Brent	**Community Wellbeing Scrutiny Committee** 10 July 2018
	Report from Brent Clinical Commissioning Group and Brent Public Health

Diabetes: Diagnosis, Treatment and Prevention in Brent

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	One: • Data reports
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Sheik Auladin, Chief Operating Officer, Brent CCG, sauladin@nhs.net Dr Melanie Smith, Director of Public Health melanie.smith@brent.gov.uk Tel: 0208 937 6227

1.0 Background and Purpose of the Report

This report provides an update for the Overview and Scrutiny Committee on diabetes services in Brent. The report focuses on high risk factors, prevention, diagnosis and treatment initiatives in Brent. It also addresses the system-wide approach to addressing the challenges of managing diabetes.

2.0 Role of Brent CCG and Brent Council

Across North West London (NWL) we have a Sustainability and Transformation Plan (STP) that sets out the strategy for health and care. The CCG strategic objectives are clearly linked to the five Delivery Areas in the plan, together with a sixth objective about developing the supporting business processes and infrastructure that will help us to be successful.

The CCG has updated its strategic objectives for 2018/19, to reflect the NWL STP priorities. The updated strategic objectives will be considered by Governing Body on the 4th July 2018. The proposed objectives are:

- Improve the health and wellbeing of the people in Brent, involving and empowering residents and stakeholders to helping shape services
- Provide better proactive care for people with long term conditions with a focus on patient education and the promotion of self-care
- Commission person centred, coordinated and integrated health and social care services that are sustainable for all our residents
- Improve mental health services, maintain parity of esteem between physical and mental health and deliver against national mental health standards
- Commission Integrated services that are safe, high quality and providing the right care in the right place at the right time
- Contributing towards a financially sustainable health and care economy through effective management of resources to ensure capability and capacity to deliver

Brent CCG and Brent Council play an important role in leading the development and implementation of diabetes strategies and programmes. They also commission a wide range of health, social care and other related services that has a direct impact on diabetic patients. As local leaders, CCGs and Councils have considerable levers at their disposal to make real changes on the ground. This has been greatly bolstered by the advent of a national programme that is being co-ordinated by the NWL STP.

The Diabetes Strategic Action Group (DSAG) is a multi-agency network which meets on a bi-monthly basis to co-ordinate resources to improve diabetes management, improve diabetic care through better patient outcomes, incorporate patient/carer opinion and experience of care into service delivery, and provides an information sharing forum for stakeholders in the borough. The group has clinical, patient and managerial representation from a range of stakeholders including Brent CCG, the Brent Integrated Diabetes Service, Public Health, Diabetes UK and Patient/Carer representatives.

The CCG has recruited 3 patient representatives to participate in the delivery of the Diabetes Transformation Programme. The patient representative's role is to collate the views of people with diabetes and attend meetings to ensure these views are considered and reflected in the way diabetes care is developed. They attend meetings of DSAG as well as other relevant meetings in Brent and North West London.

Brent Council has a key role to play in the prevention of Diabetes. Brent Council executes this role by working collaboratively with partners in the STP, the CCG and the Diabetes Strategic Action Group. The Council also works with voluntary sector and individuals on diabetes.

Aspects of this role include:

- System Leadership - Improving health and wellbeing is one of the objectives of the Borough Plan

- Working with voluntary sector partners to reduce wider health inequalities health inequalities
- Aligning Diabetes and Pre-Diabetes pathways with other initiatives such as the Social Isolation in Brent Initiative and Tobacco Control Programme.
- Programme of work and commissioning to address childhood obesity in Brent
- Raising awareness of diabetes through the work of the Diabetes Champions
- Prevention particularly through action on nutrition and physical activity
- Risk assessment through the commissioning of Health Checks
- Information for action through the use of the public health intelligence function
- Oversight and commissioning through the involvement of public health advice and evidence based inputs to CCG commissioning
- Support for Individuals which includes support for those caring with individuals with diabetes
- Information and initiatives by the Brent Library Service including books on prescription
- Social Isolation in Brent Initiative
- Housing and Social Services support

3.0 Risk Factors and High Risk Groups

There are several risk factors associated Type 2 Diabetes, being overweight is perhaps the most significant risk factor. In addition a family history of diabetes increases the chances of developing the condition.

According to Diabetes UK, the risk of developing Type 2 diabetes is determined by a number of different factors:

- It increases with age – those over 40 for whites or over 25 for the African-Caribbean, Black African, or South Asian populations.
- Individuals are two to six times more likely to get Type 2 diabetes if they have a parent, brother, sister or child with diabetes.
- Type 2 diabetes is two to four times more likely in people of South Asian descent and African-Caribbean or Black African descent.
- High blood pressure, obesity, a history of cardiac arrests and strokes, and mental health issues.

The Public Health England Diabetes Prevalence Model has found that diabetes is more common in men (9.6% compared with 7.6% women) and people from South Asian and Back ethnic groups are nearly twice as likely to have the disease compared with people from white, mixed or other ethnic groups, (15.2% compared to 8.0%). The proportion of people who have diabetes increases with age: 9% of people aged 45 to 54 have diabetes, but for over 75s it is 23.8%. Diabetes at older ages has even bigger health implications as people are more likely to be suffering from other diseases, particularly cardiovascular diseases.

4.0 Prevention

Diabetes is a condition that can be prevented, but requires a number of targeted interventions. In Brent these initiatives includes:

4.1 National Diabetes Prevention Programme (NDPP)

The National Diabetes Prevention Programme (NDPP) is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver evidence based behavioural interventions for individuals identified as being at high risk of developing Type 2 diabetes. NDPP was initially piloted in 7 sites across England, which included the Inner London CCGs in North West London and is now being rolled out nationwide from July 2018.

The NDPP behavioural intervention is underpinned by three core goals:

- achieving a healthy weight
- achievement of dietary recommendations
- achievement of Chief Medical Officer physical activity recommendations

Evaluation of the NDPP at the national level has been carried out. Overall over 50% of people have completed the flagship scheme after attending at least eight support sessions over a nine month period, losing an average of 3.3 kgs. However, when excluding those who already had normal weight and Body Mass Index (BMI) but who are on the programme due to other health and lifestyle risks associated with developing Type 2 diabetes, this increased to 3.7kg. The results can be found here: https://www.england.nhs.uk/2018/03/type-2-nhsdpp/.

The programme is made up of 13 sessions led by health coaches, with at least 16 hours face to face contact time, spread across a minimum of 9 months, with each session lasting between 1 and 2 hours. People are supported to set and achieve goals and make positive changes to their lifestyle in order to reduce their risk of developing Type 2 diabetes.

The first 7 weeks of sessions focuses on the following subjects:

- What is pre-diabetes & diabetes
- Physical Activity (chair based resistance exercises)
- Energy balance and fat awareness
- Carbohydrate awareness
- Food labels
- Long-term health complications related to impaired glucose regulation
- Physical Activity session and progress review

Followed by 4 monthly sessions:

- Barriers to change, health values, habits and goals
- Stress, emotional eating and mindfulness
- Habitual thoughts, triggers, inner critic and self-compassion and 1:1 review
- Gaining control of your health, willpower and review

Individuals eligible for inclusion have ‘non-diabetic hyperglycaemia’ (NDH), defined as having an HbA1c 42 – 47 mmol/mol (6.0 – 6.4%) or a fasting plasma glucose (FPG) of 5.5 – 6.9 mmol/l. The blood result indicating NDH must be within the last 12

months to be eligible for referral and only the most recent blood reading can be used. Only individuals aged 18 years or over are eligible for the intervention.

As part of the third and final rollout phase of the NDPP, a procurement process was held during 2017/2018 to commission a 2-year contract to deliver the programme in North West London across the 8 CCGs. The incumbent provider, Independent Clinical Services (ICS) was selected and will begin delivering the behavioural change classes in Brent and elsewhere in the region from July 2018. Brent CCG is currently working closely with the provider and Harrow and Hillingdon CCGs to ensure the effective mobilisation of the service

The 3 primary mechanisms for referral are:

- Those who have already been identified as having an appropriately elevated risk level (HbA1c or Fasting Plasma Glucose (FPG)) in the past and who have been included on a register of patients with high HbA1c or FPG;
- The NHS Health Check programme, which is currently available for individuals between 40 and 74. NHS Health Checks includes a diabetes filter, those identified to be at high risk through stage 1 of the filter are offered a blood test to confirm risk; and
- Those who are identified with non-diabetic hyperglycemia through opportunistic assessment as part of routine clinical care.

To ensure that NDPP provider receives sufficient referrals, the CCG has agreed a Local Incentive Scheme to incentive practices to refer to this new service. In Brent, NHS England has set a cap of 173 Referrals and 104 Initial Assessments per month for the first two years of the programme. The main three elements of the scheme that practices will be remunerated for include:

- Setting up and maintaining a register of patients at high risk of developing Type 2 diabetes
- Conducting annual reviews of patients on the register
- Referring patients on to the National Diabetes Prevention Programme

4.2 Brent Council Initiatives

Brent Council has a number of Healthy Living initiatives which aim at not only at preventing Diabetes but a range of health issues. These include campaigns and programmes and are aimed at not only enabling individuals to make healthy choices but also to make the places residents live, eat and exercise healthier and less obesogenic.

- Diet and Healthy Eating
  - Slash Sugar Campaign
  - Healthy Catering Commitment
  - Healthy Schools and Early Years Programme
  - Healthy Eating Workshops

- Physical Activity and Active Lifestyle
  - Outdoor Gyms
  - Instructor Led Outdoor Gym sessions

- Leisure Centres
- Healthy Self-Led Walk
- Couch to 5k running programme
- Change for Life Personalised Activity Plan
- Find another sport in Brent

Further Brent Council initiatives include:

- Multi-lingual and culturally appropriate print and web resources (websites of Brent CCG, Brent Council, www.knowdiabetes.org.uk) that are well advertised and are easily accessible to people living in Brent
- Diabetes Champions working with Public Health and Diabetes UK to raise awareness about diabetes and promoting healthy living (more details later in report)
- Multi-stakeholder partnerships that include providers, commissioners, council and community organisations to run diabetes awareness and healthy living events throughout the year. Prominent examples include Diabetes Week World Diabetes Day– for the past two years these events were held at Brent Council. In addition, awareness stalls in various community events and near super-stores are also held at regular intervals.
- Lighting the Wembley Arch blue on World Diabetes Day (14 November) as part of the global trend to light prominent landmarks in blue to raise awareness about diabetes – this has been done in partnership with Football Association since 2016.

4.3 Diabetes Champions

The Brent Diabetes Champions programme was commissioned by Public Health at Brent council in January 2015 and began operating in March 2015. The programme's objective is to raise awareness of the factors that can contribute to Diabetes Type 2 and measures that people could take to prevent the condition from developing. Awareness of the risks of developing Type 2 diabetes are raised through a range of community events by a team of community champions that Diabetes UK helped to recruit and train over a two-day period. Fifteen community champions were recruited in Phase 1 (2015) and 22 in Phase 2 (2017), representing the diversity of Brent and different age groups.

4.4 Outcomes

The Diabetes Champions (DCs) have worked at a total of 153 community events since the programme started. This has included working with faith organisations and other voluntary organisations, professional bodies such as Brent Council, Brent CCG and Brent Integrated Diabetes Service. Events have varied from presence at summer festivals, shopping centres, Civic Centre, Nurseries and Health Centres, market stalls and at places of worship.

The DCs have carried out 707 "Know Your Risk" assessments and 208 people have been referred to their GP since 2015. The Diabetes Champions have worked alongside other health professionals such as the Brent Integrated Diabetes Service,

Diabetes UK, Public Health Team, Social Isolation projects and speaking or delivering workshops/information stalls at Council organised events.

The DC Programme has engaged with over 15,000 people since 2015. This figure includes those undertaking Know Your Risk assessments, seeking advice on a range of matters including diet, food, nutrition, access to weight loss programmes, discussions around complications. Engagement is defined as a conversation between a member of the public and a Community Champion that lasts at least 3 minutes.

Furthermore, they have so far reached out to over 80,000 people in Brent. These include people who have attended various events. One of the areas of greatest impact has been within the circle of family and friends of the Community Champions. Feedback from the Champions demonstrated that diabetes has become a "conversation issue" and healthy living and cooking took on a greater focus. This was not measured as a Key Performance Indicator (KPI), but is the subject of case studies to capture why this has been so effective. This has been defined as the ripple effect of the programme given the nature of family structures in minority ethnic communities and would appear to be an effective mechanism to getting the prevention message across as it accompanies "activities within families that are capable of keeping the condition at bay."

The following themes were identified as consistently having been raised at a number of events:

- Help with losing weight, particularly amongst South Asian women
- More specific information on Asian foods, their carbohydrate and sugar content, so that individuals could tailor this to their needs
- Being told by their Health Care Practitioners that they are "border line" and to go and lose weight and exercise – but not told how much to do and where to get help

To evaluate the impact of the programme some research was carried out in 2016. 150 people were followed up in groups of 10. They were posed the following question: What has been the greatest benefit to you individually of having been engaged with the Diabetes Champion? The responses are presented below:

- An increase in knowledge, skills and confidence on what they need to do to keep Diabetes at bay
- Greater confidence to manage their own condition (already diagnosed)
- Understanding the role of food and exercise in prevention
- Reduced anxiety
- Knowledge of complications and annual check ups
- The need to adhere to treatment even if there are no symptoms

The survey indicated that 8 people had achieved their target of healthy weight, 40 people were undertaking more physical activity, 120 had changed the way food was

cooked at home and 2 people said that they had achieved their target glycaemic control. When asked, the majority of Diabetes Champions reported the positive impact that the programme had on them by:

- Giving them a high level of satisfaction from the role
- Supporting their own wellbeing and self-management
- Increasing their knowledge and skills which were shared with family and friends
- Being proud that Brent had undertaken this programme to help the local community
- Wanting to continue to undertake the role, if someone would facilitate this

5.0 Diagnosis

The intention of efforts to increase the diagnosis of diabetes and people at risk of diabetes in Brent is to influence positive behaviour and lifestyle changes to reduce the risk of progressing to diabetes or to complications thereof. In order to achieve this, the following strategies are in place:

- A Type 2 diabetes risk register in GP practices to identify people at risk using approved criteria and a recall process at periodic intervals to do relevant health checks and blood tests to screen for diabetes. HbA1c is recommended as the first line blood test. HbA1c is a measure of blood glucose for the previous 90 to 120 days. HbA1c value of 48 mmol/mol or higher is diagnostic of diabetes. In people without symptoms of diabetes and HbA1c higher than 48, a second positive test (HbA1c equal to or higher than 48) is necessary to confirm the diagnosis. HbA1c between 43 and 47 is classified as at risk for diabetes. In cases where HbA1c cannot be used (conditions that affect the life-span of haemoglobin which would make HbA1c unreliable), fasting blood glucose test is used as an alternative. Two positive values are needed in asymptomatic individuals to confirm the diagnosis.

  Residents can request an HbA1C blood test from their GP if they feel they may be at risk at developing diabetes. The GP will carry out diagnostics tests where appropriate and if the patient has been diagnosed will ensure interventions are discussed and agreed with the patient and/or carer.

5.1 NHS Health Checks

The NHS Health Check is a health check-up for adults in England aged 40-74. It's designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia... In April 2013, the NHS Health Check became a statutory public health service in England. Local authorities are responsible for making provision to offer an NHS Health Check to eligible individuals aged 40-74 years once every five years.

The NHS Health Check is made up of three key components: risk assessment, risk awareness and risk management, which are detailed below:

- Risk assessment: During the risk assessment standardised tests are used to measure key risk factors and establish the individual's risk of developing chronic conditions.
- Risk awareness: The outcome of the assessment is then used to raise awareness risk factors as well as to inform a discussion on, and agreement of, the lifestyle and medical approaches best suited to managing the individual's health risk.
- Risk Management: To maximise these benefits, everyone who has an NHS Health Check, regardless of their risk score, should be given clinically appropriate lifestyle advice, to help them manage and reduce their risk. (i.e. information such as smoking status, blood pressure, and levels of physical activity)

5.2 Tests and measures

Local authorities have a legal duty to ensure that the specific tests and measures listed below are completed during the risk assessment and that the results are recorded. In Brent health checks are commissioned from patients' GP:

- age
- gender
- smoking status
- family history of coronary heart disease
- ethnicity
- body mass index (BMI)
- cholesterol level
- blood pressure
- physical activity level
- alcohol use disorders identification test (AUDIT) score
- cardiovascular risk score

In addition, those aged 65-74 should be made aware of the signs and symptoms of dementia and signposted to memory services if this is appropriate.

5.3 Outcomes

Brent Council has a strong relationship with the GP practices in Brent who are the sole providers on NHS Health Checks in the area. The majority of practices are consistently meeting invitation and completion targets. 5 year cumulative progress year is shown in the table below.

Table 1 - Health Check Performance Breakdown by Year

	2013/14	2014/15	2015/16	2016/17	2017/18
Number of people who were offered a NHS Health Check	12,327	16,824	18,920	17,122	18,394
Number of people that received a NHS Health Check	6,335	9,424	10,453	9,387	10,342

Percentage of people that received an NHS Health Check of those offered	51.4%	56%	55%	55%	56%

Analysis of the NHS Health Checks data returns indicates the following:

Table 2 - New Disease Diagnosis

	New Hypertensive	New Diabetics	Pre-diabetics
2013/14	267	101	723
2014/15	329	193	1,296
2015/16	279	179	1,236
2016/17	42	155	1,193
2017/18	29	159	1,419

Note: Actual numbers of new disease diagnosis may be under reported as data may not have been coded for all patients. However the figures give an indication of the success of the programme in identifying high risk patients.

Take up of the NHS Health Checks was highest amongst the older age group (65-74) at 62%, and lowest amongst (45-54) at 54%. As expected, take up was higher for women than men – 61% compared with 51%.

Table 3 - Uptake by Age and Gender, 2017/18

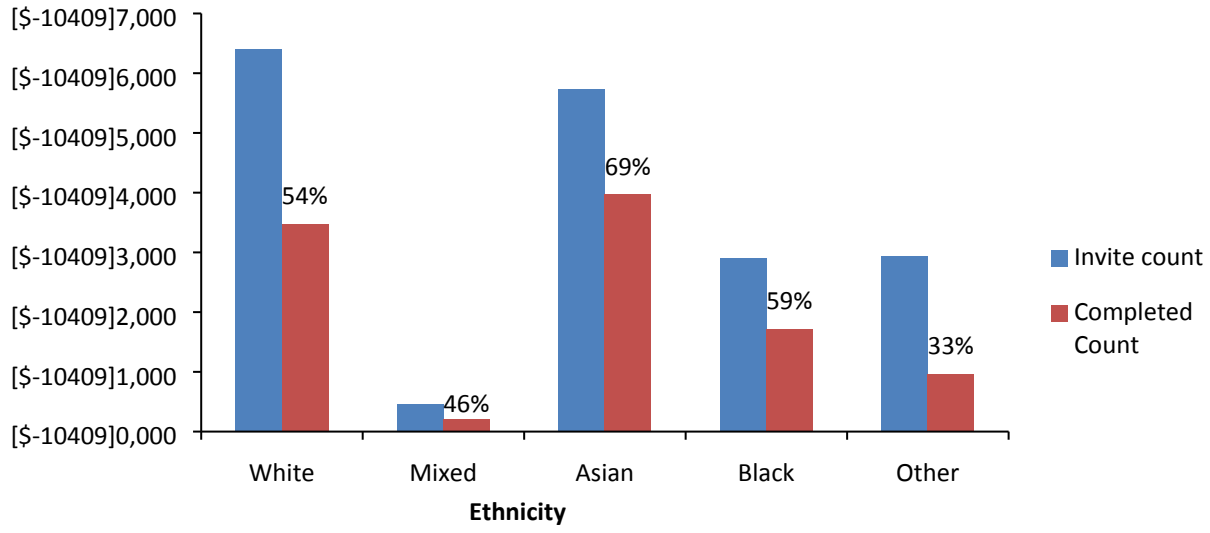
Age Group	Uptake
40-44	55%
45-54	54%
55-64	59%
65-74	62%

Gender	Uptake
Female	61%
Male	51%

<u>Uptake by Ethnic group 2017/18:</u>

The graph below shows the levels of health checks uptake between ethnicities in Brent. The highest uptake was those from Asian background at 69%.

Table 4 - Ethinicity of Brent population Invited to an NHS Health checks compared to those receiving a health check in 2017-2018



5.4 Undiagnosed population

The Diabetes Prevalence Model, produced by the Public Health England (PHE) National Cardiovascular Intelligence Network (NCVIN), was launched in 2016 and estimates the total number of adults with both Type 1 and Type 2 diabetes in England to be 3.8 million people, 90% of whom have Type 2 Diabetes. (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/612306/Diabetesprevalencemodelbriefing.pdf).

The model suggests that about one in four people with Type 2 diabetes are undiagnosed. Public Health England has estimated that there are currently 31,553 diabetics in Brent (2018) which is estimated to grow to 39,350 by 2030. Of these, they estimate that there are 7,524 undiagnosed individuals with diabetes (Type 1 and 2) in Brent.

6.0 Treatment and care

The diabetes services in Brent follow an integrated model approach to help manage and control diabetes. The CCG commissions the following services:

6.1 Brent Integrated Diabetes Service (BIDS)

BIDS was launched in October 2014 and strives to deliver high quality specialist diabetes care in the community and closer to the homes of patients. The service is run by the Brent Integrated Diabetes Team and works in partnership with Jeffrey Kelson Diabetes Centre (JKC) at Central Middlesex hospital. BIDS is a multi-disciplinary team of diabetes consultants, GPs with Special Interest (GPwSI), in diabetes specialist nurses, dieticians, educators, community podiatrists and a psychologist. This team provides weekly consultant-led multi-disciplinary clinics at Wembley Centre for Health and Care and Willesden Centre for Health and Care,

nurse-lead virtual clinics and in-practice joint diabetes clinics at GP practices. The service, delivers structured education courses for people with type 2 diabetes at various community based locations on weekdays and Saturdays and provides telephone and email support to primary care clinicians.

The main focus of the service is to:

- Strengthen and increase the overall management of diabetes
- Significantly improve health and reduce health inequalities in the Brent population
- Deliver high quality diabetes services which are equally accessible

This includes the diagnosis, treatment and education of patients and close working relationships with primary care in the building of capability and confidence in order to deliver first class diabetic care and the self-management of this condition.

6.2 Hospital based services

The CCG commissions hospital based diabetes services from a number of acute providers. The 3-main acute providers that Brent's residents use are London North West University Healthcare Trust, Imperial College Healthcare NHS Trust and the Royal Free NHS Foundation Trust.

Hospital based services provide dedicated diabetes and endocrine services that offer specialist clinics including adolescent diabetes clinics, pregnancy and diabetes clinics and diabetes foot care clinics for people with type 1 diabetes. This includes Dose Adjustment for Normal Eating (DAFNE) structured education course for adults with type 1 diabetes and Teens Empowered to Actively Manage Type 1 Diabetes (TEAMT1) which is similar to DAFNE but tailored to teenagers with type 1 diabetes. BIDS and hospital based services closely together to facilitate seamless care for people with diabetes living in Brent.

The BIDS and the JKC work closely together to facilitate seamless care for people with diabetes living in Brent. Some examples of this integrated approach include:

- Triage: Diabetes referrals received at BIDS or JKC are internally redirected to either of the services as deemed appropriate for the care needed
- Nurses and dieticians from BIDS team support DAFNE courses while nurses from JKC support the DESMOND programme (a self-care programme described below)
- Diabetes consultant for BIDS is hosted by JKC (it is a 50/50 post) that facilitates team integration and cross working
- Both teams share their IT systems and platforms which helps in accessing blood test results, clinic letters etc.
- There is full integration of foot care pathway between tier 3 (run by BIDS) and tier 4 (JKC)
- This information is shared widely as BIDS letter head prominently mentions "working in partnership with JKC"

In addition, there is collaborative working between BIDS and primary care teams:

- Nurses from BIDS visit GP practices regularly to run virtual clinics, in-practice joint clinics and training sessions
- Clinicians from BIDS attend GP locality meetings at regular intervals to update them on service, share audit data and collect feedback
- Clinical leads from BIDS and Brent CCG meet monthly to discuss quality improvement measures and any risk mitigation strategies

Table 5 - Brent Community Services Diabetes Care interventions in tier phases

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

Supports and develops essential care, including:	**and co-ordinate**:	**and co-ordinate**:	**and co-ordinate:**
• 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. • Retinal Screening Refer NEW patients to Brent Screening Programme	• 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.	• 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 • At discharge all patients will have: Care plan modified / updated • Insulin Titration formulated	• 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

7.0 Self-Care Management

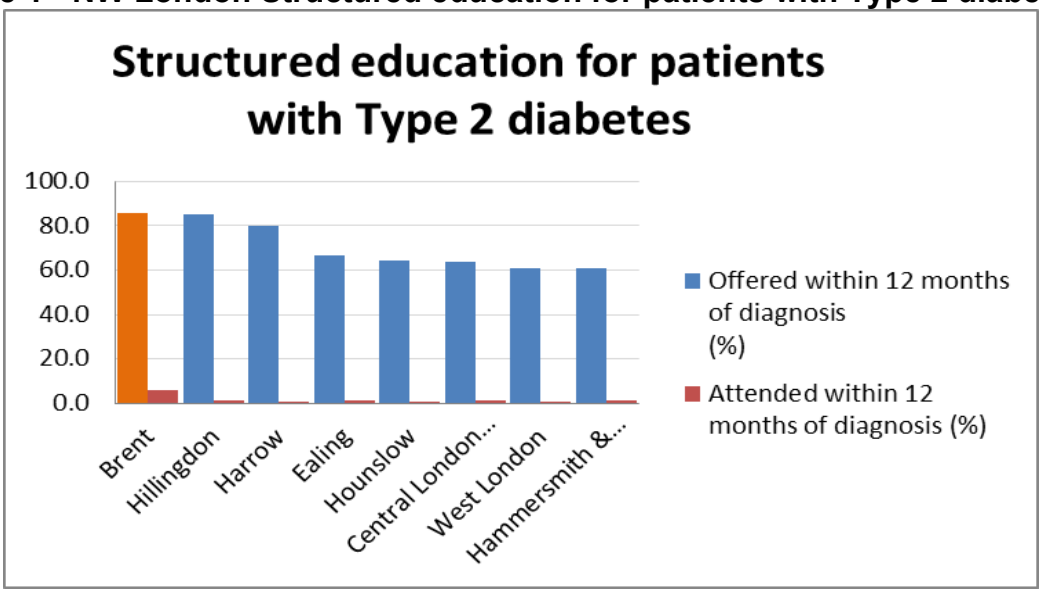
7.1 DESMOND

DESMOND is a one day self-care management course aimed at recently diagnosed Type 2 Diabetics that is offered at weekdays and weekends. Each course is attended by about 10-15 people and is offered in English and other community languages such as Arabic, Hindi, Gujarati and Tamil. The local venues for

DESMOND in Brent are Monks Park Primary Care Centre, Willesden Centre for Health and Care and Wembley Centre for Health and Care. For those diagnosed with type 2 diabetes, multiple resources are available – print, web and face-to-face.

DESMOND has been a great success as indicated by the number of people that attend and the positive feedback received from them. On average, nearly 120 people attend it every month. Running it from multiple locations, in different languages and on Saturdays has helped to increase the uptake. The effort of BIDS team was recognised in the DESMOND annual awards (2016).

Figure 1 - NW London Structured education for patients with Type 2 diabetes

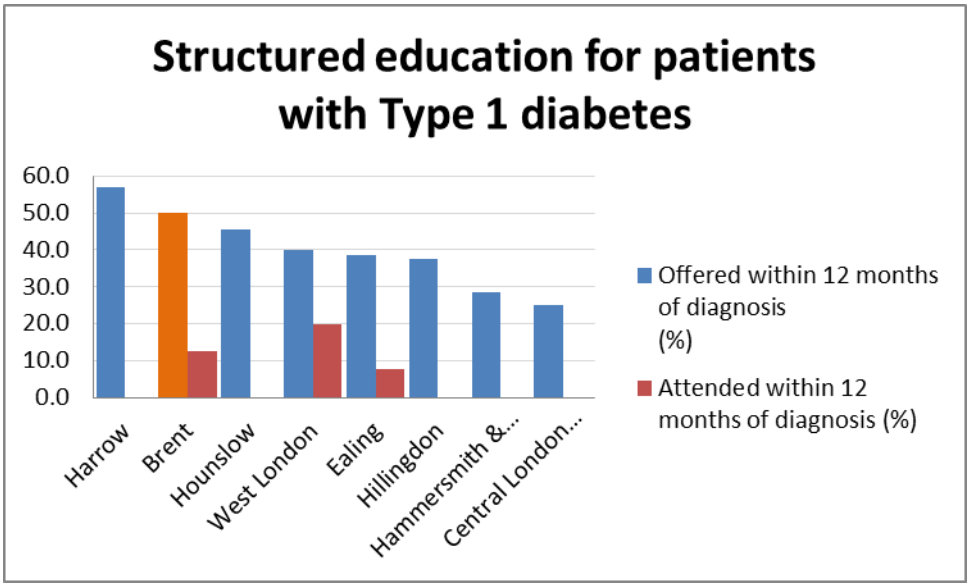


7.2 DAFNE

DAFNE is the most common structured education programme for Type 1 Diabetics in the UK. It was introduced in the UK in early 2000s and Central Middlesex Hospital was among the first centres to run this programme. DAFNE is a 5-day course (Mon-Fri 9 am to 5pm) for a group of 6-8 adults with type 1 diabetes and is held 6-8 times every year. The course is delivered by DAFNE trained nurse and dietician, and has one dedicated session for interaction with diabetes specialist doctors. The purpose of DAFNE is to educate and empower individuals with type 1 diabetes in self-care. The DAFNE-UK board monitors the quality of DAFNE courses.

In Brent, specialist nurses, dieticians and doctors are trained in delivering DAFNE. This has helped to follow DAFNE principles in clinical consultations outside DAFNE. Brent has nearly 900 people with type 1 diabetes (as per National Diabetes Audit, 2016-17) - a high proportion of them have attended DAFNE.

Figure 2 - NW London Structured education for patients with Type 1 diabetes



8.0 North West London Diabetes Transformation Programme

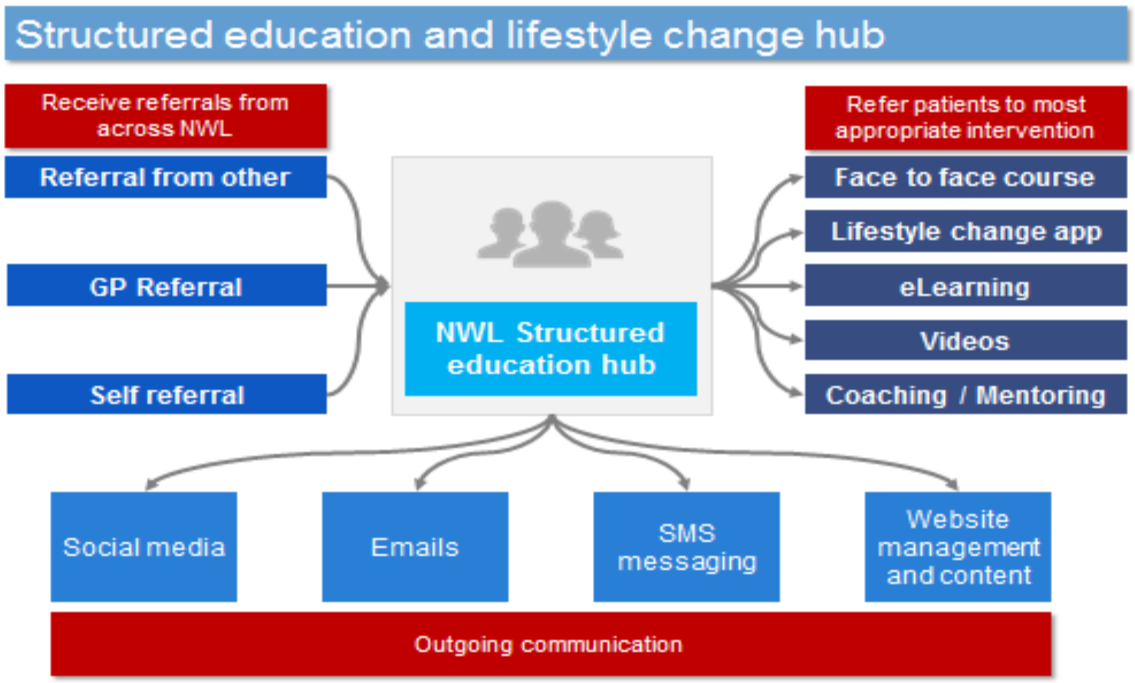
Public Health England has projected that the prevalence of Diabetes in Brent is likely to rise from 11.1 % in 2017 to 13% in 2035. Nationally spend on diabetes is projected to account for 17% of the entire health care spend by 2035. In December 2016, the NWL STP successfully bid for £2.35m share of NHS England Diabetes Transformation Funding. The work is being carried out across all 8 CCGS through a NWL Diabetes governance process which includes representation from the 8 CCG leads, acute and community provider clinicians, medicines management, public health, Diabetes UK, NHSE and people with diabetes. Links have been strengthened with local councils to ensure any strategic overlaps are noted and explored, particularly regarding lifestyle change and structured education courses for people at risk of cardiovascular issues including diabetes.

In brief, this transformation programme is a patient centred, at scale, diabetes transformation in which all staff are trained together to integrate services, manage health, and achieve common patient-reported and clinical outcomes.

The main elements of the programme are outlined below:

8.1 Self-care

A structured education hub has been developed that provides online courses, videos and other support for patients - www.knowdiabetes.org.uk There will also be a Single Point of Referral (SPoR) for signposting patients to self-care training courses in North West London. The hub will be able to report back to GP Practices on attendance/completion rates for different courses.



In addition, the NW London STP is:

- Developing an eLearning tool to educate primary care clinicians of the value of education for patients, and incentivising GPs to refer more patients
- Extending the role of Diabetes Champions and mentors to embed understanding of the risks of diabetes amongst the local community
- Trialling three self-care applications that cover goal setting, coaching/mentoring and exercise tracking
- A package of inspirational diabetes patient stories videos in non-English languages under way
- Dietary advice for diabetes in Punjabi, Guajarati and Bengali

A number of NW London targets have been for self-care including that 30% of diabetes prevalent population will receive structured education by 2021 and 80% of newly diagnosed patients to receive structured education by 2021.

8.2 Three Treatment Targets

The programme is also providing additional support to primary care to ensure diabetes care is robust and implement diabetes clinics to further develop joint working and sharing of best practice.

The Whole Systems Integrated Care Team are providing monthly reporting dashboards to GP practices to enable them to better understand their performance in the three treatment targets (Blood pressure, Cholesterol and Blood Glucose level or HbA1c) and to reduce unwarranted variation between practices. A programme of courses aimed at primary care professionals (GPs, Nurses and HCAs) are being provided at different locations across North West London. The PITstop programme aims to improve clinical skills of all clinical staff who work with Diabetic patients.

The STP is also in the process of developing an integrated clinical model for diabetes services across the whole North West London region, with a single integrated service specification.umber of new posts have been created under the programme to support primary care, which includes GP clinical leads, Diabetes Nurse Consultants and Programme Support Officers to support the up-skilling of primary care staff and other professional groups. There are plans to improve Mental Health care for diabetic patients as part of this programme of work.

The NW London Diabetes Transformation Programme has stipulated that 52% patients should achieve the following 3 Treatment Targets by 2021:

- HbA1c ≤ 58,
- BP ≤ 140/80
- Cholesterol ≤ 5

This represents a 12% an increase from a baseline of 40%

8.3 Foot care

The Programme has established the NW London STP Diabetes Foot Network. The network's role is to standardise diabetes foot data/metrics for outcome measures. A lead podiatrist and 6 additional band 7 podiatrists across the STP have been recruited to deliver weekend Multi-Disciplinary Foot-care Treatment (MDFT) clinics at vascular hubs and ensure that Mon-Fri 9-5 MDFT clinics are available at all NWL hospitals. MDFT pathway coordinators have also appointed to align the foot care pathway.

The main outcome measures will be to reduce amputation rates by approximately 50% and reduce average length of stay by 1.5 days for active foot disease by 2021.

9.0 Breakdown of Expenditure on Diabetes Services

The CCG and Local Authority together invest considerable resources in local diabetes services for Brent patients. CCG expenditure is outlined in the table below.

Table 6 - Brent CCG Annual Expenditure on Acute, BIDS and Diabetes Enhanced Services

Service	Annual Expenditure
Acute Services	£3,153,565
Brent Integrated Diabetes Services	£1,300,000
Diabetes Enhanced Services	£103,734

Much Council activity relates to the broader aims of increasing physical activity and reducing obesity, rather than simply preventing diabetes. The Council spends £1.246 million of its public health grant on these areas.

10.0 Benchmarking Data

The Appendices lists a series of tables and charts on diabetes data and performance in Brent and how this compares to other CCGs, both in North West London, the London region and nationally.

10.1 National Diabetes Audit

The headline figures from the National Diabetes Audit (NDA) in 2016/17 were:

- Participation rate: 100% (all 62 GP practices)
- Registrations of people with type 1 Diabetes: 895
- Registration of people with type 2 Diabetes: 25,005
- 43% of practices had met the Three Treatment Targets for type 2 diabetes but only 19% for Type 1
- 8.49% of Brent's population has type 2 diabetes which equates to just over 25,000 people
- 12.9% have pre-diabetes (Hba1C between 42 and 47) or just under 33,000

Brent does comparatively well at offering structured education to patients with Type 1 and Type 2 diabetes. The attendance rate is also relatively good. However, patients with type 1 diabetes are not receiving all the required care processes or meeting the treatment targets.

While Brent performs well on offering structured education, the care processes is comparatively low and achievement of three treatment targets is only average. This is largely due to a relatively low percentage of patients achieving HbA1c, blood pressure and cholesterol targets. In terms of the 8 care processes, checking BMI and smoking are areas that are underperforming in comparison to other areas.

10.2 RightCare

The NHSE RightCare team analysed data and used this to compare Brent both nationally and with the 10 most demographically similar (in terms of age, deprivation and ethnicity) CCGs. For Brent, those 10 are Waltham Forest, Ealing, Croydon, Greenwich, Haringey, Hounslow, Merton, Lewisham, Sandwell & West Birmingham and Redbridge.

The 'pathway on a page' shown below is taken from the RightCare pack. It shows the position of Brent CCG compared to the 10 similar CCGs on key indicators across the diabetes pathway. The indicators are colour coded according to performance, so a CCG has 'better' (green) or 'worse' (red) values than its peers. This is not always clear-cut, so blue is used where it is not possible to make this judgement without understanding the local context. For example, low prevalence may reflect that a CCG truly does have fewer patients with a certain condition, or it may reflect that other CCGs have better processes in place to identify and record prevalence in primary care.

Brent is performing relatively well against the majority of indicators on the diabetes pathway with the sole exception being the numbers attending retinal screening. It is

also worth noting the high diabetes prevalence in Brent and that obesity prevalence and primary care spending require further investigation.

Brent has a relatively high estimated prevalence of healthy eaters, which is reflected in the relatively low obesity rates. However, despite these relatively encouraging levels of risk for diabetes, Brent has the 8th highest prevalence of diabetes in the country. Some of this is related to the high population of people from an ethnic minority, who are at a greater risk of developing diabetes. In terms of physically inactive adults, the Rightcare data shows that Brent is comparatively high compared to other CCGs, which may also explain the high prevalence rate of diabetes in the borough.

Figure 3 - Diabetes pathway on a page