TRAFFORD COUNCIL

Report to: Health Overview and Scrutiny Committee
Date: 7th March 2019
Report of: Director of Commissioning Trafford CCG

Report Title

Diabetes Update

Summary

This paper aims to provide an overview and update of the Diabetes redesign work within Trafford

Recommendation(s)

To note the report

Contact person for access to background papers and further information:

Name: Naomi Ledwith
Extension:

Background Papers: None

Background

Diabetes care is one of the major challenges facing the NHS and the quality of care provision varies throughout the country. Diabetes is a major cause of premature mortality with at least 22,000 avoidable deaths each year. Due to the increasing obesity levels in the UK it is expected that the incidence of Type 2 Diabetes will increase and as a result it is estimated the number of people with diabetes in the UK will rise to 4.6 million by 2030. This makes it the long term condition with the fastest rising prevalence and if not managed properly, diabetes, can lead to serious life-threatening and life-limiting complications.

Although diabetic care in the UK has improved significantly over the years and the levels of premature mortality in the UK are lower than in 18 other wealthy countries. In spite of these developments there is still room to improve services delivery.

Currently, only around 1 in 5 people with diabetes are achieving all 3 of the recommended standards for glucose control, blood pressure and cholesterol. Moreover, the complications relating to diabetes are wide reaching, including;

- The most common reason for renal dialysis and the second most common cause of blindness in people of working age
- Increases the risk of cardiovascular disease by 2 to 4 times
- Increases the risk of chronic kidney disease, from an incident of 5-10% in the general population to between 18% and 30% in people with diabetes
- Results in almost 100 amputations each week, many of which are avoidable (approximately 8 out of 10)

Trafford's population is 240,000 and the estimated prevalence tells us that there are 12,594 diabetics aged 17+ registered with GP's within Trafford. We can roughly assume that approximately 90% circa 11,425, of these people are Type 2 diabetics.

This paper highlights the primary care diabetes pilot project and the wider ambition to roll out a new model for diabetic care in Trafford.

Trafford CCG has developed a diabetes strategy which will aim to lead to increased quality of care and improved outcomes for Trafford patients with or at risk of developing diabetes.

Diabetes Hub Pilot

The first phase of implementation for the strategy has resulted in a pilot scheme that aims to provide improved quality of diabetic care closer to home whilst delivering increased value for money. The pilot operates from Partington Family Practice and after a suitability assessment the service is offered to 25% of the diabetic patients registered at both Partington Family Practice and Partington Central Surgery, where 1 in 12 people are Diabetics. The pilot is run by Dr James Hider and he is supported by Dr Clive Marchi who is a hospital practitioner in diabetes.

The pilot has been operational for 9 months and offers:

- Enhanced diabetes care for patients of Partington this includes patients with well manged diabetes patients from secondary care and patients with poorly managed diabetes from primary care
- Clinical assessment and appropriate and timely interventions for patients
- All patients referred into the hub have their diabetes 8 care processes recommended by the National Institute for Health and Care Excellence (NICE). These processes ensure that people living with diabetes are monitored closely to prevent their condition from getting worse and leading to further complications.
- Improved access to services closer to home
- A service that has a strong emphasis on patient education and self-management, thereby promoting active and healthy lifestyles
- Medication reviews to ensure optimal diabetes control

Data analysis from a recent pilot hub evaluation has shown that benefits have already been delivered; there has been a 26% reduction in reduced hospital 1st appointments and 36% reduction in follow up appointments. These reductions will result in financial savings for the CCG and better quality outcomes for the patients.

There has been an 18% increase in patients who have had all 8 care processes recorded allowing better monitoring of their diabetes.

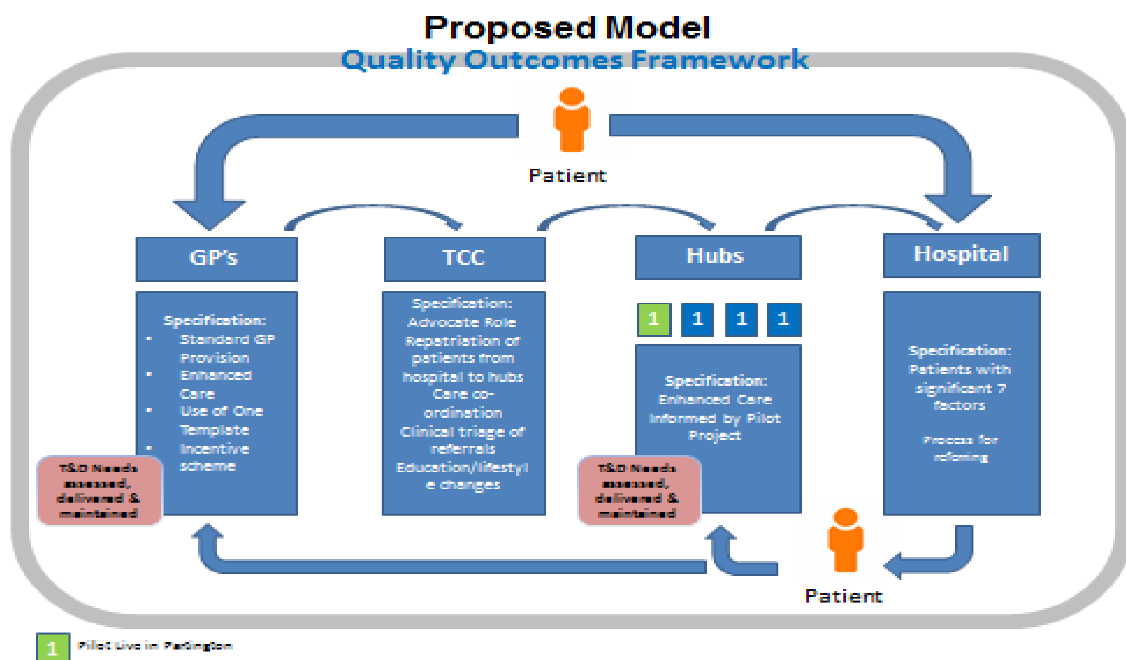
Dr James Hider who runs the pilot in Partington has recently been on national television recently with one of the patients from the Partington hub who has managed to reverse his diabetes with a complete lifestyle overhaul and support from the Diabetes hub.

https://news4trafford.co.uk/2019/02/07/a-partington-man-who-lost-6-stone-and-reversed-his-diabetes-is-inspiring-others-to-take-part-in-a-diet-plan-that-saved-his-life/

Diabetes Programme

The longer term aim is to roll out the diabetes hub model across all Trafford neighbourhoods. Within the new diabetic model of care it will be clear what patients can expect from their general practitioner and if required provision of enhanced diabetic care in locality settings such as the one in partington with only specialist diabetic care being referred into hospital.

Ultimately this will reduce the spend on secondary care, not just for first and follow up appointments for diabetic management, there will be longer term benefits from less in-patient admissions from complications that arise from poorly managed diabetes. Such as amputations, blindness, kidney problems.



The principles of the

- Implementation of a sustainable diabetic care model based on consistent pathway methodology
- A model that will operate within a Quality Outcomes Framework
- Delivers patient and value driven outcomes
- Aligns to CCG 7 priorities
- Delivery tracked and managed using PMO methodology (Logic Model)
- Seamless patient journey
- Collaborative approach to delivery
- TCC provide the advocate role for the model
- Outcomes are measureable and reportable
- Prevention and patient education
- Reducing variation through innovation

The Trafford Coordination Centre (TCC)

The TCC is supporting the diabetes redesign work in the following ways:

GP Referrals

All GP referrals sent to the TCC for booking into secondary care are being triaged by the CCG's diabetes clinical lead. Where the clinical lead feels that the patient could still be treated in primary care he contacts the GP in question to provide advice & guidance – and the referral to secondary care is prevented.

This has been in operation since November 2016 and to date 27% of referrals have been prevented for secondary care referral.

Repatriation of Partington Patients

The Partington Pilot is in the process of accepting patients who no longer need secondary care treatment. A cohort of patients has been identified and agreed.

The TCC has commenced contracting these patients to ensure they understand what is happening, provide reassurance on their future care and answer any questions the patient has.
This will then be the start of the development of the diabetes advocate role for the TCC.

Advocate Role
The TCC is currently developing the diabetes advocate role to support the wider Trafford diabetes population.
The Hospital Practitioner from Trafford General Hospital is preparing a training package for the TCC nursing team.

The advocate role will aim to help the patient:

- Improve diabetes control by reducing blood glucose levels
- Lose weight and reduce waist size
- Identify healthy foods, increase choice & drink alcohol in moderation
- Become more active
- Increase confidence and ability to look after your own health
- Improve blood pressure and blood cholesterol levels
- Improve quality of life, manage stress, sleep well (to improve mental health)
- Understand and ultimately reduce the medication you have to take for diabetes
- Stop/reduce smoking

TCC is a critical element of the diabetes redesign work and the throughput of patients interacting with this service will be managed as part of the neighbourhood roll out of the new model.

Summary
The programme of work for the wider diabetes model is currently at business case development stage, this programme will form part of the large scale Transformation portfolio of work for 19/20.

A number of workshops have been carried out a stakeholder group has been established to enable this programme of work. The clinical leadership is provided by clinicians who are involved in diabetic care on a day to day basis. Part of the focus for the stakeholder groups is to ensure that and any current challenges are being captured to ensure that they are being addressed and prevented in the redesign of the service.

Diabetes is 1 of 3 clinical priorities along with respiratory and mental health for the CCG they will form part of the 19/20 Transformation Programme and a key enabling programme for these priorities is the primary care quality standard for both general practice and relevant enhanced care standards that will be delivered through neighbourhood hubs such as the one being piloted for diabetes.

The next stage as part of the business case development stage will include data and evidence gathering, cost benefit analysis and implementation planning.

Health scrutiny are requested to note the positive developments in this area and support the development of the wider programme to roll out the model across Trafford neighbourhoods.