DIABETES UK
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Board Assurance Prompt

Oversight of local diabetes care by Health and Wellbeing Boards

What is this guide and who is it for?

This guide is targeted at members of Health and Wellbeing Boards (HWBs) in England. It is intended to support HWBs in ensuring the highest level of diabetes care and prevention in their area. In particular, it aims to help colleagues who have no clinical training understand key healthcare issues.

There are 3.8 million people in the UK, or 1 in 17, living with diabetes. This means that the prevalence of diabetes is nearly four times higher than the prevalence of all cancers combined, and this is increasing. Of these a large proportion, perhaps 650,000 people, are living undiagnosed and many more are unaware that they are at risk of developing diabetes.

The rising incidence of diabetes together with poor diabetes healthcare is fuelling a range of diabetes-related complications that are not only personally devastating but also very expensive to treat.

In June 2014, Diabetes UK reported that over 40 per cent of HWBs were failing to adequately prioritise Type 2 diabetes prevention. HWBs need to be more proactive in using their influence to help halt the continuing rise of diabetes and to address the inadequate state of diabetes healthcare.

What is diabetes?

Diabetes is a long-term condition that occurs as a result of a person having too much glucose in their blood. It is specifically a disorder of metabolism, affecting the body's ability to convert glucose into energy. There are several different types of diabetes but the two most common are Type 1 and Type 2.

- Type 1 diabetes accounts for about 10 per cent of all adults with diabetes and occurs as a result of failure to produce insulin within the body. We don't know exactly what causes Type 1 diabetes but we do know that it is not caused by being overweight. Onset can occur at any time but predominantly occurs at a younger age where the signs and symptoms develop quickly and are usually very obvious.It is the most common form of diabetes found in children.

What are the benefits of improving diabetes prevention and care services?

Diabetes care can be used as a model for other long-term conditions; focussing on diabetes prevention and treatment can create wider benefits, such as:

1. Preventing those at risk of Type 2 diabetes from developing the condition.
2. Enabling people with both Type 1 and Type 2 diabetes to take control of their lives, adopt healthy behaviours and live longer, with less ill health.
3. Reducing financial pressures on the NHS and social care.
4. Reducing unnecessary early disability and death.
5. Reducing the risk of people having multiple long-term conditions to manage.

Key questions for members of HWBs

1. What are we doing to raise awareness with groups of our local population who are at high risk of diabetes about the importance of behavioral change, maintaining a healthy weight and ensuring access to risk assessment/ NHS Health Check?
2. Has improvement of diabetes outcomes been specifically identified by the HWB within the Joint Health and Wellbeing Strategy (JHWS) and included by the CCG within their commissioning plans?
3. Is diabetes care in our area integrated around the needs of people with diabetes? How do we ensure that other local public services support the reduction of morbidity and mortality from diabetes within our area?
4. How are people with diabetes involved in service redesign locally? Do they have a voice?

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- Type 2 diabetes occurs when there is a relative, not total, deficiency of insulin alongside resistance of the body to insulin. It accounts for approximately 90 per cent of all adults with diabetes and is often linked to obesity. Family history, age and ethnicity also affect the chances of developing Type 2 diabetes. It starts gradually, usually later in life and because the symptoms might not be obvious, it may be years before it is diagnosed.

Early diagnosis and prevention of diabetes: finding people at high risk of diabetes

Diabetes UK estimates that 25 per cent of the adult population in the UK – about 11.5 million people are at high risk of Type 2 diabetes. Being high risk means that people have blood glucose concentrations higher than normal, but lower than established thresholds for diabetes itself. Up to one in ten of these people will advance to diabetes each year.

The good news is that people at high risk can take practical steps to reduce the likelihood of them progressing to diabetes. Obesity is the most potent risk factor for Type 2 diabetes and accounts for between 80 and 85 per cent of the overall risk of developing Type 2 diabetes. The Health Survey for England (2010) indicates that 26.1 per cent of adults (classed as those over 16 years of age) are considered obese. Any reduction in obesity rates will reduce the incidence of Type 2 diabetes.

Identification of those at high risk of Type 2 diabetes, and support for lifestyle change to reduce risk, is offered through the NHS Health Check Programme. The NHS Health Check Programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, should be invited (once every five years) to have a check. NHS Health Checks are commissioned by local authorities who also have a responsibility for improving uptake.

Living with diabetes

Diabetes, Type 1 and 2, is a serious and lifelong condition that can have a life-limiting or life-threatening impact on health if not managed well. Successful treatment requires partnership working with people with diabetes and their family to support self-management.

People with diabetes are able to control their health through lifestyle and drug-based therapies. However, as the disease progresses so too does the intensity and sophistication required of the treatment. Failure to control diabetes can have devastating effects; including large and small blood vessel damage leading to heart disease, stroke, sight loss and kidney failure and can damage feet and legs leading in some cases to amputation of feet and lower limbs. Adults with diabetes also have a higher risk of physical disability: older people with diabetes are 50 to 80 per cent more likely to develop a physical disability than those without. As such, diabetes can be incredibly debilitating and effective monitoring and support of those living with, and at high risk of developing, diabetes is key to maintaining good health.

Why is diabetes an important issue for HWBs?

Costs associated with diabetes account for over 10 per cent of NHS spending. 80 per cent of these costs occur as a result of complications, which if properly managed are often preventable.

HWBs are central to the government's vision of a holistic, integrated health service. You plan how best to meet the needs of the local population and also tackle local inequalities in health. Type 2 diabetes is a major indicator of health and class inequality, being more prevalent in low-income families and areas of deprivation, and, should be of concern to HWBs.

The treatment of Type 1 and Type 2 diabetes and prevention of Type 2 diabetes is something which incorporates a wide range of services, including education and social care, and is perhaps best addressed on a HWB where NHS, public health, social care, children's services, elected representatives and local Healthwatch are all brought together.

The prevention and management of Type 2 diabetes presents huge challenges to our health economy as we go forward. Any successful strategy for reducing the incidence of Type 2 diabetes must be centred around increasing public awareness while also ensuring that people have the tools available to make positive change in their lives.

The maturity matrix overleaf is designed to test and guide the development of diabetes care and prevention, and to facilitate the sharing of better practice and innovation. Key elements of diabetes care are highlighted with suggested actions for HWBs to progress from a basic level to exemplar.

For more information and references see Diabetes UK website:https://www.diabetes.org.uk.
Alternatively you can email: policy@diabetes.org.uk

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Good Governance Institute

Local diabetes services and strategy:
A maturity matrix to support better oversight by Health and Wellbeing Boards

NB: Progress levels are additive from left to right. These examples are suggestive.
We recognise that HWBs will be at different stages in their development and will approach diabetes care from a variety of angles.

PROGRESS LEVELS ▶ / KEY ELEMENTS ▼	0 No	1 BASIC LEVEL Principle accepted and commitment to action	2 EARLY PROGRESS Early progress in development	3 RESULTS Initial achievements evident	4 MATURITY Dependable local systems that delivers	5 EXEMPLAR Others learning from our consistent achievements
Awareness raising		Information on the risk factors for Type 2 diabetes and promoting healthy lifestyles is available and NHS Health Checks are being offered to those in the 40-74 age group. The need to reduce obesity in local population has been identified.	Whole population preventative strategies are employed with local authority and CCG working together to raise awareness of Type 2 diabetes and risk factors, notably obesity, and to promote healthy lifestyles. GP can access advice about what individuals can do to reduce their risk of Type 2 diabetes via the electronic patient records system. There is a stated ambition to fully implement NICE guidance PH38 and PH35.	Groups at high risk of diabetes are identified and targeted for awareness raising, risk assessment and intervention. There is a local enhanced service incentivising GPs to risk assess everyone at high risk of Type 2 diabetes, with funding provided for lifestyle change programmes for at risk individuals. Target of offering NHS Health Checks to 20% of eligible population with 66% take-up is achieved.	Systems are in place to identify all those at high risk of Type 2 diabetes. Patients identified to be at high risk are systematically reviewed by primary care and referred to support and interventions. Partnership with local employers in initiatives to screen and risk assess individuals in the workplace with monitoring of implementation and employee uptake. The rate of undiagnosed people with diabetes is reducing.	Local environment and services promote physical exercise and access to healthy food (e.g. leisure facilities that meet cultural needs, improved access to public transport, dedicated cycle lanes and access to green spaces). Take up of NHS Health Checks is over 75% and all those at high risk of Type 2 diabetes offered effective and individualised lifestyle programme to reduce their risk. Involvement of all partners including local business and third sector in measures to improve cardio-metabolic health profile of the adult population.
Strategy and planning		Improvement of diabetes outcomes/reduction of diabetes is a long-term strategic goal but there are no concrete plans.	The Joint Strategic Needs Assessment (JSNA) recognises diabetes as a priority issue for health, wellbeing and social care services within the local area. The Joint Health and Wellbeing Strategy (JHWS) includes diabetes prevention and management including variations in care and outcomes. NICE guidelines on prevention and management of diabetes are referred to in any planning.	There is a locally agreed strategy for reducing obesity and promoting healthy behaviours amongst the local population with clear roles identified across local authority, NHS, business and third sector organisations. There is agreement on the outcome measures and data sources to be used to assess progress on diabetes e.g. public health outcomes framework, the National Diabetes Audit (NDA), Diabetes Watch and Public Health England profiles. Progress with diabetes prevention and outcomes are reported to HWB at least annually.	The HWB promotes and supports strategic thinking and joint commis-sioning involving NHS, social services, education, planning for the development of an environment that promotes and supports healthy eating and increased physical activity. There is regular review to ensure that CCG plans on diabetes are in line with the JHWS and that outcomes for people with diabetes are continually improving as measured by the NDA and other measures.	There are regular opportunities to develop a shared understanding of needs and services in relation to diabetes across health, local authority, community.

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Integrated local services		Awareness that care is fragmented and understanding of where some of the problems are. Ambition to achieve integrated diabetes care and prevention cited in JSNA and JHWS.	Effective communication between primary care, community services and specialist care with clear responsibilities identified. Integrated information systems being developed.	Comprehensive community services available for people with diabetes and those at high risk of diabetes. Collaborative care planning provided for some patients. Clinicians are engaged and lead on integrated diabetes care. Published integrated care pathways for those at high risk of diabetes and those with diabetes, including foot care and emotional and psychological support.	Individual outcome focused care plans in place for people with diabetes and those at high risk of diabetes. People with diabetes can access all the support they need to manage their condition confidently. Integrated finance and information systems enable patients to be seen where they need to be in the system. Integrated clinical governance used to find those at greatest need.	Collaborative care planning provided systematically including automatic referral to specialist services for those who need them. Bulk of funding allocated to primary care and prevention with longer term and more integrated budgets targeting those at high risk of diabetes and people with diabetes. Opportunities are taken regarding regionally / nationally funded improvement initiatives and the area is recognised as an example of best practice.
Voice for people with diabetes		Patient representatives sit on some diabetes groups.	Local diabetes groups are consulted with regards to any changes in regards to diabetes service provision.	People with diabetes are represented and involved in all key decision-making groups working on diabetes. Local diabetes groups are consulted on their experience of services and changes.	There is close engagement with patient representatives in clinical service planning and preventative strategies. There is active involvement of patient groups and expert patient representatives in the review and planning of all services.	People with diabetes are actively involved in co-producing services that meet the needs of the local community. There is transparent reporting of the way people with diabetes' influence has affected service development.

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