Understanding diabetes in London



Collaboration for better patient outcomes

London Strategic Clinical Networks

February 2015

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Foreword | Dr Stephen Thomas

Diabetes has been a long-standing priority for the NHS and public health in London. Diabetes care in the capital comes with a number of unique challenges, and it is vital that we understand these challenges to ensure optimal care and outcomes for our patients. For example, almost half of the London population is obese or overweight. This not only adds to an increased risk and likelihood of type 2 diabetes, but also impacts on other cardiovascular conditions. Obesity is putting a real strain on healthcare services across all care settings, and it is vital that robust plans are developed and implemented that tackle this growing challenge.



Whilst London is considered a city of affluence, there are large parts of the capital where poverty and social deprivation are higher than the national average. This can

have a marked effect on health, outcomes and mortality. London is also ethnically diverse, and we know that the prevalence and age of onset of diabetes differs between people of different ethnicities, with a three-fold increase in black African/Caribbeans and a six-fold increase in South Asians, as compared to European Caucasians. Lastly, there is a large mobile population that access healthcare in an inconsistent, reactive way placing additional demand on the healthcare system.

There have been a number of major documents published recently which have highlighted the challenges that London and diabetes face, from the diabetes-specific report, *Blood sugar rush*¹, to the capital-focused *Better health for London*², to the *Five year forward view*³ published by NHS England and partner organisations.

A common factor across all of these publications is the challenge of obesity and how this impacts on diabetes and cardiovascular disease; both *Blood sugar rush* and the *Five year forward view* cite the Diabetes UK estimate of £10 billion cost to the NHS each year. As more people are diagnosed with diabetes these costs will escalate year on year, and we will move towards an unmanageable situation. With diabetes specifically referenced in all of these policy documents, it is imperative that we seize the opportunity at hand and act accordingly, not only highlighting the diabetes health challenge in London but offering a number of possible solutions.

Whilst there have been several exciting initiatives in London – with remarkable improvements clearly demonstrated – we must share and apply these learnings consistently across the capital so that London serves as an example of the high quality care that can be achieved.

With this document, we examine the data on demographics and diabetes complications specific to London to articulate the challenges faced in the capital.

In addition to demonstrating the scale of diabetes in the capital, this document also aims to describe the work and objectives of the Diabetes SCN and link together those with a shared responsibility for diabetes care.

In doing so, we will together improve outcomes and experience of care for all Londoners with diabetes.

Dr Stephen Thomas Clinical Director, London Diabetes Strategic Clinical Network Consultant in Diabetes and Endocrinology, St Thomas's Hospital



3. NHS England, *Five year forward view* (October 2014) | Link

EXECUTIVE SUMMARY

iabetes has been recognised as a growing problem for the NHS with prevalence set to rise to more than 700,000 – 10 per cent of the population – by 2030. This is a problem for London, due to the age and diversity of the population. The impact is felt greater amongst people of working age, and the disease is more prevalent in those of African/Caribbean or Asian descent.

This document outlines the widespread – and increasing – challenges that the London Diabetes Strategic Clinical Network (SCN) must tackle to address the issue of diabetes in the capital. It provides data and intelligence as well as background information on risk factors, ethnicity and age variances within the capital and the challenges that boroughs face in terms of funding and performance management.

In 2012/13 London diabetes prescription costs were more than £109 million alone – and this does not include treatment costs. Diabetes treatment management is approximately 80 per cent of £10 billion national spend each year, of which London has a high percentage of that cost.

The National Institute for Health and Care Excellence (NICE) recommends that people affected by diabetes take part in nine annual care processes. These key tests, completed at their annual diabetes review, help to ensure diabetes is well controlled and help to prevent future long term complications. However, evidence suggests that this is not consistent, and that there is a degree of variability based on geography. People living in the best performing clinical commissioning group (CCG) regions are four times more likely to be given eight of these key checks as compared to people living in the worst performing areas. Improving performance in the eight care processes will enable individuals to live better for longer and minimise the likelihood of complications such as renal failure, peripheral arterial disease, retinopathy, myocardial infarction and stroke. Diabetes is a major cause of premature mortality with more than 22,000 above expected deaths each year. Diabetes does not simply affect the body; evidence suggests that those affected by diabetes are twice as likely to be affected by depression and anxiety related conditions.

Elements such as poor diet and lack of exercise - often common within areas of social deprivation - are key factors leading to the onset of type 2 diabetes. This is particularly true in relation to the onset of type 2 diabetes in childhood. Childhood obesity in London is higher than the national average, and there is an increasing number of children diagnosed with type 2 diabetes. Approximately 2,500 children in the capital have type 1 diabetes.

London is very ethnically diverse, with more than 90 languages spoken; there is a broad range of ethnic groups across CCGs. The diversity ranges from 29 per cent white, 43 per cent Asian and 20 per cent black in one CCG to 88 per cent white, 5 per cent Asian and 5 per cent black in another. South Asian populations show a much higher chance of developing heart disease and end-stage renal failure, whereas black African / Caribbeans are more likely to develop hypertension, which contributes to a greater risk of stroke.

The outline programme plan (pages 17-24) contains five key work streams: Improved detection of diabetes; Better management of care; Equity of access to services; Education of patients and healthcare professionals and Better patient experience. All of these areas will help deal with the risk factors for cardiovascular disease (CVD) and renal failure which create additional problems and increased costs to the NHS.

The Diabetes SCN is working collaboratively with other CVD SCNs to reduce the impact of CVD through targeting vascular prevention, case finding, case management, and emotional and psychological support.

Background

Diabetes in London is a wide scale problem. The recently published report from the London Assembly, *Blood sugar rush: Diabetes time bomb*, notes:

> "More than one in 20 people in the UK has diabetes. In London, there are an estimated 475,000 people diagnosed with the condition. Up to a further 200,000 people could be living with diabetes by 2025."¹

The consequence of diabetes consumes approximately 10 per cent of the NHS annual budget. It is estimated that approximately 7.5 per cent of the adult population is diagnosed with the disease, though the actual figure is thought to be much higher. Diabetes UK recently reported that the estimated cost of diabetes treatment and related complications to the NHS is more than £14 billion².

Pressure has been exerted to address the issues associated with diabetes in terms of cost, diagnosis and treatment.

These figures are supported by the Association of Public Health Observatories (APHO) diabetes prevalence model for former primary care trusts (PCTs)³, The number is forecast to increase to more than 700,000 – 10.9 per cent of the adult population – by 2030 (*Figure 1*).

This increase in the number of people with diabetes will cause a corresponding increase in demand on the NHS. The diverse makeup of the capital's population poses unique challenges to diabetes care:

- » Age
- » Ethnic diversity
- » Obesity prevalence
- » Social deprivation levels

All of these contribute to the resultant high cost of treatment for diabetes and related complications in London.



Age

London has a significantly younger population compared to the rest of England (*Figure 2*).

This has an impact on costs not only to the NHS, as these patients will be living with diabetes and its associated complications for longer. It will also cost the economy as a whole through reduced employment and/or increased social security needs, as there is a greater impact on those of working age.

For women of reproductive age with diabetes, this means additionally a substantial impact on London's antenatal services, with greater numbers of pregnancies complicated by diabetes than in the rest of the country.

Ethnic diversity

The ethnic diversity of London has a significant impact on the numbers affected by diabetes. South Asians have approximately six times the risk of developing diabetes as compared to Caucasians, and those of African / Caribbean descent have five times the risk⁴. Studies have highlighted that south Asians develop diabetes five to ten years earlier than Caucasians⁵.



Source: 2012 Mid-year population estimates

Figure 2 (above): The age structure of the population in London is much younger than the rest of England.

London has a much broader range of ethnicities and cultures than the rest of England (*Figure 3*). There is wide variation of population makeup across the boroughs of the capital. For example, the borough of Newham consists of 29 per cent Caucasian, 43 per cent Asian and 20 per cent African / Caribbean / black people. On the other hand, the borough of Havering is made up of 88 per cent Caucasian, 5 per cent Asian and 5 per cent African / Caribbean / black.

There are more than 92 languages spoken in London. In some boroughs, such as Newham, more than 40 per cent of the population cites English as their second language⁶.

These distinctions in culture and language foster a challenging environment for enabling patients to self-manage their condition most effectively, particularly with regard to structured education.



■ White ■ Mixed/multiple ethnic group ■ Asian/Asian British ■ Black/African/Caribbean/Black British ■ Other ethnic group *Figure 3 (above):* London is more ethnically diverse than England, with ethnicity shown by borough

Obesity

One of the key risk factors for diabetes is obesity. Most worryingly, is the increasing prevalence amongst children.

In London, it is estimated that approximately 25 per cent of 10 to 11 year olds were overweight or obese in 2010/11⁷, and this figure is increasing. By 2030, approximately 70 per cent of adults nationally may be overweight or obese⁸.

Deprivation

Social deprivation is also a significant contributory factor to the prevalence of diabetes. The London Assembly Health Committee Report⁴ asserts that deprivation has an impact on diet, exercise and obesity.

London has wider disparity in the levels of deprivation than other areas of the country. Twenty of the 32 boroughs in the capital have higher levels of deprivation than the national average (*Figure 4*).

Costs

Diabetes complications incur the greatest costs to the patient and the NHS. In fact, 80 per cent of diabetes spend is on treatment of complications⁹.

The largest expenses accounting for diabetes complications include: £3.4 billion on cardiovascular complications (myocardial infarction, heart disease and heart failure) and £1.8 billion on excess bed days.

By 2035/36, this spend, exclusive of inflation, is predicted to rise to \pounds 16.9 billion.

There is a high prevalence of mental health conditions amongst the diabetes population, co-morbidity of depression and anxiety with diabetes can significantly increase the cost of care.

Across the geography of the London Diabetes Strategic Clinical Network, the total spend for diabetes related prescriptions were approximately £109 million between April 2012 and March 2013¹⁰.

Complications

The complications experienced by diabetes patients can be macrovasculature (stroke, myocardial infarction, heart failure) or microvasculature (renal failure, peripheral arterial disease and retinopathy), which are preventable.

People with diabetes are significantly more likely to experience these conditions and more likely to undergo renal replacement therapy or a lower limb amputation than the general population.

Amputations

People with diabetes have a 210 per cent higher risk of a major amputation (above the ankle) and a 331 percent greater risk of a minor amputation (below the ankle) than the general population. The quality of life for people after an amputation may be reduced, and may lead to disability and the loss of employment. Therefore, it is important to enable people to live well for as long as possible by preventing amputations.



Figure 4 (above): Index of deprivation: London has wide disparity in levels of deprivation across boroughs

Based on 2010-2013 data, London has an annual rate of 0.6 major amputations per 1,000 adults with diabetes. This is lower than the national average of 0.9. However, it should be noted that the range across the capital varies from 0.3 (Brent) to 1.1 (Sutton).

The annual rate of minor amputations in London is 1.3 per 1,000 adults with diabetes, compared to 1.7 nationally. A wide variance is found, from 0.4 (again, Brent) to 2.1 (Bromley).

Heart failure

Across England and Wales people with diabetes have a 64.9 per cent greater risk of a hospital admission related to heart failure (HF)¹¹. The risk of being admitted to hospital for a myocardial infarction (heart attack) is 48 per cent greater than the general population, whilst the risk for stroke is 24.9 per cent higher.

People with diabetes were 73.2 per cent more likely to be admitted to hospital with heart failure than the general population (myocardial infarction has a 55.1 per cent higher risk)^{12, 15}.

Figure 5 (below): Major amputation rates in London *Source: National Cardiovascular Intelligence Network*

Heart failure is the complication that confers the highest risk of death in the short term. People with diabetes who have been admitted to hospital with heart failure have a 261 per cent greater risk of dying in the next year than their peers who have not been admitted for heart failure¹³.

If you live in one of the 20 per cent most deprived areas of London, you are 60 per cent more likely to be admitted to hospital with heart failure than someone living in one of the 20 per cent least deprived areas¹⁴.

England

London



Annual major amputation rate per 1,000 adults with diabetes





Chronic kidney disease

In the 2011/12 National Diabetes Audit report, there were estimated to be 403,567 people with diabetes with chronic kidney disease (CKD) stages 3 and 4, requiring treatment intervention, with a further 1,055,214 in CKD stage 2.

The chance of receiving renal replacement therapy for people with diabetes is 144 per cent higher than their peers in the general population¹⁶.

Data from the 2013 Renal Registry highlights the high numbers of patients with renal problems that suffer from diabetes. Nationally. there were 3,054 incident cases of renal replacement therapy (RRT).

Of those 1,332 were in London, where nearly one-third (28.9 per cent) had diabetes as their primary renal diagnosis, as compared to the 15.5 per cent of national incident RRT cases.

Sight loss

Improvements in diabetic eye screening uptake to detect levels of maculopathy to allow effective prevention¹⁷ should be a national priority.

Diabetic maculopathy is a major cause of sight loss with a prevalence of 10 per cent requiring treatment in type 2 diabetes¹⁸.

By increasing the effort to prevent large numbers of patients progressing to severe maculopathy - which requires costly regular injections - will reduce the anticipated burden on clinical and financial resources. In London there are currently 17 different diabetes eye screening programmes.

These programs are important to screen the diabetes population and intervene to avoid progression to blindness.

Diabetes in children

Most children with diabetes have type 1 diabetes, although type 2 diabetes is becoming more common. One in every 700 children has been diagnosed with diabetes, and there are 2,500-3,000 children and young people in the capital with type 1 diabetes. Such a diagnosis before the age of ten may reduce life expectancy by up to 17 to 20 years, mainly due to the increased risk of cardiovascular events¹⁹.

Working in partnership

The London and South East **Coast Paediatric Diabetes** Network focuses on the delivery of care and the support of children and young people with diabetes, together with their parents or carers. The condition is primarily managed by paediatricians in secondary or tertiary cares settings and is based in part on the Best Practice Tariff.

Figure 7 (below): Incident RRT: London shows large proportions of patients who receive new RRT have diabetes

Incident renal replacement therapy

Source: National Renal Registry (2013)

Service provision in London

In November 2013 the London Diabetes Strategic Clinical Leadership Group (SCLG) initiated a scoping exercise to collect data across London looking at the availability of education for patients with types 1 and 2 diabetes and access to psychological support and insulin pumps for patients with type 1 diabetes.

Patient education

There are a variety of mainstream structured education programmes available, provided by both inhouse and referred services. The London scoping exercise returned 119 responses. Within the responses, the following programmes were noted:

- DESMOND is the most often offered type 2 education (53 responses)
- » DAFNE is the most frequently offered type 1 education (32 responses)
- » X-PERT (12 responses)
- » BERTIE is least offered type 1 education (6 responses; Note: 15 responses for other type 1 programmes may be based upon BERTIE)
- There is also a mixture of other type 2 programmes (19 responses)

There are programmes available in 10 languages with some services able to offer tailored courses where the appropriate interpreter is available across London.

Respondents answered as follows:

»	Arabic	(1.96%)
»	Bengali	(7.84%)
»	Chinese	(1.96%)
»	English	(45.10%)
»	Gujarati	(1.96%)
»	Hindi	(5.88%)
»	Portuguese	(3.92%)
»	Punjabi	(3.92%)
»	Turkish	(9.80%)
»	Urdu	(1.96%)

English is the most commonly available language. Turkish, the second most common as found in the survey, is available in Haringey CCG; Bengali programmes, the third most common, are available through Barts Health. To ensure patients are best informed to manage their condition themselves, all patients need to have access and/or referral to education about diabetes, whether through formal structured education programmes or other formats. Programmes need to be accessible not only in terms of location, time and delivery, but also in language and cultural relevance so that patients can engage most effectively.

Currently, there is variation in the proportion of patients offered education, where the highest levels are less than 50 per cent, and they decrease to only a few per cent in some areas. Figures regarding the rate of uptake of education are equally concerning; 45 per cent of respondents did not know the level of uptake of education by their patients, and 37 percent noted that the rate of uptake is less than 50 per cent (*figure 8*).

Figure 8 (left): Reported levels of structured education: Frequently offered, but low uptake rates

Insulin pump usage

The scoping exercise also established how many patients were receiving individualised care for insulin pumps, and whether or not their psychological needs were being met (*Table 1*).

The wide variation in the percentage of patients in secondary care centres using insulin pumps is likely a reflection of the way insulin pump services have evolved. In the past few years (in particular after the NICE guidance of 2008²⁰) insulin pump services have been established in many secondary care diabetes clinics. Prior to this, patients tended to be referred to large pump centres from other secondary care clinics across a wide area. (Such centres were likely to report higher percentages of pump patients in the exercise.)

Table 1 (below): Insulin pump usage in secondary care, ranging from 5% to 50%

How many patients in your service have type 1 diabetes?	Of these, how many are using insulin pumps?	Proportion with pumps
20	2	10%
400	100	25%
400	220	55%
500	120	24%
560	53	9%
600	50	8%
1000	80	8%
1500	70	5%
1500	300	20%

Clearly, there is wide variation in the size of services, access to local services and in the confidence of teams to ensure patients have the most effective means of managing their condition.

Psychological support

There are differences in the psychological support that is available across both geographical and care settings. Whilst some areas have a psychologist as part of their multi-disciplinary team

(MDT), others refer to a psychologist or use the Improving Access to Psychological Therapy (IAPT) service (*Table 2*).

Table 2 (*below*): Landscape of psychological support available in London

London sector	All available	IAPT	MDT & IAPT	Nothing available	Referred	Referred & IAPT	Referred & MDT	Total
North Central	4	4	1	1	5	8		23
North East	1			5	1		3	10
North West	4	2		1		1	8	16
South East	3					6	2	11
South West						1		1
Undisclosed						3	1	4
Total	12	6	1	7	6	19	14	65

Note: The figures in Table 1 and Table 2 reflect the responses received within the scoping exercise and, whilst provide an indication of the services available to patients, may not provide the full picture of coverage in the capital.

Delivering better outcomes

In view of a high prevalence of mental health conditions, risk of cardiovascular and kidney disease complications and the diversity of the ethnic population of the capital, we have developed a strategy to impact the three-fold burden of diabetes in the capital:

- Identify a greater proportion of the population likely to develop diabetes
- » Diagnose people with diabetes at an earlier stage
- » Reduce levels of complications from diabetes

NICE: Eight care processes

NICE recommends nine care processes for patients. Of those, eight are included in the Quality and Outcomes Framework (*Table 3*). Between 2009/10 and 2011/12 there were mild improvement in the percentage of patients receiving each of the eight care processes. However, there is still plenty of work to do to improve uptake. Two care processes of note are urine albumin and foot surveillance, as these can be used to monitor for the risk of developing kidney failure and foot ulcers. These are significant complications for anyone living with diabetes, as they could mean dialysis and/or amputation for patients if left untended.

	All diabetes ^a		
	2009/10	2010/11	2011/12
HbA1c ^b	92.1% 🗖	92.5% 🗖	90.3% 🔳
Blood pressure	95.2% 🗖	95.0% 🗖	95.0% 🔳
Cholesterol	91.7% 🔳	91.6% 🗖	90.9% 🔳
Serum Creatinine	92.5%	92.5% 🔳	92.5% 🔳
Urine albumin	72.3% 🗖	75.1% 🗖	76.0% 🗖
Foot surveillance	84.1% 🗖	84.3% 🗖	85.3% 🗖
Eye screening [°]	78.8% 🗖	82.1% 🗖	71.3% 🗖
BMI	90.1%	89.9% 🗖	90.3%
Smoking	86.9% 🗖	84.8% 🗖	85.1% 🗖
All nine care processes ^d	51.6% 📕	54.5%	47.7%
Eight care processes (excluding eye screening)	59.4% 📕	60.6% 📕	60.5% 📕

Table 3 (*below*): Percentage of patients in England and Wales receiving NICE recommended care processes by care process and audit year

NB The 2012/13 NDA data has been excluded from the above table, as the participation rate was approximately 70 per cent, much lower than that seen in previous years. Some London CCGs are excluded, as they did not submit sufficient data.

^d People registered with diabetes receiving all nine key processes of care processes.

^a All diabetes includes maturity onset diabetes of the young (MODY), other specified and not specified.

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

[°] Eye screening for 2011/2012 are based on a different set of Read codes than for previous years.

QOF

NICE's eight care processes should be delivered in a primary care setting to qualify for Quality and Outcomes Framework (QOF) points, which impacts funding.

Three of the care processes (HbA1c, cholesterol and blood pressure) demonstrate that the overall picture in London broadly follows the national pattern. However, there is wide variation between CCGs.

Figure 9 (below): London QOF performance (Source: Quality and Outcomes Framework, 2011/12²¹

A1c nol/mol	London Strategic Clinical Network		57.9%		32.1	1%	9.9%
Hb/ <59mm	England		59.6%		30.	1%	10.3%
mmol/I							
sterol < 51	London Strategic Clinical Network		73.1%	6		18.9%	8.1%
Chole	England		72.9%	6		16.9%	10.2%
<140/80							
ressure <	London Strategic Clinical Network		66.5%			26.1%	7.4%
Blood F	England		67.2%			25.0%	7.8%
	0	% 20	% 40	60	0%	80%	10

Within recommended limits

Checked and outside recommended limits

Excepted from indicator

COLLABORATION

Collaborative work across the Strategic Clinical Networks

Strategic Clinical Networks (SCNs) were established in April 2013 to provide clinical expertise and leadership drive commissioning decision making, reduce variation and direct service improvements. Clinical directors lead each SCN, along with associated strategic clinical leadership groups (SCLGs). The London Diabetes SCN is vital in the sharing and dissemination of best practice, both formally and informally. It plays an important role in directing the focus and ensuring a collaborative approach to turn the tide and reduce the prevalence of diabetes.

The analysis of the burden of disease in the UK highlighted the need for an integrated and strategic response to improve health outcomes²². Following the *Call to action to reduce avoidable prema*-

*ture mortality*²³ and recommendations in the *National Cardiovascular Disease Outcomes Strategy*²⁴, the London SCN has united the work of the SCLGs of the diabetes, cardiovascular, stroke and renal SCNs to enable a more focussed approach to joined up activities. Patients will benefit from improved, integrated services; the NHS will benefit from resultant cost savings.

Four cross-cutting objectives have been identified across each SCN to address areas of cardiovascular disease:

- » Vascular prevention
- » Case finding
- » Case management
- » Emotional and / or psychological support

These have been aligned in the programme plan for diabetes (*Table 4*). Addressing these areas across the whole family of diseases creates a multifaceted approach across London, which will positively impact the health of all Londoners at risk of developing cardiovascular disease in any form.

Work has been completed to address the growing issue of eating disorders amongst young children and adults with type 1 diabetes. The Mental Health, Diabetes and Children and Young People SCNs have collaborated to tackle this challenge, and will continue to work together in future.

Priorities of the Diabetes SCN

The work streams within the Diabetes SCN reflect its priorities:

- » Improved detection of diabetes
- » Better management of care
- » Equity of access to services
- » Education of patients and healthcare professionals
- » Better patient experience

Table 4 (below): Matrix of diabetes work plan within the wider cardiovascular disease agenda

Торіс	Detection	Management of care	Equity of access to services	Education of patients and healthcare professionals	Patient expe- rience	Collaboration with other SCNs
Vascular Prevention	\checkmark		\checkmark	\checkmark		√ 1
Case finding	\checkmark	\checkmark				
Case man- agement	\checkmark	\checkmark	\checkmark	\checkmark		
Emotional/ psychological support		\checkmark		\checkmark	\checkmark	√ 2

¹ Cardiovascular SCNs

² Mental Health and Children and Young People SCNs

Examples of collaboration across SCNs include:

Commissioning recommendations for psychological support for people with diabetes | Link

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Type 1 diabetes and eating disorders event summary | Link

Looking ahead

In its present model of service delivery, the NHS will be unable to sustain care for the current diabetes patient population, let alone meet the significant increase in future demand.

Increases in prevalence levels, co-morbidities, duration, and the complexity of care required for people with diabetes during the latter phases of the disease progression all point to the need for an immediate solution.

It is clear from the publication of the *Five year forward view* that the NHS recognises this. A drastic new approach to prevention and public health is needed to ensure future sustainability of the health and care system.

Diabetes has been highlighted as an initial area to address. This is both because of its high prevalence -- particularly in the capital -- as well as for the immediate impact that the current evidence documents will happen.

An agreed approach, co-designed by the NHS, Public Health England and Diabetes UK will be published in March 2015. This alliance will provide a firm direction of travel for tackling the issue of diabetes across the country. Included in this is a national, evidence-based diabetes prevention programme, linked, where appropriate, to NHS Health Check to improve detection of diabetes. A national prevention board will oversee the delivery of the published commitments. Within this national diabetes prevention programme, the London Diabetes SCN can shape a future strategic vision for the capital.

The Diabetes SCN is perfectly placed to collaborate with providers and commissioners at a strategic level to coordinate improvements in diabetes care across the capital. The SCN is working towards achieving the future following improvements as set out in *The way forward: Strategic clinical networks*²⁵:

- » Our workforce will be confident and competent at treating patients with diabetes and advising them on managing their condition.
- » Everyone at high risk of developing diabetes will be diagnosed by HbA1c and then given advice to prevent diabetes (diet, exercise, smoking cessation, statins, etc.).
- » Primary care will: manage diabetes using the <u>House</u> of <u>Care approach</u> and the eight care processes as recommended by NICE; build local networks for peer to peer support and accountability; and examine what lifestyle intervention and / or psychological support may be needed by patients.
- » All patients will have access to rapid access foot care teams, including via self-referral. The teams will be integrated across primary and secondary care, and patients will have access to the full multi-disciplinary team for assessment. The clinics should be run at least three days a week.
- » Patients who need a pump will be able to access one via the service of their choice.They will receive education for optimal disease management.
- » Education will be a facilitator and enabler. Healthcare professionals will be confident in initiating and managing patients, and patients will be empowered to manage their condition themselves.

DETECTION

Clinical leads

Adeel Ansari, Anna Hodgkinson, Somen Banerjee

Key milestones

- » Collate HbA1c guidance from all CCGs (completed)
- » Literature review of use of HbA1c for diagnosis (completed)
- » Develop recommendations (completed)

Key outputs

Develop recommendations/quality standards to share across London. To include:

- » Recommended diagnosis method with justification
- » Read code for 'at risk of diabetes' recommendation
- » Recommendations for interventions

Resource requirements

Network members to be available to discuss recommendations with local teams where necessary

Costs

Possible costs associated with implementation of NICE PH 38 guidance at a local level

- » Consistent approach to diagnosing type 2 diabetes across London
- » Early diagnosis and intervention
- » Patients living longer
- » Reduced risk of complications
- » Cost savings to the NHS

MANAGEMENT OF CARE

Clinical leads

Mark Chamley, Raquel Delgado

Key milestones

Draft strategy and project plan (completed) Analysis of new National Diabetes Audit Data (completed) Work stream report published (March 2015)

This will promote:

- » Local integrated working between primary, community and secondary care to develop diabetes services
- » Training clinicians in collaborative care planning
- » Systems of care and training which influence outcomes, not demographics (as currently, practices close to each other can have very different outcomes)
- » Local diabetes champions/specialists in facilitating change
- » Full coverage of practice submissions (100 per cent) in future National Diabetes Audit

Key outputs

» Management of care toolkit (case studies, techniques and practical ways for primary care to improve the management of diabetes)

Resource requirements

Network members to be available to discuss recommendations with local teams where necessary

Costs

Possible costs associated with local implementation of NICE eight care processes

- » Better management of people with diabetes and therefore earlier intervention sooner, enabling them to live better for longer and reducing the risk of developing complications
- » Cost savings to NHS for the treatment of complications
- » Costs saving to the economy as people are able to stay in employment for longer

EQUITY OF ACCESS | FOOT CARE

Clinical leads

Stella Vigs, Richard Leigh

Key milestones

- » Definition of a foot care MDT (completed)
- » Competency framework for screening feet (Summer 2015)

Key outputs

- » Service specification for foot protection teams
- » Recommendations for identifying high risk feet

Resource requirements

Network members to be available to discuss recommendations with local teams where necessary

Costs

Possible costs associated with implementation of foot care pathways at a local level

- » Better management of foot ulcers
- » Reduced rate of preventable amputations
- » Reduced length of stay post amputations
- » Reduced mortality through avoided amputations
- » Cost savings to the NHS

EQUITY OF ACCESS | INSULIN PUMPS

Clinical leads

Karen Anthony, Natasha Patel

Key milestones

- » Obtain pump audit data (completed)
- » Analyse audit data (completed)
- » Process map access to insulin pumps (completed)

Key outputs

- » Proposed model of care
- » Recommendations for accessing pump therapy

Resource requirements

- » Capacity planning for increase in adult pump starts and pump users transitioning from paediatric services
- » Ensuring sufficient staff trained in continuous subcutaneous insulin infusion (CSII)

Costs

- » Procurement of insulin pumps
- » Staff training

- » Improved access to pump therapy better insulin management
- » Avoided hospital admissions for diabetic ketoacidosis (DKA) and severe hypoglycaemia
- » Improved HbA1c should reduce risk of long term complications

EDUCATION | PATIENT

Clinical lead

Charles Gostling

Key milestones

- » Develop <u>interactive toolkit</u> to promote best practice for delivery of structured patient education for type 2 diabete (completed)
- » Deliver toolkit across South London (completed)
- » Share toolkit across North London (March 2015)

Key outputs

- » Create a toolkit to maximise access to education through promoting best practice, use of social media/ local champions/ directory of services;
- » Develop a set of metrics/minimum dataset for service level agreements for patient education

Resource requirements

Resource developed by Health Innovation Network, with input from North London stakeholders; will require communications resources to spread to North London

Costs

Currently borne by Health Innovation Network (South London)

- » Patients are able to understand and manage their condition better
- » People with diabetes will be able to live well for longer and delay the onset of complications
- » Reduced cost of complications

EDUCATION | HEALTHCARE PROFESSIONALS

Clinical lead

Charles Gostling

Key milestones

- » Scope competency recommendations by each professional body (completed)
- » Review available and required continuing professional education programmes (Summer 2015)

Key outputs

» Develop a set of competencies for healthcare professionals

Resource requirements

Network members to be available to discuss recommendations with local teams where necessary

Costs

Possible costs associated with implementation of education programmes at a local level

- » Healthcare professionals are able to understand the condition and enable patients to manage their care better
- » People with diabetes will be able to live well for longer and delay the onset of complications
- » Reduced cost of complications

PATIENT EXPERIENCE

Patient representatives / chairs

Melissa Holloway, Elizabeth Rowley, Lis Warren

Key milestones

- » Scoping survey of patient preference and experience for accessing services (completed)
- » Analysis and report of patient survey results (April 2015)
- » Priorities and overall aims set in line with survey results (Summer 2015)

Key outputs

- » Established network of patients that can share their views and act as a panel to improve the patient experience
- » Work closely with existing patient groups to combine efforts and share goals
- » Evaluate the patient experience and come up with a set of recommendations for healthcare professionals

Resource requirements

Online survey capabilities, possible meeting space

Costs

Project management support

- » Patients will have a better experience with the NHS and better health outcomes
- » Patients will have a stronger investment in their diabetes management

APPENDIX 2 References

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About the Strategic Clinical Networks

The London Strategic Clinical Networks bring stakeholders -- providers, commissioners and patients -- together to create alignment around programmes of transformational work that will improve care.

The networks play a key role in the new commissioning system by providing clinical advice and leadership to support local decision making. Working across the boundaries of commissioning and provision, they provide a vehicle for improvement where a single organisation, team or solution could not.

Established in 2013, the networks serve in key areas of major healthcare challenge where a whole system, integrated approach is required: Cardiovascular (including cardiac, stroke, renal and diabetes); Maternity and Children's Services; and Mental Health, Dementia and Neuroscience.