Type 2 Diabetes in Adults : A Population Approach

Strategic Framework

The Seven Key Themes

1. Partnership Approach (Clinical leadership & service user involvement)
2. Supporting Self-management
3. Prevention, Early Detection and Delaying Complications;
4. Using information to Optimise Services and Improve Outcomes ;
5. Services for People Living with Diabetes, including hard to reach cohorts & those requiring Complex Treatment and Care;
6. Enhancing the Skills of Frontline Staff; and
7. Encouraging Innovation.

Making Life Better ~ A Diabetes Strategic Framework [Nov.2016]

Northern Ireland diabetes cases up 70% in 12 years

(B Tel April 2019)

Doing nothing is not an option

- Diabetes UK ~ one in ten of the UK population could have Diabetes by 2030
- In NI it is already over 100,000 with perhaps 15% undiagnosed and is increasing by 4% per year (rate of 4% pa means increase to 148k by year 10 and 202k by 18yrs)
- There is a social gradient in diabetes leading to health inequalities. It is more prevalent in more deprived areas and varies with age, ethnicity, gender and disability. (BMJ 2016). The prevalence rate in some BME communities can be 2-3 times higher
- The complexity of cases and the complexity of drugs is increasing dependence on more expensive specialist care

Economics

NI Audit Office report 2018

- Local treatment costs for diabetes are estimated to be 10% of total healthcare costs which could rise to 17% by 2035. 80% of these costs are in managing the consequences of complications, many of which are avoidable.
- Type 2 diabetes complications account for over 4,000 hospital admissions and 15,000 patient bed days annually in NI
- Effective treatment of Type 2 diabetes requires a focus on prevention and early detection; strong workforce planning; education of patients to help them self-manage the condition; and integrated patient information systems
- One estimate by Diabetes UK has suggested that if 75 per cent of local diabetes patients were treated in accordance with best practice, health and social care could save £75.5 million by 2030

Enablers

- LCG investment in 2017 provides a foundation - included consultant-led Community MDT, specialist community foot protection and Structured Patient Education
- Regional Diabetes Strategy investment in 2018 in specialist care has complemented this local investment
- Diabetes Prevention Programme was launched April 2019
- A local diabetes network is in place with links to the regional network and local community partnerships
- Centralisation of Trust diabetes information flows and GPIP provide the basis for population and patient management

Diabetes Crisis Vs Climate Crisis

- It’s happening now!
- Action required by National, Regional & Local Government and by individuals!
- Effective resources spent now considerably lower cost than what will be needed in the future!
- Deprived citizens in any population worst hit!
- Wilful blindness by big corporations to the effect of their products on the problem!
- Whole community will benefit from the necessary interventions!

Aims of a new model of care

1. equitable access to the services ~ appropriate setting including for vulnerable and hard to reach groups
2. identification, management and support of people ‘at risk’ of developing T2 Diabetes and those living with diabetes
3. effective use of information technology in primary care to risk stratify patients and enable effective multi-disciplinary discussion on the care management of those living with type 2 Diabetes.
4. enhancement of GP (GP Team) knowledge
5. rapid access to assessment and treatment to address emergency and urgent issues in a timely way – and appropriate escalation to specialist care when necessary

Person-centred care focus on ‘Esther’

DIABETES

Esther's diverse 'personas'

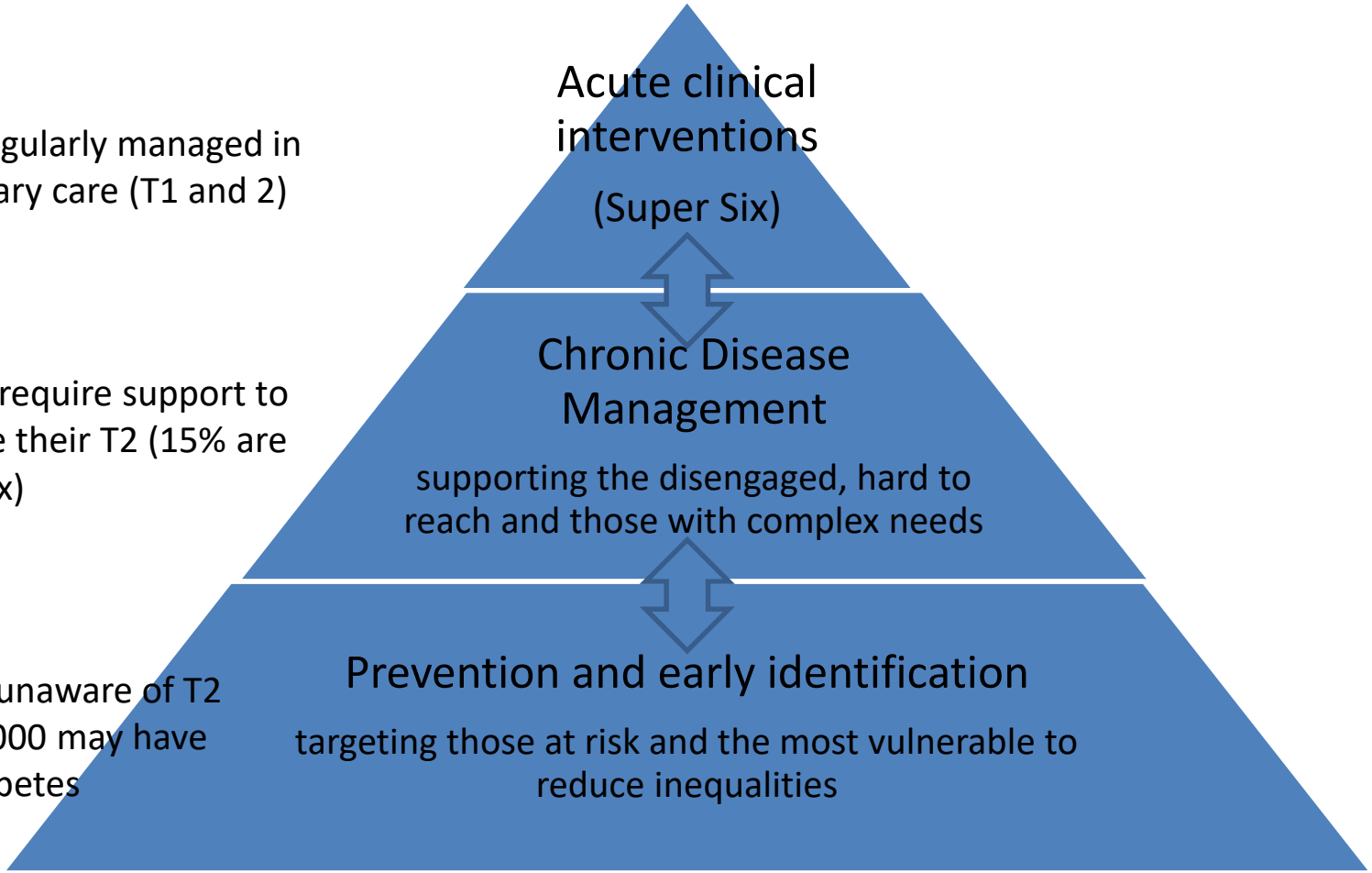
- Esther may :
  - Have complex diabetic care
  - Have a range of co-morbidities
  - Be pregnant
  - Not know she has diabetes
  - Live in a care home
  - Have a learning or physical disability
  - Have an ethnic minority background
  - Not speak English as a first language
  - Be disengaged or less likely to accept health messages
  - Lead a chaotic lifestyle
  - Suffer from depression
  - Experience a range of barriers to accessing services
  - and Esther may also be Edward

Type 2 Diabetes in Adults : A Population Approach with vertical integration

5000 regularly managed in secondary care (T1 and 2)

21,600 require support to manage their T2 (15% are complex)

c.7000 unaware of T2 and 15000 may have pre-diabetes



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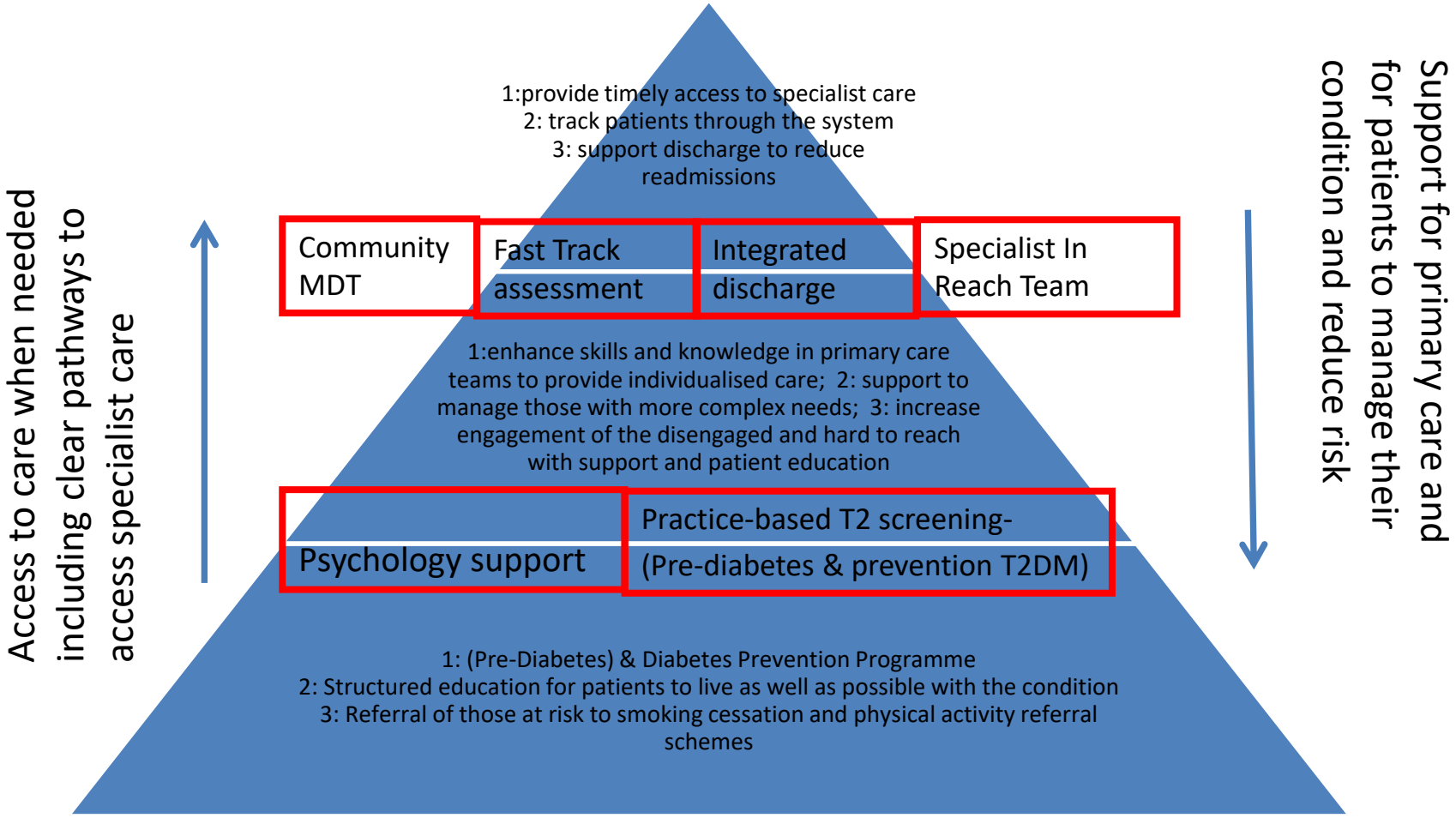


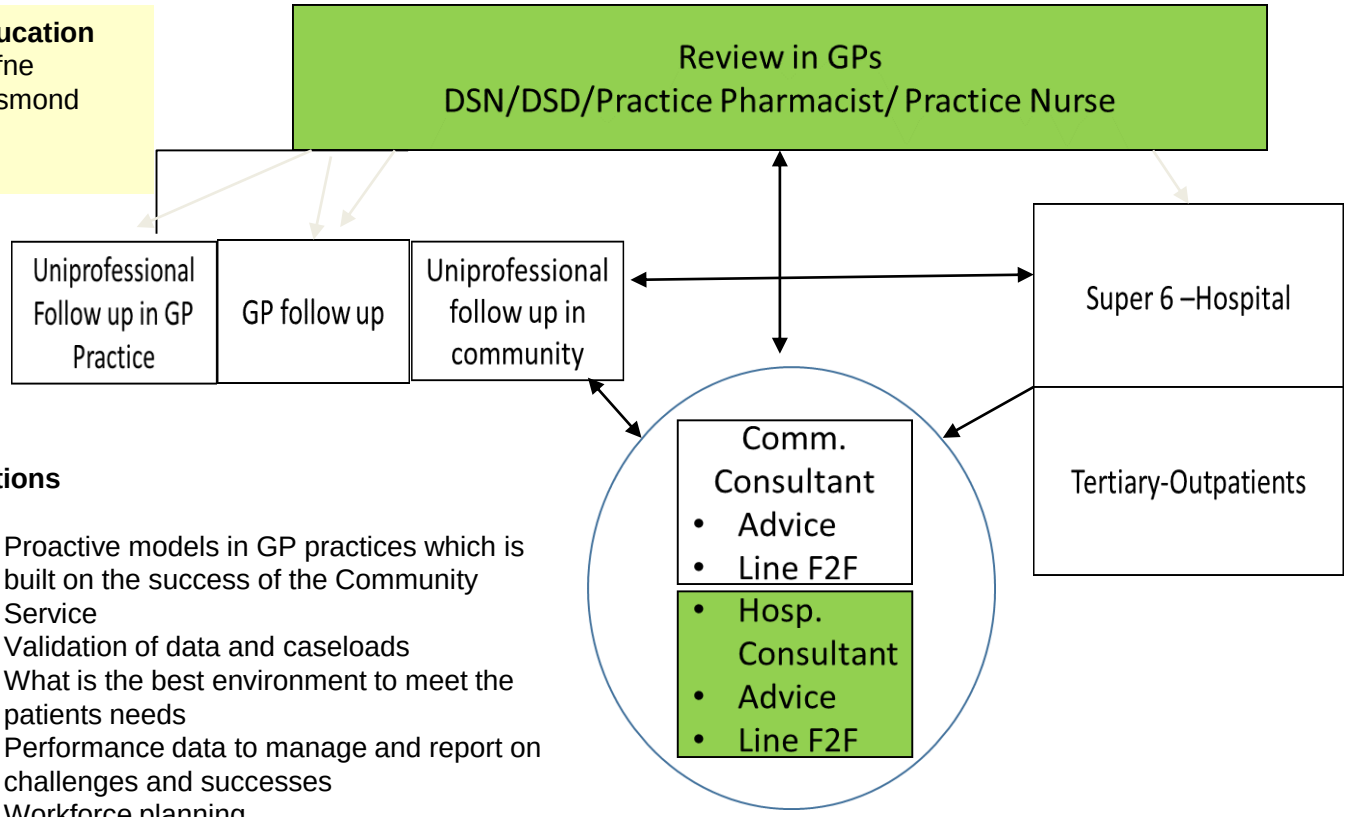
BHSCT Diabetes Project – Best practice and systems approach

Hospital -Super 6
- Inpatients
- Renal
- Maternity
- Foot
- Type 1 -New Technologies CGM
- Pumps

Emerging Caseloads
- Cancer
- Hepatobiliary
- COVID
- Cystic Fibrosis

Community /Primary Care
- 80% of Type 2 caseload
  - Type 2- Insulin
  - End of life
  - Cancer
- Home Dialysis
- Type 1 who do not attend secondary care

Education
Dafne
Desmond



Actions

- Proactive models in GP practices which is built on the success of the Community Service
- Validation of data and caseloads
- What is the best environment to meet the patients needs
- Performance data to manage and report on challenges and successes
- Workforce planning

ICP Proposal	Expected impact	Cost
Use of GPIP for Practice-level screening for patients at high risk of developing T2 diabetes	Programmed interventions for patients at high risk	£25k (admin)
Protected GP time for biannual practice reviews	Enhanced practice-based knowledge and skills to manage diabetes; reducing need for specialist care; increased support for vulnerable groups; targeting inequalities; reducing risk of serious complications	TBC (LES) £100k?
Specialist in-reach support to practices and protected GP time		£220k (DSNs, DSDs)
Expansion of Community MDT service	Meet demand for timely specialist assessment; education for practice teams through ECHO	£150k (2nd Consultant)
Fast Track Assessment and Treatment Service	Hotline for urgent assessment to avoid unnecessary admissions	£40k (Nursing cover)
Integrated discharge model	Reduce risk of readmission	£110k (DSNs)
Psychological support	Upskilling all professionals in managing patients with complex needs and the disengaged to support self care	£70k (Psychologist)

Requirements

- Approval of the model
- Incremental increase in funding of £715k over three years
- Commitment of practices to a LES and access to population data on GPIP
- Recruitment and training of DSNs/DSDs and additional consultant