

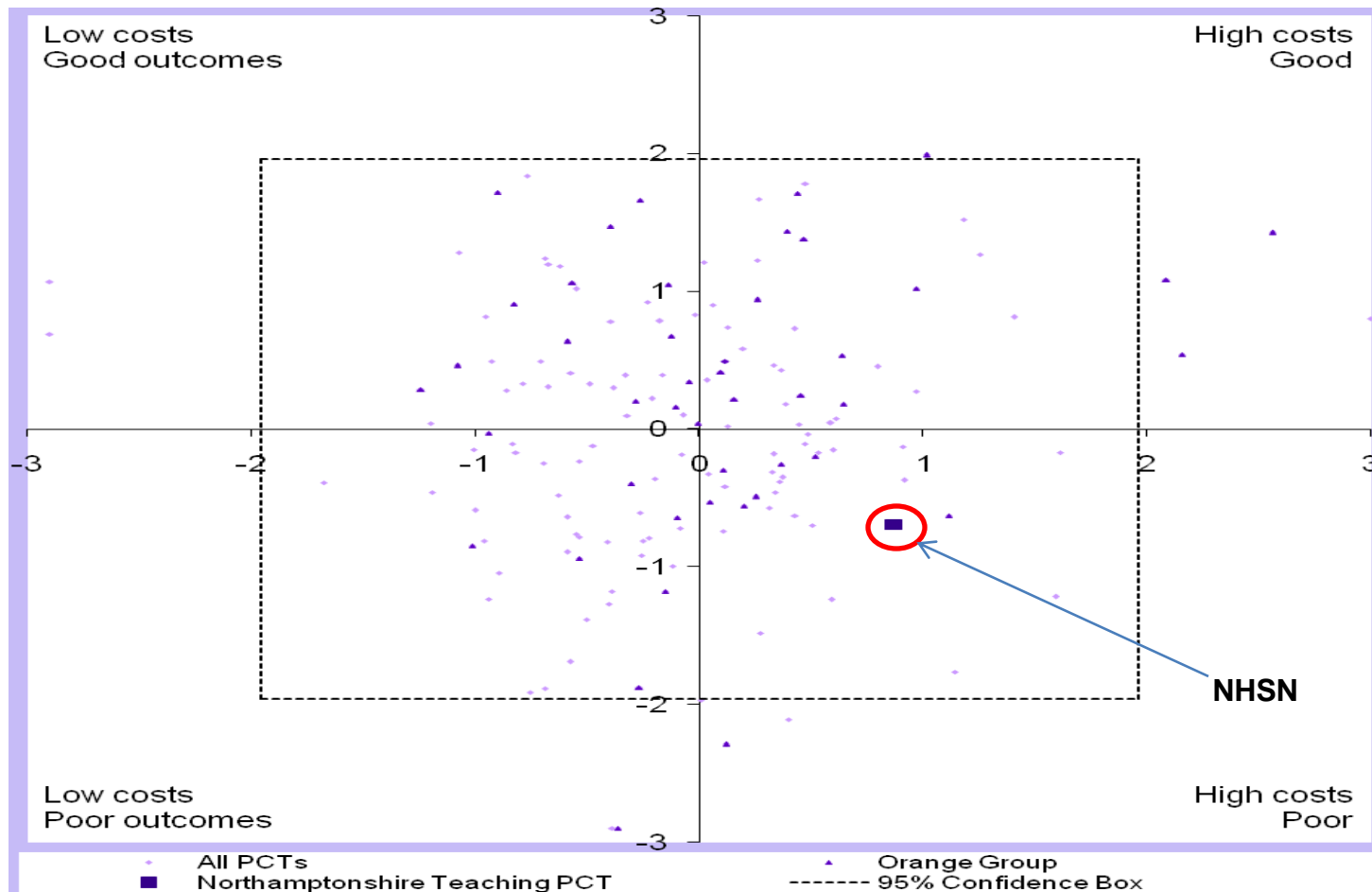
Commissioning for Quality

Diabetes

Why was Diabetes a priority for Northamptonshire

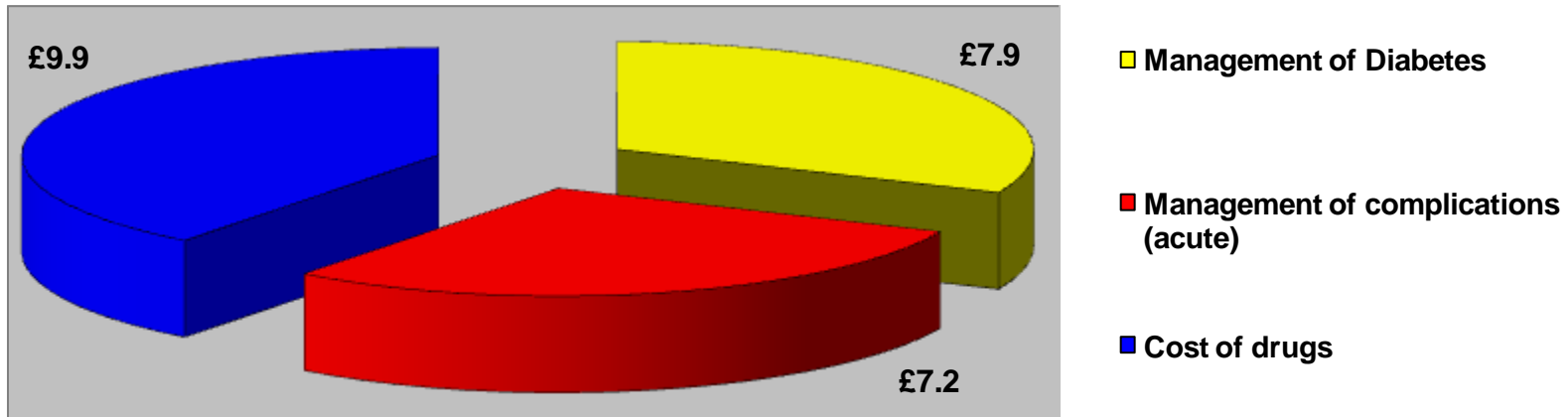
- **Analysis of total spend versus quality of care in diabetes found that when compared to other PCTs spend is high relative to quality**
- **The prevalence rate for diabetes in Northamptonshire is 4.48% (2010)**
- **By 2025 over 47,000 people will have diabetes in Northamptonshire**
- **The highest prevalence rates are Corby, Wellingborough and Northampton**
- **Kettering, East Northants and Northampton are forecast to see the biggest growth rates, in numbers over the next 10 years**

Spending on Diabetes care is currently the 17th highest out of 152 primary care trusts, covering a diabetes prevalence which is less than the national average. Despite this spend NHSN scored 'weak' in the health care commission report.



- Approximately 30% of the total spend on diabetes is attributed to the management of complications and prevention of progression within the Acute setting.
- Most patients should not require the management of complications if their diabetes is effectively managed with timely preventative measures put in place.

Breakdown of Current Spend (£M)



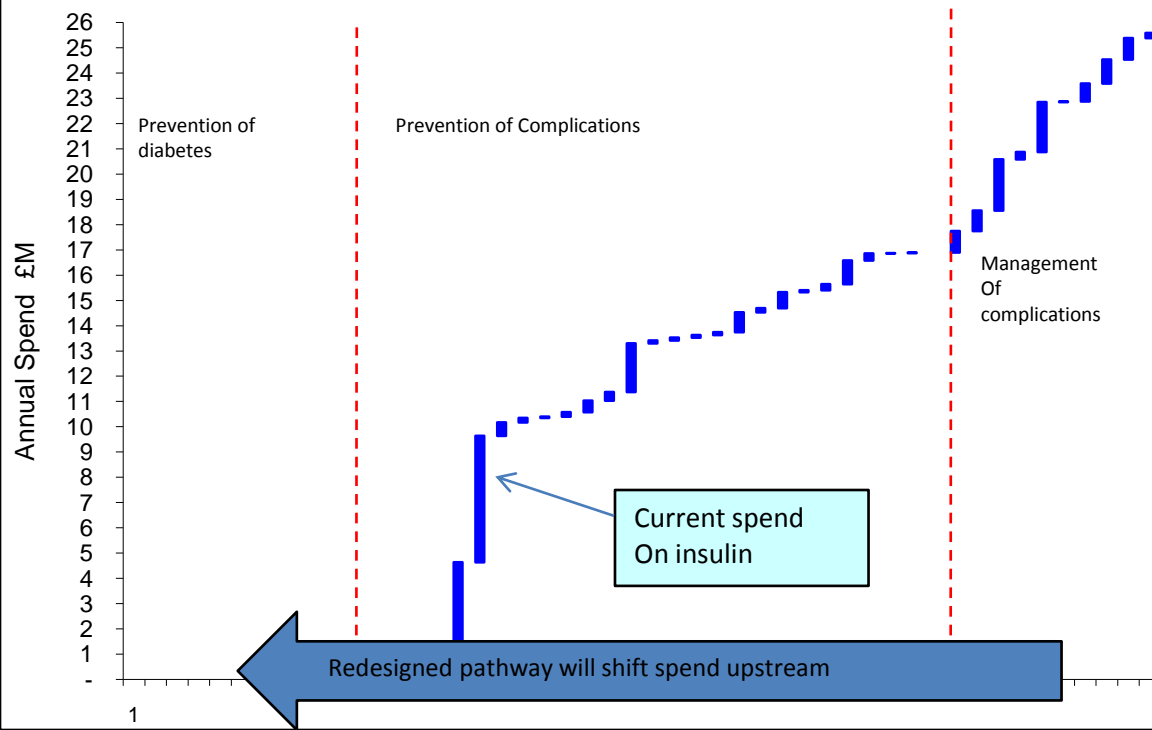
We worked with clinicians to identify Diabetes current service spend across the pathway

Diabetes Prevalence

- The prevalence rate for Diabetes in Northamptonshire is 4.48% and is expected to rise to 6.05% by 2020
- Modelling has shown that the number of people with Diabetes could rise from 28,000 to 47,000 by 2025
- If we did nothing by 2020 using today's spend we would be spending £35.0m

Existing Cost is £25m

Existing model cumulative costs



Weakness

- Emphasis on management of complications
- Prescribing costs
- Lack of equity across the county
- Lack of access to services for 'hard to reach' groups

Threats

- Increasing and ageing population
- Increasing diabetes prevalence
- High re-admission rates into acute settings

We used a four step Commissioning for Quality approach to identify opportunities for improvement in spend along diabetes pathway

- 1 Identify **evidence-based best-practice pathway**
 - Review all leading practice guidelines, used Map of Medicine to identify a patient's journey through the stages of disease
 - Determine interventions that are recommended or offered to patients at each stage
- 2 **Prioritise interventions based on strength of evidence** of clinical and cost benefit of each intervention in pathway
 - Review scientific databases and medical literature for evidence of clinical and cost effectiveness
- 3 Measure **gaps in PCT performance against best-practice** for each priority intervention on pathway
- 4 Identify and quantify opportunities for PCT to **disinvest** from less effective interventions, **reallocate** spend to more effective interventions, **ensure performance** to increase value for money, **'invest to save'** to avoid complications and identify **'potentially avoidable spend'** on complications

We set up a clinically led Diabetes Task and Finish Group to re-design the current service model

Membership

- **Diabetologists**
- **Podiatrists**
- **Dieticians**
- **Diabetes Specialist Nurses**
- **Practice Nurses**
- **GPs**
- **Patients**
- **Carers**
- **Desmond/DAFNE Leads**
- **Learning Disability Leads**
- **Pharmacist**
- **The Re-design Team**

How did we tackle it?

We worked with lead clinicians and patients to:

Workshop 1

Review Health Needs Assessment and set the vision

Workshop 2

Agree the clinical interventional pathway and review National and International best practice models

Workshop 3

Agree model of care and map agreed clinical interventions onto new model

Workshop 4:

Cost pathway and conduct a gap analysis between current practice and new model to draw up proposals

Workshop 5

Prioritise proposals

Workshop 6

Agree proposals

....and to reduce use of less validated oral treatments where not indicated


Issues

- Glitazones, Gliptins, and Exenatide...
- 60% of current Exenatide Rx do not comply with NICE
- 50% reduction in Rx of these agents would save £70k p.a.

Actions agreed

- Diabetologists to prepare education materials for GPs
- Diabetologists+PCT+ GPs to review patients taking Exenatide > 6 mo
- GPs to use patient information forms

Patient agreement



Exenatide Treatment

Today we have started / recommended a medicine called exenatide (trade name Byetta) to help treat your type 2 diabetes.

Exenatide is injected twice a day and, although it is not insulin, it should help reduce your blood glucose levels. It should also potentially help you to lose weight.

Exenatide is a very expensive medicine, costing just under £1,000 per year for each patient. We therefore need to monitor whether it is giving you these beneficial effects, as it does not work for everyone.

In order to assess this, we follow the guidance from the National Institute for Clinical Excellence (NICE), which states that treatment with exenatide should only be continued if patients see a reduction in their HbA1c (sometimes called the "H" test) of 1% or more and a reduction in their weight of 3% or more, after 6 months of treatment. If exenatide does not give you these results after 6 months then we will no longer use it.

Your weight today is

After a 3% weight loss your weight would be

Your latest HbA1c test is.....

After a 1% decrease your HbA1c test would be

Patient agreement
 The information above has been explained to me and I understand that treatment with exenatide will be stopped after 6 months if the results of that treatment are not as specified by NICE.

Patient name

Patient signature

Clinician name

Clinician signature

Date.....

Date of 6-month review

NHS Northamptonshire
 December 2009

With clinicians and patients we prioritised our evidence based interventions

Methodology

1. Gap analysis from workshop 5 resulted in 26 evidence based interventions for commissioning to get us from the current to the new model
2. These interventions were then grouped together and analysed
3. The analysis resulted in a prioritisation process
4. A final exercise mapped the interventions on a feasibility versus impact 2X2 matrix

....producing in the following prioritised interventions....

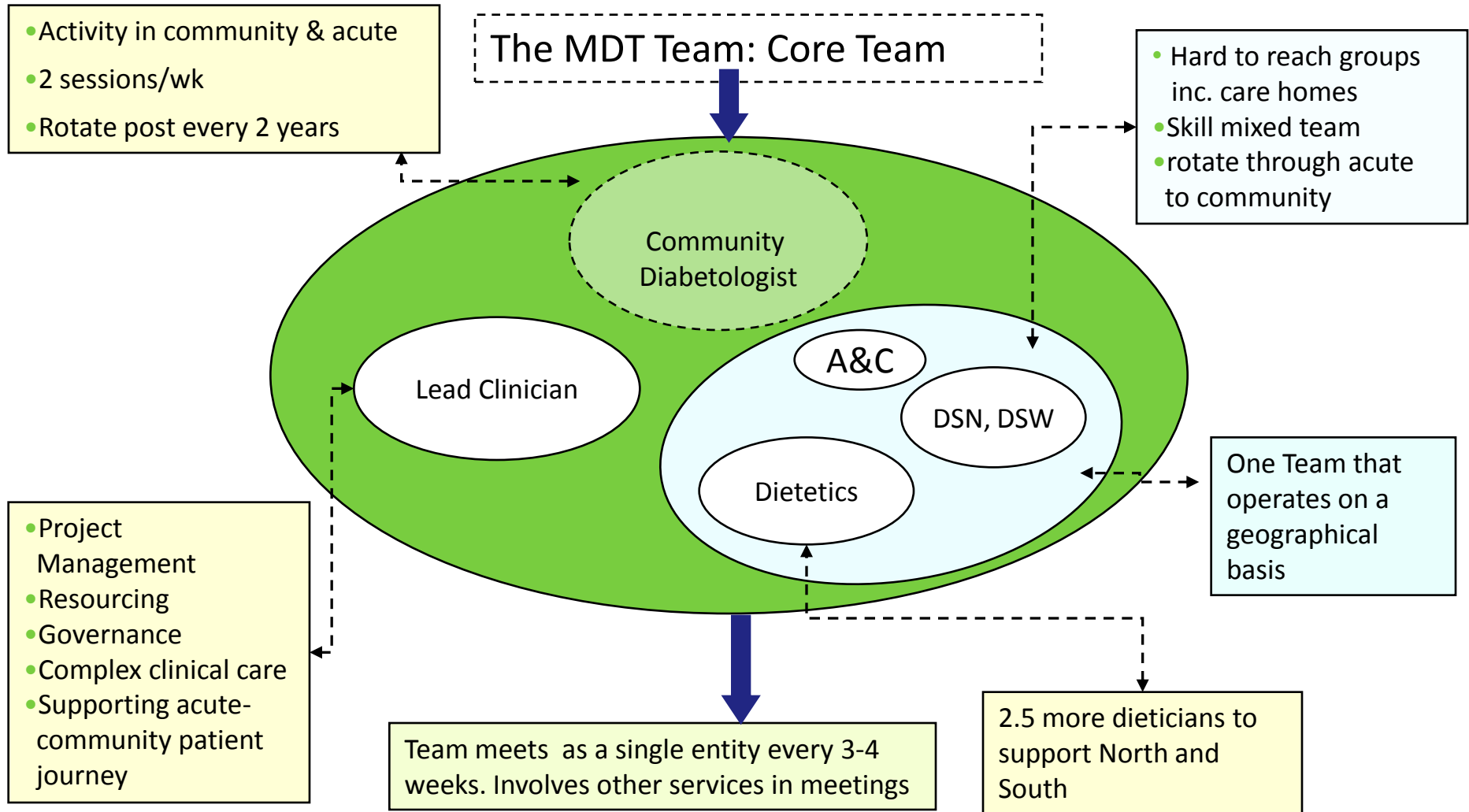
Criteria for Evaluation

Proposal Name Desmond DAFNE	Quality-Population impact		
	Quality-Patient satisfaction		
	Quality-Inequality		
	Quality overall		
	Cost	Overall	U
	Time to Realisation		Realisation
	Time to Realisation		
		Realisation	

- Community Multi Disciplinary Team
- Pre-diabetes
- Patient Education
- Staff Up-skilling
- Mental Health
- Podiatry

For Example.... Community MDT

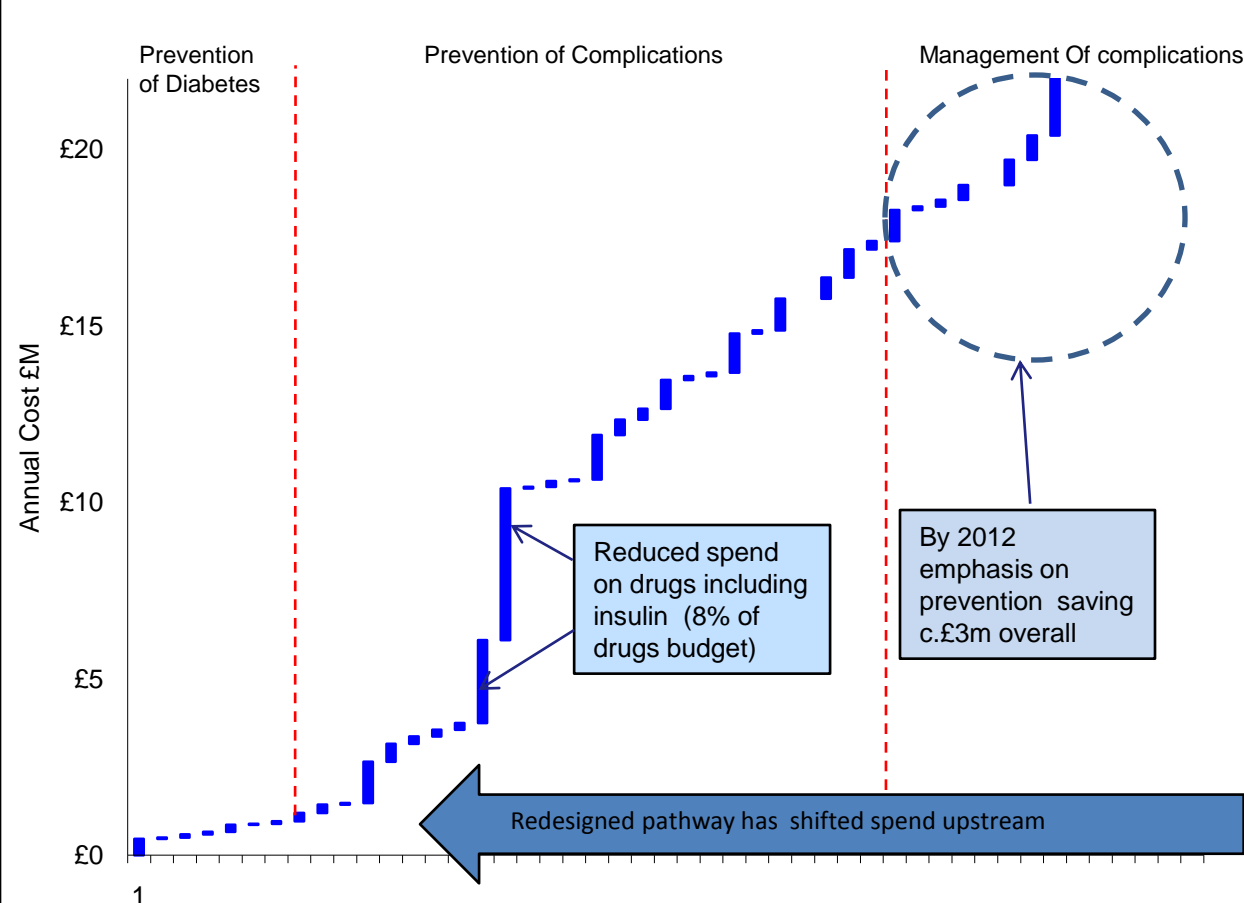
Future State



And cost the Diabetes New Service – Priority areas....

New Cost in Year 1 is £23.73m

New Model Cumulative costs based on best evidence interventions



Strengths

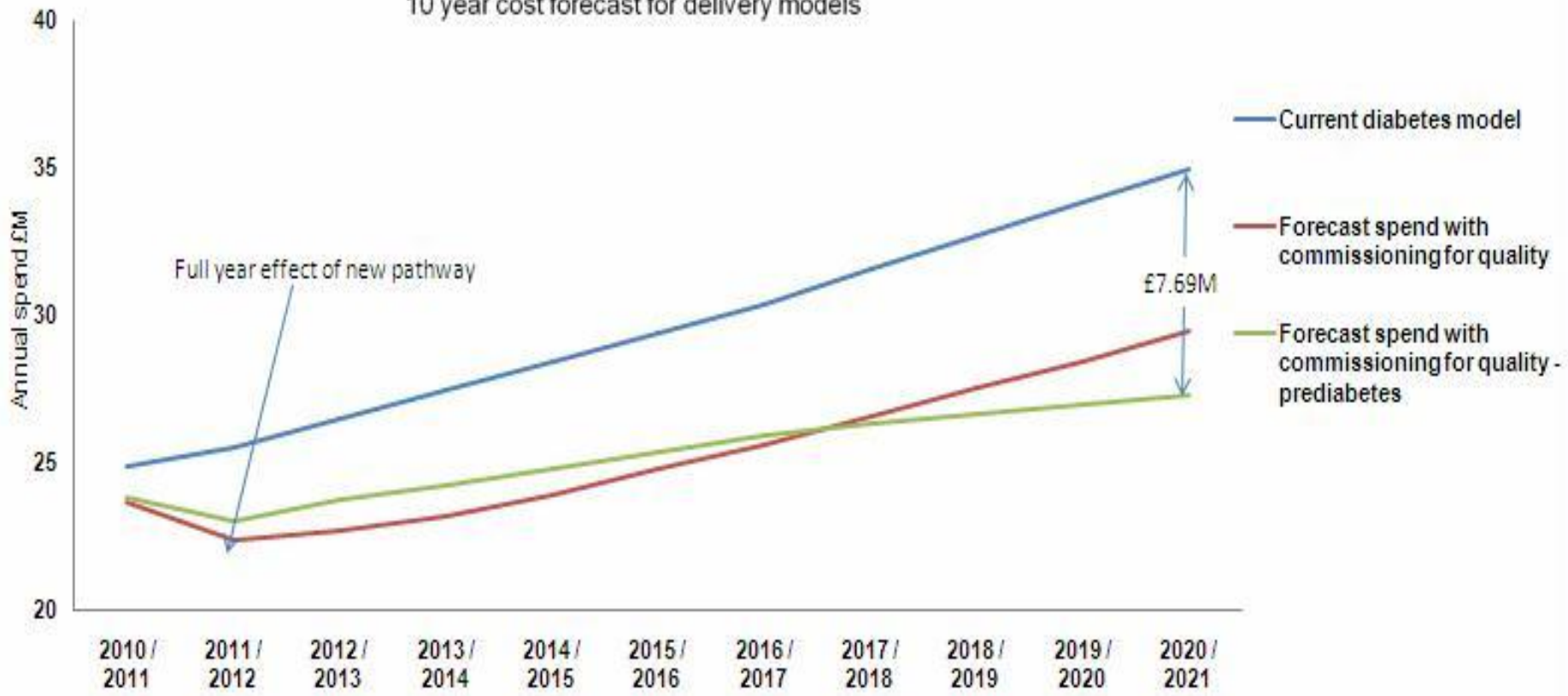
- Best Practice pathway
- International benchmarking
- Evidenced based interventions
- Costings by intervention
- Interventions agreed by local clinicians

Opportunities

- Insulin Prescribing costs ↓
- Other diabetic drug costs ↓
- Hospital admissions and re-admissions ↓
- Long term complications ↓

We modelled the financial impact of the interventions taking the medium and short term view for the pathway.....

10 year cost forecast for delivery models



What will success look like?

- Cost effective, clinically driven model of care which improve quality, reduces variance and has less reliance on acute care
- Reduced prescribing costs
- 10% less admissions and 15% less A&E admissions
- 20% less acute outpatients appointments
- Reduced foot and lower limb amputations
- Consistency in care
- Early identification of pre-diabetic population

Issue

Strategy

Outcome

..to arrive at a summary of financial impact

All Figures In £k)	2010/11 PYE	2010/11 FYE	2011/12	2012/13
New Model Investment	512	953	953	953
New Model Gross Benefit	846	1804	2054	2249
Nett Financial Impact	334	851	1101	1296

In Summary

- Issue
 - High spend for poor outcome
 - Too high emphasis on secondary care
 - Prescribing deviating from NICE guidelines
- Strategy
 - Review pathways using C4Q methodology
 - Prioritise focus based upon QIPPS outcomes
- Outcome
 - 6 areas for further development

Next Steps



Launch and Implementation

We have already kicked off the implementation process

- Organised launch event with Diabetes UK for July 13th
- Completed kick-off meetings including the clinical network oversight
- Identified top 10 Practices in need of nurse training
 - Planned for first training event in July
 - Planning for >50% of practices up-skilled by end of year
 - Already agreed the course content
 - Already agreed metrics to monitor prescribing of Insulins
- Agreement with local practice based commissioners to standardise prescribing of BGTS in July