Staffordshire and Stoke-on-Trent

Focus on Healthy Lifestyles – Diabetes Prevention

November 2015

Staffordshire Observatory

Contents

1 Purpose of Report

Performance against healthy lifestyle indicators such as excess weight, inactivity and healthy eating are a continued cause of concern in Staffordshire, particularly as trends also show a continued increase in diabetes prevalence.

The current estimated cost to the local health and care system as a result of diabetes is £222 million every year, which if current trends go unaddressed, is predicted to increase to £273 million by 2020.

The purpose of this report is to provide members of the Health and Wellbeing Board with an overview of healthy lifestyles in Staffordshire and Stoke-on-Trent based on key performance indicators to inform the development of the:

- prevention and early intervention objectives of the Health and Wellbeing Board
- "Fit & Well" work stream of the Collaborative Commissioning Congress

The report looks at the implications of performance in this area on the health economy and wider public sector through a particular look at the prevalence of diabetes. Specifically the report explores:

- performance of healthy lifestyle indicators in Staffordshire and Stoke-on-Trent
- the contribution of lifestyle factors to prevent or delay the onset of diabetes
- the projected costs to the Staffordshire and Stoke-on-Trent health economy should trends in obesity and unhealthy lifestyles go unaddressed
- the current provision of healthy lifestyle programmes and interventions
- public perceptions, patient experience, knowledge and awareness

2 How Healthy are we?

Overall life expectancy at birth continues to increase both locally and nationally with men and women in Staffordshire living on average for 80 years and 83 years respectively. Life expectancy in Stoke-on-Trent is lower than average: 77 years for men and 81 years for women.

Overall health across Staffordshire and Stoke-on-Trent is improving. The rate of preventable deaths decreased by 27% between 2001-2003 and 2012-2014 and early deaths rates from heart disease and cancer have also fallen.

These reductions can be attributed to a combination of factors, for example, the success of the prevention initiatives and campaigns run both locally and nationally including smoking cessation services, tobacco control measures and cancer screening programmes. They are also the result of quicker and more effective treatments, improved partnership working and greater public understanding of the criteria for healthy living.

These improvements demonstrate that behaviours can be changed and that the number of years spent in good health can be increased. However, not everyone is benefiting from these improvements and inequalities across Staffordshire and Stoke-on-Trent continue to exist. Men and women who are residents in the most deprived areas of Staffordshire live seven and six years less than those in the least deprived areas, whilst the difference in Stoke-on-Trent is 10 years for men and six years women.

Advances in care mean that people are living longer with diseases. A key measure of the quality of life years is healthy life expectancy (HLE) which in Staffordshire is 63 years for both men and women, similar to the national figure but below the average retirement age. In contrast men in Stoke-on-Trent have a lower HLE of 61 years whilst HLE for women is even younger at 59.

At a CCG level, HLE is also lower than average in Cannock Chase and North Staffordshire. In addition people living in the most deprived areas of Staffordshire and Stoke-on-Trent have a HLE which is 12-13 years lower than those living in less deprived areas.

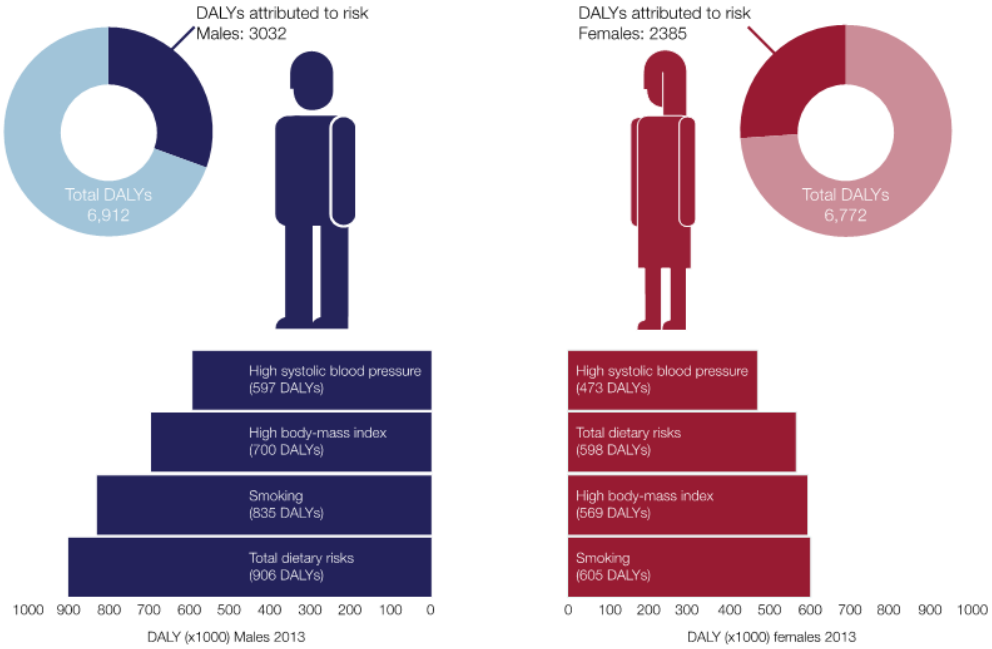
Unhealthy lifestyles are associated with the prevalence of disease and mortality. The recently published Global Burden of Disease (GBD) Study 2013 found that risk factors such as unhealthy diets, smoking, obesity and hypertension (high blood pressure) accounted for 40% of ill-health and early deaths (measured by disability adjusted life years, DALYs)[1] in England (Figure 1).

The study found that an unhealthy diet made up 10.8% of all DALYs, overtaking smoking (10.7%) as the largest contributor to ill-health and premature mortality across England. Figure 2 also shows that having a high body mass index followed by high glucose levels are the largest contributors to the time people spend in 'ill-

[1] Disability adjusted life years (DALYs) are a way of expressing burden of ill-health and is a combination of the number of years in poor health plus the number of years of life lost

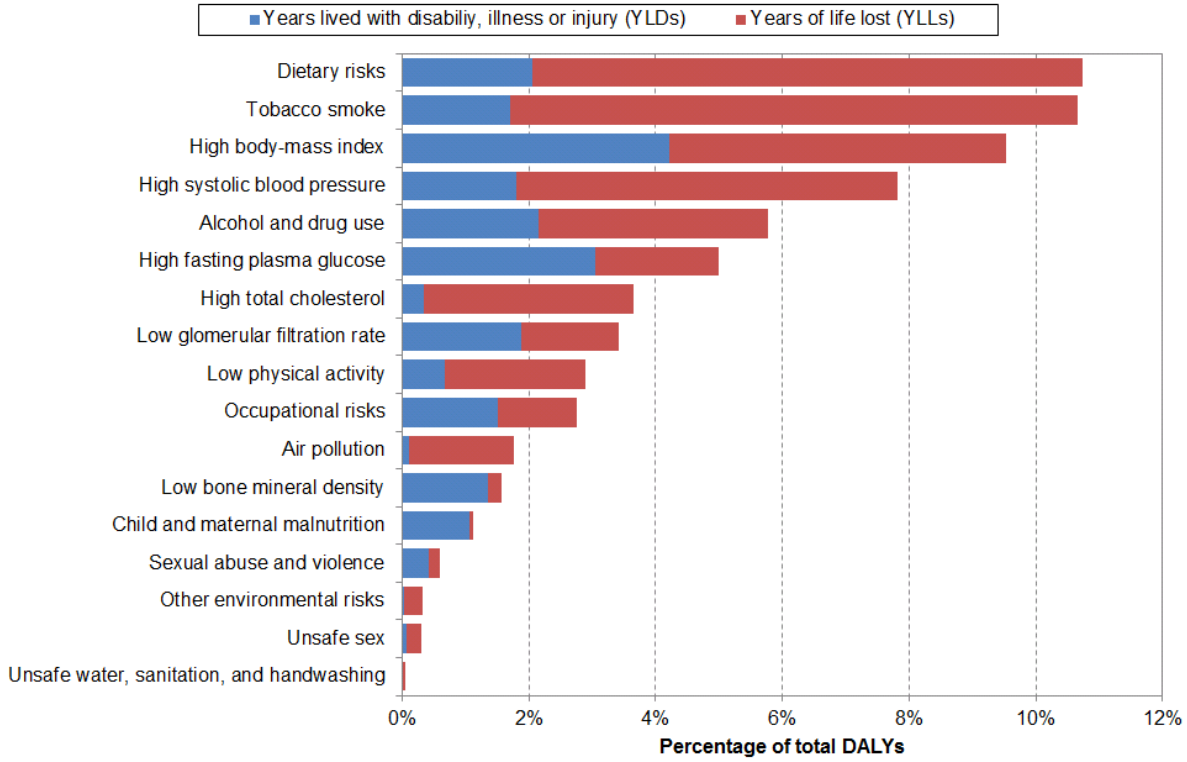
health'. The GBD study also found that **apart from diet**, the majority of risk factors contributing to the burden of disease have shown some improvements.

Figure 1: DALYs attributed to largest risk factors by gender, 2013



Source: Newton, John N et al. Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet, September 2015

Figure 2: Risk factors responsible for ill-health (DALYs) in England, 2013



Source: Newton, John N et al. Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet, September 2015

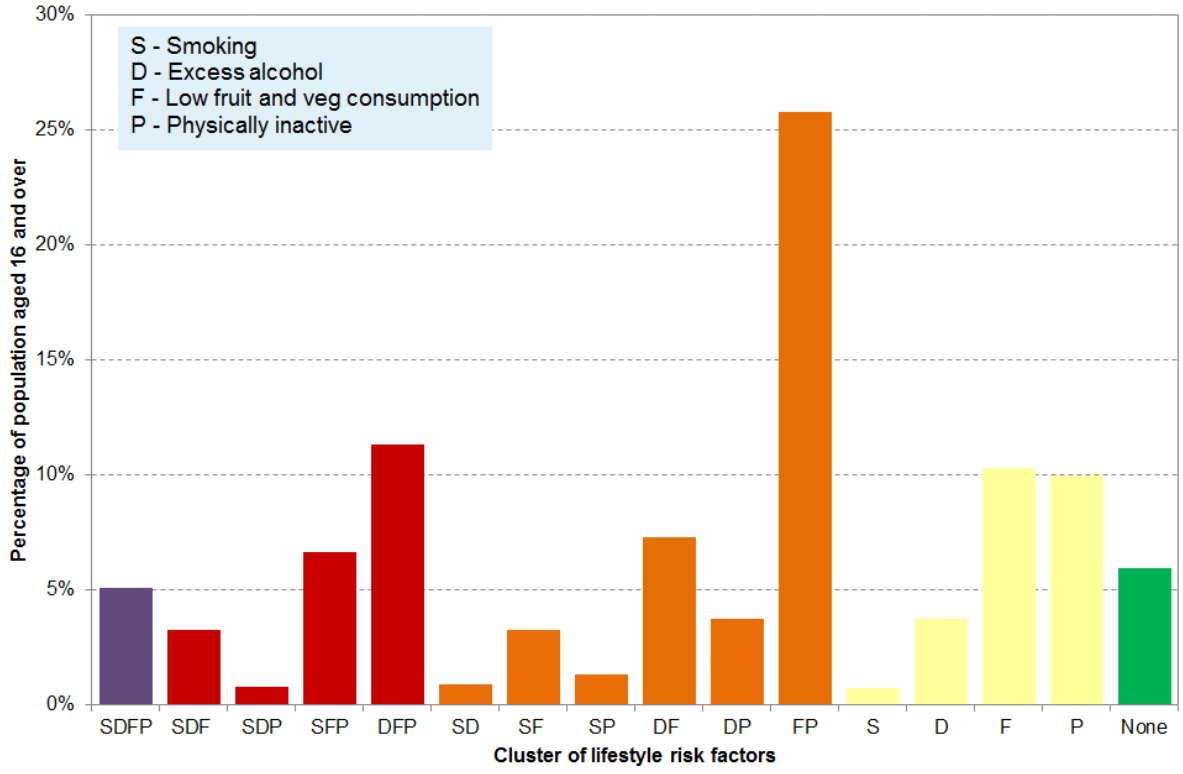
People with one lifestyle risk factor are also likely to have others as well. A King's Fund report based on the 2008 Health Survey for England found that:

- only 6% of the adult population have no lifestyle risk factor (Figure 3)
- 69% engage in two or more unhealthy behaviours
- people from deprived communities are five times more likely to engage in all four unhealthy lifestyle behaviours leading to inequalities in health outcomes
- engaging in all four unhealthy behaviours means your life expectancy is around 14 years shorter than those who engage in none of the four unhealthy lifestyle behaviours (Figure 4).

Likewise people with one long-term condition also have others with the proportion of multiple conditions being more prevalent in deprived communities and older people (Figure 5). National estimates also suggest that there is a rising demand for the prevention and management of people with multiple conditions rather than single conditions.

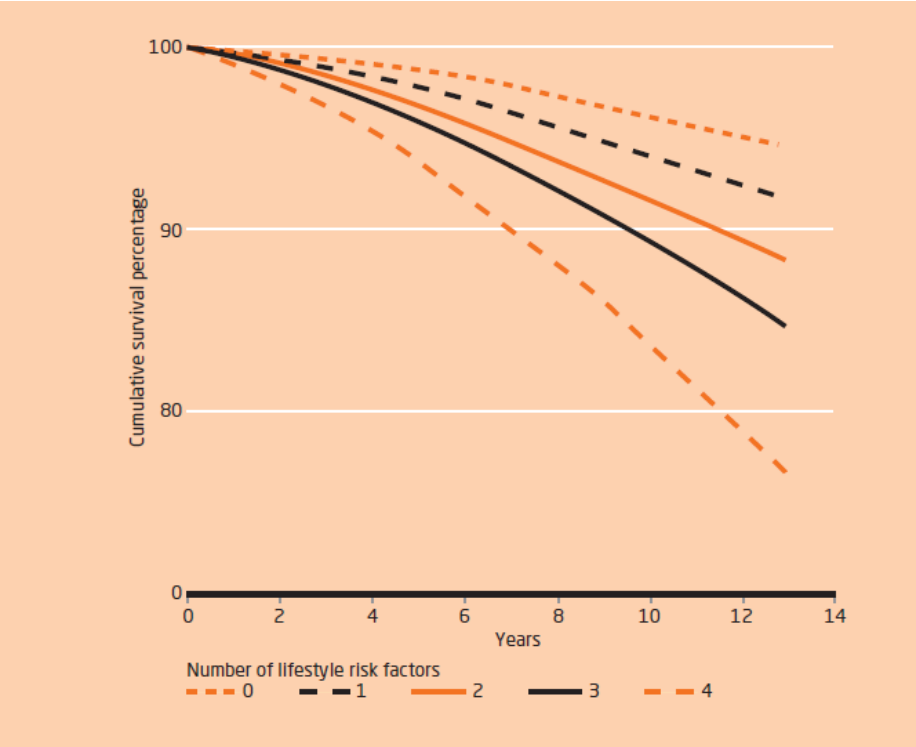
The remaining sections of this report focus primarily on healthy eating and physical activity and their role in preventing, delaying and managing diabetes and other long-term conditions.

Figure 3: Prevalence of combinations of multiple lifestyle risk factors, 2008



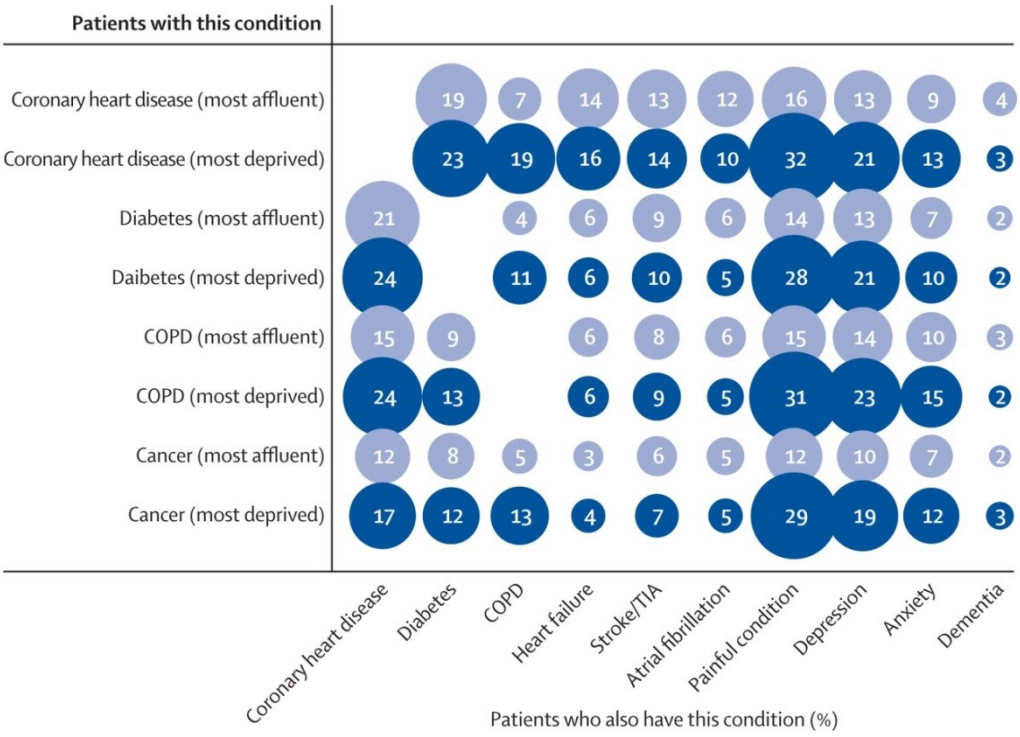
Source: Buck D and Frosini F, Clustering of unhealthy behaviours over time- implications for policy and practice, The Kings Fund, August 2012

Figure 4: The relationship between multiple lifestyle risks and mortality



Source: Buck D and Frosini F, Clustering of unhealthy behaviours over time - implications for policy and practice, The Kings Fund, August 2012

Figure 5: Multi-morbidity and deprivation



Source: Barnett K, Mercer SW, Norbury M, Watt G, Wyke S and Guthrie B (2012). Research paper. Epidemiology of multi-morbidity and implications for health care, research and medical education: a cross-sectional study. The Lancet online

3 The Case for Change in Staffordshire and Stoke-on-Trent

The increasing burden of unhealthy lifestyles that contribute to the development or early onset of preventable diseases is one of the largest pressures on health and care resources both locally and nationally. Other factors include:

- demographic changes in the population, i.e. an ageing profile, particularly in the very old age groups
- annual costs of health and care are disproportionally high for people with long-term conditions, some of which is driven by multi-morbidities, for example there has been rapid growth in hospital activity levels amongst older people, more so than the growth in numbers would allow for
- newer improved treatments coming onto the market which are more expensive and are taken for longer periods
- greater public expectations and rising demand for services

Additional costs are incurred to people who are morbidly obese (Table 1).

Table 1: The implications of obesity and social care

Adults with severe obesity may have physical difficulties which inhibit activities of daily living. This can have resource implications for social care services including:

- housing adaptations such as specialist mattresses, doors, toilet frames, hoists and stair lifts
- specialist carers (trained in manual handling of severely obese people) for people who are house bound and have difficulties caring for themselves
- provision of appropriate transport and facilities (such as bariatric patient transport and specialist leisure services)

Source: Social care and obesity – a discussion paper, © Local Government Association, October 2013

Diagnosed diabetes prevalence in both Staffordshire and Stoke-on-Trent has increased from 5.9% (43,700 cases) in 2006/07 to 7% in 2014/15 (64,600 cases). Some of the increases are due to improvements in awareness, early diagnosis and recording however based on current obesity trends, the prevalence of diabetes is predicted to continue to increase and will be 8.7% by 2020 and 11.3% by 2030.

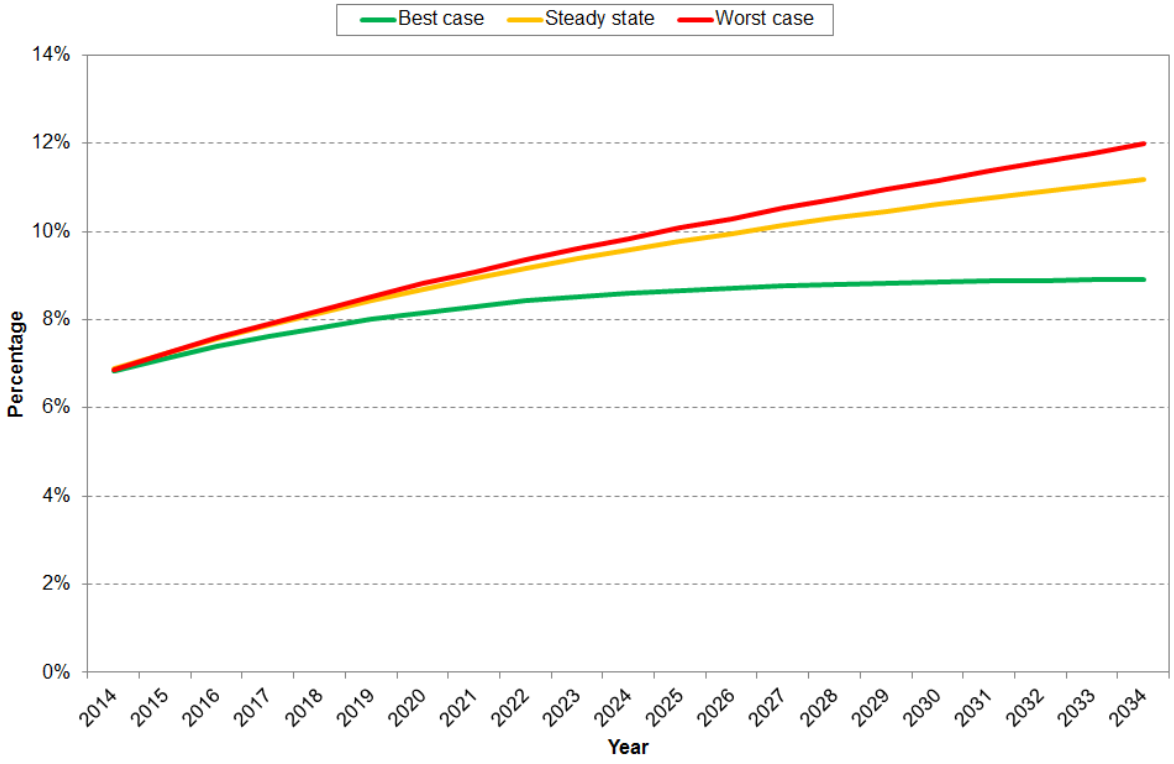
Based on estimates from Diabetes UK the current cost to the local NHS as a result of diabetes is currently £205 million, predicted to increase to £252 million and £328 million by 2020 and 2030 respectively. Around 80% of these costs are due to complications (e.g. inpatient days).

One in 20 people with diabetes also incurs social care costs due to complications such as heart disease, stroke, blindness, kidney disease and amputations, with 75% of these resulting in residential and nursing care and the remaining being community based. Estimates from Diabetes UK suggest that the total cost of caring for people with diabetes in adult social care settings in Staffordshire and Stoke-on-Trent is £17 million per year, predicted to rise to £21 million and £27 million by 2020 and 2030 respectively. Research also indicates that around one in four people living in care homes have diabetes.

Figure 6 shows the prevalence of diabetes modelled against three scenarios: the 'steady progress' scenario which is based on more recent trends which are at a smaller rate of increase than the trend predicted by Foresight in 2007, the 'best case' scenario which assumes that obesity, after adjustments to demographics, will revert to prevalence levels in 1993 (around 13% for men and 16% for women) and the 'worst case' scenario which shows what could happen if nothing is done to tackle the risk factors and obesity prevalence continues to increase as rapidly as it did between 1993 and 2011.

The biggest gain in reducing or delaying the onset of diabetes and other long-term conditions are through reductions in the mean population body mass index (BMI). **Local data suggests that excess body weight is the most prevalent risk factor across Staffordshire and Stoke-on-Trent.**

Figure 6: Modelled diabetes prevalence in England



Source: Risk factor based modelling for Public Health England. UK Health Forum, July 2014

Our performance

Around one in ten children in Staffordshire and Stoke-on-Trent aged four to five are obese which doubles to one in five by the time they are 11. Around two in three adults in Staffordshire and Stoke-on-Trent have excess weight, whilst one in four are obese with rates being higher than the national average. The Public Health Outcomes Framework also reports higher levels of physical inactivity and poor diets locally.

Obesity costs the local NHS around £86 million due to the impact on associated diseases such as diabetes and heart disease whilst physical inactivity is thought to cost £23 million every year. As evidenced in the annual report of the Director of Public Health for Staffordshire, the impact of unhealthy lifestyles also has a significant detrimental impact in older age including increased risk of physical frailty, falls, strokes and malnutrition which creates additional health and care needs in later life.

Similar to national trends, the prevalence of smoking across Staffordshire and Stoke-on-Trent continues to reduce, although there are higher rates among deprived communities. The annual cost of smoking to health, care and the wider economy in Staffordshire and Stoke-on-Trent is thought to be around £272 million.

Harmful drinking also reduces HLE due to its associated risk with hypertension, cardiovascular diseases, cancer, cirrhosis, mental illnesses and injury. Alcohol consumption is also associated with excess weight. Around a fifth of Staffordshire and Stoke-on-Trent adults are estimated to be drinking at levels that are harmful with alcohol-related harm creating over £70 million of health costs.

Stoke-on-Trent in particular is worse than the national average for numerous healthy lifestyle indicators (Table 2). With the exception of smoking, Staffordshire also performs worse than expected against its peers. In addition the absolute numbers of people engaging in unhealthy lifestyles is significant across both Staffordshire and Stoke-on-Trent.

As well as improving the quality of life years to an individual promoting good health and preventing ill-health offers long-term financial savings to the health and care economy.

Table 2: Summary of health and lifestyle performance

	Time period	Indicator value			Rank of 16 (where 1 = best performing against peers)[2]	
		Staffordshire	Stoke-on-Trent	England	Staffordshire	Stoke-on-Trent
Life expectancy – men (years)	2012-2014	79.7	76.6	79.5	9	14
Life expectancy – women (years)	2012-2014	83.2	80.9	83.2	10	8
Healthy life expectancy - men (years)	2011-2013	62.8	60.9	63.3	12	4
Healthy life expectancy - women (years)	2011-2013	63.4	58.9	63.9	14	9
Preventable mortality	2012-2014	176	251	183	10	9
Smoking in pregnancy	2014/15	11.2%	18.9%	10.7%	3	13
Smoking prevalence (children aged 15)	2014/15	7.9%	12.5%	8.2%	4	16
Smoking prevalence (adults aged 18 and over)	2014	13.7%	18.7%	18.0%	1	3
Smoking prevalence in manual workers (adults aged 18 and over)	2014	22.3%	25.2%	28.0%	1	2
Alcohol-related admission rate (narrow definition) (ASR per 100,000)	2014/15 provisional	691	983	638	13	16
Successful completion of drug treatment - opiate users	2014	5.0%	3.6%	7.4%	14	16
Successful completion of drug treatment - non-opiate users	2014	33.8%	50.0%	39.2%	10	4
Excess weight (children aged four to five)	2014/15	23.1%	24.7%	21.9%	14	12
Excess weight (children aged 10-11)	2014/15	33.4%	39.4%	33.2%	15	14
Obesity (children aged four to five)	2014/15	9.1%	10.7%	9.1%	10	10
Obesity (children aged 10-11)	2014/15	18.7%	24.4%	19.1%	14	15
Adults who are overweight or obese (excess weight)	2012-2014	68.6%	68.6%	64.6%	14	8
Adults who are obese	2012-2014	26.2%	29.7%	24.0%	14	12
Fruit and vegetable consumption - proportion meeting recommended 5-a-Day	2014	52.9%	47.0%	53.5%	15	11
Physical activity in adults	2014	54.1%	51.6%	57.0%	16	7
Physical inactivity in adults	2014	28.5%	35.4%	27.7%	15	12

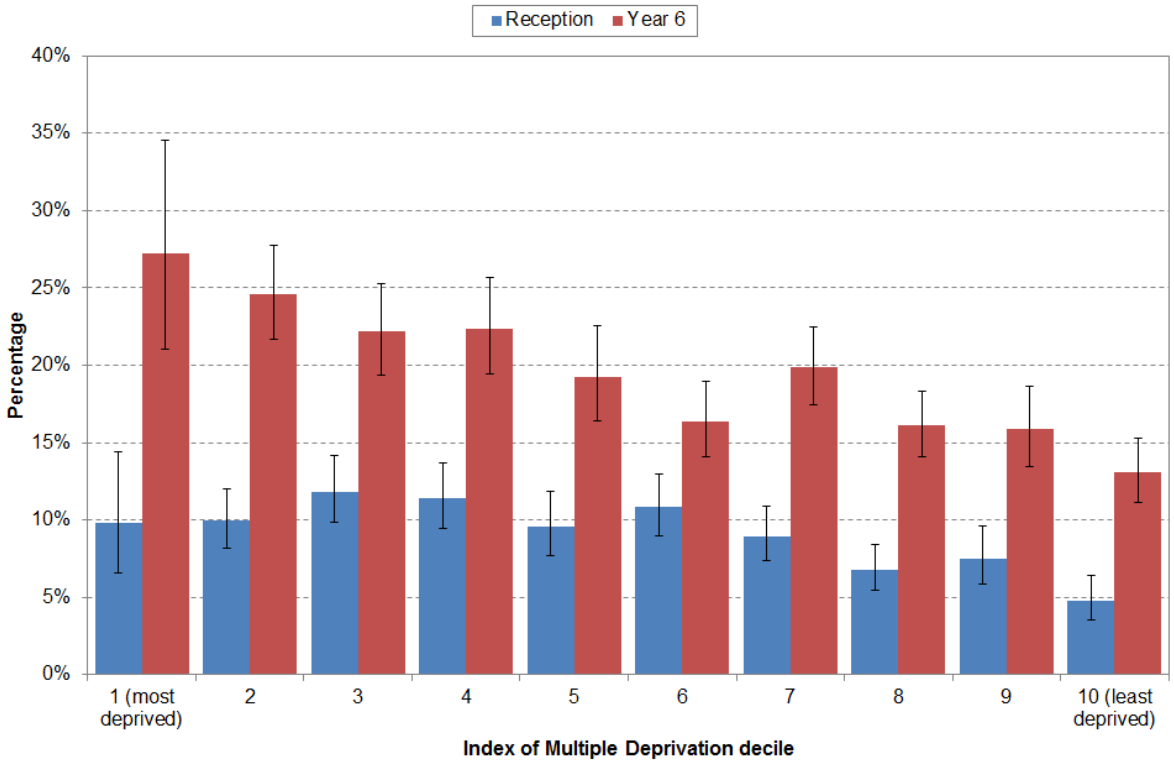
Compiled by Insight Team, Staffordshire County Council

[2] Staffordshire comparator group = Cambridgeshire, Cumbria, Derbyshire, Essex, Gloucestershire, Kent, Lancashire, Leicestershire, Lincolnshire, Norfolk, Northamptonshire, Nottinghamshire, Somerset, Warwickshire and Worcestershire. Stoke-on-Trent comparator group = Bolton, Doncaster, Gateshead, Halton, Kingston upon Hull, Knowsley, Middlesbrough, Oldham, Rochdale, Rotherham, Salford, Sandwell, St. Helens, Tameside and Wigan

The health inequalities seen across Staffordshire in terms of life expectancy and healthy life expectancy are due to multiple underlying factors such as education, employment and housing as well as lifestyles and access and the quality of preventative and treatment services.

People with unhealthy lifestyles tend to be found in more deprived communities, for example childhood obesity in Staffordshire is twice as prevalent in deprived areas compared to less deprived areas (Figure 7). Note: A map showing deprived areas is shown in Appendix 1.

Figure 7: Childhood obesity by deprivation in Staffordshire, 2014/15



Source: National Child Measurement Programme (NCMP) data extract

It is also important to note that there are groups of individuals that also have higher prevalence of unhealthy lifestyles, for example smoking, alcohol consumption and obesity levels among people with a mental health condition are significantly higher than average. Engaging in unhealthy behaviours is also linked to increased risk of poor mental wellbeing in the future.

These groups are all at increased risk of developing long-term conditions such as diabetes, heart disease, cancer and respiratory and as a result also have shorter lives. There is also some evidence of increasing rates of diabetes type 2 developing amongst young children.

4 Making a Difference

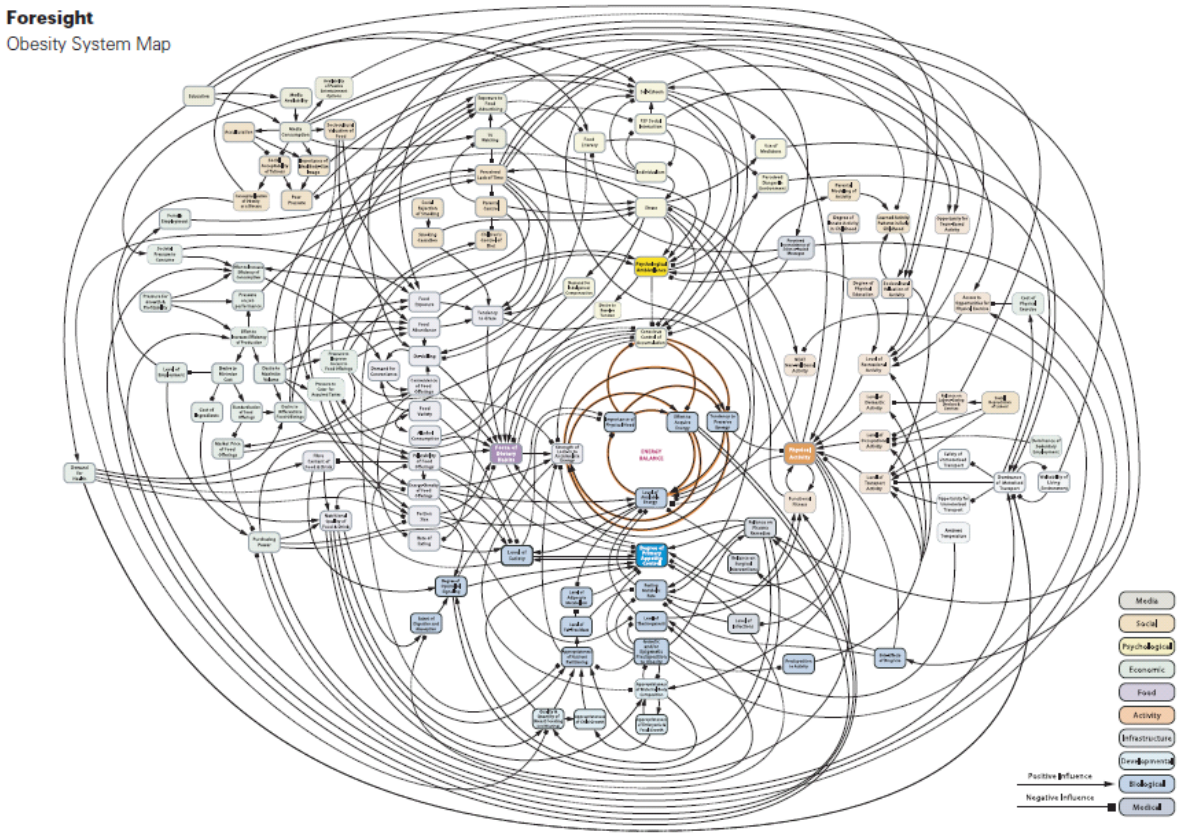
Complexity of obesity

Reducing obesity is complex as illustrated in Figure 8 and requires a whole system approach.

> *"The obesity epidemic cannot be prevented by individual action alone and demands a societal approach. Tackling obesity requires far greater change than anything tried so far, and at multiple levels: personal, family, community and national"*

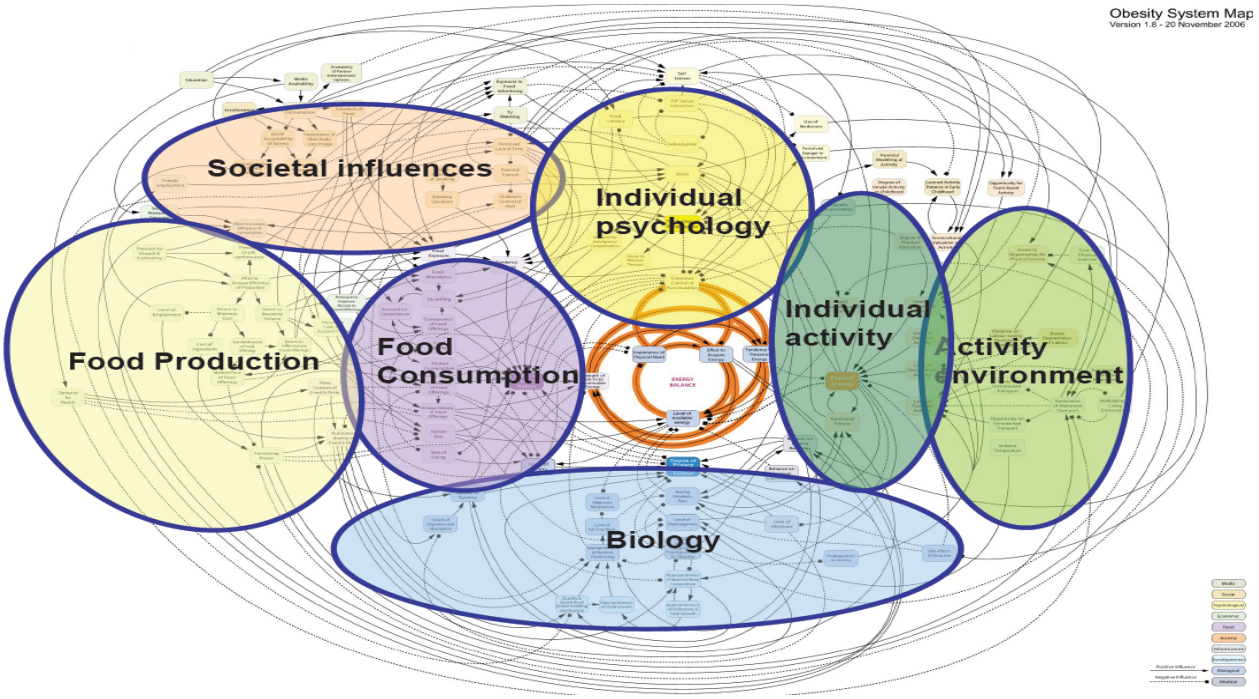
Source: Foresight 2007

Figure 8: Obesity system map



Source: https://www.gov.uk/government/collections/tackling-obesities-future-choices

Figure 9: Obesity system map (simplified version)



Source: Public Health England and https://www.gov.uk/government/collections/tackling-obesities-future-choices

As illustrated in Figure 9 obesity is influenced by a huge array of factors that extend far beyond the reach of more formal weight management programmes and pathways and can broadly be divided into seven cross-cutting predominant themes:

1. **Biology:** an individual's starting point - the influence of genetics and ill health
2. **Individual psychology:** for example a person's individual psychological drive for particular foods and consumption patterns, or physical activity patterns or preferences
3. **Societal influences:** the impact of society, for example the influence of the media, education, peer pressure or culture
4. **Activity environment**: the influence of the environment on an individual's activity behaviour, for example a decision to cycle to work may be influenced by road safety, air pollution or provision of a cycle shelter and showers
5. **Individual activity:** the type, frequency and intensity of activities an individual carries out, such as cycling vigorously to work every day
6. **Food consumption:** the quality, quantity (portion sizes) and frequency (snacking patterns) of an individual's diet
7. **Food production (environment):** the influence of the food environment on an individual's food choices, for example a decision to eat more fruit and vegetables may be influenced by the availability and quality of fruit and vegetables near home

Therefore in order to positively impact on obesity, a co-ordinated system-wide approach involving a range of partners with shared outcomes is required (Figure 10).

Figure 10: Local partners involved in obesity system

Source: Public Health England

A range of interventions and their cost effectiveness is shown in Table 3. NICE suggest that anything less than £20,000 per DALY or quality adjusted life years (QALY) saved is considered cost effective. The evidence base of local action from NICE guidelines is shown in Appendix 2.

Table 3: Cost-effectiveness of selected healthy lifestyle interventions

Intervention	Cost per DALY / QALY
Diet and nutrition	
Breastfeeding support from trained staff and peers	Cost saving
Regulation of food content	Cost saving
Pricing (fiscal measures) (fruit and veg subsidies)	Cost saving
Food advertising regulation (restrictions to children)	£2,941 (DALY)
Food labelling (traffic light scheme and education)	£3,622 (DALY)
Mass media campaigns (fruit and veg campaigns via local and national TV, radio and community)	£9,486 (DALY)
GP counselling	£10,816 (DALY)
Worksite health promotion interventions (nutritionist input and training of peer educators and food service staff)	£14,099 (DALY)
School-based interventions (involving extracurricular activities, training teachers and food service staff)	> £100,000 (DALY)
Physical activity	
Walking programme	£686 (QALY)
Workplace physical activity counselling	£864 (QALY)
Walking buses (to school)	£4,007 (QALY)
Urban trail	£10,445 (QALY)
Dance classes	£27,570 (QALY)
Free swimming	£40,462 (QALY)
Community sports	£71,456 (QALY)
Weight management	
Family based interventions (targeting multiple behaviours in females aged seven to 12 years)	£1,826 (QALY)
Joint physician and dietitian intervention	£3,876 (DALY)
Diet, exercise and behaviour modification	£6,711 (QALY)
Physician only intervention	£11,204 (DALY)
Commercial weight management programme (Weight Watchers)	£11,789 (DALY)
12 week 1:1 or group intervention following an NHS health check	£13,564 (QALY)
GP brief intervention	Cost effective but limited impact on weight

Source: Liverpool Public Health Observatory: Prevention programmes cost-effectiveness review series: diet and healthy eating, Cost effectiveness review series - number 3 and NICE

Diabetes prevention

There is a good evidence base for the effectiveness of diabetes prevention programmes (Table 4). Those combining interventions aimed at the whole population (such as environment and economic policies) with those targeting individuals at increased risk (such as lifestyle programmes) are likely to slow the rate of increase.

Table 4: What does good diabetes prevention look like?

There are a number of preventable risk factors for developing or delaying the onset of type 2 diabetes: obesity, high cholesterol levels and high blood pressure. Stopping smoking and reducing alcohol intake also help to lower the risk of developing type 2 diabetes. Early intervention to prevent type 2 diabetes should be considered as part of an integrated package of local measures to promote health and prevent a range of long-term conditions including cardiovascular disease and some cancers.

Lifestyle interventions aimed at changing an individual's diet and increasing the amount of physical activity they do can halve the number with impaired glucose tolerance who go on to develop type 2 diabetes. However, the greatest impact on the levels – and associated costs – of type 2 diabetes is likely to be achieved by addressing these behavioural risk factors in whole communities and populations.

Pre-diabetes that is identified early on can be reversed and prevented from progressing into full-blown type 2 diabetes. Evidence from the diabetes prevention programme conclusively shows that people with pre-diabetes can be prevented through lifestyle changes, i.e. making changes to diet and increasing exercise. The main elements to diabetes prevention include:

- Proactive identification of high risk patients and those with pre-diabetes, for example through NHS health checks
- Commissioning risk assessment and intensive lifestyle-change programmes
- Provision of intensive lifestyle change programmes to modify diabetes risk
- Awareness raising of physical activity (e.g. through mass media campaigns)
- Weight management and dietary advice
- Training and professional development

The NHS Diabetes Prevention Programme is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver at scale, an evidence based behavioural programme to support people to reduce their risk of developing type 2 diabetes. Staffordshire and Stoke-on-Trent CCGs and local authorities have recently expressed an interest to become first wave implementers of the national programme.

Source: NICE Type 2 diabetes prevention: population and community-level interventions, http://www.nice.org.uk/guidance/ph35 and Type 2 diabetes: prevention in people at high risk, http://www.nice.org.uk/guidance/ph38 and Evidence Update 66, October 2014

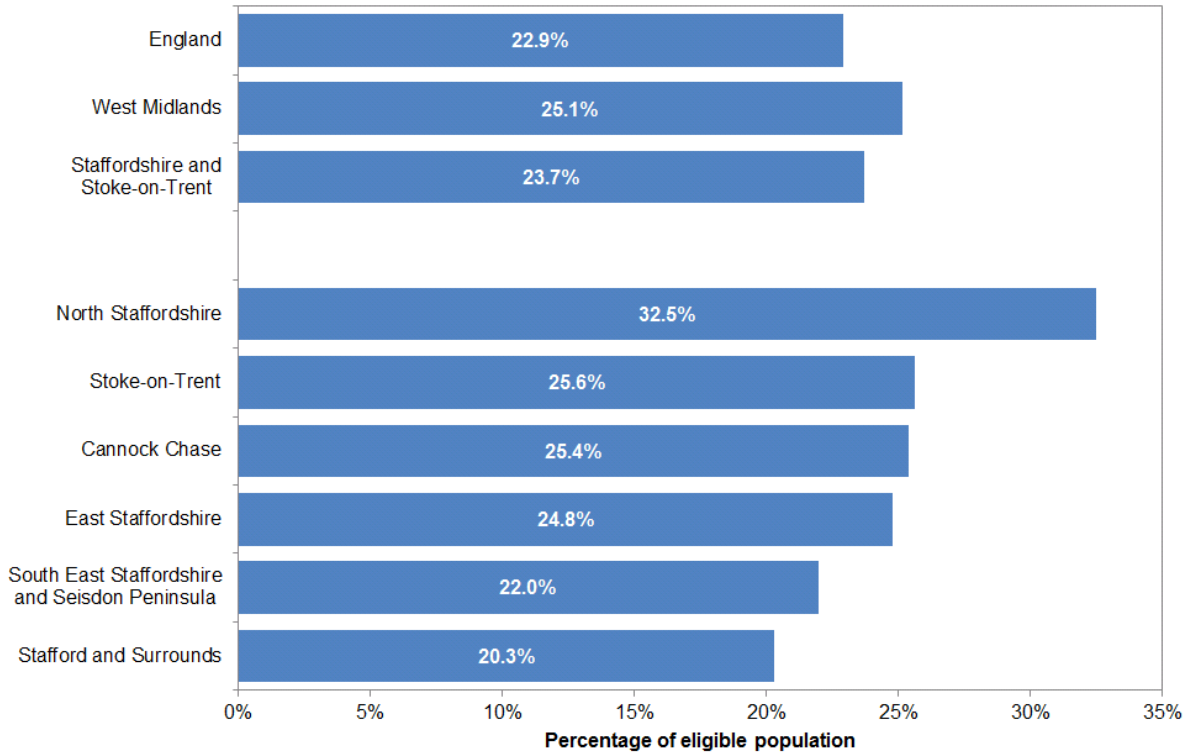
Identifying people at an increased risk of type 2 diabetes is key to preventing the onset of the disease. Across Staffordshire and Stoke-on-Trent around 12% (106,400 people) of those aged 16 and over are estimated to have pre-diabetes (non-diabetic hyperglycaemia) of which 5-10% will go on to develop type 2 diabetes every year (over 5,000 people).

One of the aims of the NHS health checks programme is to identify people at risk of developing diabetes and give them support and advice to reduce that risk. Evidence suggests that lifestyle modification can be beneficial in preventing type 2 diabetes in adults who have been identified as being at high risk of developing the disease.

There are an estimated 345,900 people who are eligible for an NHS health check over a five year period. The proportion of those eligible who have had a NHS health check between 1 April 2013 and 30 September 2015 was 24% compared to the England average of 23%. However, there were inequalities across Staffordshire and Stoke-on-Trent (Figure 11).

Based on local data around one in ten people who had a NHS health check were diagnosed with pre-diabetes.

Figure 11: Uptake of NHS health checks by CCG, April 2013 to September 2015



Source: NHS health checks local data collection, Staffordshire County Council and Public Health England

Tailoring behaviour change to meet individual need

Current research indicates only 40% of the population are highly motivated to adopt healthier lifestyles. The Patient Activation Measure (PAM) is a patient-reported measure that has been validated in the United Kingdom. It is a powerful and reliable measure of patient activation.

Patient activation scores can be used to predict a number of health behaviours. They are closely linked to clinical outcomes, health care costs and patient experience. Highly activated patients are more likely to adopt healthy behaviours, to have better clinical outcomes and lower rates of hospitalisation. They also report higher levels of satisfaction with services.

Table 5: Patient activation levels and tailoring support

Activation level	Characteristics	Tailoring support
Level 1 (low activation)	Individuals tend to be passive and feel overwhelmed by managing their own health. They may not understand their role in the care process	Focus on building self-awareness and understanding behaviour patterns, and begin to build confidence through small steps. What a coach might say: 'Let's not try to tackle everything right now. Let's just focus on one thing…'
Level 2	Individuals may lack the knowledge and confidence to manage their health.	Help patients to continue taking small steps, such as adding a new fruit or vegetable to their diet each week or reducing their portion sizes at two meals a day. Help them build up their basic knowledge. What a coach might say: 'You're off to a great start. Let's build on your success by reducing your portion sizes at lunch time too…'
Level 3	Individuals appear to be taking action but may still lack the confidence and skill to support their behaviours.	Work with patients to adopt new behaviours and to develop some level of condition-specific knowledge and skills. Support the initiation of new 'full' behaviours (those that are more than just small changes – e.g. 30 minutes of exercise three times a week) and work on the development of problem-solving skills. What a coach might say: 'You're making great strides. Do you think you're ready to take your efforts up one notch?'
Level 4 (high activation levels)	Individuals have adopted many of the behaviours needed to support their health but may not be able to maintain them in the face of life stressors.	Focus on preventing a relapse and handling new or challenging situations as they arise. Problem solving and planning for difficult situations to help patients maintain their behaviours. What a coach might say: 'You've had terrific success. Let's talk about how you can maintain that, even when life gets more stressful.'

Source: Hibbard J and Gilburt H. Supporting people to manage their health: An introduction to patient activation, The Kings Fund, May 2014

National research into the prevalence of activation levels in US adults highlights that activation levels differ considerably across population, socio-economic and health status characteristics, for example older people, some minority ethnic groups, people with low educational attainment, people on lower incomes and those with long-term conditions are more likely to have lower activation levels than average. Around one fifth of the population have low activation levels whilst around three in ten obese people have low activation levels (Table 6).

Table 6: Adult population by patient activation levels

	Level 1 (very low)	Level 2 (low)	Level 3 (high)	Level 4 (very high)	All adults
All adults aged 18 and over	6.8%	14.6%	37.2%	41.4%	100%
People with long-term conditions	8.6%	17.3%	34.0%	40.2%	100%
Smokers	14.7%	17.4%	33.3%	34.6%	100%
Obese	10.1%	19.6%	32.9%	37.4%	100%

Source: Hibbard JH and Cunningham PJ, How engaged are consumers in their health and health care, and why does it matter. HSC Research Brief No. 8, October 2008, http://www.hschange.com/CONTENT/1019

5 Knowledge, Awareness and Experience

What do residents think are the largest health and wellbeing issues?

- In terms of public opinion, data from the winter 2014 wave of Public Perceptions of the NHS and Social Care Tracker Survey conducted by Ipsos Mori found that when asked "what are the biggest health problems facing people today", cancer (35%) and obesity (33%) and age-related illnesses (23%) continued to feature as the top three.

- Concern around diabetes and mental health has however risen over the last year. Around 19% of people now name diabetes as one of the biggest health problems facing people today, compared with 14% in winter 2013 whilst mental health has risen from 11% to 15% over the same period. Alcohol abuse (16%) also continues to feature as one of the top issues.

- The majority of people recognise the Government's role in supporting people to live healthily. Almost six in ten (59%) agree it is doing more these days to help people live healthier lives whilst one in three (34%) disagree with both views remaining similar over time.

- Data from the latest *Feeling the Difference Survey* (September 2015) identifies substance misuse, alcohol misuse, and anti-social behaviour as the "biggest problems in the local area". Being overweight and smoking also feature in the top five as local problems in Staffordshire and Stoke-on-Trent. People with unhealthy lifestyles also report their health as being poor.

How knowledgeable are residents about lifestyle risk factors?

A poll conducted by Ipsos Mori in February 2015 indicated a high level of public awareness about diabetes as a condition; 73% felt they either knew either a great deal or a fair amount about the condition.

Data collected from a survey conducted by Healthwatch Staffordshire among diabetic patients during October 2015 (n= 34) found:

- A high proportion of people who had developed diabetes were not knowledgeable about the lifestyle risk factors that led to the condition developing, typical comments included "no knowledge at all" and "I didn't realise I was likely to get diabetes."

- Those who had a family history of diabetes were more likely to have an understanding of the lifestyle risk factors.

- Some also felt that recent media coverage of diabetes and associated lifestyle risks and in some cases advice shared by their GP had helped to improve understanding of the condition.

Data from the Citizens Jury North Staffordshire report into diabetes care (March 2015) has also highlighted the need for raising awareness about the risk factors for diabetes.

Levels of awareness of current self-help resources and support services

National research indicates that diabetes education helps people to stay healthy and reduces the number of related complications; however there is little local data on residents' awareness of current self-help resources and what support services are available.

Some respondents to the Healthwatch survey and focus groups referenced their awareness of Diabetes UK, Desmond, local diabetes groups and help through their GP surgeries. There were also a range of other self-help resources referenced by individual respondents including self-help books, forums, social media and advice gleaned through from other aspects of their lives e.g. as a school governor "*the message of healthy eating is communicated well in schools*".

How do people feel about the current diabetes prevention and care pathway?

It was acknowledged that awareness of diabetes, and what could be done to prevent it, was low amongst the general population. It was felt that more should be done to ensure the people understand the link between obesity and diabetes and the level of risk that this presents.

The information in this section is based on data from the Healthwatch survey and other insight collated from focus groups and online enquiries.

Responses reflect a need for more consistent information and advice on diabetes which can be easily understood and incorporated into daily lives. This was considered important to enable people to "take control" and manage their condition. There was also a request for more ongoing support to "follow up" to ensure that information has been correctly interpreted and is helping to manage their condition and lead healthier lives.

Respondents praised national specialist organisations such as Diabetes UK as well as providers of specialist training including the Desmond Day training which provides education and advice on care pathways for those with or at risk from type 2 diabetes.

At a local level is was felt that information and advice was more variable, for example *"advice from local providers has been less consistent"* with some respondents commenting on different experiences where they had changed GP practices. It was also felt that GPs and practice nurses were not always given sufficient time to talk through the diagnosis and how diabetes could potentially be managed through diet and exercise.

Where GPs and nurses had the time to talk, respondents felt this had helped them to manage and improve their condition and become less reliant on medication. These comments were echoed during a focus group with support workers who were

working with GPs to try and change the way the treatment of diabetes was being approached.

What people need in the future

Evidence collated from various sources has indicated the need for more general awareness of the link between lifestyle choices and diabetes, as well as more specific information at the point of diagnosis about how the condition could be managed through diet and exercise.

The Citizens Jury North Staffordshire Report, Diabetes Care in North Staffordshire, March 2015 also provided insight into areas of improvement in the current care pathway which are shown in Appendix 3.

6 What are we doing to Promote Healthy Lifestyles?

Staffordshire
Staffordshire has very recently transformed its approach to supporting lifestyle behaviour change through the introduction of a new programme. This includes:

- the **Healthy Staffordshire Hub** (launched on 1 July 2015):
    - This service provides free telephone and digital based self–help information and apps, brief advice and guidance on lifestyle health issues including: stopping smoking, achieving and maintaining a healthy weight, physical activity and drinking less alcohol. It also signposts or refers for further support as required.
    - This is accessible through self-referral, signposting or healthcare professional referral and offers up to 12 months support for clients.
    - The healthy lifestyle hub is set up to support any client with a body mass index over 25 kg/m^2 with dietary and physical activity support. It also supports individuals whose physical activity levels are below recommended levels and where healthy eating advice and guidance is required.
    - This service is set up to provide support for up to 16,000 individuals.

- the **Staffordshire-wide Healthy Lifestyle Service** (launched on 1 July 2015):

    - This integrated service offers tailored and structured motivational support offered either in groups or one to one offered by suitably trained non-clinical practitioners following NICE guidance that will address single and multiple lifestyle risk behaviours: smoking, excess weight and harmful alcohol intake. This service is also suitable for individuals with non-diabetic hyperglycaemia unless other comorbidities prevent this.
    - It also offers provision of evidence based interventions support sessions including: up to six alcohol brief intervention sessions, 10 to 12 weeks non-clinical weight management support, 10 to 12 weeks stop smoking support with access to stop smoking medications, up to 12 months ongoing support delivered using a variety of contact methods ranging from face to face/ telephone / online / peer support. This includes capacity for 4,220 weight management interventions in Year 1 of the contract for the healthy lifestyle service and for 8,440 in Year 2.

- **Universal and targeted physical activity, community nutrition and alcohol prevention programmes** through locality commissioning partnerships of. The types of programmes include: ‘cook and eat’ sessions, ‘grow it eat it’ opportunities, walking, cycling, exercise for older people and family play activities. These programmes are designed to support those who need to make lifestyle improvements, e.g. those who are sedentary, have a poor diet or are drinking above the recommended alcohol levels, in need of housing advice, debt and employment advice. They are accessible through self-referral or through referral from the Healthy Staffordshire Hub and the Healthy Lifestyle Service.

The current lifestyle system is specifically tailored to meet the needs of population groups at high risk of type 2 diabetes. In Staffordshire, an individual with non-diabetic hyperglycaemia identified through NHS health checks or primary care can be referred or signposted to any part of the lifestyle programme or more specialist support, dependent on the nature and complexity of their lifestyle or medical need. The hub is also set up to accept clients following the end of a community prevention programme or lifestyle service intervention to support long-term behaviour change.

As the new system has only been running for under six months, there is no outcome data available.

Stoke-on-Trent

Since 2008, Public Health Stoke-on-Trent has commissioned an intensive behaviour change service for eligible adults (18 years and over). The lifestyle service is accessed via referral from primary care and secondary care. It offers support to:

- overweight individuals with specified comorbidities / risks (e.g. on mental health, diabetes or heart disease registers
- overweight South Asian individuals
- obese individuals with or without comorbidities
- individuals that the diabetes prevention programme would specifically target, including those with impaired fasting blood glucose levels

In 2010, a randomised controlled trial was conducted to establish the impact of the lifestyle service. The peer reviewed publication indicated that the lifestyle service was most effective for high risk individuals (CVD risk score of 18.5 or higher). Contract monitoring of the service shows that currently half of all referrals are high risk with the remainder being “quota patients”. Quota patients are adults who are overweight who primary care believe will benefit.

A series of KPIs are used to measure the impact of the Lifestyle Service; weight reduction, 5-a-day consumption, physical activity levels, alcohol consumption and smoking status.

The offer made to referrals is up to 12 months of intensive lifestyle support from a lifestyle coach. Coaches reflect the demographics of the local population including a number from the South Asian community. Intensive support can be delivered face to face, via Skype, telephone or using SMS text messages. This support is “gain-framed” (messages use content to explain benefits and reinforce positive choices) to enable clients to make one or more positive changes to their lifestyle, principally diet, physical activity and weight management. Clients with goals to reduce alcohol consumption or to stop smoking are signposted into appropriate local specialist services.

In addition to the support of the lifestyle coach clients are offered group and individual support from four “wrap-around” services, cook and eat (cooking and food budgeting skills), community physical activity (20 weeks of free physical activity), community weight management (12 weeks of free activity) and Think Well session (two sessions of additional behaviour change skills and techniques to support sustained behaviour change).

The current service contract is held by Voluntary Action Stoke-on-Trent (VAST) who employ 22 lifestyle coaches who have the capacity to support 3,000 clients each year. Live clients accessing the lifestyle service have been reported at 1,838 in total in August 2015. Capacity ranges from 200 clients a year within Cook and Eat to 1,100 in the Community Weight Management Programme. At the current time all referrals to the lifestyle service are seen without the need for a waiting list although demand is growing.

As part of the Making Every Contact Count (MECC) initiative, Stoke-on-Trent has in place a single point of access known as the 'Living Well Hub'. The hub handles referrals from any member of health or social care staff trained in MECC. Clients are contacted by training call handlers and are signposted into a range of services to support their behaviour changes goals.

Care and treatment of diabetic patients

All diabetic patients aged 12 years and over should receive nine care processes recommended by National Institute for Clinical Excellence (NICE). Healthcare professionals and patients should also work in partnership to ensure patients achieve their recommended treatment targets for glucose control, blood pressure and blood cholesterol.

Data from the national diabetes audit highlights that only 60% of patients received eight care processes and 36% achieved NICE recommended treatment targets. Performance data also indicates there is inequity in the care and treatment for diabetic patients across Staffordshire and Stoke-on-Trent (Table 7). A breakdown for individual CCGs compared to their peers across the pathway is shown in Appendix 4. More recent data published in the Quality and Outcomes Framework for 2014/15 shows:

- 60% of diabetes had good glucose control
- 70% of diabetics met their blood pressure target
- 71% of diabetics met their cholesterol targets

Table 7: Care and treatment for diabetes patients, 2012/13

	Receiving all eight care processes (excluding eye screening)	Meeting all treatment targets (for glucose control, cholesterol and blood pressure)
Cannock Chase	63.9%	34.3%
East Staffordshire	49.6%	32.5%
North Staffordshire	66.2%	36.1%
South East Staffordshire and Seisdon Peninsula	61.4%	32.2%
Stafford and Surrounds	66.0%	29.5%
Stoke-on-Trent	56.0%	40.8%
Staffordshire and Stoke-on-Trent CCGs	60.5%	**36.2%**
England	**59.5%**	**36.0%**

Source: National Diabetes Audit 2012-13 - Report 1, Care processes and treatment targets, Copyright 2014, The Health and Social Care Information Centre, National Diabetes Audit. All rights reserved

7 Challenges and Recommendations

Challenges

- Declines in mortality rates have not been matched by similar declines in ill-health. Therefore there is a need to systematically focus efforts on the causes of ill-health as well as preventable mortality. This includes supporting healthy behaviours to prevent or delay the onset and severity of long-term conditions.

- There are significant lifestyle issues across Staffordshire and Stoke-on-Trent. Whilst the burden of ill-health from smoking appears to be improving the impact of poor diets and inactive lifestyles is considerable and is predicted to increase. There appears to be a gap in local preventative and community-based solutions to keep the population healthier and active for longer that can be provided at scale.

- Residents do not appear to be well informed about the lifestyle risk factors and their contribution to both preventing and managing type 2 diabetes. There is scope for improving early intervention in this area and providing more consistent information across Staffordshire and Stoke-on-Trent.

- Performance data indicates there are inequalities in care and treatment for diabetic patients across Staffordshire and Stoke-on-Trent. Residents also feel that services need to be more integrated so that standards are consistent.

What do we want the future to look like for people with or at risk of diabetes?

Prevention of Type 2 diabetes and earlier diagnosis through:

- Reducing the risk of diabetes including a whole system approach to the prevention and management of obesity
- Continued improvement of NHS health checks programme to enable early diagnosis
- Identification, diagnosis and treatment of pre-diabetics through role out of the diabetes prevention programme

Improving the quality of life for diabetics including:

- Empowering patients with information to support their choices about their health and care
- Reducing variations in care, treatment and outcomes
- Improving patient experience and joined up care where appropriate

Recommendations

- Leadership through the Staffordshire Strategic Partnership, Local Enterprise Partnership and the Health and Wellbeing Board to support a whole system approach to healthy eating and physical activity in Staffordshire and Stoke-on-Trent

- Identify and align local policies and plans to creating the right environment locally to support healthy lifestyles, e.g. planning for health and creating local healthy food system and environment through rural, economic, climate change, transport planning and spatial planning policies and plans

- Identify gaps and implement solutions within own organisations to support healthy living

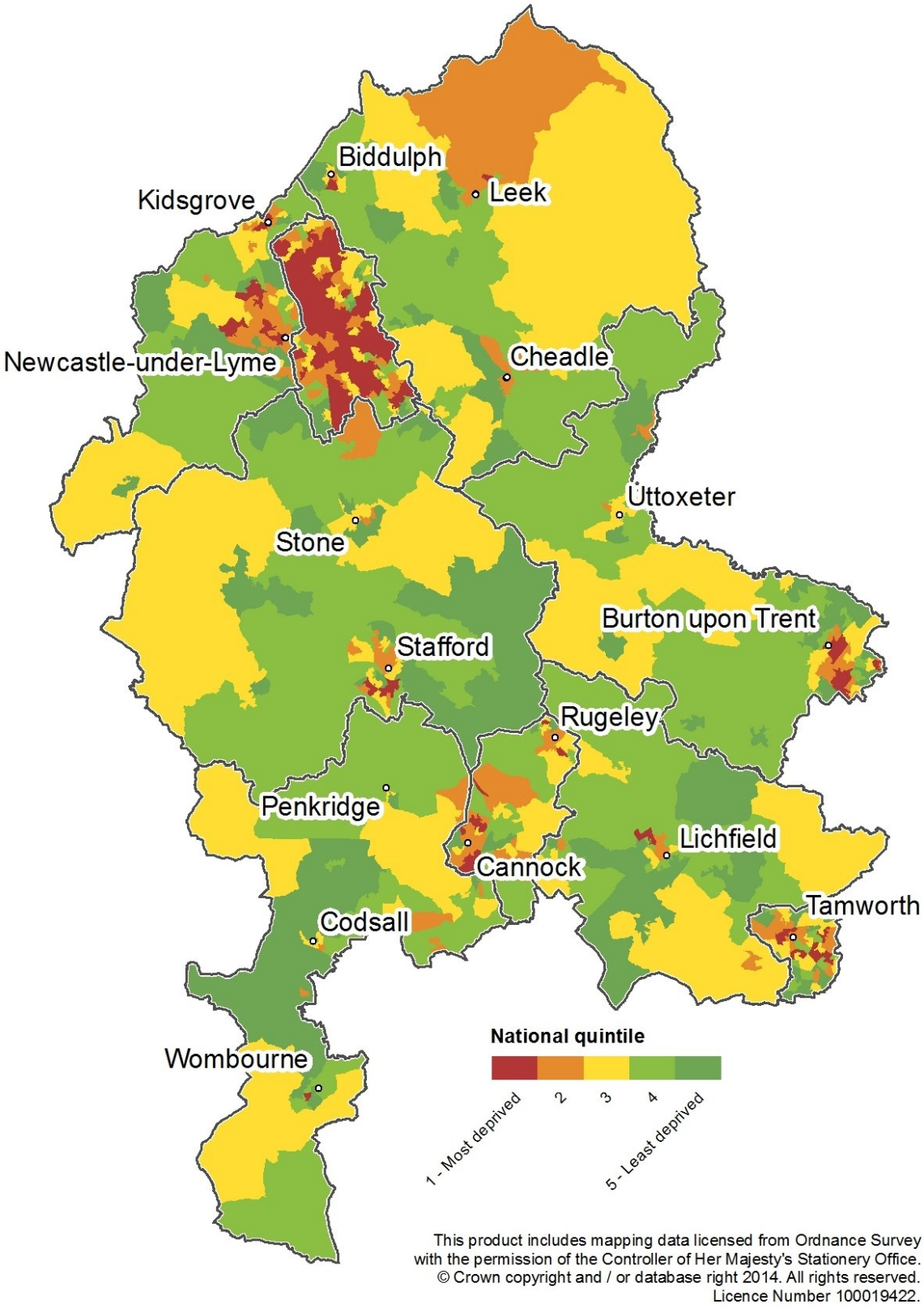
- Secure population-wide physical activity and healthy eating opportunities across Staffordshire (e.g. community-wide approach to build on or enhance existing community assets)

- Capitalise on opportunities to raise public awareness of the risks of unhealthy lifestyles and excess weight across all settings and actively promote opportunities available to support citizens to maintain a healthy weight using easily accessible information, advice and guidance (for example supporting a wider and more innovative use of technology)

- Implement interventions which effectively target and achieve successful behaviour change in higher risk populations

- Reduce inequalities in primary care across the diabetes pathway from identifying pre-diabetics through initiatives such as NHS health checks programmes to care and treatment of diabetic patients to ensure they receive good outcomes

Appendix 1: Deprivation in Staffordshire and Stoke-on-Trent



Appendix 2: NICE guidelines for healthy diets, activity and obesity

Promoting a healthy diet: local action	Promoting physical activity: local action
Make people aware of their eligibility for welfare benefits and wider schemes that will supplement the family's food budget and improve their eating patterns. This includes free school meals, free school fruit and Healthy Start food vouchers. Provide information on how to produce healthier meals and snacks on a budget. Work with local food retailers, caterers and workplaces to encourage local provision of affordable fruit and vegetables and other food and drinks that can contribute to a healthy, balanced diet. Provide nutrition education sessions (theory and practice) at times to suit people with children (or provide a crèche) or to fit with working hours. Sessions should take place in acceptable, accessible venues such as children's centres. Use existing planning mechanisms (for example, national planning guides or toolkits) to increase the opportunities available for local people to adopt a healthy, balanced diet. For example, ensure: ▪ food retailers that provide a wide range of healthier products at reasonable cost are readily accessible locally, either on foot or via public transport ▪ planning policies consider healthier eating when reviewing applications for new food outlets. Encourage local retailers to use incentives (such as promotional offers) to promote healthier food and drink options. The aim should be to make the healthier choice the easiest and relatively cheaper choice. The retailers targeted may include regional and national supermarkets and convenience store chains, as well as street markets and small independent shops. Encourage local caterers to include details in menus on the calorie content of meals to help consumers make an informed choice. If the nutritional value of recipes is not known, they should consider listing ingredients and describing the cooking methods used. Ensure local authorities and NHS organisations develop internal policies to help prevent employees from being overweight or obese. Encourage local employers to develop similar policies. This is in line with existing NICE guidance and (in England) the local obesity strategy. For example, organisations could promote healthier food and drink choices in staff restaurants, hospitality suites, vending machines and shops by using posters, pricing and the positioning of products.	Ensure local planning departments use existing mechanisms (for example, national planning guides) to: ▪ prioritise the need for people (including those whose mobility is impaired) to be physically active as a routine part of their daily life (for example, when developing the local infrastructure and when dealing with planning applications for new developments) ▪ provide open or green spaces to give people local opportunities for walking and cycling ▪ make sure local facilities and services are easily and safely accessible on foot, by bicycle and by other modes of transport involving physical activity (they should consider providing safe cycling routes and secure parking facilities for bikes) ▪ provide for physical activities in safe locations that are accessible locally either on foot or via public transport ▪ encourage people to be physically active inside buildings, for example, by using the internal infrastructure of buildings to encourage people to take the stairs rather than the lift Enable and encourage people to achieve the national recommended levels of physical activity by including activities such as walking, cycling or climbing stairs as part of their everyday life. Assess the type of physical activity opportunities needed locally and at what times and where. Consider social norms, family practices and any fears people may have about the safety of areas where physical activities take place (this includes fears about how safe it is to travel there and back). Map physical activity opportunities against local needs and address any gaps in provision. Ensure commissioned leisure services are affordable and acceptable to those at high risk of developing type 2 diabetes. This means providing affordable childcare facilities. It also means public transport links should be affordable and the environment should be culturally acceptable. For example, local authorities should consider the appropriateness of any videos and music played. They should also consider providing single-gender facilities, exercise classes, swimming sessions and walking groups – for both men and women. Provide information on local, affordable, practical and culturally acceptable opportunities to be more active. If cultural issues affect people's ability to participate, work with them to identify activities which may be acceptable. (This may include, for example, single-gender exercise and dance classes, or swimming sessions with same-gender lifeguards.) Encourage local employers to develop policies to encourage employees to be more physically active, for example, by using healthier modes of transport to and from work. Walking and cycling can be encouraged by providing showers and secure cycle parking. Signposting and improved decor could encourage employees to use the stairs rather than the lift. In addition, people could be encouraged to be active in lunch breaks and at other times through organised walks and subsidies for local leisure facilities. Flexible working policies and incentives that promote physical activity in the workplace should be considered. Ensure the basic training for professional fitness instructors covers: the role of physical activity in improving people's health, how to get marginalised groups involved and cultural issues that may prevent them from participating.

<table>
<tr><th colspan="2">Obesity</th></tr>
<tr><td>Individuals
Different population groups should be encouraged to:

▪ Follow existing advice on the recommended level of physical activity because it is likely to help increase energy expenditure and reduce the risk of diseases associated with excess weight.
▪ Follow existing advice on healthy eating because it will make it easier to have an appropriate energy intake.
▪ Avoid extreme physical activity or dietary behaviours (such as obsessively exercising or aiming to avoid all carbohydrates) because they are difficult to sustain and may not be accompanied by wider improvements in health.
▪ Ensure the local adult population is aware of:
o The health benefits for adults who are overweight or obese of losing even a relatively small amount of weight and keeping it off in the long term (or avoiding any further weight gain).
o The range of lifestyle weight management services available locally.
o Local sources of information and advice such as GPs, practice nurses, health visitors and pharmacists.
o National sources of accurate information and advice such as NHS Choices and Change4life</td><td>NHS
Managers and health professionals in all primary care settings should ensure that preventing and managing obesity is a priority at both strategic and delivery levels. Dedicated resources should be allocated for action. This includes:

▪ Setting an example through on-site catering, supporting active travel etc.

Ensuring staff are adequately trained to provide and have capacity to competently deliver both appropriate and effective interventions to prevent and manage obesity in a range of settings.</td></tr>
<tr><td>Local Authorities
As part of their roles in regulation, enforcement and promoting wellbeing, local authorities, local health boards and local strategic partnerships should ensure that preventing and managing obesity is a priority for action – at both strategic and delivery levels – through community interventions, policies and objectives. Dedicated resources should be allocated for action. This includes:

▪ Setting an example in their role as employers
▪ Engaging with the local community, to identify environmental barriers to physical activity and healthy eating
▪ Working in partnership to create and manage more safe spaces for incidental and planned physical activity
▪ Ensuring that local public policies improve access to healthy foods and opportunities for physical activity</td><td>Early Years Settings
All settings should prioritising preventing excess weight gain and improving children's diet. In particular, this involves:

▪ Minimising sedentary activities during play time, and providing regular opportunities for enjoyable active play and structured physical activity
▪ Implementing national guidance on food procurement and healthy catering in Early Years settings</td></tr>
<tr><td>Schools
All schools should ensure that improving the diet and activity levels of children and young people is a priority for action to help prevent excess weight gain. A whole-school approach should be used to develop life-long healthy eating and physical activity practices. This includes:

▪ School policies help children maintain a healthy weight, eat a healthy diet and be physically active and align with existing policies and guidance, are supported by adequate training programmes for staff and support continuation of practice outside of school.
▪ Promoting enjoyment of healthy food and physical activity.</td><td>Workplaces
All workplaces, particularly large organisations such as the NHS and local authorities, should address the prevention and management of obesity, because of the considerable impact on the health of the workforce and associated costs to industry. Workplaces are encouraged to collaborate with local strategic partnerships and to ensure that action is in line with the local obesity strategy (in England). This includes:

▪ Providing opportunities for staff to eat a healthy diet and be more physically active (e.g. through offering healthy vending, through working practices and policies).
▪ Incentive schemes (such as policies on travel expenses).</td></tr>
</table>

Appendix 3: Detailed issues from the Citizens Jury North Staffordshire Report, Diabetes care in North Staffordshire, March 2015

The Citizens Jury for Diabetes in North Staffordshire is the first of its kind. It puts patients, carers and the interested public at the heart of healthcare commissioning and gives a real opportunity for patients to shape future services. The jury has had engagement with patients, carers, clinical commissioners, managers and healthcare professionals. This highlights some of the key issues from the report.

Diagnosis

- "Awareness of the symptoms needs to improve, as patients can be undiagnosed for a number of years with type 2 diabetes. Patients with type 1 diabetes reported a more positive diagnosis experience, often being diagnosed within an acute setting".

Primary care

- "Primary care is key in the management of adult patients. Primary care is struggling with capacity issues, with a shortage of GPs and in places a high turnover of practice nurses".
- "There is variation in the levels of interest and knowledge in GPs which significantly affects the patient experience".
- "The role of the practice nurse and specialist diabetes nurse within the practice is pivotal for patients and is highly valued".
- "Often they know more about the condition than the GP's".
- "Annual checks vary in quality and comprehensiveness against nationally agreed standards and may not be sufficient to maintain wellbeing and prevent deterioration".

Community and hospital specialist care

- "There is a lack of communication between services, and patients can fall between the cracks".
- "Patients are forced to retell their stories on multiple occasions".
- "Patient records are often not available at the time of consultation".

Diabetic foot problems

- "The care provided by the podiatrists is of a high standard and the podiatrists received positive feedback".
- "There is a gap in service for patients who no longer meet the podiatry access criteria but who do not get a foot check within general practice".
- "Patients who no longer meet the criteria for specialist podiatry care feel unsupported and anxious".

Care in the hospital setting

- "Feedback about the experience and the effectiveness of the care given by consultants and diabetes specialist nurses was positive".
- "Co-ordination within the hospital is disjointed and lacking a holistic approach".
- "Patients sometimes feel unsupported within the hospital and nursing staff sometimes do not manage the condition well".
- "There is no dedicated ward for people with diabetes and so patients are placed in wards that are not always suitable for their needs".
- "Concerns were raised about the diabetes specialist nurses capacity".
- "There is repetition within the hospital with multiple examinations and histories taken".
- "Primary care and secondary care do not communicate effectively".
- "The use of insulin pumps for historical reasons is lower than elsewhere in the country".

Children and young people

- "Children's diagnosis is normally a quick process as children with diabetes tend to be more ill".
- "Children are managed within secondary care as opposed to primary care".
- "There are differences between children's and adult's services which means young adults can struggle with the transition".

People within residential care

- "This area needs further exploration as the jury heard little evidence related to this".
- "There is work under way within nursing and residential homes which should consider the findings of this report".
- "Diabetes UK North Staffs branch may be able to provide resources for the training of care home staff".

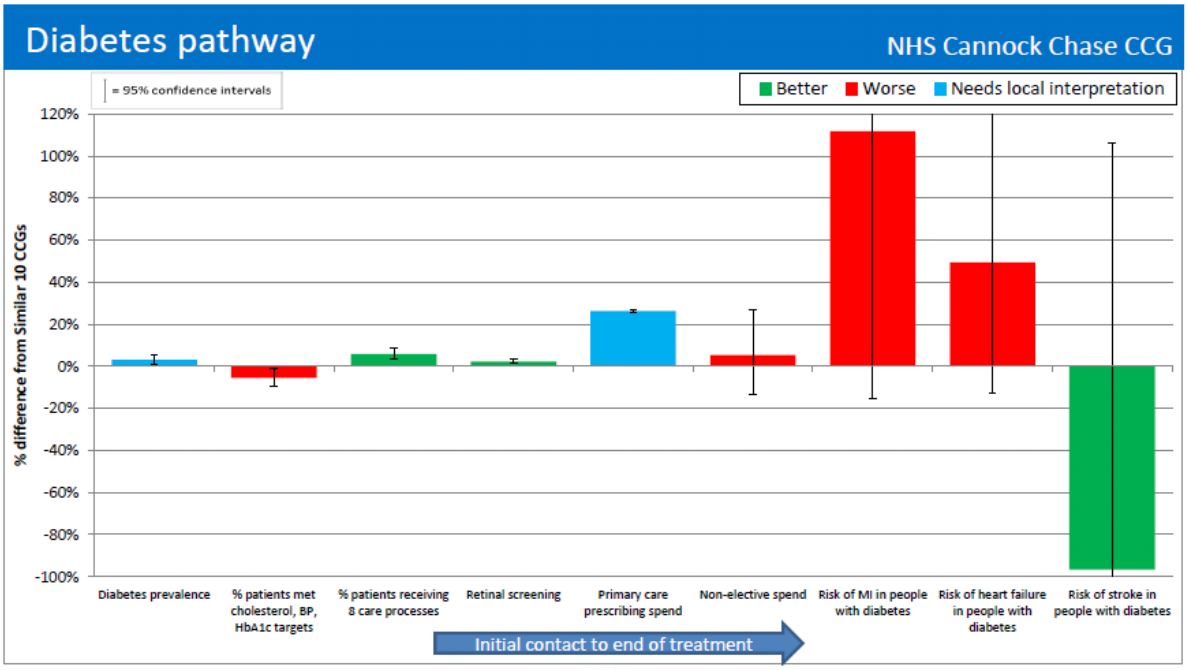
Psychological and emotional support

- “This is a major gap with patients in general reporting a lack of support for the management of this significant long-term health condition”.
- “In some practices, the nurse does offer psychological support to patients”.
- “Healthcare professionals have differing opinions about the causes of Type 2 diabetes which may affect the support available”.

Information, advice and education

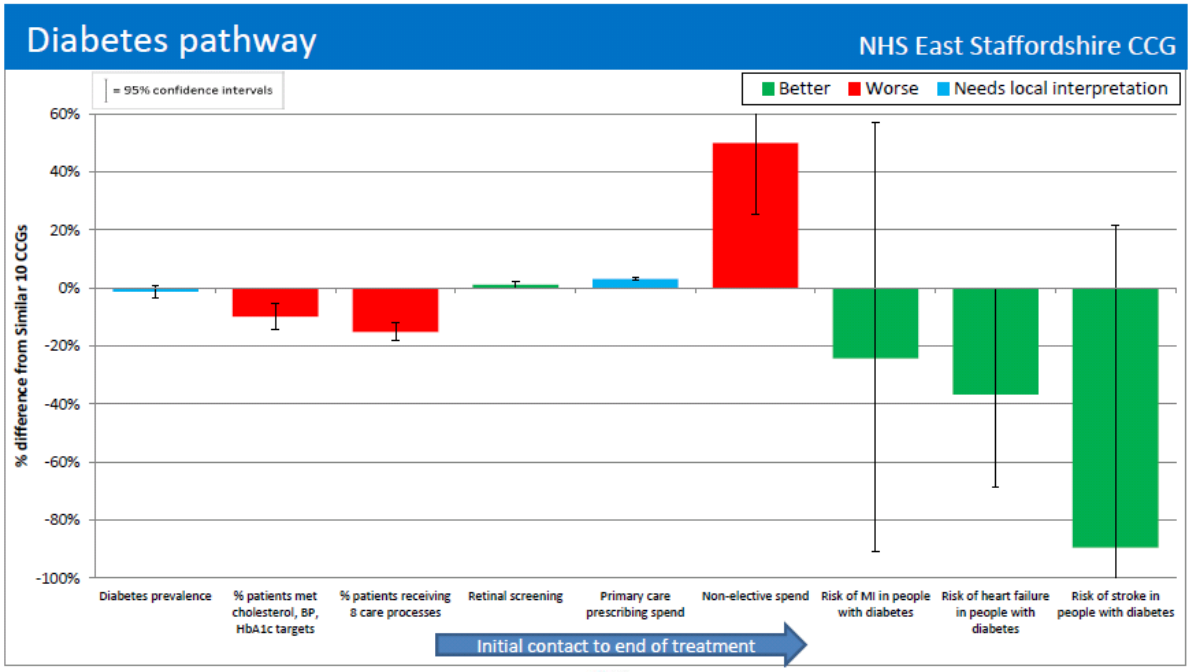
- “Patients reported a lack of information and advice on diagnosis and afterwards”.
- “People with Type 1 diabetes, children and pregnant patients tend to get more information than people with type 2 diabetes”.
- “The education courses available have access issues, with some patients being told that they are not eligible, and others experiencing courses being postponed on multiple occasions”.
- “Feedback on the courses is varied, with some patients reporting a positive experience and others feeling misinformed or given incorrect information”.

Appendix 4: Commissioning for value: diabetes pathways for CCGs



NICE guidance:
http://pathways.nice.org.uk/pathways/diabetes

Public Health England RightCare NHS England



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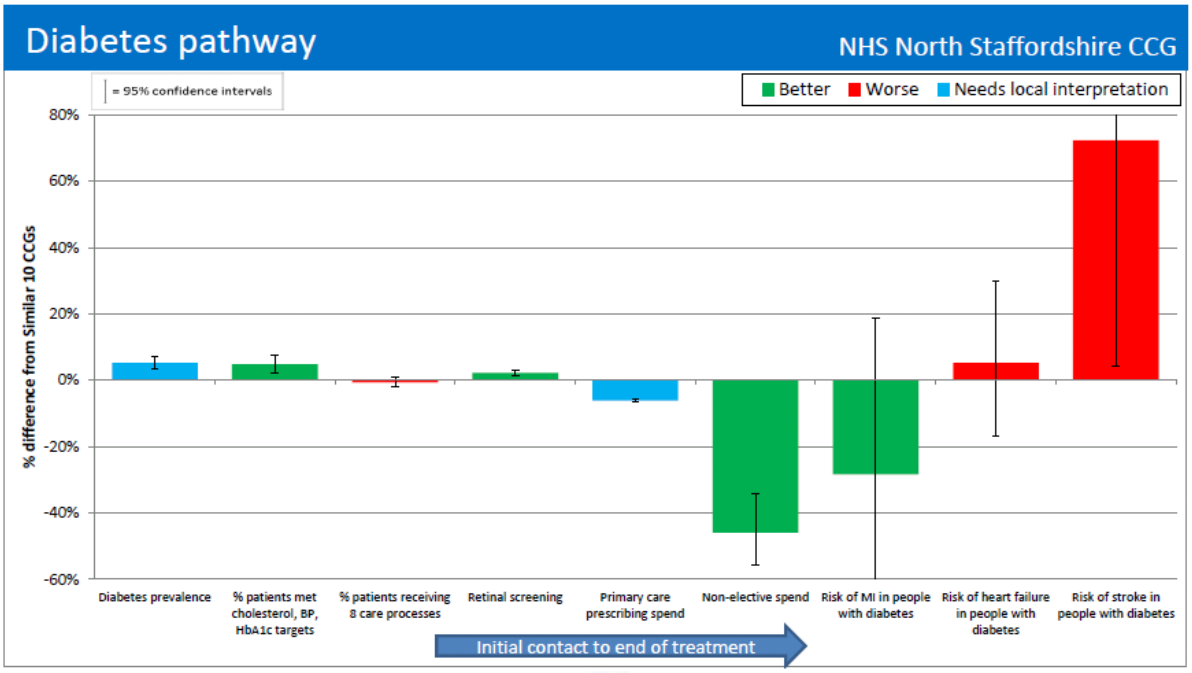

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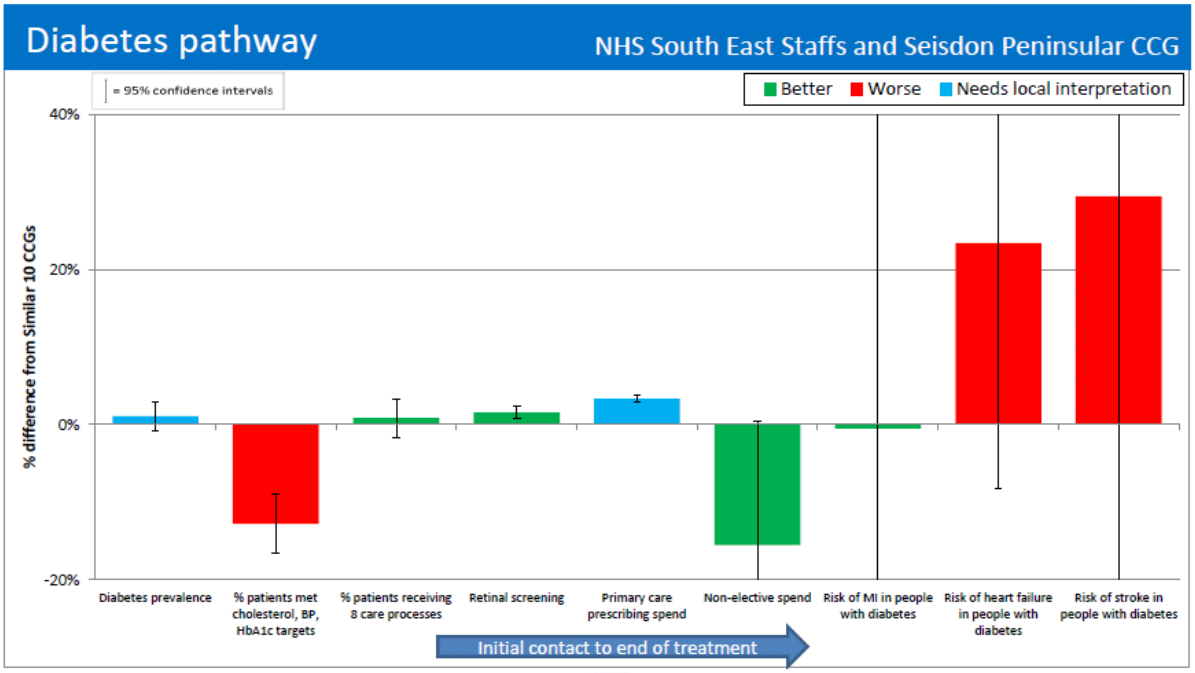

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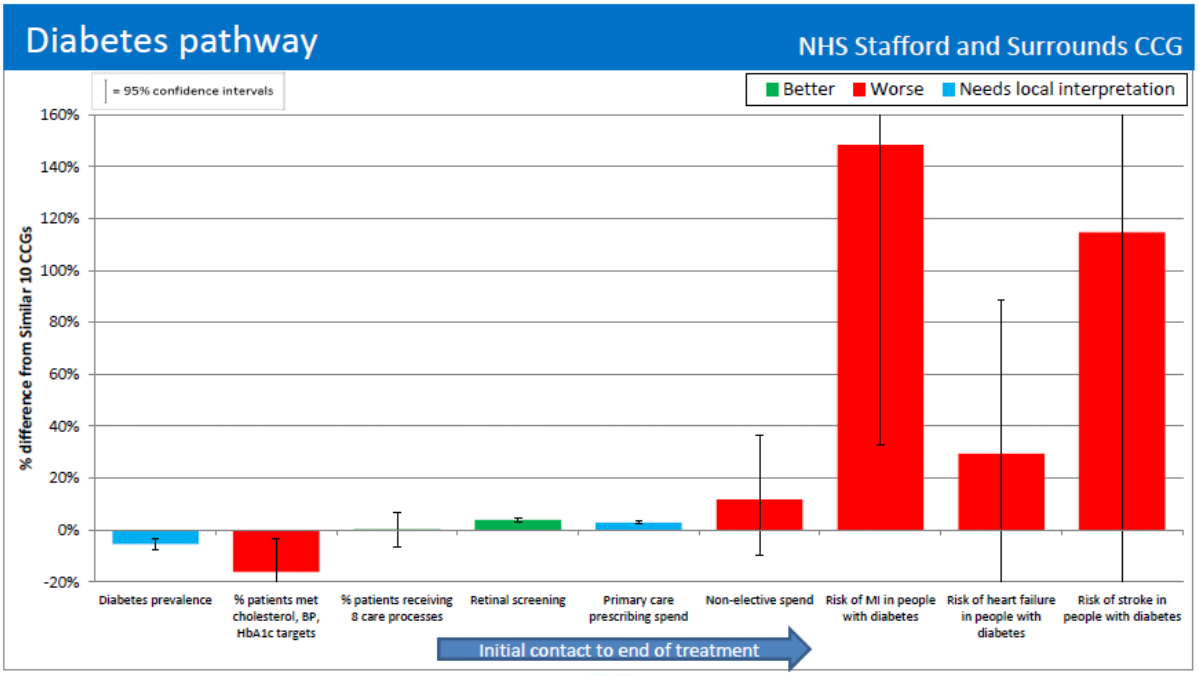

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Public Health England

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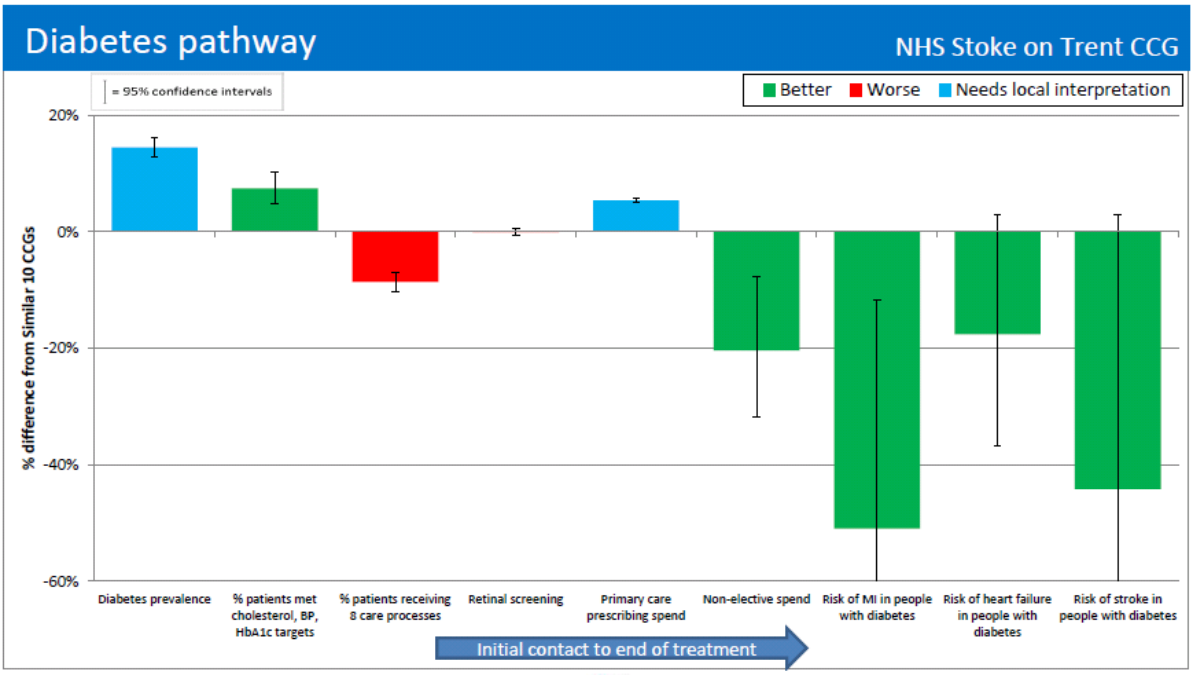
NHS England



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Public Health England

RightCare

NHS England