STP aide-mémoire: Diabetes

Publications
Gateway
Reference: 05373

1. Introduction

In March 2016, NHS England, Public Health England and Diabetes UK launched the roll-out of the NHS Diabetes Prevention Programme with an ambition to slow the projected growth in incidence of Type 2 diabetes across 27 parts of England. The STP process provides the opportunity for footprints to jointly develop a comprehensive strategy for doing this.

Alongside prevention, STPs should consider how to improve outcomes for people with Type 1 and Type 2 diabetes across the clinical pathway by tackling unwarranted variation, and empowering patients through education and community health and wellbeing initiatives. If all GP practices were to achieve at least the national median position for all 3 NICE-recommended treatment targets (for HbA1c, blood pressure, and cholesterol), significant savings and patient benefits would be realised. Increasing the proportion of newly diagnosed diabetes patients attending structured education over the next 5 years could also deliver significant savings and patient benefits by leading to fewer complications.

2. Success in 2020

i. **Reduction in the projected growth in incidence of diabetes**
- Footprints should develop comprehensive strategies to tackle obesity and prevent diabetes, with the aim of referring 500 people per 100,000 population annually to an evidence based Type 2 diabetes prevention programme.

ii. **Support more people to manage their own care effectively**
- An additional 10% of newly diagnosed people with diabetes to attend structured education per year to 2021 (as measured in the National Diabetes Audit). This will lead to improvements in treatment outcomes and a reduction in complications associated with diabetes.

iii. **Improve treatment and care received**
- GP practices to improve performance to, at least, match the current national median level of performance (40%) in relation to the 3 NICE recommended targets (HbA1c <=58mmol/mol (7.5%); Cholesterol <5mmol/L; Blood pressure <=140/80 mmHg).
- A universal infrastructure to provide access to multi-disciplinary diabetic foot teams and access to specialist diabetes teams for inpatients.
- Deliver reductions in incidence of microvascular and cardiovascular disease complications of diabetes and in order to reduce excess mortality for people with diabetes through delivery of the above.
- Increase GP participation in the National Diabetes Audit so that all CCGs have a sufficient level of participation in order to reliably measure their diabetes outcomes in the CCG Improvement and Assessment Framework.

3. How are we going to get there?

i. **Reduction in the projected growth in incidence of diabetes**		
• **Develop a comprehensive strategy to prevent obesity and diabetes**, identifying opportunities to 'make every contact count', increase uptake of existing weight management services and take action to reduce	• **CCGs should support GP practices to undertake audits of practice registers** to identify the at risk population with existing non-diabetic hyperglycaemia, for example by promoting the use of audit tools to assist	• **CCGs and local authorities should roll-out the NHS Diabetes Prevention Programme locally,** working with regional teams to assess readiness to join the National Diabetes Prevention Programme. They should

obesogenic environments. • **Local authorities should work with NHS Health Check providers** to ensure diabetes risk assessments and, where necessary, confirmatory bloods are provided to all people receiving a health check.	with case finding, such as that developed by PRIMIS which is available here.	also assess available assets and develop a prospectus to support appointment of a national NHS DPP framework provider locally.
ii. **Support more people to manage their own care effectively**		
• **CCGs should work with the National Diabetes Audit to review performance of local practices** in terms of offers and take up of structured education and improve audit participation rates. Performance data at practice level should be disseminated. • **CCGs should develop a strategy to engage potential referrers** such as GPs and other primary care staff to realise the benefits of locally run structured education programmes.	• **CCGs should ensure that attendances and outcomes at structured education are tracked** so that courses are accessible; i.e. in the right places and times for their diverse communities and are delivered well, including supporting patients to understand the personalised actions they can take to self-manage and control their diabetes. • Local contracts for the provision of structured education should include reporting requirements.	• **CCGs should develop systems locally for following up referrals** to ensure that people understand the benefits of the course and any logistical worries are addressed. • **CCGs should encourage GP practices to refer people with diabetes to guidance on self-management from Diabetes UK.**
iii. **Improve treatment and care received**		
• **Commissioners should work with the National Diabetes Audit to review performance of local GP practices** in terms of NICE-recommended treatment targets. Performance data at practice level should be disseminated. • **CCGs should support practices to understand the actions they need to take to secure improvement**, including identifying specific characteristics of their communities and the implications for effective approaches to diabetes management.	• **CCGs should ensure that they have regard to NICE guidance and quality standards.** • **CCGs should review treatment pathways with providers** in order to consider whether adjustments to these could improve outcomes. • **CCGs should ensure they have a footcare pathway with adequate capacity** to enable early referrals of people at risk of diabetic foot disease to foot protection teams and people with active disease to multidisciplinary footcare teams. CCGs should take NICE's footcare pathway guidance into account in developing the pathway.	• **CCGs should consider development and alignment of local financial flows, incentives and back office systems** (e.g. e-referral systems) to support improved integration between primary and secondary care. • **CCGs should consider supporting specialists to support and advise GPs** in the community on the management of their diabetes patients. • **CCGs should ensure that all secondary care providers have specialist teams** to assess and manage in-patients with diabetes effectively.