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Primary care & community referral routes into a diabetes prevention programme

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BACKGROUND

The English NHS Diabetes Prevention Programme (NHS DPP) offers tailored, personalised help to people at risk of diabetes (T2D), aiming to reduce the risk of type 2 diabetes through education on healthy eating and lifestyle; help to lose weight and bespoke physical exercise programmes.[1]

During 2015-2016 seven demonstrator sites were commissioned to test innovative approaches to programme delivery, with a view to shaping an English NHS DPP programme. The success of the programme depends on identification and recruitment of at-risk individuals, requiring innovative strategies to reach people neglected by traditional efforts.

One of the demonstrator sites has adopted a DPP service which involves, a) a tailored exercise programme, and b) a telephone service, based loosely on motivational interviewing.

FINDING PEOPLE AT RISK

In the UK the risk of T2D rises with age, is slightly higher in men than women, and is substantially higher among people from South Asian and Black communities. Deprivation is strongly associated with obesity, inactivity, poor diet, smoking and poorly controlled blood pressure, all of which are linked to T2D risk.[2] Primary care or community campaigns targeted towards these populations may prove fruitful in identifying those at risk of T2D.

AIM

Identify and review the role of the community and primary care referral routes in the recruitment to a diabetes prevention service.

METHODS

32 semi-structured qualitative interviews with service leads, commissioners and frontline workers from both referral pathways.

Quantitative analysis of administrative data collected by the five agencies involved in making or accepting referrals to the DPP (see Figure 1)

THE DEMONSTRATOR MODEL

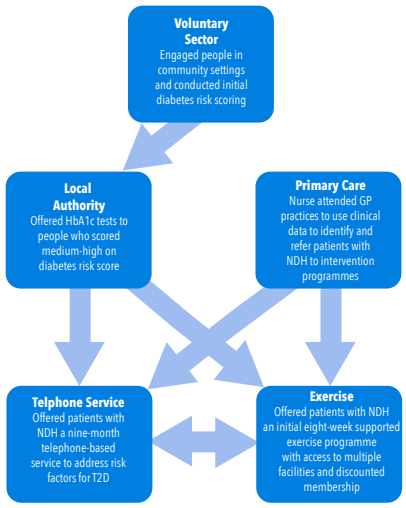

Figure 1 Data sources and flowchart of pathway activity

FINDINGS

Primary referral route

In total 883 patients were referred into lifestyle support services. Interestingly the majority of referrals 84% (774), either came directly from the nurse facilitator, or from the 16 GP practices working with the nurse facilitator, with just 12% (n=109) being referred from the 30 practices that did not have specific support. Of the 833 people referred into the diabetes prevention services, 563 (64%) commenced the programme.

Community referral route

Diabetes risk scores were completed with between 1,162 and 1,376 people, and of these, 746 people (54 - 64% of risk scores) went on to have a HbA1c blood test. There were 10% (n=71) of people whose blood test result indicated they had NDH, with 66 of these patients being referred into diabetes prevention services. Out of the 66, 24 (36%) commenced the programme.

Community activity was undertaken right across the CCG's locality, but the activity was not targeted on the areas of high deprivation. The qualitative data showed that there had been an initial focus on targeting high risk areas, but as time went on, staff focused on volume of contacts (areas with high footfall) and this obscured the focus on areas with high deprivation and ethnic minorities.

Interviews also revealed tensions in inter-agency working in the community referral route which negatively impacted on efforts to effectively co-ordinate different community services. A perceived overlap of skills and dissatisfaction with a shared-funding model, plus a short lead-in time, complicated efforts to develop genuinely collaborative working.

CONCLUSIONS

A large volume of contacts was needed to find suitable community referrals: sustained targeting, particularly to ethnic minorities, older people and deprived areas, may yield more benefit. The public nature of the community campaign has the potential for more diffuse benefits, raising awareness of diabetes, which were not measured. However, the community method was seen as acceptable to the public and potentially more accessible both in terms of reaching under-served populations and providing a more approachable, less clinical route into the service. Primary care referral was more effective, and the model of providing additional nurse support was considered essential to achieve this given the competing demands on core primary care staff.

Community referral

- Joint working between the organisations was the most problematic aspect of the programme – early and explicit steering guidance is required to negotiate and resolve issues.
- Improved targeting of people in 'hard-to-reach' areas is required to both reach under-served populations and improve referral rates through finding a higher number of eligible people.

Primary care referral

- The nurse facilitator role was valued by practices and considered necessary to enable delivery.
- Initially engaging practices was challenging and using local champions can help increase awareness.

REFERENCES

1. NHS Diabetes Prevention Programme, https://www.england.nhs.uk/ourwork/qual-clin-lead/diabetes-prevention/
2. Diabetes UK. The cost of diabetes report. 2014.

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