NHS
Birmingham South Central
Clinical Commissioning Group

NHS Birmingham South Central

National Diabetes Prevention Programme - Demonstrator Site

NHS Five Year Plan: Responding to the Prevention Challenge

Public Health England

DIABETES UK
CARE. CONNECT. CAMPAIGN.

NHS England

National Diabetes Prevention Programme

The NHS Diabetes Prevention Programme is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver at scale, an evidence based behavioural programme to support people to reduce their risk of developing Type 2 diabetes.

The NDPP has identified seven local areas, known as demonstrator sites, to learn practical lessons from delivery. The demonstrator sites are:

- Birmingham South and Central CCG
- Bradford City CCG
- Durham County Council
- Herefordshire CCG/LA
- Medway CCG/LA
- Salford CCG/LA
- Southwark Council and CCG

Birmingham South Central

- Across our CCG there is a mix of both high Black and Minority Ethnic (BME) populations and social deprivation.
- The percentage of people 17+ diagnosed with diabetes is higher in each of the Birmingham CCGs than the England average
- There is a gap in diagnosed prevalence and estimated prevalence in adults that requires investigation
- By 2025 the projected prevalence of diagnosed and undiagnosed diabetes could increase to over 90,000 (with an increase in prevalence from 8.5% to 10.3%)
- Obesity is also increasing in Birmingham and there is a strong relationship with diabetes

BSC's CVD LIS

- 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

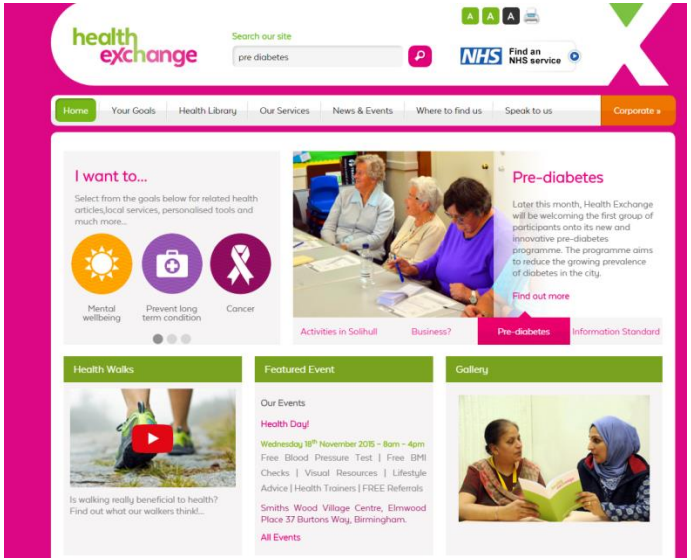
The Service

Components of the scheme include:

1. **Community Engagement** – in development and being rolled into first wave
2. **Motivational Interviewing** - Training in motivational interviewing for front line clinical staff and brief intervention techniques for lifestyle change.
3. **LIS Development** - Enhanced CVD Local Improvement Scheme that provides for structured capture (template/read coded) of lifestyle change preferences and referral route.
4. **Core Intervention** - Commissioning a pilot local structured programme for people at risk of diabetes from existing providers - to include nutrition and exercise (in line with national evidence base).
5. **Feedback** – ensuring feedback and tracking
6. **Local evaluation** - to support the wider local authority led lifestyle services re-procurement process. Including preferences and barriers to accessing services from BME groups.

Third Sector Providers

We have worked with two local well established third sector providers of lifestyle interventions, Gateway Family Services and Health Exchange:



Provider Arrangements

- Specification completed and agreed with our two Providers
  - Matched to the nationally developed evidence
- Contract agreed with two providers – Compromise agreement regarding distribution of funding across the length of the programme/ ongoing dialogue regarding the number of patient questionnaires supporting the programme
- Insight support used to finalise referral letters
- Activity plans agreed
- Builds on history of providing health trainers , ensured strong liaison between providers and practices building on existing working relationships

Provider Activity – at end of January 2016

- 6,118 at risk patients mailshotted by practices inviting them to attend an intervention
- 1,116 patients have contacted the providers following the letter to book on to the intervention
- 344 patients have attended their first session
- Health Exchange have had 38 people complete first block of 6 weeks of intervention
  - 25 people have lost weight in the programme so far.
  - The average weight loss is 1.41kg
  - Total amount of weight lost is 35.2kg.
- 95% plus retention rate at present

PATIENTS AT THE MAYPOLE TAKE FIRST STEPS TOWARDS DIABETES PREVENTION

POSTED ON 13TH NOVEMBER 2015 BY MICHELLE SMITTEN

Please leave a comment

This week we delivered the first of our pre-diabetes training sessions.

The programme has been commissioned by Birmingham South Central Clinical Commissioning Group so the first session was held in one of their surgeries, Maypole surgery in south Birmingham, with the support and help of surgery GPs.

The surgery sent a mailshot out to patients with pre-diabetes, and we were pleased to find it had a good response rate, with 29 patients expressing interest. So a session was held for the first 12 on Wednesday morning, at the surgery.

Susan Hannaby is leading the training sessions

Pre-diabetes, also referred to as "borderline" diabetes, is when someone's blood glucose (sugar) levels are above the normal range, but not high enough for them to be diagnosed as having diabetes. If someone's blood sugar levels are consistently higher than normal then they may be at risk of Type 2 diabetes if they don't take the preventative steps. It's an important warning sign that lifestyle changes need to be made. The point of the course is to educate people about their condition and to get people taking steps towards making those changes.

The course is run over 13 sessions and looks at all sorts of preventative action, including healthy eating, physical activity, food preparation, and managing portion sizes. For this first session, Trainer Susan Hannaby (pictured) was joined by Health Trainer Josh and EAST Admin Assistant Jennie, who will be the main point of communication for the group.

The activities and topics covered are based on who is in the group – what their needs are and the issues they would like to focus on – so it's a flexible format. The sessions will include a lot of group work and include practical, hands-on activities, but also some private one-to-one time for each patient.

Susan gave an example of the practical activities they did on Wednesday: "This week we looked at portion sizes – we got people to serve a 'typical' plate of food, then looked at what a serving actually is. We were all surprised at how small cereal portions are!

"We are also encouraging the group to work together and help each other. For example one woman said she used to walk a lot but had lost confidence after falling over. One of the men in the group had been planning to start walking more, but felt unmotivated on his own. So they have made plans to go walking together."

health exchange

Living Well, Taking Control

min. 9 month journey

13 sessions

6 Sessions
1 x week
90 minutes
Over 6 weeks
Face-to-face

Ongoing
Support Session

3 months
Email/ Telephone or
optional face-to-face

Post 3rd
Session

Ongoing Support
Session

GRADUATE!!!
12 month
Group sign-off
Session

If needed
ongoing
support

Telephone
Text & Mail
Facebook Group
Twitter

6 month
90 minute Group
Session face-to-face

Ongoing Support
Session

Ongoing
Support
Session

8 month
Email / Telephone
or optional face-
to-face

Ongoing
Support Session

10 month
Email / Telephone
or optional face-to face

Development: App for Healthy Lifestyle Support Buddy
Link into Health Fabric
Underpin all sessions with mobile support

Development Launch
of Mobile App Support
approx 6 months

Provider data collection

- Blood Pressure
- Dietary change (assessment tool)
- HbA1c (indicating average blood sugar levels over 3 months)
- Weight
- Perceived importance of and confidence in achieving healthy levels of activity and a healthy diet
- Quality of life (EQ5D);
- Self-reported physical activity (GPPAQ)

Patient Feedback – First 6 sessions

- “These sessions have been very useful and have helped me make healthier choices in my life. I have increased my physical activity. The facilitator is very helpful and I would definitely recommend her sessions.”
- “I have learnt so much from the programme i.e. making healthier choices, looking at labelling, better ways of cooking to cut out fats/sugars, more exercise. Loved the group experience and our facilitator was very informative and friendly. Very knowledgeable.”
- “I have enjoyed the course very much and it has changed my attitude to diet completely, the sessions were excellent.”
- “Very useful and educational.”
- “I was so impressed. This programme was very interesting, informative and enjoyable. So helpful! It gave me the incentive to lose a little weight and cut down on sugar and salt.”

Primary Care Arrangements

- NDPP LIS agreement approved and launched on 1st October
- Roll out of LIS to all member practices to support identification, case finding and referral
- 55 of the 55 CCG practices have signed up to deliver the LIS
- Practices currently mailshotting pre diabetes register patients to refer to intervention but some practices are ringing patients directly
- Primary Care motivational Interview training taking place

Local Evaluation

- CSU/CLAHRC agreed data collection format (included in contract spec)
- CSU/CLAHRC – early discussions on evaluation/quality improvement-track and intervene to improve uptake
- Evaluation logic meeting took place 7th December
- Discussing with incoming CSU

NDPP First Wave Implementer

- Successfully chosen as a first wave implementer for the National Provider Roll Out in 16/17
- First Wave footprint includes Birmingham, Sandwell and Solihull CCGs/LAs
- Provider should be in place end of April 2016
- Indicative activity in first year approximately 900

Summary

- Went live late October
- Patient enrolment via primary care with good retention
- Internal target to recruit 1500 by March
- Proof of concept of intervention pathway
- Secured first wave implementer status for national provider roll out
- Need to evaluate and understand uptake rates across demographics
- Waiting on economic case model from SchARR

Thank You - Questions