Tackling Variation In Diabetes Outcomes

The Oxford AHSN Diabetes Clinical Network Launch Event

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UNIVERSITY OF OXFORD

Newspaper headlines in 1922

The challenge, and an unmet need

Diabetes 2012

Home | What We do | Epidemiology and Prevention | Diabetes Atlas

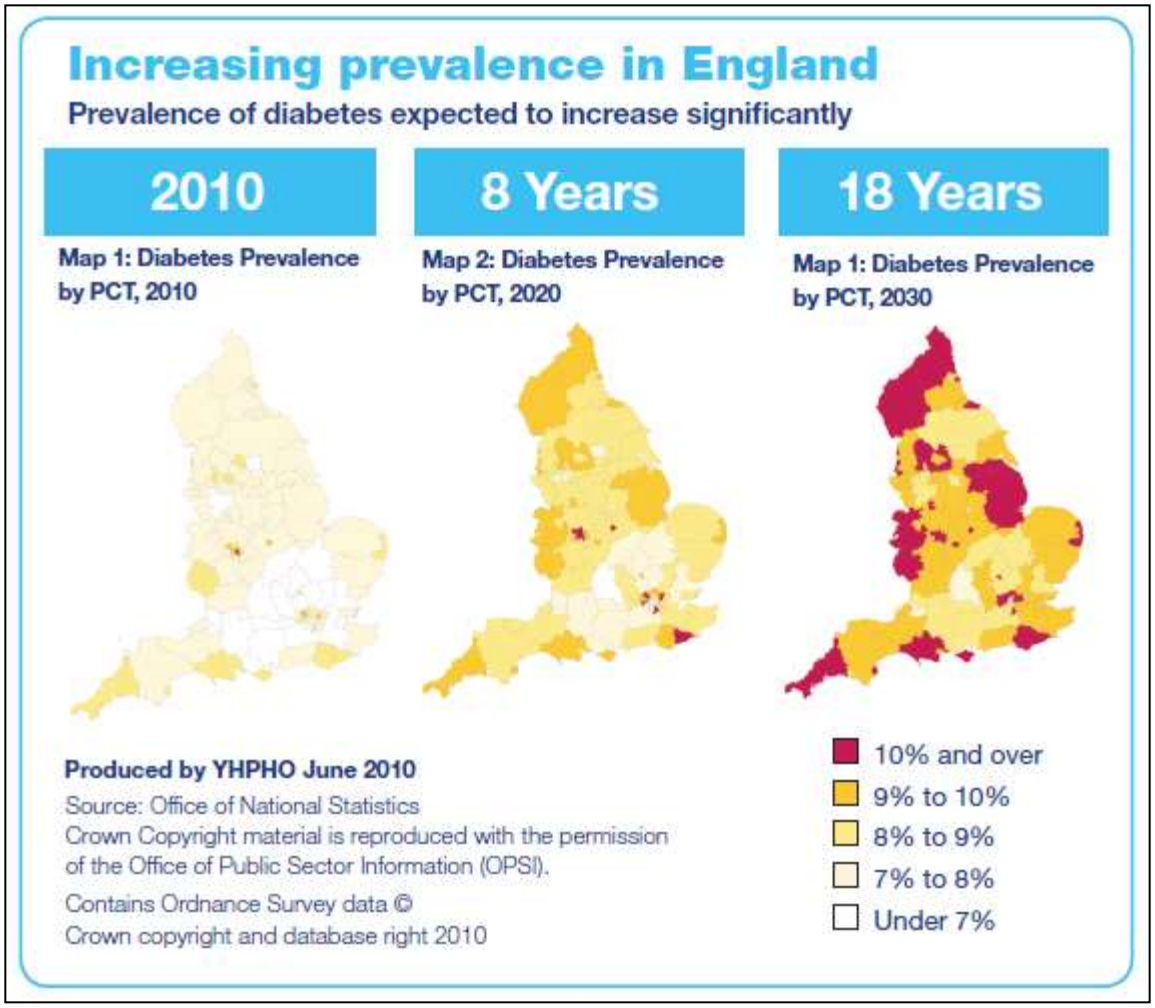
DIABETES ATLAS

- **Acknowledgements**
- **Foreword**
- **What is Diabetes?**
- **The Global Burden**
- Diabetes
- Impaired glucose tolerance (IGT)
- Undiagnosed diabetes
- Diabetes in the young
- Mortality
- Healthcare expenditures
- Generating the numbers
- **Regional Overviews**
- **Diabetes and Development**
- **Linking Local to Global**
- **Resources and Solutions**
- **References**
- **Additional resources**

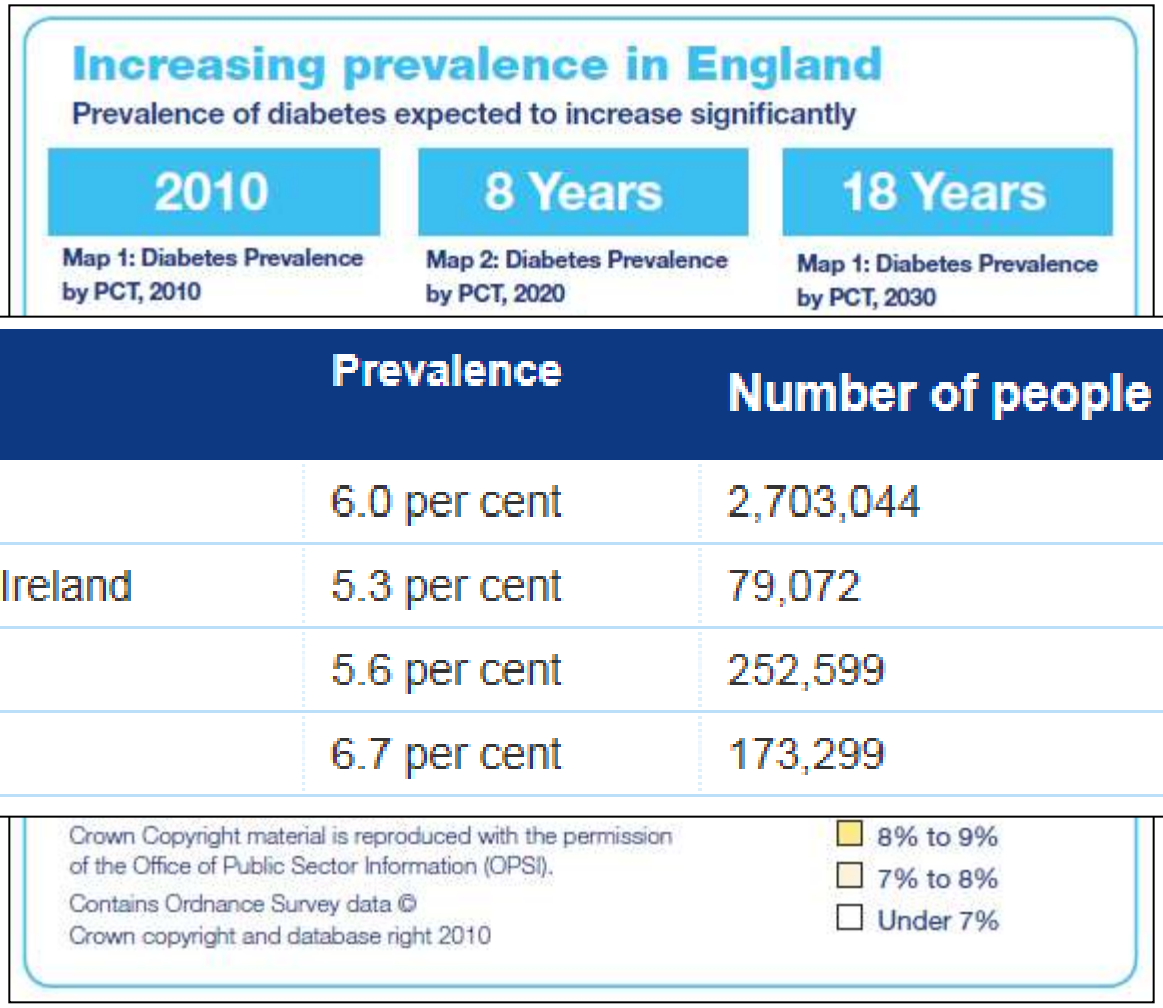
THE GLOBAL BURDEN

- **366 million** people have diabetes in 2011; by 2030 this will have risen to **552 million**
- The number of people with type 2 **diabetes is increasing** in every country
- **80%** of people with diabetes live in **low- and middle-income countries**
- The **greatest number** of people with diabetes are between **40 to 59** years of age
- **183 million** people (50%) with diabetes are **undiagnosed**
- Diabetes caused **4.6 million deaths** in 2011
- Diabetes caused at least **USD 465 billion dollars** in healthcare expenditures in 2011; **11% of total healthcare expenditures** in adults (20-79 years)
- **78,000 children** develop **type 1 diabetes** every year

Diabetes Prevalence

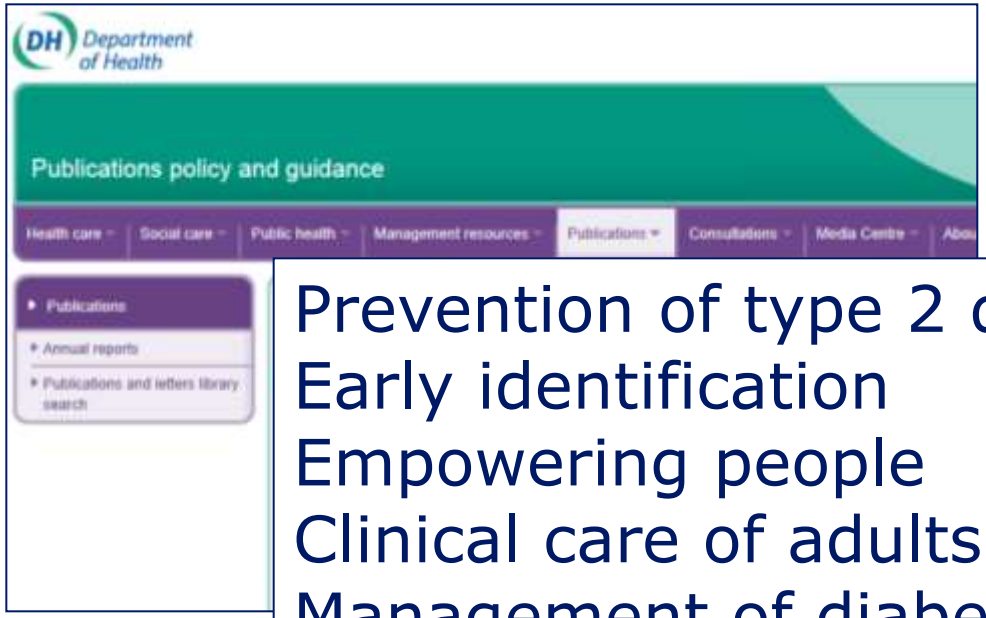


Diabetes Prevalence (2013)



Country	Prevalence	Number of people
England	6.0 per cent	2,703,044
Northern Ireland	5.3 per cent	79,072
Scotland	5.6 per cent	252,599
Wales	6.7 per cent	173,299

The Diabetes NSF (2001)
"A vision for diabetes services in England to be delivered by 2013"



Prevention of type 2 diabetes
Early identification
Empowering people
Clinical care of adults and children
Management of diabetes emergencies
Care during hospitalisation
Pregnancy
Detection and management of long term complications

New Drugs


actos Family
How type 2 diabetes affects the body

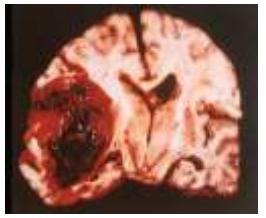

Humalog


Lantus
100 IU/ml

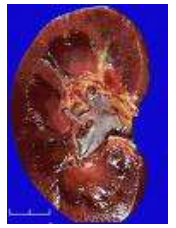

Levemir

Retinopathy increased by 118%

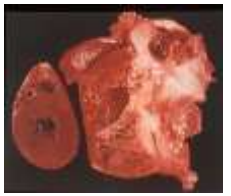
Stroke increased by 87%



Kidney failure increased by 56%



Cardiac failure increased by 43%



Amputations increased by 26%

STATE OF THE NATION 2012

ENGLAND

DIABETES UK

CARE. CONNECT. CAMPAIGN.

National variation in care and outcomes

	Percentage of people with diabetes in England (by PCT)					
	Receiving ALL 9 Key Care Processes	Receiving retinal screening	Receiving kidney functions checks (Urinary Albumin)	Achieving recommended glucose level outcomes	Achieving recommended blood pressure outcomes	Achieving recommended cholesterol outcomes
Maximum	68.7%	91.4%	86.2%	72.3%	61.2%	48.7%
Minimum	6.4%	52.9%	13.4%	50.2%	41.1%	31.2%
England average	**49.8%**	**76.9%**	**70.4%**	**63.3%**	**50.6%**	**40.3%**

	Prevalence of complications (by PCT)			Identification of people with diabetes (by PCT)	
	Diabetic retinopathy	Major amputations	Kidney failure	Actual cases diagnosed as a percentage of the estimated number of people with diabetes	Percentage of eligible people that receive a NHS Health Check at December 2011
Maximum	3.1%	0.2%	1.0%	98.5%	22.1%
Minimum	0.0%	0.0%	0.1%	49.9%	0.0%
England average	**0.5%**	**0.1%**	**0.4%**	**76.6%**	**5.4%**

National Diabetes Information Service

NHS

diabetes Health Intelligence

June 2012

NHS Atlas of Variation in Healthcare for People with Diabetes

Reducing unwarranted variation to increase value and improve quality

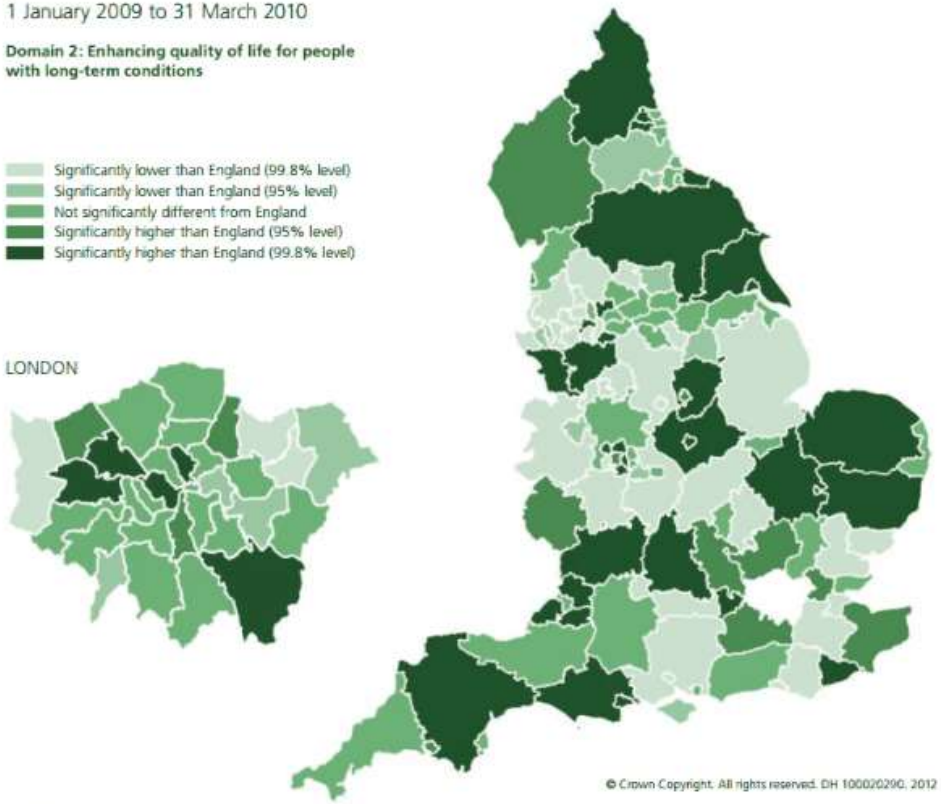
RightCare

www.rightcare.nhs.uk

Map 1: Percentage of people in the National Diabetes Audit (NDA) with Type 1 diabetes receiving all nine key care processes by PCT

1 January 2009 to 31 March 2010

Domain 2: Enhancing quality of life for people with long-term conditions



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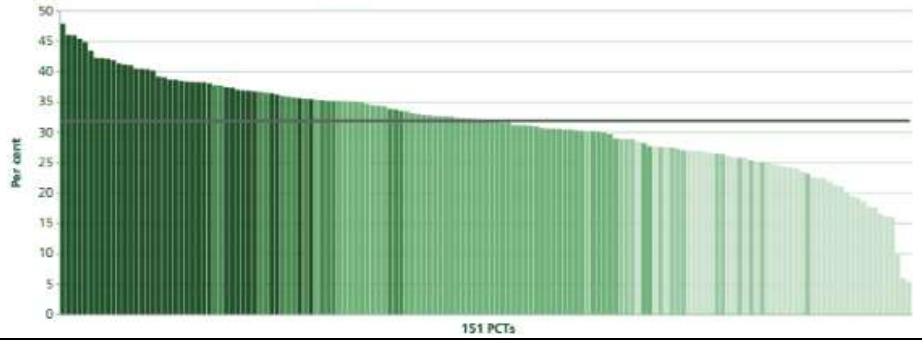
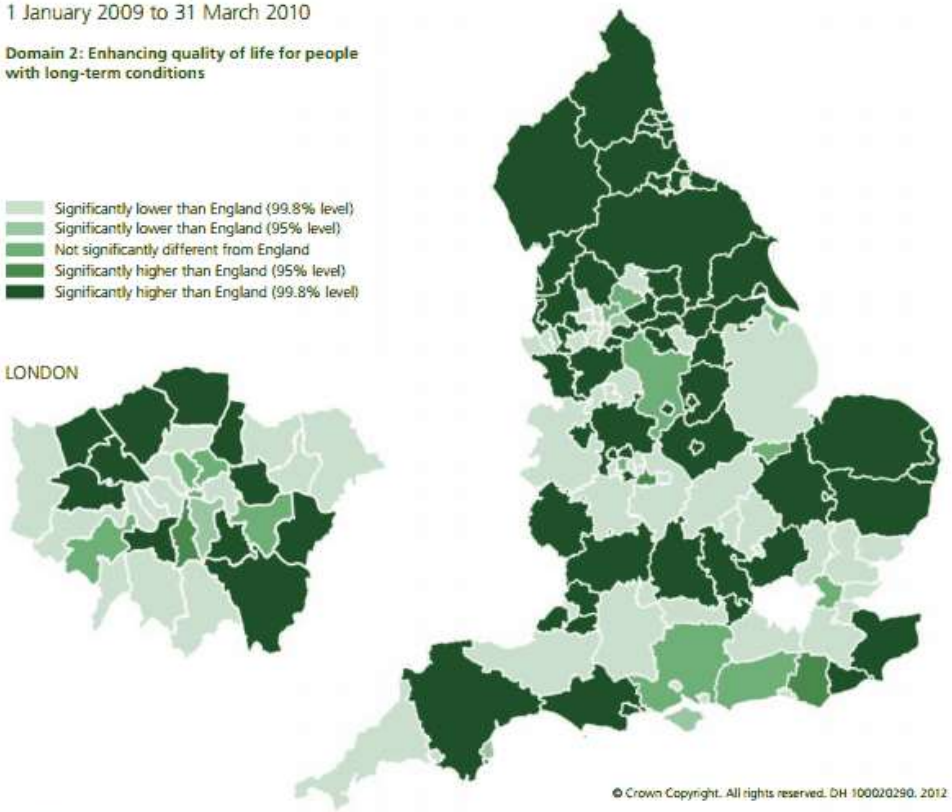


CARE PROCESSES

Map 2: Percentage of people in the National Diabetes Audit (NDA) with Type 2 diabetes receiving all nine key care processes by PCT

1 January 2009 to 31 March 2010

Domain 2: Enhancing quality of life for people with long-term conditions



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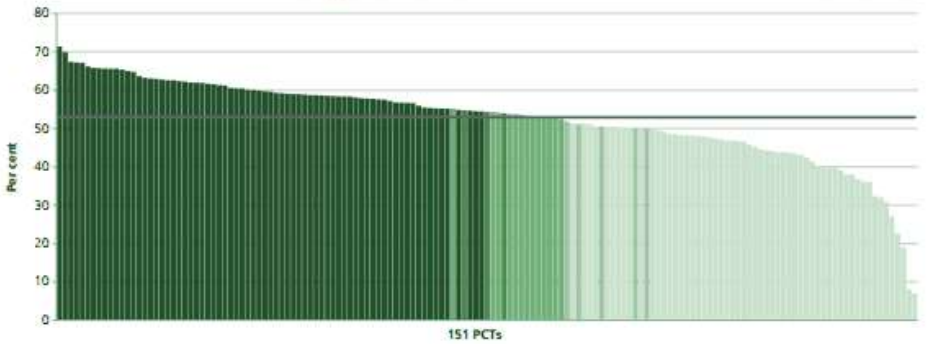
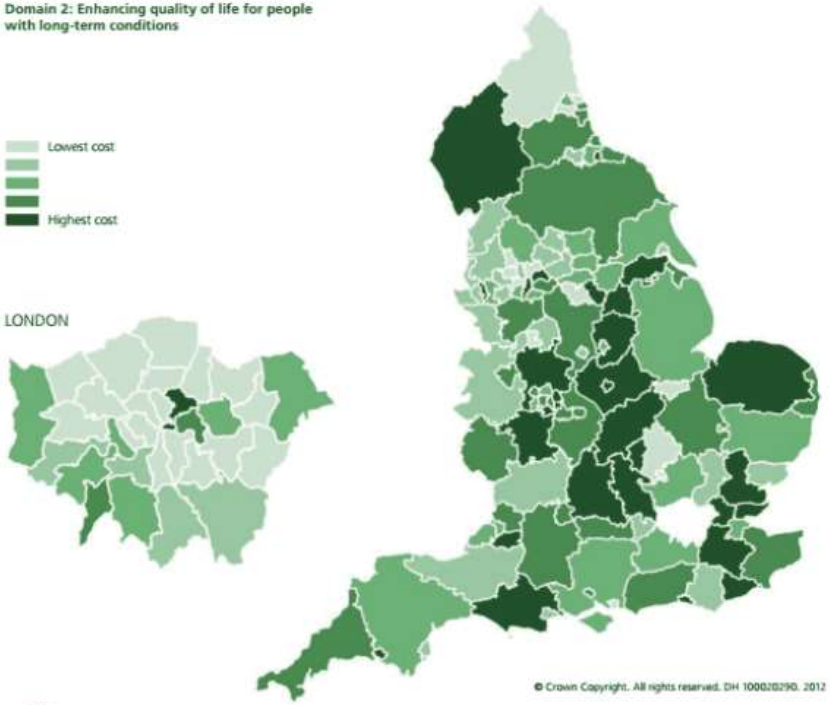


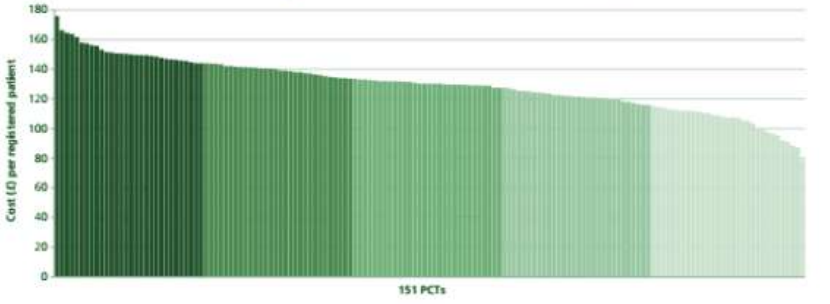
PRESCRIBING

Map 10: Insulin total net ingredient cost per patient on GP diabetes registers

2010/11

Domain 2: Enhancing quality of life for people with long-term conditions



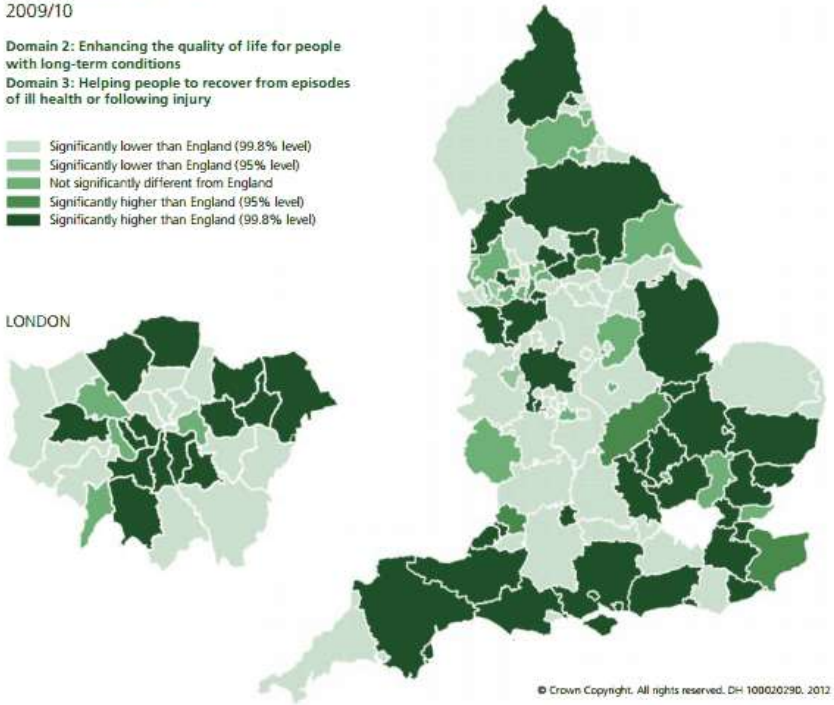


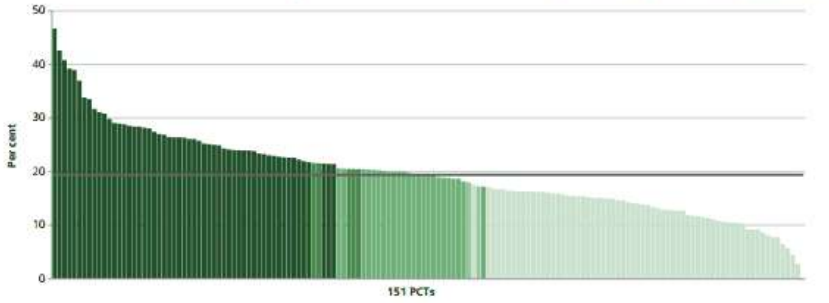
NEED FOR SECONDARY CARE

Map 13: Excess length of stay (%) in hospital among people with diabetes when compared with people without diabetes by PCT

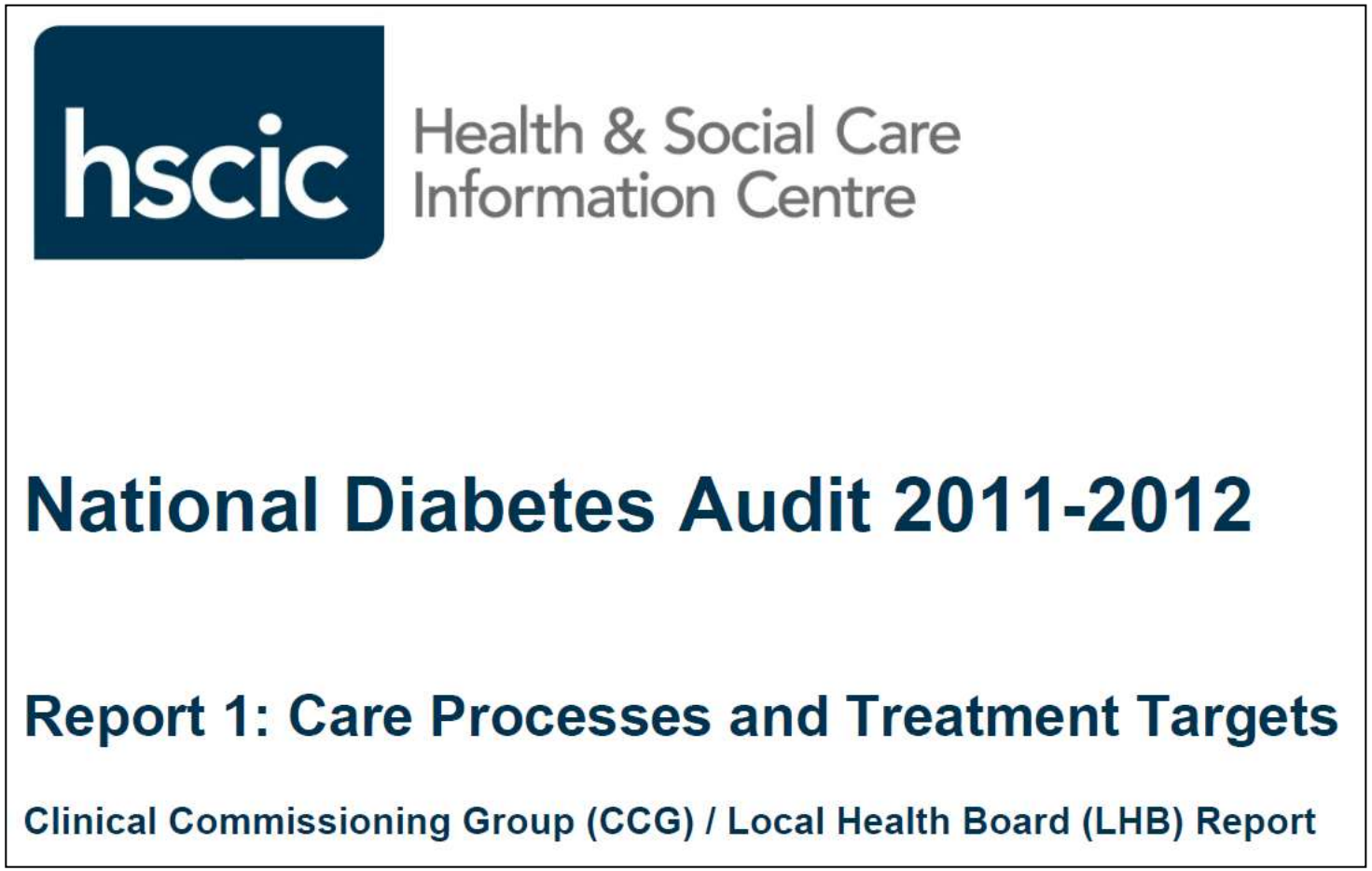
2009/10

Domain 2: Enhancing the quality of life for people with long-term conditions
Domain 3: Helping people to recover from episodes of ill health or following injury

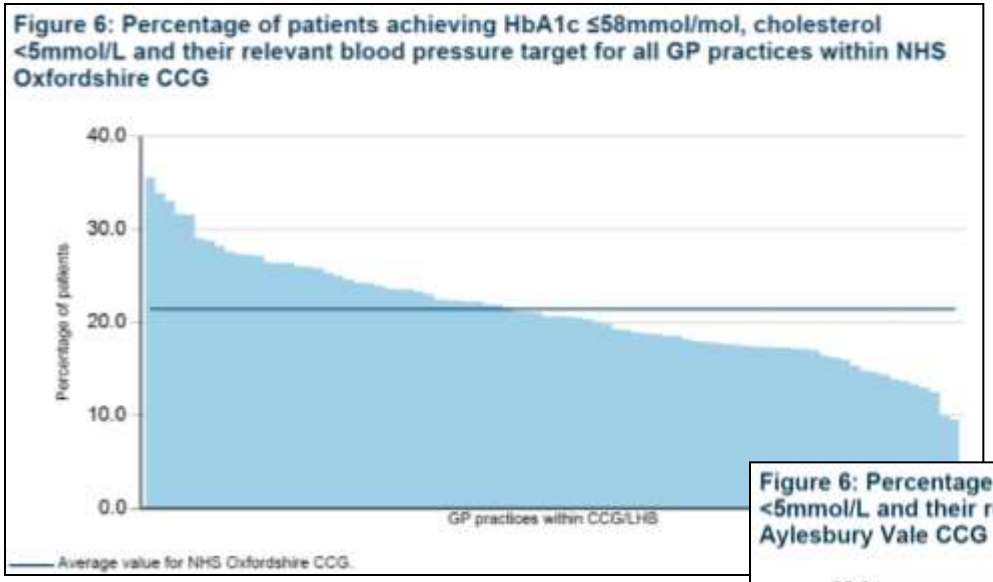


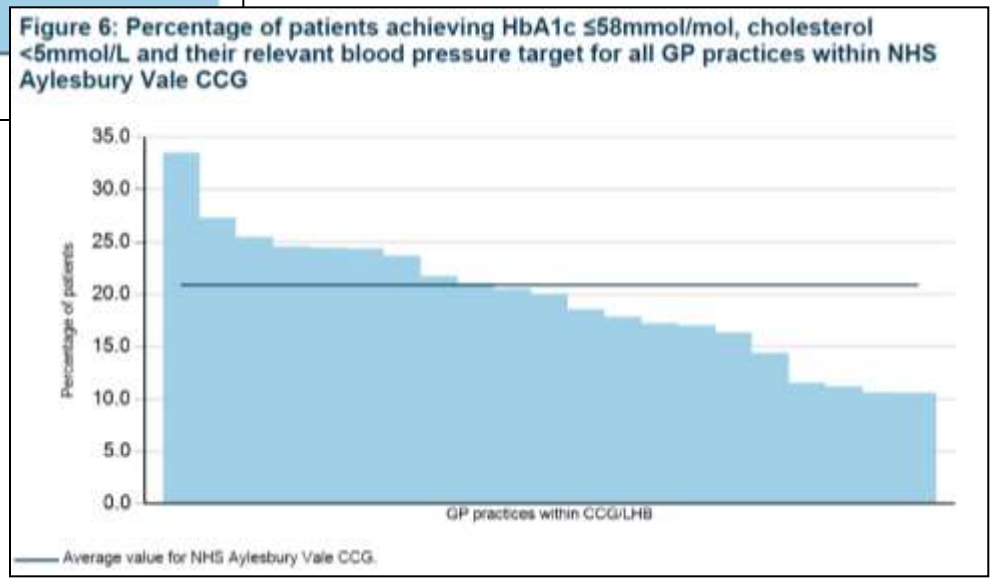


More data…


hscic
Health & Social Care
Information Centre
National Diabetes Audit 2011-2012
Report 1: Care Processes and Treatment Targets
Clinical Commissioning Group (CCG) / Local Health Board (LHB) Report

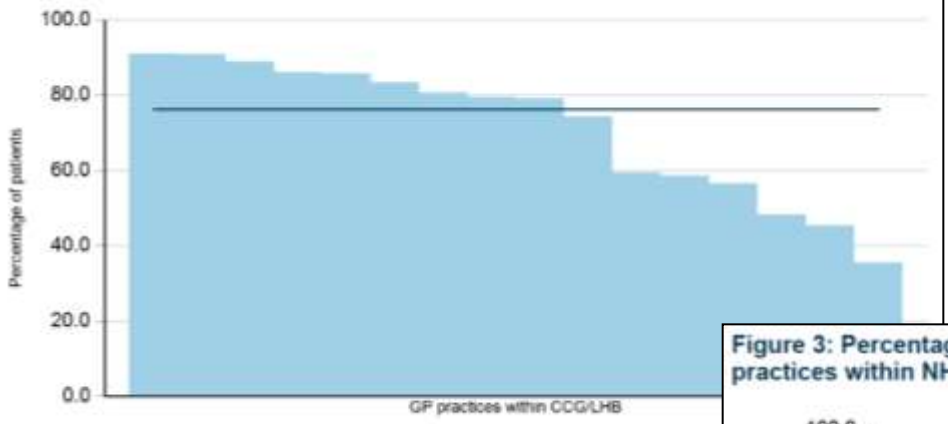
Cardiac risk factors





Eight care processes

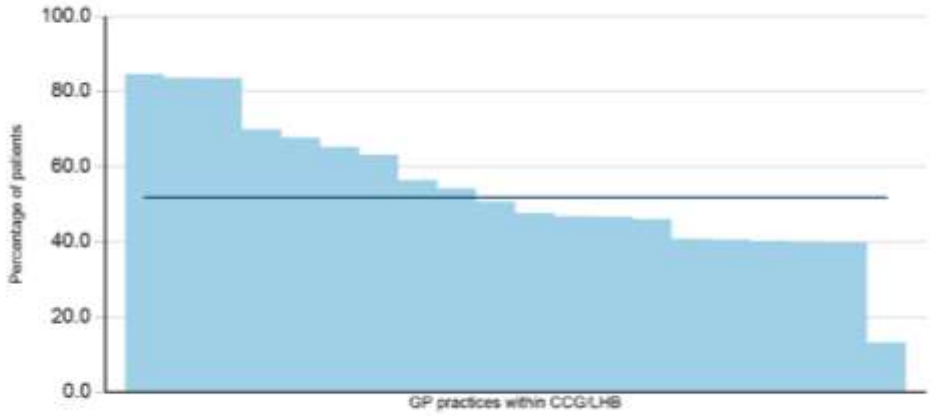
Figure 3: Percentage of patients receiving the eight care processes[a] for all GP practices within NHS Slough CCG



Average value for NHS Slough CCG.

[a] The eight care processes are those that are listed in Table 3 (i.e. eye screening is not included in this an

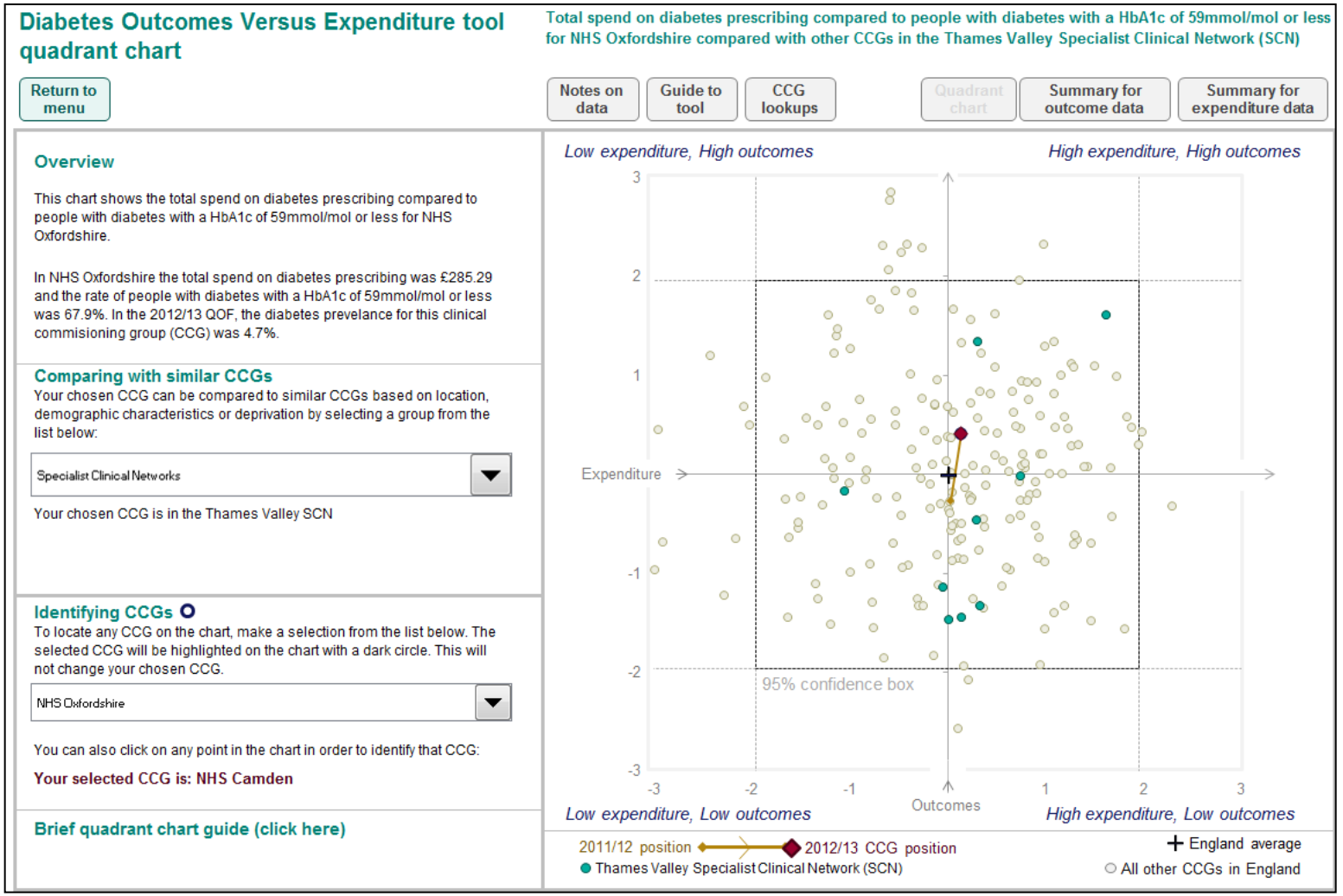
Figure 3: Percentage of patients receiving the eight care processes[a] for all GP practices within NHS South Reading CCG



Average value for NHS South Reading CCG.

[a] The eight care processes are those that are listed in Table 3 (i.e. eye screening is not included in this analysis).

Diabetes Outcomes Versus Expenditure Tool Quadrant chart (CCGs and Practices)



Case-study 3: Supporting and improving self-care management[1]

The challenge

In partnership with Islington and Haringey PCTs, The Whittington Hospital applied to The Health Foundation to become a pilot site for the Co-Creating Health[2] initiative. The Whittington Hospital was selected as a pilot; it was required to set up and implement a self-care management programme that would deliver sustainable change and improvements in patient outcomes.

Aim

The aim of the project was:

- To support an holistic approach to self-management in which the clinician, patient and the services are committed to change and improving outcomes.

What was done?

The partnership received £150,000 funding from The Health Foundation, and used it to recruit a project manager and to pay for some clinician time. Additional funding was secured from both PCTs to cover the cost of any additional clinician time.

The project group included staff from the two PCTs and the hospital trust, in addition to GPs and practice nurses, a diabetes specialist nurse (DSN), patients, a diabetologist and the director of primary care.

The Health Foundation Co-Creating Health initiative consists of three distinct but linked parts:

- An advanced development programme (ADP) for clinicians, to help them develop the skills required to support and motivate patients to take an active role in their own health. This comprises three sessions, each lasting up to 3 hours, delivered by a clinical tutor and a lay tutor.
- A self-management programme (SMP) for patients to help them develop the knowledge and skills they require in order to manage their long-term condition and work in effective partnership with their clinicians. This comprises seven weekly sessions, delivered by a clinical tutor and a lay tutor.
- An organisational development programme (service improvement programme, SIP) to support patients and healthcare professionals, working together, to identify and implement new approaches to health service delivery that enable patients to take a more active role in their own health.

What happened?

At the time of writing, 14 local sites are involved in the pilot across primary and secondary care, and 240 patients have completed the SMP. As funding from The Health Foundation completes in 2012, a business plan is being developed to secure the future of the project.

Outcomes have been measured using patient enablement questions (see Box CS.2). Significant improvements have been obtained:

- The proportion of clinician–patient relationships with a shared agenda increased from 43% to 88%;
- Goal-setting increased from 45% to 75%;
- Goal follow-up increased from 65% to 88%.

Box CS3.1: Key outcomes

- Overall patient enablement scores improved by 10%
- Patients' levels of HbA1c and LDL cholesterol were reduced over 6 months
- 88% of participating clinicians reported significant improvement in their knowledge of how to support patient self-management

1 NHS Diabetes. http://www.diabetes.nhs.uk/our_publications/diabetes_success_stories/self_care_management/supporting_and_improving_self_care_management/

2 The Health Foundation. Co-Creating Health – a large-scale demonstration programme which began in 2007 with 8 sites focussing on one of four clinical areas –diabetes, COPD, depression and musculo-skeletal pain. http://www.health.org.uk/areas-of-work/programmes/co-creating-health/

Tackling variation in diabetes outcomes

We need good data:

- Accurate
- Detailed
- Instant/Dynamic

Identify where is good and where is not so good

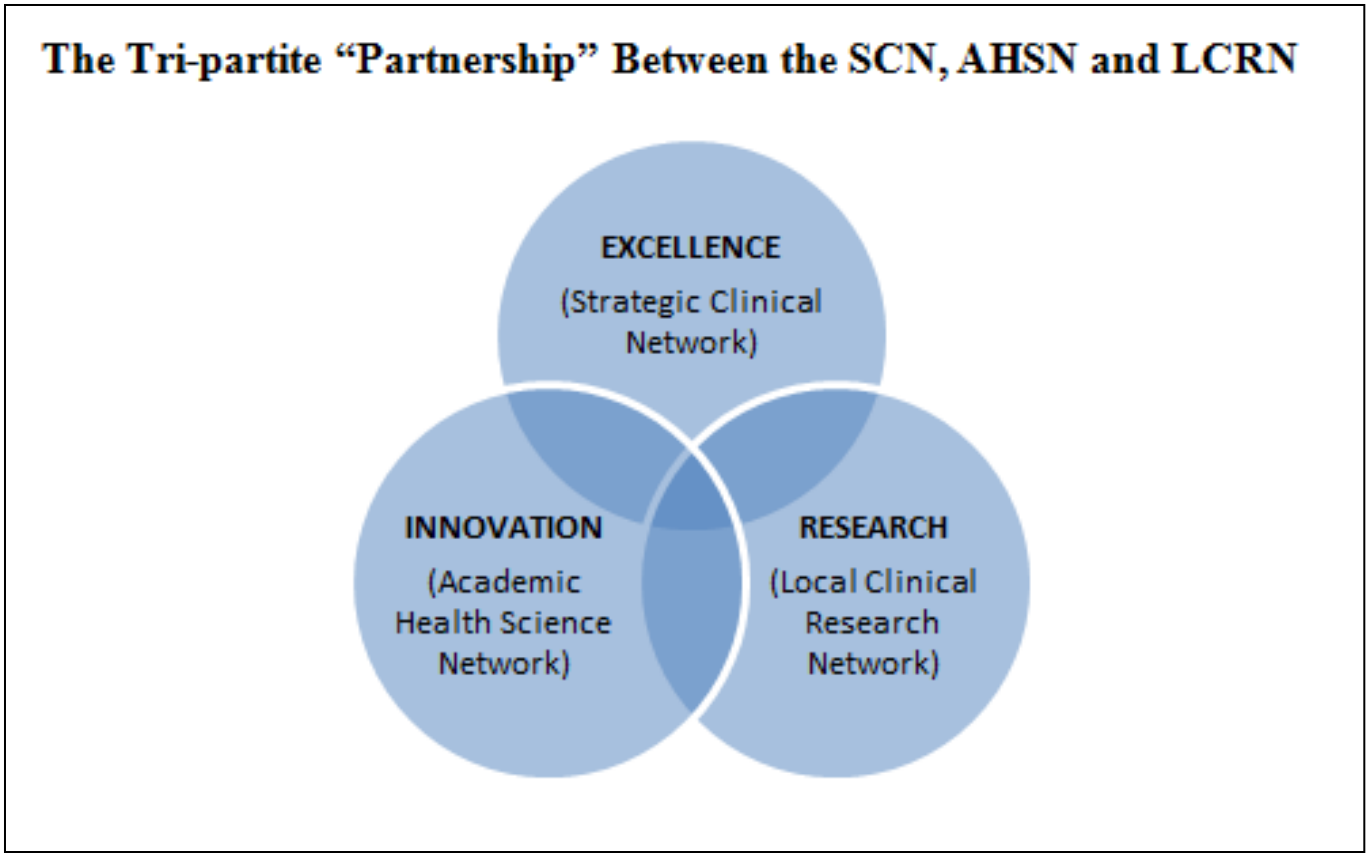
Strategies for change

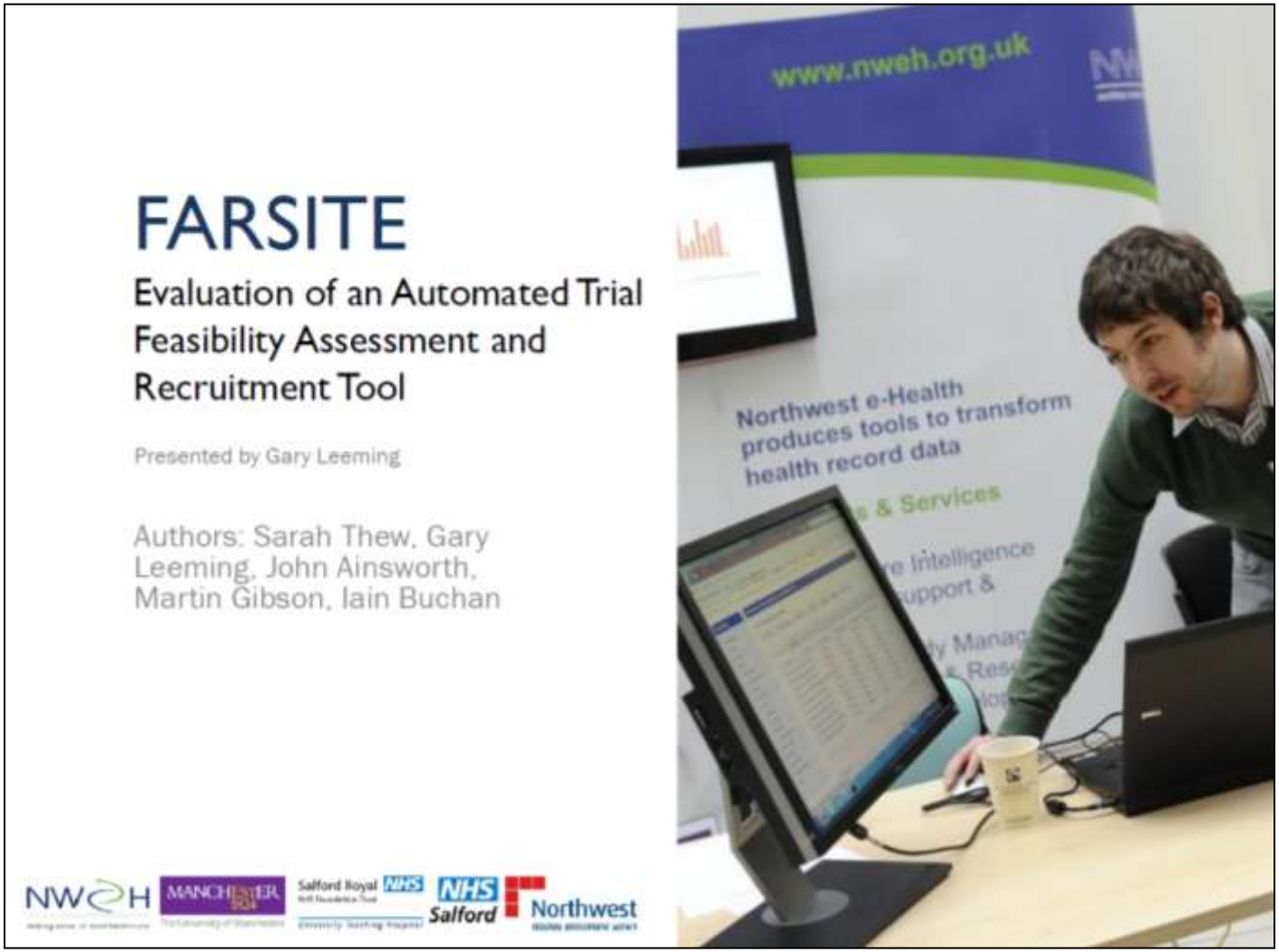
Review for outcome data

We need partners with different skill sets

First step: How do we collect data ?

Networks and Partnerships





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Strategies for change

Verify data

Systems/integration of care pathways

Access to services/patient education

Knowledge base/education

Prescribing/management patterns/access to NICE approved therapies

“New innovations”

THANK YOU

(See some of you in the workshop)