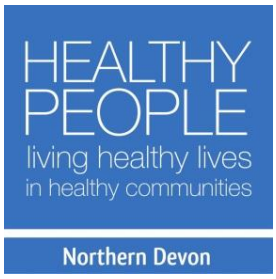

Northern, Eastern and Western Devon
Clinical Commissioning Group

Type 2 Diabetes Structured Education Business Case (Northern Locality)

Author: Nikki Bray, Commissioning Manager, NEW Devon CCG, Northern Locality
Gayle Richards, Diabetes Specialist Nurse, North Devon Healthcare Trust

Clinical Commissioning Lead: Dr Chris Bowman, GP

Date: April 2013

Version history

Version	Date issued	Brief summary of change	Owner's name
v.1	17.04.13		Nikki Bray

Office contact for this document:	

TYPE 2 DIABETES STRUCTURED EDUCATION BUSINESS CASE

Executive summary

This business case sets out the case for the commissioning of increased capacity in a structured diabetes education programme for people with newly diagnosed Type 2 diabetes in Northern Devon. As part of this proposal, it is recommended that the current service delivery model (DESMOND) is discontinued and replaced by a locally developed programme which is appropriately quality assured with the aim of:

- improving accessibility and offering care closer to home, better meeting the needs of the locality's largely rural population
- increasing the number of people accessing a diabetes education course from approximately 33% to 70-75% of those newly diagnosed annually
- strengthening integration between primary and secondary care, offering the opportunity for skills and knowledge transfer between primary care and Diabetes Specialist Nurses
- providing a more sustainable and cost effective delivery model

Provision of the education programme has the overall aim of:

- Improving clinical and patient outcomes, reducing complications of diabetes and improving levels of diabetes control

It is recommended that the Executive Team of NEW Devon CCG, Northern Locality, commission this new integrated model of diabetes education to a level which will allow for 100% of all newly diagnosed people with Type 2 diabetes to be offered a structured education course and with an expected take up rate of 70-75% of this patient population.

1. Objective

To meet NICE Guidance for Diabetes improving clinical and patient outcomes, reducing complications of diabetes and improving levels of diabetes control
Implement a sustainable service model which better meets the needs of the rural population of Northern Devon

2. Strategic context

2.1 Background

Diabetes is one of the most common chronic medical conditions in the UK, with an estimated 1.9 million adults diagnosed with the condition. Type 2 diabetes accounts for around 90% of these cases. Alongside this, some estimates suggest that there are an additional 0.5 million people with undiagnosed diabetes against a background of rising prevalence. The direct costs of type 2 diabetes are estimated to be around 7-12% of total NHS expenditure[1].

Type 2 diabetes:

- can cause severe complications, affecting the eye, the nervous system and the kidney
- is a leading cause of end-stage renal disease and blindness in people of working age
- is the most common cause of non-traumatic lower limb amputation
- doubles the rate of depression compared with the general population

- doubles the overall risk of cardiovascular disease
- reduces life expectancy by an average of 7 years

Around half of the people with the condition already have complications present at the time they are diagnosed.

It has been shown that good control of glucose levels, blood pressure and cholesterol can reduce the risks of complications (UKPDS, 1998). People with type 2 diabetes make choices about diet, physical activity and taking medication on a daily basis. For this reason United Kingdom Health Policy has recognised diabetes as a condition where effective self-management is crucial (e.g. Diabetes National Service Framework (Department of Health (DH), 2001)

2.2 NICE guidance

Structured education has been prominent in the Diabetes in Adults Quality Standard (NICE, 2011). NICE (2003) recommends that "structured patient education is made available to all people with diabetes at the time of initial diagnosis and then as required on an ongoing basis" (p4). This should be in groups with one-to-one teaching also available, however, NICE were unable to recommend a specific programme.

Consensus agreement has advised that any programme should include:

1. A structured written curriculum
2. Trained educators
3. A quality assurance process
4. An audit process (NICE, 2003)

2.3 Primary Care Quality Outcomes Framework

It is anticipated that the awareness of education for people with newly diagnosed diabetes will increase with the proposed introduction of Quality and Outcomes framework (QOF) indicator NM27 which requires practices to record those who have been referred to a diabetes structured education programme within 9 months of diagnosis.

2.4 Commissioning Outcomes Framework

The recently introduced NICE commissioning outcomes framework includes the following indicators for diabetes.

Domain 2 Enhancing quality of life for people with long term conditions

2.52	People with diabetes who have received nine care processes
2.53	People with diabetes diagnosed less than a year who are referred to structured education
2.60/2.63	People with diabetes who have an emergency admission for diabetic ketoacidosis
2.61	Complications associated with diabetes
2.62	Lower limb amputation in people with diabetes

2.4 Clinical Commissioning Group Strategic Objectives

This proposal is consistent with the following CCG corporate objectives:

- Member practices and their teams supported and developed to use their strengths to improve health and care

- Individuals supported to understand and engage with their wellbeing and decisions about their care, treatment and services

It is also consistent with the third key strategy of NEW Devon CCG:

- Moving the commissioning focus from treatment-based services to prevention and health maintenance

3. Local context

One example of a structured education programme for people with type 2 diabetes, the DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) programme has been delivered in North Devon since 2009. This programme is the only programme validated by random controlled trial (Davies et al, 2005). Delivery of the programme was agreed to be from Northern Devon Healthcare Trust (NDHT) and made available to all people within North Devon. Since then approximately 8 courses per year have run. These courses are offered to people within six months of diagnosis of Type 2 diabetes. Referrals are made from primary care to NDHT. Number of referrals per year:

Year	Number of referrals
2010-2011	138
2011-2012	150
2012-2013	128

Of those referred approximately 60-70% attend when offered a course. There is marked variation between referral rates from different GP practices. Some large practices refer very few people to the DESMOND programme. There are geographical barriers for some smaller very rural practices and some practices have made no referrals. Some practice nurses stating that people do not wish to travel to sessions in areas where DESMOND is currently delivered and some people of working age are not able to attend a whole day session.

The DESMOND programme has been delivered in Barnstaple, Bideford, South Molton, Torrington, Braunton and Holsworthy.

DESMOND has been delivered by 2 trained educators (band 6 or 7 Diabetes Specialist Nurse and band 6 Dietician. through North Devon Healthcare Trust. Staff time has been paid for through PbR tariff but license fee, hire of rooms, promotional resources, patient resources and administration have been resourced by NDHT.

The education programme consists of 1x 6 hour session (1 day).

North Devon Diabetes C2C endorsed a decision to discontinue delivery of DESMOND programme from April 2013 because DESMOND is costly to deliver and under-utilised, referral criteria too strict and there is variable professional knowledge of programme and lack of ownership. In addition with one of only two DESMOND educators going on maternity leave there will a lack of capacity to deliver the DESMOND programme from this April. The Eastern Locality of NEW Devon CCG have also developed an alternative localised model to deliver education to people with Type 2 diabetes.

It is therefore imperative that a new model of structured education is developed and efforts made to fulfil the likely increase in demand.

4. New service model

The delivery of structured education programme will take place in groups of 6 – 8 people with diabetes in community settings and will be based on the "conversation map" programme (Craddock et al, 2010). The programme will offer people with newly diagnosed Type 2 diabetes 2 two hour sessions approximately 1 week apart or one x 4hr session. Sessions will take place in mornings, afternoons and evenings, giving people with diabetes a choice of time. A similar localised education model is in use in the Eastern Locality of NEW Devon CCG.

Educators will be any health professional trained in the delivery of this programme. Training will be free and provided by a pharmaceutical company (with no promotional element). A core group of experienced practice nurses have expressed an interest in delivering the new education programme.

Practice nurses who do not wish to deliver group education will also be able to access the training. This will enable them to continue the education process when they see the attendees in follow up one-to-one consultations. In addition, practice nurses who undergo the training will have an understanding of what the programme involves when they are referring individuals and will be able to provide ongoing education This will promote an integrated education programme across North Devon.

5. Proposal

The proposal is to develop and implement a new model of Type 2 Diabetes Structured Education Model from May 2013 for people registered with a North Devon practice, commissioning increased capacity in this programme to meet local population need.

6. Benefits

The potential benefits of robustly commissioning an effective patient education programme for people with type 2 diabetes include:

- **improving** knowledge, health beliefs, and lifestyle changes
- **improving patient outcomes** such as biomedical markers, for example body weight, haemoglobin A1c, lipids and smoking; and psychosocial changes, for example quality of life and levels of depression[1]
- **improving** levels of physical activity
- **improving performance and patient-centred clinical care** through implementing the recommendations outlined in NICE clinical guideline CG66 on type 2 diabetes (update)
- **reducing** the need for, and potentially better targeting of, medication and other items, for example blood testing strips
- **reducing inequalities** and improving access to educational support, especially among black and minority populations, among those who report not attending an education course but want to, and those diagnosed some time ago
- **increasing patient choice** and improving partnership working, patient experience and engagement
- **greater cost-effectiveness**, which may help commissioners to manage their commissioning budgets more effectively.

Structured education and self-management programmes aim to improve outcomes by addressing the person's health beliefs, optimising their metabolic control, addressing their cardiovascular risk factors (helping to reduce the risk of complications), helping them to change their behaviour (such as increasing their physical activity), improving their quality of life and reducing any depression[1]. These programmes are an investment for the future. The potential consequences of not investing in such programmes are increased complications, greater future healthcare costs, and an inability to meet future goals for individual, local and national improvement. Well-designed and well-implemented programmes are likely to be effective and cost-effective interventions for people with type 2 diabetes.

NICE Diabetes Commissioning Guide available at:

http://www.nice.org.uk/usingguidance/commissioningguides/type2diabetes/commissioningapatienteducationprogrammeforpeoplewithtype2diabetes.jsp

7. The evidence base

NICE clinical guideline CG66 on type 2 diabetes (update) recommends that structured education should be offered to every person and/or their carer at and around the time of diagnosis, with annual reinforcement and review. It also recommends that people with diabetes and their carers should be informed that it is an integral part of diabetes care.

The NICE quality standard for diabetes in adults includes a statement about structured education which reads:

'People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education' (statement 1, NICE quality standard for diabetes in adults).However, there is evidence that not all people with type 2 diabetes are able to access sufficient educational input and many are unaware of some of the most important information.

8. Finance, activity and assumptions

8.1 Diabetes Local Incidence and Referral rates

According to NICE commissioning guidance, national incidence rates for Type 2 diabetes are 0.3% of the population (15 years and over). For North Devon this represents 414 new diagnoses per year with a referral rate to diabetes education expected by NICE to be 0.23% of the population or 75% of the population diagnosed with diabetes. This equates to 317 patients requiring diabetes education in North Devon annually.

Locally there has been a course take up rate of 60 to 70% of referrals with only an average of 138 patients referred per year. This equates to approximately 33% of those newly diagnosed annually. Diabetes rates are expected to increase.

8.2 Commissioning gap

		Courses required (6 to 8 patients per course)
Expected no. of newly diagnosed Type 2 annually (0.3% of over 15's)	414	
Total places required (75% opting to take up a place or 0.23% of over 15's)	317	
Existing capacity NDHT	150 places	19 -25 courses currently delivered as 15 courses
Additional places required	167 places	21-28 courses
Total courses		**40-53 per year**

N.B. courses are also open to carers to attend with the patient

This modelling does not account for people who are already diagnosed with type 2 diabetes who may wish to attend the course extra capacity could be commissioned to be able to offer this.

Courses for 150 people will continue to be delivered through North Devon Healthcare Trust's existing capacity. The extra required courses will be provided by practice nurses through a locally developed, quality assured diabetes education programme supported by Diabetes Specialist Nurses and dieticians. A similar model has been developed in the Eastern locality of NEW Devon CCG.

8.3 Service costs

NDHT will continue to provide 150 places per year as part of their commissioned service delivered by Diabetes Specialist Nurses and Dieticians.

A further 167 places to be commissioned via a practice nurse delivery model at a total cost of £11,905

Staff Costs	4,274
Venue	1,120
Staff Training	687
Quality Assurance	1,229
Admin (7.5hr per programme - Band 3)	2,395
Equipment / Stationery	1,200
Travel	1,000
Total	11,905
£ PER COURSE	425
£ PER PATIENT	71.29

Each group session is 4 hours in length or (2x2). The cost of venues could be reduced by the use of GP practices as venues.

8.5 Training costs
Practice nurses delivering the courses will have their time funded to attend Conversation Map training. Training will be provided free at a local venue by a pharmaceutical company. All other practices will be eligible to attend the training free of charge. This will ensure consistent, integrated education across North Devon.

8.6 Management costs
Northern Devon Healthcare Trust would be commissioned to manage this service and provide quality assurance. As the main provider of the existing Specialist Diabetes Service in North Devon and the current provider of the current Diabetes Education Programme capacity this would be an extension of the current diabetes education service. Managing the service will involve ensuring all educators are trained, quality assurance of the programme (this will be peer-to-peer review with other centres) and conducting appropriate audit.

8.7 Administration costs
It is anticipated that administration will continue to be delivered by NDHT. This will involve collation of referrals, booking of venues and co-ordination of educators.

9. Evaluation

See attached service specification for details of performance monitoring and evaluation data

10. Risks and issues

A decision to not commission the increased capacity within this programme may place people with Type 2 diabetes at risk of developing complications through a reduced ability to self-manage their condition.

Insufficient practice nurse capacity causing courses to be cancelled. A two tutor model minimises this risk.

Current poor referral GP rates may continue but QOF will incentivise referral. Patients should be able to self-refer to the programme and given this information at the time of diagnosis. Conversely, if there are high referral and patient opt in rates then there is a risk that the capacity commissioned may be insufficient. The national modelling assumptions may be incorrect, underestimating the number of courses required.

Demand for the education programme and service capacity will need to be reviewed at the end of the first year of the programme and capacity and funding adjusted as required.

Poor accessibility may lead to patients not opting in to the programme. This risk is mitigated by local delivery through a range of venues throughout North Devon, some delivered outside of 9 to 5pm, Mon – Fri hours. A consultation exercise with local patients is under way to understand favourable locations and times of course delivery.

11. Timescales

Decision to Commission	April/May 2013
Programme Development	April/May 2013
Practice Nurse Recruitment and Training`	June/July 2013
Programme Implementation	July 2013
6 month Programme Evaluation	Jan 2014

12. Recommendations

It is recommended that the Executive Team of NEW Devon CCG, Northern Locality agree to commission this new integrated model of education to a level which will allow 100% of all newly diagnosed people with Type 2 diagnosis to be offered a structured education course with an expected take up rate of 70-75% of this patient population.

References

Davies MJ et al (2005) the DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) programme: from pilot phase to randomised control trial in a study of structured group education for people newly diagnosed with Type 2 diabetes mellitus. *Diabetic Medicine.*22 (Supp 2) 104

Craddock S et al (2010) Using conversation maps in practice: The UK experience. *J. of Diab Nursing.* 14 (10): 380-386

Diabetes Commissioning Toolkit Home PD (2008) Impact of the UKPDS-an overview.Diabet Med. Aug;25 Suppl 2:2-8

Department of Health (2001) *National Service Framework for Diabetes: Standards*

NICE (2003) Guidance on the use of patient education models for diabetes. NICE technology appraisal guidance 60. London: NICE.

NICE (2011) Diabetes in adults. NICE quality standard. London: NICE

NICE QOF Advisory Committee 2012 summary recommendations for menu and retirement.