Diabetes Joint Strategic Needs Assessment (JSNA)

Committee: Health and Wellbeing Board Date: 13th November 2013

Author:	Acting Director of Public Health
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

1.1 The aim of this report is to inform the Health and Wellbeing Board of the findings of the Diabetes Joint Strategic Needs Assessment (JSNA), seek support for its recommendations, and raise awareness of the health care related needs of people with Diabetes in Swindon

1.2 Diabetes is an important public health problem. Diabetes that is poorly managed can not only lead to complications, but also to premature death.

1.3 The Diabetes JSNA provides an objective analysis of the current and future needs of people with Diabetes in Swindon. It uses available local and national data to: estimate current and future numbers of people affected by the disease, describe current care pathways in Swindon: identify gaps in and barriers to treatment. The findings from the JSNA inform a suite of recommendations that will ultimately improve outcomes for people with diabetes.

2. Recommendations

The Board is recommended to:

2.1 Note and agree the recommendations from the Diabetes JSNA Bulletin (appendix one).

2.2 Support the development of an action plan for the implementation of the recommendations.

3. Detail

3.1 Diabetes mellitus, (or simply diabetes), is a group of metabolic diseases in which a person has difficulty in controlling blood sugars and fats, either because the pancreas does not produce enough insulin (Type 1), or because cells do not respond to any insulin that is produced (Type 2)

3.2 At the end of 2011/12, 10,302 people aged 17 years or over, registered with Swindon Clinical Commissioning Group (CCG), (which includes both Swindon and Shrivenham residents) were living with diagnosed diabetes; at least another 1,000 people in Swindon may have diabetes that has not yet been diagnosed

Further information on the subject of this report can be obtained from Christopher Bartlett, 01793 444683, cbartlett@swindon.gov.uk

3.3 If current trends continue in Swindon, the estimated prevalence of *all* diabetes (*whether diagnosed or undiagnosed*) will rise from an estimated 6.5% in 2012 to 7.3% by 2020 and 8.3% by 2030

3.4 In 2011/12 Swindon patients with diabetes fared worse than the England averages on a number of key primary care indicators; for example, in 2011/12, a significantly lower percentage of diabetic patients in Swindon had an HbA1c ("blood sugar") level meeting the national target of 7.5% or below, than was the case in England as a whole

3.5 Data produced through national audits showed the existence in Swindon of relatively high levels of diabetic complications, requiring hospital admission

3.6 Swindon women (all ages considered) had a higher death rate (2008 to 2010) from diabetes, as compared with their peers in England, the South West and the New and Growing Towns Group

3.7 Encouraging developments in Swindon include the specialised footcare service (the "DM Foot Team") which is now active at Great Western Hospital, and the Community Diabetes Interface Service

3.8 Risk factors for Type 2 Diabetes include:

- Being overweight or obese
- Being physically inactive
- Having a close relative with Type 2 diabetes
- Being over the age of 40
- Being of South Asian or Black African Caribbean origin

3.9 NICE Clinical Guidelines stipulate that patients aged 12 years or more with diabetes should receive all of nine recommended "checks". This annual review has been identified as having the greatest impact on reducing complications and hospital admissions. The care processes that should be reviewed include: Body Mass Index, Blood Pressure, HbA1c, blood cholesterol, eyes, feet, smoking, and measures of kidney function (serum creatinine level, urinary albumin level).

3.10 In 2011 according to the annual National Diabetes Audit, there was a slight improvement in the proportion of people with diabetes in Swindon who were recorded by this audit as having had all nine care processes (21.5%), compared to the previous audit result (18% in the 2009/10 report). This is still very low compared with other areas

3.11 Diabetes that is poorly managed can not only lead to complications, but also to premature death. Data from the Compendium of Population Health Indicators show that the mortality rate from diabetes in Swindon CCG residents has declined from 9.41 per 100,000 in 2002 to 6.77 per 100,000 in 2010 (directly standardised rates). However Swindon rates for females were higher as

compared with their peers in England, the South West and the New and Growing Towns Group

3.12 A set of key recommendations have come out of the JSNA process that will ultimately improve patient experience and health outcomes for people with diabetes

3.12.1 Continue local campaigns which promote a healthy lifestyle. The full range of relevant health promotion leaflets should be used to help people with diabetes and also people who need to develop a healthier lifestyle

3.12.2 Identify and support people in Swindon who have diabetes that has not been diagnosed; this identification could take place through the existing programme of NHS Health Checks, although other methods might also be adopted

3.12.3 Conduct a confidential audit of the records of people with diagnosed diabetes in Swindon who are "excepted" from the GPs' Quality Outcomes Framework (QOF) Register (i.e. deliberately left out of the assessment of key indicators)

3.12.4 Review the services being provided for people from Black African-Caribbean groups and people from the South Asian community in Swindon, as these people are at higher risk of diabetes and its complications; the NHS Health Check programme might be of particular benefit to them

3.12.5 Conduct an audit to see that women in Swindon are benefiting as fully as men from diabetes services in Primary Care; this should include a comparison of the achievement of the HbA1c targets in men and women

3.12.6 Fully support the work of the Community Diabetes Interface Service and of the DM Foot Team at GWH

3.13 The Diabetes JSNA Bulletin is an abbreviated version of the JSNA Diabetes Profile 2013. The full Profile provides more information on the issues covered by this bulletin, and includes a full set of references, a select technical glossary and acknowledgement of contributors. It can be found on Swindon's JSNA website: http://www.swindon.gov.uk/healthandwellbeing

4. Alternative Options

4.1 Not to support the recommendations identified in the JSNA bulletin.

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5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

5.1 There are no financial or procurement implications arising from the recommendations of this report.

5.2 If additional resources are needed to implement these recommendations a detailed business case will be developed.

Legal and Human Rights Implications

5.3 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.

5.4 In consideration of any future guidance and an understanding of best practice from elsewhere, the council will work with the NHS and other partners in order to ensure that equalities and a respect for human rights are at the heart of the development of the Swindon JSNA and that everyone in Swindon has fair access to services and are free from discrimination.

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

5.5 The Diabetes JSNA highlights a number of key areas of focus that will improve health outcomes for people with Diabetes.

Links to One Swindon, Strategic Objectives, Plans and Policies

5.6 Improving health outcomes for those Diabetes links directly to the Swindon's strategic priority to find new ways to reduce vulnerability and improve health for all.

5.7 There are strong links to Swindon's Health and Wellbeing Strategy; supporting adults to live healthier and more independent lives, and improving health outcomes for disadvantaged and vulnerable communities

Diversity Impact Assessment

5.8 A Diversity Impact Assessment has not been completed at this stage.

5.9 The Diabetes JSNA considers the needs of those communities more at risk of diabetes. Any future actions or service redesign will reflect the needs and diversity of Swindon communities.

Risk Management

5.10 No specific risks identified at this stage for this report

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6. Consultees

6.1 The Board Director Finance, Revenues, Benefits and Property (Section 151 Officer) and 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 one. Diabetes JSNA Bulletin

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