

Diabetes Joint Strategic Needs Assessment 2017

Health and Wellbeing Board

Date: 15th March 2017

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Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 Diabetes in the UK is a major public health problem requiring urgent action. Prevalence is increasing nationally and in Swindon. Outcomes for people with diabetes remain poor and spend on diabetes and its complications are high. This Joint Strategic Needs Assessment (JSNA) provides evidence to help us understand diabetes prevention and care in Swindon. It builds on the diabetes profile completed in 2013.
- 1.2 There has been significant improvement in diabetes care since the last profile was compiled. However, the number of people who develop diabetes remains high and some outcomes remain poor.
- 1.3 The Diabetes Joint Strategic Needs Assessment 2017 Bulletin is attached at Appendix 1 to the report and highlights the findings. The full JSNA report will be made available at: <http://www.swindonjsna.co.uk/>.

2. Recommendations

The Board is recommended to:

- 2.1 Note and approve the recommendations identified in the Swindon Diabetes Joint Strategic Needs Assessment, as set out in paragraphs 3.6.1 to 3.6.7 of the report.

3. Detail

- 3.1 The objective of the diabetes JSNA is to identify the needs of the Swindon population in relation to diabetes, working with our local partners to formulate recommendations that will help inform future cost-effective and impactful commissioning.
- 3.2 Recommendations will be actioned through the established multi-agency Swindon Diabetes Transformation Board. This board includes the Clinical Commissioning Group (CCG), The Great Western Hospital (Acute and Community Services), Diabetes UK, representatives from Primary Care and Swindon Borough Council.

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Key messages

- 3.3 Diabetes causes high levels of sugar (glucose) in the blood. Over time this can lead to problems such as heart disease, blindness and foot ulcers. Good blood sugar control can reduce the chance of getting these problems, and the need for health and social care.
- 3.4 Prevalence: There are a higher percentage of people with diabetes in Swindon than in England and there are also a higher percentage of people who are overweight or obese which is one of the largest risk factors for developing type 2 diabetes.
 - 3.4.1 There were 12,924 people on the diabetes register in the Quality Outcome Framework (QOF) 2015/16 which includes people aged 17 years and over. This means that 7.1% of the population of Swindon aged 17 years and over had diagnosed diabetes which is slightly higher than the England prevalence of 6.6%. Approximately 90% of these people have type 2 diabetes (around 11,600 people aged 17 years and over).
 - 3.4.2 Estimates suggest that for Swindon local authority prevalence of diabetes will increase from 7.6% in 2015 to 8.5% in 2025, and to 9.1% in 2035, which equates to an additional 2,711 people with diabetes by 2025 and an additional 5,250 people with diabetes by 2035. These estimates include people with diagnosed diabetes and undiagnosed diabetes.
 - 3.4.3 Key risk factors for diabetes are excess weight and ethnicity.
 - 3.4.4 An estimated 220-250 women give birth in Swindon each year who have diabetes (type 1, type 2 or gestational). Diabetes increases maternal and fetal risk, but good blood sugar management during pregnancy can decrease these.
 - 3.4.5 Up to 9.8% of people with diabetes may have depression.
 - 3.4.6 175 children and young people (people aged up to 24 years) were treated for diabetes in the Great Western Hospitals NHS Foundation Trust. 95.5% of these children and young people had type 1 diabetes.
- 3.5 Services: There is a wide range of services for diabetes available in Swindon. The majority of people with diabetes receive their care in primary care where there is wide variation in the care and management offered. There are some areas in Swindon where improvement is required, and other areas which are performing very well. Ensuring that everyone with diabetes is able to have the same opportunities is crucial to improving outcomes for people with diabetes in Swindon.
 - 3.5.1 There are a wide range of services available in Swindon for promotion of a healthy weight and active lifestyle which contribute to the prevention of

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type 2 diabetes. These services which target prevention are incorporated in a range of strategies including Swindon Healthy Weight Strategy and Get Swindon Active Strategy.

- 3.5.2 There are a number of options to aid people with diabetes to self-manage their diabetes including a wide range of other educational options for people with type 1 and type 2 diabetes in a variety of locations across Swindon.
- 3.5.3 36% of people with type 1 diabetes and 62% of people with 2 diabetes achieved all eight care processes in NHS Swindon Clinical Commissioning Group (CCG) (2014/15, data collected in the National Diabetic Audit (NDA)). This is similar to England, but there is wide variation between practices. In addition younger people and those with Asian or Black ethnicity are less likely to receive all eight care processes.
- 3.5.4 37% of people with newly diagnosed type 1 diabetes were offered structured education and 74% of people with newly diagnosed type 2 diabetes were offered structured education (2014/15, NDA). The percentage offered structured education is similar to England however the uptake of structured education for people with type 2 diabetes is much lower in Swindon at less than 1%. Many other areas of the country get better uptake and we need to consider what they are doing that we could learn from and also consult with patients as to what they want.
- 3.5.5 15.3% of patients with type 1 diabetes achieved all three treatment targets (HbA1c \leq 58mmol/mol, blood pressure \leq 140/80 and serum cholesterol $<$ 5mmol/L) and 39.1% of patients with type 2 diabetes achieved all three treatment targets. Younger people were less likely to achieve treatment targets which may be due to physiological and social changes. Achieving good blood pressure control, good cholesterol control and good blood sugar control (as measure by QOF) is worse in Swindon than nationally.
- 3.5.6 The Swindon Community Diabetes Service offers education for healthcare professionals, advice for healthcare professionals including joint clinics and clinics for people with more complex diabetes.
- 3.5.7 Secondary care outpatient data suggests that there may be unequal access to this service for different ethnic groups but there are a large number of people with 'unknown' ethnicity status.
- 3.5.8 There are a number of other elements within the diabetes pathway such as transitions, foot care and maternity which have a large potential to improve outcomes for specific groups of people with diabetes.

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3.6 Recommendations

3.6.1 Stopping people from getting type 2 diabetes is crucial. If this is not achieved almost 9 out of every 100 people (15,931 people or 8.5% of the population) in Swindon may have diabetes by 2025.

- Make sure people know how to prevent diabetes, by promoting an active lifestyle, watching their weight and eating a healthy diet. This can be through working with communities and health and social care through appropriate campaigns.
- Promote the prevention services we provide e.g. the new Swindon Community Health and Wellbeing Hub.
- Support a national programme, called the NHS Diabetes Prevention Plan, to help local people with a high chance of getting diabetes to reduce their risk of developing diabetes.

3.6.2 Make sure people at high risk of diabetes and people who have just developed diabetes, but not been diagnosed, so that they can get the best care. We will do this through education of patients and health-care professionals. Health professionals are advised to use risk assessments to aid early diagnosis. Continued education around this area by the Swindon Community Diabetes team is required.

3.6.3 Provide better care in Swindon for people with diabetes to reduce complications. Action is required to reduce the differences in care for people with diabetes that occurs between GP practices.

- Work with the community, CCG and the Great Western Hospital NHS Foundation Trust on a community model of care.
- Increase the percentage of people with diabetes receiving all eight care processes. We will especially target young people, and those from minority ethnic groups. This could be achieved by raising the profile of the annual review for people with diabetes and taking up national opportunities for improving diabetes care.
- Increase the percentage of people with diabetes meeting all three treatment targets. We will especially target young people and those in deprived areas. To achieve this annual reviews are required, primary care education and awareness of referrals and patient engagement.
- Increase referrals, and attendance, to structured education sessions. To ensure this primary care needs to be aware of and understand these courses, refer appropriately as part of the care plan, offer a variety of course times and

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dates to suit patients and engage with patients to understand in more detail why people do not attend.

- Continue improvements in foot care processes including amputation rates by ongoing review of the service, especially availability of podiatry services in the community and secondary care.
- Continue to increase participation in National Diabetes Audit to get complete information of diabetes care in primary care, including on ethnicity.
- Continued education for people with diabetes and healthcare professionals on the increased risk of depression with diabetes is required to ensure people with diabetes and depression receive appropriate care.

3.6.4 Make sure there are continued patient and public involvement in diabetes care and any changes to care. Specific work to find out if there are any barriers to people from black and minority ethnic groups using diabetes services or being diagnosed with diabetes is needed to understand the possible differences in service use.

3.6.5 Make sure that there is continued communication between areas where people with diabetes attend for other reasons (such as maternity, podiatry and chiropody) and specialist diabetes services. We will carry on with the programme of change within diabetes transitions which aims to improve the service for children with diabetes as they move into adult services.

3.6.6 Aim to make ethnicity recording more complete in hospital outpatient's clinics so we are able to understand differences in access to diabetes specialist services.

3.6.7 These recommendations should be taken to Swindon Diabetes Transformation Board for action.

4. Alternative Options

- 4.1 Continue with the present diabetes management processes and strategies. This could lead to continued increase in the prevalence of diabetes, increased complications from diabetes and increased cost of diabetes.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

- 5.1 No additional financial implications identified at this stage.

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Legal and Human Rights Implications

- 5.2 Legal and Human rights have been taken fully into account in compiling this report. It is considered that the recommendations within this report are compatible with Convention Rights.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 Diabetes Care is 9% of the NHS budget nationally. Preventing Diabetes and improving care for Diabetes will reduce the cost of care and improve the health and wellbeing of Swindon residents.

Diversity Impact Assessment

- 5.4 Based on the information contained in this report we do not believe that there is any adverse impact for any protected equality characteristic group as set out in the Equality Act 2010.

Risk Management

- 5.5 No specific risks have been identified at this stage for this report.

6. Consultees

- 6.1 The Corporate Director, Resources and Transformation (Section 151 Officer) and the Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

- 7.1 None.

8. Appendices

- 8.1 Appendix 1 – Swindon Diabetes Joint Strategic Needs Assessment Bulletin 2017.