



# LEVELLING UP: TACKLING VARIATION IN DIABETES CARE



ALL-PARTY PARLIAMENTARY GROUP FOR DIABETES

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# Table of Contents

<b>Foreword</b>	<b>04</b>
<b>Chair's Introduction</b>	<b>05</b>
<b>The case for change</b>	<b>06</b>
<b>High quality conversations with the right healthcare professionals</b>	<b>09</b>
High quality consultations	
Seeing healthcare professionals who understand diabetes	
Using new channels	
Sharing health data between different parts of the NHS	
<b>Support for living with diabetes</b>	<b>12</b>
Diabetes education for people living with diabetes	
Information and one-to-one advice	
Informal learning and support	
Structured Education	
Emotional and Psychological Support	
<b>Technology</b>	<b>15</b>
Blood Glucose Meters	
Insulin pumps	
Continuous glucose monitoring	
Flash glucose monitoring	
<b>Making improvements happen</b>	<b>18</b>
Quality improvement	
Integrated finances	
Using data	
Leadership	
<b>Recommendations</b>	<b>20</b>
<b>Acknowledgements</b>	<b>22</b>



# Foreword

**Diabetes is affecting a larger and larger proportion of our population. There are now around 2.8<sup>1</sup> million people in England diagnosed with either Type 1 or Type 2 diabetes, and it is estimated that there are a further 940,000 people with undiagnosed Type 2 diabetes.**

To halt the increase in Type 2 diabetes, up to 20,000 people at high risk will be referred to the Healthier You: NHS Diabetes Prevention Programme by the end of this financial year, rising to 100,000 each year when the programme is fully rolled out nationally.

But we must also focus our intentions on ensuring that everyone already living with diabetes – whether Type 1 or Type 2 – has the necessary skills and support to manage their condition and reduce the risk of long term complications.

The UK outperforms many other nations in this respect. We have the lowest rates of early death due to diabetes of the 19 wealthy countries included in a recent Global Burden of Disease Study, and the risks of a person with diabetes developing complications has fallen in recent years.

But there are huge variations in diabetes outcomes. The All-Party Parliamentary Group (APPG) for Diabetes' investigation has been a welcome forum for exploring these variations.

Having attended each of the APPG's evidence sessions, I have heard first hand about the importance of equipping people with the education, technology and support that they need to manage their condition. I have also heard examples of best practice in service design, and about many of the improvements needed in healthcare settings.

The findings of this report are an important step in recognising both the excellence in diabetes care in this country and the shortcomings.

As the APPG's investigation came to its conclusions, NHS England announced that all Clinical Commissioning Groups will have the opportunity to bid for additional national funding of approximately £40million per year to promote access to evidence based interventions to improve diabetes outcomes – improving the achievement of the NICE recommended treatment targets whilst driving down variation between CCGs; improving uptake of structured education; improving access to specialist inpatient support; and improving access to a multi-disciplinary foot teams for people with diabetic foot disease.

The challenge for all of us now is to use the money and commitment from the Government wisely, to tackle diabetes and spread excellence throughout the system.

**Professor Jonathan Valabhji**  
**National Clinical Director for Obesity**  
**and Diabetes, NHS England**



<sup>1</sup> Since going to print there has been new data released on the number of people diagnosed with diabetes in England. NHS Digital (2016). *Quality and Outcomes Framework 2015/16* <http://content.digital.nhs.uk/catalogue/PUB22266>

# Chair's Introduction

**It takes a village to provide care for those with diabetes. From GPs to pharmacists, from podiatrists to nurses, they all need to be part of the solution to the diabetes crisis.**

My own diabetes story began when I was diagnosed with Type 2 diabetes almost a decade ago. I was privileged to be elected Chair of the All Party Parliamentary Group for Diabetes after the 2015 election. Having chaired the series of meetings that formed the basis of this investigation, I am left with little doubt that diabetes is the most serious challenge facing the NHS today. Getting to grips with this condition could be the defining contributor in creating the sustainable NHS that we all want to see.

With concerted effort the National Diabetes Prevention Programme and the Childhood Obesity Plan will make inroads into preventing Type 2 diabetes.

But for the 4.5 million people who already have either Type 1 or Type 2 diabetes, there is still much work to be done.

Managing diabetes is a tough job and one where the burden falls largely on the person living with the condition, or in the case of young children – on their parents.

We spend £10bn a year on treating diabetes – but the bulk of this spending comes too late: 80% of this money goes on preventable complications. Meanwhile, people with diabetes are struggling to get the technology, education and appointments they need to help manage their condition.

We spend the money on hospital stays, kidney complications, and performing amputations instead of spending it helping people to avoid those complications ever occurring.

There is a lot of great work going on to help people to manage their diabetes – but far too often, the quality of support and care for someone with diabetes depends on where they live: variations in care are marked.

Over the past year we have heard about the state of care from doctors, nurses, policy professionals, international experts, technologists and innovative companies. And of course we have heard from the real experts – the people who live with the condition 24/7.

This report details the picture they painted and the measures that are urgently needed to tackle the post code-lottery of care and support to ensure that everyone with diabetes can access care and treatment to live their life to the full.

On behalf of the All Party Parliamentary Group for Diabetes and the 4.5 million people living with diabetes today, I urge the Government to act on the recommendations with haste.

The APPG remains grateful to Diabetes UK and JDRF for their support and help during the production of this report.

**Rt Hon Keith Vaz MP**  
**Chair of the APPG for Diabetes**



# The case for change

**The APPG has heard from people with diabetes about how they experience inconsistent quality. They told us about the centrality of good quality communications with their healthcare professional (HCP), support for living with diabetes, and access to the right specialists and technology to enable them and their families to live more easily with diabetes.**

The Government and NHS England have recognised the need for improvement in diabetes services. Diabetes is one of six clinical priorities in the improvement and assessment framework for Clinical Commissioning Groups (CCG IAF) and during the APPG's investigation, NHS England announced £40m for diabetes improvement. It is vital that this opportunity to transform diabetes services is grasped. The evidence we heard shows how it can be done.

We heard from HCPs and a series of leading CCGs who have made improvements in their local areas about what can be done. It starts with the right process: collection and sharing data, using this to inform improvements, involving all stakeholders, sharing best practice, education and training incentivising quality and finding appropriate cost savings because what is being done is of good quality.

Then, changes can be made that help people with diabetes get what they deserve:

- High quality conversations with the right healthcare professionals
- Support to manage their condition
- Access to key technologies

Our message is that fundamentally variation is not a signal of despair – but of hope. It shows that good care can be achieved. Our task is to make it happen everywhere to tackle the diabetes crisis.

HOUSE OF COMMONS



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**High quality conversations  
with the right healthcare  
professionals**



## High quality consultations

**A big part of how care is perceived by people with diabetes is how they are communicated with by healthcare professionals. People often felt that they were being criticised in appointments for not meeting treatment targets and dictated to about how to manage a condition they lived with.**

**‘I would then be scolded that my numbers were too high, before my insulin doses would be revised by the doctor and I would be sent on my way. If my numbers were ‘out’, I must be doing something wrong – and I wasn’t allowed to make any changes for myself.**

**Rebecca Holden**

The use of NICE guidelines around diabetes care and relevant NHS policies that help determine a course of care are not always adapted for a particular individual’s needs, which often resulted in care that was unsatisfactory with treatment targets that were believed unachievable by the patient. Equally when specialist advice was given by non-specialists such as foot care or dietary advice, patients felt that this information was too basic and often conflicting with advice given by specialists, or what was working for them.

Great value is found by those who are given the opportunity to input into the decision-making process with their healthcare team. Consideration of their lifestyle alongside their diabetes management as well as interpretation of NICE guidance to fit their needs allows for tailored treatment plans. This means better treatment outcomes as individuals have more confidence in themselves and their healthcare team to manage their diabetes.

**‘My consultant is supportive of my treatment and a real genuine sharing of thought goes into my healthcare plans that we make at my appointments’**

**Diane Johnson**

### What the NHS is doing

The APPG heard from two areas who are tackling this issue systematically, Tower Hamlets and North East Essex through the ‘Year of Care’ model. The ‘Year of Care’ is a way of transforming the diabetes annual review into a constructive and meaningful dialogue between the healthcare professional and the person

with diabetes through care and support planning. HCPs are trained to run their consultation in a genuinely collaborative way, with time to have an in-depth conversation about the person’s priorities and goals for their own diabetes. It raises people’s motivation to manage their diabetes and means they have the support they really value and want. This has been shown to improve engagement and outcomes, as well as increasing the satisfaction of healthcare professionals with consultations.

## Seeing healthcare professionals who understand diabetes

People with diabetes and HCPs both said that expertise in diabetes was a real issue outside of diabetes specialists, for example in primary and secondary care.

As primary care deals with an ever increasing proportion of diabetes care, primary care HCPs need to have the knowledge and skills to give accurate advice. The number of people with diabetes has doubled since the mid-1990s<sup>2</sup> but this dramatic increase has not been reflected in training for HCPs.

Devices such as insulin pumps, flash glucose monitoring and continuous glucose monitoring (CGM) are all becoming more widely used. To make the most of this technology there also needs to be an increase in the number of HCPs trained in how to advise patients on their use – as well as signposting to manufacturers’ helplines.

The APPG heard that getting access to specialists was also a problem. Some reported that services were simply overwhelmed. Others that it needed them to proactively seek local services to get a referral. Services that patients really valued were Diabetes Specialist Nurses (DSNs), dietetics and podiatry. People affected by diabetes also valued their pharmacist and saw how their role could be significantly expanded to provide greater diabetes information and signposting support.

2 British Diabetic Association (1996). *Diabetes in the UK, United Kingdom, London, BDA compared to 2014/15 Quality and Outcomes Framework*

## What the NHS is doing

The APPG heard from many areas about how they are making progress on this issue. In Poole, DSNs are training their non-diabetes colleagues with a quick 10 point plan. Meanwhile, the Cambridge Diabetes Education Programme uses online modules to give professionals, such as practice nurses and care home workers, the diabetes knowledge they need to do their job well.

An impressively comprehensive approach has been taken by West Hampshire Diabetes Service who have worked to raise skills in diabetes management across primary care, ambulance crews and mental health. It means patients are much more likely to get the support they need from their own GP. Additionally there is a new service where people with diabetes have ready access to specialist advice through a telephone hotline five days a week as well as a peer to peer mentoring programme – ‘Sugar buddies’.

These changes were part of improvements being made across the whole diabetes system that has led to better use of specialist consultant time and a massive fall in the number of admissions for diabetic ketoacidosis (DKA) and amputations. 97 per cent of users would recommend the service to friends and family.

West Suffolk CCG worked to ensure the engagement of all GP practices with a community diabetes specialist nurse service. The service led to an improvement in HbA1c levels as well as falls in diabetes emergency admissions, first appointments and follow-ups. Early results suggest a 10 per cent saving in hospital costs.

A similar approach is also being taken by CCGs across County Durham and Darlington. These CCGs also reported finding value in DSNs and general practices working together to share knowledge and support patients to manage their condition better.

Meanwhile, in Solihull, pharmacists have started attending multi-disciplinary team (MDT) meetings to review patients’ notes to understand how to improve their care and medicines. The Pharmacy Adviser does a thorough review of all of a patient’s diabetes-related and cardiovascular drugs. They have simplified medication regimes, while reducing errors and costs. As well as benefitting individual patients it has raised skills in primary care so that they are more confident with the range of diabetes therapies. The work as a whole has helped to reduce average HbA1c levels across the CCG and the need for specialist care input.

## Using new channels

The constant demands of diabetes make it important that those living with the condition can seek help and support from skilled HCPs outside formal consultation appointments. Many people with diabetes are seeking more flexible ways of communicating with HCPs so they can get advice outside face to face consultations: email, telephone hotlines, Skype and text messages all play a part.

## What the NHS is doing

Some patients told the APPG that they do receive these types of communication and greatly value them. They can be especially valuable for people who are less engaged with their healthcare team or if they are newly diagnosed. Similarly if people are getting used to a new piece of technology the opportunity to get help without a formal appointment is appreciated.

**‘Within my clinic, email is used. This is a positive’**

**Tim Street**

# Sharing health data between different parts of the NHS

Sharing of routine tests results, especially before consultations, was important to people with both Type 1 and Type 2 diabetes. Patients want to have access to their test results so they can better understand and monitor their diabetes management and use these results to discuss their personal issues and goals with HCPs.

**‘Patients want and expect their medical information to be protected appropriately but also shared appropriately’**

Dr Alex Bickerton

**‘For nearly four years I have made great use of ‘My Diabetes My Way’ to monitor my own health results and help me discuss issues relevant to my health with my diabetes team.’**

Lavina McMillan

For HCPs, sharing test results helps give context to a patients’ care, prevents duplication and is more efficient. However, for this to work in practice, there needs to be sufficient IT support. Currently many different IT systems do not share information but have the ability to do so.

**‘In Somerset there are at least six different IT systems and within those a number of different software applications. The number of IT systems per se is not necessarily a problem if each is effective. Indeed, producing a single IT system for the NHS has proved impossible. The issue is that none of the IT systems are currently sharing information, despite the fact that the majority are able to do so relatively easily.’**

Dr Alex Bickerton

## What the NHS is doing

Solving this problem is something that the NHS needs to address as a whole in England. The APPG heard ways in which some areas have made improvements. For example, in West Hampshire and Tower Hamlets patient records are held securely and accessibly across the whole diabetes service.

**‘In the past four years, I had my blood glucose strips reduced to 1.5 per day (compared to the eight on average I need, e.g., driving, cycling, hypos/hypers, injecting) because the GP surgery cannot tell the difference between Type 1 diabetes and Type 2 on their database.’**

Becca Smith





**Support for people  
living with diabetes**

# Diabetes education for people living with diabetes

**Different people choose to learn about their diabetes in different ways at different times. The NHS needs to support a comprehensive approach that includes:**

- Information and one-to-one advice.
- Ongoing learning that may be informal: peer groups.
- Structured diabetes education courses.

## Information and one-to-one advice

The evidence given to this inquiry showed that there was a huge variation in the diabetes information and education given to those with diabetes. Those with Type 1 diabetes diagnosed as an inpatient received varying amounts of information around carbohydrate counting, insulin injections and general diabetes management, usually in the form of literature.

Those diagnosed in childhood have limited recollection of the information given to them about how to manage their diabetes, as their parents generally dealt with their management. Even though many do remember having follow-up appointments with a Diabetes Specialist Team for more in-depth education and management advice. However, these appointments were felt to be varied in quality.

Those diagnosed with Type 2 diabetes, usually in a primary care setting, were given literature published by the NHS or Diabetes UK.

## Informal learning and support

The majority of those who submitted evidence mention the invaluable information and support they have found in the diabetes community through local groups and online forums. Speaking with those who have faced similar experiences was often cited by patients as the most useful resource in understanding how to manage their condition. For example the GBDoc website that facilitates an online community for people with diabetes by people with diabetes.

**‘The growth of online support like the GBDoc means that any advice needed is far more likely to come from peer-to-peer support.’**

**Adrian Long**

Many of those who submitted evidence were proactive individuals who took it upon themselves to learn as much as possible about their condition from online forums, health charity websites and joining local groups.

## Structured Education

Good quality diabetes structured self-management education courses improve health outcomes, reduce the onset of complications and are cost-effective or cost saving<sup>3</sup>. Courses such as DAFNE, DESMOND and X-PERT, formally known as structured education, greatly help those living with diabetes to better understand and manage their own health.

Structured education has been recommended by NICE since 2003<sup>4</sup>. Attendance at structured diabetes education courses for the newly diagnosed is now part of the CCG Improvement and Assessment Framework – a system introduced by Department of Health and NHS England that rates all CCGs on the quality of health services in their area<sup>5</sup>.

Our evidence shows that those living with Type 1 diabetes during childhood rarely had formal education on diabetes management. However appointments with the diabetes specialist’s team nurses were seen to be valuable.

Structured education courses for both Type 1 and Type 2 diabetes helped many of those who attended as they covered a broad range of topics in-depth, with the added benefit of providing a forum to meet other people with diabetes. However, the organisation of the courses presented an issue as getting time off work or finding childcare to attend a five day intensive course could be difficult. Additionally the content of the course, although comprehensive, meant that there was a lot of information to take in and people worried about retaining all that was learnt.

Time between education sessions, as with X-pert, to digest and take on board the new information was mentioned as a way of improving course delivery. It was suggested that an annual revision and update session

<sup>3</sup> The evidence base is summarised in: *Diabetes UK (2015). Diabetes education: the big missed opportunity in diabetes care.*

<sup>4</sup> Department of Health (2007). *Working Together for Better Diabetes Care: Clinical Case for Change: Report*

<sup>5</sup> NHS England (2016). *CCG improvement and assessment 2016/17*  
<https://www.england.nhs.uk/commissioning/ccg-auth/>



should take place one year after initial attendance on a course.

**‘I have been on a number of educational courses. I found them universally helpful in explaining my condition and helping me to take control of my diabetes. I recommend these are offered as a matter of course..., as they can help to overcome the initial feeling of shock and helplessness on diagnosis.’**

**Gary Wiles**

Options to supplement diabetes education with online tools or short courses have been developed and could be a very useful way to reach more people. However the experience of a five day course, surrounded by experts and peers, was shown to be an essential and valued aspect of the course, which is a challenge for shorter or online courses.

Education around diet and carbohydrate counting was viewed as one of the more important aspects of diabetes education for Type 2 and Type 1 individuals respectively. The waiting time to attend a structured education course is often still too long. The provision of key diabetes education needs to be delivered earlier either through referral to specialists or a ‘bite size’ course.

**‘Knowledge is power and education is the facilitator to knowledge’**

**Lauren Proctor**

## **What the NHS is doing**

The APPG’s previous report on diabetes education shows the importance of not only providing courses but also having a comprehensive system to help people understand why these courses are worthwhile. The APPG received evidence from one area that has led the way – Berkshire West. They have radically increased the number of people attending structured diabetes education by investing in expanded provision with courses designed to be appealing to people with diabetes while using a strong clinical network to encourage referrals that help people see the value of the course. For example, their CarbAware course is a three hour course to help people with Type 1 diabetes better understand how to adjust their insulin dose. With theoretical and practical exercises they have reached over 700 patients and have produced

impressive results. All patients attending this course reduced their HbA1c within 12 months of attendance and almost everyone now feels confident to count carbohydrates so they can give themselves the correct insulin dose.

Nottingham City CCG has expanded its education provision with a course that is available on weekdays, evenings and weekends. Additionally if patients miss a session they can attend a catch-up one. Nevertheless with 10 hours of contact time spread over four sessions there is time for people to recap learning and make changes to their lifestyle. Early results suggest that everyone that has attended has made at least one lifestyle change and also feel more confident discussing their diabetes with their GP.

## **Emotional and Psychological Support**

The need for psychological and emotional support was a common theme in much of the evidence given to this inquiry. On diagnosis of Type 1 diabetes in particular, there is anxiety and stress associated with the management of a long-term health condition; the administration of insulin and avoiding hypos and hyps. The stigma still associated with Type 2 diabetes, that it is a self-inflicted condition due to poor diet and obesity, has harmed people’s motivation to care for themselves.

Despite the importance of this to people with diabetes we received little evidence about how the NHS can provide better psychological support.

**‘I struggled for over five years with disordered eating, and diabetes has been a massive part of that. I was on anti-depressants for over two and a half years. If I had had counselling and the help of a dietician to begin with, I think that this could have been avoided.’**

**Becca Smith**





**Technology**

## Insulin pumps

### Technology plays a key role in diabetes care, particularly for people with Type 1 diabetes.

Over the last few decades new technologies have transformed the way diabetes is treated and monitored. However, patients face a postcode lottery to get the technology they need. Specifically, this was cited as a major concern for parents of children with diabetes.

## Blood Glucose Meters

People with diabetes can test their blood glucose levels by pricking their fingertip to get a very small blood sample. This is placed on a test strip and read by a blood glucose meter. They can then vary their medication, carbohydrate intake and level of exercise to keep within the right range for blood glucose levels. Measuring blood glucose levels is necessary for safety, for example in the construction industry or people who look after children. For people with diabetes on insulin it is a legal requirement that they test before driving – and the DVLA now advise people who take medication that causes hypos to test before driving as well.

However, the majority of people with Type 2 who gave us evidence said they have to fund their own meter and test strips. Self-funding was a worryingly common theme for people with Type who provided evidence. These individuals have to use 10 strips or more a day as they are at greater risk of their blood glucose levels going dangerously high or low and need to manage their insulin doses more intensively. They were also having the number of test strips restricted.

**‘Technology improvements have provided a toolkit to manage and control blood glucose that put me back in control of my life. I have been able to control my HbA1c levels more effectively. How? By self-monitoring.’**

**Lesley Doherty**

**‘I have had to self-fund my meters and strips, and my continuous sensors, all of which have cost me a lot of money.’**

**Linda Briggs**

Insulin pumps are an alternative to multiple daily insulin injections. They provide regular insulin into the bloodstream through a small, flexible tube and can be adjusted more easily than injections. Insulin pumps allow people to get better control of their diabetes. They cost around £2,000–£2,500 and should last four to eight years. Pump consumables cost about £1,500 per year.

A paper cited in the NICE guidance (TA151) estimates that between 15-20 per cent of adult patients with diabetes meet the qualifying NICE criteria and would benefit from being on insulin pump therapy<sup>6</sup>. However, the UK’s first and most comprehensive audit of insulin pump use shows that just seven per cent of the estimated 247,500 UK people with Type 1 diabetes use a pump<sup>7</sup>.

At evidence sessions the APPG found that sometimes pump uptake depended on whether the technology was funded by local NHS services. At other times, healthcare professionals may not have the training to support people to use the technology effectively and therefore fail to prescribe it for their patients. A further issue is that for patients to use pumps effectively they need to have been on an education course that meets NICE standards. These courses are not available in all areas meaning people are effectively barred from pump use.

### What the NHS is doing

A network set up by the Academic Health Science Network for South London helped to increase the numbers of adults on pumps in South London by 31 per cent. They did this by bringing different trusts together to understand their own pathways and how they could use their time more efficiently and so create the time to help qualifying patients to start on this technology.

A partnership between hospitals in Leicester and a pump manufacturer, Medtronic, has delivered a radical increase in the number of children and young people on pumps. The six session education programme helps patients and families understand how to really benefit from their pump. Amongst children the number reaching their HbA1c target has risen from 18 to 58 per cent.

6 Pickup, J.C., (2006). Point: Are insulin pumps underutilized in Type 1 diabetes? Yes. *Diabetes Care*, 29(6), pp.1449-1452.

7 JDRF, Diabetes UK et.al (2013). *The UK Insulin Pump Audit – service level data*

**‘Ramadan was always such a challenging time which made it difficult to keep to my fast when I was on injections. Starting on the pump course couldn’t have come at a better time! I’ve had the best Ramadan ever and was able to fast and sort out my basal rates keeping my glucose levels stable throughout the day. It’s been great!’**

**Person with diabetes**

## Continuous glucose monitoring

Continuous glucose monitoring (CGM) systems give information about glucose levels every few minutes. NICE recommends them mainly for people with Type 1 diabetes who experience serious problems with hypoglycaemia and/or hyperglycaemia<sup>8</sup>. However, the APPG heard of muddled funding processes that made accessing CGM systems for people who satisfy the criteria especially difficult.

## Flash glucose monitoring

Flash glucose monitoring is a new and very promising technology. At the moment there is only one device available. It works by inserting a small sensor into the upper arm. A reader device tells patients their blood glucose levels instantly and also indicates whether their blood glucose levels are going up or down. People with diabetes can test as many times as they like and without the need for frequent finger pricking. Parents value the device as they can test their children at night without waking them.

The device is currently going through a process that would allow it to be available on the NHS. But at the moment it is costing thousands of people over £120 per month. The danger facing the NHS is that at present a life-changing technology is only available to those who can pay. Inequalities in health outcomes persist because only the well-off are able to access devices that make living with diabetes easier and contribute to improved health outcomes.

<sup>8</sup> NICE (2015). *Type 1 diabetes in adults: diagnosis and management [NG17]*





**Making improvements happen**

## Using data

**The APPG has heard from a wide range of people with diabetes and professionals working in the health service. There are some common themes in areas where there were improvements. Within these, there were some common enablers – often across a number of fronts at once.**

## Quality improvement

West Suffolk CCG undertook detailed work to understand their pathways of care and to identify how the best performing GP practices were successful. Previously diabetes patients were not supported in primary care, but referred to diabetes services at West Suffolk Hospital; patients experienced long wait times for appointments and were unable to optimally control their condition.

Diabetes UK's Service Redesign and Improvement consultancy assisted improvements and took best practice learning to other practices in the area and then worked with them to embed new ways of working. This included the development of the Community Diabetes Nurse service which improved patient access to specialist nurses in the primary care setting. The specialist nurses also helped create bespoke plans for practice improvement and supported practice nurses in their care of diabetes patients.

## Integrated finances

North East Essex retendered its entire diabetes service, apart from inpatient care, so that one provider would be accountable for the entirety of diabetes care. They then incentivised and supported primary care by regularly analysing data to understand performance with tailored support to address problems. They have increased the numbers receiving eight<sup>9</sup> care processes from 40 per cent to nearly 70 per cent in just 18 months. Patients who need to see a specialist can do so through a team of specialists who work in the community.

Despite having a diverse and deprived population, Tower Hamlets has one of the highest proportions of people receiving all three treatment targets. This is partly the result of collaborative working between primary, community and specialist services within an agreed model of care; education and support for healthcare professionals and people with diabetes, and structured care planning to focus on what is important to individuals living with diabetes.

What also stands out is their emphasis on collecting and understanding data. Key performance indicators are reviewed every two months at multidisciplinary meetings of the local diabetes network. Meanwhile, there are flexible shared records across the CCG. This helps patients by making their care more joined up, as all healthcare professionals that they meet with will have a clearer picture of the patients medical history at the start of each appointment.

## Leadership

West Hampshire's evidence emphasised the value of a Trust wide leadership development programme to deliver significant change in a short period of time. As well as the organisational changes needed, the investment in leadership to make them happen is vital. In five years they moved diabetes services into the community, trained senior specialists as leaders and used new ways of communication with patients such as patient conferences and telephone advice.

<sup>9</sup> As recommended by the National Institute for Health and Care Excellence (NICE).



# Recommendations

The APPG for Diabetes has heard evidence that indicated that people with diabetes experience a wide variation in their care and treatment.

The APPG has heard exciting examples of how local areas have worked together across different organisations to improve care standards and outcomes for people living with both Type 1 and Type 2 diabetes. From the evidence submitted to this inquiry, the APPG makes the following recommendations:

## Local health economies

### 1) Care and Support Planning

- a) Local areas need to implement the training and processes for HCPs so that person centred care and support planning that involves the patient becomes routine.
- b) Networking and sharing of expertise between specialists and generalists is needed, so more people are supported by primary care clinicians with greater expertise in managing diabetes and who are able to recognise when timely referral to specialists is needed.
- c) Integrated IT systems that allow for a patients' information to follow them across primary and hospital care are essential to improve communication between HCPs working in different organisations and patients.

### 2) Support for self-management

- a) CCGs need to plan a radical expansion in structured diabetes education meeting NICE criteria and ensure that people with diabetes within a year of diagnosis have attended a structured education course, as suggested in the CCG IAF.
- b) Develop a wider menu of other options for people to have better access to ongoing flexible learning opportunities.
- c) A national standard of diabetes education for children and young people under the age of 18, which, where appropriate, includes training on how to use diabetes technologies such as insulin pumps and CGM.

### 3) Access to key technologies

- a) Funding pathways for technologies need to become much clearer to both people with diabetes and HCPs.
- b) Healthcare professionals need to have access to training so they can support people to use devices successfully.
- c) More staff need to be available in specialist care to support people using new technologies.

### 4) A strong local diabetes system

- a) Local health economies need to have effective local networks that share data, reduce financial barriers between organisations and undertake a regular quality improvement cycle.
- b) Leadership development needs to be supported to drive effective change.

## Health Education England

- 1) Health Education England needs to recognise the growing increase in diabetes prevalence in training curricula. This means ensuring that non-diabetes specialists are able to look after people with diabetes well and ensuring there are enough healthcare professionals trained in the various services that care for people with diabetes: dietitians, podiatrists, pharmacists, optometrists and nurses.



## **NHS England**

- 1) The National Diabetes Programme care and treatment priorities focus on improving treatment targets, increasing uptake of structured education, reducing amputations and improving inpatient care. These initiatives all play a central part in reducing variations in care and need to be maintained.
- 2) NHS England needs to work collaboratively with local health economies to support the effective use of transformation funds to address the recommendations in this report, supporting and monitoring delivery to enable people with Type 1 and Type 2 with diabetes receive consistently high quality care.

## **Department of Health**

- 3) To ensure that the Mandate to NHS England recognises the importance of reducing the variation in diabetes care, by including a specific measurables on reducing variation in the number of people reaching the three treatment targets.

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