





HEALTHIER YOU

NHS DIABETES PREVENTION PROGRAMME

Preventing Type 2 diabetes in Leeds

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The Leeds Picture



- Population of 751,485
- There are 164,000 people in Leeds who live in areas that are ranked amongst the most deprived 10% nationally.
- 10 year life expectancy gap between the most deprived and most affluent areas
- There are 141,771 people from BME communities (19%) and over 85 languages spoken
- 105 GP practices; 3 CCGs within Leeds with different boundaries to LCC locality working
- Over 45,000 people known to be in the high risk
- But have an expected prevalence of over 64,000



The NHS Health Check and the NDPP Interdependencies



- NHS HC a key mechanism in Leeds for identifying individuals at increased risk of Type 2 Diabetes via the diabetes risk assessment
- Each year the programme identifies over 1000 people who are high risk
- Avoids duplication and implements systematic approach across 105 practices
- NDPP offers behavioural intervention targeted at risk people and links with local lifestyle services and networks





West Yorkshire STP and The Leeds Plan



To reduce premature mortality and health demands from CVD we will:

- Support practices to increase uptake of the NHS Health Check across Leeds
- Establish a recall mechanism for all of those people identified to be at more than 20% risk of CVD to ensure they have effective support.
- Invite those identified as at high risk of diabetes to a face to face consultation and offer of support including referral to the national diabetes prevention programme.





The Leeds NDPP approach



- Joint working LCC, Public Health lead the delivery of the MoU in partnership with the CCG's and the provider, Ingeus
- Public Health post to implement NDPP and high risk priorities
- GP Clinical Champion identified
- NDPP steering group established to offer programme governance – provider now attends half of this meeting
- 7200 referrals to achieve 2880 uptake (40%)
- Referrals generated from primary care. Eligible people will be offered a face to face appointment
- Promote the YOC approach and motivational conversation
- Incorporated into all CCG local quality improvement schemes
- Meet with Healthier you manager weekly





Referral Process



- Clinical system reports developed to target identified patients
- System template developed to manage high risk population
 - includes NDPP e-referral & read codes
- Referral pathway linked to other Healthy Lifestyle Services
- Feedback from primary care was crucial in the development
- Available in S1 and Emis
- Simple read coded discharge letter developed





NDPP e-Referral Form





NHS National Diabetes Prevention Programme Referral

<Title> <First Names> <Family Name>
NHS Number: <Patient NHS Number>
DOB: <Patient Date of Birth>

Referral Date: < Referral Date>
Tel No: < Patient Tel Number>

Practice Information

Practice Name: < Practice Name >
Practice Code: < Practice Code >
Organisation Code: < Organisation Code >

Patient Gender: < Patient Gender>
Patient Ethnicity: < Patient Ethnicity>

Carer/ Register Details

(to be completed where applicable)

Carer/Representative Name: < Carer First Name > < Carer Family Name >

Carer Contact Number: <Carer Telephone Number>
Patient on SMI Register: <SMI Register Code>

Patient recorded on LD Register: < Patient Learning Disability Status>
Patient has physical/mobility issues: < Mobility Issue Code>

Patient Medical History

Patient Height: <Patient Height>
Patient Weight: <Patient Weight>

Patient Smoking Status: < Patient Smoking Status >
HbA1c Test Result: < HbA1c Test Figure > (< HbA1c Test Date >)
Fasting Blood Glucose Test Result: < FBG Test Result> (< FBG Test Date >)

<Title><First Name><Family Name> has consented as part of the referral process to selected fields of their medical recorded (detailed above) to be shared with the service provider for the purpose of managing their diabetic risk. Further information on the programme and information sharing will be provided in the initial contact with the provider, or alternatively on the provider swebsite (www.ingeus.co.uk).

Consent Given: < Patient Medical Record Consent Code>

The NHS Diabetes Prevention Programme provider across Leeds is <u>Ingeus</u> and they will contact you directly on the telephone number provided above within the next 2 working days of your receiving this referral form.



ingeus



Practice Details

Carer details where needed

Height/ Weight, Lifestyles and HbA1c



Where are we at now....





- Over 750 referrals have been received
- 55% practices have actively referred
- Over 850 declines have been recorded in practice – we need to understand why
- 20 programmes started, 9 planned for February
- 71% of people invited on to the programme either accept or ask to go on waiting list for convenient session
- 225 people on core 1-4, 44 people on Workshops 5-9
- 83% retention of people who start the programme.
 - 2 case studies developed



Some take home messages...and shared learning



- City wide partnership approach is instrumental
- Primary Care Engagement –communicate in different ways
- Be conscious of capacity and resource required primary care
 & programme management
- Quality improvement schemes, funding considerations, targets
- Do not underestimate time required to embed process, mobilise the service and generate referrals
- Be realistic in the referrals you expect allow 6 months to become established
- Clear and easy referral process is a MUST for practices







- Communication is key take time to visit practices, explain the programme to increase uptake, and liaise with all staff
- Share data with provider monitor referral and outcome data collectively – are the right people attending?
- Monitor the number of declines to address barriers
- Slow and scattered referrals across city impacts programme delivery - causes potential barrier to start with
- Ensure there is programme capacity to match demand
- Trial different approaches
- Marketing and communications needs to be adapted for local areas by provider
- Evaluate, review and amend be flexible







Thank You

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