

APL-NDPP Diabetes prevention invitation and referral tool

User guide for SystmOne



Clinical Effectiveness Group Queen Mary University of London

V 3.0.1 March 2024

About

Systematic invitation and referral

APL-NDPP is designed for use within GP practices. It identifies patients who are eligible for behaviour change programmes through the <u>NHS Diabetes Prevention Programme</u>. Using the tool, practice teams can quickly list eligible patients and prepare a prioritised list to invite. The tool will support you to:

Prioritise

- Rank patients according to the number and importance of their relevant risk factors,
- Filter patients according to whether they have been referred to NDPP or not, or have declined referral,
- Re-import the filtered list into your clinical system to batch add codes or send appointment messages.



Tailor your approach to individuals

• See relevant details for each patient in your list including overall risk factor score, BMI, ethnicity, age and vulnerabilities - simply by clicking on their name in the tool.

How risk is calculated

The tool displays coded information from patient records and assigns a simple weighting (1 or 2) to a set of risk factors, calculating a total score for each person (maximum score = 9):

- Age: ≥ 65 years = 1
- Area-based Index of Multiple Deprivation (IMD) score Q4/5 = 1
- BMI: 35-39 = 1, 40+ = 2
- Ethnicity: Black or South Asian = 1
- Hypertension = 1
- Pre-existing cardiovascular disease: Ischemic heart disease, stroke/TIA, Atrial Fibrillation = 2
- Vulnerability: Learning disability or severe mental illness = 1

Referral eligibility

APL-NDPP uses the following criteria to identify patients as eligible for referral:

- Aged 18 years or over;
- 'Non-diabetic hyperglycaemia' (NDH), defined as having an HbA1c of 42 47 mmol/mol or a fasting plasma glucose (FPG) of 5.5 6.9 mmol/l. The blood result indicating NDH must be within the last 12 months to be eligible for referral and only the most recent blood reading can be used;
- Previous gestational diabetes and latest HbA1c <42 mmol/L.

Excludes patients who have:

- Blood results confirming a diabetes diagnosis, i.e. HbA1c of 48mmol/mol or greater or FPG of 7mmols/L or greater, or a previous diagnosis of diabetes (excluding diabetes resolved);
- A pregnancy-related code within the last 10 months;
- Palliative care;
- Eating disorders;
- Severe/moderate frailty;
- Bariatric surgery within the last two years.

About

Supporting elements

APL-NDPP is part of a wider programme of support that CEG provides to GP practices in the North East London NHS region, including 1:1 training and guidance from our team of facilitators. The tool is best used with these supporting elements in place.



Limitations

No replacement for clinical judgement

APL-NDPP is **not a diagnostic tool or intended to replace clinical judgement**. The tool displays information coded in the patient record and can be used to highlight patients who have non-diabetic hyperglycaemia. It does not make management recommendations – these are entirely a matter for the clinician.

Only presents coded information

The tool only presents information that is **coded** in the patient health record. It is important to use it with data entry templates to ensure your activity is coded correctly. In cases where the codes do not clearly describe a patient's risk factors or referral status, clinicians are advised to manually check the patient record for uncoded information which would not be picked up by the tool.

Contact us

If you have any questions or feedback about our diabetes prevention invitation and referral tool, or this user guide, please get in touch:

CEG-feedback@qmul.ac.uk

qmul.ac.uk/ceg

Our postal address is:

Clinical Effectiveness Group Queen Mary University of London Yvonne Carter Building 58 Turner Street London E1 2AB

Step-by-step: Downloading APL-NDPP

You only need to do this once

Step 1: Download

Download the APL-NDPP zip file.

Step 2: Extract

Extract the files:

APL-NDPP TOOL.xlsm (Excel file) APL-NDPP USER GUIDE.pdf SMS examples (Word document)

Step 3: Save

Save the files in a shared folder so they are accessible to other practice staff, including clinicians reviewing your work. Choose a secure device or network if you intend to save exports of patient identifiable data in the same place.



CEG APL-NDPP - SystmOne.zip 866 KB



Step 4: Unblock macros

Microsoft has introduced a security feature that blocks Excel macros by default. Macros are automated actions that the tool uses to run without them, it will not work.

4.1 Right click on the '**APL-Imms TOOL**' XLSM file and select '**Properties**'.

4.2 In the 'General' tab, tick the box to 'Unblock'

4.3 Click '**Apply**'. You must click 'Apply' before 'OK', otherwise the change won't take affect.

If you accidentally click 'OK' without clicking 'Apply', the option will no longer be visible and you will need to download the file again.

| eneral Secu | urity Details Previous Version | S |
|---------------|--|--------------|
| X | APL-Imms TOOL | |
| Type of file: | Microsoft Excel Worksheet (.xls | sx) |
| Opens with: | Excel | Change |
| ocation: | C:1 | |
| Size: | 272 KB (279,548 bytes) | |
| Size on disk: | 276 KB (282,624 bytes) | |
| Created: | 16 March 2022, 15:46:44 | |
| Aodified: | 16 March 2022, 15:46:45 | |
| Accessed: | 05 July 2022, 11:20:03 | |
| Attributes: | Read-only Hidden | Advanced |
| Security: | This file came from another computer and might be blocke help protect this computer. | d to Unblock |

Troubleshooting

If you unblocked macros but still find that some of the tool functions do not work, add the folder you saved it into as a 'trusted location'. In Excel, click 'File', 'Options', then 'Trust Center', then follow <u>Microsoft's instructions</u>. **If you have any problems installing or using the tool, contact your local CEG facilitator for help.**

Step 1: Run the search in SystmOne

1.1 Open SystmOne. Locate the **APL-NDPP Tool search** (saved in folder 8: 'CEG APL Clinical Tools'), highlight it, and click '**run**':

| ~ | 1 CEG ICS Contract Support |
|---|--|
| ~ | 2 CEG Public Health BHR Support |
| ~ | 3 CEG PCN Care Home Supplementary Service |
| ~ | 3 CEG PCN Investment and Impact Fund |
| ~ | 3 CEG PCN SMI NHSE |
| ~ | 4 CEG QOF DES CQRS Cancer Support |
| ~ | 4 CEG QOF DES CQRS Cholesterol Support |
| ~ | 4 CEG QOF DES CQRS Depression Coding support |
| ~ | 4 CEG QOF DES CQRS Depression Recall Support |
| ~ | 4 CEG QOF DES CQRS Prevalence Improvement |
| ~ | 4 CEG QOF DES CQRS Weight Management Support |
| ~ | 4 QOF DES CQRS HPV Doses |
| ~ | 5 CEG Immunisations and Vaccinations |
| ~ | 6 CEG Risk Stratification |
| ~ | 7 CEG Miscellaneous |
| ~ | 8 CEG APL Clinical Tools |
| | * APL Imms (10) |
| | + APL NDPP Tool (1) |
| | + APL Renal (1) |



1.2 Once the search has run, click the **magnifying glass** to view the patients:

| | ▶ | 🗗 🖓 🗙 | Q | i | Þ |
|-------|----------|-----------|---------------|------|-------|
| Name | ∇ | | $\overline{}$ | | |
| APL-I | NDPP | Tool Sear | ch W | Shov | v the |

Step 2: Export the search results

2.1 Click 'Select Output', on top of the ribbon:

2.2 Select '**Pre-defined report output**', select your report, click 'ok':





2.3 Click '**Save all pages to CSV**' on top of the ribbon:

Step 3: Import data into the tool

3.1 Open APL-NDPP TOOL.xlsm (Excel file).

3.2 Select your clinical system:

| Ceege APL - | National | Diabete | s Prevention Tool | een Mary University of London. All rights reserved. | | Queen Mary |
|-------------------------------|----------------|---------|--|--|--------------|--|
| Select Clinical System O EMIS | O SystmOne | | This tool has been created to present clinical information diagnostic tool or intended to replace clinical judgement | on coded in the patient health record. It is not a nt. | | Attribution-NonCommercial-ShareAlike CC BY-ND-SA |
| Press to locate CSV file | Export to xisx | | | Export NHS number | RESET to cle | |

3.3 Click 'Press to locate CSV file'. Find and select the file you just exported from SystmOne:

| <u>ceg</u> Apl | Queen Mary | | | | | | |
|-------------------------------|--|--|----------------|-------------------|--------------|-------------------------------|--|
| Select Clinical System O EMIS | Clinical System C EMIS SystmOne This tool has been created to present dinical information coded in the patient health record. It is not a diagnostic tool or intended to replace clinical judgement. | | | | | | |
| Press to locate CSV file | Export to xisx | | Export COCCUTX | Export NHS number | RESET to cle | Date of last run: 24/Jan/2023 | |

Important:

- Due to limitations in SystmOne, older blood test values may not import into the tool. In these circumstances, the tool will display 'Check record'.
- Each time you use the tool, run a new search in SystmOne and import fresh data to ensure you are seeing the latest information.

Step 4: Filter the patient list

Use the **checkboxes** to filter your patient list. The tool will list all patients who meet the criteria.

Depending on who you want to prioritise for invitation, you could list patients who have not been referred, who are under 65 years old, with risk factors 5-9 and have a BMI ≥ 40, for example.

| <u>ceg</u> AI | PL - National Diabe | tes Prevei | ntion Tool | EG), Queen M | ary University of I | ondon. All rights res | ierved. | <u>k</u> | |
|---------------------------------------|---------------------------------|---------------------------------------|---|-------------------------|---------------------|-----------------------|------------|--|-------------|
| Select Clinical System O EMIS | SystmOne | This tool has be diagnostic tool o | en created to present clinical info or intended to replace clinical ju | ormation co dgement. | ded in the patie | nt health record. I | t is not a | Attributio | n-NonComme |
| Press to locate CSV file | Export to xisx | | Export COCCUTX | | Export NHS nu | mber 📄 | | RESET to cle | Date of las |
| Filters | | | Practice Summary | | | | | Risk Factors | |
| | | | | Number | Referred | Not Referred | Declined | Ethnicity – Black or South Asian = 1 | |
| Referral 🔽 Not yet referred 🗖 Refe | rred | 65 ┌ ≥ ٥- | Entire cohort | 245 | 31.4% | 50.2% | 18.4% | Deprivation – IMD score Q4/5 = 1 | |
| Ethnic Group | hite COther Risk Factors CO | 0-4 5-9 | % BMI < 30 | 118 | 28.0% | 50.8% | 21.2% | BMI - 35-39 =1, ≥ 40 = 2 | |
| Bidtk W | Risk Pactors | 3-4 3-9 | 9 BMI 30 - 34 | 69 | 30.4% | 47.8% | 21.7% | Vulnerability – LD or SMI = 1 | |
| MI | 2 40 Interpreter Needed? Yes | Filtered patients = 33 | 5 BMI 35 - 39 | 34 | 41.2% | 50.0% | 8.8% | Pre-existing CVD – IHD, Stroke/TIA, AF = 2 | |
| | | | % BMI ≥ 40 | 23 | 39.1% | 52.2% | 8.7% | Pre-existing Hypertension = 1 | |
| ease CVD (IHD/Stroke/TIA/PAD/AF) Hype | ertension Gestational Diab? Yes | Reset Futers | % South Asian/Black | 109 | 36.7% | 45.9% | 17.4% | Age ≥ 65 years = 1 | |
| | | | 1 | | | | | | 1 |
| 'Fi | ltered patients | s' | 'Pract | ice | Sumi | mary' | | 'Risk Fact | ors |
| sh pa | break: cohor | s do t bv | how patient risk | | | | | | |
| cri | teria you have t | ticked. | and et | thni | city. | , | | maximum | sco |

Step 5: Review individuals easily

5.1 Click a patient's name in the list to see more detail from their health record:

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|--------------------------------|--------------------------|-------------|------------|----------------|-------------------|--|---|---|-------------------------|------------------|--------------------------|--------------------|--|---------------------------------|----------|
| Select Clinical System | O EMIS | 5 | ۰ Sy | rstmOne | | This tool has bee diagnostic tool c | en created to pre or intended to rep | sent clinical info place clinical ju | ormation co dgement. | ded in the patie | nt health record. | It is not a | Attributio | n-NonCommercial-ShareAlike CC B | Y-NC-SA |
| Press to locate CSV file | X csv | | | Export to xisx | × | | Export | accurx | | Export NHS nu | mber 🗾 | | RESET to cle | Date of last run: 24/Jan/2023 | |
| Filters | - | | | | - | | Practice Su | mmary | | | | | Risk Factors | | |
| | | | | | | | | | Number | Referred | Not Referred | Declined | Ethnicity – Black or South Asian = 1 | | |
| Referral Vot yet refer | red [| Referred | | Declined Age | ┌┐ < 65 | ≥ 65 | Entire cohort | | 245 | 31.4% | 50.2% | 18.4% | Deprivation – IMD score Q4/5 = 1 | | |
| | | | | | | | % BMI < 30 | | 118 | 28.0% | 50.8% | 21.2% | BMI - 35-39=1, ≥40=2 | | |
| Ethnic Group South Asian | Black | White | C Othe | r Risk Factor | 0-4 | 5-9 | % BMI 30 - 34 | | 69 | 30.4% | 47.8% | 21.7% | Vulnerability – LD or SMI = 1 | | |
| | | | | | | | % BMI 35 - 39 | | 34 | 41.2% | 50.0% | 8.8% | Pre-existing CVD - IHD, Stroke/TIA, AF = 2 | | |
| BIVII < 30 ¥ 30 - | - 34 35 - 3 | 9 1 2 40 | nterpreter | Neededr | es Hitered | patients = 33 | % BMI ≥ 40 | | 23 | 39.1% | 52.2% | 8.7% | Pre-existing Hypertension = 1 | | |
| Disease | | | n Gestati | ional Diab? | Voc | | % South Asian/B | lack | 109 | 36.7% | 45.9% | 17.4% | Age ≥ 65 years = 1 | | |
| | (e) TIA/FAD/AT | Hypertensic | | | Res | et Filters | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Full Name | Patient Reference no. | Sex | Age | Ethnic Group | Risk Factors ↓ | Hb in las | A1c t 12m | BMI | CVD | Hypertension | Gestational Diabetes? | Referral Status | Interpreter status | Main Language Spoken | 2↓ Z↓ |
| 51d2550b-f2b0-ce67-8769-17254 | | Female | 89 | Black | 5 | 43 | 27-Apr-2022 | 32.4 | Yes | Yes | No | Not referred | Interpreter not needed | Main spoken language English | |
| d96d462d-f5d5-ad9e-cbcd-1d8c7: | | Female | 89 | Black | 5 | 43 | 26-Jul-2022 | 32.0 | Yes | Yes | No | Not referred | Interpreter not needed | Main spoken language English | |
| fc7d7469-8fc1-f5dc-ee3c-018109 | | Female | 82 | White | 4 | 44 | 15-Jun-2022 | 34.2 | Yes | Yes | No | Not referred | Practice member interpreter present | Main spoken language Turkish | |
| | | | | | | | | | | | | | | | |

We used a dummy dataset for demonstration purposes, but the full names of patients will appear here.

The **Patient Information** screen pulls relevant details from the patient record, including registration data, type 2 diabetes risk factors and result and date of their last HbA1c and/or fasting blood glucose.

| CCC APL - National Diabetes Prevention Toc Queen Mary | | | | | | | | | | |
|---|--------------------------------------|----------------------------------|---------------|--------------------|----------------|--|--|--|--|--|
| Patient Information | | Total risk factors | 5 | | | | | | | |
| Full Name | 4838caa8-037e-6925-af7e-19f02a372ebe | Gender | Female | | | | | | | |
| Date of Birth | | Age | 69 | | | | | | | |
| NHS Number | | Patient Ref # | | Total risk factors | | | | | | |
| Home/Work Telephone | | Mobile Telephone | | > 6 | i risk factors | | | | | |
| Main Language Spoken | Main spoken language Bengali | Main Language Date Recorded | 30-Jul-2021 | 4 - | 6 risk factors | | | | | |
| Interpreter Status | | Interpreter Status Date Recorded | d | < 4 | l risk factors | | | | | |
| | | | | | | | | | | |
| NDDP Referral | Description | | Date Recorded | Legend | | | | | | |
| Referral Status | Not referred | | | Hig | gh Risk | | | | | |
| | | | | M | oderate Risk | | | | | |
| Risk Factors | Description/Value | | Date Recorded | Mi | ild Risk | | | | | |
| CVD (IHD/Stroke/TIA/PAD/AF) | Stroke/TIA | | | | | | | | | |
| Hypertension | | | | Risk Factors | | | | | | |

5.2 Click 'BACK' to go back to your patient list.

Step 6: Export your list for invitation

Option 1: Excel file: click 'Export to xlsx'

You could use this file to add notes of actions taken/to be taken, but these will not go into the patient record.

Option 2: Accurx csv file: click 'Export accurx'

This method will create a .csv file that you can import into the Accurx text message system to batch send text invitations to patients.

Option 3: NHS numbers: click 'Export NHS number'

This will create a .txt file that you can import back into SystmOne to run further searches.



The tool download folder includes a Word document with example SMS messages (written by NHS North East London). The Diabetes Prevention Programme invitation letter is available in SystmOne: 'NDPP Invitation Letter CEG'

Remember to use CEG templates to code any actions, including referrals and declines. This will ensure every patient record has a clear, coded history that the tool will draw from next time you use it.



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