HEALTH AND WELLBEING BOARD

8 November 2017

Title:	**Diabetes Care in Barking and Dagenham**
Report of the Health and Wellbeing Board	
Open Report	**For Decision** **For discussion**
Wards Affected: **All wards**	**Key Decision: No**
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Sponsor: Matthew Cole, Director of Public Health	

Summary:

The prevention and care of diabetes is a developing story in Barking and Dagenham. The good news for residents is that Type 2 diabetes[1] can be prevented, and that new systems and structures to help prevent diabetes for residents are now being developed. While Type 1[2] diabetes cannot be prevented, the complications of Type 1 diabetes can be prevented. There have also been significant improvements in diabetes care in the community over the past year, this paper outlines the progress to-date and the future partnership working that is desirable for continued improvements.

The number of people with diabetes in the borough is increasing, and when not found early or managed effectively having diabetes can lead to severe disease, including potential amputations, and / or kidney failure. For this reason, poor control of diabetes can have a devastating impact on residents and their families; and can also be costly to both health and social care services.

Diabetes prevention and care is an LBBD Health and Wellbeing Board priority and also a priority in the East London Health Partnership Sustainability and Transformation Plan. It is important for the residents of Barking and Dagenham that they have access to services that help them prevent developing diabetes and also to manage diabetes effectively if they do develop the long-term condition.

With the numbers of people with diabetes in the borough rising it is important that the Board are assured that partners are working collaboratively to improve diabetes prevention and outcomes.

[1] Diabetes due to Insufficient insulin produced or insufficient response to insulin

[2] Diabetes due to autoimmune disease, when the pancreas is unable to produce insulin

The paper provides a summary of the diabetes prevention initiatives commissioned on behalf of Barking Havering and Redbridge CCG by NHS England and also an update on the improving offer of diabetes in primary care in the borough. It also addresses the importance, for residents, of the pathway between primary and secondary care.
We recommend two questions for discussion:

1. What action can partners take to ensure that they work jointly to deliver effective diabetes prevention for residents?
2. What action can partners take to ensure that they work jointly to continue the improvements in care for people with diabetes who live and work in our communities?

Recommendation(s)

The Health and Wellbeing Board is recommended to agree:

1. Diabetes prevention - that a diabetes prevention approach which meets the needs of residents is supported.

2. Diabetes care processes – that system and structures that embed improved diabetes care in the borough are supported.

Reason(s)

1.1 Diabetes prevention and care are East London Health Partnership Sustainability and Transformation Plan priorities because diabetes is a costly condition to manage and the return on investment for health and social care is potentially high.

1.2 The LBBD Corporate Plan[3] and Borough Manifesto[4], in line with the Health and Wellbeing Strategy, set out the strategic framework for the council including a vision that the population will be:

- Healthy weight better than the East London average
- Rate of regular physical activity will be higher than the East London average

Both these outcomes can support the care of residents with diabetes, and reduce the numbers of people who develop diabetes in the population.

1. Introduction and Background

1.1 The prevention of Type 2 diabetes in our residents and the improvement of care for people with Type 1 and Type 2 diabetes is a developing story in Barking and Dagenham.

1.2 Diabetes prevention and care are East London Health Partnership Sustainability and Transformation Plan priorities, the reason is clear, diabetes is a long-term condition which is costly to manage and can have a devastating effect on the lives of residents.

1.3 The return on investment when diabetes is well managed can be very high, both in quality of life for residents, and financially for health and social care.

[3] https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/corporate-delivery-plan/overview/

[4] https://www.lbbd.gov.uk/wp-content/uploads/2017/07/Barking-and-Dagenham-Together-Borough-Manifesto.pdf

1.4 The LBBD Corporate Plan[5] and Borough Manifesto[6] set out the strategic framework for the council including a vision that the population will be:

- Healthy weight better than the East London average
- Rate of regular physical activity will be higher than the East London average

Both these outcomes can reduce the numbers of people with diabetes in the population.

2. Proposal and Issues

Diabetes services in Barking and Dagenham

1.5 It is important for the residents of Barking and Dagenham that they have access to services that help them prevent developing diabetes and to manage diabetes effectively if they do develop the long-term condition.

1.6 With the numbers of people with diabetes in the borough rising it is important that the Board are assured that partners are working collaboratively to improve diabetes prevention and outcomes.

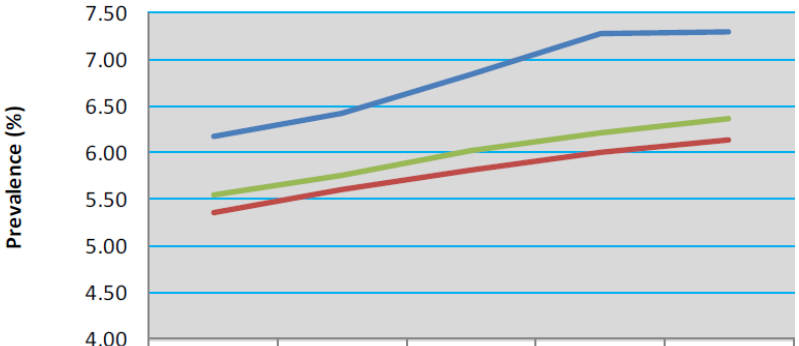
1.7 Below is a short summary of the numbers of people with diabetes in the borough and more information is available in the Joint Strategic Needs Assessment which is on the council website https://www.lbbd.gov.uk/wp-content/uploads/2017/01/7.20-Diabetes-2016.pdf.

1.8 Figure 1 shows that the numbers of people in the borough with diabetes is increasing and has been increasing over the past five years. The numbers of people with diabetes in London and England are also increasing.

Figure 1: Trend in prevalence of diabetes in the population registered with GP practices aged 17 and over in Barking and Dagenham from 2010 to 2014/15

[5] https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/corporate-delivery-plan/overview/

[6] https://www.lbbd.gov.uk/wp-content/uploads/2017/07/Barking-and-Dagenham-Together-Borough-Manifesto.pdf



	2010/11	2011/12	2012/13	2013/14	2014/15
B&D	6.18	6.42	6.83	7.27	7.30
London	5.36	5.59	5.82	6.00	6.14
England	5.54	5.76	6.01	6.21	6.37

Source: HSCIC

1.9 In 2010/11 6 of every 100 people in the borough were recorded as having diabetes; by 2014/15 this had increased to 7 of every 100 people, this is set to increase further and higher than the England and London average.

1.10 Some of the increased prevalence could be due to increased awareness of diabetes by residents and better diagnosis of diabetes by primary care.

1.11 High cost outcomes of diabetes include dependency, higher than population average A&E attendances and hospital admissions.[7].

1.12 10% of the NHS budget is spent on diabetes care along with an unknown proportion of the social care budget.

3.0 Diabetes Prevention

2.1 The good news is that diabetes can be prevented. This depends on residents who are 'at risk' being found in primary care, and offered support to increase physical activity and make positive changes to diet.[8]

2.2 The National Health Service England (NHSE) has commissioned a diabetes prevention programme that is being rolled out across England, and residents from Barking and Dagenham will benefit from this programme.

2.3 It was agreed that the borough should sign up to this diabetes prevention programme when it was first established, and evidence-based prevention of diabetes is also a Sustainability and Transformation Plan priority.

2.4 The effective deliver of the diabetes prevention programme is dependent on a strong partnership approach across the health economy.

2.5 Two types of diabetes prevention programme are proposed for residents of Barking and Dagenham, the digital diabetes prevention programme, and the diabetes prevention programme. Both are being funded and commissioned by NHS England.

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[7] National Diabetes Audit 2016-17 available at http://content.digital.nhs.uk/nda accessed 4 September 2017.
[8] NICE(2012) Type 2 diabetes: prevention in people at high risk. https://www.nice.org.uk/guidance/ph38

2.6 Where this prevention programme has been introduced to other areas of England, and it works most effectively if there is a pathway to identify 'at risk' residents in primary care, then to make sure they are referred to lifestyle services for support.

2.7 It is planned that individuals 'at risk' of developing diabetes are treated by lifestyle services commissioned by NHS England, and London Barking and Dagenham also have lifestyle services for residents who do not meet the criteria for diabetes prevention.

2.8 Prevention is though physical activity and good diet, these are topics which we've addressed at Health and Wellbeing Board previously. We will not address them in this paper. However, it is important to note that NHS England is commissioning services that will join up with local services to improve the lifestyle prevention offer for residents. The process for this has been tested in other London boroughs.

2.9 Two diabetes prevention programmes are being funded and commissioned by NHS England, the digital diabetes prevention programme, and the diabetes prevention programme.

2.9.1 **Digital Diabetes Prevention Programme** – The digital programme is an app or web-based education commissioned via NHS England that GPs can offer to residents who have a high but non-diabetic blood sugar measurement.

2.9.2 **Diabetes Prevention Programme – Face-to-Face** – The (non-digital) programme is a face-to-face programme where residents are offered the opportunity to have a programme and support to increase physical activity and change their diet.

2.10 The borough is ahead of the game, and in 2016 -17, Barking and Dagenham CCG invested £1.1m in diabetes care in primary care, and our pre-diabetes testing and diagnosis has increased over this 6 month period with an additional 3,563 patients being assessed for and determined as pre-diabetic.

2.11 For the digital prevention programme NHS England now have a final list of 5 potential products that have been offered to local health economies from which to choose. North East London boroughs have been allocated 2 providers - Hitachi and Liva and will be agreeing the referral profiles following an internal clinical assurance audit. The CCG are with local GPs to roll out this programme, it is likely that in the pilot phase residents in nine practices will be offered the service. The service will be evaluated and rolled out further if it is effective. Clearly access to this programme will depend on residents being IT literate.

2.12 The face-to-face diabetes prevention programme North East London diabetes prevention programme is likely to be delivered by Momenta, a company with whom LBBD lifestyle services already have a working relationship. In other areas Momenta and local lifestyle services have put in place arrangements to refer across from lifestyle services individuals who meet the pre-diabetes criteria. It is anticipated that a similar arrangement will be negotiated locally & this will extend the prevention services on offer to residents.

2.13 The start data for the BHR Diabetes Prevention Programme is projected to be April 2018, joint submissions were returned in October 2017.

2.14 It is likely that this project will reduce the number of people who develop diabetes in the borough.

Diabetes care

2.15 Diabetes is a long-term condition that is frequently diagnosed in primary care, and is treated in primary care and secondary care, depending on the complexity of the condition.

2.16 The borough has a community-based diabetes service. The service provides care for people with complex diabetes. The complex care team is led by Dr Nikookam. Other team members are GPs with Special Interest, Diabetes Specialist Nurses, psychologists, a dietitian, and podiatrists. An efficient and effective pathway from primary to secondary care and back to primary care is essential for the appropriate care of our residents, and for good outcomes to be achieved. An efficient and effective pathway is dependent on robust structures and knowledge.

2.17 Diabetes outcomes for residents of Barking and Dagenham have historically been poor with only 24% of the recommended 8 / 9 care processes being completed for people with diabetes and less than one in five GP practices in the borough making a return on the National Diabetes Audit (2015). This improved in the 2016 National Diabetes Audit.

2.18 The National Diabetes Audit is an annual audit of primary and secondary care, which measures the effectiveness of diabetes care against NICE clinical guidelines and NICE quality standards, in England and Wales.

2.19 As noted in 3.10 Barking and Dagenham CCG has invested £1.1m in diabetes care in primary care. This investment has enabled GP practices to re-start systems and processes no longer funded by the Quality and Outcomes Framework and raise care standards. The final data will be generated in October 2017, but the July 2017 data shows:

- The CCG average for completion of 8 care processes (not including retinal screening) is now 50%. This is a rise from 24% in October 2016. The national average is 53.7% (NDA 2015-16).
- Performance indicators around control of DM patients are improving; the main measures are control of cholesterol, blood pressure and HbA1C (glycosylated haemoglobin) with the number or practices achieving the targets is 12/37, 13/37 and 27/37 respectively.
- Practices have identified and registered 3,563 patients with pre-diabetes (out of their registered population of 223,878).

2.20 The response rate to the National Diabetes Audit has also improved to nine of ten practices making a return.

2.21 It is essential that the improvements that have been achieved are embedded in primary care practice. This is being achieved through continuation of the local incentive scheme, and via education and IT support.

2.22 However, treatment and outcome for residents could be improved through investment in primary care and improved pathways and links with secondary care.

Cost of diabetes

2.23 Significant investment has been made into the treatment of diabetes, it is important to ensure that the return on investment is being achieved.

3. Cost of diabetes care in Barking and Dagenham

3.1 We know that the cost of managing diabetes across England is high. This is because costs include the cost of drugs, and medical care, in both primary and secondary care. Equally important is the cost of social care that is needed by people who are discharged from hospital, and residents who have disabilities as a result of having diabetes.

3.2 Calculating the actual cost of medical and social care is complicated because of the many different needs that residents have, both direct and indirect linked to diabetes.

3.3 Drug costs alone are very expensive, in 2016/17 the cost of diabetes drugs prescribed in the borough was £4.3million, this is 15% of the total of prescribed drugs. This is higher than the average England average of 1% of drugs budget.

3.4 It is estimated that the cost of care, social care and other costs, including sickness absence, to the UK economy is £9.8 billion per year.

3.5 Significant investment has been made in the treatment and care of people with diabetes in the borough and it's important that residents see the financial benefit as well as the treatment benefits of good diabetes care.

6.0 Return on investment diabetes prevention programme

6.1 NHS England are investing in diabetes preventions in Barking and Dagenham.

6.2 The borough has 3,563 residents with pre-diabetes and if just 42% complete the prevention programme we can expect to see 29 fewer cases of diabetes, 4 fewer CVD events and 1 fewer strokes or similar cases in the following 5 years.

7.0 <u>Suggestions for discussion by the Health and Wellbeing Board Barking and Dagenham</u>

7.1 With the increasing numbers of residents who could develop diabetes in the borough and the increasing numbers of residents who already have diabetes it is suggested that it's important that joined up approach to both prevention and care across the borough is strong. The Board is asked to consider the following questions:

7.2 What action can partners take to ensure that they work jointly to deliver effective diabetes prevention for residents?

7.3 What action can partners take to ensure that they work jointly to continue to build on the improvements in care for people with diabetes who work and live in our communities?

4 Consultation

In writing this paper we have consulted with the East London Health Partnership; Dr K. Nikookam, Medical Consultant, BHRUT; Dr Anju Gupta, Clinical Director, Diabetes, BHR CCG, Diabetes UK representative, LBBD lifestyle team.

5 Mandatory Implications

5.1 Joint Strategic Needs Assessment

The Barking and Dagenham JSNA highlights that diabetes is a major public health problem, with low levels of physical activity and unhealthy diet linked with obesity, being important contributing factors.

Additionally, the JSNA cites the importance of addressing low levels of physical activity and unhealthy diet to support diabetes prevention.

5.2 Health and Wellbeing Strategy

The scrutiny review supports the ambitions of the borough's Health and Wellbeing Strategy:

Early pre-birth and early years:
More children are taking part in regular physical activity
Adolescents:
More children are taking part in regular physical activity and improve the opportunities to use green space
Early adulthood:
More young adults have a healthy weight and have access to healthy food produce
More young adults take regular physical activity and use active forms of transport
Established adults:
More adults have a healthy weight and more have access to healthy affordable food produce
More adults are taking regular physical activity, including cycling and walking
Older adults:
More children are taking part in regular physical activity and improve the opportunities to use green space

5.3. Financial Implications

Implications completed by Katherine Heffernan, Service Finance Group Manager:

This report is largely for information and sets out the current initiatives to improve diabetes prevention and care. As such there are no financial implications arising directly from the report. The treatment and prevention work described are NHS responsibilities and are funded from NHS budgets including the CCG and NHS England.

5.4 Legal Implications

Implications completed by: Dr. Paul Feild Senior Governance Lawyer

The Health and Social Care Act (2012) conferred the responsibility for health improvement to local authorities. The evidence is that occurrence and onset of diabetes is to a degree preventable but it relies on early diagnosis and intervention including lifestyle changes. Furthermore, the evidence demonstrates that diabetes is a prevalent heath issue for the borough. A preventative approach as set out in this report is therefore a key component of the Councils legal responsibility to work to improve the health of its community.

The Health and Well-Being Board terms of reference establish its function to ensure that the provision of health and social care services work in their deliver in an integrated matter. These proposals are in keeping with this committee's function.

6.0 List of Appendices:

None