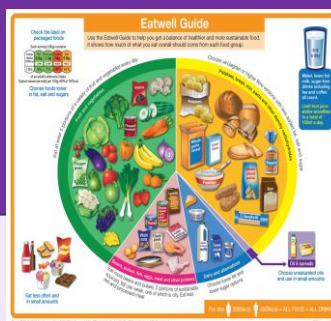


Swindon Joint Strategic Needs Assessment Bulletin

Swindon Diabetes 2017



Key Points:

- This JSNA gives health facts about people with diabetes or people who might get diabetes in Swindon. This helps us to plan for medical and social care in the future. It also helps us to think about how we can prevent diabetes.
- 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 chances of getting these problems and the need for health and social care.
- 12,924 people in Swindon had diabetes in 2015/16 (only includes people aged 17 years and over). Approximately 9 in 10 of these will have type 2 diabetes.
- 18,535 people are thought to be at high risk of getting diabetes (only includes people aged 16 years and over).
- Type 1 diabetes is caused by damage of the cells that normally make insulin. This leads to high blood sugar levels. Type 1 diabetes usually appears before the age of 40. Type 2 diabetes develops when the body can still make some insulin, but not enough, or when the insulin that is made does not work properly. It tends to start in adulthood.
- The reason most people get type 2 diabetes is that they are overweight or obese (also called excess weight). Older people, people from some minority ethnic groups and people who have a family member with type 2 diabetes are also at increased risk of getting diabetes.
- The number of people with diabetes in Swindon is forecasted to increase. There are several reasons for this. This is because in the future we expect:
 - more people will have excess weight
 - there will be more people living in Swindon
 - people to live longer
 - more people from different ethnic communities
- In Swindon there are some very good services for diabetes but there is also room for improvement.
- The JSNA makes seven recommendations – these are on page 6.

What is a Joint Strategic Needs Assessment (JSNA)?

JSNA helps us to understand:

- the current health and wellbeing needs of local people;
- how their needs are being met;
- what we think their future needs are likely to be; and
- how their needs can be best met.

We want to understand Swindon's changing population, what is going on in Swindon and what makes a difference to people's health and wellbeing so that we can plan for the best care in future. Many different people from a range of organisations help to write a JSNA. The Swindon's Health and Wellbeing Board is a group that leads the development of JSNAs.

Introduction

Diabetes in the UK is a major public health problem that needs urgent action. More people are getting diabetes across the UK and in Swindon. In the UK in 2014 almost 3.5 million adults had diabetes. It is thought that there are 549,000 people in the UK who have diabetes but have not been diagnosed.

Type 1 diabetes affects over 370,000 adults in the UK. Type 1 diabetes is caused by damage of the cells that normally make insulin. This leads to high blood sugar levels and other changes which have short-term and long-term negative effects on health. Type 1 diabetes usually appears before the age of 40, often in childhood.

Type 2 diabetes accounts for about 9 in 10 cases of diabetes (around 3.1 million adults in the UK). It tends to start in adulthood. However the National Paediatric Diabetes Audit in 2014/15 showed that 2 in 100 of children and young people (up to the age of 24 years) with diabetes had type 2 diabetes. Type 2 diabetes develops when:

- the body can still make some insulin, but not enough,
- Or when the insulin that is made does not work properly (known as insulin resistance).

People with type 2 diabetes are usually advised to adopt a healthier lifestyle; with exercise, a good diet and weight-reduction.

Then, if necessary, people are treated with glucose-lowering medication and sometimes insulin.

Problems caused by diabetes include:

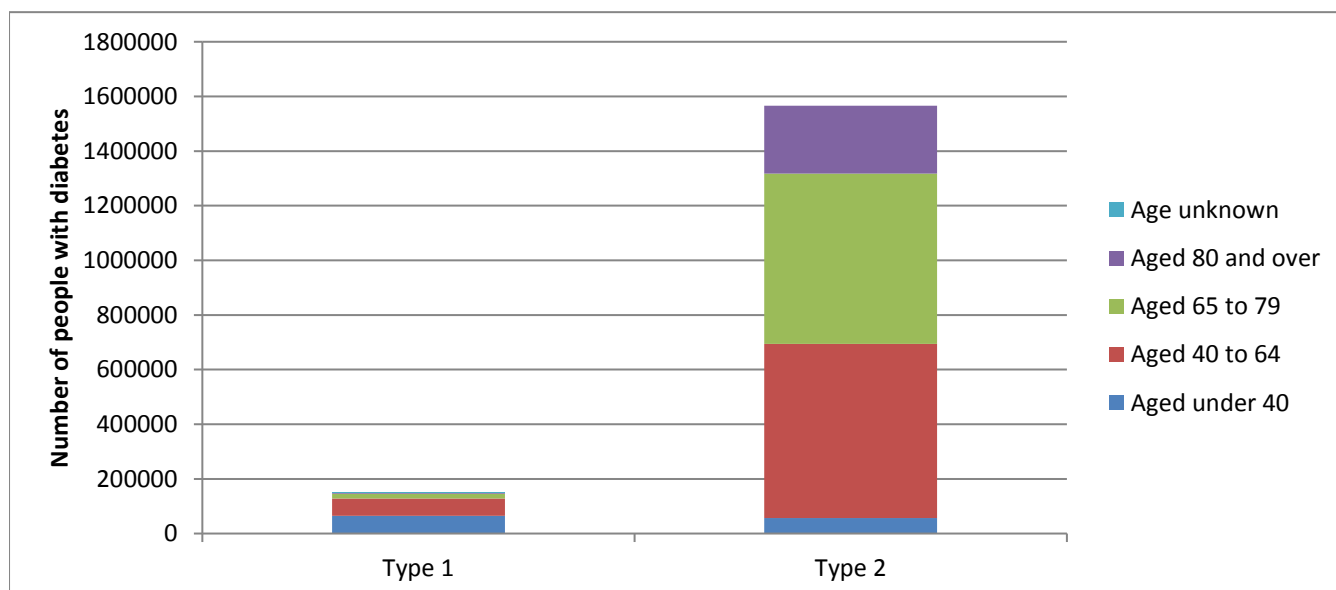
- Blindness (type 2 diabetes is a leading cause of preventable sight loss in people of working age),
- Kidney failure,
- Foot ulcers leading to amputation,
- Gum disease,
- Heart disease,
- Stroke.

The problems that can be caused by diabetes mean people are much more likely to need health and social care.

Nearly 1 in 10 people with diabetes have clinical depression which is nearly twice as many as in those without diabetes. For people who have diabetes alongside anxiety and/or depression having good blood sugar control can be more difficult and health care costs increase.

According to the National Diabetes Audit 2010–2011 report on complications and mortality, about 24,000 people with diabetes in England and Wales die early from causes that could have been avoided through better management of their condition.

Figure 1. Number of people with diabetes in England by type of diabetes and age, 2014/15. These numbers are only for GP practices which sent data into the National Diabetes Audit of General Practice which in 2014/15 was about half of practices.



How many people in Swindon have diabetes?

There are a higher percentage of people with diabetes in Swindon than in England. There are also a higher percentage of people who are overweight or obese which is one of the biggest risk factors for developing type 2 diabetes.

12,924 people in Swindon in 2015/16 had diabetes, of which around 11,600 have type 2 diabetes. This only includes people aged 17 years and over. This means that 7 in 100 people in Swindon aged 17 years and over had diabetes. It is thought that there may be nearly 1,000 people who have diabetes but have not been diagnosed.

Reasons for getting type 2 diabetes

- Excess weight:
 - 7 in every 10 adults were overweight or obese in Swindon in 2012-14.
 - 2 in 10 of 4 to 5 year olds were overweight or obese in 2015/16.
 - 3 in 10 of 10 to 11 year olds were overweight or obese in 2015/16.
 - Adults who are obese are five times more likely to have diabetes than an adult of a healthy weight.
- Ethnicity:
 - 15 in 100 of the Swindon population in 2011 were from Black Minority Ethnic groups (everyone except people who report themselves as being White British) and 6 in 100 of these were Asian/Asian British.

- Depending on ethnicity and gender, people in certain BME groups can be 3 to 5 times more likely to develop diabetes and develop diabetes younger.

Children and young people with diabetes

175 children and young people (people aged up to 24 years) were treated for diabetes in Great Western Hospital NHS Foundation Trust in 2015/16. Most of these children and young people had type 1 diabetes.

Other groups affected by diabetes

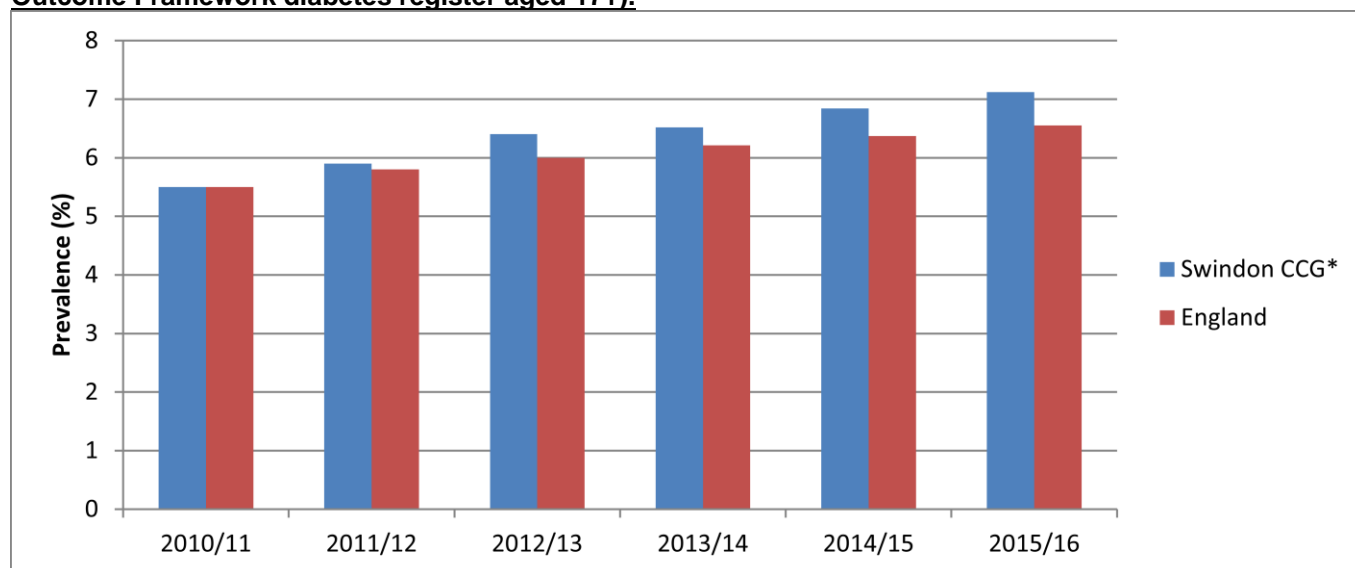
220 to 250 women who have diabetes (type 1, type 2 or pregnancy related) give birth in Swindon each year. Diabetes increases the risk to the mother and baby but good blood sugar management during pregnancy can decrease these.

In Swindon nearly 1 in 10 of people with diabetes may also have depression and nearly 16 in 100 of people with dementia could have diabetes.

People at a high chance of getting diabetes

People with non-diabetic hyperglycaemia (high blood sugar but not yet diabetes) are more likely to get diabetes. It is thought that in Swindon 1 in 10 people who are 16 years and older may have non-diabetic hyperglycaemia, (18,535 people).

Figure 2. Percentage of people with diabetes (as measured by percentage of general practice list on Quality Outcome Framework diabetes register aged 17+).



*Swindon PCT 2011/12 and 2010/11

What services do people use?

There are a wide range of services for diabetes available in Swindon. Most people with diabetes receive their care in primary care (mostly through their general practice). In primary care there are differences in the care and management offered. There are some places in Swindon where improvement is required and other areas which are performing very well. Making sure that everyone with diabetes is able to have the same opportunities is crucial to improving outcomes for people with diabetes in Swindon.

Prevention and self-management

There are a wide range of services available in Swindon for the promotion of a healthy weight and active lifestyle. There are also a number of options to aid people with diabetes to self-manage their diabetes.

Primary care and community care

Less than 4 in 10 people with type 1 diabetes and around 6 in 10 people with 2 diabetes had all eight care processes (routine tests such as blood pressure being measured) (2014/15, data collected in the National Diabetic Audit (NDA)). Younger people and those with Asian or Black ethnicity were less likely to receive all eight care processes.

Less than 4 in 10 people with newly diagnosed type 1 diabetes and around 7 in 10 people with newly diagnosed type 2 diabetes were offered structured education sessions (2014/15, NDA). However, of those referred only a very small number attended the sessions. 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 about what they want.

15 in 100 of people with type 1 diabetes achieved all three treatment targets. 4 in 10 people with type 2 diabetes achieved all three treatment targets (2014/15, NDA).

The treatment targets are; good blood sugar control (HbA1c less than 58mmol/mol), good blood pressure control (blood pressure less than 140/80) and good cholesterol control (serum cholesterol less than 5mmol/L). Younger people were less likely to achieve treatment targets. Achieving good blood pressure control, good cholesterol control and good blood sugar control is worse in Swindon than nationally (see figure 3).

The Swindon Community Diabetes Service offers:

- Education for healthcare professionals,
- Advice for healthcare professionals including joint clinics,
- Clinics for people with more complex diabetes.

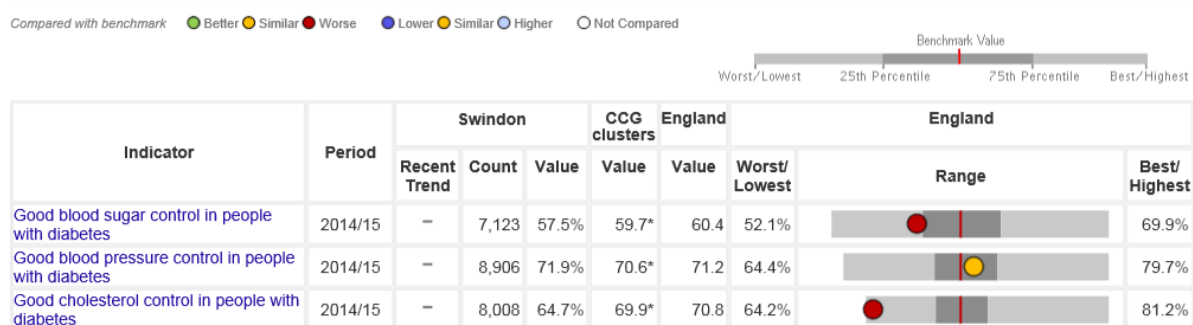
People with diabetes also use social care services if their need increases with the problems caused from diabetes.

Secondary care (hospital care)

Hospital outpatient clinic data shows that there may be unequal access to this service for different ethnic groups. However, there are a large number of people with 'unknown' ethnicity status which may be affecting the data.

There are a number of other elements within the diabetes pathway such as transitions (when children move to adult clinics), foot care and maternity which are important to improve outcomes for specific groups of people with diabetes.

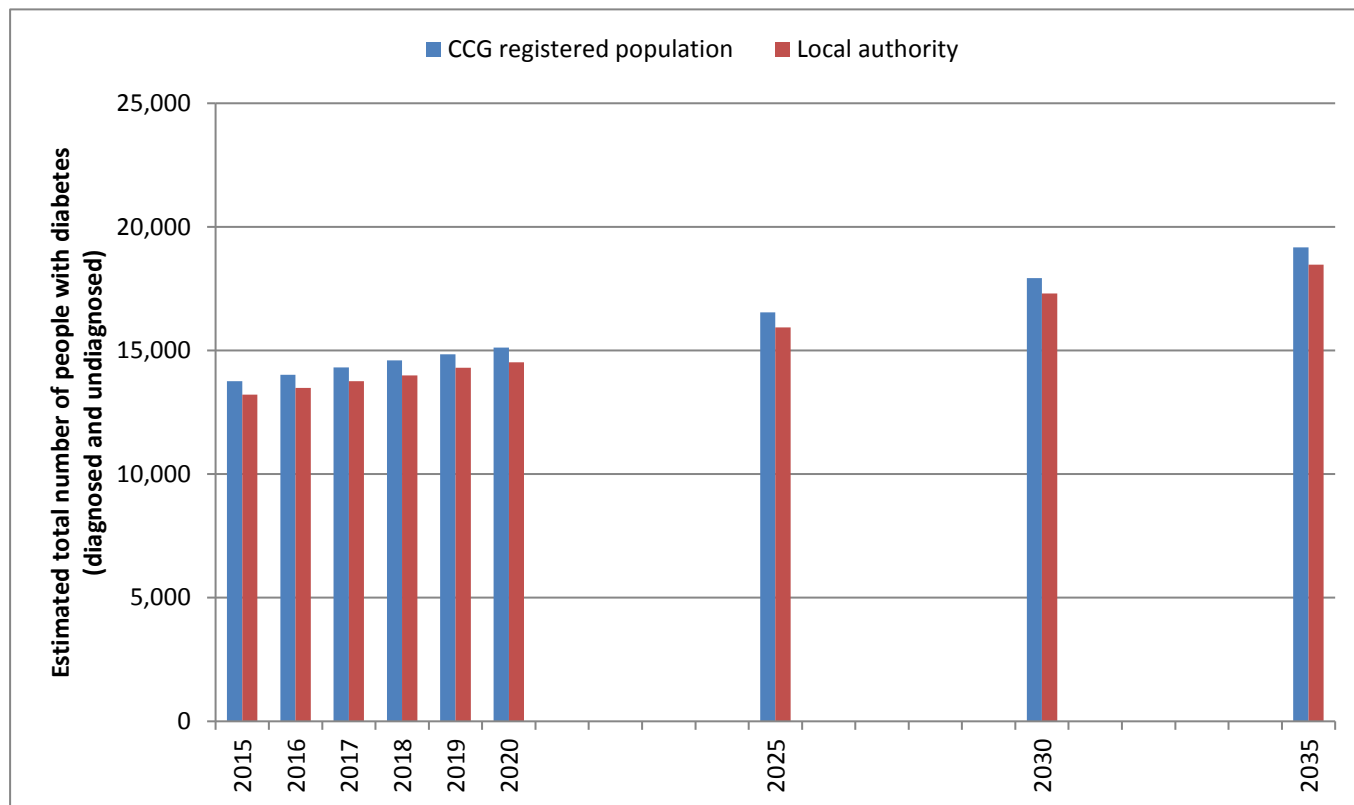
Figure 3. NHS Swindon CCG diabetes care, 2014/15.



What could the future look like?

It is thought that for Swindon the percentage of people with diabetes will increase to 9 in 100 by 2035. This means possibly 2,711 more people with diabetes by 2025 and 5,250 more people with diabetes by 2035 (see figure 4). These numbers include people with diagnosed diabetes and undiagnosed diabetes.

Figure 4. Estimated total number of people with diabetes (diagnosed and undiagnosed) in Swindon.



Recommendations

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.
 - a. 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.
 - b. Promote the prevention services we provide e.g. the new Swindon Community Health and Wellbeing Hub.
 - c. 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.
2. Make sure people at high risk of diabetes and people who have just developed diabetes are diagnosed quickly, so that they can get the best care. This will be done 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. Provide better care in Swindon for people with diabetes to reduce complications and, therefore, reduce need for health and social care. Action is required to reduce the differences in care for people with diabetes that occurs between GP practices.
 - a. Work with the community, CCG and the Great Western Hospital NHS Foundation Trust on a community model of care.
 - b. 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.
 - c. Increase the percentage of people with diabetes meeting all three treatment targets. We will especially target young people and those in deprived areas.
4. To achieve this annual reviews are required, primary care education and awareness of referrals and patient engagement.
- d. 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 dates to suit patients and engage with patients to understand in more detail why people do not attend.
- e. 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.
- f. Continue to increase participation in National Diabetes Audit to get complete information of diabetes care in primary care, including on ethnicity.
- g. 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.
5. Make sure there is continued patient and public involvement in communication of key messages, diabetes care and any changes to care. Specific work to find out if there are any barriers to people from BME groups using diabetes services or being diagnosed with diabetes is needed to understand the possible differences in service use.
6. 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.
7. Aim to make ethnicity recording more complete in hospital outpatient clinics so we are able to understand differences in access to diabetes specialist services.
8. These recommendations should be taken to the established multi-agency Swindon Diabetes Transformation Board for action.