‘Move Away From Pre-diabetes’ (MAP) Pilot Programme: an innovative service redesign to deliver significant health benefits for high risk patients

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Why Is Change Needed?

Diabetes rates in the UK have surged[1], with the BME population almost twice as likely to develop type 2 diabetes compared to the white population.[2]

Clinical outpatient dietetic services can only offer ≤ 3 appointments.

The National Diabetes Prevention Programme is limited at meeting high risk complex BME population needs.

Strategic Aim:

Improvement & redesign of diabetes prevention to deliver significant patient benefits.

Objectives:

Transform existing clinical service for pre-diabetes patients to an innovative structured behaviour-change intervention.

Measure impact outcomes pre and post intervention participation & completion rates.

Significantly improve access to quality interventions for communities with complex needs.

Leading Transformation

Built readiness to deliver the transformed clinical offer to our patients with pre-diabetes:

- Creation of new MAP waiting list on our clinical system.
- New triaging instructions for referrals that meet the MAP criteria.
- Engaged key local stakeholders & achieved buy-in (eg from local leisure services) to support MAP patients.

Methodology

Between June and August 2017 individuals (n=11) aged 40-74 years who were identified with non-diabetic hyperglycaemia (pre-diabetes) - HbA1c of ≥ 42-< 47mmol/mol or Oral Glucose Tolerance Test ≥ 7.8- < 11.1mmol/l - were triaged onto the Move Away from Prediabetes (MAP) Pilot by Nutrition & Dietetics in Brent.

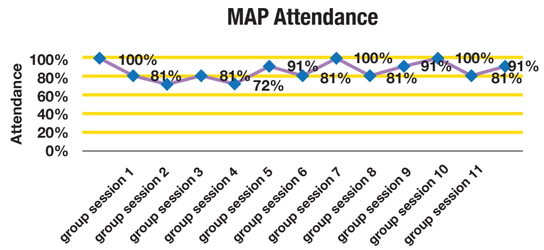
A behavioural change approach was fostered throughout the programme, empowering patients by encouraging self-management and providing each patient with tailored goals for weight loss, improving diet and increasing exercise. Participants had their anthropometry, exercise level and dietary intake measured and these results, alongside biochemistry, were compared pre and post intervention by a dietitian.

Participants received:

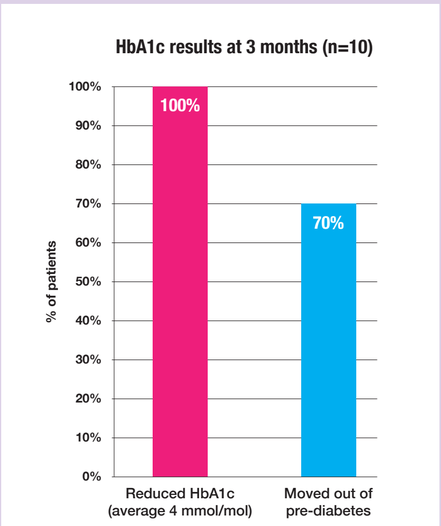
- intense pre-assessment.
- personalised 1:1 appointments with a dietitian.
- 10 weeks of structured nutrition education and group physical activity sessions (including SMART goals).
- Interpreting services at all sessions (n=5).
- motivational telephone and email support.

Measuring Impact – Results

Average attendance for sessions : 94.5%



- ★ 100% rated the nutrition group & exercise sessions as excellent.
- ★ 100% felt confident they will continue with the changes they’ve made.
- ★ **70% patients (n=10) move out of pre-diabetes after 3 months:**



“Thanks a million for waking us up and helping us U-turn our life for the better”
– MAP participant

What have we learnt?

First 90 day rapid improvement cycle illustrated the effectiveness of the programme for high-risk complex patients and demonstrated short-term improvements in anthropometric and biochemical measures.

Potential constraints:

- Building clinical capacity to meet increased demand.
- Funding to support the physical activity component.
- Buy in from Brent CCG & wider health economy (NWL STP).

Sustainability:

Follow up at 6 months post-completion of the intervention to re-check results. Second rapid improvement cycle commencing 3 October 2017 to provide comparison data.

NHS Improvement

References: 1. Public Health England. Adult obesity and type 2 diabetes, 2014. 2. Diabetes Prevalence Model; Public Health England (PHE) & National Cardiovascular Intelligence Network (NCVIN), 2016

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Acknowledgements: Harriet Knight (Primary Care Dietitian), Brent Primary Care, Vale Farm Sports Centre. October 2017