Delivery of Diabetes Care in Nottingham and Nottinghamshire

1.0. Purpose

1.1. The purpose of this briefing paper is to provide an update to Nottinghamshire County Council Health Scrutiny Committee on the delivery of diabetes care in Nottingham and Nottinghamshire.

1.2. Routine Diabetes care has been significantly impacted by COVID-19 and the measures put in place to prevent the spread of the virus.

1.3. As we emerge from the COVID-19 pandemic, the local system is focused on recovery and is in a position to continue to provide specialist diabetes support to those most in need – all people with Type 1 diabetes and those with Type 2 diabetes with high Hba1c and/or complex co-morbidities including mental health issues.

1.4. Education of the modifiable risk factors for poorer health outcomes will not only be important in people living with diabetes, but it will also be critical in guiding management and providing targeted support to those at high risk of developing type 2 diabetes and in obesity prevention.

2.0. Overview of diabetes services in Nottingham and Nottinghamshire

2.1. Diabetes mellitus is a chronic complex metabolic disorder characterised by high levels of blood glucose and caused by defects in insulin secretion and/or action. As of 2019, 3.9 million people had been diagnosed with diabetes in the UK, 90% with type 2. In addition, there are almost a million more people living with type 2 diabetes who have yet to be diagnosed, bringing the total number up to more than 4.8 million. It is estimated that by 2025 more than 5.3 million will have diabetes.

2.2. There are currently 55,210 people aged 15 and over in Nottingham and Nottinghamshire CCG with type 2 diabetes (6.1% prevalence) and a further 5,520 people aged 15 and over diagnosed with Type 1 (0.6% prevalence).

2.3. Pre-diabetes affects 5% of people aged 15 and over across Nottingham and Nottinghamshire – (Mid Nottinghamshire – 7.4%, South Nottinghamshire – 4.4%, Nottingham City – 3.2%). Obesity is a known significant risk factor for the development of type 2 diabetes, but also for the development of gestational diabetes during pregnancy.

2.4. In order to ensure people with diabetes are seen in the right location at the right time, diabetes care divides into four main tiers of care as highlighted in the figure below.

Secondary Care Trust

Population:

Inpatient diabetes, Multi-disciplinary foot teams, Type 1 diabetes, antenatal diabetes care, children and young people, clinical psychology

Care Providers: Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Trust (Diabetes and Endocrinology Teams, Maternity Teams, Vascular Surgery, Paediatrics, Clinical Psychologists)

Specialist Community Care

Population:

Referrals for complex cases unable to be managed in Primary Care, targeted clinics, stable renal patients, type 1s needing community management e.g. care home, learning disability, people with uncertain diagnoses, podiatric intervention for moderate to high risk cases, delivery of diabetes structured education, injectable therapies where extra support is needed, support for young adults with diabetes

Care Providers:

Nottinghamshire NHS Foundation Healthcare Trust (Diabetes Specialist Nurses, Dietitian, Specialist Diabetes Podiatrists)

Primary Care

Population:

Those diagnosed with diabetes on oral agents and stable with in individualised treatment targets

May include care to those needing injectable therapies

Onward referral to structured education, mental health support, social prescribing

Care Providers:

Nominated GP, Practice Nurse, Health Care Assistant, Clinical Pharmacist, NHSTier 2 weight management services for diabetics, Social Prescribing Link Workers

Prevention and Self Care

Population:

People at increased risk of developing type 2 diabetes e.g. overweight /obese, smokers, heavy alcohol consumers

People identified as pre-diabetic

Care Providers:

NHS Diabetes Prevention Programme (Living Well Taking Control), Tier 2 Local Authority Weight Management Services (Your Health, Your Way),Tier 3 and 4 Obesity Services, Community and Voluntary Sector organisations

3.0. Overview of the delivery of diabetes care during the COVID-19 pandemic

3.1. In England, the NHS has taken a number of steps to support people with diabetes during the COVID-19 pandemic, with extra measures put in place such as:

- NHS Diabetes Advice, a national helpline provided by NHS England and NHS Improvement in collaboration with Diabetes UK, set up to provide support for adults living with diabetes who use insulin to manage their condition and require immediate advice from clinical advisors;
- People considered especially clinically vulnerable were contacted by the government with advice on shielding;
- A number of online self-management tools have been made freely available for all people living with diabetes;
- Diabetes UK has been active in providing advice to people with diabetes through their website and social media;
- Where possible, diabetes structured education is now being delivered remotely using platforms such Microsoft Teams and Zoom.

3.2. Following the announcement of social distancing recommendations to help prevent the spread of COVID-19, temporary changes were made to the delivery of the NHS Diabetes Prevention Programme (NHS DPP). Since April 2020, patients have been offered 3 choices to access the service: a fully digital platform; the ability to take part in group sessions via a remote service or the option to pause until face to face service resumes. New referrals have continued to be accepted and the referral pathway has been extended to enable patients to self-refer.

3.3. General Practice is now focused on recovery and prioritising those patients who are due an annual review. During the peak of the pandemic, 'routine annual reviews' for people with diabetes were largely suspended. Patients were still able to access their GP where they had concerns in relation to the management of their diabetes.

3.4. Specialist community diabetes services, including Diabetes Specialist Nurses, continued to operate and, like General Practice, have been reviewing people remotely where possible and appropriate. If any review, urgent or routine, highlights a need for specialist diabetes care, referral to such teams proceeded without delay (or triggered communication with the specialist team if the person with diabetes is already under their care).

3.5. Secondary Care services have been maintained throughout the pandemic in line with national recommendations. This includes inpatient diabetes services, access to virtual email and telephone support, face to face foot clinics, antenatal diabetes services and urgently required face to face reviews.

3.6. The COVID-19 pandemic has shone light on some of the wider health and inequalities that persist in society. The impact of the virus has been particularly detrimental on

people living in areas of deprivation, on BAME communities, older people, men, those who are obese and people living with long term conditions including Diabetes.

4.0. Nottingham and Nottinghamshire Integrated Care System Diabetes Transformation Priorities

4.1. The Nottingham and Nottinghamshire ICS Diabetes Steering Group is comprised of key stakeholders (Commissioning leads, local clinical experts, patient representatives, NHS England, Diabetes UK, Public Health) who oversee current service offers and agree transformational change.

4.2. Transformation priorities are in addition to or developments in relation to existing services as outlined in the tiers in section 2. Existing services include the following:

- NHS Diabetes Prevention Programme (NHS DPP)
- Structured education programmes for patients diagnosed with Type 1 and Type 2 Diabetes (DESMOND, DAFNE, KAREN, Healthy Living, MyType1Diabetes)
- Education programmes for Primary and Secondary Care staff
- Diabetic Specialist Nurses working with GP Practices
- Specialist Diabetes Podiatrists
- Dieticians
- Secondary Care Specialist Services

4.3. The following table identifies key transformation priorities identified by the ICS Diabetes Steering Group and in line with the national agenda for 2021/22:

Prevention and Self-Care	Prevention is at the heart of the NHS Long Term Plan. One of the key commitments is to double, to 200,000 people per year by 2023/24, the scale of the NHS Diabetes Prevention Programme (NHS DPP). This reflects a major contribution on the part of the NHS to upstream prevention and the planned expansion will enable more at risk individuals to access the programme and support them lowering their risk of Type 2 diabetes. Locally, we will continue to work collaboratively with Living Well Taking Control to implement, deliver and ensure future sustainability of the NHS DPP. Living Well Taking Control is committed to working with local communities and along with the CCG, will be identifying priority neighbourhoods and developing culturally competent approaches.
Diabetes In Hospital	A significant number of surgeries are cancelled due to poor management of diabetes identified pre-operatively.

	Understanding and managing a patient's diabetes is especially critical when they are undergoing surgery. Getting diabetes treatment wrong could lead to hypoglycaemia and hyperglycaemia, both of which may cause serious harm. Poor diabetes control also increases the risk of post-operative surgical complications, including delayed wound healing and infection. People with diabetes who have surgery experience increased length of stay, higher readmission rates and higher morbidity compared with people without diabetes. Plans have been developed to expand the current multi-disciplinary team at Nottingham University Hospitals with a consultant led triage service that will work with surgical, anaesthetic and pre-operative assessment teams through a referral pathway to ensure timely and appropriate assessment and optimisation of control for people with sub-optimally controlled diabetes (Hba1c >69mmol/mol) prior to elective surgery.
Multi-Disciplinary Foot Care Teams	Foot disease is a known complication of diabetes. Locally, there are increasing amputation rates and increasing emergency admissions. Enhanced foot care can reduce foot ulcers, amputation incidence and reduce associated inpatient bed days. Plans have been developed to create a Diabetic Foot Protection Team to deliver foot care according to best practice. Care delivery is provided dependent on risk stratification, taking into consideration risk, progression and severity, with implementation of a care plan with referral and transfer of care across settings appropriate to reduce the risk of complications.
Improving achievement against recommended diabetes treatment targets in Primary Care	Completion of the NICE recommended 9 care processes and 3 treatment targets prevents complications of diabetes which can develop with a long-term condition. These checks are important measurements and checks for the common complications of diabetes including, cardiovascular disease, kidney disease, peripheral arterial disease, nerve and eye damage. There is currently wide variation in attainment for these targets across GP Practices in Nottingham and Nottinghamshire. To address this variation a new standardised diabetes framework has been developed. In the approach the GP Practice is the bedrock of delivering high quality coordinated care, delivered in partnership with the person with diabetes and with the diabetes specialist nurse.

5.0. In Conclusion

5.1. Recovery from COVID-19 is focused on prioritising those most at risk due to poor diabetes management and ensuring that individuals are accessing the relevant care. The promotion and take up of structured education will be a key element of this and the CCG will be reviewing programmes to see how they may need to be changed to increase uptake. The ICS transformation programme is being expedited to further provide enhanced care that is also targeted to those with the highest needs.

6.0. Contact Details

Hazel Buchanan
Associate Director of Strategic Programmes
E- hazel.buchanan@nhs.net

Laura Stokes
Senior Commissioning Manager for Diabetes
E - laura.stokes@nhs.net