NHS
Birmingham South Central
Clinical Commissioning Group

Local Improvement Schemes (LIS) to support case finding and referral

A case study from Birmingham NHS Diabetes Prevention Programme

Disclaimer: The case study presented is set out as an example of local delivery of a specific project within the NHS DPP at a specific point in time. It is not to be used as an evidence based guide or interpreted as a policy for the implementation of the NHS DPP

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Summary:

Primary care engagement and buy in to the identification and referral of at risk patients is crucial to the success of the programme. Birmingham South and Central CCG (BSC) recognised the resource pressures on primary care and sought to identify how they could support the NHS DPP through existing schemes outside of the Standard GP contract alongside other activities undertaken by the CCG and Public Health teams.

Components of the scheme included:

- Community Engagement
- Motivational Interviewing - Training in motivational interviewing for front line clinical staff and brief intervention techniques for lifestyle change.
- LIS Development and roll out - Enhanced CVD Local Improvement Scheme that provides for structured capture (template/read coded) of lifestyle change preferences and referral route
- Feedback – designing enhanced feedback and tracking for those on structured programmes.

Outcomes:

- 55 of the 55 CCG practices have signed up to deliver the LIS
- Practices mailshotting pre diabetes register patients to refer to intervention but some practices are ringing patients directly
- Primary Care motivational Interview – supporting practices and patients

Approach:
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

To deliver the requirements of the scheme, practices were paid £0.30p per patient based upon their weighted practice population. In return practices were expected to send out two mail shot invitations (funding for this action only)

Read code – Referred and/or Mailshot Patients

- Practices must Read code 'Healthy lifestyle programme offered' for each 'mailshot' patient as above to evidence on the data searches.
- Where a patient as a face to face contact and is directly signposted to the programme, practices entered relevant Read Code onto the patient's clinical record:
    - Referral to healthy lifestyle programme Read code
    - Referral to healthy lifestyle programme declined Read code

Read code - Provider Information on Patients to Practices
Practices are notified on a monthly basis by service providers' information regarding the number, names and clinical information gathered for patients who have joined the scheme and attended their first and / or follow up sessions.

Details should be entered onto the patient's clinical record using Read Codes including the commencement date of the Healthy Lifestyle Programme.

- Healthy lifestyle programme Did Not Attend (DNA) Read code
- Healthy lifestyle programme not completed Read code
- Healthy lifestyle programme completed Read code

Outcomes:

Activity analysis since the implementation of the Pre Diabetes LIS has shown really positive results. BSC CCG has strong referral numbers and this is converting in to course enrolments and to date low dropout rates.

As at the end of January 2016 activity figures are as follows:

Provider	GP Letters sent	Referrals Made	No. on Programme	Booked but Programme not started
Health Exchange	3632	596	163	192
Gateway FS	2486	520	181	204

Both GP practices and the intervention providers (are highly satisfied with the approach, engagement and service provision.

Lessons learnt:

- NDH Patients can be identified and risks reduced through GP intervention with or without lifestyle intervention
- Intervention has worked across different demographics
- Peer support, self-selecting Practice Groups, Clinical leadership in design
- Supported by clinical system pop ups and bespoke templates
- User and community engagement essential
- Payment by outcomes works

Acknowledgements:

Birmingham South Central CCG:

- Birmingham South Central Member Practices
- Carol Watson – Commissioning Network Manager
- Dr Richard Mendelsohn – Clinical Head of Commissioning
- Simon Doble – Senior Commissioning Manager

Intervention Providers:

- Gateway Family Services - Michelle Smitten
- Health Exchange - Leon Sewell /Sue Turton