Portsmouth Wellbeing Service

Progress towards Diabetes Prevention work

Wessex Health Education CPD event

19th Nov 2015
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Diabetes Prevention work

- National and local context
- Current pathway
- Prevention work progress
- Challenges and what’s next
Life expectancy and health inequalities

4 main risk factors – Tobacco, Alcohol, Poor diet and lack of Physical Activity

4 main causes of avoidable early deaths – Cancer, Cardiovascular disease, Respiratory disease, Liver disease

Contribution to reduction in life expectancy and health inequalities – 64%
Why prevent Type 2 Diabetes?

• Approx 62% adults now overweight and obese, type 2 diabetes (T2DM) and associated co-morbidities more likely

• Cost of diabetes to NHS £10bn each year and most of its is preventable complications

• Large RCTs and systematic reviews show modest changes in diet and physical activity can reduce incidence of T2DM by more than 50% of incidence of pre-diabetes.
Why Diabetes prevention work?

Compared with other Portsmouth residents, for people with diabetes

- 33.1% more likely to have a stroke
- 77.2% more likely to have Myocardial infarction
- 85.7% more likely to have a hospital admission related to heart failure
- 33.1% more likely to die & high no of amputations

Portsmouth CCG profile 2013
Local context

- 5.3% (estimated 6.5%)
- 55.2% adults with diabetes have a HBA1 measurement of 5.9 mmol/mol or less compared with other similar CCGs with 58.1%
- £270.92 for adult with diabetes on 2012/2013 compared to £281.52 across England
- <20% (local audit & QOF data)
- Few from disadvantaged groups and most in need

Prevalence

DESMOND attendance

HbA1 measurement

Prescription spent

6
Long Term conditions pathways

Prevention → Early Identification → Education & Self Management

Primary Care → Community Care → Specialist Care

Acute Care → End of Life
Diabetes Pathways
Support when diagnosed

• Education – DESMOND – newly diagnosed and refresher DESMOND
• Basal-bolus Insulin conversion group (QA)
• Carbohydrate awareness groups (QA)
• Conferences
• Primary Care – GPs support medication management, diet advice, care plans
• Referral to QA if Super 6 (Antenatal diabetes, Diabetic foot care, Severe renal disease, Inpatient diabetes, Insulin pumps, Adolescents/uncontrolled T1DM – Type 1 diabetes)
• Hypoglycaemia Hotline
• Erectile dysfunction
• Pre-pregnancy diabetes etc etc
Risk identification

• However Prevention pathways currently less defined and developed

• Health Checks – As part of risk assessment, blood glucose test; either as fasting plasma glucose or HbA1c for all identified as high risk indicated by either:
  - BP > 140/90 mmHg where the SBP or DBP exceeds 140mmHg or 90mmHg respectively; OR
  - BM1 > 30 or 27.5 if individuals from Indian, Pakistani, Bangladeshi, other Asian and Chinese ethnicity categories.

• Limitations: 40 – 74 age range; 20% invited; poor data
• Hampshire collaboration to develop cohort?
• Looked at ACG and awaiting local lifestyles surveys
Interventions for individuals at high risk of Type 2 Diabetes

- Portsmouth Wellbeing service - launched on 1st Oct 2015 – early days; pre-diabetes work not explicit but foundation blocks
- Adults 18 and above
- Advice and support on alcohol, smoking, healthy diet and physical activities; client centred holistic approach. Wellbeing cross cutting theme.
- NICE guidance 38 Preventing type 2 diabetes: risk identification and interventions for individuals at high risk
- Assets based approach – looking at increasing self confidence, resilience – individuals and communities
- Volunteers and apprentices
- Target most deprived neighbourhoods and communities
## Interventions for people at high risk of Type 2 diabetes

<table>
<thead>
<tr>
<th>Recommendation 11 Raising awareness of importance of PA &amp; 12 Providing tailored advice on PA</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Benefits of Physical activity</td>
<td>X</td>
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<tr>
<td>Tailor made plan to meet recommended minimum and fit in their daily lives</td>
<td>X</td>
<td></td>
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<tr>
<td>Identify sedentary, moderate and vigorous physical activity</td>
<td>x</td>
<td></td>
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<tr>
<td>Refer to exercise referral scheme if structured needed</td>
<td>x</td>
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<tr>
<td>Provide opportunities in local opportunities for physical activity – camera group, allotment, Fit4change</td>
<td>x</td>
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NICE guidance 38
Interventions for people at high risk of Type 2 Diabetes

<table>
<thead>
<tr>
<th>Recommendation 13 Weight management advice &amp; 14 Dietary advice</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Advise and encourage weight loss gradually by reducing their calorie intake</td>
<td>X</td>
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<td>Evidence-based behaviour-change techniques</td>
<td>X</td>
<td></td>
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<tr>
<td>Motivate and support overweight and obese people to lose weight and can maintain healthy BMI</td>
<td>X</td>
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<tr>
<td>Encourage people to check their weight and BMI periodically</td>
<td>X</td>
<td></td>
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<tr>
<td>Encourage increase high fibre food fruits and vegetables</td>
<td>X</td>
<td></td>
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<tr>
<td>Choose foods that are lower in fat and saturated fat</td>
<td>X</td>
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## Interventions for individuals at high risk

<table>
<thead>
<tr>
<th>Recommendation 10 Evaluation of Interventions</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>Evaluate health outcomes 3, 6, 12 month</td>
<td>X (depending on client’s needs)</td>
<td></td>
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<tr>
<td>Changes in amount of moderate to vigorous Physical activity</td>
<td>x</td>
<td></td>
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<tr>
<td>Dietary Intake</td>
<td>x</td>
<td></td>
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<tr>
<td>Changes in weight, waist circumference or BM1</td>
<td>x</td>
<td></td>
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<tr>
<td>Changes in fasting plasma glucose or HBA 1c levels</td>
<td></td>
<td>x</td>
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Prevention – further work needed

• Rapid Participatory Appraisals findings and engagement to shape this prevention plan
• Looking at self help and peer support models (desktop lit & mapping current provisions)
• Building relationships with Diabetes team Diabetes UK pharmacies, GP practices, voluntary sector
• Needs a Pre-diabetes strategy and action plan that joins up the pathways
• Reviews type of education for clients – not one size fits all? Vulnerable groups: Learning disabilities, Severe Mental health problems Physical and sensory disabilities, mobile communities, offenders homeless
Prevention – further work

- Education to be supported by practical support and activities in communities e.g. cookery skills, reading food labels
- Training for staff in Wellbeing Staff and volunteers on Diabetes
- Information Sharing agreements and protocols for early identification and joined up support
- Portsmouth Information and Advice strategy aims to have one stop information service on all assets
- Resources needed as Portsmouth is not a demonstrator site of National Diabetes Prevention programme
Pre diabetes work in Portsmouth

• Early stage
• Can any of this be done on a county level?
• Any lessons we can learnt elsewhere?
• Any questions?

Thank you.

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