

NHS Bradford City CCG

Improving the detection and prevention of Type 2 diabetes - Bradford Beating Diabetes (BBD)

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The setting

Bradford City CCG

The situation or problem

Bradford City CCG identified type 2 diabetes as a priority area for improving the health of the population it serves through higher quality delivery of primary care services. Of the 118,567 people within Bradford City CCG the prevalence of diagnosed cases of type-2 diabetes was 7.5% in 2013, higher than the prevalence in the UK (5.8%). However, given that around 75% of the Bradford City CCG population is of South Asian heritage and, since type-2 diabetes is up to six times more common in this group than in white British people, Public Health England estimated that the prevalence of diagnosed and undiagnosed diabetes was likely to be at least 11% (9,269 people) and maybe as high as 22% (18,538 people).

What action was taken?

Bradford City CCG used the NHS Right Care approach to inform the commissioning and delivery of programmes, using their evidence-based methods and with a clear emphasis on outcomes. They used the three-stage Right Care methodology (Where to look, What to change, How to change) to focus on clinical programmes and identify value opportunities.

Where to Look

- The NHS Right Care Commissioning for Value Insight Pack for Bradford City CCG¹ demonstrated that, in comparison with similar organisations, endocrine nutritional and metabolic problems (which includes diabetes) presented significant value opportunities in terms of improvement in quality and outcomes; spend and quality/outcomes and acute and prescribing spend. Financial savings in excess of £1.85 million were estimated to be achievable.
- The National Diabetes Audit 2012-2013² identified Bradford City CCG as being in the bottom 25% of all CCGs for delivery of the 8 (excluding eye screening) NICE recommended care processes for patients with diabetes.
- Patient engagement groups identified type 2 diabetes as an area on which they hoped the CCG would concentrate and improve.

¹ <http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/>

² <http://www.hscic.gov.uk/catalogue/PUB14970>

- During a local diabetes review in 2013 key stakeholders described high rates of South Asian patients failing to attend clinic appointments which form part of their diabetes treatment. Some health professionals felt they often spend a lot of time trying to support older South Asian patients with diabetes whilst the patients have cited difficulties in understanding English, lack of time, feeling very down about their diagnosis and feeling like they're being told off as factors that make it hard to control their diabetes.

What to Change

The actual prevalence of type-2 diabetes in this population was anticipated to be significantly higher than the prevalence of diagnosed cases. This was due to the unique nature of the population with 75% being of South Asian descent. The Bradford City CCG Governing Board and Clinical Board jointly made the decision to concentrate on the primary and secondary prevention of type 2-diabetes with the provision of a focussed service delivered within primary care settings. This programme has been entitled Bradford Beating Diabetes (BBD).

How to Change

Bradford CCG embarked on a 3-phase campaign of diabetes prevention. The tools adopted to identify individuals at risk of developing type-2 diabetes, and the most appropriate interventions dependent upon level of risk, included the Diabetes UK risk tool and NICE Public Health 38 Guidance.

Phase 1: This phase involved contacting people who were already known to be at risk of developing type-2 diabetes - through having had an impaired glucose tolerance test or impaired fasting glycaemia within the previous 12 months. 2200 individuals were contacted by letter from their GP and invited to attend the practice. Specially trained health care assistants or practice nurses measured their HbA1c and completed the Diabetes UK risk assessment to determine their current diabetes status.

Phase 2: This phase is on-going and involves contacting approximately 40,000 individuals in Bradford City who are within the at-risk group, being either over 25 years old from South Asian or other black and minority ethnic groups or white people over 40 years old. Individuals are invited to an appointment at their GP practice where their diabetes status and appropriate management /prevention programme is determined (table 1).

Table1. To demonstrate management according to diabetes status

Diabetes status	Programme Offered	Recall frequency
Type-2 diabetes (HbA1c level >48mmol/mol)	Management of their condition including delivery of the recommended 9 NICE care processes	Patients are managed as appropriate to their needs
High risk of developing type-2 diabetes	Referred by their practice to the Intensive Lifestyle Change Programme	Annually
Medium risk of developing type-2 diabetes	Brief intervention	Every 3 years
Low risk of developing type-2 diabetes	Brief Advice	Every 5 years

Individuals found to be at low risk of developing type-2 diabetes are provided with information and advice about lifestyle choices that will keep risk levels low.

Individuals found to be at medium risk are offered a brief intervention and advice on how to lower their risk of developing type-2 diabetes.

Individuals found to be at high risk of developing diabetes are invited to participate in the Intensive Lifestyle Change Programme (ILCP). The ILCP uses a group-based approach which aims to help group members to change their lifestyle choices thus reducing their risk of developing diabetes. There are currently 9 group sessions over the course of a year, with the first 5 sessions being held weekly. The groups are facilitated by BBD Champions who are health trainers and also members of the public who have been specifically trained on the criteria specified by NICE and who, through passing an exam, have achieved a qualification accredited by the Royal Society for Public Health and administered through Leeds Beckett University. The ILCP programme includes sessions on activity, healthy eating, smoking cessation and the risks of not making changes. Participants complete questionnaires and physiological measurements at the commencement and completion of the ILCP to determine the impact of the programme. The ILCP programme is being evaluated by Leeds Beckett University.

Phase 3: is focussed on improving the outcomes for people with diabetes, to reduce unwarranted variation across practices, and focus on delivering the 9 care process checks recommended by NICE.

What happened as a result?

- The BBD programme has enabled the identification of over 1000 previously undiagnosed individuals with type-2 diabetes, some of whom were asymptomatic.
- Although numbers are low, questionnaire results after the first ILCP indicate that participants increased their knowledge of the condition and how to prevent it.
- Data from the first cohort to have completed the ILCP found small reductions in average weight, BMI and waist measurement.
- A statistically significant decrease in average HbA1c measurement was seen between baseline and post ILCP with some patients moving from high risk to low risk.
- The recall programme is designed to identify individuals whose risk is increasing and who can be helped to avoid the development of type-2 diabetes through the introduction of life-style changes
- There has been a measurable improvement in delivering the 9 NICE recommended care processes for patients with diabetes (from 40% at the start of BBD to 72% in March 2015). As a result it is anticipated that, in the long-term, costly treatments such as amputations will be reduced. York Health Economics Consortium (YHEC) is developing an economic model to identify the longer term economic impacts of the work.

What was the learning as a result of this experience?

- The success of the BBD programme is linked to working with the local authority which commissions a range of ill-health prevention services including weight management, exercise referral scheme and the Health Trainer Service
- The patients at risk of developing diabetes placed importance on receiving a letter from their GP, and receiving their initial risk score during their appointment – which acted as a “wake-up call”.
- The take-up of places on ILCP and other interventions was increased by introducing a mechanism of referral/prescribing rather than an informal intervention. A free gym pass also helped to encourage individuals to commit to the programme
- The importance of making the interventions culturally appropriate. Delivery in different languages has also proved valuable.
- The numbers of people with type-2 diabetes accessing all 9 care process checks increased with the introduction of a BBD “passport”.
- The Right Care model can be applied to other commissioning priorities and Bradford CCG intends to apply this model to determine new areas of focus.

See all the Right Care Casebooks on www.rightcare.nhs.uk/resourcecentre