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Humber and North Yorkshire
Health and Care Partnership

It's your GP texting: Utilising technology at ICB level to deliver a tenfold increase in referrals to the NHS Diabetes Prevention Programme

A pilot project by Meddbase & NHS Humber and North Yorkshire Integrated Care Board



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EXECUTIVE SUMMARY

About type 2 diabetes

- Type 2 diabetes is a **largely preventable lifestyle-related condition** that increases the risk of serious health problems like cardiovascular disease (CVD), kidney disease, sight loss and amputations
- **It affects 4m+ people** in the UK and that number is predicted to reach 5.5m by 2030
- **A further 2m people** have non-diabetic hyperglycaemia (pre-diabetes), meaning they are more likely to develop type 2 diabetes if they don't change their lifestyle
- Treating type 2 diabetes places a big strain on the NHS, **costing £10 billion per year - around 10% of the NHS budget** and that number will rise with more cases

The NHS Diabetes Prevention Programme (NDPP)

- The NDPP is an evidence-based programme from NHS England and Diabetes UK that **supports people with pre-diabetes to change their lifestyle**
- 1m people have followed the programme and data shows it **cuts a person's chances of developing type 2 diabetes by 37%**, and leads to an average healthy weight loss of 3.3kgs
- While these results are impressive, studies have concluded that the public health impact of a DPP **depends on participation** as well as population coverage



Background to the pilot

- NHS Humber and North Yorkshire Integrated Care Board and its clinical management system partner, Meddbase, believed that a managed ICB-led approach, **utilising digital communications rather than sending invitations by post**, could increase the number of patients participating in the NDPP - and wanted to test this
- The ICB would **use the Meddbase system to identify and invite patients** over a focused period, using text messages
- 795 patients were invited, with the group split into two cohorts to enable **easy comparison between opt-in versus opt-out communications**. The pilot took place in January 2022

Key results from the pilot

The pilot demonstrated excellent results, including:

- **1,000%+ increase in the number of monthly referrals** generated - from an average of 32 per month (p/m) for the previous six months, to 363 in the month of the pilot
- **331% increase in the number of patients reaching Milestone 1** (M1) which was attending at least one NDPP session - from an average of 16 p/m for the previous six months, to 69 in the month of the pilot
- The impact on M1s continued, going **181% above the baseline**, with an average of 45 per month for the next three months
- The results were similar for opt-in and opt-out digital communications

Key learnings

- A strategic, ICB-managed approach **using technology to engage patients** in healthy lifestyle programmes can have a dramatic impact on uptake
- **Data quality is the biggest barrier** to effective data searches, so introducing processes to ensure up-to-date contact and preference data is key
- Utilising the right software for ICB-managed invitations enables the identification and invitation of patients to be completed quickly, effectively and efficiently, **dramatically increasing uptake** while saving time and money
- **Respecting patient choice** by taking account of contact preferences helps mitigate against the risk of digital exclusion and is also likely to increase uptake

THE CONTEXT

> "Tackling diabetes is one of the biggest healthcare challenges of our time"
>
> **Professor Jonathan Valabhji**
> National Clinical Director for Diabetes and Obesity at NHS England 2018[1]

Diabetes: A major public health challenge

Type 2 diabetes is a largely preventable lifestyle-related condition[2] that now affects more than **four million people** in the UK[3].

People with type 2 diabetes are more at risk of a range of serious conditions including cardiovascular disease, kidney disease, sight loss, amputations and mental health problems[4,5,6], and the NHS spends around **£10 billion each year** on treating people with the condition - roughly 10% of its entire budget[7].

The vast majority of NHS type 2 diabetes spend (80%) is used to treat complications[8], resulting in **1 in 6 hospital beds** being taken by people with the condition[9]. An estimated 22,000 people die each year due to complications caused by type 2 diabetes[10].

NHS England already recognises type 2 diabetes as one of the biggest healthcare challenges of our time and, with the number of cases expected to rise to 5.5million by 2030[11], the size of this challenge looks likely to increase.

In addition to the more than four million people who already have type 2 diabetes, **two million people** in the UK have **non-diabetic hyperglycaemia**[12], also known as pre-diabetes, which puts them at high risk of developing the condition in the future.

Evidence shows that it is possible to delay or even prevent type 2 diabetes for some people by delivering combined lifestyle interventions that support healthy eating habits, increased physical activity and sustained weight loss. These kinds of **interventions have been found to reduce the risk of type 2 diabetes by roughly 50%**[13].

The risks & causes of type 2 diabetes[14]

- **Being overweight or obese** can increase a person's risk of type 2 diabetes by up to seven times compared with a person who is a healthy weight
- **The Obesogenic environment** means people are increasingly nudged towards ultra-processed foods which are energy-dense and nutrient-poor, while modern lifestyles encourage people to be sedentary and less physically active
- **Deprivation** has been found to increase a person's risk of type 2 diabetes and prevalence is 60% more common among individuals in the most deprived quintile compared to those in the least deprived quintile
- **There are also a range of unmodifiable risk factors, including the following:**
  - Family history of type 2 diabetes
  - Age - being older than 40 or older than 25 for some black and minority ethnic groups
  - South Asian ethnicities living in the UK are six times more likely to develop type 2 diabetes than people in the white population, while people of African and African-Caribbean descent are three times more likely

The NHS Diabetes Prevention Programme (NDPP)

The NDPP is a joint initiative from NHS England and Diabetes UK. Launched in 2015, almost one million patients have since been referred to the NDPP[18], with patients receiving tailored, personalised help to reduce their risk of type 2 diabetes. This includes education on healthy eating and lifestyle, and bespoke physical exercise programmes to support healthy weight loss[19]. The programme can be delivered in face-to-face groups or digitally[20].

It is designed to identify those people who are at risk of developing type 2 diabetes and refer them to a nine-month evidence-based lifestyle programme[15], in order to achieve the following goals[16]:

- Reduce the incidence of type 2 diabetes
- Reduce the incidence of complications associated with type 2 diabetes i.e. heart, stroke, kidney disease and eye and foot problems relating to diabetes
- Reduce health inequalities associated with type 2 diabetes over the longer term

Patients are referred onto the programme via one of three routes[17]:

- Their GP at routine appointments identifying them as being at risk of type 2 diabetes
- The NHS Health Check programme, which systematically invites adults aged 40-74 for risk awareness and assessment every five years
- The Diabetes UK 'Know Your Risk' self-referral pathway, launched in Sept 2021, where people complete the Know Your Risk tool and then contact a local provider

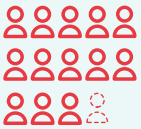
The NDPP initiative has been proven to[21]:



Cut people's chances of developing type 2 diabetes by **37%**



Lead to an average weight loss **of 3.3kgs per person**



Reduce the number of people developing type 2 diabetes by around **7% per year, equivalent to around 18,000 people**

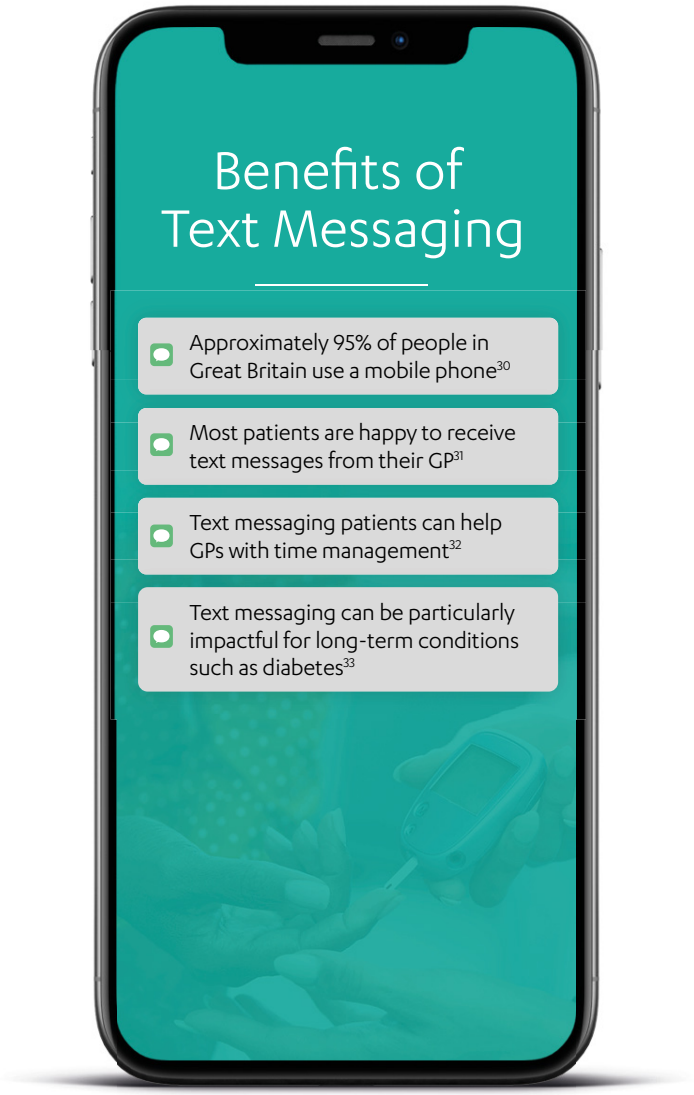
The rise of digital healthcare

Studies show that the Covid-19 pandemic led to an unparalleled surge in digital health adoption, for both patients and clinicians[22]. **Almost two out of three people (62%) reported an increased use of digital health tools post-Covid-19**[23] and NHS Providers reported that **the use of mobile communication almost doubled during the pandemic**[24] - including text messaging, audio and video calling, and conferencing.

Research had found that, even pre-pandemic, most patients were happy to receive text messages from their GP[25]. In the post-Covid landscape, the volume of **text messages from clinicians to patients increased threefold**[26].

The NHS is supportive of text messages or emails being used to communicate with patients when they aid the delivery of care[27]. In its Long Term Plan, the NHS committed to using digital health tools to allow health and care staff to complete administrative tasks more quickly in order to free up time to spend with patients, and to provide people with digital services that give them more control over their own health and the care they receive from the NHS[28].

It also committed to investing in IT systems that enable interoperability and to setting standards for keeping information secure. This is important as patients have reported valuing confidentiality when clinicians use text messaging for communications[29].



The opt-in vs opt-out debate; an even split

More than half of patients (58.7%) are interested in receiving tailored ongoing follow-up information from their healthcare professional (HCP)[34].

However, there is an even split between whether patients prefer clinician communications to be delivered via an opt-out service (49.7%), where they are sent the information and have the option to opt-out of future communications, or an opt-in service (47.7%), where they are made aware that they are eligible and invited to opt-in to receive future communications.

Opt-out services are preferred in some cases because they ensure that everyone is given access to the information, while opt-in services have the benefit of giving patients more control over the information they receive. The NHS has said that when utilising text or email services for the first time, opt-in services have the added benefit of avoiding assumptions that patients may wish to take part and that they have a mobile number or email address[35].

THE STUDY

Methodology

Background

While the health outcomes recorded by the NDPP are impressive, an international review of 38 real-world DPPs[36] noted that the **public health impact of a DPP depends on participation** as well as population coverage. Therefore opportunities to grow participation should be considered if the NHS is to maximise the potential impact.

As part of its delivery of the NDPP in its region, NHS Humber and North Yorkshire Integrated Care Board (ICB) identified Meddbase, an advanced clinical management system, as a software solution to improve its communication with patients that are eligible for the DPP and increase uptake of the programme.

This pilot study was designed to:

- Test whether a strategic, focused approach that utilises digital communications and is delivered at ICB level could increase uptake of the NDPP in this region
- Uncover learnings that could be shared with other ICBs across the UK to improve uptake nationally

A number of partners were involved in the study:

- The pilot was designed jointly by Meddbase and NHS Humber and North Yorkshire Integrated Care Board
- It involved patients from four GP practices (anonymised in the study)
- The NDPP lifestyle support programme was delivered by Xyla Health & Wellbeing (part of Acacium Group), which provides health and wellbeing services for businesses, local authorities and the NHS
- Patient data was managed by Care Plus Group

Criteria

To be eligible for the NDPP, patients must meet the following criteria:

- Have 'non-diabetic hyperglycaemia' (NDH), having recorded an HbA1c of 42 – 47 mmol/mol (6.0 – 6.4%) or a fasting plasma glucose (FPG) of 5.5 – 6.9 mmol/l within the last two years
- Be over the age of 18

Additional criteria added for this pilot were:

- The practice must have a mobile phone number for the patient
- The patient must not be pregnant or have gestational diabetes

> "I thought we were doing NDPP referrals well, but we were missing hundreds of patients with pre-diabetes. This pilot enabled the ICB to conduct advanced searches for the first time, so they could identify, invite and refer patients that would otherwise have been missed.
>
> The result was far greater uptake as well as significant time saved for clinical staff. Given the current capacity challenges within General Practice and the cost to the NHS of lifestyle-related conditions like type 2 diabetes to the NHS, the findings here could have a huge impact."
>
> **Dr. Tom Milligan**
> GP & Clinical Lead for Diabetes
> in Humber and North Yorkshire

Referral pathway

The defined pathway for referral into the NDPP is as follows:

- Invitation - patients are contacted to invite them onto the programme
- Referral - the patient's information is referred to the NDPP provider. There is some variation as to whether the patient will have been contacted by opt-in or opt-out communications
- Initial Assessment (IA) - the patient is assessed for suitability for the NDPP. Assessments include introduction, group confirmation, motivational interviewing and readiness to change, EQ-5D-5L wellbeing questionnaire, PAR-Q, smoking and demographic questions and signposting
- Milestone 1 (M1) - when the patient attends their first DPP session

NHSE sets targets for the number of patients to reach M1 and the ICB and local providers can work together to agree targets for the other stages to help them hit that M1 target.

Pilot delivery

A search of General Practice patient records at the four selected GP practices **identified 795 patients** that met the NDPP and pilot criteria. To allow for a comparison of opt-in vs opt-out digital communications, these patients were then split into two cohorts based on which practice they attended. Each cohort comprised two practices.

The digital communications process was designed using Meddbase's advanced clinical management and patient communication software. This would allow for easy automation of communications and bespoke workflow planning for improved efficiency.

To ensure easily comparable results, for this pilot it was decided to use **a single communication channel** for all digital communications and **SMS** was selected. Communications were set to run over two weeks in January 2022.

Cohort 1: Opt-out

- This cohort consisted of 433 patients and aimed to test the opt-out communication method
- Patients were first contacted and made aware of the programme at 11am on Friday 7th January 2022, with a follow-up reminder message shared seven days later
- Patients were informed that they were eligible for the NDPP, and given the opportunity to actively opt-out if they did not wish to participate. To opt-out, patients were asked to text a number and, when they did, no further communications were sent - other than a confirmation text
- Patients that did not opt-out were automatically referred through to the provider for follow-up confirmation

Cohort 2: Opt-in

- This cohort consisted of 362 patients and aimed to test the opt-in communication method
- Patients were first contacted and made aware of the programme at 11am on Tuesday 11th January, with a follow-up reminder message shared seven days later
- Patients were made aware of the programme, informed that they were eligible for it and given the opportunity to actively opt-in if they did wish to participate. To opt-in, patients were asked to text a number and a follow-up SMS was sent confirming they had opted-in to the programme
- If patients hadn't opted in by the specified date then it was assumed that they didn't want to participate in the programme and no further communications were sent

All communications were automated using the Meddbase system to prompt patients to make decisions about whether or not to participate in the NDPP, with reminders automatically shared with only those who were yet to make a decision.

The Meddbase report management suite was used to produce two patient lists. All those who were being referred were sent to Xyla Health and Wellbeing to enrol them onto the programme and all those who had been contacted but weren't being referred were sent to Care Plus Group so that patient records could be updated.

THE FINDINGS

Results

Overall

Benchmark analysis had revealed that, across the four selected GP practices, there had been an average of 32 referrals per month in the six months prior to the launch of the pilot. Over the same period, there had been 16 patients that had reached M1 following business-as-usual methods.

In the month that the managed digital communications pilot was launched (January 2022), across the four GP practices there were a combined total of 363 referrals and 69 patients reaching M1. **This represents a 1,000%+ increase in referrals and a 331% increase in patients reaching M1.**

The impact of these referrals continued for several months, as patients selected a suitable date for their first session. Over the next three months, an average of 45 patients each month reached M1 - **a 181% increase on the baseline figure** of 16 per month.

Opt-in versus opt-out

The results were similar for opt-in and opt-out digital communications.

The GP practices that tested opt-out digital communications saw a 10-fold increase in referrals, from an average of 23 per month to 236 in the month of the launch. The number of patients reaching M1 jumped from 10 per month on average, to 45 in the month of the launch - an increase of 350%.

For the GP practices testing opt-in digital communications, there were similar increases. While there had been an average of nine monthly referrals over the previous six months for these practices, that number jumped to 127 in the month that the pilot launched - **a rise of 1,300%**. There was also a big increase in the number of patients reaching M1, rising 300%, from an average of 6 per month to 24 in the month of the pilot launch.

> "We've seen phenomenal success with this pilot, which was driven by user need. Previously we had to wait to achieve the critical mass required to make the programme viable, but we can now confidently say that we will have enough patients to start a group. In fact, the success of the pilot has given us the confidence to bring in additional human resources to manage patient conversions. That's the beauty of this solution - the untapped potential is huge."
>
> **Scott Walker**
> Senior Partnership Officer (Diabetes), NHS Humber and North Yorkshire Integrated Care Board

THE LEARNINGS

The results from this pilot clearly demonstrate that a strategic, managed approach to patient communications, that is supported by the right kind of clinical management software such as Meddbase, can have a significant impact on the level of uptake for healthy lifestyle interventions.

NHS Humber and North Yorkshire Integrated Care Board and its clinical management system partner, Meddbase, would like to share the following learnings, so that other ICBs and healthcare providers can consider similar solutions.

A strategic, ICB-managed approach to patient communications can have a big impact on outcomes

It is common for communications with patients to be managed at practice level and to be delivered over an extended period, however, this might not be the most efficient or effective way.

To carry out a project like this would have typically required each practice to be able to set aside time to search patient records, interpret the results of that search and to then print and post letters to all eligible patients. Some practices may not have the expertise to do that within their team, others may struggle for capacity. Furthermore, the chances of multiple GP practice-led communications campaigns being coordinated to land at the same time would be slim, meaning that the impact would be likely to be spread over an extended period.

By running this pilot at ICB level, the North Yorkshire Health and Care Partnership was able to use Meddbase to deliver the programme in an efficient, coordinated way that reached a large number of eligible patients in a focused period. Responsibility for the pilot sat with the Partnership's Engagement Officer, meaning that patients benefited without increasing the burden on GP practice staff. The 331% increase in patients reaching M1 demonstrates that this was effective and results were similar for opt-in and opt-out.

The right software is key to being able to deliver an ICB-wide approach to patient communications in an effective and efficient way

This pilot delivered a significant increase in referrals and patients reaching M1. Utilising technology to enable an ICB to invite patients from multiple GP practices at once also appears to have unlocked a number of efficiencies, saving GP practices time and money.

The software used for the pilot enabled the ICB's Engagement Officer to quickly identify eligible patients, check them against other criteria and then schedule an intelligent text messaging workflow that detected whether a patient had opted-in or out of the programme, removing them as appropriate.

The flexibility to adjust workflows based on the specific needs of the project is likely to be useful in future work and both NHS Humber and North Yorkshire ICB and Meddbase are excited by the prospect of utilising more complex configurations that could enable even greater automation of the workflow, while giving users the optimum level of oversight. This could enable the volume of patients to be increased significantly, with no extra capacity required.

Data quality processes are key to success

Data quality is the biggest barrier to effective data searches, which are crucial both to identifying eligible patients and being able to contact them. A snapshot report based on a selection of practices in this region found that as many as 40% of patient records didn't contain a mobile phone number.

Auditing patient records to ensure that contact details and preferences are up-to-date is crucial. It can be as simple as putting a flag against a record where information is missing so that the next time they visit or contact the practice, the person they speak to asks them for the missing data points. One of the secondary benefits of this pilot was that it gave fresh impetus for the NHS Humber and North Yorkshire ICB to improve its data quality.

Patient choice mitigates against digital exclusion and improves outcomes

Patient choice is a key component of personalised care[37], which was identified as a priority in the NHS Long Term Plan[38]. It is defined as giving patients choice and control over how their care is planned and delivered.

In order to mitigate against any risk of digital exclusion, it is important that patients' contact preferences are taken into account. This avoids any risk of leaving behind any patients that do not have access to - or are not confident with - digital communications.

It is likely that contacting patients using their preferred method - whether text, email or letter - will increase the likelihood of them engaging with any recommended programme. Data suggests that for the majority of patients, this will be digital communications. That will leave a much smaller number to contact via other more costly or time-consuming means.

PILOT PARTNERS

About Meddbase

Meddbase is an advanced secure cloud-based clinical management system that integrates Electronic Medical Records (EMR), workflow planning and patient communications as part of a truly end-to-end service to **improve patient care, increase efficiencies and support clinicians.**

The powerful and flexible software is used across a range of settings including primary care, hospital management and occupational health and customers include the NHS, BUPA and HCA Healthcare UK.

Central to the benefits of the Meddbase system is Pathways, its **inbuilt industry-leading workflow management tool** that enables custom configuration of a range of tasks. These include sending a questionnaire to a patient, using the slot finder to book an appointment with the right clinician at the right time, attaching a document to a patient record, contacting a patient, making a patient referral, or creating a new task or form and finding a list of patients using filters.

Tasks can also be shared with patients via the **Patient Portal**, allowing patients to have more choice and control over how their healthcare is planned and delivered, which is the goal of personalised care.

These tasks can be packaged together in a **single automated workflow**, providing a range of benefits to both clinicians and patients, including:

- Increasing speed and efficiency
- Saving clinicians time, which can be spent with their patients
- Allowing organisations to grow without increasing staff costs
- Increasing patient engagement through a secure Patient Portal
- Ensuring that no task is ever forgotten

About NHS Humber and North Yorkshire Integrated Care Board

NHS Humber and North Yorkshire ICB is a statutory organisation accountable for NHS spend and performance for 1.7million people. The ICB is a core member of the Humber and North Yorkshire Health and Care Partnership, alongside NHS providers, local councils, health and care providers and voluntary, community and social enterprise (VCSE) organisations.

The Health and Care Partnership is one of 42 Integrated Care Boards which cover England to meet health and care needs across an area, coordinate services and plan in a way that improves population health and reduces inequalities between different groups.

The Partnership was first established in 2016 as Humber, Coast and Vale ICS, and since then partners have been working together to look for ways to join up health and care services and to make them work better for local people.

The Partnership works across a geographical area of more than 1,500 square miles including the cities of Hull and York and the large rural areas across East Yorkshire and North Yorkshire, as well as North and North East Lincolnshire, serving the different health and care needs of the population.

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