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The All Wales Diabetes Prevention Programme Intervention Protocol

Nick Gregory, Diane Kirkland, Catherine Washbrook-Davies, Amrita Jesurasa

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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
- AWDPP EMIS or VISION search templates must be used to identify eligible individuals which is based on agreed inclusion and exclusion criteria
- All relevant minimum data set information must be collected as stipulated to allow for robust evaluation 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

AWDPP Service Delivery Pathway

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

- Local lead dietitian to meet with practice managers to enable access to VISION/EMIS. Health Board IT assist with facilitating VISION/EMIS access
- Discuss room availability for clinics if applicable
- HCSW to receive training as outlined in AWDPP Supervision, Training and Quality Assurance Framework
- HCSW to become familiar with practices and EMIS & VISION
- Lead dietitian & HCSW to confirm & book venues in locality
- Ensure clinic availability & distribution across the week, AM & PM sessions.
- Set up both face-to-face and virtual clinics (demand for clinic format may vary locally)

STEP 2: Identification of Eligible Service Users

- Eligible individuals identified 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
- 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 clinically appropriate for intervention:

- BMI 20-24
- Reduced capacity/frailty
- Aged 85 and over
- Previous bariatric surgery/ exposure to weight management intervention
- Significant mental health concerns or learning difficulties

NB: For compliance and increased uptake to scheme, try to prioritise patients who are currently well i.e. if on patient record, it shows that the patient has recently seen by the doctor in the last 2 weeks and has been very unwell, speak to GP/PN to determine if appropriate to invite to AWDPP.

STEP 3: Service User Database and Quality Assurance

- Individuals identified via search at each practice recorded on AWDPP service user database
- Identify patients to be invited to intervention & those deemed clinically inappropriate
- Record details on AWDPP service user database

STEP 4: Appointment and Booking Process

- Send initial AWDPP invite letter (via VISION/EMIS using standard letter template with GP header & local email/telephone number for booking) and information leaflet, record date invitation sent on AWDPP service user database.
- After 1 week, 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 via VISION/EMIS system.
- Send appointment 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
- **If individual DNA clinic** – add DNA to AWDPP data entry template within VISION/EMIS. End of data collection.
- **If individual attends clinic** –add the following outcomes to AWDPP data entry template within VISION/EMIS:
    - Weight/Height/BMI
    - Scores for EQ-5D
    - Referral to weight management service/ exercise referral/ other (if appropriate and agreed by individual)
- Add **AWDPP attended**
- AWDPP data entry template transfers data into the individual's clinical record
- Ask individual to complete anonymous intervention evaluation form: electronic version- via link **or** hardcopy- hand in at reception.

STEP 6: Follow up at 12 months

- 12 months after the baseline HbA1c test, individual automatically recalled for a repeat HbA1c test
- **HbA1c < 42 mmol/mol**: The individual is contacted to inform them of their HbA1c result. Repeat collection of the minimum data set and reinforcement of positive behaviours as discussed during the initial 30 minute consultation needed. If appointment required to collect minimum data set, refer to step 4 for booking process. Data added into AWDPP data entry template within VISION/EMIS (data may be collected either in person or over the telephone)
- **HbA1c 42-47 mmol/mol**: The individual is invited via letter to re-enter the AWDPP intervention by attending a further person-centred compassionate conversation to review progress and repeat collection of the minimum data set - refer to step 4 for booking process. Data added into AWDPP data entry template within VISION/EMIS
- **HbA1c > 47 mmol/mol**: Refer individual to type 2 diabetes mellitus pathway as per standard practice. Referral recorded within VISION/EMIS. Request repeat collection of the minimum data set by practice clinicians and request for data to be added into AWDPP data entry template within VISION/EMIS.

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. Practices may seek IT support from their associated health

board where necessary to ensure individual user accounts permit the required data access levels.

To access EMIS sites, HCSW 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. The Health Board IT department can request support from DHCW if required.

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
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	Prior to intervention delivery
AWDPP Programme Training	Provide framework for the intervention, understanding of the wider weight management pathway,	AWDPP Lead Dietitian	2 x 3 hrs	Prior to intervention delivery

	minimum data set & taster to Motivational interviewing (MI)			
Training on Vision/EMIS database searches	To ensure accurate collection & recording of data into GP systems.	AWDPP Local Lead Dietitian	1 x 2 hrs (approx)	Prior to intervention delivery
Virtual consultation training i.e. Attend Anywhere OR AccuRX	To upskill in the use of video consultation platforms	Self-led learning	Attend Anywhere 3 videos: 45 minutes total followed by test AccuRX: YouTube videos	Prior to intervention delivery
Introduction to Motivational Interviewing training	Including 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 hr 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
Additional sessions to cover specific population groups, as required.	Additional sessions to increase the understanding of diet and nutrition needs within specific populations such as BAME communities, learning difficulties.	AWDPP lead/ or local lead dietitians	2-3 hours	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 HCSW must have received Agored Cymru Community Food and Nutrition Skills Level 2 training, prior to delivering the intervention. The learning outcomes of the training are listed in table 2.

Table 2. Learning outcomes from Agored Cymru Community Food and Nutrition Skills Level 2 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 HCSW 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 on 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 search templates, which are aligned to the eligibility criteria, must be used to identify individuals suitable for inclusion.

Table 3. Eligibility criteria for the AWDPP

Inclusion Criteria
HbA1c 42-47 mmol/mol (within the last 3 months)
Aged 18 years and over
Exclusion Criteria
Ever diagnosed with T1 or T2 Diabetes
Current BMI <20 kg/m^2
Currently prescribed metformin or other medications which lower blood glucose
Receiving palliative care
Pregnancy
Artificially fed

Examples of the EMIS/VISION search templates are available here:

AWDPP Emis Screenshots.docx

AWDPP Vision Screenshots.docx

The HCSW will use the EMIS/VISION 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.

Process for Escalation

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 (also 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 patients is recorded outside of VISION/EMIS, it is imperative that the 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. HCSW 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 during the initial GP records search 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 with input from Public Health Behaviour Change Specialists

Step 5: The AWDPP Consultation

The guide to the content of the AWDPP consultation is fully documented in the AWDPP consultation manual (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:	*<42 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 but 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 needs to be collected in full for all individuals to allow for successful evaluation of the AWDPP. Data must be recorded accurately using the EMIS/VISION data entry template in line with standard practice 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 minimum data set (MDS) template show the format of collection of the MDS as will be used within EMIS/Vision systems. Read codes are imbedded in the template.


Minimum Data Set Screenshot 1.png


Minimum Data Set Screenshot 2.png

Table 5. Baseline Minimum Dataset

AWDPP invitation sent
Mode of AWDPP delivery
Location of delivery
Ethnicity
EQ5D
HbA1c (auto populated)
Height
Weight
BMI
Comorbidities (auto populated)
Disability (auto populated)
Goals agreed
Referral as indicated by All Wales Weight Management Pathway
Referral to National Exercise Referral Scheme
Referral to other
AWDPP baseline visit completed

Person-Centred Conversation

Upon successful collection of the minimum data set, 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 Community Food and Nutrition Skills Level 2 training. The Eatwell Guide is applicable to most people including meat eaters, vegetarians and all ethnic origins with key information applicable to all including portioning key nutrients, calorie recommendations and food labelling. 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.

Goal setting

Following discussions around T2D risk, 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 T2D 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

Aligned to the All Wales Weight Management pathway, the primary behavioural support services for the AWDPP are Health Board Weight Management services, which provide support through services such as *Foodwise for Life (community based 8 week weight management programme)*, dietetic led weight management services and the National Exercise Referral Scheme. The data collection template will assist the HCSW in discussions

with the individual as to which referral service is appropriate for the individual as per the All Wales Weight Management Pathway. All referrals made 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 and available.

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 minimum data set.

In the course of the compassionate conversation, wider wellbeing issues may be identified as appropriate to a person-centred approach. 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, individuals should be offered the following resources (translated where necessary):

- AWDPP information leaflet regarding raised blood glucose & risk 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: Follow Up at 12 Months

12 Month HbA1c Test

12 months after the baseline HbA1c test, individuals should be automatically recalled for a repeat HbA1c test. The recall process should occur as per standard practice and is not specific to the AWDPP (e.g. HbA1c recall should be generated whether or not the individual is engaged with the AWDPP).

12 Month Follow Up

Depending on the 12 month HbA1c result, there are three pathway options:

- HbA1c < 42 mmol/mol: The individual is contacted to inform them of their HbA1c result. Repeat collection of the minimum data set (Table 6) and reinforce positive behaviours as discussed during the initial 30 minute consultation.
- HbA1c 42-47 mmol/mol: The individual is invited to re-enter the AWDPP intervention by attending a further person-centred compassionate conversation to review progress and repeat collection of the minimum data set (Table 6)
- HbA1c > 47 mmol/mol: Refer individual to type 2 diabetes mellitus pathway as per standard practice and repeat collection of the minimum data set (Table 6)

For evaluation to be robustly embedded into the intervention, the variables listed in Table 6 must be collected as part of the minimum data set at the 12 month follow up appointment.

Table 6. Minimum data set for 12 month follow up

HbA1c
Weight (for BMI calculation)
EQ5D
Referral (service referred to and, if available, how many sessions attended)
Prescribed metformin

Specific details regarding the 12 month follow up protocol are in development and will be released to participating AWDPP clusters when available.

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