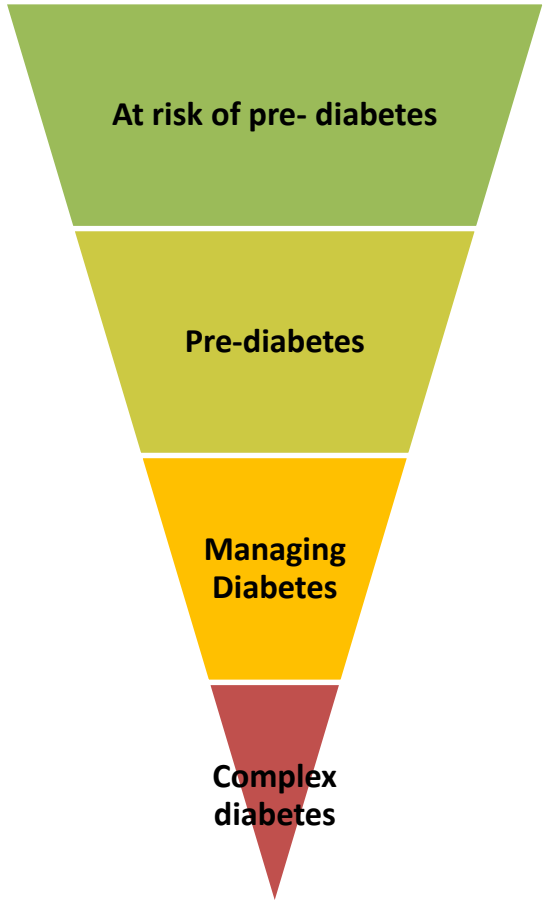
Potential population cohorts for Slough

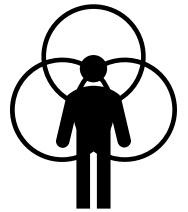
Developed mutually exclusive operational cohorts with increasing complexity and decreasing population sizes

		Total	
At risk of (pre-) diabetes	1: Coded QDiabetes score >= 20% and not in any other category	154	0.1%
	2: At risk of (pre-)diabetes (BMI 27.5+ & White Ethnicity & risk factor)	2275	1.7%
	3: At risk of (pre-)diabetes (BMI 30+ & White Ethnicity)	4811	3.6%
	4: At risk of (pre-)diabetes (BMI 25+ & Ethnicity & risk factor)	7308	5.4%
	5: At risk of (pre-)diabetes (BMI 27.5+ & Ethnicity)	12938	9.6%
	Total	**27486**	**20.5%**
Prediabetes	6: Potential missing Non-diabetic hypoglycaemia (pre-diabetes) diagnosis	414	0.3%
	7: Non-diabetic hypoglycaemia (pre-diabetes)	15058	11.2%
	Total	**15472**	**11.5%**
Managing diabetes	8: Diabetes & NOT achieving all 8 care processes in last 12m	4844	3.6%
	9: Diabetes & all 8 care processes achieved in last 12m	6753	5.0%
	Total	**11597**	**8.6%**
Complex diabetes	10: Diabetes & currently PNG Red	1255	0.9%
	11: Diabetes & Latest HbA1c >= 75	2337	1.7%
	Total	**3592**	**2.7%**
	None of the above	76205	56.7%
	Total population in scope for NNHIP Diabetes pilot	**58147**	**43.3%**
	Total 18+ population	134352	



Diabetes Risk factors included: PCOS, Stroke/TIA, Heart Failure, Family history of diabetes, smoking, LD, SMI, hypertension

Proactive identification and community based



Opportunistic, cultural and community centred approach, leveraging existing resources and estates e.g. Britwell Centre or Upton Community Hospital

Person-centred, proactive identification approach focussing on proactive diagnosis and care planning

Pre-Diabetes risk	Prediabetes	Diabetes management	Complex Diabetes
• Targeted messaging • Cultural appropriate education programs • Physical activity programs • Exercise, wellness, and healthy eating sessions • Wellbeing focused	• Expansion of key diabetes care processes • Proactive diagnosis of prediabetes and diabetes	• Improving HbA1c control and recording • Proactive diagnosis of CKD and Hypertension • 8 care process achievement	• Proactive MDTs (embedding system frailty into neighbourhood) • Virtual care

Community programmes and activity may need proxy measures to identify outcomes

There are existing measures and indicators to help us track the outcomes across the identifiable population cohorts