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Diabetes Treatment & Care Programme

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Treatment & Care transformation programme

1. Improving uptake of structured education **£10m**

2. Improving achievement of the NICE recommended treatment targets (HbA1c, cholesterol and blood pressure) and reducing variation **£17m**

3. Reducing amputations by increasing availability of multidisciplinary footcare teams **£8m**

4. Reducing lengths of stay for inpatients with diabetes by increasing availability of diabetes inpatient specialist nurses **£8m**

- Good evidence to suggest that these priorities will:
  - Have the most clinical impact
  - Are most likely to offer the highest return on investment and be sustainable
  - Will lead to improved outcomes for patients

Best Possible Value (BPV)

- Bidding process focused on which identifying bids offer Best Possible Value in terms of Strategic Fit, Value and Risk.
- Bids should be jointly agreed between CCGs and relevant providers with single Senior Responsible Officer
- Application form asks for details of:
  - Analysis of reasons for local position and actions proposed, with timescales
  - Planned improved outcomes and expected savings
  - Mutual commitment to reinvest savings in sustainable services.

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Structured education (1)

- Delivery of SE for patients with type 1 diabetes could deliver savings from reduced complications of :
  - an **estimated £440 average per person after 5 years and £1,800 after 10 years** for newly diagnosed patients
  - an **estimated £880 average per person after 5 years and £3,600 after 10 years** for the prevalent population

- Delivery of SE for patients with type 2 diabetes could deliver savings of
  - an **estimated £93 average per person after 5 years and £129 after 10 years for** the prevalent population
  - an **estimated £77 average per person after 5 years and £118 after 10 years** for newly diagnosed patients

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Structured education (2)

- Understand actual level of attendance at structured education courses- may well be higher than reported attendance levels. (5.7% reported nationally. Actual levels may be between 15-30%
- Understand why actual structured education attendance is low and agreeing actions to tackle it. Consider:
  - How clinicians explain structured education to patients
  - Are providers incentivised to maximise attendance?
  - Are attendance issues different for differing populations?
  - Do the time and locations of offer meet patient needs
  - Do content and cost reflect evidence?

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Treatment targets (1)

- Treatment target achievement associated with reduced risk of complications

- Great deal of variation in achievement:

  i) > 1 in 2 patients achieving the targets in some CCGs, <1 in 3 in others.

  ii) 40% of type 2 patients achieving targets, but only 20% of type 1.

- Estimated per patient saving (gross):

  i. After 5 years, average per patient saving would be £270 due to reduced risk of complications

  ii. After 10 years, average per patient saving would be £600 due to reduced risk of complications

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Treatment targets (2)

- Understand reasons for local underachievement of treatment targets
- Is underachievement focussed within specific GP practices, populations, localities?
- Appropriate achievement of the treatment targets will vary between different parts of local populations e.g. high elderly population, South Asian population etc.
- What are positions of comparator CCGs? If in better position, what do they consider to be reasons for this?
- Actions that have a clear rationale for why they are considered ones to bring about improvement and are sustainable.

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Footcare and Inpatient teams

- Estimated 57 hospital sties do not have a multidisciplinary footcare team and 54 sites do not have diabetes inpatient specialist nurses. Others have teams but with insufficient capacity for current demand.

- **Evidence suggests that, for every £5m invested in Multi-disciplinary Footcare Teams (MDFTs) or Diabetes Inpatient Specialist Nurses (DISNs), net savings of around £9m annually can be achieved.**

- Bids for funding for footcare and inpatient teams for sites without these in place, and expansion of capacity in existing services.

- Need to set out how teams will support other professionals also treating the same patients to promote consistency of care and improved outcomes.

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Provisional timescales and actions

- Invitation to CCGs to submit funding bids to be issued 2 December 2016.
- Funding bids to by submitted by 18 January 2017
- Bids can be by individual or groups of CCGs. Bids should be jointly agreed with providers
- Successful bidders to be advised by end February 2017