Appendix 1

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Core Diabetes Commissioning Framework

January 2020

Core Diabetes Commissioning Framework

Introduction

The prevalence of Type 2 Diabetes and Non-Diabetic Hyperglycaemia (sometimes known as Pre-Diabetes) has dramatically increased over the last few decades, following the increasing prevalence of obesity. Unfortunately, this non-communicable disease is largely associated with the wider determinants of health and the NHS previously has concentrated mostly on the management of the complications of diabetes - blindness, amputations, kidney failure, heart attacks and strokes.

As the local healthcare economy contemplates its development into an Integrated Care System (ICS), more focus and resource needs to be spent not only on the prevention of these conditions, but also to seek to help mitigate the wider social causes through education, support and coaching enabling a patient to best manage their diet and lifestyle factors to ensure a better weight, glycaemic control, blood pressure and blood lipids. Structured education has been demonstrated to enable such improvement, however only ~7% of patients with diabetes are able to attend such classroom-based teaching. Therefore, the C&P STP would seek to enable such education/information to be disseminated in a patient-centred and relevant way, proactively & opportunistically, face-to-face & digitally, crossing barriers of language, cultures, educational attainment and socio-economic divides.

Our ambition for all patients with a new diagnosis of Type 2 Diabetes or Pre-Diabetes, is that they are informed that remission is a possible outcome, and that if this is not achieved, that well-controlled diabetes, blood pressure and lipids is the norm. This diagnosis does not represent inevitable complications and high morbidity.

Such ambition requires the education and commitment of all C&P clinicians and Non-Medical Providers, working closely with our Public Health and Local Authority partners to address and reduce the obesity prevalence. As with smoking, this requires a systemic consistent approach with national impetus. C&P STP intends to be that advocate and lead to ensure that the challenge to address this 'new' non -communicable disease of obesity and its associated diseases is taken.

The aim of the Core Diabetes Framework is to deliver an integrated high-quality pathway for diabetes care between primary care, secondary care and community care. The need for change is marked and includes:

- Health inequalities, the CCG has marked difference in prevalence between the North and South of the CCG with significantly worse outcomes for patients in Wisbech, Fenland and Peterborough.
- Increasing diabetes prevalence in Cambridgeshire and Peterborough and a growing ageing population mean need for diabetes care will increase over the next 5 years.
- Disjointed services currently in place with primary care, community services and acute trusts having limited integration between them and no shared outcomes.
- The CCG is rated as requires improvement for diabetes and has been for several years. This is mainly due to the poor delivery of the 3 treatment targets (3TT) for diabetes. These are the 3 targets for blood pressure, hyperglycaemia and blood lips being within NICE limits for diabetes patients. The CCG is currently at 35.3% of patients meeting

these 3 targets vs the national average of 40.1% based on the National Diabetes Audit returns 2017/18.

- Uncontrolled 3TT is associated with increased number of cardiovascular events including myocardial infarction, stroke and ischaemic limb. Improving the number of well-managed patients with diabetes (i.e. all those who have all 3TT at target) will decrease the rate of these emergency presentations.
- The Long Term Plan sets out some key requirements of diabetes services and the system needs to evolve to meet these over the next 2-5 years (see Appendix 1).
- The STP has set out an ambitious strategy for diabetes in 2019 and this provides a compelling vision for how the STP should improve diabetes care over the next 5 years.

The CCGs role is to set out the ask from the Alliances and Clinical Community in the STP for Diabetes and assure delivery of changes to outcomes for CCG patients. Responsibility for delivery sits with the Alliances overseen by the Clinical Community

The objectives:

- Deliver improved outcomes for Patients with Diabetes in Cambridgeshire & Peterborough;
- an improved service within the existing service costs/budget and managing costs within demographic growth over 3 years;
- to ensure that all core out of hospital diabetes services are delivered for Primary Care Networks (PCNs) in Integrated Neighbourhood Teams (INBTs).

The broad definition of 'core out of hospital diabetes services' that are in scope for this framework is most services for adult Type 2 Diabetes patients. Most Type 1, paediatric, maternal and complex patients would not fall directly under the framework.

The CCG proposes the Alliances form a joint (North and South) Programme Team which will lead on the programme underpinned by this programme framework. The CCG, as commissioner, will work closely with the Alliances to assure delivery of the framework milestones, Key Performance Indicators (KPIs) and outputs and ensure the system works together on the redesign. The Diabetes Clinical Community will provide support, clinical expertise and leadership to the programme evolving from its current form to be a Programme Board including oversight of the allocation of resources.

Framework Approach

As part of the framework, the Alliances will need to adopt the following ways of working through the Programme Team:

- The key principle that all core out of hospital diabetes services are to be managed by PCNs in Integrated Neighbourhoods in the first instance.
- Engage with all relevant stakeholders including the CCG, CPFT, patients/groups, other current providers of diabetes services.
- Work together with PCNs and Alliances to agree phasing of the programme into achievable steps by defining the scope for each phase and clearly stating the deliverables for each phase. This will involve early adopters and wider roll out.
- Work with Alliances, CPFT and other stakeholders to design services to deliver core KPIs and outcomes for the redesigned pathway. Capture this in a service specification for Diabetes in Integrated NBTs
- Engage in an evaluation of the pilot model in 20/21.

Framework Delivery Programme

The proposal is to develop a Diabetes Delivery Programme through the Alliances. The programme would be phased including:

- Phase 1 – Set up Pilot PCNs and Baselining of performance, costs, staffing and programme set up
- Phase 2 – Pilot PCN development and testing of new models with time series analysis and evaluation. Write specification of delivery around PCNs/INBTs
- Phase 3 – Wider roll out to all PCNs of new specification
- Phase 4 – improvement in Diabetes outcomes and KPIs and shift of resources across the system

Framework Milestones

Phase	Milestones	Completion date
Phase 1	a. Draft discussed with Governing Body	January 14th 2020
	b. Pilot PCN early adopter sites (5 PCNs across the CCG) commence	January 20
	c. Engagement and comments from stakeholders on commissioning framework	February
	d. Forming of Programme team and governance through Alliances	February 20
	e. Review commissioning arrangements to align to local delivery	February 20
	f. Governing Body agreement of commissioning framework and commissioning arrangements	March 20
	End of phase 1 –CCG agreed baseline, costs, programme set up and plan for delivery.	March 20
Phase 2	a. Programme governance and resources in place through Alliances	April 20
	b. Redesigned KPIs and outcomes – amend provider KPIs to focus on delivery of 3TT standards and patient outcomes with primary care	April 2020/21
	c. Evaluation and learning from PCN pilot sites	Q1 2020/21
	d. Development of service specification for primary care diabetes model	April 1st – June
	End of Phase 2 – Update and sign off specification by Alliances, Diabetes community and CCG	June - Governing Body
Phase 3	a. Wider roll out of Diabetes specification to other PCNs	July 20

	b. Contractual changes to diabetes service provision in place.	From 1 October 2021
Phase 4	Ongoing monitoring of outcomes in line with agreed trajectories	April 21 – April 22

Framework KPIs and Outcomes

Issue	Interventions	KPI
Pre-diabetes and prevention	Proactive weight assessment in Primary Care Proactive identification of patients with Pre-Diabetes Referral into weight loss services Referral to NDPP Digital or Group Consultations offered at PCN Fatty liver – commissioning FIB-4 scoring of obese DM patients in Primary Care	Accurate Obesity prevalence and register Reduce forecast diabetes prevalence – Baseline and trajectory TBC NDPP (or equivalent) uptake
Diabetes diagnosis	Management to 3TT using Eclipse to Monitor Integration of digital - pathology results and clinical notes across Alliance PAM and dissemination of heath coaching methodology	3TT performance – both individual and combined: • January to June 2020 – 38% (Lower Quartile) • End of March 2021 – 41% (national average) • End of March 2022 – 44% (upper Quartile) PAM level improvements Diabetes in Remission register
Self-management and ongoing care for diabetic patients	Structured learning – referral and completion of DAPHNE and DESMOND or equivalent services Development of local SE course Utilisation of on-line digital SE courses	No. of patients starting and completing courses vs 2019 baseline
Completion of 8 care processes	Delivery of 8 care processes	Improvement in 8 care processes delivery from 2018/19 baseline
High acute costs, amputations and Length of Stay	Peripheral vascular disease – commissioning ABPI measurement in >50's with DM MDFT in acute care integrated with community podiatry Improved primary care management	No. of acute limb ischaemic presentations at secondary care Reduction in LoS, cost and amputations in acute services from April 20 baseline

Key enablers

The CCG will expect Alliances and PCNs to:

- Improve tools for and uptake of self-care and engagement with weight loss programmes, structured education and the NDPP using risk management e.g. eclipse/Vista tools and proactive engagement with patients by staff.
- Improve Patient Activation monitored through PAM tools – with coaching and motivational interviewing techniques
- Ensure there is appropriate resources for this work in PCNs through a LES, shift of staff to primary care or equivalent agreement
- Use Eclipse VISTA as a core enabler of patient identification and management
- Increase the number of diabetes and associated staff directly under control of PCN Diabetes Clinical Lead from April 2020 baseline.
- PCN annual audit of staffing, skillset and achievement of 8CPs and 3TTs
- PCN-level initiation and management of injectable and newer hypoglycaemic medications to allow complex patients be cared for nearer home.

Costings

The CCG will work with both Alliances to agree a baseline cost of diabetes services in each place. The CCG will expect these costs to reduce vs demographic growth over the next 3 years (2023) from an April 2020 baseline.

The distribution of funds and resources may fundamentally change within the North and South Alliance between providers. As an STP / ICS, monies will need to be focussed on the support of prevention of obesity, pre-diabetes and Type 2 Diabetes. There are double the number of patients with diabetes and higher prevalence of obesity in the North compared to the South Alliance and resources will need to reflect this.

Any additional national funding for Diabetes will be made available to the Alliances and PCNs in the first instance.

The table below shows the predicted level of spend on diabetes care over the next 4 years, in a 'do nothing' scenario for the CCG. The assumptions on the baseline spend are included within appendix 1.

	18/19	19/20	20/21	21/22	22/23	23/24
	Actual Spend	Forecast (18/19 + growth)	Forecast (19/20 + growth)	Forecast (20/21 + growth)	Forecast (21/22 + growth)	Forecast (22/23 + growth)
Acute	£55,930,677	£60,237,339	£63,610,630	£66,918,383	£70,398,139	£74,058,842
Community	£1,642,529	£1,750,936	£1,819,222	£1,882,895	£1,948,797	£2,017,004
Prescribing	£16,191,711	£16,920,338	£18,020,160	£19,191,470	£20,438,916	£21,767,445
Primary Care (LES)	£549,554	£572,635	£586,951	£601,625	£616,666	£632,082
Total	£74,314,471	£79,481,248	£84,036,963	£88,594,373	£93,402,517	£98,475,374

Growth applied above		**19/20**	**20/21**	**21/22**	**22/23**	**23/24**
Acute	N/A	7.7%	5.6%	5.2%	5.2%	5.2%
Community	N/A	6.6%	3.9%	3.5%	3.5%	3.5%
Prescribing	N/A	4.5%	6.5%	6.5%	6.5%	6.5%
Primary Care (LES)	N/A	4.2%	2.5%	2.5%	2.5%	2.5%

The financial baseline needs further refinement work, specifically to work with CPFT and Primary Care to ensure that all costs associated with providing diabetic care have been

appropriately identified (for example, the above Community costs relate solely to the CPFT diabetic service – are there any costs within the Neighbourhood teams that relate to diabetic patient care?). Cost identification for the North and South Alliance also needs to be completed and will require input from provider colleagues.

Expected efficiencies

As part of the programme of redesign, the Redesign Team will need to work with stakeholders, to determine where efficiencies can be improved. Key efficiency outcomes are:

- Reducing duplication of provision between primary care and community diabetes services
- Managing the forecast increase in prevalence through lifestyle and self-care initiatives
- Using digital and non-one to one face to face patient care e.g. groups, Apps etc.
- Reducing acute costs through reductions in inpatient stays and LoS
- Using skill mix and AI to reduce cost of service delivery
- Preventing diabetes and managing existing patients more effectively with subsequent reduction in system costs

Risks

Key risks of the programme include:

No.	Risk	Mitigation	Risk rating
1	Increasing demand for Diabetes services against a flat budget	• Clear outcomes and scoping of programme at outset • Regular monitoring, using agreed framework • Defined escalation routes • Procurement considered as an option, if model not successful	RED
2	Cessation of national funding	• Limited efficacy of current services • Programme Team engagement with all stakeholders	AMBER
3	PCNs - Capacity and resources to do transformation	• Innovation funding and increased capacity in primary care support and workforce	RED

Governance and Resources

How CCG will work with The Alliances: The programme will work through the Alliances and Diabetes Clinical Community which will evolve to have programme Board functions; will report to the CCG who will oversee the programme; assure delivery of the milestones, KPIs and outputs in the framework; ensure the system works together on the redesign; conduct a risk assessment; ensure stakeholders are engaged and that communication is effective; and, oversee evaluation of the proposed model.

It is proposed in discussion with the Alliances that an STP SRO for diabetes is appointed at CEO level and is accountable for delivery through the Alliances and the Clinical Community for the outcomes in the Framework. The SRO working with the proposed Diabetes Programme Team will develop a programme plan for delivery, allocate resources and

funding within Diabetes, report to both Alliances and the CCG on progress and ensure outcomes of the Framework are being delivered.

Further detail can be found in Appendix 2.

APPENDIX 1:

Draft Core Diabetes Commissioning Framework – background information

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1.1. Why Redesign Diabetes Services

The prevalence of Type 2 Diabetes and Non-Diabetic Hyperglycaemia (sometimes known as Pre-Diabetes) has dramatically increased over the last few decades, following the increasing prevalence of obesity. Unfortunately, this non-communicable disease is largely associated with the wider determinants of health and the NHS previously has concentrated mostly on the management of the complications of diabetes - blindness, amputations, kidney failure, heart attacks and strokes.

As the local healthcare economy contemplates its development into an Integrated Care System (ICS), more focus and resource needs to be spent not only on the prevention of these conditions, but also to seek to help mitigate the wider social causes through education, support and coaching enabling a patient to best manage their diet and lifestyle factors to ensure a better weight, glycaemic control, blood pressure and blood lipids. Structured education has been demonstrated to enable such improvement, however only ~7% of patients with diabetes are able to attend such classroom-based teaching. Therefore, the C&P STP would seek to enable such education/information to be disseminated in a patient-centred and relevant way, proactively & opportunistically, face-to-face & digitally, crossing barriers of language, cultures, educational attainment and socio-economic divides.

Our ambition for all patients with a new diagnosis of Type 2 Diabetes or Pre-Diabetes, is that they are informed that remission is a possible outcome, and that if this is not achieved, that well-controlled diabetes, blood pressure and lipids is the norm. This diagnosis does not represent inevitable complications and high morbidity.

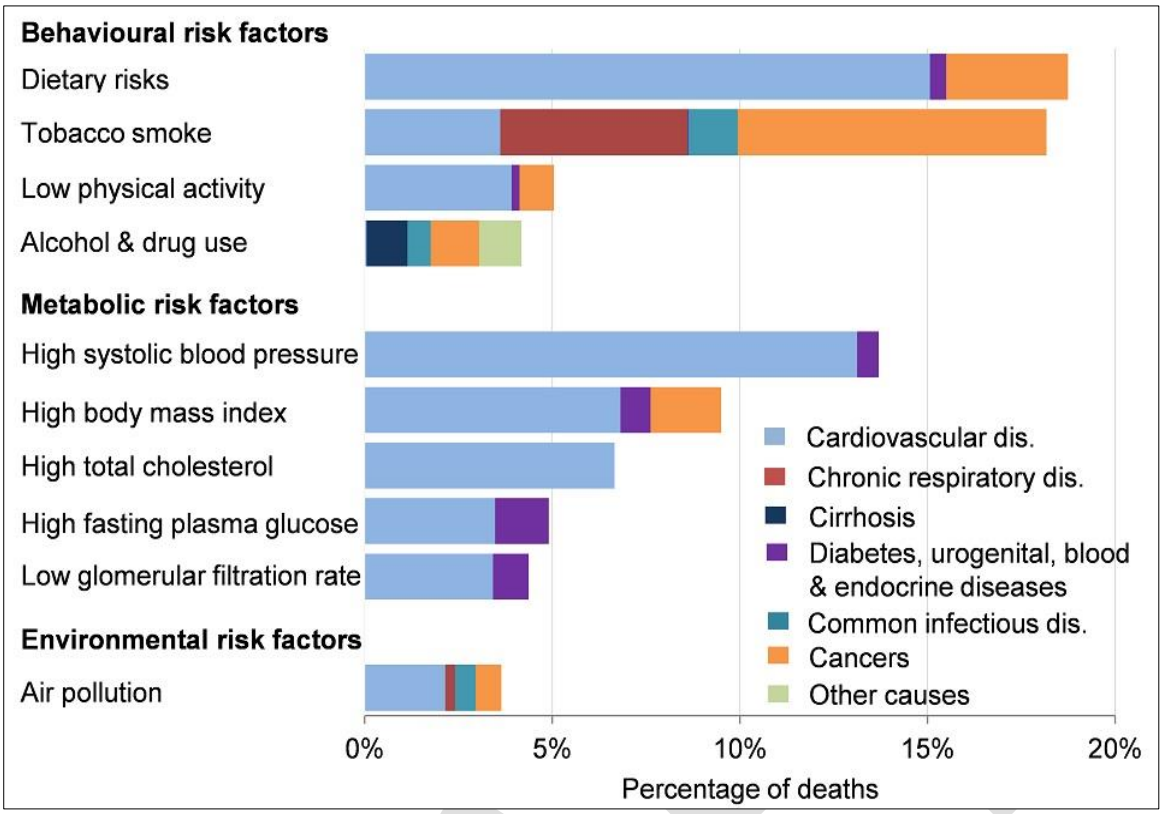
Such ambition requires the education and commitment of all C&P clinicians and Non-Medical Providers, working closely with our Public Health and Local Authority partners to address and reduce the obesity prevalence. As with smoking, this requires a systemic consistent approach with national impetus. C&P STP intends to be that advocate and lead to

ensure that the challenge to address this 'new' non -communicable disease of obesity and its associated diseases is taken.

The reasons for targeting Diabetes are several and include:

- Health inequalities, the CCG has marked prevalence between the North and South of the CCG with significantly worse outcomes for patients in Wisbech, Fenland and Peterborough.
- Increasing diabetes prevalence in Cambridgeshire and Peterborough and a growing ageing population mean need for diabetes care will increase over the next 5 years.
- Disjointed services currently in place with primary care, community services and acute trusts having limited integration between them and no shared outcomes.
- There are several variable pathways across the CCG and patients experience of diabetes services varies depending on where they are in the CCG
- The CCG is rated as requires improvement for diabetes and has been for several years. This is mainly due to the poor delivery of the 3 treatment targets for diabetes. These are the 3 targets for blood pressure, hyperglycaemia and blood lips being with NICE limits for diabetes patients. The CCG is currently at 31% of patients meeting these 3 targets vs the national average of 34%.
- The STP has £4m of funding over 3 years which ceases in April 20. There is little evidence of transformed services within the STP using this money and the service currently in place is not sustainable with the core funding available to the STP.
- The Long Term Plan sets out some key requirements of diabetes services and the system needs to evolve to meet these over the next 2-5 years.
- The STP has set out an ambitious strategy for diabetes in 2019 and this provides a compelling vision for how the STP should improve diabetes care over the next 5 years.
- The long term outcomes for diabetes are largely predicated by lifestyle factors and preventative measures the system puts in place. This requires much closer working with the Local Authority and Public Health alongside shifting funding into these services.
- NICE QS6 – Diabetes in Adults sets out quality standards for diabetes which the system needs to meet. The Quality Standard is below and covers:
    - https://www.nice.org.uk/guidance/qs6/chapter/Introduction
    - preventing type 2 diabetes in adults (18 years and older)
    - structured education programmes for adults with diabetes
    - care and treatment for adults with diabetes
    - preventing and managing foot problems in adults with diabetes.

Patient outcomes are relatively poor within the CCG compared to national benchmarks.



Prevalence of long-term and high dependency conditions by district of general practice location, Cambridgeshire and Peterborough, 2017/18

Area of GP location	Cancer*		Diabetes (17+)	
	Percentage	Number of people	Percentage	Number of people
Cambridge	1.9	3,616	3.3	5,495
East Cambridgeshire	3.3	2,778	6.8	4,660
Fenland	3.1	3,596	8.2	7,779
Huntingdonshire	2.9	5,209	6.4	9,326
South Cambridgeshire	3.3	4,560	5.1	5,557
Cambridgeshire	2.8	19,759	5.6	32,817
Peterborough	2.1	4,670	7.0	11,961
Cambridgeshire and Peterborough	**2.6**	**24,429**	**6.0**	**44,778**
England	2.7	1,593,302	6.8	3,196,124

Statistically significantly better than the England average
Statistically similar to the England average
Statistically significantly worse than the England average

Prevalence and growth:

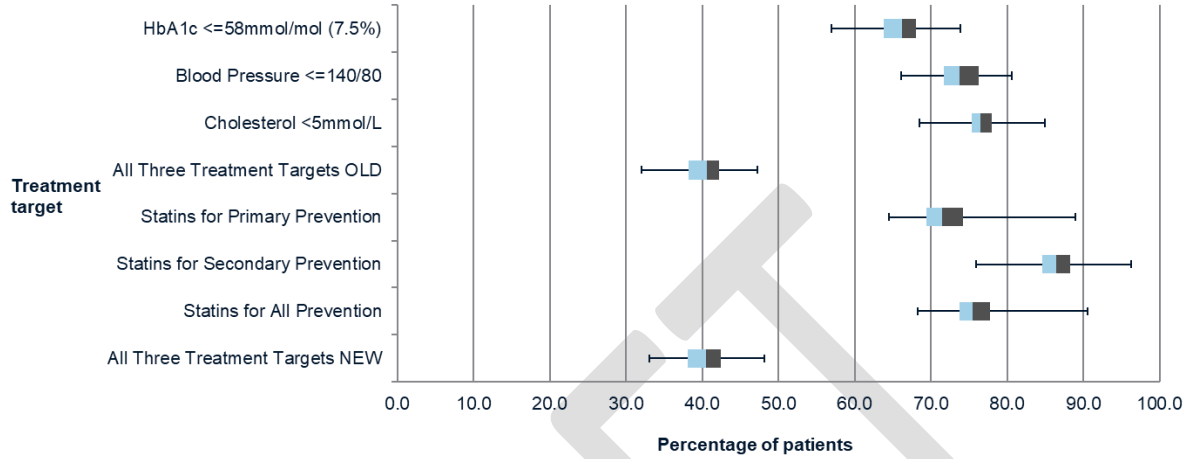
It is predicted that diabetes prevalence will increase over the next 10 years in line with national trends from the current modelled prevalence of 7.7% of the population to 7.8% in 2020 and to 8.1% by 2025. The actual identified recorded prevalence is 5.9%.

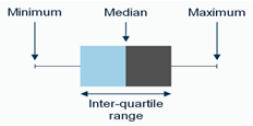
In approximate numbers this takes the current diabetes prevalence from a total in 16/17 of 44,861 up to approximately 55,000 patients by 2025.

System Performance

The STP (and CCG) and monitored against the number of patients within range of all 3 treatment targets (HBA1c, BP and Cholesterol). The current performance is 35% against a national level of 40%. This is based on the national returns a summary of the national position is below:

The range of CCG/LHB treatment target achievements for people with Type 2 and other diabetes, England and Wales, 2017-18





The CCG must improve from its current performance to get to first lower quartile, then national average and then upper quartile performance. This trajectory is approximately:

- January to June 2020 – 38% (Lower Quartile)
- End of March 2021 – 41% (national average)
- End of March 2022 – 44% (upper Quartile)

1.2. Scope of Diabetes Programme

The diabetes services that are covered span all core Type 2 diabetes services in the STP. These are all with NICE quality standards (QS6) and span from prevention services commissioned by the LA to acute endocrine and foot care. Out of scope for the initial phases of this commissioning programme is paediatrics, special patients and maternal diabetes.

1.3. STP Diabetes Strategy

The STP has written and developed a local strategy derived from national guidance and the NHS Long Term Plan. This sets out that the priorities for the STP are improving the treatment and care functions of the system which is the main theme of this Commissioning Framework

1. Address prevalence and risking risk over a number of years
2. An Ambition for Remission for T2DM
3. Invest in prevention strategies
4. Re-design, simplify and harmonise clinical pathways
5. Introduce better monitoring, intervention and evaluation

6. Diabetes to be a primary focus for Alliances, Integrated Neighbourhoods and partners
7. Address Health Inequalities
8. A system-wide Diabetes Budget
9. Future areas to be addressed. The second phase of this project (2021-2022) will include:
    1. Further therapies for Type 1 Diabetes
    2. Pre-conception, Pregnancy and Diabetes
    3. Diabetes in special patient groups (major complications, Serious Mental Illness, Learning Disorders, travellers, rough sleepers)

The strategy phases delivery into work for 2020-2021 which is focussed on improving the prevention and management of Type 2 diabetes and then to move onto Type 1, gestational diabetes and special patients' groups. This is the focus of the Commissioning Framework and although Type 1 is in scope it is not the priority focus area for the programme initially.

The Commissioning Framework is the CCG commissioning plan in its role as the strategic commissioner in the system and to enable system partners to be clear on their remit and specific outcomes to deliver.

1.4. NHSE's Long Term Plan vision for Diabetes

The CCG and STP is required to plan for the delivery of the requirements of the NHS Long Term Plan (LTP). A summary of the main asks for Diabetes is attached as Appendix XX. The headlines are:

- Prevention through reducing Obesity
- Support for more people living with diabetes to achieve the three recommended treatment targets;
- Targeting variation in the achievement of diabetes management, treatment and care processes;
- Addressing health inequalities through the commissioning and provision of services;
- Expanded provision of access to digital and face-to-face structured education and self-management support tools for people with Type 1 and Type 2 diabetes;
- Providing access for those living with Type 2 diabetes to the national HeLP Diabetes online self-management platform, which will commence phased roll out in 2019/20;
- Ensuring universal coverage of multidisciplinary footcare teams (MDFTs) and diabetes inpatient specialist nurses (DISN) teams, for those who require support in secondary care.
- Implement the Very Low-Calorie Diet

These are very much in line with the local STP Diabetes strategy and are areas that the CCG needs to further improve or has only recently started to address with non-recurrent funding. This commissioning Framework addresses the asks of the LTP.

1.5. Current Diabetes services

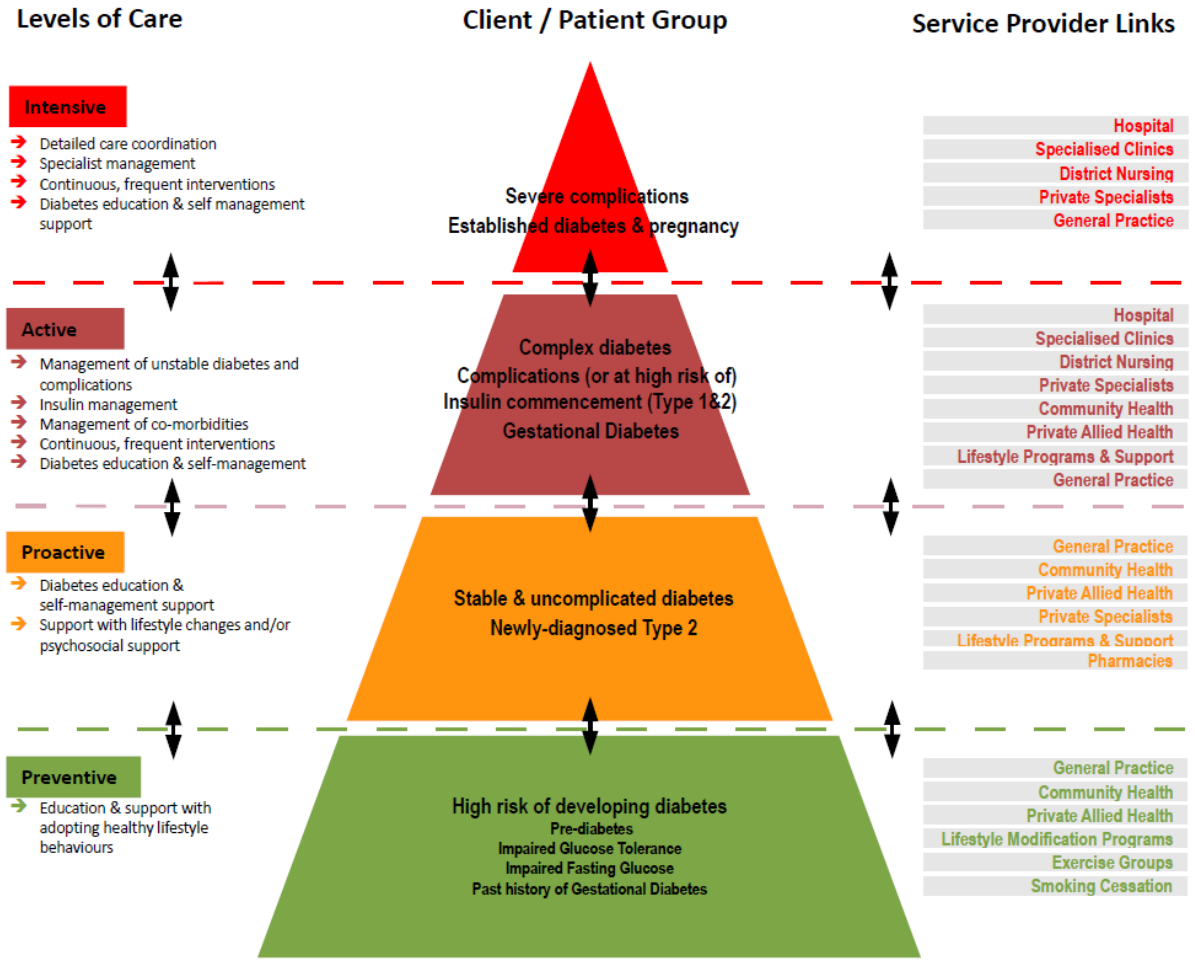
Mapping services

Current Diabetes services are provided by

- CPFT – core diabetes community services, dietetics, district nursing services, podiatry services
- Primary Care provision – GMS QOF standards for managing patients within NICE targets and foot care. The CCG has 86 practices and 21 Primary Care Networks.
- CUHFT – Accepts GP and consultant referrals for outpatients and emergency and inpatient admissions for vascular complications
- NWAFT – Accepts GP and consultant referrals for outpatients and emergency and inpatient admissions for vascular complications
- Other providers include QEH

The Diabetes pathway

The below diagram sets out how diabetes patients' should access services at various stages of acuity of the disease. This illustrates how patients should move through the pathways if their disease progresses and is set against a highly variable delivery of diabetes services currently. This aim of the STP needs to be to move as much of diabetes care down the triangle as possible.



1.6. Key stakeholders

Key stakeholders will include:

- The CCG

- North and South Alliances
- PCNs
- Acute providers including CUHFT, NWAFT
- Other providers e.g. QEH
- NHS England
- Patient groups/representatives

1.7. Benefits of Diabetes redesign

Financial Benefits include:

- Reducing the cost of diabetes to the system over 5 years vs demographic growth but movement of resources within a diabetes programme budget
- Reducing GP appointments or need to see a GP face to face for the condition utilising full MDT skillset and digital solutions
- Reducing the number of unnecessary investigations and blood tests
- Reducing the number of prescriptions for diabetic medications through ambition for remission and dietary modification
- Reducing secondary care appointments

Quality Benefits include:

- Improved prevention and pre-diabetes management to prevent disease progression through an ambition for remission
- Primary care management of the condition closer to patients' home and in an integrated team
- Improved management of key patient management metrics e.g. 3TTs and diabetic foot care processes.
- Reducing conditions becoming more persistent /chronic and therefore reduced progression of disease and complications
- Reduced mortality and morbidity through improved diabetic and cardiovascular outcomes

Health Benefits include:

- Ensuring patient sees right clinician, at right time ensuring patient is on correct management pathway early on and therefore reducing pathway length
- Improved integrated care between primary, community and secondary care, which will lead to better health outcomes
- Reduced health inequalities in the system.

1.8. KPIs and Outcome measures

KPIs are as per below:

Issue	Interventions	KPI
Pre-diabetes and prevention	Proactive weight assessment in Primary Care Proactive identification of patients with Pre-Diabetes Referral into weight loss services Referral to NDPP Digital or Group Consultations offered at PCN	Accurate Obesity prevalence and register Reduce forecast diabetes prevalence – Baseline and trajectory TBC NDPP (or equivalent) uptake

	Fatty liver – commissioning FIB-4 scoring of obese DM patients in Primary Care	
Diabetes diagnosis	Management to 3TT using Eclipse to Monitor Integration of digital - pathology results and clinical notes across Alliance PAM and dissemination of heath coaching methodology	3TT performance – both individual and combined: • January to June 2020 – 38% (Lower Quartile) • End of March 2021 – 41% (national average) • End of March 2022 – 44% (upper Quartile) PAM level improvements Diabetes in Remission register
Self-management and ongoing care for diabetic patients	Structured learning – referral and completion of DAPHNE and DESMOND or equivalent services Development of local SE course Utilisation of on-line digital SE courses	No. of patients starting and completing courses vs 2019 baseline
Completion of 8 care processes	Delivery of 8 care processes	Improvement in 8 care processes delivery from 2018/19 baseline
High acute costs, amputations and Length of Stay	Peripheral vascular disease – commissioning ABPI measurement in >50's with DM MDFT in acute care integrated with community podiatry Improved primary care management	No. of acute limb ischaemic presentations at secondary care Reduction in LoS, cost and amputations in acute services from April 20 baseline

1.9. Financial Context

Overall Programme budget for diabetes summary is set out below

	18/19	19/20	20/21	21/22	22/23	23/24
	Actual Spend	Forecast (18/19 + growth)	Forecast (19/20 + growth)	Forecast (20/21 + growth)	Forecast (21/22 + growth)	Forecast (22/23 + growth)
Acute	£55,930,677	£60,237,339	£63,610,630	£66,918,383	£70,398,139	£74,058,842
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Growth applied above		**19/20**	**20/21**	**21/22**	**22/23**	**23/24**
Acute	N/A	7.7%	5.6%	5.2%	5.2%	5.2%
Community	N/A	6.6%	3.9%	3.5%	3.5%	3.5%
Prescribing	N/A	4.5%	6.5%	6.5%	6.5%	6.5%
Primary Care (LES)	N/A	4.2%	2.5%	2.5%	2.5%	2.5%

Assumptions included in programme budget

- Acute spend is based on inpatient spells, identified to ICD10 codes in primary and secondary diagnosis. The identification criteria was agreed upon with input from diabetic clinicians. Due to the intricacies of identifying this spend, 18/19 actual spend has been used as the baseline and planned growth applied for 19/20.
- Community spend includes the core diabetic specialist nurse service within the CPFT core contract and does not include the total spend currently funded through the national diabetic treatment and care programme funding.
- Prescribing spends includes diabetic prescribing through FP10 and spend on diabetic devices and consumables with the acute trusts (ie insulin pumps).
- The growth assumptions have been taken from the 4 year plan.

1.10. Work Programme and Key milestones

The key Milestones for the Framework are set out below:

Phase	Milestones	Completion date
Phase 1	g. Draft discussed with Governing Body	January 14th 2020
	h. Pilot PCN early adopter sites (5 PCNs across the CCG) commence	January 20
	i. Engagement and comments from stakeholders on commissioning framework	February
	j. Forming of Programme team and governance through Alliances	February 20
	k. Review commissioning arrangements to align to local delivery	February 20
	l. Governing Body agreement of commissioning framework and commissioning arrangements	March 20
	End of phase 1 –CCG agreed baseline, costs, programme set up and plan for delivery.	March 20
Phase 2	e. Programme governance and resources in place through Alliances	April 20
	f. Redesigned KPIs and outcomes – amend provider KPIs to focus on delivery of 3TT standards and patient outcomes with primary care	April 2020/21
	g. Evaluation and learning from PCN pilot sites	Q1 2020/21
	h. Development of service specification for primary care diabetes model	April 1st – June
	End of Phase 2 – Update and sign off specification by Alliances, Diabetes community and CCG	June - Governing Body
Phase 3	c. Wider roll out of Diabetes specification to other PCNs	July 20
	d. Contractual changes to diabetes service provision in place.	From 1 October 2021
Phase 4	Ongoing monitoring of outcomes in line with agreed trajectories	April 21 – April 22

Alliances are required to develop plans and updates to the CCG at the end of each phase of the Framework

1.11 Innovation and Digital Diabetes

The STP's digital strategy identifies digital first primary care as a key priority, setting the ambition that, by 21 March 2024, the majority of patients with long term health conditions, including cancer, mental health or care needs will have access to digital tools in their homes and / or in their hands. For patients and their families this should enable them to feel they have access to information and support, tailored to their condition and home context, with vital sign and mobility information being monitored remotely (should they choose) to generate early alerts to carers and / or healthcare professionals (as per agreed protocols). They should also have the ability to contact their care team online, by text or by phone (and vice versa), and creatively designed information / apps that provide education, motivational support and reminders for their health and care.

This project will be our flagship for delivering this ambition, while also providing useful foundations for the technological, capability and cultural changes required to enable:

- An appetite for, and understanding of, the design for a patient held care record;
- The roll out of end to end outpatient pathway transformation – a major priority for the System in 20/21;
- The recommissioning, led by public health, of lifestyle services across Cambridgeshire and Peterborough;
- PCNs to develop a sense of common purpose and have a significant impact on their patient populations, including identifying tasks to be shared at PCN level, sharing of workforce across PCNs and workload reductions through automation;
- Social prescribing and health coaching; and
- The increase in uptake key digital first primary care must do capabilities, through giving a clear use case including:

    - Roll out of NHS App
    - Roll out of online consultations
    - Roll out of population health management (Eclipse)
    - Roll out of online appointment management in primary care

We have been successful in bidding to become a digital first primary care accelerator for the East region in 2019/20. This accelerator programme represents a significant step towards achieving the ambition for remission for patients with type 2 diabetes, in up to 5 PCNs with some of the highest levels of deprivation and with the poorest outcomes – likely to be from Peterborough, Fenland, Ely and/or north Cambridge City. The list of PCNs is being finalised from a short list at present, as it is essential that they opt into this, collectively with a population size of c 250,000.

The programme also offers a chance for the STP to develop a new innovation methodology which can be replicated across other pathways / PCNs (in our STP and across the region) if successful. We have the support of wider partners including Eastern AHSN, Cambridge University Health Partners, and the Applied Research Collaborative – where we will identify areas of mutual interest.

Digital Programme overview:

The digital first redesign of the pathways for patients with type 2 diabetes, including those with CVD risk factors and/or are overweight will involve a combination of digital tools. It is anticipated that the digital tools we would see ultimately deployed could combine:

1. Proactively identification of patients with diabetes with care gaps – the Eclipse system is already in place, and being used by a number of practices already;
2. Automating pathway management (e.g. call & recall, booking appointments, monitoring gaps in care process) – using robotic process automation like that being trialled with GPs in Suffolk and promoting the use of existing patient-led booking e.g. via the NHS App;
3. Offering digital (alongside face to face) tools for education and self-help for weight management, diet, exercise, mood, including:
    a. Online education (e.g., MyDesmond, Healthy Living – previously known as HeLP);
    b. Apps – which offer information and/or behaviour change support (e.g., Changing Health – based on POWeR study; Our Path);
    c. Tailored information prescriptions, including in other languages / pictures / videos to make them more accessible.

    and potentially making these available via district council-led front door portals, MiDOS and/or the 111 DOS, which would integrate primary care, social prescribing and urgent care pathways;
4. Remote / point of care diagnostics for HBAIC, BP, Lipids, etc – making the most of the FreeStyle Libre glucose monitors for example;
5. Online consultations:
    a. between patients and primary care clinicians (phone, email / web form, video) – integrating existing platforms into clinical workflow for this pathway; and
    b. MDTs between primary, community and secondary care clinicians – e.g., using outpatient video platforms;
6. Rapid communication between clinicians across primary, secondary and community care, for very brief and quick turnaround (e.g. sub 4 hrs response) professional support (i.e. not formal advice & guidance)

Overlap with Diabetes Commissioning Framework

The Digital work provides an enabler for the delivery of the outcomes required in the Commissioning Framework. It also comes with national funding and support otherwise not available to C&P STP. The CCG and the STP Digital Team have tried to ensure the outcomes of digital diabetes and the wider Diabetes programme dovetail with each other and are aligned.

Appendix 1:

Long Term Plan Requirements for Diabetes:

For further information and context can be found in the Long Term Plan Implementation Framework: https://www.longtermplan.nhs.uk/implementation-framework/

1. *To support the delivery of prevention activities additional funding will be made available:* ***Obesity:***
    - *The Diabetes Prevention Programme (DPP) is a nationally-funded and commissioned programme. Systems should set out local referral trajectories that will contribute to the national DPP uptake;*
    - *Targeted funding for 2020/21 and 2021/22 for a small number of sites to test and refine an enhanced weight management support offer for those with a BMI of 30+ with Type 2* diabetes *or hypertension and enhanced Tier 3 services for people with more severe obesity and comorbidities.*

2. *In April 2019 we established the national Children and Young People's Transformation Programme to support the delivery of service improvements set out in the Long Term Plan. Local plans to improve outcomes for children and young people should:*
    - *Develop plans that will deliver Long Term Plan commitments, with a specific focus on:*
        - *Improving care for children with long-term conditions, such as asthma, epilepsy, diabetes, and complex needs;*

3. *Systems are asked to set out their approach for delivering improved services in line with the Long Term Plan commitments for people with Type 1 and 2 diabetes, including:*
    - *Support for more people living with diabetes to achieve the three recommended treatment targets;*
    - *Targeting variation in the achievement of diabetes management, treatment and care processes;*
    - *Addressing health inequalities through the commissioning and provision of services;*
    - *Expanded provision of access to digital and face-to-face structured education and self-management support tools for people with Type 1 and Type 2 diabetes;*
    - *Providing access for those living with Type 2 diabetes to the national HeLP Diabetes online self-management platform, which will commence phased roll out in 2019/20;*
    - *Ensuring universal coverage of multidisciplinary footcare teams (MDFTs) and diabetes inpatient specialist nurses (DISN) teams, for those who require support in secondary care.*

4. *To support systems to deliver these improvements additional funding is available as follows:*
    - *Central reimbursement arrangements are in place for 2019/20 and 2020/21 to enable up to 20% of people living with Type 1 diabetes who are eligible under the clinical criteria for that funding, to access flash glucose monitoring devices;*

- *There will be targeted funding for MDFTs and DISNs transformation projects. In the first instance, continued funding will be provided in 2019/20 for currently established MDFTs and DISN transformation projects, supporting them to become sustainable from 2020/21 onwards. Thereafter, targeted funding will be available for systems that have not had access to MDFTs and DISNs by this point, to help improve equality of access and ensure universal coverage;*
- *Targeted funding from 2019/20 to 2023/24 to support delivery of the three recommended treatment targets and to continue funding for existing structured education projects. This funding is tapered to reduce across the period as improvements are embedded;*
- *Targeted funding to test low calorie diets for obese people with Type 2 diabetes, working with demonstrator sites covering up to 5,000 people from 2019/20;*
- *Ensuring that pregnant women with Type 1 diabetes are offered continuous glucose monitoring from April 2020, where clinically appropriate. Funding arrangements will be confirmed later in 2019/20.*

5.23 Details of the support available to systems can be found here.

Diabetes

- *Funding to pilot the use of low calorie diets from 2019/20 until 2022/23; funding to support delivery of recommended treatment targets; funding for multi-disciplinary footcare teams and diabetes inpatient specialist nurses (see 4.31).*

Appendix 2 – Governance and Programme Resources