AGENDA ITEM

REPORT TO HEALTH AND WELL BEING BOARD

29 JUNE 2016

BRIEFING ON DIABETES PREVENTION AND CARE

Briefing on Diabetes Prevention and Care in Stockton-On-Tees (NHS Hartlepool and Stockton-on-Tees CCG).

SUMMARY

This briefing (and presentation) provides an overview of the burden of diabetes in Stockton-On-Tees (NHS and Hartlepool and Stockton-On-Tees CCG), the services currently in place to address it and the key drivers for change.

RECOMMENDATIONS

It is recommended that the Board facilitates the development of an integrated model of diabetes care that will help reduce the burden of diabetes on individuals, communities and the health and social care system (see attached Diabetes UK, Diabetes Care Health and Wellbeing Boards Assurance Prompt).

This involves further developing the structures, systems and processes that will support:

1. Local implementation of the National Diabetes Prevention Programme, which aims to support people at high risk of developing diabetes to reduce the risk of getting the disease;

2. The identification of people living with undiagnosed diabetes;

3. Increased number of people newly diagnosed with diabetes to receive structured education and support (4.7% in 2012/13, England average 4%);

4. General practices to improve the quality of care for people with diabetes; to address unwarranted variations in the quantity and quality of care;

5. Care providers to have a foot care pathway with adequate capacity in place to enable early referrals;

6. Increased proportion of general practices participating in the National Diabetes Audit, which is used to monitor progress (43.9 % participated in 2014/15); and

7. Secondary care providers to have inpatient specialist teams to assess and help manage inpatients with diabetes.

DETAIL

National Context

1. About 3.5 million people in the UK have been diagnosed with diabetes, a number that is increasing by about 5% per year. About 90% of people with diabetes currently have Type 2 diabetes[1].

2. It is estimated that there are about 550,000 people in the UK who have diabetes but have not been diagnosed[1].

3. The main risk factors contributing to the rising number of diabetes are obesity and an ageing population. Diabetes prevalence is also higher in areas experiencing deprivation. People living in the 20% most deprived neighbourhoods in England are 56% more likely to have diabetes than those living in the least deprived areas.

4. An analysis of the main risk factors for diabetes estimates that about 5 million people in England (11.4% of people aged 16 and over) are at high risk of developing diabetes (pre-diabetes)[2].

5. 1 in 6 patients in hospital have diabetes and are more likely to be readmitted.

6. The cost of diabetes to the NHS is about £10 billion each year, and the majority of this is due to preventable complications associated with diabetes:
   - more than 100 amputations a week.
   - preventable sight loss in people of working age.
   - major contributor to kidney failure, heart attack and stroke.
   - the second fastest growing cause of heart failure.

7. About 20,000 people with diabetes die early every year in the UK.

Stockton-On-Tees/NHS Hartlepool & Stockton-On-Tees CCG

8. In 2014/15, 6.2% of the adult population (14,553 people) were on general practice diabetes register in NHS HAST CCG. At practice level, the prevalence of diagnosed diabetes ranged from 1.2% to 7.4%.

9. It is estimated that around 3,300 people have undiagnosed diabetes in Stockton-on-Tees.

10. Obesity level in Stockton-On-Tees is high, 26.1% in adults and 21.1% in children in Year 6, compared with England average of 23% and 19.1%[3] respectively and is continuing to grow. This together with an aging population is leading to increase in Type 2 diabetes. Stockton-On-Tees has a higher level of deprivation than the England average and is expected to have more diabetes.

11. About 17,175 (10.9% of people aged 16 and over) are at high risk of developing diabetes (pre-diabetes) in Stockton-On-Tees[2].

[1] Diabetes UK (2015). Facts and Figures.
[2] Public Health England (2015). NHS Diabetes Prevention Programme (NHS DPP) Non-diabetic hyperglycaemia. National Cardiovascular Intelligence Network (NCVIN).
[3] Public Health England: Local Authority Health Profile 2015

12. The National Diabetes Audit 2014/15 results show that in NHS HAST CCG:
    - 43.9% of general practices (18/41 practices) participated.
    - 59.7% of people with diabetes received all eight care processes, ranging from 28.7% to 84%.
    - For three treatment targets (blood sugar, blood pressure and cholesterol levels), the percentage of patients who reached the required level of control ranged from 15.4% to 49.1%
    - 82.4% of newly diagnosed diabetics were offered education, however only 4.7% were recorded as attending (England average 4%).
    - The CCG has high rates of lower limb/foot amputations.

13. The results of a Diabetes Deep Dive/service review carried out in 2015/16 showed:

    - Increases in A&E attendances with a primary or secondary diagnosis of diabetes (and other endocrinological conditions).
    - New outpatient attendances were highest in males aged 50-59 years and follow- up activity in those aged 60-69, which suggest diabetes education needs within these age groups
    - Increases in elective admissions with a diagnosis of diabetes in males and females aged 60-69 years
    - The higher proportion of men with diabetes (56% compared with 44% in women[4]) and the differences in patterns of service activities are reflected in the higher deaths in males from diabetes compared with women.

14. The cost of planned diabetes and related activity for 2016/17 in the NHS HAST CCG is estimated at £3,425,199 (may not reflect the true cost as diabetes care is part of cardiovascular disease care).

Current Services and Issues

15. Stockton-On-Tees tackles adult obesity using a four-tiered model (prevention, targeted interventions, specialist interventions and bariatric surgery). However, there is no single commissioner for the obesity pathway. There is need for a more collaborative and coordinated approach to ensure that support can be stepped up or down to meet patients' needs and to reduce risk of gap in services.

16 The NHS Health Check (Healthy Heart Check in Teesside) programme is helping to identify people at high risk of developing diabetes and those who do not know that they have diabetes. Community based checks targeted at communities in socially deprived areas and people of Black, Asian and Minority Ethnic groups who at greater risk of diabetes are being developed.

We are yet to be invited to join the National Diabetes Prevention Programme in Teesside and some work is being undertaken to prepare for implementation.

17 There are good diabetes services in place in general practices, community and hospitals. However, significant opportunities exist to improve clinical management and effective support for patients to self-manage their diabetes through evidence based structured patient education and annual reviews, and peer support.

[4] National Diabetes Audit 2014/15: Report 1: Care Processes and Treatment Targets

Key Drivers for Change

There are three key drivers for change in diabetes prevention and care.

18. There is proven UK and international evidence that more than 50% of Type 2 diabetes can be prevented through modest changes in diet and physical activity levels in individuals with pre-diabetes[5].

19. There are evidence based treatments and care to prevent, reduce or delay complications in people who have diabetes. It is estimated that people with diabetes only see a health care professional on average 90 minutes in a year. Therefore, patient education and self-management support is of vital importance.

20. Currently, the main health and social care priority is to reduce demand for services and improve the health and wellbeing of local people. For diabetes care, this means developing a model of care that helps to shift attention and investment towards preventative initiatives which will reduce demand, empower patients and communities and promote health and wellbeing.

21. A joint letter from NHS England, Public Health England and Diabetes UK on *Diabetes Prevention and Treatment Programmes (May 2016)* identified the following five care objectives.

    1. Radical scale up of diabetes prevention in at-risk individuals;

    2. Improving the achievement of the NICE recommended treatment targets and driving down variation between Clinical Commissioning Groups (CCGs);

    3. Improving uptake of structured education for patient with diabetes;

    4. Reducing amputations by improving the timeliness of referrals from primary care to a multi-disciplinary foot team for people with diabetic foot disease; and

    5. Reducing lengths of stay for inpatients with diabetes.

Diabetes Care Reform in Hartlepool and Stockton-On-Tees

NHS HAST CCG is currently working with local partners to develop a business case to support a more joined-up model of diabetes care that will help integrate prevention at all levels. This work is being informed by examples of good practice in other parts of England.

FINANCIAL IMPLICATIONS

This briefing provides a number of recommendations on how diabetes services need to be transformed to deliver the best care to Stockton-On-Tees residents. Some of these recommendations may have financial implications, depending on the model for implementation and delivery. It is not possible to quantify the financial impact at this stage.

LEGAL IMPLICATIONS

None

[5] American Diabetes A. Diagnosis and classification of diabetes mellitus. *Diabetes care*. 2012; 35 (Supplement 1):S64-S71.

RISK ASSESSMENT

None

CONSULTATION

All of the recommendations in this briefing are designed to improve diabetes prevention and care as set out in the Diabetes UK Health and Wellbeing Board Assurance Prompt. This and related national policy documents[6] provide a strategic vision for transforming diabetes services in England. Diabetes UK has led the production of some of these documents with membership that includes NHS England, Public Health England, Good Governance Institute and patient representatives. There is a Diabetes UK regional group that aims to support patient engagement in service development and patient and public education. Both Stockton-On-Tees Borough Council and NHS HAST CCG will engage and update their relevant internal groups and strategic partnerships on the diabetes care agenda.

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[6]National Audit Office Report on the Management of Diabetes in Adult (2015), Sustainability and Transformation Plans (STPs), Clinical Commissioning Group Improvement and Assessment Framework (CCG IAF), NHS Right Care Programme and Diabetes UK Networks.