



Hertfordshire and
West Essex Integrated
Care System



Hertfordshire and
West Essex
Integrated Care Board

Diabetes and Non-diabetic hyperglycaemia

HWE needs analysis

Dr Jasjot Saund, Clinical Fellow

Dr Gisèle Spencer, Clinical Fellow

Dr Sam Williamson, Associate Medical Director

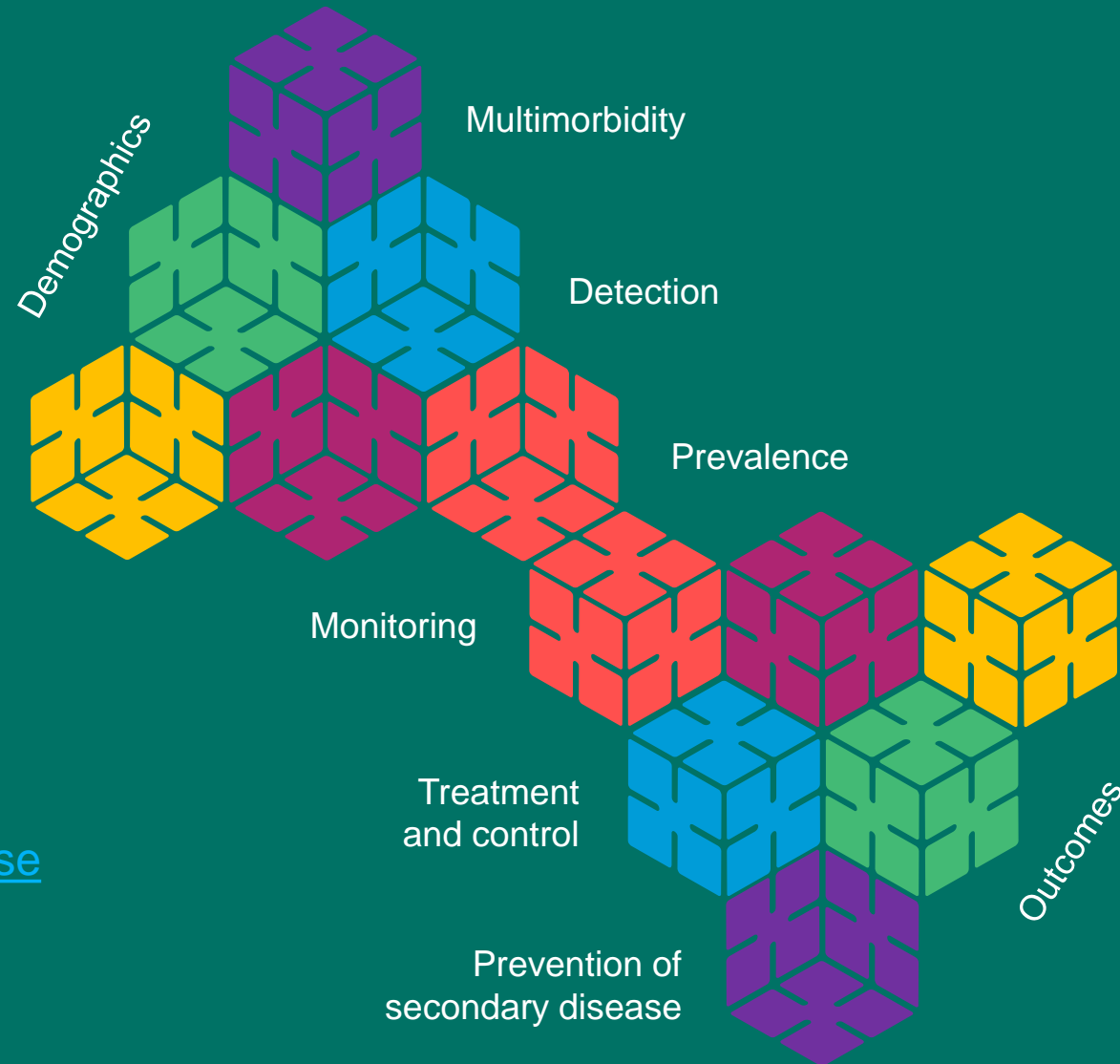
Working together
for a healthier future

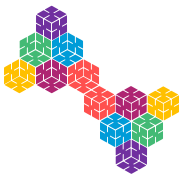




Contents

1. [Summary of Key Messages](#)
2. [Key Messages by Place area](#)
3. [Overarching themes](#)
4. [Key Messages](#)
 - ❖ [Prevalence and Detection](#)
 - ❖ [Demographics](#)
 - ❖ [Monitoring/ Care processes](#)
 - ❖ [Treatment and control](#)
 - ❖ [Prevention of secondary disease](#)
 - ❖ [Multimorbidity](#)
 - ❖ [Outcomes](#)

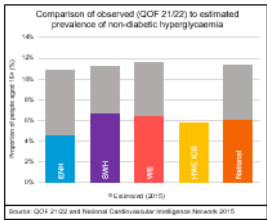




12 Key Messages – Click on each tile

Prediabetes / Non-diabetic hyperglycaemia (NDH)

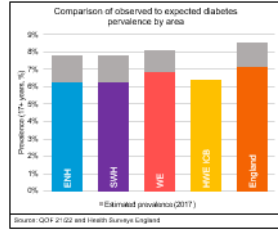
There is an under-detection of NDH, comparing disease registers to estimated prevalence. SWH has the highest prevalence of NDH and the smallest prevalence gap. ENH has the lowest prevalence and biggest gap.



- There are 74,181 people in HWE on the non-diabetic hyperglycaemia register (QOF 21/22). The overall prevalence of NDH in HWE is 5.9%. However, there is variation by Place: ENH (4.6%), SWH (6.7%), WE (6.5%).
- Nationally, it is estimated that 11.4% of people aged 16 years and over are living with non-diabetic hyperglycaemia. Locally, the estimated prevalence is highest in WE (11.8%), followed by SWH (11.3%) and then ENH (10.9%).
- The prevalence gap for NDH by Place is:
 - ENH 6.3% gap
 - SWH 4.6% gap
 - WE 5.1% gap
- People with non-diabetic hyperglycaemia are likely to benefit from initiatives like the National Diabetes Prevention Programme. [Click here for NDPP update info.](#)

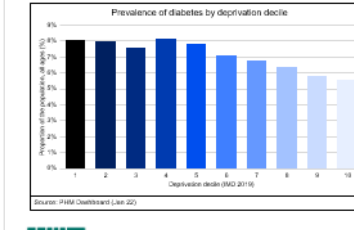
Diabetes prevalence

Diabetes prevalence is lower across the ICS compared to the national average. This is consistent with the expected prevalence's in each Place area



- There are 81,908 people registered with diabetes across HWE (QOF 21/22 register data). The overall prevalence of diabetes is 6.4%. ENH (6.3%), SWH (6.3%), WE (6.8%).
- Nationally, it is estimated that 9.4% of people aged 16 years and over are living with diabetes. Locally, the estimated prevalence is highest in WE (8.2%), followed by SWH (7.8%) and ENH (7.8%).
- The prevalence gap in each of the 3 Place areas is in line with or below the gap nationally. The prevalence gaps are shown below:
 - England – 1.4%
 - ENH – 1.5%
 - SWH – 1.5%
 - WE – 1.3%

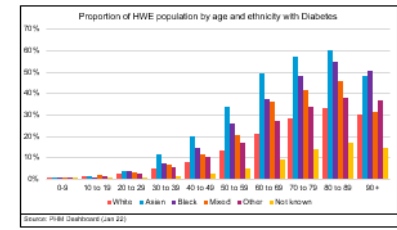
Diabetes by deprivation in HWE



- Local data (linked data from January 2022) show that:
 - Diabetes prevalence is significantly higher in more deprived groups.
 - The prevalence of diabetes in people living in the highest levels of deprivation is 8.1%, compared to 5.5% among people in the lowest levels of deprivation within HWE.
 - People with diabetes in more deprived areas are also more likely to be from Black or Minority ethnic groups (33% in deprivation decile 1, compared to 15% in the least deprived decile).

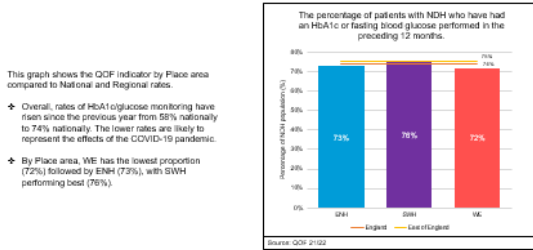
Diabetes by age and ethnicity in HWE

Asian and Black ethnicities have a proportionately higher prevalence of diabetes in all age groups.



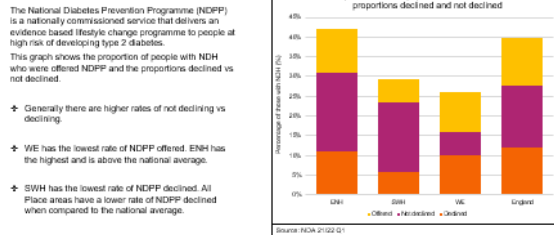
- The highest prevalence across most age bands is in people of Asian ethnicity
- People who do not have a recorded ethnicity have a very low prevalence, suggesting likely under-diagnosis.
- Ethnicity recording is also likely to be higher in those with a diagnosis of diabetes due to increased contact with the health services.

Monitoring - Non-Diabetic Hyperglycaemia



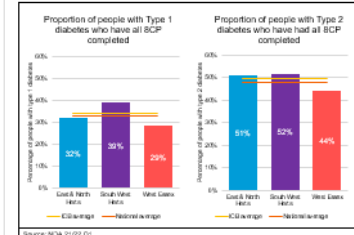
- This graph shows the QOF indicator by Place area compared to National and Regional rates.
- Overall, rates of HbA1c/glucose monitoring have risen since the previous year from 55% nationally to 74% nationally. The lower rates are likely to represent the effects of the COVID-19 pandemic.
- By Place area, WE has the lowest proportion (72%) followed by ENH (73%), with SWH performing best (76%).

National Diabetes Prevention Programme



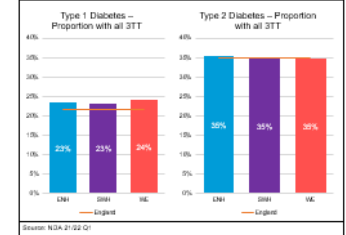
- The National Diabetes Prevention Programme (NDPP) is a nationally commissioned service that delivers an evidence based lifestyle change programme to people at high risk of developing type 2 diabetes.
- This graph shows the proportion of people with NDH who were offered NDPP and the proportions declined vs not declined.
- Generally there are higher rates of not declining vs declining.
- WE has the lowest rate of NDPP offered. ENH has the highest and is above the national average.
- SWH has the lowest rate of NDPP declined. All Place areas have a lower rate of NDPP declined when compared to the national average.

Percentage of patients with all 8 Care Processes (8CP) complete in last 12 months (21/22)



- National Diabetes Audit data show that the proportion of people with type 1 diabetes receiving all 8 care processes in HWE (34.1%) is higher than the national average (32.8%).
- Data for people with Type 2 diabetes show that a higher proportion of people in HWE (49.9%) receive all 8 care processes compared to the national average (47.8%).
- Overall, performance is better on T2DM, this may be partly due to lower rates of comorbidities leading to less interactions and lower engagement with health services amongst young people with Type 1 Diabetes.
- For both T1 and T2 diabetes SWH has the highest rates of 8 care process completion and WE has the lowest.
- Urine Albumin and Foot Surveillance are the Care Processes with the poorest uptake.
- Click link to see full 8CP breakdown:
 - Type 1
 - Type 2

All three treatment targets (3TT) by area and diabetes types



- Similar to 8CP, treatment targets are better met within the T2DM population as opposed to the T1DM population.
- All three Place areas are performing at or above the national median for both T1 and T2 Diabetes.

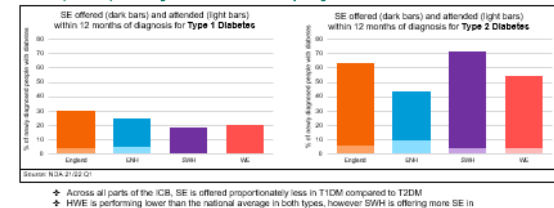
HbA1c target in T1DM by demographics

HbA1c target is <48mmol/mol or <0.5%. Between 20% and 45% of the T1DM population meet this target but variation is due to age and deprivation. Higher deprivation is linked with lower rates of meeting HbA1c targets in all three Place areas, in particular SWH (Herts Valleys).



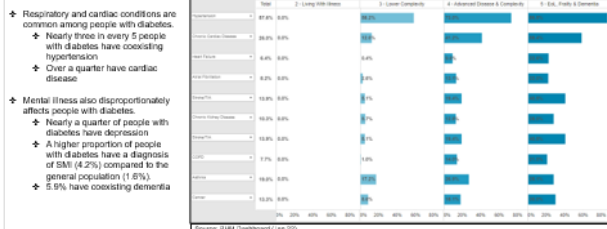
Structured Education offered and attended within 12 months of diagnosis for T1 and T2 diabetes

Dark bars represent percentage offered out of number of new diagnoses. Light bars represent percentage attended out of newly diagnosed.



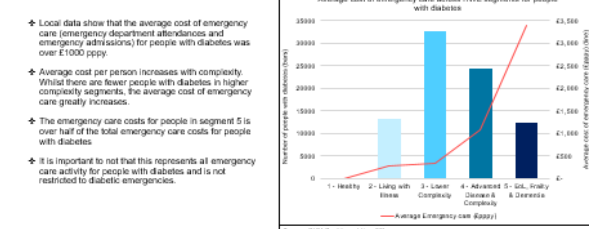
- Across all parts of the ICS, SE is offered proportionately less in T1DM compared to T2DM
- HWE is performing lower than the national average in both types, however SWH is offering more SE in T2DM compared to the national median.

Diabetes by comorbidity type

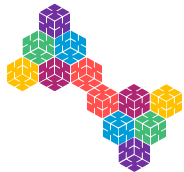


- Respiratory and cardiac conditions are common among people with diabetes.
 - Nearly three in every 5 people with diabetes have coexisting hypertension
 - Over a quarter have cardiac disease
- Mental illness also disproportionately affects people with diabetes.
 - Nearly a quarter of people with diabetes have depression
 - Over a quarter have a diagnosis of SM (4.2%) compared to the general population (1.6%)
 - 5.9% have coexisting dementia

Emergency care (all causes) for people with diabetes

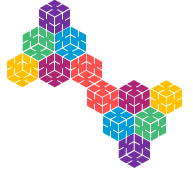


- Local data show that the average cost of emergency care (emergency department attendances and emergency admissions) for people with diabetes was over £1000 PPPY.
- Average cost per person increases with complexity. Whilst there are fewer people with diabetes in higher complexity segments, the average cost of emergency care greatly increases.
- The emergency care costs for people in segment 5 is over half of the total emergency care costs for people with diabetes
- It is important to not that this represents all emergency care activity for people with diabetes and is not restricted to diabetic emergencies.

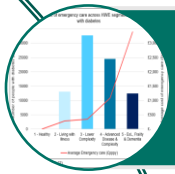


Summary of Key Messages for Place area

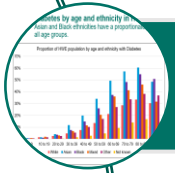
	West Essex	South West Herts	East and North Herts
Prevalence and detection	<ul style="list-style-type: none"> ❖ Highest prevalence in ICS for Diabetes ❖ Smallest Prevalence gap for Diabetes 	<ul style="list-style-type: none"> ❖ Lowest prevalence in ICS for Diabetes, highest prevalence for NDH ❖ Biggest prevalence gap for Diabetes 	<ul style="list-style-type: none"> ❖ Lowest prevalence in ICS for NDH ❖ Biggest prevalence gap for NDH
Demographics	<ul style="list-style-type: none"> ❖ Highest proportion of people with diabetes living in the most deprived 2 deciles when compared to other Place areas 	<ul style="list-style-type: none"> ❖ Highest proportion of ethnic minorities with T1 and T2 DM compared to other Place areas 	
Monitoring	<ul style="list-style-type: none"> ❖ Below national levels for HbA1c/glucose monitoring in NDH ❖ Lower than national NDPP offered ❖ Lowest in ICS and < national for 8 care processes for T1 and T2 	<ul style="list-style-type: none"> ❖ Higher than national levels for HbA1c/glucose monitoring in NDH ❖ Lowest rates of NDPP declined ❖ Highest in ICS and > England for 8 care processes for T1 and T2 	<ul style="list-style-type: none"> ❖ Lower than national average HbA1c/glucose checks for NDH ❖ Higher than national for NDPP offered ❖ Similar to England median for 8CP
Treatment	<ul style="list-style-type: none"> ❖ In line with national median for 3TTs met ❖ Lower than national referral and acceptance rates for SE in both types of diabetes 	<ul style="list-style-type: none"> ❖ In line with national median for 3TTs met ❖ High rates of SE referrals in T2DM 	<ul style="list-style-type: none"> ❖ In line with national median for 3TTs met ❖ High rates of SE offered in T1DM and highest attendance rate in both diabetes types
Secondary prevention	<ul style="list-style-type: none"> ❖ Lowest in ICS and below national median for flu vaccinations, CVD prevention and ACE prescribing 	<ul style="list-style-type: none"> ❖ Similar to national rates of statin, ACE and influenza vaccine 	<ul style="list-style-type: none"> ❖ Similar to national rates of statin, ACE and influenza vaccine
Outcomes	<ul style="list-style-type: none"> ❖ Lowest rates in ICS for major and minor LL amputations – likely indicator of historical performance as current monitoring, treatment and secondary prevention is poorest in the ICS 	<ul style="list-style-type: none"> ❖ Highest rates in ICS for major and minor LL amputations 	<ul style="list-style-type: none"> ❖ Lower than national rates but not as good as regional rates



Overarching themes



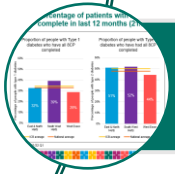
Although the prevalence of NDH and Diabetes is below the national median, the ICS prevalence is rising and estimated to continue to rise. The majority of the diabetic cohort are living with additional social or health complexities and thus are shown to require additional input from the health service.



Ethnic minorities, and those living in deprivation are disproportionately represented in the diabetes cohort.



Those living in more deprivation, ethnic minorities and those living with advanced disease/complexity, are less likely to have had care processes or annual reviews completed.

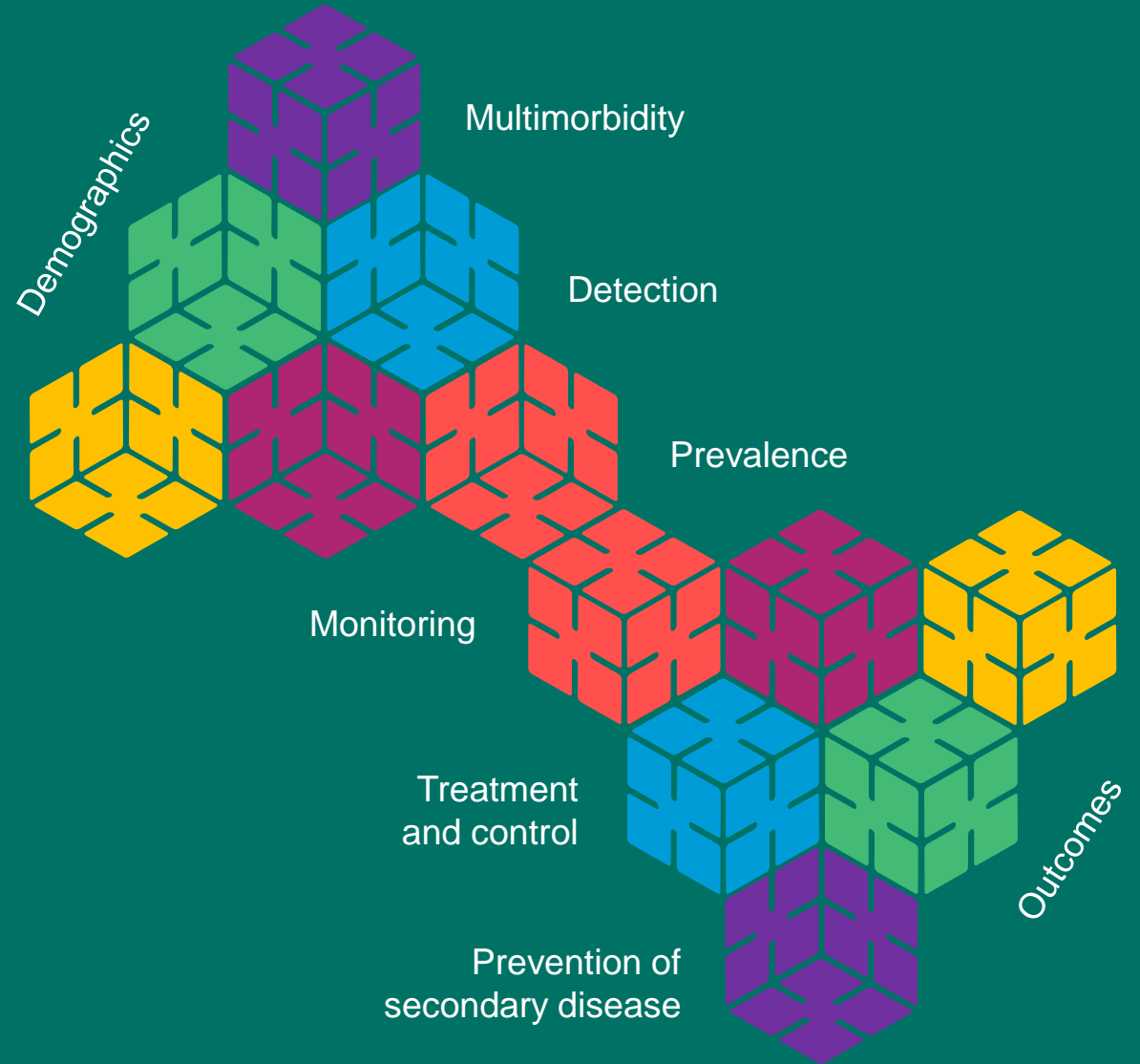


Across all place areas, T2DM has a higher rate of 8CP, 3TT and prevention measures completed when compared to T1DM.



So far all indicators have improved since 20/21, however have not recovered to performance levels pre-pandemic.





Key Messages

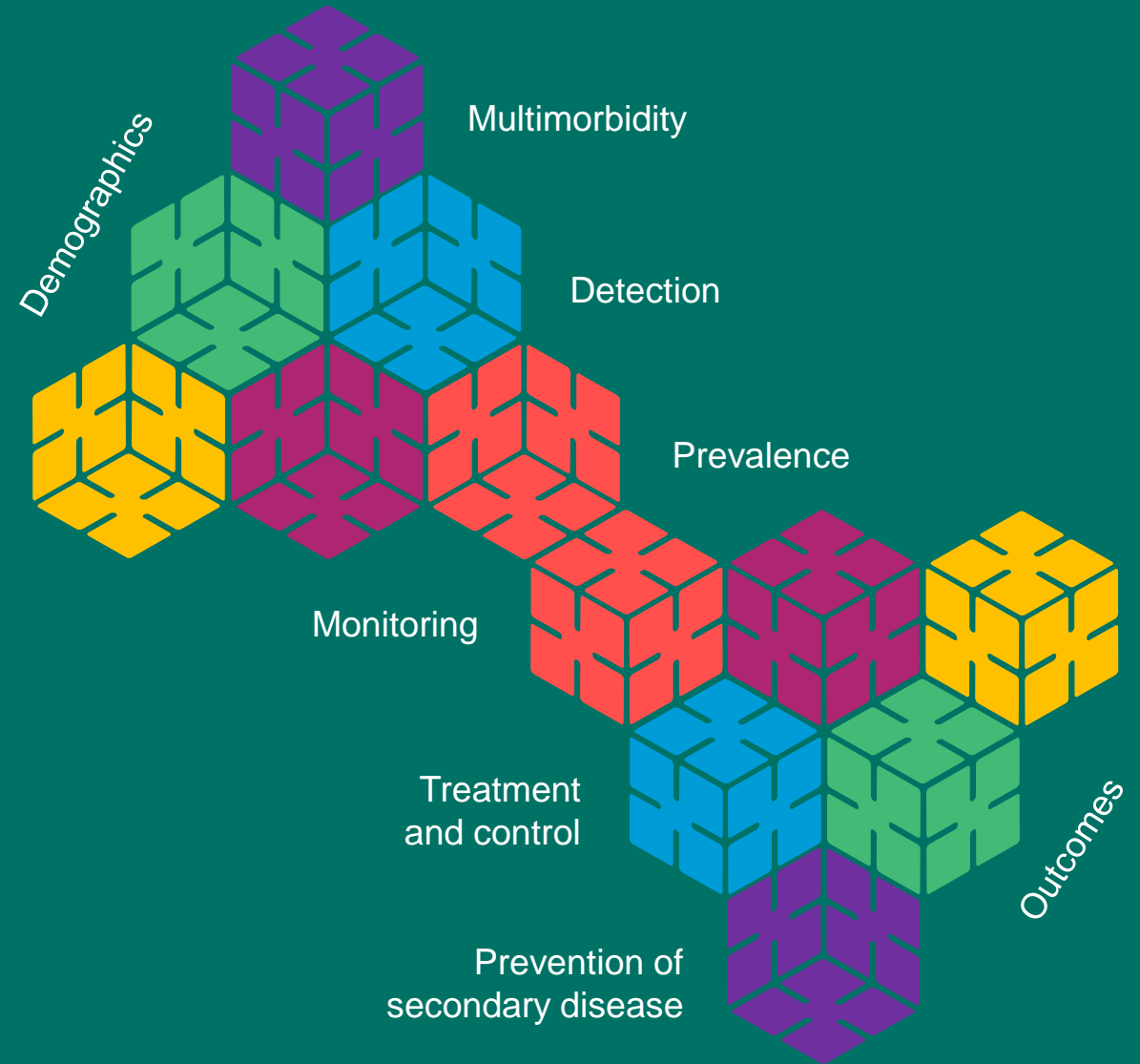
Working together
for a healthier future



Prevalence and Detection

The following slides show prevalence and detection of Non-diabetic Hyperglycaemia and Diabetes within Hertfordshire and West Essex ICS

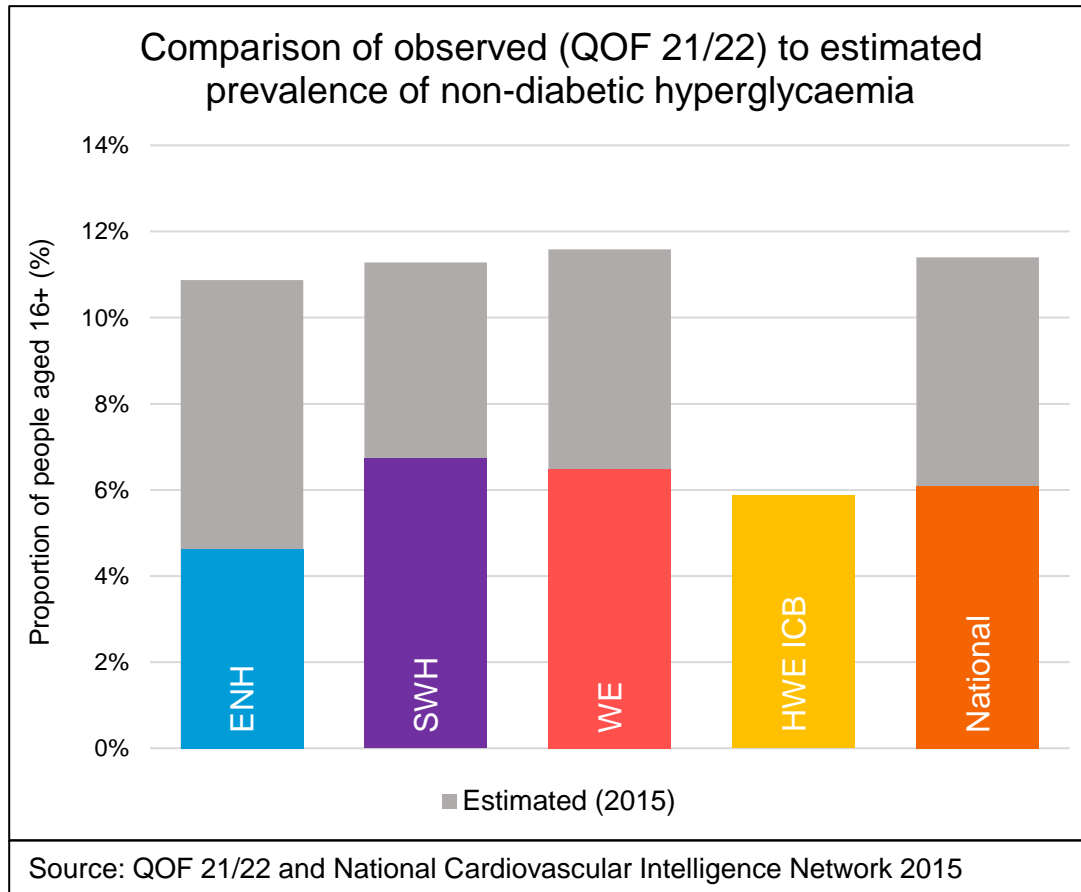
Working together
for a healthier future





Prediabetes / Non-diabetic hyperglycaemia (NDH)

There is an under-detection of NDH, comparing disease registers to estimated prevalence. SWH has the highest prevalence of NDH and the smallest prevalence gap. ENH has the lowest prevalence and biggest gap.



- ❖ There are 74,181 people in HWE on the non-diabetic hyperglycaemia register (QOF 21/22). The overall prevalence of NDH in HWE is 5.9%. However, there is variation by Place: ENH (4.6%), SWH (6.7%), WE (6.5%).
- ❖ Nationally, it is estimated that 11.4% of people aged 16 years and over are living with non-diabetic hyperglycaemia. Locally, the estimated prevalence is highest in WE (11.6%), followed by SWH (11.3%) and then ENH (10.9%).
- ❖ The prevalence gap for NDH by Place is:
 - ❖ ENH 6.3% gap
 - ❖ SWH 4.6% gap
 - ❖ WE 5.1% gap
- ❖ People with non-diabetic hyperglycaemia are likely to benefit from initiatives like the National Diabetes Prevention Programme. [Click here for NDPP uptake rates.](#)

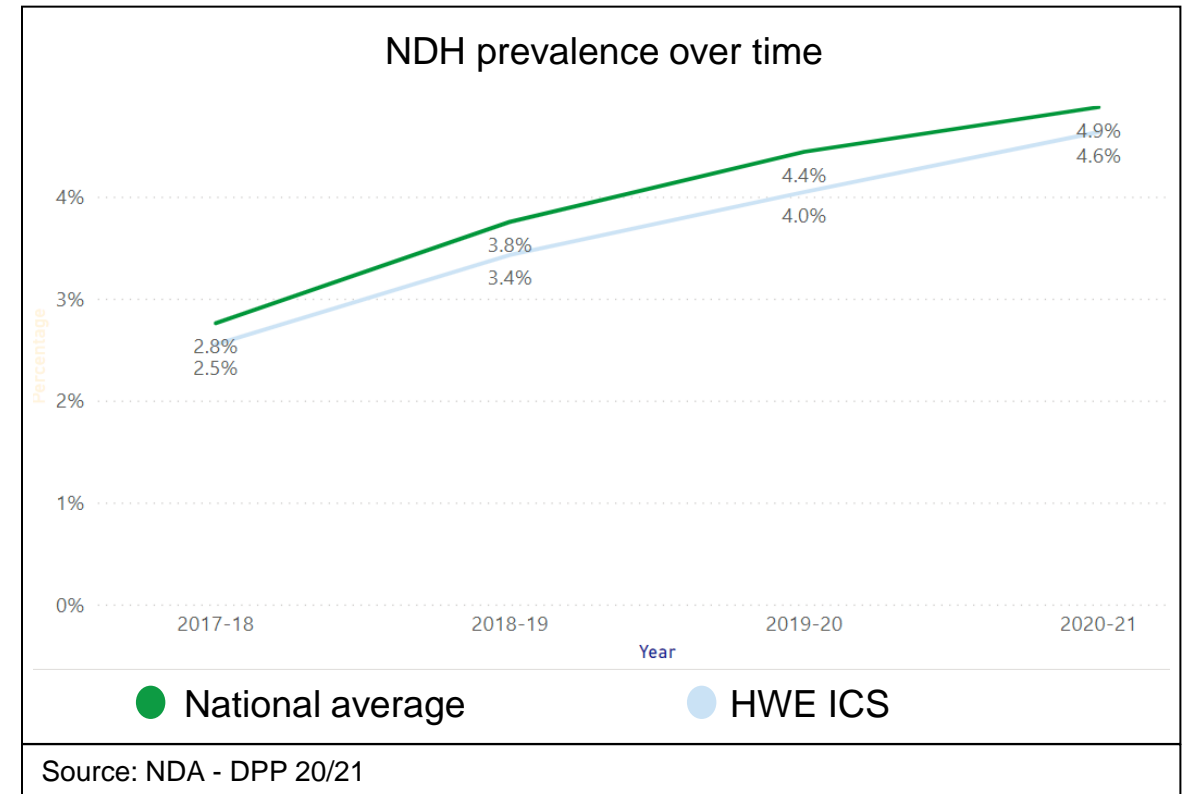




Non-diabetic hyperglycaemia prevalence and rate

NDH is increasing locally and nationally.

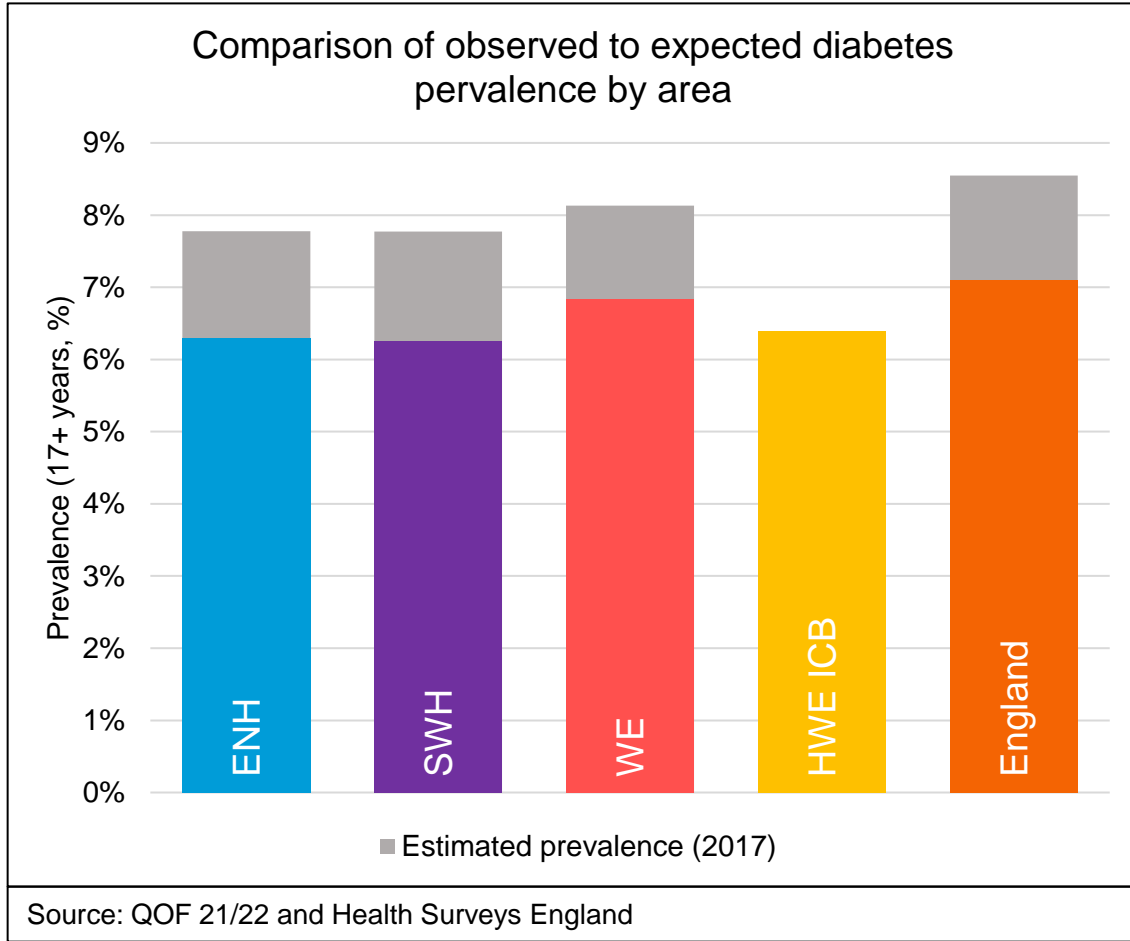
- ❖ NDH prevalence in HWE is increasing in line with national rates. As shown previously, the gaps between observed and expected prevalence are large, and this increase might be a reflection of increased detection (as this is a recently added disease register) rather than a higher proportion of the population being at risk of diabetes.
- ❖ As NDH increases, local providers of diabetes prevention programmes will need to have more capacity for people to join.





Diabetes prevalence

Diabetes prevalence is lower across the ICS compared to the national average. This is consistent with the expected prevalence's in each Place area

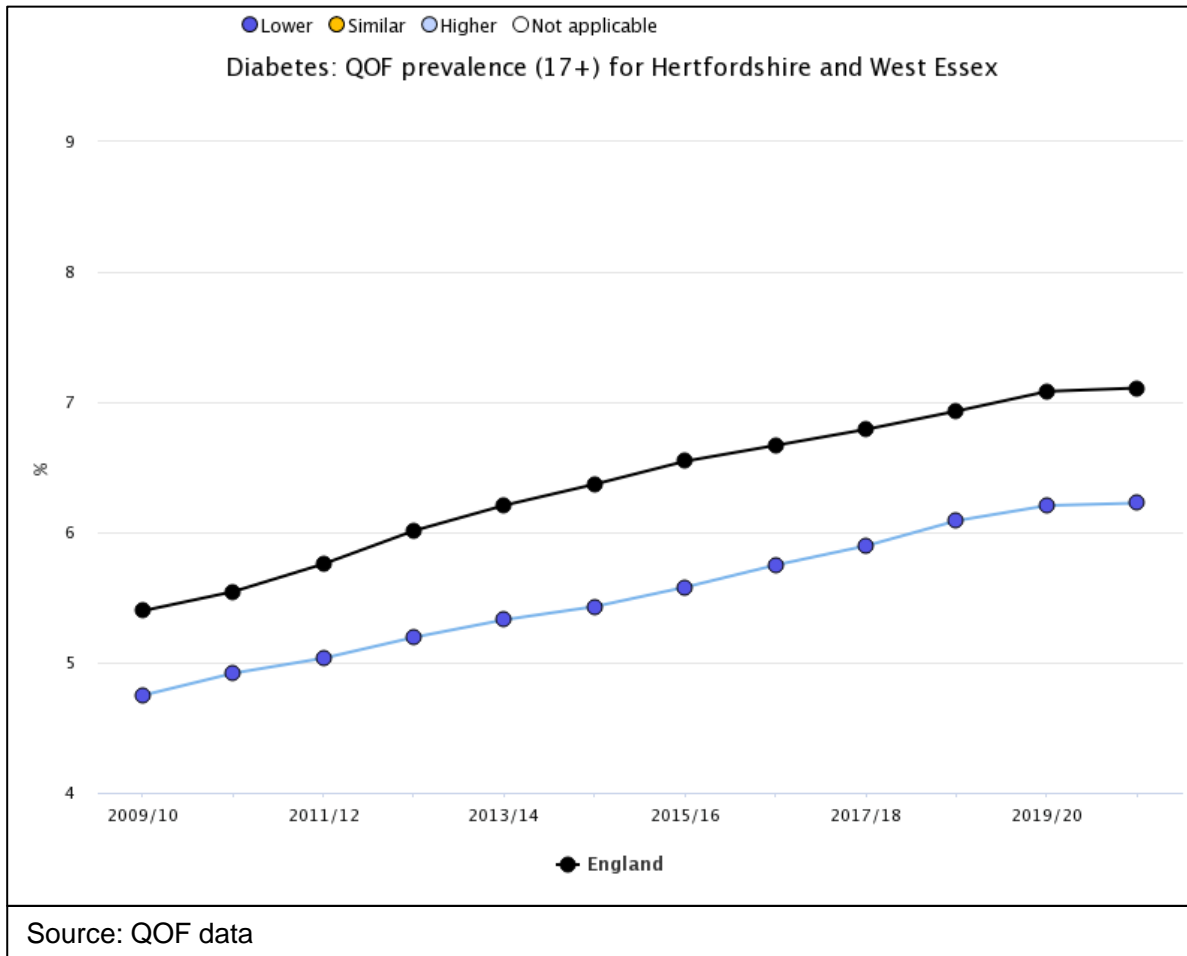


- ❖ There are 81,908 people registered with diabetes across HWE (QOF 21/22 register data). The overall prevalence of diabetes is 6.4%. ENH (6.3%), SWH (6.3%), WE (6.8%).
- ❖ Nationally, it is estimated that 9.4% of people aged 16 years and over are living with diabetes. Locally, the estimated prevalence is highest in WE (8.2%), followed by SWH (7.8%) and ENH (7.8%).
- ❖ The prevalence gap in each of the 3 Place areas is in line with or below the gap nationally. The prevalence gaps are shown below:
 - ❖ England – 1.4%
 - ❖ ENH – 1.5%
 - ❖ SWH – 1.5%
 - ❖ WE – 1.3%.





Diabetes QOF prevalence in HWE (17+)



- ❖ The prevalence of diabetes in HWE is steadily increasing, year on year.
- ❖ However, the gap between the prevalence in HWE and the national prevalence has increased from 0.7% in 2009/10 (4.7% vs. 5.4%) to 0.9% in 2020/21 (6.2% vs. 7.1%).
 - ❖ This may partially be due to a larger prevalence gap locally between observed and expected prevalence.
 - ❖ It may also be due to behaviours and lifestyle factors within the local population. E.g. lower levels of obesity.

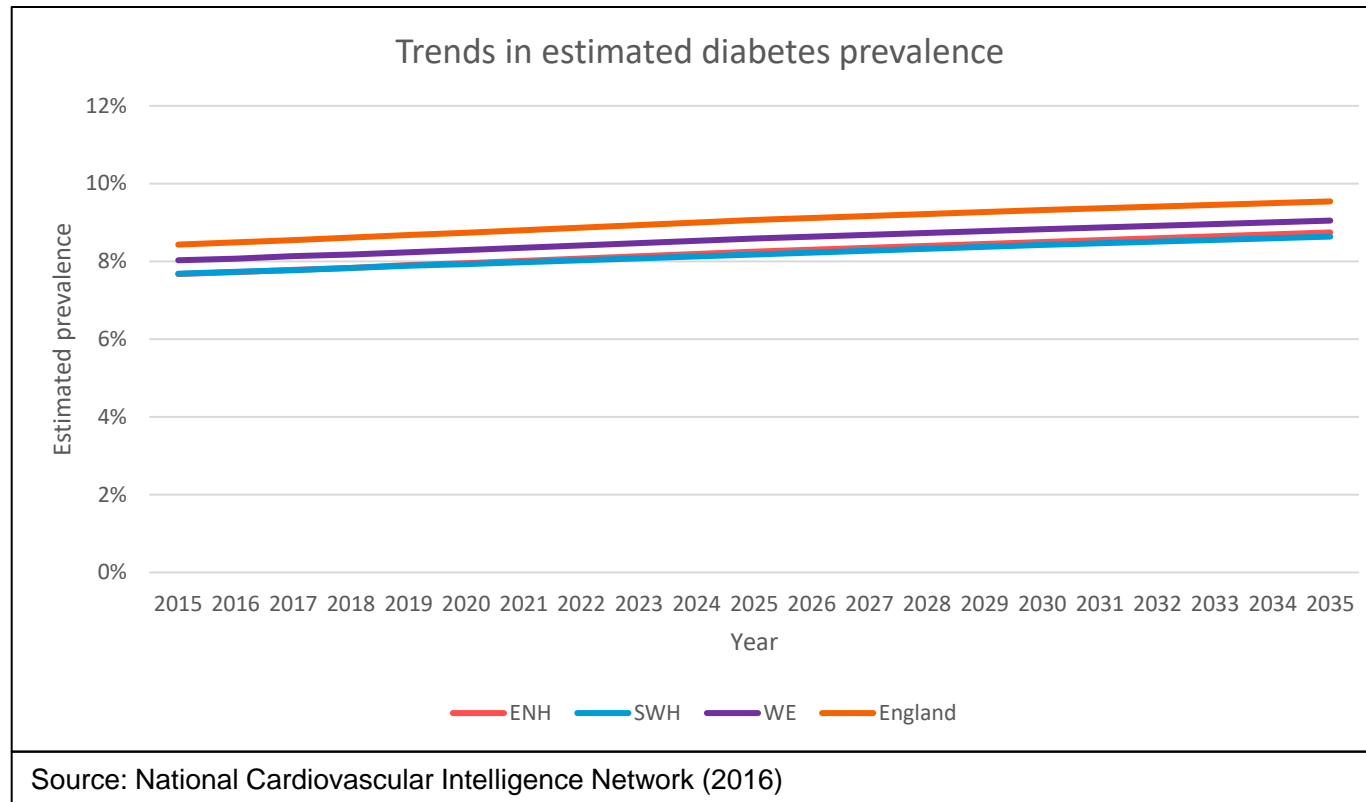




Estimated diabetes prevalence

Modelling from 2016 provides an estimated prevalence for each area over time. This shows that the upward trend in diabetes prevalence is predicted to continue as the population ages and risk factors for diabetes persist.

By 2035, it is estimated that between 8.6-9.0% of the population will have diabetes. This equates to over 128,000 people living with diabetes across HWE by 2035.

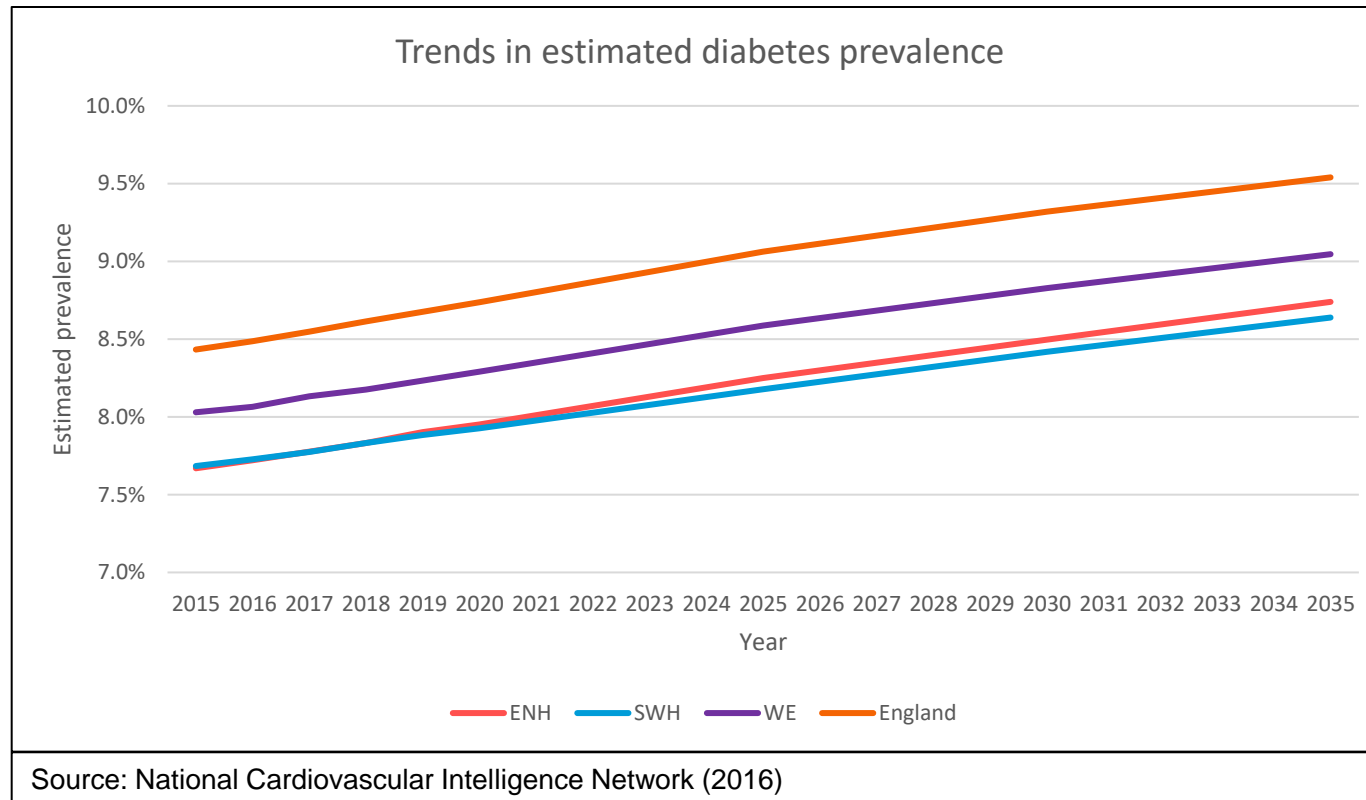




Estimated diabetes prevalence

Modelling from 2016 provides an estimated prevalence for each area over time. This shows that the upward trend in diabetes prevalence is predicted to continue as the population ages and risk factors for diabetes persist.

By 2035, it is estimated that between 8.6-9.0% of the population will have diabetes. This equates to over 128,000 people living with diabetes across HWE by 2035.

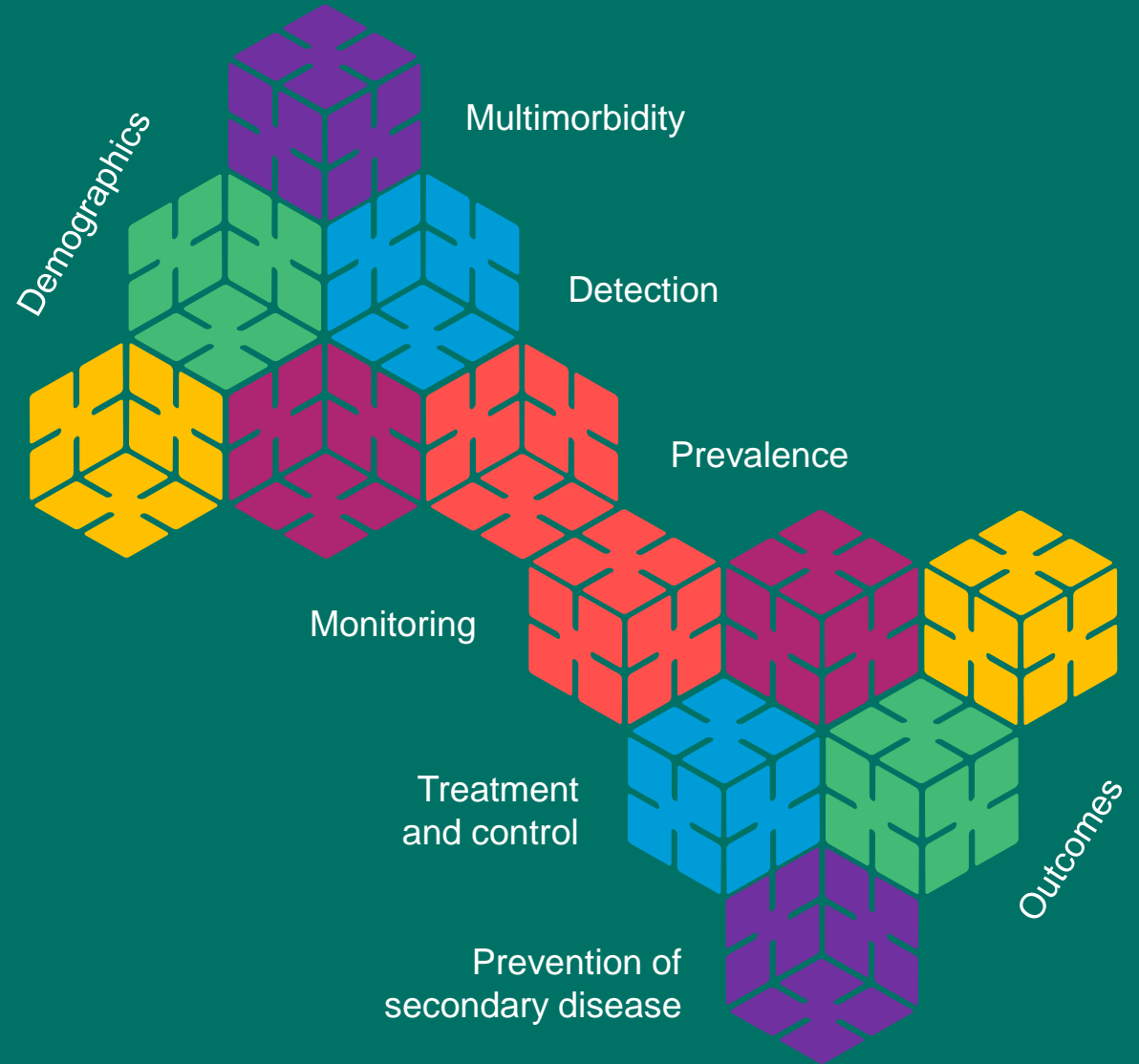




Demographics

The following slides show the demographics of the population with NDH and Diabetes

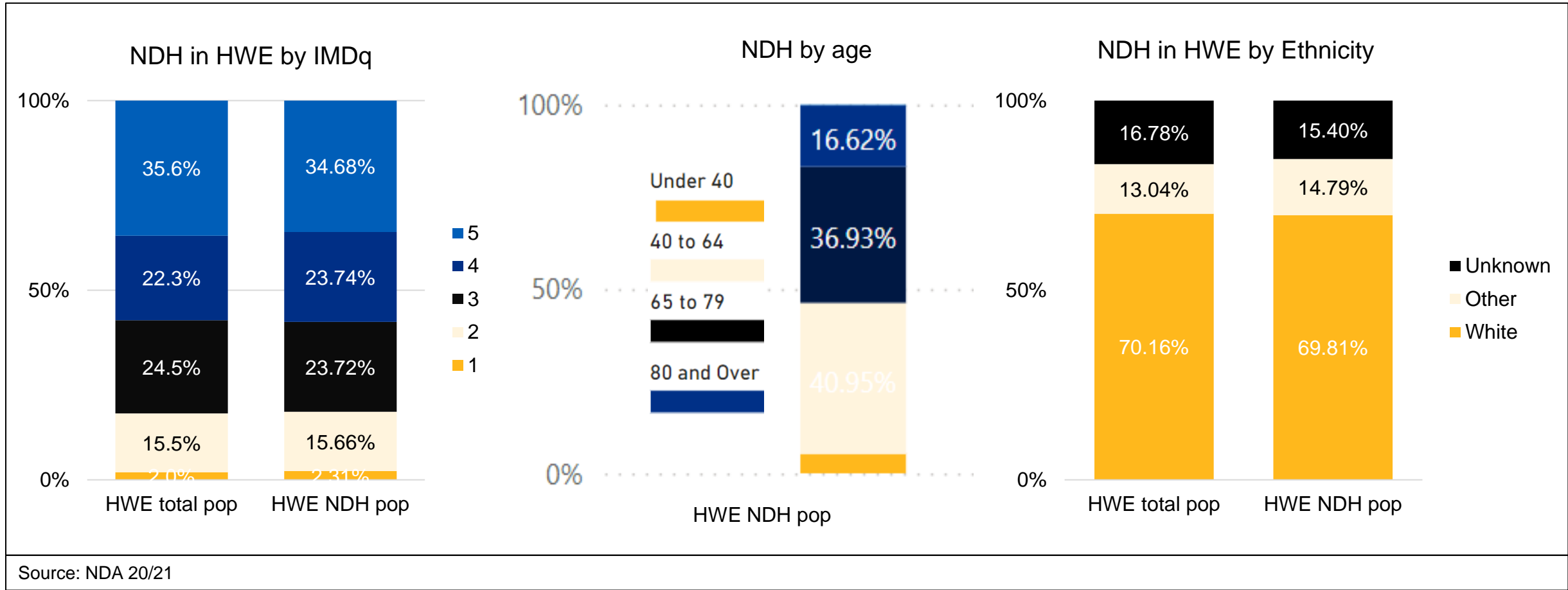
Working together
for a healthier future





NDH demographics

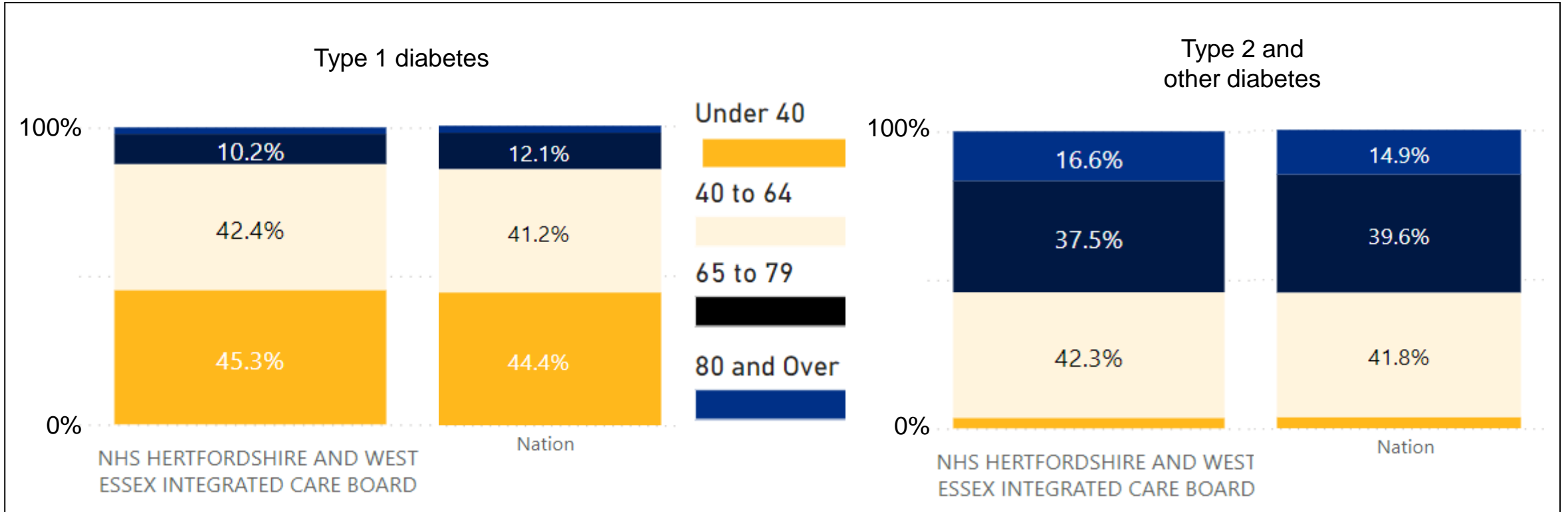
The HWE NDH population largely reflects the general population in HWE. The age distribution of NDH is similar to the age profile of people with Type 2 Diabetes.





Diabetes by age in HWE

Data from NDA 20/21. The age of the population living with diabetes varies with type. The majority of the population with Type 1 Diabetes is under 64. Type 2 Diabetes, as expected, affects mainly those above 64.

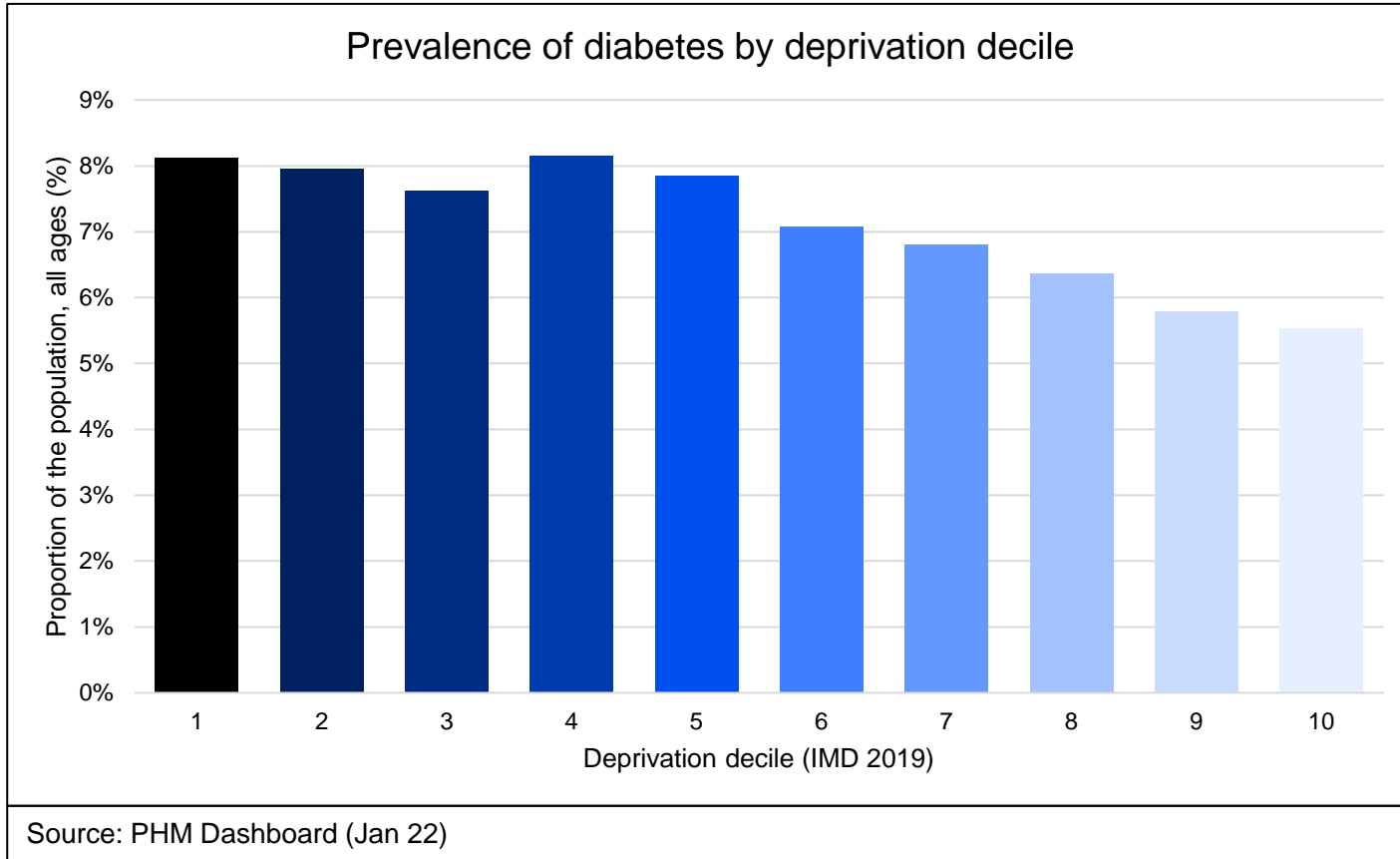


Source: NDA 20/21





Diabetes by deprivation in HWE



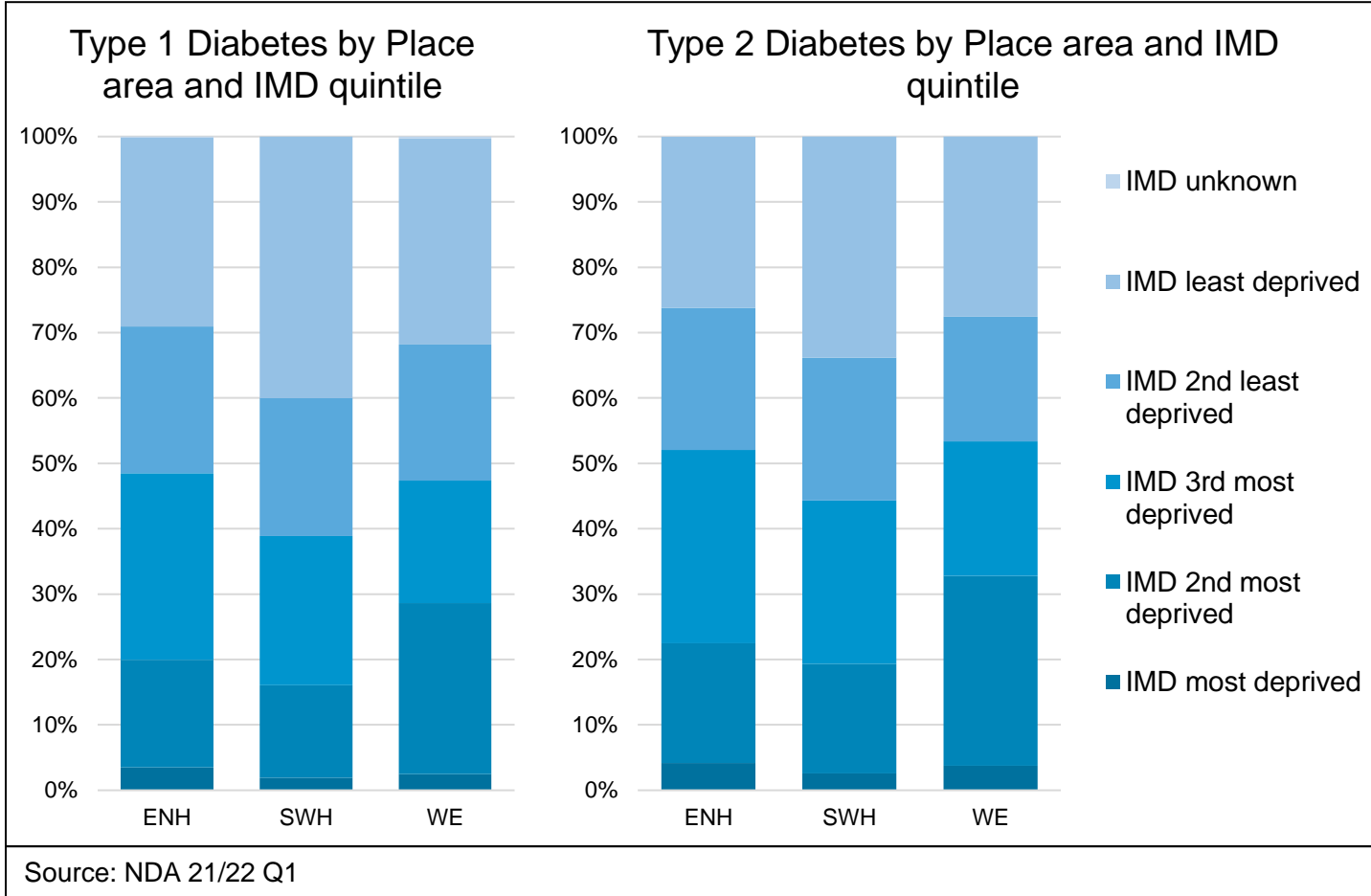
Local data (linked data from January 2022) show that:

- ❖ Diabetes prevalence is significantly higher in more deprived groups.
- ❖ The prevalence of diabetes in people living in the highest levels of deprivation is 8.1%, compared to 5.5% among people in the lowest levels of deprivation within HWE.
- ❖ People with diabetes in more deprived areas are also more likely to be from Black or Minority ethnic groups (33% in deprivation decile 1, compared to 19% in the least deprived decile).





Diabetes by Type, IMDq and Place area



These charts show the total population with diabetes within each Place area, split by IMDq. This NDA 21/22 data shows:

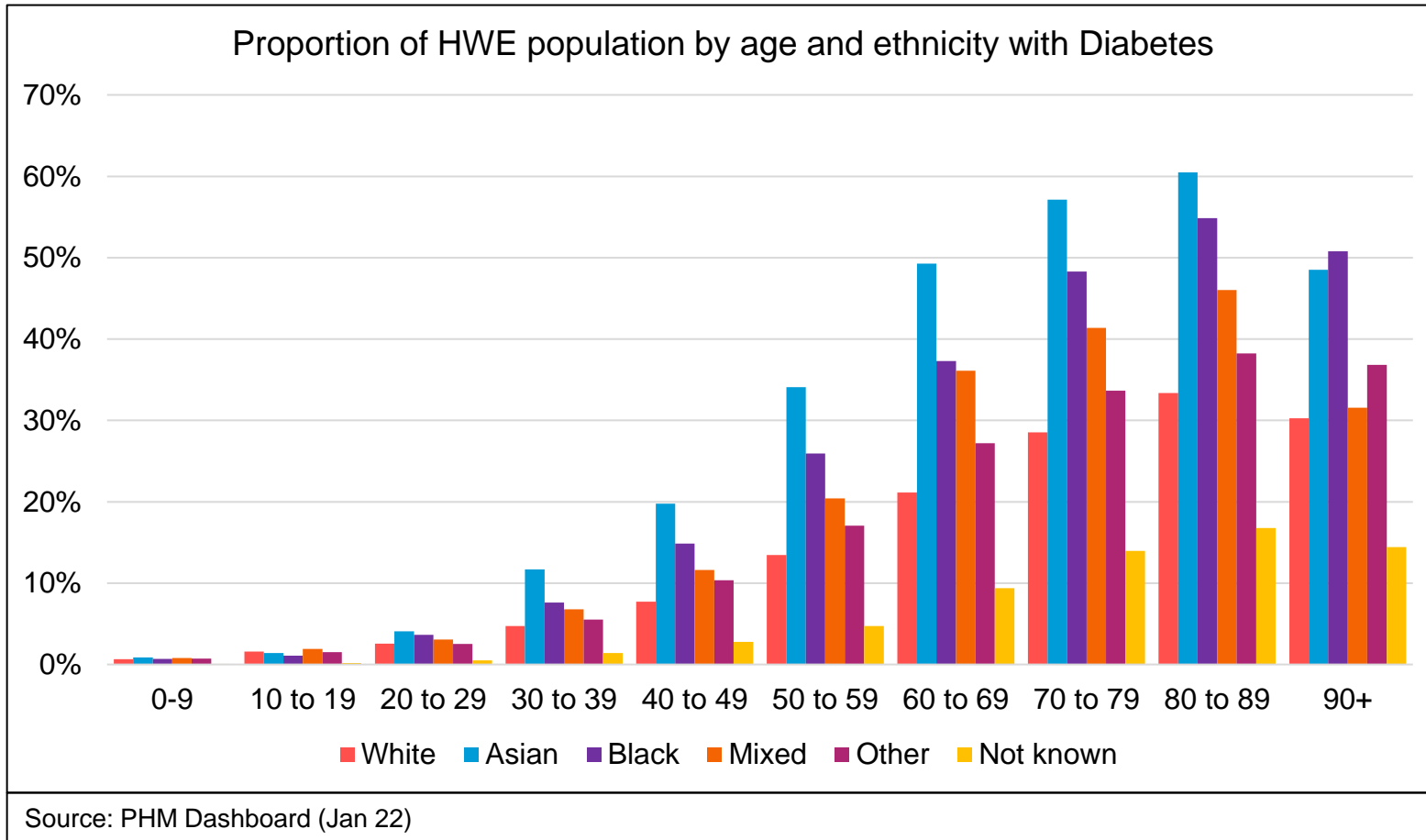
- ❖ Type 2 diabetes generally impacts a higher proportion of those in the more deprived quintiles when compared Type 1 Diabetes.
- ❖ WE has the highest proportion of people with diabetes living in more deprivation when comparing by Place area. This is likely reflective of the total population in WE.





Diabetes by age and ethnicity in HWE

Asian and Black ethnicities have a proportionately higher prevalence of diabetes in all age groups.



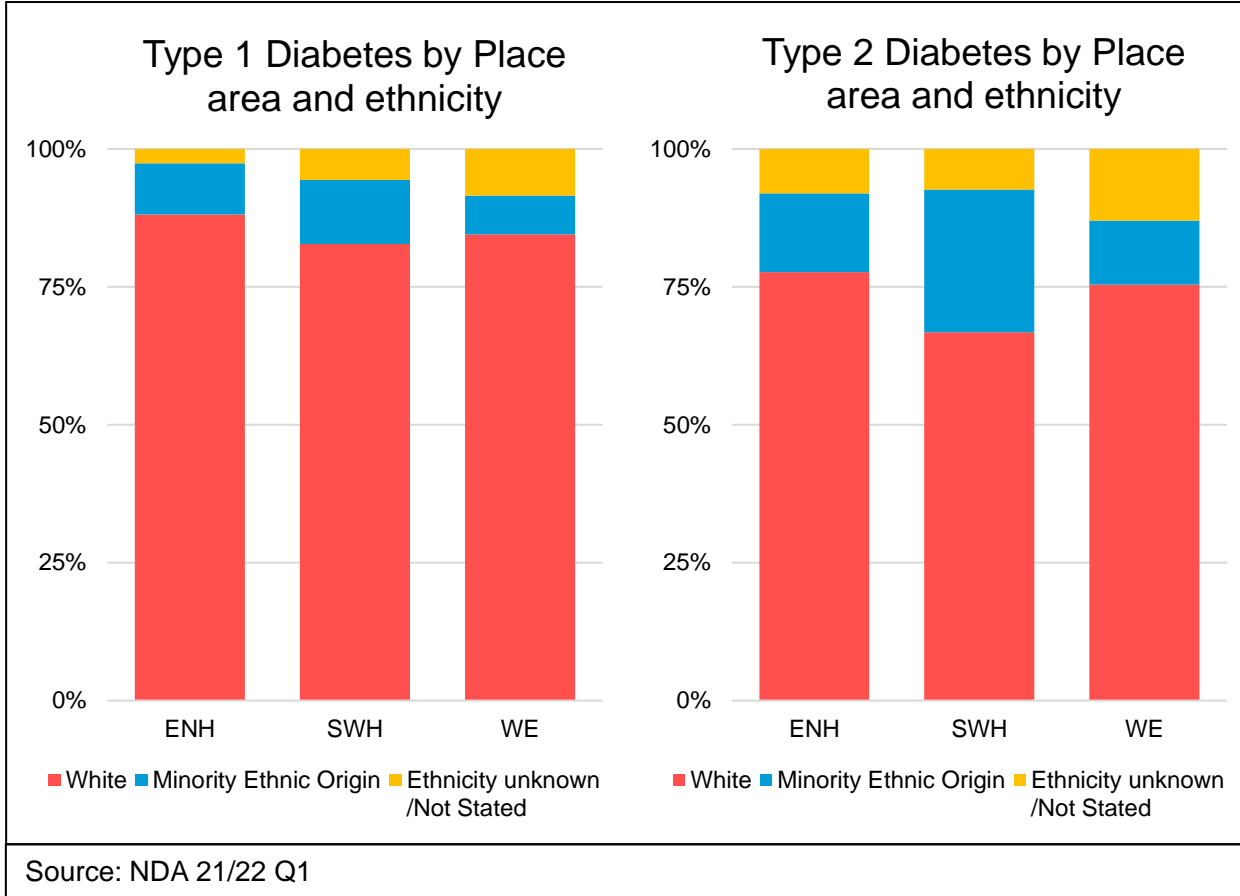
Local data (linked data from January 2022) show that:

- ❖ The highest prevalence across most age bands is in people of Asian ethnicity
- ❖ People who do not have a recorded ethnicity have a very low prevalence, suggesting likely under diagnosis.
- ❖ Ethnicity recording is also likely to be higher in those with a diagnosis of diabetes due to increased contact with the health services.





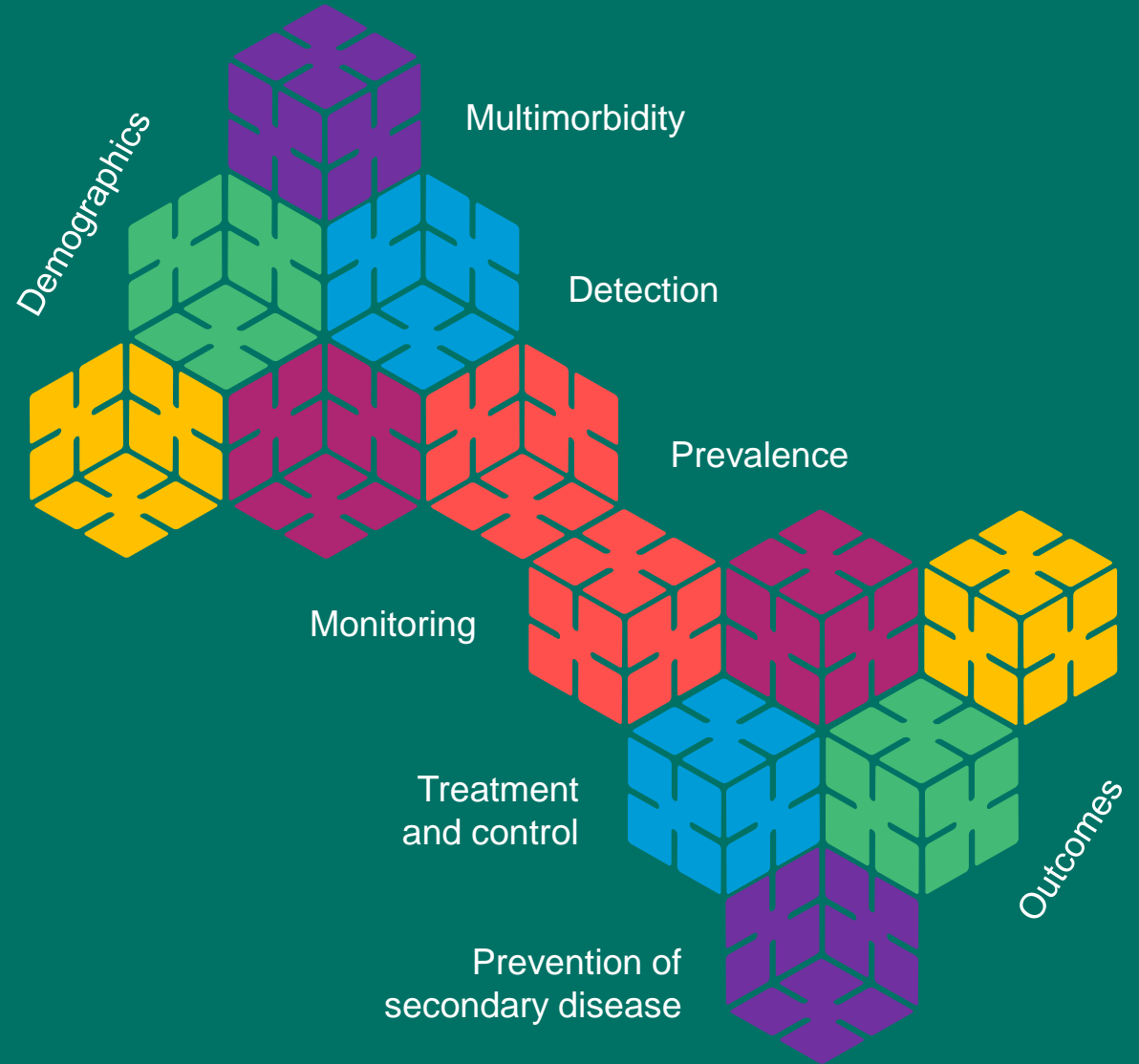
Diabetes by Type, ethnicity and Place area



These charts show the total population with diabetes within each Place area, split by ethnicity. This NDA 21/22 data shows:

- ❖ Type 2 diabetes impacts a higher proportion of ethnic minorities than in Type 1 Diabetes.
- ❖ SWH, in all types of Diabetes, has the highest proportion of ethnic minorities compared to the other place areas. This may be a reflection of the make up of the total population in SWH.





Monitoring and Care Processes

The following slides outline the monitoring of NDH and the 8 Care processes for Diabetes in the ICS

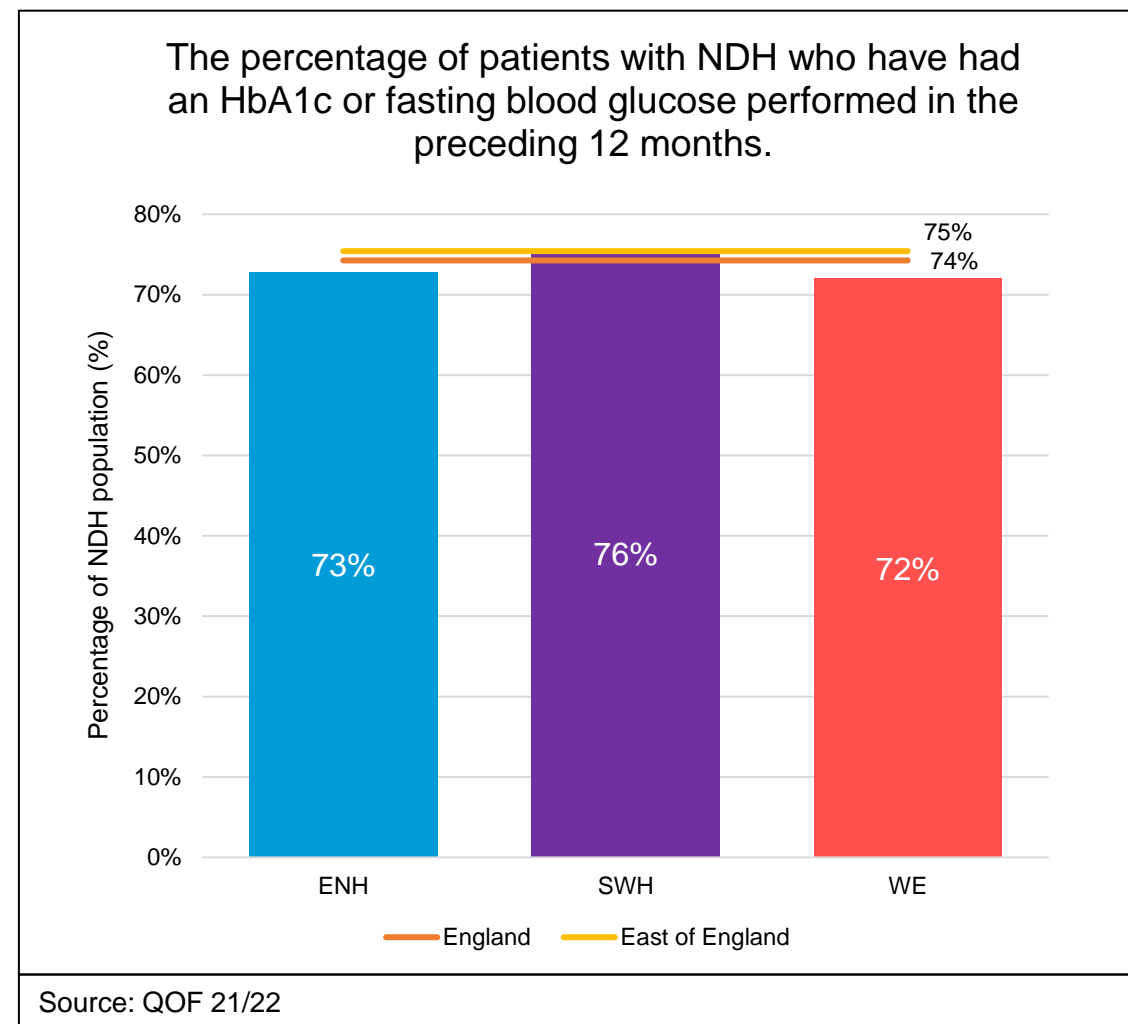
Working together
for a healthier future



Monitoring - Non-Diabetic Hyperglycaemia

This graph shows the QOF indicator by Place area compared to National and Regional rates.

- ❖ Overall, rates of HbA1c/glucose monitoring have risen since the previous year from 58% nationally to 74% nationally. The lower rates are likely to represent the effects of the COVID-19 pandemic.
- ❖ By Place area, WE has the lowest proportion (72%) followed by ENH (73%), with SWH performing best (76%).



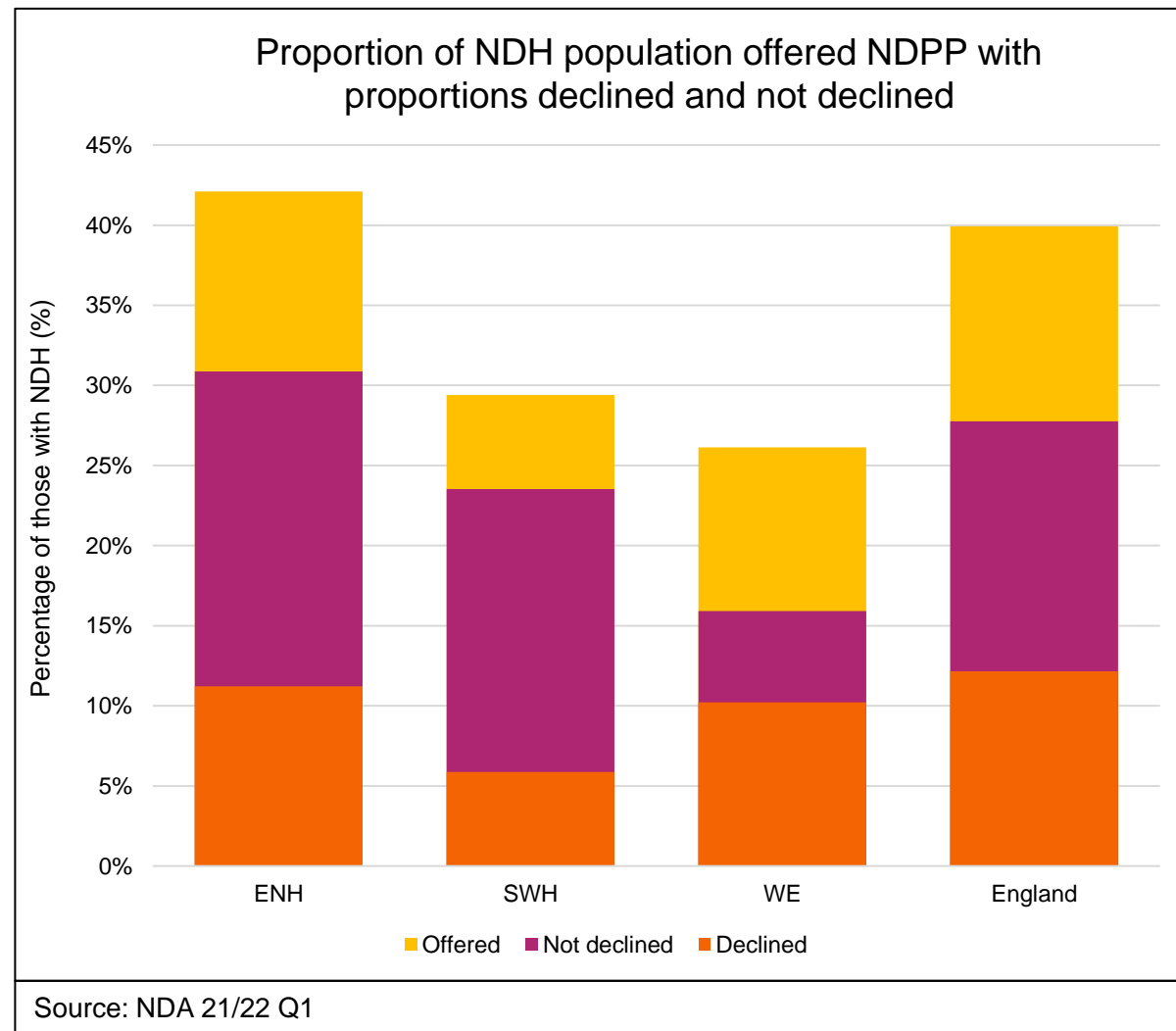


National Diabetes Prevention Programme

The National Diabetes Prevention Programme (NDPP) is a nationally commissioned service that delivers an evidence based lifestyle change programme to people at high risk of developing type 2 diabetes.

This graph shows the proportion of people with NDH who were offered NDPP and the proportions declined vs not declined.

- ❖ Generally there are higher rates of not declining vs declining.
- ❖ WE has the lowest rate of NDPP offered. ENH has the highest and is above the national average.
- ❖ SWH has the lowest rate of NDPP declined. All Place areas have a lower rate of NDPP declined when compared to the national average.





Type 1 and Type 2 Diabetes care

❖ NICE guidance recommends that all patients with diabetes receive the following checks (known as the **8 Care Processes**) each year:

- | | |
|----------------------|--|
| 1. Urine Albumin | 5. An HbA1c, checking current diabetic control |
| 2. Foot surveillance | 6. Blood pressure |
| 3. Body Mass Index | 7. Cholesterol |
| 4. Smoking status | 8. Serum creatinine |

❖ Performance of these checks is monitored each year through the National Diabetes Audit and incentivised through QOF. In recent years the QOF targets have changed, within only some of the 8 care processes now incentivised.

❖ The following charts use information from National Diabetes Audit data for HWE and England.

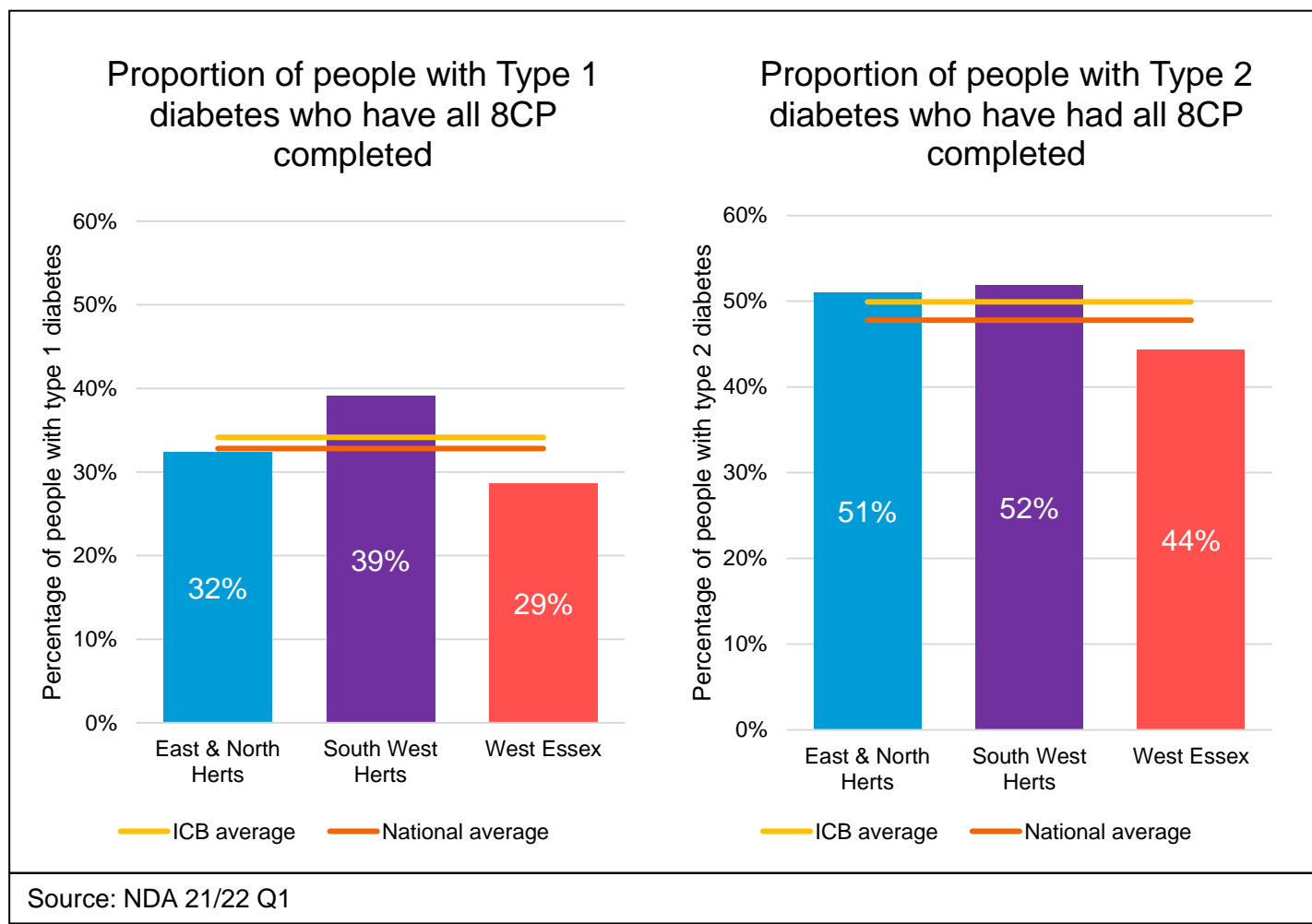


Hertfordshire and
West Essex Integrated
Care System





Percentage of patients with all 8 Care Processes (8CP) complete in last 12 months (21/22)



- ❖ National Diabetes Audit data show that the proportion of people with type 1 diabetes receiving all 8 care processes in HWE (34.1%) is higher than the national average (32.8%).
- ❖ Data for people with Type 2 diabetes show that a higher proportion of people in HWE (49.9%) receive all 8 care processes compared to the national average (47.8%).
- ❖ Overall, performance is better on T2DM, this maybe partly due to lower rates of comorbidities leading to less interactions and lower engagement with health services amongst young people with Type 1 Diabetes.
- ❖ For both T1 and T2 diabetes SWH has the highest rates of 8 care process completion and WE has the lowest.
- ❖ Urine Albumin and Foot Surveillance are the Care Processes with the poorest uptake.
- ❖ Click link to see full 8CP breakdown :
 - ❖ [Type 1](#)
 - ❖ [Type 2](#)





Diabetic care

There is variation in the routine care delivered to people with diabetes with people in more vulnerable communities less likely to receive routine care processes.

- ❖ Local HWE data show that people from the most deprived communities (decile 1) are less likely to have an annual review for their diabetes (42.6%) compared to the diabetic cohort (63.8%).
- ❖ Whilst uptake of the annual review is highest for people of Asian ethnicity (68.5%), it is lowest among people of Mixed ethnicity (55.1%) and this group is also least likely to have had an HbA1c or foot check in the last 2 years, or have received structured education.
- ❖ People in Advance Disease & Complexity segments 4c (Severe LD/ASD/ADHD) and 4d (Complex mental illness) are also least likely to have had care processes completed.

Ethnicity Group	Other ethnic groups	Asian	Black	Mixed	Other	White	Unknown	Grand Total
Overall Population Measures								
Population	623	8,688	2,926	1,157	4,570	61,768	2,901	82,712
Age	56	56	56	51	57	64	62	62
Diabetes Annual Review	55.1%	68.5%	63.3%	55.1%	62.7%	63.6%	60.5%	63.8%
HbA1C Reading (Two ...)	80.6%	88.1%	83.1%	79.0%	86.2%	83.5%	82.0%	84.0%
Diabetic Foot Check	53.1%	65.9%	62.5%	55.0%	58.8%	61.9%	67.6%	62.2%
Structured Diabetes Ed...	31.3%	35.0%	37.5%	31.5%	34.0%	34.5%	40.8%	34.8%

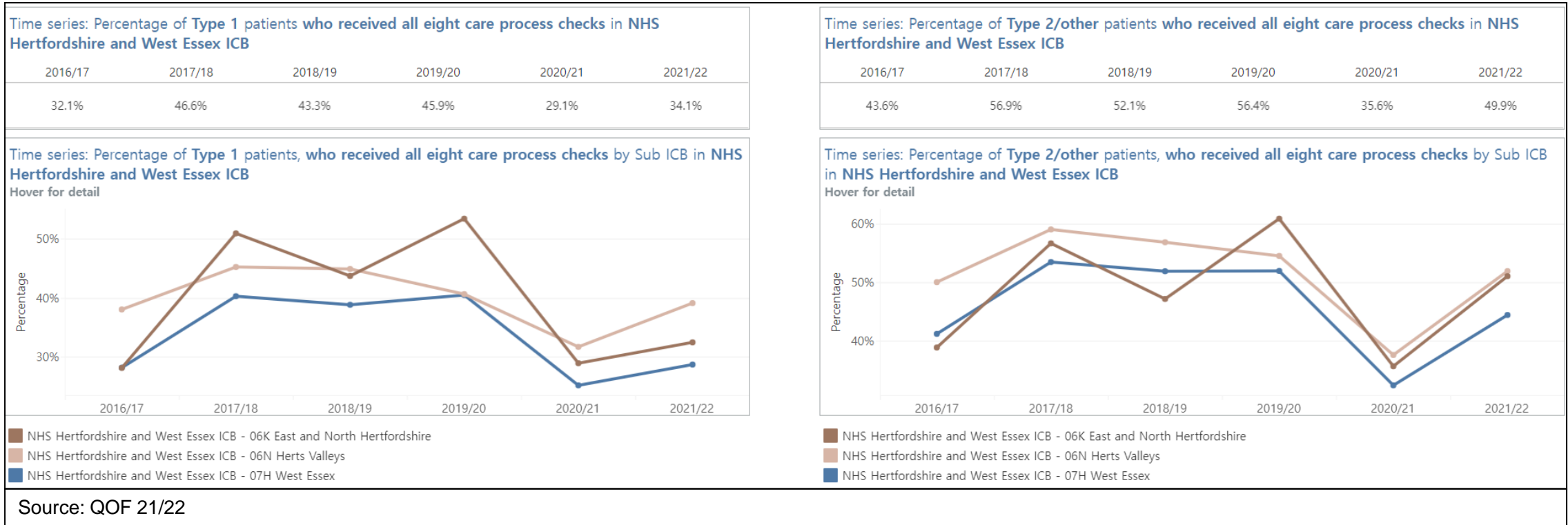
Source: PHM Dashboard (Jan 22)





Trends in completion of 8 Care processes

Care processes have been significantly affected during the pandemic, in particular foot checks, urine albumin and BMI checks.



- ❖ Completion of care processes were significantly affected during the pandemic.
- ❖ The pandemic had a similar impact on care processes amongst people with type 2 diabetes
- ❖ Whilst there has been recovery, the proportion of people with type 1 diabetes receiving all care processes is not back to pre-pandemic levels.
- ❖ Greater recovery has been seen in the last 12 months.

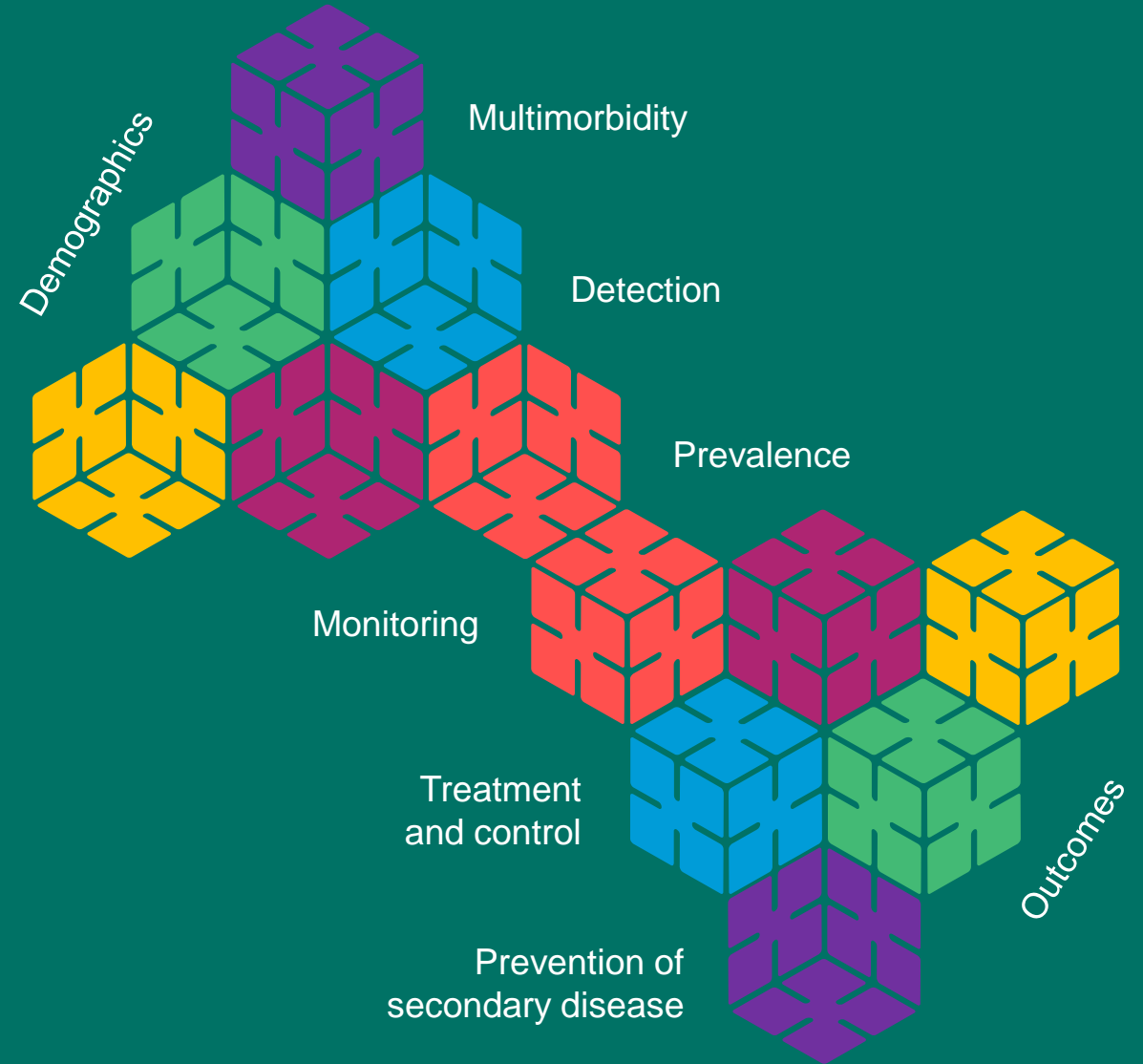




Treatment and Control

The following slides show the data for 3 Treatment Targets for Type 1 and 2 Diabetes and Structured Education rates for Type 2 Diabetes

Working together
for a healthier future





Diabetic control – 3 Treatment Targets (3TT)

In addition to the 8CPs, NHSE is focussing its transformation funding around aiming to reduce variation in the achievement of the three NICE recommended treatment targets:

1. HbA1c control

- ❖ Optimum level between 6.5% and 7.5%

2. Blood pressure measurement

- ❖ <140/80 mmHg with no kidney, eye or cerebrovascular damage; <130/80 mmHg with evidence of kidney, eye or CV damage

3. Cholesterol

- ❖ Total cholesterol should be 5.0 millimoles per litre (mmol/L) or lower

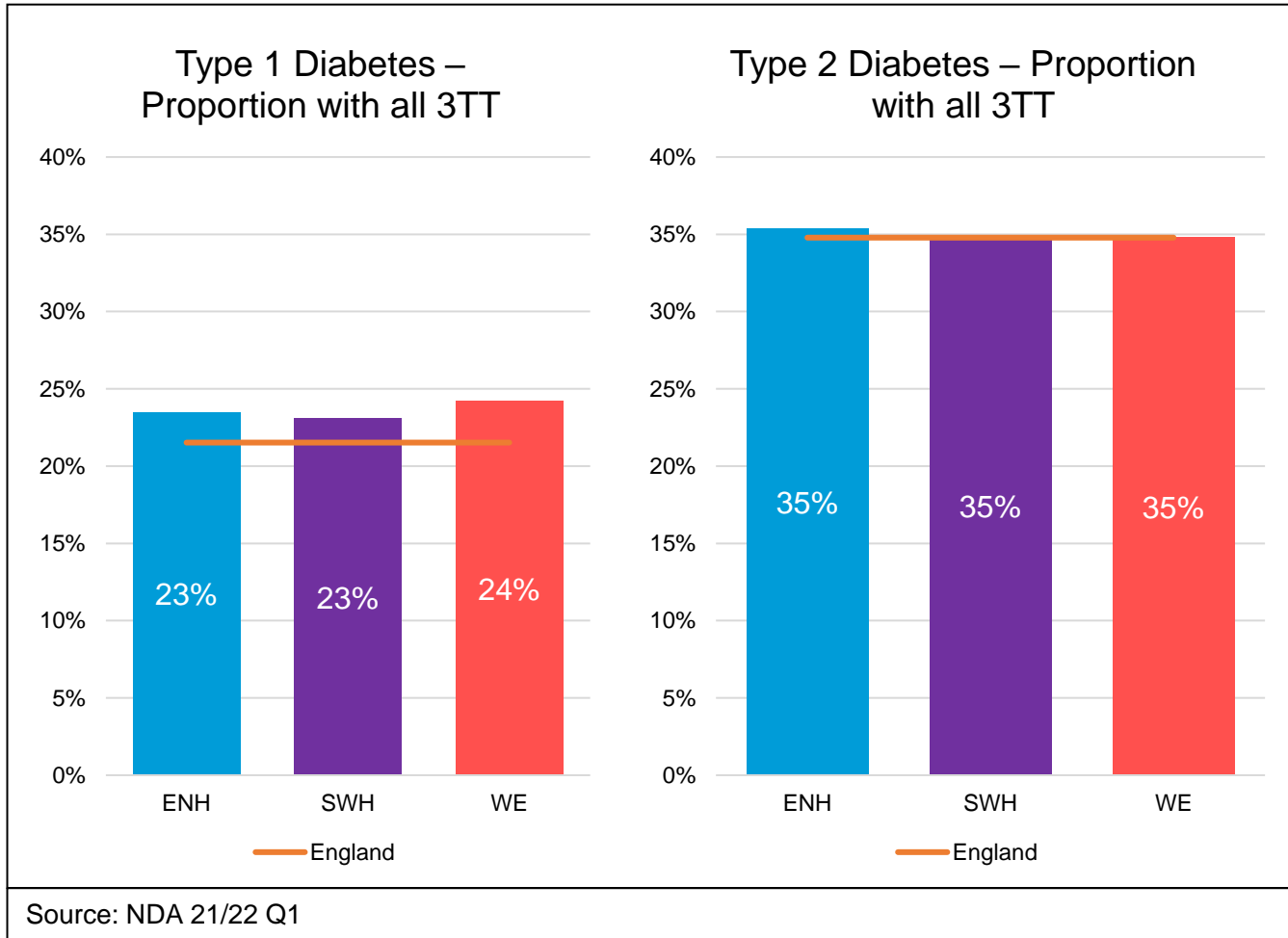
In addition to the above, expanding provision of **Structured Education** is encouraged to better support patient self-management.





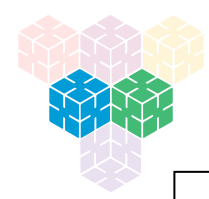
All three treatment targets (3TT) by area and diabetes types

HWE is better than national average at meeting the 3TT for both types of diabetes.



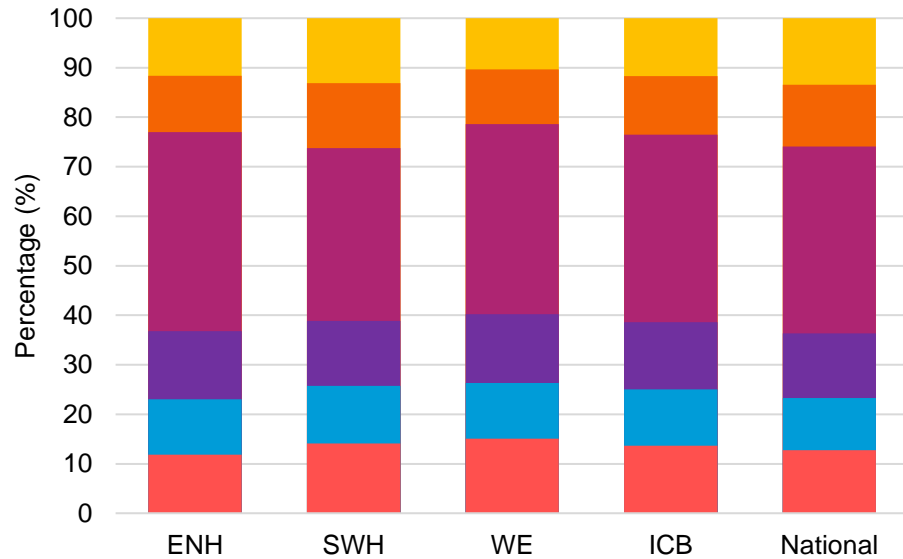
- ❖ Similar to 8CP, treatment targets are better met within in the T2DM population as opposed to the T1DM population.
- ❖ All three Place areas are performing at or above the national median for both T1 and T2 Diabetes.



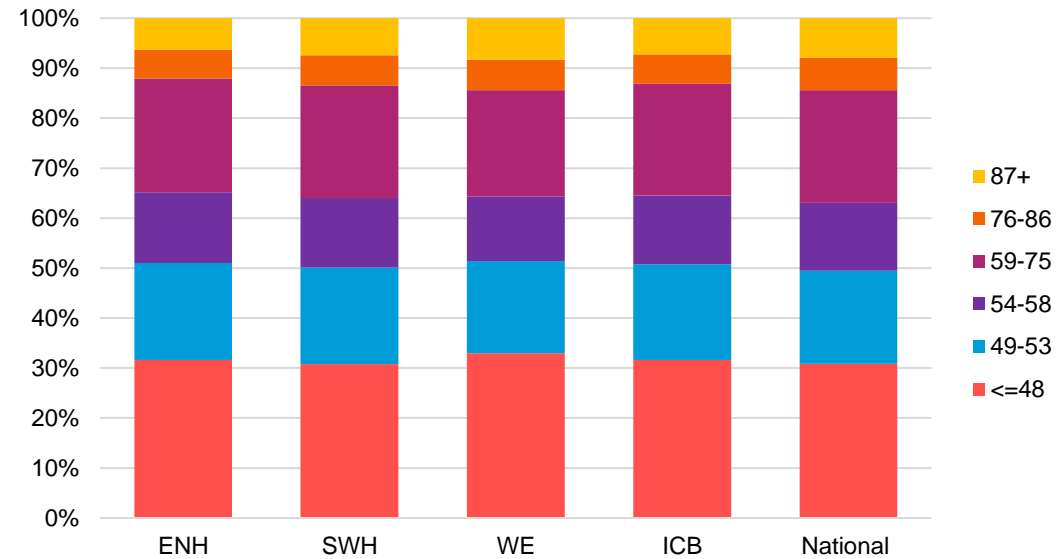


HbA1c targets

Proportion of patients with **type 1 diabetes** in each category of HbA1c, comparing ICB and Place to England average (21/22)



Proportion of patients with **type 2 diabetes** in each category of HbA1c, comparing ICB and Place to England average (21/22)



Source: QOF 21/22

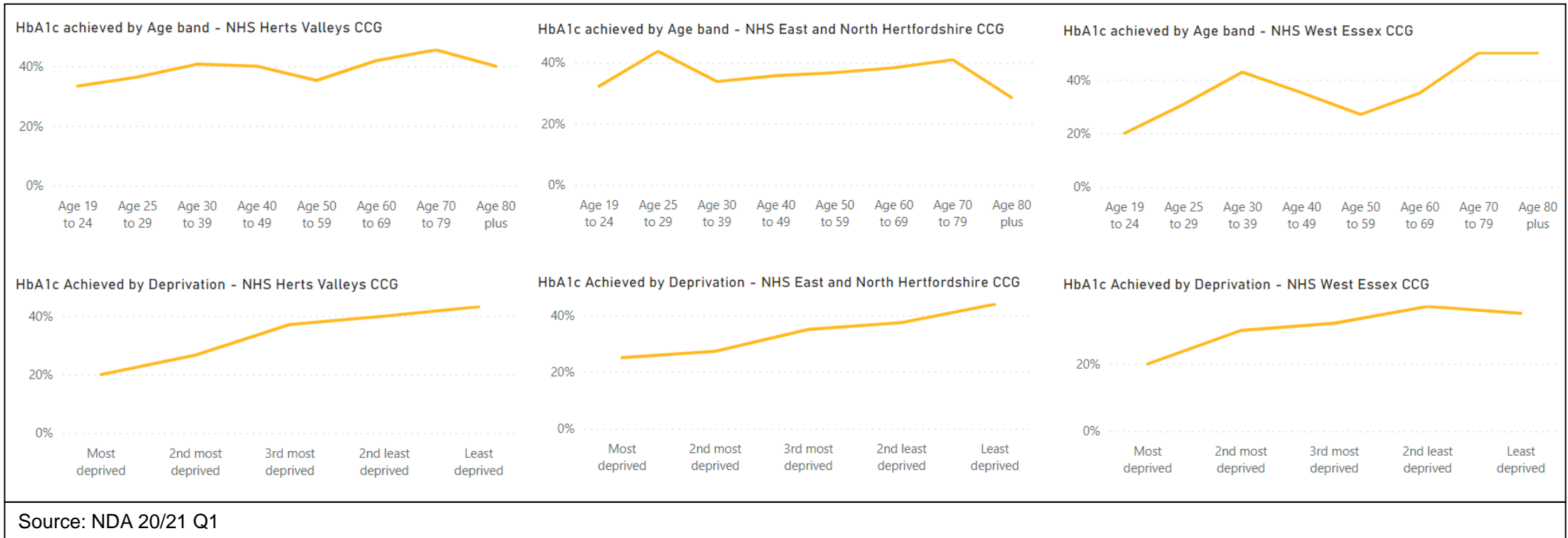
- ❖ HbA1c is used as an indicator for glucose control. Targets are generally <48mmol/mol.
- ❖ HbA1c levels are generally in line with the national averages. WE has the highest proportion of people with T1 and T2 Diabetes with <48mmol/mol.
- ❖ The HbA1c profiles of patients with T1 and T2 diabetes highlight that those with T2 Diabetes generally have a lower (better) HbA1c.





HbA1c target in T1DM by demographics

HbA1c target is <48mmol/mol or <6.5%. Between 20% and 45% of the T1DM population meet this target but variation is due to age and deprivation. Higher deprivation is linked with lower rates of meeting HbA1c targets in all three Place areas, in particular SWH (Herts Valleys).

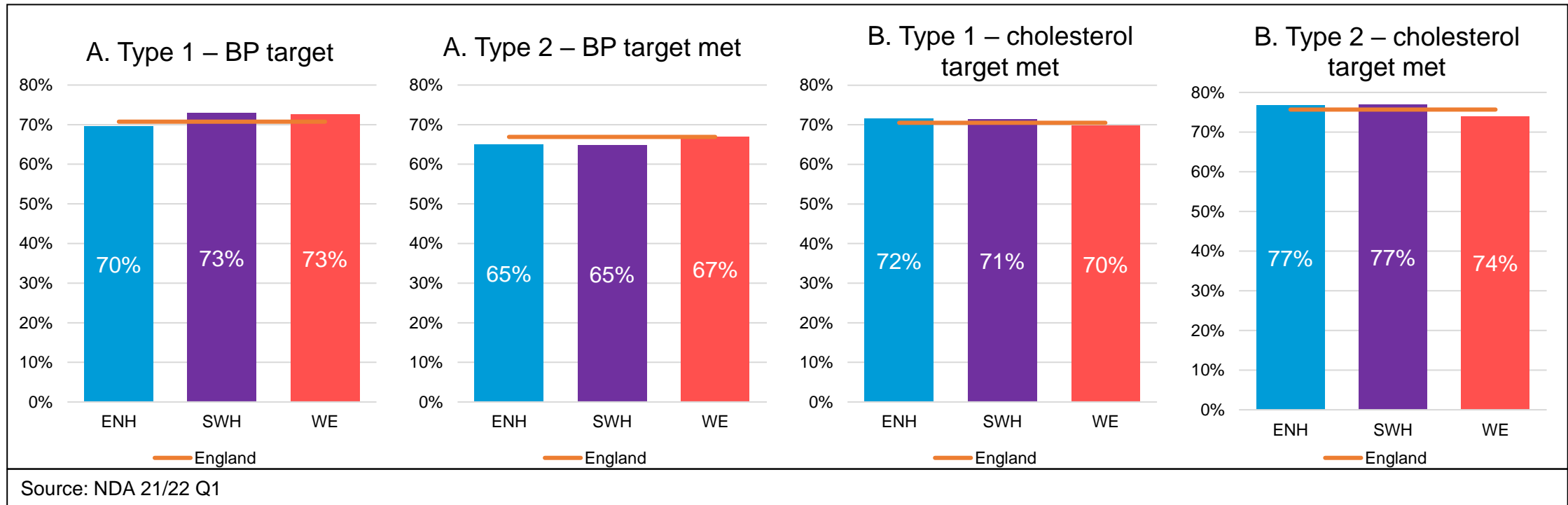




Blood pressure and cholesterol control in Type 1 and 2 diabetes

A. Proportion of patients with diabetes with BP $\leq 140/80$

B. Proportion of patients with diabetes with Cholesterol $\leq 5\text{mmol/L}$



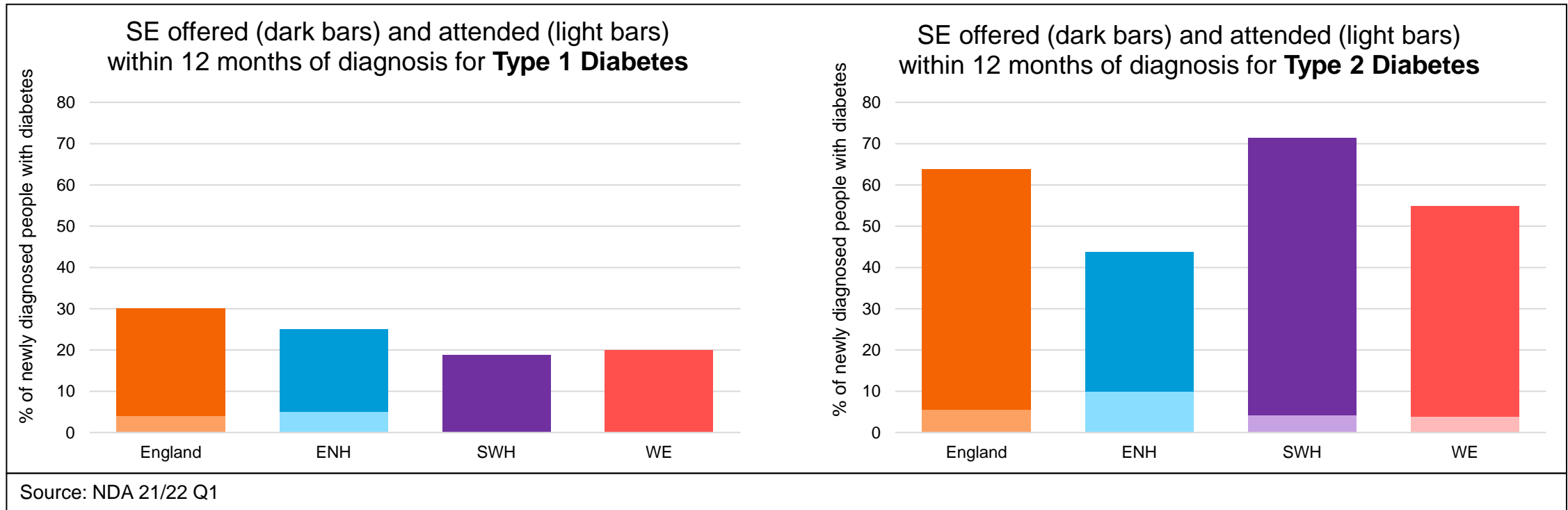
- ❖ At 74%, West Essex has a lower proportion of patients with Type 2 diabetes who have a cholesterol level within normal parameters compared with both the rest of HWE and the England average of 77.5%.
- ❖ At 65%, ENH and SWH have a lower percentage of patients with Type 2 diabetes who have their blood pressure within the target range compared to the England average.





Structured Education offered and attended within 12 months of diagnosis for T1 and T2 diabetes

Dark bars represent percentage offered out of number of new diagnoses. Light bars represent percentage attended out of newly diagnosed.



- ❖ Across all parts of the ICB, SE is offered proportionately less in T1DM compared to T2DM
- ❖ HWE is performing lower than the national average in both types, however SWH is offering more SE in T2DM compared to the national median.

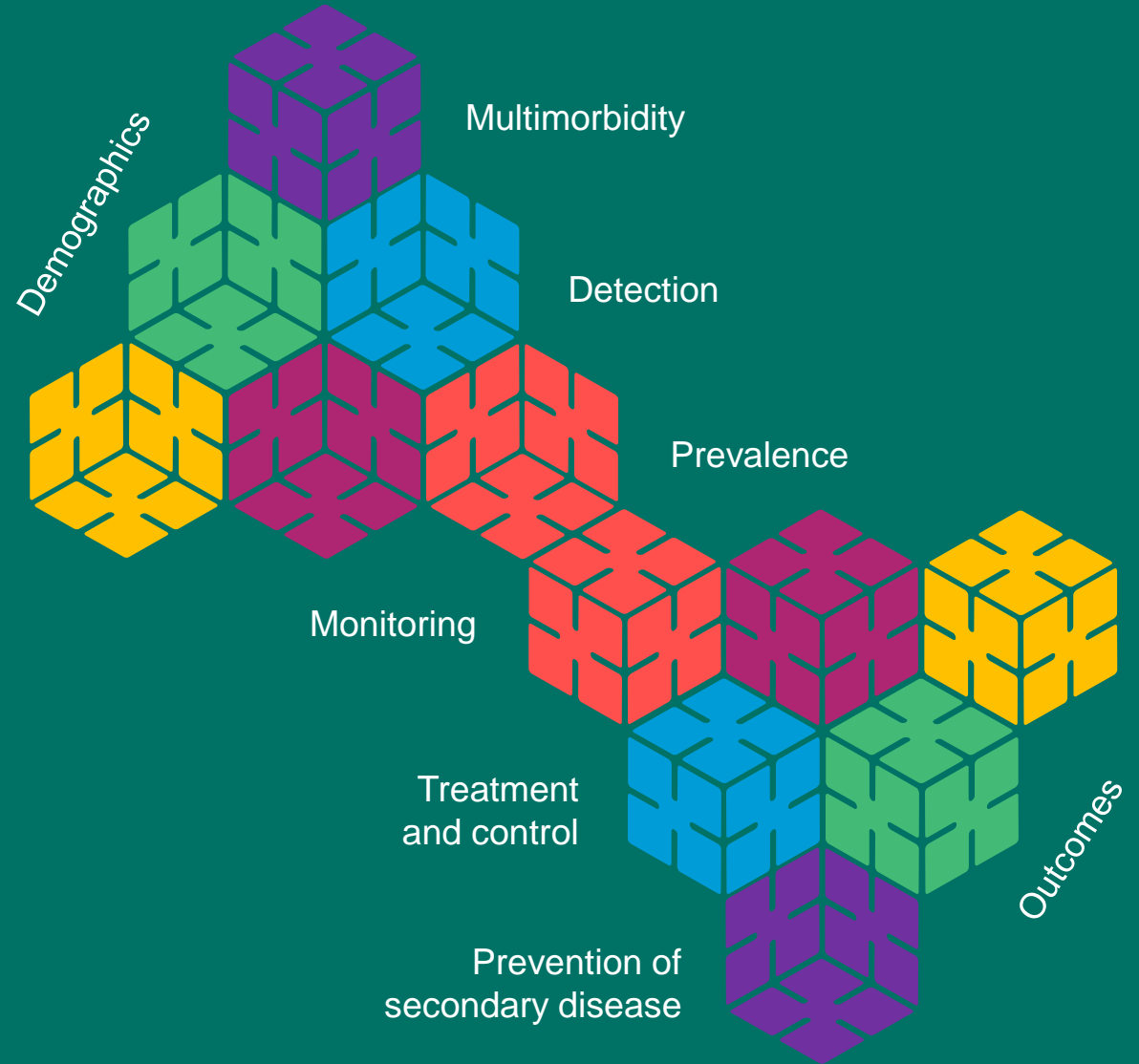




Secondary prevention

The following slides outline the data for Secondary prevention within the Diabetes population of HWE ICS

Working together
for a healthier future



Primary and secondary prevention of cardiovascular disease

Primary Prevention of CVD:

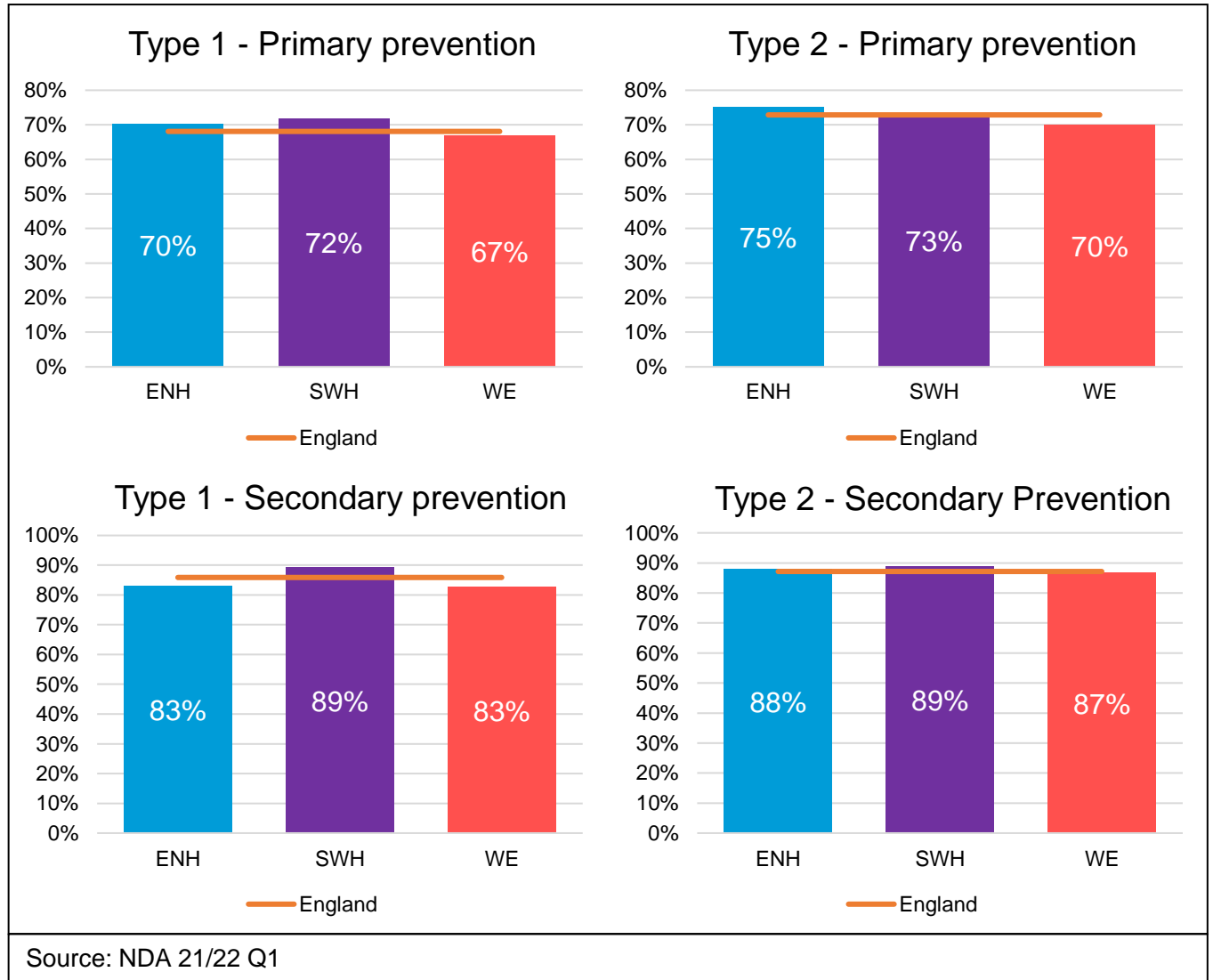
1. NICE recommends to offer statin treatment for the primary prevention of CVD to adults with type 1 diabetes who:

- ❖ are older than 40 years or
- ❖ have had diabetes for more than 10 years or
- ❖ have established nephropathy or
- ❖ have other CVD risk factors

2. Offer atorvastatin 20 mg for the primary prevention of CVD to people with type 2 diabetes who have a 10% or greater 10-year risk of developing CVD. Estimate the level of risk using the QRISK2 assessment tool.

Secondary Prevention of CVD:

Statins are recommended for patients with a history of CVD and diabetes.



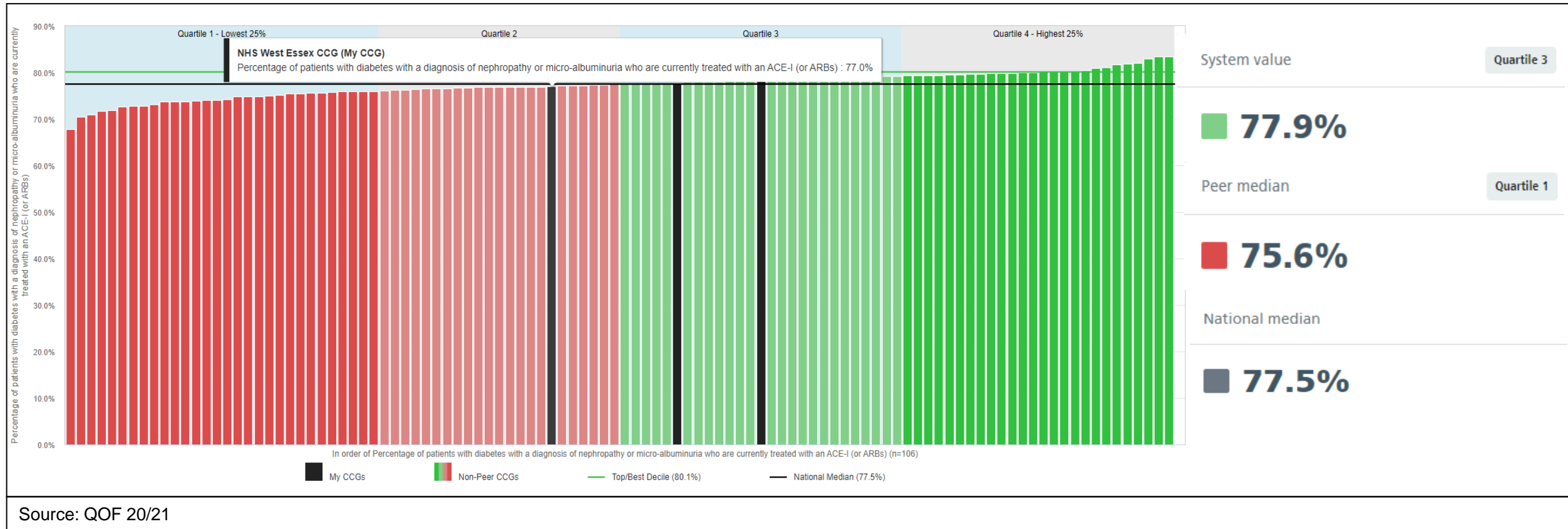
Hertfordshire and West Essex Integrated Care System





ACE and ARB prescribing in diabetic nephropathy

HWE has higher than national and peer rates with WE having the lowest rates within the ICS





Influenza Vaccination in diabetics (in preceding Aug to March 2020/21)



Source: QOF 20/21

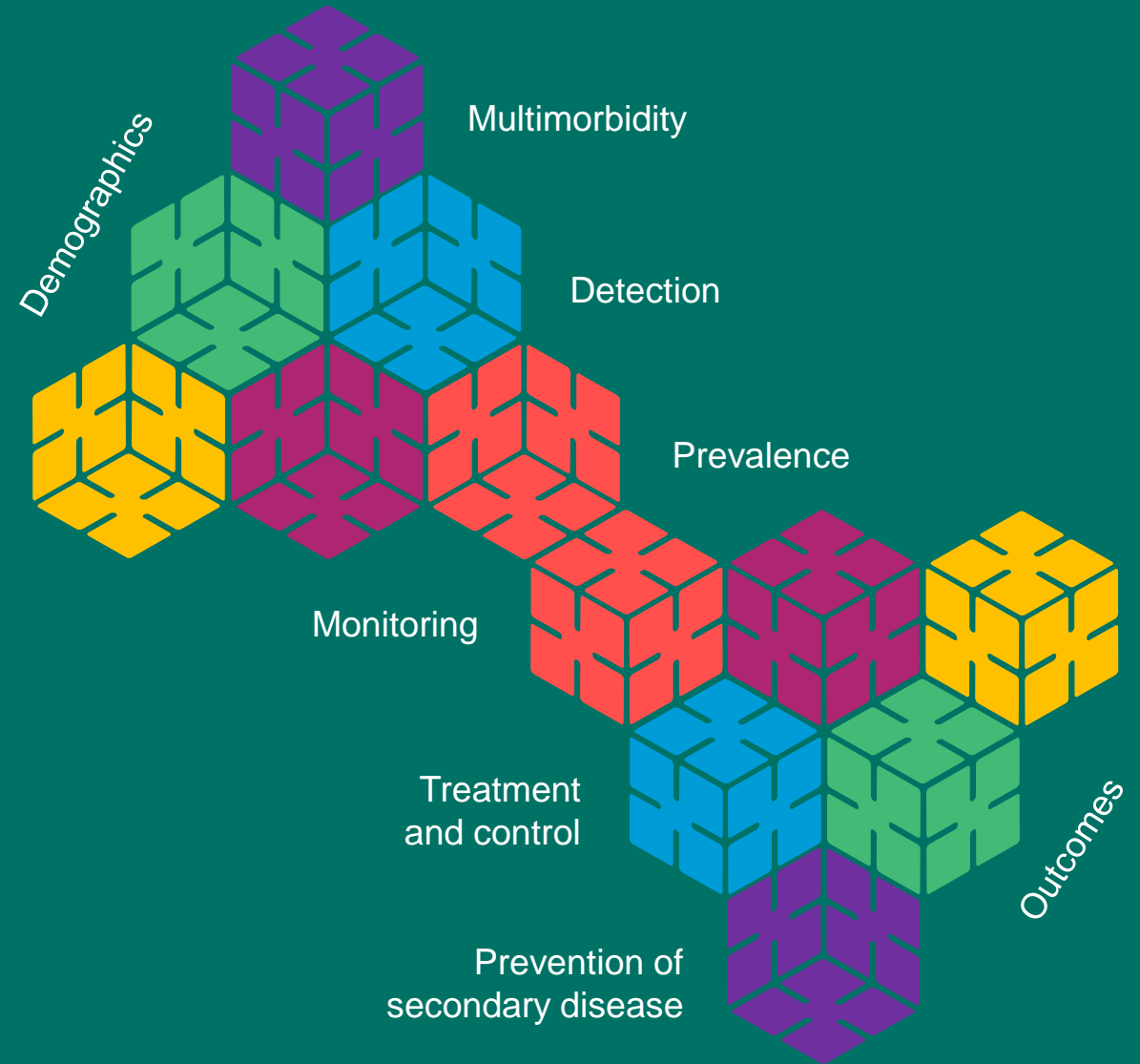




Complexity and comorbidity

The following slides describe the population with diabetes in terms of their complexity and comorbidities

Working together
for a healthier future





Risk stratification of T2DM (1)

The Clinical Effectiveness Group Risk stratification tool prioritises patients based on HbA1c, complications, co-morbidity, social factors and ethnicity in order to help with pressures during the pandemic

High risk	
Priority One Hba1c >90 OR Hba1c >75 WITH any of the following: <ul style="list-style-type: none"> • BAME • Social complexity** • Severe frailty • Insulin or other injectables • Heart failure 	Priority Two Hba1c >75 OR Any HbA1c WITH any of the following: <ul style="list-style-type: none"> • Foot ulcer in last 3 years • MI or stroke/TIA in last 12 months • <u>Community diabetes team codes</u> • eGFR < 45 • Metabolic syndrome
<small>** Social complexity includes Learning disability, homeless, housebound, alcohol or drug misuse</small> <small>(Except patients included in Priority 1 group)</small>	

Medium risk
Priority Three Hba1c 58-75 WITH any of the following: <ul style="list-style-type: none"> • BAME • Mild to moderate frailty • Previous coronary heart disease or stroke/TIA >12 months previously • BP ≥ 140/90 • Proteinuria or Albuminuria
<small>(Except patients included in Priority 1 and 2 groups)</small>

Low risk
Priority Four Hba1c 58-75 OR Any HbA1c WITH any of the following: <ul style="list-style-type: none"> • BP ≥ 140/90 • Higher risk foot disease or PAD or
<small>(Except patients included in Priority 1, 2 or 3 groups)</small>

Low risk
Priority Five All other patients
<small>(Except patients included in Priority 1-4 groups)</small>

❖ In HWE, recent searches (December 2021) identified the number of people with Type 2 diabetes who are high risk

❖ Differences in figures are likely to reflect the use of different tools to identify high risk people.

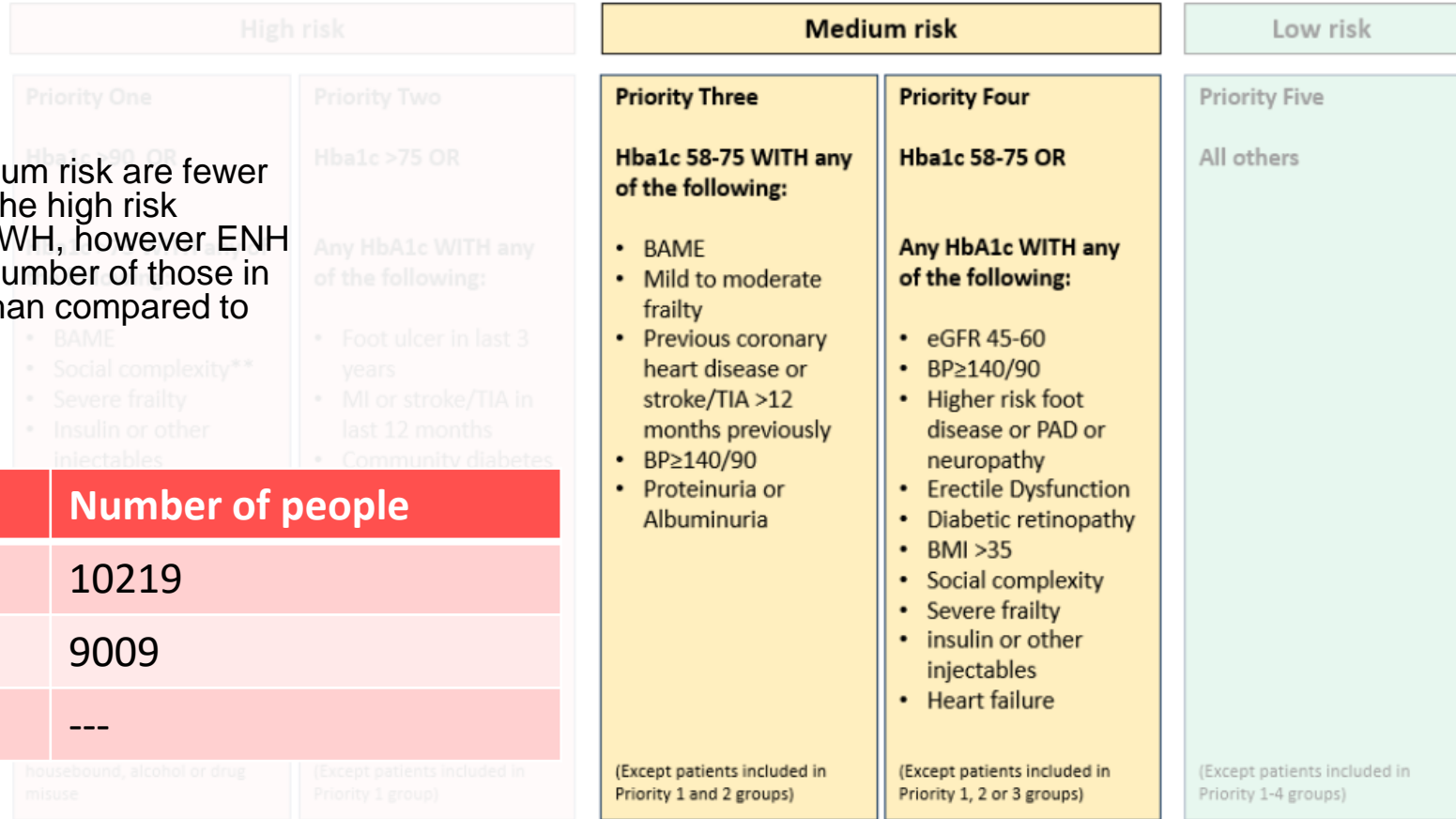
CCG	Number of people
South West Herts	16398
East & North Herts	7427
West Essex	---





Risk stratification of T2DM (2)

❖ Those at medium risk are fewer than those in the high risk category for SWH, however ENH has a higher number of those in medium risk than compared to high risk.



Place Area	Number of people
South West Herts	10219
East & North Herts	9009
West Essex	---





Diabetes by HWE segment

- ❖ The table below shows the distribution of the diabetic population across the HWE segmentation model.
- ❖ Approximately one in six people (15.8%) with diabetes are living with only diabetes. The remaining people have additional health or social issues.
- ❖ Over a third of people (39.5%) with diabetes have low levels of complexity (either additional physical or mental health conditions or social complexity) and over a quarter (29.6%) have advanced disease or significant complexity.
- ❖ Nearly one in six people with diabetes are also living with severe frailty, severe dementia or are on an end of life register or receiving palliative care.

Life Course Segment	2 - Living With Illness	3 - Lower Complexity			4 - Advanced Disease & Complexity					5 - EoL, Frailty & Dementia			Grand Total
Life Course Subsegment	2b - Lwl (LTCs)	3a - LC (Mod. Social Complexity)	3b - LC (Multimorbidity)	3c - LC (Mild Frailty)	4a - AD&C (High Complexity)	4b - AD&C - High Social Complexity	4c - AD&C (Severe LD/ASD/ADHD)	4d - AD&C (Complex SMI)	4e - AD&C (End Stage Disease)	5a - EoLFD (Severe Frailty)	5b - EoLFD (Severe Dementia)	5c - EoLFD (End of Life)	
Overall Population Measures													
Population	13,083	308	19,596	12,777	17,279	2,356	128	1,094	3,598	9,114	607	2,772	82,712
Age	49	55	57	64	65	70	42	39	69	76	80	75	62
Male %	54.2%	51.3%	55.9%	51.3%	52.9%	45.3%	38.3%	47.4%	58.8%	47.3%	37.7%	46.8%	52.6%
IMD	6.9	6.8	7.0	7.0	6.9	6.8	6.8	6.7	6.7	6.9	7.1	7.0	6.9
% BAME (where recorded)	38%	36%	27%	22%	19%	17%	27%	23%	14%	11%	10%	12%	23%
Multimorbidity (acute & chronic)	1.0	1.0	2.6	2.8	4.7	4.1	5.0	7.2	6.3	6.5	7.9	6.6	3.7

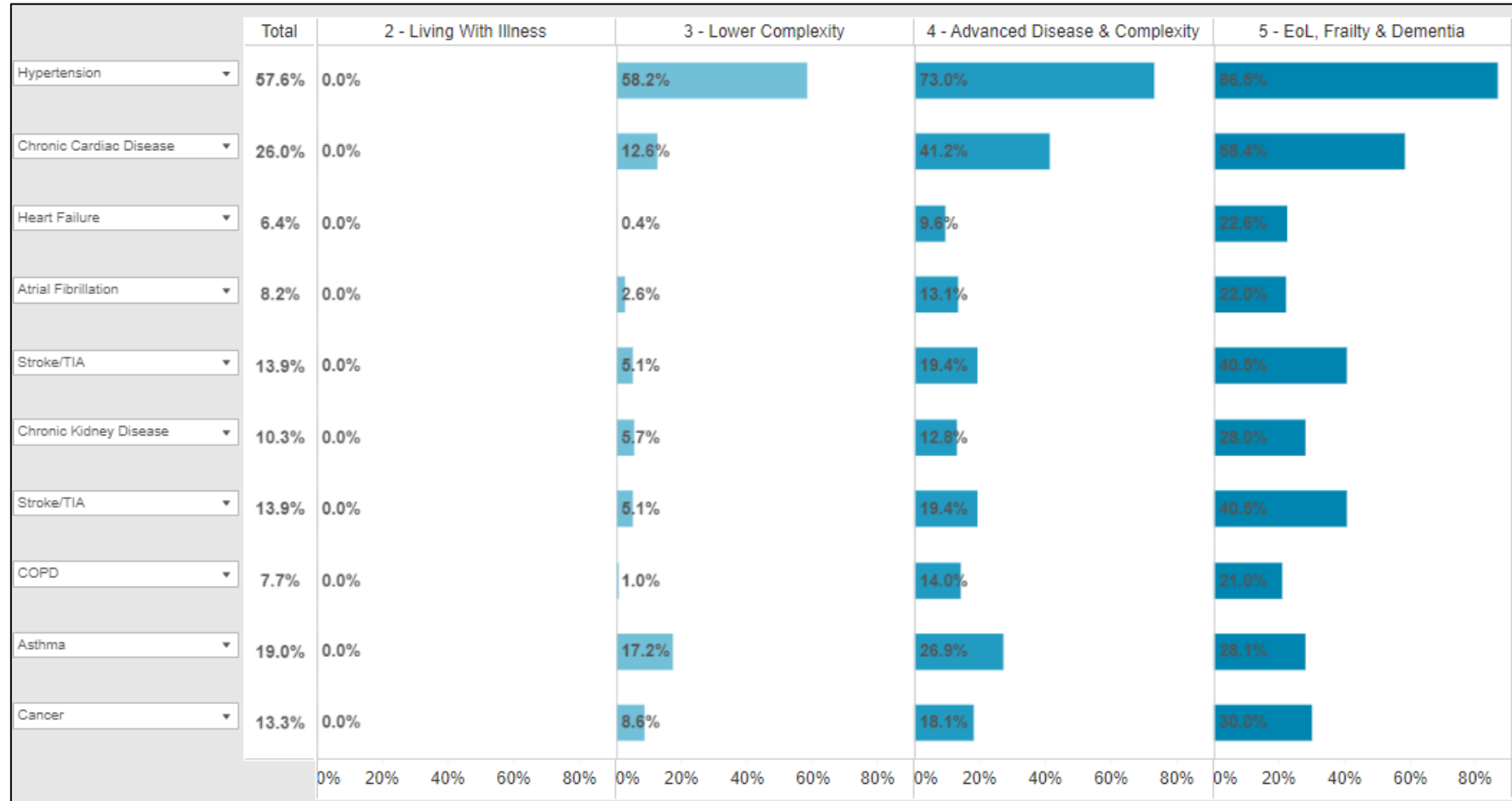
Source: PHM Dashboard (Jan 22)





Diabetes by comorbidity type

- ❖ Respiratory and cardiac conditions are common among people with diabetes.
 - ❖ Nearly three in every 5 people with diabetes have coexisting hypertension
 - ❖ Over a quarter have cardiac disease
- ❖ Mental illness also disproportionately affects people with diabetes.
 - ❖ Nearly a quarter of people with diabetes have depression
 - ❖ A higher proportion of people with diabetes have a diagnosis of SMI (4.2%) compared to the general population (1.6%).
 - ❖ 5.9% have coexisting dementia



Source: PHM Dashboard (Jan 22)

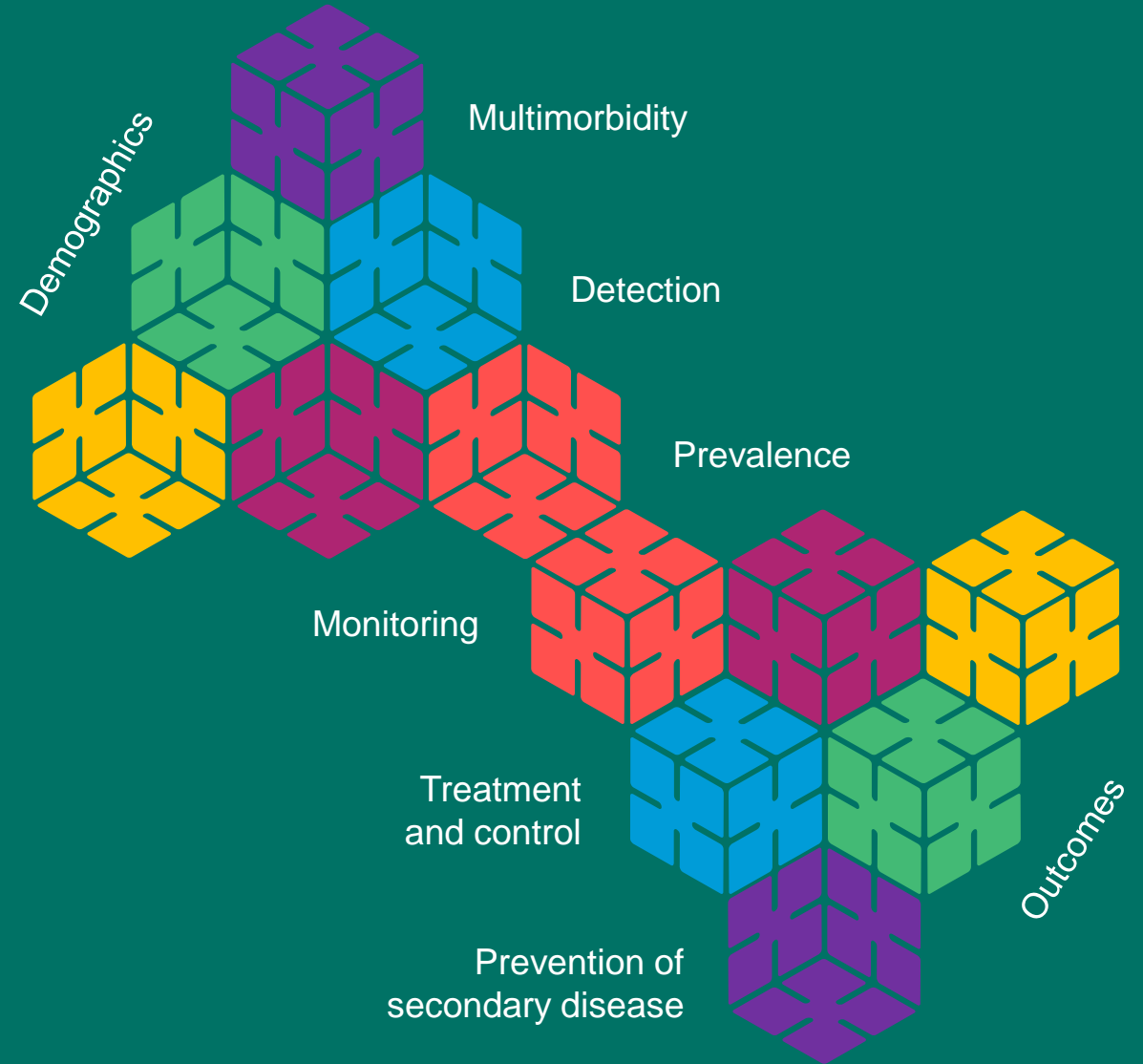




Outcomes

The following slides review the outcomes of the diabetes population in regards to use of secondary care

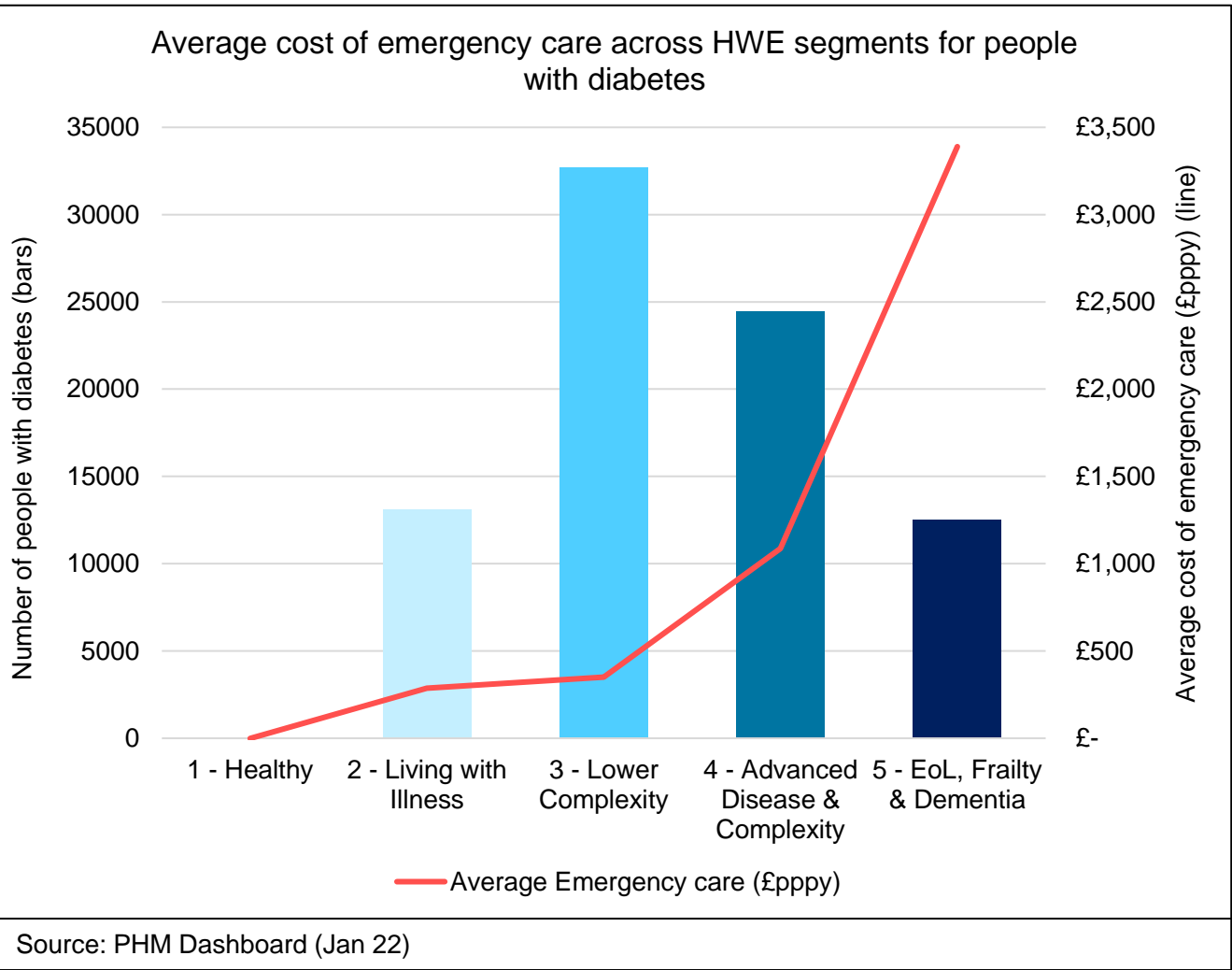
Working together
for a healthier future





Emergency care (all causes) for people with diabetes

- ❖ Local data show that the average cost of emergency care (emergency department attendances and emergency admissions) for people with diabetes was over £1000 pppy.
- ❖ Average cost per person increases with complexity. Whilst there are fewer people with diabetes in higher complexity segments, the average cost of emergency care greatly increases.
- ❖ The emergency care costs for people in segment 5 is over half of the total emergency care costs for people with diabetes
- ❖ It is important to not that this represents all emergency care activity for people with diabetes and is not restricted to diabetic emergencies.



Source: PHM Dashboard (Jan 22)

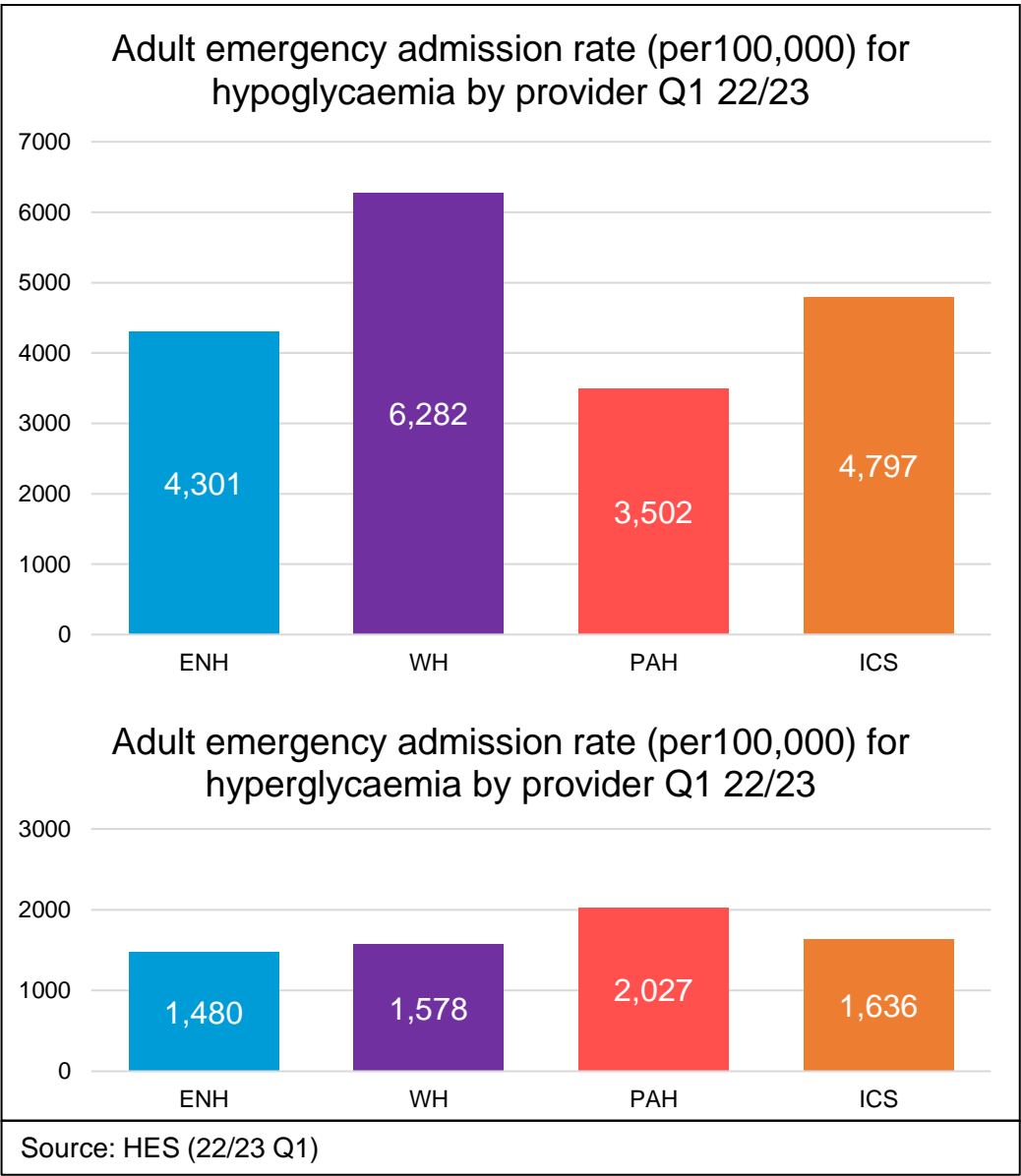




Hospital spells for hypo/hyperglycaemia

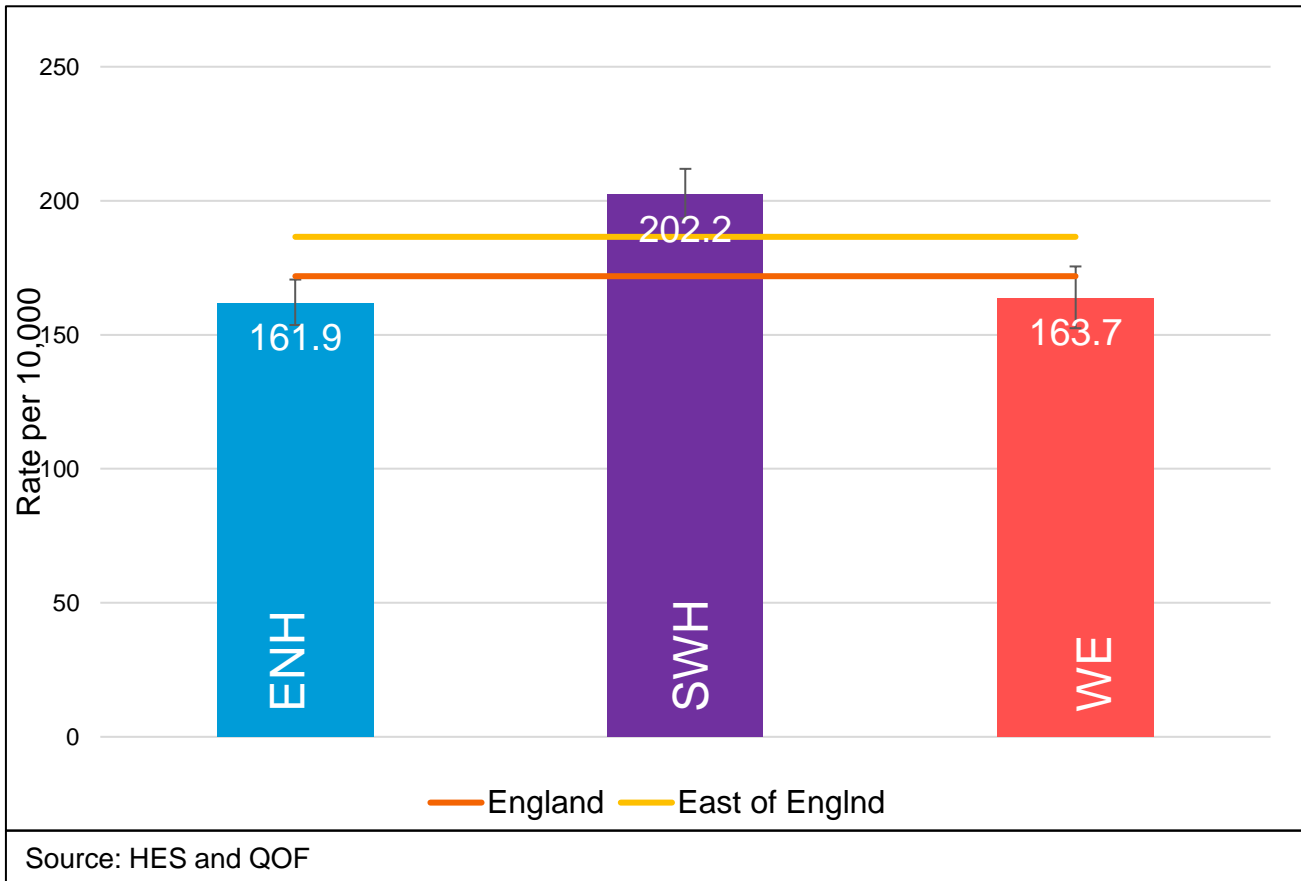
Adult non-elective admissions for hypo and hyperglycaemia in Q1 2022/2023 by provider (per 100,000)

- ❖ Adult admissions for hypoglycaemia are more common than for hyperglycaemia/DKA
- ❖ West Hertfordshire (WH) NHS Trust has the highest rate of admissions for hypoglycaemia.
- ❖ Princess Alexandra Hospitals (PAH) NHS Trust has the highest admission rate for hyperglycaemia/DKA





Hospital spells for foot disease (17/18 – 19/20)

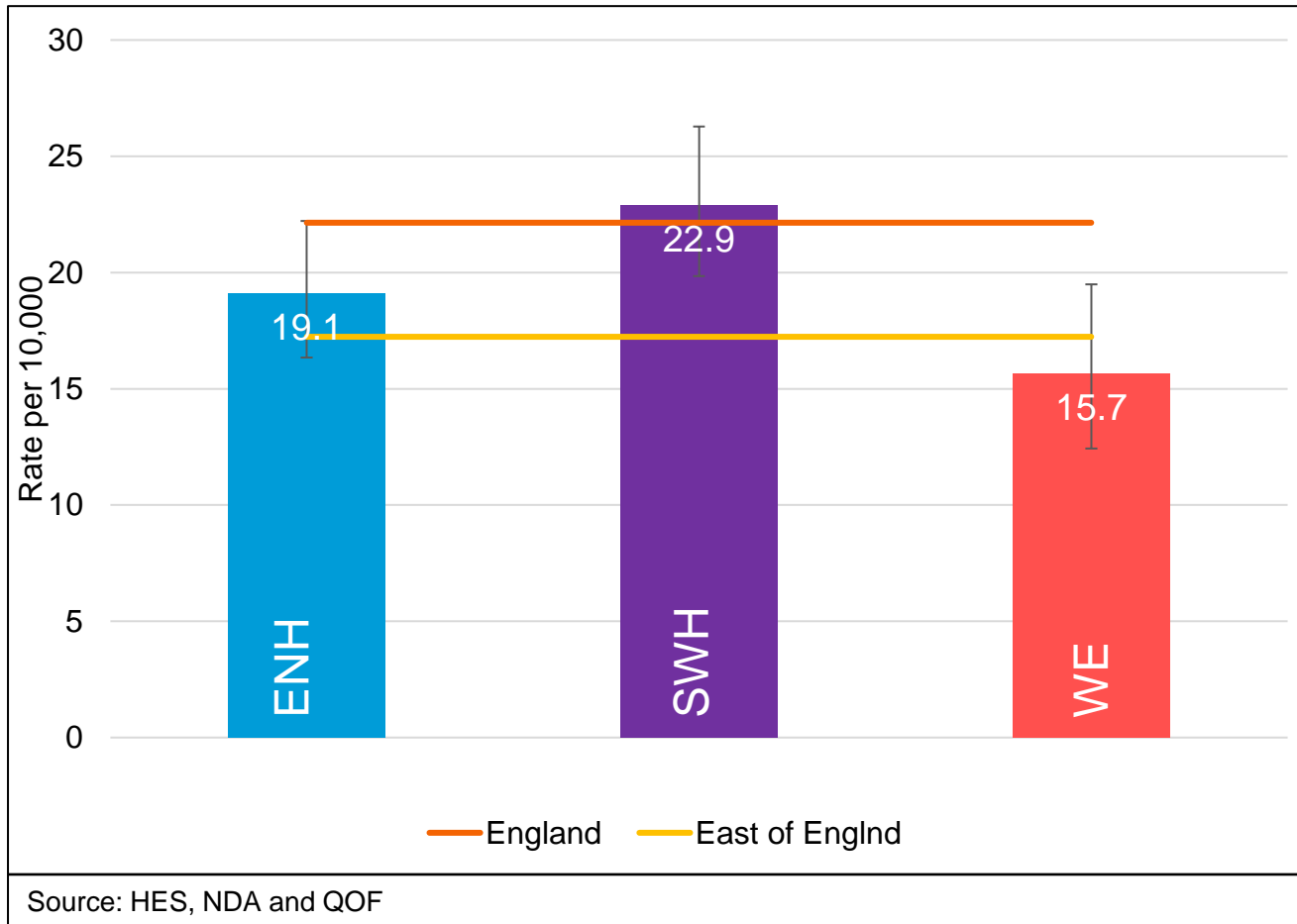


- ❖ ENH and WE both have a lower rate of admission for diabetic foot disease compared to the East of England and the National average.
- ❖ SWH have a higher than national and regional admission rate.
- ❖ Foot disease is a problem that occurs over time, thus this data may reflect previously poor foot surveillance.
- ❖ As shown [here](#), foot surveillance is actually the highest in SWH in 21/22.





Minor diabetic lower limb amputations (17/18 – 19/20)

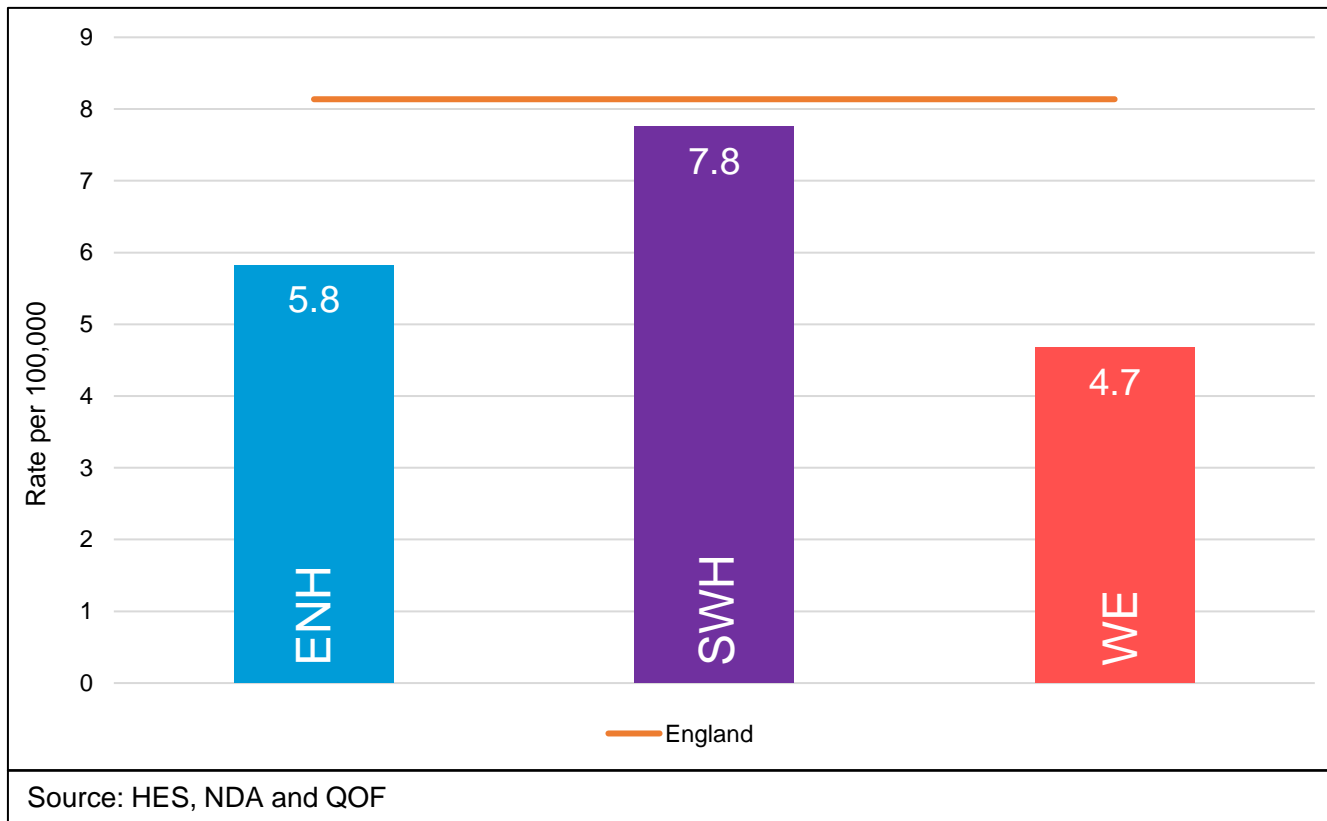


- ❖ In SWH, the higher rates of diabetic foot admissions translate into higher rates of minor lower limb amputations (defined as at the level of the ankle or below) compared to the rest of the ICS, the EoE, and nationally.
- ❖ Despite being called “minor” lower limb amputations, an amputation of this type has big effects on balance, mobility and overall quality of life.





Major diabetic lower limb amputations (17/18 – 19/20)

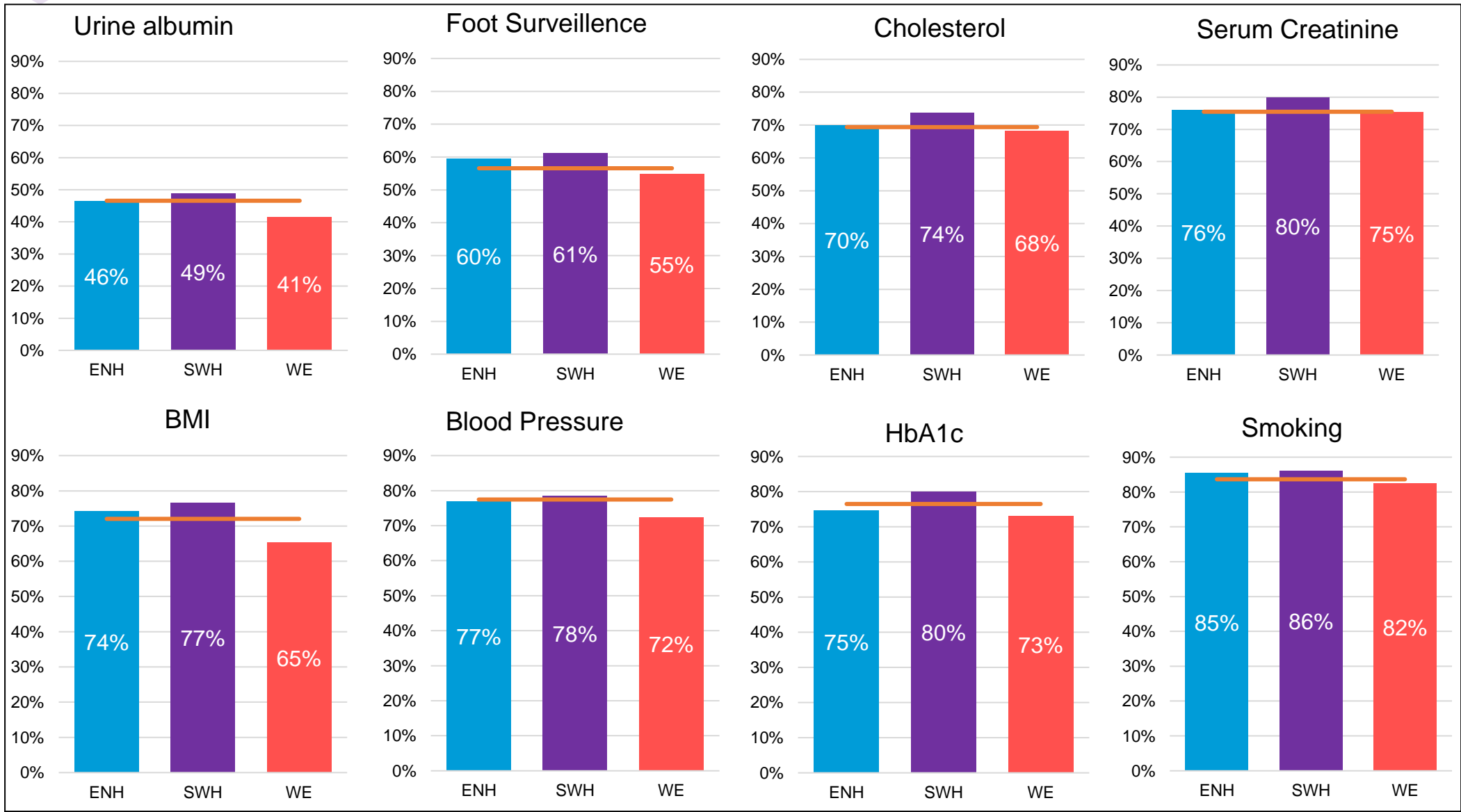


- ❖ Major diabetic amputations are an indicator of poorly controlled chronic disease.
- ❖ Low rates within the ICS could be a result of avoiding major amputations by intervening earlier – thus could explain the higher rates of minor amputations seen in HWE





Type 1 Diabetes with 8CP within 12 months (To March 2022)



Back to

Percentage of patients with all 8 Care Processes (8CP) complete in last 12 months (Sept 2021)

8CP

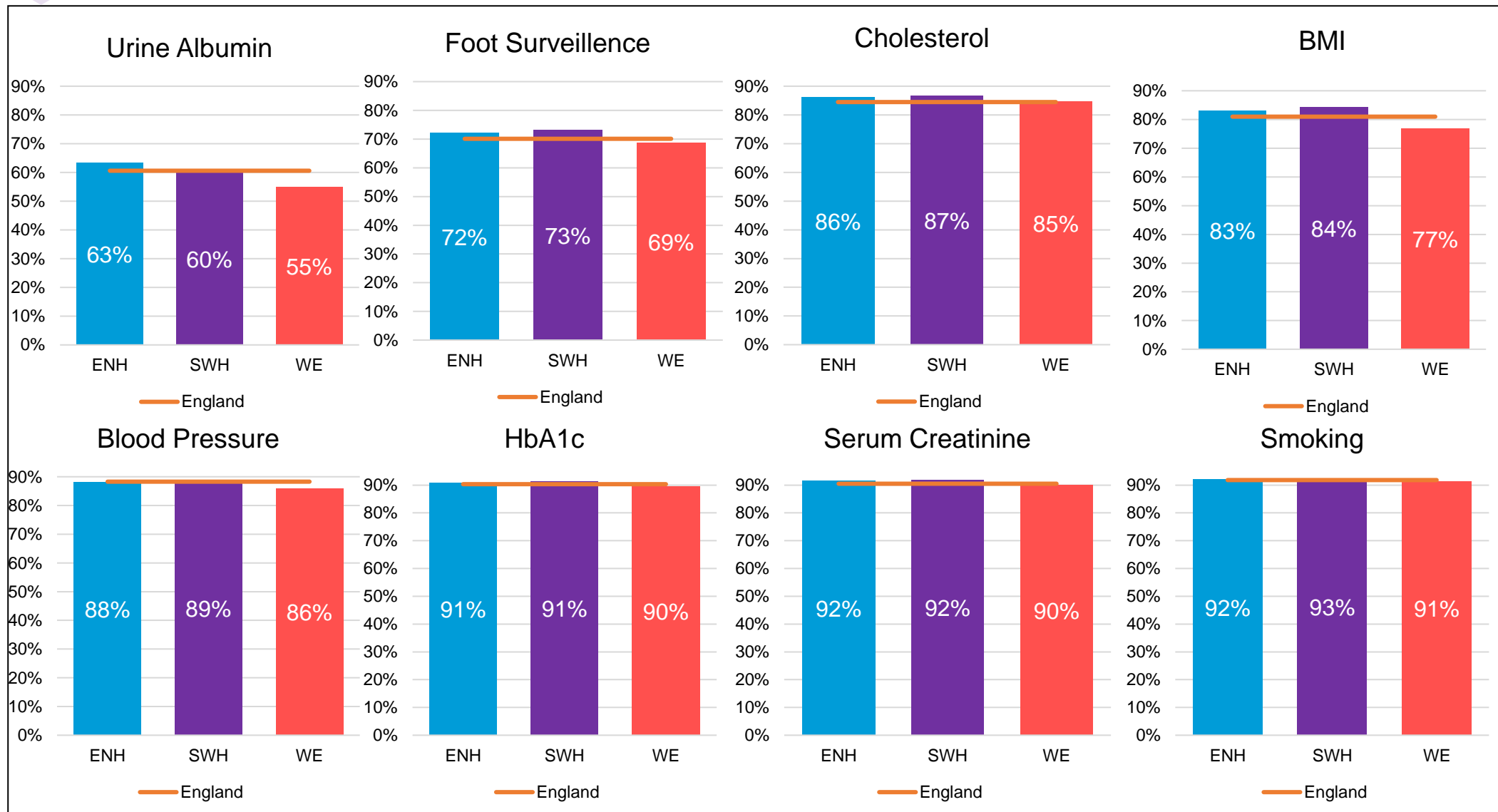
Back to

Hospital spells for foot disease (17/19 - 19/20)

Foot outcomes



Type 2 Diabetes with 8CP within last 12 months (To March 2022)



Back to

Percentage of patients with all 8 Care Processes (8CP) complete in last 12 months (Sept 2021)

8CP

Back to

Hospital spells for foot disease (17/18 - 19/20)

Foot outcomes