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

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Liz Labrum, Surrey County Council Public Health Team
Stephen Pinel, Oxfordshire County Council Public Health Team
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
Alignment of NHS Health Checks & the NHS DPP in Brighton & Hove

Tory Lawrence
Public Health Improvement Specialist
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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
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).
<table>
<thead>
<tr>
<th>Health Check Eligibility</th>
<th>‘Healthier You’ Eligibility</th>
<th>Nurse Triage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusion</td>
<td>Exclusion</td>
<td>Inclusion</td>
</tr>
<tr>
<td>- People living or working in the Brighton and Hove aged 40 to 74</td>
<td>- 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.</td>
<td>• Physical/ mobility issues.</td>
</tr>
<tr>
<td>- People who have not received a health check within the past 5 years</td>
<td>- 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.</td>
<td>• Learning disability.</td>
</tr>
<tr>
<td>- People who do not have any of the exclusion criteria</td>
<td>- Individuals with blood results confirming a diagnosis of Type 2 diabetes</td>
<td>• Serious Mental Illness.</td>
</tr>
<tr>
<td>- People who are currently registered with a GP practice</td>
<td>- Individuals with a normal blood glucose reading on referral to the Service</td>
<td>• Long term condition.</td>
</tr>
<tr>
<td>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 cardiovascular disease over the next 10 years, and placed on a high risk register.</td>
<td></td>
<td>• Co-morbidities.</td>
</tr>
<tr>
<td></td>
<td>- Individuals aged under 18 years.</td>
<td>• Those who previously had a health check or any other check and found to have ≥ 20% risk of cardiovascular disease over the next 10 years, and placed on a high risk register.</td>
</tr>
<tr>
<td></td>
<td>- Pregnant women.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Individuals with blood results confirming a diagnosis of Type 2 diabetes</td>
<td></td>
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</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Roll Out</th>
<th>Lessons learnt</th>
<th>Next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Champion practice identified in each cluster with 10 practices over four cluster areas currently referring into the NDPP</td>
<td>Use champion practices to share knowledge with other practices about how to best support NHS DPP roll out</td>
<td>Ingeus to support the roll out for the two new clusters referring into the programme working closely with the champion practices</td>
</tr>
<tr>
<td>Rolled out 1 cluster at a time for capacity and quality purposes</td>
<td>Each practices needed their own admin/nurse triage not per cluster as originally planned due to patient knowledge and confidentiality purposes</td>
<td>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</td>
</tr>
<tr>
<td>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</td>
<td>It took longer to identify champion practices in some clusters than predicted</td>
<td>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</td>
</tr>
<tr>
<td>490 referrals have been received so far into the programme</td>
<td>Opt out letter was a great success and shared around many other NHS DPP areas</td>
<td>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</td>
</tr>
</tbody>
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Aligning NHS Health Checks and the NHS Diabetes Prevention Programme in Surrey

Liz Labrum
Public Health Lead: NHS Health Checks & PH Agreements
Surrey County Council
liz.labrum@surreycc.gov.uk
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

- 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!
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
# Quality Performance Indicators

## Quality Performance Indicators

<table>
<thead>
<tr>
<th>Part of the NHS Health Check Programme Pathway</th>
<th>Quality Outcomes Indicators</th>
<th>Threshold</th>
<th>Method of Measurement</th>
<th>Consequence of breach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessment</td>
<td>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).</td>
<td>≥99%</td>
<td>Quarterly based report via the Data Management Service Provider</td>
<td>Trigger point for a Council contract review meeting</td>
</tr>
</tbody>
</table>
Monitoring/Review of Quality Performance Indicators - Quarterly
Monitoring/Review of Quality – Annually

NHS Health Check programme standards: a framework for quality improvement

February 2014
Monitoring/Review of Quality – Annually

**NHS Health Check Quality Assurance Tool 2016/17**

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 start on how to improve the inviter letter, 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-assessed Health Check Service Specification within the Community Primary Care Services APL Agreement and b) tool.

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 relating to the Oxfordshire Health and Wellbeing Plan via the QRM62 Reporting tool in November 2015 using Quarter 1 and 2 2016/17 data. Outcome dashboard.

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

[Click to see Quality Assurance](#)

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**Oxfordshire NHS Health Check Quality Assurance Outcomes Dashboard 2016/17**

### Phase 1: Quality Assurance Score vs. National Programme Standards

(requests to outcomes from Audit Tool)

<table>
<thead>
<tr>
<th>NHS Health Check Entry Point</th>
<th>Description of Standard</th>
<th>Out of</th>
<th>Practice Score</th>
<th>Practice %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invitation and Offer</td>
<td>1. Identify the eligible population and offering an NHS Health Check</td>
<td>10</td>
<td>9</td>
<td>90.0%</td>
</tr>
<tr>
<td></td>
<td>2. Consistent approach to non-responders and those who DNA their Risk Assessment</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
</tr>
<tr>
<td>The Risk Assessment</td>
<td>3. Ensuring a complete NHS Health Check for those who accept the offer is undertaken and recorded</td>
<td>20</td>
<td>20</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>4. Equipment use</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>5. Quality control for point of care testing (not applicable in Oxfordshire)</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
</tr>
<tr>
<td>Communication of Risk</td>
<td>6. Ensuring results are communicated effectively and recorded</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
</tr>
<tr>
<td>Risk Management</td>
<td>7. High quality and timely lifestyle advice given to all</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>8. Additional testing and clinical follow-up</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>9. Appropriate follow-up for all high risk assessed as ≥5%</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
</tr>
<tr>
<td>Throughout</td>
<td>10. Confidential and timely transfer of patient identifiable data (not applicable in Oxfordshire)</td>
<td>72</td>
<td>72</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

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Oxfordshire County Council  

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