

Opportunities to access Diabetes Health Inequalities Improvement Programme funding in the North West Coast Clinical Network (NWCCN).

You are invited to bid for funding to reduce health inequalities in diabetes care in the North West Coast Region from £5,000 up to £100,000. The focus should be aimed towards improving care for those groups likely to experience greater health inequalities in the Cheshire and Merseyside & Lancashire and South Cumbria. We would like to receive a mixture of community, third sector and clinical applications from a wide variety of groups that would benefit from quality improvements in diabetes care and prevention of diabetes. All bids must demonstrate how they will improve outcomes and how they are going to measure and capture improvements. ***We have attached a helpful guide to help you complete the application form.***

Dates of the application and judging.

Process	Date
Application process opens	January 6 th 2021
Closing date for submission of application	January 29 th 2021
Review and scoring- panel meeting	Mid-February
Successful bid applicants informed	End of February
Submit signed Memorandum of Understanding & Basic Project & finance plan	March 2021
Funding allocation- April 2021	April
Quarterly review	July 2021

1. Background

1.1. The NWC CN Diabetes team and Children and Young People Team (CYP), Long Term Conditions (LTCs), work in the NW Clinical Networks and Senate within the Medical Directorate of NHS England in the NW region. The Clinical Network teams support the national programmes for diabetes and CYP LTCs and their role is to deliver transformation and quality assurance in both Cheshire and Merseyside and Lancashire and South Cumbria. Essentially supporting improvement, delivery and standards in diabetes care.

1.1.1. The Focus of the national programmes and this funding opportunity is to ensure the delivery of the NHS Long Term Plan. The Clinical Network are focussing on an ambitious programme to proliferate work in inequalities with the aim of:

- 1.1.1.1.** Reducing Inequalities and variation as supported by the NW Regional NHSE/I Ambitions.
- 1.1.1.2.** Understanding barriers to diabetes care and overcoming these barriers.
- 1.1.1.3.** Supporting innovative and collaborative improvement ideas.
- 1.1.1.4.** Sharing and scaling good practice.

2. Funding

- 2.1. We would like to extend an invitation to apply for improvement funding which we will make available to a variety of stakeholders within Cheshire and Merseyside and Lancashire and South Cumbria to bid for either collectively or as a discrete organisation. The funding period is between April 2021 to March 2022, however, there may be opportunities to expand or provide a further year of funding for initiatives that demonstrate good outcomes. This is an ambitious diabetes inequalities programme and will be overseen by the North West Coast Clinical Network Diabetes Team.
- 2.2. The initiatives being funded will need to deliver improved outcomes and services for the following areas of inequalities and therefore should be:
 - 2.2.1. Initiatives which aim to reduce health inequalities, work with marginalised groups, or those with complex health needs and or
 - 2.2.2. Initiatives which aim to engage communities in developing a community-based approach to reducing health inequalities in diabetes care.
 - 2.2.3. Aimed at improving diabetes care identified in the NHS Long Term Plan. For example, improving treatment targets, structured education, care processes, footcare and self-care.

3. Why an Inequalities programme/ who are we trying to target?

- 3.1. There has been investment in diabetes treatment and care since 2017 for the main treatment areas of structured education, treatment targets (Blood Pressure, HbA1c and cholesterol), Diabetes Inpatient Specialist Nursing and Multi-disciplinary Footcare Teams. However, we know that not everybody is accessing health services equally or receiving the same level of care across the patch, moreover, their health outcomes are different and general health and opportunities to maintain good health remains a challenge. We, therefore, want to introduce a collaborative, sharing programme that encourages improvement in care for groups that face the greatest inequalities and we want to narrow that gap.
- 3.2. **BAME-** In a retrospective cohort study the findings suggest that disparity in glycaemic control, diabetes-related monitoring, and prescription of newer therapies remains a challenge in diabetes care. Both ethnicity and socioeconomic status were identified as important determinants of inequality. These disparities in glycaemic control may lead to higher rates of complications and adverse outcomes for some groups¹. The growing burden of Type 2 Diabetes is shared unequally across socio-economic status and between ethnicity groups². Indeed, there are several sources that identify disparities in glycaemic control for those in deprived communities and from Black African, Pakistani and Indian heritage compared with Caucasian groups. Also, women from the BAME population are at higher risk of developing gestational diabetes during pregnancy^{3, 4, 5, 6}. Minority ethnic communities with Type 2 Diabetes in the UK have previously been shown to have low uptake of retinal screening and are more prone to diabetic retinopathy⁷. Type 2 diabetes is up to six times more likely to develop in people of South Asian descent and up to three times more likely in African and Africa-Caribbean people⁸.

More recently BAME communities have been disproportionately affected by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) = COVID-19. A recent

population cohort study in the Lancet identified people from BAME backgrounds to be significantly more likely to die of COVID-19 and a significant proportion of individuals had diabetes. In type 1 diabetes, COVID-19-related mortality was significantly higher in people of black and Asian ethnicities than in those of white ethnicity. In type 2 diabetes, COVID-19-related mortality was significantly higher in people of black, Asian, and mixed ethnicities than in those of white ethnicity. COVID-19-related mortality compared with white ethnicity in type 2 diabetes was more pronounced in males than females ^{9,10}.

- 3.3. Learning disabilities-** People with a learning disability are more likely to develop diabetes than the general population. There is higher level of morbidity with significant health problems starting at an early age which includes diabetes ^{11, 12}. The prevalence of diabetes in people with a learning disability is unknown, but recent data indicate that is approximately 10%, nearly double the rate of the general population and in most cases, this is Type 2 diabetes. Obesity and a sedentary lifestyle are known risk factors for Type 2 diabetes. Obesity is a problem in the UK and 40% of adults with a learning disability are obese ¹³. People with a learning disability are 10 times more likely to develop serious sight loss than the general population. Moreover, it is people with learning disabilities, who also have diabetes, are less likely than the general population with diabetes to have had retinal screening (49% compared to 56%) ¹⁴.
- 3.4. Homelessness-** Individuals who are experiencing homelessness are more likely to have a higher incidence of diabetes-related adverse outcomes. There are several contributing factors to this, including financial barriers, difficulty accessing medical care, medications and supplies and a lack of trust with healthcare providers. Another contributing factor is the fact that diabetes care is often not tailored to the specific needs and challenges of those experiencing homelessness. Those facing homelessness often struggle with severe mental health problems as well as physical health issues. This presents a significant challenge when someone that is homeless has diabetes ^{15, 16}. Self-management plays a crucial role in managing health problems and involves adhering to medical therapies, investigations, blood glucose monitoring as well as managing diet, physical activity and smoking cessation which is difficult to maintain. This is particularly challenging for this group of people ¹⁷. Financial challenges, medication storage and stigma accessing health care present significant barriers to optimising health care and leads to their health being neglected ¹⁸. This can result in poor glycaemic control and death in some cases.
- 3.5. Travelling communities-** A higher prevalence of diabetes has been reported in one study for Gypsy, Roma, Irish Traveller population. Type 2 diabetes was 3 times higher in a sample of Slovak Gypsies compared with a comparison group of non-Gypsies. A diabetes diagnosis was twice as high in the Irish Traveller population than in the general population in the All Ireland Traveller Health Study²⁰. There are still significant barriers in accessing health services for the travelling communities. They often have the poorest health than any of the ethnic minority groups.
- 3.6. Sensory Impaired diabetes-** Poor access to health for deaf people means that they have a higher risk of developing Type 2 diabetes. A BMJ open study in Bristol University compared the health of people with and without hearing problems and

ascertained a higher risk for heart disease and high blood pressure in the group with hearing loss and although prevalence of Type 2 with the general population in this study was comparable there were reported poorer glycaemic control in the group representing hearing loss. There are several groups of people who are blind or visually impaired that will face challenges in respect of managing their diabetes care. For example, vision loss at birth or those individuals that have deteriorating vision as a result of disease progression, those that develop vision loss/ blindness due to diabetes retinopathy and more elderly patients with diabetes that develop macular degeneration. Each present difficulty when managing their health or self-care, including monitoring blood glucose and taking medication or insulin.

- 3.7. LGBT+-** Sexual and gender minority people experience higher rates of eating disorders, body dissatisfaction and obesity compared to the general population. Members of the lesbian, gay, bisexual, and transgender (LGBT+) community have unique health disparities and worse health outcomes than their heterosexual counterparts, which has clinical relevance in the delivery of diabetes care and education. Lesbians have the highest rates of polycystic ovarian syndrome (PCOS) prevalence (38 vs. 14% among heterosexual women). PCOS is a risk factor for type 2 diabetes²¹. Overweight and obesity rates are higher among lesbians than among heterosexual women, which is a risk factor for Type 2 diabetes^{22,23}. Type 2 diabetes risk is increased in overweight transgender women who are on hormone therapy²⁴. There are also factors which prevent LGBT+ communities receiving adequate care due to cultural bias and inequalities, stigma and isolation²⁵.
- 3.8. Care Homes-** There is an increasing number of older people aged over 65 living with type 2 diabetes and it is predicted that by 2025 this will rise to approximately five million people. When older people with type 2 diabetics become frail and are no longer able to manage at home, often a care home becomes the most appropriate place for them to live. One in four people in care homes have diabetes. Diabetes UK report that currently every 25 minutes someone with type 2 diabetes in a care home is admitted to hospital. This is predicted to rise to one person every 10 minutes. Currently it is not a mandatory requirement for care homes to have diabetes training and this leaves a gap in knowledge. There are a number of considerations in order to maximise care in care homes, including good end of life care.
- 3.9. Prison Health-** Many people in prison have poor health and have a 50% higher mortality rate than the general population. Several factors lead to this inequality for example, homelessness, drug and alcohol problems, severe mental health problems, lack of physical activity and poor diet. Whilst for some being detained might offer an opportunity to introduce better health monitoring and health promotion, it remains somewhat different than the health services received outside of prison. Several areas of health care need to improve in the prison setting for example better access to diabetes prevention programmes, better monitoring of blood glucose, improved access to choices of healthier meals, access to continuous glucose monitoring for detained pregnant women and improved access to diabetes specialist teams.
- 3.10. Risk stratification-** During the COVID-19 pandemic research in the Lancet has identified that a significant proportion of the cohort in the study of 61 million

residents in the UK a third who died of covid-19 had a diagnosis of diabetes ^{9,10}. When we make the relevant significant risk factors in this study it is clear that those likely to experience the worst health are more likely to have worse outcomes. These variables mirror the inequalities from harder to reach groups. For example, we know that covid-19 affects people with LD six times greater, BAME groups are twice as more likely to get COVID-10: after increasing age mortality is higher in BAME groups, more deprived communities, males, High or low BMI and those with poor renal function, those with heart failure and stroke and those with a higher HbA1c.

4. Funding-

4.1. Category examples which would attract greater support include:

- Improving access to National Diabetes Prevention Programme (NDPP) for BAME groups, sensory impaired and people with learning disabilities.
- Improved access and uptake of structured education, either face to face and or digital for adults or Children and Young People (CYP) people from BAME groups, LD, Prison, Travelling Community.
- Improved access to diabetes related to mental health and psychological support following diagnosis.
- Improved patient and public engagement/ involvement for adults and children and Young People.
- Improved outcomes for people in rural or socially isolated areas including homeless.
- Improved outcomes for people with diabetes in the most deprived communities with a focus on healthier lifestyles.
- Improve a reduction in adult and or CYP obesity.
- Improved access to CYP Type 2 resources.
- Project funding for a community group providing support for patients accessing NHS diabetes care.
- Improved care for harder to reach communities in respect of treatment targets (Blood pressure, HbA1c, Cholesterol), Diabetes Inpatient Specialist Nurses and Multidisciplinary footcare.
- Risk stratifying discrete groups to ensure medication and care optimisation.
- Improve outcomes in Care Homes

We anticipate most funding being directed to third sector voluntary and community organisations, Primary Care Networks and specialist diabetes teams.

4.2. Types of activities that it may support include:

- Running costs (for example, room hire for partnership activities or community engagement).
- Resources to support the involvement of groups who may be poorly represented in health and care.
- Resources to support the gathering and sharing of learning across the area.
- Small-scale equipment/ technologies.
- Development of learning materials e-learning, digital, app, other formats for inclusivity such as Makaton, Braille, Subtitle, easy read and Audio.
- Project management costs.
- Innovative ideas and solutions.

4.3. We can't fund:

- Activities that make profits for private gain.
- Activities that replace government funding (for example, we can't fund health services or staff posts which would normally be funded as part of the NHS or local authority's responsibilities for commissioning services).
- Political activities.

4.4. Levels of Funding

Funding will be considered through a competitive process in the following amounts, Programme A- £5,000 to £40,000 range.

Programme B- £40,001-to £100,000.

Matched funding will be considered but a breakdown of funding should be provided.

4.5. What is the application process/ Timescales?

- Programme A and B require the completion of the relevant application forms. The closing date will be Close of play Friday 29th January 2021.
- Shortlisted applications for Programme A might require a short follow-up conversation on Teams call with the Diabetes Network Team for any points of clarification.
- Shortlisted applications for Programme B will be reviewed at a panel discussion. Some shortlisted Programme B applications might require a more detailed discussion virtually, with the diabetes team.
- All successful projects will be subject to quality assurance processes led by the Clinical Network.

4.6. Judging- The bids will be categorised and judged by a panel representing diabetes interests. There will be a mix of lay, patients, clinical members and managerial representatives on the panel and the Clinical Network as well as an executive sponsor for NHS England.

4.7. Expectations of successful projects in Programme A- £5,000 to £40,000

Successful project will be expected to

1. Submit a basic project plan.
2. Basic spending plan.
3. Explain how improvements will be measured.
4. Have quarterly catch up meetings, virtually or face to face with quality assurance team.
5. Provide updates on a quarterly basis.
6. Present findings and evaluation either at a sharing event, poster presentation, a presentation for selected projects or with a report document.

4.8. Expectations of successful projects in Programme B- £40,001-££100,000

Successful project will be expected to

1. Submit quarterly project plan, objectives and milestone plan.
2. Quarterly spending plan.
3. Describe metrics and explain how you will measure improvements.

4. Have quarterly catch up meetings virtually or face to face with quality assurance team.
5. Provide updates and data on a quarterly basis.
6. Present findings and evaluation either at a sharing event, poster presentation, a presentation for selected projects or with a report document.

5. References

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