HILLINGDON
LONDON

Policy Overview & Scrutiny Committee
Review Scoping Report 2012/2013

OBJECTIVE

Short title of review

REVIEW OF DIABETES IN THE BOROUGH

Aim of review

To review diabetes prevention and diabetes care pathways in the Borough and make recommendations for improvements.

Terms of Reference

1. **To consider comprehensively all arrangements in the Borough with regard to diabetes care, diabetes prevention and diagnosis and any improvements that could be made;**
2. **To review whether diabetes care, diabetes prevention and diagnosis arrangements and are timely, effective and cost efficient;**
3. **To review the guidance and support that is currently available from the NHS and the Council to those with diabetes and their carers;**
4. **To seek out the views on this subject from residents and partner organisations, including the voluntary sector, using the best consultation mechanisms;**
5. **To examine best practice elsewhere through case studies, policy ideas, witness sessions and visits; and**
6. **After due consideration of the above, to bring forward cost conscious and practical recommendations to the Cabinet and our partner organisations.**

Reasons for the review

Diabetes is a long-term condition caused by too much glucose (sugar) in the blood. In the UK, approximately 2.9 million people are affected by diabetes. There are also thought to be around 850,000 people with undiagnosed diabetes.

There are three main types of diabetes:

- Type 1 - Previously known as insulin-dependent diabetes.
- Type 2 - Previously known as non-insulin dependent diabetes.
- Gestational diabetes mellitus (GDM)

Type 1

This is also known as juvenile, early onset, or insulin-dependent diabetes. It usually first develops in children or young adults. In the UK, about 1 in 300 people develops type 1 diabetes at some stage.

With type 1 diabetes the illness usually develops quite quickly (over days or weeks) as the pancreas stops making insulin. It is treated with insulin injections and a healthy diet.

Type 2

This is also known as maturity-onset, late-onset, or non-insulin-dependent diabetes. Type 2 diabetes usually develops after the age of 40 (but sometimes occurs in younger people). It is more common in people who are overweight or obese. Type 2 is the most common of the three types of diabetes.

With type 2 diabetes, the illness and symptoms tend to develop gradually (over weeks or months). This is because in type 2 diabetes you still make insulin (unlike type 1 diabetes). However, you either do not make enough for your body's needs, and/or the cells in your body are not able to use insulin properly. This is called insulin resistance.

Gestational diabetes mellitus (GDM)

Gestational diabetes mellitus (GDM) is a type of diabetes that arises during pregnancy (usually during the second or third trimester).

In some women, GDM occurs because the body cannot produce enough insulin to meet the extra needs of pregnancy. In other women, GDM may be found during the first trimester of pregnancy. In these women, the condition most likely existed before the pregnancy.

Diabetes Nationally

Diabetes in London and the UK is increasing at an alarming rate. The increase is predominately down to an ageing population and unhealthy lifestyles leading to obesity. More recently, a greater number of children are being diagnosed with type 2 diabetes.

Diabetes can cause serious health implications like heart disease, nerve damage and kidney damage. Amputation, blindness and even death can all result from not properly diagnosing or treating diabetes.

It is estimated that diabetes will cost the NHS more than a sixth of its entire budget by 2035. Diabetes and its complications account for approximately 10% (£9.8 billion) of NHS spending, but this is projected to rise to £16.9 billion over the next 25 years, or 17% of the health service's funds.

Diabetes in Hillingdon

The Joint Strategic Needs Assessment (JSNA) reported in 2011 that there are 15,176 diabetics in Hillingdon which is expected to increase to 18,974 by 2020. By the end of March 2007, 1 in every 21 of the adult population had been diagnosed with diabetes. By the end of March 2012 the figure increased to 1 in every 16 which is expected to increase further in the next 6 years to be 1 in every 10.

In order to tackle increasing rates, it is important to target action towards prevention and identification of undiagnosed diabetes. Early detection should contribute towards prevention as well as tackling obesity (which is a major risk factor), smoking, physical inactivity and poor diet. Programmes such as the NHS Health Check offers adults between the ages of 40-74 an assessment on their health. The programme assesses an individual's risk of developing heart disease, stroke, type 2 diabetes and kidney disease, which are the largest contributors to cause of death in the UK. The aim of the programme is to provide tailored advice and support to help lower or manage this risk.

Dr Rowan Hillson is a consultant physician and diabetologist at Hillingdon Hospital where she and colleagues have established a very successful local diabetes service. In 1989 she established the diabetes team in Hillingdon and led the project to develop the Hillingdon Diabetes and Endocrine Unit. This centre, named Diabeticare, gained an international reputation and in 1997 Dr Hillson and the team won the national Hospital Doctor Diabetes Team award. Dr Hillson also has the additional role as National Clinical Director for Diabetes. Dr Hillson is responsible for helping to improve the care of the 2.4 million people with diabetes in England.

Supporting the Cabinet & Council's policies and objectives

- Hillingdon Health and Wellbeing Strategy and Action Plan (draft)
- Older People's Commissioning Plan (draft)
- Joint Strategic Needs Assessment

INFORMATION AND ANALYSIS

Key Issues

1. Are residents' expectations and concerns about diabetes care, diabetes prevention and diagnosis reflected in the Council's services?

2. How well developed are local strategies and partnerships with regard to diabetes?

3. How is diabetes currently identified and dealt with in the Borough and is there any additional scope for this to be improved and standardised?

4. How have other areas/councils successfully dealt with the issue of diabetes management?

5. What impact has this had on the local service provider?

6. What training is available to health professionals to properly detect and assess diabetes cases?

7. How can education and training in relation to diabetes for health and social care professionals, care home staff, diabetes patients and their carers be improved?

8. How can diabetes-related hospital admissions and unscheduled care costs (on the health side) be reduced? What impact would this have on individuals with diabetes?

9. Why does Hillingdon have a low spend poor outcome in diabetes services?

10. How good is local awareness, early identification and diagnosis?

11. How are we working with high risk communities such as Asian and African-Caribbean populations?

12. What information and advice is available locally? What treatment and support services are available?

13. How good is care for people with diabetes in hospital? How are people with diabetes supported in living at home? What is the quality of life for people with diabetes in care homes?

14. What are the links of diabetes to obesity and how does the work of the obesity agenda contribute to the prevention of diabetes?

15. What joint work is there currently between NSH and London Borough of Hillingdon and how can this be improved?

Remit - who / what is this review covering?

With regard to Hillingdon, it is proposed that this review will look at:

1. how awareness and understanding causes and treatment of diabetes can be raised for health and social care professionals and the public;
2. improvements that could be made with regard to prevention, early diagnosis, intervention and management.
3. how to ensure a higher quality of care/living well with diabetes; and
4. how to reduce diabetes-related hospital admissions and unscheduled care costs on the health side and social care admissions on the Local Authority side.

Connected work (recently completed, planned or ongoing)

Diabetes and Endocrine Unit

The Hillingdon Diabetes and Endocrine Unit is based at Hillingdon Hospital. It includes the Pagett ward for in-patients, and Diabeticare (out-patient District Diabetes Centre) where the team also sees patients. There is also a diabetic and an endocrine clinic at Mount Vernon Hospital (no walk-in). Patients meet members of an experienced multi-disciplinary team including doctors, nurses with specialist skills, midwives, dieticians, podiatrists and psychologists.

Diabeticare is the Diabetes and Endocrine outpatient department, for patients with diabetes and other hormone problems. Staff are available without appointment (walk-in) to respond to enquiries regarding your diabetic management and equipment but it may be necessary to refer you for a further appointment. Out-patient appointments in Diabeticare: Patients with urgent problems can be seen in Diabeticare on the same day and most people can be seen within two weeks of referral.

The Explore Hillingdon Programme

Explore Hillingdon is a programme of walking and cycling and is linked to Change4life Hillingdon. It is relevant for helping to prevent diabetes as well as those who have a diagnosis of diabetes.

The Walk Hillingdon programme is part of the National Walking for Health programme and is well established in Hillingdon, having been operational for over 120 years. It was set up by the Specialist Health Promotion team locally and encourages regular physical activity through offering led walks throughout the Borough.

A new referral process has been established with Diabeticare, whereby walking activity in this programme is recorded and followed up at patient reviews by specialist diabetic nurses. This process has within 2 months seen more referrals to the walk programme by health professionals than those typically made in any one year.

This process is currently being promoted to Clinical Commissioning Groups through Multi-Disciplinary Group meeting with the aim of GP's adopting the system.

This preventative action can of moderate intensity physical activity can reduce the risk reduction of type 2 diabetes by up to 60%.

The Age Well on Wheels programme is also part of the Explore Hillingdon programme. It is a programme of free led cycle rides that are available to people over the age of 50. This programme is also being promoted to GP's through the Explore Hillingdon dissemination and through previously referred to Multi-disciplinary groups.

Integrated Care Programme (ICP)

In July 2011, NHS North West London (NWL) launched a large scale project to integrate care for its population of older people (over 75s) and those living with diabetes. The project was launched in partnership with CCG's and Local Authorities. The Integrated Care Programme (ICP) is currently being piloted in Hillingdon. The pilot brings together organisations from the acute, primary care, community care and social care sectors. The programme is aiming to develop integrated approaches and better co-ordinated health and social care plans for people with complex needs who are over 75 years old and or have diabetes. As such, better quality care in the community should reduce unnecessary emergency admissions and make better use of available resources with potential efficiencies.

Dose Adjustment For Normal Eating (DAFNE)

Dose Adjustment For Normal Eating (DAFNE) is a structured educational patient programme in intensive insulin therapy and self management where people with type 1 diabetes are taught to match their insulin dose to their chosen food intake on a meal by meal basis. The DAFNE training programme is available at The Hillingdon Hospitals NHS Foundation Trust.

Diabetes Education Structured for the Management of Ongoing and Newly Diagnosed Diabetes (DESMOND)

DESMOND is a one day session, delivered by trained facilitators using specially developed resources; the programme is delivered at several locations in Hillingdon to groups of up to ten people who have been newly diagnosed with type 2 diabetes. Following a GP referral patients are invited to attend at a venue of choice and are encouraged to bring along a friend or relative for support. Those who attend the course will learn how management of the following lifestyle changes can improve wellbeing:

- Exercise
- Blood glucose monitoring
- Medication
- What you can eat

- Sugar content in food and drink

EVIDENCE & ENQUIRY

Methodology

1. A Working Group would be set up to examine background documents and receive evidence at its public and private meetings from officers and external witnesses.

2. The Working Group Members may also make visits to sites and/or to other Boroughs or organisations with best practice examples.

3. A consultation exercise or stakeholder event could also be undertaken.

Witnesses

Possible witnesses could include:

1. Individuals with diabetes living in Hillingdon.

2. Older People's Services, Commissioning Team, Public Health Team.

3. External partners, e.g., Older People's Forum, Age UK, Community Integrated Care (CIC), Hillingdon Clinical Commissioning Group, NHS Hillingdon, The Hillingdon Hospital NHS Foundation Trust, CQC, Health and Wellbeing Board, Hillingdon LINK, NHS Health Watch, Dr Hillson and Dr Trish Hurton (Clinical Lead for Diabetes).

4. Cabinet Member for Social Services, Health and Housing.

There may need to be some prioritisation within this list of witnesses in order to make the review manageable and ensure that it is completed within the prescribed timescale.

Information & Intelligence

To be determined.

Consultation and Communications

Consultation could be undertaken with individuals with diabetes, relevant charities, service departments and outside organisations. Consideration of a possible stakeholder event, similar to the one undertaken on dementia care, which was highly successful.

PROPOSALS

To be developed as the review progresses.

LOGISTICS

Proposed timeframe & milestones

Meeting	Action	Purpose / Outcome
ESSC – 20 November 2012	Agree Scoping Report	Information and analysis
Date TBA	Site Visit / Stakeholder Event	Evidence & enquiry
Date TBA	Introductory Report / Witness Session 1	Evidence & enquiry
Date TBA	Witness Session 2	Evidence & enquiry
Date TBA	Witness Session 3	Evidence & enquiry
Date TBA	Draft Final Report	Proposals – agree recommendations and final draft report
ESSC – 19 March 2013	Agree Draft Final Report	
Cabinet – 25 March 2013		

Equalities

The Council has a public duty to eliminate discrimination, advance equality of opportunity and foster good relations across protected characteristics according to the Equality Act 2010. Our aim is to improve and enrich the quality of life of those living and working within this diverse Borough. Where it is relevant, an impact assessment will be carried out as part of this review to ensure we consider all of our residents' needs.

Risk assessment

The review needs to be resourced and to stay focused on its terms of reference in order to meet this deadline. The impact of the review may be reduced if the scope of the review is too broad.