Locality Work and the Diabetes Programme Board

23rd May 2025

Diabetes

- Diabetes is a long-term condition that causes high blood sugar levels
- 90% of all adults with diabetes have type 2 diabetes
- 8% of all adults with diabetes have type 1 diabetes
- 2% of all adults with diabetes have rarer types, including gestational diabetes
- Diabetes is a serious condition which can result in long-term complications and can impact on quality of life, wellbeing, education, and employment

Type 2 Diabetes – Risk Factors

- Obesity & inactivity
- Age
- Sex
- Ethnicity
- Deprivation
- Learning disability
- Severe mental illness
- Smoking

- Family History

  People with a first-degree relative with type 2 diabetes are 2-6 times more likely to develop type 2 diabetes

- Personal Medical History
  - People who developed gestational diabetes are more likely to develop type 2 diabetes.
  - People with non-diabetic hyperglycaemia (NDH) are at risk of progressing to type 2 diabetes
  - People with high blood pressure are at an increased risk of type 2 diabetes

Why Focus on Diabetes?

- Diabetes is a common condition - an estimated 5.8 million people are living with diabetes across the UK, including nearly 1.3 million people with undiagnosed diabetes
- The prevalence of diabetes has progressively increased in the UK and globally. An estimated 1 in 3 adults could be at an increased risk of developing type 2 diabetes by 2030.
- Diabetes is a serious and chronic illness which can lead to long-term complications, negatively impact wellbeing and have consequences on family life, education, and employment.
- In 2021/22, Diabetes costs in the UK were estimated at £14 billion, accounting for 6% of the UK health budget. An estimated £6 billion was spent on the costs relating to complications of diabetes.
- Preventing diabetes contributes to advancing health equity and addressing inequalities.

Diabetes Programme Board

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The Wigan Diabetes Programme Board brings together key partners from across primary care, Wigan council, WWL, community services, and the voluntary sector

Committed to working together to:

1. Improve the prevention of diabetes
2. Improve the early diagnosis of diabetes
3. Improve the effective management of diabetes
4. Reduce diabetes-related health inequalities

Key Workstreams

- **Primary Prevention:** population health approaches to reduce the prevalence of diabetes and other long-term conditions, including targeted interventions to tackle inequalities in those communities most at risk. Building health promoting environments, support for healthy lifestyles and action on the wider determinants of health.

- **Secondary Prevention:** early intervention and detection of diabetes. Support for those living with diabetes including high quality care & personalised approaches that empower individuals to manage their condition.

- **Specialist Services:** management of acute complications through timely access to effective advice, investigations & treatment as appropriate.

Key Workstreams

All key workstreams are underpinned by:

- Co-production informed by lived experienced
- Integrated, high quality and co-ordinated services delivered by a skilled workforce
- Action to address inequalities in access and outcomes
- Personalised, holistic care that empowers individuals to take control of their health and wellbeing

System Alignment

- Progress with Unity
- Health and Wellbeing Strategy
- Locality Plan
- Prevention Transformation Board
- Greater Manchester Tackling Diabetes Together Strategy

Progress so Far

Activities Aligned to Primary Prevention

- Workforce development: Health Coaching
- Health Improvement Transformation
- Poverty Proofing Audit
- NHS Health Checks and CVD Pilot
- Workplace Wellbeing
- Development of Wider Determinants Work Programme
- Child Health Transformation

Progress so Far

Activities Aligned to Secondary Prevention

- Healthwatch Engagement Report
- Care Processes Primary Care Quality Improvement
- Type 1 Diabetes Audit

Care Processes Improvement

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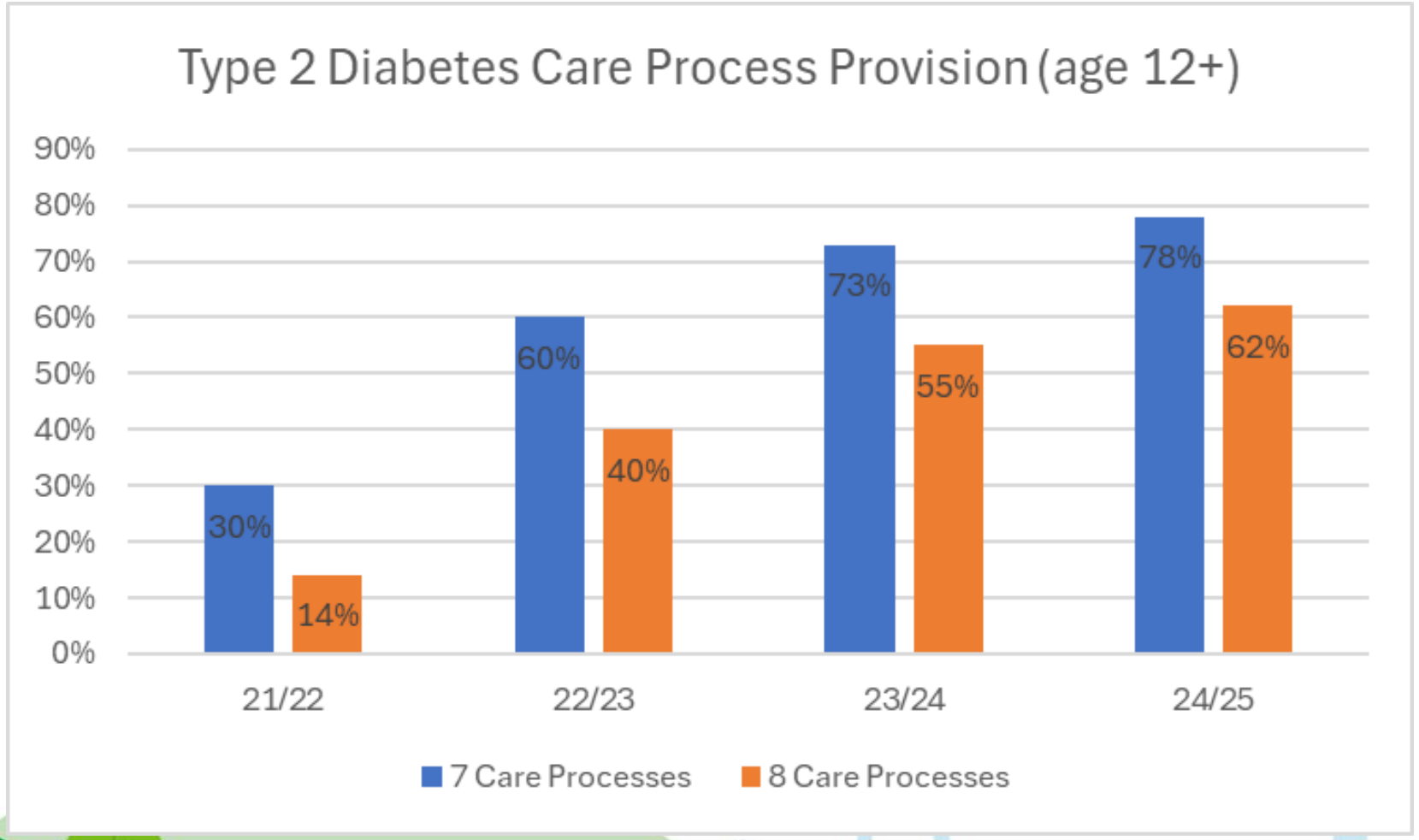
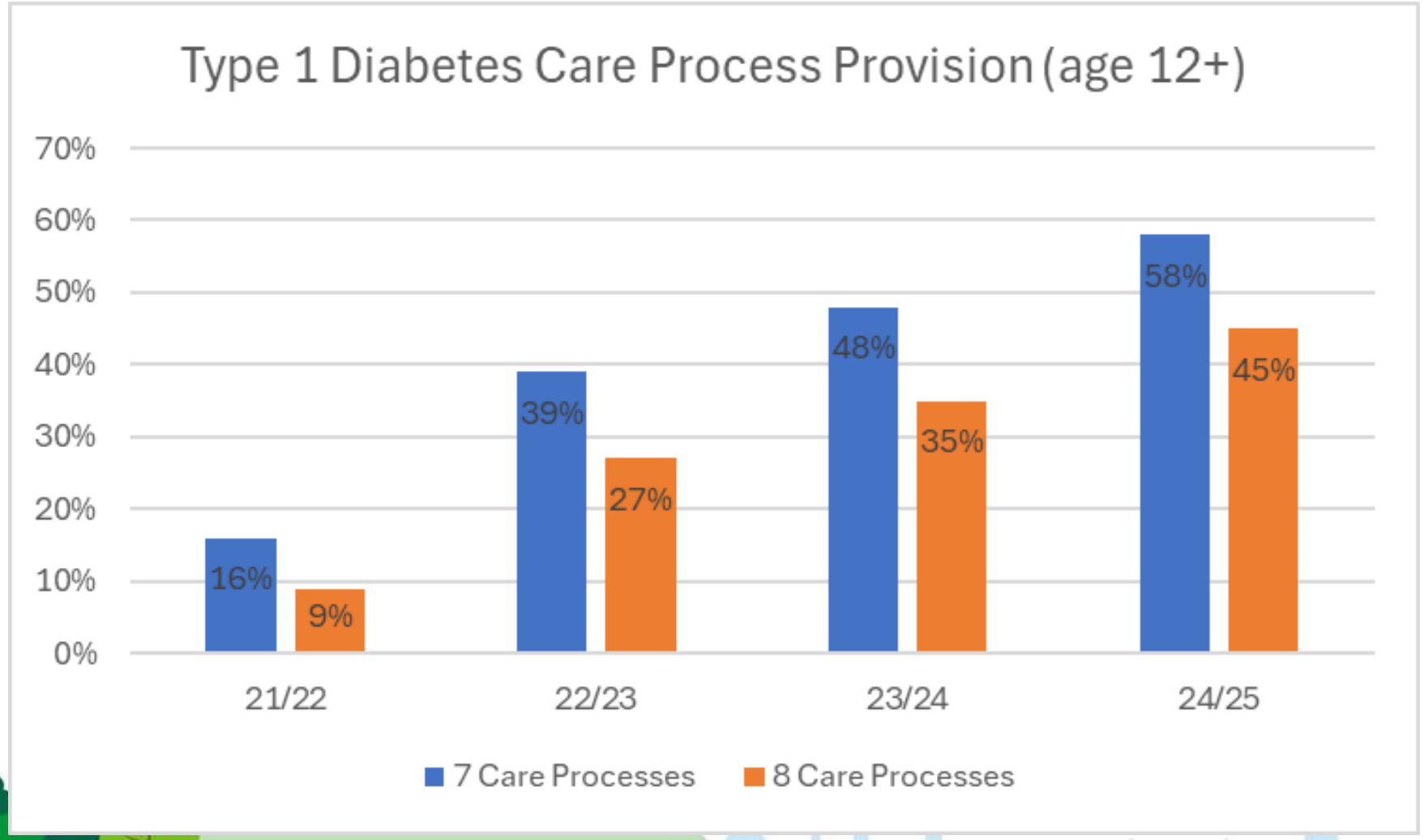


Care Processes Improvement



Care Processes Improvement

- Diabetic prevalence now at 8.9%, matching the predicted prevalence for the borough
- Diabetic patients with well controlled blood pressure (≤140/90mmHg) has improved from 77% in 23/24 to 79% in 24/24 (where BP not checked patient assumed not to meet this target) which is an additional 3,070 diabetics with well controlled blood pressure.
- Diabetic patients with well controlled blood glucose (≤58mmol/mol for T2DM or ≤53mmol/mol for T1DM) has improved from 58% in 23/24 to 61.5% in 24/25 (where Hba1c not checked patient assumed not to meet this target) which is an additional 2,382 diabetics with well controlled blood glucose.

Progress so Far

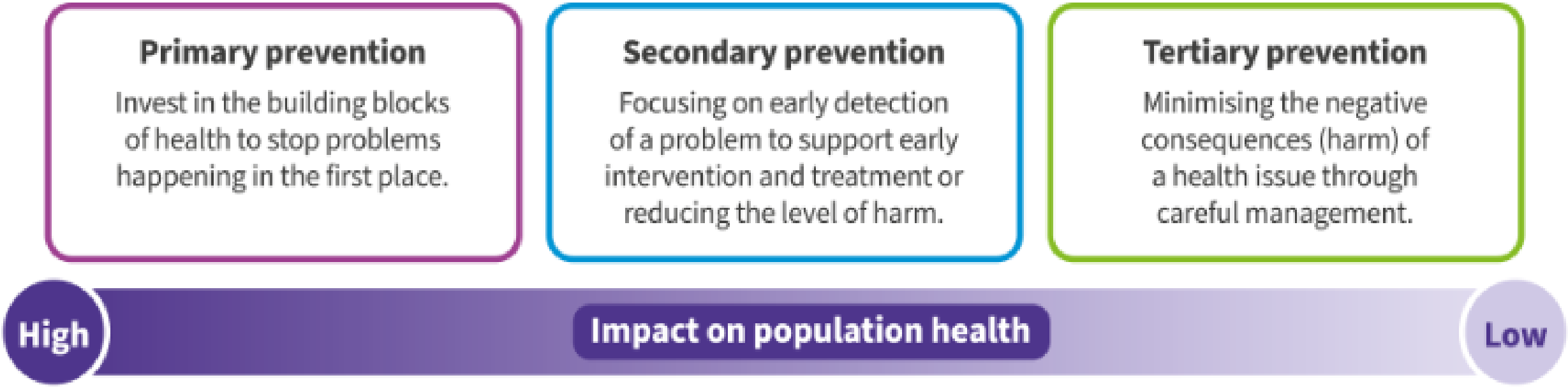
Activities Aligned to Specialist Services

- Wigan Multi-Disciplinary Foot Service
- Advice and Guidance
- Paediatric to Adult Transition

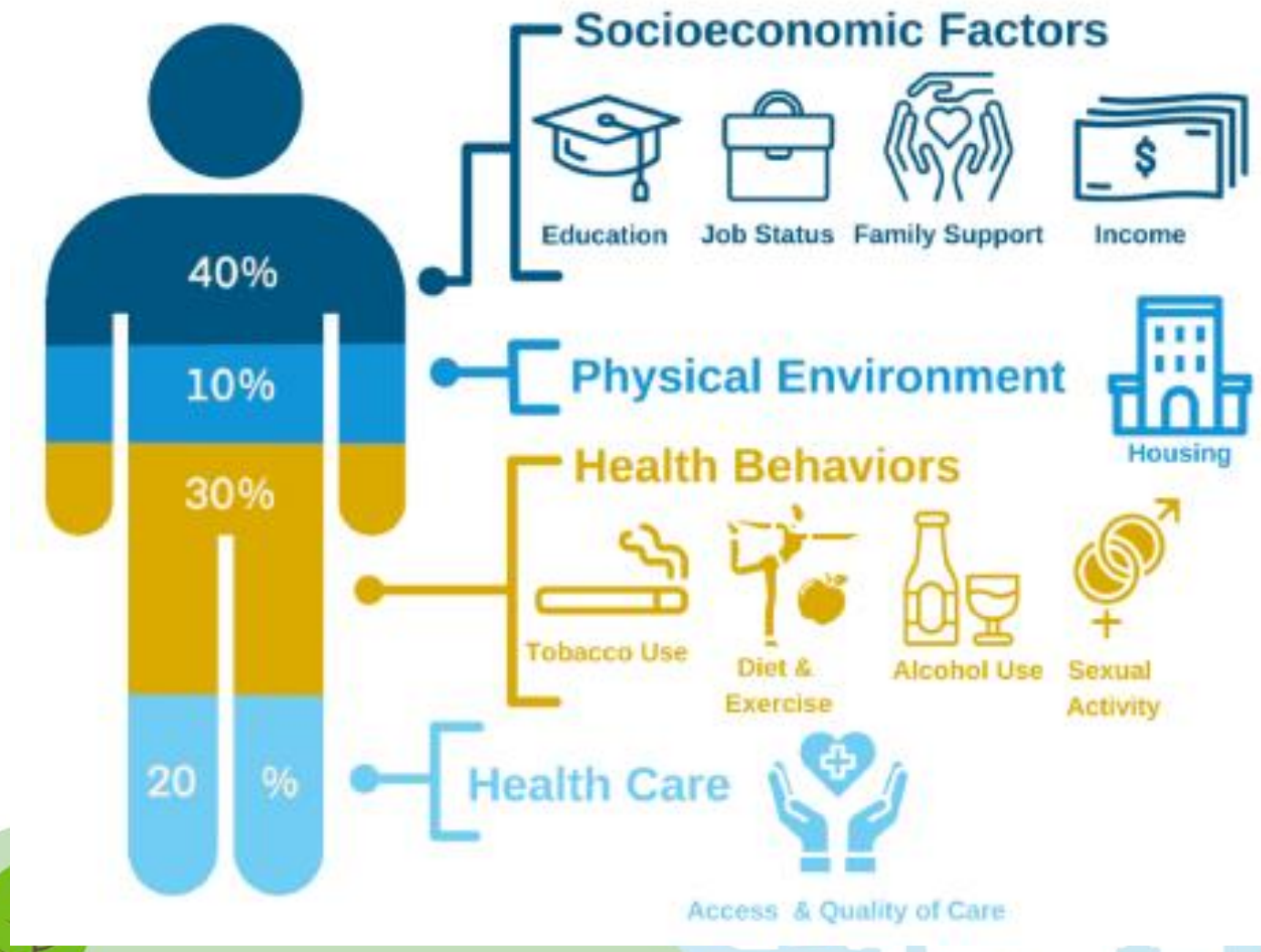
Shift to Prevention

Prevention: to prevent or minimise the risk of problems arising.

Early intervention: targeting resources on individuals or groups at high risk, or showing early signs of a problem, to try to stop it occurring.



Determinants of Health

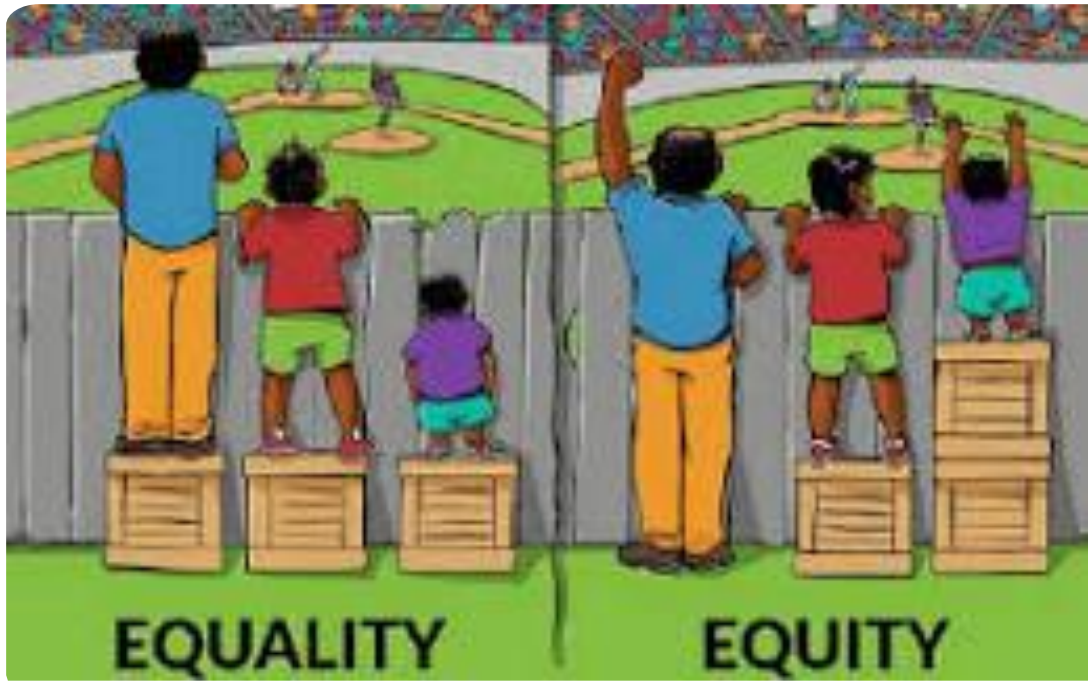


Health Inequalities

Unfair, **avoidable** and **systematic** differences in the status of people's health, the care that people receive and the opportunities that they have to lead healthy lives.

This includes differences in:

- health **outcomes**, for example, life expectancy
- **access**, for example, availability of given services
- **quality and experience of services**
- **behavioural risks to health**, for example, smoking rates
- **wider determinants of health**, for example, quality of housing, income etc.



Health Inequalities in Health Care Opportunities and Challenges

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- Inverse care law (Julian Tudor Hart) *"people who most need health care are least likely to receive it"*
- Lower uptake of preventative interventions and late presentation for diagnosis and treatment.
- Increased demand for urgent care and poorer experiences of care.
- Poorer outcomes for management and treatment of conditions.
- Multiple co-morbidities.
- Less system resource in areas with higher levels of deprivation.
- Worse outcomes and more cost.

- Neighbourhood model, integrated delivery and use of joint estate.
- Renewed place focus on HI and explicit NHS objectives (inc. CORE20+)
- Better use of data, intelligence and insight as a shared endeavour as well as how we use it.
- Engaging all health and care workforce (e.g. all of P/C) and creative workforce reform e.g. ARRS, Specialist training
- VCSF sector as a key and equal partner.
- Asset based working and training.
- Targeted case finding, service design and delivery.

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Diabetes in Wigan – The Local Picture

Diabetes Health Needs Assessment

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- Systematic approach to understand local needs
- Using publicly available health data
- Reach a consensus on recommendations for action
- Focussed on prevention and health inequalities

Diabetes Health Needs Assessment

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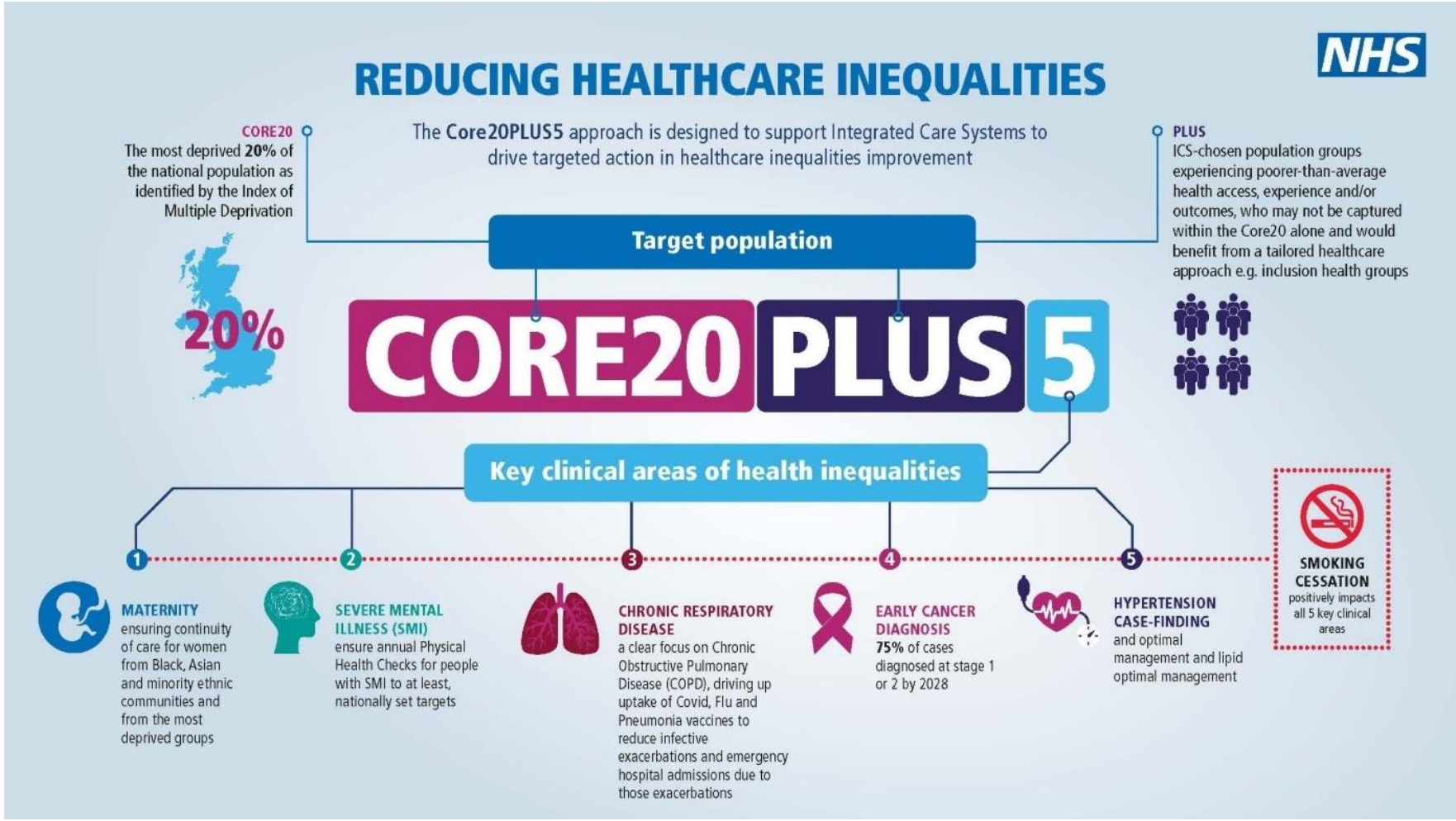


Diabetes Prevalence

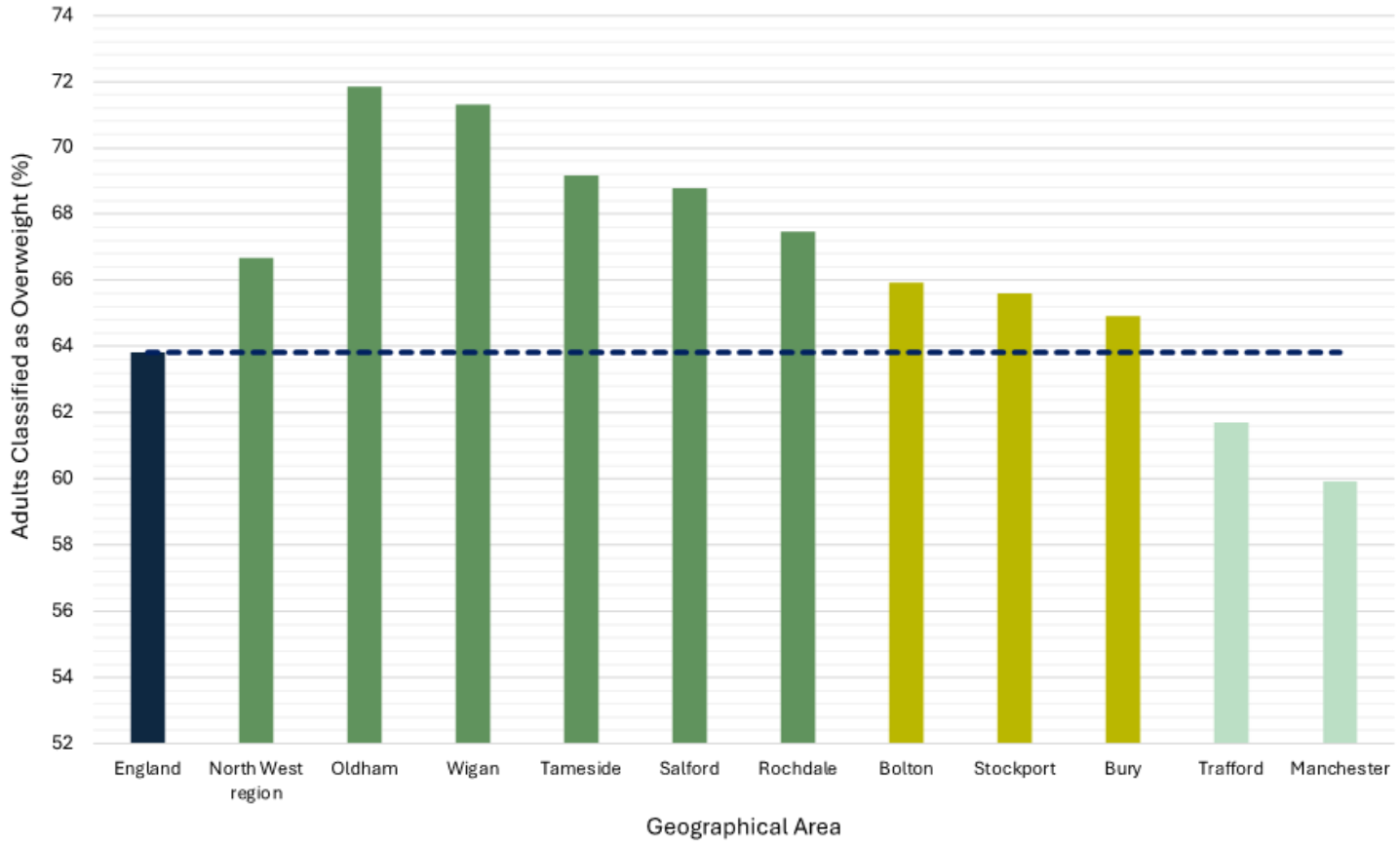
- Approximately 26,500 people in Wigan living with diabetes
- Of these, approximately 24,650 people have type 2 diabetes
- 2023/2024 QOF prevalence: 8.8%
- Predicted prevalence of diabetes in Wigan by 2035: 9.7%
- Non-diabetic hyperglycaemia prevalence in Wigan: 11.78%

Type 2 Diabetes – Non-Modifiable Risks

- **Ethnicity:** highest prevalence of diabetes by ethnicity in Wigan is in the Asian ethnic group
- **Age:** prevalence significantly increases with age
- Past medical history
- Sex
- Family History

Type 2 Diabetes – Preventable Risks

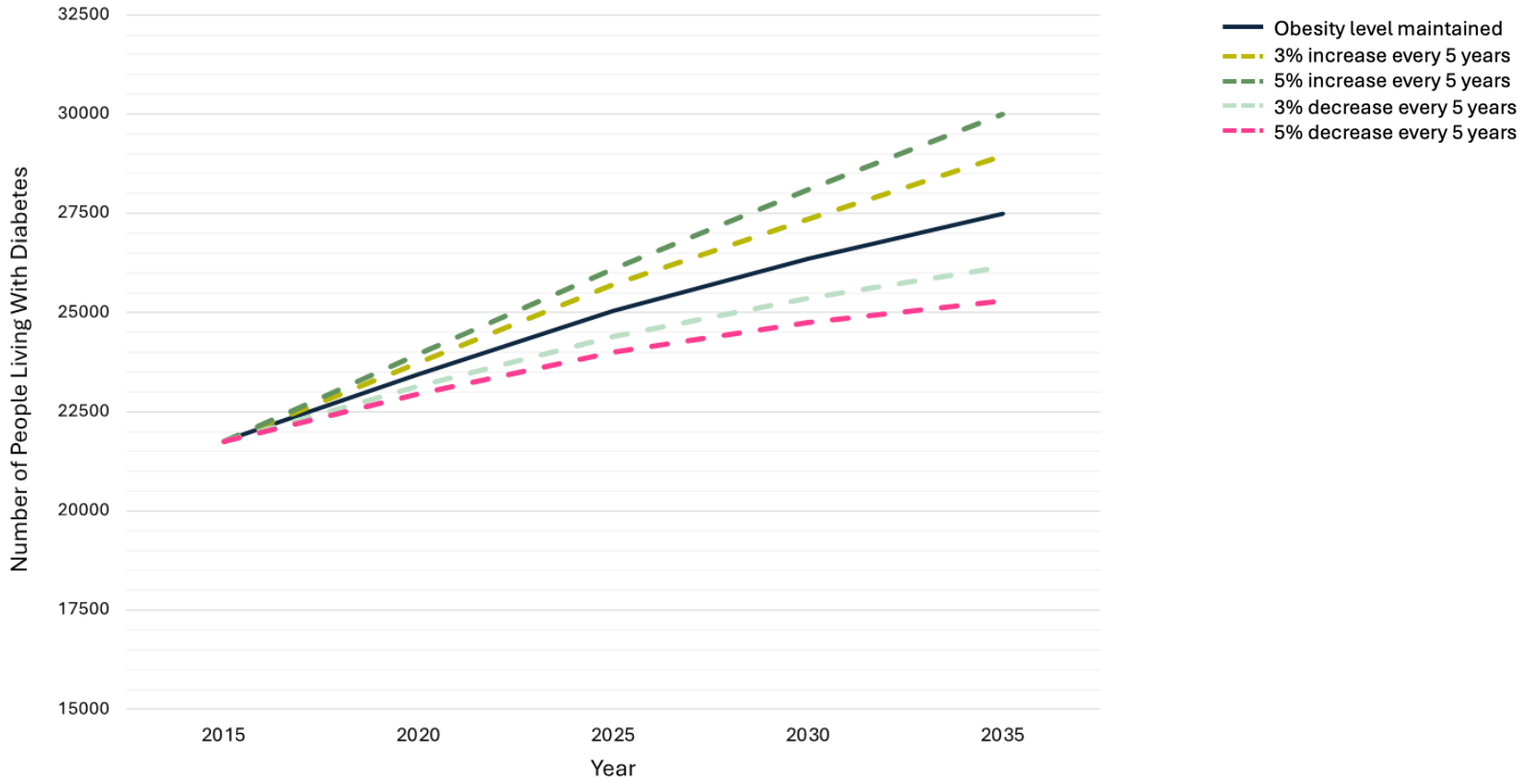
- **Obesity** accounts for 80-85% of the risk of developing type 2 diabetes



Percentage of adults classified as overweight (including obesity) in 2021/22 across Greater Manchester Local Authorities
Source: Fingertips Obesity Profile

Type 2 Diabetes – Preventable Risks

- Reducing obesity can reduce prevalence of type 2 diabetes



Predicted number of people living with diabetes in Wigan with changing levels of obesity
Source: Estimates by CCG tool for the impact of obesity on diabetes, Public Health England

Type 2 Diabetes – Inequalities

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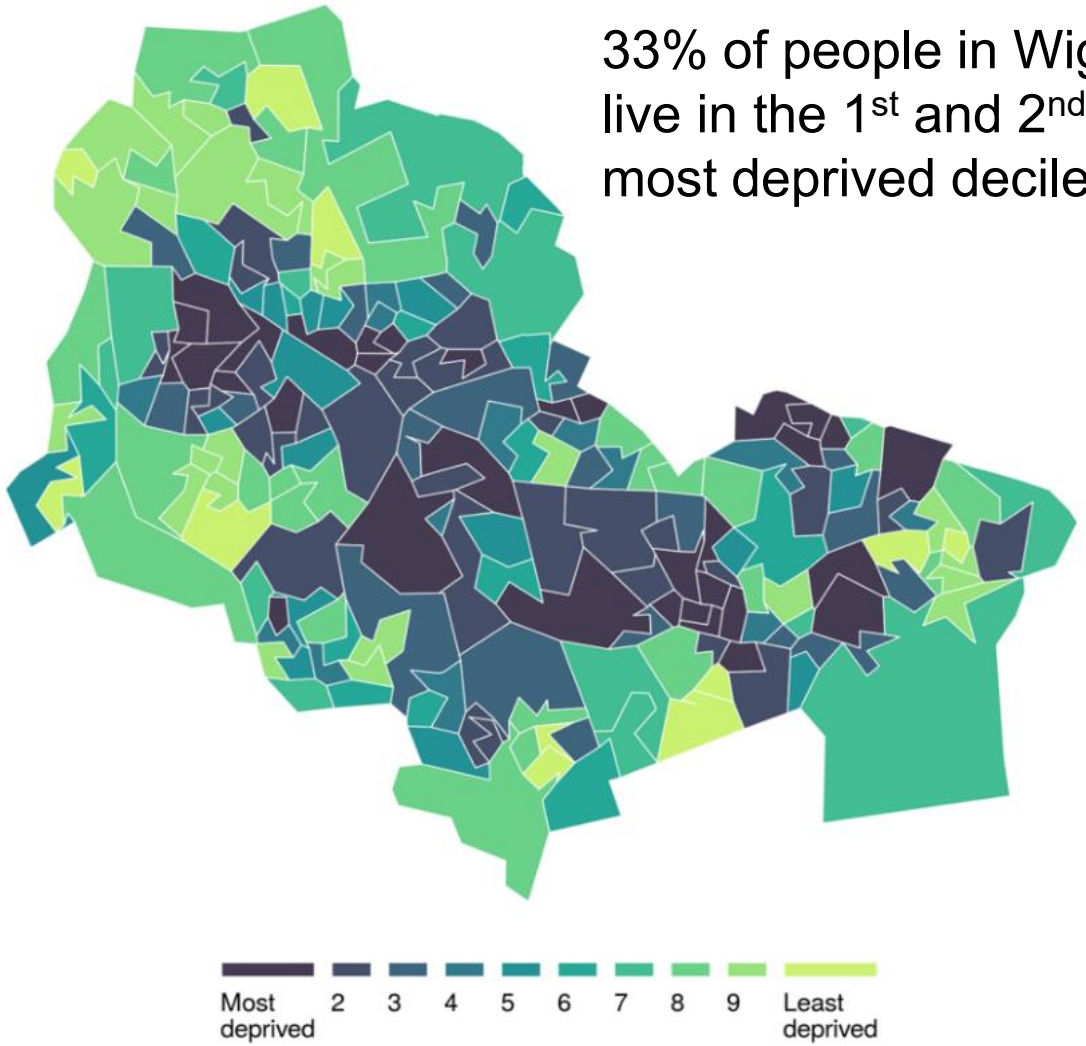
In England, T2DM is 40% more common among people who live in the most deprived quintile compared with those living in the least deprived quintile

33% of people in Wigan live in the 1st and 2nd most deprived deciles



Index of multiple deprivation 2019 Wigan lower super output area map
Source: IMD 2019 (via Trafford Data Lab)

Inequalities - Deprivation

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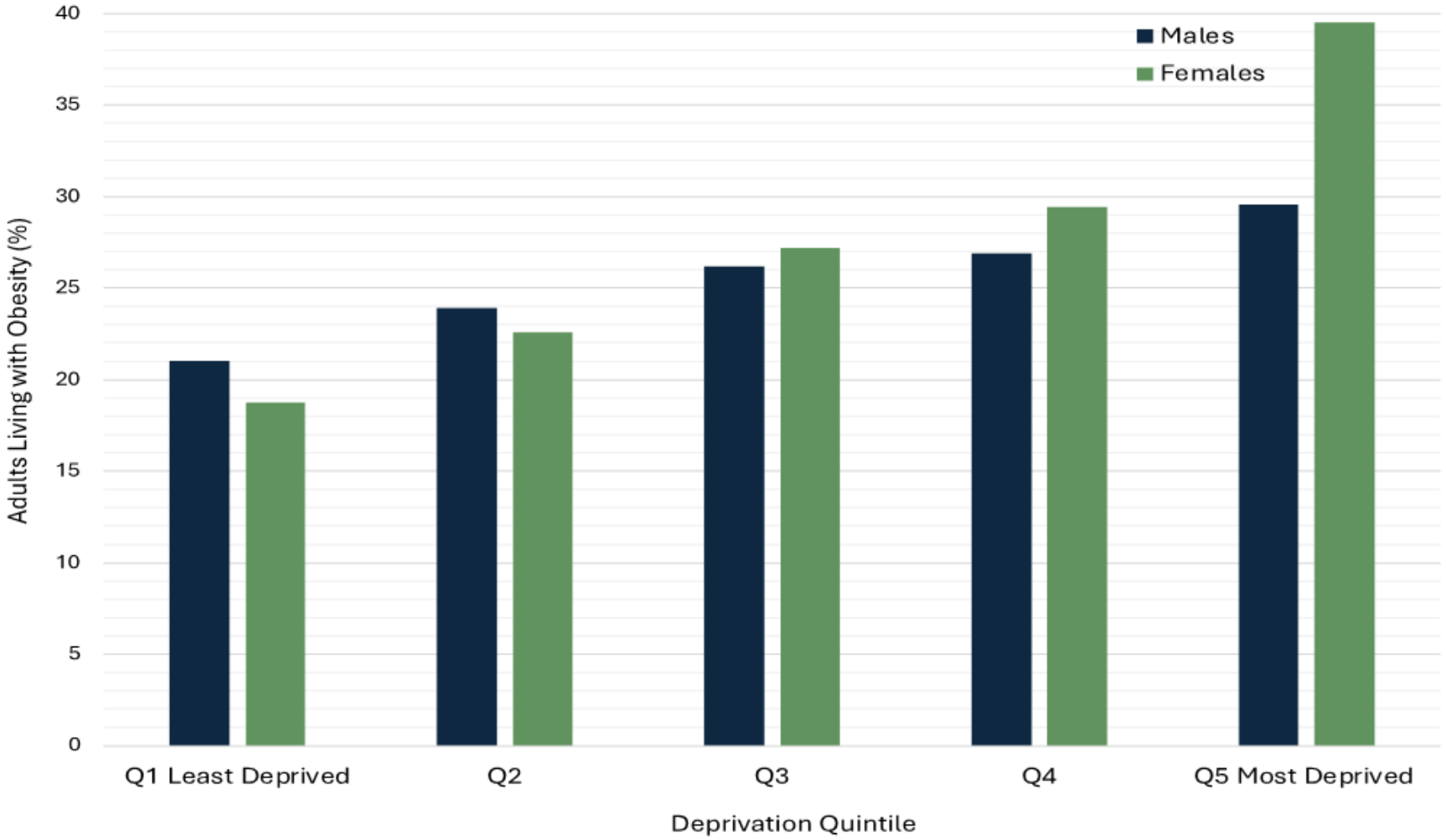
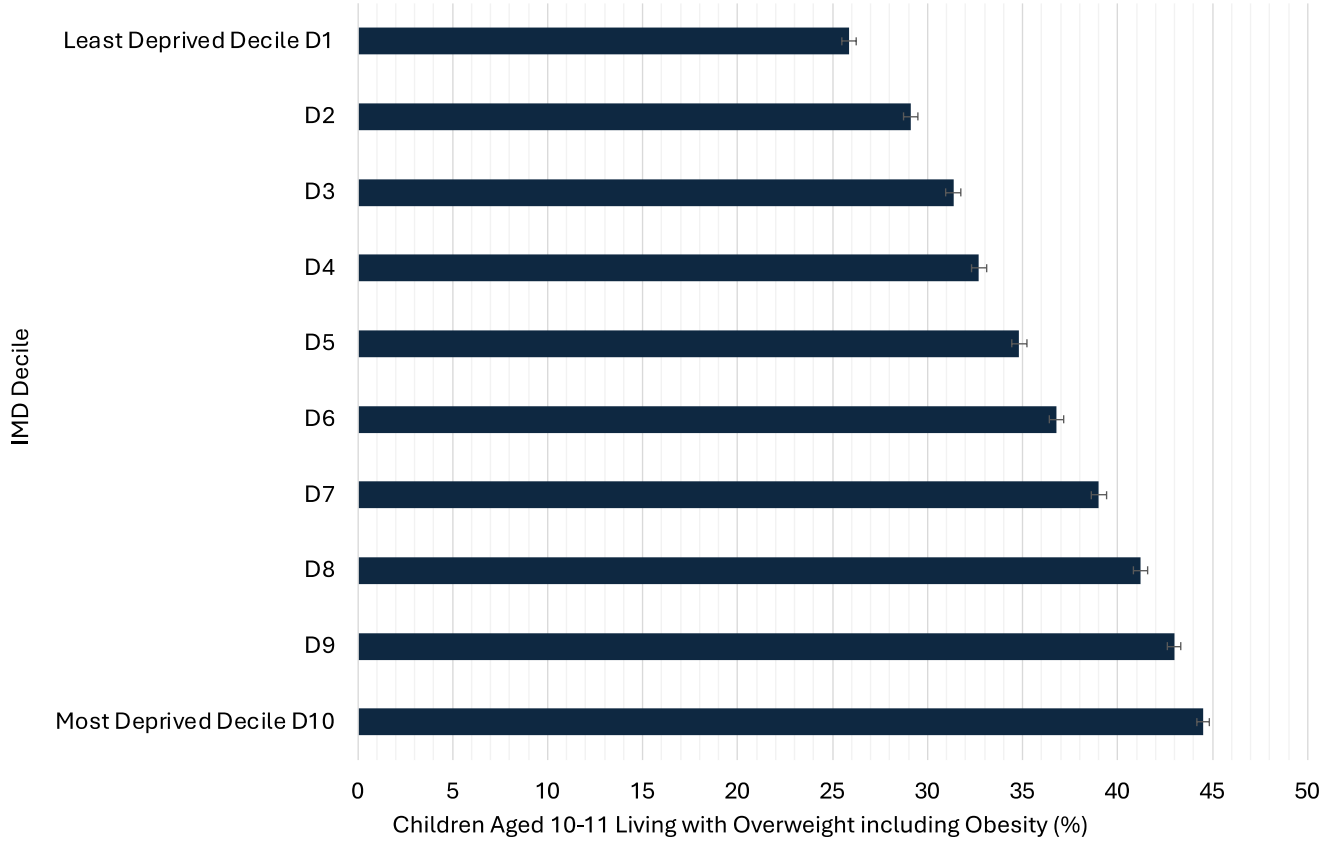


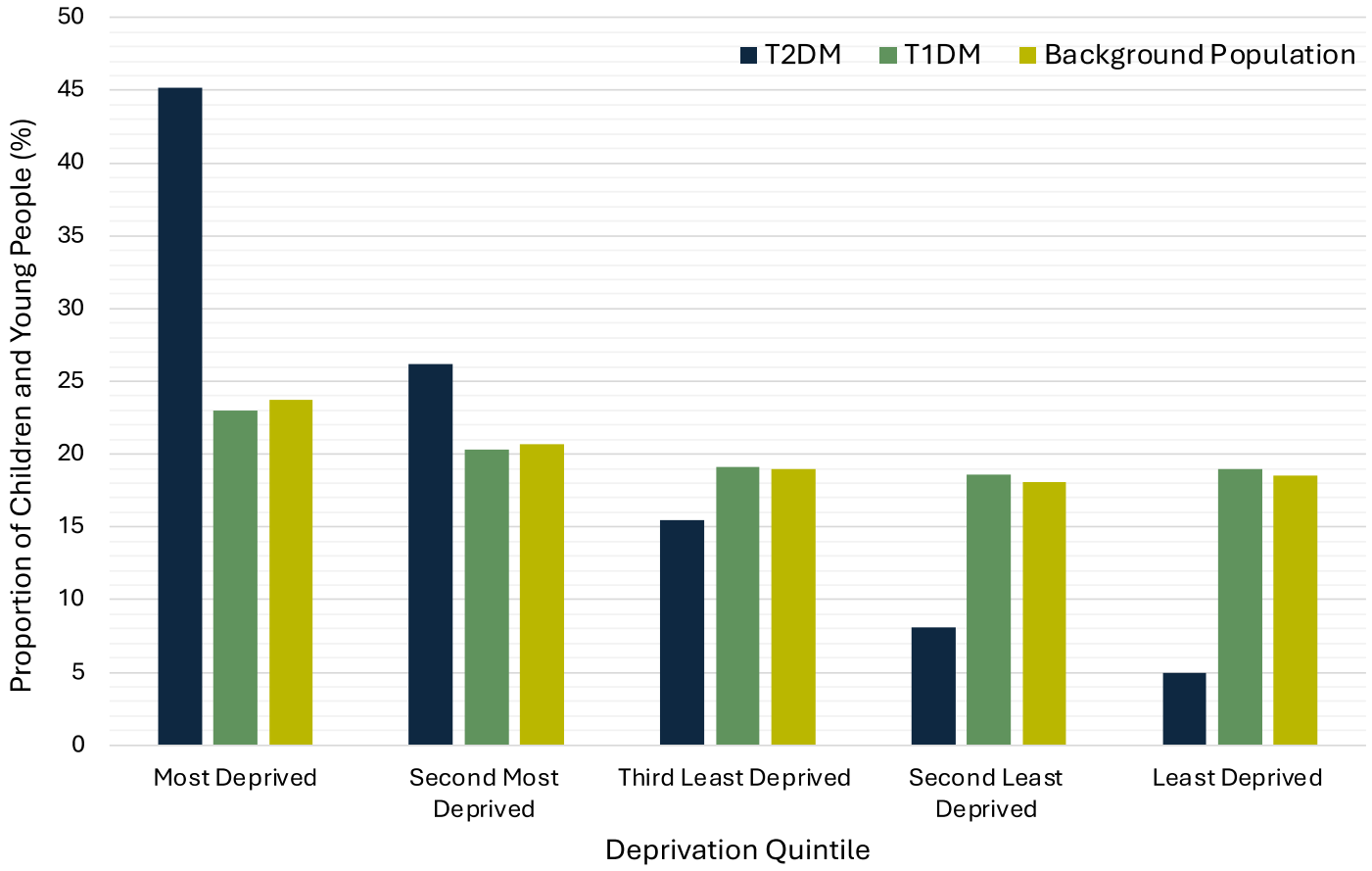
Percentage of obese adults in England by deprivation quintile
Source: Health Survey for England 2021

Inequalities - Deprivation



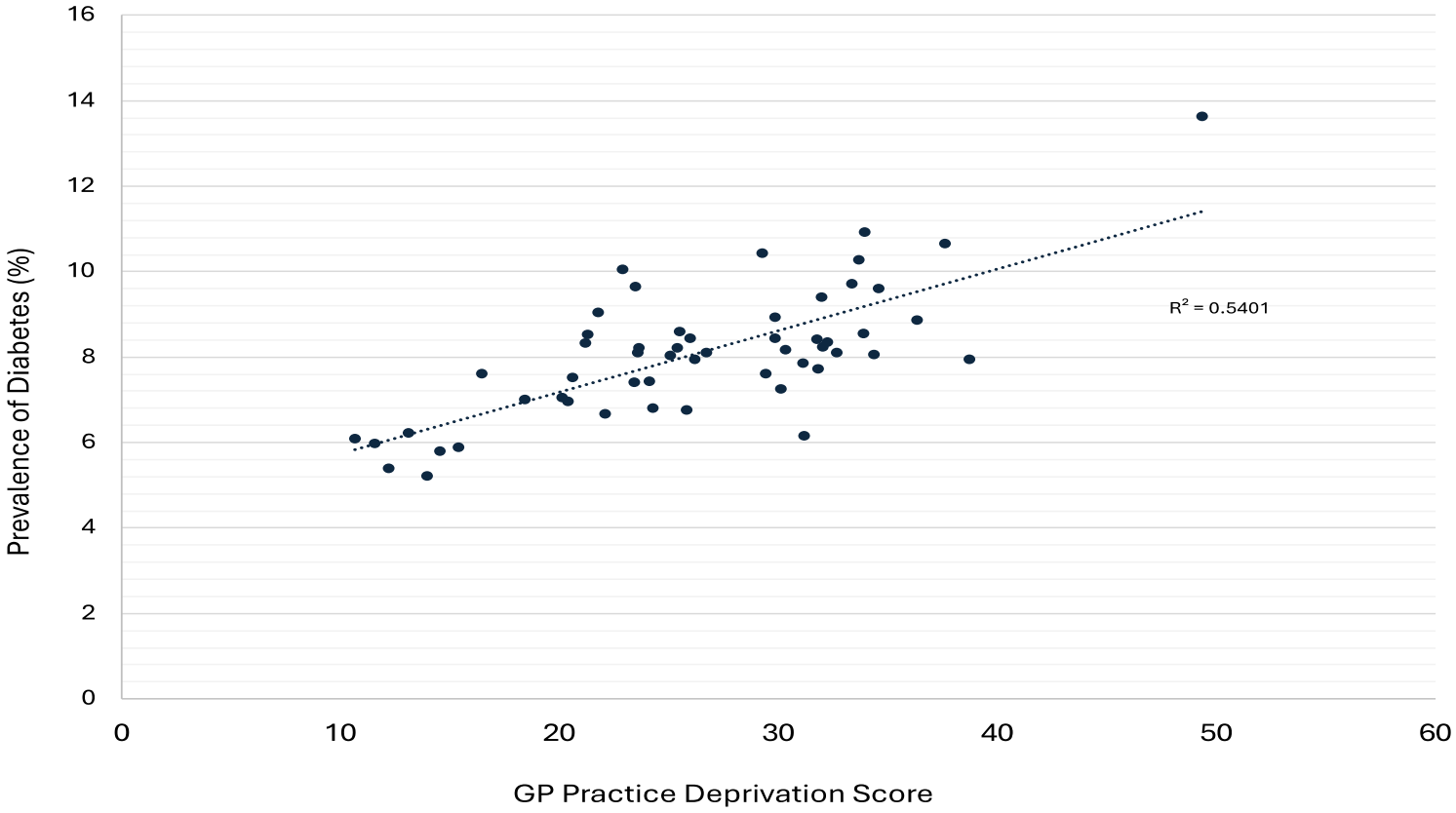
Prevalence of overweight and obesity in Year 6 children in England in 2022 by IMD deprivation decile
Source: NCMP via OHID Public Health Data

Inequalities - Deprivation



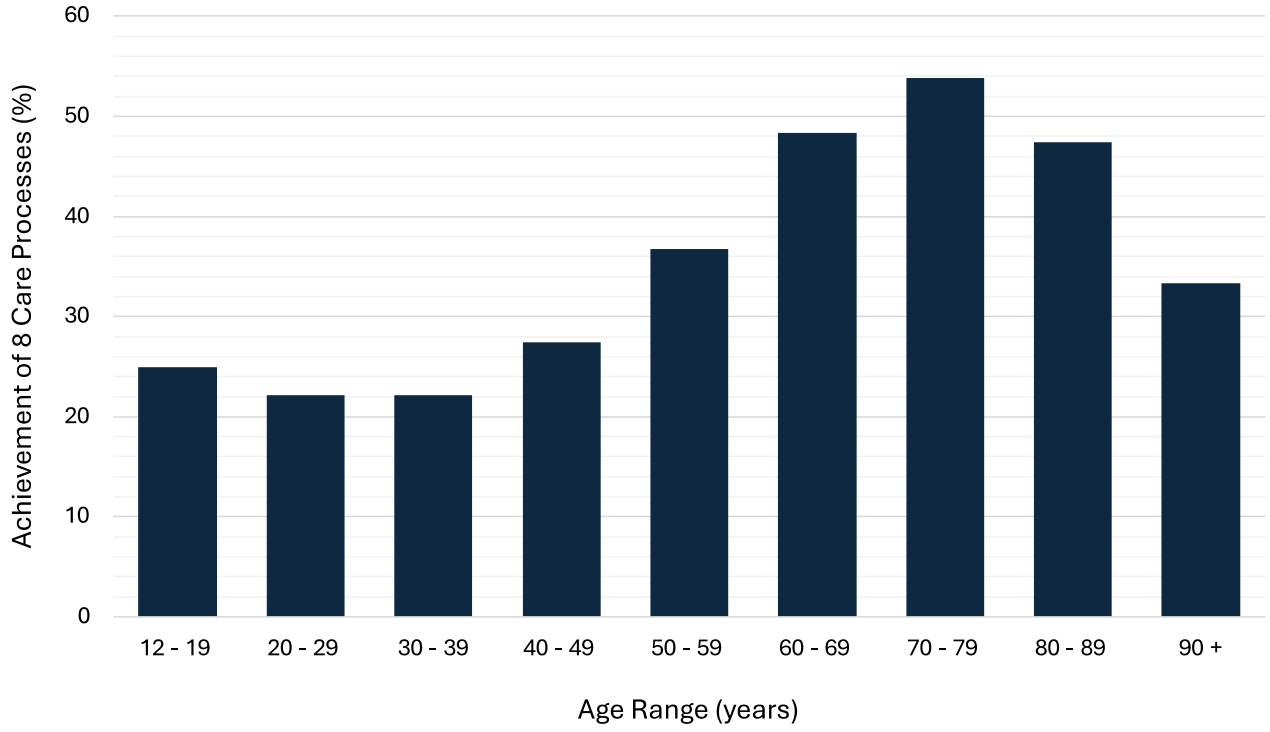
Proportion of children and young people with diabetes in each deprivation quintile in England and Wales in 2019/20
Source: National Paediatric Diabetes Audit- Spotlight audit report on Type 2 Diabetes

Inequalities - Deprivation



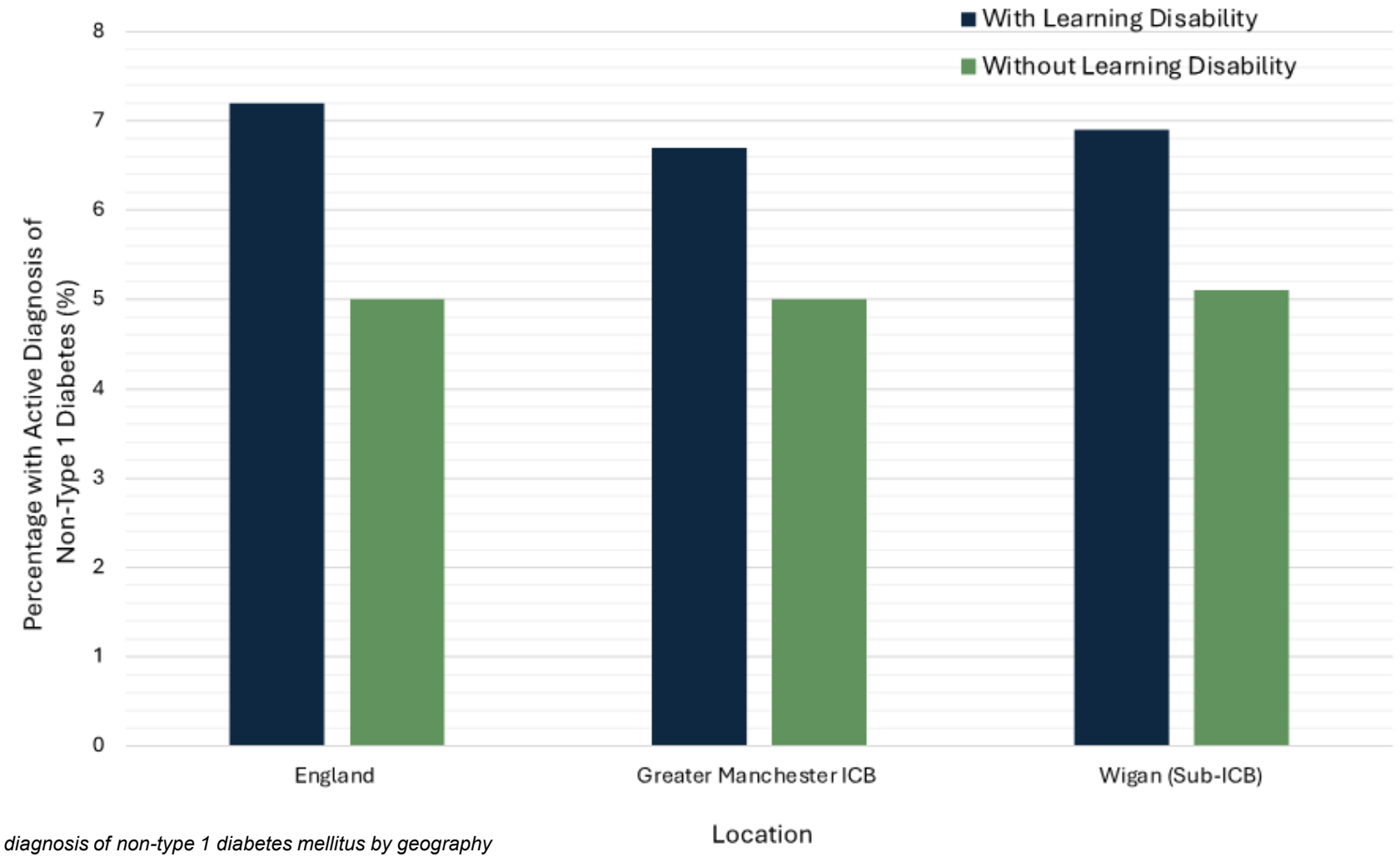
Percentage of Wigan residents Aged 40-64 with T2DM by GP practice, compared with GP practice deprivation score
Source: National Diabetes Audit Quarterly Report; National General Practice Profiles

Inequalities



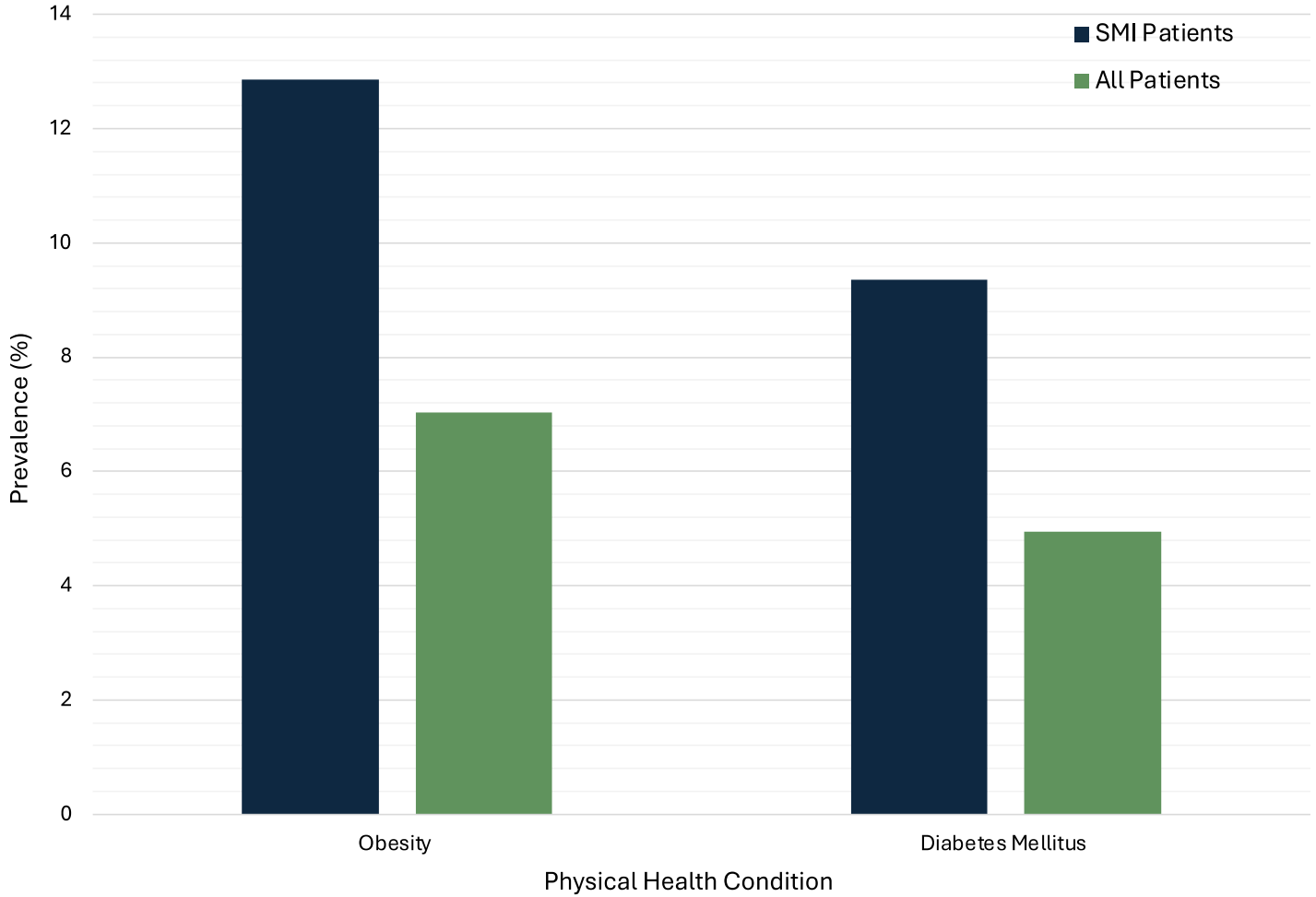
Achievement of all 8 care processes in patients with type 2 diabetes mellitus in Wigan by age group (Jan 2021-March 2022)
Source: National Diabetes Audit Core Dashboard

Learning Disabilities



Percentage of patients with an active diagnosis of non-type 1 diabetes mellitus by geography
Source: NHS Digital Health and Care of People with Learning Disabilities

Severe Mental Illness



Standardised prevalence of physical health conditions for SMI and all patients aged 15 to 74 in England
Source: Public Health England Severe Mental Illness and Physical Health Inequalities Technical Report (2018)

Summary of Recommendations

- All strategies and interventions which focus on T2DM prevention should address the inequalities in risk of developing T2DM and should direct and tailor interventions towards those most at risk of developing T2DM.

- Strengthen action to address all the factors driving the increasing prevalence of T2DM, including environmental factors, through a whole systems approach to obesity and healthy weight.

- Interventions should be culturally appropriate, inclusive, and accessible to the local population, with a particular consideration for improving accessibility and appropriateness for at-risk groups.

- Involve communities and utilise community resources to improve awareness of the key messages and improve access to appropriate services and support. Key messages should be tailored towards specific at-risk groups.

Summary of Recommendations

- Align local priorities for prevention with national data and evidence, which suggests people with learning disabilities and people with severe mental illness are at higher risk of developing T2DM.
- A further exploration of the characteristics of people with non-diabetic hyperglycaemia on a local level could help identify at risk groups.
- Utilise national data on risk factors for progression of NDH to T2DM to tailor interventions towards the most at-risk groups. Measuring outcomes for people with NDH could be used to determine the successes or limitations of an intervention and guide evidence-based changes to interventions.
- Identify and address barriers to access and participation in diabetes prevention programmes.
- Review variance between practices and PCNs on achievement of care processes and share good practice.
- Improve population understanding of diabetes, the longer-term complications and how individuals can reduce their risk. Target information towards at risk groups.

Healthwatch: Diabetes Project

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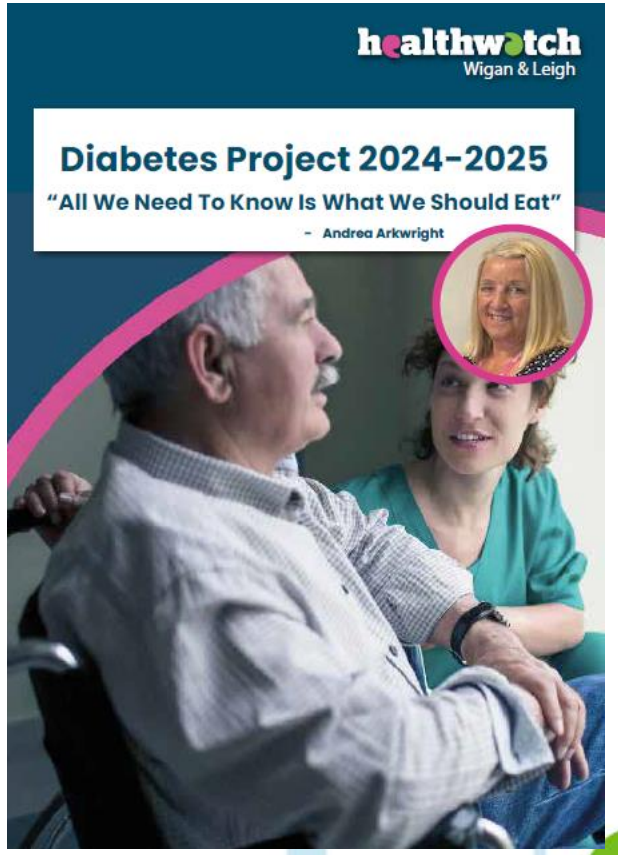
Healthwatch: the independent voice of local people to influence, challenge and question health and social care provision in the Wigan Borough

Diabetes Project 2024 – 2025

- Project aimed to seek the views of patients and carers
- Understanding of diabetes risks
- Experiences and understanding at diagnosis
- Access to structured education and foot services
- Access to services for people under 40
- Staff views



Healthwatch: Diabetes Project

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Methods

- Developed a survey: 58 responses
- In-person engagement activities: 87 participants
- Majority of respondents were people with Type 2 Diabetes (74.2%)
- Majority of respondents were diagnoses in the last year (62.5%)

Healthwatch: Diabetes Project

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Key Findings

- Whilst there is an awareness of diabetes risks, there were some gaps in knowledge, highlighting the need for clearer information to help prevent diabetes and provide improved support at diagnosis.

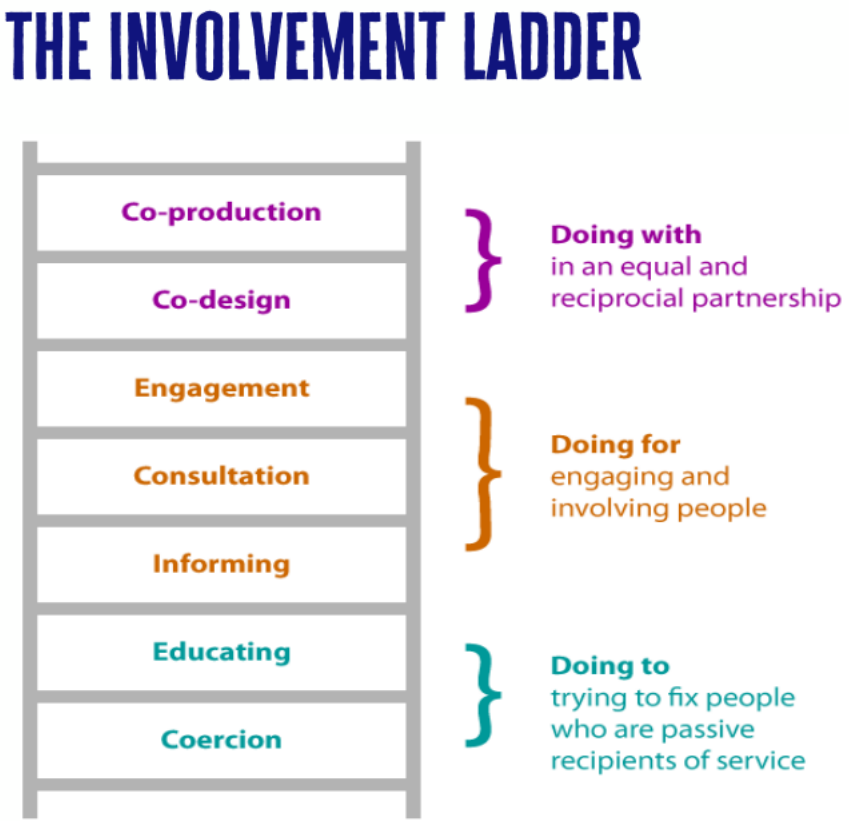
- There is a need for consistent medical advice, improved access to specialists, emotional and psychological support, and better improved education on diabetes management

- People felt diabetes education programs should be more practical, engaging and tailored to different diabetes types

- People expressed challenges in attending appointments due to conflicting demands during working hours, caring commitments and personal preferences. This is a particular challenge for younger people e.g. those under 40.

Diabetes UK

- Research Team – Supporting Recruitment for Research
- Lived Experience/Involvement Team



Diabetes Priorities

- Develop community/peer-led support groups or networks, involving communities and community assets to empower individuals and improve access to support for the prevention and self-management of T2DM.

- Strengthen the system-wide prevention offer for T2DM, including with communities and across organisations, embedding prevention into routine care and ensuring tailored and evidence-informed interventions are available locally and are accessible and appropriate for those most at-risk.

- Embed actions to tackle diabetes-related health inequalities at every stage of the ‘patient pathway’/within all workstreams, including in prevention, primary care, secondary care, and CYP activities. This includes targeted activities/interventions to identify and address barriers to access and participation for at risk groups.

Diabetes Priorities – Research Links

- Strengthen engagement and community involvement:
  - Embed resident voice
  - Make participation in diabetes research inclusive
  - Ensure research findings and implementation reach the populations with the highest need
- Evaluating local work and disseminating learning to identify best practice for addressing inequalities in diabetes prevention and management
- Learning from other long-term conditions which we can apply locally to diabetes prevention and management