SLOUGH BOROUGH COUNCIL

REPORT TO:	Health Scrutiny Committee	**DATE:** 19th November 2014
CONTACT OFFICER:	Dr Onteeru BB Reddy, Public Health Programme Manager, Public Health & Wellbeing, Dr Nithya Nanda, Clinical Lead for Diabetes & CVD Networks, Slough CCG	
(For all enquiries)	(01753) 875144	
WARD(S):	All	

PART I
CONSIDERATION & COMMENT

PROGRESS REPORT ON DIABETES STRATEGY 2013-15

1 **Purpose of Report**

1.1 The purpose of the report is to note the significant progress made on the diabetes strategy developed in partnership by Slough Borough Council (SBC) and Slough Clinical Commissioning Group (CCG). (See Appendix A - Diabetes strategy)

Key Information: For children with diabetes a mandatory Best Practice Tariff (BPT) provides an annual payment for the treatment of every child and young person under the age of 19 with diabetes. The level of the tariff provides adequate funding for all children with diabetes, and a model of funding which enables access to consistent high quality care – regardless of where it is delivered. (See Appendix B -Diabetes services for children)

2 ***Recommendation(s)/Proposed Action***

2.1 The Health Scrutiny Committee is requested to note the progress on the diabetes strategy for Slough and comment on the action plan (See section 6.6) and note that national comparator data will be published at CCG and practice level in December 2014 which will show the detailed performance improvements reported here.

2.2 The panel is asked to note that the strategy is predominantly focussed on adults and includes themes of; early identification, patient and clinical education, improved clinical management and monitoring of clinical outcomes.

2.3 The wider work on the prevention of diabetes is covered via the Health, Leisure and Physical Activity Strategies and is not reported here.

3 **Slough Wellbeing Strategy Priorities**

The Slough Joint Wellbeing Strategy (SJWS) is the document that details the priorities agreed for Slough with partner organisations. The SWS has been developed using a comprehensive evidence base that includes the Joint Strategic Needs Assessment (JSNA).

The actions that the CCG and the local authority and its partners have taken, to address the requirements of the diabetes strategy aim to both improve, directly and indirectly, the wellbeing outcomes of the people of Slough against two key priorities; Economy and Skills, Health

The strategy has to date focussed on; prevention, early detection through the NHS Health checks programme and self-management of a chronic, long-term condition (diabetes) through structured education, raised awareness, knowledge and empowerment. Thus it aims to promote people's wellbeing, enabling people to prevent and postpone the need for care and support and put people in control of their lives.

The longer term impact of improved wellbeing is related to improved mental wellbeing because diabetes is one of the commonest causes of; depression related to the side effects of uncontrolled diabetes such as; blindness, disability and complex social care needs.

The upstream interventions listed in the strategy promote prevention, better management and avoidance of complications, reducing burdens on health, social care. Better self-management and more well-informed patients, who can access health and social care services appropriately, can contribute to civic responsibility.

The following key facts and figures have been taken from the JSNA 2013 relevant to this report. The aim of the local authority and CCG will be to address the potential needs identified from the JSNA through the implementation of the delivery plan linked to the diabetes strategy.

4 Joint Strategic Needs Assessment (JSNA)

http://www.slough.gov.uk/council/strategies-plans-and-policies/diabetes.aspx

Gap between known prevalence and undiagnosed population

The JSNA using the 2011/12 data recoded a diabetes prevalence rate of 7.5%. A total of 7,765 patients in Slough had diagnosed diabetes (7.5% of the population - higher than the national average of 5.5%). However the prevalence of diabetes at the baseline of starting this strategy (2012/13) went up to 7.8% of the population figures, compared to the national average of 6.0%. (This represented 8604 people aged 17 and over in 2012/13) At that time various estimates were made of the undiagnosed population, thought to be as high as 15% from national figures.

NB caution is needed when looking at figures shown in the Slough Health Profile (PHE, 2014) as this actually reports figures two years in arrears therefore the impact of the first year of the strategy will not be known fully until 2016 (1).
If the true gap is still as high as nationally expected (15%) then there may remain 1,290 undiagnosed patients in Slough i.e making a total of 9,894 patients with diabetes in Slough - still a significant 'hidden' burden.

Another potential difficulty with using the national estimates of prevalence is that they are based on an England average age profile whereas Slough is significantly younger than England. Slough also has other risk factors such as ethnicity, inactivity levels and deprivation as described below.

High proportion of BME patients

Type 2 diabetes (T2DM) is six times more common in people of South Asian origin and up to three times more common in people of African and African-Caribbean origin (2). The Census 2011 reported that Slough has a high proportion of BME (Black and Minority Ethnic) patients: 49% of Slough's population is non-White (40% Asian, 9% Black).

Higher levels of inactivity, obesity & poor nutrition
The references cited within the strategy (Appendix A) describe the contribution of lifestyle factors to T2DM: Both inactivity (related to obesity) and deprivations are higher amongst BME groups. Physical inactivity levels in Slough remain the highest in the South according to national comparators (2012/13 data quoted in August 2014 Public Health Outcomes Profile) and much work is underway to increase workplace activity levels, active travel and community engagement in walking and leisure programmes.

British Heart Foundation (BHF 2014) guidance is now available where recommended age-appropriate activity levels can be found for; preschool children, primary and secondary school children and young people, for adults and older adults (http://www.bhfactive.org.uk/guidelines/index.html).
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Deprivation
The high level of deprivation in Slough overall compared to the rest of the Southeast and in specific parts of the borough (where one lower super output area is in the most deprived in the UK) is also associated with a higher rate of diabetes.

Obesity in adults; Obesity / underweight in children
Childhood obesity, underweight and risk of diabetes are on a rising trend in reception years children. Slough ranks statistically above the England average for childhood obesity in reception year (10.10% prevalence) but is no longer statistically different for year 6 (21.30% prevalence). Estimates of adult obesity are not statistically different to England.

Mental health and wellbeing
The JSNA (2) noted the association between depression and diabetes. Work within the community to raise awareness of mental ill health has increased and encourages early recognition of treatable conditions. Strategies to promote mental wellbeing are shown in the Wellbeing strategy and Health Strategy and smoking cessation services are now targeted more on those with mental health problems. Effective services to reduce the rates of depression include the Increasing Access to Psychological Therapies Service (IAPT). This offers general wellbeing groups but diabetes-specific psychological support for either adults or children is limited.

Primary care indicators of quality.
At the start of the strategy in 2013 only 8.5% of patients across Berkshire East with T1DM and 55.9% with T2DM were being offered all nine Key Care Processes (England overall average was 49.8%, range 6.4% - 68.9%). These wide levels of confidence show just how difficult it is to demonstrate a statistically significant change. However the Diabetes Outcomes Versus Expenditure Tool (DOVE) attempts to do so.

Based upon the 2011/2012 DOVE data, there were 2,188 patients in the Slough CCG not meeting blood pressure (BP) targets, 1,735 not meeting total cholesterol (TC) targets and 2,494 patients not meeting HbA1C targets.

Based on the 2012/13 DOVE report this performance has now improved at a CCG level (and practice profiles will be published in December 2014 to show individual improvements) While there is likely to be some overlap of patients, these numbers represent a significant population that are not receiving optimal outcomes.

Higher rates of hospital admissions
The National Diabetes Audit (NDA) showed that only 11.2% patients with diabetes were admitted specifically for the management of their condition, where as 75.7% of these with diabetes (other than all admissions) were admitted for 'medical reasons other than diabetes. This is linked to the poorer health and sedentary lifestyles amongst these patients-

5 Other Implications

(a) Financial
The implementation of the diabetes strategy has no financial implications for Slough Borough Council other than the delivery of the NHS Healthchecks programme but has financial implications for Slough CCG.

The prevention work Slough Borough Council is undertaking to deliver the physical activity, active travel(including walking and cycling schemes), health and leisure strategies is funded predominantly by the council although excellent examples of innovative work are being piloted within general practices (awaiting publication).

(b) Risk Management

The risk management for this strategy is done through the Slough CCG risk management protocols and QIPP guidance - since the clinical governance for the delivery plan sits with Slough CCG.

Risk	Mitigating action	Opportunities
Legal	QIPP risk management plan	None
Property	None	None
Human Rights	None	None
Health and Safety	None	None
Employment Issues	An MOU provides SBC PH officer time to the strategy and diabetes network	This time is shared across the East Berkshire network
Equalities Issues	Covered through Slough CCG EIA	The JSNA will be refreshed in 2015
Community Support	SBC provide prevention support through commissioned prevention services and use of community venues for delivery of the leisure, physical activity and health strategies	Diabetes champions are available through the Berkshire network
Communications	Managed through a shared communications plan	A self-care diabetes programme is being developed
Community Safety	None	None
Financial	Slough CCG QIPP	Through other strategies
Other	None	None

(c) Human Rights Act and Other Legal Implications - these implications were considered by the Slough CCG

(d) Equalities Impact - covered within the Slough CCG EIA protocols and in the SBC JSNA section on diabetes

6 **Supporting Information**

6.1 Introduction

What is the Diabetes Strategy for Slough?
This is a document outlining an approach to improve the management of patients with diabetes in Slough. It focuses on the prevention and early detection of diabetes, as well as on how to improve the management of patients with already diagnosed diabetes through monitoring of the nine care processes. The secondary aim of the strategy is to improve health outcomes in diabetes care through the education of both patients and professionals.

Why do we need a strategy?
Approximately 75,000 deaths per year nationally are directly related to diabetes or its complications – at least 24,000 of which are estimated to be preventable. (Diabetes UK, 2012). In addition, the average age at which people develop T2DM was falling; the proportion of those under 40 with T2DM has risen from 5-12% NHS spending on diabetes is approximately £14 billion, with 80% directed towards potentially preventable complications. This means that a condition affecting 5% of the population is utilising nearly 14% of the total NHS budget – a clear disparity.

6.2 National context

National best practice guidance (DH/PHE) and guidance from the Diabetes UK (DUK) has informed the strategy. This strategy mainly focuses on T2DM rather than Type 1 diabetes & diabetes <19 years of age which is managed through hospital based care - covered as part of a National Best Practice Tariff (BPT).

Type 2 diabetes is a growing problem in adults, and increasingly amongst young people, linked to the rising levels of obesity, especially amongst high risk groups such as those of Asian and African-Caribbean origin.

The prevalence of diabetes is estimated to rise to 4 million by 2025. An estimated £14 billion pounds is spent a year on treating diabetes and its complications [diabetes burden], with the cost of treating complications representing the much higher cost.

The cost of diabetes to the NHS is over £1.5m an hour or 10% of the NHS budget for England and Wales. This equates to over £25,000 being spent on diabetes every minute.

6.3 Monitoring of Primary Care Management

The National Service Framework for diabetes (2001) established nine care standards for the provision of high quality services. However the performance and benchmarking related to the offer and achievement of the 8/9 key care processes is audited annually through two systems of monitoring nationally; the **Quality and Outcomes Framework (QOF)** which is a voluntary annual reward and incentive programme for all GP surgeries in England and the **National Diabetes Audit (NDA)**.

QOF details practice achievement results in achieving *eight* of the nine diabetes Key Care Processes by a series of *proxy* measures.

NDA derived 9 Key Care Processes: The NDA requires that all patients with diabetes are expected to receive a planned programme of recommended checks each year, which include the following measures; blood glucose level, blood pressure, cholesterol level, retinal screening, foot and leg check, kidney function testing (urine), kidney function testing (blood), weight and smoking status check.

Even though there are lower rates of early death due to diabetes compared to other wealthy countries (Global Burden of disease, 2013) and recent reductions in excess mortality (Action for diabetes, 2014), there are still wide variations in diabetes care processes in terms of offer and achievement between individual practices, across the CCG and Slough LA area.

Hence the goal of this and any future diabetes strategy is to use the NDA as a guide and the QOF results as a performance measure in order to ensure consistency of standards, targets and outcome measures. We need to be cautious that there are some differences in the methodology used between the QOF and the NDA measures, so their results can differ.

6.4 Local context

Diabetes continues to pose a major health problem in Slough, due to a significantly higher than national average proportion of people with diagnosed diabetes and low physical activity rates. In 2010/11, there were 7,765 patients in Slough with diagnosed diabetes (7.5% of the population) - higher than the national average.(5.5%). This number had increased to 8604 in the 2012/13 QOF return which will be updated in December with the 2013/14 return.

In Berkshire East the prevalence of diabetes is expected to increase from 18,248 in 2013 to 32,786 by 2030 - an increase of 80%. For Slough, this could mean a total population with diabetes of 14,172 by 2030. Consequently, diabetes has been prioritised as a ‘high burden’ condition (alongside obesity) in the Slough Wellbeing Strategy (2012-2015), representing the highest health priority issue for the local area.

Performance assessment: How did Slough do? (2013/14)
Diabetes was chosen as the top priority for the Slough CCG and a synergistic partnership with public health helped drive the agenda. There was a recognition that a great opportunity exists for an active partnership and coproducing commissioning opportunities between health and social care system and beyond to improve patient outcomes. For example, prevention and early diagnosis of Type 2 diabetes through initiatives like the NHS Health Check programme (funded by Public health, Slough Borough council) screening initiatives targeted at high risk groups, and a pre-diabetes community enhanced scheme, funded and supported by Slough CCG.

The national QOF data (2010) showed a wide variation in the offer of all nine Key Care Processes, ranging from 6.4% to 68.9%. Slough was in the top quartile nationally in terms of offer. However, Slough scored poorly in terms of achieving the required treatment targets, with the NDA reporting that only 19% patients with T2DM achieved all 9 treatment targets (national average 20.5%).

Of the nine key care processes, the blood pressure (BP), total cholesterol (TC) and HbA1C targets were particularly important as they were particularly modifiable through changes to lifestyle.

For the BP target, Slough was in the top 50% of CCGs, with 71.9% patients achieving a BP <140/80mmHg (England average 70.5%).
For blood sugar control (HbA1C) and Total Cholesterol (TC) targets were below national average:

- Blood sugar control (HbA1C <59mmol/mol) was achieved amongst 66.4% patients (England average 70.2% - Slough was in the bottom 50% of CCGs).
- Total cholesterol <5mmol/l achieved amongst 77.2% patients (England average 81.7% - Slough was in the bottom 50% of CCGs).

The 2011/2012 Diabetes Outcomes Versus Expenditure Tool (DOVE) –identified that there were 2,188 patients in the Slough CCG not meeting blood pressure (BP) targets, 1,735 were not meeting total cholesterol (TC) targets and 2,494 patients not meeting HbA1C targets. While there was likely to be some overlap of patients, these numbers represent a significant population that were not receiving the optimal outcomes.

Ultimately, a key goal of good diabetes care is to reduce diabetes-related hospital admissions. The National Diabetes Audit (NDA) showed that 11.2% patients with diabetes were admitted specifically for the management of their condition, with 48.1% cases having active foot disease. 82.8% were admitted as emergencies (vs. 79.4% emergency admission for those without diabetes). 75.7% of these with diabetes (other than all admissions) were admitted for 'medical reasons other than diabetes - significantly higher than the 66.6% reported nationally, suggesting generally poorer health and lifestyle choices in these patients. This is likely to be as a consequence of the underlying high physical inactivity and obesity rates which led to the high prevalence of T2DM in these patients.

Locally the Slough Clinical Commissioning Groups (CCG) was in the bottom quarter in terms of performance at the National Diabetes Audit (NDA), highlighted through the Atlas of Variation, the National Diabetes Audit survey and Diabetes UK campaigns. Of concern was the rising rate of diabetic complications. Patients with diabetes accounted for approximately 19% of all inpatient admissions.

Notably, completion rates of care processes were lower and achievement of NICE-recommended glucose targets markedly worse for those with Type 1 diabetes compared to those with Type 2 diabetes. There was also a huge unseen burden in primary care: Nearly a third of people with diabetes were undiagnosed and a significant number had pre-diabetes.

6.5 Diabetes strategy development

Slough with its high proportion of young population, BME groups, high prevalence rates of diabetes and higher rates of premature cardiovascular deaths presented a real opportunity for an integrated diabetes care strategy across health and social care. This necessitated the need for a diabetes strategy linking public health, CCG, patient groups (DUK) and the partners in the council and the wider partners in the community, including voluntary & community groups, faith groups and charities.

One aim of the diabetes strategy was to use the NDA as a guide and the QOF results as a performance measure in order to ensure consistency of standards, targets and outcome measures.

The Slough Diabetes Network group was established with the diabetes strategy being the key driving force with an assured investment from Slough CCG through QIPP monitoring arrangements. A framework was developed guided by the Slough Diabetes Strategy but in collaboration with multidisciplinary teams and the Slough Diabetes Network to achieve the goals by 2014.

The overarching themes are to reduce morbidity and mortality due to diabetes, prevent or delay diabetes development and improve the quality of life for patients with diabetes. Each program is bespoke to deliver benefits to Slough patients, accomplished through the joint efforts of healthcare leaders, public health professionals, healthcare organizations with the engagement of Slough diabetes patient population.

Key themes in the strategy

The strategy aims to reduce inequities in diabetes outcomes by supporting:

- Evidence-based, community-focused interventions
- Successful programs and services - sustained in policy and practice
- Collaboration with key stakeholders from a national level through to local levels
- Development of service standards.
- Integration of services and resources Implementation
- Implementation of Case Management to ensure efficient use of resources and provision of excellent quality and outcomes for patients.
- Effective demand management including monitoring of key performance indicators (KPI)
- Service/Pathway re-designs, to ensure that future services and work force are fit for purpose and meet the patient centred approach with integrated pathways which are safe for patients and improve the quality of care for diabetic patients (Refer to Section 8)

6.6 Action plan development: making a tangible improvement to diabetes care

Slough's performance in diabetes care was variable - broadly comparable to national average in some areas of offer, but below average in others in terms of outcomes. There was a collective enthusiasm and commitment from motivated primary care healthcare professionals, patients, public health and adult social care to improve the diabetes offer and patient experience.

A project manager was allocated and a lead GP agreed to lead on the QIPP initiatives, named GP leads from each practice identified, informatics support and a medicines management lead allocated from the Central Southern Support Unit, all working collaboratively alongside Public Health. The chair of the CCG recognised diabetes as one the number one top priority and offered his full support and approval for the QIPP plans to go ahead.

Four main actions were identified for 2013-15 with short, medium and long term objectives. It was decided that Slough CCG and Public Health would periodically review whether these targets were being achieved. Full details can be found in the full strategy:

6.7 A staged approach to improve the identification of patients at risk of developing and with undiagnosed type-2 diabetes:
Healthcheck delivery was increased, screening initiatives were targeted at high risk population groups (South Asian, African Caribbean) and pre-diabetes pathways for people with borderline results were established for those at high risk. Slough CCG also incentivised practices to screen and refer people with borderline diabetes onto lifestyle interventions.

6.8 Offer to the high risk population groups: targeted health promotion, lifestyle interventions and education:
Structured education for patients, lifestyle interventions (like stop smoking, weight management etc) was further developed and a named GP lead from each Slough practice was identified and each provided with preliminary and advanced education programmes. Improved patient satisfaction and experience and the promotion of self-management was and remains the priority of the Slough Diabetes Network. These initiatives were streamlined through various Quality, Innovation, Productivity and Prevention (QIPP) plans led by the CCG.

Improving self-management and confidence for patients through a structured educational programme, called DEAL and DEAL plus for people with type 2 diabetes and TIDE for those with type 1 diabetes. A carbohydrate counting educational resource called CHOICE to help people with type 1diabetes mange their condition better. Improving physician confidence in managing diabetes through basic level training (Warwick – Certificate course in Diabetes management & like courses) and advanced training in initiating and prescribing insulin and other newer treatments as appropriate (Called PITSTOP).

6.9 Improved 9 Key Care Processes achievement, improved patient outcomes, better medicines optimisation and management:
Significant improvements were gained to the offer and achievement of the nine care processes of the NDA together with eye screening. There is more ongoing work underway to improve the achievement of the treatment targets, renal care and foot care and the reduction of end stage complications like foot amputations and renal replacement. The initial gains were due to the Enhanced Management of Diabetes (EMD project) led by specialist diabetes nurse/s (free external resource) visiting individual GP surgeries and interrogating the data and management of poorly controlled cases, supported by local specialist nurses (BHFT), primary care (GPs & nurses) and medicines management teams. This was achieved through engagement, close supervision, support within primary care, pharmacies and the medicines management teams.

6.10. Improving the offer, uptake and outcomes of the 9 Key Care Processes, to reduce primary and secondary care utilisation and enable patients to manage their diabetes more effectively from diagnosis
Change the health seeking behaviour of people, through an integrated care programme encouraging self-management, avoid inappropriate visits to the accident and emergency services and secondary care, increase the offer in primary care through increased investments in IT, education, benchmarking and sharing of best practice.

6.11 Primary care & Community Services:
An initial increase in demand for primary care/community lifestyle services was anticipated due to higher levels of awareness, targeted screening initiatives and pre-diabetes incentives in primary care. The increase was planned for from those with

confirmed diabetes as well as those with borderline (pre-diabetes) presenting to GPs and primary care. Also a greater demand for lifestyle, weight management, physical activity services for those passing through the screening/pre-diabetes care pathways.

6.12 Medium to long-term outcomes expected

Primary care practices having a much closer relationship with local patients can commission services more suited to their needs. This belief is fundamental to the introduction of outcome based commissioning. If services are commissioned with patients' needs truly acknowledged, this increases the probability of providing the right care in the right setting. This in turn reduces inappropriate demand on services. Patient centred commissioning may result in secondary care being provided in a mixture of settings eg acute hospital, nurse-led clinics, GPs with special interests. (NHS Institute for Innovation and Improvement)

Hence through this approach, medium to long term goals of fewer acute admissions, less non-electives /inappropriate admissions and a reduced burden on accident and emergency services was also anticipated. The action plans from the diabetes strategy provide SBC and Slough CCG with the opportunity to meet the increasing health and social care needs of the residents and patients of Slough in a more integrated way, are patient and person centred and are focussed on early intervention and prevention rather than crisis and acute care dominated.

7 Comments of Other Committees

The Health PDG approved the diabetes strategy in 2013 and has received updates since then. The Health PDG is the main governance route as this links this strategy to the physical activity strategy and health strategy which support the prevention aims. Outcomes of specific QIPP projects are reported to the operational leadership team of the CCG.

8. Diabetes Service reconfiguration and redesign

A case for diabetes service reconfiguration and redesign was presented by the public health lead for diabetes (Slough) supported by the clinical leads, Diabetes UK & the patient reps to the 3 CCG chairs of the East in September. A mandate was secured for this transformational change to happen in phases. The key stakeholders involved are the CSCSU (back office & data support), Existing estate, workforce (BHFT & Wexham/Frimley/primary care/CCG with PH support), patient groups and support/carer groups (including the Diabetes UK). This reconfiguration also involves reviewing patient journey, care pathway, care planning, medicines optimisation, total foot care redesign, adopting local educational programmes amongst other things.

The basic underlying principle is for a contractual change with potentially a shared care protocol with general practice driving efficiency, best practice, key outcomes on the nine care processes, education, care planning, coding practices and data management working closely, acute care and providing specialist services close to patient’s homes in the heart of the local community.

A project brief with a description of the service prototype (Pilot) to start in November/December. Full details of further phases and the need for resources and project management support was presented to the QIPP business Director as requested. Over the coming months there will be a series of engagement sessions and focus groups for people with diabetes across the East of Berkshire. These details will be shared with health and wellbeing boards, panels or groups as appropriate across Slough, WAM & Bracknell.

8 Conclusions

The Diabetes strategy with its short, medium and long-term action plans is in place with regular monitoring and reports to the Health PDG as well as to the Slough Diabetes Network group (Slough CCG). Slough CCG has achieved substantial improvements in terms of diabetes management (HBA1C), offer of care processes (NDA) and value for money linked to outcomes (DOVE tool). These results will be published nationally in December 2014 at a practice level.

There has also been substantial investment in; professional education, mentorship programmes, medicines optimisation initiatives supplied through the industry and via local medicines management teams.

High risk groups have been offered targeted screening initiatives held in places of worship & culture (via the Healthchecks team and other charities) and people with borderline results (called pre-diabetes) are now registered on GP registers and offered lifestyle interventions (weight management, stop smoking and PA advice) through a local incentive programme (the pre-diabetes community enhanced service).

Slough Public Health has led and supported the East Berkshire diabetes network since April 2013 and is proposing a diabetes service redesign project across the East of Berkshire. The aim of this programme, if approved, will be to achieve efficiency in achieving common outcomes, reduce manpower /resources and facilitate the implementation of innovation at scale and pace. This could create a federated platform for the three CCGs to work together, reducing variations and creating opportunities to co-commission and monitor diabetes outcomes more efficiently.

9. Appendices Attached

‘A’ - Diabetes strategy

‘B’ - Services for children with type 1 diabetes

10 Background Papers

‘1’ - Slough Health Profile 2014 available at http://www.apho.org.uk/resource/item.aspx?RID=142414

‘2’ - JSNA 2013 diabetes section available at http://www.slough.gov.uk/council/strategies-plans-and-policies/diabetes.aspx

‘3’ - DOVE spend and outcome tool for diabetes available at http://www.yhpho.org.uk/default.aspx?RID=88739

‘4’ - QOF practice profiles available at http://fingertips.phe.org.uk/profile/general-practice

‘5’ - Public health outcomes data published quarterly at www.phoutcomes.info.

Continuity of care close to people’s homes through an **integrated approach** through the following link http://www.diabetes.org.uk/About_us/What-we-say/Improving-services--standards/Best-practice-for-commissioning-diabetes-services-An-integrated-care-framework/