

Diabetes in Brent

1. Purpose of the report:

- 1.1 This report provides an update to Brent HOSC on diabetes. It covers the current and expected future numbers of people with diabetes in Brent and the level of complications in the diabetic population with comparison to the national picture.
- 1.2 The report has been produced jointly by Brent Council public health team, Brent CCG and NHS England and covers the range of services commissioned by these partners. These range from health promotion and diabetes prevention activity; awareness raising and risk assessment; intensive lifestyle support to those with pre-diabetes; diagnosis and management of diabetes in primary care (including an expansion of the traditional primary care role to include insulin initiation); and secondary care services, including diabetic eye screening.
- 1.3 The report concludes with an account of the CCG's identification of the case for change in current services for people with diabetes in Brent and the plans for service redesign.

2. The Epidemiology of diabetes in Brent

Numbers of people with diabetes in Brent

- 2.1 There are currently 22,097¹ people on GP diabetes registers in Brent. Diabetes prevalence varies across the five CCG localities in Brent, being highest in Kingsbury at 9.6% and lowest in Kilburn at 6.1%. NHS Brent has seen a 38% increase in the prevalence of diabetes between 2008/09 and 2012/13 (see table 1). This is likely to be due to a combination of population growth, improved detection and recording on GP systems, as well as an increase in the actual prevalence, as described below.
- 2.2 In October 2013 Diabetes UK reported the prevalence of diabetes in Brent to be 10.5%, the highest in the UK and compared to a national rate of 7.4%. The Diabetes UK figure is an estimate and higher than the numbers recorded by GPs, which reflect the actual number of *diagnosed* diabetic patients. It is estimated that one in four people with diabetes in London are undiagnosed. These individuals are unaware they have diabetes and are at a high risk of developing long term complications.

Table 1 - Prevalence per year (QOF register)

Year	Diabetes register (on 01 April)
2008/09	15,990
2009/10	16,699
2010/11	18,011
2011/12	20,987
2012/13	22,097 ²

¹ QMAS data as at 01 Apr 11

² See 1

Expected increase in the number of patients living with diabetes

- 2.3 The prevalence of diabetes in Brent is projected to rise, fuelled by the ageing of the population, increasing numbers of people who are obese and overweight, and the high proportion of black and Asian ethnic groups in the borough who are more susceptible to diabetes.
- 2.4 The Association of Public Health Observatories predicts the number of people with diabetes on GP registers in Brent will increase to just over 25,000 by 2020. This would represent a prevalence of 11.2% and compares to a predicted prevalence of 8.7% for London over the same time period.

Rates of complications associated with diabetes

- 2.5 People with diabetes are at risk of a range of complications, including heart disease, stroke, foot disease which may necessitate amputation, kidney disease and loss of sight. Early diagnosis, good diabetic care and self management can reduce the risk of complications.
- 2.6 The main findings of the 2011/12 National Diabetes Audit, which gathers data to identify the additional risk of diabetic complications and mortality in people with diabetes when comparisons are drawn with the general population, were as follows:
- In Brent, people diagnosed with diabetes were 35.6% more likely than the general population to have a MI (Myocardial Infarction) and 29.9% more likely to have a stroke³.
 - People with diabetes in Brent were 56.5% more likely than the general population to have a hospital admission where heart failure was recorded.
 - In Brent people with diabetes have a 19.4% greater probability of dying in a one year period than the general population.
- 2.7 Figure 1 compares the prevalence of complications in the diabetic population in Brent to that in the diabetic population in England. People with diabetes in Brent are less likely to have complications than people with diabetes in England.

³ National Diabetes Audit 2011/12

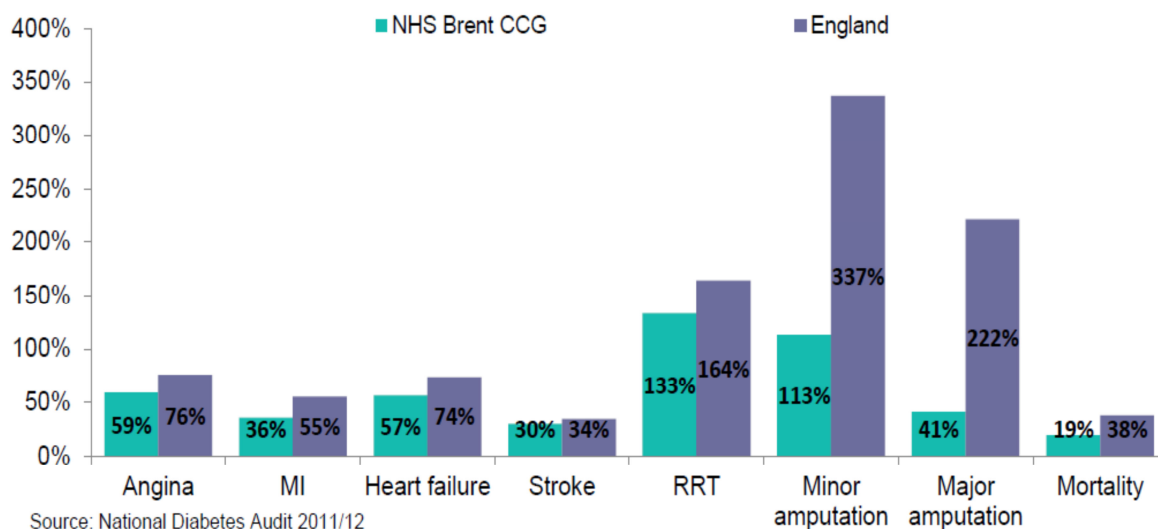


Figure 1 Prevalence of diabetes associated complications.

RRT: Renal replacement treatment – a marker for kidney disease
 Source: National diabetes audit 2011/12

2.8 The Yorkshire and Humber Public Health Observatory published data in 2012 on the number of people who were admitted to hospital for diabetic foot disease. In Brent during 2008 – 11, there were 565 episodes of care for diabetic foot disease, equivalent to 10 episodes of care per 1000 people with diabetes each year. This is lower than the national rate of 18.1 per 1000⁴.

Overview of Services in Brent:

3. Summary of NHS Brent CCG annual diabetes costs for 2013/14:

3.1 Total allocated budget is £9,493,000. This includes primary care prescribing, CCG prevention & health promotion, secondary care, urgent emergency care, community and the local enhanced service for GPs

4. Health promotion and prevention of diabetes

4.1 Brent Council in conjunction with Brent CCG has been working closely with its communities to reduce the impact of diabetes throughout the borough. The following is a summary of the main events and programmes which are already in place or will commence in January 2014.

Physical activity programmes

4.2 Brent Council Sports development unit have provided a programme of events targeted at those residents who are less active and at risk of diabetes. Programme highlights include:

- Healthy led walks programmes
- Over 50s exercise classes

⁴ Diabetic Foot Disease Profile for NHS Brent Teaching, diabetes health intelligence programme, YHPHO, January 2012.

- Free swimming for over 60s throughout Brent
- Installation of outdoor gyms in 6 parks
- An exercise referral scheme which is run through 3 leisure centres

Healthy eating

- 4.3 Brent planning team are looking to consult on changes to planning laws to reduce the saturation of fast food outlets in the borough and restrict the presence of fast food outlets to within 400 metres of schools.
- 4.4 To support these planning decisions, the Brent Council healthy lifestyles team are conducting a unique research project in which 8 local schools have agreed to participate. All year 7 and 10 year olds have completed a questionnaire to establish how frequently they use local takeaways in their lunch hour and after school.

Diabetes awareness raising, risk assessment and health checks

- 4.5 There is a cohort of people in Brent who are at high risk of developing diabetes by virtue of their family history, ethnicity, weight and waist measurement, but who may be unaware of this risk.
- 4.6 Since 2013, Brent council have collaborated with Diabetes UK to launch a community engagement programme, using community champions to promote awareness about diabetes in the high risk population in the borough. Community champions may include individuals from key faith groups, community organisations or those already suffering diabetes.
- 4.7 Diabetes UK offer individual risk assessments and advice on reducing the risk of diabetes. These were trialled in Brent at a recent Council staff health and wellbeing event at which around 50 staff took up the offer.
- 4.8 NHS health checks are offered by GPs in Brent, and since April 2013 have been commissioned by the Council as part of its new public health responsibilities. The NHS Health Check programme aims to help prevent diabetes – and also heart disease, stroke, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or who has certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk.
- 4.9 So far in 2013/14, 2750 individuals have received an NHS Health Check in Brent and from these 35 individuals were newly diagnosed with diabetes. A further 344 individuals were identified as having pre-diabetes and have been referred to our local Moving Away from Pre Diabetes Programme.

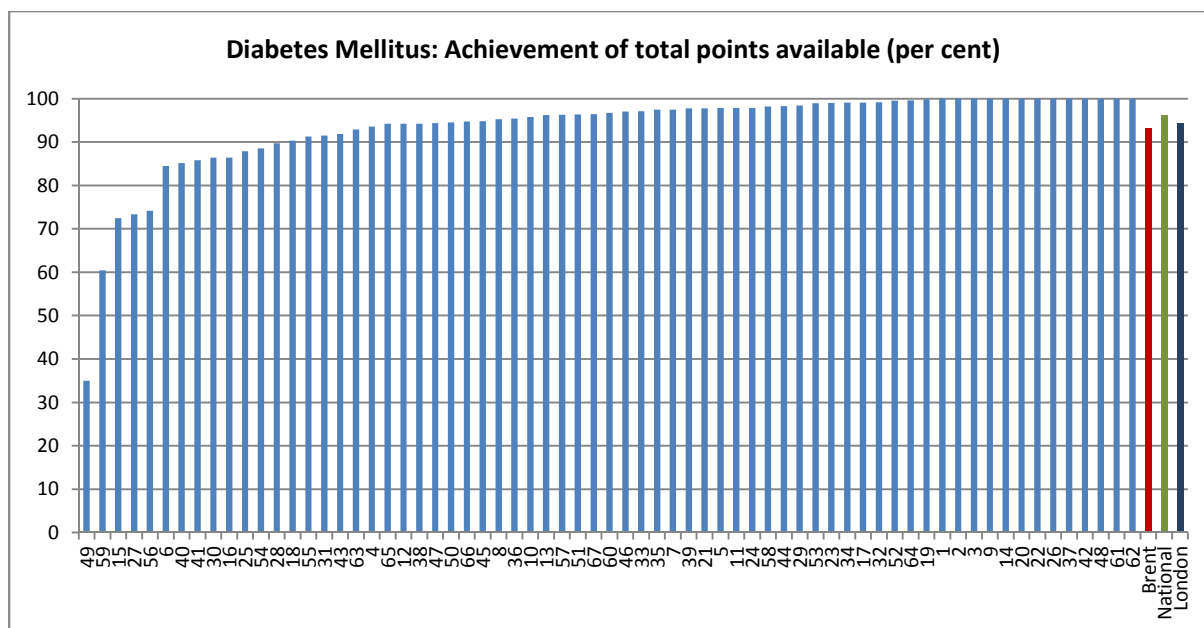
Moving Away from Diabetes Programme

- 4.10 Brent has developed its own intensive lifestyle intervention for individuals who are identified as being at high-risk of developing diabetes in the future. The Moving Away from Pre-diabetes (MAP) programme uses an intensive behaviour change approach to help residents make sustainable changes to the way they eat and exercise. The overall aim of MAP is to reduce the incidence of diabetes and cardiovascular disease in the Brent community.

- 4.11 The MAP programme is an example of collaborative working between leisure services, Brent Council and the Nutrition and Dietetic Service of Ealing Integrated Care Organisation. Brent leisure services provide the venues for the group exercise and nutrition education sessions. Brent Council Sports and Parks Service provide the fitness instructors and facilitate the provision of leisure centre membership for all participants of the MAP programme (funded by the programme). The programme content, development and implementation is overseen and delivered by dietitians from the Ealing Integrated Care Organisation.
- 4.12 Since commencing in November 2011, over 700 pre-diabetic patients in Brent, have received some level of intervention from the MAP programme. During 2012/13, 173 participants completed the program. We estimate that 71% of participants demonstrated real improvements in their blood glucose levels after the six-month programme, with one third of patients no longer being pre-diabetic.
- 4.13 The latest results (November 2012 to December 2013) for 112 patients that completed the intensive 6 month intervention, showed that 66% of those retested (70 patients) are no longer pre diabetic

5. Primary Care

- 5.1 Although there are no requirements in the standard General Medical Services (GMS) contract relating specifically to the management of diabetes, all contractors who have a list of registered patients are contractually required to provide services for the management (including consultation, examination, investigation and referral) of their patients who are suffering from any chronic disease.
- 5.2 Diabetic patients are currently managed in primary care under the standard GMS/PMS contract, including additional health checks under the Quality and Outcomes Framework (QOF). All Brent practices also participate in QOF, which financially rewards practices for meeting a range clinical and organisational quality indicators. There are currently 16 diabetes specific indicators these include: regular blood sugar levels, annual blood pressure monitoring, retinal screening, dietary review and access to diabetes education programmes.
- 5.3 The graph below demonstrates that the vast majority of Brent practices are achieving a high number of points for the diabetes domain of QOF (using 2012/13 QOF achievement data).



6. Brent GP Insulin Initiation Scheme

- 6.1 The Diabetic Insulin Local Enhanced scheme (LES) was rolled out across Brent in April 2012 and supports integrated diabetic care delivered in primary care. With 22,000 + diabetic patients in Brent it is crucial that practices are skilled in initiating insulin therapy. This is in line with the CCG vision to provide care as close to patients as possible and increase the role of primary care in both the management and self-management of people with chronic diseases.
- 6.2 Traditionally insulin conversion has been undertaken within secondary care. However, with both diabetes and other chronic conditions there is a move to provide care as close to patients as possible and therefore increasing the role for primary care in the management of diabetes.
- 6.3 Training workshops across the 5 localities were delivered to ensure practices received adequate training to meet specific standards. Uptake of the scheme has been slow. Brent CCG is exploring options to improve this in order to strengthen primary care capacity given the increasing number of patients requiring insulin.

7. Community Care – Ealing Integrated Care

- 7.1 This service provides an integrated pathway for patients with Type II Diabetes from prevention and health promotion through to intensive care and support (case management and self-management programmes). All Diabetes community care has to be delivered within the framework and competencies dictated by National Institute of Clinical Excellence (NICE). The care pathway ensures there is a seamless service from adolescent to adults for patients diagnosed with Type II Diabetes.
- 7.2 The Diabetes community pathway is a consultant led multi-disciplinary service incorporating a range of specialisms: diabetes nurse consultant, diabetes specialist nurses, nutrition and dietetics, podiatry and GPs with specialist interests in

Diabetes.

- 7.3 The service provides Primary and Secondary care services managing poorly controlled patients with Type II Diabetes. This includes offering patients the opportunity to attend rapid access outpatient clinics as well supporting the self-management of their long term condition through education programmes, domiciliary visits and case management when an exacerbation occurs. This is underpinned through the education and up-skilling of primary care community teams and the production of management and drug guidelines to standardise care.

8. Secondary Care Services

- 8.1 In conjunction with primary and community services, secondary care aims to provide a holistic treatment and management services. This includes the following:

- Outpatient services
- Admission avoidance and expedited discharged strategies
- Inpatient Provision/services

9. Brent diabetic eye screening (DES) services

- 9.1 NHS England is now responsible for commissioning of screening services which include diabetic eye screening. One of the complications of diabetes is disease of the retina which can result in visual impairment. Screening aims to detect changes in the retina early at a stage when treatment, often by laser, can preserve sight.
- 9.2 The Brent diabetic eye screening programme is provided by the Ealing Integrated Care Organisation. The screening service is community based operating across three sites:
- Wembley
 - Jeffery Kelson Centre (Central Middlesex Hospital – CMH)
 - Willesden Community Hospital
- 9.3 Following a positive screening test, patients are referred to ophthalmology services at Central Middlesex Hospital.
- 9.4 The programme is monitored through a programme board that meets quarterly. The Board is responsible for overseeing delivery of services in Brent to national standards as set by the NHS Diabetic Eye Screening Programme (DESP). The DESP sets national KPIs. The table below provides national KPI data for Q1 2013/14 and annual data for 2012/13. This indicates that performance in the Brent programme is generally to an acceptable standard.

Table 2.

KPI	KPI title	KPI description	Target	Annual performance 2012/13	Q1 2013/14 performance (latest published data)
DE1	Diabetic retinopathy - uptake of digital screening encounter	The proportion of individuals who attend eye screening following an invitation in the reporting period	Underachieving: < 70% Acceptable: 70% - 79.9% Achievable: 80% AND GREATER	77%	77% London range 70-89%
DE2	Diabetic retinopathy - results issued within 3 weeks of screening	The number of subjects attending for screening to whom a screening result letter was issued within 3 weeks (21 days) of the screening encounter.	Underachieving: < 70% Acceptable: 70% - 94.9% Achievable: 95% AND GREATER	95%	94% London range 80-100%
DE3	Diabetic retinopathy - timely consultation for R3 screen positive	Subjects referred with proliferative retinopathy receiving consultation within 4 weeks (28 days) of notification of positive test	Underachieving <80% Achieving – 80% and greater	87%	60% London average 76.4% **

** It should be noted that data for DE3 can be based on (fortunately) very small numbers of patients found to have disease which requires urgent ophthalmology assessment. Therefore when a few patients rebook their appointment this can have a disproportionate effect.

9.5 The national model for diabetic eye screening programme is changing. The recall periods, currently annual, will change so that patients with certain levels of disease will be monitored more closely within a community screening setting before being

referred to ophthalmology. This will ease pressure on ophthalmology units seeing patients that are being referred currently but do not require treatment. These changes are likely to come into affect during 2014/15.

- 9.6 A new piece of software is being developed to automatically extract data from GP systems to inform programmes of the diabetic population. Brent DES has opted to become an early implementer of the software which will remove the need for GPs to make manual referrals to the programme when a patient is diagnosed as diabetic.
- 9.7 The Wembley site is unable to cope with current demand, despite attempts to redirect patients to other sites. The service and NHSE are working to review capacity and if necessary will make amendments to the current capacity across the three sites.

10. Diabetes Service Redesign from April 2014

Case for change – National and Local Guidance

- 10.1 The residents of Brent have changing health needs, as people live longer and live with more chronic and lifestyle diseases, this places greater demand on primary and community care. Local acute providers continue to see an increase in demand for outpatient care which is putting pressure on services and increasing waiting times.
- 10.2 Brent CCG has recognised the need to invest in diabetes services. This means optimising the role of general practice in delivering planned care and ensuring that specialist advice and input is used to good effect to support local clinicians in delivering the best outcomes for patients. By supporting and enabling primary, secondary and community providers to work together more effectively there is an opportunity to avoid patients developing complications.
- 10.3 The advantages of the redesigned integrated pathway community based service are:
 - To provide a consultant led service where patients are seen by a multi-disciplinary team and treated in one appointment as clinically appropriate
 - Achieving value for money, ensuring that patients are treated in an environment most appropriate to their needs at the right cost.
 - Opportunities to up skill GPs and practice nurses in diabetes care
 - Facilitate early discharge back to GP care
 - Develop a clinical network of care to provide Tiers 1 and 2 care within localities
- 10.4 The proposed model of service will ensure that:
 - Primary care clinicians have a framework for providing Tier 1 and 2 services
 - Brent CCG have robust outcomes data to monitor the performance of providers to rapidly improve health outcomes for patients with diabetes and reduce the variation in care across primary care localities
 - The level of expertise across primary care is increased. This will enable a reduction in services duplicated across primary care, community and secondary care
 - Increase the provision and access of the DESMOND education programme including the development of an ethnic specific programme.

Proposed Investment in Diabetes

10.5 Brent CCG has approved an additional investment of £693K to enhance and further develop the community based integrated diabetes pathway. The proposed model is to increase clinical capacity as a sustainable way of delivering high quality integrated diabetic care, for all patients with type 2 diabetes except for those with very complex needs.

10.6 The new model invests in building additional clinical capacity within the service including the following:

- Diabetes Specialist Nurse (DSN)
- DESMOND Nurse Trainer
- DESMOND Dietician
- Clinical Psychologist
- Administrator
- Dietician
- Podiatrist
- Operational manager

10.7 The redesigned integrated service will work collaboratively to deliver the following:

- A single point of access to a consultant led integrated service including GPSI and specialist nurses where patients are seen by a multi-disciplinary team and treated in one appointment as clinically appropriate
- Triage to the right clinician first time
- Prompt discharge back to GPs supported by clear treatment plans.

10.8 The advantages of the redesigned integrated service is to improve health outcomes by:

- Providing early detection and identification
- Involving patients in the decisions around personalised care planning
- Developing patient knowledge, skills and confidence for better self-management
- Demonstrating robust clinical and operational outcomes
- Targeting high risk populations

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