North Yorkshire County Council
Scrutiny of Health Committee
27 January 2017

Diabetes prevention in North Yorkshire: Briefing

Purpose of report
The purpose of this report is to provide Members with a summary of the national issues raised in a recent Care Quality Commission review of diabetes care and support and highlight what this means at a local level in North Yorkshire. This includes an overview of activity to prevent the onset or and screen for diabetes.

Members are asked to review the report and identify any areas for further scrutiny.

Introduction

1. The Care Quality Commission published a review of people's experiences of community diabetes care and the support they are provided to self-manage their condition in September 2016. This review highlighted the increasing numbers of people living with diabetes and the costs to health and social care. http://www.cqc.org.uk/sites/default/files/20160907_CQC_Diabetes_final_copyrightnotice.pdf

2. There are several different forms of diabetes. The greatest increase has been amongst people with the most common form which is type 2 diabetes. Type 2 diabetes is typically associated with older age, obesity and genetic factors including ethnicity. The review notes that "when diabetes is not well-managed, it can lead to serious complications such as heart disease, kidney disease, stroke, amputations, and blindness." These are costly both to the individual affected and to health and social care systems. Approximately £10 billion is spent by the NHS on diabetes each year – 10% of the NHS budget for England and Wales. Eighty per cent of these costs go on treating complications.

3. In response to this review NYCC Health Scrutiny requested a briefing about the prevention, identification and treatment of diabetes in North Yorkshire

Prevalence in North Yorkshire

4. Often people will not realise they have diabetes for some time. It can develop gradually and symptoms such as tiredness, thirst and needing to urinate more frequently may be ascribed to aging or other diagnosed long term conditions. As a result there will be people living with diabetes who are undiagnosed.

5. The numbers of people living with diabetes are estimated using models calculating expected numbers. Actual prevalence figures are drawn from primary care records. Nationally prevalence is estimated at 8.6% in 2016, with 6.5% registered. In Yorkshire and the Humber 6.8% are registered as having diabetes. North Yorkshire is estimated to have 43,965 people (8.79%) with diabetes, but

29,254 (6%) are registered. The figures for individual CCGS are outlined in the table below.

Diabetes Prevalence rates - 2016

		Estimated		Registered		Undiagnosed	
CCG Name	CCG Code	Number	Rate	Number	Rate	Number	Rate
AWC	E38000001	11835	9.2%	8,778	6.91%	3057	2.26%
HRW	E38000069	10980	9.1%	7,167	6.02%	3813	3.11%
HaRD	E38000073	10913	8.1%	7,562	5.71%	3351	2.39%
S&R	E38000145	9526	9.6%	6,509	6.61%	3017	2.95%
VoY	E38000188	21783	7.3%	15,907	5.46%	5876	1.87%

Source: NCIN, QOF

6. It was estimated in 2015 that 12.4% over 16 year olds in North Yorkshire have non-diabetic hyperglycaemia versus 11.4% average for England. Non-diabetic hyperglycaemia, also known as pre-diabetes or impaired glucose regulation, refers to raised blood glucose levels, but not in the diabetic range. People with non-diabetic hyperglycaemia are at increased risk of developing Type 2 diabetes. They are also at increased risk of other cardiovascular conditions.

Relevant NYCC activities

NHS Health Checks

7. The NHS Health Check programme targets all individuals aged 40-74 without previously diagnosed cardiovascular disease (CVD), diabetes or chronic kidney disease (CKD) to offer appropriate lifestyle interventions and treatment to reduce their overall risk and to reduce substantially the risk of premature death or disability.

8. The programme is also intended to raise awareness of alcohol consumption above recommended levels and of dementia in those aged 65-74.

9. At present, NYCC commissions GP practices to deliver the NHS Health Check programme (risk assessment, risk awareness and risk management), within the primary care setting, to the eligible population across North Yorkshire. Individuals deemed to be at high risk of diabetes will be offered further tests as part of their assessment. In addition, brief personalised evidence based lifestyle advice is given to all individuals with lifestyle risk factors (regardless of their CVD risk) which includes smoking cessation, increasing physical activity, healthy eating and weight management. Similarly, for those who are eligible for lifestyle interventions, healthcare practitioners will recommend onward referral into lifestyle services.

10. For quarter 1 of 2016/17, of those individuals whom were offered a health check, 39.9% received a health check across North Yorkshire. This is slightly less than the current England average of 45.6%.

Quarter 1 Data 2016-17	NYCC	England
Total eligible population 2016-2017	193918	15402612
Number of people who were offered a NHS Health Check	8758 (4.5%)	682388 (4.4%)
Number of people that received a NHS Health Check	3491 (1.8%)	310904 (2%)
Percentage of people that received an NHS Health Check of those offered	39.9%	45.6%

Source: PHE, 2016

11. Currently, we have 70 practices offering the programme to their registered populations across the patch. As primary care colleagues are the main point of contact for the programme, we heavily rely on practices to promote the service and encourage patient participation. We see variance across the patch for invitations sent and uptake of an appointment following the offer of a health check. As commissioners we liaise with our practices to offer support and advice where their numbers appear low – this provides us with an opportunity to understand some of the concerns that practices may have in delivering the programme.

12. Anecdotal feedback informs us that, practices have competing pressures with issues around workforce and capacity and therefore, the programme does not always take priority.

13. NYCC launched an NHS Health Check pilot outreach service in November 2015. The aim of this pilot service was to identify and reduce the risk of cardiovascular disease by improving access to the NHS HC service, for those at higher risk, particularly those whom live and work in the farming community and those living in Scarborough. This pilot service ended in November 2016, and a full evaluation of the outreach pilot programme will be undertaken in January 2017.

14. We have renegotiated our service specification from April 2017 with the Local Medical Committee and are working to incentivise greater access to the programme as well as providing motivational skills training for practice staff.

Tier 2 weight management

15. North Yorkshire County Council currently provides grant money to the seven district councils to pilot a tier 2 weight management programme. The weight management programme in each district is for anyone aged 18 years or above with a body mass index of 25 or above. The programme delivered in each district is a 12 week group programme that includes nutrition and physical activity, underpinned by behaviour change strategy.

16. The grant funding will cease 30th June 2017. North Yorkshire County Council intend to formally procure a new tier 2 adult weight management service from 1st July 2017 as a five year contract.

National Diabetes Prevention Programme (NDPP)

17. The NDPP will offer a structured approach to preventing the onset of diabetes to those at risk who may have been identified through the NHS Health Check programme, opportunistically through primary care of through other local pathways.

18. CCGs within North Yorkshire have been involved in the bidding process for the NDPP that have been submitted on an STP footprint. To date West Yorkshire STP (including Harrogate and Rural CCG and Airedale, Wharfedale and Craven CCG) have been successful in the bidding process for NDPP funding for phase 2 of the national roll out. The STP are currently putting together a prospectus for local delivery of this programme and will embark on the process of recruiting a provider.

19. The remaining STPs are currently reviewing their position in order to join national roll-out of the programme. Humber, Coast and Vale STP which includes Scarborough & Ryedale and Vale of York CCGs is in discussion with NHS England about participating in the prevention programme.

Role of schools in preventing diabetes

Change4 Life

20. Change4Life is a national evidence based prevention and health promotion campaign designed to change the health behaviour of individuals. NYCC align with Change4Life Campaigns occurring in January (nutrition related) and July (physical activity related) and raise awareness of the campaigns among partner agencies, providing a call to action for them to assist in sharing the campaign messages with our residents and increasing sign ups to the Change4Life website. Partners who support the campaigns include the Prevention Service, 5-19 Healthy Child Programme Service and Healthy Choices Service.

21. Change4Life messages have been delivered via a number of mediums to residents within the county including, press releases, social media posts, local radio interviews/advertising, and distribution of campaign resources via schools and partner organisations. From September 2016 Reception and Year 6 children being measured in the NCMP receive Change4Life resources as part of a new national initiative in schools called “Our Healthy Year”.

Food for Life

22. The Food for Life Partnership (FFL) is a school based programme that encourages children, families and the community to eat healthily and make sustainable food choices. North Yorkshire County Council’s Energy Traded Service have recently received public health funding to deliver the Soil Association’s nationally recognised FFL programme in 20 targeted schools across the county during the 2016-2018 academic years.

Healthy rating scheme

23. From September 2017, the Department of Health have introduced a new voluntary healthy rating scheme for primary schools to recognise and encourage the contribution to preventing obesity by helping children eat better and move more. The scheme is taken into account during Ofsted inspections. Locally, there is a real opportunity to support primary schools to sign up to the healthy rating scheme and pioneer change within the school setting.

Management of diabetes

24. CCGs and hospital trusts in North Yorkshire are working together to improve diabetes care across North Yorkshire. Key issues include access to structured education programmes and care quality with particular emphasis on reducing complications such as amputations, sight loss and cardiovascular diseases including stroke, kidney failure and heart disease.

25. Motivating lifetime lifestyle choices around physical activity and healthy eating are key in preventing, identifying and managing diabetes. These are affected by individual's motivations and health literacy as well as access to sources of support.

Recommendation

The Committee is asked to consider the report and identify areas for further scrutiny.

Clare Beard
Public Health Consultant
December 2016.