Consultation Response

London Assembly Review of diabetes care in London

Date: 30 July 2013

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This is an initial response to the London Assembly Health Committee's review of diabetes care in London. We may submit further evidence before the end of the enquiry.

1. Introduction

Age UK London raises the voice and addresses the needs of older Londoners. We promote and represent the views of older Londoners; we campaign on real issues that make a difference to older people; we work with older people's organisations across London to enhance services; we offer a range of products and services tailor-made for the over 50s (via Age UK London Trading).

We welcome the Committee's review of diabetes care in London.

2. Key Challenges

The Committee has focussed on the following questions:

1. Why is London experiencing such high growth in type 2 diabetes and what impact is the growth having on health spend?
2. What can be done to stem the growth?

Taking these questions in turn:

1. We believe that the growth in diabetes in London is aggravated by various barriers to older people and others enjoying a healthy lifestyle:

- Many older people on lower incomes have difficulty accessing fresh food, either because of cost or lack of suitable fresh food on sale in their immediate local area. The cost of shopping for one person is often disproportionately high as one person cannot benefit from multi-buy offers ("buy one get one free" etc.)
- The cost of activities such as exercise classes when offered commercially is a deterrent to many older people, and cuts to local authority funding have affected many local services which were free or subsidised.
- Many people in employment, including middle aged people, are required to work long hours which conflict with healthy lifestyles.

The ageing profile of London's BAME communities is very likely also to be a factor. The GLA projects that from 2012-2031:

- The proportion of Londoners aged 60-69 who are from BAME communities will increase from 25.0% to 38.9 %;
- Of those aged 70-79, the same proportion will increase from 24.4% to 35.4%;
- Of those aged 80-89, the increase will be from 14.4% to 25.4%;
- And of those aged 90+, from 8.2% to 22.7%.

(see footnote 3 below)

National research has identified a link between belonging to some ethnic minority groups and increased risk of diabetes. For instance Age Concern England (2007) reported that "People of South Asian origin are up to six times more likely, and Black African-Caribbean origin up to five times more likely, to develop diabetes compared to white people."[1]

[1] Ageing and Ethnicity in England:A Demographic Profile of BME Older People in England, Age Concern England, 2007

We are aware of diabetes affecting older people having a knock-on effect on hospitals, GPs and community health services because of the need to deal with heart attacks and strokes, gangrene and cataracts in particular.

2. Recommended measures:

Promote and support local preventive services

We are convinced that it is vital to support and promote local preventive and public health services which can help people to age as healthily as possible and to manage long term conditions if they have them. Such services have been under particular pressure in the current funding climate.

One example of how local preventive services can play a part in combating diabetes and other long term conditions was the London programme of Fit as a Fiddle delivered by Age UK London and local Age UKs/Age Concerns between 2008 and 2012[2]. Covering 16 London boroughs, it included a wide variety of participatory activities grouped under strands on Healthy Eating, Tackling Obesity and Community Health Engagement. There were 3240 participants aged 50+ (2980 beneficiaries and 260 volunteers), of whom 49% were from BAME communities. Among the key impacts identified were:

- Healthy eating: 78% ate more fruit and vegetables and 88% cut down on high sugar/fat foods
- Physical activity/weight loss: 72% lost weight, 58% by more than 2 kg, with 37% reporting that they started regular exercise for the first time
- The outcomes most commonly reported by participants included improvements in managing long term conditions such as arthritis or diabetes;
- A study focussing on the project in one borough (Kingston) found a Social Return on Investment of £3.50 per £1 invested

Improve availability of public information about diabetes

We think there is a need for much better or more prominent public information about diabetes and would recommend that there should be a clear and well-promoted pathway to get information. Evidence available to us suggests a worrying proportion of older people may not have basic knowledge about how to recognise diabetes or how to manage it or avoid risks of complications if they have it – see the survey results from Age UK Redbridge below.

We tried to find information and support about diabetes in London boroughs online from NHS and voluntary sector sources. Diabetes UK's website has a wealth of information and the charity has local support groups in the majority of London boroughs, but not in all of them. The NHS Choices website provides an online clinic about diabetes. A search on NHS Choices for diabetes services close to Age UK London's offices in Southwark gave links to services in 10 London boroughs, but not in Southwark. We looked on the websites of all of the Clinical Commissioning Groups in London for signposting to diabetes services, but found diabetes services mentioned on only 12 of 32 CCG websites (accessed on 26 July 2013).

In addition to online information, the question remains of how to provide accessible information for digitally excluded people of all ages. The GLA reported in March 2013 that "In 2012, nearly 79 per cent of Londoners aged 75 or over and 43 per cent of those aged 65 to 74 had never used the Internet"[3].

[2] See http://www.ageuk.org.uk/london/our-services/fit-as-a-fiddle/
[3] Assessment of the GLA's Impact on Older People's Equality, Update 2013, March 2013

Make services and information relevant to older BAME Londoners

There is a need to make sure that preventive services are developed and promoted and information provided in a way that includes older BAME Londoners. For instance for some older BAME people, lack of literacy in English (and perhaps also in their mother tongue) may be an additional barrier to acquiring information about preventing or managing diabetes.

Age UK London and Greater London Forum for Older People's London Minority Ethnic Elders Group is working to set up BME Older Patients' Panels including on diabetes services. We will report when there are recommendations emerging from this process.

Age UK London, July 2013

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Annexe: Evidence provided by local older people's groups for this submission

Since the investigation was announced we have received the following inputs from local organisations:

Age UK Redbridge:

Age UK Redbridge work with an older residents' panel called Voices of Experience who provide input through meetings and surveys. In January 2012 a survey on diabetes was answered by 116 older Redbridge residents of whom at least 29 were from BAME communities.

Notable points in the responses:

- 69% of the older BAME respondents said they had diabetes! (52% being type 2)
- 16% of all respondents said they did not know where they can get more information about Diabetes and managing the condition, and 33% did not answer the question (a far higher non-response rate than for most questions in the survey)
- 26% of respondents who had diabetes either did not know or were unsure, how they could reduce the risk of complications from the condition
- Of respondents who did not have diabetes, 31% (44% in BAME groups) said they did not know or were unsure of the signs and symptoms of diabetes

Age UK Hillingdon:

Age UK Hillingdon was aware of reports of GPs "rationing" test strips in the borough. Local Age UK services which help prevent or raise awareness of diabetes include Age Well groups and health forums which promote healthy living and exercise, and footcare clinics which require users to be screened for diabetes by their GP.

Matt Bailey

From: Ann Prescott <ann.prescott@talktalk.net>
Sent: 12 May 2013 20:17
To: Carmen Musonda
Subject: Proposed London Assembly review of Diabetes Care in London

Dear Madam,

I am delighted to read that The London Assembly Health and Environment Committee have agreed in principle to review diabetes Care in London. Below are my comments.

One of the reasons I feel London are experiencing such high growth in Type 2 Diabetes is for two reasons. Firstly is the growth in obesity, and secondly the ethnic minority are now eating westernised food and not eating as healthily as they would have done and this is leading to a growth in Diabetes in this population. The reason I feel that the NHS spend on Diabetes is ten per cent and rising is because there are unnecessary amputations, kidney disease and eye disease happening. A lot of these complications could be avoided if people with Diabetes were educated more fully and diagnosed more quickly.

The way I feel further growth might be curbed is by making people aware that overweight is a factor that can contribute to this condition. There should be more advertising on T.V. and in cinemas advising people to look out for symptoms and to lose weight. People with Type 2 Diabetes are too often undiagnosed for too long and the complications have already set in hence the huge cost to the N.H.S.

Possibly the care is varied across London due to insufficient Diabetes staff in G.P. surgeries, clinics and hospitals. Education should be offered to all people with Diabetes. This to me is the key factor. A lot of people with this condition are not even aware of the 15 health care checks that they should be receiving from their health care professionals.

I am not sure at this stage how the new NHS and public health arrangements will impact on people with Diabetes. The Clinical Commissioning groups are not inviting people with Diabetes to have their say. It is important that the London Assembly see that there is no postcode lottery for people with Diabetes and they all receive the best care and education across London. Many people with Diabetes feel very alone when they are diagnosed and need support which their G.P. cannot always give them.

Ann Prescott (a person living with Type 1 Diabetes and a member of Diabetes U.K.)

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Mr Murad Qureshi
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Friday, May 31 2013

RE: Proposed London Assembly review of diabetes care in London (Ref HEC/CM)

Dear Mr Qureshi,

Thank you for asking for the views of the ABCD diabetes specialist group on key areas for diabetes care in London. These are addressed individually below:

Why is London experiencing such a high growth in Type 2 Diabetes and what impact is this growth having on health spend?

Type 2 Diabetes (T2DM) has greater prevalence in people and communities of Afro-Caribbean, Asian, Chinese and Arabic origin and prevalence figures in a cosmopolitan city such as London reflect this variation. Other risk factors which are not specific to London, but contribute to the increased risk of developing T2DM, are principally obesity, which is due to dietary factors and sedentary lifestyles. A background ageing population produces further increased prevalence as the risk of developing T2DM rises with age.

Eight per cent of the UK diabetes healthcare budget is still spent on the care and treatment of diabetes-related complications and this represents 10% of the annual NHS budget in England.[1] Early diagnosis and improved quality of care for people with T2DM is crucial to prevent further projected rises in healthcare spend on this condition and related complications.

How might further growth in type 2 diabetes be curbed?

Prevention and effective management of obesity should, in part, mitigate the alarming rise in the incidence of T2DM. There are a number of public health strategic approaches that should be adopted to help achieve this.
There is clear evidence to link consumption of sugar added beverages and high glycaemic load diets to the development of metabolic syndrome and T2DM.[2]
The city of New York, in a drive to limit the rise in obesity and associated metabolic problems, has advocated to implement portion size restriction to high sugar content drinks and enforcement of calorie content labelling in fast food outlets.[3] A firm public health initiative in the Capital should be considered in line with this.

The rates of childhood obesity in London are rising; a coherent public health strategy which incorporates schools and tackles issues such as nearby fast food shops or vending machines containing energy dense foods, as well as advertisements of unhealthy foods aimed at children, would be advantageous. Incorporating physical activity into the safe transport of children to school should also be explored.
Improved public awareness of the causes and risks of developing diabetes is central for the success of a preventative programme. A recent commissioned survey shows that only 37% of people are aware that a large waist is a risk factor to developing the condition.[4] Overall London appears to have a similar prevalence of obesity compared to the rest of the UK, but certain ethnic groups and areas have the highest rates of obesity.[5]

The University of Leicester alongside Diabetes UK have produced a validated UK on-line risk assessment tool to help people gauge individual risk of developing T2DM.[6] These types of tools should be made widely available in communities in a variety of ways, e.g. Touchscreen surveys in community pharmacies and supermarkets.

Identifying people with pre-diabetes, a condition which predisposes to T2DM, would target those at highest risk and aid prevention. Clinical trials have demonstrated the onset of T2DM can be prevented or delayed in adults at high risk of developing the condition. There is economic evidence to show that screening and intervention in younger people of South Asian origin, who are at risk of this condition, improves health and reduces cost.[7] Local screening programmes should be adopted for this group of people as well as other ethnic groups who are at high risk. Screening programme initiatives should be linked to the recently introduced NHS Health Check Programme.[8]

Why is patient care across London so varied, and what can be done to improve patient care and outcomes?

Significant variation in the quality of diabetes care across London has been previously demonstrated.[9] Reducing variation both in the community and in hospitals is desirable and should lead to more optimal patient outcomes. The healthcare commission audit in 2007 of former Primary care trusts (PCTs) found not one London PCT was rated excellent for diabetes care and that 26 per cent were rated as "weak".[10]

Variation is probably due to both patient related and healthcare related factors, including infrastructure. People with diabetes in London are more likely to suffer

from social deprivation and common mental health problems than elsewhere in the UK. It is estimated the prevalence of common mental health problems in South East London is double the national prevalence.[11]
The complex needs for patients can make both the delivery and uptake of comprehensive diabetes services for these people more challenging and highlights the need for more integrative approaches to delivery of care across healthcare settings.

Traditional patient self-care programmes and care planning needs to be tailored to suit the cultural background as well as working pattern of people in the Capital. According to the Census of 2011 more than 50% of the population of London are not White/British in origin and this proportion is higher in inner London boroughs. Programmes and interventions should be delivered in well attended community settings near, or even within the workplace, with provisions made to provide appropriate language facilitation.

Further compounding the challenge to deliver high quality healthcare is that the population in London appears to be mobile. Current access to diabetes services across geographical boundaries is limited and needs to change.
There are numerous providers involved in diabetes care across the Capital and this can lead to added complexity faced by Clinical Commissioning Groups (CCGs) involved in service redesign, and can potentially contribute to fragmented care experienced by patients. The use of information technology (IT) should aim to seamlessly facilitate the timely sharing of patient clinical information across providers.

An example of an integrative approach to healthcare delivery in London is the North-West London Integrated Care Pilot. Provisional evaluation of this project has concluded improved co-ordinated care and positive experiences for people with diabetes.[12] The three dimensions for people with diabetes (3DFD) project in South London looks to provide enhanced care for those with mental health issues and poverty, and has embedded social care and mental health teams within diabetes teams to help improve diabetes control.
The experiences and learning from these and similar projects need to be more effectively shared across London and further afield to help influence other health models in progress.

How will the new NHS and public health arrangements impact on the quality of care provided to patients, and how might effective strategic overview be maintained in London?

Resource allocation for diabetes care is subject to the commissioning process and this is likely to lead to variation in service models and provision across London boroughs. There appears to be considerable variation in the amount of spending on diabetes care by former PCTs, which on average ranged from £353 to £1253 per person.[13]
Individual CCGs should determine local prevalence data and of related complications, together with patient experience and available expenditure tools to help design and implement effective integrated services. This collaborative approach is likely to need clinical leadership in each locality. A widely endorsed framework for this is available outlining key principles to aid the process.[14]

Potential areas of concern which could fragment services include new commissioning arrangements for retinal (eye) screening and the possibility for services to be delivered by Any Qualified Provider (AQP) which may bypass established multidisciplinary pathways of care.

Access to structured education programmes, specialist foot care teams and hospital consultants has historically been a concern in some areas of London. A seamless approach to patient care, across healthcare settings and where incentives are shared across organisations would represent a more optimal healthcare model. A joint venture approach of this nature has been successfully piloted in other parts of the country.

Strategic clinical networks for Diabetes do have the potential to help share information, learning and best practice to help reduce variation in healthcare. This can cover larger localities. There has been evidence of success in using such networks in other disease areas.

The use of data will help bench mark outcomes and identify unwanted variation in care across areas. Information from databases including Quality Outcomes Framework (QOF), National Diabetes Audit and Atlas of Variation should facilitate this and identify areas of priority to help ensure an on-going commitment to improving patient outcomes in London.

We hope that this information is useful for your discussions on how best to tackle the rising burden of T2DM in the Capital. Please do contact us if you require further information or clarification.

Yours sincerely

Dr Dipesh Patel	Dr Patrick Sharp	Dr Chris Walton
Committee Member ABCD	Secretary ABCD	Chair ABCD
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On behalf of ABCD committee

References

1 Hex et al (2012) Estimating the current and future costs of Type 1 and Type 2 diabetes in the United Kingdom, including health costs and indirect societal and productivity costs

2 Malik VS et al., (2010) Diabetes Care vol 33 (11);2477-2483

3 Lawrence O. Gostin, JAMA Forum, March 2013: The New York City "Soda Wars": Public Health vs Paternalism

4 Diabetes UK IPSOS MORI survey; Available: http://www.diabetes.org.uk/About_us/News_Landing_Page/Majority-of-people-unaware-of-link-between-waist-size-and-Type-2-diabetes-risk/

5 London Health Observatory (2010) Available: http://www.lho.org.uk/LHO_Topics/Health_Topics/Lifestyle_and_Behaviour/Obesity.aspx

6 Diabetes UK (2013) Available: https://www.diabetes.org.uk/Riskscore/

7 Public health guidance, PH38 - Prevention of type 2 diabetes: risk identification and interventions for individuals at high risk Economic Review and Modelling Issued: July 2012

8 NHS Health Check Programme. Available: http://www.nhs.uk/Planners/NHSHealthCheck/Pages/Diabetes.aspx

9 NHS Atlas of Variation in Healthcare for People with Diabetes (2012)

10 Healthcare Commission, Managing diabetes: Improving services for people with diabetes (2007)

11 Hatch S, et al., Plos One (2012) Vol 7(12) ;e48012

12 North West London Integrated Pilot; Evaluation of the first year (2013) Nuffield Trust

13 London Health Forum (2011). Talking diabetes. Joining up policy and practice in London

14 Best Practice for Commissioning Diabetes Services (2013) Available: http://www.diabetes.nhs.uk/document.php?o=4099

ABCD
Association of British Clinical Diabetologists

From:	Hodges Lisa
To:	Carmen Musonda
Subject:	Proposed London Assembly Review of Diabetes
Date:	23 May 2013 16:54:55
Attachments:	Diabetes Scrutiny Exec Summary Barking & Dagenham.docx

Hi Carmen,

I have recently been passed a copy of your letter regarding the proposed London Assembly review of Diabetes.

The Health & Adult Services Select Committee has recently completed a scrutiny review into Type 2 Diabetes Services in the London Borough of Barking and Dagenham.

I attach a copy of the Executive Summary for that report together with the 10 recommendations. I also include below a link to the full report on our website:

http://www.lbbd.gov.uk/CouncilandDemocracy/Scrutiny/Documents/Diabetes%20Scrutiny%20170413.pdf

If you would like to discuss the report and recommendations or our approach to the scrutiny review, please do not hesitate to contact me.

Kind Regards

Lisa Hodges, Business Support Officer
Adult and Community Services
London Borough of Barking & Dagenham

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Health and Adult Services Select Committee Scrutiny Review into Type 2 Diabetes Services in the London Borough of Barking and Dagenham

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.

Murad Qureshi, AM Chair
Health and Environment Committee
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Barnet & Harrow Public Health
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London N11 1NP

28th May, 2013

Dear Chair,

Re: Proposed London Assembly review of diabetes care in London

I am writing in response to your letter dated 8th April 2013 to Cllr. Hart, Chair of the Barnet Health and Wellbeing Board, regarding the proposed London Assembley review of diabetes care in London. As Director of Public Health for The London Borough of Barnet, I have been asked to respond to the points raised in their letter.

Why is London experiencing such high growth in type 2 diabetes and what impact is this growth having on health spend?

Type 2 diabetes is common, affecting over 5% of the population of England. Its prevalence has doubled in the past 16 years and has grown even faster in London. Diabetes is associated with obesity and increasing age. It is also more prevalent within the South Asian and African Caribbean populations than in the white population, e.g. diabetes is up to five times more common in people of Pakistani and Bangladeshi origin. It is also more prevalent amongst people living in areas of deprivation. London's population is not aging as fast as the wider UK population and is not as obese on average, but has a much higher proportion of people from minority ethnic backgrounds and living in relative economic deprivation, which combined both account for the high prevalence of diabetes in the Capital.

Barnet is London's most populous borough, with a population of 356,000 people. 9.3% are of Black African, Black Caribbean and other Black origins and over 18% are of various South Asian, Chinese or other Asian origin. In Barnet the prevalence of diabetes in people aged 17+, as recorded in Quality and Outcomes Framework registers in 2011/12 was 5.76%, which is slightly higher than the England average of 5.5%.

The YPHO diabetes community health profile gives a summary of the quality of diabetes in care in Barnet currently. The extract below is illustrative:

In Barnet 55.2% of all people with diabetes aged 17 years and older who are not excepted from the Quality and Outcomes Framework have a HbA1c of 7% or less. This is statistically significantly higher than PCTs with populations with similar diabetes risk factors and statistically significantly higher than England as a whole.

Analysis of total spending on diabetes care compared to HbA1c outcomes shows that NHS Barnet is not statistically different from England in programme budgeting spending and not statistically different from England in terms of HbA1c outcomes.

Barnet has the 20th (13.88%) highest number of excess deaths attributable to diabetes in 20-79 year olds when compared to all 152 PCTs in England

How might further growth in type 2 diabetes be curbed?

'Pre-diabetes' (which is also referred to as 'impaired glucose tolerance' and 'impaired fasting glucose') is an asymptomatic condition characterised by higher than normal blood glucose levels and insulin resistance, or impaired responses to it. Without intervention and appropriate treatment, people with pre-diabetes are at risk of developing Type 2 diabetes within ten years.
The evidence suggests that providing intensive lifestyle interventions for people identified with high risk of diabetes, i.e. "pre-diabetes", is a cost-effective way of preventing diabetes. Applying this approach to the whole population is neither cost effective nor affordable, but we are able to identify some of those at high risk through the health checks programme. Other measures to prevent diabetes could include some forms of drug therapy, but it is often less effective than lifestyle interventions.

The Barnet joint strategic needs assessment makes the following recommendations regarding diabetes, to improve helath at the population level:

1. A Diabetes Prevention Strategy for Barnet should be developed
2. Opportunistic screening in practices and the community should be encouraged to identify people with diabetes and impaired glucose tolerance ('pre-diabetes') and also to manage this effectively
3. The development of an outreach service within the community targeting different ethnic and socioeconomic groups to raise awareness of diabetes and address lifestyle risk factors
4. Training of people with diabetes should be continued and encouraged to enable people to manage their own condition more effectively
5. Increased uptake of diabetic retinopathy screening
6. The training needs of ward nurses in the care of patients admitted with diabetes should be reviewed.

Why is diabetes care across London so varied and what can be done to improve patient care and outcomes?

There has been variable investment in and priority given to training of primary care staff; structured education for patients; specialist nursing; shared care and integrated care approaches as well as quality improvement initiatives such as fully implementing the national service framework, Year of Care, etc.

In Barnet, the community services operator is Central London Community Healthcare which provides a structured Diabetes Education programme at Finchley Memorial Hospital, this is for newly diagnosed and established diabetics. It is an Xpert programme run by the Diabetes Specialist Nurse and a Dietitian and takes place on a monthly basis. Barnet GPs refer their patients into the community diabetes service.

How will the new NHS and public health arrangements impact on the quality of care provided to patients and how might effective strategic overview be maintained in London?

The new NHS arrangements have created some fragmentation and loss of relationships that had been developed over a number of years between commissioners and the providers of diabetes services, in particular those between public health teams and providers.

Public health teams are currently establishing new relationships with CCGs in order to provide specific public health commissioning support to NHS commissioners via the "core offer". Strategic work that had been useful in providing frameworks for care pathways, etc. was previously led by cluster PCTs or the SHA and there is now no identified lead for this and as such this could be usefully led by a London-wide body, such as the London Health Board.

Please feel free to contact me should you have any further questions.

Yours sincerely,

Dr. Andrew Howe
Director of Public Health

Ms Bindie Wood

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30 May 2013

Dear Carmen

Re: Proposed London Assembly review of Diabetes Care in London

I am writing to express both my views on the above review and to represent the voices and opinions of the people I work with.

I was diagnosed with Type 2 Diabetes five years ago, prior to which I had no knowledge of what it meant to live with a long-term condition. I had moved to London as a University Graduate for career opportunities some fifteen years earlier not anticipating to stay long in 'the city'. In my mid thirties I was still of the view that 'ill health' was a long way off. Although I worked long hours, sometimes over two jobs, I would have breakfast on the train and often worked through lunch. I did not prioritise exercise or a healthy work-life balance. Also, I thought that diabetes would 'never happen to me'.

I now have roles as Lay Tutor on Self Management Programmes for Patients with Type 2 Diabetes and Lay Co-facilitator for the Advanced Development Programme for Health & Social Care Professionals within Whittington Health. I am Vice Chair for Islington Diabestes UK and Lay Self Management Support Leadership Fellow for the Health Foundation. I also have an interest in the role of e-health and new technologies and am a Lay Member for UCL on the DSM Steering Group developing an online resource for people with Type 2 Diabetes.

Although I disagree, I have been told that my reponse to the diagnosis in seeking out the information that has led to these roles makes me an 'atypical patient'. Most importantly I see myself as an activated patient receiving services in Hackney and member of Diabetes UK.

Having read the Stakeholder address I was keen that the agreement 'in prinicple to review diabetes care in London' should be carefully considered, appropriately resourced and carried out by the London Assembly Health and Environment Committee.

Prior to diagnosis I was completely unaware that I was developing the condition or recognised signs when I was developing it. With an 'estimated additional 80,000

people unaware that they have the condition' I strongly urge you to address this gap in knowledge and awareness by promoting self management and maintenance of the general population, particularly targeting those with genetic or lifestyle predisposition to developing the condition.

In addressing your key questions I have the following points to raise on behalf of myself and others:

Why is London experiencing such high growth in Type 2 Diabetes and what impact is this growth having on health spend?

Factors influencing growth include the number of take aways and fast food restaurants, therefore not having the time or incentive to cook at home. Commuters and people living in London are working longer hours, travel time increases and transport takes longer. All of which leads to unhealthy lifestyle and lack of work-life balance. Health is often not prioritised until crisis, by which time prevention is too late.

Pockets of ethnic minorities living in London where rates of Type 2 Diabetes are high or increasing may skew statistics for London growth rates. However demographics are helpful in showing where resources for community education are to be prioritised. Is there a need for research on the impact of living & working in London on the health of specific minority groups, with commitment to meet potential unmet need?

What is the role played by the Capital City itself? Does the population increase in London mean that more people are developing the condition? Or is it that with an increased population the numbers of people developing diabetes within the population will show in the statistics?

Impact on health spend is that limited health resources are stretched further. Population in London is increasing, however this is not reflected in resources allocated to permanent and transient poulations.

How might further growth in Type 2 Diabetes be curbed?

Conduct a review of migration and imigration policies. There is an anxiety around the resources and limitations available on the NHS and the desire to be an 'inclusive' society.

Cheaper housing and incentives for people to relocate out of London as was the case post war in places such as Welling Garden City and Crawley. This would also spread health care costs nationally.

Need to ensure even spread of employment opportunities accross the country. Introduce a four-day working week accross London, review London weighting, and provide incentives for employers to develop healthy workforce.

Start teaching health literacy early on, specifically basic cooking in schools. Have more encouragement for healthy lifestyle in schools with more support for working mothers. Increase after school clubs and increase healthy eating and sports activities.

Actively promote a paradigm shift in personal responsibility for health as well as the societal changes that will support this. Offer incentives and provide financial rewards for patients that self-manage their condition and safe NHS costs as a result.

Why is diabetes care across London so varied and what can be done to improve patient care and outcomes?

The varying standards and continuity of health and social care professional training in both permament and locum staff needs to be addressed. Patient education, DESMOND and Self Management Programme for people with Type 2 Diabetes needs to be standardised. Recommend that all patients to be offered training on e-health, with online patient record as part of their care pathway following the UCL/Whitttington Health trial.

Best practice needs to be replicated. In an ideal situation this has been described as:

"A dedicated GP Specialist for diabetes care should be available at each group practice with time to answer patient questions and concerns. Also a Diabetes Nurse Specialist to ensure continuity of relationship, maintain patient record and share information. Patients should 'know their numbers' as recommended by Diabetes UK and be given that information in a way they understand. Health Care Professionals should have excellent communication skills and reflect the Co-Creating Health Consultation style. But, it does work both ways. Patients need to cooperate as well with self care, medication compliance and they need to get positive feedback on how they're doing".

Patient developed and led Kite mark for standards in diabetes care.

How will the new NHS and public health arrangements impact on the quality of care provided to patients and how might effective strategic overview be maintained in London?

Sounds like an ideal situation but questions raised as to how will it work in practice. The caseload will increase but not the number of GP's, how will they find the time to meet the needs of patients? Many concerns have been expressed regarding the on-call system with increasing workloads and whether priority can be given to people with diabetes or more than one long-term condition?

How can patient education and support be maintained? Can translation services or part-time community workers be provided for particular ethnic minority groups?

There is no need to create extra ‘bodies’ just use existing organisations more effectively to help maintain strategic overview in London.

In conclusion, I am of the view that the rest of the country looks to London, as a microcosm of the UK. As such I hope that the review will develop a model and strategy that can be replicated in local health economies and sustained in the long term.

I look forward to hearing how you will take this process forward and to receiving outcomes of the review.

Yours faithfully

Ms Bindie Wood

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28 May 2013

Diabetes UK response to the Proposed London Assembly review of diabetes care in London

- Type 1 diabetes develops if the body cannot produce any insulin. About 10% of people with diabetes have Type 1.[1]
- Type 2 diabetes develops when the body can still make some insulin, but not enough, or when the insulin produced does not work properly (known as insulin resistance). It accounts for around 90% of people with diabetes. [2]

Type 2 diabetes is one of the biggest health challenges of our time: 3.9 million people live with diabetes in the UK.[3] In London we have 395,000 people living with diabetes including 80,000 who have not been diagnosed.

Why is London experiencing such a high growth in Type 2 Diabetes and what impact is this growth having on health spend?

The non-modifiable risks to developing Type 2 diabetes are age, family history and ethnicity. Older people are more likely to develop diabetes. In England the prevalence across all ages is currently 5.5%. This increases with age to a 14% prevalence in the over 65s.[4] Alongside this we are seeing the growth of Type 2 diabetes in adolescents, mainly girls.

There is a complex interplay of genetic and environmental factors in Type 2 diabetes. It tends to cluster in families. People with diabetes in the family are 2 – 6 times more likely to have diabetes than people without diabetes in the family.[5]

Within the Caucasian population the risk of Type 2 diabetes increases from 40 years onwards. This is not true for the diverse communities that make up the population of London. Within the South Asian populations the risk increases from 25 years old. Type 2 diabetes is 6 times more common in those of South Asian decent and 3 times more common in those of African/African Caribbean decent. [6]

London has the dual issues of an aging population coupled with the very young populations in some boroughs where both may be of high risk of developing Type 2 diabetes.

In addition to these non-modifiable factors obesity accounts for 80 -85% of the overall risk of developing Type 2 diabetes.[7]

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[1] Diabetes UK (2012) Diabetes in the UK
[2] Diabetes UK (2012) Diabetes in the UK
[3] Based on the number diagnosed (3milion) plus those who are unaware they have diabetes or have no confirmed diagnosis (approximately 850,000)
[4] Diabetes UK (2012) Diabetes in the UK
[5] Vaxillaire, M and Froguel P (2010) The Genetics of Type 2 diabetes: from candidate gene biology to genome-wide studies, in Holt, RIG et al (ed) Textbook of diabetes, 4th edition
[6] Department of Health (2001) national Service Framework for Diabetes
[7] Hauner H (2010) Obesity and diabetes, in Holt RIG et al (ed) Textbook of diabetes, 4th edition, Oxford: Wiley-Blackwell

The impact of this is that 10% (around £10bn) of the annual NHS budget in England goes on treating those living with diabetes.[8] The majority of this spend is on treating the complications of the condition – heart disease, stroke, amputation, loss of vision and kidney failure. Of the NHS spend on diabetes, 80% goes on managing avoidable complications.[9] One of the main reasons for this is that it can take up to 10 years for a clinical diagnosis and by the time people are diagnosed with Type 2 diabetes 50% show signs of complications.[10]

The budgetary spend on non-insulin anti-diabetic drugs in London is high. 10 PCTs in London showed the highest drug spend compared with 20 PCTs in total for the rest of England.[11] Within London there are also a significantly high number of people with diabetes receiving renal replacement therapy, in 10 PCTs. This compares with a total of 9 PCTs across the rest of England.[12]

There is variation in the length of stay in hospital for people across London with diabetes when compared to those without. In 2009/10 it was found that 14 PCTs showed a significantly higher length of stay compared to the England average.[13] In areas where the length of stay is lower, reasons given for this variation were felt to be the organisation of local services and the presence of a dedicated Diabetes Specialist Nurse in the hospital.[14]

How might further growth in Type 2 Diabetes be curbed?

If nothing is done to curb the rise of Type 2 diabetes it is predicted that by 2025 there will be 5 million people in the UK with diabetes.[15]

The key elements for curbing the growth of Type 2 diabetes are:

- Prevention
- Risk assessment and early diagnosis
- A full implementation of the NHS Vascular Screening Health Checks

The NHS Vascular Screening Health Checks programme was implemented in England April 2009 for people aged 40-74. The offering of these checks has been extremely slow to be implemented in some London boroughs. Whilst these health checks are welcomed, they are not screening the high risk groups we have in London, particularly where there is increased risk of developing Type 2 diabetes from the age of 25 in some BAME communities.

Working with Diabetes UK may be one way of diagnosing Type 2 diabetes earlier. Diabetes UK runs healthy lifestyle roadshows providing information about the condition and how leading a healthier lifestyle can reduce the risk of developing Type 2 diabetes. The only UK validated risk assessment (Diabetes UK and Leicester University Trust Risk Score) is used at the roadshows. Last year we held 10 roadshows across London and this year we have a further 9 planned. The risk assessment tool can be used to establish the risk of developing Type 2 diabetes across all age ranges from 18 years old upwards. This means that those who

[8] Hex et al (2012) Estimating the current and future costs of Type 1 and Type 2 diabetes in the United Kingdom, including health costs and indirect societal and productivity costs
[9] Kerr, M (2011) Inpatient Care for People with Diabetes – the Economic Case for Change.
[10] Diabetes UK (2012) Diabetes in the UK 2012: Key statistics on diabetes.
[11] NHS Atlas of Variation (2012) Map 11
[12] NHS Atlas of Variation in Healthcare for people with Diabetes (2012) Map 18
[13] NHS Atlas of Variation in Healthcare for People with Diabetes (2012) Map 13
[14] NHS Atlas of Variation in Healthcare for People with Diabetes (2012) p. 53
[15] Figure based on AHPO diabetes prevalence model.

are not in the age range for the NHS Vascular Screening Programme age are being screened and those at moderate to high risk given a letter to take to their GP. Evaluation from the roadshows reports memory recall of risk factors amongst people, and of intention to take action to address them, one to two months after their visit.[16]

Diabetes UK also trains "Community Champions" to raise awareness of the risk of Type 2 diabetes and carry out risk assessments by engaging with those communities most at risk. We have been commissioned to recruit, train and support these volunteers in several London boroughs over the last few years.[17]

Why is diabetes care across London so varied and what can be done to improve patient care and outcomes?

The key elements to improving diabetes care are:

- Earlier diagnosis
- Implementation of the Nice Quality Standards[18]
- Implementation of the recommendations in the Diabetes Guide to London (2009)[19]
- Education of people with diabetes to self-manage their condition
- Education of Health Care Professionals caring for those with diabetes.[20]
- Individual Care Planning underpinned by access to well-coordinated care based on multidisciplinary local networks

There is great variation across London in the percentage of eligible people being offered an NHS Health Check. In 2011/12 this varied from 2% to 36.1%.[21] There is also a wide variation in the estimated percentage of undiagnosed in London – ranging from 2.9% to 44.6%.[22] Within the UK up to 7 million people are at high risk of developing Type 2 diabetes.[23]

The National Diabetes Audit (NDA) 2010/11[24] showed that people with diabetes living in London received varying levels of care. The number who received all 9 Key Care Processes varied between 31% (Hounslow) and 62.8% (Newham).[25] The National average for this being 54.3%. Whilst there is improvement from the 2008/9 NDA when all London PCTs were in the bottom 25% in England we still have 11 PCTs that are not achieving even average results for people receiving the 9 Key Care Processes.[26] In the 2010/11 NDA only 3 London PCTs were in the top 25% for England.[27] In PCTs where those with diabetes have attained the treatment targets for blood glucose, the blood cholesterol and blood pressure target varies from 14.8% (Barking and Dagenham) to 27.3% (Tower Hamlets). The National average for this is 19.9%.

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[16] Diabetes UK (2012) The NHS Health Check Programme p.10; Diabetes UK Evaluation of Roadshows

[17] Community Champions have been trained in Bexley, Croydon, Hammersmith and Fulham, Harrow, Newham in 2011/ 2012. In 2013 the Equality and Diversity team in Diabetes UK are working in Ealing, Lambeth, Lewisham and Southwark.

[18] NICE (2011) Quality Standards for Diabetes in Adults

[19] Healthcare for London (2009) Diabetes Guide for London

[20] Healthcare for London (2009) Diabetes Guide for London

[21] Diabetes UK (2012) Prevention and Early Diagnosis of Type 2 Diabetes: The NHS Health Check Programme - Let's Get it Right p20

[22] Diabetes UK (2012) Prevention and Early Diagnosis of Type 2 Diabetes p20

[23] Diabetes UK (2011) Impaired glucose regulation (IRG)/Non-diabetic Hyperglycaemia (NDH)/Prediabetes. Available: http://www.diabetes.org.uk/about_us/Our_views/Position_statements

[24] National Diabetes Audit 2010/11 Health and Social Care Information Centre, Report 1 Care Process and Treatment Targets (2012). This is the last NDA of which we have data. The 2011/12 data is not due to be published until July 2013

[25] NDA, 2010/11

[26] NDA 2008/9; NDA 2010/11

[27] NDA 2010/11 – the 3 PCTs were City and Hackney, Newham and Bexley

The care that Londoners with diabetes are getting is not just variable across boroughs but also within boroughs, with variation from GP practice to GP practice. The work being carried out by the Diabetes Modernisation Initiative in Lambeth, Southwark, Guy's Hospital, St Thomas' Hospital and Kings College Hospital is looking at care across the diabetes pathways with a view to having more integrated care. The Integrated Care Pilot in North West London has introduced integrated care pathways that include social care, care planning and multidisciplinary group meetings to discuss complex cases. With the movement of people with diabetes away from secondary care and into GP care there needs to be specialist diabetes services in community settings that are a structured part of integrated care models, with clear access points in every part of London.

How will the new NHS and public health arrangements impact on the quality of care provided to patients and how might effective strategic overview be maintained in London?

There is concern that within the new NHS and Public Health arrangements, the care of people with diabetes will become fragmented. A small study of Joint Strategic Needs Assessments (JSNAs) and Health and Wellbeing Strategies undertaken by Diabetes UK showed that there is a disconnect between the assessments undertaken by local authorities and their strategies for delivering service improvements.[28]

The move to Any Qualified Provider (AQP) may also have an impact on services and needs to be commissioned in a way that ensures a Pathway that is seamless. An example of this is podiatry services, which in some London areas are being offered to AQP. Good contacts with secondary care providers need to be maintained so that a fast referral into a Multi-Disciplinary Foot Team happens in the event of the need for emergency treatment. The danger is the possibility of late referral which could lead to poor outcomes for people with diabetes and an increase in the number of amputations.

There is anecdotal evidence that some of the Clinical Commissioning Groups in London want the care of people with Type 1 diabetes to be transferred to primary care from the secondary care setting where they have previously had their diabetes care. There is a concern that this group, who only make up 10% of the diabetes population, will not receive the expert and specialist care they need in a primary care setting.

A Strategic Clinical Group for Diabetes, which is part of NHS England – London, is being set up. The terms of reference of this group needs to ensure that it does have both a strategic overview but also some power to influence the performance of the CCGs.

Roz Rosenblatt
London Regional Manager

[28] Diabetes UK (2013 forthcoming) Are Health and Wellbeing Boards Taking Account of Diabetes?

PROPOSED LONDON ASSEMBLY REVIEW OF DIABETES CARE IN LONDON.

- Why is London experiencing such high growth in Type 2 Diabetes and what impact is this growth having on health spend?

1. *London has a very high number of black and south Asian citizens who are at a much higher risk of developing diabetes at a younger age. London also has areas of social deprivation which which results in large numbers of people who do not have a healthy diet or exercise enough partly due to low income and low self esteem.*

2. *London is also a special case due to transient population. London attracts people arriving in the UK for work and also for people who wish to settle in this country. Large numbers of people from Africa, the Caribbean and South Asian countries settle in London and they have a higher risk of being diagnosed with diabetes at a younger age. This reflects in high numbers of people with diabetes in Harrow which has a very large* ***Asian community.*** *Richmond and Twickenham tend to have a higher number of people with above average incomes. These families access healthcare more frequently and also have a higher standard of living which will result in healthy eating and more exercise and as a result lower numbers of people being diagnosed with Type 2 diabetes.*
   London is also a magnet for people from all parts of the UK.
   Huge number of people commuting into and out of London everyday puts even greater demand on hospital services for emergency diabetic care.

3. *Larger health spend will result from unhealthy lifestyles leading to the complications of diabetes, including cardio vascular disease, blindness, kidney failure and amputation. The economics of caring for people suffering from the results of these complications are enormous. All people with Type 2 diabetes should be offered and be encouraged to attend structured patient diabetes education courses, ie. X-Pert and DESMOND.*

- How might further growth in Type 2 Diabetes be curbed?
  Better education delivered locally through places of worship and schools etc. in appropriate language and materials where necessary. Set up healthy eating programmes and activity programmes ie. After school sports activities for children and a programme of walks, easy and affordable (or preferably free) access to swimming pools and gyms.
  Due to more crime on the streets of London people are less likely to walk to exercise especially after dusk and even in parks where due to low police presence people are sometimes intimidated by gangs (sometimes school age gangs) and assaults have been reported. Bike riding should be encouraged as a form of exercise for young and not so young but there needs to be safer provision on roads for this and also all parks opened up for bike riders.

- Why is diabetes care across London so varied and what can be done to improve patient care and outcomes?

1. *Convince local PCTs/Clinical Commissioning groups to put diabetes at the top of the agenda and make sure that the service has all the resources required to raise awareness of diabetes, diagnose people earlier and provide an excellent care to avoid or delay the onset of complications.*
2. *Fairer allocation of health funding to all London boroughs/PCTs/CCGs. At the present time Bexley receives the lowest level of funding per head of population for healthcare in London. This is unfair. Why should boroughs such as Bexley which is an outer London Borough be penalised for achieving above average rates of early diagnosis which results in a bigger spend on diabetic health care? Bexley still has to provide same levels of care as other boroughs and costs are higher as HCPs in Bexley do not receive London weighting. Bexley is deemed to be a 'green and leafy' borough but still has large areas of social deprivation, particularly in North Bexley, and Thamesmead where there are large non ethnic communities.*

- How will the new NHS and public health arrangements impact on the quality of care provided to patients and how might effective strategic overview be maintained in London?
    1. *The joining up of health and social care should, hopefully, improve patient care but there is a danger that the new Clinical Commissioning Groups will access private providers for some aspects of patient care, ie podiatry. This could result in a lowering of standards and will also threaten patients' integrated healthcare pathways. Private providers will be more focussed on making profits rather than providing good care which has previously been accessed from the NHS where standards have to be maintained. CCGs will also seek to save money by down-grading some aspects of patients' care, i.e. Reducing the number of specialist consultant appointments etc., poorer podiatry services.*

    Diabetes care in London will have to be audited to ensure that there is a uniform high standard of care across the whole of London and resources provided to ensure that this happens and that there is no postcode lottery which exists at the present time. Diabetes care takes 10% of NHS spending at the present time, the majority of this being spent on the 'complications' of diabetes. If more effective structured patient education and higher standards of care were in place there would be reduced cost and improved quality of life for patients.

    Sheila Burston, Diabetes UK Bexley Service Champion
    Filton
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    Sidcup
    Kent DA14 4BX
    21st May 2013
    Email: sheilaburston@tiscali.co.uk
    Tel: 0208 302 2446

Please reply to:

Hon. Chairman
Tim Read
12 Rutland Gardens,
Croydon CR0 5ST

25 May 2013

Health and Environment Committee
London Assembly
City Hall, The Queens Walk,
More London
London SE1 2AA

Dear Sir

Diabetic Care in London

Croydon Voluntary Group of Diabetes UK is very willing and happy to work with the Health and Environment Committee of the London Assembly to improve services in London - and Croydon particularly - in the future. To further demonstrate our commitment to improving future diabetes service transformation initiatives we are very willing to prepare a number of case studies to the Committee.

There are a number of unique circumstances in Croydon that have a great impact into the rapid growth of Type 2 diabetes and these are:

1. high ethnic population
2. low incomes found in the area
3. social issues and the consequent poor diet
4. lifestyle and inadequate exercise.

These issues are linked to inadequate self management and then when diabetic and the consequent need for high levels of medical services available to meet the need for diabetes care. We believe that there is no one factor that directly leads to the growth of Type 2 diabetes but rather a combination of circumstances.

The answers to your questions from our experience are:

Q1: Why is London experiencing such high growth in Type 2 diabetes?

- High ethnic population particularly African, Caribbean and Asian communities with a high risk of developing diabetes
- Social issues, "food poverty" and associated poor management of self care in the widest sense leading to diabetes. "Food poverty" is the budgetary constraints as a result of low incomes, ensuring that high sugar foods are provided. This is made worse by the combination of very sweet ethnic foods.
- Young people today live a "fast food" diet, and this demands leads to a glut of shops selling poor quality food for children especially. The writer has seen many schoolchildren in Croydon leaving

school and consuming fried chicken and chips on the way home, he has even seen one child consuming the same on the way to school at about 07.00 one morning. Lifestyle changes onto computer games, mobile devices and less active outdoor sports activity

Q2: How might Type 2 growth rates be curbed?

- Education of young people into living a healthy diet
- Education of parents into the effects of an unhealthy diet for themselves and their family:
- Education of what constitutes a good diet to children particularly, and parental information as well ,- children at risk are the potential diabetics of the future.
- Leads into key areas like temples, churches and schools to emphasise this information.
- Curbs on fast food shops particularly around schools and transport links used by children – Croydon for example has far too many at West Croydon near bus and tram stations
- There is a clear unmet need for community education to reduce the risks run by undiagnosed people living with diabetes symptoms in London which is essential as diabetes demands self care
- Education into the benefits of exercise on health in general and diabetes in particular

Q3: Why is diabetes care so varied across London?

- Care is delivered by local GPs: there needs to be consistency of services, quality monitoring, peer review and a means of monitoring complaints. The changes recently introduced demand greater specialist care for people living with Type 2 diabetes in GP surgeries.
- The standard of care so provided is not of a uniform standard and varies significantly between practices. We have a complaint from Mr Shanks as evidence of inadequate care.
- Once a diabetic has been admitted to hospital either under emergency treatment or as part of a programme of treatment, there should be a safety net that catches such people to provide continuing care and support on discharge.
- We have had comments that where people move to the Croydon area the care standards are significantly below other areas.
- There is an unacceptable waiting time for people living with diabetes to be seen following referral to intermediate care services.
- Improvements to services can be made by setting appropriate standards that have to be met by all GPS, peer reviews of GPs, a patient complaint scheme as well as an independent regular diabetes survey that goes to an independent third party organisation, and particularly a specialist support service with high skills in diabetes. It is known that type 2 diabetics do move onto injections with insulin after some time (usually 10 years after diagnosis) and this does need specialist monitoring.

Q4**: How will the new NHS and public health arrangements impact onto the quality of care provided to patients?**

- It is our view that the first change to primary care being provided by GPs has had a detrimental effect on the quality of services provided to people living with Type 2 diabetes for the reason identified to Q3.

- The dismantling of budgetary control from the NHS trusts to GPs may lead to less emphasis on key long term illness like diabetes which are expensive to service and may lead to alternative lower cost being sought which are not necessarily the highest quality or highly specialist.
- The change to CCG arrangements leads to the same point as the second one
- The ability of care groups such as Diabetes UK Voluntary Groups to have a voice in these new arrangements is very difficult and less influential when the control mechanisms are spread across multiple control points. This is now happening in Croydon.
- The solution is to have an overarching mechanism that has the ability to have relevant and timely information from all CCG bodies in London and compare as well as contract key statistics like spend per head, diagnosis rates of Type 2 diabetes per head of borough and race: and development of information such that management of issues can be quickly implemented.
- The involvement of care organisations like Diabetes UK and its Voluntary Groups who operate in the communities of London can provide real life case studies of what is actually happening on the ground and what needs to happen in future to improve matters.

Yours faithfully

Tim Read

Chair

Copies to:

Dame Barbara Young, Chief Executive Diabetes UK

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Recd 20/5/13

DIABETES UK
CARE. CONNECT. CAMPAIGN.

VOLUNTARY GROUPS NETWORK
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0208 245 0948

Carmen Musonda,
The Greater London Authority
City Hall,
The Queen's Walk,
London
SE1 2AA

17 May 2013

Dear Carmen Musonda,

I am the Vice Chairman and Treasurer of the Enfield Diabetes Support Group that was reformed about 10 years ago particularly because it was considered there appeared to be a lack of understanding by people with Diabetes concerning the disease and its possible consequences.

Nearly every Type 2 who has attended our Group initially said the same thing "nobody told me that when I was first diagnosed". It would appear that too many Medical Professionals appeared not to fully understand the Disease and in particular failed to explain the possible complications that could occur, as well as also explaining that currently it is incurable and can only be helped by Exercise and Diet, followed by Tablets and possibly Insulin.

Some of our Members were even told they had 'slight diabetes' which presumably is like being slightly pregnant and it is this lack of understanding by too many medical professionals that is worrying.

I can confirm that when treated at the A & E Department at the North Middlesex Hospital, receiving excellent medical attention, I was extremely disappointed with the Senior Nurse who when advising her that I was an Insulin dependant Type 2 Diabetic kept telling me 'No, because if you take Insulin you become a Type 1'. I gave up trying to correct her as she wouldn't listen. This is exceedingly worrying as adamant lack of knowledge could be very serious.

With regard to Diet there does not seem to be the emphasis on 'Fresh Vegetables and Fruit' as well as explaining the 'No No's' about pre-prepared meals, and whilst there was the encouragement to eat porage instead of cerial, some of our members said there had been no specific mention of not covering it with sugar or honey!

The Support Group Committee fully appreciated that many General Practitioners do not have enough time to fully explain the Disease, so we produced a booklet 'Living with Diabetes' that, in lay-mans terms, answers many of the questions that were asked at our meetings. This was vetted by the PCT including Doctors and Nurses before being produced and delivered to all the Practices in Enfield.

As there is no longer a PCT we used the Enfield Council for the up-dated version only to run into a brick wall about printing further copies. Consequently we have to obtain funds in order to supply a supplement that was highly praised by everybody who has read it.

So in answer to the key questions obviously prevention is better than treatment but most of our members, including myself, were completely unaware of the symptoms of Diabetes until being diagnosed when it is too late.

I believe London's high growth in Type 2 especially in certain Boroughs probably with Ethnic minorities may be due to Poor Diet, lack of Exercise, and Poor Education, and if, as predicted, the number of Type 2's vastly increases then the impact on the health spend will reach an unsustainable level.

It is important that people with diabetes do much more to help themselves rather than rely on the NHS and it is the Government's responsibility to explain to the population that it will become impossible to continue funding the NHS on the current basis and changes will have to be made as to who pays what for the continuation of Our Health Service.

Yours sincerely,

David Petts
Vice Chairman and Treasurer of the Enfield Diabetes Support Group

From:	Alastair Mackinlay
To:	Carmen Musonda
Cc:	Roz.Rosenblatt@diabetes.org.uk
Subject:	London Assembly Consultation on Diabetes
Date:	26 May 2013 18:22:48

Dear Carmen,

I refer to Murad Qureshi's letter of 10 April to "Stakeholders".

I will respond first by saying who I am and my interest in the subject.
I am a 75 year old male who has had Type 1 diabetes for 61 years.
I am chair of the Diabetes UK Richmond and Twickenham Voluntary Group, a support group for people with diabetes and their families living in the LB of Richmond. Our membership of some 400 covers the full range of people with, or with an interest in, diabetes, from the long term elderly patient with Type 2 and his/her carers to the parents of children newly diagnosed with Type 1.
I have been a member of a succession of consultative bodies concerned with local diabetes care for 15 years, from the LDSAG to the Diabetes Network for Richmond.

My comments on the questions raised are

Why is London experiencing such high growth in Type 2 Diabetes and what impact is this growth having on health spend?

Growth in Type 2 is high across the UK but may be greater in London because of the greater percentage of ethnic minorities prone to the disease.

How might further growth in Type 2 Diabetes be curbed?

The growth might be curbed by increased effort in outreach by Public Health to community groups, schools and the population at large, preaching the benefits of exercise and a sensible diet. Role models from the world of sport could be used to put across the message. The government should set out and enforce standards for healthy meals in **all** schools. It should also move from the voluntary arrangement with food producers and lay down enforceable rules for fat, sugar and salt content of food.

Population screening for the pre-diabetes state should be intensified.

Why is diabetes care across London so varied and what can be done to improve patient care and outcomes?

There has been a wide range of effort put into designing and implementing care pathways in the different PCTs. Most pay lip-service to the idea of good care, but they don't always follow that up by monitoring performance.

About 25% of residents of Care Homes have diabetes. Greater education of the staff on diabetes and diabetes care would make a great difference to outcomes.

The arrival of the new CCGs should provide an opportunity to improve matters. Patients and carers should be given the right to be involved at an early stage in the planning and commissioning of the pathways and to be part of the monitoring process.

How will the new NHS and public health arrangements impact on the quality of care provided to patients and how might effective strategic overview be maintained in

London?

I have no idea, but I fear that the new arrangements putting the main responsibility in the hands of CCGs will not result in a London wide programme susceptible of strategic overview. Many of those GPs are already disclaiming any interest in the new arrangements and will probably not get involved in care planning. The abolition of the Strategic Health Authority that was NHS London is a great mistake. Under the umbrella of Healthcare for London, Lord Darsi's strategic plan for London's healthcare needs, a Diabetes Plan for London was drawn up. It , or something very like it, could and should be implemented now, but there is no body with powers to oversee and implement such a plan. I imagine that The London Assembly's Health and Environment Committee will have no power to do more than exhort and implore.

Little of the forgoing is original but I hope it will reinforce other people's comments.

Yours sincerely,

Alastair Mackinlay, Chair Diabetes UK Richmond and Twickenham Voluntary Group

NHS
Hammersmith and Fulham
NHS
Kensington and Chelsea
NHS
Westminster

London Assembly review of diabetes care - DUG Response May 13

These were the responses of the Diabetes User Group to the questions posed by the London Assembly, which were sent to Murad Qureshi, Chair of the Health and Environment Committee.

These were discussed by the group members at their regular monthly meeting on 15th May.

Why is London experiencing such high growth in Type 2 Diabetes and what impact is this growth having on health spend?

- Lifestyle choices eg obesity rates, lack of exercises
- Awareness re prevention
- Lack of understanding of what are the causes
- Not enough encouragement, people are not aware how dangerous diabetes is.
- Too many people living on fried food eg fish & chips
- Too much sugary food & salt on food supplied in the supermarkets
- Too much consumption of free radicals from environmental pollution
- Lack of education.

What impact is the growth in type diabetes having on health spend?

- Increasing expenditure year on year
- Will stretch resources & more money needed in prevention
- Reduce health funding for other conditions.

How might further growth in Type 2 Diabetes be curbed?

- Training to exercise & provision of more exercise facilities including walks.
- Regular exercise eg walking & healthy eating habits

- Provision of dietary advice
- Doctors making patients aware how serious diabetes is
- More awareness, especially in schools
- More people taking courses/education eg Xpod to make them aware of prevention of diabetes

Why is diabetes care across London so varied?

- GPs not liaising with each other
- There is no standard best practice
- Shortage/uneven balance of care centres
- A good number of GP surgeries have nobody to tackle diabetes issues, not even screening early or appropriate early intervention
- GPs are private businesses
- Different commissioning policies across former PCTs
- Some areas have better patient participation than others

What can be done to improve patient care and outcomes?

- All patients admitted to hospitals to be given foot checks.
- More information
- Shorter stays in hospital
- Implementation of an agreed care plan for all patients with diabetes
- Booking services need to be overhauled, especially podiatry
- Walk-in nail cutting services for people with diabetes at foot clinics, instead of having to book.

Corinne McCrum
Peoples' Views Matter
Mob: 07905 905570

Review of Diabetes Care in London

I am Elaine Clark, a Widow; I lost my Husband John in 2008 due to complication of Diabetes. He was 51. I have worked for the last 10 years as a passionate Patient Representative for better treatment, education, information and improved services, both in Barking & Dagenham where is live and in London as a whole.

I have been part of Barking & Dagenham improving their services from having no Diabetes Specialist Nurses to the service they have now with a Community Diabetes Team and am proud to have been part of developing these.

The best way to understand diabetes care in London is to speak to those who live with the condition or have family with it. Consultants, GPs and other Clinicians have knowledge of the condition, but I do not feel they always understand how it is to live with it, it is not something you can learn from a text book of off of the Internet. Real life experience is the best knowledge, but it is being able to get that information from patients, families and carers.

Question 1
In my opinion London is experiencing a huge growth in Type 2 Diabetes for many reasons. The first is the many different ethnicities in the Capital; it is very hard to reach a lot of these people and to make sure they get the correct support and treatment they need. Lifestyle is a huge factor, fast living, eating out, not much exercise, low incomes, and ignorance. There are so many people who do not realise how their lifestyles can affect their health. Information is getting better about diabetes, but it is still a silent killer with people not understanding what is can do to their bodies, especially as you cannot see it and it does not always show symptoms until it is too late.

The lateness of diagnosis is one of the reasons for the high health costs. Obviously if someone has a heart attack or stroke through uncontrolled or undiagnosed diabetes, their health costs will be higher. Sight loss and amputation could all be reduced if people were given more information and support in the beginning. It is essential that all the population are totally aware of what Type 2 diabetes can do if uncontrolled, it is not just a matter of stop eating cakes and biscuits.

Pre diagnosis and education is essential for the population of London and it needs to be consistent across the region.

Question 2
The only way to curb Type 2 diabetes is to make people more aware of it. Make sure people know the symptoms, the complications, why and how the complications can happen. We also need to ensure that people understand that diabetes in the family means that the risk for other family members getting the condition is higher. This in turn will mean that they too will be at higher risk of heart disease, strokes, etc. When people are told they have cancer they immediately think that they might die, when people are told they have diabetes they think they can't have anything sweet. This sums it up, people are just not realising just how serious it is and what

can happen to them. However the difference is that if they get medication and the right education on how to self-manage their condition they can lead a more or less normal life.

Question 3

Diabetes Care across London is horrendous, I have been involved in many projects regarding Diabetes in London and I have met people from across the capital and talked about the different care. There is absolutely no standard, it is just luck if you get good treatment.

Patient care needs to be consistent; it is not acceptable that it is so varied. Even the annual health check recommended for patients with their GPs is not always given in each borough, let alone across London. It is essential that all patients receive good quality care, education and support, including out-of-hours, weekends and bank holidays. Long-term conditions such as diabetes is 24 hours a day, 7 days a week, patients do not get a day off of the condition just because it is a national holiday! More often than not it is just guidance or re-assurance that a patient needs if a situation occurs, but they have nowhere to phone or go for help other than being sent to A&E, which is not appropriate or what a patient wants.

The only way patient care and outcomes will improve is to put in place the right resources, education, support and good quality training for GPs and Practices Nurses as well as the Specialist Diabetes Teams. This also needs to be well monitored and evidenced.

Patients will only respond to Clinicians who they have faith in and believe they are giving them a good service, which is not what is happening at present.

Question 4

The impact of the new NHS and Public Health arrangements will in my present opinion, make the levels of care more varied and inconsistent. Each CCG has their own priorities for their area and one would hope that if diabetes is a huge problem in that area then the CCG/Public Health will address it and have the levels of care needed. However that could mean that area where diabetes is not as much of a problem, then the services could be less. Also I am not sure that all areas will invest in more pre-diabetes checks, or support education programmes.

I strongly feel that firm guidelines across London should be enforced to help control the increase of complications of diabetes. I do not feel that the growth in Type 2 can easily be stopped until people are aware of what it does to their bodies and why it does it. Programmes need to be introduced in schools so that the implications can be understood from when you are young. We need to ensure that people totally understand that uncontrolled diabetes can make you go blind, can increase your risk of having heart attacks and strokes and that you are more at risk of having an amputation.

It is not just the patient who is affected by diabetes, it is the whole family. I became a widow at the age of 50. Since my Husband John died, I have watched my daughter get married and have my Grandson; my eldest son is expecting a baby daughter in August. My youngest, the apple of her Dads eye is now 19, working, driving and in a serious relationship. John has missed all this, and I have

experienced it on my own without him by my side. My children have been without their Dad at some of the most important times of their lives. Diabetes took his life, and also took a big part of ours.

Poor control, poor education and poor support meant that John had 2 heart attacks, 2 strokes, went totally blind, he was developing kidney failure and eventually had dementia as the diabetes affected his brain. He was 51 when he died and cost the NHS a lot of money, money that could have been better spent on early help and support to prevent these complications. In my opinion his death could have been avoided and the suffering and pain we all went through as a family should never have happened.

I now use my experiences to help develop services in my area and am Secretary of my local Diabetes Support Group. I am seeing services improve in my area but it is not enough and if London doesn't sort this out soon then there are going to be a lot more John's and a lot more families suffering needless loss of loved ones.

I am more than happy to be contacted by yourselves if you want to ask me any questions and would like to thank you and wish you luck with improving diabetes care in London.

My contact details are:-

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020 8984 8611
07762 544777

Matt Bailey

From: Niki Lang <Niki.Lang@hounslow.gov.uk>
Sent: 31 May 2013 15:57
To: Carmen Musonda
Cc: Maha Saeed; Estelle McLaughlin; Avril Imison
Subject: London Assembly review of diabetes care

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Carmen

Thank you for your letter dated 13 May to Councillor Sharma around diabetes care.

My colleague Dr Saeed is leading eight major workstreams around diabetes in Hounslow. The Hounslow diabetes strategy should be completed in early autumn of this year and I am sure Dr Saeed would be happy to share this with you when completed

I attached a link to the JSNA that Dr Saeed also leads on,

http://www.hounslow.gov.uk/index/health_and_social_care/health_policies.htm

and also to the diabetes fact pages which outline the Hounslow specific diabetes issues

http://www.hounslow.gov.uk/jsna_2012_diabetes_narrative_dec12.pdf

which you may find of great interest.

As you know, CCGs are the commissioners of secondary care, and public health in local authorities has a role in commissioning vascular health checks, healthy lifestyle and other preventive services that have a key synergy with diabetes including obesity.

Please do not hesitate to contact us if you have any further queries on diabetes in Hounslow.

With best wishes

Niki

Dr Nicola Lang

Consultant in Public Health Medicine and Acting Director of Public Health

London Borough of Hounslow

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This email has been scanned for viruses and inappropriate content.

From:	idublin@tiscali.co.uk
To:	Carmen Musonda
Subject:	Review of Diabetes Care in London
Date:	28 May 2013 16:05:25

Dear Carmen Musonda
My husband is a Type II diabetic who lives in Islington, London. He was diagnosed in January/February 2002. His diabetes arose from having to be on large doses of steroid drugs for a condition called "Polymyalgia Rhematica". Last year around June 2012 he had to be reviewed by a specialist diabetes nurse to whom he was referred to by our GP in Highbury in Islington. Following this referral his medication was changed to include Insulin Medication and retaining his maximum diabetes tablets too. He was also referred to a DESMOND COURSE which is an educational course for diabetics which was very useful, and I as his carer was allowed to attend too. We both found the course very educational and helpful. Since being referred to the specialist nurse and starting Insulin, his HBA1C has decreased from 7.8% to 6.8% which everyone is really pleased about, and on the basis of this he has been discharged back to his GP for routine "looking after". His care also includes retina eye screening once a year, an annual podiatrist review for his feet, and also Podiatry treatment which unfortunately has decreased in frequency because of the cuts made by the Government, so that treatments can now be 12 weeks apart as before it was 4 weekly treatments. In addition he has regular blood tests for his HBA1C. We attend a Diabetes UK Group on a monthly basis in Islington, where possible speakers are invited to come and talk about diabetes and the different aspects of it.
We know that it is a very serious disease and can lead to very bad complications if not monitored and controlled properly.

In my husband's family one of his cousin's is an amputee both in one leg and two of his toes on the other leg and is bed bound in 24 hour nursing care now, following the neglect by his carers to look after him properly at home. Care in the home is a major problem I feel in London, as the carers I have encountered in his and other close friends and relatives care do not seem to really want to do the job, look for a quick exit as soon as they come to visit and do not spend much time with the patient they proporte to be caring for.

With regard to education, I have attended with my husband a couple of certificated basic cookery and nutrition courses, not specifically for diabetics but on healthy eating, and cooking healthily, which we found are a great help. If these could be offered to people with Diabetes on a more regular basis, I am sure it would help, as it is the practical cooking and putting together suitable ingredients that can be beneficial.

In addition, my husband attends a Day Centre two days per week and does his excerise at the Gym there and walks regularly weather permitting and

when he is able to.

I am not sure how helpful this information has been, but I do hope it will go someway to listen to the views of a Carer of a person with Type II Diabetes, as I have found it very challenging to deal with over the past 11 years, and it can very easily fall back into a "slump" if you are not careful. I have to monitor and re-order all my husband's medications and hospital visits for varying appointments, and in addition monitor and make sure he gets his blood tests done.

Yours sincerely

Irene Dublin (Mrs.)
Islington Resident

Councillor Catherine West
Leader of the Council
Labour Member for Tollington Ward
LGiU & CCLA 'Leader of the Year' 2013

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Ms Carmen Musonda
The Greater London Authority
City Hall
The Queen's Walk
London SE1 2AA

6th June 2013

Dear Carmen

I am writing in response to the letters received from the Health Committee at the London Assembly regarding diabetes care in London. I realise that this response is late but hope that you are still able to include our thoughts in your submission to the review:

1. Why is London experiencing such high growth in Type 2 diabetes and what impact is this growth having on health spend?

In Islington, there is currently an estimated prevalence of diabetes of 6.3%. This is estimated to rise to 7.9% by 2030 (APHO prevalence modelling, 2011). There are a number of factors which contribute to this rising prevalence:

- Rising levels of obesity, linked to poor diet and low levels of physical activity
- Ageing population – risk of diabetes increases with age
- Increasing ethnic diversity – particularly Asian population groups are at higher risk of diabetes
- Deprivation – areas of higher deprivation are associated with greater prevalence of diabetes, and deprivation is linked to other risk factors associated with diabetes such as obesity and smoking.

2. How might further growth in Type 2 diabetes be curbed?

In Islington, there are a number of programmes which aim to address the growing prevalence in diabetes:

Primary prevention:

- Smoking cessation programmes
- Weight management service

- Exercise on Referral services for people with BMI>30, individuals at high risk of cardiovascular disease, or with certain conditions such as diabetes
- Programmes of work in collaboration with multiple stakeholders to encourage increased levels of physical activity and healthy eating
- A new Locally Enhanced Service (LES) for GPs in which, as well as enhancing management of diagnosed diabetes (see below), patients with non-diabetic hyperglycemia ("pre-diabetes") receive an annual review and advice and referral into lifestyle services as appropriate, aiming to decrease risk of progression to diabetes.

Case finding and early diagnosis:

- NHS Health Checks Programme: Islington has a strong Health Checks programme, targeted at 35-74 year olds due to the increased risk profile of the Islington population (Nationally the targeted age group is 40-75). People are invited for tests and review, and if diagnosed as having diabetes or non-diabetic hyperglycemia, managed in primary care with advice and referral to lifestyle services as appropriate
- A new LES in which GP practices to identify those that are at high risk for diabetes (in addition to other conditions) and inviting them in for a diabetes test. A risk stratification tool QDiabetes is used on practice patient lists to stratify patients and invite in those that are high risk. Patients identified as having diabetes or non-diabetic hyperglycemia can then be managed appropriately in primary care, to improve patient outcomes and reduce risk of disease progression.

Management and control of patients with diabetes:

Activity to ensure diabetes is managed appropriately will improve patient outcomes and minimise admissions into secondary care.

- The new diabetes LES goes beyond QOF to enhance the annual review for people with diabetes, introducing a care planning approach (Year of Care) to annual reviews
- Self-management/self-care training such as DESMOND is available to people with diabetes
- Multi-disciplinary team approach to care for complex patients
- Other innovative approaches to self-care such as support via a website are being scoped.

3. Why is diabetes care across London so varied and what can be done to improve patient care and outcomes

- Possible varied levels of investment into diabetes care at a strategic level?
- See above for ways in which patient care and outcomes are being addressed in Islington, including a care planning approach to diabetes care.

4. How will the new NHS and public health arrangements impact on the quality of care provided to patients and how might effective strategic overview be maintained in London?

- Public health will need to continue to work closely with CCGs to address diabetes care in the local population

- Policy support and evidence of what services or interventions are effective and used elsewhere could be useful – in a similar approach to the previous NHS Diabetes.

Yours sincerely

Councillor Catherine West

John P G Grumitt
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Tel 07808 400022

Murad Qureshi
Chair, Health and Environment Committee
City Hall
The Queen's Walk
More London
SE1 2AA

13th May 2013

Dear Murad,

Care for people with Type 2 diabetes in London. More for less is possible.

Thank you for the invitation to respond to your questions and the opportunity to contribute to the timely review of services by your committee. The growth of diabetes and the current outcomes achieved in London pose one of the greatest threats to the health of our population and the systems responsible for serving them.

I am a London resident and have had diabetes for 21 years. Until my retirement from the board last year, I was vice chair of Diabetes UK and am now a vice president. I am also a non exec director of the International Diabetes Federation.

Having built a number of successful consumer businesses, the question occurred to me as to why my care seemed to be centred on provider institutions rather than the patient. Having spotted this anomaly I decided to do something about it and created Metapath Solutions (www.metapathsolutions.com) . Since then Metapath has led the turnaround of underperforming healthcare systems to create some of the best outcomes in the country. One of these has been the area that achieves the best outcomes in London, which is in Bexley. Our contribution has been recognized by the DH and Diabetes UK, as well as numerous others.

To answer the questions you raised, in turn.

Why is London experiencing such high growth in Type 2 Diabetes and what impact is this growth having on health spend?

The causes of diabetes are well documented. In a nutshell, people's lifestyles are worsening as more, less healthy food is consumed. To add to the challenge, people are leading increasingly sedentary lifestyles. Changing

demographics are also heightening the impact. As Type 2 is a progressive condition, its impact increases with age meaning that more people develop the disease as they become older, although worryingly, it is also affecting people at an earlier age too.

People from certain racial groups are at greater risk of developing Type 2 diabetes. For example, those of south Asian and African and Afro Caribbean origin can be up to 8 times more likely to develop the disease than others.

The evidence base for this is well documented and I am sure you will receive submissions referring to this evidence.

80% of the financial burden of diabetes is spent on treating the devastating complications. Diabetes is the leading cause of blindness, lower limb amputation, CVD and end stage renal failure.

If our care systems achieved better outcomes, we could avoid a substantial portion. A person with diabetes spends about 5 hours a year with a healthcare professional. For the remaining 8,765 hours, they make decisions on their own. Yet, in London we spend more on treating renal failure than educating people to make informed decisions.

With little consequence of failure, there has been little pressure on healthcare providers to improve their outcomes. For example, Hounslow achieves the worst HbA1c outcomes in England and has done for some time. As a local resident I have approached them, more than once, offering to share what I have learned in delivering some of the countries best outcomes. Most recently the GP diabetes lead made such a proposal to the CCG board. In their wisdom, the board felt that this was not of sufficient value to them. I could site numerous other examples of what could be termed "satisfactory under performance.

At the same time, we are all well aware that financial resources are scarce. Healthcare investment has increased 40% since 2000 yet according to the national audit office, productivity has fallen, year on year. The challenge is to do more with what we have. That requires providers and commissioners to work much more smartly.

How might further growth in Type 2 Diabetes be curbed?

There are two parts to answering this question. The first relates to primary prevention, i.e. stopping diabetes in the first place. The second relates to secondary prevention, i.e. the prevention of complications.

Stopping diabetes requires that we address the causes, where we can. Some people have a genetic disposition to diabetes which right now we can do little about, but the advances in science mean we may be able to do so one day, if we invest in academic scientific research. Incentivizing wellness can prevent the vast majority of cases. We need to create London as a healthy place to be. Where people are encouraged to lead more healthy lives. This may be covert or overt. It requires that all those who can have an impact work collectively,

for example, infrastructure planners with public health officers and clinicians. We could follow the lead from New York by adding more informative food labeling in restaurants. We could make healthier decisions easier to make and less healthy decisions harder.

Currently being active is still presented as a cost to individuals. We do not sufficiently incentivize people to take more exercise.

There is an enormous weight of academic exercise behind the view that if those at risk of type 2 diabetes lost 5-10% of their body weight they would have their risk of developing the disease as well as reduce their risk of a cardiovascular event by a 1/3rd. Surely that prize is worth considerably more than is currently invested in it.

Empowering patients to better manage their health achieves improved secondary prevention. Ensuring providers deliver the basic healthcare essentials that according to the National Diabetes Audit elude the majority of people (for further detail see the Diabetes UK State of the Nation Report and the NDA report, published annually) will also improve outcomes.

Why is diabetes care across London so varied and what can be done to improve patient care and outcomes?

The reasoning behind this is tragically simple, yet so many try to make it complicated, perhaps to disguise the failing of many organisations.

Any high performing organization, in any walk of life, be that state run or the most commercial, has common attributes, namely:

- A very clear purpose that is understood by all. This becomes a passion to serve the cause and people .
- A set of values that underpin this that shape the way decisions are made. These values enable people in that organization to easily make decisions consistent with that purpose. As a result, their employees achieve more, the organizational processes are the most efficient, staff turnover is low and satisfaction high of all stakeholders.
- The keep score of how they are doing and use this to improve what they do and how they do it. Such measurement systems are not viewed as a burden or a threat but a genuine opportunity. Poorly performing organisations, in contrast have little information, what they have is not used and is largely inaccurate or unreliable.

I have no doubt that we can recognize those organisations as we patronise them with our time and resources every single day.

Commissioning of diabetes services has often been poor. Those doing the commissioning are often ill informed and do not have the skills to do the job

asked of them. Thus, the nature of services across London varies enormously, not because they are tailored to the local needs, but because the service specification is poor, the KPIs are not relevant and not used to track performance. This is despite the fact that an excellent document was produced that provides an excellent reference point. That document is The Diabetes Guide For London, published some years ago by Healthcare for London. If this were followed closely and consistently variation would be greatly reduced.

How will the new NHS and public health arrangements impact on the quality of care provided to patients and how might effective strategic overview be maintained in London?

There are some opportunities presented by the new structures. The new Academic Health Science Networks give an opportunity to spread best practice simultaneously across wide areas of London. CCGs have the potential to being healthcare professionals closer to commissioning decisions. This should generate better, clinically lead decisions.

However the pressure on resources means that there needs to be more flexibility to enable the synergies and other operating efficiencies to be delivered. Currently, there are huge barriers to make this happen. Integrated care organisations and budgets could work around the dysfunctional barriers created, for example by the separation of primary and secondary care and bring together social care too. Right now, up to 20% of hospital beds are taken up by people with diabetes. Yet only 9% of these people are there with a primary diagnosis of diabetes. Only integrated working will address this.

The new information strategy, if followed through should help greatly. The amount of information available and used is woeful. Particularly when compared to any other organization outside healthcare. We should be encouraging far greater use of information in decision making. However, many view information as a source of power. Those with vested interests may fight to maintain their power rather than see it diluted by resisting the publication of performance and other valuable data. I have seen this repeatedly while we see the examples of the benefits derived elsewhere.

I hope this brief overview provides some initial thoughts to stimulate your review. I would be more than happy to develop these further. My work across the country has clearly evidenced vastly improved outcomes as well as far greater efficiencies.

Yours sincerely,

John Grumitt

LONDON COUNCILS

Mr Murad Qureshi
Chair, Health and Environment Committee
London Assembly
City Hall
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SE1 2AA

Contact: Barbara Salmon
Direct line: 020 7934 9509
Fax:
Email: barbara.salmon@londoncouncils.gov.uk

Our reference:
Your reference:
Date: 23 April 2013

Dear Murad,

Thank you for your letter dated 8 April 2013 regarding submissions to the proposed review of diabetes care in London.

London Councils welcomes the London Assembly Health and Environment Committee's review of diabetes care in London. This is a major issue for health care in London and the increased prevalence of Type 2 diabetes is an important concern both in London and nationally.

London Councils had undertaken research in 2011 into the benefits of integrated approaches to improving diabetes care which included some mapping of provision in London at the time, a copy of the executive summary is attached for information. This research did not however bear on the questions that your inquiry is investigating and so we are not in a position to comment in any detail on the specific areas being explored by your Committee.

London Councils will be very interested to learn from your findings when the review is completed.

Yours sincerely

Jules Pipe

Mayor Jules Pipe
Chair

London Councils: Diabetes Integrated Care Research

SUMMARY REPORT

Date: 13th September 2011

In partnership with

Public Health Action Support Team

Community Interest Company: A Social Enterprise Organisation

Contents

Acknowledgements

The authors would like to thank the many local authority and NHS colleagues from across London who gave up their time to participate in this research, and to share their stories and insights about integrated health and social care services. We would also like to thank representatives from national and regional organisations, in particular Roz Rosenblatt and Barbara Young from Diabetes UK, and Leena Sevak from NHS Diabetes who provided important information about integrated models for diabetes care, both in London and across the UK.

Finally, we would like to thank London Councils for commissioning this research, and for their interest in promoting more integrated and better quality care for people with diabetes. We hope the findings and recommendations set out in this report help to generate greater clinical and service integration and better outcomes in the future.

1 Introduction

"The quality and productivity gains we need to make lie not within individual NHS organisations but at the interfaces between primary and secondary care, between health and social care, and between empowered patients and the NHS. At the heart of this is the importance of transforming patient pathways, leading to the integration of services and in some cases, the integration of organisations. Where organisational change takes place, it is not necessarily one organisation taking over another, but creating new services with patients and their needs at the centre"[1].

Type 2 diabetes is a serious condition that, if diagnosed late or poorly managed, can result in complications such as heart disease, stroke, kidney failure, blindness and amputation. Diabetes is also a growing problem. Over 450,000 people in London are estimated to be living with diabetes (both diagnosed and undiagnosed).[2] Around 90% of these are people with type 2 diabetes. This represents around 7.5% of the London population[3] and is expected to grow to 9.3% by 2025.

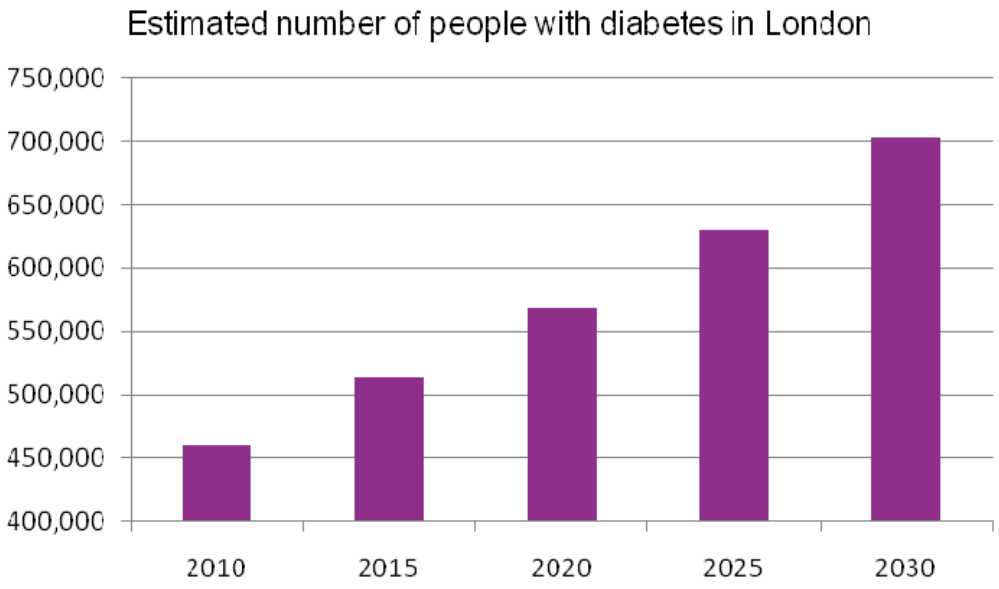


Figure 1: Estimated number of people with diabetes (diagnosed and undiagnosed) in London, 2010 (SHA boundary)

[1] *NHS Chief Executive David Nicholson, Operating Framework for 2010*
http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/links/operatingframework2010-2011.pdf
[2] Source: Association of Public Health Observatories, Diabetes Prevalence Model, last updated 28/9/2010. Estimate is for the number of people aged 16 or over.
[3] Source: ibid. Lower uncertainty limit = 4.6%, Upper uncertainty limit = 12.2%

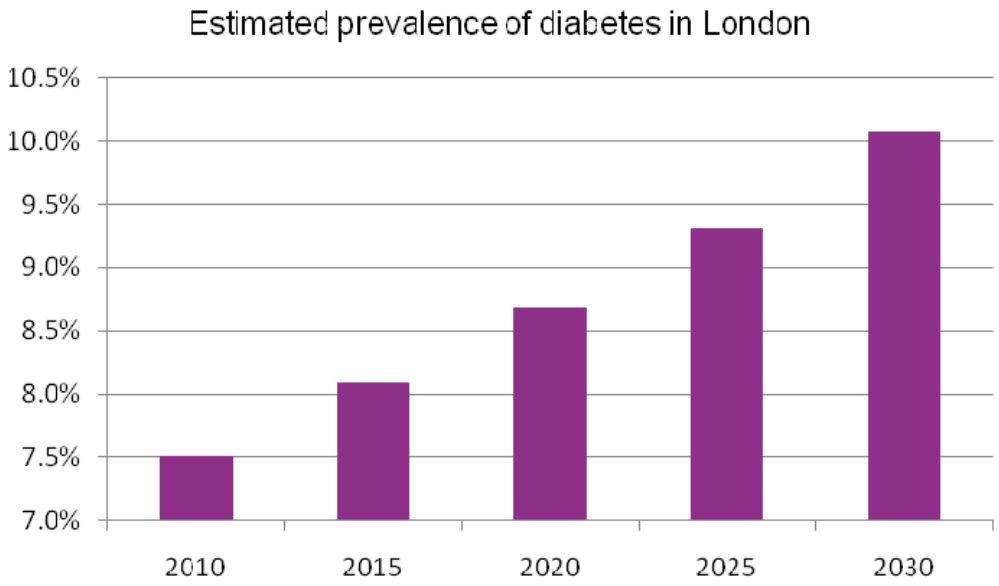


Figure 2: Estimated prevalence of diabetes (diagnosed and undiagnosed) in London, 2010 (SHA boundary)

The delivery of patient centred, clinically effective diabetes care and prevention is essential in order to minimise the growth in the number of people with diabetes in London and effectively manage the associated financial impact on health and social care services. It is also essential to maximise the clinical and lifestyle outcomes for individuals and the wider population. Clinical and service integration is recognised as one of the most important enablers of patient centred care, and the underlying principles of integration have been well documented over recent years. Whilst integration itself can take a variety of different forms, there is a growing evidence base of the benefits it can have to deliver better outcomes for individuals, improve patient experiences of care, and improve quality and productivity across health and social care services.

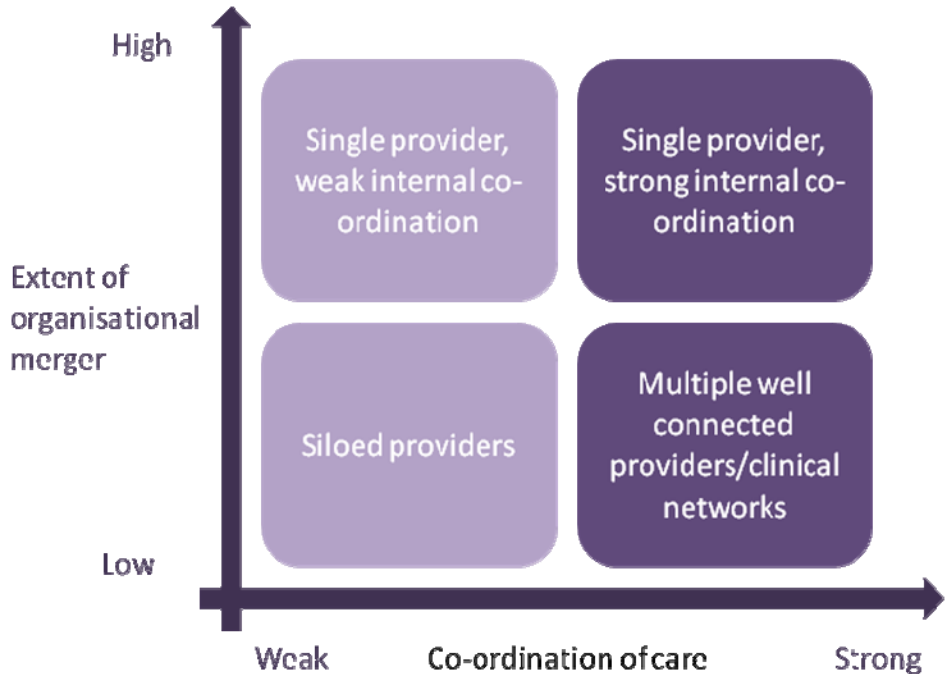


Figure 3: Relationship between organisational integration and care co-ordination. Source: Curry & Ham, 2010

This report sets out the findings of a review of integrated care[4] for people with type 2 diabetes in London. It brings together key learning from current practice and international perspectives on integration, along with some important insights into the main barriers locally to integration between health and social care services. The report presents a number of opportunities for local authorities within the current policy reform context and makes specific recommendations which will help to facilitate further integration of diabetes services within the NHS, between health and social care providers, and within local authorities themselves in the future.

[4] For definitions of integration and integrated care, see *C*urry, N. & Ham, C. 2010. *Clinical and service integration. The route to improved outcomes*. London: King's Fund, and *What is integrated care*, 2011, London: Nuffield Trust.

2 Opportunities within the context of health & social care reform

The current Government is embarking on an ambitious and far reaching programme of reform to health and social services in England. The NHS will see Clinical Commissioning Groups (CCGs) established and potentially quite radical changes to the way health services are commissioned at the local level, with service integration (both within the NHS and between health and social care services) central to the way care should be provided in the future. This is also a key strand of the Government's NHS Future Forum which will make recommendations about how health and social care can be more integrated in the future. These recommendations are likely to lead to further clinical and service level integration locally, and some organisational integration at a more regional level over the coming years.

Within local government, local authorities are being given much greater responsibility to improve the health of their local population, some of which will be enabled by the role of new Health and Well-being Boards (HWBs), along with the transfer of public health responsibilities from the current Primary Care Trusts (PCTs). There are also changes ahead for the way social services are funded and delivered following the report from the Dilnot Commission on Funding of Care and Support. In light of this, there is a huge opportunity during this transition phase to shape the implementation of these reforms in the Capital and to maximise the benefit this offers to the people of London.

In practical terms these considerable change proposals within the NHS, local authorities and for public health mean that, at the time of writing this report, there are major transitions taking place, but there is also uncertainty as to how the new systems will work together. In particular there have been changes to the initial proposals for CCGs to increase the breadth of professional representation involved in commissioning decisions, and also to the role and functions of HWBs within local authorities. Similarly, there is still much work taking place on their respective roles and how they need to work together to 'commission' the range of services needed across local authorities and the NHS to address both health improvement and care delivery. This is a critical time but also a critical opportunity to 'get it right'.

In terms of the care, treatment and prevention of type 2 diabetes, it is both 'getting it right' through integration within the NHS across primary, secondary and community care, but also between NHS services and local authority services. Although the main focus of this report is on integration with social care, there are wider local authority services that are relevant to people with diabetes, including housing, transport, work place health, and development of sport and leisure facilities. There are important opportunities for these to be better commissioned and coordinated as part of the integrated care package for people at risk of, or living with, type 2 diabetes.

Over and above this there are also important implications in terms of the existing and new local authority role in public health. There is a major opportunity for local authorities, through joint strategic needs assessments (JSNAs) and HWBs to ensure that there is a suitable focus on prevention of diabetes. Type 2 diabetes is closely associated with overweight and obesity and, as such is a 'preventable disease' through the delivery of services to encourage exercise and healthy diets. These 'social determinants' of health are known to be important and to be within the province of the new and emerging role of councils. In addition, there are a number of short and medium term opportunities within the context of the current reform proposals:

- Within the new structures for commissioning in the NHS (CCGs) and their relationship to HWBs, there is an opportunity to raise the profile and importance of integration between health and social care. In practice there is a 'subset' of people newly diagnosed or with existing type 2 diabetes who have social needs[5]. These need to be identified through JSNAs and integrated health and social care services commissioned specifically for them;
- A robust business case for integration needs to be developed by local authorities, based on the principles of the 'ideal' model for integration (as proposed in this report). This could be supplemented with examples of good practice and case studies drawn from existing practice in London;
- Recognition that more formalised integration between health and social care requires investment in infrastructure, particularly information sharing and consideration of new contracting arrangements and legal structures to support integration;
- Through the existing multi-disciplinary teams, social workers need to become more central to care planning arrangements in primary and community care settings, and to receive advice, guidance and workforce development opportunities from experts;
- Leverage from the expertise of public health professionals in local authorities and use this to think more broadly than just social services about how other local authority services such as leisure, housing, and transport can be more integrated into the traditional 'care pathway', and help tackle prevention and well-being more effectively. This will include for example tackling obesity more effectively and hence prevention of type 2 diabetes.

[5] Social needs might include: support to live independently at home, housing or accommodation support, advice to manage personal matters such as finances, and assistance with transportation and mobility.

3 Summary of recommendations

In light of the findings from this research, we can make a number of important and quite timely recommendations within the context of the transition towards new arrangements for commissioning and delivery of health and social care services for diabetes in London. These are:

1. **Develop a robust business case to support investment in integration between health and social care (for people with type 2 diabetes)**
   - The business case should set out the potential costs and benefits of integration, particularly in light of the wider public health remit of local authorities
   - HWBs could include in their remit a responsibility for developing aligned financial and operational incentives to promote integration between providers of health and social care services, and
   - Further modelling and analysis could be undertaken to build such a business case, recognising the need for sustainable investment and commitment, but allowing sufficient local adaptation and ownership.

2. **Promote and share best practice in order to build a more comprehensive and practical evidence base for integration**
   - Local authorities, in conjunction with their NHS partners in London, could work in collaboration to bring together and share case studies and patient stories of successful integration locally, within the NHS and between health and social care. This would help to illustrate the different elements of the 'ideal' model for integration set out in this report and provide practical learning for wider adoption
   - HWBs and CCGs should seek to identify and promote the features of successful integration models, elsewhere in the UK and internationally, in particular the learning from organisational integration models such as the Veterans Health Administration in the US, and clinical / service integration models such as Torbay in the UK, and
   - A London-wide online resource or community of practice could be established to share this evidence base and provide a forum for discussion and learning about models of integrated care.

3. **Provide CCGs with the tools necessary to develop provider networks across health and social care, as a means to facilitate greater clinical and service level integration**
   - CCGs should ensure they develop mechanisms for commissioning whole care pathways through provider networks, building on the tools and methods which already exist, so as to ensure social services are fully integrated into the care pathway, and
   - Given the current level of integration between health and social care in London, further work could be undertaken to understand the practical application of approaches such as Accountable Care Organisations and Medical Homes in order to better understand their practical application in the London context.

4. **Support HWBs to commission services which reflect the wider responsibilities local authorities can play in prevention and promoting healthy lifestyles**
   - Develop and provide guidance for HWBs to carry out needs assessments jointly with the NHS for people with diabetes who have social care needs, and to identify gaps in service provision.

HWBs should ensure that commissioning plans across health and social care are designed to address these gaps, and

- Support HWBs to make the links between other local authority services (for example housing, work place health, and transportation) and health and well-being, in order to understand how they can better support both prevention and treatment of type 2 diabetes.

5. **Support local authorities to engage more widely with professional bodies and patient groups as a means to design more integrated care services at a local level**
    - Professional bodies and patient groups are key advocates of integrated care – local authorities, jointly with their NHS partners, should be encouraged to use existing forums and networks to engage more widely with these groups as a key step towards designing and implementing more integrated models of care across London.

4 Models of integrated care for diabetes in London

4.1 Aims of this research

There have been several important initiatives in diabetes care in the United Kingdom such as the National Service Framework for Diabetes, a series of evidence-based diabetes guidelines from the National Institute of Health and Clinical Excellence (NICE), and the inclusion of diabetes care monitoring as part of the Quality Outcomes Framework (QOF) in primary care. These approaches have resulted in a greater emphasis on integrated diabetes care, both within the NHS, and between health and social care organisations, although with a focus largely on integration between community-based and primary care working.

In 2009, Healthcare for London published the London model of care for people with diabetes. This has provided a framework to help embed the innovative work and many of the models of care already in place in the capital. It has also led to an acceleration of new and more sophisticated care and support arrangements at both borough and cross borough level.

The aim of this research was to understand the existing level of integration of diabetes services in London, the policy and operational barriers to integration, and the opportunities during the next stages of health and social care reform. In carrying out the work, the research team adopted a relatively broad definition for integration. This included looking at formal and informal commissioning and provider arrangements, and joint working within the NHS, between the NHS and local authorities, and also within local authorities themselves. On the latter, the particular focus was on how local authorities were tackling the wider prevention and health improvement agenda. The objective was to identify examples of models of care in London that offered high quality, integrated, and cost effective services, accessible to the local population of people with diabetes including the vulnerable and those who are hard to reach.

The research was undertaken through wide stakeholder engagement with leaders of diabetes services in local authorities and NHS organisations across London, representatives of regional and national bodies, and supplemented with detailed review of relevant documentation and a rapid review of recent international literature. This included business cases for integrated services, commissioning specifications, strategy documents and stakeholder presentations. In addition to this the team also reviewed relevant health and social care policy documentation and looked at the progress of some HWBs and CCGs in London, given that these are currently two of the main vehicles through which the current reforms are being shaped and implemented locally.

Financial modelling was also undertaken, based on the data collected in relation to existing models of integration, and combined with regional and national data. The aim of this was to estimate the opportunity for financial savings from integration within the NHS and between health and social care, by comparing baseline cost benefit data with an expected 5 year cost and activity profile. The analysis explored the areas where localities had already identified anticipated savings and the potential scale of these – both for the local organisations themselves, and also at a London-wide level.

Overall, the research identified three predominant models of integration for diabetes services in London.

4.2 The Healthcare for London model

From the data gathered in this review it is apparent that the vast majority of integration, however it is defined, is happening within the NHS rather than between health and social care. To date, this has focused largely on variations of the Healthcare for London model for diabetes and joining up care across primary, secondary and community care through joint commissioning and the development of provider networks. This does have a number of important features, and the evidence gathered in this review shows that this can be a strong enabler for more joint working between health and social care at the local level. Examples of this approach include:

- The work being undertaken in the North Central London cluster to provide an intermediate diabetes care team across a number of London boroughs
- The diabetes modernisation initiative, being provided by Kings College Hospital and Guy's and St Thomas' Hospital, in conjunction with NHS Southwark and NHS Lambeth to reduce variation in quality of care through local networks and agreed clinical pathways
- The integrated diabetes service provided by Bexley Care Trust which aims to integrate care within the NHS from primary through to community and specialist care, and
- The provider network model in place in Tower Hamlets which brings together groups of GP practices into networks under a single contract for the provision of evidence-based diabetes care.

4.3 The NHS Westminster model of care

The NHS Westminster Model of Care for Diabetes Services has now been established for five years. Since the introduction of the consultant led service in 2008 led by St Mary's Hospital (Imperial College NHS Trust), the demand for services has rapidly increased. Clinicians work to locally agreed evidence based care pathways, referral guidelines and audit plans for managing people with type 2 diabetes. The service focuses largely on integration within the NHS, with coordination of the primary, intermediate and secondary care services to enable patients to have improved access to appropriate high quality personalised diabetes care from a range of settings. All patients referred to the diabetes care pathway are triaged to either intermediate or secondary care appointments. Referrals are also made to social services and more formalised links are now being formed to bring social care into the core delivery team.

4.4 The North West London Integrated Care Pilot

The North West London Integrated Care Pilot, formally launched in June this year (2011), is perhaps the most ambitious and wide-ranging model of integrated care for diabetes in London. The pilot is clinically-led by GPs, hospital doctors and other care professionals and brings together organisations from both health and social care. It covers an initial population of around 375,000 across five London boroughs[6]:

- Hounslow
- Ealing
- Hammersmith and Fulham
- Kensington and Chelsea, and
- Westminster

The population coverage could extend to 750,000 over the longer term.

[6] The pilot is not specific to Diabetes but also covers care for older people over the age of 75.

The pilot brings together multi-disciplinary teams from health, social care and the third sector to provide more coordinated care. Care delivery is supported by aligned financial incentives and an information infrastructure which facilitates more efficient sharing of information between care professionals.

4.5 Learning from models elsewhere

There is a wide body of published literature on integration and integrated care. As part of this research, a rapid review was undertaken covering the most recent national and international literature. Amongst other things, the evidence points to a number of common features of successful integration models in health and social care. These are:

1. Clear governance arrangements and team accountability, including strong clinical leadership and involvement
2. Changes in organisational structures and behaviours to support more integrated ways of working, particularly across professional boundaries
3. Workforce reconfiguration, aligned to the care pathway
4. Shared funding systems and financial incentives
5. Shared information systems, including care plans and patient records
6. Common performance management arrangements, including agreed measures and standards to reduce variation and improve the quality of care in line with evidence based protocols.

Within this, the models most commonly cited as best practice examples of integration are:

1. Torbay Care Trust in the UK and the Veterans Health Administration in the US, as examples of organisational integration which brings health and social care professionals together under a single organisation
2. Regionale HuisartsenZorg Heuvelland, Maastricht, as an example of clinical and service level integration through the delivery of 'modules of care' through provider networks, and
3. Integration models between health and community care in Sweden, where physicians and case workers from social services develop joint care plans for people with more complex and high-end care needs prior to discharge from hospital.

Whilst each of these examples clearly has practical application to the health and social care landscape in London, a more detailed review would be useful in order to understand how best to learn from these experiences within the context of the current policy environment.

5 Key findings

This review brings together data and information from a wide range of sources, including current practice, published literature, and insight from senior leaders within local authorities and the NHS who have been responsible for developing and implementing integrated care for people with diabetes. Based on this, the review has identified four main findings:

- There is a real opportunity, in light of the current policy reforms, to expand the role local authorities play in tackling type 2 diabetes, based on an 'ideal' model of integration and with a particular focus on prevention, engaging local communities, and making links with wider health improvement and lifestyle initiatives
- Integration between health and social care services for people with diabetes in London is largely based on informal networks and localised, case by case arrangements between teams of care professionals – there are opportunities to develop more formalised arrangements within the current policy reform context
- Local authorities face a number of barriers to integration with the NHS and specific attention should be given to these as the current reforms are implemented
- The financial case for integration, both within the NHS and between health and social care is based largely on shifting activity away from hospital settings in order to offset the initial set up costs and to generate longer term return on investment. Further work needs to be done to establish a convincing business case for integration from the perspective of local authorities.

5.1 An 'ideal' model for integration

Effective integrated commissioning and provision of care for people with diabetes is a complex task. Organisations face a number of barriers, particularly in the current economic environment. Whilst there is a growing theoretical evidence base which describes effective integration approaches between health and social care, practical learning and experience is limited.

A proposed 'ideal' model for integration of diabetes services is presented below, building on various theoretical models of integration, the principles underlying successful integration described in the literature, and what this review has found from looking at current practice in London.

Figure 4 represents the different levels of care from a patient perspective, with the breadth and complexity of integration increasing as a person moves from 'at risk' (at the top of the triangle) through to diagnosis and ongoing management. As a person's needs become more complex over their lifetime, the range of services and hence the level of integration required increases.

Within this model, we see three main levels at which integration between the NHS and local authorities should take place:

- Reaching out to the whole population to promote healthy lifestyles and to prevent the onset of diabetes

- Screening and diagnosis, including education, self-management and psychosocial support for people newly diagnosed and those with less complex needs, and
- Specialist care delivery and support for people with complex needs, including co-morbidities, and people in residential care or nursing homes.

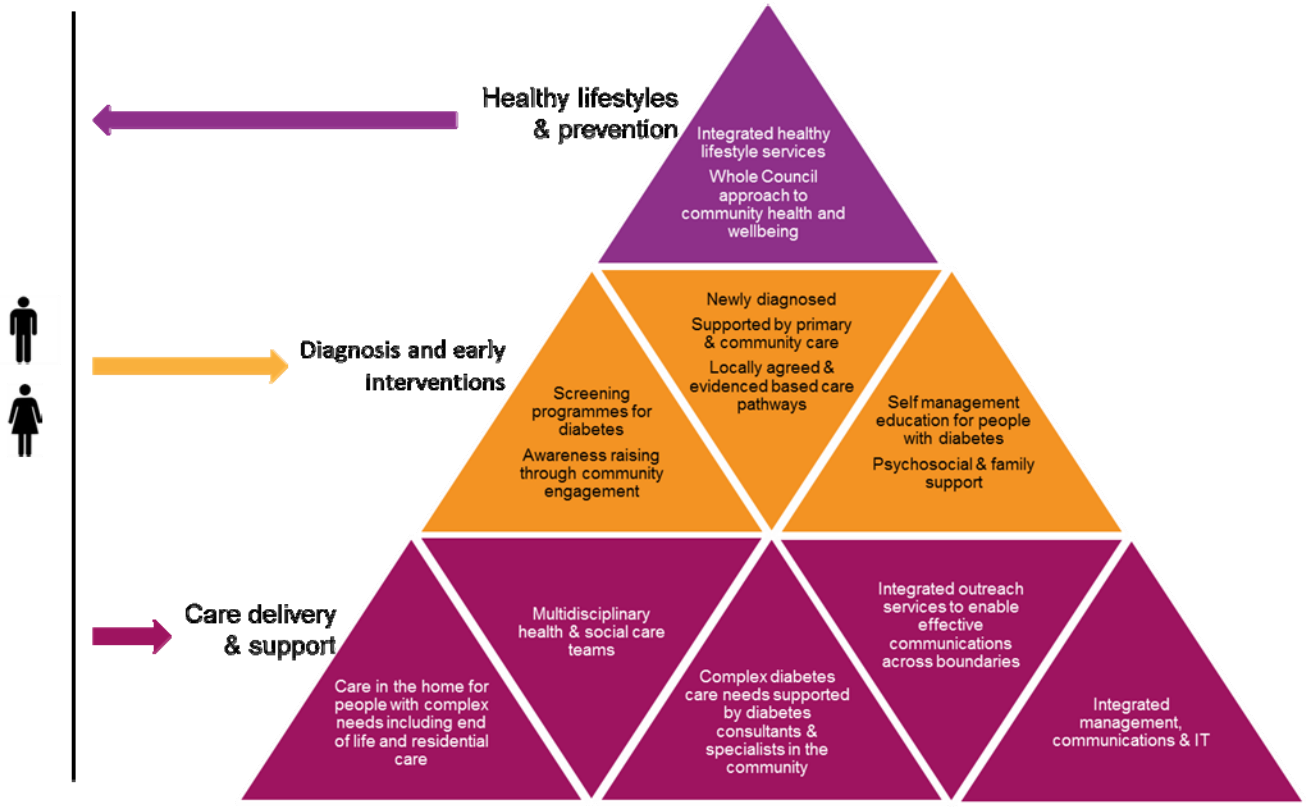


Figure 4: Features of the 'ideal' model for integration between health and social care of services for diabetes

5.2 A picture of integration between health and social care in London

Integration between health and social care for people with diabetes in London is driven largely by informal network arrangements. These are effective at leading to better care planning and coordination amongst multi-disciplinary professional groups, however, they are generally not formalised to the level necessary to lead to long term cost savings over and above the initial investment needed. This is not to say they are not worth continuing to pursue, and perhaps for the proportion of the population which really needs high level care these informal arrangements are sufficient in the majority of cases.

However, there is a huge opportunity for local authorities to become more engaged in integration with the NHS. Not just with respect to social care. But perhaps where councils can be adding most value is in supporting the health service to tackle the prevention and promotion agenda more effectively, including:

- Helping to target local communities which specific cultural needs, barriers to access and education
- Commissioning services in consultation with the NHS which will help to tackle the wider determinants of health (such as housing, transport and employment)
- Expanding lifestyle services and opportunities to improve overall quality of life for people at greatest risk of disease and/or long term health problems

5.3 Barriers to integration between health and social care

In discussion with key stakeholders, we identified a number of common perceived barriers to integration between health and social care. The most significant of these are:

The evidence base to support integration

- A limited practical evidence base describing the benefits of integrating health and social care
- Existing guidance and care pathways for diabetes focus largely on health services and don't make a compelling case for the role social services can play
- Despite a long history in the academic literature, integration is a relatively new concept and there is a need to test and evaluate approaches in order to build the evidence base of what works

Structural & organisational issues

- Recent changes in the NHS, particularly in relation to commissioning and the role of primary care trusts
- The physical location of existing services and facilities
- Lack of integrated infrastructure such as human resources, IT and access to training and professional development
- Lack of common leadership structures across organisations
- Misalignment of financial incentives, with no integrated funding model to enable funds to be released for investment in integration

Cultural barriers

- Professional boundaries can often inhibit innovation across professional groups and these need to be broken down in order to facilitate retraining to work in a more integrated way
- An unwillingness to invest funding up-front to develop integration, due to lack of clarity about the business case from a local authority perspective and concerns about it putting additional pressure on social services in the short term
- Concerns about confidentiality and sharing of information

Whilst in some cases these barriers will be difficult to overcome, there are a number of opportunities, particularly in the current transition phase, to promote greater integration across health and social care with the above issues in mind.

5.4 The financial case for integration from a local authority perspective

The financial modelling work undertaken as part of this research and by others to date centres on the movement of expensive hospital activity into a community setting, therefore releasing funds to invest in the infrastructure requirements of integration. If an approach such as the one being implemented in North West London, for example, was adopted right across the capital we estimate that the public sector could save between £81.8 million and £188.6 million over the next 5 years. This is against a projected growth in costs of nearly £89 million over the same period if no further integration takes place. However, there is very little robust evidence about the tangible financial and / or economic benefits associated with integration of health and social care, and little formal evaluation carried out of the approaches to date. Although the North West London pilot is putting in place the measures to achieve this in the longer term, assessments of benefits currently are drawn from a range of assumptions about population growth, achievable shifts in hospital activity, and the number of people diagnosed with diabetes.

Our analysis shows that there has been very little work done, in London and elsewhere, to quantify the financial benefits of integration between health and social care. In addition to this, there is an opportunity now to set out the potential value which local authorities can create through greater integration within their portfolio of services in light of their expanding public health and health improvement roles described above.

The findings also suggest that integration has a greater potential to save and deliver wider benefits when this is part of broader integration, rather than when it is focused on just one disease area.

Whilst local authorities may have been reluctant to integrate services with the NHS to date because of the potential strain it might place on already limited social work resources in the short term, the adoption of a risk sharing approach similar to the financial model developed in North West London might help to facilitate this up-front partnership investment and commitment, before the longer term benefits are realised.

MAYOR OF LONDON

Murad Qureshi AM
City Hall
The Queen's Walk
More London
London SE1 2AA

Our ref: MGLA110413-3944

Date: 11 JUN 2013

Dear Murad

Proposed London Assembly review of diabetes care in London

Further to my letter to you of 1 May, I am pleased to send you my views to inform the Assembly's proposed review of diabetes care in London. I have structured my reply under the questions posed in your letter of 8 April.

1. *Why is London experiencing such high growth in Type 2 Diabetes and what impact is this growth having on health spend?*

The growth in Type 2 diabetes is a global phenomenon of concern to all health professionals and policy makers as well as those affected. I am particularly concerned not just due to the significant health impact, but also due the major health inequalities dimension of Type 2 diabetes. The projected impact on future costs across the health economy also means that this is a very significant issue.

Public Health England is the executive agency with responsibility for public health intelligence. They are best placed to explain the long term growth in London.

NHS England, with responsibility for delivering patient care, is best placed to assess the impact of growth in diabetes on future health spend.

2. *How might further growth in Type 2 diabetes be curbed?*

The growth in Type 2 diabetes can be curbed through the adoption of healthier lifestyles across the population. The rise of obesity, poor diet and insufficient physical activity are directly related to the rise of diabetes.

There is responsibility across all parts of society to address these issues.

Type 2 Diabetes is unequally spread across the population of London and is a cause of health inequalities. I have a duty to have a strategic view of how the various parts of the system can act to reduce health inequalities and to have regard for health inequalities in all my strategies.

I am leading on, or involved in, a range of programmes and initiatives with the aim of meeting my commitment to do what I can to reduce health inequalities across London. By creating a healthier city, each of the following actions has potential to impact on the future growth of diabetes:

a. *London Health Board*: This partnership board, which I chair, will provide a leadership forum to develop a collective London overview of health issues in the capital as we move into the new structures and responsibilities.
b. *London Health Inequalities Strategy:* Promoting equalities in health across five main objectives: empowering individuals and communities; equitable access to high quality health and social care services; income inequality; health, work and well-being; healthy places
c. *Healthy schools*: Healthy Schools London is an Awards Programme that will potentially reach out to every London child, through working with schools to improve children and young people's well-being.
d. *Creating healthy places:* Working across transport, environment and planning, to create places which promote health and physical activity for example the Mayor's Cycling Strategy increasing active travel. The London Food Board encourages access to healthy food for all Londoners.
e. *Creating healthy workplaces*: The London Healthy Workplace Charter provides a framework to support employers develop good practice by promoting health in their organisation in a practical way.
f. *Well London*: This programme is working with deprived communities to improve their own health particularly around issues of physical activity and diet.
g. *London Mental Health*: improving our understanding of the impact of poor mental health across London and its contribution to health inequalities.

3. *Why is diabetes care in London so varied and what can be done to improve diabetes care and outcomes?*

I welcome the Health Committee's review of diabetes care and await with interest its findings on variations of care and outcomes across London.

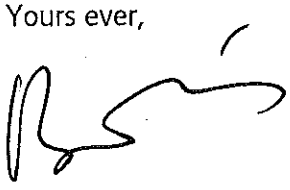
4. *How will the new NHS and public health arrangements impact on the quality of care provided to patients and how might effective strategic overview of care be maintained in London*

I hope that the new NHS and public health arrangements will improve quality of care with a more locally sensitive and clinically-led response to the needs of patients and communities.

In my role as Chair of the London Health Board I, alongside partners from across the NHS, public health and local authorities, will seek to champion the interests of Londoners and ensure a strategic city-wide perspective bringing major partners together.

I await the findings of the review with interest.

Yours ever,



Boris Johnson
Mayor of London

Cc: Onkar Sahota, AM Chair, Health Committee

Newham London

30 May 2013

Mr M. Qureshi
London Assembly
Chair Health and Environment Committee
City Hall
The Queen's Walk
London SE1 2AA

Dear Mr. Qureshi,

Re: Proposed London Assembly review of diabetes care in London

Thank you for contacting the London Borough of Newham with regards to the proposed review of diabetes care in London.

Newham is estimated to have one of the highest prevalence of diabetes in London and significantly higher prevalence than the rest of England. According to the Diabetes Prevalence Model, in 2013, 9.9% of Newham's population is living with diabetes, compared to 7.7% for London and 7.4% for England[1]. This means that 17,235 Newham residents are presently affected by this long term condition.

In Newham the issue of diabetes is made all the more complex by existing levels of economic deprivation and rising levels of obesity, coupled with an increase in the number of adults with low levels of physical activity. The costs of managing this service are also significant in Newham.

Estimated high levels of diabetes prevalence in Newham can also potentially be explained by Newham's ethnically diverse population. Type 2 diabetes is up to six times more common in people of South Asian decent and three times more common among people of African and African-Caribbean origin, compared to the UK national average[2].

The issues in combating and trying to curb growth of Type 2 diabetes in Newham are the same as for London as a whole: low levels of physical activity, rising levels of obesity and an increasing number of patients suffering from diabetes at an increasingly earlier age.

Diabetes is a very complex problem rooted on several factors other than genes or individual health behaviours. The social, urban and economic environment in which people live can also determine in whether someone is more likely or not to develop certain habits or lifestyle choices that might lead to a higher propensity to develop diabetes. Promoting walking and discouraging the use of private car, promoting healthy food choices and tackling the over concentration of hot-food takeaways on the high street, delivering attractive and secure open spaces and sport infrastructure that invite people to physical activity, can greatly contribute to curbing further growth in Type 2 diabetes. There is a role for the proposed review to tackle these issues in a more co-ordinated way throughout London and to develop a more strategic approach to the problem. Local Authorities and the London Assembly are

[1] APHO Diabetes Prevalence Model for England
[2] Department of Health (2001). National service framework for diabetes www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4096591

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now in an excellent position to join forces to achieve these and deliver real attractive choices to all London residents that promote healthier lifestyles.

There is also a local awareness that diabetes care and outcomes in Newham could be improved. In order to achieve this, Newham proposes to:

- Strengthen primary prevention pathway;
- Reduce treatment variation and strengthen patient pathways (especially secondary prevention);
- Challenge health beliefs about diabetes and health behaviours to ensure people access care.

These measures can also be implemented London wide, with best practice and knowledge sharing from other Boroughs and areas of London being disseminated and placed at the heart of a new "Tackling Diabetes" strategy.

A series of other initiatives can also be implemented by the Local Authority and the London Assembly, particularly for the promotion of primary prevention, namely:

- Target highest risk groups – south Asians, black African/ Caribbean, family history of disease, low birth weight, family history of obesity;
- Life course approach – start at antenatal stage supporting mums and families;
- Cross generational (e.g. learn from school cancer awareness projects)
- Review physical activity offer.
- Review healthy eating offer within children's centres and schools;
- Look for join up across the agenda and different services.

The Newham Health and Wellbeing Board would like to thank you for the opportunity to participate and to be engaged in the review process and would very much welcome future opportunities to develop this work alongside the London Assembly.

Please do not hesitate to contact us if you have any further queries regarding the above.

Yours sincerely

Dr Graeme Betts
Executive Director Strategic Commissioning and Community

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NHS England

London Strategic Clinical Networks

London Strategic Clinical Networks
NHS England (London Region)
Southside, 105 Victoria Street, London SW1E 6QT

Friday, May 31 2013

RE: Proposed London Assembly review of diabetes care in London

Dear Mr Qureshi,

As the London Strategic Clinical Network Director for Diabetes, I am pleased to respond to your 8 May letter as was sent to NHS England (London Region).

Diabetes mellitus is a condition where the amount of glucose in the blood is too high because the body cannot use it properly. There are two types of diabetes:

- ***Type 1 diabetes*** develops because the body cannot produce any insulin, and accounts for approximately 10 per cent of people with diabetes.

- ***Type 2 diabetes*** develops when the body cannot produce enough insulin and is resistant to the insulin that is produced. Type 2 diabetes is often associated with being overweight and usually appears in people over 40 years of age (or over 25 in south Asian and African-Caribbean people). More recently a greater number of children are being diagnosed with type 2 diabetes.

Why is London experiencing such high growth in type 2 diabetes, and what impact is this growth having on health spend?

There are several risk factors for type 2 diabetes, which are common to the lifestyle of many people in the capital:

- **Ethnicity** - The risk of type 2 diabetes varies across ethnicities. Those of black and south Asian descent have higher risks with a higher prevalence of type 2 diabetes and earlier onset of the disease. The prevalence of diabetes, is up five times higher in people of black or south Asian descent (including Pakistani and Bangladeshi), and these groups have a higher risk of developing diabetes-related long term conditions.
- **Sedentary lifestyle** – As the level of exercise decreases, the risk of type 2 diabetes increases.
- **Dietary factors** – Diets which include high fat and/ or sugar intake increase the risk of weight gain and type 2 diabetes. There are more than 8,000 fast food outlets in London[1].
- **Weight gain** – Weight gain / obesity is a major factor, and London has some of the highest rates of excess weight /obesity, including childhood obesity in the UK.
- **Ageing population** – The risk of type 2 diabetes increases with age, albeit at different rates in different ethnicities. Whilst not solely a London issue, this will also be a factor.

All of the above lifestyle risks can lead to increased rates of type 2 diabetes, though those ethnicities at highest risk are affected to a greater degree and at a younger age. (The increase in detection of type 2 diabetes in recent years may also account for the rising known levels, though would not explain the growth of the disease.)

The growth in type 2 diabetes has a clear impact on health spending. It is estimated that 10 per cent of the NHS budget is spent on diabetes each year[2]. As such, it was projected in 2011 that the increasing prevalence of type 2 diabetes in London could amount to an increased cost of almost £90 million over five years[2]. Across the UK, It is estimated that the current annual cost of direct

[1] Greater London Authority, *Mayor urges action on healthier eating* (2012, link; accessed 28 May 2013).
[2] The London Health Forum, *Talking Diabetes: joining up policy and practice in London* (2011, link; accessed 28 May 2013).

patient care for those with type 2 diabetes (treatment, interventions and complications) is around £8.8 billion[3].

Regarding symptom management and mortality, diabetes is associated with approximately 19,500 deaths4 in the UK each year (or 52 people per day). Type 2 diabetic-related complications can lead to coronary heart disease (25.2%), stroke (9.6%) and peripheral neuropathy (28%). Each week 73 lower limb amputations are carried out and 1,280 people each year become blind due to diabetes-related complications[4].

Finally, it is important to recognise that earlier detection and treatment of type 2 diabetes reduces the risks of diabetic complications. In London it is thought that there are 102,0002 people with undiagnosed diabetes.

How might further growth in type 2 diabetes be curbed?

The largest single preventable risk factor for diabetes is an unhealthy lifestyle. The number of people overweight in the UK has more than trebled in the last 25 years. In London, 20 per cent of children aged 10-11 are at risk of being obese, a rate higher than the national average. This is both a combination of a physical inactivity and an unhealthy diet. The sheer volume of fast food outlets in London – more than 8,000 [5] – proves a challenge for those who are trying to maintain a healthy lifestyle. A study by the Greater London Authority (GLA) found that London boroughs with the highest concentration of fast food takeaways tend to also rank among the most deprived. It has been shown that there is a correlation between deprivation and poor diet. Reducing unhealthy weight and obesity will lead to a reduction in the longer-term incidence of type 2 diabetes.

Incidence could be minimised at a local level by implementing recommendations from the National Institute for Health and Care Excellence (NICE) public health guidance, including:

- Preventing type 2 diabetes - population and community interventions (PH35, 2011)
- Preventing type 2 diabetes - risk identification and interventions for individuals at high risk (PH38, 2012)

Guidance PH35 recommends local needs assessments and strategies pertaining to diet and physical activity among high risk communities, whilst guidance PH38 focuses on risk assessment and the provision of effective, cost effective and appropriate interventions for people at high risk.

Large-scale trials have shown that the onset of type 2 diabetes can be prevented or delayed among adults at high risk, with a reduction of more than 50 per cent in risk demonstrated, following structured lifestyle interventions. Behaviour-change strategies can help people to increase their physical activity, eat more healthily and maintain a healthy body weight.

Why is patient care across London so varied, and what can be done to improve patient care and outcomes?

A 2007 Healthcare Commission audit of Primary Care Trusts (PCTs, formally abolished April 2013) on diabetes care found that 26 per cent of the 'weak' performers in the country were in London. Not one London PCT was rated 'excellent'[6].

Delivering diabetes care in London can be more challenging than other areas of the country due to certain demographic reasons, such as higher risk ethnic groups, greater pockets of deprivation and more patients with limited mobility.

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[3] NHS Diabetes, Diabetes Health Intelligence, National Diabetes Information Service, *The care of people with diabetes in NHS London* (2012, link; accessed 28 May 2013).
[4] Kanavos, P, van Den Aardweg S, and Schurer W; LSE Health, London School of Economics, *Diabetes expenditure, burden of disease and management in 5 EU countries* (2012, link; accessed 28 May 2013).
[5] Greater London Authority, *Mayor urges action on healthier eating* (2012, link; accessed 28 May 2013).
[6] Healthcare Commission, *Managing diabetes: Improving services for people with diabetes* (2007, link, archive accessed 28 May 2013).

There exists a higher proportion of at-risk communities in London, and these communities are unevenly distributed within the capital itself. In areas with increased higher risk populations, primary care professionals encounter a greater number of individuals with complex type 2 diabetes at a younger age than elsewhere in the UK. Not only does this create a greater workload for practices, many of these individuals, because of their [younger, working] age, are less able to access traditional 9-5 care due to work commitments and for many repeated time off work is not an option.

Many of the boroughs with highest diabetes risk also have high levels of deprivation and patient mobility, making care harder to organise and increasing the need for social support.

However, substantial variation across London cannot be explained solely by demographics. There is also inequality in access, uptake and care delivery (both in primary and specialist care). Self-management support in London varies, too, with substantial differences in the availability of structured education for people with diabetes, coupled with few tailored education programmes for those of working age or of different ethnicities.

Further exacerbating the challenge is that although London's population may be mobile, its health system is not. For example, although an area may develop services for a particular hard-to-reach community, an individual living across the area's border may not be able to access it.

These inconsistencies contribute to differences in morbidity and mortality across London. In the Healthcare Commission audit, few PCTs had effective networks, as recommended in the National Service Framework for Diabetes[7].

However, unacceptable variation within primary and secondary care can be challenged and changed. Although more robust data is required in some areas, data on outcomes and standards of diabetes care exist and can be used to highlight unacceptable performance as a lever for change.

Some progress has been made to reduce this variability, both at a local level (such as work done in the former NHS Tower Hamlets) and at a regional level (such as the south London project, funded by Guy's & St Thomas' Charity, and the north west London project, based at Imperial College London). The 3 Dimensions for People with Diabetes (3DFD) project provided by King's Healthcare Partners in south London has integrated medical and psychological support with social support with positive effects.

Fragmented care is a real concern and could be avoided by developing effective clinical networks based on user input. With greater numbers of providers and a mobile population such networks of information sharing and increased use of technology would be particularly beneficial in the capital.

There is much expertise and learning across London in how to manage and solve complex diabetes needs. However, there is little sharing of best practice or of learning from pilots or projects, both successful and unsuccessful. Appropriate, ongoing learning for the specific problems encountered in London would be of clear benefit, in conjunction with national and international learning.

How will the new NHS and public health arrangements impact on the quality of care provided to patients, and how might effective strategic overview be maintained in London?

It is essential that care for people with diabetes does not become more fragmented; indeed, it is vital that care becomes easier to access. Those who suffer most from fragmented, unstructured care are those with poorest health literacy.

A national review, Our Health, Our Care, Our Say[8], highlighted specific issues and common

[7] Department of Health, *National Service Framework for Diabetes* (2001, link, accessed 28 May 2013).
[8] Department of Health, *Our Health, Our Care, Our Say* (2006, link, archive accessed 29 May 2013).

shortcomings in the delivery of care for people with long-term conditions, including fragmentation between care providers and also between health and social care. Overall, diabetes care is poorly structured in London with organisational boundaries significantly affecting diabetes care provision and access to services for patients – whether provider or commissioner organisational boundaries. This particularly disadvantages those with more complex needs and/or lower health literacy.

From April 2013, local authorities in England have lead responsibility for public health and are allocated ring-fenced budgets by Public Health England to commission and provide a range of services. This includes the commissioning and provision of risk assessments for those aged 40–74 who are eligible for the NHS Health Check programme. This national vascular risk assessment and management programme is an integrated approach to identifying and preventing four diseases: diabetes, cardiovascular disease, stroke and kidney disease. They will also commission and provide lifestyle interventions, as appropriate, to manage that risk.

Services should aim to tackle and prevent lifestyle issues via community nutrition initiatives and encouragement for people to become more physically active (thus addressing the key risk factors for diabetes).

Workplace-based initiatives working in partnership with large employers with diabetes risk assessments could be considered, as could screening at healthcare settings such as emergency departments.

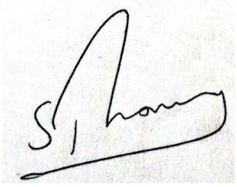
High quality diabetes prevention and risk assessment services should actively seek out those at risk of diabetes, assessing recorded versus predicted prevalence from primary care diabetes registers and NHS Health Check.

In addition, diabetes risk assessments should be offered to people at high risk of diabetes (e.g. aged 25–39 in high-risk black and minority ethnic groups, such as south Asian, Chinese, African-Caribbean, black African).

Strategic Clinical Networks have been established in the focus areas of cardiovascular, renal and diabetes. Networks have been praised as an NHS success story; firmly based in partnership working, best practice sharing, and clinical pathway development over large territories and localities. The new London Diabetes Strategic Clinical Network has appointed its clinical director, and a Strategic Clinical Leadership Group will soon be developed, the role of which is to provide collective leadership, strategic direction and specialist clinical advice to providers and commissioners in relation to diabetes in London.

I hope that you find this information useful and thank you for offering me the opportunity to take part in the diabetic review. Please do not hesitate to contact me should you require further information.

Yours sincerely,



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Consultant in Diabetes and Endocrinology
London Diabetes Clinical Director

Dr Andy Mitchell

Medical Director
NHS England (London Region)

cc: Lucy Grothier, Associate Director, London Strategic Clinical Networks, NHS England (London Region)

Why is London experiencing such high growth in type 2 diabetes and what impact is this growth having on health spend?

Prevalence of diabetes

Diabetes is a complex group of diseases with a variety of causes. People with diabetes have high blood glucose, also called high blood sugar or hyperglycemia. There are two main types of diabetes are type 1 diabetes and type 2 diabetes. A third type, gestational diabetes, develops only during pregnancy. Other types of diabetes are caused by defects in specific genes, diseases of the pancreas, certain drugs or chemicals, infections, and other conditions. Some people show signs of both type 1 and type 2 diabetes.

There is undoubtedly a genetic component to diabetes - First degree relatives have a higher risk of developing T1D than unrelated individuals from the general population (approximately 6% vs. <1%, respectively) (Dorman and Bunker, 2000). Equally, Family studies have revealed that first degree relatives of individuals with T2D are about 3 times more likely to develop the disease than individuals without a positive family history of the disease (Flores et al., 2003; Hansen 2003; Gloyn 2003). In 2010 it was estimated that there were 3,099,853 people aged 16 and older with diabetes in England (7.4%). This prevalence is expected to rise to 8.5% by 2020 and 9.5% by 2030 (4,603,363 people). Approximately half of this increase in estimated diabetes prevalence is due to the changing age and ethnic group structure of the population and half due to increasing obesity (Diabetes Health Intelligence, 2010).

In London (2013) prevalence of diabetes is estimated at 7.9% e.g. 491, 741 people. This is expected to rise to 8.1% by 2015 (512,962), 8.7% (568,789) by 2020, 9.3% (630,551) by 2025 and 10.1% (703, 385) by 2030 (YHPHO, 2013). Increasing prevalence of diabetes in London echoes rises in global prevalence; in 2004 the World Health Organisation estimated that this would rise from 2.8% in 2000 to 4.4% in 2030 (Wild, 2004).

Reasons for the rise in prevalence of Type 2 diabetes

Rises in prevalence of T2 diabetes are attributed to changes in age structure and unhealthy lifestyles. Certainly prevalence of T2 diabetes increases with age; in 2006 prevalence was estimated to range from under 1% in those aged 16-24 to over 10% in those aged 75+ (Diabetes UK, 2010). However, natural experiments indicate that even in those who might be susceptible to diabetes this may not necessarily arise. Amongst Yemenite Jews diabetes was almost unheard of until they were air-lifted

into Israel (and Western lifestyles in the 1940s and 1950 whereupon prevalence rose to over 10% Similar histories have been documented for the Pima Indians, Nauru Islanders, Aboriginal Australians and Wanigela people in Papa New Guinea. Similar differences have been found within countries with large socio-economic inequalities e.g. India and China (Diamond, 2012).

No-one is advocating returning to a pre-industrial lifestyle but evidence is that the Western lifestyle e.g. low levels of physical activity, coupled with excessive food consumption of (often) high density food consumption has led to an increasing prevalence of diabetes.

Impact on spend

The cost of diabetes varies enormously but is self-evidently expensive. PCT budgeting indicated that diabetes spend varied from £1.39 to 5.79 million per 100,000 population. Others have calculated that each diabetes case costs between £3,233-£3,717 (Kanavos, 2012). Clearly therefore any increase in prevalence will impact upon health and social care expenditure.

How might further growth in Type 2 Diabetes be curbed?

There are two principle means of reducing prevalence of Type 2 diabetes – increasing physical activity and / or reducing excessive calorific consumption. However, achieving this behaviour change will require sustained commitment.

Physical activity

Robust trend data on physical activity is limited. Difficulties include that measures are often self-reported, that different indicators are used and that surveys are often for either leisure or travel activity rather than of total activity undertaken by the individual. Hence whilst 39% of men and 29% of women self-reported meeting recommended levels of physical activity in the Health Survey for England 2008 objective measures using accelerometers indicated that the actual percentages meeting these guidelines were 6% and 4% respectively (NHS Information Centre, 2009). Equally, the Active People Survey which began in 2005/6 collects self-reported data on achieving three sessions of 30 minutes activity per week of moderate sport or physical activity (Sports England, 2013) rather than the recommended five sessions of 30 minutes a week (Department of Health, 2004, p.21) and does not include active transport. 'Sports' also include snooker, archery and fishing (Sports England, 2010b) which may undermine its usefulness in indicating physical activity. They also do not take into account new physical activity guidelines published by the Chief Medical Officers of the Home Countries (Dept. of Health, 2011).

The above methodological difficulties above make it extremely difficult to make robust conclusions about trends in physical activity in the population. Other data though may be more indicative: the percentage of homes owning a television has risen from approximately a third in 1956 to almost 100% today and the average person aged 4+ watches up to nearly five hours a day. Whilst this is not greatly different from 1992 it does not include the internet, computer games etc (British Audience Research Board, 2010).

The above data may indicate that increasing physical activity may require another focus other than sports and recreation e.g. that physical activity needs to be a means of doing something else rather than an end in itself. Active transport may be a potential solution; evidence from Northern Europe (e.g. Holland, Denmark, Germany) indicates that population levels of physical activity can be achieved but that an infrastructure for this must be put in place for it to happen (Pucher and Buehler, 2008)

Active transport may have greater explanatory power; Roberts and Edwards (2010) point out that the per capita number of miles walked or cycled has fallen from 306 in 1975 when data collection began to 242 in 2009 and that a substantial decline in active transport may have already taken place. They further report a positive correlation between male BMI and per capita gasoline consumption across 130 countries. Whilst this data is correlation rather than causation and may be subject to the 'ecological fallacy' it does indicate where a fall in physical activity prevalence may have occurred and indeed, may be gained.

Food Consumption

It is paradoxical that despite general societal preoccupation with weight and some 30,000 weight control methods on public record (Health Education Authority,1995) that obesity is so prevalent. However, estimating the impact of gluttony is complex; per capita calorie consumption on food consumed outside the home was not collected until 2001 and calorific figures still exclude alcohol.

There is evidence to link diabetes to high sugar diets; The Nurses' Health Study found that nurses who said they had one or more servings a day of a sugar-sweetened soft drink or fruit punch were nearly twice as likely to have developed type 2 diabetes during the study than those who rarely had these beverages (Schulze et.al.;2004). A recent study by Imperial College, London found strong links between sugary drink consumption and an increase in a person's risk of developing type 2 diabetes (Interact Consortium, 2013)

The National Food survey indicates that calorie consumption peaked in the 1970's before falling by approximately 9% by 2004 (Swanton, 2008). Between 2001/2 and 2008 total calorie intake fell by 5% whist calorie consumption outside the home fell by 20%. Whilst energy inherent to food does not necessarily equate to the energy that the human digestive system can obtain from it (Wrangham,2009) there has also been a fall in fat consumption; from 111.4g per person per day in 1974 to in 94g in 2008 (Department for Environment, Food and Rural Affairs,2010). Average spend on alcohol similarly fell between 2001 and 2008 (the only years available) and therefore does not seem to be able to explain the obesity epidemic, particularly for children.

The above indicates that diets and education have been largely ineffective. This in turn may mean that more environmental determinants of calorie consumption may be required to reduce diabetes prevalence e.g. restriction of fast food restaurants and possible taxation of higher-density foods.

References

British Audience Research Board (2010) Average Weekly Viewing. Webpage Graph. Available at: http://www.barb.co.uk/graph/weeklyViewing?data_series[]=2007&data_series[]=2006&data_series[]=2005&submit=View+Graph [Accessed 30th November, 2010].

Dept of Health (2011) Start Active, Stay Active. A report on physical activity for health from the four home countries' Chief Medical Oficers.

Diabetes Health Intelligence (2010) APHO Diabetes Prevalence Model: Key Findings for England. June.

Diabetes UK (2010) Diabetes in the UK 2010: Key statistics on diabetes. March 2010.

Diamond, J. (2012) The World Until Yesterday. What Can We Learn from Traditional Societies. Allen Lane, an imprint of Penguin Books.

Dorman and Bunker (2000) HLA-DQ Locus of the Human Leukocyte Antigen Complex and Type 1 Diabetes Mellitus: A HuGE Review*. Epidemiologic Reviews. Vol. 22, No. 2. Pp.218-227.

Flores, J.C., Hirschhorn, J., Altshuler, D. The inherited basis of diabetes mellitus: implications for the genetic analysis of complex traits. Annu Rev Genomics Hum Genet, 2003. 4: 257-291.

Interact Consortium (2013). Consumption of sweet beverages and type 2 diabetes incidence in European adults: results from EPIC-InterAct. Diabetologia, DOI 10.1007/s00125-013-2899-8.

Kanavos et.al (2012)Diabetes expenditure, burden of disease and management in 5 EU countries. . LSE Health, London School of Economics. 2012.

NHS Information Centre (2009) 'Health Survey for England 2008. Physical Activity and Fitness.' Edited by Craig, R., Mindell, J. and Hirani, V. The Health and Social Care Information Centre.

Pucher and Buehler (2008) Making Cycling Irresistible: Lessons from The Netherlands, Denmark and Germany. Transport Reviews, 28:4, 495-528.

Roberts, I. and Edwards, P. (2010) The Energy Glut. The Politics of Fatness in an Overheating World'. Zed Books, London.

Schulze MB, Manson JE, Ludwig DS, Colditz GA, Stampfer MJ, Willett WC, Hu FB. Sugar-sweetened beverages, weight gain, andincidence of type 2 diabetes in young and middle-aged women. Journal of the American Medical Association. 2004;292:927-934.

Sports England (2010) Webpage. Available at: http://www.sportengland.org/research/active_people_survey.aspx [Accessed 3rd May 2013].

Sports England (2010b) 'Once a week participation rates by sport '. Excel sheet. Available at: http://www.sportengland.org/research/active_people_survey/active_people_survey_4/aps4_quarter_3.aspx [Accessed 6th November 2010].

Wild et.al (2004) Global Prevalence of Diabetes. Estimates for the year 2000 and projections for 2030. DIABETES CARE, VOLUME 27, NUMBER 5, MAY 2004. http://www.who.int/diabetes/facts/en/diabcare0504.pdf site accessed 3rd May 2013.

YHPHO (2013) http://www.yhpho.org.uk/resource/view.aspx?RID=81090 site accessed 3rd May, 2013.

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30 May 2013

Dear Dr Onkar

Proposed London Assembly Review of Diabetes Care in London

Thank you for your letter dated 13 May 2013 requesting views in preparation of the London review on Diabetes care. Please find below my response based on our experience and epidemiology of diabetes in Greenwich.

Why is London experiencing such a high growth in Type 2 Diabetes and what impact is this growth having on health spend?

The response is threefold in that: increasing obesity linked to diets high in saturated fat and sugar and low levels of physical activity are the key drivers for increasing diabetes, some impact from an increase in the diagnosis of disease amongst healthcare professionals, plus an increasing population.

Diabetes in Greenwich is predicted to rise from 11,695 cases in 2010 to 15,779 in 2020 (an increase of 35%) based on estimates of changes to the population in terms of age, sex and deprivation. Trends in diabetes (directly attributable) in females appear to be decreasing slightly from the previous year, however female deaths where diabetes was a contributing factor although the death not directly attributable to diabetes appear to be rising rapidly from 2006 to 2010.

For some interventions (such as blood glucose control in people with diabetes) most people with the condition are being identified by health services, but of them only a small proportion are being successfully treated. In these situations more needs to be done to provide effective treatment to existing patients with the condition.

Greenwich saw between 6% – 9% rise in expenditure on diabetic care between 2009/10 and 2010/11.

How might further growth in Type 2 Diabetes be curbed?

Lifestyle interventions to improve diet, reduce obesity levels and improve physical activity are key to reducing the rising tide of diabetes. Finding people at high risk of disease e.g. through the NHS Health Checks programme, and supporting those people to manage their risks effectively is critical. People who are pre-diabetic need fast access to appropriate support in this regard (we have a Walking Away from Diabetes programme in Greenwich tailored to this group identified through the Health Check programme).

Up-skilling primary care clinicians in the early diagnosis, treatment and management of diabetes along with patient education on how to avoid or to increase their chance of a better health outcome needs to become main stream.

Why is diabetes care across London so varied and what can be done to improve patient care and outcomes

Variability in pockets of deprivation, ethnicity and social-economic factors across the borough compared to local health priorities for commissioners could adversely impact on people having access to the right services at the right time. Concentration on treatment give short term benefits in terms of financial management, but preventative health and social care management can give a higher financial saving on spend, but will only be realised in the longer term.

Since the last Joint Strategic Needs Assessment, the NHS Greenwich Public Health department has carried out a detailed piece of work to characterise the preventive health needs of those receiving social care. The project revealed that one third of all cardiovascular disease and diabetes can be prevented in the short-term by early identification and management of risk factors such as high blood pressure, cholesterol and smoking.

Obesity is one of the most significant health challenges currently facing the population of the UK, both in children and in adults. Obesity in childhood can lead to a number of health problems in later life, including, diabetes. The National Child Measurement Programme (NCMP) is a school-based initiative to monitor the prevalence of obesity and overweight in children in Reception and Year 6 ages. This shows that in 2010/11 12.4% of reception age children are obese, with a further 14.9% being overweight. In Year 6, 24.9% of children are obese and 16.3% are overweight. Early intervention in lifestyle management at home and in schools is key to prevention.

In Greenwich, we are working to a more holistic approach to healthcare, looking at patients with co-morbidities and encouraging primary and community care, through our integrated commissioning approach, to treat patients based on their ‘portfolio’ of medical conditions and lifestyle issues, and not just on an individual morbidity.

How will the new NHS and public health arrangements impact on the quality of care provided to patients and how effective strategic overview might be maintained in London.

The new Health and Well-being Board architecture should facilitate a local focus on priorities such as diabetes across the new NHS and Public Health system. If these Boards work well, they should ensure that care is co-ordinated and remains high quality across providers and pathways. In our area (Greenwich) the Public Health department which has moved into the Royal Borough retains a strong role in healthcare public health. The public health team will continue to provide critical support and advise to providers of diabetes care, as well as detailed analysis of diabetes issues for the borough through a dedicated chapter within the Joint Strategic Needs Assessment which is in the process of being updated (May 2013). London wide, Public Health England could fulfil a strategic role in reviewing quality of diabetes care and outcomes for London's populations, and in supporting local Public Health teams in their role as advisors to commissioners and providers of care on evidenced based best practice.

I hope the information above is helpful.

Yours sincerely

Dr Hany Wabha
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30 May 2013
Our ref : AS/la

Dear Dr Sahota

Re: Proposed London Assembly review of diabetes care in London

Thank you for your letter of the 13 May, below are the responses to the key questions you asked:

1. The growth in type 2 diabetes can be attributable to an ageing population, rise in numbers of overweight and obese people, and related lifestyle factors e.g. unhealthy diet, lack of exercise. Perhaps also a change in demographic population i.e. certain ethnicities are at higher risk of developing type 2 diabetes. Screening programmes i.e. NHS Health Checks and other case finding work are also helping to identify previously undiagnosed patients. An increase in type 2 diabetes would cause an increase in spend due to an increase in outpatient and inpatient appointments, emergency admissions due to complications and related co-morbidities, and prescription costs.

2. Further growth of type 2 diabetes could be curbed through prevention and self-care services to support lifestyle changes in order to reduce the rise in obesity and improve education and awareness. Additionally, screening through the NHS Health Checks programme, primary care (based on symptoms or glucose/urine/blood tests), and community pharmacies (screening, health promotion campaigns), will help to identify high risk people and people with impaired glucose tolerance/impaired fasting glucose who have pre-diabetes benefiting from early prevention. Appropriate referral to lifestyle support services is needed. For example, we have a Walking Away from Diabetes programme for patients with pre-diabetes and other lifestyle support services through LiveWell Richmond e.g. Exercise referral, health walks, weight management, stop smoking, health coaches for the whole local population 16 and over.

3. Diabetes care across London is so varied due to differences in prevalence and demographics. Additionally, local budgets may influence services available and capacity of services. Patient care and outcomes can be improved through local diabetes pathway reviews for improvement on current services and implementing evidence based care and models of best practice locally. We have recently completed a diabetes care pathway review and have identified a variety of recommendations for local implementation e.g. case finding, referral to lifestyle services, reviewing GP LES, embedding NICE quality standards in provider contracts, reviewing provision and referral criteria for dietetic

services, offering non face-to-face communication for ongoing management, developing integrated community based diabetes services, and developing pathways to address multiple morbidity of diabetes.

4. We have recently undertaken a review of our local diabetes care pathway in collaboration between Public Health, Commissioning, GPs, service providers, etc. in order to identify areas for improvement around quality of care and outcomes.

Yours sincerely

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3 June 2013

Your ref: HEC/CM

Dear Mr Qureshi

RE: Proposed London Assembly review of diabetes care in London

Thank you for your recent correspondence, sent to Dr Anwar Ali Khan, Interim Chair for NHS Waltham Forest CCG concerning the proposed review of diabetes care within London by the Health and Environment Committee.

NHS Waltham Forest CCG welcomes this proposal for scrutiny as diabetes is a key local priority. We recognise that, in order to improve management of diabetes partnership working key in London.

We have responded to the questions raised in the briefing. Each response explains our strategies and plans, and key interventions required to address the London-wide exponential growth in Type 2 diabetes.

The key factors for Waltham Forest are:

- Rapidly-changing demographics, including an ageing population and higher growth within black and minority ethnic groups in the over 50 age range – compared to the general population;
- Higher levels of diabetes relating to social determinants of health – such as deprivation;
- Higher levels of diabetes relating to risk factors – such as obesity, physical inactivity and unhealthy eating;
- Poor health literacy and the impact of this on patient health outcomes;
- Inadequate investment in culturally-acceptable diabetes prevention, physical activity and weight management programmes, particularly those aimed at high-risk and hard to reach groups;
- Wide variation across London and general practice in prevention and primary care management.

We trust that you find the information attached useful, please do get in touch if you have any further questions.

Yours sincerely

Dr Syed Masoor Ali
Clinical Director for Diabetes

Diabetes Briefing – 3 June 2013

Prepared for the Health and Environment Committee by NHS Waltham Forest Clinical Commissioning Group and the London Borough of Waltham Forest

Background

Diabetes is a group of disorders with a number of common features characterised by raised blood glucose. In England type 2 diabetes is the most common form. The modelled prevalence of diabetes for England, London and for Waltham Forest in 2010 is 7.4%, 7.5% and 8% (13,681 patients) respectively. Between 2006 and 2011 the number of people diagnosed with diabetes in England has increased by 25 per cent, from 1.9 million to 2.5 million. Nationally, NHS spending on diabetes is 10% of the NHS budget with 80% related to managing avoidable complications. People with diabetes account for around 19% of hospital inpatients at any one time, and have a three day longer stay on average than people without diabetes.

Q1a: Why are people in London at such risk of Type 2 diabetes?

Current ethnicity mix, higher level of deprivation, above average prevalence of lifestyle risk factors, genetic predisposition together with low investment in evidence based culturally appropriate preventive strategies all contribute to higher than average risk of developing diabetes in Waltham Forest. Projected faster rate of growth among the over-50's coupled with a higher rate of growth among Black and Minority Ethnic (BME) group in this age cohort in comparison to their White counterparts are likely to contribute to the predicted increase in diabetes[1]. The percentage of residents from all BME origin categories for 2011 is 48.8%. This has risen from 35.7% in 2001, which is an increase by 13.1%.

Being obese or overweight, a large waist circumference, low physical activity levels are key risk factors for type 2 diabetes. Furthermore, people of South Asian, African-Caribbean, black African and Chinese origin are also at particular risk. For example, proactive screening of hard to reach high risk groups aged 35-74 in Greenwich found that 29% in Asians, 22% in Blacks and 17% in Caucasians were at high risk of diabetes.

Evidence indicates that people from lower socioeconomic groups and those from black and minority ethnic communities may face economic, social and cultural barriers which prevent them from being physically active and managing their weight. Barriers include, for example, lack of funds for a healthy diet or a lack of awareness and opportunity to being physically active or taking part in weight management programmes targeting people at high risk of diabetes and those with pre-diabetes that are culturally acceptable.

Case finding to identify individuals with Type 2 Diabetes is performed at GP Practices either opportunistically for high risk groups, through the NHS Health Check Programme, or as part of registering new patients to the practice. This pathway needs to be further developed to appropriately signpost those at high risk of diabetes or with pre-diabetes to appropriate lifestyle services.

Q1b. What impact does this have for health spend?

By end March 2010, there were 12,233 people aged 17 and over with diabetes in Waltham Forest with a prevalence of 5.9%, which is higher than the prevalence recorded nationally and in London[2] but lower than the estimated prevalence of 8.1%. There are an estimated 742 adults with undiagnosed diabetes. Undiagnosed patients do not receive appropriate high quality care predisposing them to develop diabetes. Diabetes related emergency admission rates in Waltham Forest are higher than in London and nationally.

Diabetes related complications not only result in high health and social care cost but also lead to premature death or disability and also loss of productivity to our economy. Concern has been raised about the wide variation in the quality of diabetes prevention and management in London, leading to

[1] GLA Round Ethnic Group Projections (Revised), August 2010.

[2] QMAS database data as at year ends. Copyright © 2007; 2008; 2009; 2010 The Health and Social Care Information Centre, Prescribing Support Unit.

inequalities, and this would be a welcome focus for the scrutiny. Above average exception reporting under QOF by some GP practices further widens this variation and inequalities in access to prevention and treatment.

The current programme budgeting total spend per person on the diabetes QOF register in Waltham Forest is £535.42. This equates to a total spend in 2009/10 of £7.1 million. This ranks as the 47th lowest programme budgeting total spend per person on the diabetes QOF register nationally but is currently outside the lowest 25% nationally.

Q2. How might further growth in diabetes be curbed?

NICE Public Health Guidance PH35 (2011) provides the evidence based approach to prevent Type 2 Diabetes through population and community interventions. Putting this evidence into practice requires adequate investment in prevention approaches in partnership with local authorities, health, social care, voluntary sector and the private sector, working together to reduce the risk.

This may involve:

- Identification of local unmet needs and service gaps reflecting socio cultural and demographic mix of the local population;
- Updating local diabetes strategies to reflect above NICE guidance and NICE Quality standards and London Model for diabetes;
- Service redesign in order to improve clinical and cost effectiveness, productivity and equity in local diabetes service provision;
- Active engagement of people at high risk of diabetes and those with established disease together with systematic consultation of clinical and service providers need to inform future service provision.

The following specific approaches are likely to reduce the growth in diabetes:

a) Establishing diabetes risk register to monitor those who may be at risk of developing diabetes in the future will enable appropriate follow up of those identified at risk;

b) Target high-risk groups for prevention and early detection;

c) Proactively support adults who are at high risk and provide them with a high quality, evidence-based, intensive lifestyle-change programme to educate and up skill self-management skills. The NHS Health Check programme (NHSHCP) is an ideal opportunity to make this happen. It may be appropriate to undertake NHSHCP for people from 35 years of age for high risk communities e.g. South Asians (develop diabetes at an earlier age), those with a strong family history of diabetes, and women with a history of gestational diabetes.

d) Social marketing and behaviour change communication to improve health literacy address lifestyle risk factors and identify people at high risk. Use strategic social marketing approaches to ensure healthier lifestyle messages are consistent, clear and culturally appropriate and are integrated within other health promotion initiatives or interventions. Emphasis need to be on:
    i. Increased levels of awareness of the signs and symptoms of diabetes and its consequences.
    ii. Achieving and maintaining a healthy weight
    iii. Physical activity
    iv. Cultural appropriateness

e) Strengthen integrated working across diabetes, obesity and NHS Health Checks pathways to ensure a coherent, integrated approach to reduce diabetes and related inequalities.

f) All people with diabetes to receive the NICE aligned essential care standards to reduce complications, costs and premature death.

g) Further analysis of patients who are exception reported is needed in order to identify this cohort of patients to plan appropriate interventions and to reduce variation across practices.

Q3. Why is diabetes care across London so varied and what can be done to improve patient care and outcomes?

London requires a strategic and whole-system approach to improve patient care and outcomes. Currently there is wide variation in the commissioning of culturally sensitive diabetes programmes. Equally, the variable level of exception reporting in QOF can give a false picture of the quality of care provided in primary care.

There has also been variation in the implementation of the Year-of- Care model across London. Active participation in the Year-of- Care approach has the potential to drive up essential standards leading to greater concordance with NICE guidelines. However, it is important to recognise that practices with smaller list sizes find it challenging to offer the full suite of diabetes specialist care as a result of insufficient in-house diabetes expertise, and the national 40% shortage in the district nurse workforce.

Waltham Forest is responding to this challenge in primary and community care in part by looking to develop clinical networks- groups of general practices that work in an integrated way to provide care packages for patients across multiple care settings. This promises to increase the ability of GPs to respond to the rising prevalence of diabetes and provide optimal patient care. The network model of care should also enable the CCG to take action to tackle locality-specific demographic issues, even at ward level, by ensuring that the allocation of available resources reflects local geographic priorities.

Commissioners and providers can gain from scale economies, for example they can share specialist staff that before were too costly for one practice to absorb, and in doing so can optimise patient care and deliver a premium patient experience. A culture of multi-disciplinary working and sharing information systems enables clinical networks to reduce variation across practices and to work together to manage resources effectively and efficiently.

Q4. How will the new NHS and public health arrangements impact on the quality of care provided to patients and how might effective strategic overview be maintained in London?

An effective strategic overview could be maintained in London by building a strong strategic relationship between the CCG, Health and Wellbeing Board, NHS England and Local Authority to optimise the quality of diabetes care.

The Scrutiny Commission may want to look at:

- NHS England (London Regional Office) has a statutory function to regulate primary care, underpinned by the Department of Health's combined strategies. These are: the Operating Plan (deliverables), National Outcome Framework (quality premium) and Financial Regulatory Frameworks (achieving financial balance). NHS England and CQC each have a mandate to take action to raise standards in healthcare provision. Active enforcement of their statutory responsibilities should lead to significant improvements in the quality of care.

- Overall it is partnership working that will assist in developing a joined-up approach to tackling diabetes across London and will provide critical strategic overview that is needed to drive these improvements forward.

- Ways of incentivising and up-skilling health and social care providers to detect and manage diabetes effectively. Additional initiatives that could be investigated are investment in an incentive scheme to provide care planning for people with diabetes (such as the Year- of- Care programme); and strengthening the diabetes education programme to align with NICE standards of quality.

- Is there a case for systematic screening of the population for diabetes in London, or is case finding adequate?

- How could the contribution of the NHS health checks programme to detecting people at risk of diabetes early be maximised?

- The role of the Joint Strategic Needs Assessment at local level and London wide level in identifying the health needs of the local population and informing the development of credible, deliverable diabetes plans.

London Assembly Response

Dear Ms Musonda,

I am writing on behalf of Dr Mark Sweeney and West London CCG with regards to your recent request for our views on diabetes in London. I am the diabetes project lead for reviewing our community diabetes services and have thus been asked to respond to your questions. I have attempted to address each of these in turn below:

Why is London experiencing such high growth in Type 2 Diabetes and what impact is this growth having on health spend?

London is a mix of social and ethnographic demographics which is unique in the UK. Though diabetes is a condition treated by health professionals the intimate links to public health issues such as obesity, high sugar content in soft drinks, availability of spaces and schemes for exercise etc., mean that the growth of diabetes is often outside the remit of the GP practice/hospital. Indeed these are some of the modifiable factors.

Non-modifiable factors of genetic predisposition are much harder to manage in a highly mobile population that is often harder to reach with social, cultural and language barriers as exists in the capital.

There is a subsequent rise in prevalence which should be accompanied by a higher rate of engagement with health professionals not only for treatment but also for preventative management. This however is not the case and we see complications from diabetes as a consequence. The health spend for problems that have already arisen is always going to dwarf that which could have been spent on prevention through supporting primary care.

The knock on effects to the economy also adds up with this i.e. the diabetic who is unable to go to work, the disabilities from impaired vision, impaired mobility etc.

The cost of living in London with high housing and transport costs increases pressure and may also be working as a disincentive to seek time to go for screening health checks.

How might further growth in type 2 diabetes be curbed?

Public health and social services in general can have an effect with having more robust publicity and engagement schemes. This would be particularly helpful in hard to reach communities where there is an opportunity to harness the resource of diabetic patients. Adopting co-productive methods this may be done in a low cost manner with high levels of patient engagement and improving outcomes.

The work done through public health is also crucial to curbing growth of diabetes. In collaboration with broader organisations such as Transport For London there is an opportunity to use strategies such as bike schemes/cycle lanes to encourage physical activity. The power of larger bodies may be harnessed through initiatives to improve

health and wealth being such as reviewing school dinner provision, incentivising exercise schemes, and incentivising healthy eating options and other such measures.

The use of governmental levers such as taxation should also play a key role in curbing type 2 diabetes. The modifiable risk factors of diet and exercise particularly are ripe for this type of intervention. Taxation on food and drink with high sugar and salt content, regulation on advertising these particularly to children and even addressing the national school curriculum to include more physical activity are just a few examples where this could work.

The establishment of the Health and Wellbeing Boards under the recent health and social care changes provides a forum for joined up work to be done in this regard. West London CCG along with other CCGs have already begun to engage in this manner and strategies are likely to emerge that would help such a multifaceted problem as diabetes.

Why is diabetes care across London so varied and what can be done to improve patient care and outcomes?

London's diabetes care has necessarily been varied to reflect the variation in its social demography. The variation has evolved through an ethos of adapting to local needs and understanding that things that work in a certain context are less effective in other contexts.

Though this may have been the initial aims sadly a lot of the variation exists because we have too often worked in isolation to our partners and not appreciating that there are lessons to be learned from examples of success or otherwise. Local interests other than pure healthcare quality concerns have also played a role.

The pressure of primary care, particularly in areas of social deprivation where prevalence is likely higher, is also a significant reason why there is limited consistency in diabetes care.

In the past diabetes networks have existed and still exist over smaller areas. Learning from each other and recognising ways we can pool resources via these networks is one way to improve outcomes.

Removing the view that we are providing a service for our users, and genuinely inviting diabetic patients in becoming an integral part of the system we have in place will also improve outcomes, they are an untapped resource.

Irrespective of variation, there is remarkable consistency in how primary care engages with diabetes. With a GP perspective this often involves dealing with emergencies and satisfying the Quality Outcomes Framework (QOF) targets. A GP may spend 3 – 5 appointments throughout the year with a given patient equating to about 50 minutes, the remaining 525,550 minutes in the year the patient is left to deal with this multifaceted condition on their own. By building in mechanisms to support this self-care outcomes will inevitably be improved.

Of course, incentivising or creating environments where people are encouraged to take advantage of opportunistic health screening could certainly help with finding the undiagnosed and helping prevent their deterioration. Using the voluntary sector and other healthcare resources such as pharmacists or opticians would also help with this.

How will the new NHS and public health arrangements impact on the quality of care provided to patients and how might strategic overview be maintained in London?

The shifting of public health to be working more closely with local authorities under the new arrangements provides an opportunity to tackle issues with more gusto than traditionally healthcare has been able to do.

The establishment of CCGs also enables third sector organisations, particularly non-profit entities to be commissioned to provide services that make sense locally, whilst working in collaboratives across CCGs will maintain the bigger picture and strategy thinking.

The local power to negotiate and engage in competitive tendering processes may present a risk to having coordinated care across boundaries, however this could be addressed by having agreed pan-London goals. The establishment or re-establishment of a diabetes network across the capital would help to provide an overall strategy for this. These strategies could be made robust by underpinning them to national guidelines and international evidence based best practice.

A strategy to support primary care services for diabetes through education and training as well as capital resources can be implemented on a large scale and would not interfere with the work of individual CCGs, as the remuneration of GP practices now lies with other bodies.

I hope this is useful for your upcoming diabetes review. Please do not hesitate to contact me for any further comments or if anything I have stated needs further clarification.

Kind Regards

Dr Siddartha Dutta
Darzi Fellow
Diabetes Project Lead
West London CCG

RCN submission to the London Assembly Health Committee review of diabetes services in London

With a membership of over 410,000 registered nurses, midwives, health visitors, nursing students and health care assistants, including 53,000 working in London, The Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. The RCN promotes patient and nursing interests on a wide range of issues by working closely with Government and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

Introduction

This submission is based on the personal response and recommendations of nurses working across London. RCN members in our region work with patients with diabetes in a variety of hospital and community settings in the NHS, the independent and voluntary sectors.

From a nursing perspective, there are four important steps that need to be taken to improve care for those living with diabetes:

- It should be a priority to improve and standardise diabetes education for all nurses so that they can feel confident in identifying and treating diabetes
- Commissioners must ensure that there are sufficient diabetes specialist nurses to support patients and other health colleagues in diabetes management
- Those with diabetes need to be supported to acquire the skills and knowledge to self manage their condition
- Given the increased prevalence of diabetes in people from certain ethnic groups, the importance of public education programmes in diverse populations must be addressed.

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1) The impact of diabetes for patients in London

"Diabetes needs differ here from elsewhere in the country, because London is so diverse. Preventative programmes need to be designed specifically with cultural differences in mind." – Shirley Ali, Senior Anaesthetic Nurse, Lewisham Hospital

London's diverse, young and mobile population bring specific challenges in delivering diabetes care. London contains areas with extremely good outcomes, such as Bexley, but typically these areas have more stable populations than inner London.

Social deprivation has a big impact. Health maintenance is often fairly low on the agenda of those who have worries about their housing and income. Parts of London have the highest rates of childhood obesity in the country, with obvious knock on effects.

London's ethnic diversity leads to a higher rate of type 2 diabetes. South Asian or Afro-Caribbean people are 6 times more likely to develop type 2 diabetes than other ethnic groups. The issue is particularly acute for men. Areas with relatively homogenous populations have had some success in combating diabetes, but commissioners elsewhere in London can struggle to design services for patients speaking over 100 different languages.

Nurses at the front line of diabetes care are clear that education is key to combating the rise of type 2 diabetes in diverse populations. Lessons can be learned from successful projects such as that carried out by Diabetes UK and NHS Haringey in training Diabetes Community Champions from the Black, South Asian and Turkish communities in north London.

Commissioners must recognise the importance of public education programmes in combating the rise of diabetes. These programmes cannot be seen as an easy target when seeking to balance budgets.

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2) The role nurses play in diabetes management

"It's not just about specialist nurses – it's about how to make sure that the whole nursing workforce has a level of competence and confidence to manage diabetes" – Siobhan Pender, Diabetes Specialist Nurse, Guys and St Thomas'

Nursing staff have an important role and clear responsibilities when treating patients with diabetes or who are having tests to diagnose diabetes. Nurses are responsible for promoting self care; for meeting clients' individual nutritional needs; for enabling safe use of glucose monitoring treatments and the administration of medication and insulin; and in a hospital setting for managing a patient's diabetes when it is not the main reason for admission.

Nurses are at the frontline of prevention, looking for the signs and symptoms of diabetes to enable early diagnosis and treatment. Practice nurses often undertake the annual Diabetes Checks for patients on their GP Practice register and support people in the management and monitoring of their diabetes. Diabetes should be recognised as an essential part of nursing.

District nurses have a huge impact on the management of diabetes and play a particularly important role for the elderly or the homebound in supporting their care. In a snapshot taken by Lambeth and Southwark Community Care, 50% of district nurses' workloads involved giving insulin.

To improve services it is essential that the role of the district nurse in diabetes management is recognised and that sufficient numbers of district nurses are trained to deliver services to the housebound.

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3) How nursing education affects care for diabetes patients

"Many people with diabetes currently experience poor levels of care following admission to hospital. Diabetes care should be delivered by appropriately trained professionals." – National Audit Office Report, May 2012

The NAO report into diabetes care in May 2012 estimated NHS savings of £34m a year by reducing hospital admissions for diabetes patients by 10%; savings of £34m by reducing late referrals to foot specialists; and savings of £99m a year by ensuring safe discharge from hospital for diabetes patients. A nursing workforce systematically trained in the diagnosis and management of diabetes will play a leading role in achieving each of these targets.

Although there is a comprehensive diabetes post registration module for registered nurses who are interested in specialising in diabetes care, some nurses get significantly more training in diabetes at undergraduate level than others – this in turn affects the level of competence and confidence which they carry into diabetes management during their careers. There is a case for allocating more time for students to cover areas such as the NICE guidelines relating to diabetes, the role of education in diabetes, and self management.

Post registration education remains an important part of nursing, and several nurses told us they would support mandatory training for diabetes management, with corresponding targets for trusts to hit training standards. Training in communication skills is seen as extremely important. There was support for training all nurses in motivational interviewing, techniques such as Health Coaching in order to better offer information and support to effectively encourage behavioural change.

It should be a priority to improve and standardise diabetes education for all nurses so that they can feel confident in identifying and treating diabetes

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4) The value of diabetes specialist nurses

"Every diabetes patient should have access to a diabetes specialist nurse. Availability of these nurses and access to them varies from one locality to another – in other words it's a bit of a postcode lottery." – Trevor Neal, RCN member in North East London

Nurses working across London have made clear to us the value of diabetes specialist nurses (DSNs), both as a benefit to patients and in support of other staff. In surveys by Diabetes UK patients consistently report improvements in their management condition after seeing a DSN. There are also knock on benefits for other services. We were told of one trust which had identified a reduction in bed days for diabetes patients on wards with access to a DSN.

Despite this, we have been told of redundancies and down bandings for DSNs across the capital, suggesting that the work done by these nurses is not valued at the highest level or taken seriously by some in senior management. The role of DSNs will need to be carefully considered in the move to greater integration in health services, particularly with an increased focus on care in the home. The current funding set up leads to a feeling of disjointedness. Specialist nurses have told us that their roles can feel particularly vulnerable.

The lack of a register for diabetes nurses makes identification difficult and makes it impossible to track numbers or compare standards. A more systematic approach to identification and registration of DSNs would be of clear benefit to workforce planning.

Given the important role played by diabetes specialist nurses in tackling diabetes, commissioners must ensure that there are sufficient specialist nurses to support people living with diabetes and health colleagues in diabetes management

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5) Lifestyle choices and the growth of type 2 diabetes

Nurses play a central role in encouraging patients to make changes to their lifestyle that are personalised to their age, sex, ethnicity and other existing health concerns. Lifestyle choices which help an individual manage diabetes include healthy eating, keeping active, weight management, smoking cessation and lowered alcohol consumption.

Diabetes does not have to be a burden. People can live normal, active and healthy lives and very small adjustments to their lifestyle can make significant improvements. Motivation is central to effective treatment and individuals need help to understand the impact that lifestyle choices can make to their condition. The most important way to combat the growth of type 2 diabetes is to educate people about the causes and growing incidence of diabetes.

School nurses and local authorities will play a key part in ensuring that lifestyle education starts early enough to make a real difference in reducing the development of type 2 diabetes in our young people.

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6) Improving self care management

"Ultimately diabetes management is about self management. The role for nurses is to help patients recognise when they should do things on their own and when they should seek help." – Cathy Jenkins, Whittington Health Strategic Lead for Diabetes Specialist Nursing Services

Type 2 diabetes is effectively controlled when a person is involved in the management of their own programme of treatment. Effective self management is essential for individuals to successfully achieve healthy targets for HbA1c, blood pressure and cholesterol levels.

Nurses have been at the forefront of innovation to encourage patients to participate in and persist with programmes of self management. The Whittington Health Co-Creating Health programme, the Year of Care project in Tower Hamlets, and the Diabetes Modernisation Initiative funded by Guys and St Thomas's charity have all had a positive impact by seeking to engage clients with their condition in order to improve self management.

We recommend the Committee look at the lessons that could be transferred from successful schemes such as these. It is important that people living with diabetes are supported to acquire the skills and knowledge to self manage their condition

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The role of nurses in effective prevention and management of diabetes should not be underestimated. From ante-natal care, to school, work and home, to care home, high street and hospital, everyone will know of someone who is living with diabetes.

Individually and as part of the wider multi professional team there need to be sufficient numbers of suitably trained nurses to effectively support people to prevent and manage their diabetes, and an emphasis on all nurses having a good understanding of diabetes and its management.

Above all education, for patients, for the public and for nurses themselves, should be seen as a priority for reducing incidences of diabetes and for ensuring the highest quality care is available to those living with the condition.

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24 June 2013

For further information please contact: Ewan Russell, London Region Communications Officer, Royal College of Nursing, ewan.russell@rcn.org.uk, 020 7841 3337

Tower Hamlets Shadow Health and Wellbeing Board

Response to questions for proposed London Assembly review of diabetes care in London

Why is London experiencing such a high growth in Type 2 diabetes and impact is this having on health spend?

This is explained straightforwardly by the rise in obesity that is occurring globally as a consequence of increased consumption of calorie rich foods and increasingly sedentary lifestyles. We expect the numbers of people with diabetes in Tower Hamlets to increase from 13,000 currently to 23,000 by 2030. We know that diabetes accounts for around 10% of healthcare costs. For Tower Hamlets this equates to around £50million and this figure is likely to continue to increase year on year.

How might further growth in Type 2 diabetes by curbed?

As set out above, the driver for the increase in type 2 diabetes is obesity. The evidence indicates that this relates particularly to diet and the food environment. There are therefore important interventions at national level around regulation of the food industry in terms of calorific content, food labelling and advertising that would likely to have substantial impacts at a population level on the rising trend in obesity.

There is also a need to make the public more aware of the direct link between obesity and diabetes. It is not evident that the public are fully aware that diabetes is preventable and that they are fully aware of the devastating impact diabetes can have on lives.

Over the past years, risk assessment tools have been introduced to help people assess their risk of diabetes over the next ten years (eg QDRisk calculator). We have been piloting QDRisk locally in Tower Hamlets and it is potentially a powerful tool in motivating people to make the changes needed in both diet and physical activity to reduce their risk of diabetes. It would be helpful to promote this tool at London level eg through the QDRisk calculator website.

Why is diabetes care across London so varied and what can be done to improve patient care and outcomes?

For people living with diabetes, important factors are that their diabetes is diagnosed early, that they get access to high quality person centred care through their GP and that more complex cases are referred to more specialist care through an integrated pathway. The reason for variable care and outcomes (over and above population variation) is that the quality of provision of these elements of care varies. In particular, there are variable models of primary and community and variable levels of integration across pathways. The care package approach in Tower Hamlets for primary care introduced in 2009 aimed for a systematic and standardised approach based around the needs of the patients. There is evidence from recent data that this has resulted in above trend improvements in outcomes in primary care (eg blood pressure and cholesterol) and has reduced hospital admission rates for diabetes related conditions.

How will the new NHS and public health arrangements impact on the quality of care provided to patients and how might effective strategic overview be maintained in London?

In order to sustain and improve quality of diabetes care, it will be critical that there is a whole system approach in which NHS England, PHE England, CCGs and the council (including public health but also social care and wider council services) work together. Local Health and Wellbeing Board will have a key role in ensuring that this happens.

The improvements that were made in Tower Hamlets around primary care management of diabetes were driven by clear local vision and engagement with primary care clinicians and managers. As the new commissioner of primary care, it will be important that NHS England continues to drive the vision of high quality and innovative service based on local understanding of need.

An integrated model of care will also require the CCG , as commissioners of acute and community care, to work in partnership with NHS England to ensure that integrated pathways are developed that are built around the needs of patients at all points along the pathway (primary, community, hospital). This in turn, will require alignment with council funded social care services.

Public health in the council plays a key role in the provision of needs assessment, evidence review and evaluation to underpin the continued development of diabetes care pathways to reflect and respond to local need. It is therefore critical that it maintains strong relationships with NHS commissioners.

Public health will also have an important role in bringing together partners across the council, NHS, community organisations, academia, schools and business to play their part in diabetes prevention, increasing diabetes awareness in the community and supporting people living with diabetes.

Healthwatch will also provide a vital role in providing the insights needed to ensure that commissioning is built around how people perceive local services.

Strategic overview at London level would usefully provide a critical analysis of how well the system for diabetes care is delivering through monitoring of a set of common outcome indicators, assessment of how well the elements of the new health economy are working together and support in ensuring that local systems deliver for their residents.

Contact for queries on above:
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0207 364 7014

Councillor Ahsan Khan
Cabinet Member for Health and Wellbeing

Waltham Forest

Waltham Forest Town Hall, Forest Road, Walthamstow, London E17 4JF

Ask for: Cllr Ahsan Khan
Our Ref: AH/
Email: Cllr.ahsan.khan@walthamforest.gov.uk
Direct line: 020 8496 4441
Date: 30th May 2013

Murad Qureshi
Chair, Health and Environment Committee

Dear Murad Qureshi

Thank you for your letter of 8th April 2013 seeking our views on the proposed London Assembly review of diabetes care in London. Improving the detection and management of diabetes is a key priority in Waltham Forest and we would welcome progress in this area.

Background

Diabetes is a group of disorders with a number of common features characterised by raised blood glucose. In England type 2 diabetes is the most common form. The modelled prevalence of diabetes for England, London and for Waltham Forest in 2010 is 7.4%, 7.5% and 8% (13,681 patients) respectively. Between 2006 and 2011 the number of people diagnosed with diabetes in England has increased by 25 per cent, from 1.9 million to 2.5 million. Nationally, NHS spending on diabetes is 10% of the NHS budget with 80% related to managing avoidable complications. People with diabetes account for around 19% of hospital inpatients at any one time, and have a three day longer stay on average than people without diabetes.

Q1: Why are people in London at such risk of Type 2 diabetes?

Current ethnicity mix, higher level of deprivation, above average prevalence of lifestyle risk factors, genetic predisposition together with low investment in evidence based culturally appropriate preventive strategies all contribute to higher than average risk of developing diabetes in Waltham Forest. Projected faster rate of growth among the over-50's coupled with a higher rate of growth among Black and Minority Ethnic (BME) group in this age cohort in comparison to their White counterparts are likely to contribute to the predicted increase in diabetes[1].

[1] GLA Round Ethnic Group Projections (Revised), August 2010.

Being obese or overweight, a large waist circumference, low physical activity levels are key risk factors for type 2 diabetes. Further, people of South Asian, African-Caribbean, black African and Chinese origin are also at particular risk. Proactive screening of hard to reach high risk groups aged 35-74 in Greenwich found that 29% in Asians, 22% in Blacks and 17% in Caucasians were at high risk of diabetes.

Evidence indicates that people from lower socioeconomic groups and those from black and minority ethnic communities may face economic, social and cultural barriers which prevent them from being physically active and managing their weight. Barriers include, for example, lack of funds for a healthy diet or a lack of awareness and opportunity to being physically active or taking part in weight management programmes that are culturally acceptable.

Case finding to identify individuals with Type 2 Diabetes is performed at GP Practices either opportunistically for high risk groups, through the NHS Health Check Programme, or as part of registering new patients to the practice. This pathway needs to be further developed to appropriately signpost those at high risk to appropriate lifestyle services.

Q2. What impact does this have for health spend?

Diabetes is a growing public health problem and current spending accounts for around 10% of the NHS budget. By end March 2010, there were 12,233 people aged 17 and over with diabetes in Waltham Forest with a prevalence of 5.9%, which is higher than the prevalence recorded nationally and in London[2] but lower than the estimated prevalence of 8.1%. There are an estimated 742 adults with undiagnosed diabetes. Undiagnosed patients do not receive appropriate high quality care predisposing them to develop diabetes. Diabetes related emergency admission rates in Waltham Forest are higher than in London and nationally.

Diabetes related complications not only result in high health and social care cost but also lead to premature death or disability and also loss of productivity to our economy. Concern has been raised about the wide variation in the quality of diabetes prevention and management in London, leading to inequalities, and this would be a welcome focus for the scrutiny. Above average exception reporting under QOF by some GP practices further widens this variation and inequalities in access to prevention and treatment.

The current programme budgeting total spend per person on the diabetes QOF register in Waltham Forest is £535.42. This equates to a total spend in 2009/10 of £7.1 million. This ranks as the 47th lowest programme budgeting total spend per person on the diabetes QOF register nationally but is currently outside the lowest 25% nationally.

[2] QMAS database data as at year ends. Copyright © 2007; 2008; 2009; 2010 The Health and Social Care Information Centre, Prescribing Support Unit.

Q3. How might further growth in diabetes be curbed?

NICE Public Health Guidance PH35 (2011) provides the evidence based approach to prevent Type 2 Diabetes through population and community interventions. Putting this evidence into practice requires adequate investment in prevention approaches in partnership with local authorities, health, social care, voluntary sector and the private sector, working together to reduce the risk.

This may involve:

- Identification of local unmet needs and service gaps reflecting socio cultural and demographic mix of the local population.
- Updating local diabetes strategies to reflect above NICE guidance and NICE Quality standards and London Model for diabetes
- Service redesign in order to improve clinical and cost effectiveness, productivity and equity in local diabetes service provision.
- Active engagement of people at high risk of diabetes and those with established disease together with systematic consultation of clinical and service providers need to inform future service provision.

The following specific approaches are likely to reduce the growth in diabetes:

a) Establishing diabetes risk register to monitor those who may be at risk of developing diabetes in the future will enable appropriate follow up of those identified at risk.

b) Target high-risk groups for prevention and early detection

c) Proactively support adults who are at high risk and provide them with a high quality, evidence-based, intensive lifestyle-change programme to educate and up skill self-management skills. The NHS Health Check programme (NHSHCP) is an ideal opportunity to make this happen. It may be appropriate to undertake NHSHCP for people from 35 years of age for high risk communities eg South Asians (develop diabetes at an earlier age), those with a strong family history of diabetes, and women with a history of gestational diabetes.

d) Social marketing and behavior change communication to address lifestyle risk factors and identify people at high risk. Use strategic social marketing approaches to ensure healthier lifestyle messages are consistent, clear and culturally appropriate and are integrated within other health promotion initiatives or interventions. Emphasis need to be on:
    i. Increased levels of awareness of the signs and symptoms of diabetes and its consequences.
    ii. Achieving and maintaining a healthy weight
    iii. Physical activity
    iv. Cultural appropriateness

e) Strengthen integrated working across diabetes, obesity and NHS Health Checks to ensure a coherent, integrated approach to reduce diabetes and related inequalities.

f) All people with diabetes to receive the agreed essential care standards to reduce complications, costs and premature death.

g) Further analysis of patients who are exception reported is needed in order to identify this cohort of patients to plan appropriate interventions and to reduce variation across practices.

Q4 Impact of new arrangements and maintaining a strategic overview for London

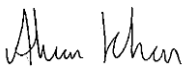
At a local level, Health and Welllbeing Boards will bring together the relevant partners to take this agenda forward. However these groups are still forming and have a complex transition of responsibility across health and wellbeing at a local level to oversee so will need to prioritise local action carefully in the early years.

Diabetes UK (2012) recommends close monitoring of the risk factors for diabetes at London and local level. Strong leadership will be required for the type of whole-system approach required to improve diabetes prevention and management across London. Consideration should be given to the following, based on learning from success in improving stroke outcomes and cancer pathways in London:

- Developing a convincing case for change in London across organisations
- Strong, multidisciplinary clinical networks
- Leadership for quality improvement in all relevant disciplines
- Embedding quality improvement and management into services
- Facilitation of cross-organisational treatment and care- building on the 'year of care' approach

I hope you find our submission helpful in shaping your scrutiny of diabetes in care in London, and wish you every success in taking it forward.

Yours sincerely



Ahsan Khan
Chair, Waltham Forest Health and Wellbeing Board

Matt Bailey

From: William Spring <william.spring@employeesrepresentatives.com>
Sent: 31 May 2013 22:59
To: Carmen Musonda
Subject: diabetes

Follow Up Flag: Follow up
Flag Status: Flagged

To Carmen Musonda

As a sufferer from Type 2 diabetes I will try & answer these questions for your survey:

- Why is London experiencing such high growth in Type 2 Diabetes and what impact is this growth having on health spend?

I can't speak for London, I can only speak for myself. Why did I get Type 2 diabetes. One contributory factor, probably the most important, is the sedentary life style I led from the year 2000 until 2007, when I was diagnosed. I say sedentary as I was seated a lot of the time, behind the steering wheel of a bus operating in London. Working with a London bus company I was shocked @ the catastrophic & inhumane conditions foisted on bus drivers & engineers, the very long hours we were expected to work leading to general fatigue, snatched meals etc....I didn't bother as there was never time for a proper meal, I only took sandwiches, which I now learn was the very worst thing to eat. I blame Boris Johnson & TFL for this. They caused my diabetes. They know the sweat shop Bangladeshi style drivers work in, but they are not interested in health & safety & will not interfere with the greed of the bus companies. In addition Boris controls the union....so the union is forbidden to say anything re these 19th century conditions.

- How might further growth in Type 2 Diabetes be curbed?

  It wd help if we given proper test kits & supplies of needles & test trips. Also someone in the NHS who cd show us how to work these kits. I could not find out so I went to speak to a NHS diabetic nurse & said "how do I work this kit?" She said no idea. Her job she said was not to demonstrate test kits & I should go to the manufacturer in Switzerland to find out. Consequently I never use the kit & have no idea what my sugar level is. I think it is probably quite bad as I feel very wobbly.

- Why is diabetes care across London so varied and what can be done to improve patient care and outcomes?

  Nothing can be done, because if something could be done it would already have been done.

- How will the new NHS and public health arrangements impact on the quality of care provided to patients and how might effective strategic overview be maintained in London?

This is just NHS bureau-speak.

Please send these answers in to Mr Qureshi.

William Spring 1 Scales Road London N17 9HB