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CVD prevention webinar series - NHS Health Check and NHS Diabetes Prevention Programme: alignment in the South East

Tuesday 31 October 2017
10:30-11:30

Please ensure your microphone is on mute, we will commence promptly at 10:30am

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NHS Health Check and NHS Diabetes Prevention Programme: alignment in the South East

Tuesday 31 October 2017

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Nicky Jonas, South East Clinical Network

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6 national alignment principles:

1) **NHS Health Checks:** a key mechanism for identifying individuals at increased risk of type 2 diabetes

2) **Opportunistic identification via patient records:** where patient attending appointment & records indicate high risk but no blood test, consider undertaking test as part of NHS Health Check

3) **Clinical audits:** where using patient records to identify those with raised NDH but blood test >12 months old, consider NHS Health Check as means of confirming risk.

4) **Linking to local pathways:** Providers of NHS DPP must ensure that links are made with existing local lifestyle services & NHS Health Checks (e.g. refer to wider NHSHC were eligible and not had)

5) **Direct recruitment:** approaches to identify/refer to NHS DPP must target high risk groups and/or less likely to access services.

6) **Direct recruitment:** provider should give priority to those referred by GPs &/or via NHS Health Check over those directly recruited

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Brighton & Hove City Council

Alignment of NHS Health Checks & the NHS DPP in Brighton & Hove

Tory Lawrence
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City wide LCS

LCS Innovations: Reducing the impact of non-diabetic hyperglycaemia (NHD)

- **Aim:** Providing a cluster-wide identification and referral service to the National Diabetes Prevention Programme (NDPP) and other locally commissioned services
- **Summary of Activity:**

1. Identify lead practice per cluster.
2. Identify registered individuals with Non Diabetic Hyperglycaemia across the cluster by using the agreed searches.
3. Invite patients for an NHS Health Check.
4. Refer to the 'Healthier You' National Diabetes Prevention Programme.
5. Or other healthy lifestyles services if not eligible for this services

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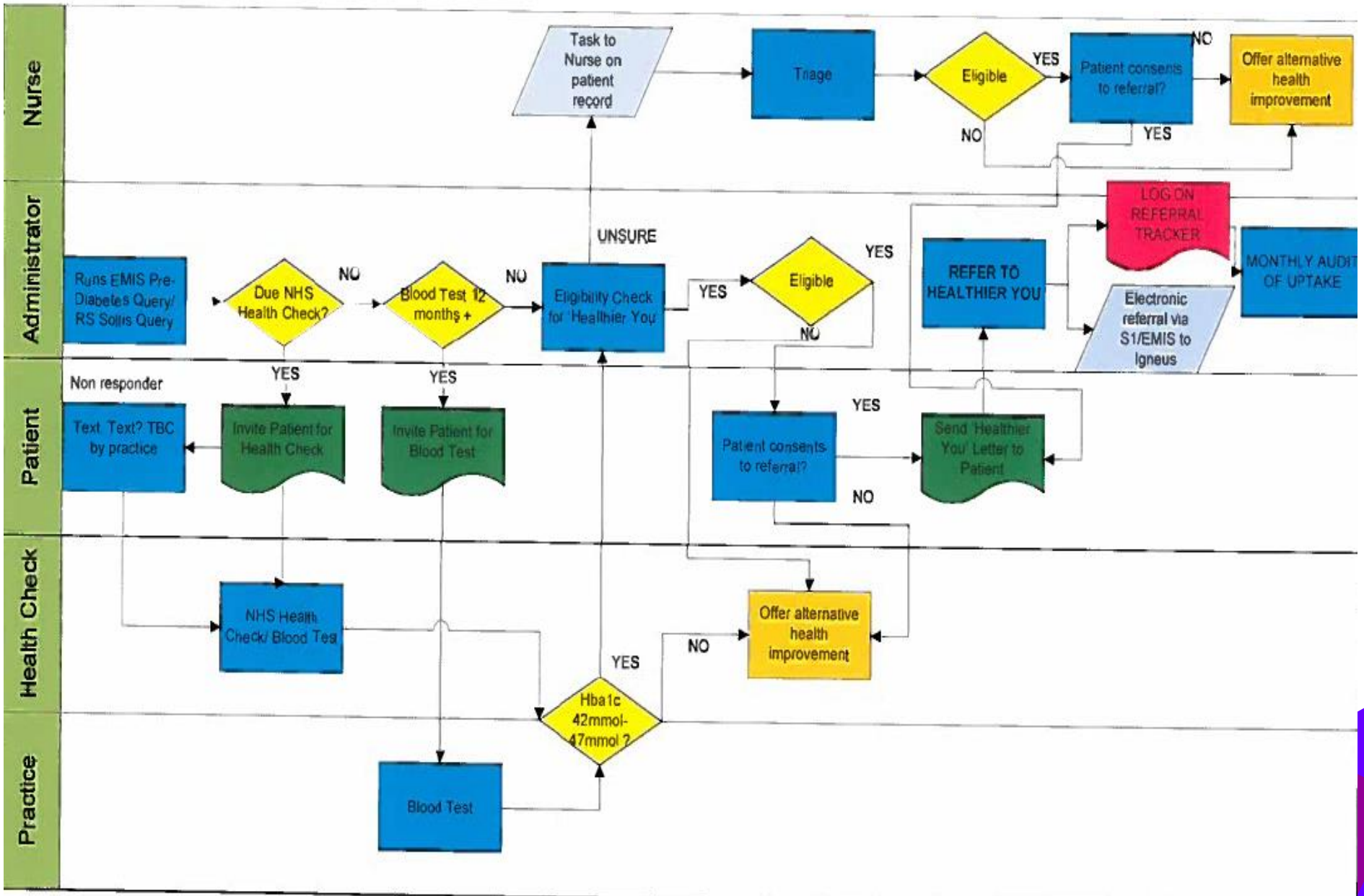
Healthier You – NHS National Diabetes Prevention Programme



LCS Process

Identify lead practice per cluster.

Step 1 A practice per cluster will be funded to be responsible for rolling the 'Healthier You' National Diabetes Prevention Programme out across their cluster. The lead practice will receive funding to ensure delivery across the cluster:

Step 2 Identify registered individuals with Non Diabetic Hyperglycaemia across the cluster. (See embedded process map slide 2 and eligibility criteria document opposite).

Administration:

- Identify registered individuals, using the agreed searches with a diagnosis of Non Diabetic Hyperglycaemia.
- Send standardised letters to patients.
- Refer eligible patients on to the NHS DPP or other local services.
- Invite eligible patient in for their NHS Health Checks

Triage

- Where necessary to review identified patients from practice lists.
- To review patients who have had an HbA1C test in range and who meet the criteria for nurse triage (see document).

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Health Check Eligibility		'Healthier You' Eligibility		Nurse Triage
Inclusion	Exclusion	Inclusion	Exclusion.	• Housebound/Cared for at Home.
• People living or working in the Brighton and Hove aged 40 to 74 • People who have not received a health check within the past 5 years • People who do not have any of the exclusion criteria • People who are currently registered with a GP practice	• People who are on a disease register or have been diagnosed with coronary heart disease, chronic kidney disease (CKD stages 3-5), diabetes or who have had a stroke. In addition: • Hypertension • Atrial Fibrillation • Transient Ischaemic Attack (TIA) • Familial Hypercholesterolemia. • Heart failure • Peripheral Arterial Disease (PAD) • Treatment with a statin • Those who previously had a health check or any other check and found to have ≥ 20% risk of	• Individuals who have already been identified as having non-diabetic hyperglycaemia (HbA1c of 42 – 47 mmol/mol (6.0 – 6.4%) in the past 12 months via GP systems. • Individuals who have already been identified as having non-diabetic hyperglycaemia (HbA1c of 42 – 47 mmol/mol (6.0 – 6.4%) in the past 12 months via the NHS Health Check programme.	• Individuals aged under 18 years. • Pregnant women. • Individuals with blood results confirming a diagnosis of Type 2 diabetes • Individuals with a normal blood glucose reading on referral to the Service	• Physical/ mobility issues. • Learning disability. • Serious Mental Illness. • Long term condition. • Co-morbidities. • Those who previously had a health check or any other check and found to have ≥ 20% risk of developing cardiovascular disease over the next 10 years, and placed on a high risk register. • History of DNA's. • BMI 40> • Unclear requires clinical triage.

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Searches/Invite letter

- Search's were created by our centre of excellence for both EMIS and SystmOne
- Templates and codes were also created and embedded on practice systems
- Opt out letter was created as part of the pilot, the administrator sends a standard 'opt out' letter to the patient. (See embedded patient opt out letter opposite).
- This letter advises that the patient record show that their most recent blood test indicates their blood glucose level falls into a 'pre-diabetic' range, offering them the opportunity to participate and benefit from the Programme.
- A date, two weeks from the date of the letter, must be given to allow the patient time to consider if they wish to opt out of the program.
- If the patient does not make contact to 'opt out' within the stated timescale a referral will then be made to Ingeus the provider of the National Diabetes Prevention Programme in Brighton and Hove.

Dear Mr Mouse

RE: National Diabetic Prevention Programme

Our records show that your most recent blood test indicates your blood glucose level falls into a 'pre-diabetic' range. This increases your risk of developing diabetes in the future.

At the beginning of 2016 the Government implemented the National Diabetes Prevention Programme, which is due to be rolled-out across the country. The aim of the Programme is to support people, identified as being at increased risk of diabetes, to reduce their risk of developing the disease by providing advice on diet, weight and activity.

We would like to offer you the opportunity to participate and therefore benefit from this Programme.

Once referred you will be contacted by a member of the National Diabetes Prevention Programme team who will provide more information and be able to answer any questions you may have. You may already have been referred to 'Walking Away from Diabetes' but you will still benefit from this Programme.

Should you wish to opt out of the program please can you contact the nurses reception on 01273 560109 by Monday 14th November.

If you have any questions or concerns regarding this please do not hesitate to contact us on 01273 560109.

Yours sincerely

Sarah Meacock
Practice Nurse, Diabetes Lead

Brighton & Hove City Council

Roll Out	Lessons learnt	Next steps
Champion practice identified in each cluster with 10 practices over four cluster areas currently referring into the NDPP	Use champion practices to share knowledge with other practices about how to best support NHS DPP roll out	Ingeus to support the roll out for the two new clusters referring into the programme working closely with the champion practices
Rolled out 1 cluster at a time for capacity and quality purposes	Each practices needed their own admin/nurse triage not per cluster as originally planned due to patient knowledge and confidentiality purposes	Ingeus to work with the CCG and other practices to get the final two clusters up and running with NHS DPP across Brighton and Hove
Process map ensured consistency across the City and also NHS Health Check as a key part which has seen offers and invites double for the last 2 quarters	It took longer to identify champion practices in some clusters than predicted	Ingeus to review those patients still on the waiting list and identify alternative days/times to offer them so they are able to attend a programme in their area
490 referrals have been received so far into the programme	Opt out letter was a great success and shared around many other NHS DPP areas	Ingeus to work closely with local services that can support NHS DPP and vice versa so that patients can be made aware of and know how to access appropriate resources

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SURREY COUNTY COUNCIL

Aligning NHS Health Checks and the NHS Diabetes Prevention Programme in Surrey

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Surrey NHS Health Check Health Equity Audit

- Health Equity Audit – residents in areas of deprivation not receiving NHS Health Checks
- Oldest receiving highest proportion of checks
- Funding
- Resources needing to reach those with highest need
- Opportunity to align programme with up coming DPP roll out

Alignment of NHS Health Checks to NHS DPP in Surrey

SURREY COUNTY COUNCIL

- GP practices slow to take up DPP programme
- Early referrals based on practices using approaches such as patients on existing registers and inviting by letter, or stratifying on HbA1c
- Public Health worked with CCGs offering to role out PRIMIS tool to all NHS HC GP providers
- Pragmatic approach to suggest stratification on eligibility and latest HbA1c
- Plus those in deprivation due to higher risk of CVD, developed a LSOA postcode tool

NHS DDP – referrals from NHS Health Checks in pharmacies

- Pharmacies use data entry template based on best practice guidance
- Template includes trigger for HbA1c
- Referral pathway: awaiting discussion with South East (KSS) Clinical Network, Ingeus and developers of Pharmoutcomes
- *So* reliant on the fact results are sent back to GP with results and these *should* go on patient record . . . . .for follow up!

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OXFORDSHIRE COUNTY COUNCIL

Quality Assuring the diabetes filter & follow-on tests in Oxfordshire

Stephen Pinel, Health Improvement Principal,

Oxfordshire County Council

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Commissioning using the Best Practice Guidelines

What in the NDDP can **we,** as Commissioners of the NHSHC, control?

- Full
- Partial
- None

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Quality Performance Indicators

Quality Performance Indicators

Part of the NHS Health Check Programme Pathway	Quality Outcomes Indicators	Threshold	Method of Measurement	Consequence of breach
Risk Assessment	Compliance to the diabetes risk assessment filter based on either the Service Users BMI and/or Blood Pressure (as defined in Section 3.2.2).	≥99%	Quarterly based report via the Data Management Service Provider	Trigger point for a Council contract review meeting

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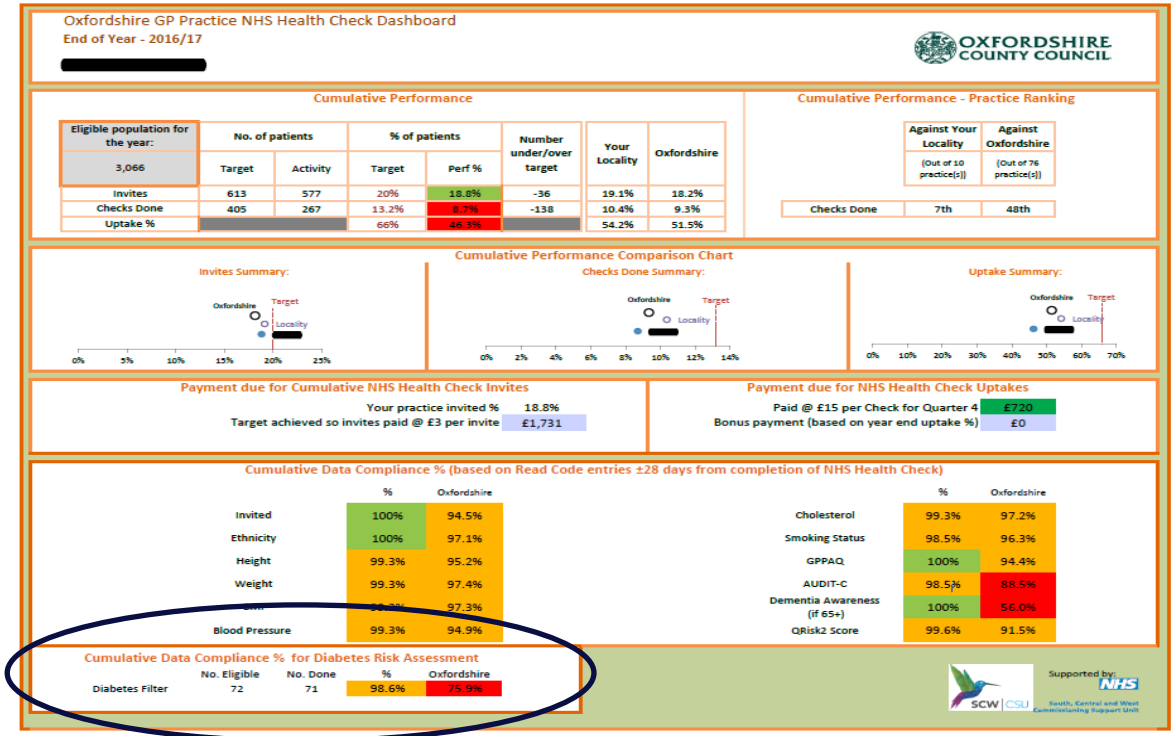
Monitoring/Review of Quality Performance Indicators - Quarterly



Oxfordshire GP Practice NHS Health Check Dashboard
End of Year - 2016/17

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Cumulative Performance

Eligible population for the year:	No. of patients		% of patients		Number under/over target	Your Locality	Oxfordshire
3,066	Target	Activity	Target	Perf %			
Invites	613	577	20%	18.8%	-36	19.1%	18.2%
Checks Done	405	267	13.2%	8.7%	-138	10.4%	9.3%
Uptake %			66%	46.3%		54.2%	51.5%

Cumulative Performance - Practice Ranking

	Against Your Locality (Out of 10 practice(s))	Against Oxfordshire (Out of 76 practice(s))
Checks Done	7th	48th

Cumulative Performance Comparison Chart

Invites Summary: Oxfordshire, Target, Locality; 0% 5% 10% 15% 20% 25%

Checks Done Summary: Oxfordshire, Target, Locality; 0% 2% 4% 6% 8% 10% 12% 14%

Uptake Summary: Oxfordshire, Target, Locality; 0% 10% 20% 30% 40% 50% 60% 70%

Payment due for Cumulative NHS Health Check Invites

Your practice invited %	18.8%
Target achieved so invites paid @ £3 per invite	£1,731

Payment due for NHS Health Check Uptakes

Paid @ £15 per Check for Quarter 4	£720
Bonus payment (based on year end uptake %)	£0

Cumulative Data Compliance % (based on Read Code entries ±28 days from completion of NHS Health Check)

	%	Oxfordshire
Invited	100%	94.5%
Ethnicity	100%	97.1%
Height	99.3%	95.2%
Weight	99.3%	97.4%
[illegible]	[illegible]	97.3%
Blood Pressure	99.3%	94.9%

	%	Oxfordshire
Cholesterol	99.3%	97.2%
Smoking Status	98.5%	96.3%
GPPAQ	100%	94.4%
AUDIT-C	98.5%	88.5%
Dementia Awareness (if 65+)	100%	56.0%
QRisk2 Score	99.6%	91.5%

Cumulative Data Compliance % for Diabetes Risk Assessment

	No. Eligible	No. Done	%	Oxfordshire
Diabetes Filter	72	71	98.6%	75.9%

Supported by: NHS South, Central and West Commissioning Support Unit

SCW CSU

Cumulative Data Compliance % for Diabetes Risk Assessment

	No. Eligible	No. Done	%	Oxfordshire
Diabetes Filter	72	71	98.6%	75.9%

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Monitoring/Review of Quality – Annually

3. THE RISK ASSESSMENT: ensuring a complete health check for those who accept the offer is undertaken and recorded	
Description	A complete NHS Health Check must include **all** the elements outlined in the best practice guidance **all taken at the time of the check** unless specified: a. age b. gender c. ethnicity d. smoking status e. family history of coronary heart disease f. blood pressure, systolic (SBP) and diastolic (DBP) g. body mass index (height and weight) h. General practice physical activity questionnaire (GPPAQ) i. Alcohol use score (AUDIT-C or FAST can be used as the initial screen, further guidance is in the best practice guidance 2013) j. cholesterol level: total cholesterol and HDL cholesterol (either point of care or venous sample if within the last six months) k. cardiovascular risk score: a score relating to the person's risk of having a cardiovascular event during the ten years following the health check, derived using an appropriate risk engine that will predict cardiovascular risk based on the population mix within the local authority's area l. dementia awareness (for those aged 65 to 74) m. diabetes filter (BMI and BP) see standard 8

8. RISK MANAGEMENT: additional testing and clinical follow up	
Description	Individuals should not exit the programme until all abnormal parameters have been followed up and a diagnosis has either been made or ruled out. Timely access to further diagnostic testing should take place as outlined in the best practice guidance at the following thresholds: 1. Following the **diabetes filter**, undertaken as part of the risk assessment, blood glucose test; either fasting plasma glucose **or** HbA1c (glycated haemoglobin) for all identified as high risk. Indicated by either: a. BP ≥140/90 mmHg or where the SBP or DBP exceeds

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	140mmHg or 90mmHg respectively b. BMI ≥ 30 or 27.5 if individuals from the Indian, Pakistani, Bangladeshi, other Asian and Chinese ethnicity categories

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Monitoring/Review of Quality – Annually

NHS Health Check Quality Assurance Tool 2016/17

Free NHS Health Check

As Commissioner of the NHS Health Check Programme, Oxfordshire County Council (the Council) has a duty to work with its Service Providers to ensure the safety and quality of the Programme. This is inclusive from the identification and invitation of eligible individuals, through their risk assessment, advice and treatment, and ultimate safe exit from the Programme.

Over the past two years the Council have worked in partnership with you to participate in Quality Assuring your service using a locally developed audit tool. In 2014/15 this was completed using an external assessor and in 2015/16 the tool was adapted to allow you to voluntarily complete the Quality Assurance tool by self-assessment.

For 2016/17, the Council would like to repeat the offer of a support visit to your practice to review the quality of the NHS Health Check Programme. This will include advice to practice staff on how to improve the invite/offer, the uptake % and ultimately increase payments to your practice through the Approved Provider List (APL) Agreements.

The Programme Standards referenced within the Tool are taken from Public Health England's (PHE) 'NHS Health Check Programme Standards: a Framework for Quality Improvement' (February 2014). The Tool itself is based on the PHE's NHS Health Checks Programme Standards Self-asses
Health Check Service Specification within the Community Primary Care Services APL Agreement and b) Prov

Upon successful completion of your NHS Health Check Support Visit the GP Practice will be reimbursed £50.

The second phase of assessing quality in 2016/17 will again include the monitoring of data compliance relati
County Council via the QRisk2 Reporting tool in November 2016 using Quarter 1 and 2 2016/17 data. Outcom
dashboard.

The tool is being sent to you prior to the visit for your information only and is locked to prevent self-assessm

Click to see Quality Assurance

Oxfordshire NHS Health Check Quality Assurance Outcomes Dashboard 2016/17

[redacted]

Phase 1: Quality Assurance Score vs. National Programme Standards (relates to outcomes from Audit Tool)		Phase 1 completed on:	09/11/2016	
NHS Health Check Pathway Point	Description of Standard	Out of	Practice score	Practice %
Invitation and Offer	1. Identify the eligible population and offering an NHS Health Check	10	9	90.0%
	2. Consistent approach to non-responders and those who DNA their Risk Assessment	5	5	100.0%
The Risk Assessment	3. Ensuring a complete NHS Health Check for those who accept the offer is undertaken and recorded	20	20	100.0%
	4. Equipment use	6	6	100.0%
	5. Quality control for point of care testing (Not applicable in Oxfordshire)			
Communication of Risk	6. Ensuring results are communicated effectively and recorded	9	9	100.0%
Risk Management	7. High quality and timely lifestyle advice given to all	9	9	100.0%
	8. Additional testing and clinical follow-up	8	8	100.0%
	9. Appropriate follow-up for all if CVD risk assessed as ≥ 20%	5	5	100.0%
Throughout	10. Confidential and timely transfer of patient identifiable data (Not applicable in Oxfordshire)			
	Total:	72	71	98.6%

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Summing up: other issues to consider

- **National alignment principles:** highlight issues for consideration & local resolution
- **Local models of delivery determine what's important** e.g. East Sussex direct referral pathway – large scale NHS workplace programme of NHS Health Checks
- **Blood glucose testing** a core element of NHSHC risk assessment (where need indicated by filter), so should be included in **service specs.** To **maximise referrals**, training & QA required to ensure ***filter*** being applied and ***blood glucose*** testing undertaken where required.
- **Direct referral pathways:** ensure pathways in place from primary care (GP, HCA, PN, pharmacy) and community (outreach/workplace)
- **Coding to identify NHSHC as referral source:** currently no national code – discuss with DPP provider local code or flag
- **Opportunity for clinical engagement:** NHSHC **ongoing source of referrals** once raised HbA1c register backlog cleared

QOF Consultation – 2019/20

Draft wording:

- **GP8:** The practice establishes and maintains a register of all people with a diagnosis of non-diabetic hyperglycaemia.
- **GP9:** The percentage of people newly diagnosed with non-diabetic hyperglycaemia in the preceding 12 months who have been referred to a Healthier You: NHS Diabetes Prevention Programme for intensive lifestyle advice
- **GP10:** The percentage of people with non-diabetic hyperglycaemia who have had an HbA1c or FPG test in the preceding 12 months

Any Questions?

- Please type your full questions in the chatbox/instant messenger if you would like us to read it out OR type your name if you would prefer to come off mute and ask your question verbally.
- For those on the phone, we will ask you to come off mute to ask any questions – remember you will need to press *6 to mute and unmute yourself