APPENDIX 3

Health and Wellbeing Board Discussion

20 June 2017

Proposal for diabetes to be adopted as a HWB Priority for 2017/18

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1 Summary

This report sets out the current status and challenges relating to diabetes in Merton, the areas that the Merton CCG and Public Health are proposing to address in 2017/18, and the opportunity to use this key disease area as an exemplar to develop a whole systems approach in Merton and potentially wider across SW London.

The report makes the case for the HWBB to adopt diabetes as a priority for 2017/18.

2 Background

A Merton Snapshot of diabetes and further information is presented in Appendices 1, 2, 3 and 4

2.1 Diabetes rates are increasing in the UK with a large cost to the NHS. In the UK around 700 people a day are diagnosed with diabetes. That's the equivalent of one person every two minutes[i]. There are an estimated 4.5 million people in the UK with diabetes[ii] of which an estimated 1.1 million are undiagnosed[iii]. It is also estimated that there are currently a further 4-5 million people in England (10.7% of the population) at high risk of developing type 2 diabetes[iv].

2.2 Type 2 diabetes usually appears in middle-aged or older people, although more frequently it is being diagnosed in younger overweight people, and it is known to affect people from BAME backgrounds at a younger age[v]. People with diabetes in the family are two to six times more likely to have diabetes than people without diabetes in the family[vi]. People from South Asian and Black communities are two to four times more likely to develop Type 2 diabetes than those from Caucasian backgrounds[vii]. Obesity is the most potent risk factor for Type 2 diabetes. It accounts for 80–85 per cent of the overall risk of developing Type 2 diabetes and underlies the current global spread of the condition[viii]. The risk of developing Type 2 diabetes can be reduced by changes in lifestyle.

2.3 In part, because of the types of risk factors described above for diabetes, it is a disease of inequalities. Lack of awareness and access to services further compound these inequalities.

2.4 People with diabetes experience disproportionately high rates of mental health problems such as depression, anxiety and eating disorders[ix].

3. DETAILS

Why is Diabetes important to the HWBB?

3.1 Diabetes is an area where the 'traditional' medical model centred on hospital based care has been unable to curb the rise in diabetes cases, complications and costs, over the last five years.

3.2 There are a number of challenges faced by the system:

- It currently cannot cope with patient numbers (and the trend is upwards)
- Not enough is being done to halt the trend
- There are increasing numbers of complex patients
- People are not empowered to manage their own condition
- There is considerable variation in process and outcomes for patients, particularly in Primary Care, but also in community and hospital care.
- Patients, who suffer from serious complications of diabetes like sight impairment / loss, amputations etc., have an impact not just on health care but also social care and carers.

3.3 Therefore the approach needs to shift to a whole system life-course approach with the added focus on prevention and tackling stark inequalities linked with poverty and ethnicity. This approach widens the scope of diabetes work to include childhood obesity, behaviour change and early diagnosis, and holistic integrated health and care in the community (spanning health and social care, physical and mental health).

3.4 Diabetes as a priority fully chimes with HWBB ethos and the HWB Strategy. In 2016/17 childhood obesity and social prescribing were priority areas for the HWBB. Both are linked very strongly with diabetes. Addressing childhood obesity is a key factor in the early years, in preventing or delaying the onset of type 2 diabetes later in life and can significantly reduce the burden of disease in the future.

3.5 Tackling diabetes offers a unique opportunity to bring together and amplify existing priorities including childhood obesity, social prescribing, East Merton Model of Health and Wellbeing (including the Wilson), health and care integration, and HIAP (including Think Family).

3.6 In 2016/17 a task group of the Healthier Communities and Older People Overview and Scrutiny Panel completed a report on 'Preventing Diabetes in the South Asian Community'. The recommendations from this report formed the basis of an action plan to improve awareness, prevention, access, early diagnosis and better management among Merton residents of South Asian

origin.
https://democracy.merton.gov.uk/mgIssueHistoryHome.aspx?IId=9112&Opt=0

3.7 Tackling diabetes also builds on the numerous strands of existing on-going work including the implementation of the childhood healthy weight action plan, scaling up the social prescribing pilot, developing the Wilson health and wellbeing offer, implementation of the national diabetes prevention programme, new provider and service model for healthy lifestyle service and health check programme, action plan for diabetes prevention in South Asian community, and planned care programme.

3.8 There is a request from the SWL Clinical Board to all HWBBs in SW London to adopt diabetes as a priority, and this will offer synergies across the region.

3.9 Diabetes fits well in the prevention framework developed in Merton, which looks across the whole system from place level solutions, to community level and individual level solutions. It is about prevention investment across the life-course and impact at scale (see appendix 5).

3.10 Diabetes is also being addressed in the SW London STP as a system exemplar for prevention because it lends itself so well to clinical, non-clinical and prevention approaches. The planned focus is 'embedding the prevention framework in policies and practice'- using local borough/CCG examples to demonstrate what this could look like. Diabetes is an example that lends itself to demonstrating impact across the whole system.

3.11 There is potential for ongoing joint work with vision leadership centre – and diabetes could be used as an exemplar.

3.12 It is recognised that the suggestion for the HWBB to adopt diabetes as a priority, is an opportunistic one rather than a systematic exercise but hoped that members will see the potential for the HWBB to make a real difference to this important issue.

4. Questions for the HWBB to consider

4.1 Does the rationale (as set out above) for diabetes as a 2017/18 priority for the HWBB make sense?

4.2 Have you any early ideas how the HWBB / partner organisations can help deliver this priority?

4.3 Do you agree diabetes as a 2017/18 priority for the HWBB?

5 Next steps

If agreed by the next step would be to develop an action plan with clarification of the roles of all partners and timelines to be reported to the HWBB.

APPENDICES

Appendix 1: Diabetes – Essential Facts

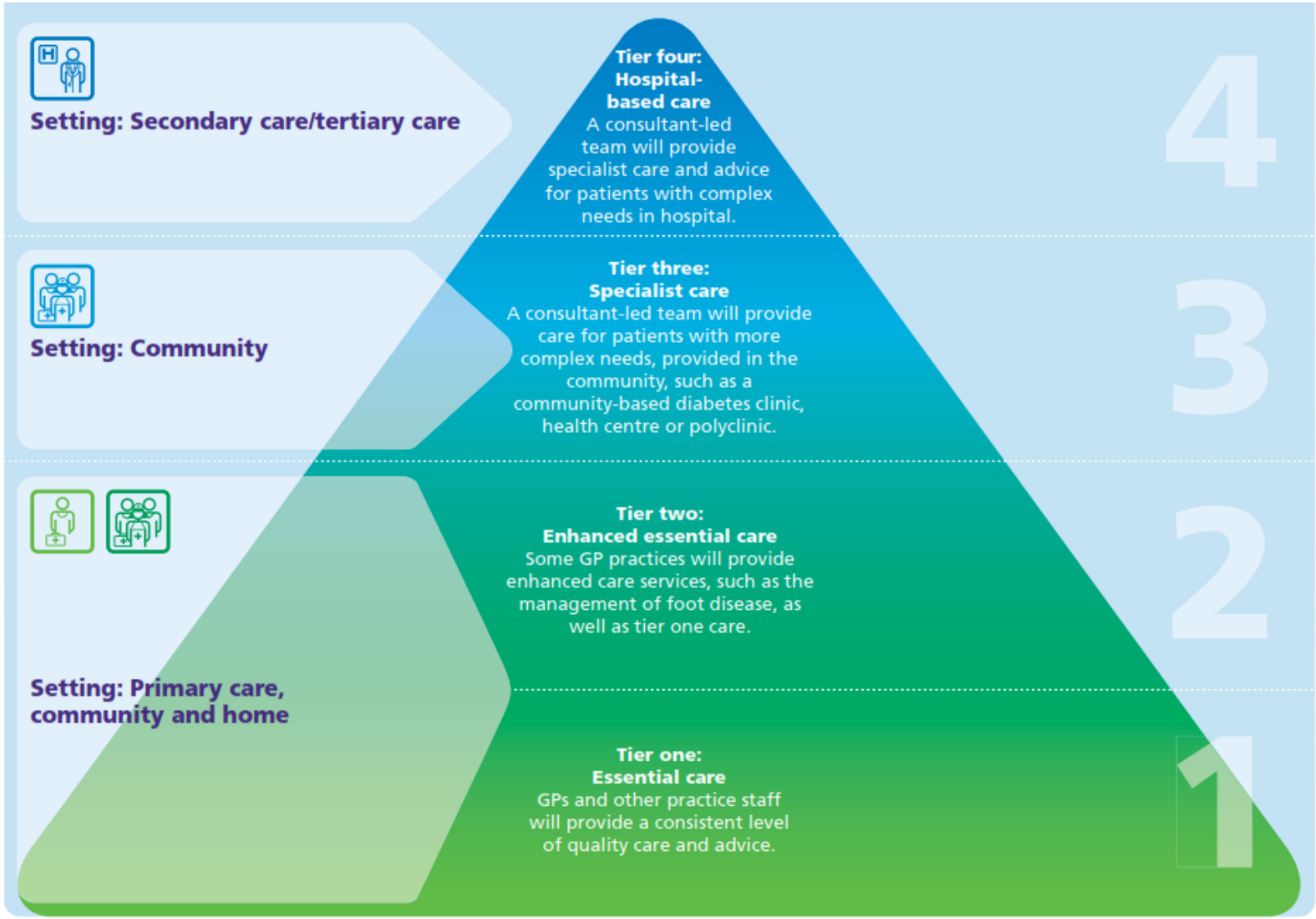
1. It is estimated that 10% of all adults and children with diabetes have Type 1 diabetes and 90% have Type 2 diabetes[x].
2. Good diabetes management has been shown to reduce the risk of complications. But when diabetes is not well managed, it is associated with serious complications including heart disease, stroke, blindness, kidney disease and amputations leading to disability and premature mortality. There is also a substantial financial cost to diabetes care as well as costs to the lives of people with diabetes.
3. It is currently estimated that about £10 billion is spent by the NHS on diabetes, which is 10 per cent of the NHS budget. This is only taking into account the NHS healthcare costs. When the total cost (direct care and indirect costs) associated with diabetes are taken into account, diabetes in the UK currently costs an estimated £23.7 billion and is predicted to rise to £39.8 billion by 2035/6[xi].
4. There is a strong evidence base for the effectiveness of diabetes prevention programmes delaying the onset of disease. The NHS Diabetes Prevention Programme (NDPP) was announced in the NHS Five Year Forward View, published in October 2014, which set out the ambition to become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to NHS Health Checks. Under the brand “Healthier You” the NDPP is a joint initiative with NHS England, Public Health England (“PHE”) and Diabetes UK which aims to deliver at a large scale services which identify people with non-diabetic hyperglycaemia who are at high risk of developing Type 2 diabetes and offer them a behavioural intervention to reduce their weight and increase physical activity.
5. All 12 South London boroughs, encompassing all the CCGs and Local Authorities in South London (including NHS Merton CCG and London Borough of Merton) with NHS Southwark CCG as the lead organisation, entered into an MOU with NHS England to provide the NDPP across South London.
6. Once diagnosed with diabetes, all patients aged 12 years and over should receive all of the nine NICE recommended care processes. These are: the annual checks for the effectiveness of diabetes treatment (HbA1c), cardiovascular risk factors (blood pressure (BP), serum cholesterol, body mass index (BMI), smoking) and emergence of early complications (eye screening, foot surveillance and urine albumin/serum creatinine (kidney surveillance)).
7. Every year a national diabetes audit (NDA) is carried out to assess the quality of diabetes care, including the nine care processes mentioned in point 6 above, and is reported for each borough. This is predicated on the participation of, and the timely return of data from, GP Practices – in order to obtain a truly representative local picture. Merton GP Practices have been particularly poor in their participation in the NDA (see below in Merton Snapshot).
8. The diabetes model of care is based on four tiers of care provided in three settings: primary care, the community and in hospital. According to their individual needs, a

person with diabetes may receive care in all of these settings. The majority of diabetes care is currently provided in primary care and community settings; and around 80% of care will be provided in these settings in future. The four tiers of care are depicted in appendix 3.

Appendix 2: Merton Snapshot

1. 6% of adults in Merton (approximately 10,700 individuals aged 17+years) were diagnosed with diabetes in 2015/16. Current estimates indicate that around 14,300 adults have diabetes, and therefore an estimated 3,700 adults remain undiagnosed (although diagnosis rates have improved over the last 3 years).
2. The level of diabetes is projected to rise significantly locally - to 15,300 adults with diabetes in 2020 (8.3% of the adult population). The increase is due to the rise of obesity and lack of understanding of unhealthy levels of sugar consumption.
3. Although Merton has lower prevalence of adult obesity than nationally, 60% of adults in Merton are overweight or obese are at risk of developing diabetes and dying prematurely.
4. Merton has a poor ranking in meeting standards of management and control of diabetes risk factors - blood sugar levels, cholesterol and hypertension. In 2015/16, 56.7% of Merton patients were recorded as having good control of their blood sugar levels compared to 58.2% regionally and 60.1% nationally.
5. Only five out of twenty-four GP practices in Merton participated in the National Diabetes Audit (NDA) in the 2014-15 and 2015-16 rounds. In 2015-16 this was a participation rate of 20.8% compared with an England average of 81.4%.
6. The NHS Diabetes Prevention Programme (NDPP), under the brand “Healthier You”, aims to deliver at a large scale services which identify people with non-diabetic hyperglycaemia who are at high risk of developing Type 2 diabetes and offer them a behavioural intervention to reduce their weight and increase physical activity.
7. Modelling data from Public Health England’s Health Survey estimates that there are 18,450 people living in Merton with non-diabetic hyperglycaemia, giving a prevalence of 11.0%. There are an estimated 4000 patients on GP Practice registers in Merton who have documented non-diabetic hyperglycaemia and are eligible for the NDPP.

Appendix 3: Four tiers of diabetes care (HealthCare for London)

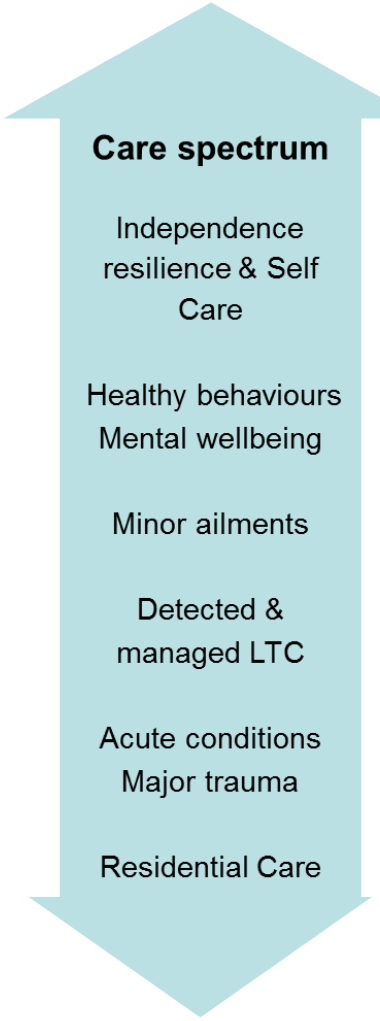


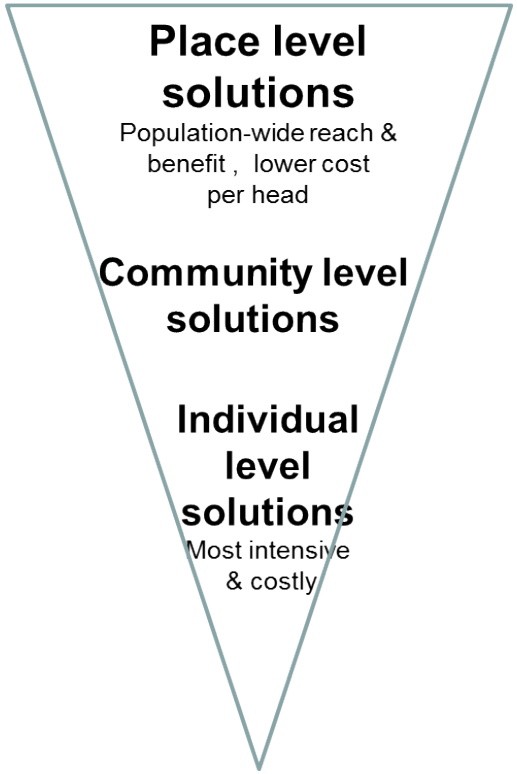
Appendix 4: Summary of existing work

1. With the development of the SW London CCG alliance and the Wandsworth-Merton LDU (Local Delivery Unit), the work on diabetes is increasingly in partnership with Wandsworth spanning across the LDU.
2. Wandsworth CCG has recently commissioned a Multispecialty Community Provider (MCP) model of delivery for their community health services, and this includes community diabetes services. This is following a number of years of project work developing the model for diabetes based on local knowledge and experience and evidence of best practice elsewhere.
3. Merton CCG has in place an established community diabetes services (since April 2016) and the priority areas for Merton are:
    a. increasing the utilisation of this service
    b. agreeing and implementing criteria for specialist input from secondary care
    c. addressing variation in primary care
    d. increasing the currently poor participation in the National Diabetes Audit
4. The different models operated in the two CCGs (including services funded for delivery in primary care) presents a challenge as there is potential for variation in quality across the two. It also offers the opportunity of sharing learning, however, to ensure the best standard of care for patients across the two CCGs.
5. In Merton, the NDPP is due to commence from June 2017 and will run a full 12 months, with the aim of referring 1200 eligible patients with non-diabetic hyperglycaemia to the commissioned nine-month lifestyle intervention service provided by Reed Momenta. This will be implemented through Merton GP Practices.
6. NHS Merton CCG and Public Health Merton are jointly addressing the recommendations ensuing from the Healthier Communities and Older People Overview and Scrutiny Panel report on ‘Preventing Diabetes in the South Asian Community’, through an action plan approved by the Panel.
7. Public Health Merton has recently recommissioned the Merton Lifestyle and Stop Smoking Services as well as the NHS Health Checks programme- with a population focussed approach to prevention and early detection. Both tie closely with the prevention and early detection of diabetes, while addressing health inequalities and equity issues through a targeted model aimed at marginalised and high priority groups.

Appendix 5: Prevention Framework (next page)

A whole systems approach to prevention





Adapted from Richmond & Kingston

Approach

Promoting healthy daily choices through environmental / social changes
e.g. Planning, active travel, community safety, licensing

Community led and owned support
e.g. healthy setting such as work place, school, high street

Social marketing

E-solutions for self-care and self-management

Individual-focused interventions
e.g. Smoking cessation, weight management, alcohol brief intervention

Appendix 6

Proposed next steps if agreed as HWBB priority

At HWB level, this is to develop an action plan with clarification of the roles of all HWB partners and timelines.

Among commissioners approach is to focus on a realistic number of defined areas over 2017/18 and deliver within the resources available, making use of a whole systems approach to amplify the impact of the work.

In 2017/18 NHS Merton CCG in partnership with other stakeholders including Public Health Merton intend to address the following areas:

i. Primary care variation in diabetes diagnosis and management, and increasing participation in the NDA

ii. Strengthening the delivery of the four tiers of diabetes care, ensuring that patients are seen at the most appropriate and least cost level of care for their need.

iii. Increasing the uptake of structured education programmes

iv. Implementing the NDPP in Merton

v. Implementing the action plan for the Healthier Communities and Older People Overview and Scrutiny Panel report on ‘Preventing Diabetes in the South Asian Community’

The intention would be to re-establish a multi-agency diabetes steering group (there was one before) hosted by the CCG and understanding the gaps between what is currently provided, and the outcomes and aims of the services in accordance with the four tiers of care. This will help to identify what is required to change over the longer term to ensure equity of service and a high standard of service provision. This programme of work requires scoping and the project work is in its initial stages.

References

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[i] Figure based on newly diagnosed figures from the 2011/12 and 2012/13 National Diabetes Audit, extrapolated up to the whole population with diabetes indicated by the QoF data for the equivalent years and divided by two to give an annual average

[ii] Quality and Outcomes Framework (2014/15), Diabetes Prevalence Model 2016 (Public Health England) and 2012 APHO Diabetes Prevalence Model.

[iii] This figure was worked out using the diagnosed figure from the 2014/15 Quality and Outcomes Framework, the 2016 Diabetes Prevalence Model and the 2012 AHPO diabetes prevalence model.

[iv] Public Health England (2015) NHS Diabetes Prevention Programme (NHS DPP) Non-diabetic hyperglycaemia. Produced by: National Cardiovascular Intelligence Network (NCVIN)

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[ix] https://www.diabetes.org.uk/Professionals/Resources/shared-practice/Psychological-care/

[x] HSCIC: National Diabetes Audit 2012/13: Report 1: Care Processes and Treatment Targets, and Scottish Diabetes Survey 2012: http://www.diabetesinscotland.org.uk/Publications/SDS2013.pdf

[xi] Hex, N., et al (2012) Estimating the current and future costs of Type 1 and Type 2 diabetes in the United Kingdom, including direct health costs and indirect societal and productivity costs. Diabetic Medicine. 29 (7) 855-862