

Diabetes

Introduction

The prevalence of diagnosed diabetes among people aged 17 years and older for Kent is 5.8%. In NHS Eastern and Coastal Kent 57.5% of all people with diabetes aged 17 years and older who are not excepted from the Quality and Outcomes Framework have an HbA1c of 7% or less. HbA1c is a measure of blood sugar which indicates how well diabetes is being controlled. In west Kent the figure was 56.3%. Both percentages are statistically significantly higher than PCTs with populations with similar diabetes risk factors and statistically significantly higher than England as a whole.

Of the people with diabetes included in the National Diabetes Audit in NHS Eastern and Coastal Kent 21 per 1000 had had a stroke in the previous year compared to 6.9 per 1000 across the whole of England. In NHS Eastern and Coastal Kent 5.4 per 1000 of people with diabetes had a myocardial infarction (heart attack) in the previous year compared to 5.8 per 1000 in all PCTs in its cluster group.

Of the people with diabetes included in the National Diabetes Audit in NHS West Kent 6.1 per 1000 had had a stroke in the previous year compared to 6.9 per 1000 across the whole of England. In NHS West Kent 4.4 per 1000 of people with diabetes had a myocardial infarction (heart attack) in the previous year compared to 5.8 per 1000 in all PCTs in its cluster group.

Analysis of total spending on diabetes care compared to HbA1c outcomes shows that both NHS Eastern and Coastal Kent and West Kent are not statistically different from England in programme budgeting spending and not statistically different from England in terms of HbA1c outcomes.

In 2010/11 there were 37321 people aged 17 years and older diagnosed with diabetes in NHS Eastern and Coastal Kent. There is also an estimated 9582 adults with undiagnosed diabetes.

In 2010/11 there were 28777 people aged 17 years and older diagnosed with diabetes in NHS West Kent. There is also an estimated 9933 adults with undiagnosed diabetes.

1. **Can you provide a summary of the demographic data relating to the prevalence of diabetes across Kent? How do different parts of the County compare with each other?**

1. Summary of demographics and how different parts of the county compare with each other

Table 1: Patients aged 17+ with diabetes mellitus Kent CCGs 2011/12

Organisation	Number	Prevalence
NHS Ashford CCG	5,515	5.7%
NHS Canterbury and Coastal CCG	9,609	5.5%
NHS Dartford, Gravesham and Swanley CCG	11,207	5.7%
NHS South Kent Coast CCG	10,446	6.4%
NHS Swale CCG	5,632	6.7%
NHS Thanet CCG	7,662	6.8%
NHS West Kent CCG	18,990	5.1%
Kent	69,061	5.8%

2. **What estimate have you made of undiagnosed diabetes in the County and what is being done to address this?**

Table 2: Expected prevalence of diabetes 2012

Organisation	Registered	Expected	Missing
NHS Ashford CCG	5,515	7,001	1,486
NHS Canterbury and Coastal CCG	9,609	12,681	3,072
NHS Dartford, Gravesham and Swanley CCG	11,207	12,823	1,616
NHS South Kent Coast CCG	10,446	13,064	2,618
NHS Swale CCG	5,632	6,023	391
NHS Thanet CCG	7,662	9,036	1,374
NHS West Kent CCG	18,990	25,095	6,105
Kent	69,061	85,723	16,662

Source: York and Humber Diabetes expected model

Please also refer to **Appendix 1** for a summary of diabetes prevalence in the population aged 17 and over across the Kent Clinical Commissioning Groups.

Good data is available on the numbers of patients that are undiagnosed and these figures would be part of the individual data sets shared with CCGs as part of any Health Needs Assessment.

NHS Health Checks provides the opportunity to reduce the number of people who have yet to be diagnosed with existing diabetes as well as preventing people going onto to develop diabetes in the future.

Individual CCGs will be addressing this issue with specific targeting of areas as part of the work on health inequalities as both national and local evidence supports the fact that the

prevalence of diabetes is higher in areas experiencing deprivation. We know that people living in the 20% most deprived neighbourhoods in England are 56% more likely to have diabetes than those living in the least deprived areas.¹ It is also known that people from Asian and Black ethnic groups are more likely to have diabetes and tend to develop the condition at younger ages. To improve the outcomes for diabetic patients, access is a key issue and the engagement of patients and local communities' is paramount in making sure service re-design is appropriate for the local population.

Tackling health inequalities is a key objective of Dartford Gravesham and Swanley (DGS) CCG and measures are being taken to improve awareness amongst the general public and within general practice. The CCG is working jointly with the specialist diabetes team at Darent Valley Hospital to arrange a full-day seminar for all GPs, practice nurses and other professionals involved in diabetes care. The specialist diabetic podiatrist recently attended a half day education event where she presented the 'diabetic foot assessment pathway' to GPs, and then separately to practice nurses. This pathway and referral process has now been added to the GP electronic directory of services from which referral can be made.

The 2010/11 QOF registers show that the population of DGS has a higher prevalence of obesity, than England. Obesity is shown to have a link with the onset of Type 2 diabetes. In addition, the population of DGS is more ethnically diverse than the rest of Kent with a larger Asian population which may go part way to explain the increased prevalence.

Although West Kent CCG is relatively affluent there are pockets of deprivation particularly in the towns.

Primary Prevention

West Kent CCG will focus on prevention which will be grounded in local interventions rather than just giving advice. Up skilling primary care staff to care for people with Type 2 diabetes alongside health checks will identify those patients who are yet to be diagnosed.

Secondary Prevention

Secondary prevention for people with diabetes is important to prevent complications. West Kent CCG is working with acute trust colleagues and those within primary care to ensure that patients receive the 'year of care' services. Newly diagnosed patients now receive a comprehensive 'New Patient' information pack with a patient held record to back up the support they receive from their responsible clinicians.

3. What is the cost of diabetes to the Kent Health economy; both in terms of commissioning spend and wider impact

Data taken from the NHS Comparators site is shown below for both east and west Kent.

¹ Source: Information Centre, 2010/11 and Quality and Outcomes Framework, 2010/11

The data shows the following tables:

- a. Total diabetes admissions per 1000 Population Period/Year: Rolling Year - 2011/2012; Activity and cost
- b. Emergency diabetes admissions per 1000 Population Period/Year: Rolling Year - 2011/2012; Activity and cost
- c. Cost of Enhanced Services in East Kent 2011-12

Information from the NHS Comparators site suggests that the total number of diabetes admissions into secondary care for Kent in terms of activity for 2011-12 was 1,330 at a cost of £2,577,810.

Of these admissions 1,075 were emergency admissions at a cost of £2,132,061.

Financial Costs	
Primary Care	£181,606,000
Secondary care	£2,132,061

- a. Total diabetes admissions per 1000 Population Period/Year: Rolling Year - 2011/2012; Activity

Code	Organisation	Crude Rate	Standardised Rate	Population	Total Count
	National	1.1	1.1	55471952	59688
		0.9	0.9	1494569	1330
5P9	West Kent PCT	0.8	0.8	716070	592
5QA	Eastern and Coastal Kent PCT	1	0.9	778499	738

- a. Total diabetes admissions per 1000 Population Period/Year: Rolling Year - 2011/2012; Cost

Type	Code	Organisation	Crude Rate	Standardised Rate	Population	Total Cost £
National		National	1725.3	1725.3	55471952	95705848
Group			1724.8	1640.9	1494569	2577810
PCT	5QA	Eastern and Coastal Kent PCT	1654.1	1540.9	778499	1287720
PCT	5P9	West Kent PCT	1801.6	1754.6	716070	1290090

- b. **Emergency diabetes admissions per 1000 Population Period/Year: Rolling Year - 2011/2012; Activity**

Type	Code	Organisation	Crude Rate	Standardised Rate	Population	Total Count
National		National	0.7	0.7	55471952	38032
Group			0.7	0.7	1494569	1075
PCT	5P9	West Kent	0.7	0.7	716070	479

		PCT				
PCT	5QA	Eastern and Coastal Kent PCT	0.8	0.7	778499	596

b. Emergency diabetes admissions per 1000 Population Period/Year: Rolling Year - 2011/2012; Cost

Type	Code	Organisation	Crude Rate	Standardised Rate	Population	Total Cost £
National		National	1324.7	1324.7	55471952	73485338
Group			1426.5	1358.9	1494569	2132061
PCT	5QA	Eastern and Coastal Kent PCT	1408.4	1312.5	778499	1096440
PCT	5P9	West Kent PCT	1446.3	1411.7	716070	1035621

c. Cost of Enhanced Services in East Kent 2011-12

	Cost £
Level 1	93,256.00
Level 2	88,350.00
Total	181,606,000

Measuring the wider impact of diabetes is very difficult. The table set out below estimated the cost of diabetes in the UK.

Cost of diabetes treatment in the UK in 2010				
Area of expenditure	Type 1 diabetes	Type 2 diabetes	Total cost	Percentage of costs
Source: Kanavos, van den Aardweg and Schurer: Diabetes expenditure, burden of disease and management in 5 EU countries, LSE (Jan 2012)				
Diabetes drugs	£0.344 billion	£0.712 billion	£1.056 billion	7.8%
Non-diabetes drugs	£0.281 billion	£1.810 billion	£2.091 billion	15.2%
Inpatient	£1.007 billion	£8.038 billion	£9.045 billion	65.8%
Outpatient (excluding drugs)	£0.170 billion	£1.158 billion	£1,328 billion	9.7%
Other (including social service)	-	-	£0.230 billion	1.7%
Total	£1.802 billion	£11.718 billion	£13.750 billion	100%

Direct costs are those costs that are clearly and directly attributable to the condition in question. This commonly includes medical costs, such as hospital, medical professional and pharmaceutical costs, as well as non-medical costs, which may include transport, carers and lifestyle change costs.

Indirect costs are imputed costs used to reflect the impact to production caused by an illness. The inclusion of indirect costs is a much debated practice. Depending on the viewpoint taken for the cost of illness (COI), indirect costs may have more or less relevance. When costing from a societal perspective, indirect costs are applicable, as changes in society's production, and therefore consumption and utility are being estimated.

Intangible costs estimate the cost of an illness in terms of the reduction in quality of life caused. This reduction may manifest itself as pain, anxiety, disability or suffering. As Intangible Costs do not have any resource impact per se, they are not generally included in a COI study.

Cost Components of Cost of illness (COI) Model²

Direct Costs (Medical)	Hospital Related Costs MBS Rebates Claimed PBS Rebates Claimed Diabetes Nurse Educator Costs Dieticians Podiatrists
Direct Costs (Non Medical)	Cost of Equipment/ Consumables used in management of diabetes Cost of additional Physical Activity for management of diabetes Additional costs of special diet consumed in management of diabetes
Indirect Costs	Cost of Carer for people with diabetes Short Term Labour Loss due to diabetes Permanent Labour Loss due to diabetes

The costs to the national economy of lost working time and early death from diabetes are very difficult to quantify, but estimates for the UK put the costs to industry at £531 million in 2006, rising to £780 million in 2026.³

² Published July 2007 by the South Australian Department of Health Population Research and Outcome Studies Unit PO Box 287 Rundle Mall 5000 South Australia, Australia

³ Bramley-Harker E, Barham L. The human and economic value of pharmaceutical innovation and opportunities for the NHS. NERA Economic Consulting for the ABPI, 2004

The cost of caring for people with diabetes is vast, increasing and threatening to present an unsustainable challenge to healthcare services within the next 20 years, 94% and the vast majority of the cost goes on treating diabetes complications.

In 2010, the NHS spent about £9 billion a year, £1 million an hour,⁴ on treating diabetes. Much of this is spending on 1.1 million inpatient days each year,⁵ with only 6% of the costs spent on prescription medicines.⁶

People with diabetes also face significant personal costs, estimated at £500 million a year, due to missing work, the cost of travel for medical treatment, and often loss of employment or early retirement because of ill health. About 6% of people with type 2 diabetes are unable to work at all.

Family members may also suffer financially, especially parents of children with diabetes who may be forced to give up work to care for them.

One in 20 people with diabetes need assistance from social services, at a cost of £230 million per year. More than 75% of these costs are for residential or nursing services, with most of the remainder for home help. It has been estimated that diabetes doubles the chances of entering a care home, and one in four care home residents have diabetes. Recent evidence from Canada has shown that the presence of chronic conditions, such as diabetes, has a much greater impact on healthcare resources than age alone.⁷

Although these figures are based on National data, data produced by the Yorkshire and Humberside Public Health Authority suggests that Kent is not different from the National picture in fact prevalence rates appear to be higher.

Estimated total (diagnosed and undiagnosed) diabetes prevalence in adults



www.yhpho.org.uk/default.aspx?RID=154049

⁴ Diabetes.co.uk. Diabetes costs the NHS one million pounds an hour, 27 October 2010 <http://www.diabetes.co.uk/news/2010/Oct/diabetes-costs-the-nhs-one-million-pounds-an-hour-93645072.html>

⁵ Roberts S. Working together for better diabetes care: Clinical case for change. Department of Health, May 2007

⁶ Diabetes UK. Diabetes in the UK 2010: Key statistics on diabetes

⁷ Canadian Institute of Health Information. Seniors and the health care system: What is the impact of multiple chronic conditions? January 2011. http://www.cihi.ca/CIHI-ext-portal/internet/en/Document/types+of+care/primary+health/RELEASE_27JAN11

4. Could you provide an outline of the range of diabetic services provided, along with their locations, and how care along the pathway is co-ordinated?

East Kent and Swale

Primary Care: Local Enhanced Services

The aim of this Local Enhanced Service is to address the physical healthcare needs of patients with impaired glucose tolerance (IGT), impaired fasting glycaemia (IFG), previous gestational diabetes and other relevant type 2 diabetic patients through recognising and encouraging the development of expertise in primary care.

The Quality and Outcomes Framework rewards practices for ensuring that systematic care has been provided for type 2 diabetic patients. However there is not a requirement that practices undertake a regular review for patients identified with lipid or glucose abnormalities, nor does it incentivise certain critical components of care to patients with type 2 diabetes.

The specification of this service therefore outlines a more specialised service to be provided, beyond the scope of essential services and QOF. The purpose of this enhanced service is to enable the delivery of a more comprehensive, structured package of care to patients in primary care so that only patients of high risk or with complicated diabetes require hospital attendance.

Expansion of capacity and skills within primary care will improve the quality of diabetes care provided in the community, help deliver the National Service Framework standards and promote a safe, co-ordinated shift of the delivery of care for patients from hospital clinics to primary care services.

Practices participating in this Local Enhanced Service will provide the following care to patients with IGT, IFG, previous gestational and type 2 diabetes who are free from significant complications or co-existing conditions likely to make the management of their diabetes more complicated.

Not all practices will be in a position to offer a fully developed service that includes conversions to insulin. Consequently, this Local Enhanced Service is defined at two levels. A practice may apply to provide the service at either of these levels, commensurate with its expertise.

Level 1

The patient and, where appropriate, their carer should be at the centre of care and practice staff should support them in self-management wherever possible.

For patients with IGT, IFG and previous gestational diabetes, specific responsibilities in delivering this agreement include;

1. The development and maintenance of a register. Practices must produce up-to-date registers of patients who are IGT, IFG or who have previous gestational diabetes.

2. Call and recall. Practices will ensure the systematic recall of all IGT, IFG and previous gestational diabetic patients using appropriate read codes.
3. Review. Practices will review all patients on the IGT and IFG registers annually, which must include fasting sugar check, blood pressure and cardiac risk assessment as a minimum. Women who have had gestational diabetes and have tested normal following delivery should be tested 1 year post-partum and then three-yearly.
4. Education of patients. Practices must include education and lifestyle advice in the annual review.
5. Individual Care Plan. Practices should prepare with the patient an individual care plan. A comprehensive print-out of the agreed care plan will be provided for the patient to keep.
6. Record Keeping. Practices are to maintain records incorporating the fasting sugar levels, blood pressure and outcomes of cardiac risk assessment.
7. Training. Each practice must ensure that all staff involved in providing any aspect of care under this service has the necessary training and skills to do so. Please see 'Training and Accreditation' section for further details.

Level 2

Involves initiation of insulin / injectable therapy for people with type 2 diabetes who are not achieving HbA1c targets with maximum tolerated oral combination therapy and who do not have other reasons for requiring hospital assessment. Specific responsibilities in delivering this agreement include;

1. The development and maintenance of a register. Practices must produce an up-to-date register of patients who have undergone insulin / injectable therapy conversion.
2. Call and recall. Practices will ensure the systematic recall of all patients who have undergone insulin / injectable therapy conversion using appropriate read codes, with systems in place for ensuring regular contact during the initial stages of dose adjustment.
3. Follow-up. Practices will review all patients who have undergone insulin / injectable therapy conversion a minimum of twice yearly. Practices cannot count hospital-based reviews towards their total.
4. Education of patients. Practices will ensure that all patients converted to insulin / injectable therapy (and / or their carers) receives appropriate structured education and advice on the management of insulin treated diabetes. This will include written information.
5. Individual Care Plan. Practices should prepare with the patient an individual care plan which outlines the planned therapeutic range to be obtained. A printed copy will be provided for the patient to keep.

6. Record Keeping. Practices are to maintain records incorporating all known information relating to significant events (for example drug reactions, hospital admissions, premature withdrawal of therapy), HbA1c levels and outcome of initiation.
7. Training. Each practice must ensure that all staff involved in providing any aspect of care under this service has the necessary training and skills to do so. Any practice staff involved must have successfully completed an accredited course for insulin initiation.
8. GP and primary care professionals are to be trained to Certificate in Diabetes Care standard or similar at each practice (or provide evidence of competency and knowledge to show that this is not required).
9. Diabetes trained primary care professionals should ensure that a minimum of 6 hours on going diabetes training is incorporated into their continuing professional development.
10. All staff providing Level 2 diabetes care must have undertaken the 'Insulin for Life' training programme validated by Warwick University or The Merit Norvonordisk Modules 1+11.

Community Diabetes Services

Kent Community Trust

Eastern and Coastal Kent commission the Kent Community Health Trust to provide three main services in relation to the care of diabetic patients that services the population of the four CCGs.

- Diabetic Specialist Nurses
- Podiatry
- Dietetics

Medway Community Health Care (MCH)

Eastern and Coastal Kent commission MCH to provide three main services in the relation to diabetic patients that services the population of Swale CCG.

Diabetic Specialist Nurses

In January 2013 the Kent Community Trust re-structured their teams so that the Diabetes Specialist Nurses (DSNs) are now managed as a stand-alone team rather than being under the management of a Long Term Conditions Team. There are five Diabetes Specialist Nursing teams in East Kent. The teams are based in, Ashford, Shepway, Dover/Deal, Thanet and Canterbury. Each team has approximately 2 WTE Band 6/7 nurses with the support of Band 3 Diabetes Assistants. The teams work 5 days a week offering a 9 to 5 service.

Referrals into the service are via GPs, and Consultants who send referrals into their locality team bases. Nurse led clinics are then provided at a range of community settings across east Kent but excluding Swale.

The DSNs take referrals of patients who have a confirmed diagnosis of diabetes and will offer education and disease management advice for those patients newly diagnosed and those with episodes of deteriorating control. When episode of care complete the DSNs will discharge the patients back to the GP. The DSNs work closely with the practise nurses and will provide support to them at the surgery if requested.

The DSNs attend joint multi-disciplinary ante -natal clinics (one a week) on the three acute hospital sites. The Trust has seen a significant increase in the numbers of mothers who have gestational diabetes and the number of pregnant women who have Type 2 diabetes, due to both lifestyle issues and high prevalence of diabetes in East Kent.

Integrated working takes place with secondary care to provide an insulin pump service for those patients who meet the NICE criteria. This service has been limited but is currently undergoing some development in order to meet demand. The DSNs work closely with the Diabetes Paediatric service to provide transition of care to those children who need to move into the adult service.

Data supplied by the Trust states that during the period April 2012 to December 2012 the number of contacts for the DNS was 2,663 patients for East Kent (this includes Swale figures).

Podiatry

There are three teams that cover east Kent. The three teams cover Ashford/ Shepway, Dover/Deal/Thanet and Canterbury Coastal. There are called the 'Vulnerable Foot Care Team' and are a specialist team within the main podiatry team. Patients are seen at a variety of community clinics e.g. Newington Road, Deal Community Hospital and acute settings depending on the severity of the intervention required.

Home visits are undertaken and visits to residential and care homes fall within the teams remit. Some patients can also be seen at GP surgeries depending on availability of appropriate clinical space in each locality.

Patients are usually referred through their GP or they can self-refer into the service.

The Trust is working towards a central booking system and the podiatry service is a pilot service for a new IT system which will improve communication with the Community Trust. The new system will also provide much better data on patient outcomes. The new system should be live in April 2013.

In the period April 2012 to December 2012 363 contacts were recorded. Most of the diabetic patients are long term patients and usually stay in the system with regular intervention being required over a period of years. As well as improving communication the Trust is working on pathways of care for each condition so that there is clarity in terms of the care the patient should receive.

There is some integrated working within the service in that the Acute Trust has a service level agreement with Kent Community Health NHS Trust to enable staff to visit patients on the wards on some sites.

Currently there is a multi-disciplinary steering group with membership from both the Trust and the Community Trust to agree an 'inpatient foot care pathway' which will improve the care patients receive on being admitted to an acute hospital site.

Dietetics

The aim is to provide a high quality diabetes, weight management and obesity dietetic service for people of all ages and their carers across East Kent. The service is effective, accessible, equitable, safe, cost effective, provides choice and is integrated with other services and agencies including Health and Wellbeing.

Clinical services provided by the Diabetes and Obesity Dieticians include:

- Dieticians and dietetic assistants provide one to one consultations in outpatient clinics situated in a variety of community and hospital locations throughout east Kent. Patients can choose the location of their appointment through the centralised booking system.
- Domiciliary service provided across east Kent for patients who are housebound
- Six month care pathways for patients referred for weight management, type 2 diabetes and impaired glucose tolerance/impaired fasting glucose. These involve dietetic assessment, goal setting and review and the opportunity for regular weight checks and further review from dietetic assistants. In addition where appropriate patients are signposted to other services including exercise on referral, healthy walks programme, stop smoking and health trainer's service
- Adult weight management service provided as part of the integrated weight management pathway run in conjunction with Health and Wellbeing
- Dietetic input to multidisciplinary diabetes ante-natal clinics in acute hospitals.
- Provision of the dietetic service within the multidisciplinary diabetes paediatric team which provides diabetes care for all children and young people across east Kent
- Participation in the development and implementation of a pilot project for a specialist weight management programmes for adolescents
- Participation in the delivery of the multidisciplinary type 2 diabetes structured education programme: DEREK (diabetes education & review in east Kent). This is held monthly in 5 locations across east Kent
- Participation in the delivery of the new multidisciplinary type 1 diabetes structured education programme: KAT1E (Kent adult type 1 education). 12 KAT1E courses will be held per year in locations throughout east Kent
- Participation in multidisciplinary insulin pump service
- Provision of dietetic group education sessions for cardiac rehabilitation programme.

Training provided by the Diabetes and Obesity Dieticians

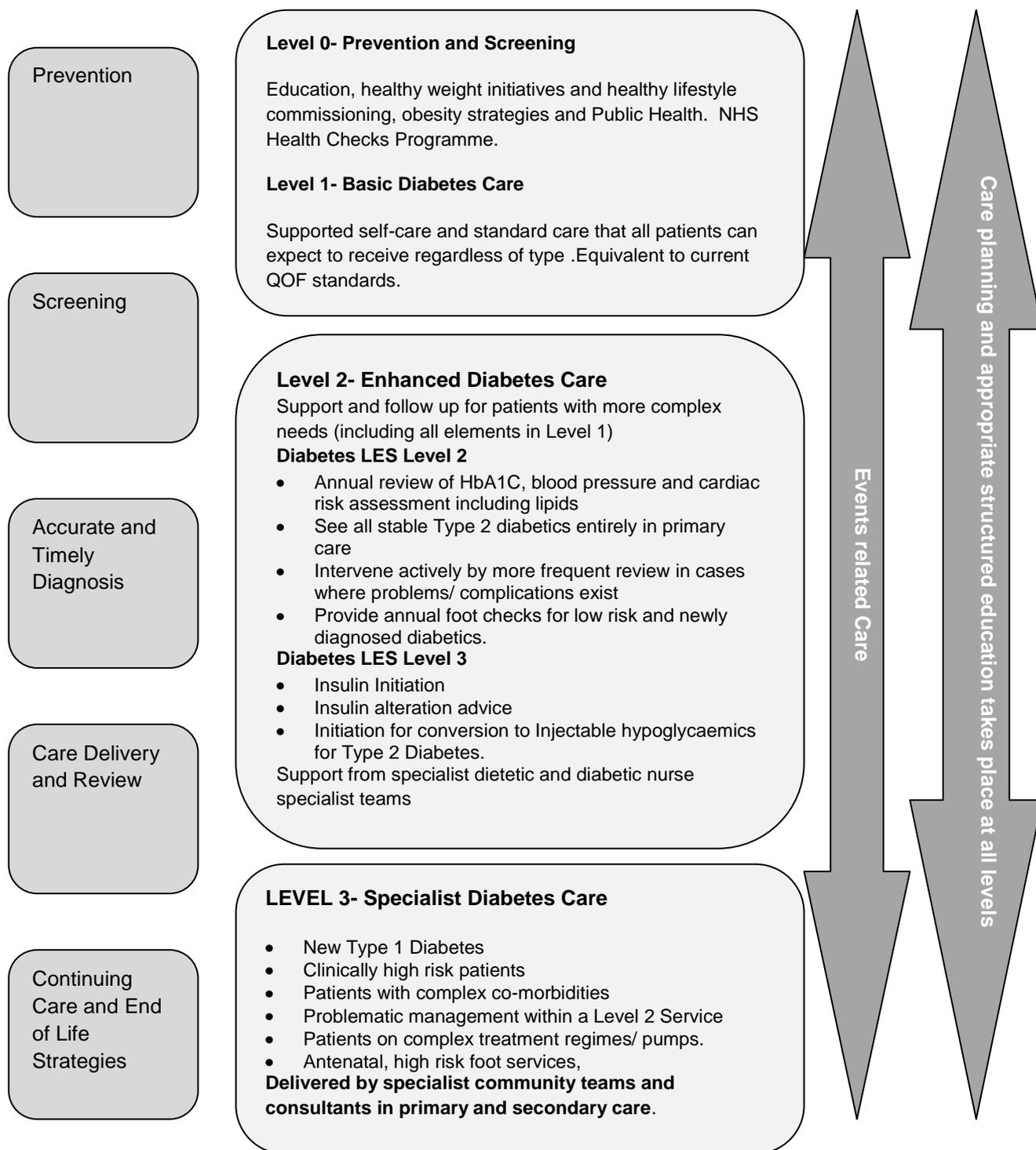
Training and education on diabetes/weight management is provided to other members of the health care team including:

- Pharmacy advisors on weight management
- Diabetes 3 day course for trained staff

The appended document shows the pathways for the patients into the service.

Please refer to **Appendix 2** for further information.

Fig 1 Sets out the current Care Pathway for Diabetes in east Kent



Dartford, Gravesham and Swanley

The current diabetic care pathway is being reviewed by the CCG and local clinicians, to a more integrated and simplified process. Details of the current pathway can be found in **Appendix 3**.

a) A specialist hospital diabetes centre based at Darent Valley Hospital.

The clinical team provides the majority of care to people with insulin-treated diabetes and those with specific related complications. The consultant diabetologists oversee the wider multi-disciplinary clinical team, including specialist nurses, dieticians, podiatrists, GPs, practice nurses and health care assistants. This allows sharing of clinical expertise and continuity of care. The majority of people with diabetes will experience an improved level of care through shared goal setting and care planning. As well as at the hospital, diabetes care is delivered from a number of locations including local clinics and care homes.

Services offered for all patients with diabetes are:

- Both inpatient and outpatient care by consultant Diabetologist , Diabetes Registrar and diabetes specialist nurses;
- Emergency/acute care of those with diabetes within agreed protocols in order to provide rapid effective treatment reducing length of hospital stay and potential re admission in the future (NSF standard 7);
- General diabetes clinics for people with more complex diabetes needs;
- Diabetes nephropathy clinic for people who have diabetes-related kidney problems (liaison with Consultant Nephrologists);
- Patients are assessed for hypertension, hyperlipidaemia and other metabolic risk factors;
- The diabetes specialist dieticians are also available in clinics to give advice on lifestyle changes and carbohydrate counting, weight management via 1:1 sessions;
- A treatment plan will be constructed in a letter to the GP with recommendations for future management, and a care plan will be agreed between patients and healthcare professionals in line with NSF standard 3.

In addition, for those with Type 2 diabetes

- Problem solving with those patients who have poor glycaemic control, despite use of some/maximal oral hypoglycaemic drugs;
- Assessing specific issues for patients with diabetes e.g. assessment of poor glycaemic control, nephropathy, erectile dysfunction, neuropathy, hypertension and renal disease.

In addition, for those with Type 1 diabetes

- An annual review is undertaken by the consultant diabetologist and diabetes registrar for patients who are seen in their clinics;
- Problem solving with those patients who have poor diabetes control is available from the diabetes team.

Young adult/adolescent clinic/Transitional Clinic

- Young Adult Clinic, appropriate for young adults with type 1/2 diabetes ages 16 – 24years;
- Annual review and problem reviews are also undertaken. Diabetes specialist dieticians and diabetes specialist nurses provide educational input;
- Consultant diabetologist and paediatrician clinic. Diabetes specialist dieticians and diabetes specialist nurses provide educational input;
- Outside of these twice monthly MDT clinics, individual support is provided by specialist dietician and diabetes specialist nurse;
- This fulfils national standards NSF standard 6.

Structured Education

Type 1 diabetes (DAFNE)

The aim of the course is to impart tools to enable people with Type 1 to accurately match the insulin requirements to the food they eat, enabling them to enjoy a more flexible and enjoyable lifestyle, while still attaining good glycaemic control. The course is limited to eight people and is delivered by a diabetes specialist dietician and diabetes specialist nurse together with a section of the programme being run by the diabetes consultant. This is a prerequisite to pump therapy. The programme fulfils The National Recommended Criteria from Department of Health (DOH) on Structured Education 2004 and NSF standard 4.

Type 2 diabetes (DESMOND)

DESMOND is a national accredited structured education programme for people with type 2 diabetes. The course is run by diabetes specialist nurses and specialist dieticians. The programme consists of one day, delivered at The Arrow Riding Stables Dartford but managed centrally at Darent Valley Hospital. DESMOND is offered to patients who attend all our clinics, or patients can be referred directly by their GP or practice nurse. Referrals are taken for people who are newly diagnosed. The programme fulfils The National Recommended Criteria from DOH on Structured Education 2004 and NSF standard 4.

Initiating insulin therapy

This service is offered to patients requiring insulin for both Type 1 and Type 2 diabetes. Initiating insulin therapy in clinics for those who are not acutely ill, is more convenient for the patient, reduces stress and avoids costly inpatient care. People with Type 1 diabetes are often unwell at diagnosis and are started on insulin at the onset of treatment. People with Type 2 diabetes usually only switch to insulin after a varying amount of time on diet and anti-diabetic agents. An initial appointment is arranged to discuss the need and benefits of insulin treatment. Referrals are taken from GPs or practice nurses.

Initiating GLP therapy

This service is offered for patients requiring GLP therapy for type 2 diabetes. People with type 2 diabetes usually only trial GLP after a varying amount of time on diet and

anti-diabetic agents (NICE 2009). An initial appointment is arranged to discuss the need and benefits of GLP treatment. Referrals are taken from GPs or practice nurses.

Pump initiation and maintenance

This service is offered for patients with type 1 diabetes who require insulin, to be delivered via a pump, in accordance with NICE guidelines. A series of appointments are arranged to discuss need and develop patient's knowledge of the different delivery systems. Attending DAFNE is a pre requisite and will be arranged through the diabetes service, along with 1:1 assessment of carbohydrate counting skills, by the dietician. The Pump Clinics are highly specialised and are run by a Consultant Diabetologist, diabetes specialist nurses and specialist dietician, all of whom have had specific 'pump' training and hold specific pump competencies.

Conceptual Care

Pre-conceptual advice is offered to all those of conceptual age with either Type 1 or Type 2 diabetes. Referrals are taken from GPs or practice nurses, or can be self-referred by the patient. Antenatal care referrals are taken from Obstetricians, GP and practice nurses for those with either Type 1 or Type 2 diabetes. Gestational diabetes referrals are taken from Obstetricians. These specialised clinics are attended by a Consultant Diabetologist, diabetes specialist nurses, specialist dietician, specialist midwife and Obstetrician in accordance with Standard 9 of the NSF.

Podiatry

Highly specialised care for both inpatients and outpatients with diabetes-related foot problems that require specialist attention. Clinics are led by a specialist podiatrist held at Darent Valley Hospital. Patients are seen within 24hours of referral in line with NICE guidance. A once weekly Multi-Disciplinary Team meeting (MDT) for all diabetes inpatients with high risk feet is held and this consists of specialist podiatrist, a diabetologist, and vascular surgeon. Referrals are taken from GPs, Practice Nurses, Physicians, Community Nurses and Community Podiatrists.

b) Community and Primary Care

For those people with diabetes who are not on insulin, care is provided by their GP and their practice nurse. To avoid duplicated care and the inconvenience of hospital visits, the hospital specialist diabetic nurses hold monthly clinics within a number of GP surgeries (The Orchard Practice at Dartford West Health Centre, Istead Rise Surgery and The Cedars in Swanley). This initiative is aimed to help people to manage their condition better.

c) Professional Training, Education and Advice

The diabetes team work closely with all inpatient and community staff to ensure good standards of diabetes care by acting as a consultant resource and providing education and training for staff. This includes:

- At Darent Valley hospital, ward link nurse meetings are held to enhance ongoing staff development;

- Diabetes Consultants and diabetes specialist nurses work closely with GPs, Practice Nurses, Community nurses to enhance diabetes care by attending multi-disciplinary team meetings, up-skilling staff at 1:1 sessions within their own areas of practice, organising educational events e.g. Merit Courses, HCA education day, Saturday morning GP workshops.
- The Diabetes team act as a consultant resource to patient/carers who contact the service for advice
- The diabetes nurse specialists offer telephone support, either general advice structured advice to all who contact the service directly.
- Diabetes team also attend community meetings in an educational role e.g. Health Awareness.
- The consultants at DVH also provide an Advice and Guidance Service via Choose and Book to GPs, for non-urgent advice in managing patients locally rather than requiring the patient to attend an outpatient appointment.

In development

- Education sessions to ambulance staff in relation to hypoglycaemia as this may reduce number of conveyances to hospital
- A full-day seminar is being arranged by the specialist diabetes team at Darent Valley Hospital for all GPs, practice nurses and other professionals involved in diabetes care.

West Kent

West Kent Clinical Commissioning Group (WKCCG) has identified as one of its key priorities for this year to focus on the delivery of care for adult patients with diabetes. In order to do this; work has been on going with the wide range of people involved in these services. Liaising with and listening to a range of peoples' views including patients, clinicians, health care managers and charities has led to significant progress in co-designing services to improve access, diagnosis, and increase patient support.

The two specialist hospital diabetes centres are based at The Paula Carr Diabetes Centre in Maidstone Hospital and Abbey Court Medical Centre in Tunbridge Wells. The clinical teams at these two centres provide the majority of care to patients with insulin treated diabetes and those with specific related complications.

The GPs and Practice Nurses in the area provide the majority of diabetes care for those patients not on insulin and also some do provide enhanced services for those on insulin.

For some patients their care is duplicated with visits to both specialist hospital centres and their GP team, this is inconvenient for both patient and clinician and is also creates an unnecessary use of resources. With the growing number of people diagnosed with diabetes capacity is needed within the specialist services to deal with those patients who clinically need to be seen by a specialist team. It is estimated that up to 31% of patients with diabetes in the area are yet to be diagnosed this is above the national average of 25%. To accommodate the increasing number of adults with diabetes in the area, delivery of services within GP and community settings is being enhanced ensuring that those who need specialist services can access care where clinically appropriate.

Patients with diabetes will have their care delivered from a variety of diabetes centres and wherever possible more conveniently from around their local GP practice. Some patients

will experience changes in their care provider as services will be assigned depending on clinical need. Consultants specialising in diabetes care will manage patients with conditions related to diabetes that are complex and require specialist care. They will also oversee the wider multi-disciplinary team clinical delivery and training, inclusive of diabetes specialist nurses, dietetics and podiatry, GPs, practice nurses and health care assistants.

Therefore, future services will be delivered by skilled teams in more convenient locations than previously for the majority of patients. There will be a much stronger sharing of clinical expertise across the hospital and community staff, improving quality and continuity of care. With shared goal setting and care planning it is anticipated that the majority of patients with diabetes will experience an improved level of care and as a result may avoid emergency admissions to hospital.

In July 2012, the launch of the new 'Intermediate Diabetes Service' (known as level 3 Service), for patients and Clinicians in West Kent CCG took place. This is provided by MTW, initially from 3 centres (Paula Carr Centre at Maidstone Hospital, Abbey Court in Tunbridge Wells and Sevenoaks hospital). This level 3 Service is separate from the current secondary care diabetes services (to be called level 4 Service) and will be specialist diabetes nurse led with consultant, podiatrist and dietitian presence in some of the clinics.

The key aims behind establishing Level 3 services are:

1. Specialist access to a wider range of diabetic patients especially type 2 whose diabetic control is not optimally controlled in primary care.
2. Structured education (DESMOND or alike) to a much larger cohort of patients than present
3. Care closer to the patient's home.
4. Timely GLP-1 and Insulin initiation for patients in practices who are not trained to initiate these therapies.
5. Improve access to dietetics and podiatry more accessible, when necessary.
6. Structured training for practices.

In April 2013 the primary care Level 2 Diabetes service will be launched to ensure that all our diabetic patients have care consistent with the "NICE Diabetes in Adults Quality Standard". The acute Trust will be transferring some people with Type 2 diabetes follow ups to the level 2 service in order to free up capacity to cope with increased diagnosis.

We know that practices deliver diabetes care aiming for the QOF standards, but wish to encourage them to provide all the care processes within 12 months as is nationally recommended. Therefore practices will be incentivized to provide an enhanced level of diabetic service (level 2) are expected to provide GLP-1 and Insulin initiation for type 2s as well as manage more insulin treated diabetics. This is an incentivized service (replacing the current insulin LES scheme) with the ultimate aim that most practices in west Kent are able to deliver level 2 Services.

The main developments in this service relate to a comprehensive review of practice competence and a bespoke training package particularly for West Kent practice staff

Please refer to **Appendix 4** for further information.

5. How is the NICE quality standard for diabetes in adult used to inform commissioning and provision of Kent?

The NICE guidance is used rigorously to benchmark local services and to identify where providers are not compliant with NICE guidance. Diabetes has been very well researched and therefore there is a plethora of evidence and guidance that can inform effective commissioning of local services.

There are 14 standards which are used in order that:

- a. Health and social care professionals can make decisions about care based on the latest evidence and best practice.
- b. Patients can understand what service they can expect from their health and social care providers.
- c. NHS trusts can quickly and easily examine the clinical performance of their organisation and assess the standards of care they provide.
- d. Commissioners to be confident that the services they are providing are high quality and cost-effective. Commissioning responsibilities include planning services, based on assessing the needs of our local population; securing services that meet those needs; and monitoring the quality of care provided.

- Quality statement 1: Structured education

People with diabetes and/or their carers receive a structured educational programme that fulfills the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education

- Quality statement 2: Nutrition and physical activity advice

People with diabetes receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured educational programme.

- Quality statement 3: Care planning

People with diabetes participate in annual care planning which leads to documented agreed goals and an action plan

- Quality statement 4: Glycaemic control

People with diabetes agree with their healthcare professional a documented personalised HbA_{1c} target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%), and receive an ongoing review of treatment to minimise hypoglycaemia.

- Quality statement 5: Medication

People with diabetes agree with their healthcare professional to start, review and stop medications to lower blood glucose, blood pressure and blood lipids in accordance with NICE guidance.
- Quality statement 6: Insulin therapy

Trained healthcare professionals initiate and manage therapy with insulin within a structured programme that includes dose titration by the person with diabetes.
- Quality statement 7: Preconception care

Women of childbearing age with diabetes are regularly informed of the benefits of preconception glycaemic control and of any risks, including medication that may harm an unborn child. Women with diabetes planning a pregnancy are offered preconception care and those not planning a pregnancy are offered advice on contraception.
- Quality statement 8: Complications

People with diabetes receive an annual assessment for the risk and presence of the complications of diabetes, and these are managed appropriately.
- Quality statement 9: Psychological problems

People with diabetes are assessed for psychological problems, which are then managed appropriately.
- Quality statement 10: 'At risk' foot

People with diabetes at risk of foot ulceration receive regular review by a foot protection team in accordance with NICE guidance.
- Quality statement 11: Foot problems requiring urgent medical attention

People with diabetes with a foot problem requiring urgent medical attention are referred to and treated by a multidisciplinary foot care team within 24 hours.
- Quality statement 12: Inpatient care

People with diabetes admitted to hospital are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin.
- Quality statement 13: Diabetic ketoacidosis

People admitted to hospital with diabetic ketoacidosis receive educational and psychological support prior to discharge and are followed up by a specialist diabetes team.
- Quality statement 14: Hypoglycaemia

People with diabetes who have experienced hypoglycemia requiring medical attention are referred to a specialist diabetes team.

6. Specifically what is being done around patient education?

Structured Education Programmes

East Kent

Kent Community Trust is commissioned to deliver two structured education programmes.

KAT1E (Kent Adult Type 1)

This is an educational programme for Type 1 diabetics. This programme runs one day a week for four weeks. The facilitation of this course is by the DSNs service and Diabetes Dieticians. Diabetologist from secondary care are invited to speak for a session on the programme.

12 courses a year are currently offered at various venues across East Kent. 8 participants can be accommodated on each course.

The KAT1E course has been designed to meet local needs and based on the DAFNE and *BERTIE* principles of Diabetes Management.

DEREK (Diabetic Education and Revision in East Kent)

This is an education programme for Type 2 diabetics. The programme is for newly diagnosed diabetics and those patients that have had diabetes for a long time and would benefit from updating their knowledge.

This is a one off course of 4 hours. The course has input from podiatry and dietetics.

Quality assurance and audit of the course is currently under review in order to acquire validation from the Diabetes Education Network.

Referral into the education programmes is from GPs, practice nurses and other health professionals. The course has been designed to meet local needs and is unique compared with some of the nationally recognised course in that we are offering the revision element and have podiatry input.

The Community Trust offer 5 courses a month at various venues in East Kent. Each course offers 8 places and those 8 people are invited to bring their partner/friend etc along to the course. In order for learning to take place the course has been designed to be a facilitated course using Conversation Mapping Tools which are a nationally recognised Tool to enable participants to take an active part in the session. People who are not comfortable taking part in a group session can be seen on a 1:1 basis for education. Currently the Trust is receiving 70-100 new referrals every month.

Swale

Medway Community Healthcare provides structured education programmes to the patients in Swale with Type 1 (MINT1E) and Type 2 diabetes MINT1E (X-PERT).

MINT1E (Medway Intensive Type 1 Education) is delivered via a similar programme to KAT1E. Three courses are planned to be provided per year with 8 places per course.

X-PERT is an accredited education programme for people with Type 2 diabetes. The programme provides essential knowledge on self-management, pitfalls of poor management, how medications work and the balance between exercise, food and treatment. It is a 2-hour session every week for six weeks. There are fifteen courses planned per year with 15 places per course.

Dartford, Gravesham and Swanley

a) Structured Education

Additional funding has been provided to the Acute Trust to increase the provision of structured education (DAFNE & DESMOND) for those people with Type 1 or Type 2 diabetes, to reduce hospital admissions and improve self-management of diabetes. Please refer to **Appendix 3**.

b) Nutrition and physical activity advice

There are a range of interventions available funded through Public Health which are available to all. A directory of local Healthy Lifestyles Activities in DGS is provided to all GPs and the diabetic team in hospital. Please refer to **Appendix 5**.

The *Healthy Club* is a web-based programme which directs individuals to healthy living programmes such as walking, nutrition programmes, weight management, smoking cessation, health trainers etc.

Healthy Living Centre Teams at Temple Hill Dartford, the Gr@nd Gravesham and the Get Sorted Team in Swanley provide a range of health improvement programmes based on local need;

Dartford, Gravesham and Sevenoaks District and Borough Councils provide both *adult and family weight management programmes*. The adult programme is available to any residents with a BMI of 30 or over and a BMI of 28 if there are existing conditions such as diabetes or if the participant is from an ethnic group. All providers of adult weight management services are required to provide a diabetes risk assessment as part of the programme;

Tier 3 specialist weight management programmes are currently out to tender (Specialist Commissioning provide bariatric surgery for those who have been unable to lose weight through other programmes);

The *national Health Check programme* is designed to identify people who have an undiagnosed condition – it is a 5 year rolling programme for people between 40-75;

Health Trainers provide individualised holistic support for people on a 1:1 basis, who are motivated to make behaviour changes;

The move of Public Health into Kent County Council should provide opportunities for more strategic working across directorates that influence the wider determinants of health e.g. planning, transport, housing, education etc.

West Kent

Type 1 diabetes patient education (Dafne) and Type 2 education (Desmond) is delivered by the local acute trust. The new pathway with increased expectation of improved patient outcomes relies on patient education being offered to more patients which will require further investment in services. A programme of work is underway to review and plan for the future of these services with the aim of increasing provision. As an example we are considering increasing provision with other alternative hours of delivery to attract those working during the week and young people. With the up skilling of our primary care service staff, patients will benefit from experts in their surgeries. A Business case is currently underway to propose a way forward to deliver more structured education.

7. In its report the management of adult diabetes services in the NHS, published earlier this year, the National Audit Office identified nine basic care processes for people with diabetes to be delivered annually. Are these care processes still used when planning services and if so, how successfully are they being delivered across the County?

The National Audit Office (NAO) data provides us with a good base line in terms of how Kent is doing compared to other areas. The nine key processes are very important for the improvement of services for diabetics and enable commissioners to work with practices that need additional support to improve or achieving better outcomes.

Data for the latest NAO for 2010-11 reported that out of the 114 registered practices, 84 practices participated in the audit (73.7%). The audit reported that there were 29,239 patients registered with East Kent practices of which 2,782 were type 1 and 26,223 were type 2.

Table 1 shows the percentage of all patients in Eastern and Coastal Kent PCT receiving NICE recommended care processes by care process type.

Care Process recorded	Percentage of registered patients in PCT (including RAG Score)	Percentage point change since 2009-2010	Median score across all PCTs	National quartile ranking
All Care Processes*	60.0% ■	+5.77%	55.5%	1
Blood Creatinine	93.4% ■	+0.29%	93.1%	2
Blood Pressure	94.8% ■	-0.28%	95.2%	3
BMI	89.5% ■	+0.09%	90.0%	3
Cholesterol	92.2% ■	+0.19%	91.7%	2
Eye Screening	83.1% ■	+6.87%	82.4%	2
Foot Exam	84.8% ■	+1.02%	84.5%	2
HbA1c**	92.8% ■	+0.23%	92.9%	3
Smoking Review	85.3% ■	-1.01%	85.7%	3
Urinary Albumin	80.4% ■	+2.06%	76.3%	1

*People registered with diabetes receiving all nine key processes of care processes

**For patients under 12 years of ages, 'all care processes' is defined as HbA1c only as other care process are not recommended in the NICE guidelines for this age group.

RAG (Red-Amber-Green) score key: ■ <70% ■ 70% - 90% ■ >90%

In West Kent 101 (100%) participated in the 2010-11 audit. The audit reported that 29,239 patients were registered with West Kent practices of which 3,012 were type 1 and 25,610 were type 2. Table 2 below shows the percentage of all patients in West Kent PCT receiving NICE recommended care processes by care process type.

Care Process recorded	Percentage of registered patients in PCT (including RAG Score)	Percentage point change since 2009-2010	Median score across all PCTs	National quartile ranking
All Care Processes*	42.2% ■	+4.77%	55.5%	4
Blood Creatinine	91.1% ■	-0.71%	93.1%	4
Blood Pressure	94.7% ■	-0.06%	95.2%	3
BMI	88.4% ■	-0.03%	90.0%	4
Cholesterol	89.2% ■	-1.07%	91.7%	4
Eye Screening	80.0% ■	+3.36%	82.4%	4
Foot Exam	82.7% ■	-0.69%	84.5%	4
HbA1c**	91.5% ■	+0.34%	92.9%	4
Smoking Review	83.5% ■	-1.20%	85.7%	3
Urinary Albumin	58.7% ■	+4.26%	76.3%	4

*People registered with diabetes receiving all nine key processes of care processes

**For patients under 12 years of ages, 'all care processes' is defined as HbA1c only as other care process are not recommended in the NICE guidelines for this age group.

RAG (Red-Amber-Green) score key: ■ <70% ■ 70% - 90% ■ >90%

The NDA goes into more detail with respect to Type 1 and Type 2 diabetes and provides a breakdown of the individual practices that participated in the audit. This information provides commissioners with independent data as to where improvements can be made and is being systematically in both east and west Kent to improve the commissioning of local services.⁸

8. Specifically a) what percentage of the eligible population take up the offer of an initial diabetic retinopathy screening test and b) what percentage of the population take up the offer of a repeat diabetic retinopathy screening test?

The Diabetic population for east and west Kent and Medway is estimated at 83,543 patients from 2011/12 annual audit. There are 76,309 eligible diabetic patients within the screening service.

The eligibility criteria for QOF is any patient over 15 who has diabetes and the criteria for the NSF is any patient over 12, the Paula Carr work to both criteria.

Paula Carr is also looking to expand their service to include any child under 12 who has had diabetes for more than 5 years.

The numbers of patients invited during 2011/12 for screening across Kent was 73,067, of these 7,723 were initial screening invites and 64,199 were repeat screening invites.

Some patients exclude themselves from the screening. The definition of 'exclusion' is those patients that do not attend for their appointment after two letters of invitation.

Please refer to **Appendix 6** for further details.

The total number of patients screened across Kent was 62,502, 7,840 attended for their initial screen and 54,662 attended for their repeat screen. 10% of those patients screened were seen for the first time as these patients had been newly diagnosed.

An addition 1,982 (3%) patients are seen at the SLB (Slit lamp Bio) clinics which is one of the recommended national surveillance clinics that provide additional imaging for some patients.

Public Health has produced a Diabetic Eye Screening Health Equity audit, which shows the variation across practices. The audit was undertaken in June 2012 and a copy of this report is available on request.

DGS CCG will be working with practices and Public Health to implement the recommended actions, targeting those with higher than average DNA rates.

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⁸ *The National Diabetes Audit 2010-2011 Report 1 Care Processes and treatment targets is available at http://www.ic.nhs.uk/webfiles/Services/NCASP/Diabetes/201011%20annual%20reports/National_Diabetes_Audit_2010_2011_Report1_Care_Processes_And_Treatment_Targets.pdf*

An addition 1,982 (3%) patients are seen at the SLB (Slit lamp Bio) clinics which is one of the recommended national surveillance clinics that provide additional imaging for some patients.

9. Has any assessment been made of how equitable access to diabetes services is across Kent?

There has been a Health Equity Audit undertaken for diabetic retinopathy screening and work has been undertaken on referral pathways at each of the acute hospital sites on the foot care pathway.

Enhanced services (levels 1 and 2) have been mapped across Eastern and Coastal Kent to look at the level of expertise within primary care.

10 .What plans are currently underway to develop diabetes services more generally in Kent and what are planned for the future?

Currently a strategy is being prepared to go to the 4 CCG Boards in the East Kent Federation area that sets out the vision for diabetic Services for Kent. The main aim of the strategy is to agree the model for commissioning diabetic services across the whole pathway and then to work with individual CCGs to tailor services so that they are appropriate for their populations.

This strategy sets out a vision for the commissioning of an integrated model for diabetes services. The main objectives of the strategy are to:

- Enable robust and meaningful patient engagement to co design local services appropriate to their needs
- Devolve elements of secondary care to primary care to ensure care is integrated and more localised
- Ensure that service re-design takes into account other Long Term Conditions (LTCs)
- Reduce inequalities in health and well-being to achieve health improvement
- Improve the experience of people who use diabetic services
- Sustain a high quality of care for people who have diabetes
- Invest resources effectively

The strategy sets out an assessment of need in terms of prevalence and activity for people with diabetes in East Kent and some of the policy context behind these proposals.

The strategy acknowledges that there are issues around the implementation of the strategy and these are with reference to:

- Workforce development
- Local availability of health facilities

- IT interface
- Cultural changes
- Governance

Swale has worked collaboratively with Swale in Medway CG to review diabetes services across the pathway. The main focus of the review outcomes is to improve the education and training within primary care to support levels 1 and 2 in the pathway. This will also support care being delivered in the most appropriate setting, closer to home by the right professionals. The Medway and Swale plan includes improved and increased care and treatment in primary care.

In addition Medway and Swale with its partner organisations a group of patients that can be cared for within the community specialist service as opposed to the secondary care specialist service.

Swale is also reviewing assistive technology to support its diabetes pathway in primary care.

Within DGS, the CCG intends to review the Diabetes Pathway to be more integrated and 'whole system' for the patient, and to include improving early recognition and management of condition. Prevalence of diabetes is higher in DGS than the national average, and it is recognised that earlier diagnosis and intervention can help

Within West Kent CCG pathway redesign process there are future programmes of work that are already in their infancy – improving access to structured education, dietetics and foot care are examples.

11. How are diabetic services paid for (tariff, block, and contract?)

All diabetic treatment in acute hospitals is on tariff. All diabetic treatment in community trust is on block (at the moment). Diabetic retinopathy is on block. Diabetic patient education training programmes are block.

12. How do diabetes services feature in the QIPP plan?

East Kent:

The four CCGs in East Kent have recognised that there are economies of scale to be made if some services are commissioned using a federated model. Diabetes, along with Long Term Conditions, Planned Care and Urgent Care are being planned and commission using this model. East Kent also has one Acute Trust and one Community Trust as main providers which facilitate this particular model of working. East Kent has supported a Diabetic project Manager to look at the Diabetic pathway as there is an acknowledgement that services need to be improved.

Swale CCG has recognised that there are economies of scale to be made by working collaboratively with Medway CG as well as a North Kent Alliance.

One of Swales' CCGs priority areas is tackling health inequalities (Beats and Breaths Project). The project includes direct action in primary care to reduce variation in care and treatment, working with the voluntary sector and a public campaign to increase awareness and encourage behaviour change around cardiovascular disease, COPD, diabetes, and obesity. This project has been operation for two years and has further two years duration.

Diabetes features in CCGs QIPP plans by improving services to bring about the following outcomes:

- Deliver more effective outcomes for patients
- Improved diagnosis rates for the disease
- Improve on-going care management at a primary care level
- Improve preventative services thus reducing the prevalence and complications
- Reduce access to secondary care
- Reduce avoidable emergency admissions
- Improve prescribing practices