NHS
Birmingham South Central
Clinical Commissioning Group

Delivering NDPP in a super diverse population

Simon Doble, Senior Commissioning Manager BSC CCG

Philomena Gales, NDPP Programme Manager

NDPP Midlands & East Diabetes Regional Event
2nd December 2016

Birmingham, Sandwell and Solihull

National Diabetes Prevention Programme Demonstrator and Wave 1 Site

Focus of talk

- Background to the CCGs/Local Authorities
- Our Service – from Demonstrator to Wave 1
- Does deprivation or ethnicity affect uptake
- Take up numbers and early results
- What could we do better?

NHS
Birmingham South Central
Clinical Commissioning Group
Best care, Best place, Best time.

In partnership with…….

NHS
Birmingham CrossCity
Clinical Commissioning Group
Excellence in Commissioning
Through Excellent Primary Care

NHS
Solihull
Clinical Commissioning Group

Sandwell & West Birmingham
CCG
healthcare
without boundaries

Birmingham City Council

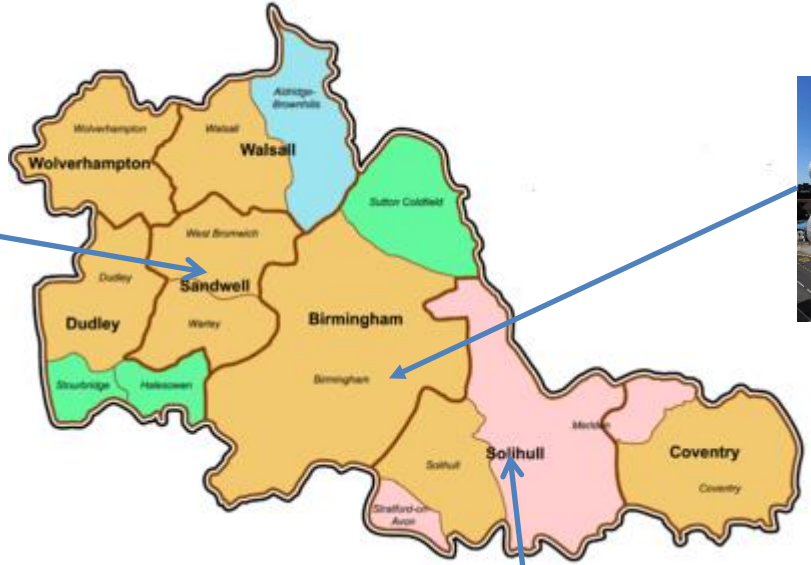
Solihull
METROPOLITAN
BOROUGH COUNCIL
URBS·IN·RURE

Sandwell
Metropolitan Borough Council

NHS HEALTH CHECK
Helping you prevent
diabetes | heart disease | kidney disease | stroke & dementia

HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

Birmingham, Sandwell and Solihull

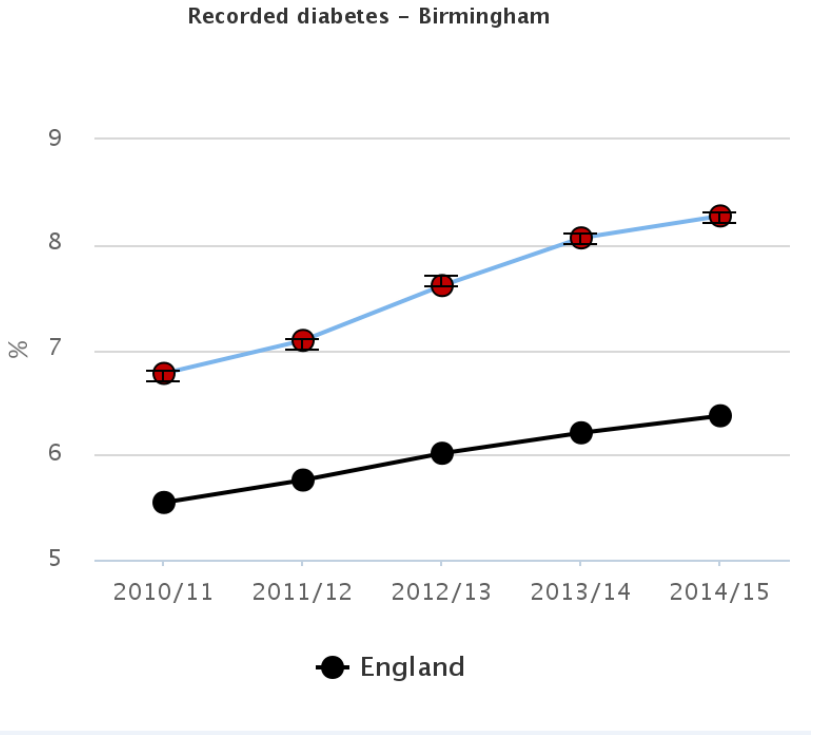


NHS HEALTH CHECK
Helping you prevent
diabetes | heart disease | kidney disease | stroke & dementia

HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

Birmingham- the diabetes burden

Source: PHE – fingertips tool



NHS HEALTH CHECK
Helping you prevent
diabetes
heart disease
kidney disease
stroke & dementia

HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

Estimates of non-diabetic hyperglycaemia in England in 2015

The data below gives the estimated number of people aged 16 and over who have non-diabetic hyperglycaemia by local authority

Source: NCVIN

Area	Estimated NDH Number	Prevalence
England	5,047,891	11.4%
Birmingham	101,924	11.9%
Sandwell	30,798	12.3%
Solihull	20,264	11.9%

Prevalence estimates of diabetes by clinical commissioning group (CCG)

The data below gives the estimated number of people age 16 years or older who have diabetes (diagnosed and undiagnosed) by CCG
Source: www.ncvin.org.uk

	2015 Population	2015 Estimated Prevalence	2025 Population	2025 Estimated Prevalence	2035 Population	2035 Estimated Prevalence
England	3,807,042	8.6%	4,389,884	9.2%	4,936,102	9.7%
NHS Birmingham Crosscity CCG	56,452	9.9%	62,840	10.2%	70,291	10.6%
NHS Birmingham South and Central CCG	15,781	9.9%	17,541	10.3%	19,604	10.7%
NHS Sandwell and West Birmingham CCG	43,324	11.5%	48,395	11.9%	53,843	12.3%
NHS Solihull CCG	15,203	8.9%	16,959	9.5%	18,522	9.8%

BSC's CVD LIS 14/15

- BSC CCG established a CVD Local Improvement Scheme (LIS) in 2014 with an emphasis on identifying and managing patients at risk of developing type II diabetes mellitus.

- Local Improvement Scheme including:
  - Case finding and management of patients with pre-diabetes
  - Promote self care through individual management plans, including in-practice care education and the offer of referral for structured education programmes
  - Designed by GPs for GPs
  - Uses Practice List as resource for case finding

EOI for Demonstrator Sites –Service Proposal

Components of the scheme included:

1. **Motivational Interviewing** - Training in motivational interviewing for front line clinical staff and brief intervention techniques for lifestyle change.

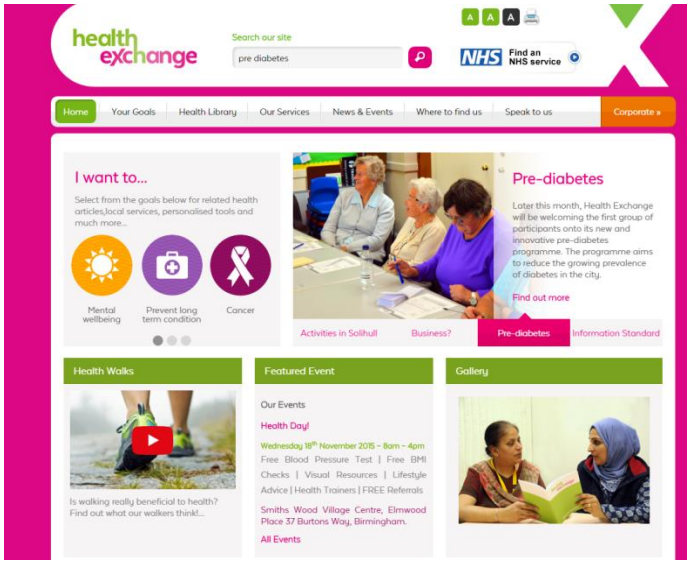
2. **LIS Development** - Enhanced CVD Local Improvement Scheme that provides for structured capture (template/read coded) of lifestyle change preferences and referral route.

3. **Core Intervention** - Commissioning a pilot local structured programme for people at risk of diabetes from existing providers - to include nutrition and exercise (in line with national evidence base).

4. **Feedback** – ensuring feedback and tracking

Third Sector Providers

We have worked with two local well established third sector providers of lifestyle interventions, Gateway Family Services and Health Exchange:



NHS HEALTH CHECK
Helping you prevent
diabetes | heart disease | kidney disease | stroke & dementia

HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

Provider Arrangements

- Specification completed and agreed with our two Providers
  - Matched to the nationally developed evidence
- **Contract agreed with two providers – Negotiation regarding distribution of funding across the length of the programme**
- Insight support used to finalise referral letters
- Activity plans agreed
- Builds on history of providing health trainers, ensured **strong liaison between providers and practices building on existing working relationships**

health exchange

Living Well, Taking Control

min. 9 month journey

13 sessions

6 Sessions
1 x week
90 minutes
Over 6 weeks
Face-to-face

Ongoing
Support Session

3 months
Email/ Telephone or
optional face-to-face

Post 3rd
Session

Ongoing Support
Session

GRADUATE!!!
12 month
Group sign-off
Session

If needed
ongoing
support

Telephone
Text & Mail
Facebook Group
Twitter

6 month
90 minute Group
Session face-to-face

Ongoing Support
Session

Ongoing
Support
Session

8 month
Email / Telephone
or optional face-
to-face

Ongoing
Support Session

10 month
Email / Telephone
or optional face-to face

Ongoing Support
Session

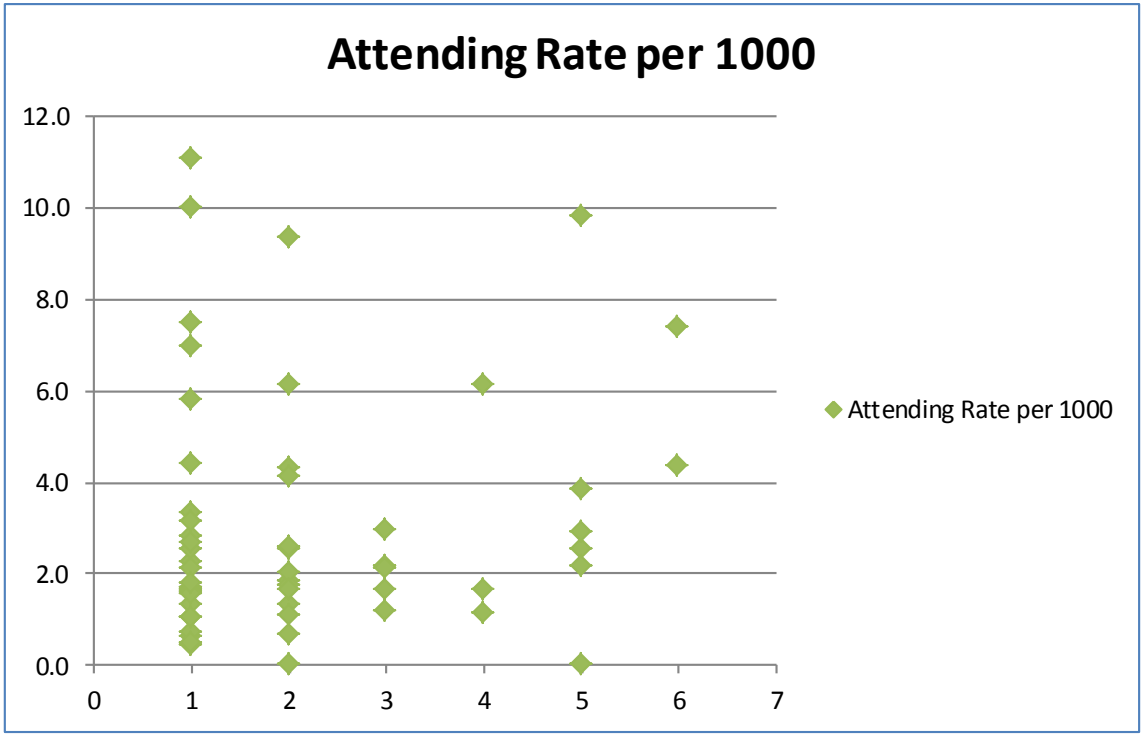
Development: App for Healthy Lifestyle Support Buddy
Link into Health Fabric
Underpin all sessions with mobile support

Development Launch
of Mobile App Support
approx 6 months

NHS HEALTH CHECK
Helping you prevent
diabetes | heart disease | kidney disease | stroke & dementia

HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

Uptake IMD* vs Attending Rate/1000



CC = 0.1

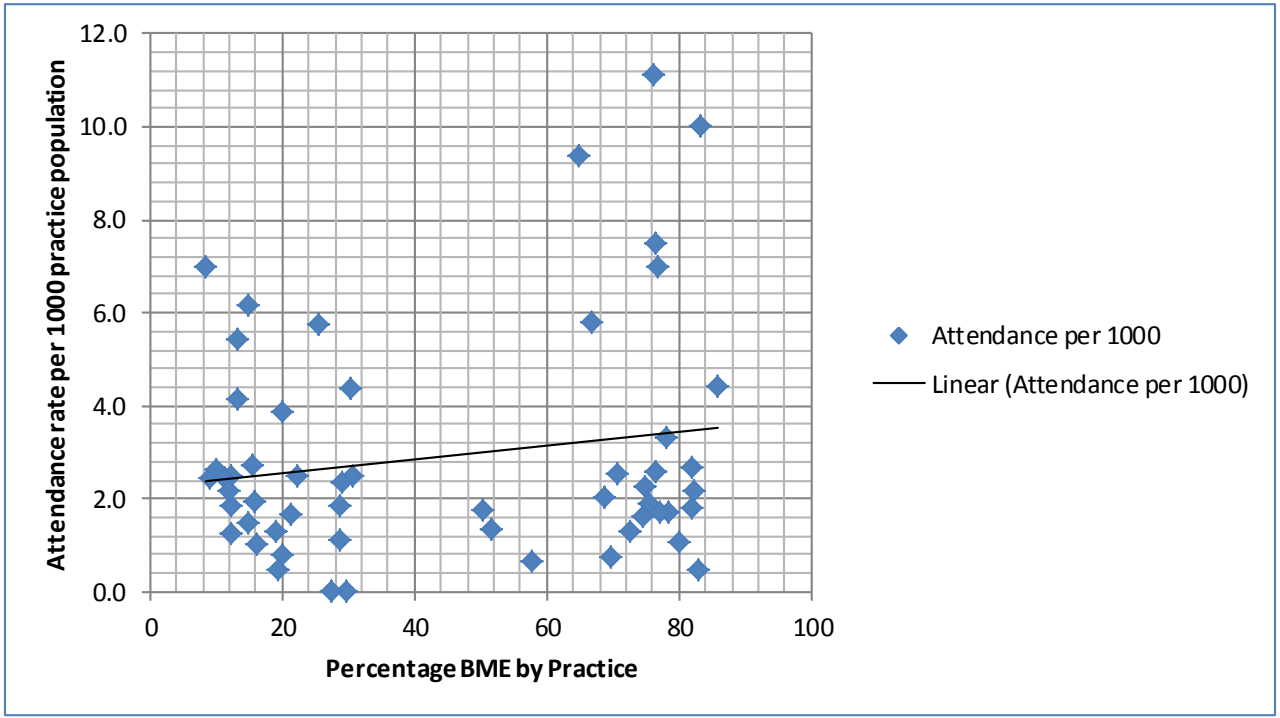
- Seems to depend on Practice enthusiasm
- Suggests deprivation not a barrier here

*see PHE fingertips – National Practice Profiles

NHS HEALTH CHECK Helping you prevent diabetes heart disease kidney disease stroke & dementia

HEALTHIER YOU NHS DIABETES PREVENTION PROGRAMME

Uptake BME vs Attendance Rate



NHS HEALTH CHECK Helping you prevent diabetes heart disease kidney disease stroke & dementia

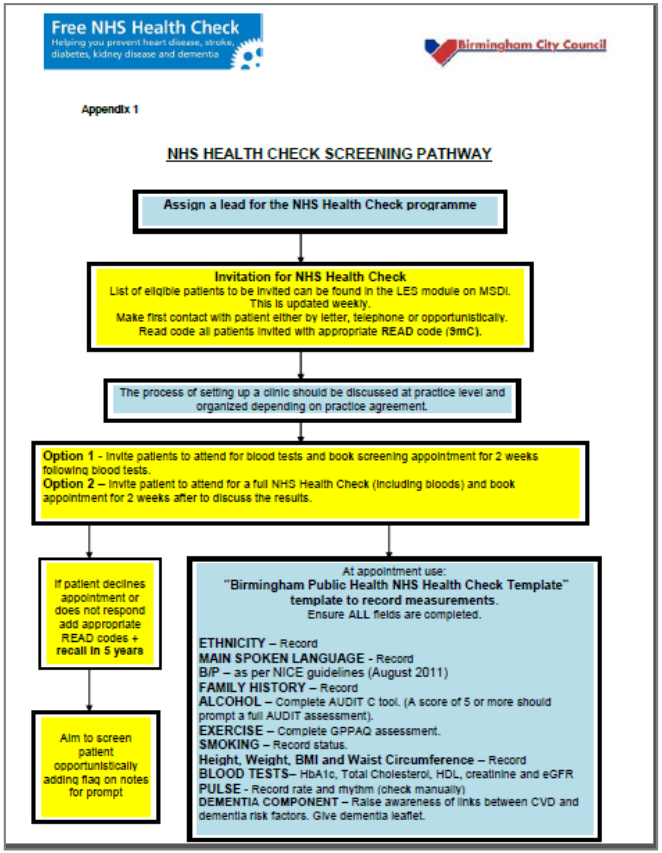
HEALTHIER YOU NHS DIABETES PREVENTION PROGRAMME

NDPP First Wave Implementer

- Successfully chosen as a first wave implementer for the National Provider Roll Out in 16/17
- First Wave footprint includes Birmingham, Sandwell and Solihull CCGs/LAs
- Provider appointed from National Framework: Living Well Taking Control – Health Exchange
- Indicative activity in first year approximately 900
- Service "soft launched" 13th June 2016
- Main source of referrals NHS Health Checks and opportunistic finding via general practice
- Direct Recruitment model under development (focus on South Asian 25-40 population / deprived parts of areas

NHS HEALTH CHECK Helping you prevent diabetes heart disease kidney disease stroke & dementia

HEALTHIER YOU NHS DIABETES PREVENTION PROGRAMME



Free NHS Health Check
Helping you prevent heart disease, stroke, diabetes, kidney disease and dementia

Birmingham City Council

Appendix 1

NHS HEALTH CHECK SCREENING PATHWAY

Assign a lead for the NHS Health Check programme

Invitation for NHS Health Check
List of eligible patients to be invited can be found in the LES module on MSDI. This is updated weekly.
Make first contact with patient either by letter, telephone or opportunistically.
Read code all patients invited with appropriate READ code (**9mC**).

The process of setting up a clinic should be discussed at practice level and organized depending on practice agreement.

Option 1 - Invite patients to attend for blood tests and book screening appointment for 2 weeks following blood tests.
Option 2 – Invite patient to attend for a full NHS Health Check (including bloods) and book appointment for 2 weeks after to discuss the results.

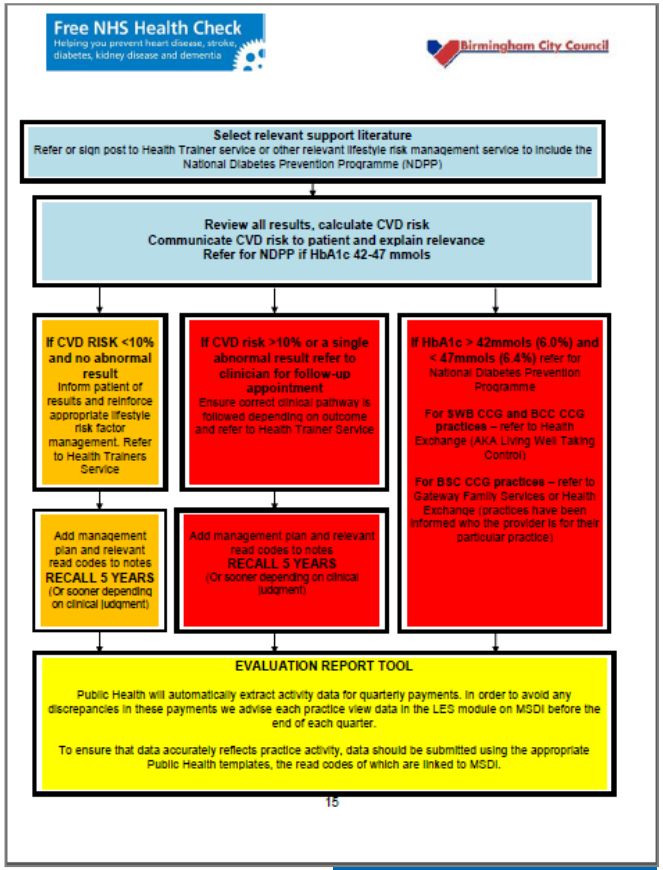
If patient declines appointment or does not respond add appropriate READ codes + **recall in 5 years**

Aim to screen patient opportunistically adding flag on notes for prompt

At appointment use:
"Birmingham Public Health NHS Health Check Template" template to record measurements.
Ensure **ALL** fields are completed.

ETHNICITY – Record
MAIN SPOKEN LANGUAGE - Record
B/P – as per NICE guidelines (August 2011)
FAMILY HISTORY – Record
ALCOHOL – Complete AUDIT C tool. (A score of 5 or more should prompt a full AUDIT assessment).
EXERCISE – Complete GPPAQ assessment.
SMOKING – Record status.
Height, Weight, BMI and Waist Circumference – Record
BLOOD TESTS– HbA1c, Total Cholesterol, HDL, creatinine and eGFR
PULSE - Record rate and rhythm (check manually)
DEMENTIA COMPONENT – Raise awareness of links between CVD and dementia risk factors. Give dementia leaflet.

Health Checks Screening Pathway



Free NHS Health Check
Helping you prevent heart disease, stroke, diabetes, kidney disease and dementia

Birmingham City Council

Select relevant support literature
Refer or sign post to Health Trainer service or other relevant lifestyle risk management service to include the National Diabetes Prevention Programme (NDPP)

Review all results, calculate CVD risk
Communicate CVD risk to patient and explain relevance
Refer for NDPP if HbA1c 42-47 mmols

If CVD RISK <10% and no abnormal result
Inform patient of results and reinforce appropriate lifestyle risk factor management. Refer to Health Trainers Service

Add management plan and relevant read codes to notes
RECALL 5 YEARS
(Or sooner depending on clinical judgment)

If CVD risk >10% or a single abnormal result refer to clinician for follow-up appointment
Ensure correct clinical pathway is followed depending on outcome and refer to Health Trainer Service

Add management plan and relevant read codes to notes
RECALL 5 YEARS
(Or sooner depending on clinical judgment)

If HbA1c > 42mmols (6.0%) and < 47mmols (6.4%) refer for National Diabetes Prevention Programme

For SWB CCG and BCC CCG practices – refer to Health Exchange (AKA Living Well Taking Control)

For BSC CCG practices – refer to Gateway Family Services or Health Exchange (practices have been informed who the provider is for their particular practice)

EVALUATION REPORT TOOL

Public Health will automatically extract activity data for quarterly payments. In order to avoid any discrepancies in these payments we advise each practice view data in the LES module on MSDI before the end of each quarter.

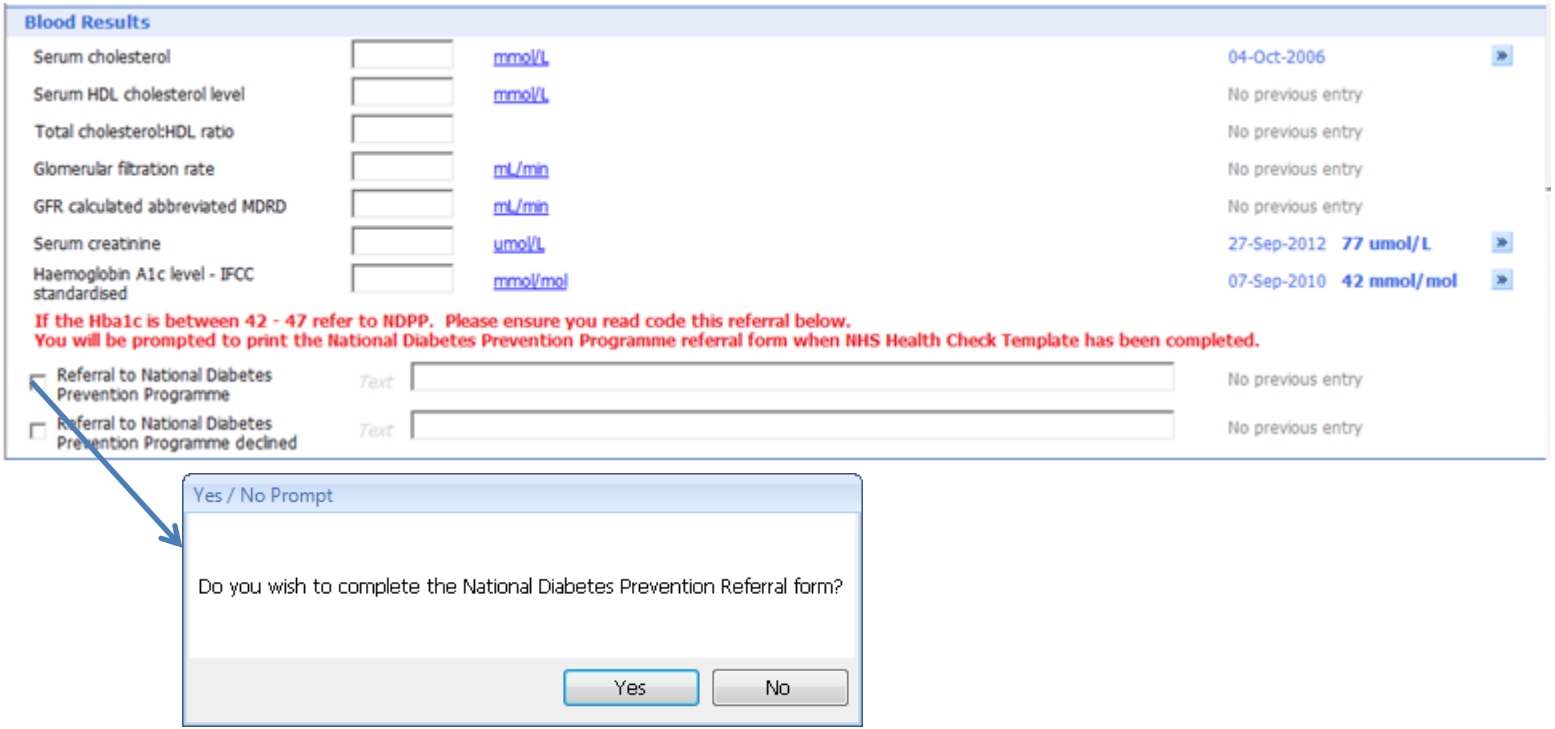
To ensure that data accurately reflects practice activity, data should be submitted using the appropriate Public Health templates, the read codes of which are linked to MSDI.

15

NHS HEALTH CHECK
Helping you prevent
diabetes | heart disease | kidney disease | stroke & dementia

HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

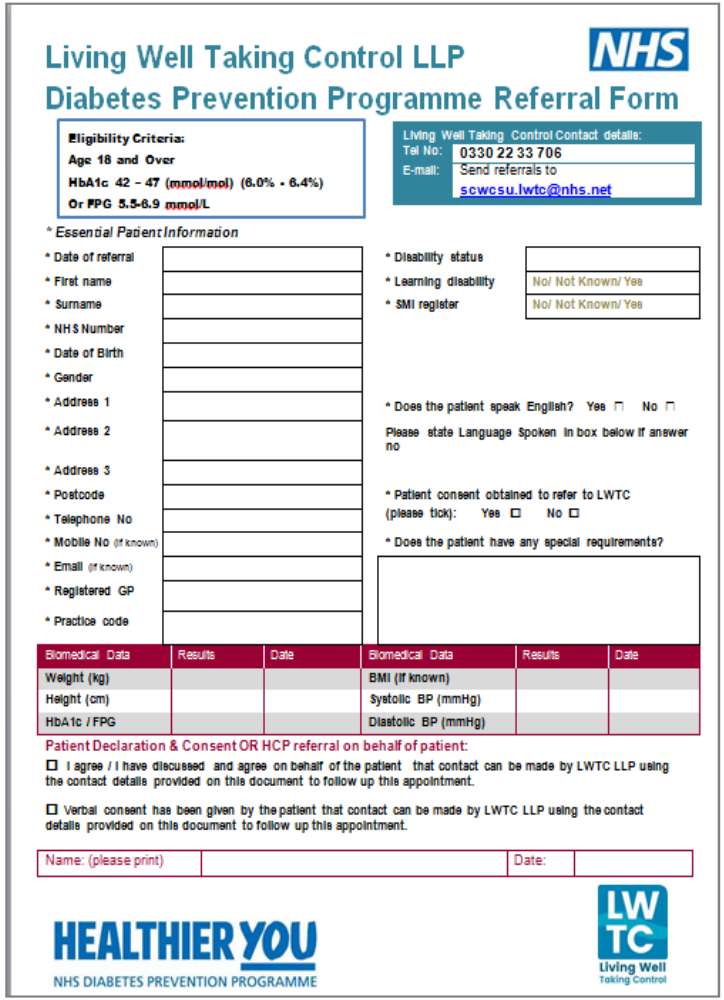
‘Pop Up’ reminder on health check clinical template



NHS HEALTH CHECK Helping you prevent diabetes heart disease kidney disease stroke & dementia

HEALTHIER YOU NHS DIABETES PREVENTION PROGRAMME

Health Exchange Referral Form



Living Well Taking Control LLP

NHS

Diabetes Prevention Programme Referral Form

Eligibility Criteria:
Age 18 and Over
HbA1c 42 – 47 (mmol/mol) (6.0% - 6.4%)
Or FPG 5.5-6.9 mmol/L

Living Well Taking Control Contact details:
Tel No: 0330 22 33 706
E-mail: Send referrals to scwcsu.lwtc@nhs.net

** Essential Patient Information*

* Date of referral	
* First name	
* Surname	
* NHS Number	
* Date of Birth	
* Gender	
* Address 1	
* Address 2	
* Address 3	
* Postcode	
* Telephone No	
* Mobile No (if known)	
* Email (if known)	
* Registered GP	
* Practice code	

* Disability status	
* Learning disability	No/ Not Known/ Yes
* SMI register	No/ Not Known/ Yes

* Does the patient speak English? Yes ☐ No ☐

Please state Language Spoken in box below if answer no

* Patient consent obtained to refer to LWTC (please tick): Yes ☐ No ☐

* Does the patient have any special requirements?

Biomedical Data	Results	Date	Biomedical Data	Results	Date
Weight (kg)			BMI (if known)		
Height (cm)			Systolic BP (mmHg)		
HbA1c / FPG			Diastolic BP (mmHg)		

Patient Declaration & Consent OR HCP referral on behalf of patient:

☐ I agree / I have discussed and agree on behalf of the patient that contact can be made by LWTC LLP using the contact details provided on this document to follow up this appointment.

☐ Verbal consent has been given by the patient that contact can be made by LWTC LLP using the contact details provided on this document to follow up this appointment.

Name: (please print)		Date:	

HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

LWTC Living Well Taking Control

NHS HEALTH CHECK
Helping you prevent
diabetes | heart disease | kidney disease | stroke & dementia

HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

Direct Recruitment Pilot

- Health Exchange successfully bid to be a pilot site for Direct recruitment into the NDPP
- 3 month pilot commencing in November
- Target population people aged **≥25yrs and ≤40 years of age** with a high BMI (30 kg/m²) living in the deprived areas of North Solihull, Birmingham and Sandwell including:

  Males and Females

  Any employment status, any ethnicity but particularly targeting South Asian, African or African Caribbean population and the predominantly white population in the deprived area in North Solihull

NHS HEALTH CHECK Helping you prevent diabetes heart disease kidney disease stroke & dementia

HEALTHIER YOU NHS DIABETES PREVENTION PROGRAMME

Activity – at end of October 2016

Headline figures (Demonstrator site and post launch Wave 1)

- Mailshot 1 in 5 response rate
- 1,966 referral (contacted following letter from GP/opportunistic referrals/NHS Health Checks referrals)
- 1,104 patients are attending the programme
- 85% plus retention rate at present
- Declined/DNA'd rates vary by provider 36% to 17%

Early results – six months into programme

Gateway Family Services

84:198 HbA1c results back to date – patients reported the following:

- **55 (65.5%) no longer at risk**
- **13 (15%) reduced – still at risk**
- **10 (12%) no change**
- **6 (7.5%) increased**

Weight: 121:198 patients

- **12 no longer obese**
- **15 no longer overweight**
- **86 have reduced weight**
- **30 have increased weight**
- **5 have remained the same**
- **Biggest weight loss 108kgs down to 92kgs**

71% of patients have lost weight

NHS HEALTH CHECK Helping you prevent diabetes heart disease kidney disease stroke & dementia

HEALTHIER YOU NHS DIABETES PREVENTION PROGRAMME

Early results – six months into programme

Health Exchange – Living Well Taking Control LLP

128:179 HbA1c results back to date – patients reported the following:

- **55 (43%) no longer at risk**
- **35 (27%) reduced – still at risk**
- **14 (11%) no change**
- **24 (19%) increased (of which 3 are now above 47mmol)**

NHS HEALTH CHECK Helping you prevent diabetes heart disease kidney disease stroke & dementia

HEALTHIER YOU NHS DIABETES PREVENTION PROGRAMME

Early results – six months into programme

BMI: 46 customers found to have BMI between 25 and 29.9 at initial assessment were classed as Overweight.

- **5 decreased their BMI under 25 at six-months follow-up and were classed as Healthy**
- **37 sustained their initial BMI result. 30 of this cohort were found to have decreased their weight between referral and six-months follow-up;**
- **4 increased their BMI and were classed as Obese at six-month follow-up;**

BMI: 68 customers found to have BMI equal to or greater than 30 at initial assessment were classed as Obese.

- **12 achieved BMI under 30 and were classed as Overweight;**
- **56 sustained their initial BMI range. 38 of this cohort were found to have decreased their weight between referral and at six-months follow-up**

Our Experience – what has helped implementation

- Board arrangement – commissioner leads, providers, local authority leads, CCG finance, expert advice from Dietetics local community trust - Local Authority GP, community champion
- Existing relationships with Third Sector Providers
- Initial LIS scheme component designed by our GPs
- Explicit linkage into developing Sustainability and Transformation Plans
- Local networking - Diabetes Clinical Network, CCG locality Networks
- Getting GP IT support – easy downloadable form

Our Experience – what could we do better?

- A “Hard” launch for wave 1 would have improved local knowledge
- Incentivise case finding as well use incident cases via Health Checks
- Considered local equity earlier
- Ensured that the pathway is understood by primary care
- Used the referral data better to improve knowledge at CCG Clinical Network level

NHS HEALTH CHECK Helping you prevent diabetes heart disease kidney disease stroke & dementia

HEALTHIER YOU NHS DIABETES PREVENTION PROGRAMME