Mid and South Essex Health and Care Partnership

Southend Health and Wellbeing Board
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TITLE:	Diabetes: prevention and Mid and South Essex HCP Framework
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FOR:	AGREEMENT

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1. Summary

1.1 With an increased prevalence of Diabetes indicated in Mid and South Essex over the next 5 years it is expected that there will be significant impact on the health and social care system to effectively deliver to the needs of people with this long-term condition. Failure to meet these needs is not acceptable and would have a severe impact on the populations health outcomes and increase costs to the NHS and partners significantly. It is therefore required that we take a structured approach to managing and improving Diabetes care within the system.

1.2 The Mid and South Essex Diabetes Framework has been developed to encompass key evidence-based information and Diabetes statistics regarding prevalence, demographics and health care target performance for the health and care partnership to inform health service requirement for the next 5 years. The key statistics indicate the requirements of the health care service to adapt and improve to meet the care and wellbeing needs of those at risk of, or living with Diabetes.

1.3 The framework intends to provide;

- Structure to deliver new collaborative models of integrated diabetes care to meet the needs of local people with diabetes
- Intention to improve the quality and consistency of services in line with both local and national standards and funding programmes
- Methods to deliver best outcomes for people living with diabetes or at risk of developing the condition across the Mid & South Essex HCP.

1.4 The framework and model of care will assist the HCP to identify priority areas and in doing so will help to achieve the requirements set out in the NHS Long term Plan, influenced by the changing demographics of diabetes and the economic case for change; a move to more person-centred care; and move to a population-based approach to health and well-being.

1.5 The framework outlines some specific offers that are set to tackle issues in key stages of the Diabetes pathway and implement improvements that will impact patient outcomes, the key elements include;

- Prevention - Tackling obesity and social factors that lead to increased risk of Type 2 Diabetes
- Identification – Increased use of risk screening tools
- Management of Diabetes – Supporting people to pro-actively manage their condition better
- Complex Care – Fast and effective treatment and care associated with diabetes complications

1.6 Additionally, there are offers to support;

- Hard to reach groups and communities - To ensure equity of care across the system.
- Workforce - Development of the workforce including staffing levels, ensuring skilled, knowledgeable and competent workers are in place providing a high-quality service.
- Data and technology – To be data driven and embrace and implement effective new technologies where suitable and relevant.

2. Introduction

2.1 Diabetes is a common and complex multisystem condition that affects people of all ages and backgrounds. Whilst many people with Diabetes live well, others face significant challenges or develop serious long-term complications that impact on health and wellbeing and contribute to the difficulties of living with a life-long condition.

2.2 Mid and South Essex Health and Care Partnership share an ambition to work together and with the local populations to deliver new models of integrated diabetes care. The approach will be based around the needs and location of the people, rather than boundaries of organisations and will focus on prevention and supporting the strengths of communities and individuals.

2.3 In Addition, the development and subsequent maturity of Primary Care Networks (PCN’s) will build upon core primary care services and enable greater provision of proactive, personalised, coordinated and integrated health and social care providing seamless pathways for patients with long term conditions including diabetes.

2.4 The overall aim of the diabetes framework is to improve quality and consistency of services in line with both local and national standards and funding programme; to deliver best outcomes for people living with diabetes or at risk of developing the condition. Whilst also acknowledging that people, empowered through self-management, can optimise their personal health, well-being and quality of life.

2.5 The framework and model of care will assist the HCP to identify priority areas over the next 5 years and in doing so will help to achieve the requirements set out in the NHS Long term Plan; influenced by the:

- Changing demographics of diabetes and the economic case for change;
- Move to more person-centred care; and
- Move to a population-based approach to health and well-being.

2.6 Once agreed this document will be used as the foundation to enable development of local implementation plans.

3. Body of the report

3.1 Nationally there are 3.7 million people diagnosed with diabetes and an estimated further 1 million people who have diabetes but are undiagnosed and this is thought to rise to over 5 million by 2025, meaning diabetes is a significant health and resource risk (Diabetes UK 2019). The costs of diabetes to the person living with the condition, to family members and the system are significant. Complications arising from diabetes take both a personal and societal toll on those affected.

3.2 The monetary cost of Diabetes to the NHS each year is around 9% of the National Budget, and around 80% of diabetes costs are currently being spent on treating its complications, many of which are avoidable.

3.3 In Mid and South Essex, there are approximately 61,300 people living with either Type 1 or Type 2 diabetes. Around 5300 have Type 1 and 56,000 Type 2. A considerable number of people are thought to be at high risk of developing Type 2. If incidence continues at the same rate or more, there will be over 90,000 people living with diabetes in Mid and South Essex by 2025. (statistics from the Mid and South Essex Diabetes Framework 2019).

3.4 In 2017/18, the financial cost of diabetes care across the HCP economy was approximately £27.6m, split between community and acute contracts and prescribing. The latter being the largest cost to the system at £19.5m, followed by non-elective inpatients at £2.1m (based upon primary diagnosis) for which amputations and hyperglycaemia were the highest cause of admission.

3.5 At an average of 6.6%, the prevalence of diabetes in the population aged 17 years and older in Mid and South Essex HCP is broadly in keeping with the England average of 6.8%. The CCG prevalence range from 6.4% in Mid Essex and Basildon and Brentwood to 7.2% in Castle Point and Rochford.

3.6 Factors that influence the prevalence of Type 2 diabetes are:

- Obesity accounts for 80-85% of the overall risk of developing the condition
- Deprivation (obesity, physical inactivity and a diet low in fruit and vegetables, association with risk factors for poor diabetic outcomes from smoking and hypertension)

3.7 The outlook for Mid and South Essex in regards to these factors;

- Southend-on-Sea and Basildon are forecast to continue having the highest and largest increasing proportion of overweight or obese adults in the M&SE catchment area.

- Basildon has the lowest proportion of adults physically active and eating healthily, and the largest decrease across the STP since 2015/16.
- Maldon and Thurrock were the only districts of the HCP with a higher proportion of overweight or obese children than England in Reception and Year 6, respectively.

3.8 Mid and South Essex faces a significant challenge in meeting the growing demand upon its Diabetes services and population health and in order to identify, frame and highlight the specific health service needs the Mid and South Essex Diabetes framework was developed.

3.9 The framework offers an evidenced based view of Diabetes population data and provides a dossier of considerations required to safely manage the health of the Diabetic Population. It sets out to improve the health and wellbeing of those at risk of developing and those living with Diabetes and strive for equity of care across the whole of the M&SE Health and Care Partnership. It specifically highlights hard to reach groups including the prevalence within these groups and challenges faced to provide a consistent approach to care delivery. The goal of the framework is to channel an approach with the collective knowledge of people to make lasting improvements that are; person-centred, equitable and outcome orientated.

3.10 There are several elements associated with key stages of the diabetes pathway, these are listed in the framework with specific intention to offer improvement;

Prevention and Identification

3.11 To prevent onset of Type 2 Diabetes by early identification of risk factors associated with Diabetes, and providing the education and support for patients to take responsibility for their own health management where possible.

3.12 The specific offers of the Health and Care partnership for prevention as listed in the framework;

- Alignment with the HCP Population Health Management and prevention strategy and self-care JSNA to embed a more proactive approach to person centered prevention and early intervention practice
- Development of professional facing information intended to inform and support professionals to deliver health improvement.
- Promotion of public -facing information intended directly for members of the public appropriate needs, age, language and culture.
- Increased use of risk screening tools within primary care with a focus on high risk groups

Management of Diabetes

3.13 Supporting people to proactively manage their condition more effectively through helping patients to understand their Diabetes, leading to better informed lifestyle choices and control.

3.14 The specific offers of the Health and Care partnership for management of Diabetes as listed in the framework;

- Enhanced and improved access to structured self-management education programmes for people with diabetes, including the newly diagnosed.
- Annual or more frequent examination, as clinically indicated, offered to all people with diabetes.
- Variation in annual care processes and treatment targets is reduced across Mid and South Essex.
- Psychological and emotional support assessed as an annual care process.
- Consistent high-quality information provided to all at appropriate times in a variety of formats.

Complex Care

3.15 Tackling long term complications of diabetes including quick identification, fast and effective treatment and care including referrals to specialist service. The most common long-term complications of diabetes being; cardiovascular disease, diabetic nephropathy, diabetic retinopathy, Diabetic neuropathy, limb amputations, erectile dysfunction, diabetic ketoacidosis and gestational diabetes.

3.16 The specific offers of the Health and Care partnership to tackle complex care in Diabetes are as listed in the framework;

- Variation in quality of care, access and treatment is reduced across Mid and South Essex.
- People at high risk of developing lower limb problems are identified and managed within a revised foot pathway to ensure they receive the right care, at the right time and at the right place.
- Access to personal insulin pumps and technologies are made available to those suitable.
- Diabetes specialist leads are available in the community to advise and help treat those with complex care needs.
- In-hospital care for people living with diabetes but admitted for other reasons is improved by enhancing the Specialist Diabetes Teams to provide care, advice and support.

Hard to Reach Groups

3.17 With population trends indicating increased diversity there may be widening gaps in the health needs of different groups leading to different challenges to healthcare providers. In these groups there may people who are at high risk of developing diabetes and/or those who are in a position where diagnosis and management of Diabetes is difficult or inadequately provided. These groups include; Children and adolescents, older people in residential settings, people with cognitive impairment, people with learning disabilities, ethnic minorities and people from hard to reach communities.

3.18 The specific offers of the Health and Care partnership to support hard to reach groups are as listed in the framework;

- Appropriate diabetes services are in place to enable people from hard to reach groups to access required services.
- Clearly defined strategies to target hard to reach groups.
- Care home staff educated around the needs of residents with diabetes.

- Individuals with a cognitive impairment diagnosed with diabetes are supported by appropriately skilled teams to achieve treatment and goals.

Workforce

3.19 Ensuring that the workforce is of high-quality with a strong person focus and multidisciplinary integration to help achieve the best possible health outcomes for patients.

3.20 The specific offers of the Health and Care partnership regarding workforce are as listed in the framework;

- Staff coming into contact with people living with diabetes will have the skills and competence to understand their needs and ensure that these needs are met in a way that is person-centred, whatever their professional background.

Data and technology

3.21 A diabetes framework and care model need to be underpinned by effective (and easy to use) technology and information management to maximize success. With new technology being created we must embrace its potential to ease and better quality of care and assess the for implementation in practice.

3.22 The specific offers of the Health and Care partnership regarding workforce are as listed in the framework;

- New intervention and technologies, where appropriate and effective, will be used to support treatment and care for people living with diabetes.
- Information management will underpin the development of diabetes services.
- Diabetes health outcomes are evaluated so we can target and assist local areas in further need of support.

3.23 Implementation of the ask needs a considered approach with governance and timelines therefore it is intended that the we will work within the existing HCP governance arrangements, ensuring system approval and sign up, to achieve the optimum level of embedded success whilst acknowledging the move towards an Integrated Care System may require an element of flexibility to delivery.

3.24 The diabetes framework and model of care has a 5-year delivery plan which compliments the HCP Long Term Plan and strategies currently in development. However, due to the impact of COVID-19 on the health systems there has been delay in delivery to many of the expected time line deliverables listed in the report. With the severe impact that the pandemic has had on those with Diabetes including; prevalence of Diabetes in up to 1/3 of patients who died from COVID-19 and; the potential impact on those who have not received essential routine health checks, the framework is ever more relevant and important.

3.25 It is requested that the board approve the framework. Once agreed with all relevant boards and stakeholders this document will be used as the foundation to enable development of local implementation plans to deliver the aforementioned offers.

4. RECOMMENDATIONS

4.1 The Health and Wellbeing Board are asked to provide approval of the Mid and South Essex Health & Care Partnership Diabetes Framework.

5. List of appendices

- 2019 MSE STP Diabetes Framework Finals
- Appendix A Diabetes Overview in MSE
- Appendix B Diabetes Framework Elements and Requirements
- Appendix C National Framework and Standards
- Appendix D Prescribing Algorithm for the Treatment of Type 2 Diabetes in Adults