

DUK 2014 State of The Nation

Challenges for 2015 and beyond

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**INTRODUCTION**

Last year’s DUK State of the Nation report commented on the absence of national plans to improve the quality of diabetes care and reduce complications, and to tackle the rising incidence of this condition. There is a Type 2 diabetes prevention programme in the NHS Five Year Forward View.

CCGs and Local Authorities are currently being identified to become demonstrator sites for the [National Diabetes Prevention Programme](https://web.nhs.net/OWA/redir.aspx?SURL=CkBlgZV_xzfRS28VQNg658zLBLHKNou1QPU4eu4zqwkuhNQkPynSCGgAdAB0AHAAOgAvAC8AbABpAG4AawBzAC4AbgBoAHMALgBtAGsAdAA1ADYANAAzAC4AYwBvAG0ALwBjAHQAdAA_AGsAbgA9ADcAJgBtAHMAPQBOAEQAZwB4AE4AagBrADEATwBUAFkAUwAxACYAcgA9AE4AVABNAHkATQBqAGMANABNAHoAVQB6AE4ARABjAFMAMQAmAGIAPQAwACYAagA9AE4AagBRAHcATgB6AE0AMQBNAFQAawB6AFMAMAAmAG0AdAA9ADEAJgByAHQAPQAwAA..&URL=http%3a%2f%2flinks.nhs.mkt5643.com%2fctt%3fkn%3d7%26ms%3dNDgxNjk1OTYS1%26r%3dNTMyMjc4MzUzNDcS1%26b%3d0%26j%3dNjQwNzM1MTkzS0%26mt%3d1%26rt%3d0). The diabetes prevention programme is a joint partnership between PHE, NHS England and Diabetes UK as outlined in our [From Evidence Into Action](https://web.nhs.net/OWA/redir.aspx?SURL=6adMD7xvuU5PGls9Gc2VgckDqch8oqDnHZz8ruY91pIuhNQkPynSCGgAdAB0AHAAOgAvAC8AbABpAG4AawBzAC4AbgBoAHMALgBtAGsAdAA1ADYANAAzAC4AYwBvAG0ALwBjAHQAdAA_AGsAbgA9ADYAJgBtAHMAPQBOAEQAZwB4AE4AagBrADEATwBUAFkAUwAxACYAcgA9AE4AVABNAHkATQBqAGMANABNAHoAVQB6AE4ARABjAFMAMQAmAGIAPQAwACYAagA9AE4AagBRAHcATgB6AE0AMQBNAFQAawB6AFMAMAAmAG0AdAA9ADEAJgByAHQAPQAwAA..&URL=http%3a%2f%2flinks.nhs.mkt5643.com%2fctt%3fkn%3d6%26ms%3dNDgxNjk1OTYS1%26r%3dNTMyMjc4MzUzNDcS1%26b%3d0%26j%3dNjQwNzM1MTkzS0%26mt%3d1%26rt%3d0" \t "_blank) and the [NHS Five Year Forward View Into Action](https://web.nhs.net/OWA/redir.aspx?SURL=HA0544-uiFfSia2K551vhNtBwa75GCuGDQTo3m3vg4wuhNQkPynSCGgAdAB0AHAAOgAvAC8AbABpAG4AawBzAC4AbgBoAHMALgBtAGsAdAA1ADYANAAzAC4AYwBvAG0ALwBjAHQAdAA_AGsAbgA9ADEAJgBtAHMAPQBOAEQAZwB4AE4AagBrADEATwBUAFkAUwAxACYAcgA9AE4AVABNAHkATQBqAGMANABNAHoAVQB6AE4ARABjAFMAMQAmAGIAPQAwACYAagA9AE4AagBRAHcATgB6AE0AMQBNAFQAawB6AFMAMAAmAG0AdAA9ADEAJgByAHQAPQAwAA..&URL=http%3a%2f%2flinks.nhs.mkt5643.com%2fctt%3fkn%3d1%26ms%3dNDgxNjk1OTYS1%26r%3dNTMyMjc4MzUzNDcS1%26b%3d0%26j%3dNjQwNzM1MTkzS0%26mt%3d1%26rt%3d0" \t "_blank). Once implemented, the programme will focus on identifying those who are at high risk of developing diabetes, and referring these individuals into appropriate and evidence based lifestyle management services to support them in reducing their risk of type 2 diabetes.

During 2014, there were four national diabetes audit reports, covering care processes and treatment targets, inpatients, children and young people, and – for the first time – pregnancy in women with diabetes.

‘Diabetes Watch’ – was also launched, an online tool for people with diabetes and professionals to look at and compare CCG-level data. Of note is that some people with diabetes – those with Type 1, working age people, and people living in certain parts of the country – are receiving considerably worse routine care than other people with diabetes, and are achieving poorer outcomes. People with diabetes are also failing to receive the support they need to self-manage their condition effectively. Nationally, few people are offered or attend diabetes education, have personalised care plans, or have access to emotional support and specialist psychological care.

**The SOTN report sets out a range of suggested actions for Government, Health & Social Care to address the challenges identified.**

There are significant variations between clinical commissioning group areas in terms of achievement rates for treatment targets for HbA1c, cholesterol and BP, and receiving the 9 NICE recommended care processes to ensure treatment is effective and early identification of complications.

Go to the following link to see individual CCG profiles of the 15 Healthcare essentials compared with the National average:

<http://diabeteswatch.diabetes.org.uk/profiles/profile?profileId=1&geoTypeId>

**Suggested actions:**

**Commissioners and providers across primary, community and specialist care should work together to design and commission integrated care pathways to ensure people with diabetes get the specialist support they need. This involves:**

– assessing local need

– reviewing local workforce capacity and competency

– defining and agreeing the local model of care and the local pathways to deliver all the services needed to meet the diabetes service specification

– ensuring the key enablers of integrated diabetes care are in place. These are integrated IT, aligned finances and responsibility, collaborative care planning, clinical engagement, and clinical governance.

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| **CCGs** | **NHSE** | **Secondary Care Providers** |  |
| **Commissioners and providers** should work together to design and implement integrated diabetes services in their area, which cover the full spectrum of mental and physical healthcare | Ensure CCGs are rolling out care planning – and are supporting people with diabetes to engage in the care planning process |  | Personalised, collaborative care planning should replace traditional routine care for people with diabetes, as part of an integrated system that focuses on the patient’s perspective of care. |
| **CCGs** need to ensure an integrated foot care pathway is being delivered across primary, community, and specialist care services. This includes having a multidisciplinary foot care team and a foot protection service in every area. | **All healthcare professionals working in hospitals should be competent in diabetes care**. To help achieve this, Health Education England should encourage CCGs to include competency assessment within contract specifications. | **Ensure:**  – people with foot ulcers are referred to a multidisciplinary foot care team within 24 hours of being admitted  – all people with diabetes have their feet checked during their stay, and preventative actions are taken to reduce the risk of a foot ulcer developing. |  |
| **CCGs** should commission specialists in psychological care and diabetes, and ensure these form part of multidisciplinary diabetes teams and paediatric diabetes services |  | **All hospitals** should employ specialist diabetes staff, including nurses, dietitians, and podiatrists. | **Commissioners and providers need to recognise the importance of diabetes specialist nurses when designing cost-effective diabetes services, and ensure:**  – people living with diabetes have access to appropriately skilled and qualified nurses in all care settings  – Recommended minimum staffing levels are maintained (at least five DSNs per 250,000 people, and one diabetes inpatient specialist nurse per 300 beds. |
| **CCGs** need to ensure relevant learning and peer support opportunities are available, using data to identify local needs and inform the commissioning process. |  |  |  |
| **CCGs need to:**  – ensure appropriate learning opportunities are available for all people with diabetes, and they are encouraged to take up those opportunities  – review the uptake of learning and education programmes, and identify and address local barriers  – have systems that check the effectiveness of local learning and education programmes, including quality assurance and audit. |  |  |  |
| **CCGs** need to review the National Diabetes Audit data on urine albumin screening for their area, set targets for improvement, and implement action plans to achieve these targets. |  |  |  |
| **CCGs** need to commission a range of services and programmes to help people with diabetes to manage their weight (and address the behaviours that influence weight), and evaluate the effectiveness of these programmes. |  |  |  |
| **CCGs** should make sure smokers with diabetes, particularly people at risk of foot problems, neuropathy, or other complications, are being identified and referred to smoking cessation services. |  |  |  |
| **CCGs need to:**  – provide training in care planning for healthcare professionals and GP practices and incentivise attendance through an enhanced services payment and commission the support needs identified in the care planning process. |  |  |  |

Summary recommendations:

**The Department of Health should**: - guarantee ongoing financial support for the NHS Health Check programme, and incentivise local authority improvement.

**NHS England and Public Health England should:** – develop a national, evidence-based diabetes prevention programme, as proposed in the NHS Five Year Forward View, building on the NHS Health Check programme & clarify where responsibility lies for commissioning and evaluating lifestyle interventions.

**NHS England should: -** mandate appropriate follow up and management of people identified as being at high risk of Type 2 diabetes through the GP contract.

**Local authorities should:**

– work with NHS England to improve the entire diabetes prevention pathway, ensuring people attend a Health Check, receive a quality check, and are followed up appropriately

– initiate local awareness-raising campaigns, particularly among those groups that the Health Check programme is failing to reach, and design the local environment and services to promote active lifestyles and access to healthy food.

**Health and wellbeing boards should:**

– make prevention of Type 2 diabetes a priority in the Joint Health and Wellbeing Strategy

– set out their local strategy for improving the availability and take up of the Health Check programme, and for ensuring those at high risk have access to a diabetes prevention programme including strategies to target obesity.

**The new government should:**

– encourage the food and drinks industry and retailers to promote healthier choices to consumers

– continue to support a consistent front-of-packet labelling system

– legislate on reformulation of foods to reduce overall calorie intake

– consider taxation of unhealthy foods

– restrict the marketing of foods high in salt, sugar and fat to children

– invest in national awareness-raising campaigns.

–**All CCGs need to set themselves performance improvement targets and implement plans of action to ensure that all people with diabetes have access to the support they need to self-manage effectively, and that the local health system is designed to deliver this:**

1. - increase the availability of all of the recommended care processes – for everyone with diabetes
2. - ensure all people with diabetes are supported to meet recommended treatment targets
3. - implement integrated pathways of diabetes care across all local health systems
4. - improve access to, and uptake of, a range of appropriate education and learning opportunities
5. - fully implement collaborative care planning
6. - improve access to a range of specialist diabetes healthcare professionals, in all care settings.