Diabetes

Topic information	
Topic title	*Diabetes*
Topic owner	*Nottingham City LTC Strategic Group*
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Topic quality reviewed	*April 2016*
Topic endorsed by	*Nottingham City LTC Strategic Group February 2016*
Current version	*2016*
Replaces version	*2012*
Linked JSNA topics	*Cardiovascular disease, stroke*

Executive summary

Introduction

Diabetes Mellitus (DM) is a group of disorders that results from the body's inability to control blood glucose levels. The raised blood glucose levels over time lead to damage to blood vessels and organs. It is a chronic disease which causes substantial premature morbidity and mortality, and imposes a heavy burden on health services.

- 2.8 million adults (6.2% of the adult population) in England had a diagnosis of diabetes in 2013/2014 (HSCIC, 2015), but a high number remain undiagnosed. The true prevalence in 2015 is estimated to be around 3.4 million (7.6% of the adult population) (YHPHO, 2012).
- There are 4 sub-categories of diabetes: *Type 1, Type 2, gestational* and 'other' types. Type 2 is the most common and is usually diagnosed in people over 40. As the symptoms often appear gradually, diagnosis can be delayed.
- Diabetes prevalence is increasing in all age groups and is predicted to continue rising over the next two decades. It is expected to be one of the main diseases accounting contributing to longstanding illness in the elderly.
- Diabetes accounts for approximately 10 per cent of the annual National Health Service budget. This is nearly £10 billion a year, or expressed another way: £192 million a week; £27 million a day; £1 million an hour; £19,000 a minute or £315 a second (Hex, N., et al, 2012)
- The total cost (including direct care and indirect costs) associated with diabetes in the UK is currently estimated at £23.7 billion. These costs are predicted to rise to £39.8 billion by 2035–36 (Hex, N., et al, 2012).
- Eighty per cent of NHS spending on diabetes goes on managing complications, most of which could be prevented (Kerr, M, 2011)
- One in 20 people with diabetes incurs social services costs. More than three-quarters of these costs are associated with residential and nursing care (Kings Fund et al, 2000)
- One in seven hospital beds is occupied by someone who has diabetes, although this may not be the immediate cause of that illness. In some hospitals, it is as many as 30% (HSCIC, 2013).

- People with diabetes are twice as likely to be admitted to hospital as those without (Sampson MJ, Doxio N, Ferguson B et al, 2007).
- One in four people admitted to hospital with heart failure, heart attack or stroke has diabetes. People with diabetes experience prolonged stays in hospital. This results in about 80,000 bed days per year (Sampson MJ, Crowle T, Dhatariya K et al, 2006).
- 42.2 million prescription items were dispensed in primary care units across England in 2012 at a net ingredient cost of nearly £768 million. This is an increase in cost of 7.7 per cent over 2010 (The Health and Social Care Information Centre, 2013).
- People with diabetes in England and Wales are 37.5% more likely to die early than their peers. For Type 1 diabetes, mortality is 129.5% greater than expected and for Type 2 diabetes it is 34.5% greater. The greatest increased risk of death is in younger ages and in females (Diabetes UK 2014).
- Effective control of blood glucose and blood pressure helps prevent the development and progression of complications. As 95% of diabetes management is self-care, this makes patient education essential.

This chapter focuses on Type 2 diabetes. Cardiovascular disease, obesity in adults and children and diet and nutrition are considered in detail in their own respective chapters.

Unmet need and gaps

- Early local involvement in the national Diabetes Prevention Programme gives a potential opportunity to reduce the numbers of people developing DM, or delaying the onset of diabetes with people remaining healthy for longer, although success is not guaranteed.
- There are currently a comparatively large number of people in Nottingham City with undiagnosed DM, largely type 2. The diagnosed prevalence in 2014 was 5.2% in Nottingham City compared to 6.2% in England (estimated prevalence is 7.2% compared to 7.3%). This means that within the City, only an estimated 72% of people with diabetes have been diagnosed, compared to 85% nationally (PHE: Cardiovascular Disease Profile, Diabetes, 2015).
- For those known to have DM in the City, although care is comparatively good, there is significant room for further improvement, which can be expected to improve clinical outcomes. A key priority is to improve achievement of proven therapeutic goals, such as control of high blood pressure and cholesterol and glucose control, which the new contract incentives. Variability in care delivery across the City may be significant.
- The recent Equity Audit of retinopathy screening to prevent blindness among people with DM found a number of inequities in access, which should be addressed.
- There have been large recent increases in gestational diabetes and the new payment system may not be meeting the full costs of treatment.
- NHS Nottingham City CCG spent £250 on prescribing per person with diabetes. This is lower than the England average of £285. The total spend on prescribing for anti-diabetic items between April 2013 and March 2014 was £3,770,000. This accounted for 9.0% of the total CCG prescribing budget (PHE: Cardiovascular disease profile, Diabetes, 2015).

Recommendations for consideration by commissioners

1. Ensure successful delivery of the National Diabetes Prevention Programme in Nottingham City.
2. Undertake further work with Public Health programmes and Primary Care providers to increase the detection and diagnosis of type 2 DM, particularly among those communities most at risk of the condition.
3. Support the implementation of newly commissioned services, with the aim to ensure that the patient pathway is well-coordinated.
4. Expand the availability and accessibility of culturally-sensitive educational programmes for those with DM and their carers.
5. Consider the provision of psychological care for patients with diabetes, alongside other long-term conditions.
6. Progress and monitor actions to resolve inequity of access to diabetic retinopathy screening identified in the Health Equity Audit.
7. Improve foot care, with pathway improvement and integration with podiatry services, to address avoidable morbidity and hospital admissions.
8. Improve care for young people in transition from children's' services to the new, community-based adult services.
9. Work with the medicines management team to develop pharmacist-led services for patients with diabetes, and ensure they are integrated effectively into the care pathway.
10. Ensure that patients and carers continue to be involved in the development and implementation of service changes.
11. Work with the primary care commissioning team to ensure robust performance management and support (including data to highlight clinical variation) to general practices to reduce unwarranted variations in the care of patients with diabetes.
12. Work with providers to review the pre-discharge procedure for patients admitted to hospital with diabetes-related complications and determine how the Nottingham City Diabetes Service can best support community follow up (as indicated by patient need and severity of disease).
13. Pending the completion of the research, consider making use of the findings of the Interim Report *Increasing the uptake of primary and community long-term conditions services in Black and Minority Ethnic (BME) communities in Nottingham - an exploratory research study,* to improve access to long-term conditions services for people from BME communities.
14. Use Equity Audits to monitor access and utilisation of the new Diabetes Service.

Full JSNA report

What do we know?

1) Who is at risk and why?

Diabetes is a chronic disease that can cause substantial premature morbidity and mortality. Good blood glucose control and effective treatment of cardiovascular risk factors, particularly high blood pressure, are important for avoiding the complications of diabetes.

- For people with diabetes, cardiovascular disease is a major cause of death and disability. It accounts for 44% of fatalities in people with Type 1 diabetes and 52% in people with Type 2 (UK Prospective Diabetes Study (UKPDS) Group)
- People with Type 2 diabetes have a two-fold increased risk of stroke within the first five years of diagnosis compared with the general population (Emerging Risk Factors Collaboration, 2010 and Jeerakathil T, Johnson JA, Simpson SH et al 2007).
- Diabetic retinopathy accounts for about 7% of people who are registered blind in England and Wales (Leamon, S. Davies, M, 2014).
- Diabetes is the leading cause of preventable sight loss in people of working age in the UK (Liew, G et al., 2014).
- Within 20 years of diagnosis nearly all people with Type 1 and almost two thirds of people with Type 2 diabetes (60 per cent) have some degree of retinopathy (Scanlon PH, 2008).
- People with diabetes have nearly 50% increased risk of developing glaucoma, especially if they also have high blood pressure (Newman-Casey, PA et al., 2011), and up to a three fold increased risk of developing cataracts both of which can also lead to blindness (Mukesh, BN et al, 2006)
- Diabetes is the most common cause of lower limb amputations (Amputee Statistical Database for the UK, 2007) and in excess of 6,000 leg, toe or foot amputations happen each year in England alone. This is over 100 amputations a week amongst people with diabetes (HSCIC, 2013).
- People with diabetes are estimated to be up to 30 times more likely to have an amputation compared with the general population (Khanolkar, MP et al., 2008).
- Neuropathies (nerve damage) may affect up to 50 per cent of patients with diabetes (Boulton AJM, 2005). Chronic painful neuropathy is the most common type of neuropathy and is estimated to affect up to 26% of people with diabetes (Ziegler, D., 2010).
- In 2009, a world literature review found that the reported prevalence of erectile dysfunction was between 35 per cent and 90 per cent among men with diabetes (Malavige LS & Levy JC, 2009). One study found that 27 per cent of women with Type 1 diabetes reported sexual dysfunction. This is, however, an under-researched area (Enzlin P, Mathieu C, Van den Bruel A et al, 2003).
- Women with diabetes are five times more likely to have a pre-term baby than women without diabetes and three times more likely to have a Caesarean section delivery. They are also twice as likely to have a baby weighing more than 4kg (CEMACH, 2007).
- One in 250 pregnancies in England, Wales and Northern Ireland involve maternal diabetes. Babies born to women with diabetes are five times as likely to be stillborn. They are three times as likely to die in their first months of life (CEMACH, 2007). Also they are three to six times as likely to have a major congenital anomaly. This number could be higher as this figure is not adjusted for the higher rate of abortions in women where congenital abnormalities are found (Bell, R. et al., 2012).

- A recent study based on Scottish primary-care records suggested that many patients with DM also had other long-term conditions: high blood pressure (54%), coronary heart disease (23%), a painful condition (21%), depression (18%), stroke or TIA (stroke-like symptoms lasting less than a day, 9%) and COPD (8%). Fewer than one in five (17.9%) only had DM (Barnett et al, 2012).
- People with Type 2 diabetes are at a 1.5 – 2.5-fold increased risk of dementia (Strachan, M.W.J. et al, 2011).

The risk factors for developing Type II Diabetes are:

Non-modifiable factors

- Increasing *age* and having a strong *family history* of diabetes are known risk factors.
- Risk is also associated with a person's ethnicity. Type 2 diabetes is more than six times more common in people of South Asian descent and up to three times more common among people of African and African-Caribbean origin (Nazroo, JY, 1997).
- Studies show that people of Black and South Asian ethnicity also develop Type 2 diabetes at an earlier age than people from the White population in the UK, generally about 10 years earlier (Winkley, K et al., 2013).

Modifiable risk factors

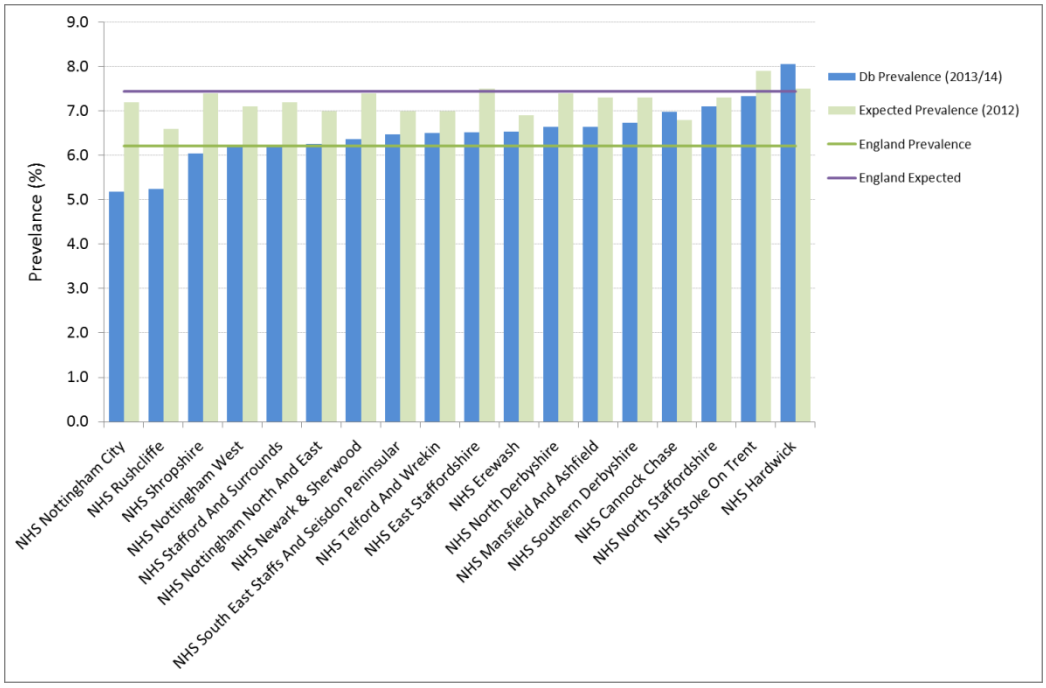
- The main risk factors are *obesity, low physical activity levels, poor diet* and *nutrition*. These risk factors are all associated with deprivation.
- Obesity is the most potent risk factor for Type 2 diabetes. It accounts for 80– 85 per cent of the overall risk of developing Type 2 diabetes and underlies the current global spread of the condition (Hauner H, 2010).

2) Size of the issue locally

Prevalence

- The expected prevalence of diabetes in people aged 17 or over in Nottingham in 2015 based on YHPHO modelling was 20,353 (PHE: Cardiovascular Disease Profile, Diabetes, 2015). The actual reported prevalence based on GP disease registers in 2013/14 was 14,501. This suggests that there may be a difference of around 28% (5,852) of people with diabetes who have not been diagnosed (East Midlands Academic Health Sciences Network, 2015).
- Nottingham's prevalence of diabetes on practice registers (5.2%) is significantly lower than the national average (6.2%). It has been estimated that the true prevalence in the City is 7.2% compared to an estimated national prevalence of 7.3%. This means that within the City, only an estimated 72% of people with diabetes have been diagnosed, compared to 85% nationally (PHE: Cardiovascular Disease Profile, Diabetes, 2015).
- Nottingham City CCG commissioned Diabetes UK to undertake a more detailed audit of primary care data relating to people with DM. Completed in late 2015, this identified 16,168 adults (aged 18 years and over), suggesting a significant improvement in the completeness of diagnosis.
- The audit also showed that 16.3% (2,640 patients) of those diagnosed with DM were current smokers; this is a particularly important risk factor that could be addressed (Diabetes UK, 2015).

Figure 1 – Actual and expected prevalence of diabetes in Nottingham and North Midlands CCGs, 2013/14

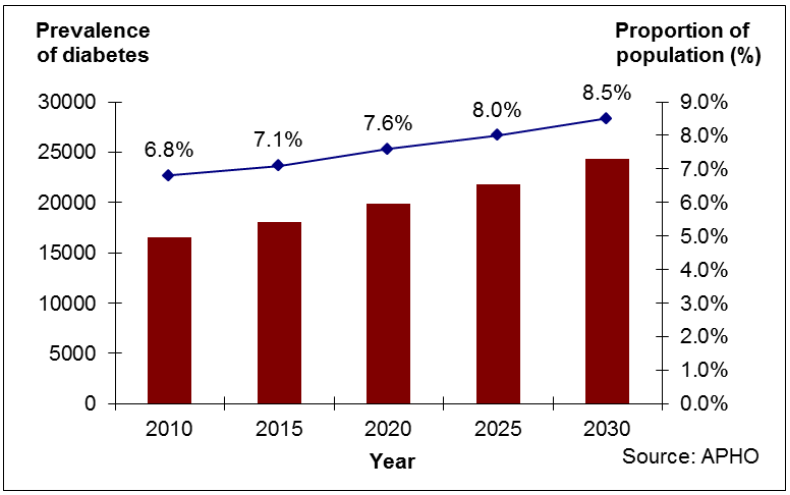


Source: Public Health England Diabetes Profile; Expected Prevalence (age 16+ years, adjusted for age, sex, ethnic group and deprivation; Diabetes Prevalence(age 17+years): QOF 2013/14

Locally, there are wide variations in the prevalence of diabetes between general practices ranging from 0.4% to 10.4% (QOF, 2014/15). This is partly due to the different demographic profiles of each practice population (for example practices serving university student populations would be expected to have a lower prevalence of diabetes), although the range also suggest variability across practices in the completeness of detection and diagnosis.

Of note, diabetes prevalence locally is predicted to continue to rise over the next 20 years by around 20.3% between 2010 to 2020. This equates to 3,342 more persons developing the disease (Figure 2). Persons who are overweight (~115,000) and obese (~76,500) are at particular risk.

Figure 2 – Predicted prevalence of diabetes in adults in Nottingham (Source: APHO, 2010)



Referrals for gestational diabetes (i.e. diabetes in pregnancy, GDM) increased from 54 in 2005, to 121 in 2009. GDM is rising more rapidly over recent years. The year ending July 2014, saw a 32.5% increase in referrals with GDM to Nottingham University Hospitals (NUH) NHS Trust's Maternity Services, with a further 11.9% increase into 2015. As there was only a very small change in the total number of women seen at NUH, this is due to demographic changes within the population (e.g. more older mothers, more women from ethnic groups at high risk of GDM) and an increasing prevalence of overweight/obesity among women of childbearing age. It will be necessary to investigate further to assess how many of the additional women with GDM are residents of the City. Changes to the payment by results (PbR) tariff system, which reimburses hospitals for the clinical complexity of the patients they treat, does not meet the extra costs incurred in treating patients whose GDM develops late in their pregnancy.

3) Targets and performance

Mortality

- Nottingham City's diabetes-related mortality is high compared with England (Figure 3), but has been falling (Figure 4).
- If we applied the best and mortality rates from other organisations to Nottingham City, this gives a range of between 8 and 40 excess deaths due to diabetes, suggesting some potential to reduce or delay mortality due these DM.

Figure 3 – Diabetes mortality (standardised mortality ratio, all ages, persons, 2012-14).

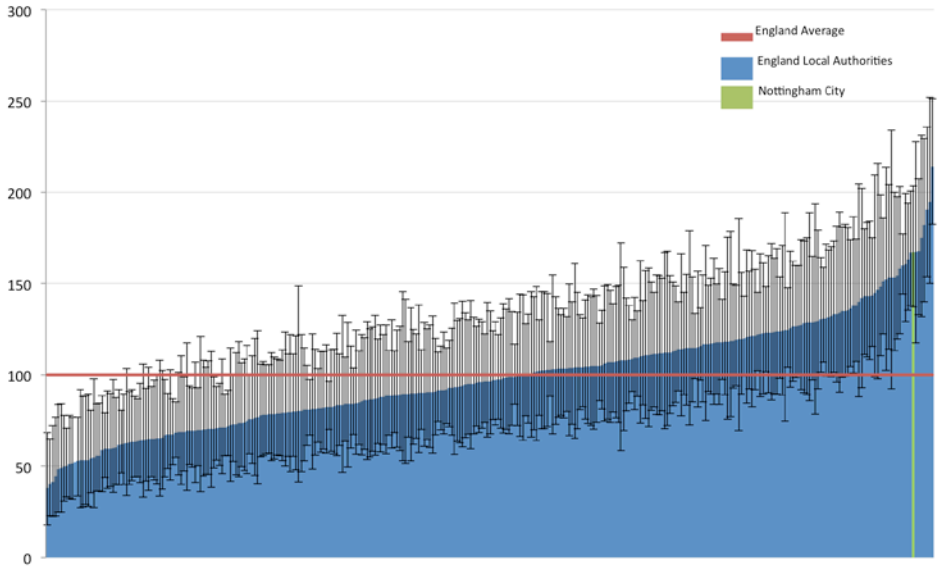
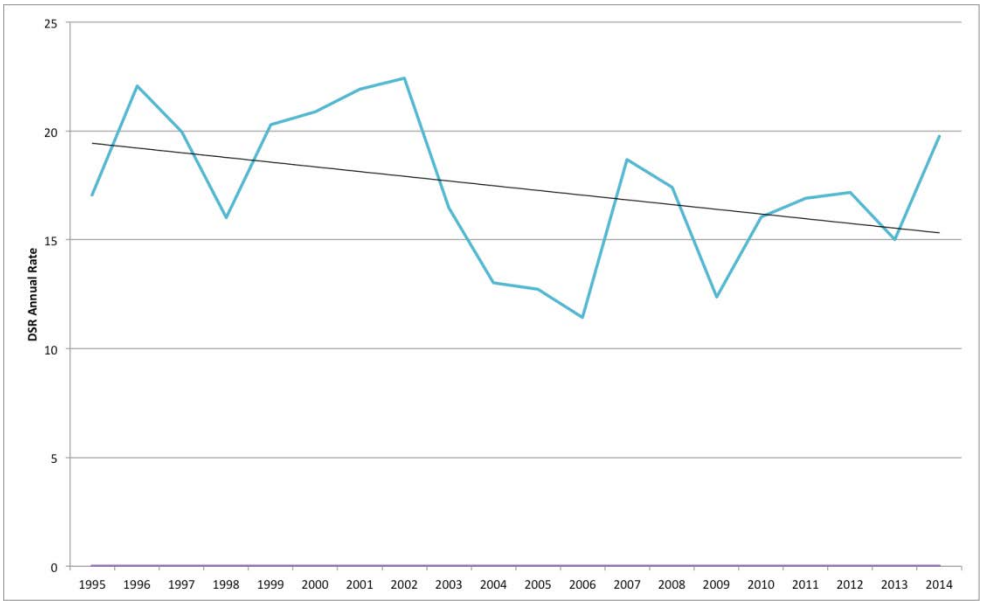


Figure 4 – Diabetes mortality (directly standardised mortality rate, all ages, persons, 1995-2014; individual years = blue, trend = black).



Complications of diabetes

The National Diabetes Audit for 2010/11 compared a number of the potential adverse outcomes of diabetes. For Nottingham City's population with DM, although these outcomes were all more common than for similar people without DM, some of the more serious, life-threatening outcomes (heart attack, heart failure and stroke) were slightly less common than the national average, and both minor and major amputations were much less common than

nationally. This may reflect the younger age-profile of the City's population, but the differences on amputations suggest better care is making a contribution to the better outcomes. Less positively, angina (signalling underlying vascular disease) and kidney failure were not lower than the national average. Overall mortality, though 34% higher than for the general population in Nottingham, was not as raised as the national average, where it is 38% higher (HSCIC, 2013).

Analysis of hospital data for 2011-14, found that hospital admissions for foot care were higher for Nottingham City than the national average, though amputation rates were very similar to the national average (PHE, 2015).

Treatment of established diabetes

The recent audit of the GP records of patients with DM examined the achievement of three particular treatment goals; control of high blood pressure, control of high blood sugar (as measured by HbA1c) and cholesterol. In summary:

- Almost 2/3 (65%) of patients had reasonable BP control (<140/80).
- Almost 2/3 (66%) of patients had reasonable cholesterol level (<5mmol/L).
- Only 2/5 (39%) of patients had good glucose control (HbA1c <53mmol/L or 7%).

The audit also assessed how many patients had good control of all three factors (21.45%). This shows scope for improvement.

4) Current activity, service provision and assets

Most care for patients with diabetes will be provided either in primary care or by community-based services.

A new community service has recently been commissioned and commenced on 1 January 2016. The aim of the service is to provide an integrated diabetes service in the community for patients with Type 1 and 2 diabetes. This includes; telephone education, advice and support to both patients and healthcare professionals, emotional and psychological support, structured education programmes (both group and 1 to 1 sessions), continuous blood glucose monitoring, foot assessment, care planning and insulin pumps initiation and management. In addition, patients presenting post or with a hypo/hyperglycaemic attack will be given advice and support through the hypoglycaemia pathway. Mentorship/training opportunities for healthcare professionals will also be provided.

<u>Type 1</u>

The new service will support all Type 1 stable diabetes patients. There are approximately 1,450+ (Type 1) patients diagnosed as recorded on GP practice registers. This includes all planned care for Type 1 diabetes patients (in the Community) and this should include post diagnosis discharge patients.

<u>Type 2 Patients</u>

The provider is expected to support all Type 2 diabetes patients (approximately14,450+ registered patients) in the Community where appropriate, including those with complex needs in the Community.

The following patient groups will be cared for by more specialised services:

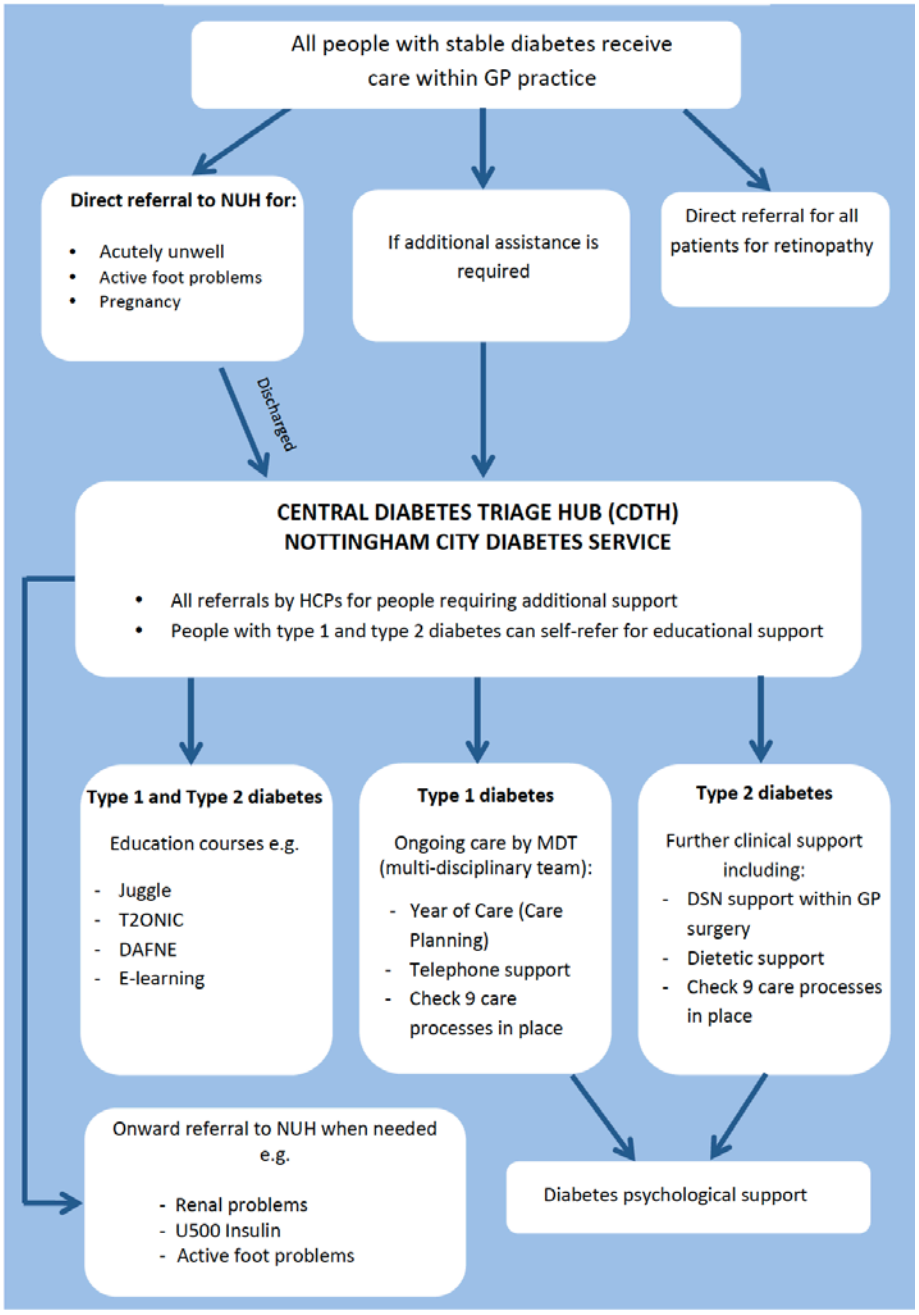
- Unstable Type 1 patients
- Patients with pre-existing diabetes who become pregnant
- Foot care requiring secondary care facilities
- In-patient (urgent referral requiring admission)
- Patients with unstable renal function (EGFR <30)
- U500 patients
- Patients under 18 years of age (with flexibility relating to the care of young adults in transition)

Around 400 patients with diabetes have recently been discharged from secondary care OP follow-up. The new service aims to support the discharge of a further 500 patients over the next five years.

The service will provide a single point of access for healthcare professionals to refer service users with diabetes (Type 1, Type 2 other), and will include:

- A system to respond to referrals and queries regarding diabetes support from the service user/carer/health professional 7 days a week (where evidence is provided)
- Co-ordination of community based packages and care management plans for diabetes care
- Clinical support
- Tier 3 service
- Links to social support and rehabilitation
- Sign posting to Complementary therapies
- Links to medicines management
- Links to Podiatry

Figure 5 – Nottingham City Diabetes Service.



v5 February 2016

5) Evidence of what works

Evidence has been reported to show that:

- The onset of Type 2 diabetes can be delayed or even prevented by sustained lifestyle changes in diet and physical activity;
- The early diagnosis and tight control of blood sugar levels and blood pressure, especially early in the disease, can increase life expectancy and reduce complications (UK Prospective Diabetes Study (UKPDS) and the Diabetes Control and Complications Trial (DCCT)). Eye screening and treatment can reduce severe visual loss.
- The impact of diabetes and its complications can be reduced by providing well-organised, integrated care from diagnosis, including, in particular the education and empowerment of patients and their families and the early identification of complications.

National guidance

- National Service Framework for Diabetes (2001)
- Diabetes Commissioning Toolkit (2006)
- Commissioning Diabetes Without Walls. NHS Diabetes (2009)
- Diabetes in pregnancy: management from preconception to the postnatal period. NICE guidelines NG3 (2015).
- Diabetes (type 1 and type 2) in children and young people: diagnosis and management, NICE guidelines NG18 (2015).
- Type 1 diabetes in adults: diagnosis and management
  NICE guidelines NG17 (2015)

- Type 2 diabetes in adults: management NICE guidelines NG28 (2015).
- Type 2 Diabetes Clinical Guideline: The management of type 2 diabetes: CG87 (May 2009): Partial update and replacement of CG66, including newer pharmacological agents.
- Diabetes Care Pathways NICE, accessed 27 January 2016.
- Diabetes Health Intelligence – hosted by Yorkshire and the Humber Public Health Observatory.
- NHS Diabetes – Department of Health team supporting the implementation of the Diabetes NSF.
- Diabetes UK – produce educational and other materials for professionals and patients.

Modelling

- Modelling carried out by the National Support Team for Health Inequalities suggests that if everyone with an HbA1c over 7.5% (59 mmol/mol) reduced their blood sugars by one unit, 16 deaths might be delayed (DH, 2009).

Effectively treating hypertension in six patients with diabetes prevents one serious cardiovascular event in the following ten years, including death. For patients with hypertension and no diabetes, 150 people require treatment to prevent one event (Rixom, 2009).

6) What is on the horizon?

The Public Accounts Committee Report (HoC, 2016) has recently reported on the prevention the treatment of DM. Although they expressed satisfaction that the NHS has achieved comparatively good and improving health outcomes, they also expressed concern that the quality of care was variable across the country, even between small areas and individual general practices. They felt that there was considerable potential to:

- Make greater efforts to prevent type-2 DM.
- Reduce the variability in clinical care for those with established DM.
- Specifically, increase the capacity and capability of diabetes education programmes and increase uptake of education, particularly for newly-diagnosed patients.

National Diabetes Prevention Programme

NHS England, Diabetes UK and Public Health England are about to launch a National Diabetes Prevention Programme. The programme aims to identify people who have had blood tests that suggest they are at particular risk of developing type-2 DM and give them intensive support to reverse or delay the deterioration in their glucose control. NHS Nottingham City, in partnership with Nottingham City Council, and East Midlands Strategic Clinical Network, have submitted a successful bid and have been selected to be part of the first wave for implementation of this programme. This will secure, at least initially, national financial support for the preventative interventions, although modest local resources are likely to be needed to support the management of those at-risk in primary and secondary care. The recent audit undertaken by Diabetes UK, has identified around 5,100 patients who are ‘at-risk’ of developing diabetes in the future, who might prove eligible for the service.

Treatment and management of established DM

In 2013, the US Agency for Healthcare Research and Quality (AHRQ) published a Horizon-scanning report on DM (AHRQ Healthcare Horizon Scanning System – Potential High-Impact Interventions Report, Priority Area 07: Diabetes Mellitus (AHRQ, 2013). The exercise only identified one intervention judged to have a high likelihood of major strategic impact on the treatment of DM; the artificial pancreas device system (APDS). In addition, the NIHR Horizon Scanning Research & Intelligence Centre at the University of

Birmingham assessed the potential of these systems and judged that 18 systems were currently at various stages of testing and that a small number of systems would become commercially available in Europe over the next three years (Trevitt, Simpson & Wood, 2015). Essentially, these systems continuously monitor blood glucose and deliver insulin automatically, on the basis of measurements and expected needs.

7) Local Views

Extensive engagement (survey, focus groups etc.) of patients with DM and other stakeholders has been undertaken since the last JSNA was published, and has been summarised (Diabetes Services Procurement, Nottingham City CCG, 2015). While there were several aspects of care where high levels of satisfaction were expressed (e.g. hospital OP clinics, information and education), patients did express a number of priorities for development:

- More flexible access to services; telephone advice, community settings and greater flexibility around clinic times (i.e. outside working hours) were requested.
- Individual care planning should develop further. Follow-up care should be more flexible, and tailored to individual need, rather than strict, routine check-ups (e.g. annual checks). Culturally-sensitive care should be developed further.
- Integrated community service should improve access, though quality had to remain high. It was necessary to ensure equitable access across the City to high-quality primary and community care.
- Greater access to structured education for patients of all ages with all types of DM, including those at-risk of developing the condition. Better information should support self-management.
- Peer and other support groups, including for patients and carers could be increased.
- A number of specific services were thought to require development or improvement:
    - Dietitians – people would like to see a speedier response from the dietitian within the community, being able to access them via the GP or nurse.
    - Podiatry – it was felt there was a lack of information detailing how to access the podiatry service and that the referral process often impeded access.
    - Pharmacists – it was highlighted that there was more scope to utilise pharmacists within the pathway to help relieve pressure on other services e.g. they could be used for screening, education around medication, education and risk assessments.
    - Hospital in-patient care – it was felt that there was an inadequate response to glucose testing (although the testing process itself was identified as good). People were also unhappy that they were not given their medication with food – they were not asked or informed of anything to do with their care whilst in hospital.
    - Mental health – there needs to be a strengthened link between diabetes and community mental health services, specifically talking therapies.

These views have influenced the re-procurement of the new Diabetes Service.

Increasing the uptake of primary and community long-term conditions services in Black and Minority Ethnic (BME) communities in Nottingham - an exploratory research study - Interim Report

This interim report of on-going research commissioned by the City's CCG, has reviewed previously published research and identified a number of potential barriers to uptake by minority ethnic groups and also likely enablers of improved access. Enablers were categorised as:

- Use of evidence
- Communication and trust
- Culturally-adapted interventions/training
- Community links
- Finance
- Family support and social networks
- Patient involvement

What does this tell us?

8) Unmet needs and service gaps

- Early local involvement in the national Diabetes Prevention Programme gives a potential opportunity to reduce the numbers of people developing DM, or delaying the onset of diabetes with people remaining healthy for longer, although success is not guaranteed.
- There are currently a comparatively large number of people in Nottingham City with undiagnosed DM, largely type 2. The diagnosed prevalence in 2014 was 5.2% in Nottingham City compared to 6.2% in England (estimated prevalence is 7.2% compared to 7.3%). This means that within the City, only an estimated 72% of people with diabetes have been diagnosed, compared to 85% nationally (PHE: Cardiovascular Disease Profile, Diabetes, 2015).
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- The recent Equity Audit of retinopathy screening to prevent blindness among people with DM found a number of inequities in access, which should be addressed.
- There have been large recent increases in gestational diabetes and the new payment system may not be meeting the full costs of treatment.
- NHS Nottingham City CCG spent £250 on prescribing per person with diabetes. This is lower than the England average of £285. The total spend on prescribing for anti-diabetic items between April 2013 and March 2014 was £3,770,000. This accounted for 9.0% of the total CCG prescribing budget (PHE: Cardiovascular disease profile, Diabetes, 2015).

9) Knowledge gaps

1. Following implementation of the new service, equity audits to monitor and address service inequity.
2. It is necessary to assess how many of the additional women with GDM are residents of Nottingham City, and review the commissioning of services to manage and follow-up women with gestational diabetes.

What should we do next?

10) Recommendations for consideration by commissioners

1. Ensure successful delivery of the National Diabetes Prevention Programme in Nottingham City.
2. Undertake further work with Public Health programmes and Primary Care providers to increase the detection and diagnosis of type 2 DM, particularly among those communities most at risk of the condition.
3. Support the implementation of newly commissioned services, with the aim to ensure that the patient pathway is well-coordinated.
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14. Use Equity Audits to monitor access and utilisation of the new Diabetes Service.

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