Leeds Diabetes Strategy

2019 – 2024

Working together to deliver the best outcomes for people at risk of or living with diabetes

Published: September 2019
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How to use this document

This document can be viewed online or can be printed off. There are hyperlinks to other information which appear in blue text and are underlined. A number of terms are explained within the document to help with understanding. If you have any feedback on this document, please contact leedscq.comms@nhs.net
Acknowledgments

We would like to thank all of the people living with diabetes, their carers and colleagues working in Leeds, who have shaped, and will continue to shape our diabetes strategy for the city.

We would also like to show our appreciation to colleagues in the Norfolk and Waveney Sustainability and Transformation Partnership (STP), as the initial structure for our strategy document was inspired by theirs.
Foreword

This strategy aims to describe our response to people of all ages – regardless of background and circumstances and whether they are at risk of or living with diabetes, or caring for someone with diabetes; it describes our intentions over the next five years to improve outcomes.

This strategy also extends to the staff and volunteers who work across the diabetes service in Leeds, including healthcare professionals working in community, primary and secondary care, and our partners in public health. This strategy supports the Leeds Health and Wellbeing Strategy vision that Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

We want to build on what we do well in Leeds, address any gaps that we identify, and focus on both the care we provide as well as improve the support to people to self-manage, using our existing resources better.

The strategy is a living piece of work; the Diabetes Strategy Summary will be reviewed each year and we will only be able to deliver what we are describing with the continued support and involvement of people living with diabetes, their carers and our colleagues across the health and social care system in Leeds.

What we hope to achieve is ambitious, both in the scale of change proposed and in the intended outcomes for people and their families in Leeds. We know that implementing our strategy will take time and require a great deal of work and investment.

We want people to notice and feel that our diabetes service across the city is different and better, which is why we depend on the support from people living with diabetes and colleagues working across our diabetes service to continue to inform how and what we do over the next five years. By working together, we hope to share expertise to better support people living with diabetes and for those working within diabetes services in Leeds.

The use of digital technology as part of supporting people to manage diabetes is increasingly important and has a key role in achieving ambitions outlined in this strategy.

Co-production has been at the heart of this work. Our aim has been to create an ambition for people and carers, focusing on the whole person, not just their condition. We recognise that people with diabetes live with their condition all day, every day and face many things in everyday life that impact on their health and wellbeing (physical, emotional and mental) as well as their diabetes care.

We would like to thank everyone who has contributed to our first diabetes strategy for Leeds. Developing the strategy has involved people living with diabetes and their carers, our partners in public health at Leeds City Council, voluntary sector organisations supporting people at risk of developing or living with diabetes, commissioners, and the many dedicated staff who work across our diabetes service in Leeds.

We know that the path ahead isn’t easy, but it’s the right thing to do. Therefore we ask that you support this strategy and continue to work together in making every effort to deliver exceptional care for people affected by diabetes.
Bryan Power, Clinical Lead for Long Term Conditions, NHS Leeds Clinical Commissioning Group (CCG)

Lucy Jackson, Consultant in Public Health, Leeds City Council

Elaine Goodwin, Clinical Lead, Leeds Community Healthcare NHS Trust

Mike Mansfield, Consultant Diabetologist, Leeds Teaching Hospitals NHS Trust
Executive summary
This strategy sets out our ambition over the next five years for diabetes prevention and care. It includes the priorities we have identified for 2019-2024, accepting that we will need to review these each year to check that they are still reflective of the needs of people in Leeds.

We have involved people to understand what is important to them in order to describe what we intend to achieve. Crucially, this has involved people living with or caring for someone with diabetes to ensure that what we do is in response to their needs.

We are aiming to change the way in which we interact with people at all levels and we know that how we are and how we speak with each other is linked to people’s outcomes. The NHS England document, Language Matters: language and diabetes stresses the importance of the words people use. Our approach in Leeds will reflect this and our hope is that what people notice and feel is different and better.

Our work over the next five years will be to address gaps in current provision, which we know involves improved access to services for mental health as well as physical health. We want to become more efficient in our care and develop flexible ways of working with people and their carers to enable the right resource to be available when people need it.

Whilst we have produced this detailed strategy document, a summary of our strategy can be found on Leeds CCG website. We would encourage you to read, share and own it.
## Acronyms and abbreviations used within this document

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AF</td>
<td>Atrial Fibrillation</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>CCSP</td>
<td>Collaborative Care and Support Planning</td>
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<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<tr>
<td>CVD</td>
<td>Cardiovascular Disease</td>
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<tr>
<td>CYP</td>
<td>Children and Young People</td>
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<tr>
<td>DAFNE</td>
<td>Dose Adjustment for Normal Eating</td>
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<td>GDM</td>
<td>Gestational Diabetes Mellitus</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>IAF</td>
<td>Improvement and Assessment Framework</td>
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<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<tr>
<td>ICS</td>
<td>Integrated Care Systems</td>
</tr>
<tr>
<td>LCC</td>
<td>Leeds City Council</td>
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<tr>
<td>LCH</td>
<td>Leeds Community Healthcare NHS Trust</td>
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<tr>
<td>LTHT</td>
<td>Leeds Teaching Hospitals NHS Trust</td>
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<tr>
<td>MECC</td>
<td>Making Every Contact Count</td>
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<tr>
<td>MDT</td>
<td>Multi-Disciplinary Team</td>
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<tr>
<td>MSOA</td>
<td>Middle Layer Super Output Area</td>
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<tr>
<td>MUS</td>
<td>Medically Unexplained Symptoms</td>
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<tr>
<td>NaDIA</td>
<td>National Diabetes Inpatient Audit</td>
</tr>
<tr>
<td>NDTAQIC</td>
<td>National Diabetes Transition Audit Quality Improvement Collaborative</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<td>NHS DPP</td>
<td>NHS Diabetes Prevention Programme</td>
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<tr>
<td>Acronym</td>
<td>Full Name</td>
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<tr>
<td>NHSE</td>
<td>NHS England</td>
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<td>NICE</td>
<td>National Institute of Clinical Excellence</td>
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<tr>
<td>NTC</td>
<td>National Treatment and Care Programme</td>
</tr>
<tr>
<td>PCN</td>
<td>Primary Care Network</td>
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<tr>
<td>PCQIS</td>
<td>Primary Care Quality Improvement Scheme</td>
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<tr>
<td>PHE</td>
<td>Public Health England</td>
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<tr>
<td>PYLL</td>
<td>Potential Years of Life Lost</td>
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<tr>
<td>QOF</td>
<td>Quality and Outcomes Framework</td>
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<tr>
<td>SPA</td>
<td>Single Point of Access</td>
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<tr>
<td>STP</td>
<td>Sustainability and Transformation Partnership</td>
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<tr>
<td>UCL</td>
<td>University College London</td>
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<tr>
<td>VAL</td>
<td>Voluntary Action Leeds</td>
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<tr>
<td>VLCD</td>
<td>Very Low Calorie Diet</td>
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Context setting

What is diabetes?

Diabetes is a lifelong condition that causes a person’s blood sugar (glucose) level to become too high. Although high blood glucose levels are considered the main abnormality in diabetes, the condition is more complex than just abnormal blood glucose metabolism alone, and treatment of diabetes needs to consider multiple clinical factors. People who live with diabetes must learn to self-manage their condition for the rest of their life.

Diabetes can be broadly classified into four groups or types:

1. **Type 1 diabetes** - where the body’s immune system attacks and destroys the cells that produce insulin. Although it can occur at any age, type 1 diabetes is the most common type of diabetes affecting children and young adults. We don’t know what triggers type 1 diabetes but some people may be genetically predisposed, and environmental factors, such as viral infections, may play a role. Type 1 diabetes is not caused by lifestyle factors and is neither preventable nor reversible with lifestyle interventions. Type 1 diabetes must be treated with insulin therapy, which is given by injection.

2. **Type 2 diabetes** - where the body doesn’t produce enough insulin, or the body’s cells don’t react to insulin (insulin resistance). A number of factors increase an individual’s risk of developing type 2 diabetes, including age (the risk of developing type 2 diabetes gets higher as we get older), genetic factors (ethnicity and family history), being overweight or obese, sedentary lifestyle and low levels of physical activity, as well as high blood pressure. Type 2 diabetes can be treated in different ways, including lifestyle interventions, diet and exercise, oral medications and injectable therapies, including insulin.

3. **Gestational Diabetes Mellitus (GDM)** – during pregnancy, some women have such high levels of sugar in their blood that their body is unable to produce enough insulin to absorb it all.

4. **Specific types due to other causes** – such as diabetes secondary to pancreatic disease (pancreatitis, pancreatic malignancy and cystic fibrosis), diabetes due to specific gene defects (Monogenic diabetes e.g. MODY, lipodystrophy), Latent Autoimmune Diabetes in Adults (LADA) and drug-induced diabetes.

5. **At high risk (pre-diabetes)**

We define those people at high risk of developing type 2 diabetes as those who have either:

- Had a blood test which shows that their blood HbA1c as equal or greater than 42mmol/mol or greater than 42, but less than 48 mmol/mol
- Or they have used a screening tool such as Qdiabetes and have a score greater than 5.6
- Or the Diabetes UK ‘Know your risk’ tool has been completed with a score greater than 16.
- Women with a history of Gestational Diabetes Mellitus (require annual HbA1c)
UK statistics – diabetes

Diabetes UK, in its publication ‘Us, Diabetes and a lot of facts & stats’ (2018) reports that:

- It is estimated that in the UK, 4.7 million people in the UK have diabetes (one in 15 people).
- By 2025, it is estimated that more than 5 million people will have diabetes in the UK.
- It is estimated that 12.3 million people are at risk of type 2 diabetes in the UK.
- About 90% of people with diabetes have type 2.
- About 8% of people with diabetes have type 1.
- About 2% of people with diabetes have rarer types of diabetes.

Leeds geography and diabetes statistics

NHS Leeds Clinical Commissioning Group (CCG) has 97 member GP practices (as at 1 April 2019) working within 19 primary care networks (PCNs) in Leeds. A primary care network consists of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. Networks are based on populations of 30,000 to 50,000.

The number of people registered with a GP in Leeds totals 885,629 (January 2019). Leeds has a diverse population. Over 170,000 people live in areas ranked amongst the most deprived 10 per cent nationally. One in five children in Leeds live in poverty. People living in deprived neighbourhoods are more likely to experience multiple disadvantage, die earlier, and have more years in long-term ill health (Leeds Joint Strategic Assessment; 2018).

The key challenges facing us in Leeds are to tackle health inequalities and unwarranted variations in quality of care and a growing elderly population with more long term conditions, for example diabetes, high blood pressure and chronic obstructive pulmonary disease (COPD).

Further information relating to our local Leeds geography, social determinants of health and risk factors relating to diabetes can be found in Appendix 1.

Prevalence is a term used to describe the proportion (or ratio) of people expected to be affected by a medical condition, compared to the total population. We know that in Leeds just over 44,000 people (all ages) are registered with diabetes (GP Data Extraction – October 2018). There are also just over 35,500 people (aged 16 years and over) in Leeds known to be at high risk of developing type 2 diabetes. Figure 1 below, displays the percentage of the population with a high risk of diabetes by geography, technically known as Middle Layer Super Output Area (MSOA), as at October 2018 in Leeds.
Whilst the prevalence of diabetes is closely linked to deprivation, HbA1c prevalence shows a different picture as areas in the outer north west, outer north east and outer east areas of Leeds represent the highest proportion of high risk individuals whilst the Inner and more deprived areas of the city have the lowest. This may reflect the way that patients engage with their practices and the more active uptake of health prevention strategies e.g. NHS Health Checks in affluent areas.

**Comorbidity**

Comorbidity is the co-existence of other conditions in addition to the primary condition (in this case, diabetes). The presence of two or more long-term conditions is often referred to as multi-morbidity. The table below (Figure 2) demonstrates comorbidity within Leeds in 2018.
In people with diabetes, the most common associated comorbidities are:

- Cardiovascular disease (CVD) – particularly hypertension (high blood pressure) - 16,866 patients have hypertension in addition to diabetes in Leeds whilst 9,705 have coronary heart disease (angina and heart attacks) in addition to their diabetes.
- 7,178 people with diabetes have arthritis recorded as a comorbidity.
- 5,931 people with diabetes have depression recorded as a comorbidity.

Many of these comorbid conditions are likely to have a greater impact on overall health and wellbeing than diabetes alone. It is important therefore that as well as focusing on the management of diabetes and blood glucose control, clinicians and service providers adopt a person-centred, holistic approach to diabetes care that attempts to identify all of the factors that impact on health and wellbeing, prioritising the management or support for these in order to improve overall health and wellbeing.

A number of projects are currently being focused on by NHS Leeds CCG working with the West Yorkshire and Harrogate Health and Care Partnership to support the management of linked comorbidities. These are summarised towards the end of this strategy document.
Current diabetes service provision

Figure 3 below illustrates the location of existing service provision for people at high risk of developing diabetes or who are living with diabetes in Leeds compared to the latest figures on diabetes prevalence, as at April 2018. The map illustrates that locations are predominately sited in areas where there is greatest prevalence of diabetes.

![Map of Leeds with diabetes service provision](image)

In summary the current programmes and providers delivering diabetes services in Leeds are:

**Primary care in Leeds**

GP practices in Leeds are central to the screening, identification and management of patients with diabetes. Practices provide care for patients with all types of Diabetes.

The majority of care for patients with type 2 diabetes is delivered by GPs and practice nurses in routine clinic settings focusing on patient support, good diabetes control and prevention of complications.

Practices also screen for patients at high risk of diabetes. Additional detail documenting primary care provision is included within [Appendix 2](#).
Healthier You: National Diabetes Prevention Programme (NHS DPP)

People who are identified as at high risk of developing type 2 diabetes (as defined earlier in this document) are offered a referral to the Healthier You: NHS Diabetes Prevention Programme (NHS DPP), which is an intensive lifestyle behaviour change programme.

There is strong international evidence which demonstrates that up to 26% of people at high risk can be prevented from developing type 2 diabetes by attending intensive behaviour change programmes (PHE, 2015*) which support people to maintain a healthy weight and be more active.

Reed Wellbeing has been secured to deliver NDPP services across West Yorkshire and Harrogate, including Leeds from July 2019. The programme is made up of 13 sessions lasting 90 minutes each over a period of 9 months. Sessions are held for groups of up to 20 active participants and there is a digital offer to be introduced where suitable. The programme is delivered from multiple community locations across Leeds.

Leeds Teaching Hospitals (LTHT)

Leeds Teaching Hospitals (LTHT) provides care for patients with type 1 diabetes and complicated / poorly controlled diabetes via an inpatient diabetes team and outpatient clinics at St James’s and Wharfedale General Hospital. The type 1 diabetes service offers structured education (type 1), insulin pump provision and care for pregnant women with diabetes and those planning pregnancy. The service also manages patients whose risk factors for complications have not responded to management in primary care and patients with recurrent hypoglycaemia. LTHT also delivers an outpatient specialist service/clinic known as the Diabetes Limb Salvage Service for diabetes patients with foot ulcers and diabetic related foot problems.

Leeds Community Healthcare (LCH)

Leeds Community Healthcare (LCH) manages poorly controlled type 2 diabetes patients in the community. LCH also offers structured education known as ‘The LEEDS Programme’ (Learning, Empowering, Enabling Diabetes Self-Management) to anyone who has been newly diagnosed with type 2 diabetes or has had a diagnosis in the past 12 months and is registered with a Leeds GP. LCH also provides a Multi-Disciplinary Foot team working in close collaboration with the LTHT Diabetes Limb Salvage Service. Clinics are delivered across Leeds as illustrated in Figure 3.

The Diabetic Eye Screening Service

The Diabetes Eye Screening Programme is delivered by The Mid Yorkshire Hospitals NHS Trust from a number of community venues across Leeds. Diabetes eye screening is a test to check for eye problems caused by diabetes known as diabetic retinopathy. Diabetic retinopathy can lead to sight loss if not found early. People aged 12 or over with diabetes are invited for diabetic eye screening at least once a year.
Drivers for change and work started to date in Leeds

The need for focused work on diabetes pathways and the formation of this strategy has arisen as a result of a number of drivers including the NHS Long Term Plan, current CCG performance, the need to ensure that local diabetes services are accessible for hard to reach groups and communities and feedback from engagement exercises.

The NHS Long Term Plan

The NHS Long Term Plan was published in January 2019, and identifies the following key priorities for diabetes:

- **Prevention is key.** One of the commitments made is to double the scale of the NHS Diabetes Prevention Programme currently offered.

- **Access to diabetes professionals is crucial for optimum treatment and care.** Within the NHS Long Term Plan, there is a commitment to ensure that all hospital providers have access to expanded multi-disciplinary foot care teams and diabetes inpatient specialist nursing teams (teams which we have established in Leeds, thanks to NHS England Treatment and Care Funding received).

- **Self-management has a key role in ‘upstream prevention’.** The NHS Long Term Plan is investing over £2 million to implement and evaluate digital delivery models for self-management education for people living with type 2 diabetes so that we can further boost uptake of services.

- **Very low calorie liquid (VLCD) diets may be a potential treatment option for type 2 diabetes.** Medical research has shown that some people with type 2 diabetes can achieve remission through adoption of low calorie diets. The DiRECT and DROPLET trials have recently published promising results and the potential to allow some people to stop taking anti-diabetic drugs and still achieve non-diabetic range glucose levels. Plans to test an NHS programme supporting low calorie diets for obese people with type 2 diabetes are outlined in the NHS Long Term Plan. Within Leeds we have been ahead of this development and are already testing a very low calorie liquid diet, with evaluation underway.

- **Diabetes prevention, treatment and care is going digital.** The Long Term Plan outlines strategies to provide a new digital route of access within the NHS Diabetes Prevention Programme to widen patient choice in particular for working age populations, expanding access to Healthy Living for people with type 2 diabetes (Healthy Living); an online self-management tool for those with type 2 diabetes which NHS England has licensed, and crucially providing patients with type 1 diabetes who meet clinical guidelines access to life changing flash glucose monitors, ending the variation in some parts of England.

- In addition, by 2020-21, all pregnant women with type 1 diabetes will be offered continuous glucose monitoring, helping to improve neonatal outcomes.
CCG performance

Introduced in March 2016, the CCG Improvement and Assessment Framework (CCG IAF) provides information to healthcare organisations, professionals and people living with diabetes about how their local services are performing. It is used by NHS England to monitor and support improvement for diabetes and includes the following measures which are reported at CCG level. Figure 4 below summarises CCG 2017-18 IAF assessment ratings (latest figures available at publication of this document).

Figure 4: CCG IAF Performance

<table>
<thead>
<tr>
<th>Rating Requirement</th>
<th>NHS Leeds South and East</th>
<th>NHS Leeds West</th>
<th>NHS Leeds North</th>
<th>National Median / Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement of NICE treatment targets (Hba1C, Cholesterol and Blood Pressure)</td>
<td>Inadequate: 34.5% of diabetes patients achieved all the NICE recommended treatment targets</td>
<td>Inadequate: 36.6% of diabetes patients achieved all the NICE recommended treatment targets</td>
<td>Inadequate: 34.5% of diabetes patients achieved all the NICE recommended treatment targets</td>
<td>40% (national median)</td>
</tr>
<tr>
<td>Structured education attendance</td>
<td>Inadequate: 1.4% of people with diabetes diagnosed less than a year attend a structured education course</td>
<td>Inadequate: 1.0% of people with diabetes diagnosed less than a year attend a structured education course</td>
<td>Inadequate: 0.8% of people with diabetes diagnosed less than a year attend a structured education course</td>
<td>7.3% (national average)</td>
</tr>
</tbody>
</table>

Please note that Figure 4, includes the performance of the three former Leeds CCGs – NHS Leeds South and East, NHS Leeds West and NHS Leeds North, which merged in April 2018 to form one organisation, NHS Leeds CCG. There is evidence to suggest that low attendance figures for structured education are not due to lack of capacity in structured education provision. Areas for improvement are in generating referrals and improving uptake of those who have been referred, or in improving recording of attendance.

The education gap assumes accurate reporting of attendance within primary care; however we know this is not the case. We do not know to what degree attendance is under reported. This may be clearer once the National Diabetes Audit Data, which includes structured education provider data, is published later in 2019.
A number of initiatives have been implemented to support improvement of our inadequate rating:

- Achievement of NICE treatment targets – The Leeds Primary Care Quality Improvement Scheme (PCQIS) 2018-21 is a three-year scheme providing additional financial resource into primary care as the foundation stone of the NHS to support practice resilience, service transformation and improving outcomes for patients. Within the scheme, reference to diabetes describes:

  1) Identifying those at high risk of diabetes, including those with gestational diabetes and supporting them with an effective and appropriate intensive lifestyle-change programme to prevent or delay the onset of type 2 diabetes and

  2) Better management of those at high risk or living with diabetes in terms of increasing the number of people participating in the NHS Diabetes Prevention Programme (NHS DPP) and other lifestyle activities and increasing the number of people treated to target in line with the revised 2019/20 National Diabetes Audit.

- NHS Leeds CCG continues to support GP practices in 2019-20 on improving the quality of diabetes assessment and utilisation of appropriate treatments.

- Working with its member practices, there is a joint commitment to maintain a focus on diabetes care and long term conditions. Live data on the achievement of treatment targets is now available through an NHS Leeds CCG funded tool (RAIDR), to enable practices to track performance dynamically.

- Monitoring of current performance - system wide performance on diabetes is monitored by the Leeds Diabetes Stakeholder and Steering Groups. The dashboard captures data from a number of sources, including:

  o The National Diabetes Audit National Diabetes Foot Care Audit, 2014-2018
  o The National Diabetes Inpatient Audit (NaDIA) – 2018
  o The National Diabetes Inpatient Audit - Harms, 2018
  o The Patient Experience of Diabetes Services
  o The Paediatric Diabetes Audit
  o The National Pregnancy in diabetes Annual report 2016 (the fifth annual report will be released on 10 October 2019 for pregnancies from January 2017 – December 2018.

- Collaborative Care and support planning (CCSP) for people with long term conditions has been rolled out across NHS Leeds CCG during 2018-19, with this continuing to be adopted and encouraged in 2019-20. The collaborative care and support planning approach allows time for diabetic assessment, an opportunity for patients to receive and reflect on their results and to return to their GP practice to have an informed conversation with a medical practitioner about their goals to support their disease management. This has been implemented for patients with diabetes and those at high risk of diabetes alongside other long term conditions. The benefits of CCSP
should be evidenced and reflected in future CCG assessments concerning the achievement of treatment targets.

- NHS Leeds CCG is working with all providers to improve completion and coding of care processes to ensure more effective use of clinical and patient time to avoid duplication.

- NHS Leeds CCG recognises that appropriate staffing skill sets are essential to ensure that patients receive correct assessment and access treatment pathways appropriate to their needs. Within the CCG, time has been taken to reflect on skill sets for primary care practitioners, with work being undertaken to ensure that clinical staff are skilled and confident to engage with people and that treatment pathways are clear with people being directed appropriately. One such example is the delivery of 15 primary care diabetic foot assessment training sessions designed to educate primary care staff, care homes, neighbourhood teams and independent podiatrists to support the achievement of NHS Treatment Targets in the future. A minimum of six training sessions are scheduled for 2019-20, alongside an accompanying film which serves as a refresh not a replacement to attending the LEEDS FEET! training. We have also produced a short film for people living with or caring for someone with diabetes on how to look after their feet.

- Within Leeds, the Leeds Care Record (aka PPM+) is used to share information across all healthcare providers in Leeds. Work specifically relating to diabetes information in the form of an electronic patient record (information on clinical systems) is underway to understand what information is currently available, which staff currently have access to it, identifying what may be missing and how we might address these gaps with a strategic solution.

- Structured education investment from the NHS England Treatment and Care programme has enabled more work with primary care and people living with type 2 diabetes to understand that attending the LEEDS Programme is a crucial part of treatment for people with the condition, especially those who are recently diagnosed.

  We now deliver 125 sessions each year (34 previously) in Leeds. Leeds Community Healthcare NHS Trust as the provider for this service in Leeds now offer evening and weekend sessions in various venues across the city, and have the option to complete the programme in one day, providing the flexibility people need to access it. Between January 2018 and March 2019, the service received 1,902 referrals, with an average of 76% of people completing the programme. In addition, 100% of all people completing the LEEDS programme reported that they felt more confident in managing their diabetes.

  We have also extended our reach, in that 48% of participants are from the most deprived areas of Leeds, 51% are from Black and Minority Ethnic groups and 49% are men over the age of 40; all of which were all targeted groups as part of NHSE funding.

  We have established an annual follow up with people who have completed the LEEDS Programme which will take place 12 months after completing the programme.
to understand if people have improved their HbA1c. In 2019-2020 we are aiming for 1750 referrals, with at least 1,350 people attending the LEEDS programme and an improvement in the numbers of people completing the course.

- In relation to structured education for adults living with type 1 diabetes, the DAFNE (Dose Adjustment For Normal Eating) course is commissioned by NHS Leeds CCG and delivered by LTHT. Work to further understand demand and capacity of this provision is underway.

- NHS Leeds CCG is also committed to the Diabetes UK “taking control pledge,” with the aim that by 2023, over half of people with diabetes will attend an education course within one year of diagnosis. The commitment also extends to offer more people, who are already living with diabetes, the opportunity to attend an education programme.

**Hard to reach groups and specific communities – addressing access and health inequalities**

The following sections describe some of the groups of people and communities who find it harder to engage with NHS services or not at all. Leeds is socially and culturally diverse and this has important implications for this strategy. This requires diabetes services to adapt and think differently about how they engage with these groups in order to support self-management and equity of access.

Social challenges have significant impacts on resilience, attachment, agency, risk taking behaviour, readiness to learn, social behaviour, attainment, physical health, mental health, social and community cohesion, substance misuse, youth offending, unhealthy eating, employment and ability to move on to higher education. The impact of these wider social challenges require integration of novel approaches to addressing barriers to access in prevention and support services.

To prevent diabetes and improve diabetes management, it is important to ensure that the communities have access to, and can benefit from, diabetes support, education and services. Many people may experience cultural and language barriers, as well as geographic and socio-economic barriers, that limit access. Thus culturally competent mainstream services or additional support for vulnerable individuals, who find it hard to access mainstream services, should be an integral part of any diabetes service.

Those living with frailty, the elderly or those with dementia may also struggle to self-manage. Those with severe and enduring mental health may require outreach. Each barrier warrants particular attention and may require different approaches.

Addressing these issues and identifying barriers within a disease-specific vulnerable subgroup is key to disease prevention, support, management and access. A key priority for Leeds providers is to work with hard to reach, specific communities and marginalised groups to ensure that services are accessible, appropriate and continuously strive to improve delivery.

**Marginalised groups**

Marginalised groups tend to experience greater inequalities than the general population; thus it is particularly important for the healthcare system to have strategies to support them.
Sometimes defined as ‘hard to reach’, but are mainly accessible, these groups are underserved, service resistant or seen as just slipping through the net. Within Leeds, specific examples of marginalised groups include sex workers, asylum seekers/refugees/those with no recourse to public funds (migrants), ex-offenders, Gypsy and Traveller communities and the homeless. This list is ever changing, and consideration needs to be given to specific subgroups of the population who have poorer outcomes. Redesign of services needs to focus on inclusive practice and equity of access for all patients.

Examples of how we are adapting diabetes services in Leeds are provided below.

**People with common mental health disorders, including depression**
Physical and mental health is interdependent and the case for seeking to support physical and mental health in a more integrated way is compelling. The Kings Fund (2016) has set out four related challenges. These are:

- High rates of mental health conditions among people with long-term conditions (LTC) (which includes diabetes)
- Poor management of ‘medically unexplained symptoms’ (MUS)
- Reduced life expectancy among people with serious mental illness, largely related to poor physical health
- Limited support for the wider psychological aspects of physical health and illness.

NICE estimate that around 40% of people with depression and anxiety disorders also have a long term condition. Around 30% of people with an LTC and 70% with MUS also have mental health comorbidities. Currently, mental and physical health care services provided around the country and in Leeds are separate services that are rarely coordinated. This is inconvenient for the person and costly to the NHS. The Five Year Forward View for Mental Health (2016) requires NHS Leeds CCG to increase access to psychological therapies (IAPT) by 2020-21; two-thirds of this expansion will be for patients with long-term conditions.

Expansion of psychological therapies in Leeds will focus on increased integration to improve service user experiences and outcomes. Psychological provision will comply with all IAPT standards, including the key national access and recovery targets. A procurement for a new IAPT provider in Leeds has just concluded (Summer 2019), with mobilisation underway. Work is underway to design pathways between IAPT and diabetes services, and explore the opportunity for co-location of services. The implementation of our diabetes strategy will be responsive to this opportunity to support the psychological wellbeing of people living in Leeds with diabetes.

**People at risk of cognitive impairment or dementia**
Due to the increasing ageing population, the prevalence of diabetes is predicted to rise, particularly among people over the age of 75. Research shows that older people with diabetes are more likely to develop cognitive impairment or dementia, compared to people without diabetes. Hypoglycaemia has been linked to an increased probability of developing dementia and, not surprisingly, poor quality of life.

A key priority in Leeds, therefore, is to work to prevent hypoglycaemic episodes through careful monitoring of risk factors that predispose individuals to hypoglycaemia, while also selecting therapies that can minimise the incidence of hypoglycaemic episodes. In 2018-19
the local GP prescribing incentive scheme identified patients on oral glucose lowering therapies who may have been at risk of hypoglycaemia, and set targets for review. In addition, focused local efforts on hypoglycaemic episodes are supported via the 2019-20 Quality and Outcomes Framework (QOF) for primary care, which has less stringent treatment targets for older people with moderate or severe frailty, aimed at guarding against unnecessary overtreatment of blood glucose, blood pressure or lipids. Setting individualised glycaemic goals and choosing the most appropriate medications is crucial in reducing the risk of hypoglycaemia.

People with learning disabilities
The prevalence rates of both type 1 and type 2 diabetes nationally have been identified to be higher in people with a learning disability compared to the general population. Higher rates of obesity are also seen in people with a learning disability compared to those without as cited in NHS England News November 2017. To reduce these risks, the NHS Rightcare pathway for diabetes advocates a greater understanding of needs of people with a learning disability and recommends adapting existing lifestyle programmes.

In May 2019, our LEEDS Programme piloted a version of the programme for people with learning disabilities, with input from Leeds University. This will be reviewed later in 2019-20.

Other examples of how in Leeds we are looking to continue to support people with learning disabilities include:

- University of Leeds REMAIN diabetes and learning disability project (2017-18) produced a series of resources developed and trialled supported self-management for people with mild to moderate learning disability and type 2 diabetes. They have developed resources for commissioners and professionals to aid reasonable adjustments to diabetes services.

- The Ok Diabetes! study in partnership with the University of Leeds research team, aims to provide important information on the nature of type 2 diabetes in adults with learning disability living in the community, on the challenges of identifying those with milder learning disability, and on the possibilities of evaluating a standardised intervention to improve self-management. This includes work to increase the positive impact of annual health checks, looking at lifestyle interventions and diabetes.

- Easy read versions of diabetic foot leaflets have been produced for Leeds patients.

Children and young people
In Leeds, all children and young people (CYP) living with type 1 diabetes and their families have access to the best possible care and are involved in decisions that affect them. Leeds Children’s Hospital Paediatric Diabetes Service is fully compliant with the specification standards laid out in the Best Practice Tariff NHSE Pricing Handbook (Annex F, 2016) and is delivered by a multidisciplinary team (MDT), which includes access to psychological support. The paediatric MDT supports families and key settings where children spend significant periods of time, such as schools and children’s centres. This enables the systems around the child to effectively contribute to the children’s ability to be safe, to live life to the full and have fun growing up. Figure 5 below describes the NICE Quality Standard for Diabetes in Children and Young People.
Figure 5: NICE Quality Standards for children and young people

NICE Quality Standard for Diabetes in Children and Young People (QS125) requires:

1. Children and young people presenting in primary care with suspected diabetes are referred to and seen by a multidisciplinary paediatric diabetes team on the same day.

2. Children and young people with type 1 or type 2 diabetes are offered a programme of diabetes education from diagnosis that is updated at least annually.

3. Children and young people with type 1 diabetes are offered intensive insulin therapy and level 3 carbohydrate-counting education at diagnosis.

4. Children and young people with type 1 diabetes who have frequent severe hypoglycaemia are offered ongoing real-time continuous glucose monitoring with alarms.

5. Children and young people with type 1 diabetes are offered blood ketone testing strips and a blood ketone meter.

6. Children and young people with type 1 or type 2 diabetes are offered access to mental health professionals with an understanding of diabetes.

In Leeds, we will adopt and optimise the use of digital technology to support self-care, telemedicine and education in the CYP pathway.

We recognise that most children and young people have type 1 diabetes but a small and growing number have type 2. For these people, key recommendations align with the Leeds childhood obesity strategy described in the next section.

Obesity among children and young people

Being overweight as a child can significantly increase your risk of developing serious conditions like type 2 diabetes in the future and therefore action to reduce child obesity are key to tackling the growing incidence of type 2 diabetes.

Leeds Child Healthy Weight Partnership was established by Public Health in 2005 and has provided clear systems leadership informing the development of the Leeds Child Obesity Strategy (2006 -16) and more recently the Leeds Child Healthy Weight Plan (2017 – 2022). The partnership is responsible for delivering the plan and provides the link to many other plans, programmes and services e.g. sustainable travel, planning and design, healthy school programme, healthy child programme, physical activity and active lifestyles work, and the adult-focused integrated healthy lifestyles services enabling a whole systems approach to the prevention of childhood obesity.

A Leeds Maternal Healthy Weight Steering Group was also established in 2017 to design and deliver actions aimed at reducing obesity in pregnancy.

Given how difficult it is to lose weight and sustain weight loss, the focus has been on prevention and supporting families to make a healthy start in the early years.
Key actions include:

- The HENRY programme (Health Exercise and Nutrition in the Really Young) which is available as a group and 1 to 1 programme for families with children under 5. Over 1400 staff, predominately from the Early Start Teams, have participated in HENRY training and are therefore more confident and skilled in working with families on the sensitive issue of weight and healthy lifestyles using a collaborative approach.

- The Leeds Healthy Schools Service works to enable schools to achieve the Leeds Healthy School Standard, which includes taking action to prevent child obesity, including developing a whole school food policy, and improving the quality and take up of school meals.

- The Watch It service provides a weight management programme for children aged 5 - 19 wishing to become a healthier weight.

- The Leeds Best Start Plan launched in 2014 and the Leeds Breastfeeding Plan both focus on supporting responsive feeding and infant led weaning.

- The Planning, Design, Health and Wellbeing group formed in 2016 is establishing key principles such as active neighbourhoods, new housing developments, better air quality and green space to be integrated into the planning and design process.

- Food and Activity for a Healthy Pregnancy’ train the trainer course, delivered by Public Health, is enabling midwives to deliver a healthy lifestyle session to support parents to be.

- Bi-annual national Change4Life campaigns have been promoted each year with partners, resources are distributed and ideas shared on how to support the campaign locally. The current interactive campaign focuses on reducing the consumption of sugar.

Transition care in diabetes
Transition is the process of moving from children's to adults' services. It refers to the full process including initial planning, the actual transfer between services, and support throughout. Transition in health care is recognised as a developmentally mediated process that ensures optimal health and wellbeing outcomes for young people as they move, in partnership with their health care teams, towards and into adult services and lifestyles. In the majority, children and young people have type 1 diabetes but there are small numbers of children living with diabetes due to other causes, including type 2 diabetes, genetic forms of diabetes, medication-induced diabetes and children with cystic fibrosis or other forms of pancreatic disease leading to diabetes. It is important that these young people also have access to specialist clinics and support to help them live well with their diabetes.

The transition process should commence in the paediatric diabetes service and should start at around 11 years of age (as stated in NICE guidance on Transition), ensuring that it is developmentally appropriate and takes into account the young person’s abilities, needs and hopes for the future. Young people with diabetes must be helped to develop the confidence to self-manage their condition(s) as part of the transition process. This should include an
assessment of young person’s ability to confidently self-manage their condition in readiness to move to the young adult diabetes clinics within the adult service.

LTHT is a participant of the National Diabetes Transition Audit Quality Improvement Collaborative (NDTAQIC). This collaborative has supported colleagues working in diabetes transition and young adult diabetes services to develop skills to design and deliver services to help improve the quality of care and outcomes for young people living with diabetes. The team have benefitted from coaching support to develop this local diabetes improvement plan to support young people in the transition process from paediatric to adult diabetes health care services.

**Strategy development informed by local engagement**

For a number of years, a diabetes network has existed in Leeds, which involves people living with diabetes, voluntary sector groups (for example Diabetes UK and JDRF), Leeds City Council (LCC), NHS Leeds CCG, LCH, LTHT and NHS England via the Yorkshire & Humber Diabetes Clinical Network. Early in 2018, the diabetes network undertook work with our partners to begin the development of this strategy for the city, extending the invitation to a wider audience including colleagues from Health Watch Leeds and Voluntary Action Leeds.

We held two workshops on 4 July and 26 September 2018 to agree what our five year strategy for diabetes needed to include, some basic principles we would all work to, highlighting what we do well and where there are gaps. We also began to describe the outcomes (what we want to achieve for people in Leeds) and outputs (what we will measure to know we have improved things). We also asked people in Leeds living with or caring for someone with diabetes and people working in the diabetes service to tell us what they thought of services via online and hardcopy surveys, which were available from 4 July to 8 October 2018. Focus groups and support regarding the distribution of the survey to ‘seldom heard communities and hard to reach groups’ [e.g. older people, people with a learning disability and people from Black and Minority Ethnic groups such as Asian and Black African) took place during September 2018 via Voluntary Action Leeds (VAL). We received 612 responses in total. The table below (Figure 6) highlights the key themes and recommendations identified.

**Figure 6: Themes and recommendations from diabetes engagement work 2018**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Themes identified</th>
<th>Recommendations / work already underway</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Waiting! Whether waiting longer for follow-up appointments, or spending too long in waiting rooms, respondents, carers and professionals alike agree that there is an issue with waiting times for diabetes services</td>
<td>Proposal for a Single Point of Access and the further integration of specialist teams (LCH and LTHT) should have a positive impact on this. In addition, giving consideration to other ways of delivering support e.g. skype, virtual clinics, etc. should help to increase access</td>
</tr>
<tr>
<td>2</td>
<td>Reducing unnecessary appointments/duplication.</td>
<td>Technology is key – improved access to information for healthcare professionals and people living with or caring for someone with diabetes i.e. development of the electronic health record, PPM+ (Leeds Care record) and HELM (person held record) should help reduce unnecessary and duplicate appointments.</td>
</tr>
<tr>
<td>Ref</td>
<td>Themes identified</td>
<td>Recommendations / work already underway</td>
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<tr>
<td>3</td>
<td>People at all stages of diagnosis, and their families and carers need to be kept updated with clear, reliable information about their diagnosis and about self-management and self-support advice and guidance.</td>
<td>This includes work underway to standardise the resources available to patients and health care professionals to ensure consistency of information. People living with or caring for someone with diabetes are involved in this work with resources are now published on Leeds Health Pathways. In addition work is underway to develop HELM (as 2 above).</td>
</tr>
<tr>
<td>4</td>
<td>There is a lack of culturally and ethnically appropriate information and interventions – specifically around South Asian, African and Caribbean communities, which are known to be 3 to 6 times more likely to develop type 2 diabetes than the white population.</td>
<td>Work to address this already includes Diabetic Foot and My Diabetes leaflets translated into different languages and services required to address specific languages and cultural needs (e.g. LEEDS Programme for type 2). Keen to develop further and access and learn from existing resources that are available.</td>
</tr>
<tr>
<td>5</td>
<td>The importance of acknowledging the differences between type 1 and type 2 diabetes, especially amongst non-specialist healthcare professionals – achieving a basic level of understanding across all services.</td>
<td>Utilise existing literature and resources already available, e.g. from Diabetes UK, JDRF and ensure that we are promoting this as widely as possible (e.g. standardisation of information as well as promotion to the general public).</td>
</tr>
<tr>
<td>6</td>
<td>Poor links and communications between different departments and between hospital and community settings.</td>
<td>As within themes 1 &amp; 2. Specific focus on improvements to pathways such as mental health support, and addressing practical issues such as multiple IT systems, admin teams, etc. The aim is to ensure that all relevant and current clinical information is available to clinicians across healthcare providers when providing direct patient care.</td>
</tr>
<tr>
<td>7</td>
<td>One size does not fit all – There is a need to consider each individual patient’s situation holistically, and ensure services are able to adapt in order to provide the most appropriate treatment and support, for example, the lack of suitable meals available for people staying in some residential inpatient settings.</td>
<td>We need to continue to work with patients and carers and involve them in decision-making. We will build on the collaborative care and support planning framework (CCSP), (the CCG GP process for patient annual review) which recommends a proactive holistic, flexible, and tailored approach to care, and recognises the individual as an expert in their own care. Plus Better Conversations work across the city – establishing conditions to support both people living with or support someone with diabetes and the professional involved in their care are on an equal footing (i.e. removing implication that professional knows more about the condition). As with recommendation 5, to ensure that we appropriately differentiate between the needs of people living with the different types of diabetes as well as accepting that some support is common across the condition.</td>
</tr>
<tr>
<td>8</td>
<td>There is a need for wider support – some people feel very isolated</td>
<td>As above within theme 5, plus Information and signposting to existing support – highlighting</td>
</tr>
<tr>
<td>Ref</td>
<td>Themes identified</td>
<td>Recommendations / work already underway</td>
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<td></td>
<td>(mentioned by some type 1 respondents particularly) or alone with their condition, and others felt unsure about how they were managing their condition on a day-to-day basis.</td>
<td>websites, support groups, helplines, forums, education, etc., including carers and families. Consider gaps, and extend reach of information to wider support groups, charities, networks, etc. Explore including self-management/peer support and links within the Leeds Directory.</td>
</tr>
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</table>

The themes above are now considered within our future vision which follows.
What we need to do: the future vision

Introduction
This is the most important section of this document, as it describes what we intend to do over the next five years to improve outcomes for people at high risk of diabetes and those living with diabetes. We have also produced a summary of what and how we intend to do this, which we will review every year. Below are some of the comments from people involved in this work to date, around the things that matter most to them:

“There needs to be a mixture of clinically approved online and offline support”

“We want a seamless service for diabetes management across the city”

“We want people to notice and feel that the Leeds diabetes service is different and better”

“Mental health is a massive issue with managing diabetes”

Our ambition and key principles
Underpinning our work is our ambition statement:

“Working together to deliver the best outcomes for people at risk of, or living with, diabetes”

We will achieve this by working together across the range of health and social care organisations to ensure we provide care and support that meets individual need and is of the highest quality. Importantly, our diabetes strategy recognises that many people living with diabetes are knowledgeable about their condition and should be increasingly supported to self-manage to stay in the best health they can and achieve the best quality of life possible. We have described a set of 10 principles (Figure 7) which are inclusive of all the needs of people at risk or living with, all types of diabetes as well as support for their families and carers. These principles also relate to those working in the Diabetes Leeds Service. We describe our Diabetes Leeds Service as the service that cares for people living with or at high risk of diabetes (and their carers). It involves NHS staff whoever their employer is (e.g. GP practice or Leeds GP Confederation, LCH, LTHT, NHS Leeds CCG or Leeds City Council). The service also works alongside people at high risk of or living with diabetes. The service also extends to delivering NHS care alongside voluntary and independent sectors e.g. care homes and charities.

Figure 7: Leeds Diabetes Strategy Principles

<table>
<thead>
<tr>
<th>Number</th>
<th>Principle</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>We will work together with people (at risk or living with, all types of diabetes), their carers and health and care professionals to improve services</td>
</tr>
<tr>
<td>2</td>
<td>We will put people and carers at the heart of our strategy, focusing on the whole person and not just their condition (diabetes)</td>
</tr>
</tbody>
</table>
We will improve access to services for communities who are at greatest risk of developing diabetes and do whatever we can to support people who are at risk and identify those who have the condition as early as possible.

We will support people with diabetes and their carers to gain the confidence, knowledge and skills to look after their health, tailoring support to meet their needs.

We will do whatever we can to treat people with diabetes more effectively to prevent complications.

We will be mindful of inequalities so that no matter where you live in Leeds you can access the best possible care available.

We will use information to help us deliver services that are likely to have the greatest impact for patients and their carers.

Our staff are important in delivering the best possible services; we will provide them with opportunities to develop their skills and work together across Leeds.

We will work differently across the system and adopt appropriate new technology wherever possible.

We will make sure that we get best value for people living in Leeds within the available resources (staff and money) so that we can commit to delivering the principles of our strategy.

Our five year strategy covers those services which are commissioned by Leeds City Council Public Health, NHS Leeds CCG and include services funded by NHS England (NHSE) Transformation funding but excludes services directly commissioned by NHSE, namely the Diabetes Eye Screening Programme. It is important to note that whilst our diabetes strategy has the ambition of improving outcomes for all of our Leeds population, it will specifically address key areas of improvement rather than detail every aspect of the diabetes service which touches people’s lives.

The outcomes we want to achieve
The outcomes we want to achieve are listed below and will be captured through person reported surveys and data available across our diabetes service:

- An improvement in early identification of diabetes and those at high risk of developing diabetes
- A reduction in the proportion of people at high risk of diabetes progressing to type 2 diabetes
- Prevention of complications, with the aim of reducing the rate of people of all ages developing avoidable long term conditions
- An improvement in patient outcomes by reducing unwarranted clinical variation between primary care networks and providers
An improvement in people’s experience of the diabetes service
An increase in people taking an active role in managing their condition and treatment
An improvement in quality of life
An increase in people returning to and maintaining their normal activities and functions
A contribution to a reduction in premature mortality (PYLL) – with greatest reduction in poorest areas

Outcomes related to obesity will form the basis of work for the Leeds Obesity Network, under development in 2019-20. The way in which we intend to measure performance against delivery of these outcomes has been determined via the selection of measurable outputs. These are summarised within our strategy summary ‘How we will measure impact’ section available at Diabetes Leeds Outcomes.

**Key priorities**

As a result of our work throughout 2017-18 and 2018-19, we have identified a number of key priorities and specific areas for improvement. Figure 8 below outlines these priorities. Prior to the publication of this strategy, progress towards a number of these priorities has already been actioned via work streams underway.

**Figure 8: Diabetes strategy priorities**

<table>
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<tr>
<th>Year one priorities</th>
<th>Priorities in years 2-5</th>
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<tbody>
<tr>
<td><strong>For all individuals</strong></td>
<td></td>
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<tr>
<td>Implementation of single point of access for specialist services (adults) – September 2019</td>
<td>Training delivered to health and social care professionals and people living with or at risk of diabetes (e.g. diabetic foot screening, NHS DPP, LEEDS Programme, DAFNE)</td>
</tr>
<tr>
<td>Ensuring that recommissioned IAPT services are accessible for people living with diabetes (improving access to psychological therapies) – November 2019</td>
<td>Reduction in unwarranted variation including access to services and achievement of treatment targets across the city</td>
</tr>
<tr>
<td>Standardisation of information for healthcare professionals and people living with or at risk of diabetes – April 2019 (Complete)</td>
<td>Development of a single diabetes service, including continued consultation with primary care networks recognising that over 80% of care is delivered in primary care</td>
</tr>
<tr>
<td>Workforce – training needs analysis for all healthcare professionals working in the diabetes service – December 2019</td>
<td>Increased screening and symptom awareness of diabetes</td>
</tr>
<tr>
<td>Re-procurement and mobilisation of NHS Diabetes Prevention Programme – July 2019 (Complete)</td>
<td>Increased use of new technologies (e.g. continuation of access to Freestyle Libre, insulin pumps and sensor augmented pump therapy for appropriate groups of people, and other digital tools to support self</td>
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<tr>
<td>Year one priorities</td>
<td>Priorities in years 2-5</td>
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<td>---------------------</td>
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<td></td>
<td>management)</td>
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<tr>
<td></td>
<td>Expansion of working with community assets e.g. existing peer support networks and individuals</td>
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</table>

### For specific groups

| Type 1 – mapping data flows across the diabetes service to ensure treatment targets are recorded by any healthcare professional involved in care and shared with the individual – June 2019 (Complete) | NHS Diabetes Prevention Programme is tailored to meet needs of Leeds residents |
| Type 1 – work to understand and better address the specific needs of people living with the condition who are struggling to engage with services – November 2019 | Improving the transition of young people into adult services (age 17 – 25 years) |
| Type 2 Diabetes remission service (for people who have BMI over 30 and living with type 2 diabetes and newly diagnosed in last 6 years) – to help lose weight and place diabetes into remission (testing impact) July 2019 (Service has commenced) | Improving our service to ensure that it better meets the needs of people living with a learning disability and/or significant mental ill health |
| Implement improved pathway for people with hypoglycaemia – Summer 2019 (complete) | Ensuring every woman with gestational diabetes receives appropriate follow up in primary care post delivery |
| Medicines management – review of blood glucose meters and strips – June 2019 (complete) | Refresh existing Freestyle Libre policy to ensure compliance with national guidance – May 2019 (complete) |

One of the key goals within Leeds is to integrate our specialist teams and work even more closely with staff in primary care settings, including health care assistants, practice nurses, GPs and community pharmacists in the delivery of care closer to home, alongside supporting those affected by diabetes to self-manage. In early 2019 we conducted a series of workshops to continue the development of a single point of access (SPA) for diabetes. This means we will have a single route for referrals, which will help them be managed better and more quickly in the hope this will reduce waiting times and support us locally to redesign how and where care and support is accessed and delivered.

To support the move towards integrated care with a focus on prevention and self-care, we will continue to promote the collaborative care and support planning (CCSP) process across Leeds GP practices. This offers a collection of tools and information to support healthcare
professionals in conversations with people about their condition alongside other factors that may be affecting their life. This holistic approach is flexible and tailored to individuals and crucially recognises that people are experts in their own care. Involving the person with diabetes (or other long-term condition) and helping them understand their condition and their test results is a fundamental part of supporting people in living well with their diabetes.

The enablers which will support delivery of our strategy

The Leeds Health and Wellbeing Strategy
In Leeds, our Health and Wellbeing Strategy 2016-2021 has a bold ambition that “Leeds will be the best city for health and wellbeing”. Its vision is that “Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest”. Our diabetes strategy aligns to this ambition and vision, whilst retaining an identity of its own.

This strategy aligns with the Leeds Health and Wellbeing strategy, in that we are committed to ensuring that “our Leeds diabetes service will achieve the triple aim of reducing inequalities, improving quality and financial sustainability”.

We have a wealth of expertise in Leeds around diabetes; from people living with diabetes and their carers, through to the staff delivering support. As the Leeds Health and Wellbeing Strategy states “everyone plays their part” and this is no different to our diabetes ambition for the city.

As well as the changing profile of diabetes, sadly the sheer scale of the issue and the demand on our services means that we need to think differently about how we use the resources available to us. This crucially includes supporting people at risk of developing diabetes as well as those living with or caring for someone with diabetes even more.

NHS RightCare – diabetes
The diabetes pathway defines the essential elements of an optimal diabetes service for people with or at risk of developing type 1 and type 2 diabetes, delivering better value both in terms of outcomes and cost.

NHS RightCare – cardiovascular disease (CVD)
People with diabetes are more at risk of heart disease; known as cardiovascular disease (CVD) or coronary disease because high blood sugars for a period of time, (even slightly high) can cause damage to blood vessels which can lead to heart complications, like heart attacks and strokes. Poor circulation can make other diabetes complications worse – like problems with eyes and feet.

There is a CVD work stream currently underway across Leeds which focuses on the prevention and management of CVD in primary care. A CVD steering group is in place, with focus being placed upon:

- Hypertension (high blood pressure)
- Atrial fibrillation (irregular heart beat)
- High cholesterol and familial hypercholesterolemia
- Heart Failure
Significant focus is being placed on Atrial Fibrillation (AF), as Leeds has high prevalence and a large number of patients not on appropriate medication. NHS Leeds CCG is also working with the West Yorkshire and Harrogate Health and Care Partnership on its Healthy Hearts project, with focus placed on the implementation of a hypertension protocol for primary care to follow on the diagnosis and management of people with hypertension. A further phase of the program specifically aimed at managing risk of CVD in people with diabetes is currently being developed. More information on NHS Rightcare CVD can be found here.

**National Treatment and Care Programme (NTC)**

On behalf of the city, NHS Leeds CCG has been awarded NHSE Transformation funding to support the improvement of three specific areas of diabetes care during 2017-20 listed in Figure 9:

**Figure 9: NTC Funding within Leeds**

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<tr>
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<tbody>
<tr>
<td>To improve uptake of structured education - with an emphasis on targeted</td>
<td>£116,000</td>
<td>112,000</td>
<td>£67,000</td>
<td>£295,000</td>
</tr>
<tr>
<td>groups (men over 40, BME and those from highest deprivation) with the</td>
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<tr>
<td>overall outcome that people feel well supported and confident to manage</td>
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<tr>
<td>their condition and maintain normal HbA1C 12 months after completion.</td>
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<tr>
<td>Increasing from 33 courses to 125 per annum.</td>
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<tr>
<td>Multidisciplinary Foot Care Team (MDFT) To reduce amputations by</td>
<td>£332,000</td>
<td>£313,000</td>
<td>£219,000</td>
<td>£864,000</td>
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<td>improving the timeliness of referrals from primary care to a multi-</td>
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<tr>
<td>disciplinary foot team (MDFT) for people with diabetic foot. Expanded</td>
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<tr>
<td>MDFT (Foot Protection Service) with a focus on high and moderate</td>
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<td>risk patients initially and ulcer prevention</td>
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<tr>
<td>Diabetic Inpatient Specialist Nurse team (DISN) To reduce length of</td>
<td>£181,000</td>
<td>£252,000</td>
<td>£176,000</td>
<td>£609,000</td>
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<td>stay for people in hospital with diabetes by increasing the number of</td>
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<tr>
<td>specialist nurses and dieticians, to improve health professionals</td>
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The Leeds bid for diabetes transformation funding was set within the context of the ambition in the Leeds Health and Wellbeing Strategy to improve the health of the poorest fastest, and has targeted extra resources for structured self-management in areas of high deprivation, encouraging particularly men and people from South Asian origin to attend.

**The NHS Long Term Plan**

The NHS has written a Long Term Plan covering the next 10 years, so that it can be fit for the future. Key priorities are identified for diabetes and are summarised towards the beginning of this document. The priorities within the NHS Long Term Plan have reinforced that our priority areas identified in this strategy are correct and have enabled a recurrent increase in CCG funding for diabetes services. One such example is our shared early ambition to explore and implement the provision of very low calorie liquid diets in Leeds. Clinicians identified this as an emerging priority. Work has therefore been focused on establishing a service to test the proof of concept for 18 months, within one locality in Leeds. The service is now up and running with full evaluation underway, prior to NHS England announcements that they are to test the concept. This demonstrates the forward thinking nature of partners working within the Leeds diabetes system.

**Digital**

Digital is a further enabler and one of our guiding principles - the adoption of new technology where appropriate is essential. We acknowledge the need to understand what the digital world has to offer and therefore held an information sharing event in January 2019, to explore/understand digital solutions for diabetes covering four layers:

- **Information** – education and advice, documented pathways, etc. – website
- **E-learning** – for example for structured education
- **Tracking of health status** – i.e. tracking of bloods, medications
- **Clinical management** – tool for responding to tracking of health status

To ensure we are at the forefront of digital development, NHS Leeds CCG, together with other members of the West Yorkshire and Harrogate Health Care Partnership, have been selected as one of the areas to help test the further development of the platform during 2019-20.

Healthy living for people with type 2 diabetes (also known as healthy living) is an online self-management support programme and accompanying structured education pathway for adults with type 2 diabetes, developed by a team at University College London (UCL). The tool provides information about type 2 diabetes and its treatments, offers emotional support, and helps with adopting and maintaining healthy behaviours (e.g. diet, exercise). A National Institute of Health Research, (NIHR) funded Randomised Control Trial (RCT) of the healthy living intervention showed modest but significant improvements amongst the group using the healthy living diabetes tool in HbA1c levels and a reduction in diabetes-related distress in newly diagnosed patients, compared with controls.
It is also worth noting that Leeds were one of the early adopters of Freestyle Libre insulin pumps and other continuous glucose monitoring, sensor augmented pumps for type 1 diabetes which are all a form of digital technology. One of the priorities for 2019-20 is mapping data flows across the diabetes services, with particular focus on people living with type 1 diabetes, to ensure treatment targets are recorded by and shared with any healthcare professional involved in care and most importantly communicated to the individual. Part of this work will look at whether HELM (a digital person-held record being developed in partnership with NHS organisations in Leeds and Leeds City Council which will allow people to view their information from GPs, hospital, community, and social care systems as well as other sources of data), will also enable people living with type 1 diabetes to contribute information to their own health record, such as meter readings.

**Digital inclusion**

Thousands of adults in Leeds lack basic digital skills. A lack of digital skills can have a huge negative impact on a person’s life, and it’s those who are already at a disadvantage – through age, income, disability, unemployment, or education – who are most likely to be digitally excluded. Leeds City Council and the Good Things Foundation – the UK’s leading digital inclusion charity – are working together to create 100% Digital Leeds, a cross sector collaboration ensuring everyone in the city has the digital skills they need.

We know that helping people to become digitally included will bring wider social benefits. Improved digital skills help people be better informed, pay less for things, be more employable, feel more independent, be less isolated, and live better, easier, longer lives. We want everyone to understand how digital would benefit them, be able to gain the skills they need to make the most of digital, and get connected. Find out more information at [https://digitalinclusionleeds.com/](https://digitalinclusionleeds.com/)

**Making every contact count**

Making every contact count (MECC) is an approach to behaviour change that utilises the millions of day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations.

Many long-terms diseases are closely linked to known behavioural risk factors; tobacco, hypertension, alcohol, being overweight or being physically inactive.

**In order to effectively tackle the rising prevalence of diabetes, it will be necessary for all ICS partners to work together to address not just the clinical condition but the accompanying socio-economic factors which limit an individual’s ability to make and sustain change. Resources and information have been developed to support people and organisations to implement MECC at a local, regional and national level.**
What you should expect from us: accountability and programme governance

Finally, to conclude this strategy document, we would like to highlight that there is a robust governance structure that supports the decision making process and necessary accountability surrounding delivery of our diabetes strategy as described, which for the purposes of this document focuses on the Diabetes Steering Group, Diabetes Stakeholder Group and Leeds Diabetes Operational Delivery Group.

Figure 10 provides a visual representation of city wide governance that relates to our diabetes strategy.

![Figure 10: Diabetes Governance in Leeds](image)

Accountability for the success of this strategy lies with all of us whether you are someone at high risk, living or caring for someone with diabetes or working within or commissioning the diabetes service.

Leeds Diabetes Operational Delivery Group

This group was established to lead on the delivery of the strategy in terms of the specialist element within the Diabetes Leeds Service (hospital and community providers) and reports to the Leeds Diabetes Stakeholder Group to keep all stakeholders fully briefed / aware of any issues and the Leeds Diabetes Steering Group if required. This group is, for example, responsible for delivery of the SPA.
**Diabetes Stakeholder Group**

This group principally supports the delivery of this strategy and is well placed to influence its annual review (e.g., identification of priorities for the Leeds population). It is also there to:

- To provide clinical and patient feedback to the development of work plans, to ensure they are clinically informed, and meet the needs of patients and carers
- To identify issues that need addressing and feedback on the views of colleagues
- Information sharing and dissemination of good practice.
- Support training and development of staff delivering care to patients with diabetes
- Support interpretation of national guidance
- Identify and support innovation in care delivery
- Build consensus from patients and clinicians on developments in diabetes services across Leeds

**Diabetes steering group**

Additional governance is in place which includes the Diabetes Steering Group (programme board) which reports to the Leeds Diabetes Stakeholder Group and in turn the Leeds Long Term Conditions Board NHS Leeds CCG).
Appendices

Appendix 1: Social determinants of health and risk factors relating to diabetes

The social determinants of health are the economic and social conditions that influence individual and group differences in health status. These include factors found in both living and working conditions. Some related statistics are provided below for Leeds:

- Health outcomes in Leeds are varied when compared with national and regional data. Life expectancy is lower than the England average for men and women and there are gaps in life expectancy of up to 11 years for men and 8.4 years for women when we compare life expectancy in the most and least deprived areas of the city (ONS 2015).

- Life expectancy is influenced by a variety of factors including deprivation, wider determinates, lifestyle, genetics and access to healthcare. Average life expectancy from birth for males in Leeds is 78.2 whilst the average life expectancy for females in Leeds is 82.1 (PHE 2015-17). Local data shows that life expectancy depends where you live with an average life expectancy of 75.5 to 77.6 for people living in the most deprived areas of the city such as Burmantofts and Richmond Hill, City and Hunslet and Middleton Park more likely to experience poor health outcomes and premature mortality compared to affluent areas of the city such as Harewood, Adel and Wharfedale, Alwoodley, Wetherby and Weetwood where average life expectancy ranges from 83.9 to 86 years (Figure A, Persons, 2013-15).

- In deprived areas of Leeds the rate of avoidable mortality is over 9,000 per 100,000, compared to less than 5,000 per 100,000 in non-deprived Leeds. This is almost double the rate and shows the variation of health inequalities in the city (age standardised rates in the under 75s population). Whilst this may be due partly to lifestyle behaviours it is important to consider the differing social, environmental and economic challenges across the city.
In the last decade the black and ethnic minority population in the city has increased from 11% to 19% and the number of residents born outside of the UK has doubled to over 86,000 people. This presents a range of complex issues due to the speed of change, national identity, language proficiency and transient populations (JSNA, 2015).

Figure B below illustrates the prevalence of diabetes recorded by GPs in Leeds by ethnicity. This illustrates that the highest percentage of recorded diabetes is in people from an Asian background whilst people from a black background are the second most likely to be diagnosed with diabetes.

Figure B: GP recorded diabetes and GP registered populations by ethnicity Oct 2018
Source: Leeds City Council PH intelligence team

Having explored some of the social determinants of health within Leeds, there are also a number of associated risk factors that can contribute towards the development of type 2 diabetes; these include obesity, physical activity, alcohol and smoking. These risk factors within Leeds are now explored.

**Obesity in adults**

The latest NHS review into obesity in England revealed 58% of women and 68% of men are obese. Compared to the previous year’s report obesity figures for women remain the same whilst the figures for men have risen by 3%. These statistics released by NHS digital (2017) highlight obesity as a major health issue for the UK with clear links to a range of health problems, including heart disease, diabetes, osteoarthritis and some cancers. Figure C displays age standardised rates of obesity (BMI 30 and above) taken from GP audit data in Leeds. It highlights the increased prevalence of obesity in the deprived areas of Leeds, particularly the inner ring around the city centre and the inner south and inner east areas of
the city. The outer north of Leeds which includes the areas of high life expectancy has the lowest prevalence of obesity reinforcing the link between deprivation and obesity. Within Leeds, we are in the process of establishing a Leeds Obesity Network which will bring together people from across the city to look at how we address this growing challenge.

Physical activity

The Active People Survey conducted across England by Sport England (2016) detailed in Figure D highlights the increased prevalence of inactivity amongst deprived communities in comparison to more affluent communities. In particular the Inner South and Inner East areas of Leeds have the lowest percentage of the population engaged in recommended physical activity levels (3 x 30 minutes per week). Outer North West and Outer North East areas of Leeds have some of the highest levels of physical activity.
Smoking

According to the Annual Population Survey (2016) smoking prevalence among adults in Leeds (17.8%) is slightly higher than the Yorkshire and Humber average (17.7%) and significantly higher than the England average (15.5%). Amongst routine and manual occupations Leeds has a higher smoking prevalence than the national average but a lower smoking prevalence in comparison to the Yorkshire and Humber (Figure E).

Figure E: Smoking prevalence Source: Annual Population Survey (APS)

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<th>England</th>
<th>Y&amp;H</th>
<th>Leeds</th>
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<tbody>
<tr>
<td>Smoking prevalence in adults</td>
<td>15.5%</td>
<td>17.7%</td>
<td>17.8%</td>
</tr>
<tr>
<td>Smoking prevalence in Routine and Manual occupations</td>
<td>26.5%</td>
<td>28.9%</td>
<td>28.4%</td>
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</table>

Alcohol

Over 35,000 adults living in Leeds are estimated to be high risk drinkers and 17,255 who are dependent on alcohol. Levels of binge drinking are amongst the highest in the country. The economic and social costs of alcohol-related harm in Leeds was estimated as £438 million in

**Appendix 2: Diabetes care provided in primary care**

*(Diagnosis, Treatment & Management and Annual review)*

1. Screening and maintaining the high risk of diabetes (type 2) register
   - Maintain up-to-date diabetes register
2. Recall system
3. Collaborative care and support planning (CCSP)
4. Medication reviews for all diabetes patients. Discussion of BP and lipid management as per NICE and local guidelines.
5. At diagnosis, appropriate assessment to determine diagnostic type and refer if unclear.
6. At diagnosis, initial patient education (excluding structured). Record of referral/attendance and completion of structured education (if applicable).
7. Appropriate and timely referrals to other settings (NDPP, dietetics/podiatry/retinal screening/specialist diabetes services/IAPT/social prescribing).
8. Family planning advice and referral to the preconceptual service.
10. Safe management of insulin and GLP-1 Receptor Agonists RA with input from specialist services when necessary.
11. Commencement of home glucose monitoring for those patients on sulphonylurea tablets and insulin.

**Resources**

A list of resources have been produced for people at high risk or living with diabetes and available via the [diabetes strategy summary document](#) in the ‘resources’ section. These alongside additional resources for healthcare professionals are available on [Leeds health pathways](#).
### Key contacts

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bryan Power</td>
<td>Clinical Lead – Long Term Conditions</td>
<td><a href="mailto:bryan.power@nhs.net">bryan.power@nhs.net</a></td>
</tr>
<tr>
<td>Lindsay Springall</td>
<td>Senior Commissioning Manager – Long Term Conditions and Cancer</td>
<td><a href="mailto:l.springall@nhs.net">l.springall@nhs.net</a></td>
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### Version control

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</tr>
<tr>
<td>2</td>
<td>Amended to reflect comments from Bryan Power, CCG Clinical Lead and Mike Mansfield, Diabetes Consultant (LTHT)</td>
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<td>3</td>
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<tr>
<td>4 &amp; 5</td>
<td>Incorporation of comments and content contributions from commissioning and clinical leads</td>
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