BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Diabetes Overview – West Berkshire

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What is Diabetes?

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Diabetes is a serious condition where an individual's blood glucose levels are too high.

It can happen when the body doesn't produce enough insulin, the insulin it produces isn't effective; or when the body can't produce any insulin at all.

- **Type 1 Diabetes** is a lifelong condition where the body's immune system attacks and destroys cells that produce insulin.
  The cause of Type 1 is unknown, diet and lifestyle factors do not affect the risk of developing it and it cannot be put into remission.
  All patients with Type 1 Diabetes need insulin to survive.

- **Type 2 Diabetes** is more common than Type 1…**over 90% of people in the UK who have diabetes, have Type 2.**
  People who are overweight or obese and people from some ethnic backgrounds are most at risk of developing the condition.
  Type 2 diabetes is where the body does not produce enough insulin or the body's cells do not react to insulin properly.
  For many people, Type 2 diabetes can be put into remission through weight loss and lifestyle changes.
  If left undiagnosed, blood levels can rise to very high levels. If high blood glucose levels are left untreated, they can cause serious health complications such as : eye diseases which can lead to blindness, circulation problems which lead to heart attack, stroke, and vascular problems contributing to amputations, kidney problems and nerve damage, amongst others.

- **Type 2 Diabetes** can be prevented in most cases by eating healthily, maintaining a healthy weight and waist size, and keeping active.
  These factors make it easier to maintain a healthy blood glucose level and prevent insulin resistance.
  10% of the NHS budget for England and Wales is spent on diabetes treatment, management and complications.

BOB ICB Integrated Diabetes Delivery Network (IDDN)

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The IDDN is the key group of stakeholders across the ICB, who come together to facilitate a **collaborative approach to deliver on local, regional and national diabetes priorities.**

It is also their responsibility to identify and address variation, share best practice and enable integrated care that is high quality and patient-centred.

In addition, they aim to address health inequalities & plan for and address the increase in demand for services, provide strong clinical leadership and enable effective working across organisational boundaries.

Their **key priorities**, set out in the Joint Five Year Forward Plan are to:

- Support education and training of our workforce.
- Reduce clinical variation and health inequalities.
- Adopt new diabetes care technologies and treatments, and to improve access to services.
- Continue to improve primary prevention of type 2 diabetes and secondary prevention to slow the progress and reduce likelihood of complications of all types of diabetes.
- Embed supported and personalised self-care to enable people with diabetes to manage their health so they can live the life they want to live.

They aim to achieve this by :

- Reaching and exceeding pre-pandemic attainment of the **eight diabetes care processes (8CPs) and the three treatment targets (TTTs)** as set out in the National Diabetes Audit.
- Innovation and service development focusing on digital technologies to improve outcomes and reduce inequalities.
- Deliver a high-quality integrated care approach, promoting self-care for primary and secondary prevention so people with diabetes experience fewer preventable complications.

Why does this need ICB/ICS action?

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National

- Over **4.3 million** people are living in the UK with a diagnosis of diabetes with approximately 90% of those diagnosed with type 2.
- Without the right care and support people with all types of diabetes can be at risk of developing serious complications. Every week in the UK, diabetes leads to **184 amputations**, more than **770 strokes**, **590 heart attacks** and **2,300 cases of heart failure**.
- Diabetes UK predict that without significant action up to **5.5 million** people in the UK could be living with diabetes by 2030 – that's as many as one in 10 adults.

BOB

- Across BOB 86,140 of our residents have a diagnosis of type 2 diabetes and 8,733 are living with type 1 diabetes.
- In BOB-ICS, 68.1% of people with diabetes have **one or more comorbidities.**
- Diabetes accounts for significant resource use within BOB-ICS – e.g. Average acute expenditure per capita: £2,542.
- Diabetes is the single most common **"at risk" condition for Covid-19 vulnerability** in BOB ICB.
- There is significant variation in the achievement of NDA targets across BOB-ICB by sub-ICB/place – e.g. the variation in 8 care process achievement ranges from 25.0% to 86.6% for practices in Berkshire West.

Data obtained from ICB's IDDN Deep Dive Jan 24

Focus on West Berkshire, as part of the ICB footprint

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The West Berkshire footprint covers **4 Primary Care Networks (PCNs)**:

- A34 (2,025 registered as being Type 2 Diabetic out of 49,000 registered patients)
- Kennet (2,310 out of 43,000)
- West Berkshire Rural (1,040 out of 23,000)
- West Reading Villages (1,875 out of 43,000)

Total number of patients in West Berkshire with Type 2 Diabetes: **7,250**

Total West Berkshire PCN patients registered: **158,000**

'T2 patient data' taken from National Diabetes Audit (NDA) (Jan – Dec 2023). 'Patients registered' data taken from NHS Digital Dashboard (May 2024).

Diabetes Prevalence in West Berkshire

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- The Type 2 Diabetes prevalence in West Berkshire is **lower than the national average** but (just) **above the BOB ICB** average. However, you will see that prevalence has **increased** in West Berkshire and at ICB & national level.

	Type 2 Prevalence 2019/20	Type 2 Prevalence 2022	Type 2 Prevalence 2023/24
A34	3.5%	3.9%	4.1%
Kennet	4.4%	4.9%	5.4%
West Berkshire Rural	4.5%	4.5%	4.5%
West Reading Villages	3.8%	4.0%	4.4%
West Berkshire	4.1%	4.3%	4.6%
BOB ICB	4.2%	4.2%	4.4%
National	5.3%	5.4%	5.6%

'T2 Prevalence' worked out by total T2 patients / total registered patients.

'T2 patient data' taken from National Diabetes Audit (NDA) (Jan – Dec 2023). 'Patients registered' data taken from NHS Digital Dashboard (May 2024).

8 Care Processes & Three Treatment Targets

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8 Care Processes

Body Mass Index (BMI)
Blood Pressure
Cholesterol
Creatinine eGFR
Foot Screening
HbA1c
Smoking Status
Urine ACR

The ninth care process is retinal screening. This is managed by secondary care and coded in the primary care record.

Three treatment targets

HbA1c
<= 58 mmol/mol

Blood Pressure
<= 140/80

Cholesterol
< 5 mmol/L

8 Care Processes & Three Treatment Targets – West Berkshire

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	Achievement of all 8 Care Processes	Achievement of three treatment targets
A34	55.8%	35.9%
Kennet	69.5%	36.5%
West Berkshire Rural	63.0%	35.0%
West Reading Villages	64.5%	38.1%
West Berkshire	63.2%	36.4%
BOB	60.4%	35.8%
National	51.3%	36.6%

Data taken from National Diabetes Audit (NDA) (Jan – Dec 2023)

Place Based work being delivered in West Berkshire

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Pre-Diabetes / Non-Diabetic Hyperglycaemia – now BOB ICB Pre-Diabetes Locally Commissioned Service (LCS)

In 2023, practices in West Berkshire were offered a financial incentive to monitor and support people at risk of developing Type 2 diabetes: the Pre-Diabetes Locally Commissioned Service (LCS).

This scheme is ending this June 2024, and is being replaced by a fit-for-purpose **BOB wide harmonised Diabetes LCS**. This ensures that we align the work being covered in all three places within BOB ICB. The LCS will focus on improved management of diabetes and improving timely access to insulin initiation and management.

NHS Diabetes Prevention Programme (NDPP)

West Berkshire practices are incentivised to refer patients to the NDPP through the **Weight Management Enhanced Service**. Our practices continue to **exceed** target numbers of referrals.

Diabetes Structured Education (DSE)

- The ICB has a number of programmes of work to support West Berkshire patient education / self-management :

    - **T2Day:** a locally commissioned service has been developed to support primary care to improve outcomes for people with Early Onset Type 2 Diabetes (18-39y) and increase awareness among HCPs of the additional challenges this cohort faces. Resources have also been developed to support both HCPs and patients, including a set of patient information videos: Type 2 diabetes - Stay Well (staywell-bob.nhs.uk)

    - **Type 2 Path to Remission** (formerly the Low Calorie Diet):
        - the service launched in BOB on 1 September 2023 in Wave 2 of the national roll-out. The service will run for two years with 250 places available per year for eligible BOB residents. As of 30 November 2023, just three months after its launch, 125 referrals had been made to the service and 30 people had started the total diet replacement programme. This is more than double the number of referrals made to our provider from any other ICB in wave 2.
        - The ICB has been **commended by NHS England** on our efficient management of the launch of the service; as such we have been invited to speak and share learning at national webinars for the ICBs launching in wave 4 of the roll out

- Our Community (BHFT) offering CHOICE programme for T1 patients; and X-PERT for T2 patients. There is now also a much shorter programme offered to T2 patients known as DEAL.

- RBH and BHFT are beginning to roll out the NICE Technology Appraisal on **Hybrid Closed Loop (HCL)** systems (artificial pancreas) for adults and children with type 1 diabetes. There will be a five-year implementation of HCL systems which is in-line with NICE guidance.

Patient Pathway (across BOB system)

Prediabetes / Non Diabetic Hyperglycaemia (NDH)

Patient identified as NDH

Patient invited for annual review which includes blood test, weight, waist circ and BP. Care plan agreed and offered referral to NDPP

Patient attends NDPP/Other lifestyle interventions.

Patient declines referral to NDPP

Patient recalled for annual blood test and review.

Blood test normal

Patient stays on the NDH register. Risk stratification used to determine frequency of blood test reviews

Blood test confirms NDH. Patient continues on NDH recall register for annual blood test.

Blood test confirms Type 2 Diabetes

Type 2 Diabetes

Patient diagnosed with Type 2 through Health Check or opportunistic screening

Type 2 Diabetes diagnosis code added to patient record and automatically added to the recall register

- Baseline assessment inc 8CP metrics
- CVD risk assessment
- Medications started as appropriate to achieve the three treatment targets
- Patient offered referral to Diabetes Structured Education (DSE).
- Referred for annual retinopathy screening

Patient invited for an annual review based on either their birth month or month of diagnosis or more frequent reviews as required.

Patient attends first appointment to have 8CP metrics collated

Second appointment to review data and diabetes management. Support with goal setting and life style advice. DSE offered if not attended previously.

Medication initiated and optimised on an ongoing basis as appropriate, using a personalised care approach throughout Type 2 pathway to keep the patient managed within the parameters of the three treatment targets.

Lifestyle advice inc. weight management, smoking cessation, physical activity, mental wellbeing and sleep advice and support offered throughout pathway.