

Targeted case finding approaches

A case study from Salford 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

Table of Contents

Summary	2
Approach:	2
Lessons Learnt:	3
Supporting Information:	4
Acknowledgements:	4

Summary

There are an estimated 19,693 people with Impaired Glucose Regulation (IGR) in Salford (National Cardiovascular Intelligence Network, 2015). Less than a third of these are known to Primary Care i.e. they are recorded on GP records with IGR or a related read code.

Salford is the 22nd most deprived local authority of the 326 districts in England. There are significant health inequalities; for example the gap in life expectancy in England for men between those who live in the most deprived areas to those who live in the most affluent areas is 2.8 years. Within Salford it is 12 years.

For the Salford programme it was therefore considered important that case finding included approaches to target the two thirds of people not identified, particularly those not routinely engaging with health services. This would contribute to reducing health inequalities.

The method was therefore to target communities using a range of innovative engagement methods, to identify and directly refer people with IGR into the intervention. The outcome has been that 7% of those assessed as high or moderate risk are then found to have IGR. All of these people then agree to a referral.

Approach:

Mapping of the prevalence of diabetes, ethnicity and IGR identified areas where people at high risk of diabetes are likely to live within the City. This was concentrated in some of the more deprived areas of the city.

Salford had an established Long-term Conditions Prevention Service which is based on volunteers engaging within their communities and networks to raise awareness of long term conditions. The Health Improvement Service has also been commissioned for opportunistic Health Checks in areas where GP practices are not commissioned. It was decided to enhance the work of these two services and for them to work collaboratively to find at risk people.

Point of care testing (POCT) machines were leased by the service and the health bus was used to visit identified areas to risk assess and test people. NHS DPP

POCT guide can be access through this link <https://www.england.nhs.uk/wp-content/uploads/2016/07/poct-paper.pdf>

Outcomes:

As the community programme started on November 15 the data on outcomes is not yet complete. The linkage to person outcomes i.e. following the community referral to intervention outcome is part of the external evaluation, not yet reported.

The conversion rates for each stage of the pathway, is as follows*:

1. 31% people approached agree to a risk assessment
2. 59% people who are risk assessed are high or moderate
3. 10% people tested have IGR
4. 97% people with IGR agree to referral to the intervention

*Note this reporting uses data between November 15 and January 16 and may change slightly as the programme continues and further embeds processes.

Stage 1 gives a drop off to that is anticipated for similar interventions, while stage 2 confirms the right people have been targeted. Stage 3 shows that 1 in 10 high risk people tested have IGR. This is consistent to the rate that GPs are finding from Health Checks in Salford which is 9.6%. As nearly all those with IGR agree to referral for the intervention this also suggests targeting in the community is useful to identify people and get them into the intervention. This requires corroboration, for when the evaluation follows people through the pathway.

Lessons Learnt:

- Large work places are a good place to find at risk people, in addition to community venues and groups. Work places with Routine and Manual Groups are more likely to employ local residents.
- Diabetes champions are useful in engagement with specific groups.
- People responded to local marketing and promotion.
- Health checks enable a way of testing to be built into existing systems.
- IGR detection rate in high risk groups was lower than expected at 10%. For every 50 people approached in community (targeted in high risk groups / areas) one person will have IGR and for every 50 people assessed as high risk there are 3 with IGR.
- Bad weather affected take up at some venues.
- Data recording and data link between community and intervention is problematic.

- Referral without NHS number impacts on the administration burden for the intervention team.
- The New Year offers a good time to engage as people are prepared for change while December is not an ideal month as people are not engaged to change diet behaviour.

To set up this process at least two months are required for agreement of approaches, training of those involved, purchasing of relevant equipment and development of contracts.

Supporting Information:

The following website provides some information and contact details

<https://www.way2wellbeing.org.uk/health/long-term-conditions/diabetes/know-diabetes/>

Local marketing /engagement materials and plan are available upon request.

Service specifications used for the community services involved are available upon request.

Contacts for further information:

lan.ashworth@salford.gov.uk

Sarah.cannon@salford.gov.uk

Acknowledgements:

- Salford CCG
- Health Improvement Service (Angela Eden, Wendy Kirkpatrick, Peter Lock and Health Improvement Officers)
- Unique Improvements Ltd (Adrian Smith, Bruce Poole and team members - volunteers)