Diabetes Transformation in Oxfordshire

Health Improvement Board: 12th September 2019

1. Population

Table 1: Oxfordshire Diabetes Dashboard July 2019 registered diabetes prevalence

	Population	% prevalence of Oxfordshire CCG GP register
Type 1	2,942	0.38%
Type 2	29,599	3.87%
Total	32,541	4.25%

1.1. Public Health England models the prevalence of Diabetes in Oxfordshire rising from 7.5% in 2017 to 8.0% in 2025 and 8.5% in 2035. The number of people with diabetes in Oxfordshire is projected to rise to 46,300 in 2025 and 52,400 in 2035[i]. The number of people in Oxfordshire with undiagnosed diabetes is expected to rise from about 11,000 now to 16,000 in 2035.

2. NHS Diabetes Prevention Programme (NDPP)

2.1. The NDPP is a behavioural intervention to prevent or delay the onset of Type 2 diabetes in those people who are at risk of developing the condition, defined as those who have non-diabetic hyperglycaemia (NDH). It is underpinned by three core goals for those taking part in the programme of:

- Achieving a healthy weight
- Achievement of dietary recommendations
- Achievement of physical activity recommendations

2.2. Oxfordshire CCG (OCCG) in partnership with Buckinghamshire CCG joined Wave 2 of the NDPP. NDPP is commissioned by NHS England and OCCG has a memorandum of understanding (MOU) with NHS England to enable mobilisation of NDPP within Oxfordshire and to facilitate referrals onto the programme.

2.3. The NDPP commenced in Oxfordshire from June 2017. From June 2017 until July 2019 the provider of the NDPP in Oxfordshire and Buckinghamshire was Ingeus. NHS England re-commissioned the NDPP for the Buckinghamshire, Oxfordshire and Berkshire West (BOB) area under a single contract in early 2019. As a result, a new provider ICS Health and Wellbeing was awarded a three year contract to provide the NDPP across the BOB area. The new contract commenced on 1st August 2019, and so far the switchover from Ingeus to ICS Health and Wellbeing has been implemented smoothly.

2.4. For those joining the programme the total duration is 9 months, starting with an initial assessment and 6 fortnightly face-to-face group sessions in the first 3 months followed by a further 7 group sessions and end of programme review over the remaining 6 months. For those who cannot attend the face-to-face sessions a digital option is available.

2.5. From June 2017 to July 2019:

- **4,241** people have been referred to the programme in Oxfordshire. Nationally 86% of GP practices are referring into the programme, across the BOB area 97% of GP practices are referring.
- **2,013** people have started the programme in Oxfordshire, a referral to start conversion rate of 47%.
- From NHS England data for the South of England 50% of people who start the NDPP go onto finish it. NHS England classifies completion as a person attending at least 60% of the programme sessions.

Figure 1: Referrals to NDPP in Oxfordshire

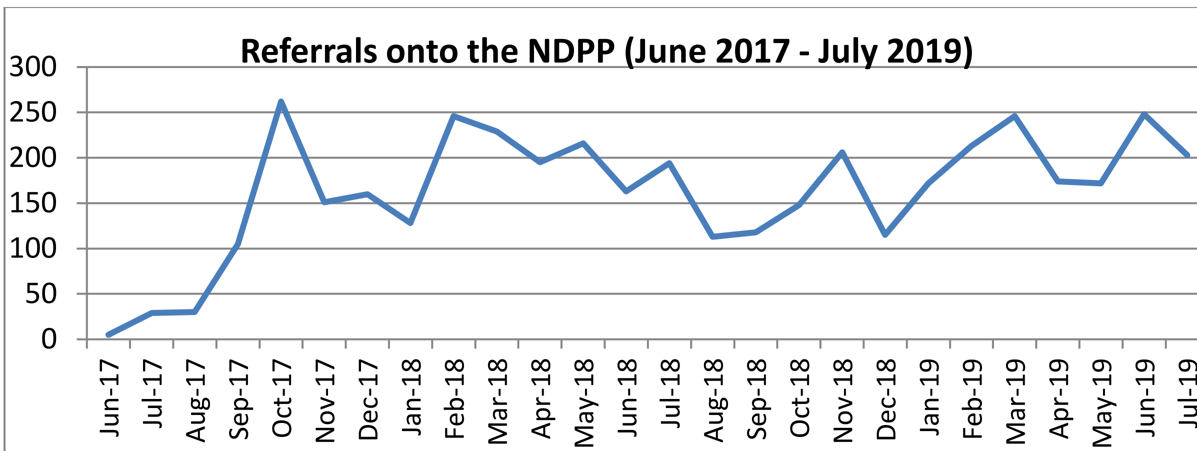


Figure 2: Starts on the NDPP in Oxfordshire

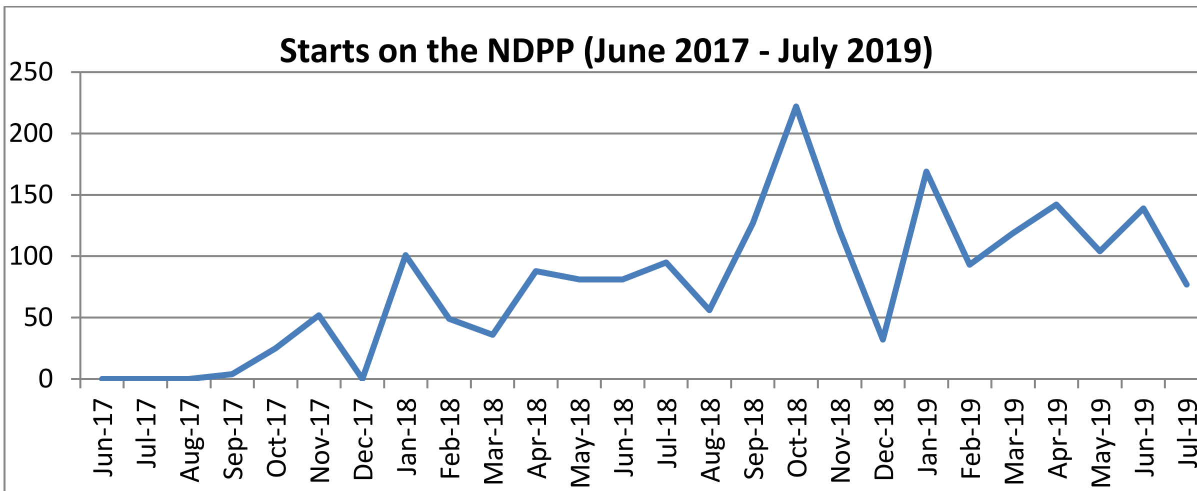
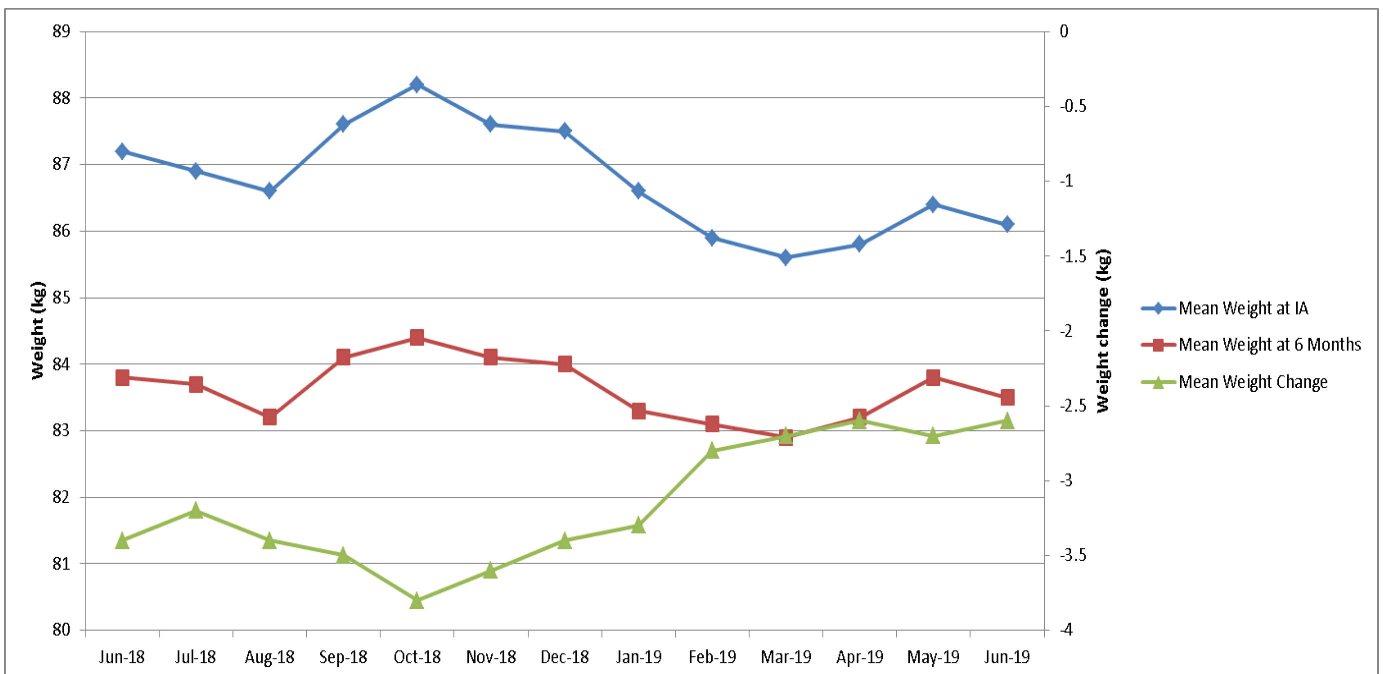


Figure 3: Weight Recording and Weight Change over 6 months on the NDPP (Oxfordshire)



3. Diabetes Transformation

3.1. OCCG in partnership with local NHS providers successfully bid for NHS England Diabetes Transformation Funding in April 2017. This included three project streams:

- Increasing access to patient structured education
- Improving achievement of treatment targets
- Access to a multi-disciplinary footcare team (MDFT)

3.2. Commencement and implementation of each project stream took place over the course of 2017. The initial NHS England funding allocation was for the two years 2017/18 and 2018/19. NHS England has extended that funding into 2019/20 but as a partial contribution from the original total. OCCG has committed extra funding in 2019/20 to ensure the project streams continue.

3.3. Diabetes transformation has been supported by an OCCG diabetes locally commissioned service (LCS) for primary care over the same time period that has included the following:

- Training and support to primarily enable the embedding of Care and Support Planning (Year of Care) for people with diabetes, with additional support and training on motivational interviewing and behaviour change and Making Every Contact Count (MECC).
- Delivery of insulin initiation within primary care for people with Type 2 diabetes, bringing care closer to home for patients.
- Better integration of primary, community and specialist clinicians in the care of people with diabetes through diabetes multi-disciplinary meetings in GP practices and population review and shared best practice meetings at locality level.
- Outcomes focus on improving the completion of all 8 care processes and the three treatment targets.

3.4. Further work is continuing between OCCG and NHS providers to further integrate and improve care for people with diabetes in Oxfordshire.

3.5. Care Process completion

- These are the 8 NICE recommended care processes that diabetes patients should receive on an annual basis. The 2015-16 National Diabetes Audit (NDA) Report found that over a longitudinal analysis there is an association between consistent care process completion and better outcomes including;
  - Lower mortality
  - Reduced progression to heart failure
  - Reduced progression to Renal Replacement Therapy
- Oxfordshire has significantly improved in ensuring all diabetes patients receive all 8 care processes since 2015/16. Care process completion for Type 1 patients was above the England average in the 2017/18 and has continued to improve since as tracked on the Oxfordshire Diabetes Dashboard. Care process completion for Type 2 patients in Oxfordshire in the 2017/18 NDA was the best compared to all other CCGs in Oxfordshire's NHS RightCare Group (comparative group of 10 most similar CCGs).
- The dip in care process completion since March 2019 is being reviewed. This may be related to the timing in the year of when patients are recalled for their annual review appointment.

Figure 4: Type 1 patients receiving all 8 care processes in Oxfordshire (National Diabetes Audit)

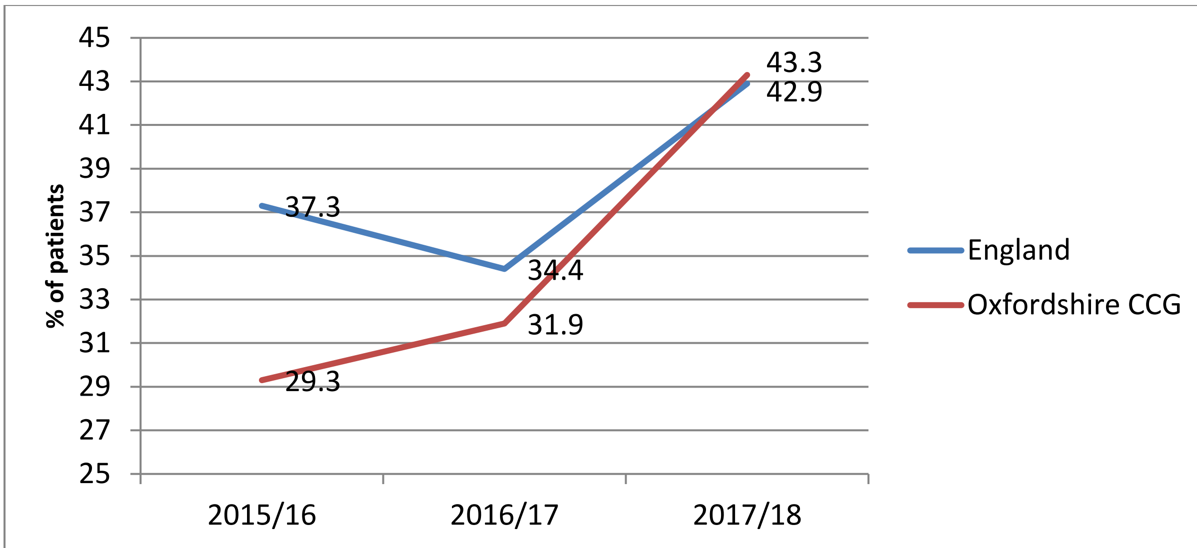


Figure 5: Type 1 patients receiving all 8 care processes in Oxfordshire (Oxon Diabetes Dashboard)

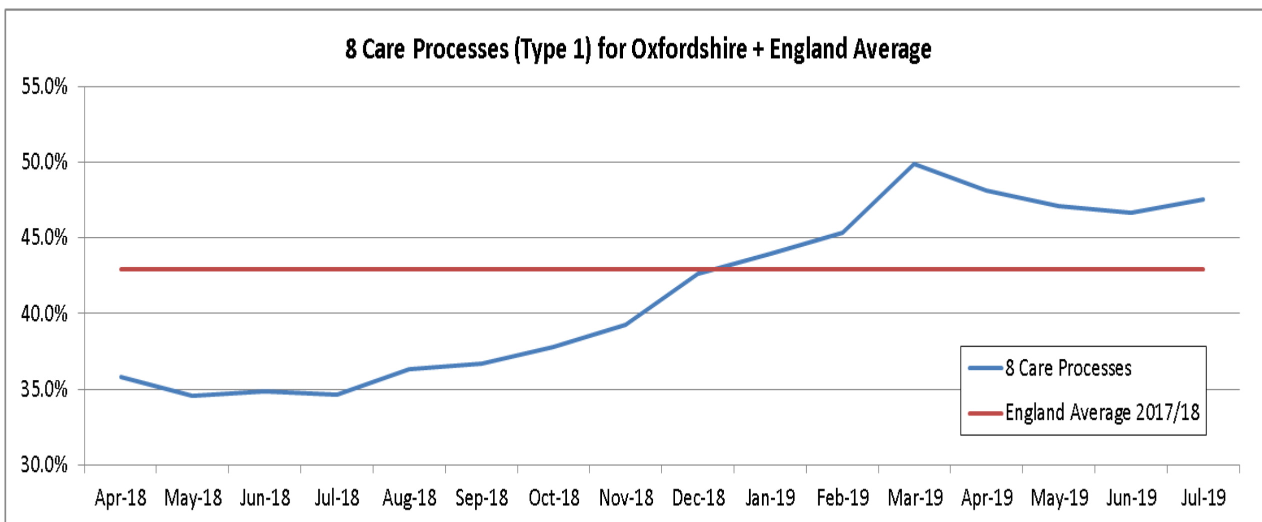


Figure 6: Type 2 patients receiving all 8 care processes in Oxfordshire (National Diabetes Audit)

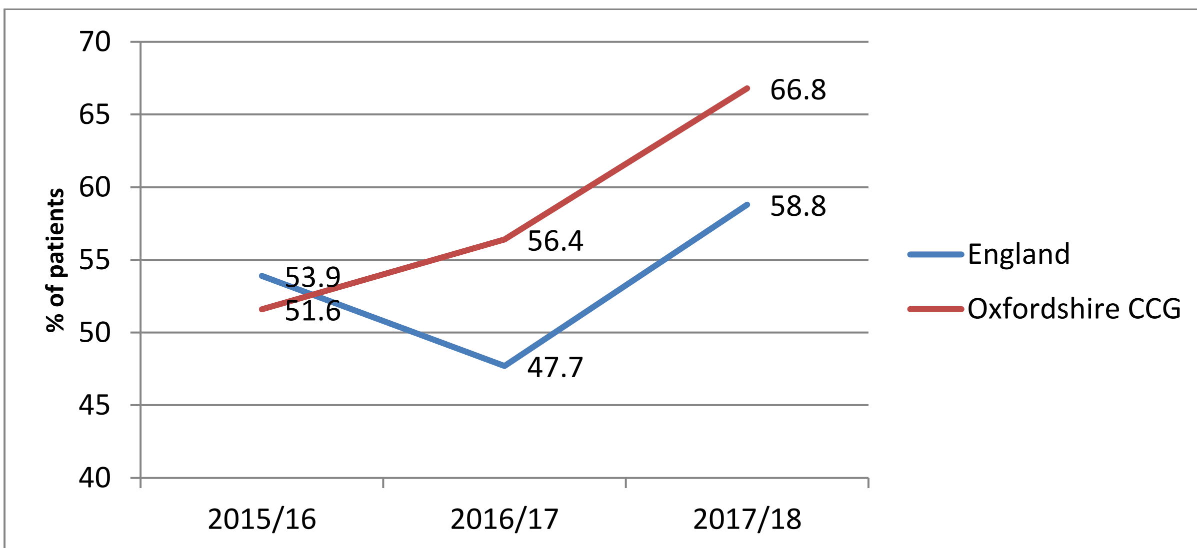
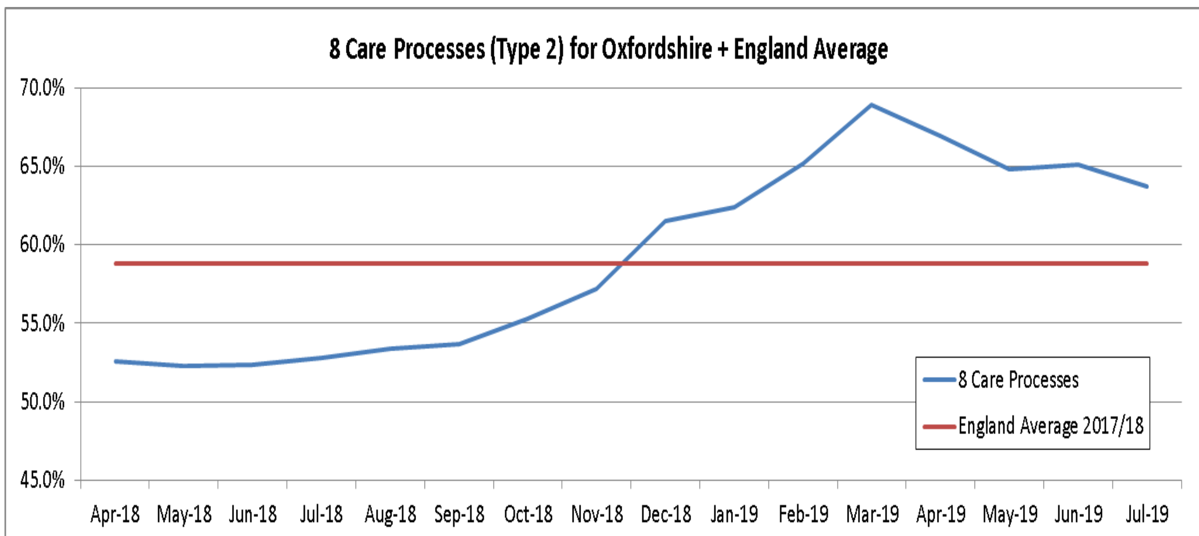


Figure 7: Type 2 patients receiving all 8 care processes in Oxfordshire (Oxon Diabetes Dashboard)



3.6. *Treatment Target achievement*

- These are NICE recommended treatment targets for blood sugar, blood pressure and cholesterol. They are recommended because achieving them reduces the risk of future complications from diabetes.
- Achievement of treatment targets in Oxfordshire Type 1 patients was above the England average in the 2017/18 NDA and the best compared to other CCGs in Oxfordshire's NHS RightCare group.
- Achievement of treatment targets in Oxfordshire Type 2 patients was below the England average in the 2017/18 NDA, but reached the England average in March 2019. It should be noted that the drop in treatment target achievement locally in 2017/18 was also reflected in national data.
- Improving treatment targets is an outcome rather than a process and can therefore take longer to achieve. There is a concerted effort to improve treatment target achievement to reach above the England average consistently for all diabetes patients; however this has not currently been achieved for Type 2 patients. The specific dip in treatment target achievement since March 2019 is being reviewed; this may be related to the timing in the year of when patients are recalled for their annual review appointment.
- The expectation is that the significant improvement in care process completion will have a positive effect on improving treatment target achievement as this has been shown to follow over time. A number of other initiatives are underway to improve treatment targets, some of which are mentioned above but also include: an increase in the community diabetes nursing workforce, diabetes education for healthcare professionals, and physical activity support for people with diabetes. With these initiatives and further diabetes transformation work planned, we remain confident that treatment target achievement will improve.

Figure 8: Type 1 patients achieving all three treatment targets in Oxfordshire (National Diabetes Audit)

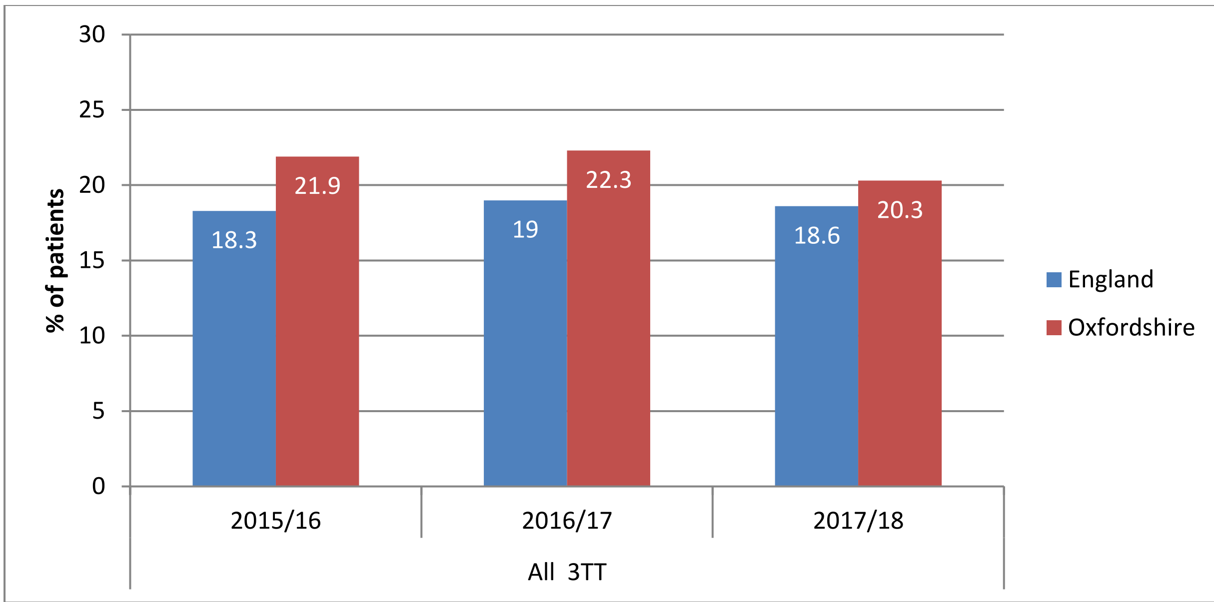


Figure 9: Type 1 patients achieving all three treatment targets in Oxfordshire (Oxon Diabetes Dashboard)

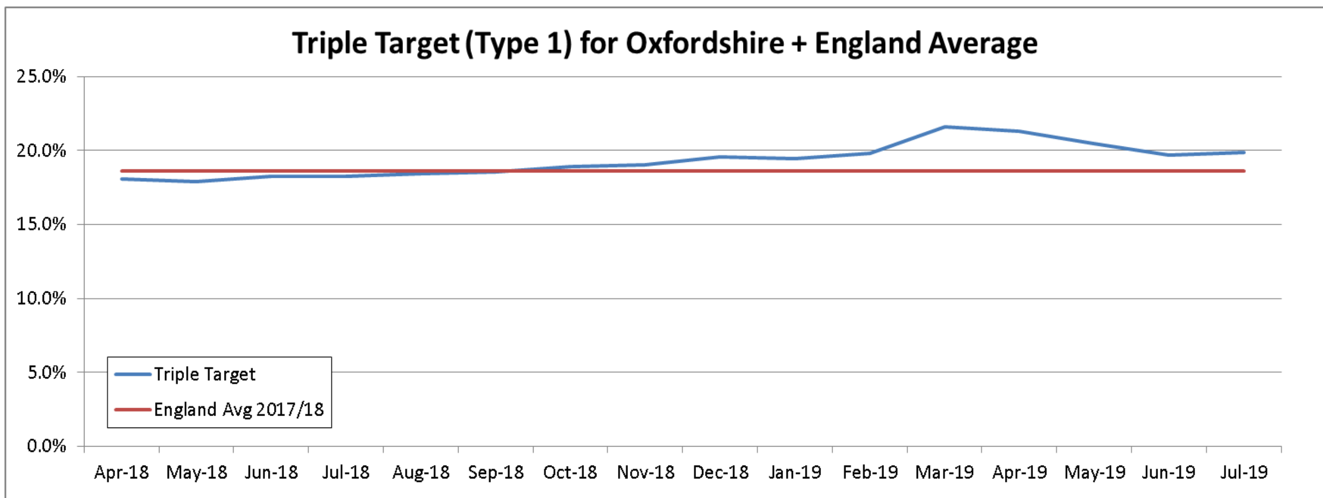


Figure 10: Type 2 patients achieving all three treatment targets in Oxfordshire (National Diabetes Audit)

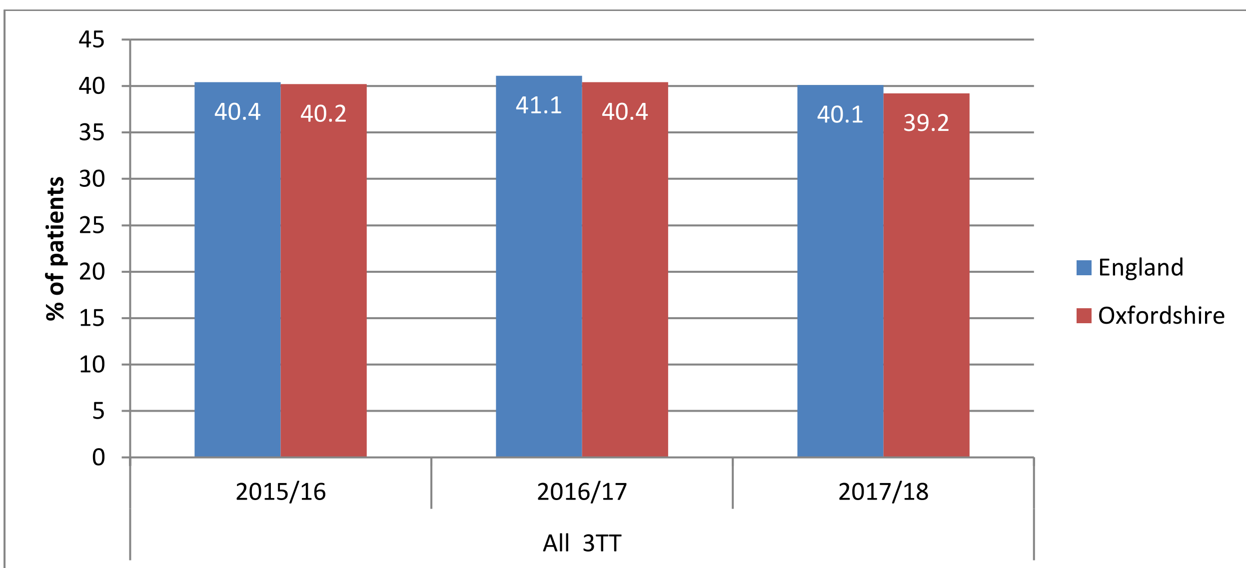
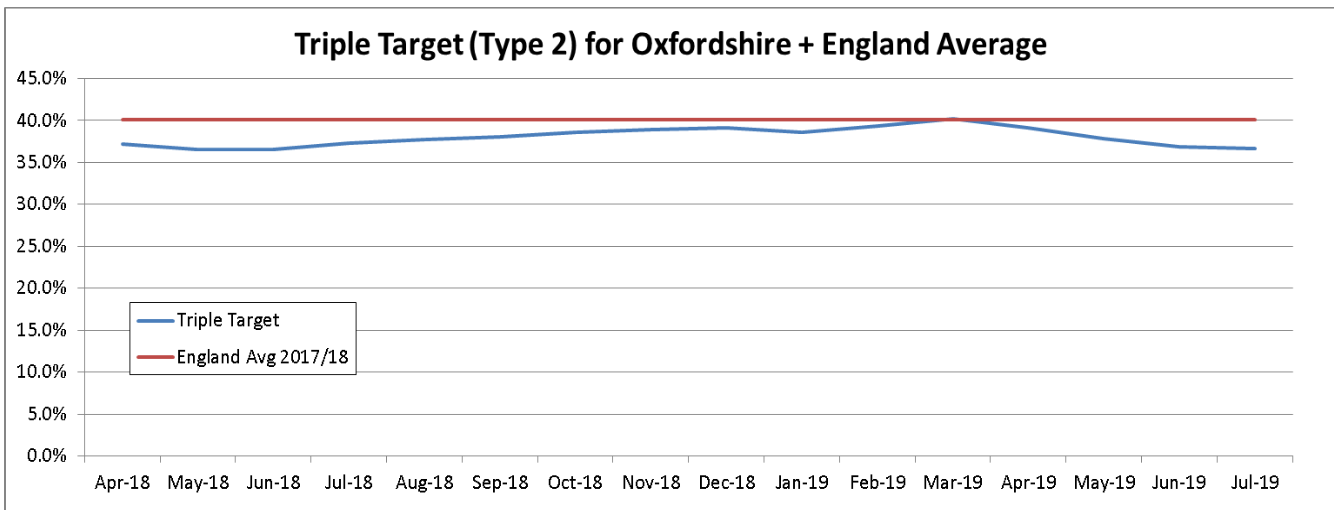


Figure 11: Type 2 patients achieving all three treatment targets in Oxfordshire (Oxon Diabetes Dashboard)



3.7. Structured patient education attendance

- Structured education is recommended under NICE guidelines for all diabetes patients to improve their understanding of their long-term condition and provide them with the knowledge, skills and confidence to be able to manage their condition effectively.
- For Type 1 patients the Diabetes Transformation Funding enabled the adoption of the NICE accredited DAFNE education programme, the training of staff to deliver it and the programmed delivery to both newly diagnosed and those who have been diagnosed beyond 12 months. This is delivered by Oxford University Hospitals NHS FT, which is now the second busiest centre in the country delivering the DAFNE programme.
- The Diabetes Transformation Funding enabled investment to increase the workforce of the Oxford Health NHS FT Community Diabetes Nursing Team, who are the same team that deliver structured education to Type 2 patients. The funding also enabled the team's locally developed courses to become nationally accredited through QISMET. As shown below the team has delivered a significant uplift in education activity from 840 attendances delivered in 2016/17 before the transformation funding was allocated.
- As a system we need to continue to improve the coding of patient attendance at structured education within the primary care record, because the National Diabetes Audit data does not reflect the true number of patients that have attended structured education as set out in provider data below.
- In 2018/19:
  - ➢ 209 people with Type 1 diabetes were referred to structured education and **108** of those people attended structured education.
  - ➢ 2,417 people with Type 2 diabetes were referred to structured education and **1,312** of those people attended structured education

Figure 12: Oxfordshire Type 1 Diabetes Patients Referred and Attending Structured Education (Provider Data)

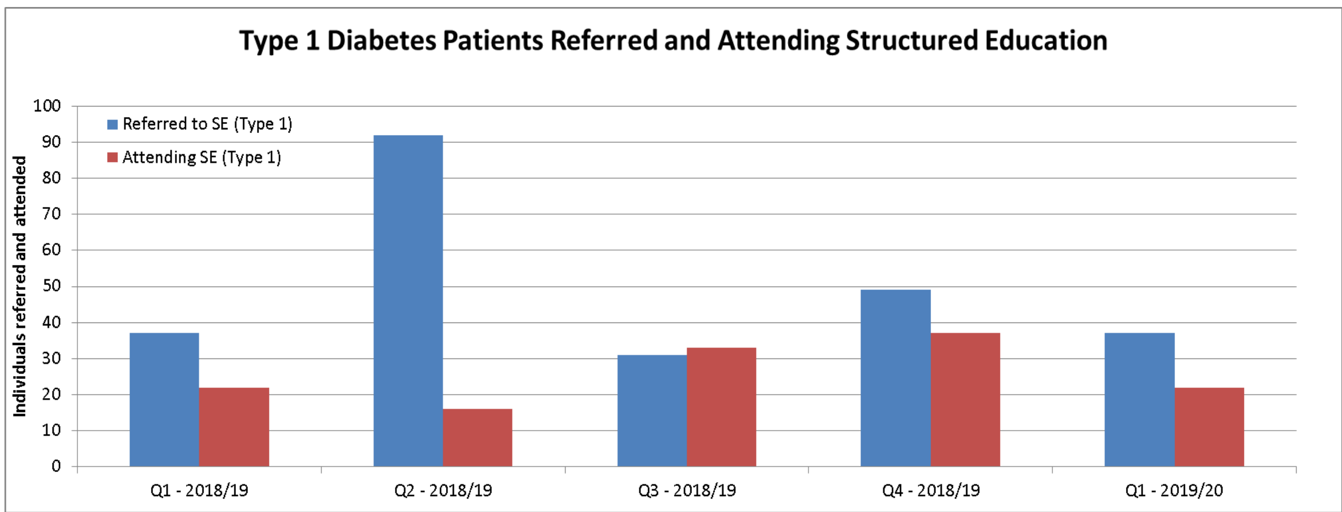
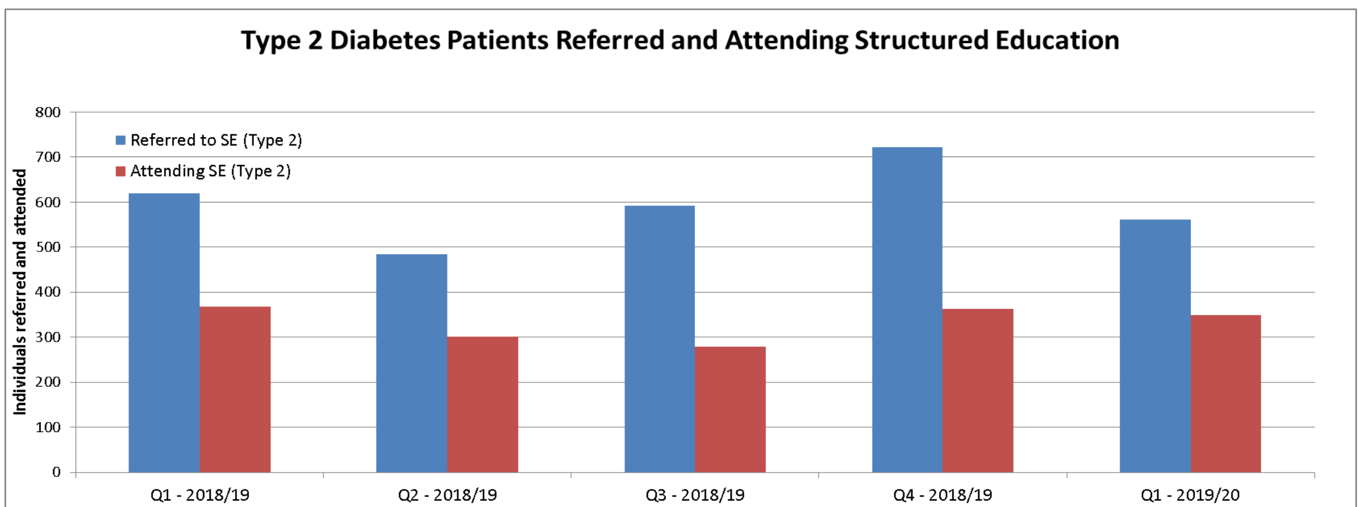


Figure 13: Oxfordshire Type 2 Diabetes Patients Referred and Attending Structured Education (Provider Data)



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[i] Diabetes prevalence estimates for CCGs by ONS resident populations, Public Health England, 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/611265/Diabetes_prevalence_estimates_for_CCGs_by_ONS_resident_populations.xlsx