AGENDA ITEM
REPORT TO THE HEALTH AND WELLBEING BOARD

26th JULY 2017

REPORT OF DIRECTOR OF PUBLIC HEALTH

IMPROVING DIABETES PREVENTION AND CARE IN STOCKTON

SUMMARY

The Health and Wellbeing Board is aware of the increasing prevalence of obesity and diabetes Type 2 and has recommended to establish a multiagency task and finish group to explore how diabetes prevention and care could be improved.

The task and finish group with membership from Hartlepool and Stockton CCG (HAST), North East Commissioning Support Unit (NECS), North Tees Hospital Trust, Catalyst, Hartlepool and Stockton GP federation (HASH) and Stockton Borough Council (SBC) was established in March 2017.

The purpose of the report is to present the findings and recommendations from the Stockton Diabetes Task and Finish Group to the board and to ask the board to consider and support the proposed recommendations.

The Health & Wellbeing Board is asked to:

- Note the scale of the problem and the impact on the health and wellbeing of the population
- Consider the recommendations of the multiagency task and finish group
- Identify key partners to follow up the discussion and to form an action plan to be reported back to the future board meetings

RECOMMENDATIONS

1. Note the scale of the problem and the projected increase in prevalence of diabetes
2. Consider health impact assessments of decisions on urban planning, transport, licencing, schools, leisure and other services.
3. Consider the development of local healthy schools and healthy town programme to create health promoting settings to promote active lifestyles and physical activity.
4. Consider the role of wider teams and services in helping to prevent diabetes e.g. evidence-based messages and brief interventions for key risk factors, delivered by teams such as social care.

5. Primary care to systematically identify patients at risk of or with undiagnosed diabetes through health checks, obesity and pre- diabetes registers, data led identification on practice register considering all groups at risk.
6. It is recommended that Board members support multi-agency sign-up to wave 3 (2017) of the National Diabetes Prevention Programme.
7. Ensure appropriate follow up of patients identified at risk of diabetes through referral into weight management services or diabetes prevention programme
8. Address variation in care of patients with diabetes in GP practices to ensure that all patients have access to good quality basic care.
9. Ensure that all patients have access to advice and support that is appropriate to their needs through structured education or other information for newly diagnosed patients and information and support at other stages of the disease.
10. Continue to improve access and uptake of foot care and diabetic eye screening
11. Ensure access to the right level of care at the right time for all patients through clear referral pathways and criteria between primary care, community specialist service and secondary care.
12. Develop the capacity and skills of the workforce in primary and community care to manage patients in the community.
13. Consider integrated care models to provide seamless, high quality care for all patients.

BACKGROUND

Overview

14. Diabetes type 2 is a metabolic disease characterised by insulin resistance and insufficient pancreatic insulin production resulting in raised blood glucose levels. Diabetes is a leading cause of loss of vision in people of working age and contributes to the development of CVD resulting in kidney failure, heart attack and stroke.
15. There are more than 3 million people in England diagnosed and living with diabetes. It is estimated that one million people with diabetes are undiagnosed and a further five million at high risk of developing Type 2 diabetes. If current trends persist, one in three people will be obese by 2034 and one in 10 will develop Type 2 diabetes.
16. Type 2 diabetes costs the NHS budget around £8.8 billion a year and accounts for around 9% of the total NHS budget.
17. Overweight, obesity and physical inactivity are significant and preventable risk factors. Obesity rates have been increasing steadily over the last decades. 64% of the population in England were overweight or obese in 2015 compared to 53% in 1993. Weight reduction and physical activity can prevent or delay the development of diabetes. Early identification and treatment with strict blood sugar control are crucial to avoid serious complications such as loss of vision or foot ulcers resulting in amputations.
18. NICE offers detailed clinical and public health guidance, pathways, quality standards and technology appraisals on prevention and treatment of type 2 diabetes. People should be encouraged to be physically active and eat healthily through information, access to lifestyle

services and health promoting environments such as active transport or through licencing. NICE treatment standards and guidance provide detailed guidance on clinical care. [ii][iii][iv]

19. NHS England has published 'Action on Diabetes', a reference document for CCG, to improve outcomes for patients with or at risk of diabetes. NHS England has set up a transformation fund to support improvement leads on the National Diabetes Prevention Programme. Right care, NHS England recommends high value interventions in diabetes including the National Diabetes Audit. [v][vi][vii][viii]

20. The National Diabetes Prevention Programme offers patients with increased blood glucose levels (pre-diabetes) and therefore at risk of developing diabetes, access to a structured programme of information and advice on healthy eating and lifestyle, physical exercise and support to lose weight. Member organisations of the Durham, Darlington, Tees, Hambleton, Richmond and Whitby STP have agreed to apply for the programme in 2017. The CCGs across the STP patch have agreed to participate and HAST CCG has agreed to be the lead organisation.

21. It is recommended that Board members support multi-agency sign-up to wave 3 (2017) of the National Diabetes Prevention Programme. The Programme would be accountable to the STP prevention workstream to ensure clear governance and learning from previous waves, in the context of the other prevention work underway. Extensive work is ongoing regarding the ability for local providers to collaborate with or be sub-contracted to the national provider of the programme; and locally Public Health would work with partners to ensure the programme interfaces with existing local services around healthy weight.

22. There are many examples of innovative care and good practice for diabetes prevention, improving the quality of diabetes education and care as well as new service models by NHS England and Diabetes UK. Integrated care models, such as the 'super six' in Portsmouth, promote an integrated pathway between primary and secondary care with increased ability of primary care to deliver diabetes care, and rapid access to specialist care as needed.[ix][x][xi]

23. A local pilot project in Durham Dales, Easington and Sedgefield CCG, similar to the Portsmouth model, has introduced an integrated primary, community and secondary care model in January 2017. The 5 years programme is consultant led with clear pathways and cooperation, training and support between partners. Additional funding and support was available at the start with an expectation to improve the quality of care and reduce cost in the medium to long term.

Epidemiology

24. 24% of children in reception, 35% of children in year 6 and 72.1% of adults living in Stockton are overweight or obese. The proportion of overweight or obese children and adults has been increasing steadily over many years albeit slower than previously over the last decade. Only 48% of adults were physically active and achieved 150 minutes of moderate activity per week.

25. 17,100 (10.9%) adults in Stockton are estimated to have increased blood glucose levels and therefore are at risk of developing diabetes

26. 10,055 people living in Stockton (6.3%) have been diagnosed with diabetes and an estimated 2,600 people are living with undiagnosed diabetes. As more people are expected to develop diabetes the number could rise to over 15,800 people (9.3%) by 2035.

27. The recorded prevalence of diabetes in GP practices varies considerably between 2.7% and 7.5%. Differences are caused by different practice populations and clinical practice.

28. All GP practices are asked to participation in the National Diabetes Audit (NDA). Participation has improved from 43.9% in 2014-15 to 61.5% in 2015-16 but was below the national average of 82%.

29. The national diabetes audit looks at three treatment targets. In 2015-16 an average of 61% of all patients received good blood sugar control and 73% had good blood pressure and cholesterol control, similar to the national average. There was however significant variation in achieving these treatment targets between practices ranging from 43-79% for blood sugar control, 59-85% for blood sugar control and 64-83% for cholesterol control.

30. The national diabetes audit further looks at eight care processes (HbA1c, blood pressure, cholesterol, serum creatinine, urine albumin, foot surveillance, BMI and smoking). 54% of all patients with type 2 diabetes have received all care processes, similar to the national average. Variation between GP practices for all care processes was between 7 and 67%.

31. Foot ulcers are a common complication in diabetes and contribute significantly to the need for hospital admissions, length of stay and if not treated successfully to amputations. Yearly foot checks are recommended. 83.4% of patients in Stockton had a record of a foot examination and risk classification in community and primary care; this is statistically significantly higher than the national average of 81.4%.

32. Diabetic retinopathy (DR) is the most common microvascular complication of diabetes and affects about a third of patients with diabetes. Diabetic eye screening is recommended yearly. The uptake of diabetic eye screening was 87% compared to the national average of 82%. A health equity audit has shown that uptake was lower in those living in more deprived areas particularly in the town centre and for young people with only 60% of young people aged 25-34 attending for screening. [xii][xiii]

33. Patients who have been newly diagnosed with diabetes are offered to attend a structured education programme on diabetes. In Stockton and Hartlepool CCG the majority of newly diagnosed patients were offered to attend the programme but only 81% attended in 2016/17. Referral and attendance rates have improved significantly over the last 3 years. [xiv]

34. The outpatient department at UHNT has approximately 500 patients with diabetes on their list which would be 5% of all patients with diabetes living in Stockton. However not all of these will be Stockton residents, whilst other Stockton residents may be in treatment at UHH or JCUH.

Interventions and Services

35. Services and organisations contributing to the prevention and care of diabetes in Stockton include public health, GP practices, community specialist service including podiatry and diabetic eye screening and in- and outpatient diabetes services in the hospital.

36. Stockton Borough Council promotes active transport to encourage physical activity in children and adults. This includes improvements to walking and cycling networks and cycle to work schemes as well as cycling and pedestrian training in primary schools. Stockton plans to limit access to fast food through limiting the establishment of new outlets within 400m of schools or parks.

37. People living in Stockton have access to several leisure centres and other offers to become more physically active such as walking and cycling activities and events.

38. The ‘Lite 4 life’ weight management programme is a group based intervention to support people to reduce weight and become more active. The Active Health Exercise Referral scheme is a progressive exercise programme to help patients to manage their medical condition.

39. The Better Health at Work Award Programme promotes healthy lifestyle advice and interventions including healthy diet and healthy weight to employees of participating organisations.

40. NHS health checks which are offered through GP practices support the Identification of patients at risk of or with undiagnosed diabetes through an HbA1c blood test. Patients with increased blood glucose are then placed on pre-diabetes registers or referred for further diagnosis and treatment.

41. GP practices maintain obesity registers and have started to compile non-diabetic hyperglycaemia or pre- diabetes registers. Patients on the obesity register should be offered HbA1c testing and those on the non-diabetic hyperglycaemia register should be offered advice and lifestyle interventions such as the National Diabetes Prevention Programme.

42. GP practices maintain diabetes registers and provide treatment and annual checks for patients with diabetes. Patients are usually seen by practices nurses with additional skills in management of long term conditions.

43. Diabetic foot care is provided by the local podiatry service and eye screening is provided by the DRSS which is a national service. Patients are invited annually to attend these service.

44. A specialist diabetes community service provides care for patients who require addition support to manage their condition. Diabetes specialist nurses a structured education programme (DESMOND) offered to all patients newly diagnosed with diabetes type 2. Patients with diabetes type 1 are offered to attend the Hattie programme (DAPHNE).

45. The specialist diabetes service at North Tees Hospital offers in- and outpatient care for patients with more complex needs, unstable diabetes or significant complications. The service is delivered by diabetes specialist nurses, dieticians, podiatrist and consultant diabetologists.

46. A family support group is run by community volunteers for those with Diabetes in Stockton-on-Tees and Hartlepool and is advertised through North Tees and Hartlepool NHS Foundation Trust. The group offers support for people with diabetes by improving access to education and information, improving communications between patients and health professionals and offering recommendations and influencing decisions for the improvement of local services for people with diabetes.

47. Billingham Environmental Link Project (BELP) works with Marsh House GP practice and the GP federation to establish a diabetes peer support group.

48. Marlborough House/Sporting Chance (Volunteering Matters) offers weekly men’s health and fitness session for men from the BME community who are diabetic.

Challenges

49. The number of people being overweight or obese and at risk, undiagnosed or diagnosed with diabetes is huge. With a projected increase in people at risk and diagnosed with diabetes prevention and interventions need to match the scale of the problem.

50. Improving the health and wellbeing of the local population is a key priority of all partners. Although Stockton promotes healthy lifestyles through active transport, opportunities for physical activity and restricting the availability of fast food, there is a need to consider the health impact of decisions systematically.

51. There is also the opportunity to consider the role of wider teams and services in helping to prevent diabetes e.g. evidence-based messages and brief interventions for key risk factors, delivered by teams such as social care.

52. Healthy settings such as healthy workplaces, healthy schools and healthy towns enable people to lead healthy lifestyles through providing a health promoting environment in which healthy choices are the easiest choice such as walking or cycling instead of driving. Stockton offers a healthy workplace programme (Better Health at Work Award) but there is only limited activity around healthy schools or healthy town programmes.

53. Too many people in Stockton do not know that they are at risk of diabetes or have undiagnosed diabetes. There is currently no systematic, population-based pathway for identifying those at risk or with undiagnosed disease. Only 10% of adults aged 40-74 attend a NHS health check in any year. This excludes at risk groups who might develop diabetes at a younger age and working age people who are less likely to access a health check. Identification of patients at risk of or with undiagnosed diabetes through practice obesity registers is variable and excludes patients who do not access general practice.

54. People identified at risk of diabetes are not systematically referred to existing weight management services. Only 19% of people identified as overweight or obese at the NHS health check were referred and 5% accepted the referral.

55. Although there are national standards for diabetes treatment in primary care, there is significant variation in care between GP practices. Differences in capacity and specialist skills to manage patients with diabetes in primary care contribute to the variation.

56. Structured education on diabetes and self-management (DESMOND) is only accessed by a minority of patients newly diagnosed with diabetes. Although 90% have been referred, significantly fewer attended the course. Patients who are first diagnosed in secondary care are not always referred for DESMOND. The course in mostly delivered during the week between 9 and 5 on a face-to-face basis. There is currently no-online component for the course or provision for those with learning difficulties or language barriers. No further structured input to support the patient to self-manage is subsequently provided over the course of the disease although it is recognised that patients might gain further benefit from educational updates during the course of the disease.

57. Specialist community based services have limited capacity. Referral and discharge criteria between primary care and specialist community services could be improved to enable patient with the highest need to access the service

58. Foot ulcers can lead to serious complications such as amputations and cause a significant burden on patients, services and budgets. Although access to foot care is above the national average, it could be improved to prevent complications and hospital admissions. There is currently no information which groups of patients are least likely to access the service.

59. Diabetic eye screening is generally well attended. There are however groups which are less likely to attend diabetic eye screening particularly those living in the centre of town or younger patients.
60. Specialist secondary care services have limited capacity and ongoing recruitment issues. With increasing prevalence of diabetes access to and provision of care will become more difficult. To enable patients with complex needs to access and receive care from the service more patients will need to be treated in community or primary care.

NEXT STEPS

In order to deliver the recommendations in this paper the Health and Wellbeing Board is asked to consider the following next steps

61. Establish a multiagency group with leadership from the NHS and membership from local authority and VCS including Diabetes UK. The group would oversee the development of a joint action plan to improve diabetes prevention and care based on the above recommendations for Stockton.
62. Support the regional strategic direction of the DDTVHRW STP with a view of working with CCGs and Local Authorities across the STP footprint towards the implementation of the National Diabetes Prevention Programme in 2018/19.
63. Plan and conduct a joint consultation with patients and carers on diabetes related health and health care needs and views on current services and proposed changes.

FINANCIAL IMPLICATIONS

The proposed recommendations will require funding from commissioning and providing organisations.

LEGAL IMPLICATIONS

There are no legal implications.

RISK ASSESSMENT

No specific risk assessment required.

COUNCIL PLAN IMPLICATIONS

The implementation of the recommended improvements will have a positive impact on the Joint Health and Wellbeing Strategy.

CONSULTATION

No consultation at this stage.

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APPENDIX

NICE Quality Standards

1. People with diabetes and/or their carers receive a structured educational programme that fulfills the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education.
2. People with diabetes receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured educational programme.
3. People with diabetes participate in annual care planning which leads to documented agreed goals and an action plan.
4. People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%), and receive an ongoing review of treatment to minimise hypoglycaemia.
5. People with diabetes agree with their healthcare professional to start, review and stop medications to lower blood glucose, blood pressure and blood lipids in accordance with NICE guidance.
6. Trained healthcare professionals initiate and manage therapy with insulin within a structured programme that includes dose titration by the person with diabetes.
7. Women of childbearing age with diabetes are regularly informed of the benefits of preconception glycaemic control and of any risks, including medication that may harm an unborn child. Women with diabetes planning a pregnancy are offered preconception care and those not planning a pregnancy are offered advice on contraception.
8. People with diabetes receive an annual assessment for the risk and presence of the complications of diabetes, and these are managed appropriately.
9. People with diabetes are assessed for psychological problems, which are then managed appropriately.
10. People with diabetes at risk of foot ulceration receive regular review by a foot protection team in accordance with NICE guidance.
11. People with diabetes with a foot problem requiring urgent medical attention are referred to and treated by a multidisciplinary foot care team within 24 hours.
12. People with diabetes admitted to hospital are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin.
13. People admitted to hospital with diabetic ketoacidosis receive educational and psychological support prior to discharge and are followed up by a specialist diabetes team.
14. People with diabetes who have experienced hypoglycaemia requiring medical attention are referred to a specialist diabetes team.

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