DIABETES THINK TANK
Wednesday 9th April 2014

2.30pm – 4.30pm
Meeting Room Q, Portcullis House

Preventing diabetes

Meeting Report

Introduction

There are 2.7 million people diagnosed with diabetes in England, a number that is increasing by about 5% per year (with about 10% of people with diagnosed diabetes having type 1 diabetes).[i] Estimates suggest that more than 500,000 people in England have diabetes but are as yet undiagnosed.[ii]

Diabetes represents a significant cost – both to the NHS and to society in general: diabetes, for example, is estimated to have cost the UK £9.8 billion in direct costs in 2010/2011 – equating to approximately 10% of the total NHS expenditure. [iii]

Given the scale of this cost, there are significant cost savings – and improvements in patient care – to be achieved through strategies to prevent diabetes. On 9 April, the Diabetes Think Tank met to discuss possible ways in which strategies to prevent diabetes could be implemented. A discussion paper was circulated beforehand (containing seven questions set out in the annex), and focussed on three, key challenges, as follows:

1. Health and Wellbeing Boards may suffer from the absence of **accurate, local-level data** about the costs of diabetes to help them assess the appropriate level of investment in preventative services

2. The handing of responsibility for some public health services to local government **may have created a perverse incentive**: it means, for example, that the organisation which is expected to invest in prevention – the local authority – does not benefit financially from this investment

3. There are concerns that the **NHS health checks programme** may be falling short of its full potential due to a lack of clarity over the organisations responsible for the commissioning

The discussion was wide-ranging, and covered topics broader than those in the discussion paper. Specifically, the Think Tank noted at the outset that 'prevention of diabetes' is a broad term, which can be understood to mean both the prevention of the onset of diabetes ('primary' prevention) and the prevention of the complications arising from diabetes ('secondary' and 'tertiary' prevention). Additional points raised outside the scope of the discussion paper included:

- The challenges which are currently being experienced in the structure of the reformed healthcare system, particularly over the challenge of delivering co-ordinated diabetes services

- The loss of focus on diabetes which the organisational changes had created

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- The importance of ensuring stability in NHS organisations; the Think Tank concluded that cross-party consensus over the need for organisational stability would be welcomed.

Summary of recommendations

The following three recommendations were agreed upon:

1. The NHS Diabetes website should be re-established as a matter of urgency – as an accessible, live site – to provide a central repository of information on diabetes – including data on the costs of diabetes at the local level, and the benefits which investment in prevention may bring

2. The Department of Health should consider the inclusion of diabetes-related indicators in the Health Premium Incentive Scheme. However, careful consideration should be given to indicator design in partnership with the diabetes community

3. The provision of NHS Health Check follow-up services, as distinct from the provision of NHS Health Check services by themselves, should be made a mandatory requirement on local authorities and overseen by Public Health England (PHE)

The Chair of the Diabetes Think Tank, Adrian Sanders, will write to Health Minister, Jane Ellison, to request that these recommendations are acted upon.

A number of other policy recommendations were made by attendees – these included:

- To retain the public health ring-fence, in order to focus action on diabetes prevention and obesity management
- To establish a diabetes liaison group – to act as an intermediary between PHE, Clinical Commissioning Groups (CCGs) and local authorities, and to address challenges with fragmentation
- To commit to investing in education for healthcare professionals
- To screen high risk groups for diabetes, including ethnic minorities and obese patients
- To ensure people presenting pre-diabetes have access to services

The Think Tank will reflect and consider these points further in future meetings, as appropriate.

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Theme one: data gaps

Background

As the National Audit Office (NAO) has reported, the Government (and the NHS) do not have a handle on the costs of diabetes at a national level – and this filters down to a paucity of information at the local level. As the NAO has stated:[iv]

"The NHS does not clearly understand the costs of diabetes at a local level, and so lacks clarity about the most effective ways to deliver diabetes services… While the Department expects NHS organisations to deliver services in ways which best meet the needs of their local population, a lack of good-quality cost data means that primary care trusts lack clarity on the cost of their chosen delivery model."

Discussion

The Think Tank discussed ways in which data gaps could be filled. There was consensus that the closure of the NHS Diabetes website represented a major loss to those with an interest in information on diabetes services, including healthcare professionals, commissioners, and provider organisations.

Other key discussion points included:

- The potential of the National Diabetes Audit (NDA), which provides data at a CCG level on the number of complications, including amputations. This information needs to be better publicised and utilised by local commissioners and providers to facilitate investment in service design and in prevention services

- Using NDA data to demonstrate the number, and subsequent cost, of complications associated with diabetes may motivate commissioners and providers to:

  - Consider ways to deliver a more cost-effective service, and achieve year-on-year savings
  - Collect more robust data on diabetes and service costs
  - Ensure diabetes is not subsumed under the banner of long-term conditions alone
  - Establish a long-term focus for how data on diabetes can be best utilised

- The importance of Joint Strategic Needs Assessments (JSNAs) as a tool for driving recognition of and action to address local unmet need in diabetes – both in terms of preventing diabetes in the first instance and also in preventing the complications of diabetes. It was felt that requiring local authorities to assess the diabetes-related needs of their local area (through mandatory guidance on JSNAs) would not be possible in the current environment. However:

  - Think Tank members agreed that Health and Wellbeing Boards should be encouraged to include diabetes in their JSNAs (further thought would need to be given to appropriate mechanisms for this)
  - The Think Tank noted the recently published London Assembly's 'Blood Sugar Rush: Diabetes time bomb in London,' paper which highlighted that only 2 out of 33 boroughs in London made reference to diabetes as a local priority in their JSNAs

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It was resolved that:

- There must be a concerted effort to identify what data are available and to harness the data available in those areas where there have been good examples of savings and service improvements

Consensus was reached that the NHS Diabetes website should be re-established – and re-launched as an accessible live site – and populated with relevant up-to-date information which would help all of those in the NHS with an interest in improving diabetes services

Theme two: perverse incentives

Background

The reforms to the NHS which took effect on 1 April 2013 have resulted in:

- NHS public health services being commissioned by local authorities
- NHS diabetes treatment services being commissioned by CCGs

The discussion paper presented to the Think Tank noted that this division had possible advantages, but also possible drawbacks.

- On the positive side, the original aim of giving a ring-fenced public health budget to local authorities was to ensure that money intended for public health was not 'raided' to prop up hospitals or community services
- On the negative side, the fact that preventative services invested in by local authorities may only have a beneficial impact on NHS budgets for which they have no responsibility, might discourage local authorities from investment which would have a positive budgetary impact on the NHS

The discussion paper also noted the way in which the Government has chosen to minimise the risk of perverse incentives through the 'Health Premium Incentive Scheme (HPIS)'. HPIS is a 'reward' payment designed to encourage local authorities to take action on public health issues – and the first payment will be made in 2015-16.

Discussion

The Think Tank discussed the ways in which the perverse incentive could be addressed noting that:

- To date the work of the Joint Committee on Resources Allocation – which advises the Department of Health on the design of HPIS – has not identified an indicator relating to diabetes in its work

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- CCGs are choosing to invest in services that will save money in the next three years alone, and are prioritising short-term spending decisions over the benefit of long-term investment. This short-termism means that prevention strategies, including investment in diabetes prevention, are less likely to be prioritised

- More could be done to identify the people most at risk of developing diabetes. Members considered the possibility of encouraging GP practices to identify those people most at-risk of developing diabetes – perhaps incentivised to do so through the Quality and Outcomes Framework (QOF)

Whilst noting the challenges of designing a diabetes-specific indicator for HPIS (and, in particular, ensuring that it was underpinned by robust data which incentivised the right behaviours), the Think Tank agreed that the Department of Health should consider the inclusion of diabetes-related indicators in HPIS. However, the Think Tank noted that careful consideration should be given to indicator design in partnership with the diabetes community.

Discussion also took place on the theme of integration: it was noted that bringing organisations together in a more formal way – perhaps through pooled funding or joint control, or through structural changes – might help to address perverse incentives. However, 'change fatigue' was also noted during the discussion.

Theme three: NHS Health Checks

Background

There is much to gain from investing in services, which aim to prevent the onset of diabetes, or diagnose it earlier:

- It is estimated that 24,000 people with diabetes die each year from diabetes-related causes, some of which could be prevented[v]

- Of the 3.2m people in England estimated to have diabetes in 2013, only 2.7 million were diagnosed – a gap of some 500,000 people [vi]

The NHS Health Check is a programme designed to identify those at risk of vascular disease and intervene to prevent it. It has the potential to prevent 4,000 people a year from developing diabetes.[vii]

Discussion

The Think Tank noted a number of challenges, which were facing the NHS Health Check Programme:

- While there is a standard guide on implementing NHS Health Checks, there is no guidance on who should commission them

- There was concern about the way in which the NHS Health Check programme is currently designed to identify those with undiagnosed diabetes (through the 'diabetes filter', which

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examines ethnicity, body mass index and blood pressure). There was discussion that the filter should be redesigned to ask for people to receive blood tests if their blood pressure and BMI are high. It was also suggested that they should include waist measurement, as well as the patient's family history in each health check[1]

- There was concern over the lack of public awareness of the NHS Health Check programme

Above all, a large number of concerns were expressed over the lack of 'follow-up' services for people identified through the NHS Health Check programme at risk of diabetes. It was felt that the patchy availability of follow-up services was caused by a failure to identify an organisation with a clear responsibility for commissioning the follow-up services – with either clinical commissioning groups or local authorities taking the lead in different areas of the country, and some areas of the country missing out on services because no organisation was taking the lead.

As a result, it was resolved that:

- Responsibility for commissioning NHS Health Check follow-up services should be clearly defined to prevent inconsistency

- The organisation responsible for commissioning NHS Health Check follow-up services should be determined nationally

Consensus was reached that the provision of NHS Health Check follow-up services, as distinct from the provision of NHS Health Check services by themselves, should be made a mandatory requirement on local authorities and overseen by Public Health England.

[1] It was noted by a Think Tank member in the process of drafting this report that NICE has issued new recommendations on health checks

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List of attendees

Adrian Sanders MP	Chair *Diabetes Think Tank* and *All-Party Parliamentary Group for Diabetes*
Dr Gary Adams	Associate Professor in Diabetes Health *University of Nottingham School of Health Sciences*
Louise Ansari	Director of Communications *Diabetes UK*
Jessica Braddock	Secretariat *Incisive Health*
Louise Brant	Government Affairs Manager *Sanofi*
Amanda Cheesley	Long Term Condition Advisor *Royal College of Nursing*
Debbie Cook	Vice Chair *National Obesity Forum*
Trudi Deakin	Chief Executive *X-Pert Health*
Professor Roger Gadsby MBE	Associate Clinical Professor *University of Warwick*
Charles Gostling	GP and Clinical Director *South London Health Innovation Network*
Dr David Haslam	Chair *National Obesity Forum*
George Howarth MP	MP for Knowsley
Nikki Joule	Senior Policy Officer *Diabetes UK*
Fiona Kirkland	Consultant Nurse for Diabetes *Staffordshire and Stoke on Trent Partnership NHS Trust*
Debra Lake	Diabetes Specialist Nurse Consultant *Tunbridge Wells and Maidstone NHS Foundation Trust*

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Bill Morgan	Secretariat *Incisive Health*
Sara Nelson	Quality Improvement Lead *London Strategic Clinical Network*
Susan Onslow	Quality Improvement Lead *SEC Strategic Clinical Networks and Senate, NHS England*
Dr Milan Piya	NIHR Clinical Lecturer in Diabetes and Endocrinology University of Warwick and YDEF
Gemma Snell	Senior Project Manager *London Strategic Clinical Network*
Mike Townson	Director *College of Podiatry*
Rt Hon Keith Vaz MP	MP for Leicester East
Lyndi Wiltshire	Head of Diabetes Care *Birmingham and Solihull Mental Health Foundation Trust*

Annex: list of questions posed

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- Discussion question one: what steps should be taken to ensure local services recognise the costs of diabetes, and the potential rewards in investing in prevention? Is there evidence of good practice locally?

- Discussion question two: given the burdens of diabetes and the importance of taking action across the country, should there be a requirement to assess the diabetes-related needs of local population through joint strategic needs assessments?

- Discussion question three: is there potential for local authorities and NHS clinical commissioning groups to operate gainshare agreements to encourage investment in diabetes prevention services?

- Discussion question four: should a diabetes-related indicator be included in HPIS? If so, what should it be?

- Discussion question five: should a clear service specification for NHS Health Checks, against which providers can be held to account, be developed by Public Health England? If so, what should it say? What measures of success should it include?

- Discussion question six: should Public Health England produce best practice guidance on the commissioning of NHS Health Check services to ensure local authorities have the evidence to inform their commissioning decisions? What kinds of commissioning approaches might work best?

- Discussion question seven: is this concern valid? Should a single organisation be responsible for commissioning the lifestyle interventions? If so, should it be the responsibility of local authorities or clinical commissioning groups?

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References

[i] NHS England, *Action for diabetes*, January 2014
[ii] Diabetes UK, *Diabetes: Facts and Stats*, March 2014
[iii] NHS England, *Action for diabetes*, January 2014
[iv] National Audit Office, *The management of adult diabetes services in the NHS*, 23 May 2012
[v] National Audit Office, *The management of adult diabetes services in the NHS*, 23 May 2012
[vi] Diabetes UK, *Diabetes: Facts and Stats*, March 2014
[vii] *Hansard*, 13 March 2014, Col. 349W

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