

Scrutiny Review

Health & Adult Services Select Committee

September 2012 – March 2013

Review on Type 2 Diabetes Services across the London Borough of Barking and Dagenham



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Foreword

The number of people in the borough living with Type 2 diabetes continues to rise. However, we have learned that it is one of those conditions where with the right help and advice, individuals can live healthy lives for longer.

For those living with diabetes, the right care and lifestyle changes can help them avoid complications such as blindness and amputation. For everyone else, making good choices now can reduce the risk of diabetes developing or can help limit the severity of the condition.

It has been a real eye opener to speak to people who live with Type 2 diabetes in the borough. We have heard about the impact that the condition has on people's lives day-to-day and the very real issues that people who live with Type 2 diabetes experience in terms of information, support and care.

We are pleased that diabetes is showing as a priority in the Health & Wellbeing Strategy and would urge the Health & Wellbeing Board to fully consider this report and take forward our recommendations.

The Select Committee would like to express their thanks to those who attended Committee meetings and supported our investigation. The effort and contribution of everyone we met indicated a clear commitment and energy amongst all of those working to improve diabetes care in Barking and Dagenham.



SAlasia

Cllr. Sanchia Alasia
Chair, Health & Adult Services Select Committee

Executive Summary and Recommendations

Type 2 diabetes is a serious health concern for Barking and Dagenham with more than 9,000 people already diagnosed. With the changes to the ethnic makeup of the population and the challenges associated with increases in adult obesity, experts believe that the numbers of people likely to develop diabetes in the next twenty years are set to rise by 50%.

In addition to primary care and community services required to support and maintain the health of people living with Type 2 diabetes, the development of complications as a result of poor management of the condition will continue to put pressure on existing services.

Members of the Health & Adult Services Select Committee (HASSC) were concerned by the expected increase in prevalence and the release of a National Audit Office report in 2012 which highlighted the need to improve the national delivery of high standards and value for money in diabetes care. As a consequence, the Committee decided to carry out an in-depth scrutiny which reviewed the current provision of services and information available to people living with Type 2 diabetes in the Borough. The scrutiny review was carried out between September 2012 and February 2013.

The Select Committee's investigations looked closely at the services and support available in the Borough for people who had just been diagnosed and were living with Type 2 diabetes and how they could be helped to manage their condition more effectively.

A number of issues were identified including the expected prevalence and diagnosis rates for Type 2 diabetes in Barking and Dagenham and the lack of up-to-date baseline data. The review also highlighted a lack of consistency in the execution of diabetes health checks across GP surgeries as well as the up-take of annual appointments by patients, especially in light of the number of emergency admission rates for diabetes-related illness. Additionally, HASSC questioned the availability of information for people who were already diagnosed and newly diagnosed with Type 2 diabetes which might help them better understand their condition, particularly in regard to self management and long-term complications.

HASSC were pleased to see that, broadly speaking, all of the right services were in place and working to a good standard. However, with a renewed emphasis on integrated working and sustained activity to improve the take-up of health checks both for diabetics and those at risk, the borough could do more to prevent the awful complications of this condition. Given the high costs of diabetes-related medication in the borough, this could also release valuable resources for this and other priorities.

The detailed recommendations made by HASSC are presented on the following two pages.

Recommendations

A number of proposals were suggested throughout the scrutiny process, and these have been collated to form the following recommendations.

Recommendation: Prevalence data

It is recommended that a future iteration of the Joint Strategic Needs Assessment provides a clearer account of the source of competing data and the 'best estimate' that the borough is using to monitor its progress and identify the challenge it faces in addressing undiagnosed diabetes.

Recommendation: Improving screening and diagnosis

It is recommended that a programme of proactive screening opportunities is established, linked to improved entry routes to an integrated diabetes care pathway, with more medical professionals seeking opportunities for the proactive identification of diabetes in their patients and service users, and for GP's to take a more pro-active role in diagnosis.

Recommendation: Patient understanding of health checks

Specifically, it is recommended that action is taken to improve patients' understanding of the annual diabetes health checks, what they should expect to receive, and their importance in preventing complications.

Recommendation: Clinicians' adherence to health check process

It is further recommended that the CCG takes steps to ensure that all clinicians are familiar with the NICE recommendations for the Annual Health Check and have arranged the provision of high-quality interventions, with associated processes for prompt arrangement of patient appointments and their reminders.

Recommendation: Performance monitoring of the health check process

For the longer term, it is recommended that the data is improved and the baseline for understanding uptake of the nine health checks is brought up to date, with on-going robust monitoring thereafter.

Recommendation: Information and advice

The Committee recommends that the whole range of information provided to people already diagnosed and people newly diagnosed with Type 2 diabetes is reviewed, ensuring that it gives them what they need to know to improve self-management of their diabetes and their understanding of long-term complications.

Recommendation: Young people's support (Type 1 and Type 2)

That the Health & Wellbeing Board facilitates consideration of how young people with diabetes (either Type 1 or Type 2) could be supported in the Borough, inviting the participation of the health group of the Barking & Dagenham Youth Forum.

Recommendation: Younger adults developing Type 2 diabetes

That the Diabetes Support Group participates in a short review of the support needs of younger adults developing Type 2 diabetes, and how they may be met from a service user led group, led by an agency to be identified by the Health & Wellbeing Board.

Recommendation: Learning from South West Essex

That the Health & Wellbeing Board ask Public Health professionals to work with commissioners and North East London NHS Foundation Trust to understand the reasons why services which are on the face of it similar appear to be linked to different outcomes for patients, and to capture the lessons for future local commissioning.

Recommendation: Reviewing the integrated care pathway

That the Health & Wellbeing Board oversees a review of the care pathway to ensure that all opportunities for joint working are being harnessed and that the flow of patients between services is effective.

About this Scrutiny Review

The Health and Adult Services Select Committee agreed to carry out an in-depth scrutiny review of diabetes services and support for diabetics in Barking and Dagenham. The review focuses on Type 2 diabetes and how Type 2 diabetics could be helped to manage their condition more effectively.

Following initial scoping discussions, the Select Committee agreed a project plan for the scrutiny review at their meeting on Wednesday 4 July 2012. The scrutiny review has been primarily conducted through a number of themed investigative sessions over the period from July 2012 to March 2013.

Over the course of the review, the Select Committee conducted their investigations through a number of different channels, and received information from a wide range of sources, including:

- Clinicians at Barking, Havering & Redbridge University Hospitals Trust (BHRUT)
- Porters Avenue Integrated Diabetes Service
- North East London Foundation Trust (NELFT)
- NHS North East London and the City (NELC)
- Barking & Dagenham Clinical Commissioning Group (CCG)
- Barking and Dagenham Council
- South West Essex Community Services – Diabetes (SWECS)
- Diabetes UK
- Patients and carers from Barking & Dagenham Diabetes Support Group and other patient engagement forums
- Clinical and GP specialists
- Pharmacists
- Retinopathy services
- Barking and Dagenham Local Involvement Network (BDLINK)

Members also invited people living with Type 2 diabetes to participate in a survey to give the Committee more insight into how patients manage their diabetes, what services patients use and their thoughts and experiences of service provision in Barking and Dagenham. The results of this, along with the information gathered in sessions and site visits have also informed the findings and analysis of this final report.

About the Health & Adult Services Select Committee (HASSC)

HASSC consisted of the following nine Councillors in the 2012-13 municipal year:

- Councillor S Alasia (Chair)
- Councillor E Keller (Deputy Chair)
- Councillor L Butt
- Councillor J Davis
- Councillor A Gafoor Aziz
- Councillor M McKenzie MBE
- Councillor C Rice
- Councillor A Salam
- Councillor J Wade

Elaine Clark, Secretary of the Barking & Dagenham Diabetes Support Group was appointed as a Co-opted Member of the Select Committee to give advice and lend expertise to the evidence gathering. In her role as Co-optee Elaine was the voice for local diabetics (and their carers) ensuring that the opinions of the support group and their experiences of local services were raised during the Committee's discussions.

Matthew Cole, Joint Director of Public Health provided professional advice and support to the Committee.

Anne Bristow, the Corporate Director of Adult and Community Services, nominated as the HASSC Scrutiny Champion, supported the Select Committee throughout the review and provided expertise and guidance.

Scope of the review

HASSC particularly wished to explore how diabetics could be helped to manage their condition effectively. Members noted the timely release of a National Audit Office report on the need to improve the national delivery of high standards and value for money in diabetes care.

In establishing the review, HASSC identified five areas which it would explore as part of the review and these form the basis of this report:

THEME 1: Prevalence

What is the expected prevalence of Type 2 diabetes against the number of known diagnosed diabetics?

THEME 2: Provision of health checks

How does Barking and Dagenham compare with the targets - are people with Type 2 diabetes having the nine annual health checks recommended by the National Diabetes Framework?

THEME 3: Provision of information

How sufficient is the readily available information for people living with Type 2 diabetes?

THEME 4: Hospital admissions

Is the current provision of services reducing high hospital admission rates?

THEME 5: Costs of diabetes

What is the annual spend on diabetes-related treatments for Barking and Dagenham

Conduct of the review

The scrutiny review took place around five themed sessions.

A **Patient Perspective Session** was held in September 2012 to explore the experiences of patients and carers with Type 2 diabetes and services in the Borough. The session allowed patients and carers to talk to Members about their experience of living with Type 2 diabetes, the problems they have faced since diagnosis and how they access services. Representatives attended from patient engagement groups such as the Barking and Dagenham Diabetes Support Group, Patient Advice and Liaison Service (PALS) at Barking,

Havering & Redbridge University Hospitals NHS Trust (Queen's Hospital) and Barking and Dagenham Local Involvement Network (BDLINK).

The session was very useful and Members were able to ask how diabetics manage Type 2 diabetes on a day-to-day basis and their experiences of diabetes care provision and availability of information in the borough.

In December 2012, representatives from Diabetes UK and South West Essex Community Diabetes Service (SWECS) attended to talk to Members about examples of **Good Practice**. Members were able to look at service provision and performance at SWECS to understand how it compares to Porters Avenue Services. Members were also able to consider some of the issues raised by Diabetes UK about quality of foot checks.

Two sessions were held in January and February 2013 which focused on **Service Provision** across the Borough. Representatives were invited from a number of care services including Clinical services (GP's and GP's with Special Interest [GPwSI]), Low Vision/Retinopathy services, Community Nursing, Mental health Services, Pharmacists and staff from the Integrated Diabetes Service at Porters Avenue. Members had an opportunity to discuss some of the key issues of service provision including service integration, quality of service and how to improve the patient experience.

A copy of the notes from each of the session is included in Appendix 1.

Site Visits

In addition to information gathering sessions, Members also carried out two site visits.

Members attended a Barking & Dagenham Diabetes Support Group meeting. This really helped Members experience first-hand the work that the support group do in terms of keeping its members informed about diabetic health issues and services available. On the evening of the site visit, a nurse from Porters Avenue attended to talk about the importance of foot health and long term complications of ignoring foot care.

Members also visited Porters Avenue Integrated Diabetes Services where they were able to meet with staff and discuss in more detail problems around educating young people about diabetes and the importance of a healthy lifestyle and what we can do as a Borough to raise awareness about diabetes among the general population.

Survey

In order to better understand the patient perspective, the Committee proposed a survey of people who are currently living with Type 2 diabetes and people who care for someone with Type 2 diabetes. The survey was distributed between 28 November 2012 and 31 January 2013 and aimed to find out more about diagnosis, provision of information, support for both patients and carers and accessing services and education programmes. A copy of the survey can be found at Appendix 2.

In order to ensure the highest return rate possible, the survey was distributed through a number of routes, including on-line via the Council, Barking & Dagenham LINK and Clinical Commissioning Group websites, with additional hardcopies of the survey were provided to the B&D Diabetes Support Group and GP surgeries with diabetic clinics. Council officers and volunteers also undertook sessions at the Barking Learning Centre and Dagenham Library during January 2013.

The survey closed on 31 January 2013 with a total of 62 responses received. The findings from the survey are included throughout this report and a full analysis of the results may be found in Appendix 3.

It is important to note that since Type 2 diabetes affects only approximately 7.3% of the Borough population, the number of respondents was expected to be relatively low.

A note of caution should be given about the survey results. The number of respondents cannot be considered representative of all patients living with Type 2 diabetes in the Borough since the demographics of the survey respondents are not reflective of the demographics of the general population of the Borough:

- 81% of the respondents were between 40-74 (40-59 year olds 44%, 60-74 year olds 38%)
- 67.3% were from a 'White British' background
- 86% stated 'English' as their first language

What is Diabetes?

Diabetes is the name used to describe a metabolic condition of having higher than normal blood sugar levels. There are different reasons why people get high blood glucose levels and so a number of different types of diabetes exist.

Most of the food we eat is turned into sugars for our bodies to use for energy. The main sugar is called glucose, which passes through the gut wall into the bloodstream. However, in order to remain healthy, blood glucose levels should not go too high or too low.

Therefore, when blood glucose levels begin to rise after eating, the level of a hormone called insulin should also begin to rise. Insulin works on the cells of the body to make them extract glucose from the bloodstream. Some of the glucose is then used by the cells for energy and some is converted into glycogen or fat (both of which are stores of energy). When blood glucose levels begin to fall (between meals), the level of insulin falls. Some glycogen or fat is then converted back into glucose which is released from the cells into the bloodstream.

The pancreas, an organ that lies near the stomach, makes insulin to stimulate the cells of our bodies to extract glucose from the bloodstream. Insulin is produced in the beta cells of the pancreas. When you have diabetes, your body either doesn't make enough insulin or can't use its own insulin as well as it should. This causes sugars to build up in the blood.

Type 1 Diabetes

- Type 1 develops if the body cannot produce any insulin. It usually appears before the age of 40 and especially in childhood. It is the less common of the two types and accounts for around 10% of all people with diabetes.
- Type 1 cannot be prevented and is treated by daily insulin doses – taken either by injection or via an insulin pump – as well as a healthy diet and regular physical activity. In Type 1, the insulin-producing cells in the pancreas have been destroyed. It is not known exactly why these cells have been damaged.

Type 2 Diabetes

- Type 2 accounts for around 90% of people with diabetes. It is treated with a healthy diet and increased physical activity. In addition, tablets and/or insulin may be required.
- Type 2 develops when the body can still make some insulin, but not enough, or when the insulin produced does not work properly (insulin resistance). Risk factors for developing Type 2 include family history, ethnicity, being overweight or having a large waist, high blood pressure, heart disease or having had a heart attack.

Diabetes is becoming increasingly common throughout the world, including the UK, due to increased obesity.

If left untreated, diabetes can lead to complications such as loss of feeling in fingers and toes (a condition called diabetic neuropathy), kidney problems, heart problems, loss of vision (through a condition called retinopathy) and other disorders. At advanced stages, diabetes can cause kidney failure, lower-extremity amputation, blindness and stroke.

However, complications can be prevented or significantly delayed by keeping good control of the diabetes, blood pressure and cholesterol levels.

The symptoms of diabetes

Diabetes is predicted by a clear set of symptoms, but it still often goes undiagnosed. The main initial signs of diabetes are:

- Increased thirst;
- Increased need to urinate;
- Increased hunger.

Type 1 diabetes symptoms often appear suddenly and can additionally include:

- High levels of sugar in the blood and urine;
- Weight loss;
- Weakness;
- Tiredness;
- Mood swings;
- Nausea;
- Vomiting.

Type 2 diabetes symptoms tend to come on very gradually, and include most in the list above. Additionally, skin infections, blurry vision, tingling or dry skin are also relatively common symptoms. The gradual onset of symptoms means that it is important that people are not tempted to dismiss the symptoms as simply getting old.

Possible complications of diabetes

Short-term complications include a very high blood glucose level, which is not common with Type 2 diabetes, but is more common in untreated Type 1 diabetes when a very high level of glucose can develop quickly. However, a very high glucose level develops in some people with untreated Type 2 diabetes.

Long-term complications, where blood glucose levels are higher than normal over a long period of time, can gradually damage blood vessels. This can occur even if the glucose level is not very high above the normal level. This may lead to some of the following complications (often years after the disease first develops):

- Atheroma (furring or hardening of the arteries). This can cause problems such as angina, heart attacks, stroke and poor circulation.
- Kidney damage which sometimes develops into kidney failure.
- Eye problems which can affect vision (due to damage to the small arteries of the retina at the back of the eye).
- Nerve damage.
- Foot problems (due to poor circulation and nerve damage).
- Impotence (again due to poor circulation and nerve damage).

The type and severity of long-term complications vary from case to case. Some people do not develop any at all. In general, the nearer the blood glucose level is to normal, the lower the risk of developing complications. Risk of developing complications is also reduced if you deal with any other risk factors that may be present, such as high blood pressure.

Who is at risk of developing Type 2 diabetes?

Type 2 diabetes often develops in people who are over the age of 40 years old and who may also have one or more of the following risk factors:

- A close family history of the condition, in parents, or siblings;
- Being overweight or obese;
- Having a waist measurement of more than 80cms (31.5in) if you are a woman, or 94cms (37in) if you are a man.

In addition, there are increased risks for certain groups within the community, including particular ethnic groups or those who have experienced other serious health conditions. Some examples include:

- People of South Asian origin (Indian, Bangladeshi and Pakistani) are six times more likely to develop Type 2 diabetes than any other ethnic group;
- There are links to other common conditions such as Poly Cystic Ovarian Syndrome, although the links are not fully understood;
- Those with heart disease or who have had a heart attack.

A condition called 'impaired glucose intolerance' may also precede a diagnosis of diabetes, often by many years, and will be evidenced by moderately raised levels of blood glucose. Both conditions (impaired glucose intolerance and diabetes) can be brought on during pregnancy.

Theme 1: Prevalence

What we currently know about prevalence

The Association of Public Health Observatories (APHO) data shows that average registered adult prevalence of diabetes in England is about 5.5%, and that 90% of adults with diabetes have Type 2 diabetes. Whilst this sort of diabetes usually appears in adults who are middle aged or older, there are an increasing number of children and younger people being diagnosed and this is linked to rising obesity prevalence in young people.

The Joint Strategic Needs Assessment 2012 found that in Barking and Dagenham, at the end of March 2012, 9,523 people had been diagnosed with diabetes, a rise of 14% since 2009/10, although it is estimated that at least 1,642 people remain undetected as at November 2012.

Figure 1 - Prevalence of diabetes in Barking & Dagenham

Year	Actual number of people with diabetes	Predicted number	Estimated undetected	Diagnosed prevalence	Predicted prevalence
2009/10	8,349	9,426	1,100	4.5	5.1
2011/12	9,523	11,049	1,642	4.9	5.7

Source: Public Health Observatory Diabetes Prediction Modelling and Quality Management and Analysis System QMAS

However, a Diabetes Audit undertaken by the NHS Information Centre in 2010/11 reported 9,125 diabetes registrations, which is consistent with the increase from 4.5% diagnosed prevalence to 4.9% shown above.

Availability of Baseline Data for Barking & Dagenham

As part of the scrutiny process, Members raised some concern that there was a disparity of information relating to prevalence data for diabetes in Barking and Dagenham. The data presented to Members throughout the scrutiny process all agree that the prevalence of diabetes is increasing although there is a lack of consistency around the figures themselves.

Figure 2 - Variations in prevalence of diabetes data

Organisation	Porters Avenue	JSNA 2013 / Public Health Observatory
Data	9305 (6.12%)	9,523 (4.9%)

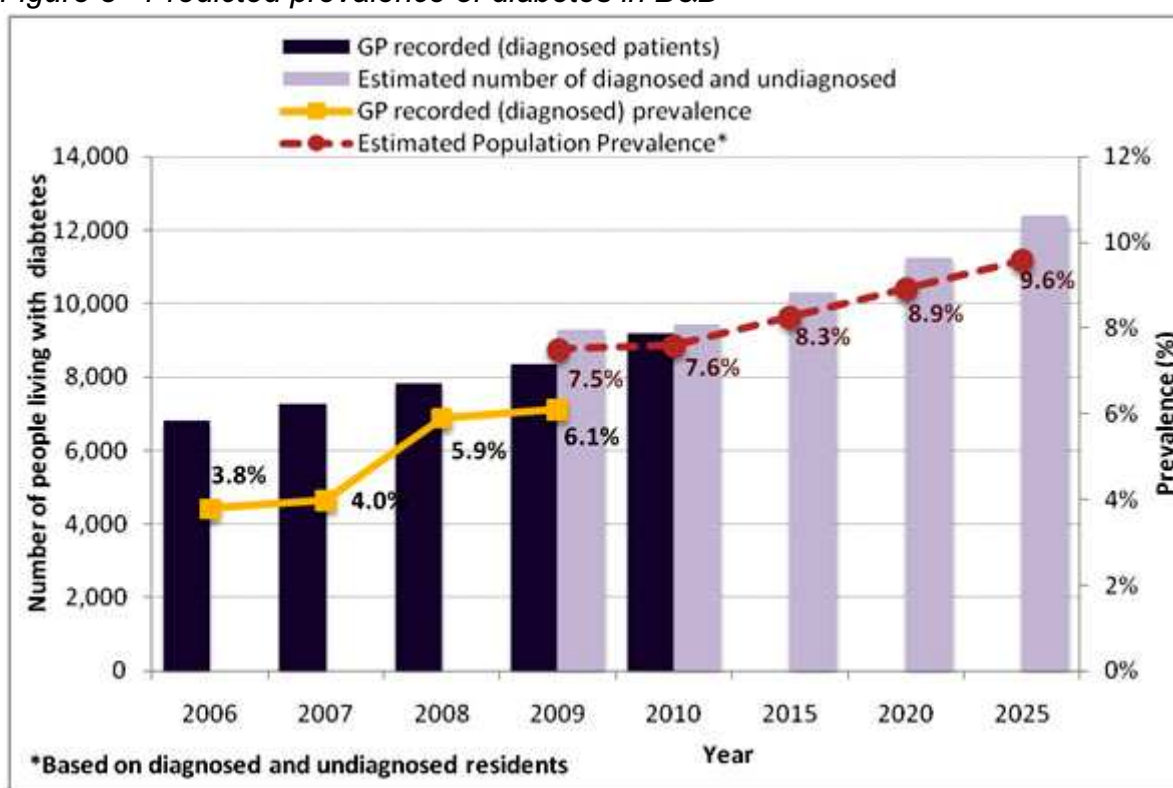
However, what service providers at all of the sessions agreed is that the figure is set to increase due to the changing socio-ethnic make-up of the borough.

Predicted prevalence of diabetes

With increases in adult obesity and the challenges associated with poor diet and lack of exercise, the incidence of diabetes is predicted to increase over the coming years. Estimates indicate that diabetes is expected to increase by about 50% over the next twenty years as related conditions such as obesity continue to rise, so that by 2030, 14,000 people are expected to be living with diabetes in Barking and Dagenham.

The data also indicates that the gap between the actual number of people diagnosed and the expected diabetes prevalence is narrowing across the borough. While this could reflect an increase in levels of diagnosis, the changes in ethnic make-up of the Borough means that the model could actually be an underestimate.

Figure 3 - Predicted prevalence of diabetes in B&D



Association Public Health Observatories (APHO), Disease prevalence Models (2010) and Quality Outcomes Framework 2009-2011 data (from QMAS)

Variances in prevalence data across the borough

The prevalence of diagnosed diabetes in Barking and Dagenham varies from 2.4% to 7.9% between GP practices in the borough as of November 2012.

The JSNA 2010/11 argues that difference in prevalence across GP practices is directly related to the variation in demography such as the number of elderly patients, those from a

minority ethnic group, and those who are obese: all factors which increase the likelihood of a person developing Type 2 diabetes. The JSNA also suggests that:

“further analysis is needed to determine whether there is any correlation between poor diabetes control and the population demography of the practice population, or whether the variation in control is more likely to be due to the effectiveness of the support patients receive, and the systems and processes within the practices which help support good management.”

The three demographic factors most closely associated with the likelihood of developing Type 2 diabetes, obesity, ethnicity and age (particularly where two or more of these factors are combined) are prominent in the demographic make-up of the population and must be taken into account when predicting future prevalence models.

Obesity

Obesity is a firmly established risk factor for developing Type 2 diabetes and as increased levels of obesity in the population rise, so too will the likelihood of Type 2 diabetes.

The ‘Annual Report of the Director of Public Health for Barking & Dagenham 2013’ found that Barking and Dagenham is estimated to have the highest percentage of obese adults in London, with more than one in four adults obese, the third highest rate of child obesity in England at Year 6 [10-11 years] (26.9%) and the second highest at Reception age [4-5 years] (13.7%).

Adult obesity is a serious problem in Barking and Dagenham with one in four adults with a BMI (Body Mass Index) of more than 30. The Annual Report also found that obesity rates vary according to socio-economic status, with ***“low income and deprivation having a greater impact on female obesity levels than male. In addition, there is a higher prevalence of obesity among some ethnic groups, in particular among Black Caribbean and Pakistani women....The high costs of obesity result from the increased risk of many chronic conditions, including diabetes....”***

Ethnicity

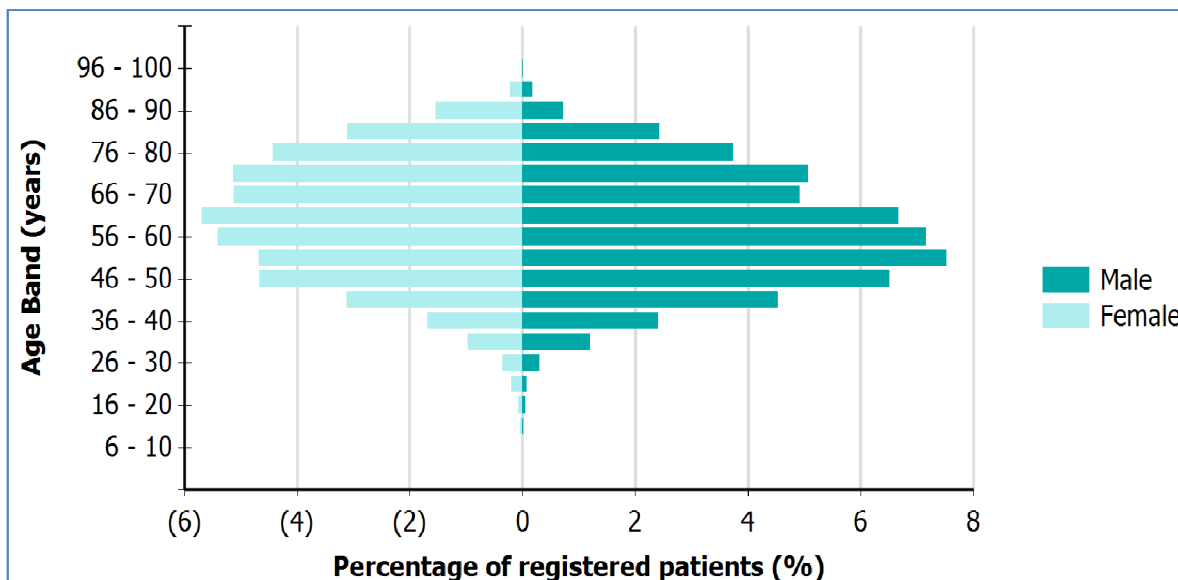
The 2011 census shows that an estimated 16.4% and 18.14% of the borough’s population is South Asian and African/African-Caribbean respectively, some of the ethnic groups that are more significantly affected than others by Type 2 diabetes. Type 2 diabetes is up to 6 times more likely in people of South Asian descent and up to three times more likely in African and African-Caribbean people.

This means that an expected continued increase in the prevalence of Type 2 diabetes is also likely. At present there is no diagnosis data available which shows the breakdown of Type 2 diabetes against ethnicity.

Age

The 2011 census data shows that a majority of residents in the Borough are in the age range most likely to develop Type 2 diabetes (40+ years) and this should be taken into account when combined with other factors such as ethnicity and obesity when predicting future prevalence models.

Figure 4 - Age and gender of people with Type 2 diabetes in Barking & Dagenham



Source: National Diabetes Audit (2010/11)

The National Diabetes Audit found that in Barking and Dagenham, the highest numbers of Type 2 diabetics were in the 51 to 65 age group.

Gap between diagnosis and predicted prevalence

With an estimated 1,642 people living with undetected diabetes, the Committee was interested to hear from witnesses about the potential improvement that could be made in diagnosis rates. Representatives attending the sessions confirmed that there is little funding for local screening events although Pharmacists and staff at Porters Avenue do run ad hoc events and that commissioners may wish to explore the option of Pharmacists providing screening tests to help make screening for Type 2 diabetes more easily accessible.

In addition, there was a consensus that all medical practitioners, GPs amongst them, require ongoing training about Type 2 diabetes to ensure that all opportunities are being taken to identify those at risk and living with the disease, as well as to keep up to date with current medication and research.

Given the changing demographics of the borough, it was also suggested to Members that work is required which looks at actively screening people who have a high risk of developing diabetes such as people from African/Afro-Caribbean and Asian backgrounds.

Funding for screening programmes should also be considered to help make screening more accessible as well as thinking more proactively about other ways of screening people for diabetes for example, holding sessions at pharmacies, supermarkets, holy places and car parks in order to reach people who do not routinely go to GP surgeries.

Members also felt that commissioners need to ensure that guidelines are being followed to check other disease registers for people who may potentially have diabetes e.g. asthma register.

Recommendations

The Committee felt that a lack of accurate baseline data, for both diagnosis and expected prevalence data, will make it more difficult to accurately predict future trends and commissioning requirements especially in light of the fact that current prediction models are based on historical data (2010/11).

Members suggest that baseline data should include the actual number of people already diagnosed with Type 2 diabetes together with a demographic breakdown.

Recommendation: Prevalence data

It is recommended that a future iteration of the Joint Strategic Needs Assessment provides a clearer account of the source of competing data and the 'best estimate' that the borough is using to monitor its progress and identify the challenge it faces in addressing undiagnosed diabetes.

Recommendation: Improving screening and diagnosis

It is recommended that a programme of proactive screening opportunities is established, linked to improved entry routes to an integrated diabetes care pathway, with more medical professionals seeking opportunities for the proactive identification of diabetes in their patients and service users, and for GP's to take a more pro-active role in diagnosis.

Theme 2: Provision of health checks

Establishing national standards for diabetes care

There are a number of national guidelines which set out the standards for diabetes services which commissioners must incorporate when commissioning local diabetes services. The two main guidelines are the National Service Framework for Diabetes and the National Institute of Health and Clinical Excellence (NICE) Quality Standards for Diabetes.

The National Service Framework for Diabetes

The National Service Framework (NSF) was established to improve diabetes services through setting national standards to **“drive up service quality and tackle variations in care.”** The Framework aims to enable more people to live free of diabetes and free from the complications of diabetes and their consequences.

Under the NSF, diabetes services should be:

- **Person-centred:** empowering the individual to adopt a healthy lifestyle and to manage their own diabetes, through education and support which recognises the importance of lifestyle, culture and religion, and which, where necessary, tackles the adverse impact of material disadvantage and social exclusion.
- **Developed in partnership:** ensuring goals and the respective responsibilities of the individual and the diabetes team are agreed and clearly set out in a regularly reviewed care plan.
- **Equitable:** ensuring that services are planned to meet the needs of the population, including specific groups within the population, and are appropriate to individuals' needs.
- **Integrated:** drawing on the knowledge and skills of health and social care professionals across a multidisciplinary diabetes health care team, including primary care and social care as well as specialist services.
- **Outcomes oriented:** narrowing the inequalities gap between those groups whose outcomes are poorest and the rest; minimising the risk of developing diabetes and its complications and maximising the quality of life for individuals by empowering staff to deliver, evaluate and measure care.
- **Delivering this vision** and embedding these principles in practice requires staff throughout the NHS to understand the experience of diabetes and diabetes care, and to recognise the expertise of people who live with diabetes. The aims will be to empower people with diabetes through skills, knowledge and access to services to manage their own diabetes and fulfil their potential to live long lives free of the complications that can accompany diabetes.

In particular, the NSF sets out the expected health checks and treatment options that should be available to all type 2 diabetics. In particular, Standards 10 and 12 seek to ensure that all young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes, and that all people with diabetes requiring multi-agency support will receive integrated health and social care.

The National Institute of Health and Clinical Excellence (NICE), Quality Standards for Diabetes.

The National Institute of Health and Clinical Excellence (NICE) published a Quality Standard for diabetes in 2011 which supports the existing NSF and provides a definition of **'good quality'** care. The NICE quality standards enable:

- health and social care professionals to make decisions about care based on the latest evidence and best practice.
- patients understand what service they can expect from their health and social care providers.
- NHS trusts to quickly and easily examine the clinical performance of their organisation and assess the standards of care they provide.
- commissioners to be confident that the services they are providing are high quality and cost-effective.

The standards include giving people knowledge to understand their condition to help with self-management through structured education programmes, access to specialist diabetes advice, care planning discussions and annual checks. A summary of the standards is included in Appendix 4. Full details of the standard are available on-line:

<http://guidance.nice.org.uk/QS6>

The Nine Health checks

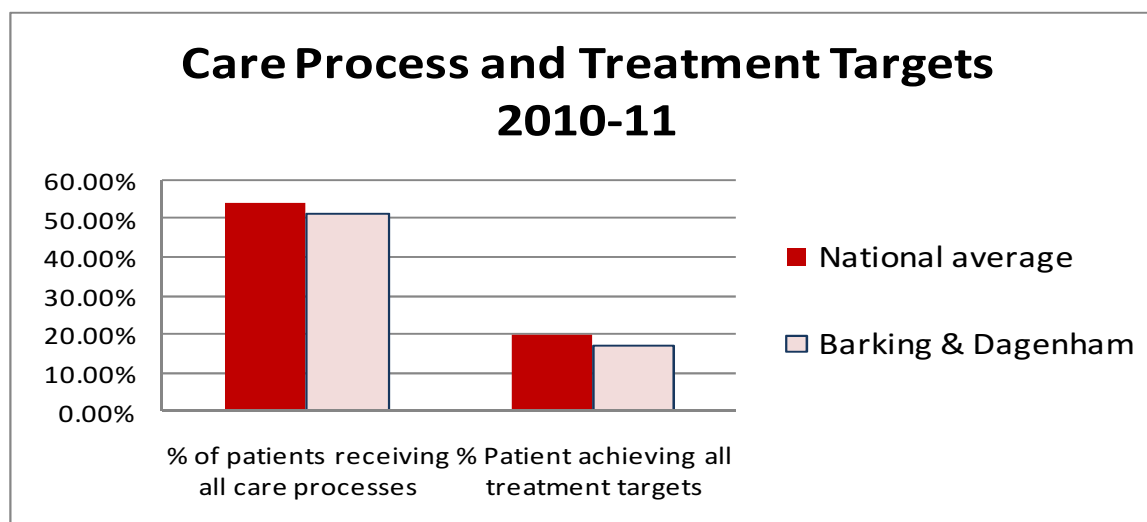
To help achieve these standards, NICE recommend nine key health tests which people living with Type 2 diabetes should have annually to help monitor and manage their diabetes and to reduce the risk of complications such as amputations. The nine annual health checks for people with diabetes are:

1. Weight and BMI Measurement
2. Blood pressure
3. Smoking status
4. Blood test (HbA1c – blood glucose levels)
5. Urinary albumin test (or protein test to measure the kidney function)
6. Serum creatinine test (creatinine is an indicator for renal function)
7. Cholesterol level check
8. Eye check (retinopathy screening)
9. Foot check

Uptake of Recommended Nine Health Checks in Barking and Dagenham

The National Diabetes audit 2010/11 found that only 51.2% of people living with diabetes in Barking & Dagenham are receiving all 9 of the annual essential healthcare checks.

Figure 5 - Care Process and Treatment Targets for Barking & Dagenham



Health and Social Care Information Centre (HSCIC)

The National Diabetes Audit (2010/11) reviewed the performance of the annual health checks in Barking and Dagenham and found that just over half (51%) of people with diabetes get all of them annually; the corresponding national figure is 54%. The audit was undertaken over a three year period (1 April 2008 to 31 March 2011) and Barking and Dagenham were identified as performing in the bottom 25% of PCTs.

The audit also found that people with Type 1 diabetes are less likely than those with Type 2 to receive all the tests annually – 38% against 53% – and that in both categories, people under 55 are less likely to receive all the tests than people over 55 years.

The table below gives an overview of performance against each test, as identified by the National Diabetes Audit 2010/11.

Figure 6 - Percentage of all patients in B&D receiving NICE recommended care processes

Care Process recorded	Percentage of registered patients in PCT	Percentage point change since 2009-2010	Median score across all PCTs	National quartile ranking
All Care Processes*	51.2%	+16.69%	55.5%	3
Blood Creatinine	91.0%	-0.25%	93.1%	4
Blood Pressure	94.6%	-0.62%	95.2%	3
BMI	87.7%	-3.74%	90.0%	4
Cholesterol	90.1%	-0.49%	91.7%	4
Eye Screening	82.3%	+25.23%	82.4%	3
Foot Exam	84.9%	-0.05%	84.5%	2
HbA1c**	89.6%	+0.37%	92.9%	4
Smoking Review	84.1%	-3.68%	85.7%	3
Urinary Albumin	71.2%	+10.87%	76.3%	4

*People registered with diabetes receiving all nine key processes of care processes

** For patients under 12 years of ages, 'all care processes' is defined as HbA1c only as other care process are not recommended in the NICE guidelines for this age group

The latest Joint Strategic Needs Assessment still bases its judgment of performance against these essential annual health checks on the basis of the 2010/11 data. Whilst the sample size was small, a more recent indicator is provided by the Patient & Carer Survey commissioned by the Select Committee. It suggests that there has been relatively little consistent improvement in the take-up, although the consistency of eye checks appears to be positive. However, this cannot compare to the standard of data in the original 2010/11 audit. The clinicians who addressed the Committee during the review confirmed that they see Barking and Dagenham as having a low percentage of people having annual health reviews, with significant variation in take-up numbers across different practices.

This continued questionable performance suggests that more robust and consistent data needs to be employed to drive improved delivery.

Figure 7 - Prevalence of annual health checks in Barking & Dagenham

Health Check	Annually	Sometimes	Never	Didn't Know they should
Kidney check (creatinine and albumin)	59.2%	4.1%	8.2%	4.1%
Blood pressure	77.6%	16.3%	0.0%	0.0%
Weight check	73.5%	14.3%	2.0%	0.0%
Cholesterol level	77.6%	10.2%	2.0%	2.0%
Eye check	98.0%	0.0%	0.0%	0.0%
Leg and feet check	71.4%	10.2%	2.0%	2.0%
Blood glucose levels (HbA1c)	42.9%	6.1%	0.0%	0.0%
Support for smoker	8.2%	6.1%	10.2%	4.1%
Personal health and care plan*	26.5%	10.2%	16.3%	8.2%

*This information was requested in the survey to ascertain how many people reviewed their care plan annually.

Diabetes Patient and Carer Survey 2012-13 LBBD

Patients' perception of health checks

The JSNA 2013 suggests that the diabetes focus group (consulted as part of the JSNA review) felt low levels of annual checks may be due to the following factors:

- Not being invited annually – patients were often reminding their practice that they were due testing not vice versa;

- Lack of automated invitations;
- Inability to get appointments at convenient times especially for people of working age (hence the lower completion rate in under 55 year olds).

Members felt that additional work is need to better understand why this may be the case and to work towards not only encouraging patients to have their annual check but to ensure that GPs maximise the number of annual reviews that they do.

Only a small percentage of people indicated that they didn't know they should be having annual checks, which therefore suggests that, by and large, patients are aware that annual check-ups should take place. In terms of the low take-up, therefore, there are three possible conclusions which may be drawn from this:

- The patient does not understand the importance of having annual checks or does not understand what the Annual Health Check involves;
- GPs may not be reinforcing the importance of the tests and actively encouraging patients to have an annual check up;
- In some cases, there may be other reasons, unique to individuals, as to why regular health checks are not being followed up.

Clinicians who participated in the scrutiny process said that GPs and nurses should ensure that they explain to the patients the purpose of the annual review and what to expect. They felt that booklets explaining what happens in the annual reviews are essential as significant number of people do not seem to understand what to expect.

The Committee were concerned that if the annual checks are not regularly taking place, patients are more likely to develop future complications which may have been avoided. Members recommend that information about the importance of annual health checks, and what patients should expect from them, is provided to people with diabetes.

Foot Health

People with diabetes are more likely to be admitted to hospital with a foot ulcer than with any other complication of diabetes. This is due to the fact that diabetes can cause poor circulation and reduced feeling in the feet, as well as inhibiting healing. The Annual Foot check should include:

- Testing sensation and pulse
- Examination for signs of deformity, infection or ulceration
- Checking footwear is suitable
- Discussing any pain or previous ulceration

The **'Healthy Feet'** campaign promoted by Diabetes UK focuses on providing advice about maintaining healthy feet and the importance of annual feet checks.

The National Diabetes Audit found that 84.9% of people with diabetes in Barking and Dagenham received a foot check in 2010/11. The audit also showed that of those who did receive the annual foot check, patients reported that the level of the foot check is poor. It should be noted that this information is based on patient satisfaction and what is not clear is whether the patient understood what they should expect from their annual foot check. Given that this is the most common complication, it is concerning that it ranked in the bottom five of the regular health checks amongst respondents to the Patient & Carer

Survey. However, it appears to correlate with the feedback from clinicians who attended the Committee, who reported that the quality of foot checks among local practitioners varied and that not all of the elements of the foot checks were being completed. For example, feedback received by clinicians from patients indicates that some GPs do not check footwear or routinely carry out a pulse test. They also reported that some patients said that their GPs did not even inspect their feet. Representatives of the CCG attending the sessions advised Committee Members that it needed to increase awareness of the importance of foot checks and health checks in general to ensure that they are being carried out properly.

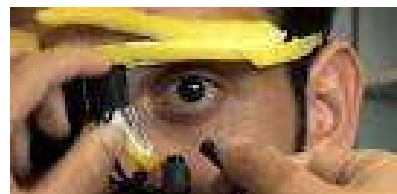
Care plan review

It has already been discussed that one of the factors for reducing the risk of complications is to adopt a healthy lifestyle which includes good diet and exercise and yet the figures from the Patient & Carer survey show that of those who responded, only 26.5% regularly review their care plan. What is not clear is of the 73.5% not reviewing their care plan, how many are no longer following it; and whether there had been any significant health changes as a result.

Pharmacists attending the Service Provision session expressed concern that care plans often didn't take into account all of the different services available, because the care plan always end at surgery level. The representatives suggested that GP's should work to develop partnerships between pharmacists, other professionals and the public to enhance shared care, especially in changing patterns of behaviour among patients to move towards '*self-care*'.

Eye health: diabetic retinopathy screening

As is shown in the data on health checks, the proportion of people offered a retinopathy screen is high. This also leads to the number of people with diabetes in Barking and Dagenham who have retinopathy diagnosed by screening being above the national average. However, at present only around 80% of people accept the offer of retinopathy screening. Encouraging more people to take up the offer of screening and reduce their risk of eye disease progressing is another important opportunity to improve their health.



The borough's Vision Strategy 2010-2015 identified that of those people with diabetes who were screened, over 1,750 had some degree of retinopathy. It further identified that over 2,100 people with diabetes had failed to attend their retinopathy screening appointments, which roughly correlates to the 20% identified in the JSNA as not taking up the offer. This has led to additional appointments being offered to encourage everyone to have at least 3 fixed appointments for screening, plus an open offer of being able to phone up and choose a screening date at any time.

Retinopathy services provided evidence to the Committee during the review. At the session on 31 January 2013, representatives from the Retinopathy Service at Porters Avenue reported concern that, while there is good uptake for the retinopathy screening, patients do not always understand that they also need to have the annual NHS eye test. This potentially leaves other health issues, such as glaucoma, undetected. The results from the Patient & Carer survey showed that 98% of respondents had an annual eye check but it doesn't indicate whether that included the NHS standard eye test, and there is no

method for tracking whether patients are having both retinopathy screening and an NHS eye test at present.

Overview of the issues presented around health checks

What has become apparent through the scrutiny is that the current screening process for complications associated with diabetes is not performing as well as it should be, in certain areas. This view is supported by pharmacists, GPs and healthcare workers who attended the information gathering sessions.

Members heard that training for GPs is provided across the borough, but that clinicians suggested that the training focuses primarily on medication and could be enhanced to provide wider professional development around encouraging patients to more effectively self-manage their diabetes.

When the issues above were presented to representatives from the CCG in March 2013, the CCG agreed that the standards of care across the borough, particularly in regard to the standard and adherence to the 9 NICE health checks was not consistent from all GP surgeries. HASSC welcomed the assurance that the CCG would address these findings through a programme of peer review and would also review GP training on diabetes.

Recommendations

Based on the information received by the Committee, Members concluded that there was a need to raise awareness amongst both diabetic patients and their community health professionals (GP's and practice nurses in particular) about the importance of the annual health checks.

Recommendation: Patient understanding of health checks

Specifically, it is recommended that action is taken to improve patients' understanding of the annual diabetes health checks, what they should expect to receive, and their importance in preventing complications.

Recommendation: Clinicians' adherence to health check process

It is further recommended that the CCG takes steps to ensure that all clinicians are familiar with the NICE recommendations for the Annual Health Check and have arranged the provision of high-quality interventions, with associated processes for prompt arrangement of patient appointments and their reminders.

Recommendation: Performance monitoring of the health check process

For the longer term, it is recommended that the data is improved and the baseline for understanding uptake of the nine health checks is brought up to date, with on-going robust monitoring thereafter.

Theme 3: Provision of information

From the outset of the diabetes scrutiny review, Members were particularly interested in looking at the information and advice which was available to people with Type 2 diabetes. At the Patient Perspective session issues were raised that the availability of information was poor, specifically the guidance and help provided by GPs to those who are newly diagnosed, and about the complications which may be associated with poor management of diabetes.

Those whom the Committee interviewed displayed some measure of consensus on the point that information is poor, especially around managing the condition and the long term impact if diabetes is not managed well. One representative said that:

“Information and communications are very poor in the borough [about long term complications]. I was not told about what to do after I lost my leg for 6 years. I started losing my sight 4 years ago and had to pack up work. I drove an automatic car before that but losing my sight has meant life has changed.”

It was also felt that the lack of information about the seriousness of the condition can cause people to think that it “...it won't happen to them....” And that having the right information early enough might make people take diabetes more seriously.

Patient representatives and GP's generally agree that complications related to Type 2 diabetes may be preventable with education about self-management.

Service providers felt that while there is information available, as a Borough we should be taking a more targeted approach to produce better outcomes, for example, targeting the general population with information about the signs and symptoms of diabetes.

Why is the provision of information important?

Both patients and health care professionals who participated in the scrutiny process agreed that good quality information about Type 2 diabetes is essential to help:

- Reduce the risks of developing Type 2 diabetes;
- Recognise the signs and symptoms of Type 2 diabetes and get early diagnosis;
- Inform people how to manage their condition effectively post-diagnosis;
- Reduce the likelihood of developing long-term complications.

The Joint Strategic Needs Assessment cites research that found that many patients locally had not been informed about what their target levels of blood sugar were, and so could not actively participate in their own care. Others saw their results – for example, glucose control or cholesterol – and thought them high but their medications weren't changed and they were not given any instructions. Service providers generally agreed that providing patients with better information about their condition and the service expectations would improve self-management and help to change patterns of behaviour to develop a healthier life-style.

Standard 3 of the National Framework supports this view and identifies the importance of empowering people with diabetes in order to help them gain more control over the day-to-

day management of their condition to **“enable them to experience the best possible quality of life.”** This includes areas such as:

- Knowing how to recognise and act upon symptoms
- Dealing with acute attacks or exacerbations of the disease
- Making the most effective use of medicines and treatment
- Understanding the implications of professional advice
- Establishing a stable pattern of sleep and rest and dealing with fatigue
- Accessing social and other services
- Managing work and the resources of employment services
- accessing chosen leisure activities
- Developing strategies to deal with the psychological consequences of illness
- Learning to cope with other people's response to their chronic illness.

One of the key learning points from the scrutiny process is that people living with Type 2 diabetes are required to make lifestyle changes which they may find difficult to adapt to at the beginning.

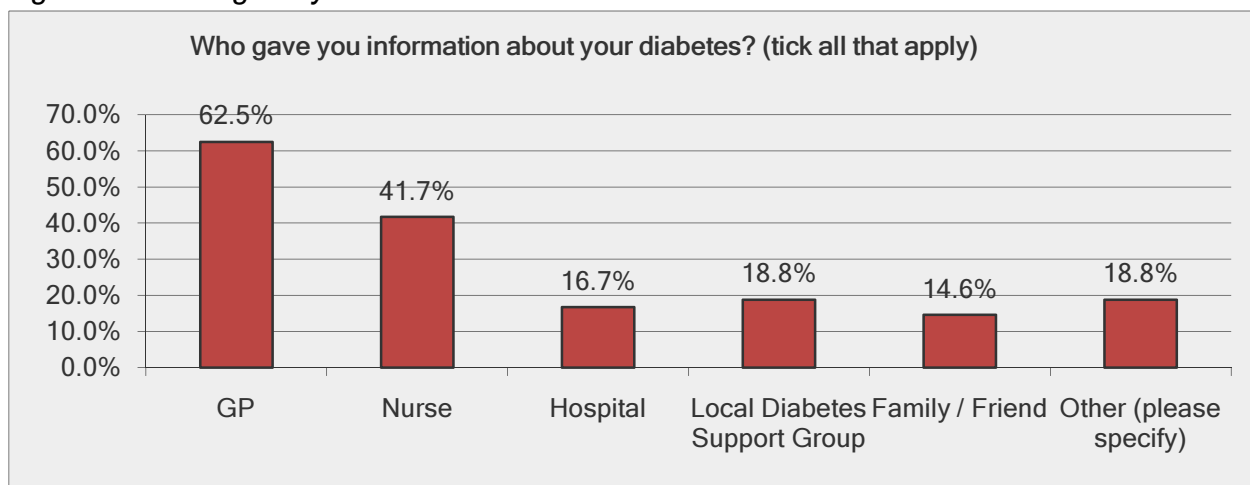
How can patients in Barking and Dagenham currently access information?

As part of the scrutiny process Members requested a review to see what information was already available. The review has identified a number of different ways in which a person living with Type 2 diabetes could access information.

General Practice

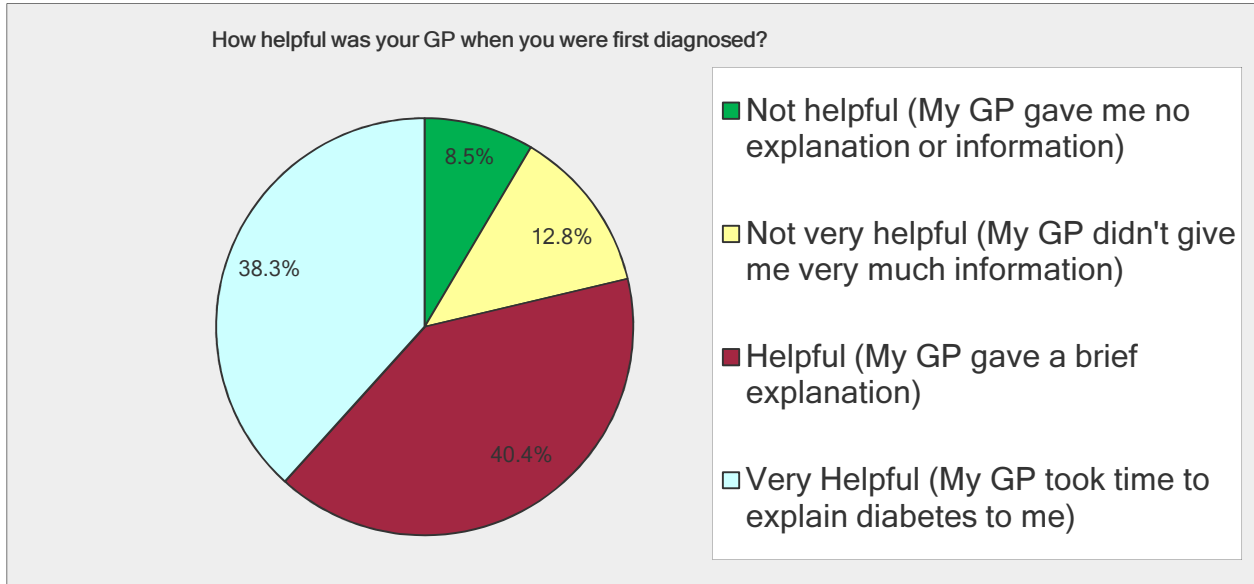
In contrast to the feedback from the patient perspective session, the data from the Patient & Carer survey suggests that GPs are the primary source of information at point of diagnosis, with 62.5% receiving information from this source. A large proportion of those attending the patient perspective session had lived with diabetes for a number of years, and it is reasonable to interpret this difference as indicating that, since their experience of being diagnosed, the process has improved for patients.

Figure 8 - ‘Who gave you information?’



78.7% of respondents also thought that the knowledge and support from their GP was helpful or very helpful with only 8.5% saying that their GP gave them no explanation or information upon diagnosis.

Figure 9 - 'How helpful was your GP?'



Members also noted that GPs were providing information across a broad range of subjects including managing diabetes and the long-term health impacts of diabetes.

Figure 10 - 'What sort of information did they give you?'

Information	Response (%)
Information about diabetes	72.3%
How to manage my diabetes	78.7%
Information about diabetes medication	46.8%
Dietary information	66.0%
How to live with diabetes	40.4%
Long term health impacts of diabetes	53.2%
Other (please specify)	8.5%

Of those that responded, 89.6% said that this information was *'fairly helpful'* or *'very helpful'* which suggests that GPs are a good source of information once a patient has been diagnosed. It is also a very different position reflected during the patient perspective session and reflects the GP education and training around Type 2 diabetes.

On-line Resources

There are a number of resources available to people with Type 2 diabetes on-line. Information on the websites is comprehensive and covers a broad range of areas including:

- Identifying the symptoms of diabetes;
- Information about Type 2 diabetes;
- Diabetes at different life-stages: children, young people, older adults;
- Living with Type 2 diabetes;
- Food and recipes and tips on healthy life-style;
- Treatments;
- Self-management including information about annual health checks;
- Complications;
- Support and user forums.

Some of the best websites include Diabetes UK and NHS Choices.

Information about national frameworks and what patients should expect from their annual health checks are also available via the Diabetes UK and the Department of Health websites.

Education Programmes

Porters Avenue offer an education programme called DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) for anyone who has been diagnosed with Type 2 diabetes. It is a one-day programme which helps develop knowledge and understanding about Type 2 diabetes, how to control it, and the long-term impacts of the condition. The target audience are people with poorly controlled diabetes, hypoglycaemia and new and existing Type 2 diabetics.

Voluntary Support Groups

In Barking and Dagenham there is only one voluntary support group available to people living with Type 2 diabetes, the Barking & Dagenham Diabetes Support Group. The group provides advice and support to patients as well as carers of people living with diabetes. The group meets regularly and is attended by healthcare professionals.

While the Support Group is open to anyone with Diabetes or affected by Diabetes (such as a carer) the majority of people who attend the Support Group are 50+. The Support Group found that when younger people did attend they tended not to become regulars. Parents of young children with diabetes have attended, and they are often referred to the Havering Family Diabetes Group in Harold Hill. This group has other parents and a crèche facility as well as offering different programmes for people living with diabetes. It is not known how many people have been referred to this group.

Members were appreciative of the energetic work that the Diabetes Support Group put into improving services for their members. However, with an increasingly younger cohort of

people living with diabetes, the Committee would like to see if there was an opportunity for the Support Group to look at ways to attract younger members.

Members also felt that there is a lack of co-ordinated support for children and young people within the Borough and recommended that this should be explored in more detail.

Information provided to professionals to support their work

It was also clear during the patient perspective session that patients were not aware of the services available to them, for example financial advice. This point was also raised by a GP with a special interest (GPwSI) who attended the session on 13 February. He noted that GPs do not always have enough information about what services are available in the Borough. For example, in 2010 a booklet was issued to GPs advertising the different exercise schemes available which proved useful when GP's were developing a care plans with patients. This booklet has not been re-issued. The feedback from GPs suggests that they would be happy to sign-post services if they knew what was available.

As an example, DABD UK provides a range of services to support independent living and to promote independence. This service is available to patients living with Type 2 diabetes, and their welfare benefits service provides a free and confidential advice on matters such as help completing benefit forms, benefit entitlement checks and income maximisation. DABD representatives attended the B&D Diabetes Support Group on 11 February 2013 to advertise their services, but it is clear that more could be done to put this information into the hands of professionals working with those with diabetes.

It was clear from both the information gathering sessions and site visits that better sign-posting of services is required. This is not limited to patients and carers but also to GPs and other service providers.

When CCG representatives were presented with these findings in March 2013, HASSC were pleased to be assured that the CCG are currently reviewing diabetes literature and will particularly review information packs that are given to patients in light of the concerns raised by HASSC.

Culturally relevant information

In Section 1, it was advised that the survey respondents were not reflective of the Borough demographics as a whole. What the scrutiny could not identify is how difficult it is for people from different ethnic backgrounds to access information particularly where there are language barriers.

Porters Avenue offers a variation on the DESMOND programme which is specifically aimed at people from different ethnic backgrounds and includes an interpreter.

Members felt that any work around information and sign-posting services should take into account the diverse demographics of the population of Barking and Dagenham.

Recommendations

Members recommend that further work is required to ensure that there is adequate information and support for people living with Type 2 diabetes in the Borough.

Recommendation: Information and advice

The Committee recommends that the whole range of information provided to people already diagnosed and people newly diagnosed with Type 2 diabetes is reviewed, ensuring that it gives them what they need to know to improve self-management of their diabetes and their understanding of long-term complications.

This could include, but not limited to:

- Affordable healthier food options (at home and in the workplace)
- Active involvement in negotiating, agreeing and owning goals
- Understanding the consequences of different choices

The Committee also recommends that this review takes account of the need to ensure that the information and advice reflects the changing diversity of the population, and is easily accessible by the target audiences.

Support for younger people

Although it is outside the scope of the scrutiny, Members were concerned that there is not enough targeted support for younger people in the Borough, for both Type 1 and Type 2 diabetes. There are likely to be two age groups affected: firstly, younger people, including children, who may be more likely to have Type 1 diabetes; secondly, and more within the scope of this report, those between the ages of approximately 30-50 who may be developing Type 2 diabetes as a result of lifestyle factors.

The Committee felt that work needed to be carried out to explore what both of these groups would like, noting that their needs are likely to be different, and to foster a service user-led response to the need for more support services in each case. For the younger age range, it may be that the health group of the Barking & Dagenham Youth Forum would like to undertake some work on this issue.

Recommendation: Young people's support (Type 1 and Type 2)

That the Health & Wellbeing Board facilitates consideration of how young people with diabetes (either Type 1 or Type 2) could be supported in the Borough, inviting the participation of the health group of the Barking & Dagenham Youth Forum.

Recommendation: Younger adults developing Type 2 diabetes

That the Diabetes Support Group participates in a short review of the support needs of younger adults developing Type 2 diabetes, and how they may be met from a service user led group, led by an agency to be identified by the Health & Wellbeing Board.

Theme 4: Hospital admissions

Barking and Dagenham has the highest emergency admission rate to hospital in London. Around 40% of hospital admissions are unplanned and a **“significant proportion of these are related to conditions such as congestive heart failure, diabetes, asthma, angina, epilepsy and high blood pressure, which generally should be managed without emergency admission.”** (Annual Report of the Director of Public Health, 2013)

In 2011-12 there were 100 admissions per 1,000 population in Barking & Dagenham, which was an increase of 11.4% from the level in 2010-11. More significantly, for those conditions (called ‘ambulatory care sensitive conditions’) that give rise to a higher risk of admission, the rate was 16.5 per 1000 population at a total cost of £5.5m per year. Diabetes is one of these conditions. The pressure on accident and emergency services and the use of hospital beds is substantial, adding to the challenges that Barking, Havering and Redbridge University Hospitals NHS Trust face in meeting the demands of the local population.

It is therefore the complications arising from poor management of diabetes that place a pressure on local hospital services. Both the Director for Public Health Annual Report and the JSNA 2013 found that in Barking and Dagenham the rate of emergency admissions for diabetes is above the national average (in the top 10% in London) and is also high for planned admissions.

The JSNA suggests that this indicates a lack of sufficient support and care in the community, with care being hospital-focused. This view was supported by the B&D Diabetes Support Group who suggested that when someone has a problem but can’t get hold of a GP, they ring the emergency doctor who advises them to go to A&E. This may be an issue regularly raised with the general population, but it is an added concern given the risks facing those managing their diabetes.

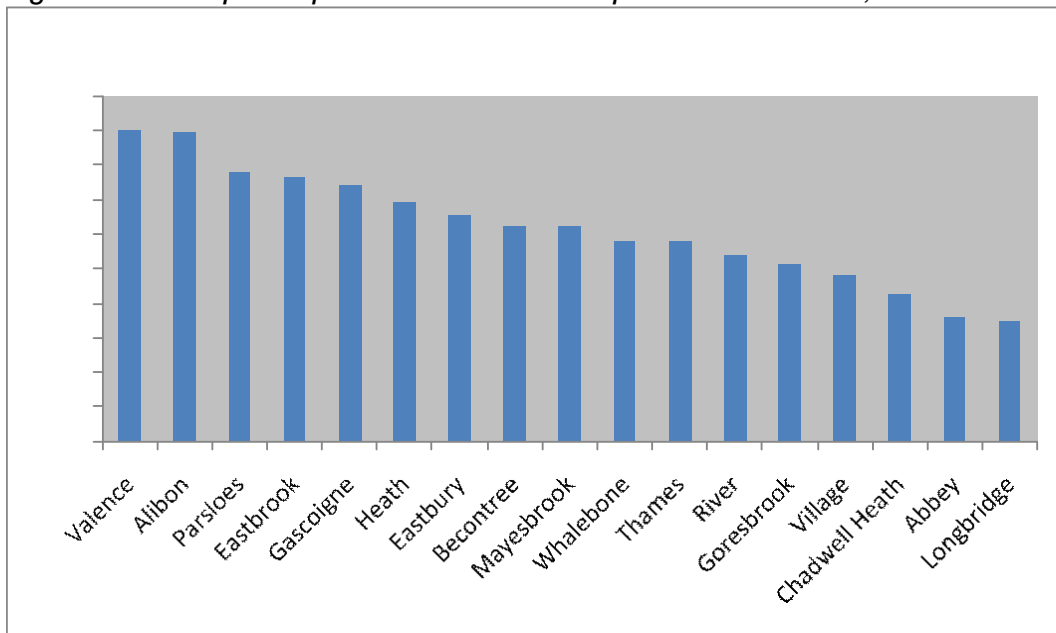
Figure 11 - Rate of Emergency Diabetic Admissions per 100 on the diabetes register (2010/11)

	Rate of Admission (%)
England	1.6
London	1.6
Barking & Dagenham	2.1
Havering	1.6
Redbridge	1.1
Waltham Forest	1.2

Source: NHS comparators (2010/11 data)

Admission rates also vary between wards with Valence and Alibon wards having the highest annual hospital admission episodes.

Figure 12 - Hospital Episodes for Diabetes per 1000 Patients, B&D wards



Source: NHS Secondary Uses Service (data warehouse), analysis by Peter Condon

Members were concerned that the data surrounding hospital admission rates is based on 2010/11 data and felt that baseline data for 2011/12 should be made available.

Integrated services for better diabetes management

South West Essex Community Services (SWECS) Diabetes Service

Representatives from South West Essex Community Diabetes Service (referred to here as SWECS) were invited to attend a HASSC session on 12 December 2012 to discuss the community diabetes services.

South West Essex has a prevalence of 5.4% of adults with diabetes. The service was commissioned in April 2011 to provide a diabetes hub within the community, and has since been cited for its excellent outcomes, particularly in reducing diabetes-related hospital admissions. The team includes 1 assistant practitioner, 7 diabetes nurses and 1 nurse consultant, 1 specialist dietician and Clinical consultants from Basildon Hospital.

Representatives from SWECS advised members that since the start of the integrated service, staff have found that patients are showing better care and management of diabetes, improved glycaemic control and improved quality of life. In particular, there are no longer any outpatients at Basildon Hospital with patients being seen at one of 13 outreach clinics across the Borough. The service includes diabetes education (similar to Porters Avenue) and has around 4,000 patients and includes home and care home visits.

Members were interested to note the reasons that SWECS gave for the reduction in hospital admissions, which included:

- Good relationship with acute colleagues**
 Staff work closely with ambulance staff who report that repeat admissions often don't want to say anything in case they get **"into trouble"** with their GP for not looking after themselves. Ambulance staff refer repeat admissions to the 'Hub'

so that nurses can make a home or care home visit. Nurses also work closely with GPs to help review their diabetic patients.

- **Urgent referrals**
SWECS nurses have adopted a '**no barriers**' attitude which means they will see patients without a referral if they receive urgent calls from GPs or Basildon Hospital to avoid a person going to A&E.
- **Work in partnership with GP practices**
SWECS nurses work in GP practices not only to help with the shortfall in expertise and resources in GP practices but also to up-skill staff. They also run an annual conference for all staff in their area and a forum every 3 months to promote diabetes education. They also noted that a large group of nurses means that there is a lot of expertise and support amongst each other.
- Patients are being **moved through the pathway quickly**.

When the Committee compared the information presented about SWECS to that provided by Porters Avenue Integrated Diabetes Service, they were interested to note the similarities, and the opinion of many of the professional witnesses that there is little practical difference in the operation of the two services. However, it is clear that the outcomes being achieved are markedly different. The Committee were surprised to hear that there had been relatively little exchange of knowledge and best practice between the two services. The Committee suggested that an exchange of information would be of particular benefit to integrated community services locally as they look for ways to improve the outcomes from the local diabetic care pathway.

Integration of Services in Barking & Dagenham

The Committee heard from some clinicians that there was scope to review the care pathway to improve its integration across different services, to ensure that all the relevant players are included, and to understand how each service can offer support. Taken together with a review of best practice, Members felt that commissioners in Barking and Dagenham need to review the way in which individual services work together to form a more holistic approach to patient management. As an example, care plans should take into consideration how pharmacists access support and advice.

Members of the Committee also reflected that, with the changes in responsibility across the health system, any review of integrated service delivery may need to confirm that the correct information sharing protocols are in place to ensure that patient information is passed between services safely and efficiently.

At a meeting in March 2013 in which CCG representatives were presented with the findings of this report, HASSC were pleased to be assured that the CCG have established a diabetes forum to address areas for improvement. The diabetes forum will particularly look at developing services at Porters Avenue and learning from national and local best practice examples, such as South West Essex.

Recommendations

Recommendation: Learning from South West Essex

That the Health & Wellbeing Board ask Public Health professionals to work with commissioners and North East London NHS Foundation Trust to understand the reasons why services which are on the face of it similar appear to be linked to different outcomes for patients, and to capture the lessons for future local commissioning.

Recommendation: Reviewing the integrated care pathway

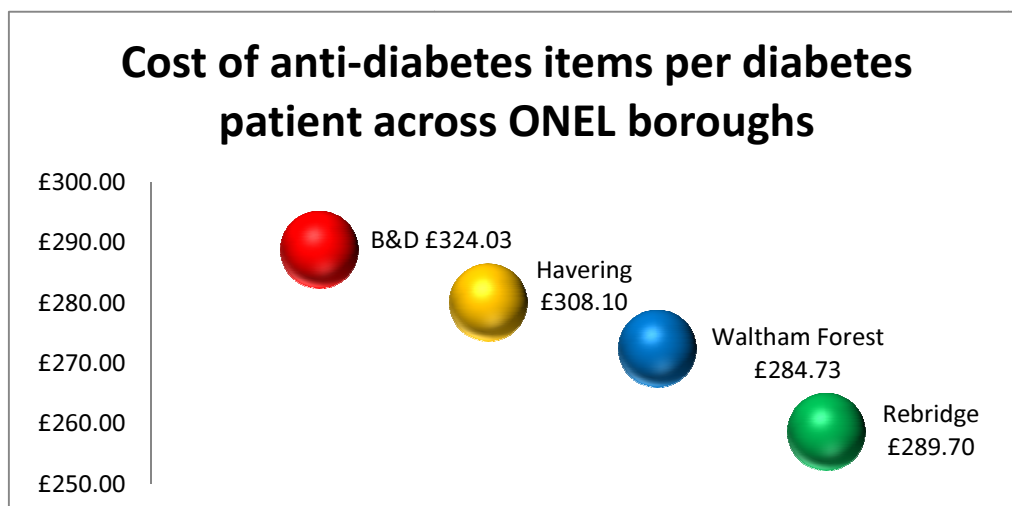
That the Health & Wellbeing Board oversees a review of the care pathway to ensure that all opportunities for joint working are being harnessed and that the flow of patients between services is effective.

Theme 5: Annual cost of diabetes

At a national level, spending on diabetes is amongst the highest. In Barking and Dagenham some elements of the cost are notably high.

In particular, Barking & Dagenham have the fifth highest number of prescription items and spending costs in London. In 2009/10, NHS Barking & Dagenham spent £2.4m on anti-diabetic prescription items, which equates to £287 per known diabetic at the time. In 2010/11 the overall cost for anti-diabetes items (measured per diabetic patient) was found to be higher than any other Outer North East London (ONEL) borough. This suggests that people may not be managing their condition as effectively as they could be.

Figure 13 - Cost of Anti-diabetic items per patient



Source: Yorkshire and Humber Public Health Observatory (YHPHO), Diabetes health intelligence

Testing equipment

The 2013 review of the Joint Strategic Needs Assessment has pointed out that certain aspects of expenditure are high, such as blood glucose testing strips. It cites evidence that home blood sugar testing in Type 2 Diabetes does not influence long term control but yet the spending is high in the borough, and this may be one area in which expenditure could be reduced. In particular, it recommends that these **costs “be reviewed by the Clinical Commissioning Group, as there are obvious costs savings with no detriment at all to patient care.”**

However, anecdotally, home testing is popular with patients who feel it offers an element of control, despite the evidence that, in the main, this doesn't always translate into better management of blood sugar levels, so any removal of this option would need to be managed carefully to maintain the commitment of diabetics to their treatment and food regimes.

Adherence to medicines programmes

Expenditure may also be affected by patients not taking medication correctly. Pharmacy representatives who addressed the Committee advised that, while medicines are still the most 'common therapeutic intervention', patients are not taking them correctly:

- 30-50% prescriptions are estimated not to be taken as intended;
- 5% of hospital admissions are due to the preventable adverse effects of medicines (*all medicines, not just diabetes medicines*);
- For 41% patients, there had been little or no explanation of the side effects of their medication, which can affect adherence to the prescribed regime.

Recommendations

In terms of the recommendations arising from this section, Members are minded to support the Joint Strategic Needs Assessment's own recommendation to review cost of testing equipment. Additionally, the Committee considers it sensible to factor into the review of the care pathway the opportunities to improve cost-effectiveness of community services and to improve adherence to medicine programmes by individuals.

Therefore there are no specific recommendations relating to cost above and beyond those already identified by Public Health and clinicians.

Conclusion

Diabetes is a big problem and is set to grow in the future especially in light of its association with related conditions such as obesity. There is currently little funding for targeted screening events to identify people with a higher risk of developing diabetes which could have a real impact on improving the current levels of diagnosis. The review has highlighted the need to find better ways to engage with the people most likely to develop Type 2 diabetes to raise awareness about the condition and help people recognise the early symptoms.

For those people who have already been diagnosed, early detection aligned with good quality information and advice could help patients to better understand and manage their condition. Providing patients with knowledge about life-style choices can help to reduce the likelihood of developing avoidable long-term complications such as blindness and lower limb amputation – which places additional pressures on social care resources and the acute sector, but most importantly stops people living fulfilling and healthy lives.

The cost of diabetes medication is higher in Barking and Dagenham than elsewhere and there are real gains to be made both in terms of improving people's health and lowering costs. Furthermore, General Practice needs to be consistent with the standard of diabetic care provided across the borough. Increased performance monitoring against NICE's nine annual health checks could help to drive up the quality of diabetic patient care, as well as helping patients to manage their condition more effectively and prevent long-term complications from developing.

The presentation by South West Essex Community Diabetes Services has demonstrated the benefit of integration and communication between professionals and it is hoped that professionals within Barking and Dagenham can meet with North East London Foundation Trust to understand the reasons why similar services appear to be linked to different outcomes for patients, and to capture these lessons for future local commissioning to improve the way in which patients move between services and prevent the need for secondary care.

We welcome the move of Public Health to the local authority and the opportunity that this brings for more joined-up thinking about the way in which work on other health conditions may impact Type 2 diabetes, for example, tackling issues around obesity and smoking cessation will help to reduce the levels of people likely to develop the condition.

This report identifies ways in which the Health & Wellbeing Board may wish to address some of the issues when developing future delivery plans and we are pleased that the Chair of the Health and Wellbeing Board has assured the Select Committee that the findings of this review will inform the next iteration of the Health and Wellbeing Strategy. All of the main building blocks for effective diabetes service provision appeared to us to be in place, but greater emphasis needs to be placed on ensuring full take-up and improved promotion if every opportunity is to be harnessed to minimise the serious impacts of this condition. It is hoped that the recommendations identified by HASSC are taken forward.

Appendices

1. Session notes from the Committee's investigations
2. Copy of the Patient and Carer Diabetes Survey
3. Findings from the Patient & Carer Survey results
4. Overview of the National Standards Framework for diabetes
5. Site visit 'Menu of Involvement'

Appendix 1 Information Gathering Session Notes

Patient Perspective Session

Date of Session: 12 September 2012

Organisations: Barking and Dagenham Diabetes Support Group
Barking and Dagenham Local Involvement Network (BDLINK)

How long have you suffered from diabetes?

I've been a type 2 diabetic for 21 years. In this time I have had a leg amputated and suffered from kidney problems.

I was diagnosed 20 years ago. As a result of my diabetes I have lost ½ an eye, had a toe amputated, suffered from osteoporosis, and lost some of the sensation in my legs.

Type 2 for 10 years.

I have been a diabetic for 37 years, the only problem I have is mild neuropathy.

What were the first symptoms of diabetes that you noticed? What made you go to your GP?

I had an extremely stressful job and high blood pressure so I went regularly to my GP. Eventually the GP said I was diabetic but I'd had no symptoms to indicate it, it was "out of the blue".

I had a chest infection and went into hospital and was diagnosed there with asthma and diabetes.

I was passing a lot of water and started to get infections so I went to my GP.

It's in everyone but something sets it off.

Insulin is created naturally in the pancreas, but with Type 1, the body stops making insulin which makes it work properly. Mostly affects younger people under the age of 40.

With Type 2, the body makes insulin but either doesn't make enough or the quality isn't as good as it should be. You might need to change your diet e.g. not as much carbohydrates and sugar. If that doesn't work you go on tablets and if that still doesn't work you go on insulin. Taking insulin in this case doesn't make you a Type 1.

They are two separate illnesses but as serious as each other if undiagnosed.

How supportive was your GP when they told you that you had diabetes? (E.g. did they give you the right advice and information?)

When I took my mother to the GP he admitted that he knew very little and if she wanted to know she had to go to the hospital. She was referred immediately to hospital for tests.

Oldchurch Hospital gave mum and appointment for a month's time. When she went to her appointment the doctor said she should have been dead by then and wondered why hadn't come earlier.

On one occasion the GP was visiting mother and noticed her blood monitor and asked her to do a blood test on him as he thought he had it.

Mother was Type 1 so I knew what to stop eating. I lost 1 ½ stone in weight.

The first time I'd been to the doctor in 17 years as I was generally in good health. The GP was not very supportive.

My GP has changed but the GP I've got now doesn't know much either.

Can you tell us about how you felt when you found out you had diabetes

I never believed I would get it even though mother had it because read somewhere that it wasn't hereditary. I was devastated.

Mother said start off on tablets but I went straight onto injections as a Type 1.

My mother was the only one who provided any support as she knew a little as she was a diabetic but she didn't know very much because she didn't really want to know more.

People generally didn't know much about it so I read books, went to the library to research myself (we didn't have the internet then) to read what to do. I did this until about 5 years ago. At that time I saw a nurse at the surgery for asthma and I came across information about the DAFNE programme. The nurse said someone in borough was doing that and that she would put her in touch with me. I met Elaine Whitlock who runs the service team at Porters Avenue who said they had a course which teaches people about diabetes. I would have to attend daily for week but the course was excellent.

I found out about the pen which meant that I could play around with mealtimes and as a schoolteacher that was brilliant. I had written to ask about it earlier but was advised that had to apply to the hospital and be referred to see if I was suitable to handle a pen.

DAFNE revolutionised my life for handling and managing my diabetes.

Can you tell us about your day-to-day routine

I check my blood sugar level as soon as I get up. I check 3-4 times per day. Most evenings I don't take insulin as in morning my level is very very low. I don't find it difficult to wake up and get up out of bed.

I check my blood sugar levels and a car worker visits me to help with showering, dressing and breakfast. I take 32 tablets and 4 injections a day to keep my insulin levels steady plus other medication for the pain in my legs and aspirin to thin the blood. I'm pretty much housebound unless there is a care worker to visit and take me out. I only get out once a week due to budgets for having carers. I have injections 4 times a day and 32 tablets.

Not everyone who gets diabetes is overweight, I was 13 stone but due to insulin, I put on weight. It's not always true and GPs say that being overweight is why people get diabetes.

I take tablets to absorb my help absorb diabetes medication which is normally around 120 units and 100 units. I also take medication for my heart and neuropathy (my nerves are dying off below knees).

Is there a stigma around diabetes? (e.g. weight)

Yes. I was only 12 stone before I was diagnosed but since having my leg amputated I have put on 15 stone. My family know I'm not a big eater. It was also uncomfortable using a prosthetic limb.

Is it difficult to take the stigma?

The point is that *[name withheld]* is not overweight.

Type 2's tend not to be overweight.

There was a recent report in a paper where a doctor in Canada said that if you're diabetic it's your own fault.

That's insulting.

Some doctors say you are a 'bit diabetic'. You can't be a bit you either are or you aren't.

How did you feel when you found out your family member had diabetes?

My mother was diagnosed with diabetes very late in life. Mum had been to her GP with weight loss and had blood tests. At the hospital she was checked for infection and was asked if she'd lost weight and I said another GP investigating that so nurse left it. Mums health stabilized. She also suffered depression. Her weight remained fairly stable.

When we were in the GPs surgery I saw a poster giving the 6 symptoms of diabetes including excessive tiredness, genital itching and weight loss so I asked for an appointment to see the nurse. Mother did urine sample and blood sugar test which was 3 times higher than it should be.

Mother had an elder sister at the same GP surgery but around the time that mum was diagnosed (aged 76 at diagnosis) the surgery did away with over 75 health checks. One of the first things my aunt was asked for during a health check (when they still did them) was urine sample. If mother had been for a health check she might have been diagnosed sooner.

Once she was diagnosed she was quite good and was monitored regularly for the nine points test. The diabetes was caught and controlled but few years later she started getting back trouble and dementia. I took her to doctors for something else and mentioned the memory issues to the GP who thought it could be a complication of the diabetes. He sent her for an MRI which showed that the blood was not circulating around the brain as a direct result of complications due to diabetes. I think that if she had been diagnosed properly it might have been avoided.

I feel that the late diagnosis made things more difficult than needed to be for me and my mother which frustrates me.

It didn't really affect my daily life too much although I had to go to the hospital with my mother for regular blood tests. The bigger impact was her dementia managing her diabetes was easy in comparison. We had 2 care workers visiting a day to help and give me respite. Financing her care was a concern.

If the doctor is interested in patients, and if their knowledge was as such, I'm sure that they should be able to do what's necessary. But many have an ignorance of diabetes and don't know what it is so they can't follow up.

It is similar to many years ago with knowledge of sickle cell. As a country, diabetes has come a long way but it's not as it should be and we still a lot to learn. There is a stigma being placed on weight. We need to look at Type 1 and where that crossover is, to be alert to yourself, about what is happening.

How has caring changed your life?

Mum did blood tests until the diabetes stable. The doctor did do annual checks but in the end the

diabetes became secondary to the dementia.

In due course mum needed two carers a day and I needed a respite.

Over the years there are complications developing which had a massive impact. Mum was very good with her diet and the nurse did advise her that she could have an occasional treat.

My husband had diabetes for 11 years before he lost his sight. We had three teenage children and I had to become a full time carer.

I couldn't change my mortgage and had to go into shared ownership housing association.

He never came to terms with the blindness and our youngest daughter remained his little girl in his mind. There were lots of other complications such as kidney damage, several small strokes and heart attacks.

[Name withheld] was not a good diabetic, he smoke and drank.

Some days I would spend 8 hours a day at the hospital for 33 weeks while he was there as couldn't be left alone. He was 51 and had dementia in end.

As for the impact, I was a widow at 50. He was not there to give his daughter away or for his grandchildren. Our youngest left school four years after he died and is now 18. I'm a single parent and as the family situation changes the emotions come back again.

It affects the whole family. You need the support in beginning. No one tells you what to do for example, if lose a leg and no one checks you are doing things correctly (e.g. medication). No one's there, it's not fair and it's hard work. There was no information from GPs.

Information and communications are very poor in borough. I was not told about what to do after lost my leg for 6 years. I started losing my sight 4 years ago and had to pack up work. I drove an automatic car before that but losing my sight has meant life has changed. I had my own house and there's no help for you if you own your own home.

2 years ago, ATOS told me I could go back to work but I need to be wheeled about it.

I had to stop work and because of my assets I was not eligible for benefits and had to sell my house. I have received help from the Independent Living Association but because of a cut to their funding they cannot support me as much; this is a shame because you get used to dealing with people and then it changes. DABD are hard to contact and I have no one to help me with form filling to get financial support.

My father was a stroke patient and my cousin had a stroke. People with disabilities don't get the funding they used to and it's very difficult. My cousin was told to sell his house to cover his costs, but he has six children, and where do you live once you've sold your house?

As an authority, we would like to move into a direction of taking this into schools to catch it early. Educating children about health issues should be on curriculum so that they learn how to take care of own health.

We still have best system in country.

Where should support come from?

The tragedy is that complications are preventable with education.

Hospital budgets take up 20% of in-patients for diabetes related–issues worldwide.

We eat too much of wrong stuff, you only have to look at the ingredients on the side of packets; it's like a listing in a chemical factory.

Type 2 is preventable, Type1 isn't. People think it's not serious or it won't happen to them. Getting children involved is a brilliant idea. People do not understand the complications that come with diabetes and better public awareness would help.

Type 2's use services through the hospital.

I was diagnosed at Queen's and one of things that was really apparent at the time was the inconsistency between what the hospital and GP said. The communications element and opinions of individual consultants, doctors and nurses about the right thing to do varies.

Diabetes is an individual thing as well as growing problem in the community. Individuals can help themselves by getting the right advice which is most important.

There are no hard and fast rules for dealing with it but we need experts to actually deal with individuals that are diagnosed in a way the patients can understand.

Individuals need to take responsibility too; it wasn't until I had my leg amputated that I woke up to the challenge of living with diabetes.

People rely on hospitals instead of managing their condition properly, this is wrong and people need to use programmes like DAFNE and get better educated.

What do you think is good about the services locally?

Porters Avenue is excellent when you've been diagnosed. You are not given a 10 minute slot like at a GP surgery. The clinic gives you the time you need as diabetics have a lot of questions. The

leaders there insist the patient has time to talk.

I have to keep a daily diary for blood sugar levels, food, amount of carbohydrates, insulin, ratios, and driving. They go through it with you.

The GP hasn't a clue. You need expertise in running these services.

The nurses at Porter's Avenue inspire confidence; they have the doctor's ear, are knowledgeable, and can spot the signs quickly. Non-specialist centres do not understand diabetics; the staff in those places do not have the right training. For example, I had a foot problem and was on crutches for a year and 2 weeks (and within 6 days of foot amputation). The Podiatrist sent me to a different doctor for different treatment and the foot healed. The GP wouldn't have known about this treatment.

The same applies to Type 1 and 2. If the GP doesn't know there is nowhere else to go.

Type 1's go to hospital annually and this is no good as once per year although they are good when you are there.

We need a community service to help which not only deals with helping a diabetic but also prevention of complications. They try to get into communications and advise people about diabetes.

All of the facilities are in same building and should be expanded not reduced. Diabetes is on increase in B&D so the service needs expanding.

We no longer have to go 'pillar to post' because we have all of the specialists under one roof. Funding for this service needs to be protected.

The service isn't there to go out to everyone.

There are also psychologists available at Porters Avenue. They have a complex care clinic weekly which sees 10 patients a day including a podiatrist and dietician.

You need to be referred but the service is brilliant.

Mum was referred to a dietician but they didn't want to know due to funding issues.

Porters Avenue is an integrated service which works together. How did you get on before?

When I was first diagnosed services were brought in from Havering as there was nothing in B&D.

I came to the launch night of Porters Avenue. We would like a drop-in service especially at night when there is nowhere to go or anyone to call – even just for advice. B&D Diabetes Support Group people often call me or the Chair. We often need reassurance, especially as a carer, so it

would be good to have someone to talk to as carers get no information or training.

Porters Avenue has been there four years and is continuing to develop and we should be proud of it and promote it. You need it in beginning though not when it's too late.

I was in a car crash four years ago. The paramedic at the scene took my blood and asked where my insulin was as my blood sugar level was 23. I didn't know I was even diabetic so I went to the doctor who didn't even give me a diet sheet or any information. Mum had it and also had no information.

We have to be more forceful and demanding when going to see doctors. This is what actually happens. When we go to the doctor, challenge them to find out what is happening. We owe it to ourselves to get a second opinion. We depend on the NHS for care.

Thanks for saying something good about one of our services. When go to the doctor demand and ask questions, it doesn't matter if they think you are a trouble maker, it's for your own benefit. Make sure they are uncomfortable and know you want a second opinion. If you are not comfortable demand the service from them if they are not giving you the service you want, talk to someone.

Question to Committee: What will happen now?

We are trying to hear from a patient perspective from both carers and sufferers.

As a health committee we will come up with recommendations, continue to support what's working well and look at changes that are required.

The meetings are in the public domain so you will be able to read about it.

More information is needed. There isn't information for people to find about it.

The B&D Diabetes Support Group run a stall once per month in Queen's Hospital and provide pamphlets. We get about 50 odd people during the day and are often asked how people know if they will get diabetes.

When first diagnosed, my GP specialised in diabetes but said that if I kept doing what I was doing I'd know more than GP. A GP gets ½ day on average of training in their career on diabetes.

Good Practice Session

Date of Session: 12 December 2012

Organisations: Diabetes UK
South West Essex Community Diabetes Service (SWECS)

Diabetes UK

Diabetes UK is the UK's leading diabetes charity and provides an on-line one-stop-shop for patients and carers which give information about living with and managing diabetes as well as signposting services and training programmes at a national and local level. Their presentation focused on the national picture of diabetes, as well as preventive activity and campaigns. The presentation gave the Select Committee ideas to what the Borough could be doing in regards to local campaigns and diabetes provision.

Notes from presentation by Diabetes UK

Of Type 2, 90% remain undiagnosed and people can have it for 8-10 years before being diagnosed and usually as a result of being tested due to another condition e.g. heart attack.

Type 1 can develop at any age but generally before 40.

A report was published last week which stated that people with diabetes had a 48% higher risk of cardiac arrest/death.

B&D are in the bottom 25% in respect of patients having 5 of 9 of the annual tests.

Healthcare Essential is the key thing all patients should have annually. Survey's often ask whether patients have the 9 health checks but since many people don't know what they are they have no baseline *[Note: the Patient & Carer survey does ask people to indicate each health check they have annually]*

The key message to people is that there is no such thing as mild diabetes.

All health care professionals need to have a good understanding of diabetes not just GPs and diabetic nurses.

The NHS has an 18% target for diagnosing diabetes in the undiagnosed; this is quite low and reflects the failure of health services to do so.

Children's Campaign started on 14 November and will last for 5 years. Need to raise awareness

among GP's of the importance of diagnosing diabetes in children quickly as it can develop and progress very suddenly.

Q&A SESSION NOTES

How can B&D link up to national campaigns?

NHS Foot Profile is a good example of what B&D could do. Diabetes UK figures for B&D reflect the expected numbers.

Middle-age to older people tend to get Type 2 but it is progressive and slower and is often overlooked due to age. Need to encourage people who are over 40, Black/Asian, family history of diabetes or overweight to get risk assessed.

Why is there is often no information in GP surgeries?

Diabetes UK do have a "Measure up" campaign and do regular road shows but if a person has had another medical condition, they are often automatically tested for diabetes without being advised.

What are the key components to good practice?

The population of individual boroughs requires a different approach. Generally, everyone should have annual checks and their needs to be support and help to keep health to a good level and a multidisciplinary foot care team to help reduce unnecessary amputations.

Is there anything else a person can do other than use medication?

Type 1 must have insulin and watch their diet. Type 2 can be managed by diet/exercise alone although some have oral medication. A third go on to take insulin as Type 2 is progressive.

What are the main issues coming through for patients?

Diabetes UK recently did a survey around foot checks as many GPs did not do them properly. GPs are getting paid but the level of the check is poor.

Emotional/psychological support is also necessary as diabetics have a higher rate of depression generally. Severe mental issues are higher due to diabetic needs.

How can we improve our services in B&D to work with Diabetes UK?

Need to meet with the area manager to talk about what can be done. Make sure that the "Healthcare Essentials", "10 Steps to Healthy Feet" and children's posters are available in schools and surgeries.

CCG Response:

The CCG are keen to improve services in B&D and met with a diabetes forum this week. The CCG are keen to receive feedback from HASSC.

GPs in the local area need awareness of health checks being done properly. If feedback from the Diabetes UK survey can be provided it will be used as we are CCG are keen to make a change/improvements.

South West Essex Community Services (SWECS)

SWECS are a newly commissioned model for the delivery of community diabetes services in South West Essex and have been identified as good practice by the North East London Foundation Trust (NELFT). As NELFT are one of our community service providers, it was thought that this community-level organisation would be able to give Members a focus as to what the facets of a good diabetes service delivery model should look like and to shape some of the questions that they may ask local providers during site visits and future HASSC sessions.

Notes from presentation by SWECS

Area covers Purfleet to Wickford.

York and Humber found that 6.2% of people have diabetes in B&D and 6.6% in Thurrock which is what is expected based on the population levels.

In Thurrock in 2011 a scoping exercise took place and the Community Diabetes Service was commissioned to enable care to be delivered closer to home.

The service includes 3 consultants from Basildon Hospital and a specialist diabetes dietician. There are no outpatients at Basildon any more.

Patients are usually referred by their GP and triaged at the Hub at Orsett. There are 13 outreach clinics plus Orsett and patients are able to choose where they want to be seen once they have been triaged.

Run the DESMOND (Type 2) and DAFNE (Type 1) courses at all outreach clinics.

Also run Group Carbohydrate sessions and recent evaluation indicates that it has been well received by patients who seem to prefer the group sessions. The group aims to dispel the myths around diabetes.

There is an Insulin pump clinic (for Type 1) for people struggling to use insulin and a recent audit shows that it has done very well over the 18 months it has been running.

Nurses undertake visits to people in their own homes/care homes.

They work closely with ambulance staff who report repeat offenders to them (people often don't want to say anything in case they get into trouble with their GP for not looking after themselves) and refer people to the Hub so that nurses can make a visit.

Nurses will see patients if they receive urgent calls from GPs or Basildon Hospital.

They run an annual conference for all staff in their patch and a forum every 3 months.

Nurses work in GP practices to help with the shortfall in expertise and resources.

Since the service was set up there has been a marked reduction in unplanned hospital admissions.

Q&A SESSION NOTES

What are the 2 or 3 key things that you think makes a service work well?

No Barriers – something is always done.

Large group of nurses means that there is a lot of expertise and support amongst each other.

Good relationship with acute colleagues.

What is the difference between an insulin injection and an insulin pump?

The injection lasts as long as the insulin should last, the pump sits under the skin and gives little shots and can be increased/ decreased as required.

Which carbohydrates should diabetics cut out?

There are sugar and starch in all carbs including rice, potatoes. A typical day involves a carb-heavy diet e.g. cereals for breakfast, bread at lunch, rice/potatoes for dinner, crisps for snacks. However, fruit also contains high levels of sugar. A better snack option would be nuts.

A dietician is very helpful at getting people into good eating patterns.

Do you have links to other services such as local IAP team for therapeutic interventions?

In SWECS there are links to the South East Partnership (SEP). Also a specialist nurse in SE Essex who works for the mental health team.

Why is SWECS working so well and yet Porters Avenue (which has similar services) is not

as successful? Why has there been no crossover of learning?

Michelle Stapleton advised that she will contact her counterpart at Porters Avenue to begin discussions about information and best practice sharing.

What other options do patients have? What are the waiting times? What are the levels of care and intervention by GPs? Is the service showing value for money? Do you run a GPwSI Service?

The GP with a Special Interest (GPwSI) Service was decommissioned when the new service was started. Month on month figures are going down – 900 have been diagnosed this month.

Blood glucose strips were expensive and costs have been reduced by 5% in this area alone.

MS advised that clinical staff made a case to work with the acute trust and predicted savings around decommissioning approx £1m.

Patients are being moved through the pathway quickly.

People often go to A&E because they can't get GP appointments or have no way of getting advice after hours.

Urgent cases are seen by the Hub although they do not have the medical history but they get a GP referral and access it this way. They would love to have an out of hours/walk-in services.

What are you doing in terms of preventing diabetes?

This is not part of the service remit but is a public health remit although it makes sense to be part of the service. Need a public health remit attached to a diabetes service.

Service Provision Session

Date of Session: 31 January 2013

Organisation: Clinical Services
Low Vision / Retinopathy Services
Community Nursing
Mental Health Services
Integrated Diabetes Service

Clinical Services

Works out of King George and Porters Avenue, previously Redbridge and GPwSI Service at Havering.

There are less and less referrals to hospitals as most patients are referred to Porters Avenue. Of all the referrals who come to hospitals only 10-15% of them are diabetics.

Cases are quite complex. After 3 consultations patients are usually discharged back to community services where despite new medication being prescribed in hospital the local GP often changes the medication. This is often due to changes in the NHS and hit and miss management.

Porters Avenue works reasonably well although it is not cheap to run. Patients get referred and are able to see everyone under one roof except retinopathy services. It is a very good services and a recent questionnaire to patients show an outcome of 98% satisfaction with the service.

Need to look at training of GPs with a special interest (GPwSIs) to ensure a direct result on outcomes for patients.

The GPwSI service started 3 years ago.

The prevalence of diabetes is increasing. In 2005 there were 5.4% of people known to have been diagnosed with diabetes, now that figure sits at 6.2% although it is more likely to be nearer 8% due to lifestyle and ethnicity changes in the Borough population.

80% of patients are treated in community practices. Some GPs are not interest or trained in diabetes and training should be ongoing. GPwSIs are a good model but not value for money as new standardized payments can vary across the country.

Low Vision Services / Retinopathy

Offer a service for people with learning disabilities to ensure that they receive appropriate eye care. The service is part of the Community Learning Disability Team.

Generally, people with learning disabilities have poorer health and there are approximately 550 known to the team.

People with Type 2 diabetes can develop sight loss via diabetic retinopathy.

There is a vision strategy group in the Borough which looks at issues associated with people with disabilities.

A Low Vision Service is available at Porters Avenue. There are moves to make it a more enhanced service by providing specialist services through opticians. The new service was recently approved by the Health & Wellbeing Board.

Diabetics should have annual retinol eye screening tests.

Not many people know the difference between a retinol screening and a standard eye test and this is one of the main problems in B&D. People used to get a full eye check which included a check for different diseases (including diabetes retinol screening) but in 2009 this changed and retinol screening became an independent test from the standard eye check. The service has found that many people who have the retinol test do not have a standard eye check so often miss being diagnosed with issues such as glaucoma. As a diabetic, people are not receiving the service they should be.

There is currently no link between opticians and retinol screening services so it is difficult to easily track whether a patient has had both tests.

There are 12 practices in Havering which carry out an enhanced service already, it works very well and this is the model B&D used until 2009. In Havering a patient can choose where they have their sight test done received the combined standard eye test and retinopathy test at the same appointment.

It was noted that there are some accessibility issues to the current service as it not commissioned as part of Porters Avenue.

The commissioning issue should be referred back to the commissioners.

This is similar to the Catalyst Scheme set up with opticians. There are potentially 600 people who could use this service but only approximately 140 have taken it up. It was suggested that the enhanced service was not doing very well in the Borough and this is often because the optician will need to see someone on 2-3 separate occasions because the tests can be quite frightening (e.g. eye drops and flashing lights).

Community Nursing

There are exclusion criteria around this service and that service users must have a learning disability (this excludes people with substance issues).

There are at least 7 people with learning difficulties at the Support Group which enjoy attending sessions but find it hard to understand what is being discussed and this can make things difficult for people with diabetes where they are required to understand issues around medication and self-management. As a result they often end up in and out of hospital.

A nurse attends the Support Group meetings and advised that this matter is a big concern. A diabetic nurse from Porters Avenue also attends the sessions and ensures that any service users are referred to Porters Avenue.

If a patient is required to go to a day centre their blood sugar levels are not monitored as there are no policies or training around this in the day centres. Staff at the day centres liaises with Porters Avenue to arrange staff training and look at what is being done for the service user.

Services try to take a person-centred approach and try to ensure that staff at the day centres understands that where a service user is displaying challenging behaviour that it may be due to the fact that they are diabetic and have low blood sugar levels.

A DES (Direct Enhanced Service) scheme is in place to provide training for GPs to enable GPs to provide an annual health check for people with learning disabilities. Those signed up must achieve their targets as part of the Health Action Plan (HAP).

For people who are living independently, some chose to have their annual checks and it is difficult to identify whether they have been until they have their annual HAP review. It would be useful to get a report of all people who have had tests to date.

Mental Health Services

S75 agreement for Mental Health Services includes general population and older adults with learning and psychological issues.

Physical and mental health is complex especially among Type 2 diabetics including staying connected, exercise, lifestyle and stress. There is no easy typology for depression as there is for other mental disorders such as schizophrenia but people with mental health issues are twice as likely to have Type 2 diabetes. Someone with Type 2 diabetes is twice as likely to suffer from depression due to the range of complex psychological needs associated with their condition.

There are a range of treatments in community services and in the Integrated Services to be able to detect and work with people with different psychological requirements including different people from ethnic backgrounds.

NELFT have a specialist psychological IAP service and works with GPs with less specialism in diabetes and a combined approach to physical and mental health with multi-disciplinary teams.

Integrated Diabetes Services

There are more sessions to work with people from BME which provide interpreters. Work with the voluntary sector to increase awareness at mosques and temples.

The Complex Care Clinic is a good way to look at all issues associated with a patient to reduce acute admission.

Increased confidence as a result of the DAFNE and DESMOND education programmes as well as a user group for patients.

There are also strong links with B&D Support Group who helped structure the services at Porters Avenue when the service was first set up.

Work with GPs to help improve diagnosis and identify people at risk.

The Integrated Care management service works with community teams to look after people with Type 2 diabetes.

Flexible clinic times (e.g. before and after work) help to improve accessibility.

General Comments

Need to support Public Health and health promotion strategies. The CCG need to improve diabetes management. NELFT should look to having a more generic team with a single access point to help reduce the need for referral.

The B&D Support Group would like to see more service progression and education of GPs and people generally. They also noted that they are grateful for the service and support provided by Porters Avenue to the B&D Support Group. They also believe that diabetics need a holistic package which includes physical, mental and clinical help as well as support groups.

Links with the CCG are essential as services should be developed with clusters.

There needs to be a focus on early intervention/detection as people can't work on self-management unless they know they have a condition.

The same applies for identifying diabetics in depression cases. Support is also needed for carers.

Education in care homes and for nurses in residential nursing homes/people with learning disabilities required.

On 30 January a representative from the B&D Support Group spoke at the Barking Job Centre to the disability advisers to help them understand about the impact of diabetes and how it affects patients and carers for example if someone misses an appointment because a family member had a diabetic episode it is a real issue for the carer.

There is a high risk group (people with learning disabilities) who need help cooking and are currently enrolled on college courses to gain cooking skills. Some also have diabetes but they are being taught to bake cakes. Educators need to change their way of teaching. Colleges also sell junk food but they should be helping people make healthier choices. Colleges give a different message to the client group than the community nursing teams.

Need to encourage GPs to send people to a DESMOND/DAFNE programme.

Need to think about how we get the message across to the broader population:

- People at risk need a targeted approach
- Social care – carers education

- Awareness of looking after people with alzheimers/dementia

Q&A SESSION NOTES

How we can improve links between services? Do we need an investigation into how we can improve the communications issue?

There is no holistic approach/communications between services. For example, although there is a retinopathy screening service at Porters Avenue the pictures are not sent to hospital staff if a hospital referral is made.

Advised that Havering have a computer system which allows them to do this.

What improvements need to be made? What are the next steps?

Things have improved having a health psychologist on board as it is important to help 'change behaviour'. Need to grow this service alongside other mental health teams.

Nursing/residential homes require staff training (and resources) for working with the elderly population to ensure they are getting the care they need.

Intervention is essential but also need to work with carers and train them to be able to give insulin injections in the future so that clients aren't required to wait in for a district nurse.

If someone has a problem but can't get hold of a GP they ring the emergency doctor who advises them to go to A&E. Help lines, especially for people living independently are necessary even just for advice.

Why is the Retinopathy Service at Porters Avenue is not as good compared to Havering?

The main issues are access/IT issues rather than the service itself.

Patients give good feedback about the retinol scan but it's more the issue of having to get the results from the patients or ringing the GP if the patient is referred.

Are there any GP's or anyone else it would be useful for HASSC to meet?

Dr Kalkat and Dr Goraparthi look at broad level service, possibly retinol screening personnel.

There are ways in which service could be improved. People do see that the work is being done properly but the issues around accessibility remain. Havering have a rate of 5% of people not taking up the Service, this is higher in B&D. She felt it worked better pre-2009.

Some patient's prescriptions get changed or take a lot of medication – who assess medication?

At hospital specialist take a holistic point of view as it diabetes affects different parts of the body different so different medications are recommended for each issue. Doctors recommend a biannual check up for medication for patients not on insulin and three times annually if the patient is on insulin.

Service Provision Session

Date of Session: 16 February 2013

Organisations: GP with Special Interest (GPwSI)
Retinopathy Services
Pharmacy Services

Pharmacy

Greater role for patients to take on responsibility for their own care.

Pharmacies and voluntary organisations could work together to provide more help to patients.

Pharmacists can help with lifestyle, management of minor ailments (Minor Ailments Scheme in B&D).

No difference between PG and Pharmacists in terms of dealing with long term medication.

Other areas for contribution could include providing education, self-care skills, benefits advice, care plans (these always end at surgery level) as well as what can be done in terms of preventing and support and communications.

Need to develop new skills to support patients locally. There is regular training available and up to 150 pharmacists attend regularly. But there is a need to ensure Continuing Professional Development (CPD).

There is a stage on medicines. Pharmacists try to look at reducing hospital admissions. They have looked at respiratory ailments and diabetes will be next.

Patients often have loyalty to the same Pharmacy/Pharmacist as they develop a relationship, especially those with long-term conditions.

Joint work between GP and Pharmacists needed. Each pharmacist can carry out up to 400 medication reviews each year. Pharmacists go through the disease and treatment as well as lifestyle choices.

Pharmacist can help with sign-posting services as they look at all of the patient's conditions.

Good practice examples e.g. weight management and vaccination at Tower Hamlets and Newham.

Need to publicise what pharmacists can offer.

No integrated system between the newly diagnosed to help them find their way around health and social care systems. Need to find a model to help people use the system effectively as well as working with carers and voluntary organisations and develop links with these groups.

There is a fundamental need to identify why people waste medication. It is largely down to support around changes in a healthy lifestyle and help with educating patients to self-management and self-care.

Patient satisfaction feedback from pharmacists indicate that more work is needed around repeat prescriptions and making the system easier for patients.

There is a role for pharmacists in terms of diabetes prevention. Access is not an issue as most people live within a 20 minute walk from a pharmacist and there are usually good opening hours including weekend services.

Pharmacists could help with screening diabetes patients.

Some pharmacists put up posters on a voluntary basis. The PCT has been asked to circulate information about reviews and new meds service – these will go out in the next few weeks. Some pharmacists also do prick tests for diabetes.

Retinopathy Service

Screen diabetics for eye problems, the sooner conditions are picked up the easier it is to treat them.

B&D and Havering had a diabetic eye screening programme with closed as the service had an uptake of only 47%.

The Homerton is in Hackney and a centralised fixed site at Porters Avenue.

A patient experience survey was undertaken at Porters Avenue in November 2012.

GP with a Special Interest (GPwSI)

Unhealthy eating habits as a child can cause an increased risk especially if the family has unhealthy habits. Made worse by obesity and lack of exercise.

If screening is done early on many could get diagnosed before the symptoms start.

Cycle of diabetes care: Diagnosis ⇒ look at lifestyle ⇒ refer to special education programme ⇒ medication ⇒ increase meds as diabetes progresses ⇒ complications (secondary care)

Public Health needs to help reduce diabetes prevalence especially in children and family units through school education and an increase in sports at school.

Need to ensure that we screen people early as age is a strong risk factor (40-74) for developing diabetes. People should be screen in this age group regularly but B&D do not screen enough. Should be using the pharmacies to help with the screening process. Last year pharmacists attended a mosque to carry out a screening event. Similar activities could be carried out in supermarkets/car parks. It is difficult for GPs to screen effectively but this activity could be commissioned in collaboration with surgeries/pharmacies.

There needs to be some work done around advertising to people that they need to be screened and reinforce the symptoms of diabetes.

There is a big variation relating to what happens in different GP surgeries e.g. some surgeries have a higher prevalence of diabetes but the practice is not doing a good job. This could be down to demographics, organisation of surgeries, and education of GP/practice nurses. Commissioners need to understand why there is such a variation in this area.

It is important to manage blood pressure and cholesterol levels. Patients need to be advised that there have double the risk of a heart attack and kidney problems if they have diabetes. We need to be reinforcing the seriousness of the disease and explaining the different issues. Providing leaflets to support and reinforce this would help as people only hear the first two points after receiving bad news. Dr Kalkat said that there is not enough money to do this but patient-friendly information and language issues in printed material need to be addressed.

Reinforce the DESMOND and other training programmes among patients as not enough people are being referred. Many patients don't realise they are entitled to attend.

People do not understand what to expect from GP/Nurses especially in annual reviews. EG foot checks should be done properly and the review should include reviewing footwear but due to time pressure this does not always happen which is unfortunate as foot problems are hard to treat.

Training sessions across the PCT (cluster-based) is already offered but is mostly based on medications and not enough education is given about providing holistic care and patient interview techniques. GPs need to know how to work with a patient's lifestyle to help them develop suitable self-management techniques.

Internet resources, email etc... are possible options especially an on-line user forum but there are confidentiality issues associate with this. Patients also need to understand what services are available before we could consider doing something like this.

Community Care - less than 5.5% of patients come to the clinic. Need to see a bigger impact in B&D and work closer with GPs and cluster practices. All services need to be more seamless so that all health professionals understand how to access the service.

Self Help is important as people are more likely to take their medication properly and be more prepared in their annual health review.

Additional comments sent by Dr Goriparthi after the HASSC meeting

Obesity epidemic - we need Public Health to:

- a. help manage this problem and to work to reduce unhealthy dietary habits and inactivity in children and adults
- b. work with schools to provide healthy meals, encourage healthy living lessons, and increase time for physical activity
- c. work with family units to help with healthy habits if children are noted to be overweight
- d. help poorer population to have affordable fruits and veg and sports centre passes etc
- e. advertise healthy living messages at schools, pubs, parks, holy places etc

Pre-diabetes - make available intensive dietary physical activity courses to:

- a. help people delay the conversion into full blown diabetes
- b. GPs/practice nurses need to explain clearly the importance of healthy living to delay Diabetes and reduce complications in this group

Diabetes diagnosis - prevalence of Diabetes is increasing but still several people with

diabetes remain undiagnosed. GPs need to actively screen people with risk factors for diabetes early and we need to consider about other ways of screening people for diabetes e.g. at supermarkets, pharmacies, holy places, parks to catch people who do not routinely go to GP Surgeries.

Diabetes management - once diagnosed a good explanation from GPs/ Nurses needs to take place on more than one occasion to help patients understand Diabetes. We need to make available information booklets to give to patients so that they can read and understand further about what they discussed. All patients need access to proper education courses like DESMOND and all patients should be offered exercise referral.

Medication - GPs should make sure that the medication that they prescribe is working by repeating the blood tests appropriately and stopping medication if not effective regular audits to help this process.

Annual reviews - GPs/nurses have to explain to the patients about the purpose of the annual review and what to expect. Booklets to explain what happens in the annual reviews are essential as significant no. of people do not seem to understand what to expect. Locally we are very low in the percentage of people getting annual reviews and there is significant variation across different practices. We need to better understand why this is so, and we need to encourage patients to attend and encourage GPs to make sure that they maximise the no. of annual reviews that they do.

More **seamless pathway** for the patients across the different Tiers of service is essential. It would be better for more patients to be managed within their GP surgeries. The CCG is looking into GPwSIs and DSNs are considering how to work more closely with practices to support them.

Special groups - we need to identify people who would require a different type of service that routine service will not be able to provide. People who are housebound or with Learning difficulties or with palliative care needs and we need to work closely with the teams looking after these people to better identify their needs and improve the support that Diabetes services can provide people with significant medical problems like Kidney or Heart need. More closely working across different department's people with significant language barriers will need to have easy access interpreting services -already available and working people need services outside the normal working times. Diabetes affects young working people and needs several appointments over the year. It is hard for people to keep taking significant time of work to attend these day time appointments.

CCGs already looking at how to use peer-led education support and pressure to help reduce variation and improve the service offered by the GPs.

No. of GPwSIs - I have conflict of interest so, I am not the right person to discuss this but it would be important for the members to consider what the role of GPwSI would be in the future is the role is to see and manage patients at Tier 2 level (higher than usual GP care) like we are doing now or is the role in the future to work more closely with practices, train local GPs/Nurses to help them manage their Diabetic patients at Tier 2 Level.

Consultant/Secondary care support - we would need more consultant time and support to help oversee the local services for Clinical Governance some other areas had more consultant input and have shown that this can help create closer links between primary and secondary care and helped reduce the need for patients going to hospital.

Special GPs – Work closely with the LD team and outbound patients or where English is not the first language as approach needs to be different. Working people require extended surgery hours including late nights and weekends to increase access to services.

Other Issues

Member comment: We need to make sure that the report states that the survey is not representative of all diabetes patients.

Pre-diabetes, patients have a slightly elevated blood sugar level. We need to identify how we can organise a co-ordinator programme for pre-diabetes patients.

Q&A SESSION NOTES

Pharmacists do a good job and there is a good link between pharmacists and patients. The relationship building element has gotten better and they are very helpful and friendly. We would like to see better integration between pharmacists and GPs.

The patient repeat prescription service makes it more complicated for patients to get a repeat prescription especially if the medication is not in good supply and they have to wait for it to be ordered.

Pharmacists could also do things such as peak flow tests and check that the condition is being controlled. There has been a 60% increase in prescriptions over the past 10 years and there is a strategy to train technicians and a contract with Barking College for an apprentice scheme (the aim is to get 200 people onto the apprentice scheme) to increase

the number of pharmacists.

IAP leaflets: Work has started to trial this and it has gone very smoothly. All pharmacists are trained to give proper support to patients as well as giving out leaflets and sign-posting people to the correct place.

Need to strategically review the care pathway to ensure that all the relevant players (including pharmacy) are included and understand how pharmacists can offer support through pathways (e.g. new meds service, meds use reviews. Because work is not co-ordinated between the GP-Pharmacist-Patient, activities appear to produce no real outcome. Should advise the patient to get a med use review from the pharmacist before a request for a repeat prescription is made.

Member Comments

Member Question about Results sharing

Response: There is a national stand to report results to patients within 3 weeks and to cc the GP. There is an 87% achievement rate for this target in B&D.

Member Comment: It is nice to see B&D have a high achievement rate for sharing retinopathy screening results. At the last meeting it was indicated that our service does not perform as well as Havering. It was also said that pictures were not sent to Queens as this was not possible with the current system.

Response: This is not true as there is a web-based programme that any doctor can request a login for to obtain the pictures. Every diabetes patient is advised to see an optician annually but if urgent action is required they are automatically referred to an ophthalmology department.

Member Question: What is the difference between annual optician and retinopathy service tests?

Response: In the previous service, opticians did the diabetes test as well as the standard eye test. Opticians now just do the general eye health check and sight test. Retinopathy is not done as part of the standard check as there are different standards for retinol screening. There are double checks I the retinopathy screening service to ensure quality assurance.

Member Question: It is important that exercise and healthy living are part of the self-management process. What can GPs do to promote this?

Response: GPs ask how much patients currently engage in but more could be done to

explore this issue with the patient. In 2010 there was a booklet of exercise schemes across the borough which was sent to GPs and was helpful when GPs gave advice to patients. However, this book hasn't been updated so it's difficult to sign-post services without knowing what's still available.

Member Question: The Adult College could do out-reach work in PA or at the new Ripple Road Centre. Could be used to do some of this work?

Response: It would be good to see a central telephone number which patients could ring to understand choices and services available.

Member Question: Is there any rationalisation of medication?

Response: Sometimes medications are no longer effective. There was an audit carried out last year to look at effectiveness of medication after 6 months or at least at the point of the annual health review.

Member Question: Where there are side-effects do GPs advise patients of the most serious or common ones?

Response: Yes they do.

Meeting with Chairs of the Barking & Dagenham Clinical Commissioning Group and Health & Wellbeing Board

Date of Session: 6 March 2013

Representatives: Cllr Maureen Worby, Chair of the Health & Wellbeing Board
Dr Waseem Mohi, Chair of the Barking & Dagenham Clinical Commissioning Group

Q&A SESSION NOTES

How high is diabetes on the Health & Wellbeing Board's (H&WB) list of priorities?

There is no special priority per se as the approach of the Health & Wellbeing Strategy is based on life stages and diabetes will have a role to play in each of those stages. The H&WB Board welcomes the focus of HASSC and money has been put aside to look at diabetes, although not as much as HASSC would like to see. It is important not to let diabetes slip through the net. The H&WB Board will wait to see a more detailed action plan.

With a predicted increase of 50% in the prevalence of Type 2 diabetes, what improvements will H&WB make?

H&WB need to get the processes right. Promotion and prevention work to catch it early on and ensure that people take diabetes seriously. The Board hopes to tackle some of the causes of Type 2 diabetes such as obesity/age-related issues/smoking. There needs to be joined up thinking around prevention work which will have a knock on effect of reducing Type 2 diabetes prevalence.

The CCG has signed up for health improvement plans to identify gaps in 2013/14. An audit, led by Dr Kalkat, is already underway to investigate this. There has been no improvement in care despite commissioning a community service. Detection and early treatment of diabetes is important and we need to make sure that people get the message early. Patient education in GP practices and community services needs to be smarter and the CCG will work with the H&WB Board to identify how we can better target information.

The health picture for the borough is changing rapidly and we need to understand the scale of the problem. Detection and prevention during childhood is increasing. We need to be able to identify groups of people via primary health care teams and look at ways of improving the health of these groups. Health checks in some practices are very advance

although poor in others especially around the nine annual diabetic health checks. A peer review scheme has been developed to look at practices which are underperforming and providing training for GPs and practice nurses as part of the continuous review of process.

There is a lack of posters in GP practices and hospitals which raise awareness of early diagnosis. Is there also any automatic testing for diabetes in the same way people are automatically tested for HIV?

Patients over 14 years old are entitled to free health checks, and this includes a screen for diabetes. There is a need to get the message to young people as although a majority of people diagnosed with Type 2 diabetes are over 40 years old, a small number of patients are as young as 16.

Recent work has been done in collaboration with the Barking and Dagenham (BAD) Youth Forum. This group may be able to advise how to get the message to a young age group. IT might be worth considering commissioning BAD to do some work for us around lifestyle advice.

People are not routinely tested for HIV whenever they provide a blood sample. Only people donating to a blood bank or using maternity services are routinely tested.

Can the CCG confirm that they are committed to funding literature?

Literature is already available on computer for GPs to print off in the surgery. Packs of literature on diabetes are also delivered by Pharmaceutical companies.

The current packs are being reviewed at present to ensure the information is up to date as they were designed 4-5 years ago. 10,000 packs were distributed 2 years ago.

The B&D Support Group found that despite GPs having high stocks of the packs, none of their members were ever offered one. The group has also never been asked to participate in a focus group with the CCG.

A recent survey revealed that there needs to be better work with patients and the CCG is looking at membership of the Health Improvement Partnership as part of this.

What work is being done to target people with mental health issues who have diabetes?

A lot of work is being done with GPs to ensure people with mental health issues have

annual health checks.

General practices target all mental health patients to ensure that they have annual health checks as well as the diabetes health checks as medications can often cause diabetes. IAP services are also accessible for diabetic patients due to high levels of depression.

We need to understand what the baseline is in order to better gauge how to target groups. How do we target specific groups and deliver services to those groups?

What can we do to improve services? How can we help get information to the newly diagnosed?

The H&WB Board do not deliver services directly. The CCG is responsible for delivering and commissioning services. H&WB Board can try to influence what the CCG commissions and it can monitor performance and hold the CCG to account.

Diabetes is a recognised problem for community services and there are also other issues which affect the health economy of patients and this affects what the system can do. Health checks can be advertised along with the range of services we can offer.

Maintaining quality of care is important and the CCG are looking at prescribing efficiency across ONEL and to ensure that good use is being made of the DESMOND programmes as well as improving patient/public engagement about diabetes.

There remains an issue of an out-of-hours service as many people are told to go to A&E when they phone for support.

Diabetes underpins the integrated case management strategy and is fundamental to the strategy going forward. Diabetes needs to be dealt with in an integrated way in order to keep people out of hospital.

Maintenance of diabetics within the community is essential as if a patient goes to A&E they will be admitted to hospital. Reacting to diabetic patients is critical.

The committee has heard evidence from patients and GPs that the 9 annual tests are not all carried out well for example foot checks. They also found that a patient's ability to take in information when they are first told that they have diabetes is limited. The CCG need to look into this and consider how this will be tackled in future work. A report will go to H&WB Board to consider this as part of the priorities for 2014 so there is some time to undertake further investigations into this issue.

Routine MOT health checks can help to detect diabetes. At a national level, only 50% of diabetics are shown to receive the 9 annual diabetic health checks. In a recent review, many GP practices were above this figure but there are also a lot falling below it. This information has been shared with GPs in a league table in order to encourage peer reviews.

Appendix 2 Diabetes Survey

We are reviewing the diabetes services across Barking and Dagenham and we would like you to tell us about how you manage your diabetes, what services you use and what else you think we should be offering. Your response will help us make recommendations to the Council's Cabinet about how services could be improved.

We would really appreciate it if you would take 10 minutes to answer a few questions.

Everything you tell us will be kept completely confidential, and will only be used as part of this review.

To thank you for completing the survey, you will have the chance to enter a prize draw to win an iPod Shuffle. The competition will close on the 4 January 2013 and the winner will be presented with their prize at Barking Town Hall during January 2013.

To enter, please provide your name and contact telephone number below and tick the box to confirm that you would like to enter the draw.

Please tick if you would like to enter the prize draw

Name:

Contact Number:

****If completing it on paper, please hand your survey back to the surgery reception****

If you would like to complete this survey on-line please go to the following link:

<http://www.lbbd.gov.uk/DiabetesSurvey>

For office use	
Ref.	



1. How are you affected by diabetes? (tick all that apply)

- I have diabetes (*Please jump to Section 1 below*) I look after someone with diabetes (*Please jump to Section 2 on page 5*)

Section 1

2. How long have you had diabetes?

- 0-2 years 3-5 years
 6-10 years 11-15 years
 16-20 years 21 years and over

3. What type of diabetes do you have

- Type 1 Type 2

4. How do you manage your diabetes? (tick all that apply)

- Insulin Physical Activity
 Medication Other (Please indicate
 Diet

5. If you selected "Medication" in Question 4, please state which medication you take

.....

6. How helpful was your GP when you were first diagnosed?

- | Not helpful | Not very helpful | Helpful | Very Helpful |
|---|--|--------------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My GP gave me no explanation or information | My GP didn't give me very much information | My GP gave a brief explanation | My GP took time to explain diabetes to me |

7. When you visit your GP do you:

- | | Never | Almost never | Sometimes | Fairly often | Very often | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Prepare a list of questions for your GP? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ask questions about the things you want to know? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ask questions about the things you don't understand? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

8. Who gave you information about your diabetes? (tick all that apply)

- | | |
|--|--|
| <input type="checkbox"/> GP | <input type="checkbox"/> Nurse |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Local Diabetes Support Group |
| <input type="checkbox"/> Family/Friend | <input type="checkbox"/> Other (<i>please specify below</i>) |
-

9. What sort of information did they give to you? (tick all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Information about diabetes | <input type="checkbox"/> Information about diabetes medication |
| <input type="checkbox"/> Dietary information | <input type="checkbox"/> How to live with diabetes |
| <input type="checkbox"/> How to manage my diabetes | <input type="checkbox"/> Long term health impacts of diabetes |
| <input type="checkbox"/> Other (<i>please specify</i>) | |

10. Was this information helpful? (Please circle the one which applies)

- Not at all helpful Not very helpful Fairly helpful Very helpful

Please tell us what was helpful or unhelpful about the information you received?

.....

.....

.....

11. Have you developed more health issues as a result of your diabetes?

- Yes No I didn't know that might happen

12. If you answered "Yes" to Question 12 please say what health problems you have developed

- | | |
|---|--|
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Circulation | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Other problems (<i>please specify below</i>) | |
-
-

13. Do you think they could have been avoided if you had received better advice and information about diabetes?

- Yes If I had understood the consequences I would have managed my diabetes better
- No I don't manage my diabetes
- Don't Know
-

14. Which of the following services have you heard of (tick all that apply)

Heard of	Used this service	
<input type="checkbox"/>	<input type="checkbox"/>	Porters Avenue Integrated Diabetes Service
<input type="checkbox"/>	<input type="checkbox"/>	Barking & Dagenham Diabetes Support Group
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes UK

15. Which of the following programmes have you heard of (tick all that apply)

	Heard of	Have attended	Not heard of
DAFNE (Dose Adjustment for Healthy Eating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. If you have attended did you find these programmes useful?

	Not at all helpful	Not very helpful	Fairly helpful	Very helpful
DAFNE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DESMOND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. If you haven't attended a programme please indicate why not?

- | | |
|--|--|
| <input type="checkbox"/> The time/day was inconvenient | <input type="checkbox"/> The location was inconvenient |
| <input type="checkbox"/> Nobody offered it to me | <input type="checkbox"/> I do not like group training |
| <input type="checkbox"/> Other reason – please state | |

18. Do you have annual check-ups for your diabetes? (tick all that apply)

Check up	Annually	Sometimes	Never been checked	Didn't know I should
Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye check	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg and feet check	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney check	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight check	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support for smoker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal health and care plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 2 – Only complete this section if you look after someone with diabetes

19. Have you received any emotional support or counselling as a carer of someone with diabetes?

	Heard of	Used this service	Not heard of
Porters Avenue Integrated Diabetes Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barking & Dagenham Local Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient Advice and Liaison Service (PALS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barking & Dagenham Diabetes Support Group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. Do you think you have been given enough information about looking after someone with diabetes

	None	Too little	About right	Too much
Amount of information received on diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amount of information received since diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Do you feel confident in administering medication for the person you are caring for?

Not at all confident	Not very confident	Fairly confident	Very confident
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. Please add any other comments below:

.....

.....

.....

Thank you for completing this diabetes survey.

We can make much better use of the information if we know a little about you. Please could you take a minute to answer the ‘about yourself’ questions on the next page?

If you would like to receive more information about the DAFNE or DESMOND programmes or would like to know more about the services offered at the Porters Avenue Integrated Diabetes Service please contact Porters Avenue on:

Tel: 020 8522 9826

e-Mail: diabetes.bdchs@nhs.net

Please tell us a little about yourself

(a) How old are you?

Under 20	<input type="checkbox"/>	40 – 59	<input type="checkbox"/>
20 – 39	<input type="checkbox"/>	60 – 74	<input type="checkbox"/>
	<input type="checkbox"/>	Over 75	<input type="checkbox"/>

(b) What is your ethnic group?

WHITE	<input type="checkbox"/>
English/Welsh/Scottish/ Northern Irish/British	<input type="checkbox"/>
Irish	<input type="checkbox"/>
Gypsy or Irish Traveller	<input type="checkbox"/>
Any other White background	<input type="checkbox"/>
MIXED	<input type="checkbox"/>
White & Black Caribbean	<input type="checkbox"/>
White & Black African	<input type="checkbox"/>
White & Asian	<input type="checkbox"/>
Any other Mixed/ multiple ethnic background	<input type="checkbox"/>
ASIAN or ASIAN BRITISH	<input type="checkbox"/>
Indian	<input type="checkbox"/>
Pakistani	<input type="checkbox"/>
Bangladeshi	<input type="checkbox"/>
Chinese	<input type="checkbox"/>
Any other Asian background	<input type="checkbox"/>
BLACK or BLACK BRITISH	<input type="checkbox"/>
Caribbean	<input type="checkbox"/>
African	<input type="checkbox"/>
Any other Black/ African/ Caribbean background	<input type="checkbox"/>
OTHER ETHNIC GROUP	<input type="checkbox"/>
Arab	<input type="checkbox"/>
Any other ethnic group	<input type="checkbox"/>

(h) What is your religion?

No religion	<input type="checkbox"/>
Christian (all denominations)	<input type="checkbox"/>
Buddhist	<input type="checkbox"/>
Hindu	<input type="checkbox"/>
Jewish	<input type="checkbox"/>
Muslim	<input type="checkbox"/>
Sikh	<input type="checkbox"/>
Other religion (please specify)	<input type="checkbox"/>

(i) What is your postcode

(c) Gender

Male	<input type="checkbox"/>	Female	<input type="checkbox"/>
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(d) Do you consider yourself disabled?

No	<input type="checkbox"/>
Visual impairment	<input type="checkbox"/>
Speech impairment	<input type="checkbox"/>
Wheelchair user	<input type="checkbox"/>
Mental health issues	<input type="checkbox"/>
Hearing impairment	<input type="checkbox"/>
Restricted mobility	<input type="checkbox"/>
Learning difficulty	<input type="checkbox"/>
Other hidden impairment (please specify)	<input type="checkbox"/>

(e) Are you a carer?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If Yes, do you care for....

Disabled person in your family	<input type="checkbox"/>
Older family member	<input type="checkbox"/>
Child/ren under 14 years	<input type="checkbox"/>

(f) What is your sexual orientation

Heterosexual	<input type="checkbox"/>
Gay man	<input type="checkbox"/>
Lesbian	<input type="checkbox"/>
Bisexual	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>

(g) Do you identify, or have you ever identified, as "Transgender"?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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(j) Is English your first language?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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(k) What is your level of fluency in English?

	1 = Poor					5 = Fluent				
Reading	1	2	3	4	5	1	2	3	4	5
Speaking	1	2	3	4	5	1	2	3	4	5

THANK YOU FOR COMPLETING THIS DIABETES SURVEY

For office use	
Ref.	<input type="text"/>

Appendix 3 Findings from the Patient and Carer Survey

1.1 Who Took Part in the Patient and Carer Survey?

The survey was aimed at people with Type 2 diabetes and carers of people with diabetes. Responses from LBBD staff were also accepted, but are not the main focus as they may not be residents in the Borough

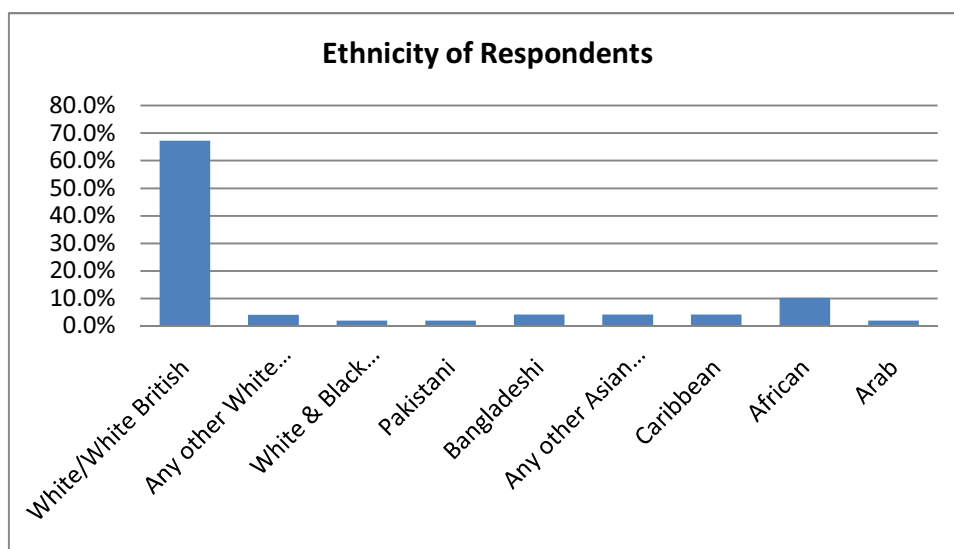
1.2 Patients

1.21 Age and gender

The age range of the respondents was between 40-59 (44%) and 60-74 (38%) which is in line with the expected age range of people most likely to develop Type 2 diabetes. There were very few respondents under 40 (12%). A majority of the respondents were female (40%).

1.22 Ethnicity

A large proportion of the respondents were White/White British (67.3%). The ethnic groups which are most likely to develop Type 2 diabetes (Black Caribbean, Black African and Asian) were not well represented among the respondents as indicated in the chart below:

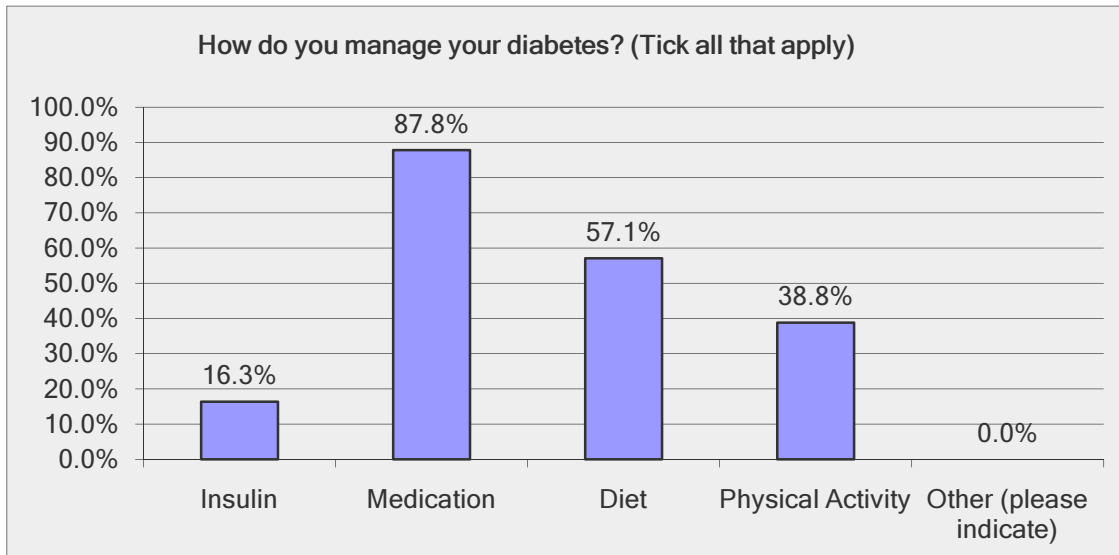


1.23 How long have you had diabetes?

The majority of the respondents have had their diabetes between 6-10 years (36%) with only a small proportion of respondents who participated in the survey being diagnose over 21 years ago (4%). It is interesting to note that during the patient perspective session many of the respondents attending had been diagnosed between 15-20 years ago and the information available to them at point of diagnosis was markedly different to those diagnosed 10 years ago or less which leads Members to conclude that the quality of information has improved over the past 10 years.

1.24 Type of Medication

87.8% of the respondents indicated that they were taking medication for their diabetes and at least 84.2% of these were taking Metformin, although some are taking a combination of diabetes drugs such as Meformin and Sitagliptin.



1.25 Annual Check ups

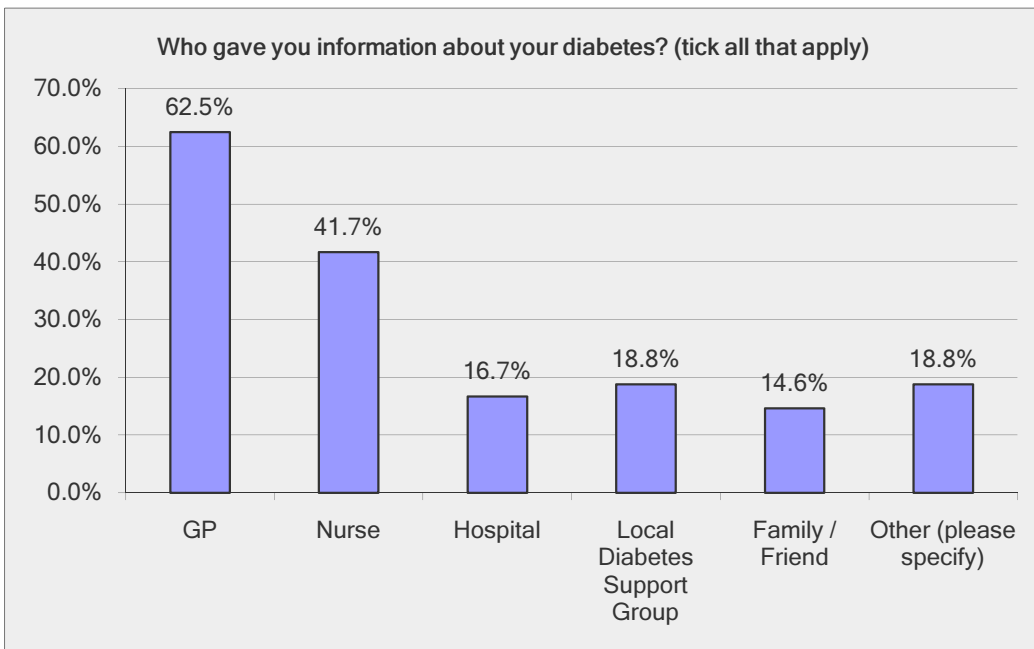
The responses for annual check ups among respondents was fairly good especially for retinol screening (98%). Only 71.4% had annual feet checks which was identified as an area of concern by Diabetes UK. Also very low, was the number of respondents having an annual care plan review (26.5%). Care plans was identified by Pharmacists as one of the key areas in which support could be offered to people living with Type 2 diabetes as this was one of the ways in which patients could improve self-management of their condition.

1.26 How helpful was your GP when first diagnosed?

At the patient perspective session representatives indicated that they did not receive very positive support and information from their GP. Those attending the session were generally diagnosed between 15-20 years ago. The survey indicated that this trend has now changed and that people generally feel that their GP is very helpful (38.3%) or helpful (40.4%) with only 8.5% saying that their GP was not helpful.

1.27 Who gave you information about your diabetes?

In contrast to the patient perspective session, many of the respondents 62.5% said that they got their information about diabetes from their GP. However, one of the areas of concern from service providers was that while there is good quality information available through GP surgeries, there are not enough leaflets provided to surgeries. Members suggest that commissioners may wish to review the quantity of information provided.



What is also worth noting is that GP surgeries are also working with patients on issues such as dietary information (66%), managing their condition (78.7%) and the long term health impacts of diabetes (53.2%)

1.28 Development of further health issues

41.7% of the respondents had developed further health issues, mostly relating to neuropathy and foot conditions. Only 2.1% of respondents did not realise that long-term complications were possible which indicates that a majority of patients are aware of the importance of managing their condition to prevent further health issues.

1.29 Services and Support

69.6% of the respondents had either heard /and or used services at Porters Avenue, which included education programmes such as DESMOND with 52.9% of those who said they attended saying that it was very helpful. 54.3% of the respondents used the B&D Diabetes Support Group which offers support for people living with diabetes of 50+.

1.3 Carers

1.31 Support and Counselling

16.1% of the respondents cared for someone with diabetes and of that number none had received support or counselling and under half had received information about diabetes since diagnosis of the person they cared for.

1.32 Administering Medication

One of the concerns carers who attended the patient perspective session had was they did not always feel confident in administering medication because they had received little advice about doing so. The survey indicates that 28.6% of carers who responded did not feel very confident and only 57.1% feeling fairly confident.

Members suggest that some further work around information/education for carers may be required.

1.4 Conclusions from the Survey

Members found that the survey suggests that on the whole, those who responded were satisfied with the information they received at diagnosis and from their GP although commissioners may wish to consider increasing the amount of printed information available in GP surgeries.

Patients and GPs also appear to be very poor in terms of reviewing care plans annually, although it is not clear if this is because the GP did not include this as part of the review process or if patients are not aware that it should be reviewed annually.

There also needs to be a review of the information and support offered to carers. This was raised during the patient perspective session and the survey indicates that carers are receiving very little education particularly around administering medication.

Appendix 4 Overview of the National Standards Framework for diabetes

The National Service Framework for Diabetes includes standards, rationales and key interventions which should be taken into account when planning services. The standards are summarised below.

Prevention of Type 2 diabetes

Standard 1

The NHS will develop, implement and monitor strategies to reduce the risk of developing Type 2 diabetes in the population as a whole and to reduce the inequalities in the risk of developing Type 2 diabetes.

Identification of people with diabetes

Standard 2

The NHS will develop, implement and monitor strategies to identify people who do not know they have diabetes.

Empowering people with diabetes

Standard 3

All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in this process.

Clinical care of adults with diabetes

Standard 4

All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimise the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.

Clinical care of children and young people with diabetes

Standard 5

All children and young people with diabetes will receive consistently high-quality care and they, with their families and others involved in their day-to-day care, will be supported to optimise the control of their blood glucose and their physical, psychological, intellectual, educational and social development.

Standard 6

All young people with diabetes will experience a smooth transition of care from paediatric diabetes services to adult diabetes services, whether hospital or community-based, either directly or via a young people's clinic. The transition will be organised in partnership with each individual and at an age appropriate to and agreed with them.

Management of diabetic emergencies

Standard 7

The NHS will develop, implement and monitor agreed protocols for rapid and effective treatment of diabetic emergencies by appropriately trained health care professionals. Protocols will include the management of acute complications and procedures to minimise the risk of recurrence.

Care of people with diabetes during admission to hospital

Standard 8

All children, young people and adults with diabetes admitted to hospital, for whatever reason, will receive effective care of their diabetes. Wherever possible, they will continue to be involved in decisions concerning the management of their diabetes.

Diabetes and pregnancy

Standard 9

The NHS will develop, implement and monitor policies that seek to empower and support women with pre-existing diabetes and those who develop diabetes during pregnancy to optimise the outcomes of their pregnancy.

Detection and management of long-term complications

Standard 10

All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.

Standard 11

The NHS will develop, implement and monitor agreed protocols and systems of care to ensure that all people who develop long-term complications of diabetes receive timely, appropriate and effective investigation and treatment to reduce their risk of disability and premature death.

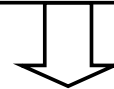
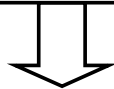
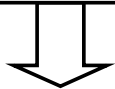
Standard 12

All people with diabetes requiring multi-agency support will receive integrated health and social care.

Overview of the National Standards Framework

Newly diagnosed patients should receive the following from their diabetes care team:

- A full medical examination.
- An agreed care plan.
- An appointment with a diabetes specialist nurse (or practice nurse) to explain what diabetes is and discuss individual treatment and the equipment needed.
- Agreed named healthcare professional to contact for support, advice or more information, if needed.
- An appointment with a state registered dietitian, to discuss usual diet, advice on how to match diet with diabetes - a follow-up meeting should be arranged for more detailed advice.
- Discuss the beneficial effects of a healthy diet, exercise and good diabetes control.
- Discuss the effects of diabetes on work, driving, insurance, prescription charges, and if the patient is a driver, whether they need to inform the DVLA and insurance company.
- Provide regular and appropriate information and education, on food and footcare for example.
- Refer to a structured education programme meeting national criteria.
- Provide information about Diabetes UK services and details of local Diabetes UK voluntary group.
- Refer to a psychologist should the person need to discuss how to cope with the diagnosis/condition.



If treated by insulin injections patient should:

- Have frequent visits demonstrating how to inject, look after insulin and syringes and dispose of sharps (needles). Also how to test blood glucose, test for ketones and be informed what the results mean and what to do about them.
- Be given supplies of, or a prescription for the medication and equipment needed.
- Discuss hypoglycaemia (hypos): when and why they may happen and how to deal with them.

If treated by tablets the patient should:

- Be given instruction on blood or urine testing and have explained what the results mean and what to do about them.
- Be given supplies of, or a prescription for the medication and equipment needed.
- Discuss hypoglycaemia (hypos): when and why they may happen and how to deal with them.

If treated by diet alone the patient should:

- Be given instruction on blood or urine testing and have explained what the results mean and what to do about them.
- Be given supplies of equipment needed.
- Be offered nutritional advice.

Once the diabetes is reasonably controlled, the person should:

- Have access to their diabetes care team at least once a year - to discuss how diabetes affects them as well as diabetes control.
- Be able to contact any member of the diabetes care team for specialist support and advice, in person or by phone.
- Have further education sessions when they are ready for them
- Have a formal medical annual review once a year with a doctor experienced in diabetes.

On a regular basis, the diabetes care team should:

- Provide continuity of care, ideally from the same doctors and nurses.
- Work to continually review the care plan, including diabetes management goals
- Ensure the person shares in decisions about treatment or care.
- Enable the patient to manage their own diabetes in hospital after discussion with the doctor, if they are well enough to do so and that is what you wish.
- Organise pre and post pregnancy advice, together with an obstetric hospital team, if the person is planning to become or already are pregnant.
- Encourage a carer to visit with the person, to keep them up to date on diabetes to be able to make informed judgements about diabetes care.
- Encourage the support of friends, partners and/or relatives.
- Provide educational sessions and appointments.
- Give advice on the effects of diabetes and its treatments when the person is ill or taking other medication.

Appendix 5 - Site Visit 'Menu of Involvement'

Site visits to the following locations were organised for Members as part of the diabetes scrutiny review.

ORGANISATION	ORGANISATION DETAILS	DATE	TIME	LOCATION	EVENT	EVENT DETAILS	ATTENDING MEMBERS
B&D Diabetes Support Group	The B&D group was set up in 2003 and provides an opportunity for people with diabetes and carers of people with diabetes to meet to discuss issues relating to medication, diet and long term issues associated with diabetes. The group specifically deals with diabetics over the age of 50. There is regular attendance by health care professionals who provide advice and information.	11-Feb-13	8 to 9.45pm	Dagenham and Redbridge Football Club Victoria Road Dagenham RM10 7XL	Foot and leg ulcers – complications and impact	Meet with patients and carers to discuss some of the different issues faced by diabetics and carers of people with diabetes.	Cllr Alasia Cllr McKenzie Cllr Wade
Integrated Diabetes Service	The team helps patients to develop their knowledge and understanding about diabetes, controlling long-term condition. Includes patient education programme (DESMOND) and 3 clinics: Complex Care Clinic, Individual Patient Support and Intervention Clinic, diabetic Retinopathy Screening Clinic.	19-Feb-13	11:30-2pm	Porters Avenue	Complex Care Clinic Individual Patient Support and Intervention Diabetic Retinopathy Screening Clinic	Meet with service providers about the different clinics and programmes being offered to patients with diabetes.	Cllr McKenzie Cllr Salam

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