	**72.1**	**66.4**	**24.0**	**17.7**	**2.0**	**33.1**	**15.2**
Fenland	**185**	**205**	**20**	**43.6**	**28.4**	**70.8**	**80.3**	**19.5**	**20.1**	**5.4**	**36.6**	**6.4**
Wisbech	**215**	**225**	**10**	**38.2**	**24.3**	**76.4**	**62.9**	**15.9**	**18.8**	**-2.9**	**32.5**	**5.7**
Ely	**365**	**390**	**25**	**54.2**	**33.9**	**73.2**	**66.5**	**19.3**	**18.3**	**1.0**	**42.8**	**11.4**

Table 4: 2016/17-2017/18 Comparison T1DM

16/17 and 17/18 comparisons for Type 1 diabetic patients (source NDA data 2017 - 18)

Type 1 comparison between 16-17 and 17-18 (Data from NDA)

		Registrations	8 care processes	HbA1c <= 58 mmol/mol (7.5%)	Blood Pressure <= 140/80	Cholesterol < 5 mmol/L	All three treatment targets
		Number of patients	% of patients	% of patients	% of patients	% of patients	% of patients
CCG	2016 - 2017	3855	37.7	31.5	72.3	66.7	18.1
CCG	2017 - 2018	4070	47.7	32.4	70.3	68.6	18.7
	Change	215	10.0	0.9	-2.0	1.9	0.6

Type 1 comparison between England and CCG 2017 - 2018

		8 care processes	HbA1c <= 58 mmol/mol (7.5%)	Blood Pressure <= 140/80	Cholesterol < 5 mmol/L	All three treatment targets
		% of patients	% of patients	% of patients	% of patients	% of patients
England	2017 - 2018	42.9	29.9	74.8	70.3	18.6
CCG	2017 - 2018	47.7	32.4	70.3	68.6	18.7
	Difference	4.8	2.5	-4.5	-1.7	0.1
England	16/17	34.4	30.4	76	69.4	19
CCG	16/17	37.7	31.5	72.3	66.7	18.1

Annex 3 - RightCare data; outcomes and costs

Table 6: Cambridgeshire & Peterborough STP Diabetes RightCare data

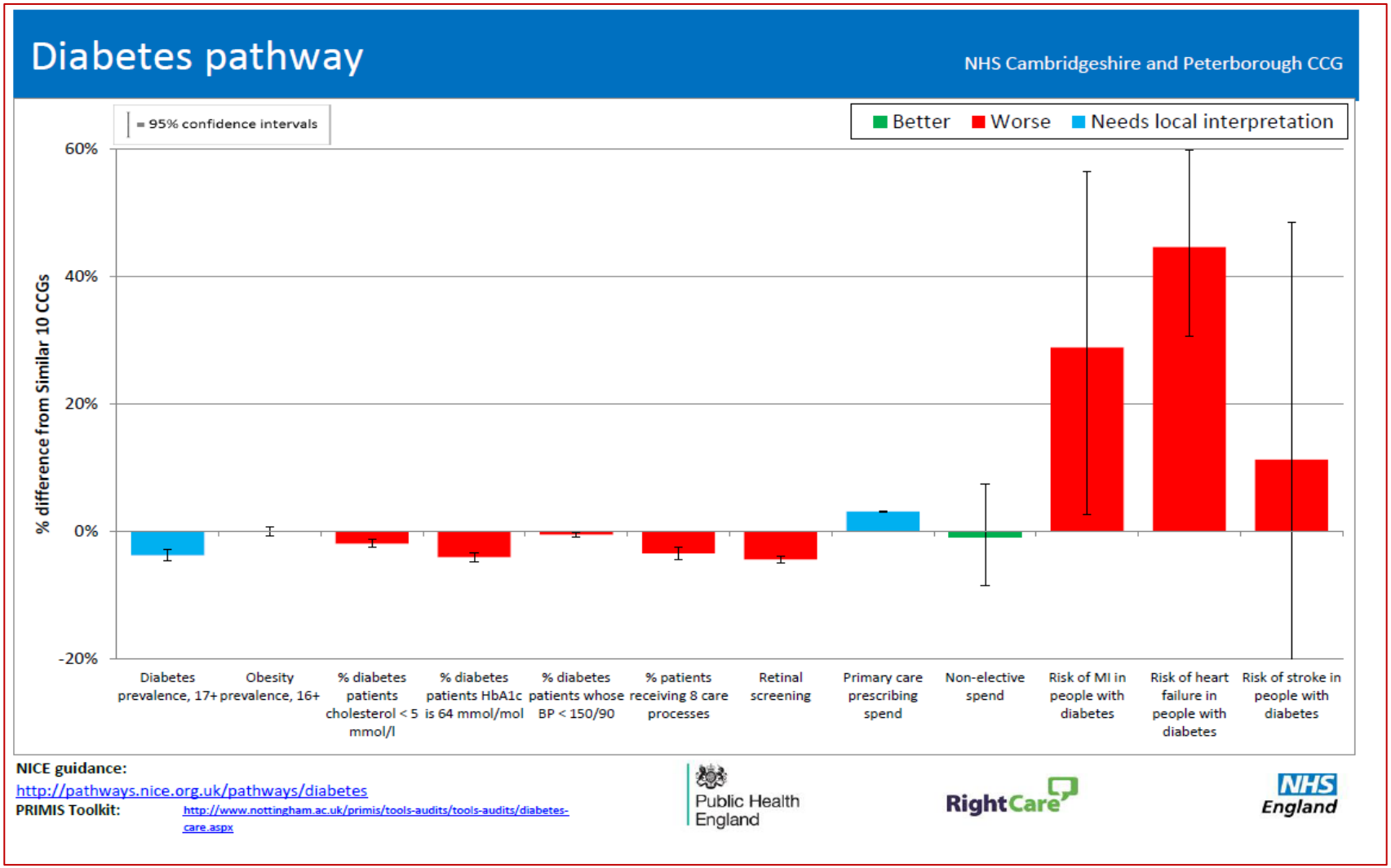

Table 7; total (T1DM + T2DM) spend in CCG compared to NHSE and 10 comparators