Joint Strategic Needs Assessment
Understanding health and wellbeing needs

**Diabetes**

**Why is it a priority?**
Diabetes is a long term condition that affects an estimated 15,464 (7.8%) people in Greenwich and is linked to complications including retinopathy, kidney disease, amputation and cardiovascular disease. On average at age 55, the life expectancy of people with type 2 diabetes is 5 to 7 years less than for the general population. Around 85% of people with diabetes have type 2, which is often preventable.

There is a consistent year-on-year rise in the number of diabetics. In 13/14, 6.13% of Greenwich adults had been diagnosed with diabetes, and the pace of increase of prevalence is higher than in England, London, and demographically similar boroughs. Mortality where diabetes is an indirect cause has been increasing by 2.5 deaths per year, and in 2011 there were 45.8 deaths per 100,000 were diabetes was an indirect cause.

Type 2 diabetes is six times more common among people of South Asian descent and three times more common among people of African and African-Caribbean descent. Overweight and obesity are the strongest modifiable risk factors for diabetes. Increased risk is associated with incremental increases in body weight in early adulthood and duration of obesity. Greenwich experiences the 3rd highest rate of overweight/obesity in Reception in London and a greater than England or London rate in Year 6.

There are 8 essential care processes, in addition to retinal screening, that together substantially reduce complication rates. Despite this, around a third of people with diabetes do not receive all 8 care processes, and there is a widespread variation between CCGs and practices in levels of achievement.

**What could make a difference at a local level?**
Systematic, scaled up healthy lifestyle behaviour change support, linked to positive changes in the physical and cultural environment to help people make healthier choices

Breastfed babies have a 39% risk reduction of diabetes as adults compared to bottle fed babies

Systematic identification of people at risk of developing diabetes (and people at high risk) through NHS Health Checks and referral into effective programmes such as Walking Away from Diabetes (WAfD) and smoking cessation services
Closing the gap between diagnosed and undiagnosed people with diabetes
Systematic and consistent implementation of nationally recommended care processes, linked to personalised care planning

What are the opportunities for improvement in Greenwich?
Strengthening the prevention pathways from NHS Health Checks, to identify and manage diabetes risk and to reduce smoking prevalence. This will involve expanding the current WAfD resource in line with NICE guidance
Pursuing opportunities to increase capacity for intensive lifestyle prevention through the National Diabetes Prevention Programme
New contracts and services for Greenwich Healthy Living to ensure services are capable of processing increased demand
Implementation of Make Every Contact Count leading to greater identification of those at risk and signposting to preventative services
Local leadership and action planning for system change, to tackle particular areas of local variation (e.g. estimated/actual prevalence, diabetes clinical outcomes), to achieve models of person-centric care e.g. Year of Care, and to redesign the diabetes care pathway to reduce costs and maximise outcomes