Bedfordshire
Clinical Commissioning Group

Improving outcomes for patients with Diabetes 2017-2021

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Bedfordshire Clinical Commissioning Group

Diabetes Case for Change

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- Rising number of people with diabetes
  - 8.0% (29,744) - 2015
  - Forecast to rise to 9.2% (42,680) by 2035
- High prevalence of obesity - a key contributor to the development of Type 2 diabetes
- Lack of personalised care planning with patients as part of their Diabetes Annual Review
- Some variation of care across practices
- High rate of activity and expenditure on unplanned Diabetes admissions
- High rate of amputations and admissions for people with foot care problems

NDA - Diabetes Care Processes and Treatment targets

Type 1	2015/16	2016/17
% Received NICE Care Processes	51.6%	47.4%
% Achieved Nice treatment targets	19.8%	20.1%

Type 2	2015/16	2016/17
% Received NICE Care Processes	65.5%	43.2%
% Achieved Nice treatment targets	37.6%	38.1%

Our transformation plan to improve care for patients with pre-Diabetes 2017-2021

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Issue	Solution
A rising number of patients with pre-diabetes	**NHS Diabetes Prevention Programme (Healthier You)** A joint initiative from Public Health England, NHS England and Diabetes UK. Long term intervention - 13 group sessions, spread across a minimum of 9 months. Participants aim to make positive changes to their lifestyle to achieve 3 key goals: • Weight loss • Achievement of dietary recommendations • Achievement of physical activity recommendations The programme commenced in May 2018.

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NHS Diabetes Prevention Programme

- Original referral targets for BCCG were:

2017/18	2018/19	Total
800	940	**1740**

Up to July 2018 :

- 32% of the referrals attended the Initial Assessment
- 92 people have attended 6 months session
- There is on an average of 3.4 kgs weight loss noticed in the 6 months in these patients.

BLMK
Sustainability & Transformation Plan

Our transformation plan to improve care for patients with pre-Diabetes 2017-2021

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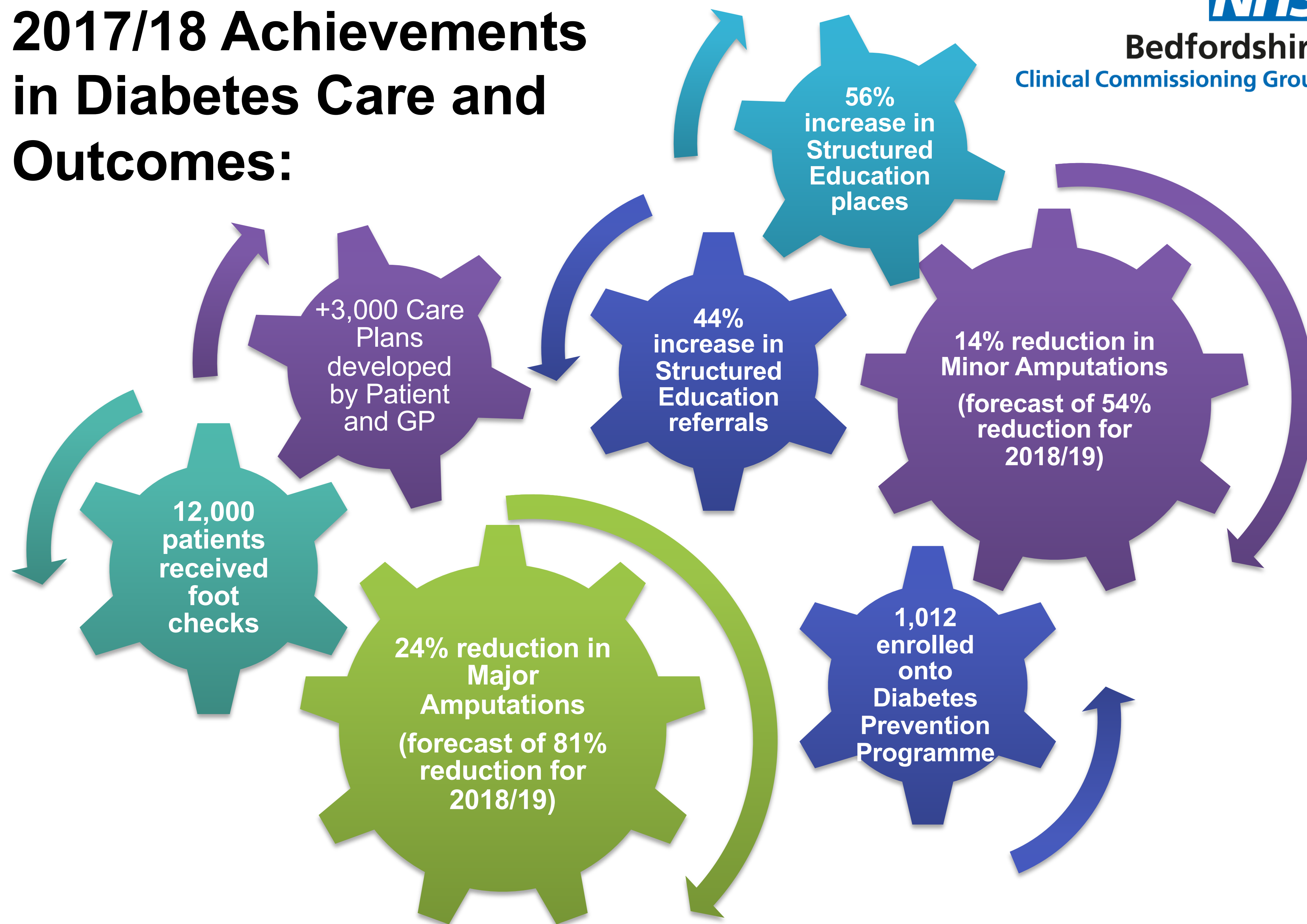
Issue	Solution
Patients not achieving NICE recommended treatment targets (HbA1c, cholesterol and blood pressure).	**Diabetes Treatment & Care Programme** Personalised Care Planning for patients diagnosed with Diabetes supporting improved understanding and management of Diabetes, supported by specialist nurses.
Lack of access to structured education.	Increasing access, availability and uptake to specialised Diabetes Structured Education.
High number of admissions to hospital with diabetic foot disease and high number of amputations.	Improved access to community foot protection team and hospital multi-disciplinary foot team

Transformation Plan supported by investment programme including 2-year NHS England funding. of 2017/18 £564,000 to 2018/19 £814,000

2017/18 Achievements in Diabetes Care and Outcomes:



Bedfordshire Diabetes Improvement Network

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The Transformation Plan has been led by the **The Diabetes Network 'Team'** which includes all of the following key stakeholders:

- Bedfordshire CCG
- Bedford Hospital NHS Trust
- Luton & Dunstable Hospital University Hospital NHS Trust
- East London Foundation Trust
- Bedford Borough Council
- Central Bedfordshire Council
- Diabetes UK
- Health Watch
- Patients

Together, we are confident of continued improvement for our patients as we continue to expand and improve the programme in 2018-19 and beyond.

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What our patients are saying …

‘I would like to let you know about my satisfaction over the consultation and personal care plan I have received from my GP in dealing with my Diabetes.

I have had a personal care plan and support from my GP and I must say that the difference it has made is huge. This is very much different to the traditional treatment and talks I have been having over the years with different GP’s and makes me feel that my GP very much understands my personal treatment needs and it is no longer a generic discussion. This has restored my faith back in the NHS’

Bedfordshire CCG Patient

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What our GPs are saying…..

‘The pathway is fully supported by the new gold standard comprehensive template. Its ability to meticulously complete a comprehensive annual assessment has hugely reassured both us as clinicians and our patients.

I also gladly receive the prominence which has been given to the lifestyle measures section (with embedded patient information) as this is an integral part of the management process.

Finally I would like to thank Dr Ponnala, GP clinical lead, and his team for introducing the new diabetic care planning pathway.’

Dr Roshan Jayalath, Bedfordshire GP

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Questions