NHS
Yorkshire and the Humber
Clinical Senate

Clinical Senate Review

of the

Diabetes Service Model on behalf of the Bradford Provider Alliance

March 2017

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1. Chair's Foreword

1.1 The Yorkshire and the Humber Clinical Senate thanks the Bradford Provider Alliance for the invitation to work with them on their proposals for an improved service model of care for diabetes across Bradford. I would like to thank the expert clinicians who have worked with us on this review.

1.2 We commend the Bradford Provider Alliance on the concept and the principles of this model and we fully support the Alliance in their bold vision of a truly integrated diabetes service. The Senate has welcomed the opportunity to help shape and develop this early draft and we hope that our comments and observations will assist the Alliance in developing the detail of the model.

2. Summary of Key Recommendations

2.1 The Senate agrees that the concept and the principles of this integrated diabetes model of care are commendable. We fully support commissioners' intentions to move disparate services into a patient centred integrated model where diagnosis, treatment and ongoing care is commissioned in its entirety. The vision of this single seamless service fits with the national recommendations. We recognise that this is a difficult task, particularly in determining the scope and financial envelope, and the draft model provided to the Senate is very much a work in progress. There is more detail required to demonstrate how this vision can be achieved and our recommendations focus on where the Alliance can add that detail to strengthen the proposals and make clearer the intentions for the model. The Senate hopes that these comments will be helpful to the Alliance in supporting the next steps in this model's development and we wish the Alliance success in achieving their vision.

The Senate recommends that the Alliance:

Recommendation 1

Include substantial quantifiable information that details the challenges in the current system and its inability to meet future needs and how this would be overcome with the new model of care.

Recommendation 2

Provide further detail to explain the true integration being provided in the new model and the role of the community hub so that it can be more clearly understood how this differs from the existing system.

Recommendation 3

Define both the in scope services more clearly and explain the interrelationship between the in scope and out of scope services. This needs to include how the relationship with those out of scope services will impact upon the success of the model and how this will be managed.

Recommendation 4

More clearly define the relationship with primary care and their role in the delivery of this model. Within this the Alliance are recommended to highlight their key success in bringing every GP practice across Bradford City and Bradford District Clinical Commissioning Groups (CCGs) as partners in this Alliance and to make clearer their intention around training and education.

Recommendation 5

Provide more detail on the fit of secondary care within the model.

Recommendation 6

Discuss the approach to the management and reduction of co-morbidities.

Recommendation 7

Provide greater financial detail and clarity on the uplift over the 10 year span and set out the relationship between those integral services that are financially excluded from the model but need to be influenced and included within the care provision.

Recommendation 8

Include an explanation of the accountability and clinical leadership structure within the document and describe the legal and governance framework for the Bradford Provider Alliance.

Recommendation 9

Provide clarity of the impact of this service on the Airedale and Craven population and the relationship with the Sustainability and Transformation Plan (STP) and the Bradford and Craven 5 Year Forward View.

Recommendation 10

Better articulate the integration of the model to address the concerns about the fluid movement of patients across the tiers of care and to provide more detail on the use of technology to support the Multi-Disciplinary Team (MDT).

Recommendation 11

Provide more emphasis and detail on the role of education within the model and include a section that details the relationship with prevention and how commissioners are tailoring their prevention work to meet the needs of their largely South Asian population.

Recommendation 12

Provide more detail about the relationship with the voluntary community sector and how they will be supported in delivering this model.

Recommendation 13

Provide a greater level of detail on podiatry which is a key part of this service.

Recommendation 14

Provide further detail on the medicines management strategy.

Recommendation 15

Expand upon the opportunities for innovation and the use of technology within the model.

Recommendation 16

Provide more information on how patients with mental health conditions will be cared for and clarify the care of the child within this model.

Recommendation 17

Provide the evidence base for the outcomes with further thought about the timeframe and the presentation of those outcomes that are out with the scope of the model.

3. Background

Clinical Area

3.1 Diabetes is one of the biggest healthcare challenges facing the NHS. There are now 2.2 million people with diabetes in England and the number of people developing Type 2 diabetes continues to increase. There are a range of factors contributing to the rise in diabetes cases, including the increasing levels of obesity and an ageing population.

3.2 The overall costs to those affected and their families are considerable, with diabetes increasing the risk of stroke, heart attack, blindness, kidney failure and amputation. Prevalence of diabetes is also higher in areas of higher socio- economic deprivation and in people of South Asian descent. NHS Bradford City, NHS Bradford Districts and NHS Airedale, therefore experience a higher prevalence of diabetes than the national mean, given the large South Asian population and the difference in socio-economic status across the locality.

3.3 The Bradford Provider Alliance is leading a redesign of the integrated diabetes service involving many stakeholders in the development of an end to end diabetes pathway and patient journey from prevention through to acute intervention.

Role of the Senate

3.4 The Senate has been provided with an early draft of the proposed model with the scope to consider:

- The comprehensiveness of the model
- The areas for improvement
- Whether the model will deliver the outcomes

3.5 Bradford Provider Alliance and Bradford CCGs are seeking independent clinical advice from the Senate to inform the future development of the model. This will assist in the development of a successful and clinically robust business case and help to provide buy in from stakeholders.

3.6 The specific questions the Senate has been asked to address are:

- ***Can the Senate advise on the Integrated Diabetes Model of Care and whether this provides a comprehensive model of care for the population of Bradford?***
- ***Can the Senate advise on any clinical concerns relating to any elements of the model?***
- ***Can the Senate highlight potential improvements to the model, with a view to how it could be further optimised?***
- ***Can the Senate review the assumptions of the impact of the model and offer a view as to whether the integrated model is ambitious enough to deliver the improved outcomes set by commissioners?***

Process of the Review

3.7 The Terms of Reference for this review were agreed on 7th February 2017 and are available at Appendix 3.

3.8 The draft service model was provided to the Senate on 12th January and provided to the Senate Council at their meeting on 17th January for an early discussion. Council comments were then circulated to the members of the Working Group to aid debate. The Senate Working Group held a teleconference on 25th January and comments were also made via email discussion. A discussion was arranged with the commissioners for the 6th February to provide opportunity to explore the issues in further detail. The report was drafted and discussed in detail during a teleconference held with the Working Group on 14th February. The final draft was provided to the commissioners for comment on the 17th February 2017.

3.9 Commissioners are given 10 working days to respond with any comments on the accuracy of the report. The report is to be ratified by the Senate Council on the 15th March prior to publication.

Evidence Provided for the Review

3.10 The documentation provided for this review was the Bradford Provider Alliance Draft Integrated Diabetes Service Model Specification dated 14th December 2016.

4. Evidence Base

4.1 The National Institute for Care and Health Excellence (NICE) has produced a range of pathways, quality standards and advice on the topic of diabetes which are available here. The Senate has developed its advice in accordance with this national guidance.

5. Recommendations

5.1 The Senate agrees that the concept and the principles of this integrated diabetes model of care are commendable. We fully support commissioners' intentions to move disparate services into a patient centred integrated model where diagnosis, treatment and ongoing care is commissioned in its entirety. The vision of this single seamless service fits with the national recommendations. We recognise that this is a difficult task, particularly in determining the scope and financial envelope, and the draft model provided to the Senate is very much a work in progress. There is more detail required to demonstrate how this vision can be achieved and our recommendations focus on where the Alliance can add that detail to strengthen the proposals and make clearer the intentions for the model. The Senate hopes that these comments will be helpful to the Alliance in supporting the next steps in this model's development and we wish the Alliance success in achieving their vision.

Can the Senate advise on the Integrated Diabetes Model of Care and whether this provides a comprehensive model of care for the population of Bradford?

5.2 The broad principles of the model demonstrate concordance with NICE guidance[1] and the Diabetes service specification[2]. There are however, a number of gaps in the detail of the model which do not allow us to have confidence in the comprehensiveness of the model at this stage. Information on many of these areas was provided by the Alliance clinicians in conversation with them. It is clear that these issues have been thought through but they have not been adequately explained within the paper. These gaps are detailed below.

Demonstrating the problems with the current model and how these will be addressed by the proposed model

5.3 Currently there is no evidence and analysis of the impact of the current model or supporting baseline data of the diabetic population. To be able to demonstrate the changes, the Senate recommends that the Alliance sets out the current model, the

[1] Diabetes | Guidance and guideline topic | NICE
[2] Best Practice for Commissioning Diabetes Services, An Integrated Care Framework

issues there are with this model and how the proposed new model will address these.

5.4 We understand from discussion with the Alliance, that the current diabetes service provision is good but with elements of the pathway where the provision is not working as well. There are projected figures which show that there are not the resources to maintain the existing service against the challenge of a large diabetic population and a growing demography with an increasing prevalence of the disease, or to improve the current service within the identified resources.

5.5 We also understand that true integration is not there within the current model with inverse incentives that create blockages to moving patients between the teams. The Alliance have explained the duplication of work in the current service and the poor engagement of patients and workers, particularly with the self-care agenda.

5.6 We understand that the challenge is to improve the quality of diabetes care and create an end to end seamless service which is financially viable and can meet future demand. The Alliance may want to consider including a pathway case study to show the current journey of a patient and how this would translate into the new service. This would help to demonstrate what an integrated service can deliver for the patient.

Recommendation 1

The Alliance should include substantial quantifiable information that details the challenges in the current system and its inability to meet future needs and how this would be overcome with the new model of care.

Understanding the new model

5.7 The Senate understands that the principle of the new service is that all the different providers will work in a truly integrated model. The hub based model will provide a team offering a one stop shop where patients can access care easily. The aim is for patients to flow through the service, regardless of who is employing the staff.

5.8 The Senate recommends that the delivery of that seamless diabetes pathway, with a greater emphasis on self-management and self-care, with a single outcomes framework, needs more explanation. The main area where further explanation is needed is the community hub, the components of it and how this differs from the Level 2 care that is currently being offered. The Senate is also unclear if it is the intention for the Diabetologist to run the Level 2 care. We would recommend flexibility on the Diabetologist inclusion as it may be difficult to recruit to the numbers needed. It would be helpful if commissioners could confirm what population the hub will cover and what will be the demand on the Multi-Disciplinary Team to provide assurance that it has the capacity to meet those needs.

5.9 The paper states that the location of these community hubs is still being worked through. Our patient representatives have emphasised the need for taking the service to the patient, thinking differently to accommodate those hard to reach groups and the Alliance may wish to consider a range of alternatives in their locations, or a mobile service, to accommodate this.

Recommendation 2

To provide further detail to explain the true integration being provided in the new model and the role of the community hub so that it can be more clearly understood how this differs from the existing system.

The focus and scope of the model

5.10 The document currently does not read clearly on the scope of the elements included within the model. This makes it difficult to fully understand the vision of the integrated end to end service. Examples of this lack of clarity are in prevention, podiatry and the Level 1 tier.

5.11 In paragraph 4.1 it states that the maximum benefit can be gained from early intervention to reduce diabetes related complications. This work is delivered in Level 1 care but Level 1 care is excluded from the financial scope which leads the reader to question why the area where the maximum benefit is to be gained is excluded from the model.

5.12 In discussion with commissioners, the Senate understands that Level 1 finances are not in the scope of the proposal but the responsibility for the standards of care within Level 1 is within the scope. The Alliance has stated that they have full engagement from the 67 GP practices it intends to serve and are confident that they can influence the care that is being provided at that level. We understand that the aim is to move away from the Level 1 variability of care and provide education and support for GP practices to deliver consistent standards at Level 1 and also to develop their service to Level 2. This relationship and intention needs to be made clearer and we have more comment on this within our section on primary care.

5.13 There are also questions about the acute care scope of the model. In Section 3 the Senate questions whether the acute element of care should be included within the service scope. This has various levels of complexity:

- Some admissions that clearly relate to diabetes, i.e. for diabetic ketoacidosis (DKA), for severe hypoglycaemia
- Acute diabetes related foot disease
- Some admissions where diabetes is one of a number of known risk factors, e.g. acute coronary syndrome
- Some admissions where diabetes is a co-morbidity rather than a primary diagnosis

5.14 The Senate was also not clear what is meant by complex in this section which could include those parts of diabetes care such as out-patient diabetes with foot disease and antenatal diabetes.

Recommendation 3

The Senate recommends that the Alliance define both the in scope services more clearly and explain the interrelationship between the in scope and out of scope services. This needs to include how the relationship with those out of scope services will impact upon the success of the model and how this will be managed.

The role of primary care

5.15 The Senate agrees that the paper would benefit from further explanation about the relationship with primary care and their role in the delivery of this model.

5.16 Following discussion with the Alliance, the Senate are now clear that the GP core contract is excluded from the scope but identifying what care is provided under the core contract and what is provided under this Alliance model is difficult. The Senate now also understands that it is not the intention that all the GP practices will offer Level 2, although that is also not clear from the paper.

5.17 The Alliance have built a very strong relationship across the 67 GP practices in their area, with them all included as partners within the Alliance. The strength of that relationship does not come through within the paper and it reads as if many assumptions are being made about the capacity of primary care to deliver the services.

5.18 All patients should have involvement with their primary care service. The majority of patients will receive their core service through their GP but even patients under specialist care need to have a holistic approach to care which can be supported by primary care. The reliance on primary care therefore, is great but the workforce analysis of the GPs and their willingness to upskill is lacking. If the Alliance have conducted this and an analysis of the Multi-Disciplinary Team (MDT) components and the availability of staff, e.g. Allied Health Professionals (AHPs) and specialist community nurses, then the document would benefit from this narrative. This will enable the reader to understand the new model of workforce and the proposals for creating this.

5.19 Under the section “GP Core Diabetes Care” in Paragraph 6.3, it refers to the required consideration of an incentive scheme for general practice to ensure full compliance with core diabetes care. If it is the expectation that each GP practice will have this clearly defined team, then these incentives may be a necessity. The Alliance has to ensure that there is funding and resources to turn this model into reality and the training and quality assurance of the delivery against the standards will take time to achieve

5.20 The Alliance are also recommended to describe the localities of GP practices and how they will align with the MDTs.

5.21 Within the paper there is reference to the mandatory training for GPs and the Senate recommends that this wording is changed to more accurately reflect the Alliance intention to provide opportunities for CQC training and accreditation and the

professional development and education of the workforce. A clear statement on the aim to reduce variation in practice would be helpful both at practice and locality level. This integration needs to enable the delivery of consistent service standards across all practices and core standards and competencies for all Health Care Professionals delivering diabetes care. The Alliance may wish to add an aim about staff training within section 6.1

5.22 It would be helpful if the Alliance could make clear if there will be the capacity for supervised training in practice, for example in foot care assessment and if there will be an ongoing programme of assurance and maintenance of skills and competencies.

Recommendation 4

To more clearly define the relationship with primary care and their role in the delivery of this model. Within this the Alliance are recommended to highlight their key success in bringing every GP practice across Bradford City and Bradford District CCGs as partners in this Alliance and to make clearer their intention around training and education.

The role of secondary care

5.23 The Senate has a number of questions about how secondary care has contributed to the development of the model and where hospital specialists fit into this model. The specific questions are listed on pages 15 – 17.

Recommendation 5

To provide more detail on the fit of secondary care within the model.

The management of co-morbidities

5.24 This is a heavily hyperglycaemic model with a focus on blood pressure management, blood sugar and lipid management. Because of the complexities around the scope, this paper does not explain the management of co-morbidities, e.g. obesity and angina. It could benefit from discussing the wider focus to ensure a more holistic approach in preventing stroke and hypertension, for example, and adding more detail about the other facets of diabetic care. This is a good opportunity to address some of these related issues and the evidence does support a multi factorial approach.

Recommendation 6

To discuss the approach to the management and reduction of co-morbidities.

The finances of the model

5.25 The Senate recommends that the paper would benefit from greater clarification on where the Alliance are within the financial process. Diabetes is so intertwined with other diseases that it is difficult to financially package up the diabetes management. The Senate questioned how much confidence the Alliance has in the figures within this paper and whether that confidence was sufficient to award a 10 year contract. Currently, the plan appears stretched and we felt that the paper would benefit from a

better demonstration of the priorities for this service answering the questions of what the Alliance intend to invest in early and whether they will focus on specific population cohorts or structured education, for example, as they transition to this new service.

5.26 It is clear from our conversation with the Alliance, that the need to financially manage the predicted rise in demand from the rising population and increasing prevalence is a key concern. We understand that the discussions about the financial viability of the 10 year model and the allocation year on year are ongoing but establishing this financial framework must be a priority. The Senate acknowledges that taking a 10 year view is commendable from a healthcare perspective but the Alliance need to be able to manage the political variability within that timescale and consider if a 10 year timescale is appropriate.

Recommendation 7

To provide greater financial detail and clarity on the uplift over the 10 year span and to set out the relationship between those integral services that are financially excluded from the model but need to be influenced and included within the care provision.

Clinical governance and clinical leadership

5.27 There is no mention of the clinical governance of this model and therefore there is no clarity on who is accountable for its delivery. The Senate understands that the Bradford Provider Alliance is a partnership across the Care Trust, The Foundation Trust, primary care, the local council and the Voluntary Sector and that a full legal framework is still in development to set out that mutual risk and accountability. The Integrated Management Board is well established however, and will hold the accountability for this service. This position needs to be stated in the paper. Appendix 6 also needs to reflect the overall clinical leadership.

Recommendation 8

The Alliance should include an explanation of the accountability and clinical leadership structure within the document and describe the legal and governance framework for the Bradford Provider Alliance.

The geography

5.28 The model encompasses both Bradford District and Bradford City CCGs and all the providers within that geography. However, within the STP, the place based proposals for Bradford also include Airedale, Wharfedale and Craven CCG and yet there is no reference to the relationship of the Alliance with this CCG and how this model will impact on the service of those border populations. This relationship between the service specification stakeholders, the STP and the Bradford and Craven 5 year forward view needs further explanation.

Recommendation 9

To provide clarity of the impact on the Airedale and Craven population and the relationship with the STP and the Bradford and Craven 5 Year Forward View.

The presentation of the model

5.29 As a general point, it was difficult to navigate through the paper and simple improvements like the addition of page numbers will help. It is clearly a detailed paper for healthcare professionals but it may help the Alliance to focus and order the document if they considered its presentation from the perspective of the patient.

5.30 The Alliance may also wish to consider the development of a patient charter to be clear and explicit to patients and the public on the expectation and consistency of service delivery across the system. The partnership model of working with patients also needs to be clear on the responsibilities and expectations of patients with diabetes in order to deliver quality outcomes.

Can the Senate advise on any clinical concerns relating to any elements of the model?

5.31 The Senate has summarised the clinical concerns in the following section but many of the gaps discussed in the above section cross over into this. This includes the working of the community hub and the population size and how the Alliance will use a targeted approach to risk stratify and manage populations at highest risk with the most benefit.

Movement of patients between the tiers

5.32 There are potential challenges with the tiered levels of care which are currently not addressed within the paper. The patient needs to be able to move easily between the tiers of care and the process for that is not explained. This led the Senate to question whether the exit and entry criteria make sense and how those high risk patients are managed within this.

5.33 The tiers should work with a truly integrated workforce which is the intention of this model, but as this integration does not come through strongly enough within the paper it leads to concerns about the management of those handoff points between the tiers.

5.34 The Alliance will also need to ensure the integration of care records across primary and secondary care across the range of laboratory tests to support this fluid movement of patients across the different levels of care. This IT infrastructure is not demonstrated within the paper.

Recommendation 10

To better articulate the integration of the model to address the concerns about the fluid movement of patients across the tiers of care and to provide more detail on the use of technology to support the Multi-Disciplinary Team.

Prevention and education

5.35 The document reports previous difficulties with the current education programme and the high numbers of Did Not Attends (DNAs). It is unclear what is different in the education offer in this model to improve upon previous issues. The Alliance intention to link the provision to demographics and ensure the education is relevant to the patient's culture/religion/ age and lifestyle, for example, does not come through. One example of this is the impact of the month of fasting on hyperglycaemic management within the South Asian population. There is also opportunity to strengthen the terms of referral to and participation in diabetes prevention lifestyle programs by high risk patients. There are differing and successful approaches to diabetes education in other parts of the country which the Alliance may wish to learn from. In Leeds, the education programme has been tailored into 3 core classes and additional models. It provides a more flexible approach than a formal expert programme which patients struggled to fit with the competing demands in their life. The Worcester model, as another example, has successfully used an e-learning approach.

5.36 The Voluntary Care Sector plays a really important role in engaging with the patient and this also needs to be explained further within the education proposals.

Recommendation 11

To provide more emphasis and detail on the role of education within the model and to include a section that details the relationship with prevention and how commissioners are tailoring their prevention work to meet the needs of their largely South Asian population.

Voluntary sector

5.37 The Voluntary Sector are crucial partners in this model and have a very important role in working with the public and providing those messages to patients about the management of their disease. The training and upskilling of these staff is really important. This sector, however, is under considerable financial pressure and it would be helpful to set out how the Alliance is going to manage that risk.

Recommendation 12

To provide more detail about the relationship with the Voluntary and Community Sector and how they will be supported in delivering this model.

Podiatry

5.38 We are not clear on the role of podiatry within this model. If it is excluded from scope financially, it falls within the range of services that the Alliance need to engage with and influence to ensure the success of the model. Podiatry is rarely mentioned within the document and the following areas are not clear:

- Within Tier 1, how will the foot screening yearly checks be provided? Is this through Any Qualified Provider or practice nurses and how will the Alliance ensure their competence to provide the service?
- Within Tier 2 there is no mention of the Foot Protection Team and where this sits within the community podiatry service. The Alliance will need to ensure it has the capacity to manage the moderate and high risk case load. The foot screening education and management of moderate/high risk foot patients is detailed in NICE NG19
- Within Tier 3, how is podiatry included and funded within the hospital based service for acute foot problems? Is the 24 hour review by the Multi-Disciplinary Foot Team hospital based and how does it sit within this model?

5.39 Podiatry obviously plays a very important role throughout the tiers of service and this needs fleshing out within the model.

Recommendation 13

Podiatry is a key part of this service and the model would benefit from a greater level of detail on this area.

Can the Senate highlight potential improvements to the model, with a view to how it could be further optimised?

Medicines management

5.40 Medicines management is an expensive part of the service but there is little detail on the medicines management strategy within the paper. It would benefit from more detail on addressing variation in prescribing and frameworks to promote use of medicines optimisation in diabetes care. The Alliance may wish to consider the development of a formulary to support the implementation of local guidelines.

Recommendation 14

To provide further detail on the medicines management strategy.

Innovation

5.41 From discussion the Senate is aware that the Alliance have a number of small scale innovative projects across diabetes care that they are looking to roll out into future years, including skype consultations, for example. These innovations are not discussed in the paper, which led the Senate to question whether the Alliance were making the most of the opportunity to engage the public in a different approach to managing their diabetic care and to utilise technology as an enabler for delivery. Our

patient representatives have asked about the opportunities to change the care setting and the way that patients manage their disease. It would be helpful to include some narrative about your innovative ideas.

Recommendation 15

To expand upon the opportunities for innovation and the use of technology within the model.

Mental health/population/children

5.42 The cost of mental health conditions in diabetes is enormous nationally and yet mental health is rarely mentioned in this paper. In discussion with the Alliance, this has been acknowledged as a gap and will be addressed. This links into the wider comments about those high risk patients and those with underlying health problems who are not given enough attention in this model.

5.43 Children are usually under the care of a Diabetologist in a hospital setting and are therefore minimally impacted by this model. A sentence to explain this would be helpful as would consideration of the transition from child to adult care needs within this model.

Recommendation 16

To provide more information on how patients with mental health conditions will be cared for and to clarify the care of the child within this model.

Can the Senate review the assumptions of the impact of the model and offer a view as to whether the integrated model is ambitious enough to deliver the improved outcomes set by commissioners?

5.44 The outcomes need to reflect the aspirations for the service and demonstrate the gains that will be achieved through the new model. Our lack of understanding of the detail of the new model means that at times we struggled to make the connection with the outcomes. The outcomes also appeared quite arbitrary as the evidence base for the outcomes was not adequately explained.

5.45 This model focuses on the management of diabetes and not the complications of diabetes, however, the outcomes are complications related, for example, a 10% reduction in cardiovascular disease (CVD) outcomes. We understand that the Alliance want to present one outcomes framework across diabetes care but we recommend that the Alliance think more about how this is presented.

5.46 10 years is a long time frame over which to measure the outcomes. Commissioners need to ensure that within that they can demonstrate that the model has delivered 7 year and 5 year and 3 year milestones. Within 3 years the outcomes could include evidence of improvement within the process measures, e.g. in structured education/ foot protection/reduced admissions/reduced amputations and also in patient satisfaction and clinical satisfaction.

Recommendation 17

The Alliance are recommended to provide the evidence base for the outcomes with further thought about the timeframe and the presentation of those outcomes that are out with the scope of the model.

Additional secondary care questions

5.47 The Senate has a number of specific queries regarding secondary care which are listed below:

Section 2.1

- The Alliance may wish to consider adding the promotion of clinical research and staff training and development as a means of driving up quality within the vision statement. It would be helpful to clarify if the acute hospital care of older people with diabetes (i.e. over 80 or 85yrs old) is included in the plan.

Section 3.1

Within the service in scope Table 1, the Senate questioned:

- What Inpatients Healthcare Resource Groups are included?
- If outpatient means acute hospital diabetes outpatient attendances and diabetes specialist nurse appointments at the acute hospital?
- Does the Level 3 (consultant) mean in the community?
- Does the cost of medication include glucose testing strips?

Section 3.2

- For the out of scope services, does the 1st bullet point also exclude ophthalmological care of established diabetic retinopathy from the model?

Section 3.3

- In figure 1, does pre-diabetic mean non-diabetic hyperglycaemia and what is the estimate here?

Section 4

- Level 2 enhanced services - what is injectable therapy mobilisation? Does it mean initiation of injected glucose lowering therapies?
- Level 3 enhanced specialist services - can some examples be provided for the sentence “Level 3 services are also enhanced and are for patients who are not suitable for management at Levels 1 or 2”. Some care will need to be delivered by hospital consultants and possibly at the acute hospital site too, e.g. antenatal diabetes care

Section 6.1

- The Alliance may want to consider adding a goal to offer patients entry to relevant (NIHR portfolio) research trials

Section 6.2

- The clinical leadership and governance arrangements need to be made clear here

Section 6.3

Figure 3 Children [Acute] Type 1 & Adult [Level 3]:

- Type 1 = 350 - Where is the number taken from?
- Type 2 = 0 - The Alliance need to consider patients with Type 2 diabetes and active foot disease/ulceration or Type 2 diabetes with chronic kidney disease etc, Type 2 diabetes with pregnancy. It would suggest that this 0 figure is not accurate and in fact it may be as large as 100-200
- Does this mean no adult outpatient diabetes care happens in the acute trust or is it implying a mix of community and acute trust provision?

Advanced community-based glycaemic care

- Is this Level 3 or Level 2 in the previous diagram?

Specialist care

- Bullet point 5 - Is the insulin pump service in an acute trust or community setting? If in the community, will there be an increase in numbers of patients requesting pump therapy as these are all managed at Level 3 currently?
- 2nd paragraph - Does this suggest that there is no provision for Type 1 diabetes at Level 2?

Remote access & community hubs

- Where does this fit in the previous diagram?

Section 6.6 and Section 6.8

- Need to set out the leadership of the service

Section 7.2 table

Advanced community based care

- In the entry criteria, is bullet point 3 necessary? Many practices can manage Type 2 diabetes mellitus patients on insulin and/or glucagon-like peptide 1 (GLP-1) analogues

Remote access & community hubs

- Who is delivering the service?
- In the entry criteria, bullet point 8 - There is a high risk group in here and specialist care needs to be considered

Specialist care

- In the entry criteria, bullet point 12 - Palliative care might be better managed by specialist involvement via telephone/ hub
- In the exit criteria, bullet point 4 - What is the plan for patients who serially Do Not Attend?

Section 7.3 – Table

- How is the reduction in complications microvascular renal & retinopathy defined?

6. Summary and Conclusions

6.1 The concept and the principles of this integrated diabetes model of care are commendable but determining the scope and financial envelope for this integrated service is a difficult task. These areas are not worked through to conclusion in the draft model provided to the Senate which we recognise is very much a work in progress.

6.2 In the next stages we recommend that the Alliance focus on developing the Bradford Provider Alliance into a legally accountable body to set out the accountability structure to govern the performance of this model. In addition, the Alliance need to prioritise establishing the financial framework for this model with the supporting evidence and data and ensuring they have clarity on the in scope and out of scope services and the relationship between these. Finally, we also suggest that the Alliance focus on how they can provide greater emphasis on the prevention and education programme.

6.3 The Senate is concerned to read in the Sustainability and Transformation Plan that a date of April 2017 has been set for the commissioning of this new model of care. We feel that neither the Provider Alliance nor the proposed model will be in a position to start in April. We would suggest that this date is revised.

6.4 We hope that the comments from the Senate are helpful to the Alliance in supporting the next steps of the models development.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Council Members

Dr Caroline Hibbert, Joint Medical Director, Surgery Health Group, Hull & East Yorkshire NHS Trust

Peter Allen, Citizen Representative

Rebecca Bentley, Nursing Professional Lead & Non Medical Prescribing Lead, Bradford District Care Foundation Trust

Dr Steve Ollerton, Clinical Leader, Greater Huddersfield CCG

Assembly Members

David Ita, Citizen Representative

Co-opted Members

Bryan Power, Clinical Lead, NHS Leeds West CCG

Amjid Rehman, GP & Diabetes Network Co-Chair, NHS Greater Huddersfield CCG

Steven Cleasby, Assistant Clinical Chair, NHS Calderdale CCG

Marie Walker, Principal Podiatrist – Diabetes / AHP Professional Lead, Humber NHS Foundation Trust

Katharine Speak, Senior Podiatrist, Huddersfield Royal Infirmary

Dr David Partridge, Consultant Microbiologist, Sheffield Teaching Hospitals NHS Foundation Trust

Mr Michael Mansfield, Consultant Physician – Diabetes, Leeds Teaching Hospitals NHS Foundation Trust

Appendix 2

PANEL AND COUNCIL MEMBERS' DECLARATION OF INTERESTS

Name	Title	Organisation	Date of Declaration	Reason for Declaration	Proposed way of Managing Conflict
Dr Akram Khan	CCG Chair	NHS Bradford CCG	16.1.17	Chair of the CCG which is seeking advice from the Senate	To manage this conflict of interest we will need to ensure that Akram does not take part in any Council or sub group discussions as they relate to this matter
Rebecca Bentley	Nursing Professional Lead & Non Medical Prescribing Lead	Bradford District Care Foundation NHS Trust	16.1.17	Employed by one of the organisations within the Alliance	To manage this conflict we agreed that Rebecca could participate to give her broad nursing perspective on the proposals but not to comment on any service detail for which she had an association with in her position within the Care Trust.

Appendix 3

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Review of the Diabetes Service Model on behalf of the Bradford Provider Alliance

Sponsoring Organisation: Bradford Provider Alliance

Terms of reference agreed by: Rebecca Brown, Project Manager, Bradford Provider Alliance and Joanne Poole, Senate Manager

Date: 7th February 2017

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Dr Caroline Hibbert, Joint Medical Director, Hull & East Yorkshire NHS Foundation Trust

Citizen Representative: Peter Allen and David Ita

Clinical Senate Review Team Members:

Name	Role	Organisation
Rebecca Bentley	Nursing Professional Lead & Non Medical Prescribing Lead	Bradford District Care Foundation Trust
Dr Steve Ollerton	Clinical Leader	Greater Huddersfield CCG
Bryan Power	Clinical Lead	Leeds West CCG
Amjid Rehman	GP & Diabetes Network Co-Chair	Greater Huddersfield CCG
Steven Cleasby	Assistant Clinical Chair	Calderdale CCG
Marie Walker	Principal Podiatrist – Diabetes/AHP Professional Lead	Humber NHS Foundation Trust
Katharine Speak	Senior Podiatrist	Huddersfield Royal Infirmary
Dr David Partridge	Consultant Microbiologist	Sheffield Teaching Hospitals NHS Foundation Trust
Mr Mike Mansfield	Consultant Physician - Diabetes	Leeds Teaching Hospitals NHS Foundation Trust

2. AIMS AND OBJECTIVES OF THE REVIEW

Question: Could the Senate advise on the Integrated Diabetes Model of care and whether this provides a comprehensive model of care for the population of Bradford. Considering the model of care can the Senate review the service model and advise on any clinical concerns relating to any elements of the model.

If the Senate could highlight potential improvements to the model, with a view to how it could be further optimised. Also we ask that the Senate review the assumptions of the impact of the model, and offer a view as to whether the integrated model is ambitious enough to deliver the improved outcomes set by commissioners.

Objectives of the clinical review (from the information provided by the commissioning sponsor): The advice will allow Bradford Provider Alliance and Bradford CCGs to be assured that there has been a Clinical Senate review of the suggested integrated model of care for the population of Bradford, which will help with stakeholder buy-in and the development of a successful and robust business case.

Scope of the review: To advise commissioners on:

- The comprehensiveness of the model
- The areas for improvement.
- Whether the model will deliver the outcomes

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 31st October 2016

Agree the Terms of Reference: 7th February

Receive the evidence and distribute to review team: 11th January 2017

Teleconferences:

- Initial discussion took place at the January Council meeting
- Working Group teleconferences - 25th January and 14th February 2017
- Teleconference with Commissioners – 6th February 2017

Draft report submitted to commissioners: 17th February 2017

Commissioner Comments Received: 3rd March 2017

Senate Council ratification; 15th March

Final report agreed: 17th March

Publication of the report on the website:

Commissioners to advise if there are any key dates which they want to tie in with our publication of the report. Ideally the report should be published as soon as possible after the ratification, if not, the Council request that this is by the date of the following Council meeting (May 2017)

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the handling of the report and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

- Draft Integrated Diabetes Service Model Specification

The review team will review the evidence within this document and supplement their understanding with a clinical discussion.

6. REPORT

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor, provider, NHS England (if this is an assurance report) and made available on the senate website. Publication will be agreed with the commissioning sponsor.

8. RESOURCES

The Yorkshire and the Humber clinical senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

9. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable

Clinical senate council and the **sponsoring organisation** will:

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical senate council will:

i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will:

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc, that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END