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EoE Diabetes Clinical Network

Nick Morrish

9th November 2016

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The history……

- Started April 2013 as part of the EoE Cardiovascular Strategic Clinical Network incorporating existing Cardiac and Stroke Networks and adding Renal as well
- Now EoE Diabetes Clinical Network

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Activity to date

- Liaison with CCGs / Existing Diabetes Groups
- Sub regional Diabetes Advisory Groups
  - Anglia
  - Essex
  - Beds & Herts (MK)
- Resurrected East Anglia Footcare Network (ex NHS Diabetes)
- Maximise National Diabetes Audit Participation
- Local Prevention Projects

NHS

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NHS England

Di... NHS con...

CCG improvement and assessment framework 2016/17

NHS Operational Planning and Contracting Guidance 2017-2019

Diabetes Treatment Programme

HEALTHIER YOU

NHS DIABETES PREVENTION PROGRAMME

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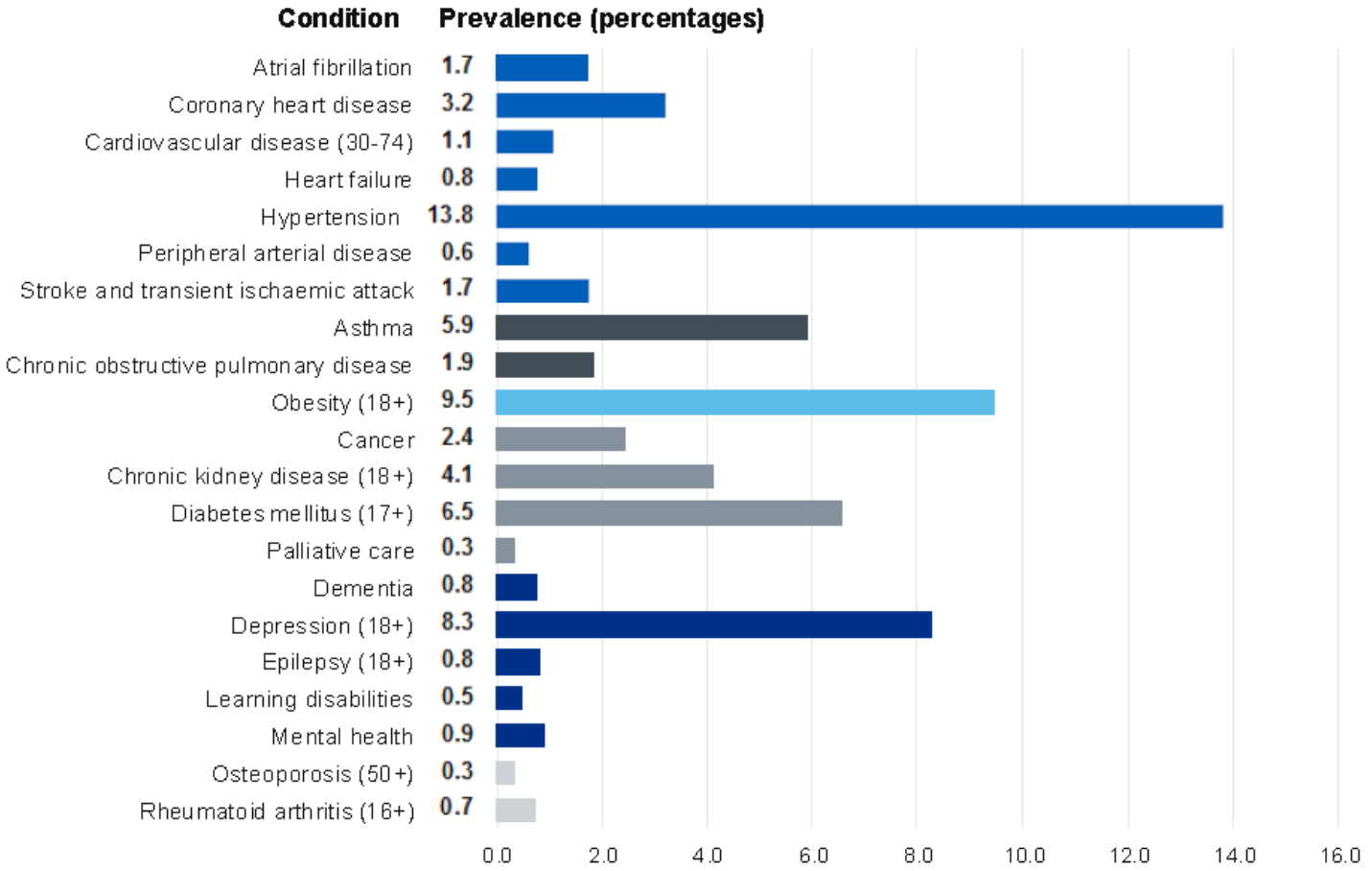
2015/16 QOF

England, 2015-16



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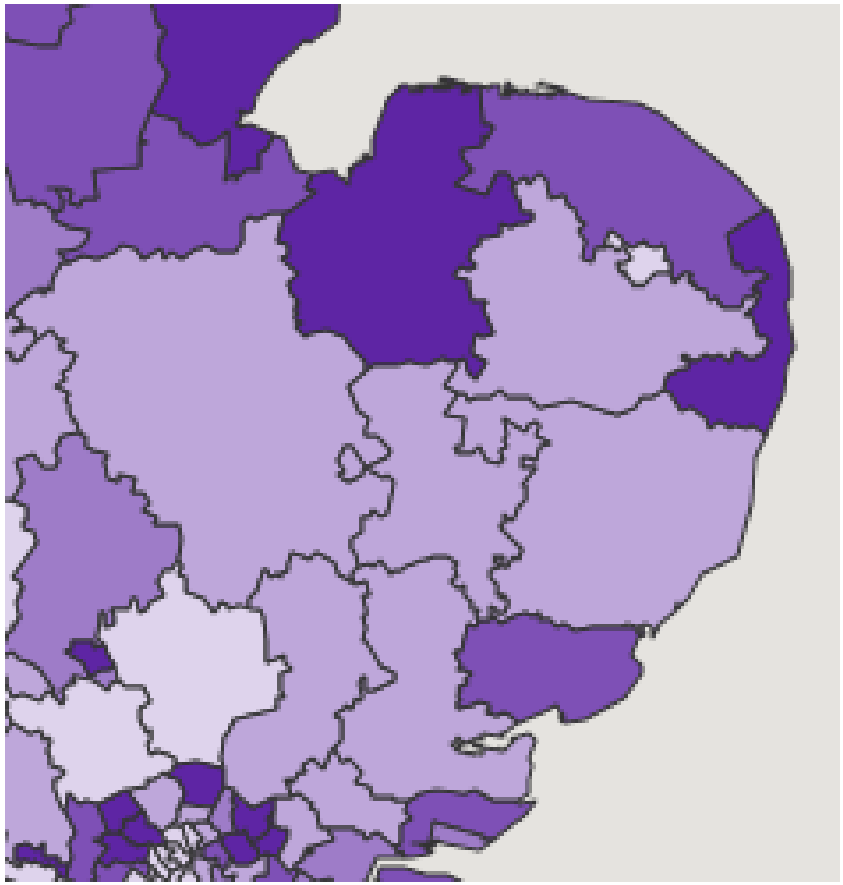
Diabetes Prevalence by CCG

QOF 2015-16

England - 6.55 per cent

	7.4 to 10.3 per cent	(37)
	6.9 to 7.4 per cent	(43)
	6.5 to 6.9 per cent	(39)
	5.8 to 6.5 per cent	(45)
	Less than 5.8 per cent	(45)



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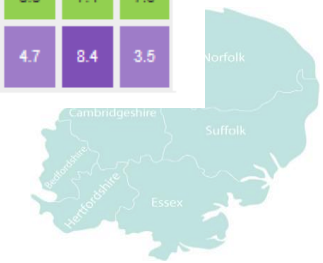
There's a lot of it about…..

Indicator	Period	England	SCN East of England	NHS West Norfolk CCG	NHS Luton CCG	NHS Great Yarmouth And Waveney CC...	NHS Castle Point And Rochford CCG	NHS North Norfolk CCG	NHS North East Essex CCG	NHS Southend CCG	NHS Thurrock CCG	NHS Bedfordshire CCG	NHS West Suffolk CCG	NHS Mid Essex CCG	NHS South Norfolk CCG	NHS Basildon And Brentwood CCG	NHS West Essex CCG	NHS Ipswich And East Suffolk CCG	NHS Cambridgeshire and Peterborou...	NHS East And North Hertfordshire...	NHS Herts Valleys CCG	NHS Norwich CCG
Deprivation score (IMD 2015)	2015	21.8	-	23.2	27.6	28.5	13.9	17.9	22.0	24.5	21.6	14.9	16.4	13.9	15.9	19.6	16.1	17.4	16.4	13.1	11.4	22.9
People over 65	2015	17.1	18.6*	25.4	11.5	23.8	23.0	28.8	22.1	18.5	14.0	16.9	21.9	19.3	22.6	17.7	17.6	21.1	16.1	16.7	15.9	16.8
Diabetes prevalence	2014/15	6.4	6.1	8.0	7.6	7.4	6.9	6.7	6.7	6.3	6.3	6.3	6.2	6.1	6.1	6.0	6.0	5.8	5.7	5.5	5.1	4.8
GP recorded prevalence of obesity in adults (16+)	2014/15	9.0	8.9*	10.6	9.8	10.9	7.9	9.4	9.4	7.9	10.9	9.9	8.7	8.2	10.5	8.5	8.0	9.9	8.5	8.8	7.4	7.6
Percentage of population who identify their ethnicity as Asian or Asian British	2011	7.8	4.8*	1.2	30.0	1.0	1.1	0.6	2.5	3.7	3.8	5.9	1.6	2.0	0.9	2.9	3.8	2.2	5.7	4.7	8.4	3.5



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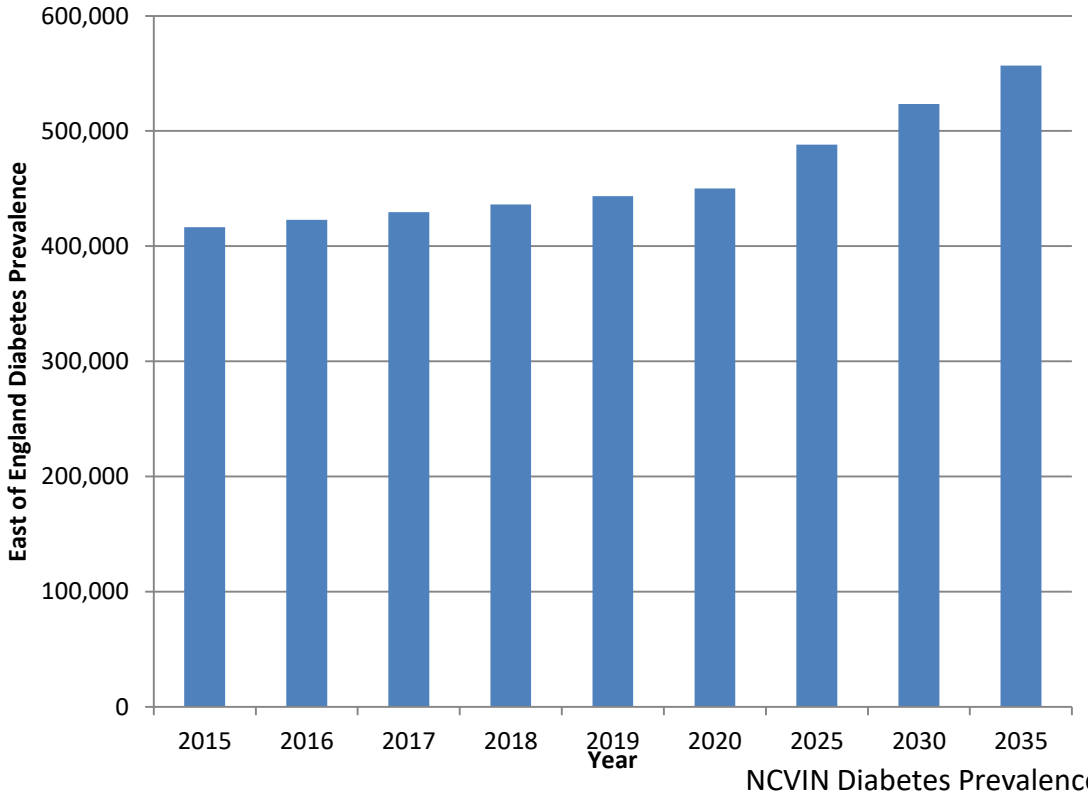
And more to come…..



NCVIN Diabetes Prevalence Model. 2016

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National Diabetes Prevention Programme

- Identify those at high risk of diabetes
- Refer them onto a behaviour change programme.
- Personalised help to reduce risk of Type 2 diabetes:
  - education on healthy eating and lifestyle
  - help to lose weight
  - bespoke physical exercise programmes.

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Phased Roll out

- No demonstrator sites in EoE
- First wave:
  - East and North Hertfordshire
  - Norfolk and Norwich
  - Essex
  - Cambridge and Peterborough
- Second wave announced: BLMK

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CN Funded Local Prevention Projects

Bedford – ESTA (Eat smart, think active) Programme

Weight management groups for people who are at high risk of developing type 2 diabetes

CAM Health LCG

Identify patients at risk during health checks, at other primary care appointments and opportunistic leaflet distribution. Then offered lifestyle change programme including tailored advice and support.

Hunts LCG

Project will reduce the number of new diabetics by identifying those patients at the highest risk of being diagnosed. Identification is by using the Q Diabetes risk scores.

Luton CCG

Increase knowledge in at risk South Asian population. deliver key messages about diabetes, how to prevent it and what support is available

South Norfolk CCG

Education courses for people with a learning disability and their carers in community day centres

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National Diabetes Treatment and Care Programme

New initiative additional to, and separate from, NDPP

Priority areas: Evidence based with proven health economic value

1. Improving uptake of structured education
2. Improving access to diabetes inpatient specialist nursing teams
3. Improving access to a multi-disciplinary foot team for people with diabetic foot disease
4. Improving the achievement of the NICE recommended treatment targets.

- NICE Targets
  - HbA1c <= 58 mmol/mol
  - BP <= 140/80
  - Cholesterol < 5 mmol/l
  - (Children HbA1c <=58 mmol/mol)

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National Diabetes Treatment and Care Programme

- £80m over two years
- Applications due to start soon: ?details released mid-Nov
- Separate application for each clinical area
- Applications from CCGs or ?STP footprints

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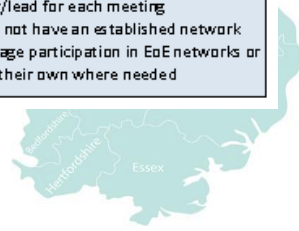
- Regional Diabetes Oversight Group
- CN Diabetes Steering Group
- National Diabetes (S)CN
- Liaison with EoE PHE

East of England Diabetes Clinical Network Work Programme 2016-17

Project Name	Project Objective	Impact	Reference(s)	Project Deliverables
Referral strategy	Work with STPs to develop diabetes prevention strategies that will be able to refer 500 per 100,000 population annually to an evidence based type 2 diabetes prevention programme.	Reduce number of patients who are known to be NDH from developing Type 2 diabetes Reduce variation	FYFV/NHSE National Diabetes Prevention Programme	1. Support identification of appropriate provider for DPP for each STP footprint 2. Work with each STP footprint to establish method of identifying appropriate patients for referral. 3. Work with each STP footprint and PHE to produce appropriate referral pathway.
DPP awareness	Work with areas not yet part of the DPP to support readiness and share learning from the DPP.	Increased number of CCGs and providers aware of the importance of the national DPP	FYFV/NHSE National Diabetes Prevention Programme	1. Diabetes treatment and quality of care, and diabetes prevention included in STPs. 2. KPIs identified and agreed.
Local DPP projects	Continue to support the five local prevention projects through to completion	Over 1000 non-diabetic hyperglycaemic targetted for referral into a local prevention programme	Local Diabetes Network	1. All projects identify suitable patients for prevention programme. 2. All programmes able to demonstrate and report outcomes/findings
NDA participation	Encourage all CCGs and GP practices to fully participate in the NDA.	Increased participation in the NDA across EoE	HSCIC/National Diabetes Audit/PAC	1. Highlight collection dates to all CCGs. 2. Promote consistent message around consent and confidentiality. 3. Highlight low participation to relevant CCGs. 4. Identify issues for IT systems or training causing barriers to participation.
Structured education	10% of newly diagnosed people attending structured education per year to 2021	Increased number of patients attending a structured education programme	FYFV/CCG IAF	1. Improve participation in NDA to enable feedback on areas requiring improved access to diabetes education
NICE treatment targets	40% of patients achieving NICE treatment targets	Increased number of patients achieving all three NICE treatment targets	NICE	1. Improve participation in NDA to enable feedback on areas requiring improved level of performance in relation to the three NICE treatment targets.
Foot care pathway	Improve capacity and pathways for foot care through EoE diabetes foot care network	Reduced variation in access to foot care treatment	NICE	1. Raise awareness of STPs with foot care network 2. Share best practice across network 3. Encourage learning from areas who have existing MDT services e.g. NEE
Inpatient specialist team	Work with all secondry care providers to ensure they have specialist diabetes teams to assess and manage patients with diabetes and that all patients with diabetes have access to those teams.	Reduced variation in access to specialist inpatient	STP planning and assurance process	1. Undertake stocktake of provision of services across EoE. 2. Highlight any gaps in service provision/commissioning to CCGs
CCG IAF	Raise awareness of the CCG IAF across the CCGs in the EoE, proactively identifying areas of variation and poor outcomes, and linking poor performing CCGs with those doing better to try and understand what can be don differently to drive improvement. Working with and supporting CCGs to develop plans to improve care and outcomes.	CCGs across EoE proactively improving care for patients living with diabetes	CCG IAF	1. Raise awareness of CCG IAF and expectations within the document with CCGs at local diabetes meetings 2. Raise awareness of CCG IAF and expectations within the document with Diabetes foot care network 3. Support partners to make links and work together to improve
Leadership	Endorse and further develop locality based diabetes networks to enable clear communication, clinical advice and to cascade national information about diabetes progress, outcomes and new developments and to share best practice, insights and learning across the whole pathway including prevention as identified through the diabetes prevention programme	Increased networking and knowledge sharing between stakeholders	STP planning and assurance process	1. Understand local diabetes networks already established e.g. Essex, C&P, Beds and Herts, paeds, foot care) 2. Make links with chair/lead for each meeting 3. Identify areas who currently do not have an established network 4. Work with stakeholders to encourage participation in EoE networks or enable them to establish their own where needed



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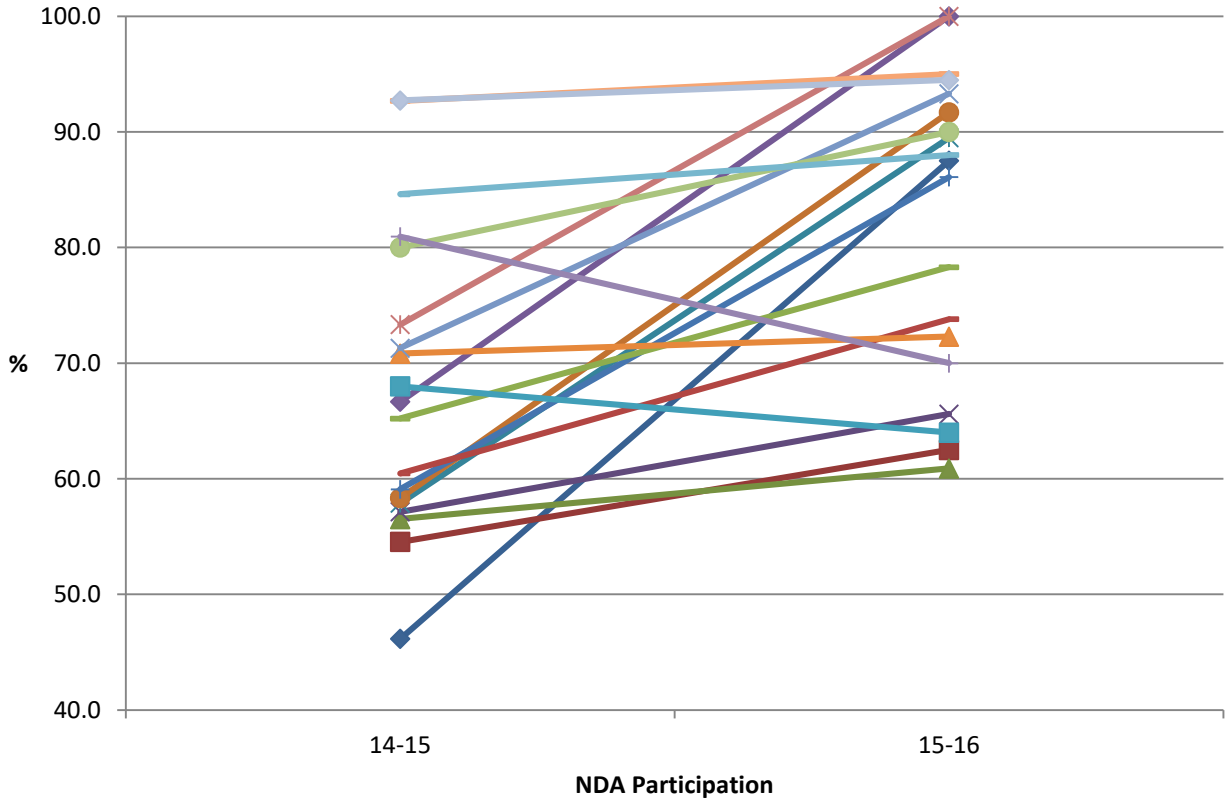
NDA Participation in EoE



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NICE Treatment Targets

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Good blood sugar control in people with diabetes	2014/15	60.4	58.9*	60.5	57.8	56.6	62.5	61.6	61.3	59.0	62.2	58.9	55.3	54.4	60.8	58.0	60.1	57.9	60.4	57.6	64.2	58.2
Good blood pressure control in people with diabetes	2014/15	71.2	69.4	71.8	67.1	66.8	68.0	71.0	69.8	71.2	71.1	66.7	67.9	71.6	69.7	67.0	70.7	69.9	73.4	67.2	73.1	70.1
Good cholesterol control in people with diabetes	2014/15	70.8	69.6*	68.2	70.2	69.3	71.6	70.3	67.2	74.7	69.6	69.3	66.6	72.1	68.4	68.1	69.7	68.4	69.5	65.9	69.3	69.1

PHE Public Health Profile

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IAF 3 NICE Targets

NHS Castle Point and Rochford CCG	G	46.8%
NHS Southend CCG	G	45.4%
NHS Thurrock CCG	G	45.2%
NHS West Norfolk CCG	G	43.0%
NHS East and North Hertfordshire CCG	G	42.5%
NHS West Essex CCG	G	42.4%
NHS Ipswich and East Suffolk CCG	G	42.3%
NHS Basildon and Brentwood CCG	G	42.0%
NHS Herts Valleys CCG	G	41.5%
NHS Luton CCG	A	40.0%
NHS North Norfolk CCG	A	38.4%
NHS West Suffolk CCG	A	38.2%
NHS Great Yarmouth & Waveney CCG	R	37.8%
NHS Norwich CCG	R	37.7%
NHS South Norfolk CCG	R	37.6%
NHS Mid Essex CCG	R	37.0%
NHS Bedfordshire CCG	R	36.7%
NHS Cambridgeshire and Peterborough CCG	R	35.4%
NHS North East Essex CCG	R	34.9%

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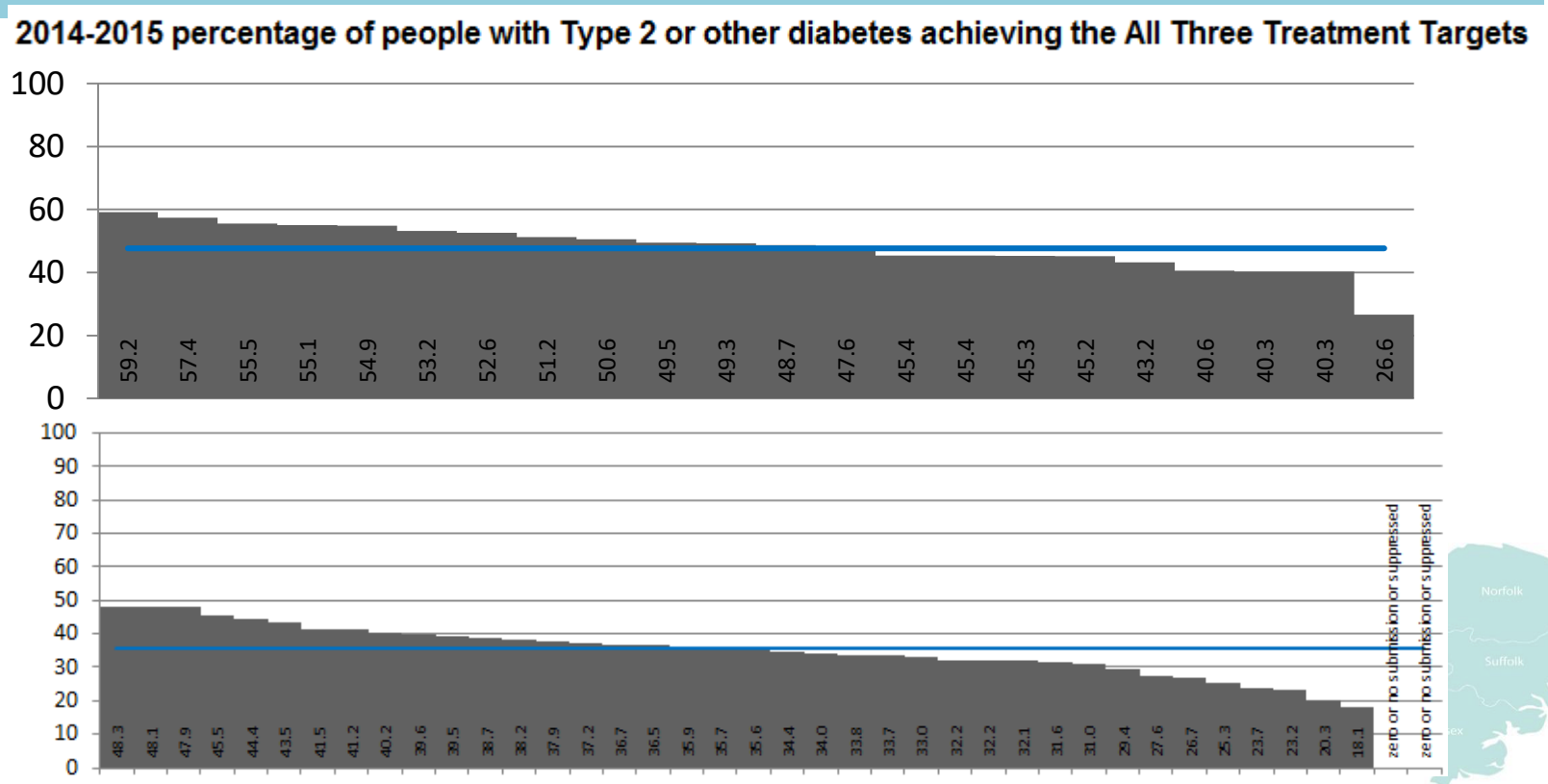
Variation in ‘best and worst’ CCGs



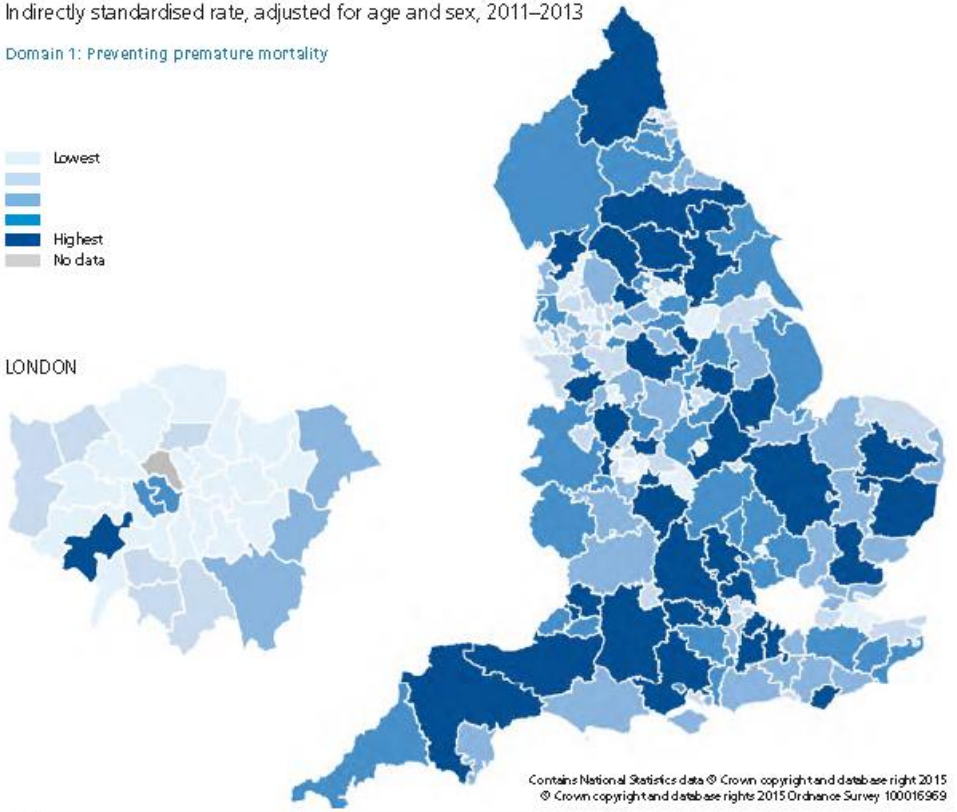
National Diabetes Audit (NDA) 2013-2014 and 2014-2015

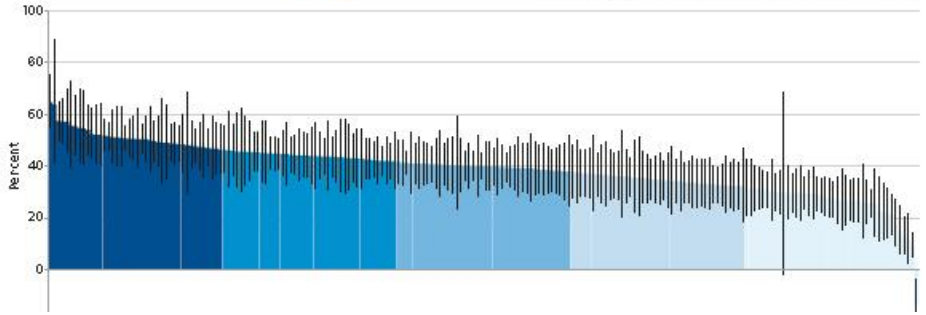
CARDIOVASCULAR FAMILY OF DISEASES: DIABETES

Map 33: Additional risk of mortality among people in the National Diabetes Audit (NDA) with Type 1 and Type 2 diabetes compared with the general population by CCG

In directly standardised rate, adjusted for age and sex, 2011–2013

Domain 1: Preventing premature mortality





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NHS Atlas of Variation in Healthcare, Sept 2016

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Map 35: Relative risk of major lower limb amputation among people in the National Diabetes Audit (NDA) with Type 1 and Type 2 diabetes compared with people without diabetes by CCG

In directly standardised rate, adjusted for age and sex, 2010/11–2012/2013

Domain 1: Preventing premature mortality