Joint Working Executive Summary

Joint Working between: Napp Pharmaceuticals limited and City Health Limited otherwise known as Bradford City Health Federation

Project Title: Quality Improvement in Diabetes

Background: The Bradford City Health federation (from here on within this executive summary referred to as CHL or the Federation) has a long history of implementing innovation quality improvement projects and pilots.
The board members of the federation have been involved in the production of the Bradford CCGs' diabetes formulary and the implementation of the Bradford Beating Diabetes programmes.

Diabetes is a major health issue in Bradford and major burden on the local health economy. The federation have recently completed an initiative to identify pre & non diagnosed type 2 diabetes patients. As a consequence of this & the population demographics, the prevalence rate of diabetes in Bradford is above the UK national average of 6.6% at 10.4% (1 in 10 v 1 in 15 UK national average)

The current number of patients on the Federation diabetes register is 10,124

The federation practices have highlighted that unless effective management of diabetes is developed as a high priority area, the service is not sustainable and appropriate care standards will not be achieved. The project proposes to implement a quality improvement work stream to support its member practices with additional support to achieve high standards of care & improve outcomes in this disease area.

Project Principal Objectives: The Bradford City Federation practices have highlighted diabetes as a high priority area and propose to implement a quality improvement work stream to support its member practices with additional support to improve outcomes in this disease area.

- To identify and review all patients with Type II Diabetes Mellitus (DM) taking oral hypoglycaemic agents or diet controlled but have a HBA1C >59mmol/l and not on Insulin therapy.
- Ensure all interventions are in line with the most recent ADA/EASD guidelines (2018) (or NICE Guidance: Management of Type 2 diabetes in adults (updated 2017)) and have an individualised approach to patient care including appropriate use of medicines to optimise health gains and reduce health inequalities.
- Agree attainable and measurable outcomes (including patient engagement and experience)/ deliverables/ milestones, baseline data and data analysis. Follow up review that will publish project achievements that will help deliver change and share best practice

The project will additionally focus on the following quality elements:

- Risk stratification of cardiovascular disease risk using QRISK2 clinical tool.
- Prescribing in impaired renal function.
- Treatment failure with existing therapies.
- Medicines optimisation and polypharmacy review.

- Referral into community pharmacy services for adherence support.

Outcomes:

The project will confer the following:

Plans for sustainability:

It is proposed to make the programme sustainable once the project is complete by putting a proposal to CCG for future years funding via a local QOF or Diabetes QIPP programme

The project will provide a full reporting mechanism for each practice and for the whole federation population at the end of the programme. This will highlight data and clinical outcomes of the project.

The learning from the programme once analysed would be of potential interest to clinical / health economy publications and potential learning that could be shared with other CCG's, NHS England, NHS innovation etc.

Benefits to Patients:

- All patients will receive optimised care according to international/ national guidelines and health inequalities will be reduced.
- Additional supportive contact with HCP over and above usual care package.
- Risk stratification of patients at high risk and case loaded appropriately

Benefits to the NHS:

- Improve the management of Type 2 DM across a large patient population with a proactive approach to care.
- Increased uptake of NICE guidance, individualised patient care and reduction in health inequalities
- Clinical governance and audit.
- Whole system thinking – increased utilisation of community pharmacy
- Opportunity the share best practice – broader health system impact

Benefits for Napp Pharmaceuticals Limited:

- Improved reputation of Napp Pharmaceuticals Limited ability to work in partnership with the NHS to benefit patient outcomes and experience.
- By implementing the project, an appropriate proportion of the medicinal interventions used based upon clinical need, clinical indication and the Federation clinical policy for diabetes management will be marketed by Napp Pharmaceuticals Limited.
- Anonymised data collection, project evaluation and case study which relates to appropriate clinical intervention using medicinal therapies including that marketed by Napp Pharmaceuticals Limited, which may be disseminated and used to share best practice to other NHS organisations by Napp Pharmaceuticals Limited.

CHL shall contribute a maximum of £125,000 to the Project

Napp shall contribute a maximum of £5000 per Federation practice participating in the Project subject to a maximum aggregate total contribution of £125,000.

The project will on the commence on the 30th January 2019 and complete on or before 1st June 2020

References:

Bradford has highest rate of diabetes in UK, study reveals (Last Accessed December 2018)

NHS: Bradford Joint Strategic Needs Assessment 5.3.01 Diabetes (Last Accessed December 2018)

ABPI Code of Practice for the Pharmaceutical Industry 2016 http://www.pmcpa.org.uk/thecode/Documents/Code%20of%20Practice%202016%20.pdf (Last Accessed December 2018)

ABPI guidance notes on joint working between pharmaceutical companies and the NHS and others for the benefit of patients. http://www.abpi.org.uk/publications/code-guidance (Last Accessed December 2018)