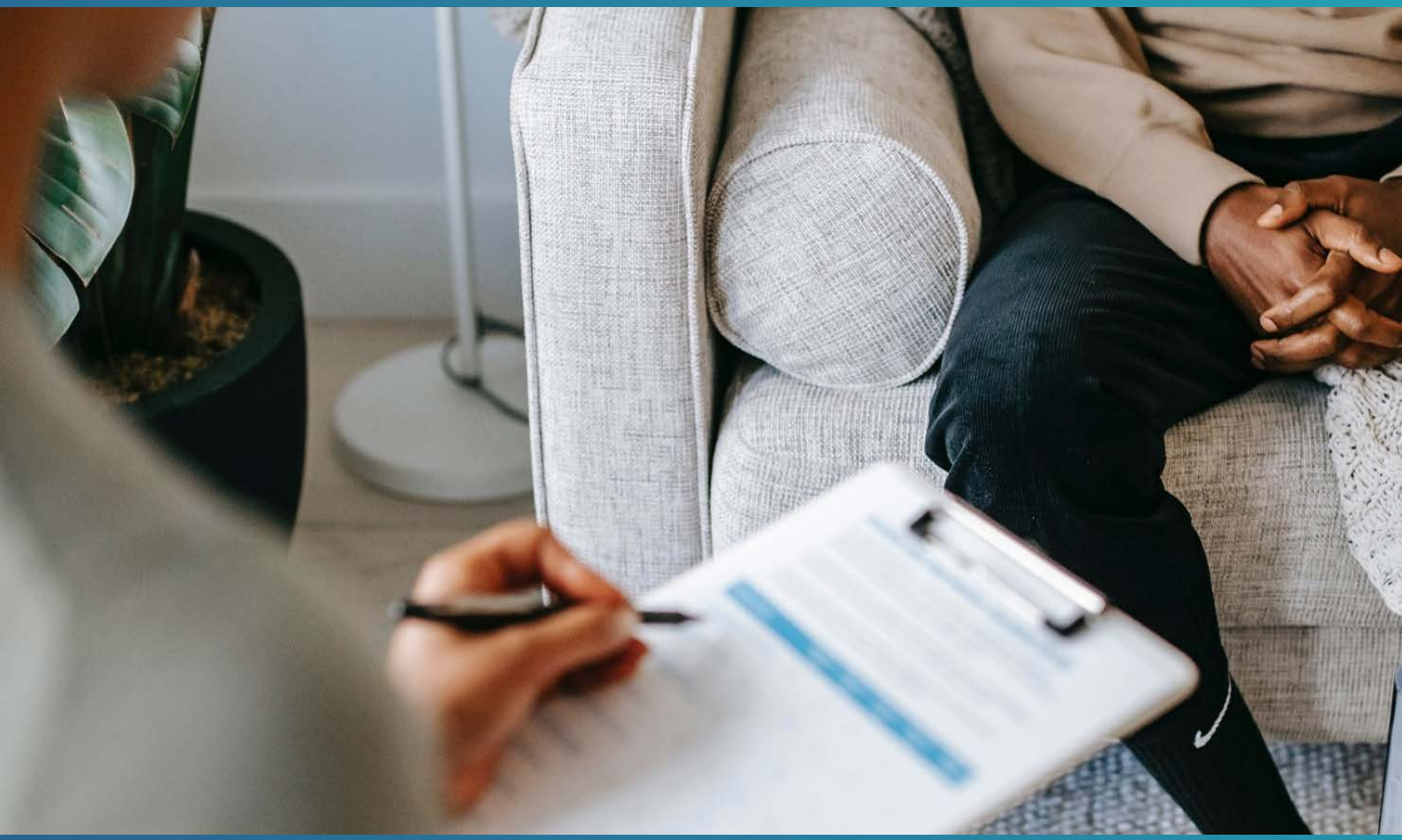
GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales



The All Wales Diabetes Prevention Programme Protocol

Version 3.0
November 2026

Mae'r ddogfen yma ar gael yn y Gymraeg/
This document is available in Welsh

Contents

Executive Summary **4**

AWDPP Service Delivery Pathway **6**

Step 1: Setting up the AWDPP Service **10**

Arranging Access to EMIS 10

Staff Training and Resources 10

All Wales Diabetes Prevention Programme Training 12

Agored Cymru Community Food and Nutrition Skills 12

Motivational Interviewing Training 13

Accommodation for AWDPP Consultations 13

Step 2: Service User Identification **14**

Process for Escalation 15

Step 3: Service User Database and Quality Assurance **15**

Step 4: Appointment and Booking Process **16**

Step 5: The AWDPP Consultation **17**

Introductory Discussion 17

Collection of the Minimum Data Set 17

Person-Centred Conversation 18

Diet and Nutrition 19

Physical Activity 19

Goal setting 19

Referral to Additional Support 20

Resources 20

Step 6: Annual/12 month Follow Up **21**

12 Month HbA1c Test 21

Purpose of the 12 Month Follow Up 21

12 Month Follow Up Intervention Pathways 22

12 Month Follow Up Consultation 22

Introductory Discussion 23

Collection of the Minimum Data Set 23

Person-Centred Conversation 24

AWDPP following Gestational Diabetes 25
Supporting Health and Wellbeing After Pregnancy: The PATHS model 25
Referral and Triage following GDM 26
Identification of women with GDM: Role of Midwifery team and/or primary care provider 27
Identification of individuals with GDM: Role of local AWDPP team 27
Implementing the AWDPP for women with GDM 29
AWDPP Intervention for women with GDM 29
Annual HbA1c testing for women following GDM 29
Appendix: One-year follow-up letter for individuals at reduced risk 30

Background

The purpose of this protocol document is to:

- Outline the requirements of the specification of the All-Wales Diabetes Prevention Programme (AWDPP) as highlighted in the AWDPP Service Delivery Pathway below.
- To support those planning and delivering the AWDPP in each Health Board and Primary Care Cluster.
- To facilitate fidelity to an all-Wales approach regarding the key elements of the AWDPP.
- To support an equitable service across Wales, whilst recognising the complex delivery landscape, which indicates the need for some local variation to enable alignment with other local services and arrangements.
- A separate document outlining how the AWDPP was developed can be found here.

Key Points and Actions

To support consistent implementation of the AWDPP, whilst recognising that there will be some variation in local delivery reflecting the differing contexts across Wales, the following key points and actions need to be addressed:

- Healthcare support workers (HCSWs) need to receive training, supervision and quality assurance of their practice as set out in the AWDPP Training, Supervision and Quality Assurance document.
- Retrospective process: AWDPP EMIS search templates must be used to identify eligible individuals with an existing HbA1c which is based on agreed inclusion and exclusion criteria.
- Prospective process: Direct referrals to the AWDPP from Primary care must be made using local referral pathways with inclusion and exclusion criteria applied.
- All relevant minimum data set information must be collected as stipulated to allow for robust monitoring of the AWDPP.
- Information given to individuals must be aligned to the AWDPP standardised consultation manual.
- HCSWs must be aware of their scope of practice and that any clinical questions raised within the AWDPP appointment must be escalated as appropriate.
- All information governance considerations highlighted in this protocol must be adhered to.

The service delivery pathway is a key component of the AWDPP. The summary version included here provides an overview of the key steps involved in programme delivery and is supported in greater detail in later sections of this protocol.

STEP 1: Setting up the AWDPP Service		
Training of HCSWs	Facilitate access to IT systems	Book accomodation for AWDPP clinics

STEP 2: Identification of Eligible Service Users	
Prospective identification: direct referrals received via WCCG/ WPRS and **retrospective identification:** AWDPP EMIS search templates applied	Triage to ensure AWDPP is appropriate for eligible service user

STEP 3: Service User database & Quality Assurance
Document individuals invited for intervention or reasons for those deemed inappropriate for AWDPP

STEP 4: Appointment & Booking Process	
AWDPP invitation letter & information letter sent	Date & time of appointment confirmed

STEP 5: AWDPP Consultation	
Undertake person centred consultation utilising the AWDPP Consultation manual and AWDPP Desktop resource	Complete AWDPP data entry clinical template in EMIS

STEP 6: Annual/12 month Follow up Booking Process		
Discuss current surgery process & ensure method for repeat HbA1c test in place	Review HbA1c result	Repeat HbA1c >48: patient enters T2D care pathway & contacted by GP/PN

STEP 7: AWDPP Follow up	
Undertake person centred consultation utilising the AWDPP Consultation manual 12 month supplement and AWDPP Desktop resource	Complete AWDPP data entry clinical template in EMIS

AWDPP Service Delivery Pathway

STEP 1: Setting up the AWDPP service – Training, IT and Accommodation

- Local lead dietitian/clinician to meet with practice managers to discuss AWDPP and share all relevant documents (AWDPP Intervention Design, AWDPP Protocol, Data Protection Impact Assessment) and enable access to EMIS for dietitian and HCSW
- Health Board IT assist with facilitating EMIS access via IT equipment with relevant software
- Discuss room availability for clinics if applicable
- HCSW to receive training as per AWDPP Supervision, Training & Quality Assurance Framework
- HCSW to become familiar with practices and EMIS
- Confirm and book venues in locality
- Ensure clinic availability and distribution across the week, AM & PM sessions
- Set up both face-to-face and virtual clinics (demand for clinic format may vary locally)
- Lead dietitian/HCSW to liaise with practice managers to upload AWDPP data entry clinical templates to EMIS, utilising EMIS user guide where needed

STEP 2: Identification of Eligible Service Users

- Eligible individuals identified either:
- Retrospectively on system using standardised AWDPP EMIS search templates based on inclusion/exclusion criteria, export list securely for use within the AWDPP service user database OR;
- Prospectively during routine primary care – referrals made from primary care to AWDPP using local dietetics referral pathways including Welsh Clinical Communication Gateway (WCCG) and Welsh Patient Referral System (WPRS)
- Identify other useful information such as; translator required or any flags for escalation/discussion with dietitian. Collate information of eligible individuals on the AWDPP service user database

Flags for escalation with Dietitian to consider if the intervention is clinically appropriate for the individual:

- Unintentional weight loss
- Reduced capacity/frailty
- Currently attending a weight management intervention
- Significant mental health concerns or learning difficulties
- Clinical conditions that require therapeutic dietetic intervention (refer to Clinical Triage SOP)
- NB: For compliance and increased uptake to scheme, try to prioritise individuals who are currently well i.e. if on patient record, it shows that the individual has recently been seen by the doctor in the last 2 weeks and has been very unwell, speak to GP/nurse to determine if appropriate to invite to AWDPP

STEP 3: Service User Database and Quality Assurance

- Document individuals invited for intervention and record reasons for those deemed inappropriate on the AWDPP service user database

STEP 4: Appointment and Booking Process

- Send initial AWDPP invite letter and information leaflet, record date invitation sent on AWDPP service user database
- After a maximum of 3 weeks, if no contact by individual, telephone & discuss AWDPP (utilising the telephone script)
- If individual agrees, arrange an appointment date, time & venue and book into clinic of their choice
- Send face-to-face or video appointment confirmation letter via post or email (as requested by individual)
- If individual declines, enter this into AWDPP data template on EMIS. Ask if happy to share reason for declining and document this on AWDPP service user database
- If no reply, try to re-contact at a different time/day. If still no contact, document as non-responder on AWDPP service user database

STEP 5: The AWDPP Consultation

- Add date AWDPP invitation letter sent to EMIS data entry template

Clinically inappropriate for AWDPP

- Include reason in free text box: End of data collection

Patient declined

- Include reason in free text box (if known) and add to service user database
- Add annual HbA1c recall to EMIS. End of data collection

Patient DNA clinic:

- Add DNA to AWDPP data entry template within EMIS
- Add annual HbA1c recall to EMIS. End of data collection

Patient attends clinic:

- Undertake person-centred consultation utilising the AWDPP Consultation manual and AWDPP Desktop resource
- Add the following information to EMIS AWDPP data entry template:
  - Mode of delivery & location
  - Ethnicity
  - Weight/Height/BMI
  - Goals discussed and/or agreed utilising standard entries guides, as found in the AWDPP Training, Supervision & QA Framework
  - Provide signposting or referral to weight management service (if appropriate and agreed by individual)
  - Referral to NERS – complete NERS referral form (if appropriate and agreed by individual) or advise patient to ask GP/nurse about referral.
  - Add AWDPP attended (NB: AWDPP data entry template transfers all data into the individual's clinical record)

STEP 6: Follow up at 12 months

- Discuss current surgery process and ensure method for repeating HbA1c testing is in place

Search for 12-month HbA1c result & triage

- For individuals coming up for their annual/12 month follow up appointment, search for most recent HbA1c result and record on service user database
- HCSW to triage and escalate any queries.

AWDPP Teams offer to support the practice by:

- Using the service user database spreadsheet for the surgery to identify individuals who require a repeat HbA1c. Provide the Practice manager with a list of people who require a repeat HbA1c test, depending on the number of individuals identified, from one quarter/one search pull, or stagger as necessary to help manage capacity OR;
- Run search through EMIS to identify individuals who were invited to the AWDPP the previous year and those who do not have a repeat HbA1c OR;
- AWDPP HCSW sends text or letter reminders to individuals that require recall, with sufficient detail in the clinical notes so that primary care/surgery staff will be aware of the necessary blood forms to prepare

Process for sending HbA1c blood test reminders:

- If the individual requires an updated HbA1c blood test, send a text reminder to the individual by utilising a block text reminder process within EMIS or via team mobile phone
- If the individual does not have a mobile number or has opted out from text messages, a reminder letter will need to be sent instead. Ask the practice manager to create and save a template of the letter to EMIS

Invite to AWDPP follow up appointment:

If previously declined, cancelled or DNA baseline AWDPP appointment:

- Send AWDPP initial invitation letter & AWDPP information leaflet

If attended baseline AWDPP appointment:

- If repeat HbA1c ≤41mmol/mol as a minimum, via a standardised letter, affirm and reinforce positive behaviours. (see example; appendix). Add this contact to the Emis data entry template by ticking Follow Up AWDPP and Mode of delivery is “letter encounter”.
- If repeat HbA1c remains between 42-47mmol/mol: Send AWDPP review appointment letter

STEP 6: (Cont.)

If declines follow up appointment:

- Ask individual if they are happy to share the reason for declining
- Provide the individual with their most recent HbA1c, if they are unable to attend a F2F appointment offer a telephone appointment to support the discussion around their recent HbA1c result
- Record on the service user database
- Record 'declined' AWDPP appointment in EMIS data entry template OR telephone intervention if conversation occurred following the phone call
- Add annual HbA1c recall to EMIS.

If agrees to book follow up appointment:

- Book follow up appointment at a convenient time and location for the individual

STEP 7: The AWDPP Follow up Consultation

- Add date AWDPP follow up invitation letter sent to EMIS AWDPP data entry template

Patient DNA clinic:

- Add DNA to AWDPP data entry template within EMIS. End of data collection

Patient attends clinic:

- Undertake person-centred consultation utilising the AWDPP Consultation manual 12-month supplement and AWDPP Desktop resource.
- Add the following outcomes to EMIS AWDPP data entry template:
  - Mode of delivery & location
  - Ethnicity
  - Weight/Height/BMI
  - Goals discussed and/or agreed utilising standard entries guides, as found in the AWDPP Training, Supervision & QA Framework
  - Provide signposting or referral to weight management service (if appropriate and agreed by individual)
  - Referral to NERS – complete NERS referral form (if appropriate and agreed by individual) or advise patient to ask GP/nurse about referral.
  - Add AWDPP attended *(NB: AWDPP data entry template transfers all data into the individual's clinical record)*
- Where the support worker has competency and resources to measure Blood pressure this may be recorded as an additional outcome

Whilst the AWDPP Service Delivery Pathway above demonstrates the steps needed to deliver the AWDPP, within each of these, some information and considerations are addressed as follows:

Step 1: Setting up the AWDPP Service

Arranging Access to EMIS

To access EMIS, HCSWs will require EMIS Web client installed on their health board computer. The HCSW will have access to the "OrgID" of the practice they need to connect to and can then use "EMIS configuration switcher" to flip between practices so they can use the login information provided to them. Health Board IT departments are responsible for the installation as they support the individual's computer.

Where assistance is required in arranging access to EMIS, practices should seek assistance from their Health Board IT team, as advised by Digital Health and Care Wales (DHCW).

Staff Training and Resources

The AWDPP will be delivered by HCSWs trained and supervised by local health board lead dietitians. Both the HCSWs and local lead dietitians have been recruited to provide dedicated resource to the programme. The training elements to be undertaken by the HCSWs are outlined in Table 1 below.

Table 1. Training elements to be undertaken by HCSWs

Programme title	Purpose	Delivered by / access route	Duration	Timing
Essential training				
Employing organisation mandatory training	Ensures staff remain up to date with organisational requirements and duty of care.	Electronic Staff Record (ESR) e-learning	Dependent on organisation	Within 3 months of start date
Agored Cymru Level 2 Community Food and Nutrition Skills	Covers balanced diet, community health, dietary change and population needs.	NHS Wales registered dietitians through Nutrition Skills for Life	2 hours self-directed plus 1 hour weekly for 10 weeks	Before intervention delivery
AWDPP programme training	Covers the intervention framework, pathway, dataset and motivational interviewing taster.	AWDPP lead dietitian	2 x 3 hours	Before intervention delivery
Training on EMIS	Supports accurate GP system data recording.	EMIS/local AWDPP support	Variable	Before intervention delivery

Video consultation platforms, e.g. Attend Anywhere or AccuRX	Upskills staff in video consultation delivery.	Self-led webinars and assessment	Attend Anywhere: 45 minutes plus test	Before intervention delivery
Motivational interviewing (MI) e-learning	Introduces MI through demonstrations and practical resources.	Y Ty Dysgu e-learning module	30 minutes	Before intervention delivery
Introduction to Motivational Interviewing	Builds MI skills using case examples.	Motivational Interviewing Network of Trainers (MINT) accredited trainer	4 x 3-hour virtual sessions	Within first 3-6 months of delivery
Observe local diabetes education session	Covers type 2 diabetes and key food messages.	Health board dietetic department	2.5 hours	First 1-2 months
Making Every Contact Count (MECC) Level 1 and 2 Generic	Supports brief behaviour-change conversations and builds on MECC Level 1 knowledge.	Online e-learning via ESR, Learning@Wales or Y Ty Dysgu;		
In-person training subject to local availability	30 minutes	First 1-2 months		
Smoking Cessation: Very Brief Advice on Smoking (VBA+)	Promotes quitting and can be delivered in less than 30 seconds.	Online e-learning via the National Centre for Smoking Cessation and Training (NCSCT)	30 minutes	First 1-2 months
Desirable training				
Cultural awareness training	Enhances understanding of food, nutrition and dietary habits across different communities.	Local dietitians; relevant webinars may also be used.	1-3 hours	First 6-12 months
CDEP diabetes education module	Provides general information about diabetes, types of diabetes, risk factors and complications.	CDEP account registration; Wales access key where applicable.	1-3 hours	First 6 months

Module 7A: Nutrition for infants	Relevant to the gestational diabetes (GDM) cohort; supports healthy first foods and continuation of breastfeeding.	Health board dietitians, where not already completed as part of Nutrition Skills for Life.	2 hours	As required
MECC Healthy Weight Conversations Level 1 and 2	Supports effective healthy weight conversations using MECC techniques.	Online e-learning via ESR or Learning@ Wales	1 hour	After completing MECC generic e-learning
MECC Alcohol Brief Intervention Level 2	Supports conversations about positive changes to alcohol consumption.	Online e-learning via ESR or Learning@ Wales	1 hour	After completing MECC generic e-learning
Contraception after pregnancy e-learning for health and care staff	Builds knowledge and confidence for person-centred conversations about contraception after pregnancy.	Y Ty Dysgu	1 hour	As required

All Wales Diabetes Prevention Programme Training

The HCSW will receive training specific to the AWDPP, and this will be led centrally by the national AWDPP lead dietitian. This training must be completed prior to the HCSW delivering the AWDPP intervention.

Agored Cymru Community Food and Nutrition Skills

All HCSWs must have received Agored Cymru Level 2 Community Food and Nutrition Skills training, prior to delivering the intervention. The learning outcomes of the training are listed in table 2.

Table 2. Learning outcomes from Agored Cymru Level 2 Community Food and Nutrition Skills training

Learning outcomes
1. Understand the constituents of a balanced diet (based on the NHS Eatwell Guide)
2. Understand the benefits of good nutrition to health and well being
3. Understand how a balanced diet and physical activity contribute to weight management, health and well being
4. Understand factors that affect food choice
5. Be able to use goal setting to help change eating and lifestyle habits
6. Understand food labelling
7. Understand a balanced diet for a range of population groups
8. Be able to adapt recipes and meals to comply with healthy eating guidelines
9. Understand evidence-based sources of nutrition information

Motivational Interviewing Training

The HCSW will receive additional training in motivational interviewing techniques to help support conversations held during the 30-minute consultation. The training will be delivered by a motivational interviewing certified trainer and delivered later into the AWDPP once HCSWs have gained experience in delivering the intervention.

Accommodation for AWDPP Consultations

Availability of venues/rooms for AWDPP appointments should be discussed with participating clusters and a timetable of available appointment slots devised and set up either on the practice system or health board system prior to appointments being made. It is important to try and fill the slots without any major gaps in the day, to maximise use of HCSW time in Practice and to allow sufficient time for infection, prevention and control procedures.

Step 2: Service User Identification

For inclusion in the AWDPP, individuals must meet the AWDPP eligibility criteria (Table 3). The AWDPP eligibility criteria are designed to ensure the programme is offered to those most likely to benefit from a brief diabetes prevention intervention, while excluding those for whom participation may be clinically inappropriate due to frailty or complexity and may require alternative care pathways. For retrospective identification of individuals eligible for inclusion, the AWDPP search templates, which are aligned to the eligibility criteria, must be used.

If a prospective referral to the AWDPP has been received from Primary Care via local dietetics referral routes (WCCG and WPRS), the eligibility criteria must be applied to ensure the individual is appropriate for inclusion and if ineligible, consider if there are alternative local interventions that meet the person's needs.

Table 3. Eligibility criteria for the AWDPP

Inclusion Criteria
HbA1c 42-47 mmol/mol (within the last 3 months)
Aged 18-79 years
Previous gestational diabetes (see section: Women with Gestational Diabetes)
Exclusion Criteria
Ever diagnosed with Type 1 or Type 2 Diabetes
Current BMI <20 kg/m2
Receiving palliative care
Pregnancy
Artificially fed
Previous bariatric surgery

For retrospective searching of electronic patient records, the HCSW will use the EMIS search template to generate a list of eligible individuals. This list should then be used to contact individuals and invite them into the AWDPP. Prior to accessing the list of eligible individuals, a joint data controller agreement (available on request by contacting PHW.AWDPP@wales.nhs.uk) must be undertaken between each practice participating in the AWDPP and the health board who employ the HCSW, in line with information governance procedures. The process of initial data gathering for the purposes of identification will be overseen by the local lead dietitian. The HCSW must record how many individuals are initially identified as eligible from the first database search

Where assistance is required in completing the Joint Controller Agreement, assistance should be sought from the local Health Board's Information Governance Team.

Process for Escalation

The HCSW will undertake triage of the individuals identified via the search, following the Clinical Triage standard operating procedure (SOP) (available on request by contacting PHW.AWDPP@wales.nhs.uk). Where it is unclear whether an individual is eligible for inclusion in the AWDPP, their suitability should be raised with an appropriate health professional. Initially this should be the local AWDPP lead dietitian who may request clarifying information through the primary health care team. There may be instances where eligibility or suitability of an individual is unclear, for example the individual has a diagnosis of cancer; could be experiencing frailty; has diminished mental capacity; has safeguarding concerns; or has recently received a similar intervention. These examples are not exhaustive and do not represent the full spectrum of conditions which mean the AWDPP is not suitable for an individual. Where doubt exists regarding the suitability of an individual's involvement, a decision regarding their participation must always be escalated to an appropriate health care professional for review. The number of individuals and reason deemed unsuitable for inclusion following further review must be recorded (see Table 4).

Step 3: Service User Database and Quality Assurance

An AWDPP training, supervision and quality assurance framework document has been developed and will be provided to the local lead dietitian to promote a consistent, equitable approach to delivery of the AWDPP across Wales (available on request by contacting PHW.AWDPP@wales.nhs.uk). To support the quality assurance and efficient running of the programme, local lead dietitians will develop a database using the fields shown in Table 4 below. The database offers a practical approach for ensuring appropriate escalation, application of eligibility criteria, completion of data collection and to support system understanding of reach and equity of access to the AWDPP intervention. As this information about individuals is recorded outside of EMIS, it is imperative that any personal information pertaining to an individual who has been identified as eligible or is actively participating in the AWDPP is kept under strict protection. As this data will reside with the health board's local lead dietitian and HCSW, it is the health board who are both responsible and accountable for the data and must ensure robust processes are in place for storing and protecting the data. Local lead dietitians and HCSW must ensure they are up to date and comply fully with their health board's information governance arrangements. This data must only be stored for as long as is necessary under general data protection regulations and must be deleted securely once the data is no longer current. HCSWs and local lead dietitians should discuss with their local information governance teams on the correct methods for data disposal.

Table 4. Service User database fields

Action	Response (dropdown options)
Individual escalated for eligibility review	Yes/No
Reason for exclusion	Provide reason/N/A
Invitation Letter sent	Yes/No
Response to invitation	Agreed/ Declined/ Non-response
Follow up phone call (if required)	Yes/N/A
If declines	Provide reason (free text)/N/A
Reason for incomplete data collection	Provide reason/N/A

Step 4: Appointment and Booking Process

The appointment process should be undertaken as follows:

- Using the list generated either from the initial GP records search or via primary care referral, individuals will initially be invited into the AWDPP via a letter and information leaflet sent to their registered home address (letter template and information leaflet available on request by contacting PHW.AWDPP@wales.nhs.uk).
- All participating health board clusters must use the same invitation letter template[1]. The letter will invite individuals to book an AWDPP face-to-face or virtual appointment and contain localised booking information.
- The HCSW should follow local procedures for bookings as booking systems may vary by health board. There is standard all Wales booking guidelines that health boards will be familiar with.
- If the individual does not respond to the AWDPP invitation letter, a follow up phone call should be made by the HCSW to enhance engagement with the intervention using a phone call script [2] (phone call script available on request by contacting PHW.AWDPP@wales.nhs.uk).

  Should the individual agree to participate in the intervention during the phone call, an appointment should be arranged immediately.

  If unable to reach the individual by telephone, follow local booking procedures to send a reminder invitation letter.
- Should an individual not wish to participate in the AWDPP or requires further time to consider their participation, this should be afforded.
- No further follow up phone calls should be made unless necessary.

[1] Designed with input from Public Health dietitians and Behaviour Change specialists
[2] Developed by AWDPP local lead Dietitians & All Wales Lead Dietitian

Step 5: The AWDPP Consultation

The guide to the content of the AWDPP consultation is fully documented in the AWDPP consultation manual (available on request by contacting PHW.AWDPP@wales.nhs.uk). The sections below highlight the key areas which are to be covered in the consultation.

Introductory Discussion

- Welcome the individual to the AWDPP
- Explain to the individual the reason they have been invited to attend the intervention by providing their HbA1c result and why this result means they are at increased risk of developing type 2 diabetes.
- Briefly explain what type 2 diabetes is and why it is important to take action to reduce the individual's risk (e.g. increases risk of dementia, sight loss, kidney disease, foot problems, heart disease, nerve pain & damage, sexual dysfunction).
- Explain that HbA1c can move in both directions and with positive action, can return to normal however may also move into the diagnostic range for diabetes without behaviour change and/or other treatment.
- Explain that some information is going to be collected from the individual before having a discussion centred on the actions which can be taken to reduce type 2 diabetes development.

HbA1c risk category	HbA1c result
Normoglycaemia	≤41 mmol/mol
At risk of type 2 diabetes	**High risk:** 42–47 mmol/mol **High risk:** 39–47 mmol/mol if previous GDM diagnosis **Moderate risk:** <39 mmol/mol if previous GDM diagnosis
Diabetes	≥48 mmol/mol
If declines	Provide reason (free text)/N/A

Collection of the Minimum Data Set

The minimum data set (MDS) needs to be collected in full for all individuals to allow for successful monitoring of the AWDPP. Data must be recorded accurately using the EMIS data entry template and completed during or immediately after the appointment to ensure full data capture. Data to be recorded as part of the initial 30-minute consultation is listed in table 5.

Table 5. Baseline minimum data set

AWDPP invitation sent
Individual declined AWDPP/ DNA/ clinically inappropriate for AWDPP
AWDPP visit completed
Mode of AWDPP delivery (virtual/face-to-face/telephone)
Ethnicity
HbA1c (auto populated)
Height
Weight
BMI
Blood Pressure (auto populated)
Cholesterol: total, LDL, HDL and triglycerides (auto populated)
Comorbidities (auto populated)
Disability (auto populated)
Goals agreed
Referral to weight management service (refer to weight management programme/referral to weight management declined/weight management plan started)
Referral to National Exercise Referral Scheme
Referral to other
Add recall for annual HbA1c test

Person-Centred Conversation

Upon successful collection of the MDS, the HCSW will discuss eating a healthy balanced diet, foods which have a bigger impact on blood glucose levels and physical activity using the resources outlined below. Both diet and physical activity must be discussed as part of the consultation although enhanced focus may be applied to either diet or physical activity depending on the individual's existing knowledge on either subject.

Diet and Nutrition

The dietary advice provided will be based on the NHS Eatwell guide and supported by the Agored Cymru Level 2 Community Food and Nutrition Skills training. The Eatwell Guide is applicable to most people including meat eaters, vegetarians and all ethnic origins with key information applicable to all including portion sizes, key nutrients, carbohydrates in relation to blood glucose levels and alcohol and diabetes risk. If required, tailored resources are available which may be more appropriate for some groups and should be provided to individuals where necessary.

For women who have had gestational diabetes: Along with many other health advantages, breastfeeding reduces the risk of developing diabetes for mothers and babies. For mothers who have had gestational diabetes, lactation and breastfeeding significantly reduces the chance of developing type 2 diabetes (T2D). The longer breastfeeding continues, the greater the protection, so women should be supported to continue breastfeeding if that is their wish. For queries around breastfeeding and/or lactation, AWDPP delivery staff will signpost to the National Breastfeeding Helpline. This helpline offers highly trained phone and direct message support 24/7, in English, Welsh and other languages. They also have a dedicated service for queries around breastfeeding and medication and a range of fact sheets.

Physical Activity

The physical activity advice provided must be tailored to the individual's age and circumstances in line with UK physical activity guidelines. The relevant guidance for those eligible for the AWDPP intervention is grouped by age and relevant sections include; ages 19-64 and ages 65 and above, disabled adults and postpartum women (birth-12 months).

Goal setting

Following discussions around type 2 diabetes risk, weight (when appropriate), diet and physical activity, the HCSW will ask the individual if they are able to think about and set some achievable goals which can contribute to reducing their risk of type 2 diabetes development. Goals should be person-centred and contribute to improving the individual's health. The individual must be given autonomy to agree their own goals with the HCSW supporting the conversation and providing examples where appropriate which may contribute to achieving goal success.

Referral to Additional Support

If the individual would like support to achieve a healthier weight, aligned to the All-Wales Weight Management pathway, the primary behavioural support services for the AWDPP are Health Board Weight Management services. These provide support through programmes such as Foodwise for Life (community based 8-week weight management programme), dietetic led weight management services and the National Exercise Referral Scheme (NERS). All referrals should be made in agreement with the individual. Any referrals to onward services need to consider the capacity available within these services and recognise that the core AWDPP intervention is a stand-alone brief intervention; additional referrals are only appropriate where these are indicated, available and requested by
the individual.

Availability of weight management support services vary by health board. The local lead dietitian will support the HCSW with referrals onto services available within the local area/health board. All referrals to weight management support services should be recorded in the MDS.

During the compassionate conversation, wider wellbeing issues may be identified as appropriate to a person-centred approach such as smoking cessation, stress management or new parental support. The local lead dietitian will support the HCSW with referrals or signposting onto other support services available within the local area/health board.

Resources

To support discussions held during the 30-minute consultation, a desk top resource is available, and individuals should be offered the following resources (translated where necessary):

- AWDPP information leaflet regarding raised blood glucose & risks of type 2 diabetes
- Diabetes UK Information Prescriptions (Eating Well & Being Active)
- NHS Eatwell Guide
- Let's Prevent Diabetes bilingual flyer/link (Digital education & support for preventing Type 2 diabetes)
- Baby Steps: reducing the risk of developing T2D for women with a history of gestational diabetes (GDM only; see section: Women with gestational diabetes)
- Every Child: Newborn to age 2 (GDM only; see section: Women with gestational diabetes)

All resources will be made available to the healthcare support worker prior to consultations being delivered and available on request by contacting PHW.AWDPP@wales.nhs.uk.

Step 6: Annual/12 month Follow Up

12 Month HbA1c Test

12 months after the baseline HbA1c test which identified the person as eligible for the AWDPP intervention, NICE guidance recommend individuals be recalled for a repeat HbA1c test. We recommend recalls be undertaken prior to the eligible person reaching the 12-month period following their initial HbA1c result, with consideration given to the time it takes between recalling an individual for a repeat HbA1c test and the test being undertaken. In the event a recall for an individual has moved beyond 12 months, an invite for a follow up test should be made at the earliest opportunity. Where more frequent HbA1c testing has been undertaken for an individual, the latest HbA1c result may be used to inform any onward intervention if it was collected within the previous three months/or at least 10 months from the baseline value. If the latest result available was collected beyond three months, a new test must be undertaken.

To ensure that individuals due for recall receive a follow up HbA1c, the AWDPP service user database should be reviewed regularly to identify which individuals are approaching or have reached 12 months since their initial HbA1c test that facilitated entry into the AWDPP and have been offered a repeat HbA1c test. Due to local variation in recall methods, consult with the Practice Managers within each cluster to determine their specific process for recalling individuals for a repeat HbA1c test, this is usually by letter or text message (see AWDPP service delivery pathway for further details).

Following the 12 month follow up HbA1c result being recorded on the patient record, a review should be undertaken as soon as possible to ensure an individual's involvement in the AWDPP remains appropriate and no significant health issues have been recorded since the initial appointment. Where it is unclear whether an individual should remain involved in the AWDPP, their suitability should be raised with an appropriate health professional. Initially this should be the local AWDPP lead dietitian or the individual's GP or Practice Nurse.

Purpose of the 12 Month Follow Up

As part of reassessing a person's risk of type 2 Diabetes, NICE guidance (PH38) states any person identified as being at high risk of type 2 diabetes (HbA1c 42 to 47 mmol/mol [6.0 to 6.4%]) must be offered a blood test at least once a year. Conducting a follow up blood test identifies what further intervention, if any, the individual requires to prevent progression to type 2 diabetes. Regular monitoring of an individual's type 2 diabetes risk status is both a duty of care towards the individual and of significant benefit to the wider primary care system in helping prevent type 2 diabetes.

12 Month Follow Up Intervention Pathways

For individuals with HbA1c ≤ 41 mmol/mol:

- As per NICE guidance, the individual is considered at moderate risk of T2D and should have their HbA1c monitored every 1-3 years
- As a minimum, via a standardised letter, affirm and reinforce positive behaviours. (see example; appendix).

For Individuals with HbA1c 42-47 mmol/mol:

- The individual remains at high risk of T2D, invite to re-enter the AWDPP and repeat collection of the MDS (Table 6).
- A further person-centred compassionate conversation is held to review progress and review/set goals. This will support the opportunity for take up of local health behaviour change support services.
- If an individual has attended the AWDPP repeatedly, consider escalation for clinical review and alternative intervention

If an individual's HbA1c has increased ≥ 48 mmol/mol:

- The GP or Practice nurse will refer the individual to the type 2 diabetes mellitus pathway as per local clinical practice.
- It will not be possible to collect the full MDS for this group due to the individual's entry into a different care pathway.

12 Month Follow Up Consultation

Individuals who remain at high risk of type 2 diabetes (HbA1c 42-47 mmol/mol [6.0 – 6.4%]) should be invited, if appropriate, to an AWDPP follow up consultation. The information below highlights the key areas which are to be covered in the follow up consultation. For a full guide to the content of the AWDPP follow up consultation, please consult the AWDPP consultation manual 12-month supplement (available on request by contacting PHW.AWDPP@wales.nhs.uk).

Introductory Discussion

- Welcome the individual to the AWDPP follow up consultation.
- Explain to the individual the reason they have been invited to attend the follow up consultation by providing their latest HbA1c result and what this result means in terms of their diabetes risk.
- Briefly reiterate what type 2 diabetes is and why it is important to minimise the individual's risk (e.g. increases risk of dementia, sight loss, kidney disease, foot problems, heart disease, nerve pain & damage, sexual dysfunction).
- Explain that HbA1c can move in both directions and with positive action, can return and be maintained within the normal range but may also move into the diagnostic range for diabetes without adopting healthy behaviours and/or other treatment.
- Explain that some information is going to be collected from the individual before having a discussion centred on the actions which can prevent type 2 diabetes development.

Collection of the Minimum Data Set

Data must be recorded accurately using the EMIS data entry template and completed during or immediately after the follow up consultation to ensure full and accurate data capture. Read codes for the data below are embedded into the templates.

Table 6. Annual/12-month follow-up minimum data set

Learning outcomes
AWDPP invitation sent
Individual declined/DNA/clinically inappropriate
Mode of AWDPP delivery (virtual/face-to-face/telephone)
AWDPP visit completed
Ethnicity
HbA1c (auto populated)
Height
Weight
BMI
Blood Pressure (auto populated)
Cholesterol: total, LDL, HDL and triglycerides (auto populated)
Comorbidities (auto populated)
Disability (auto populated)
Goals agreed
Referral to weight management service (refer to weight management programme/referral to weight management declined/weight management plan started)
Referral to National Exercise Referral Scheme (refer to exercise programme/ declined referral to physical activity programme)
Referral to other
Add recall for annual HbA1c test

Person-Centred Conversation

- Upon successful collection of the MDS, the HCSW will utilise agenda setting tools to determine 'what matters to you' for the individual and what they would find most helpful to discuss during the follow up appointment. This will vary depending on whether the individual did or did not attend the AWDPP in the previous year.
- The main topics to discuss include the importance of eating a healthy balanced diet, foods which have a bigger impact on blood glucose levels and physical activity. Both diet and physical activity should be discussed as part of the follow up consultation although enhanced focus may be applied to either diet or physical activity depending on the individual's existing knowledge and experience on either subject.
- The follow up consultation and compassionate conversation enable another opportunity for referral or signposting to the support services available (e.g. Weight management, other health behaviour/wellbeing support), which may not have been taken up following the initial AWDPP consultation.
- For further details on the primary discussion topics, see Step 5 of the AWDPP protocol.

AWDPP following Gestational Diabetes

Supporting Health and Wellbeing After Pregnancy: The PATHS model

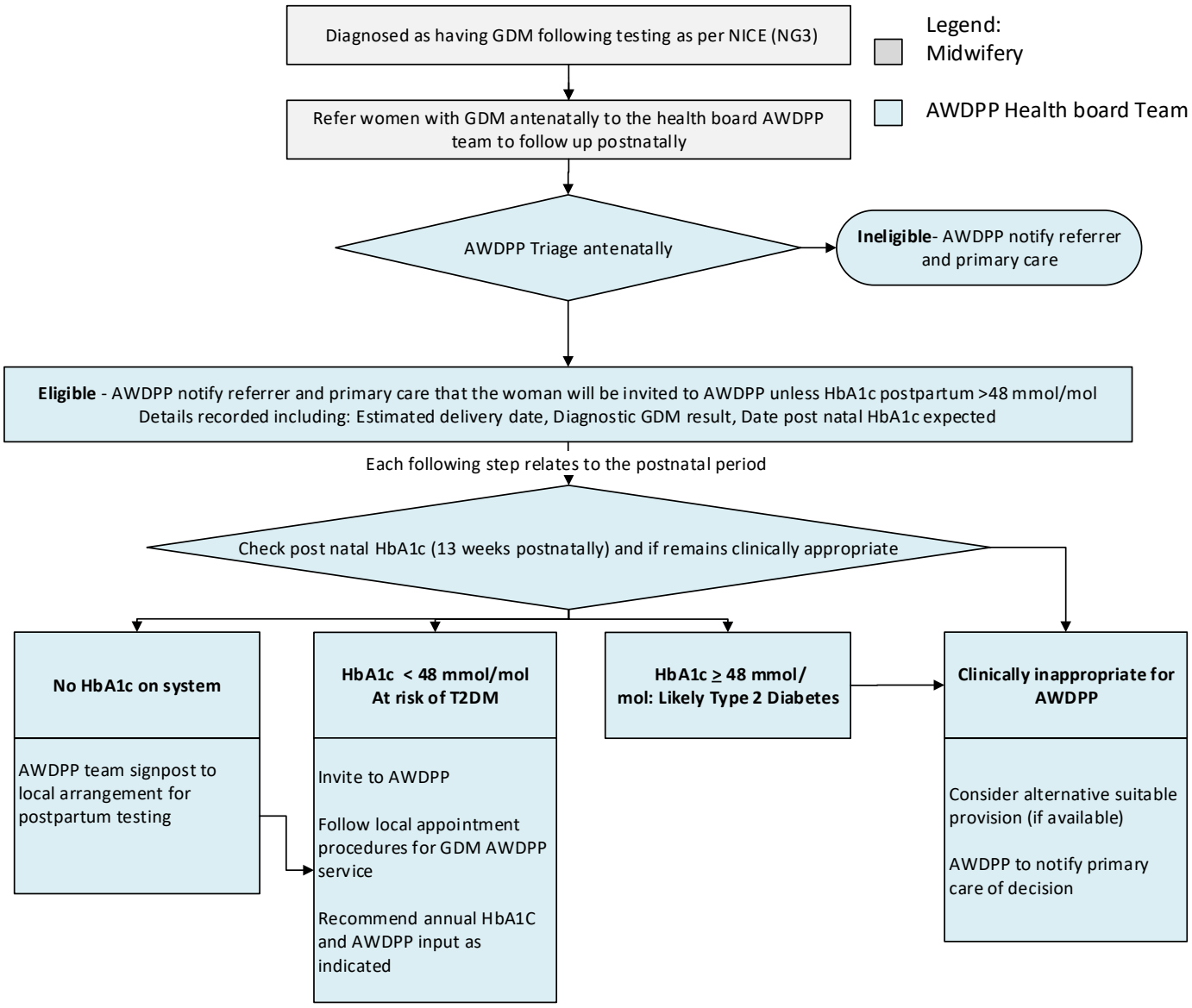
The period after pregnancy can be a highly vulnerable time for women[3]. A key principle of postnatal care, as highlighted by NICE guidance, is to listen to women and be responsive to their needs and preferences. PHW have developed the PATHS model for supporting women's health and wellbeing after pregnancy, which incorporates five key components – the woman's **Pregnancy** outcome & experience, **Assessing** health & wellbeing needs , providing **Tailored** person-centred support, and considering both the **Household** & family context, and Social circumstances:

- **Pregnancy outcome & experience** - care should be supportive, and be sensitive to the woman's pregnancy outcome and experiences, which may involve a live birth, pregnancy loss, abortion or baby entering care.
- **Assessing health & wellbeing needs** - services need to consider women holistically, encompassing their physical, social and mental health and wellbeing. Women may have pre-existing conditions, develop new health issues during pregnancy, or experience worsening of existing conditions. Some women may be dealing with physical and/or mental health consequences of childbirth.
- **Tailored person-centred support** - emphasis should be placed on what matters most to the woman, recognising that health and wellbeing after pregnancy can be complex.
- **Household and family context** - women may or may not wish for partners or wider family members to be involved. A family-centred approach provides opportunities to support the health and development of the new baby, any other dependants, as well as the wider household. For example, conversations regarding diet and nutrition can be beneficial to both women and infants, conversations on smoking cessation may benefit the whole household.
- **Social circumstances** – care should take into account the woman's circumstances, such as, childcaring responsibilities or financial resources. Services should also recognise inequalities which may be experienced by different population groups as described in the AWDPP equity toolkit.

[3] We recognise that some individuals who need access to women's healthcare do not identify themselves as women or girls, and we are clear that all services must be appropriate and sensitive to individual needs. We use the terms 'woman' and 'women's health' with the understanding that trans men and non-binary people recorded female at birth are included and may also require access to these services

Referral and Triage following GDM

Women who have had gestational diabetes (GDM) are at increased risk of developing T2D. The flow chart below summarises the entry route into the AWDPP following GDM and described in full thereafter:



Identification of women with GDM: Role of Midwifery team and/or primary care provider

Referrals for women with GDM to the local AWDPP team should be made using agreed local standard referral procedures within the antenatal period. The referral to the local AWDPP team should include all relevant clinical and demographic information (Table 7.)

Table 7. Clinical information required for referral into the AWDPP for women with GDM

Clinical information required
Reason for GDM screening (E.g. BMI, family history of diabetes)
Estimated delivery date
GDM diagnostic result
Age
Ethnicity
Postcode
Other relevant circumstances (e.g. planned neonatal unit admission/plan for baby to go into care)

Postpartum testing following GDM should be undertaken in accordance with NICE (NG3) to indicate presence of T2D or identify those at highest risk of developing T2D. HbA1c is commonly used and is valid if taken at least 13 weeks post-partum. HbA1c should continue to be checked annually following GDM.

Identification of individuals with GDM: Role of local AWDPP team

All GDM referrals into the AWDPP should be triaged by a trained member of the AWDPP team during the antenatal period, using the programme's eligibility criteria and the clinical triage SOP, to ensure only clinically appropriate women receive access to the intervention. Where a women's eligibility is unclear, the referral should be escalated to an appropriate health professional for further review, initially this would be the local AWDPP lead dietitian. If a decision is made that the woman is not clinically appropriate for the AWDPP, primary care and the referring professional would be notified.

For eligible women, all referral details received must be recorded securely by a member of the local AWDPP team. A crucial step is to ensure the estimated delivery date is recorded as this will allow the AWDPP team to calculate the date in which an AWDPP invite should be sent. The AWDPP invite letter should usually be sent **4-6 months** following the estimated delivery date. While pregnancy is listed as an exclusion criterion, this does not prevent the referral process into the AWDPP from starting but rather precludes active involvement in the AWDPP during an ongoing pregnancy.

Women eligible for the AWDPP after their pregnancy will require an HbA1c test to be undertaken prior to booking and attending their AWDPP consultation. This is to confirm they have not developed diabetes since their initial referral. Where an HbA1c test indicates a diagnosis of diabetes (HbA1c ≥ 48 mmol/mol), standard procedure must be followed in line with the All-Wales GDM Guidelines, and the AWDPP intervention will not be offered. In accordance with NICE guidance, women who have had gestational diabetes will be invited to AWDPP and HbA1c should be tested annually. In addition to checking HbA1c for eligibility, AWDPP teams should review the primary care record for changes in whether the women remain clinically appropriate [4].

If an HbA1c has not been undertaken, local AWDPP teams should inform women who have been referred to the programme to remind them of their 13-week HbA1c test and signpost locally to where the test can be undertaken. The health professional responsible for requesting the HbA1c test 13-weeks post-partum may vary. Local agreements must be developed to identify who is responsible for requesting the HbA1c test and interpreting the result.

[4] Not all pregnancies conclude without loss or complication, including but not limited to miscarriage, stillbirth, termination, neonatal or special care needs or a baby going into care. Referring teams should notify AWDPP teams of any additional circumstances, furthermore AWDPP will review the primary care record post-partum as a second stage triage. and AWDPP teams must take this into account and exercise appropriate sensitivity when considering invitation for HbA1c testing and subsequent AWDPP involvement. However, a diagnosis of GDM remains an important marker of future diabetes risk, and women may still benefit from preventative intervention in the longer term when clinically and sensitively appropriate to do so.

Implementing the AWDPP for women with GDM

Eligible women can book their AWDPP consultation using the contact information provided within their invite letter. Due to the complex delivery landscapes across the seven health board areas, it is acknowledged that there is a need for some local variation to enable alignment with other local services and established processes. The challenges and complexities at this stage of the life course for women are well recognised and services should be delivered in a way that reflects the needs of service users. Health board services are encouraged to undertake their own insight and quality improvement work to better understand the needs, preferences, and barriers experienced by women in relation to GDM follow-up and engagement with the pathway while maintaining fidelity to the agreed All Wales Diabetes Prevention Programme. This locally led insight work will support the adaptation of delivery approaches, optimise engagement and uptake, and ensure services are responsive to local context, inequalities, and available resources. Examples of adapted delivery approaches could include open access clinics dedicated for postnatal women; delivery in community settings; or codelivery with other interventions e.g. immunisations for the baby.

AWDPP Intervention for women with GDM

The content included in the updated AWDPP consultation manual is also relevant to women who enter the programme with GDM. It is recommended that all AWDPP team members are familiar with the version 3 updates of the AWDPP protocol in addition to the updated consultation manual.

Annual HbA1c testing for women following GDM

Women diagnosed with GDM who have negative postnatal testing for diabetes after the birth should be offered annual HbA1c testing as per NICE guidance. Annual monitoring of blood glucose levels will identify if a person with GDM remains at risk of developing or has developed diabetes. Local processes should ensure that the individual's registered GP is informed of the initial GDM diagnosis, the diagnosis is recorded in the patient record and individuals themselves are informed of the importance of annual HbA1c testing in monitoring future diabetes risk.

If you have any questions relating to the contents of this protocol, please contact the All-Wales Diabetes Prevention Programme Team at Public Health Wales via email PHW.AWDPP@wales.nhs.uk

Appendix: One-year follow-up letter for individuals at reduced risk

PRIVATE & CONFIDENTIAL

[~TITLE~] [~INITIALS~] [~SURNAME~] Date: [~SYSDATE~]
[~ADDRESS1~]
[~ADDRESS2~]
[~ADDRESS3~]
[~POSTCODE~]
NHS NUMBER: [~NHS_NO~]

Dear [~FORENAME~] [~SURNAME~],

All Wales Diabetes Prevention Programme

Your latest HbA1c result:

We are pleased to inform you that your recent HbA1c test shows you have reduced your risk of developing type 2 diabetes. Your HbA1c level is now under 42 mmol/mol. This means your blood glucose is currently in the normal range.

Last result	**_____ mmol/mol**	**Most recent result**	**_____ mmol/mol**

What happens now?

We will let your primary health care team know that you have completed the All Wales Diabetes Prevention Programme.

What do I need to do next?

To keep your blood glucose in the normal range, you should continue to follow the healthy eating and physical activity advice we discussed with you in clinic last year. You should attend any routine health checks and blood tests as advised by your GP practice.

If you have any questions about the All-Wales Diabetes Prevention Programme, please call us to speak to one of the team on #####.

Further information to help keep your blood sugar in the normal range through healthy eating and physical activity can be found here:

www.letspreventdiabetes.wales

To view the All-Wales Diabetes Prevention Programme privacy notice, please speak to one of the team using the contact details above.

Yours sincerely

[Insert name]

Health care support worker (All Wales Diabetes Prevention Programme)

GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

Gweithio gyda'n gilydd i greu Cymru iachach

Working together for a healthier Wales

© 2026 Public Health Wales NHS Trust
Terms of Use