GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

The All Wales Diabetes Prevention Programme Intervention Protocol

Version 2

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Canolfan Datblygu ac Arloesi Gofal Sylfaenol a Chymunedol
Datblygu Gofal Sylfaenol yng Nghymru

Primary and Community Care Development and Innovation Hub
Developing Primary Care in Wales

Contents

Executive Summary

Background

The purpose of this protocol document is to:

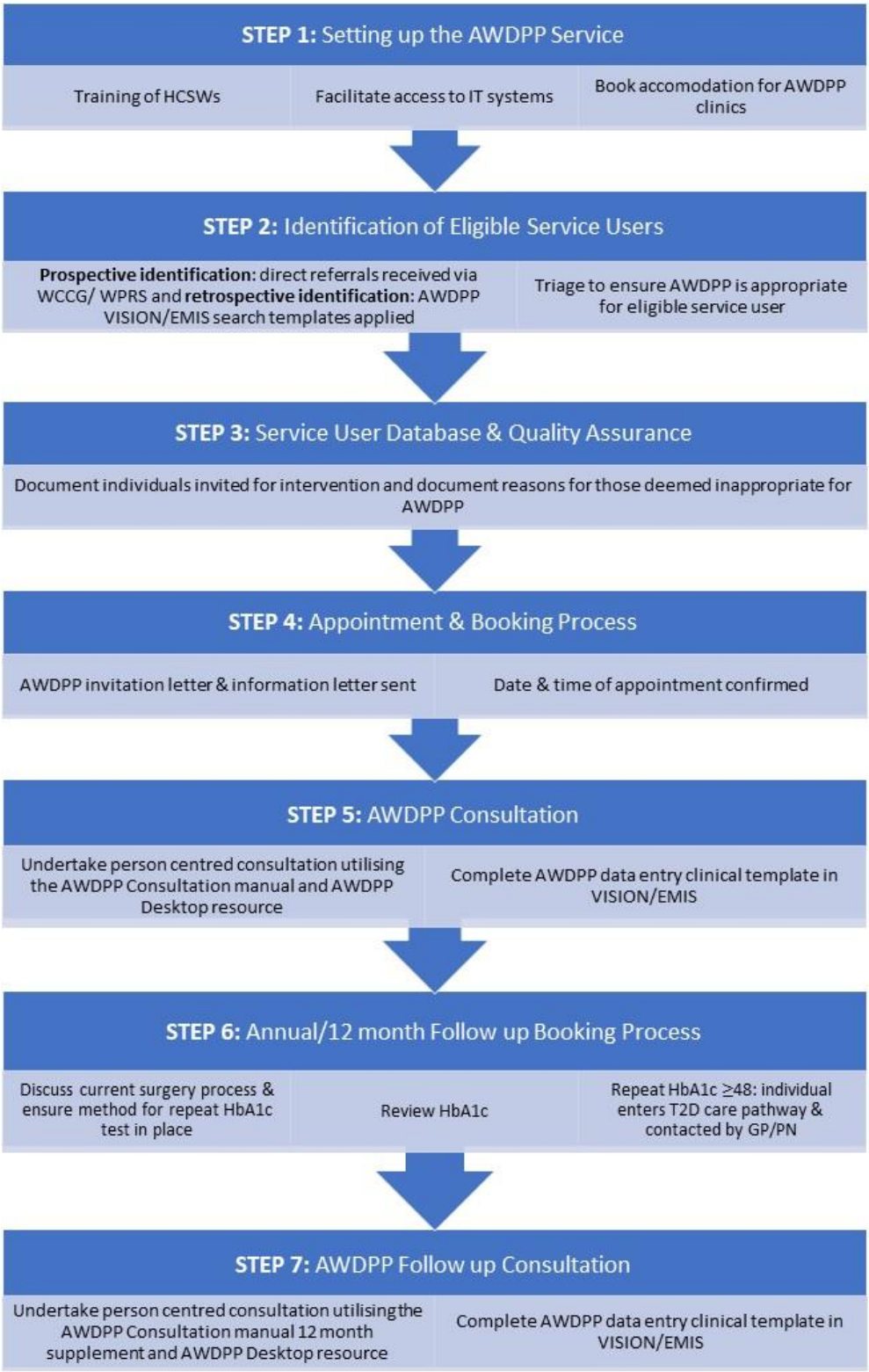
- Outline the requirements of the specification of the All Wales Diabetes Prevention Programme (AWDPP) as highlighted in the AWDPP Service Delivery Pathway below.
- To support those planning and delivering the AWDPP in each Health Board and Primary Care Cluster.
- To facilitate fidelity to an all Wales 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:

- Health Care Support Workers (HCSW) 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 VISION or 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 dietetic referral pathways with inclusion and exclusion criteria applied.
- All relevant minimum data set information must be collected as stipulated to allow for robust evaluation and monitoring of the AWDPP.
- Information given to individuals must be aligned to the AWDPP standardised consultation manual.
- HCSW 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.



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 VISION/EMIS for dietitian and HCSW
- Health Board IT assist with facilitating VISION/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 VISION/EMIS
- Lead dietitian & HCSW to 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 VISION/EMIS, utilising VISION/EMIS user guide where needed

STEP 2: Identification of Eligible Service Users

- Eligible individuals identified either:
- Retrospectively on system using standardised AWDPP VISION/EMIS search templates based on inclusion/exclusion criteria, export list securely to excel 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:

- BMI 20-24
- Reduced capacity/frailty
- Previous bariatric surgery/exposure to 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 VISION/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 VISION/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 VISION/EMIS. End of data collection

Patient DNA clinic:

- Add DNA to AWDPP data entry template within VISION/EMIS
- Add annual HbA1c recall to VISION/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 VISION/EMIS AWDPP data entry template:
    - Mode of delivery & location
    - Ethnicity
    - Scores for EQ-5D
    - 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. If >80 years and seen for intervention previously, escalate to lead dietitian/clinician

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 VISION/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 VISION/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 VISION/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 or remained 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 VISION/EMIS data entry template OR telephone intervention if conversation occurred following the phone call
- Add annual HbA1c recall to VISION/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 VISION/EMIS AWDPP data entry template

Patient DNA clinic:

- Add DNA to AWDPP data entry template within VISION/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 VISION/EMIS AWDPP data entry template:
    - Mode of delivery & location
    - Ethnicity
    - Scores for EQ-5D
    - 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*)

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 VISION and EMIS

To access VISION sites, the HCSW will use a shortcut to each practice's clinical system environment (via the computer's desktop). As well as the practice setting up individual user accounts in VISION itself, Digital Health and Care Wales (DHCW) Service Desk will add a remote desktop client onto the workstation and provide contact details to connect the desktop to the practice's hosted servers. This needs to be submitted to DHCW by authorised individuals at each practice.

To access EMIS sites, 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 VISION and EMIS, practices should seek assistance from their Health Board IT team, as advised by 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 HCSW

Programme Title	Purpose	Delivered by	How long	When
ESSENTIAL				
Mandatory training (to include health & safety, equality, information governance, violence & aggression, resuscitation)	All staff have a duty of care to ensure they are up to date with mandatory training.	ESR e-Learning		Within 3 months of start date
Agored Cymru Level 2 Community Food & Nutrition skills (unit code: NH22CY001)	To enable the learner to understand the role of the balanced diet in maintaining individual and community health; how to improve nutritional intake by amending diets; how different populations may require different diets to maintain health.	Delivered and assessed by a Registered Dietitian in NHS Wales - part of the all Wales *NUTRITION SKILLS FOR LIFE™* programme developed by Public Health Dietitians in Wales and the Welsh Government.	2 hours self-directed learning per week, followed by a 1 hour virtual face-to-face session per week for 10 weeks (Other formats for delivery may be possible)	Prior to intervention delivery
AWDPP Programme Training	Provide framework for the intervention, understanding of the wider weight management pathway, minimum data set & taster to Motivational interviewing	AWDPP Lead Dietitian	2 x 3 hours	Prior to intervention delivery
Training on VISION/EMIS	To ensure accurate collection & recording of data into GP systems.	IT system companies i.e. Cegedigm/EMIS/ AWDPP Local Dietetic Lead/ local practice staff. EMIS Web Videos - Customer Support (emisnow.com)	Variable depending on HCSW knowledge and experience	Prior to intervention delivery

Use of video consultation platforms i.e. *Attend Anywhere* or *AccuRX*	To upskill in the use of video consultation platforms	Self-led learning via Online webinars & assessment	Attend Anywhere 3 videos: 45 minutes total followed by test AccuRX: YouTube videos	Prior to intervention delivery
Motivational Interviewing in Brief Consultations	A practical introduction to motivational interviewing, evidence-based approach to carrying out discussions around change	Self-directed learning Motivational interviewing in brief consultations Online course | BMJ Learning	1 hour	Prior to intervention delivery
Introduction to Motivational Interviewing training	The content will be around consolidation of the intro skills learning. There will be managing ambivalence, building confidence for change, etc. They will be experiential and attendees can bring case examples to discuss and practice	MINT accredited trainer	4 x 3 hour sessions (delivered virtually)	Within first 3-6 months of delivering the intervention
Observe local patient Diabetes education session (e.g. Diabetes Awareness session/ week 1 of X-PERT)	To enhance the knowledge and understanding of type 2 diabetes, symptoms & management. To observe delivery of key messages regarding 'what is diabetes' and how food effects blood glucose levels.	Local diabetes dietitians	1-2 hours	First 1-2 months
Making Every Contact Count (MECC)	MECC is a programme designed to support staff to make the most of every appropriate opportunity to talk to people about improving	Online e-Learning via ESR portal (000 NHS Wales- MECC)	30 minutes	First 1-2 months

	their health and wellbeing.			
Smoking Cessation: Very Brief Advice on Smoking (VBA+)	Very Brief Advice on Smoking (VBA+) is designed to promote quitting and can be delivered in almost any situation with a smoker in less than 30 seconds.	Online e-Learning via: NCSCT e-learning	30 minutes	Smoking Cessation: Very Brief Advice on Smoking (VBA+)
DESIRABLE				
Cultural Awareness Training (as available and relevant locally)	To enhance the knowledge and understanding of food, nutrition and specific dietary habits within the different communities.	Local dietitians Webinars: The African & Caribbean Eatwell Guide • MyNutriWeb South Asian Eatwell Guide • MyNutriWeb	1-3 hours	First 6-12 months
Modules within Cambridge Diabetes Education Programme (CDEP). Chose CORE level: • What is Diabetes? • Nutrition • Physical activity in people with prediabetes, gestational or type 2 diabetes	General information about diabetes, types of diabetes, risk factors, complications, etc.	For FREE access to CDEP: How to register: 1. Go to CDEP's website at www.cdep.org.uk 2. Click on the link in the top right corner: SIGN IN/REGISTER 3. Under NEW CANDIDATE REGISTRATION, enter your EMAIL address and click CREATE ACCOUNT. 4. Complete the rest of the registration form and you are all set to start CDEP! For FREE access, please don't forget to enter the REGISTRATION KEY CODE: WALES		

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 contributes 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 to 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). 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.

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
Exclusion Criteria
Ever diagnosed with Type 1 or Type 2 Diabetes
Current BMI <20 kg/m^2
Currently prescribed metformin or other medications which lower blood glucose
Receiving palliative care
Pregnancy
Artificially fed

For retrospective searching of electronic patient records, the HCSW will use the VISION/EMIS search templates 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 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 or the individual's GP/Practice Nurse. 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 may be created using office functions such as Microsoft Excel spreadsheets and 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 VISION/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/NA
Invitation Letter sent	Yes/No
Response to invitation	Agreed/ Declined/ Non-response
Follow up phone call (if required)	Yes/NA
If declines	Provide reason (free text)/NA
Reason for incomplete data collection	Provide reason/NA

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 are 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 in an attempt 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.

- 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.

- A record of the number of individuals invited to participate must be kept regardless of participation status so uptake rates can be calculated and evaluated (see Table 4).

[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 considered to be 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).

Normoglycaemia:	*≤41 mmol/mol*
At risk of type 2 diabetes:	*42-47 mmol/mol*
Diabetes:	*≥48 mmol/mol*

- 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.

Collection of the Minimum Data Set

The minimum data set (MDS) needs to be collected in full for all individuals to allow for successful evaluation and monitoring of the AWDPP. Data must be recorded accurately using the VISION/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. The screenshots of the MDS template show the collection

format of the MDS as will be used within VISION/EMIS systems. READ codes are imbedded in the template.

Table 5. Baseline Minimum Dataset

AWDPP invitation sent
Individual declined AWDPP/ DNA/ clinically inappropriate for AWDPP
AWDPP visit completed
Mode of AWDPP delivery (virtual/F2F/telephone)
Location of delivery (GP surgery/Community room)
Ethnicity
EQ5D
HbA1c (auto populated)
Height
Weight
BMI
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


AWDPP VISION 3
Data Entry Screen Sh


AWDPP EMIS Data
Entry Template Scree

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.

Physical Activity

The physical activity advice provided must be tailored to the individual's age in line with UK physical activity guidelines. The relevant guidance for those eligible for the AWDPP intervention are grouped by age and includes; age 5-18*, age 19-64 and ages 65 and above.

*ages 18 years and above are eligible

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.

In the course of the compassionate conversation, wider wellbeing issues may be identified as appropriate to a person-centred approach such as smoking cessation or stress management. 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 has been developed 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)

All resources will be made available to the healthcare support worker prior to consultations being delivered and also 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. For evaluation purposes, all follow up HbA1c results should ideally sit within 10-14 months of the initial HbA1c result.

To ensure that individuals due for recall have 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). An AWDPP dashboard is being developed within the All Wales Diabetes Audit+ module which will streamline the future recall process. Details will be shared with AWDPP dietitians and HCSWs once the module is fully developed and operational.

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.

The value of the AWDPP outcome evaluation also relies heavily on the availability of the AWDPP follow up MDS to inform its outcome measures, without which meaningful conclusions with regard to the effectiveness of the AWDPP may not be able to be drawn.

12 Month Follow Up Intervention Pathways

Individuals with HbA1c ≤ 41 mmol/mol or between 42-47 mmol/mol must be invited to attend a follow up appointment.

For individuals with HbA1c ≤ 41 mmol/mol:

- The individual is invited to attend an appointment to repeat collection of the MDS (Table 6).
- Affirm and reinforce positive behaviours as discussed during the initial 30 minute consultation (see below).

For Individuals with HbA1c 42-47 mmol/mol:

- The individual is invited 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 (see below). This will support the opportunity for take up of local health behaviour change support services.

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.

- Alongside the follow up HbA1c test result already available, weight, height and BMI will be recorded upon type 2 diabetes diagnosis by the appropriate healthcare professional

12 Month Follow Up Consultation

Individuals who remain at high risk of type 2 diabetes (HbA1c 42-47 mmol/mol [6.0 – 6.4%]) or who are now at lower risk with an HbA1c ≤41 mmol/mol (< 6%) should be invited 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

- For evaluation to be robustly embedded into the intervention, the variables listed in Table 6 must be collected in full as part of the MDS at the 12 month follow up consultation.
- Data must be recorded accurately using the VISION/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 Dataset

AWDPP invitation sent
Individual declined/DNA/clinically inappropriate
Mode of AWDPP delivery (virtual/F2F/telephone)
Location of delivery (Primary care centre/Community room)
AWDPP visit completed
Ethnicity
EQ5D
HbA1c (auto populated)
Height
Weight
BMI
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 enables 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.

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