

Report to HOSC on Proposed Redesign & Investment into Brent Diabetes Services Feb 2014

1.0 Purpose of the report

This report provides an update to Brent HOSC on proposed diabetes service redesign and focuses on the case for change in current services for people with diabetes in Brent and details the plan for the service redesign. The report also provides information on the Local Enhanced Service (LES) for provision of insulin initiation for Type 2 diabetes and covers the actual spend, the number of patients initiated and the number of practices providing this service.

2.0 Background

2.1 Case for change – National and Local Guidance

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.

The objective of the community diabetes services is to ensure that resources are managed in a more co-ordinated way to deliver care which is timely and effective and available closer to home. 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 more ad hoc and reactive demand management of diabetes which risk storing up demand through short term initiatives to manage waiting times

2.2 Diabetes Prevalence in Brent

The table below sets out diabetes prevalence as the sum of diabetes mellitus (diabetes) Register (ages 17+) and represents actual GP recorded number of diagnosed diabetic patients. The recorded prevalence for Brent is 8.1 which is both higher than the national and London rate.

However Diabetes UK in October 2013 reported the prevalence of diabetes in Brent to be 10.5% the highest in the UK compared to a national rate of 7.4%. These figures take into account an estimate of undiagnosed diabetes in the population. The number of undiagnosed patients is currently being addressed by the NHS Health Check Programme for people 40yrs -74 years to identify those at risk.

Table 1: Prevalence of Diabetes for 2012-13

Population	No of diabetics register ages 17+	Prevalence
National (UK)	2,703,044	6.0%
London	418,346	5.8%
Newham	20,645	7.1%
Brent	22,097	8.1%

HSCIC (Health and Social Care Information Centre) QOF 2012-13 data

Table 2 - Distribution of Diabetes Registered Patients across Brent

Locality	Registered population age 17+	No of diabetics register age 17+	Prevalence
Harness	64,643	5,458	8.4%
Kilburn	63,072	3,861	6.1%
Willesden	41,100	3,020	7.3%
Wembley	42,732	3,899	9.1%
Kingsbury	61,313	5,859	9.6%
Totals	272,859	22,097	8.1%

HSCIC (Health and Social Care Information Centre) QOF 2012-13 data

2.3 Current Diabetic Specialist Nurse Staff Profile

Table 3 sets out a comparison of Brent and Newham Diabetic Specialist Nurses for the community integrated service teams.

Table 3: Current Diabetic Specialist Nurse Profiles

Location	Diabetic Specialist Nurses (DSN)
UK	587 DSNs – Diabetes UK Survey 2010
London	Information not available
Brent	1 WTE Consultant Diabetic Nurse 2 WTE DSNs 1 WTE Paediatric DSN (funding provided to NWLH)
Newham	0.8 WTE Adolescent and young adult DSN(16 -25 years) 5.2 WTE Adults>25 years old 1 WTE Paediatric DSN 0.5 WTE Team leader

2.4 Brent & Newham Comparison of Care Processes

The National Diabetes Audit (NDA) 2011-12 presents key findings for CCGs on achievements of the 8 National Institute for Health and Care Excellence (NICE) key care processes of diabetes care. The recommended care processes are annual checks for the effectiveness of diabetes treatment for HbA1c control, cardiovascular risks and detection of emergence of early complications. Tables 4 and 5 set out the completion rates for Brent and Newham as our statistical neighbour.

Table 4: Percentage of patients in NHS Brent CCG & England and Wales receiving NICE recommended care process, diabetes type and audit year

		All diabetes ^a			Type 1			Type 2		
		2009-2010	2010-2011	2011-2012	2009-2010	2010-2011	2011-2012	2009-2010	2010-2011	2011-2012
HbA1c ^b	CCG/LHB	91.6%	91.3%	90.6%	85.7%	84.1%	83.6%	92.5%	92.2%	91.4%
	England & Wales	92.1%	92.5%	90.3%	85.7%	86.0%	83.0%	93.2%	93.5%	91.3%
Blood pressure	CCG/LHB	94.8%	94.7%	94.5%	89.6%	90.8%	89.5%	95.3%	95.1%	94.9%
	England & Wales	95.2%	95.0%	95.0%	88.9%	88.7%	88.4%	96.1%	95.9%	95.8%
Cholesterol	CCG/LHB	91.7%	91.1%	90.1%	82.9%	82.3%	80.8%	92.4%	91.8%	90.8%
	England & Wales	91.7%	91.6%	90.9%	79.1%	78.8%	77.8%	93.2%	93.1%	92.4%
Serum creatinine	CCG/LHB	92.5%	91.9%	91.5%	84.4%	83.2%	82.3%	93.2%	92.6%	92.2%
	England & Wales	92.5%	92.5%	92.5%	81.0%	81.2%	81.1%	93.9%	93.8%	93.8%
Urine albumin ^c	CCG/LHB	81.5%	81.0%	80.3%	69.9%	69.5%	68.5%	82.9%	82.3%	81.4%
	England & Wales	72.3%	75.1%	76.0%	56.2%	58.4%	59.2%	74.3%	77.1%	77.9%
Foot surveillance	CCG/LHB	85.3%	84.7%	86.2%	77.5%	76.8%	78.1%	86.5%	85.9%	87.2%
	England & Wales	84.1%	84.3%	85.3%	71.7%	71.5%	72.8%	85.9%	86.1%	87.0%
BMI	CCG/LHB	87.9%	89.5%	90.2%	83.3%	84.7%	86.1%	88.5%	90.2%	90.8%
	England & Wales	90.1%	89.9%	90.3%	83.6%	83.4%	83.7%	91.1%	90.8%	91.3%
Smoking	CCG/LHB	84.8%	82.6%	81.6%	78.7%	75.8%	77.6%	85.3%	83.2%	82.0%
	England & Wales	86.9%	84.8%	85.1%	80.8%	78.6%	79.0%	87.7%	85.7%	85.9%
Eight care processes ^d	CCG/LHB	65.6%	65.1%	64.0%	53.7%	50.9%	51.1%	67.0%	66.6%	65.1%
	England & Wales	59.4%	60.6%	60.5%	42.4%	43.3%	43.2%	61.6%	62.8%	62.6%

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

^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.

^c There is a 'health warning' regarding the screening test for early kidney disease (Urine Albumin Creatinine Ratio, UACR) but we believe that this does not concern NHS Brent CCG.

^d The eye screening care process has been removed from this table; therefore 'eight care processes' comprises the eight care

Source: National Diabetes Audit 2011-2012 Report 1: Care Processes and Treatment Targets – NHS Brent CCG
Copyright © 2013, The Health and Social Care Information Centre, National Diabetes Audit. All rights reserved

Findings

- In 2011-12 Brent achieved > 90% in 5 of the key processes for diabetes Type 2 patients
- In 2011-12 Brent achieved 70% - 90% for 3 of the key processes for diabetes Type 2 patients
- In 2011 -12, urine albumin was the most poorly recorded care process in Brent at 81% however this is higher than the rate of 78% for England & Wales
- For the 8 care processes combined Brent achieved 65%

Table 5: Percentage of patients in NHS Newham CCG & England and Wales receiving NICE recommended care process, diabetes type and audit year

		All diabetes*			Type 1			Type 2		
		2009-2010	2010-2011	2011-2012	2009-2010	2010-2011	2011-2012	2009-2010	2010-2011	2011-2012
HbA1c ^b	CCG/LHB	91.9%	92.2%	91.7%	82.2%	79.8%	78.8%	92.6%	93.1%	92.4%
	England & Wales	92.1%	92.5%	90.3%	85.7%	86.0%	83.0%	93.2%	93.5%	91.3%
Blood pressure	CCG/LHB	96.2%	95.6%	95.2%	89.5%	88.8%	89.7%	96.6%	96.1%	95.5%
	England & Wales	95.2%	95.0%	95.0%	88.9%	88.7%	88.4%	96.1%	95.9%	95.8%
Cholesterol	CCG/LHB	92.3%	91.5%	91.0%	73.1%	69.1%	67.9%	93.2%	92.7%	92.0%
	England & Wales	91.7%	91.6%	90.9%	79.1%	78.8%	77.8%	93.2%	93.1%	92.4%
Serum creatinine	CCG/LHB	92.9%	92.4%	92.3%	76.1%	74.0%	73.1%	93.8%	93.4%	93.2%
	England & Wales	92.5%	92.5%	92.5%	81.0%	81.2%	81.1%	93.9%	93.8%	93.8%
Urine albumin ^c	CCG/LHB	82.2%	82.5%	82.3%	58.7%	59.3%	56.0%	83.5%	83.9%	83.6%
	England & Wales	72.3%	75.1%	76.0%	56.2%	58.4%	59.2%	74.3%	77.1%	77.9%
Foot surveillance	CCG/LHB	88.9%	88.9%	89.1%	72.5%	74.4%	71.3%	89.9%	90.0%	90.1%
	England & Wales	84.1%	84.3%	85.3%	71.7%	71.5%	72.8%	85.9%	86.1%	87.0%
BMI	CCG/LHB	93.7%	93.2%	93.7%	88.7%	87.7%	87.4%	94.1%	93.7%	94.1%
	England & Wales	90.1%	89.9%	90.3%	83.6%	83.4%	83.7%	91.1%	90.8%	91.3%
Smoking	CCG/LHB	92.3%	92.1%	92.1%	86.3%	82.6%	82.6%	92.7%	92.7%	92.6%
	England & Wales	86.9%	84.8%	85.1%	80.8%	78.6%	79.0%	87.7%	85.7%	85.9%
Eight care processes ^d	CCG/LHB	74.3%	75.7%	73.7%	49.4%	47.7%	45.0%	75.8%	77.3%	75.1%
	England & Wales	59.4%	60.6%	60.5%	42.4%	43.3%	43.2%	61.6%	62.8%	62.6%

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

^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.

^c There is a 'health warning' regarding the screening test for early kidney disease (Urine Albumin Creatinine Ratio, UACR) but we believe that this does not concern NHS Newham CCG.

^d The eye screening care process has been removed from this table; therefore 'eight care processes' comprises the eight care processes that are listed above

Findings

- In 2011-12 Newham achieved > 90% in 7 of the key processes for diabetes Type 2 patients
- For the 8 care processes combined Newham achieved 75%

Overall Brent is behind Newham by 10% for the 8 care processes combined the highest differences being; smoking, foot surveillance and Body Mass Index (BMI). In consideration of the variation in Brent for each of the 8 care processes it is recommended that an action plan to improve one or two of the poorer care processes be undertaken.

2.4 Prevalence of Complications

Table 6 provides a comparison of additional risk of diabetic complications, comparing Brent against England and Newham.

Table 6: Benchmark of prevalence of complications

Clinical complication	England (%)	Newham (%)	Brent (%)
Angina	76	59	59
Myocardial Infarction	55	42	36
Heart Failure	74	60	57
Stroke	34	10	30
Renal Replacement Treatment	164	103	133
Minor amputations	337	189	113
Major amputation	222	100	41
Mortality rates	38	6	19

Source: National diabetes audit 2011/12

<http://www.yhpho.org.uk/diabetescommunityhealthprofiles/default.aspx>

The data shows the following key points:

- Brent compared to England has better outcomes for all 8 key additional risk of diabetic complications.
- Brent compared to Newham performs better in 4 out of 7 key risk areas of diabetic complications
- Brent compared to Newham has poorer outcomes in 3 out of 7 risk areas and have the same additional risk for angina

The redesigned pathway in Brent aims to improve all the areas of additional risk of complications and will drive up performance in areas where we compare unfavourably with Newham as our statistical neighbour.

3.0 Planned Changes to Brent Diabetes Services

The model is proposed as a sustainable way of delivering high quality care integrated diabetic care in community settings for patients with type 2 diabetes except for those with very complex needs. DSNs will be located in the localities and in addition to holding a caseload will also provide greater clinical support to practices in terms of providing education to GPs, practice staff, patients, carers and nursing homes.

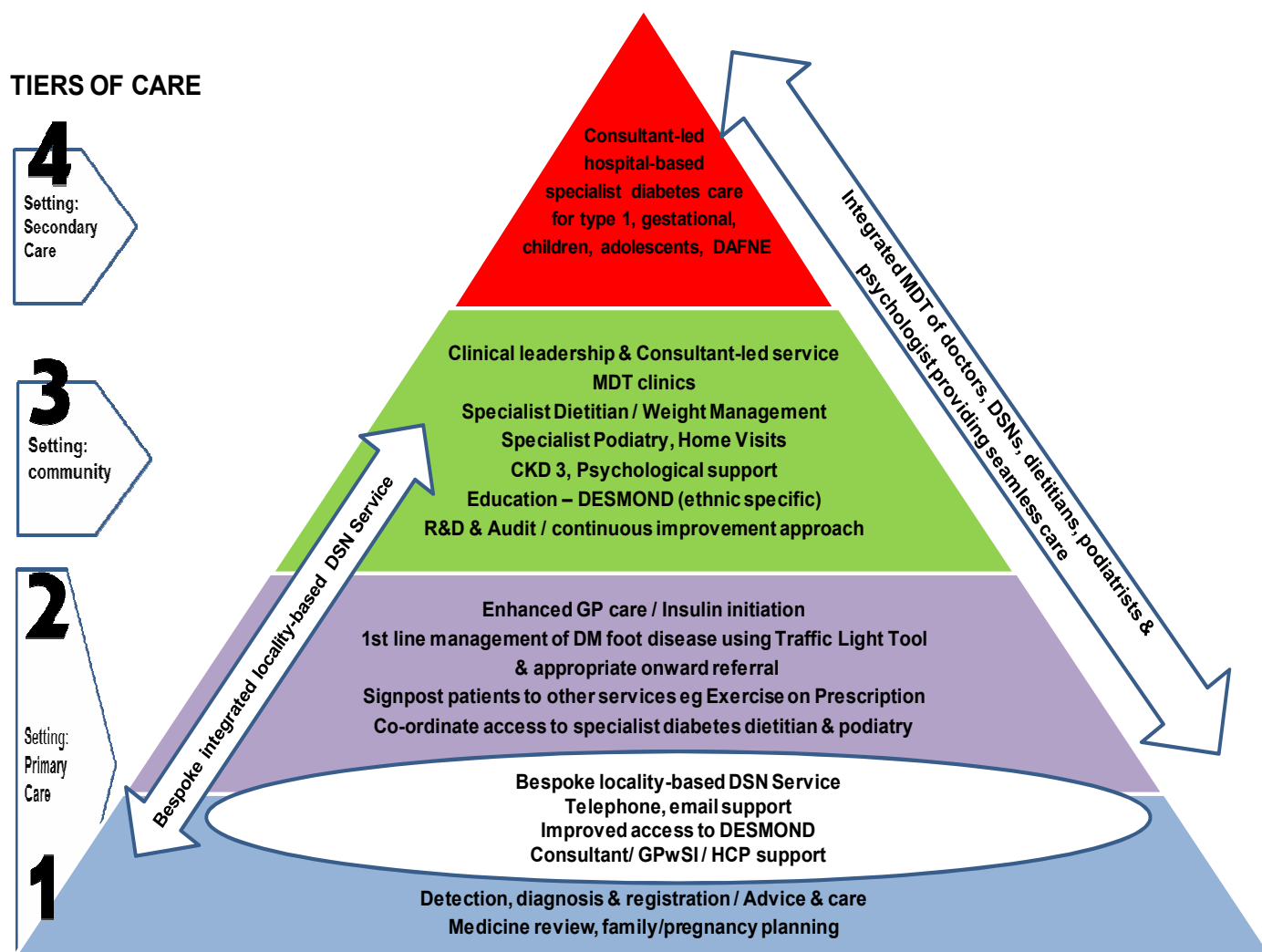
This model of care builds on the current model, in which the majority adult patients, both newly diagnosed and those requiring long term monitoring, are seen and treated in the community. Some complex patients, for example those seen in joint

specialty clinics such as gestational diabetes will continue to be seen in hospital settings.

The redesigned service will be based on the following principles:

- Early detection and identification
- Individuals with diabetes at the centre of their care and treatment
- Patients involved in the decisions around personalised care planning
- Develop patient knowledge, skills and confidence for better self-management
- Integration of care
- Quality assurance, evaluation and monitoring
- Targeting high risk populations
- Tiers of care relating to primary, intermediate and secondary provisions
- Prevention and diagnosis of patient groups with particularly complex needs
- Robust monitoring, evaluation, audit and satisfaction surveys to assess clinical effectiveness and improved patient experience

Table 7: Brent Diabetes New Integrated Pathway Service Model



The diabetes service for Brent aims to achieve and deliver the strategic objectives set out in NHS Brent's CSP and QIPP Plans. The new model of service will ensure that:

- Improved clinical outcomes as a result of timely access and better coordination of care around the patient
- Primary care clinicians have a framework for providing Tier 1 and 2 services
- Brent CCG have robust data to monitor the performance of providers to 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 which will enable a reduction in services duplicated across primary care, community and secondary care
- Primary care services are incorporated within a locality clinical network to improve access and outcomes
- Patients will be offered dedicated diabetes education packages to help them to understand and manage their condition.

3.1 Interventions

All patients (22,097) receive their basic care in tier (tier 1) in primary care and many patients requiring tier 2 care are also managed in primary care. Patients step up and down through the tiers according to clinical needs. Table 5 below describes the interventions in the various settings of care. All care settings contribute to collaborative care planning and will be evaluated to ensure improved outcomes.

Table: 8 Pathway Interventions

Brent Community Services Diabetes Care - Interventions			
Tier 1	Tier 2	Tier 3	Tier 4
GP Essential Care Managed at GP Practice	GP Enhanced Care Managed at GP Practice	Ealing ICO Community Services Managed in Intermediary Care	Specialist Care Managed in Secondary Care
<p>Supports and develops essential care, including:</p> <ul style="list-style-type: none"> • Detection, diagnosis, register maintenance; • Patient education programmes e.g DESMOND • Dietary advice • Personal care planning; • Medicines review • Complications screening; • Patient and carer advice/education • Family planning and initial pregnancy planning advice • Where necessary co-ordinate access to: specialist diabetes dietetics & podiatry; • Telephone and email support. <p>Retinal Screening Refer NEW patients to Brent Screening Programme</p>	<p>Deliver and co-ordinate:</p> <ul style="list-style-type: none"> • Patient education programmes (DESMOND); • Access to insulin initiation and new therapies if appropriate; • Or Insulin initiation • Joint clinics; • Specialist diabetes dietetics • Psychological support; • Podiatry. • Access to specialist opinion when needed. • Telephone and email support. 	<p>Deliver and co-ordinate:</p> <ul style="list-style-type: none"> • Multidisciplinary clinics; • Consultant-level support; • Access to specialist diabetes dieticians, • podiatrists or other specialists; • Patient education; (DESMOND) • Insulin titration; • Family planning and pregnancy planning advice. • Psychological support; • Research and development, and training; • Professional training & education • House bound for Home visit by DSN * poor glycaemic control & related co-morbidities Referral to Tier 4 <p>At discharge all patients will have:</p> <ul style="list-style-type: none"> • Care plan modified / updated. • Insulin Titration formulated 	<p>Deliver and co-ordinate:</p> <ul style="list-style-type: none"> • Joint clinics; • Foot/Kidney services; • Children and Adolescent services; • Care and Education for people with Type 1 diabetes; • Insulin titration • Patient education; (DAFNE) • Patients with complex multiple co-morbidities • Research, Development, and training; • In-patient management. • Adolescent/ Transition into adult services Antenatal • Complex multiple co-morbidities • Podiatry –Grade 3

3.2 Service Model

The service shall offer multi-disciplinary community clinics which will comply with best practice outline in the Healthcare for London Standardised Diabetes Care Model. The service redesign incorporates the following key elements:

3.2.1 Service Description

The Service shall support each CCG Locality to establish Tier 2 diabetic clinics in the GP practice and locality-based Diabetes Network – primarily by providing DSN and GP with Special Interest (GPwSI) advice and support. Each locality shall have a named DSN providing this support. In addition the service shall support each Locality to develop NICE compliant care plans for all diabetics with a time line to review and update individual Care Plans

3.2.2 Joint Consultation Clinics

The Provider shall initiate monthly Joint Consultation Clinics which will be done through identified need and planned sessions within each locality. Practice patients with diabetes will simultaneously consult a primary care clinician and a service clinician as defined by the practice. Increasingly this will be the vehicle through which most patients with complex diabetic presentations are managed.

3.2.3 The Link Clinician Service

The Service shall allocate a named DSN – the ‘link clinician’ to each GP practice in the CCG. There is a requirement that each locality DSN attends a monthly meeting with the locality Diabetes lead for support and advice. The Link Clinician shall offer joint case note reviews for all patients on the practice’s diabetic patient list and subsequently offer advice on a management plan.

3.2.4 Home Visits

The Service shall offer a clinically equivalent service to housebound patients including the following cohort of patient:

- Patients receiving end of life care
- Patients with very complex needs who requires an assessment visit to their home
- Patients with poor engagement in diabetes care and poorly controlled diabetes.
- Patients who may require short term case management to improve control and improve patient compliance.

3.2.5 Self-Care, Patient and Carer Information and Patient Education

The Service shall adhere to the principles of empowering self-care and collaborative care planning and will be reflected in the written care plans, which will be expressed in a form the patient can engage with and use.

Letters will be addressed to patients and copied to GPs after each significant engagement with any clinician from the Service; to inform them of the outcomes, along with their test results.

The provider shall make information available in various formats such as audio, Braille and in suitable other languages.

The Service shall deliver DESMOND programmes at suitable locations around Brent, reflecting the prevalence in each locality. Inclusion of pre-conceptual and Pregnancy advice in the DESMOND educational programmes

4.0 Increased workforce Capacity of Proposed Model

In order to deliver an integrated care pathway resulting in improved outcomes the proposal is to increase clinical capacity and capability which requires a significant investment sum of £638,993 on top of the existing costs of £391,095.

Table 9: Outline of Diabetes Pathway Costing

POST	BAND	CONTRACTED WTE	NEW COST	EXISTING
PAY				
Consultant Physician	Diabetologist/Endocrinologist	0.50	£68,000	£56,112
Diabetes Nurse Consultant	AfC Band 8c	1.00	£79,898	£74,682
Operational Manager	AfC Band 8a	1.00	£64,868	£1,812
Clinical Psychologist	AfC Band 8a	0.50	£32,434	
Diabetes Nurse Practitioners	AfC Band 7	4.00	£226,563	£106,171
Diabetes Nurse - DESMOND	AfC Band 6	1.00	£49,045	
Dietician - DESMOND	AfC Band 6	1.00	£49,045	
Administrator	AfC Band 3	1.00	£28,622	
Lead Administrator	AfC Band 4	1.00	£30,574	£30,574
Nutrition and Dietetics	AfC Band 7	1.00	£56,640	
Podiatrist	AfC Band 7	1.00	£56,640	
GPwSI Support to the Pathway Pharmacist				
TOTAL PAY			£742,329	£269,351
TOTAL NON-PAY			£89,000	£16,327
Pay and non-pay total		13.00	£831,329	£285,678
TOTAL ESTATES & OVERHEADS			£198,759	£105,417
GRAND TOTAL			£1,030,088	£391,095

5.0 Key Measurable Outcomes

Delivery of the service will continue be measured via a system of Key Performance Indicators (KPI) and includes the following measures:

- Improved Clinical Outcomes for e.g. Better HbA1c control
- Reduction in hypoglycaemic episodes
- Reduction in hospital admissions and A&E attendances
- Improved Self Care
- Increased engagement with Primary Care
- Improved capability within Primary Care
- Improved access to Podiatry
- Improved patient experience
- Reduce the complications of diabetes
- Increase the management of more complex patients across primary care
- Reduce demand on secondary care

- Deliver psychological support to support compliance to treatment and self-care#
- Reduction in avoidable admissions
- To improve self-management a 100% of newly diagnosed diabetic patients to be offered DESMOND and a maximum wait for patients of 4 weeks.
- Increased uptake of annual diabetes Health Check and Patient Satisfaction Survey

6.0 Diabetes Insulin Local Enhanced Services (LES)

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.

Traditionally insulin conversion has been undertaken in hospitals. 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.

Across Brent there is variation in practices providing tier 1, tier 2 and tier 3 services and there are also differences in practices use of intermediate and secondary care diabetic services. One way of improving care across all practices is by education and further training for staff in the delivery of insulin initiation.

For poorly controlled diabetics on tablets insulin or other injectables would be the next step in treatment. With the increasing prevalence of diabetes, the numbers requiring insulin will also increase. To address this there is a need for primary care to retain and develop expertise in insulin initiation. This is accepted as good practice and fairly well implemented across the country.

Insulin initiation is complex and there are a number of steps involved. Patients are started on a low dose and this is built up slowly requiring close monitoring and intense patient education. Insulin dose titration is a skill that can be developed by experience and education in primary care.

6.1 Injectable Treatments for Diabetes

Injectable treatments such as Insulin, Exenatide, Liraglutide are increasingly being used to improve diabetes control to prevent diabetes long term complications therefore ideally many more patients should convert to injectable treatments. For 2012, it was projected that approximately 15,000 diabetics may require injectable management the majority of which will require insulin.

6.2 Brent Insulin Initiation Activity and Spend

Currently GP practices receive a payment of £100 per patient initiated, £30 per follow up appointment – up to a maximum of 7 appointments. Practices delivering the service (host) on behalf of non- participating practices receive a payment of £200 for insulin initiation or £50 if the patient is referred but does not require insulin to cover costs.

Table 10: Activity and Spend 2012/13

Quarter's	Claim	Number of Practices	Number of Start 'ups'	Number of follow 'ups'	Hosted not initiated
Q1 Apr – June	£6,470	12	27	109	10
Q2 July - Sept	£6,610	12	28	92	21
Q 3 Oct - Dec	£210	1	0	7	0
Q 4 Jan – Mar	£9,750	15	42	150	21
Total	£23,040	40	97	358	52

Findings:

- For 2012/13 - £23,040 was claimed by practices
- The number of practices claiming per quarter ranged from 12 – 15
- There is a disparity between the number of practices (41) who report they are providing the service to the number actually claiming for initiation each quarter

Table 11: Activity and Spend 2013/14 up to Q3

Quarter's	Claim	Number of Practices	Number of 'insulin start ups'	Number of follow ups	Hosted not initiated
Q1 Apr – June	£6,980	12	23	131	15
Q2 July - Sept	£4,760	9	15	92	10
Q3 Oct - Dec	£6,450	11	26	120	5
Totals	£18,190	32	64	343	30

Findings:

- Up to Q3 - £18,190 was claimed by practices
- The number of practices claiming per quarter ranged from 9-12

- There continues to be a disparity between the numbers of practices who report they are providing the service to the number actually claiming for initiation each quarter. An audit will be undertaken with recommendations to improve activity across Brent.

Table 12: Insulin initiation by locality & practice 2012 -2014

Locality	QTR 1 – Apr – June 2012
Harness	Oxgate Gardens Wembley Park Medical Centre Church End Medical Centre Brentfield Medical Centre The Surgery The Stonebridge Medical Centre Acton Lane Surgery Hilltop
Kilburn	The Law Medical Centre Lonsdale Medical Centre Kilburn Park M.C. Chamberlyne Road Surgery Staverton Windmill
Kingsbury	Chalkhill Medical Centre Premier Medical Centre Fryent Medical Centre Willow Tree Family Doctors Stag Lane Medical Centre Forty Willows Primary Care Kenton
Wembley	Preston Medical Centre
Willesden	Burnley Road Practice Gladstone Medical Centre St Georges Medical Centre St Andrews Medical Centre Neasden Medical centre

The above table gives a list of practices across Brent who have submitted claims for insulin initiation and does not necessarily represent actual activity as some practices may not have claimed.

7.0 Local Target For Identification of Chronic Kidney Disease (CKD)

According to the East Midlands Public Health Observatory (EMPHO) on behalf of NHS Kidney Care; in England in 2008/09 there were 1,739,443 people aged 18 and over who were registered with CKD (stages 3-5). This represents an overall crude (not adjusted for age) proportion of 4.1% in the 18 and over age group. The QOF prevalence only represents the people who have been detected and registered as having CKD, the actual prevalence will be higher.

The prevalence of kidney disease in diabetics is high and for Brent CKD prevalence as measured in Quality Outcomes Framework (QOF) is lower than expected at 2.2%.. Brent CCG has identified this as a local target for improvement and practices will be encouraged to improve detection rates to 2.7% for micro- albuminuria in

diabetics, improve rates of CKD stage 3 and above and treating these patient with the relevant drugs as appropriate.

8.0 Conclusions

There are changing health needs and demands in the population of Brent. We have seen an upward trend over the last four years in the number of recorded diagnosed diabetics and as highlighted by Diabetes UK's estimated prevalence (10.5%) there is a significant number of undiagnosed diabetic patients.

The increase in diabetes is being fuelled by: the ageing of the population, increasing rates of obesity and the high proportion of black and Asian ethnic groups in the borough who are more susceptible to diabetes.

Given that the prevalence of diabetes in Brent is projected to rise even higher Brent, CCG recognises that there is increasing demand on services and there is a need for additional investment in improving services in the community. The investment is intended to increase clinical capacity to improve the health outcomes for people with diabetes. This will enable early diagnosis, improved access to education programmes; deliver integrated care and reduce variation in care across Brent.

The reported risk of diabetic complications (National Diabetes audit) shows that Brent compares favourably to England. When compared to Newham, Brent performs better in 4 of the key risk areas of diabetic complications. Brent has 3 identified risk areas that are higher than Newham in particular stroke and this may need further investigation in terms of triangulation with the demographic differences as a cause.

Brent compares less well with Newham on the National Diabetes Audit (NDA) 2011-12 presents key findings for CCGs on achievements of the 8 National Institute for Health and Care Excellence (NICE) key care processes of diabetes care. Overall Brent is behind Newham by 10% for the 8 care processes combined the highest differences being; smoking, foot surveillance and Body Mass Index (BMI). In consideration of the variation in Brent for each of the 8 care processes it is recommended that an action plan to improve one or two of the poorer care processes be undertaken.

A task group was set to look at the issues and implications of diabetes in the borough of Brent. The groups findings and recommendations are set out in the report 'Tackling Diabetes in Brent '(November 2012), the recommendations fell into three key areas; joint services, education and prevention and healthier lifestyles

We are also working closely with Brent Council to reduce the prevalence of diabetes, and improve outcomes for patients with diabetes through several public health measures, including strategies to reduce obesity in children, encouraging physical activity and promoting healthy eating all of which are specific objectives in the Health and Wellbeing Strategy for Brent.

The CCG is working closely with Brent Council to continue with the NHS health checks program, which was initiated by Brent CCG with the public health department. Last year's 2012/13 performance was good with 9672 completed

checks and 161 newly diagnosed diabetics identified through this programme. Both the CCG and the Brent Council are working together to address performance during this year which has been lower with 3416 checks completed by the third quarter.