North Central London
Integrated Care System

Diabetes in NCL

January 2024

Summary

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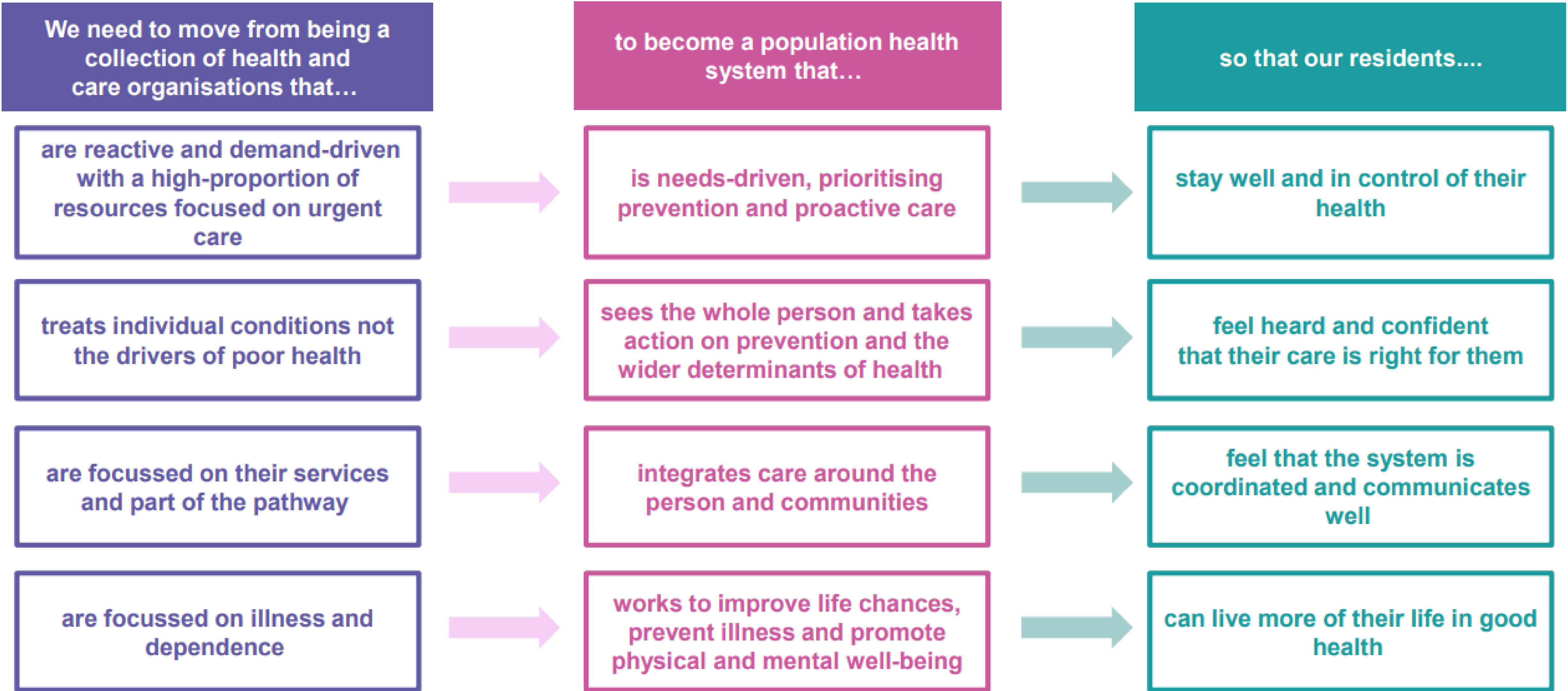
Integrated Care System

- These slides provide a summary of *out of hospital* care for adults with Diabetes in North Central London (NCL).
- We include information on Diabetes prevalence, performance and management and our approach to making care for those living with Diabetes or other Long Term Conditions (LTCs) proactive, equitable across our five Boroughs and outcomes focused.
- There is opportunity for partners to work together to deliver improvements for people with Diabetes and other Long Term Conditions. Many people live with multiple LTCs and this is especially true for people with Type 2 Diabetes. As we take a 'population health' approach and focus on prevention, we have identified a particular opportunity in NCL for early intervention with people aged 20-44 who are at risk of developing multiple conditions.
- We are also working as a system to address inequalities - tackling the root causes of poor health, putting more investment into proactive care, ironing out variation in the offer between boroughs from primary and community services and ensuring resources are available to support engagement from communities who have historically experienced the greatest gaps in outcomes.
- Diabetes and other LTCs are also a real opportunity for patient led care and innovation. For example, Continuous Glucose Monitoring (CGM) is a game-changing innovation in Diabetes care enabling improved self-management. This is now being systematically rolled out across NCL through a multi-year programme.

We are a system focussed on prevention, early intervention and proactive care



National legislation and initiatives, such as the Health and Care Act 2022, the Fuller Stocktake and the CORE20PLUS5 framework, have given us an opportunity to develop and act on our ambitions. These are outlined further in Appendix 2.

The Root Causes of Diabetes

The Wider Determinants of Health are all the non-medical reasons for poor health outcomes for some groups. These include:

- Housing
- Employment
- Food security
- Overweight and Obesity
- Alcohol consumption
- Tobacco dependency

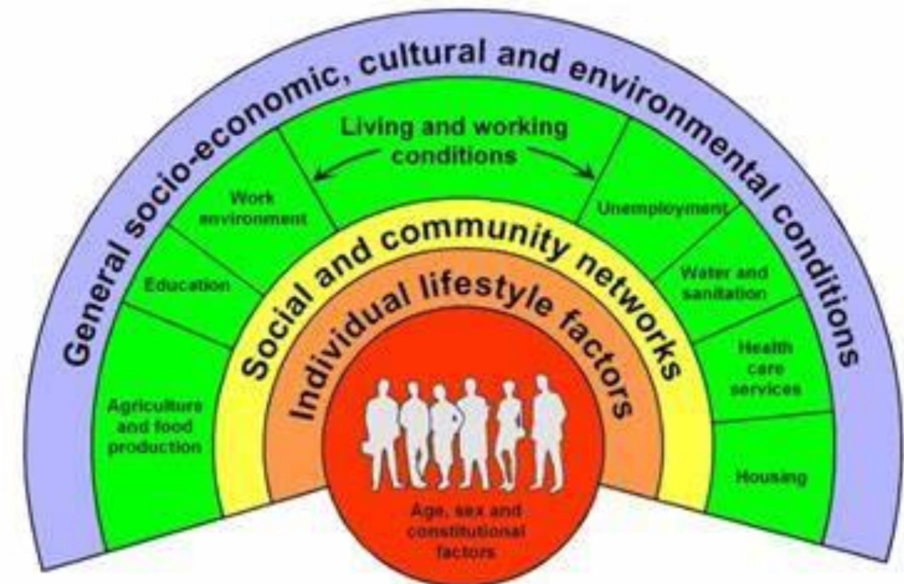
As an Integrated Care System, NCL is committed to working in partnership to tackle these issues that affect our population and drive variation and health inequalities.

At a local and hyper-local level, practical projects are reaching into communities. Examples include:

- Haringey Health Champions
- Community Workers for Pathway to Remission

NHS
UK Genetic Testing Network

Wider determinants of health



Source: Dahlgren and Whitehead, 1991

What is Diabetes?

Diabetes is a condition that causes someone's blood sugar level to become too high.

There are 2 main types of diabetes:

- Type 1 diabetes – a lifelong condition where the body's immune system attacks and destroys the cells that produce insulin
- Type 2 diabetes – where the body does not produce enough insulin, or the body's cells do not react to insulin properly

Type 2 diabetes is far more common than Type 1 Diabetes. In the UK, over 90% of all adults with Diabetes have Type 2.

Diabetes prevention and treatment often requires changes to diet and lifestyle. Detection is key so Diabetes can be properly managed.

Once diagnosed patients self-monitor and self-manage and receive support from primary care and others (e.g. medications and check-ups). There are evidence based interventions (*the 8 care processes*) and outcomes (*3 treatment targets*) that we work to achieve for all.

The Difference Between Type 1 and Type 2 Diabetes

	Type 1 Diabetes	Type 2 Diabetes
Insulin production	Pancreas does not produce enough insulin	Patient becomes unable to use insulin produced
Treatment	Requires insulin	May be managed with medication, diet, and exercise
Age of diagnosis	Typically diagnosed in childhood	More common in adults
Cause	Autoimmune disease	Often called a "lifestyle disease"

Detection of Diabetes

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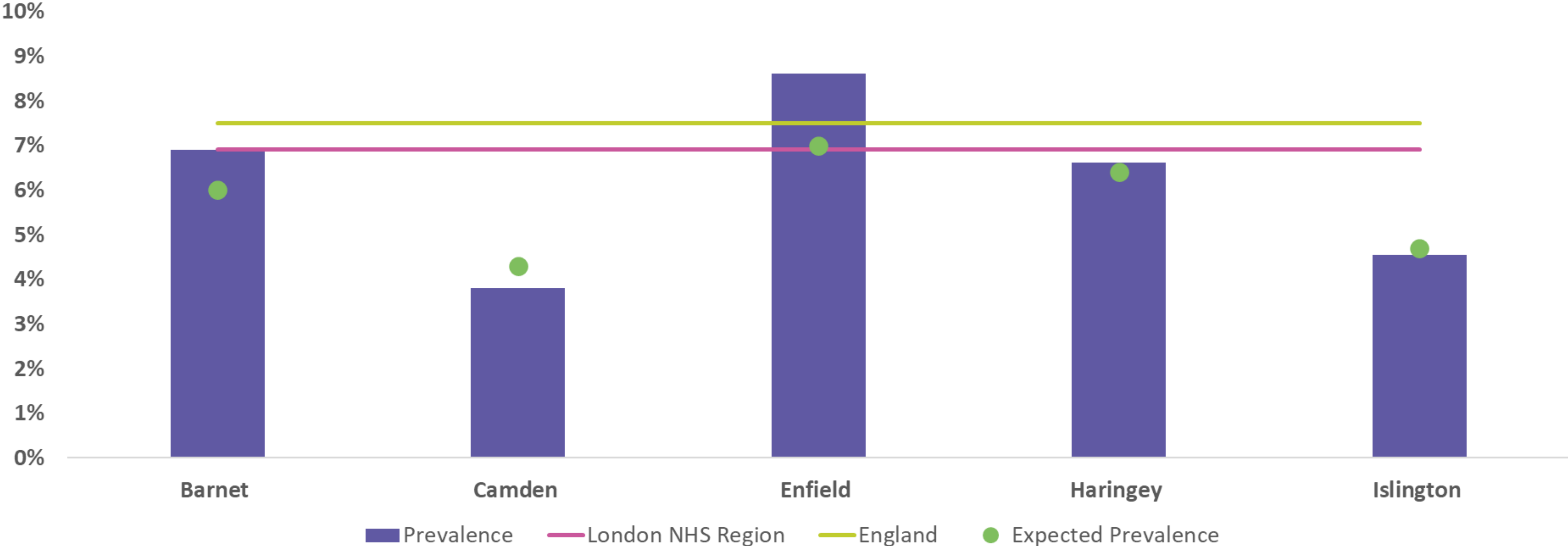
To ensure we are effectively detecting Diabetes in our population we look at how many people we would expect to have Diabetes (expected prevalence), how many we know of (prevalence / those diagnosed) and work to close the gap. We also benchmark ourselves against London and England averages, although prevalence is impacted by population demographics, deprivation and other factors local to us. Data for 22/23 (the latest data available) is shown below.



Source: Fingertips, Note: London 2022/23 figure is NHS London Region

The 8 care processes

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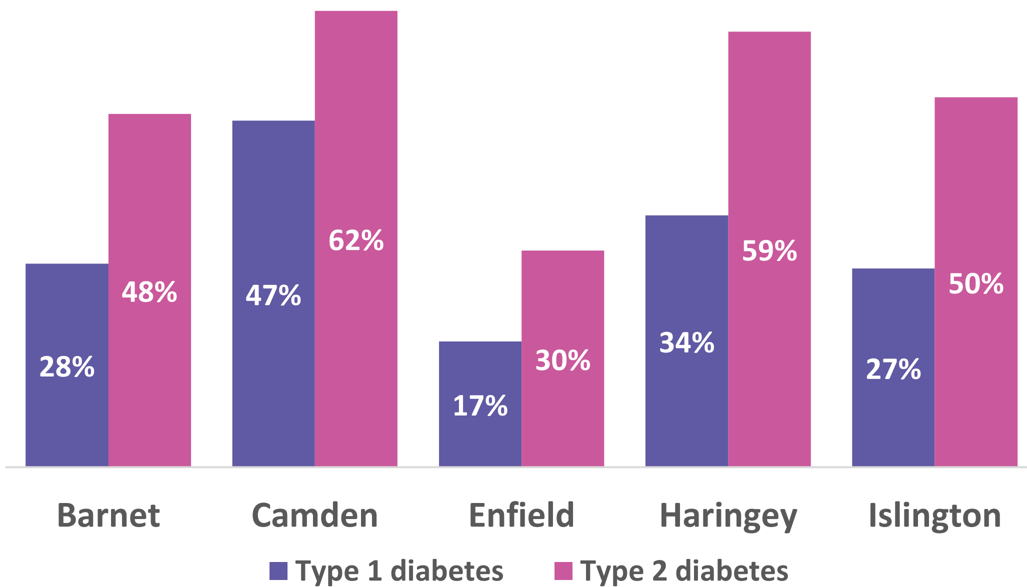
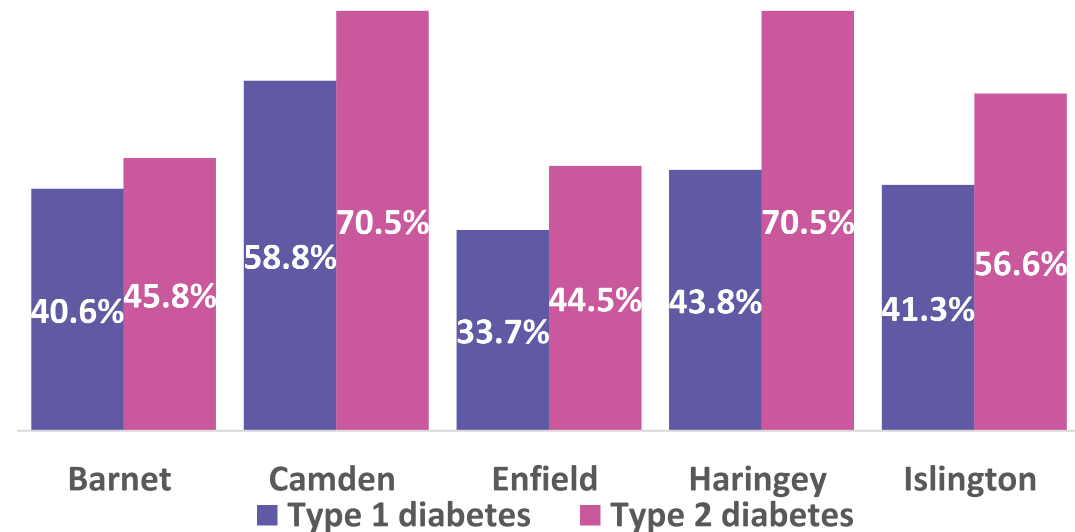
We want to improve Diabetes care and reduce variation between boroughs and communities. The 8 care processes are evidence based & NICE supported. The care processes include monitoring, blood pressure management, serum cholesterol, body mass index, kidney checks, smoking cessation and regular foot examinations. Primary and Community based services support this work, linking with partners as needed. Patients and professionals have shared responsibility around effective management. There has been continued focus on Diabetes in NCL over the last few years (with some disruption during COVID) and the % of diagnosed patients receiving all 8 care processes has been increasing:





- Source: National Diabetes Audit, Note: The graph on the left is analysis done by CF

The 8 care processes

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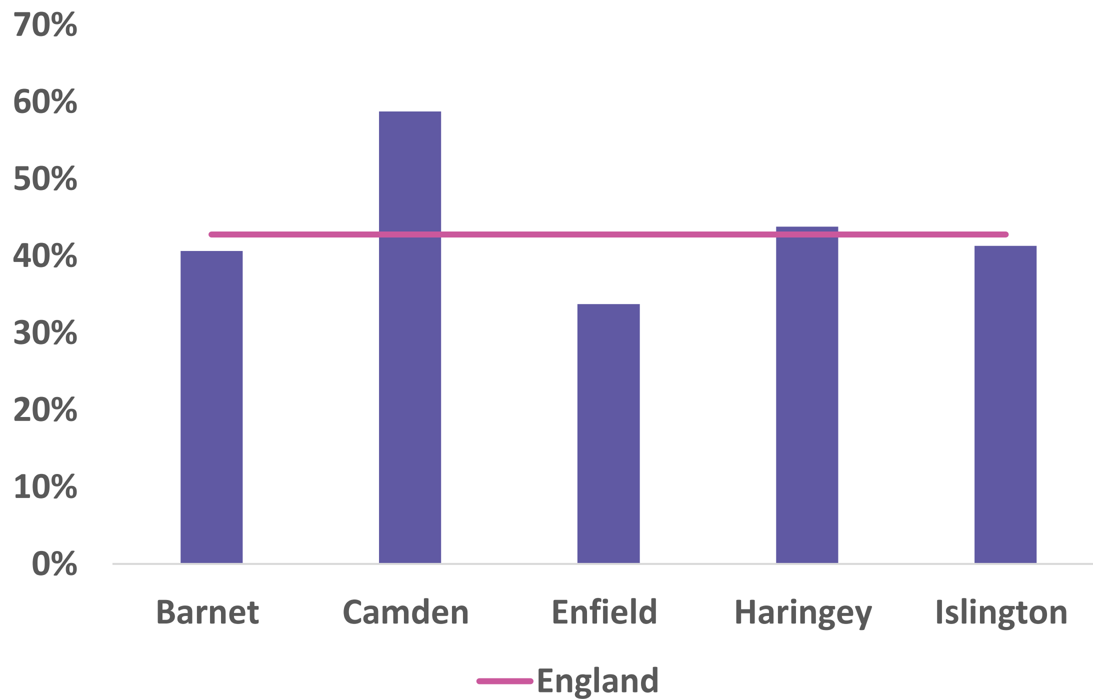
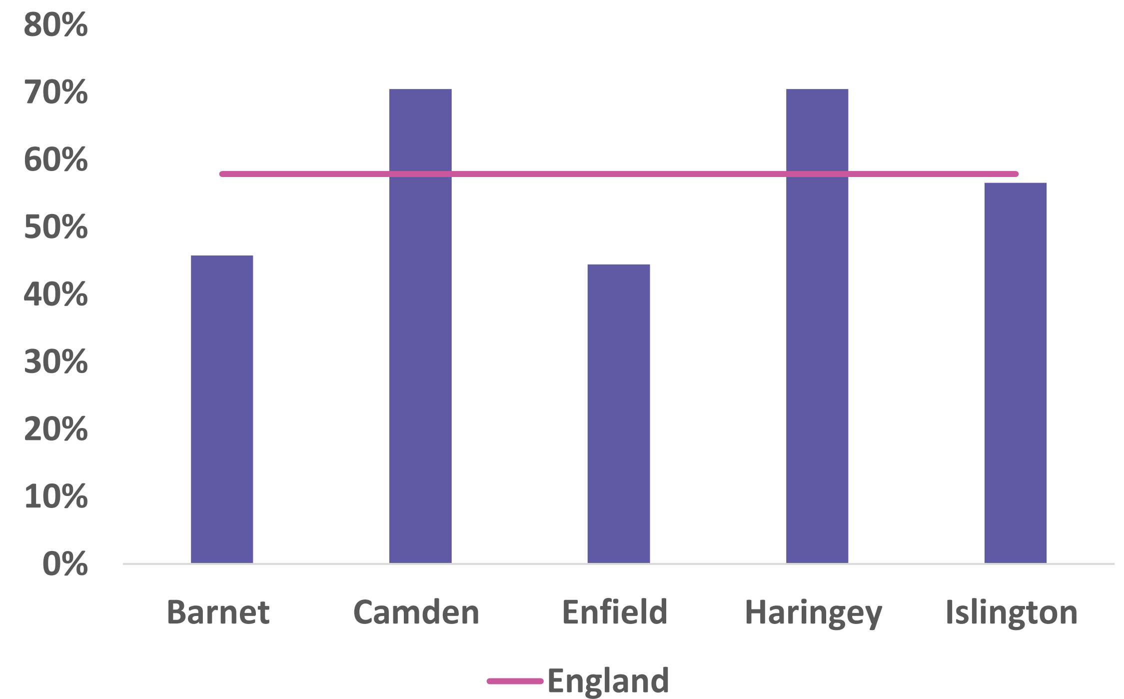
We benchmark reasonably well against England averages for treatment of Type 1 and Type 2 Diabetes (with comparison supported by the National Diabetes Audit) but there is significant variation between Boroughs. Diabetes outcomes are key primary care outcomes for 24-25, our priority is achievement of local targets which are tailored to the local population.

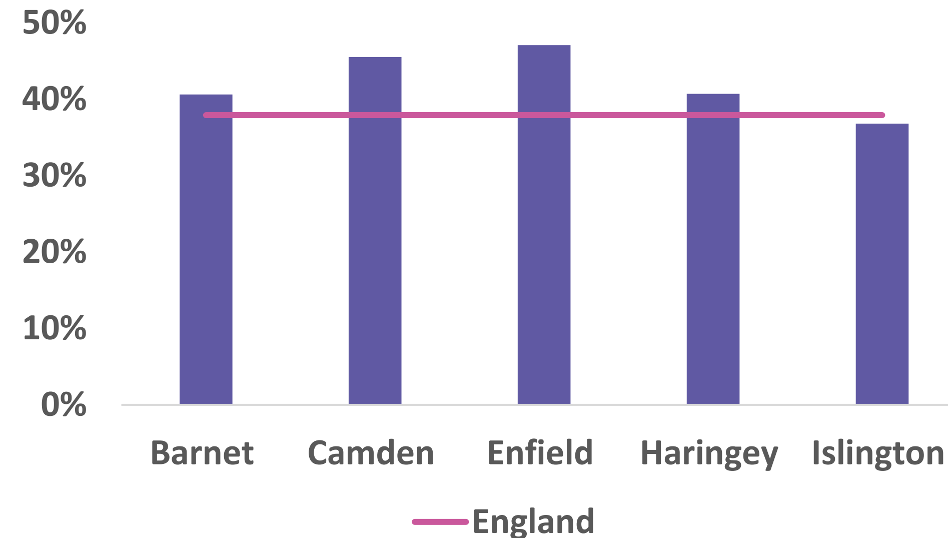




Source: National Diabetes Audit

The 3 Treatment Targets (3TTs) is the other key diabetes outcome

The 3TTs are also supported by NICE. They are a combination of blood test, blood pressure and medication goals that together reflect good diabetes control. NCL performs well against the 3TTs when compared to the England average, but the % of diagnosed patients meeting all 3 targets is still relatively low, so this remains a key focus for us:



Source: National Diabetes Audit

New technology offers opportunity for people to take control of their health and self-manage their condition

What is Continuous Blood Glucose Monitoring (CGM)?

CGM is a small device that sticks to the skin. It measures glucose levels continuously throughout the day and automatically transmits blood sugar readings, data and alerts to a reader or smartphone. CGM can help patients and care professionals see:

- if glucose levels are going up or down
- how glucose levels change over time
- what happens to levels when asleep

It can support better management and reduced complications. CGM allows users to predict and prevent acute events that may lead to admission or attendance at A&E. Recently NICE expanded their recommendations on who is eligible to receive CGM:

- Diabetes in Pregnancy
- Adults - Type 1 Diabetes
- Adults – Type 2 in certain circumstances
- Children and Young People

Rolling out CGM in NCL

CGM is already available in NCL for some Type 1 diabetics

NCL ICB has approved the funding to extend access to CGM as per the updated NICE guidelines

A pan-London working group was established to develop and approve implementation documents for the NICE recommendations of rolling out CGM for eligible patients.

NCL is in the process of adopting the London pathways via widespread engagement to ensure appropriate and equitable access

Over a 5 year period, we plan a gross increase in activity of 4000 new prescriptions for CGM.

Community Services Core Offer for Diabetes

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Current operating models vary by Borough

- Diabetes service for Type 2 patients, support self-management and agree care plans.
- Support Patients with Type1 Diabetes who disengage or DNA hospital care
- Management between Primary and Secondary care referrals inwards and out. MDT led by a diabetes medical consultant.
- Links with psychological services.
- Provide online structured education programme on diabetes management for primary and secondary care staff.
- Give support to social services and care homes.

Standardising best practice across NCL

The ambition for consistent diabetes support across NCL is being **implemented as part of the Community Service Core Offer** *(diabetes and podiatry service descriptions right)*. Investment has been made in Enfield's community diabetes service.

The **NCL Diabetes Collaborative** has set ambitions for 5 best practice areas:

- Education (for Healthcare Professionals)
- Diabetes self-management education (behaviour change)
- Standardisation of the Skill Mix within MDTs
- Weight management
- Digital infrastructure

Core Offer descriptions

Core offer care function: Diabetes (LTC management)

Overview

Description of the care function

Specialist community diabetic support for adult patients which enables development of enhanced self care and management. Includes 1-1 clinic appointments, home visits and group education sessions.

Support the use of technology to help patients manage their condition

Capabilities required	Who the care function is for	How the function is accessed
Specialist diabetic and podiatry nurse competencies, clinical psychology input who can carry out assessments and deliver short term psychoeducation; delivery of DESMOND	Adults diagnosed with Type 1 and 2 diabetes who require support beyond that provided by primary care	Via primary care (via central point of access) and diabetic clinic. Patient initiated follow up

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, leisure facilities, service users' homes and places of work/study, virtual or face to face	9-5 Mon-Fri. with some flexibility to meet needs of patients and families	Same day for advice to primary care; two weeks for initial patient contact	Four week follow up Patient initiated follow up

Integration with wider health and care system

Integrated with acute diabetic clinics; available for advice and support to primary care, community nursing, other community health services. Contributes when required to complex care MDTs

Core offer care function: Podiatry

Overview

Description of the care function

The podiatry service provides assessment, diagnosis, advice, treatment and referral for a wide range of foot conditions although the expectation is that most patients will have high risk Type 1 diabetes. Nail cutting is only provided for patients with high risk foot conditions (eg sensation loss and reduced circulation

Supports individuals with compromised tissue viability associated with vascular disorders, diabetes and other underlying medical conditions that affect their feet, and support wound management.

Works closely as part of the Diabetes team given interface with management of diabetic patients.

Service users and their families and carers trained and supported to actively participate in the management of their condition.

Capabilities required	Who the care function is for	How the function is accessed
Podiatrists and foot care assistants	Adults requiring assessment, treatment and advice on foot conditions.	Referral through central point of access by GP or other health professional. Can also be through self-referral

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics or in service user's home if house-bound	9-5 Mon-Fri with some flexibility	New patients within 4 weeks Urgent referrals within 1 week	As required up to twice weekly review

Integration with wider health and care system

Provide expert advice and support to primary care, community nurses, and other specialist services including diabetes, MSK and AHPs.

Integration with orthotics services.

Direct referral for podiatric surgery as required

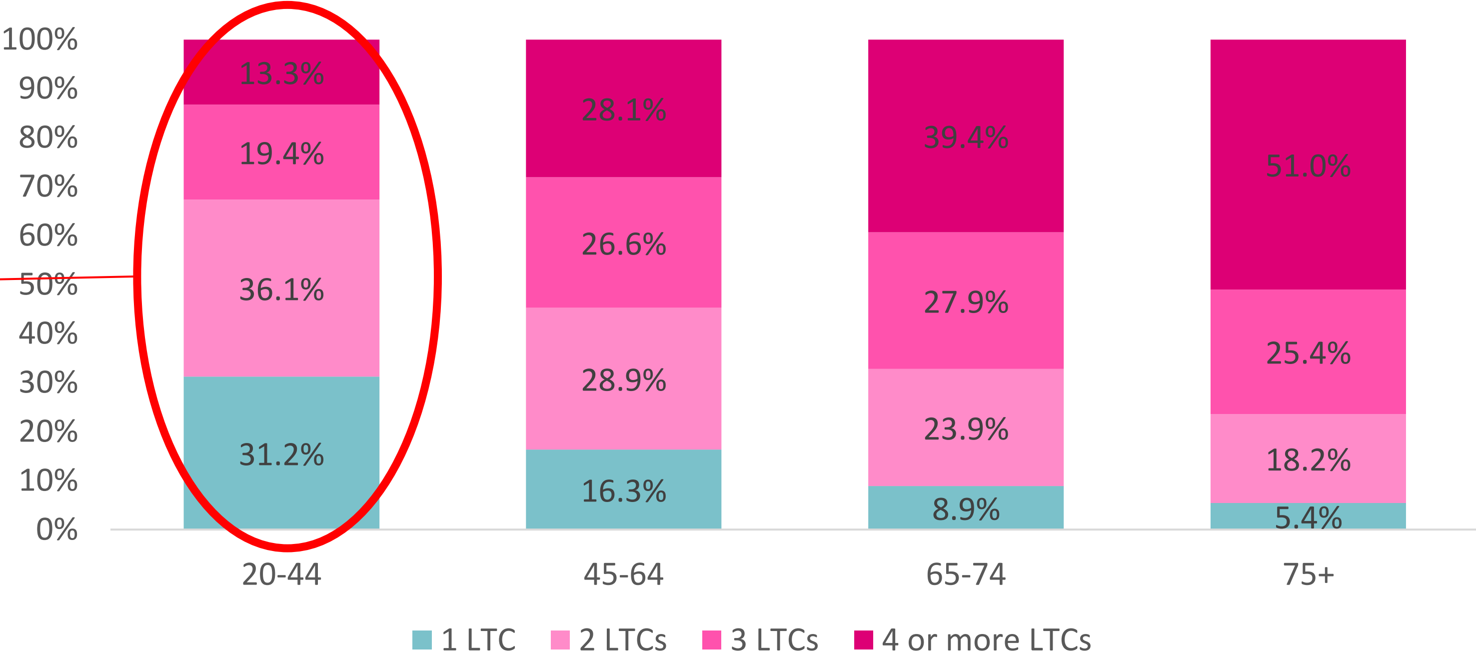
Support acute hospitals with ward in-reach for high risk podiatry referrals

Diabetes and multimorbidity

Multimorbidity (multiple Long Term Conditions and complexities) is one of the biggest challenges our patients and health services face. People with Diabetes are more likely to develop other conditions and accumulate more diagnoses as they age. There is a real opportunity for us to intervene earlier when younger people have only 1 or 2 diagnoses. If this is managed effectively we can change their outcomes, improve their lives and make our services more sustainable.

Proactive care opportunity - early intervention to reduce burden of multiple LTCs

Proportion of patients diagnosed with diabetes comorbid with any other long term conditions (LTCs), 2020, split by age.



Source: NEL Specialist Business Intelligence, Patients comorbid with diabetes and Long Term Conditions (LTCs)

Proactive care is at the heart of NCL's approach to diabetes with the emphasis on partnership and early intervention

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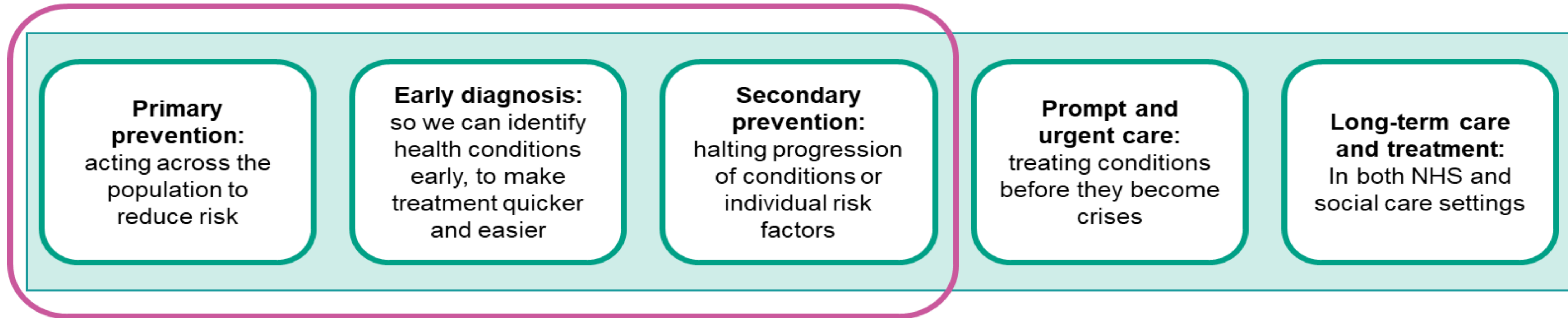


System collaboration to address the key risk factors:

- Overweight and obesity
- Physical activity
- Smoking
- *wider determinants of health*

- **Primary care**
- NHS health checks and early diagnosis
- Structured education
- LTC Year of Care
- Risk stratification
- Path to remission

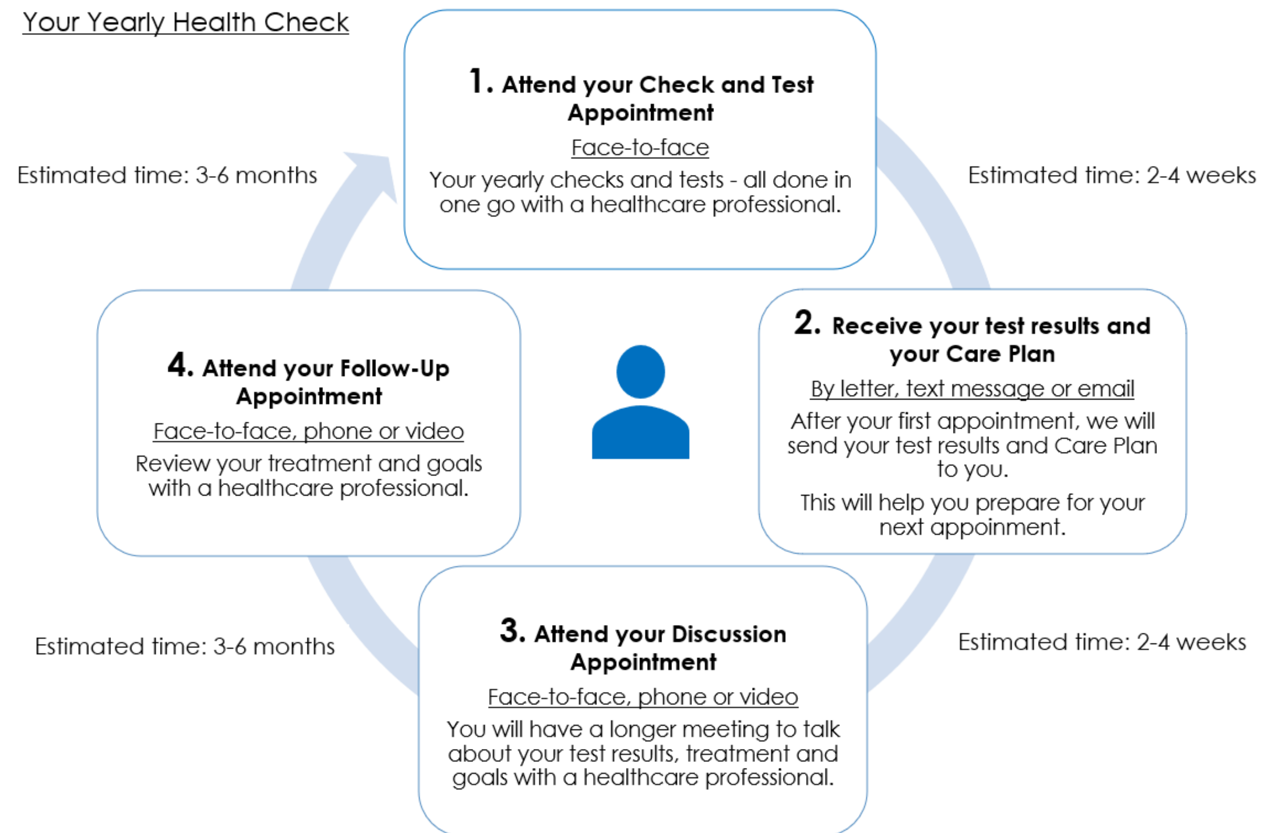
- **Community care**
- Diabetes Specialist Nurses
- Diabetes Foot Care Nurses
- Structured Education
- Support to care homes
- Diabetes Provider Collaborative

- **Secondary care**
- Specialist services
- Ambulatory Acute Foot Service (Royal Free)

New Long Term Conditions (LTC) primary care model for NCL - focussed on proactive care, personalisation and multimorbidity

Diabetes is a core condition in the new model. The model gives us an unprecedented opportunity to work across our whole system to drive out variation and improve outcomes. There is interest across London in our work and opportunity to expand the model over time to cover other conditions and patient groups. If supported it will drive neighbourhood working:

- **Stratified response delivered over the year** - matching workforce, and frequency of contact, to level of risk. Patients will be invited based on their level of complexity.
- **Holistic and personalised** - includes personalised care and support planning, lifestyle interventions & care coordination alongside medical care. Will cover all the patients LTCs (including mental health) ensuring a 'whole person approach'..
- **Not GP-centric** - wider primary care workforce contribute supporting deliverability and effective use of resources.
- **Benefits primary, community and secondary care** and supports greater integration.
- **Supported by population health management tools**– to identify cases, understand variation and target communities with poorer outcomes



Next steps

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Area	Description	Timeline
Primary care outcomes	• Setting Borough and GP practice improvement goals with first focus on 8 care processes • PCN weighted payments will target communities with poorer outcomes	First goals set in Q4 23-24
Core Offer investment	• Progressing 5 borough Diabetes Collaborative implementation plan to share agreed best practice elements • Continue transformation of diabetes services in line with Core Offer description	24/25
Diabetes community provider collaborative	The collaborative has five workstreams, **1.** Education for healthcare professionals, **2.** Behavioural change (patient education), **3.** Standardisation of skill mix, **4.** Weight management, **5.** Digital enablers.	underway
Rolling out CGM in NCL	Continue roll-out of CGM and monitoring of impact	
Ongoing work with the UCL Health Alliance about a refreshed network for Diabetes	• Establishing new collaborations that link the NHS with wider system partners • Taking a population health approach – using data to understand variation and drive improvement • Weight management network to consider role of new interventions to reduce risk factor of overweight and obesity	New networks in 24-25