REPORT TO:	Health and Wellbeing Board
DATE:	17 July 2013
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Adults
SUBJECT:	Support for patients identified with Impaired Glucose Regulation (IGR)
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform members of the Health and Wellbeing Board of a proposed Merseyside wide project to support patients identified as having IGR and thereby prevent or delay the progression to type 2 diabetes.

2.0 **RECOMMENDATION: That the report be noted and the Health and Wellbeing Board comment on the proposed pathway.**

3.0 **SUPPORTING INFORMATION**

3.1 Impaired Glucose Regulation (IGR, also known as non-diabetic hyperglycaemia or pre-diabetes) refers to blood glucose levels that are above the normal range but are not high enough for the diagnoses of Type 2 diabetes.

3.2 Type 2 diabetes is a chronic costly condition which in the majority of cases is preventable. Local prevalence of Type 2 diabetes is increasing. Before people develop Type 2 diabetes they almost always have IGR and over a third of IGR patients will go on to develop Type 2 diabetes within 6 years. However, there is evidence to suggest that the onset of Type 2 diabetes can be delayed for an average of 8 years through intensive lifestyle intervention (primarily weight management), avoiding substantial future costs. In particular, evidence shows that:

- Modest lifestyle changes can significantly postpone the onset of diabetes for high risk individuals;
- A weight reduction of 3.7 - 6.8kg in overweight people aged 30-50 equates to a 33% reduction in the risk of developing Type 2 diabetes;
- Lifestyle intervention is more effective than the drug treatment Metformin in reducing the incidence of Type 2 diabetes in IGR patients.

3.3 An audit of patient records across 148 GP practices in Merseyside (including Halton) undertaken in September 2012 revealed that:

- The known incidence (number of new cases diagnosed per year) of IGR has roughly doubled since 2006 rising from 644 new cases in 2006-07 to 1,203 new cases in 2010-11;
- The current known adult prevalence (total number of cases in a population) of IGR across Merseyside is 0.8%, ranging from 0.5% in Liverpool to 1.6% in Halton and St Helens;
- This equates to 1,998 patients known to have IGR in Halton. Using NHS Health Check modelling it is estimated that a further 874 Halton residents are potentially undiagnosed;
- 34.5% of known IGR patients are overweight (BMI between 25 and 30) and 47.3% are obese (BMI over 30);
- Only 0.2% of overweight and 1.2% of obese IGR patients were recorded has having been referred to a weight management intervention by their GP (note that in Halton patients can self refer to weight management interventions so there may be a level of under recording of IGR patients accessing weight management services);
- 65.7% of those diagnosed with IGR in 2009-10 were not offered a follow up blood test in the following 12 months.

4.0 Proposed IGR pathway

In September 2012 a QIPP business case (attached as Appendix A) was developed for a standardised diabetes prevention pathway to identify and manage patients with IGR across the Mersey Cluster. The proposed pathway (Appendix B) is based around a five step process which is described below.

4.1 Step 1 - Identification of high risk patients

It is proposed that high risk patients will be identified through searches of GP practice registers, via NHS Health Checks and opportunistically. NICE Guidelines recommend stratifying the whole population using real and estimated data and then offering blood tests to those identified as high risk, however, the steering group deemed it more appropriate to manage patients already identified as having IGR before expanding the identification process.

4.2 Step 2 – Offer blood test

High risk patients would be tested by GPs for IGR using the HbA1c blood test. An HbA1c of between 42 to 47mmol/mol indicates that the patient has IGR. It is proposed that patients diagnosed with IGR would be placed on an IGR register and would be referred or encouraged to self refer to lifestyle interventions (primarily weight management) .

4.3 Step 3 – Patient invited for clinical/lifestyle review

This step would be undertaken by the Health Improvement Team currently located in Bridgewater NHS Trust. The team already undertake reviews of clients prior to registration onto the Fresh Start weight management programme to assess their suitability for the programme and where appropriate make referrals to the Dietetic service offered by Warrington and Halton Hospital Trust.

4.4 Step 4 – Patient offered IGR education and lifestyle intervention

The precise model for patient education is currently under consideration by the IGR steering group but will include education around risk of cardiovascular disease, diabetes and how to reduce risk. Although the Merseyside business case proposes that patient education is delivered separately from weight management intervention it is likely that in Halton the patient education element will be integral to the Fresh Start weight management programme. This is currently a 10 week course but there are proposals to increase this to 20 weeks which will easily accommodate the IGR patient education element. Halton has an advantage over other areas within the Mersey Cluster due to the well established weight management programmes on offer which are run by staff who are highly experienced in delivering behavioural change training for clients.

4.5 There will, however, be a need to provide IGR specific training for approximately 20 staff from the Health Improvement Team (predominantely Lifestyle Advisors and Health Trainers). It is proposed that training is delivered on a Merseyside wide level to ensure consistency across the sub region and deliver economies of scale. The various options for this are currently being considered but Directors of Public Health have been requested to set aside £20,000 each to contribute to the training.

4.5 Step 5 – Patients thereafter invited for annual review

Participants of Halton's Fresh Start programme already have their progress monitored regularly in terms of weight and BMI for the duration of the course. However, it is anticipated that the annual review will be undertaken by the patient's GP and will include an HbA1c test. The annual review also ensures that patients who do progress to diabetes are identified at an early stage and managed by the practice.

4.6 It is proposed that a range of IGR educational material be developed for those patients who choose not to participate in a lifestyle intervention but who wish to manage their condition themselves and to support those that do participate in interventions. Funding for this element has been provided through the Quality, Innovation,

Productivity and Prevention (QIPP) Programme.

4.7 Halton's CCG Governing Body confirmed its support for the pathway at its meeting of 20th September 2012 and agreed to fund annual reviews for patients known to have IGR and those identified as having IGR through Health Checks. It is anticipated that, subject to delivery of the training element, the pathway will be formally launched and rolled out to GP practices in September 2013. Directors of Public Health from all local authorities involved have also given their in principle support for the new pathway.

5.0 POLICY IMPLICATIONS

Obesity is a contributory factor in a number of the priorities contained in Halton's Health and Wellbeing Strategy including increased risk of various forms of cancer, mental health and wellbeing, child development and has been associated with an increased risk of falls due to impaired balance.

6.0 OTHER/FINANCIAL IMPLICATIONS

GPs have indicated through the CCG Commissioning Body that they consider the IGR pathway to be part of their core contract, therefore, there is no additional cost arising from the need to take HbA1c readings and undertake annual reviews.

Directors of Public Health across the Mersey cluster have been requested to set aside £20,000 to support the commissioning of an IGR training package.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 Children and Young People in Halton

The pathway is aimed at adults, however, it has the potential to bring about positive benefits for the children of participating adults resulting from their parents improved knowledge about the risks associated with unhealthy eating and lack of exercise and reducing potential caring responsibilities for children if the parent were to go on to develop Type II diabetes.

7.2 Employment, Learning & Skills in Halton

The pathway includes a training element for Lifestyle Advisors and Health Trainers around IGR.

The pathway could also help to increase the self confidence of overweight and obese participants which in turn can increase their chances of finding employment.

7.3 A Healthy Halton

The symptoms of type 2 diabetes can lead to a range of health complications including angina, heart attacks, stroke, kidney damage, eye and foot problems. A study carried out in 2012 by the

York Health Economic Consortium estimated that by 2035 type 2 diabetes could cost the NHS £16.9 billion (up from £9.8bn in 2012).

7.4 A Safer Halton
None directly

7.5 Halton's Urban Renewal
None directly

8.0 RISK ANALYSIS

The QIPP business case identified a number of risks and mitigating actions as outlined in section 5 of the original Business Case attached as Appendix A.

9.0 EQUALITY & DIVERSITY ISSUES

None identified

10.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None under the meaning of the Act