Appendix 3

Health inequalities and diabetes

1.1 As referenced above, the CCG and the council are doing more joint work together, and one example of this is around health inequalities and diabetes. An Executive Group, sitting under the ICP Executive Committee has been set up specifically to address these health inequalities as part of a holistic approach, with a focus on the social determinants of health. Brent has a high prevalence of diabetes, which is due to a number of factors; including deprivation, obesity rates and a high number of people with south Asian heritage, (we know that people with this heritage are more susceptible to diabetes than other populations).

1.2 NWL CCG has developed dashboards with information about performance of different practices and Primary Care Networks across a range of metrics including the 3 treatment targets (optimal HbA1c, blood pressure and cholesterol) and the 9 care processes (which include carrying out regular checks on aspects such as BMI and retinal screening, amongst others).

1.3 The medical aspects of treating diabetes is only a small component affecting service user outcomes. Type 2 diabetes is largely a disease that can be prevented or controlled through lifestyle interventions, and so a diabetes check with a GP may involve titrating medications. This, however, will not on its own address the other lifestyle associated factors, which in turn are affected by the person's environment, such as housing, access to healthy foods, hours of work, opportunities for exercise etc.

1.4 It is therefore key that health and social care work together in partnership with our communities and the voluntary sector to help people to make the changes that they need, to either maintain a healthy outlook and prevent the disease entirely, or to prevent it from deteriorating further.

1.5 We have recently set up a work stream under the ICP Executive Group to look at health inequalities and diabetes, and we need to work with social prescribers and with our Health Champions to encourage people to make healthy choices, including diet, exercise, cooking and recreational opportunities.

1.6 As well as self-care and promotion of healthy lifestyles, it is important that we optimise the medical care that we can offer, and make it as accessible as possible.

1.7 North West London CCG has recently launched a standardised diabetes enhanced service, and has levelled up funding across the patch to ensure that those historically underfunded areas (including Brent) received additional investment to provide better care. This has meant that Brent has received an additional £1.9 million for investment into primary diabetes care.

1.8 The enhanced services is intended to enable improvements in diabetic care across the population of patients with diabetes by:

(a) Up-skilling and increasing the resource into the primary care workforce through supported diabetes education
(b) Reducing variations in diabetes care and outcomes across network populations
(c) Enabling better self-management of diabetes through care planning

1.9 As part of the service specification, GPs will need to:

- Deliver measurable improvements in clinical quality
- Enhance patient satisfaction with the care and support they receive

- Support the implementation of a clear clinical management pathway for diabetes
- Reduce the number of patients needing to have routine follow up appointments in secondary care
- Set up group consultations at Primary Care Network level

1.10 The CCG is setting up a dashboard to monitor diabetes outcomes and the primary care team will work closely with the PCNs to monitor the outcomes and to share best practice to enable more practices to reach the best standards. These standards are also being looked into at NWL level when the primary care System Oversight Meeting (SOM) is held. This means that Brent GPs need to attend an NWL level meeting and hold accountability for explaining what action is being taken to reduce any unwarranted variation in diabetes care.

1.11 In addition to the enhanced service, there are also new specifications for non-diabetic hyperglycaemia (which means that your blood sugar level is getting too high even though you do not (yet) have diabetes). It can be a sign of pre-diabetes, and indicates a stage at which lifestyle interventions should be undertaken to prevent the onset of diabetes.

1.12 For people already diagnosed with diabetes, some may be suitable for the REWIND programme. This stands for Reducing Weight with Intensive Dietary Support. As part of this programme all anti-hypertensive, diuretic and anti-diabetes drugs are stopped and Total Diet replacement is commenced. In basic terms, the programme consists of a low calorie, low carbohydrate diet that promotes weight loss and promotes natural control of blood sugar and reduces insulin resistance. The programme is not suitable and does not work for all patients, but is supported by trial evidence and can work for a number of patients. This programme has been launched in Brent and GP practices are identifying suitable patients to come forward for the programme.

1.13 In addition to general practice, there is also a community-based service called Brent Integrated Diabetes Service (BIDS). This provides an enhanced level of care, and allows general practice to access more specialised expertise in a community setting, such as diabetes specialist nurses, counselling psychologists and consultant diabetologist/ endocrinologist advice. The service aims to bridge the gap between primary and hospital care, and to upskill the level of knowledge on diabetes management within primary care.

1.14 The diabetes work stream will need to optimise the care pathways between primary care, the BIDS service and specialist hospital care, as well as pathways into preventative services or voluntary sector organisations that focus on prevention and lifestyle changes.