CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

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Reduce the Prevalence of Diabetes

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Public

Purpose of this report

1. To receive an update on the rising rates of diabetes and low proportion of people with diabetes meeting their treatment targets

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. **note the developments in improving care of patients who are diagnosed with Type 2 Diabetes across Central Bedfordshire, in particular in relation to improving achievement of NICE recommended treatment targets;**

2. **lead and influence health and social care partners to improve the early diagnosis of Diabetes though improved uptake of NHS Health Checks and promotion of Diabetes UK's 'Know your risk' tool. This is particularly required more in known population who have high risk such as BME and deprived communities; and**

3. **ensure that all partners actively implement the Excess Weight Partnership Strategy to tackle excess weight to both prevent diabetes and ensure that treatment targets are improved for those with diabetes.**

2. Diabetes is a lifelong condition that causes a person's blood sugar level to become too high.

3. There are two main types of diabetes:

- Type 1 diabetes – where the body's immune system attacks and destroys the cells that produce insulin.

- Type 2 diabetes – where the body doesn't produce enough insulin, or the body's cells don't react to insulin.

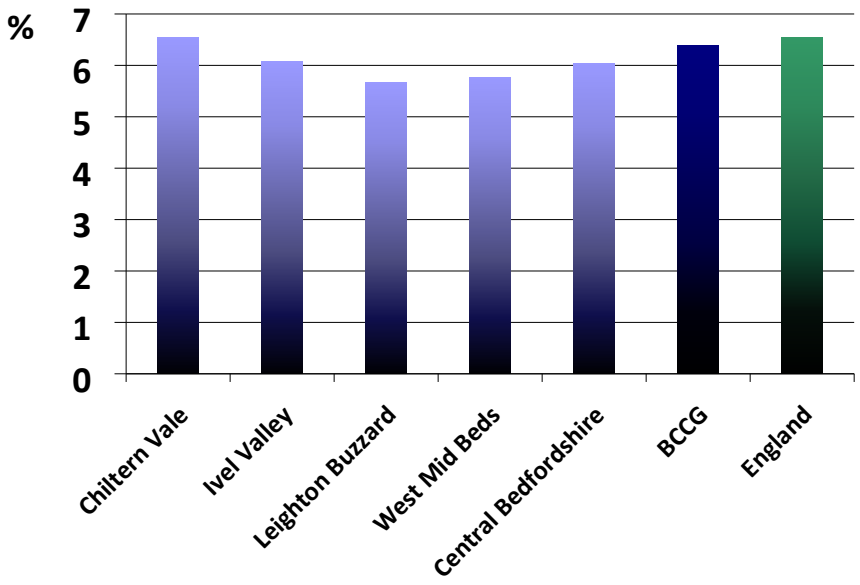
4. Type 2 diabetes is far more common than type 1. In the UK, around 90% of all adults with diabetes have type 2. Excess weight is a risk factor for Type 2 diabetes.

Type 2 Diabetes Central Bedfordshire

5. In Central Bedfordshire the prevalence of diagnosed adult diabetes aged 17 years and older was 6.0% (13,993, 2015/16) which is lower than the NHS England figure (6.6%), see Figure 1. We are aware that there is a significant proportion of adults who are not diagnosed with Diabetes and present with morbidity and complications later in life.

6. The prevalence of Diabetes (percentage of adults known with Diabetes) for Central Bedfordshire is presented in the Diagram below.

Prevalence for diabetes mellitus aged 17 or over, 2015/16

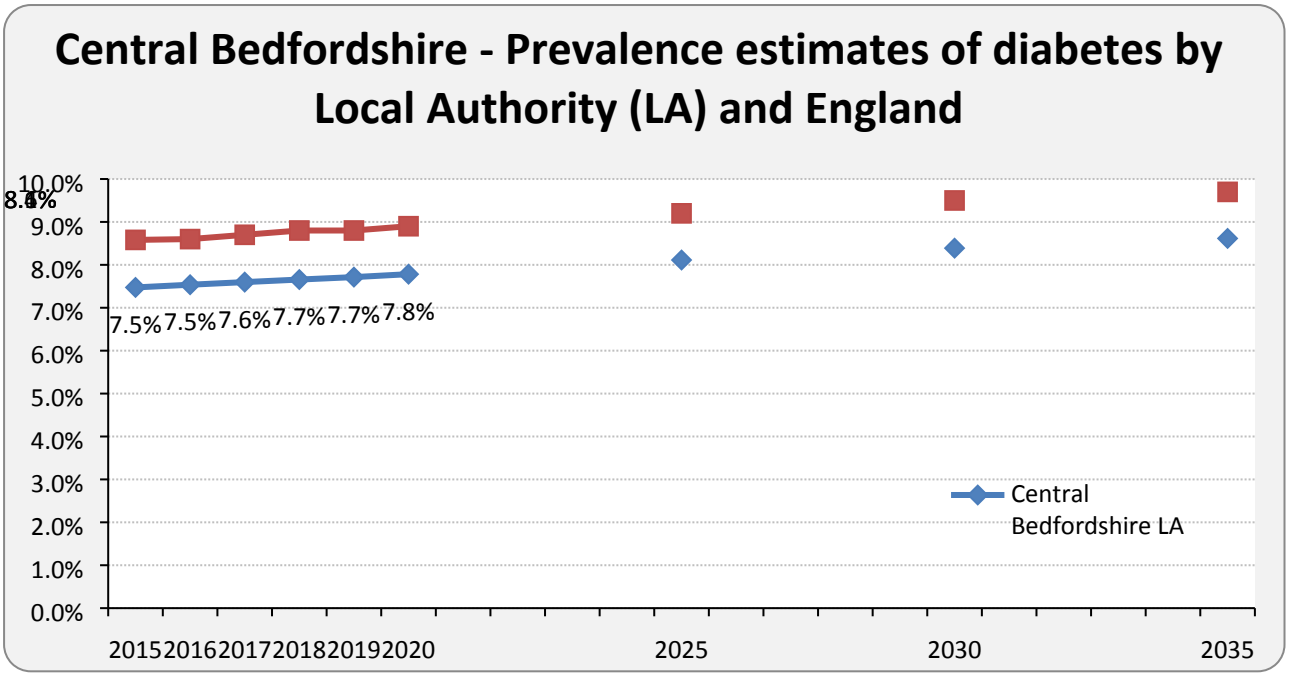


Source: QoF 2015/16

7. The above map outlines the localities served by Bedfordshire Clinical Commissioning group. Further information is available from the Bedfordshire Clinical commissioning group website. Link is: https://www.bedfordshireccg.nhs.uk/page/?id=3880

8. We are noticing an increasing trend in patients developing Diabetes. The increase in numbers of people developing Diabetes across Bedfordshire is evident from the diagram below.

9. In Central Bedfordshire 67.1% of adults have excess weight therefore we will continue to see an increase in adults developing Type 2 Diabetes unless we work across partners to halt this rise in excess weight.



Preventing Diabetes

10. Three of the main risk factors for developing type 2 diabetes are:

- Age – being over the age of 40 (over 25 for people of south Asian, Chinese, African-Caribbean or black African origin, even if born in the UK)
- Genetics – having a close relative with the condition, such as a parent, brother or sister
- Weight – being overweight or obese

11. People of south Asian and African-Caribbean origin also have an increased risk of developing complications of diabetes, such as heart disease, at a younger age than the rest of the population

12. Many cases of Type 2 diabetes are preventable and there is strong international evidence that behavioural interventions can significantly reduce the risk of developing the condition, through reducing weight, increasing physical activity and improving the diet of those at high risk.

National Diabetes Prevention Program:

13. The NHS Diabetes Prevention Programme (NHS DPP) is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver at scale, evidence based behavioural interventions for individuals identified as being at high risk of developing Type 2 diabetes.

14. People will be identified through three primary mechanisms to be eligible for this program:

    - Those who have already been identified as having an appropriately elevated risk level (HbA1c or FPG) in the past and who have been included on a register of patients with high HbA1c* (Glycosylated Hemoglobin Test) or FPG (Fasting Plasma Glucose)

    - The NHS Health Check programme, which is currently available for individuals aged between 40 and 74. NHS Health Checks includes a diabetes filter, those identified to be at high risk through stage 1 of the filter are offered a blood test to confirm risk; and

    - Those who are identified with non-diabetic hyperglycemia (HbA1c of 42 – 47 mmol/mol (6.0 – 6.4%) or a fasting plasma glucose (FPG) of 5.5. – 6.9 mmol/ml) through opportunistic assessment as part of routine clinical care.

*Glycosylated Hemoglobin Test (Hemoglobin A1c) - A blood test can measure the amount of glycosylated hemoglobin in the blood. The glycosylated hemoglobin test shows what a person's average blood glucose level was for the 2 to 3 months before the test. This can help determine how well a person's diabetes is being controlled over time.

15. The NHS DPP behavioural intervention is underpinned by three core goals:

    - achieving a healthy weight
    - achievement of dietary recommendations
    - achievement of Chief Medical Officer physical activity recommendations.

16. The long-term aims of the NHS DPP are:

    - to reduce the incidence of Type 2 diabetes;
    - to reduce the incidence of complications associated with diabetes - Heart disease, stroke, kidney, eye and foot problems related to diabetes; and
    - over the longer term, to reduce health inequalities associated with the incidence of diabetes.

National Diabetes Prevention Program across Central Bedfordshire

17. Bedfordshire along with Luton and Milton Keynes were chosen to be on the wave 2 of the national roll out of National Diabetes Prevention Program.

18. Bedfordshire program is commencing from June 2017.

19. Practices from Ivel Valley and Chiltern Vale localities are being approached to take part in this program. Patients registered with GP practices who have high prevalence of Diabetes are being prioritised at the outset to take part in the National Diabetes Prevention Program.

Management of patients with Type 2 Diabetes:

Care Processes

All people with diabetes aged 12 years and over should receive all of the nine NICE recommended care processes and attend a structured education programme when diagnosed**.**

Nine Annual Care Processes for all people with diabetes aged 12 and over

1. HbA1c
(blood test for glucose control)
2. Blood Pressure
(measurement for cardiovascular risk)
3. Serum Cholesterol
(blood test for cardiovascular risk)
4. Serum Creatinine
(blood test for kidney function)
5. Urine Albumin/Creatinine Ratio
(urine test for kidney function)
6. Foot Risk Surveillance
(foot examination for foot ulcer risk)
7. Body Mass Index
(measurement for cardiovascular risk)
8. Smoking History
(question for cardiovascular risk)
Responsibility of NHS Diabetes Eye Screening (screening register drawn from practices)
9. Digital Retinal Screening

20. **NICE recommends treatment targets for HbA1c (glucose control), blood pressure and serum cholesterol:**

    1. **Target HbA1c** reduces the risk of all diabetic complications.

    2. **Target blood pressure** reduces the risk of vascular complications and reduces the progression of eye disease and kidney failure.

    3. **Target cholesterol** reduces the risk of vascular complications.

21. The percentage of people with Type 2 Diabetes across Bedfordshire who achieved the NICE recommended treatment targets:
(National Diabetes Audit 2015-16)

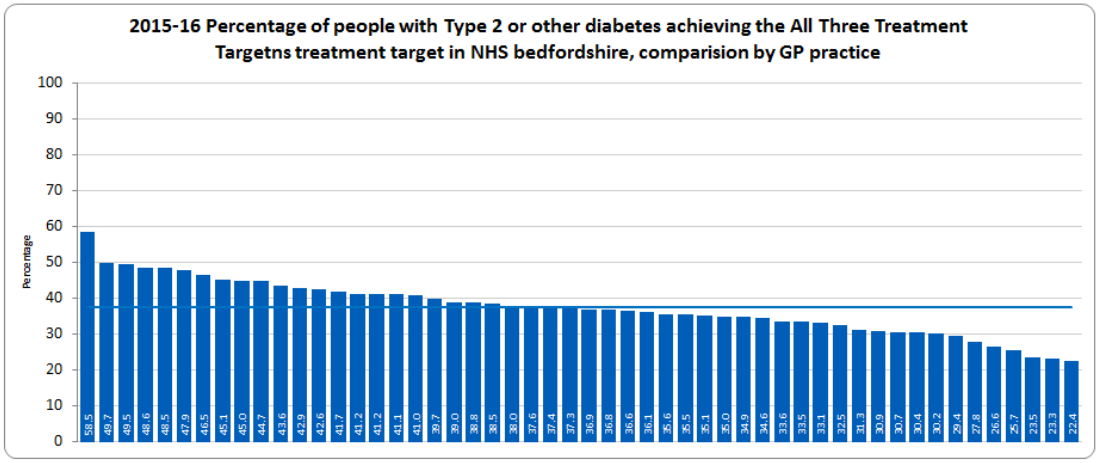
	NHS BEDFORDSHIRE CCG (06F)	ENGLAND
	Percentage completed	**Percentage completed**
HbA1c < 48 mmol/mol (6.5%)	28.1	28.2
HbA1c <= 58 mmol/mol (7.5%)	66.5	65.9
HbA1c <= 86 mmol/mol (10.0%)	94.6	93.4
Blood Pressure <= 140/80	68.5	73.7
Cholesterol < 4 mmol/L	41.6	42.3
Cholesterol < 5 mmol/L	77.1	77.2
All Three Treatment Targets	37.6	40.4

22. **<u>Detailed analysis of information published by NHS England</u>** has been combined with our local information which has suggested that there is huge variation across Bedfordshire in practices achieving the NICE treatment targets.

23. The key findings compared to the top 5 CCGs in our comparator CCG group shows:

- Lower proportion of diabetic patients receiving 9 care processes
- Lower proportion of HbA1c <64mmol/mol
- Lower percentage of patients with diabetes attending structured education.

The diagram below shows the variation of treatment targets by GP practice across Bedfordshire:



* This chart contains all GP practices that have participated in 2014-15 and 2015-16 within the selected CCG.

24. The **<u>possible causes of underachievement</u>** of the diabetes treatment targets are:

a) Lack of capacity within primary care to support patients with diabetes to develop care plans that is comprehensive and has holistic support in the form of clinical management, lifestyle interventions as well as medicine management.

b) Lack of awareness of up-to-date clinical information for practice nurses and GPs who are managing care of diabetes.

c) Lack of live and regular data available to GPs to monitor patient's progress at practice level so that call/recall can be established to target patients who are consistently non-compliant on their treatment.

d) Inadequate provision for structured education and self-empowering techniques used along with clinical management of patients with diabetes.

e) Lack of support from a trained psychologist to work with patients with diabetics who are resistant to change in lifestyle and medication compliance.

f) Lack of a population focus on diabetes and lack of targeted approach for patients from deprived communities, men and specific age groups.

g) Not enough local information about the experience of patients with diabetes who are from specific cohorts such as BME, pregnant mothers, men and children.

h) Consistent approach to annual reviews and optimisation of the treatment targets and NICE care processes in GP practices.

i) Lack of care planning for all patients with diabetes.

Plan to improve treatment targets for Diabetes for patients across Central Bedfordshire

25. We plan to increase our achievement of three treatment targets from our 2014/15 baseline of 37.4% as follows:

2017/18 40%
2018.19 44%
2019/20 47%
2020/21 50%

26. We will achieve our aim by delivering on the following plan:

a) To **commission a Locally Commissioned Service (LCS)** for our GP practices to deliver care planning process to all patients with Diabetes. Care plans requires additional effort and time within general practice to work with the patient and develop holistic plans. The locally commissioned service will incentivise for this additional work within primary care.

b) **GP Practices to develop networks** between themselves to share expertise and workforce, expected to cover a minimum of 30-50,000 patients.

c) To invest in **training of practice nurses** to undertake care planning coupled with adequate medicine management.

d) Development of **care planning templates** with quarterly dashboards for practices and CCG providing primary care colleagues with data regularly.

e) **Protected learning time sessions** with GPs and practice nurses with particular focus on case studies of patients who are struggling to optimise their control of treatment targets.

f) An **additional Diabetes Specialist Nurse will be appointed within the community based integrated diabetes service** to focus on practices where patients have poor achievement of treatment targets.

g) **Structured education (SE) -** The provision for structured education will be overhauled across Bedfordshire to support patients with Diabetes who are newly diagnosed as well as those who have been diagnosed in the past but haven't been taking advantage of the structured education. We will provide SE flexibly out of normal working hours and weekends and according to the needs of the patient. For example, patients with learning difficulty and mental health may need a separate approach to accepting SE. This will be delivered by increasing capacity within community based integrated diabetes service by employing additional Diabetes Specialist Nurses. £64K has been secured through the NHS England transformation funds (2017/18) to deliver on this important priority.

h) **A part-time psychologist** with special skills to work with patients who lack motivation will be appointed**. Bedfordshire Wellbeing Service** will work closely with GPs and integrated diabetes service to provide additional support to patients with Diabetes where required.

i) All patients with BMI over 28 will be referred to a **community weight management service.** All patients who smoke will be referred to **smoking cessation services.**

j) **Community Based Integrated Diabetes Services will be aligned to GP practices.** Focus of work for these specialised services will be to work with those practices and those patients who are particularly finding it difficult to improve their outcomes.

27. We have been fortunate to secure £170K NHS England Transformation funds (2017/18) to make further investments within our primary care and hospital services to implement the plans above.

Financial and Risk Implications

28. The following two factors can result in delay in delivering on the action plan:

- Inability to recruit to posts within local Integrated Diabetes Services to deliver added support to primary care may delay the improvement journey.

- Capacity and pressures within primary care continue to be challenging.

29. Mitigation plans are being developed by accessing Specialist Diabetes Nurses from other organisations such as National Service for Health Improvement (NHSI) to support those practices who have limited capacity and struggling with recruitment of staff.

Governance and Delivery Implications

30. Updates will be made available to the Central Bedfordshire Health and Wellbeing Board on a regular basis.

Equalities Implications

31. There is ample available evidence nationally as well as locally which clearly points to the fact that socio-economic inequalities in diabetes care do exist. Low individual Socio Economic Status and residential area deprivation are often associated with worse process indicators and worse intermediate outcomes, resulting in higher risks of microvascular and macrovascular complications. These inequalities exist across different health care systems. An evidence based, system wide approach of addressing overall care for patients with Diabetes is therefore warranted across Central Bedfordshire.

Conclusion and next Steps

32. Improving care of patients with Diabetes requires a system approach. We look forward to working in partnership across health and social care to improve outcomes for patients with Diabetes.