Life & Times

Tackling inequalities in diabetes care:

a data-led approach from Barking and Dagenham CCG

The NHS was set up as an equitable healthcare system, free at the point of delivery and equally accessible. The fundamental principle behind the health service was that high-quality health care should be available to all. However, people living in the poorest areas of England are still dying earlier and spending more of their lives living with disability; the variability in health care and outcomes is especially evident in relation to the outcomes of long-term conditions like diabetes. The prevalence of long-term conditions increases incrementally with increasing levels of deprivation, but the quality of care is seen to deteriorate.[1] The 2011 *Atlas of Variation* shows the marked variation in quality of care provision — for example, the percentage of people with type 2 diabetes receiving all nine processes of care for diabetes ranged from 7% to 71.4%.[2] Socioeconomic deprivation and ethnicity have long been associated with poorer health outcomes[3–5] due to a complex interplay of the long-term impact of migration, poor engagement with health care, and cultural differences.[6]

Barking and Dagenham is an area of marked deprivation and an escalating ethnic population. The local health economy is challenged by high care costs for diabetes. Within the borough, there is significant inter-practice variation in the quality of care provided.

With the NHS offering free health care to all, is it still fair to assume that factors like socioeconomic status and ethnicity are major causative factors for variability in health outcomes? New evidence suggests that there is no statistically significant correlation between diabetes care and outcomes and locality deprivation. There is some indication that the degree of variation observed is related to how well services are organised.[2]

THE INITIATIVE

In 2016, Barking and Dagenham CCG took action to reduce variability and improve diabetes outcomes by rolling out a Local Improvement Scheme. An external consultancy was employed to extract and evaluate practice-level data, providing lead clinicians and administrators with training calls and a website regularly updated to show achievements to date. Areas requiring additional input were highlighted. A financial incentive was offered to practices that achieved the following targets: 60% of patients receiving the eight care processes recommended by NICE;[7] 50% of patients receiving the nine care processes (including retinal screening);[7] a 3% improvement in achieving HbA1c, blood pressure (BP), and cholesterol targets; at least 50% of patients offered structured education; and a Pre-Diabetes Register established.

All 37 practices participated in the scheme (12 210 patients with type 2 diabetes, 488 patients with type 1 diabetes). Results after 12 months showed significant improvements with patients receiving all eight care processes increasing from 24% to 60%. The results were reflected in the National Diabetes Audit reports.

SUCCESSES

The highest increase was seen in urine albumin:creatinine ratio testing, which rose from 36% to 70%. Patients receiving nine care processes increased from 15.7% to 49.4%. More patients were offered structured education (40.7% to 63.1%). This increased focus on delivering care processes led to a reduction in the mean HbA1c for the CCG (56 to 53 mmol/mol), and patients achieving HbA1c ≤58 mmol/mol increased from 45.7% to 53.6% ($P = 0.000052$). Treatments to target were also improved, with over half of the practices gaining a 3% improvement in the number of patients achieving a BP <140/80 mmHg and a serum cholesterol value <5 mmol/mol; 30 of the 37 participating practices gained a 3% improvement in patients achieving an HbA1c ≤58 mmol/mol. The percentage of patients achieving an 11 mmol/mol (1%) improvement in HbA1c in 12 months rose to 12.0%, compared with 6.9% in the previous 12 months. Across the CCG, patients diagnosed with pre-diabetes increased from 0.62% to 4.7%. The improvements were seen across most practices and inter-practice variability was reduced.

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OVERCOMING INEQUALITY CHALLENGES

The success of the initiative was down to coordinated efforts by the CCG and the practices. Regular networking sessions and one-to-one training on the web-based analytics system helped identify areas of improvement, and discussions allowed practices to share ways of using data to optimise care. The project proves that better organisation of care, clinical leadership, and meaningful use of clinical data can overcome the challenges posed by socioeconomic deprivation and achieve high-quality care.

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