TRAFFORD COUNCIL

Report to:	**Health Scrutiny Committee**
Date:	**09/03/22**
Report for:	**Information**
Report of:	**Helen Gollins, Acting Director of Public Health and Mark Jarvis, Medical Director, NHS Trafford CCG**

Report Title

Update on diabetes and inequalities

Summary

Recommendation(s)

To note the progress made since the previous report in March 2021.

Contact person for access to background papers and further information:

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1. **Background**
   Further to the report from March 2021, this is an update on work to address health inequalities and diabetes.

2. **Updates**
   a. **Recording ethnicity in primary care**. The Primary Care Quality Assurance Group (PCQAG) have improving data as one of their key themes, and within this, ethnicity recording is a priority action. There has been significant work on this action in the last 12 months, focusing on a process that can be used across all practices to request this information from patients and upload it to the patient record on EMIS.

      Various processes were considered and investigated to facilitate this action, with the result being a practice-wide text being sent out requesting the data to be returned which would then be automatically coded to the patient record in EMIS. This was piloted with one practice in August 2021, and then rolled out across Trafford practices following this.

      The progress report in appendix 1 shows the progress made on data quality, with the percentage of valid records (those with a valid ethnicity code) now standing at just below 77%. In addition, the percentage of records coded as 'other' is steadily decreasing. It should be noted that this report reflects work in progress, with these being early results from a single campaign to contact patients by text message.

   b. **Progress on delivery of health checks** – COVID-19 has had a large impact on practices' ability to deliver the NHS Health Check programme. Nationally the percentage of eligible people receiving an NHS Health Check dropped from 7.7% in 2019/2020 to 1.2% in 2020/2021. On a Greater Manchester level it fell from 10.2% to 1.3%

      Most recent guidance has advised that the NHS Health Check Programme be deprioritised by practices for January and February 2022, due to the increase pressure on the health system due to the Omicron wave of COVID-19.

      A review of NHS Health check activity has taken place, which is due to be taken to the PCNs to discuss next steps, via the PCN Network Meeting. The next steps are to work collaboratively with practices to encourage them all to be able to deliver the programme in line with the current national average. This would be 1.8% of their eligible population attending.

      The table below shows each PCN compared to the national averages for Q1 and Q2 of the current financial year and also their historical delivery over the last 5 years. In the current financial year the areas most impacted by COVID-19 are the two PCNs in the South of the borough (AHA and South Trafford). The positive news is the areas with the greatest issues relating to health inequalities (the North and West) are also the best performing.

While as a whole some PCNs are performing above national and regional averages, there is a large disparity in the number of practices currently delivering, with only 17 of the 31 practices registering activity. It is therefore important we are able to ensure all practices are delivering to improve equity of access both across and within the PCNS.

Area	16/17	17/18	18/19	19/20	20/21	21/22
AHA	8.54%	5.70%	6.81%	7.11%	0.18%	0.26%
Sale	16.71%	16.94%	11.45%	9.10%	3.28%	2.66%
West	4.48%	6.10%	6.22%	6.72%	1.12%	3.82%
North	7.02%	8.61%	13.86%	3.93%	0.33%	4.74%
South	15.06%	14.57%	12.66%	7.78%	0.44%	0.85%
Trafford	10.30%	10.55%	9.69%	7.32%	1.26%	2.58%
Greater Manchester	9.20%	9.40%	10.30%	10.20%	1.30%	2.45%
England	8.50%	8.30%	8.10%	7.70%	1.20%	1.80%

There are pockets of good practice across Trafford, such as Partington Family Practice, who are targeting their health check invitations to patients with known risk factors (such as smoking or obesity). This has led to over 30% of the eligible population from this practice attending for a health check. The next steps are to replicate this good practice across all practices, in order to ensure that health checks are being offered to those with the greatest risk factors.

Percentage of Eligible people who attended an NHSHC by practice						
Practice	**16/17**	**17/18**	**18/19**	**19/20**	**20/21**	**21/22**
Partington Family Practice	0.6%	17.3%	18.2%	15.0%	0.2%	30.5%
England	**8.50%**	**8.30%**	**8.10%**	**7.70%**	**1.20%**	**1.80%**

The above table highlights how successful Partington Family Practice's approach has been, and how this best practice could be shared across the PCN and other Trafford PCNs. In quarter 1 and 2 Partington Family Practice have delivered 403 health checks, compared to their previous best of 199 in a full year, and the previous highest by any Trafford practice of 380 (in 2019/2020).

c. **Diabetes education programme** – A community-based education programme (Xpert) is offered by Trafford Local Care Organisation (TLCO); however again this service was stood down during Covid and is in the process of re-starting. The service is delivered by specially trained dieticians and both group and individual clinic sessions are offered to provide patient choice. A trial of a digital delivery option will take place this month with a view to offering both face to face and remote learning options

moving forward. Recent activity information post-Covid is not yet available, but 2020-21 data by PCN is below:

PCN	Structured education referrals	Structured education referrals %	Trafford attendance %	England attendance %
Central	84	67.7%	7.2%	13.2%
North	59	51.3%	7.2%	13.2%
South	31	55.4%	7.2%	13.2%
AHA	18	30.5%	7.2%	13.2%
West	50	40.7%	7.2%	13.2%

In addition, consultation is taking place with providers and CCGs at a GM-level to understand whether a unified GM-wide diabetes education offer would be an effective way to improve education attendance and improve patient outcomes in future.

d. Progress on narrowing inequalities

March 2021

Neighbourhood	Number on diabetes register	Number on practice list	Neighbourhood%	Trafford%	England%
Central	3,081	50,385	6.11%	6.50%	7.08%
North	2,978	34,366	8.67%	6.50%	7.08%
South	3,275	62,783	5.22%	6.50%	7.08%
West	3,131	44,241	7.08%	6.50%	7.08%
	12,465	**191,775**			

This shows an inequality gap in prevalence (between North and South) of 3.45%.

March 2022

Neighbourhood	Number on diabetes register	Number on practice list	Neighbourhood%	Trafford%	England%
Central	3,198	50,442	6.34%	6.57%	7.11%
North	3,124	36,526	8.55%	6.57%	7.11%
South	3,368	63,506	5.30%	6.57%	7.11%
West	3,014	43,035	7.00%	6.57%	7.11%
	12,704	**193,509**			

This shows an inequality gap in prevalence (between North and South) of 3.25%.

Over the last 12 months, inequalities in childhood obesity, adult obesity and adult and child physical activity have widened, so maintenance of the inequalities gap in terms of diabetes prevalence at neighbourhood level may be a positive step in this context.

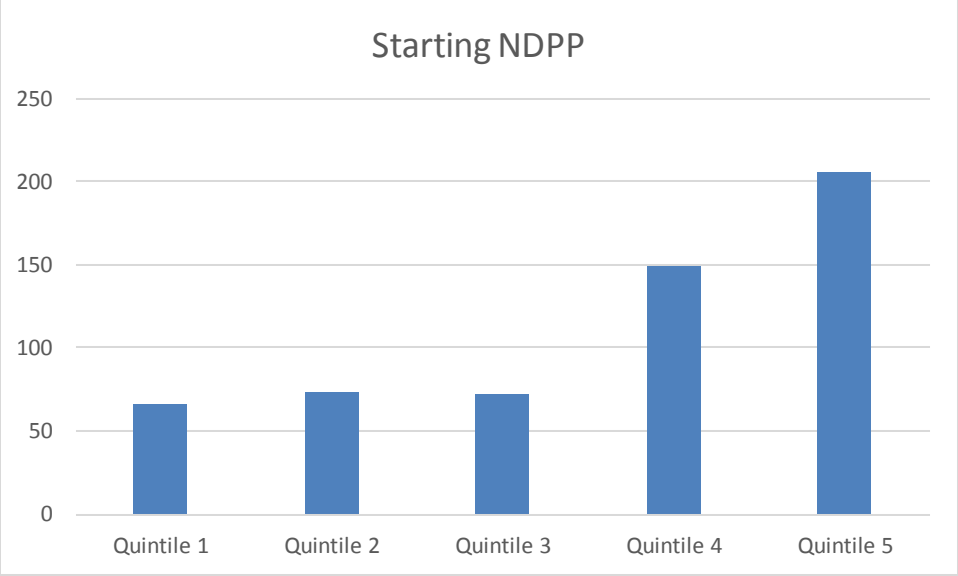
In terms of referrals to the National Diabetes Prevention Programme, significant work has been undertaken alongside the provider (Xyla Health & Wellbeing) and GM

commissioners of this service. This has included the deployment of Primary Care Engagement Officers to work with specific practices to identify and invite eligible patients onto the programme. This work has focused on practices serving the most deprived wards of Trafford, and in particularly North Trafford PCN due to the bulk invitations not being sent out from these practices back in early 2020.

There have been 797 referrals into the programme (up to 31/01/2022), with 407 achieving milestone 1 (initial appointment and attendance at week 1 of programme), maintaining a conversion rate of 51%. The referral rate has increased significantly from 20/21, despite the continued pressure on primary care with the roll-out of the Covid vaccination programme and other direct and indirect impacts of the pandemic.

Year	**Number of referrals**
Feb 2019 – Jan 2020	315
Feb 2020 – Jan 2021	114
Feb 2021 – Jan 2022	368
Total	**797**

There is still a social gradient in terms of access to NDPP with more people taking up the programme from the least deprived areas:



Attendance at NDPP by quintile, up to 31/10/21.

Dr. James Hider (GP from Partington Family Practice, and Clinical Lead for Diabetes Prevention at Greater Manchester Strategic Clinical Network) has been working with colleagues across GM to learn from best practice and implement these techniques in Trafford to address these inequalities in access. The report from Dr Hider in appendix 2 details the work that is being undertaken both in terms of clinical care and diabetes prevention. It is clear that the pressures within primary care over the last two years have had a significant impact on referrals into the NDPP as well as delivery of NHS health checks, but there are robust plans to address this through visiting practices, updating contact lists, and providing additional training and education sessions for practice staff.

In terms of wider programmes of work around reducing inequalities in healthy weight and physical activity, there is ongoing work with specific communities to increase engagement alongside those described in the previous report. For example:

- Trafford Community Collective are delivering a project to work with specific communities to increase engagement with weight management programmes, supporting people to access local services and providing supplementary activities to enable people to achieve success (such as support around healthy eating on a limited budget).
- Work to link Active Travel and Social Prescribing in North Trafford, addressing barriers to walking and cycling through provision of support, access to equipment, training, confidence building, route planning etc.

Appendix 1

Practice Ethnicity Coding – Progress Su

Appendix 2

Report from Dr James Hider.docx