NHS

HEALTHIER YOU

NHS DIABETES PREVENTION PROGRAMME

Professional guidance for referring organisations

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Service provided by

ingeus

Contents

Welcome

The Healthier You service

Welcome to the Healthier You NHS Diabetes Prevention Programme (NDPP) - a national joint initiative between NHS England (NHSE), Public Health England (PHE) and Diabetes UK (DUK). The purpose of the programme is to deliver behavioural and lifestyle intervention services for people who have already been identified with non-diabetic hyperglycaemia, and who are therefore at high risk of developing Type 2 Diabetes.

Ingeus, together with our partner, the Leicester Diabetes Centre (LDC), have been appointed as one of the four framework providers of intervention services working with local health services across the country. We are working directly with your local Clinical Commissioning Group (CCG) and Local Authority (LA) to deliver these services in your region.

About this guide

We have designed this guidance booklet for Practice Mangers and Healthcare Professionals working with patients who have been identified as being at risk of developing Type 2 Diabetes.

It contains important information about the Healthier You programme, how to make referrals to the service and what you and participants can expect from their time on the programme.

We hope you find this booklet useful. If you have any questions about the Healthier You service, the referral process or any other aspect of the NHS Diabetes Prevention Programme, please call our freindly Contact Centre Team who will be happy to help.

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Public Health England

Leicester Diabetes Centre
Committed to Growing International Research, Education & Innovation

Lloydspharmacy

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The importance of prevention

Prevalence of Type 2 Diabetes is increasing both at local and national levels; this is driven by the ageing population and increases in attributable factors such as obesity, smoking, sedentary lifestyles and alcohol consumption.

Nearly four million people in the UK have diabetes, representing approximately 11.3% of the population; over 90% of all adults affected have Type 2 Diabetes.

The cost of treatment to the NHS is rising steadily; over £900m was spent on diabetes drug treatments alone in 2015.

The impact of diabetes on individuals and families

The long-term impact of diabetes and the complications which can occur with the disease can be devastating for individuals and their families.

- Around 22,000 people with diabetes **DIE** early every year
- Diabetes is the leading cause of **BLINDNESS** in people of working age in the UK
- Over 130 limb **AMPUTATIONS** are carried out every week on people with diabetes.

Evidence shows that behavioural interventions, which support people to maintain a healthy weight and be more active, can significantly reduce the risk of developing the condition.

Designed for a healthier life

Those who are referred to the Healthier You service will receive tailored, personalised support, including education on healthy eating and lifestyle changes, help to lose weight and advice on bespoke physical exercise programmes.

Overview of the programme

Vision and aim

The vision and primary aim of the Healthier You service is to reduce the incidence of Type 2 Diabetes across England by:

- raising awareness of the seriousness of diabetes
- establishing a person's risk of developing Type 2 Diabetes
- reducing blood glucose parameters (HbA1c or Fasting Plasma Glucose (FPG)) in participants
- reducing a participants weight and BMI
- maximising engagement and completion rates of participants in the programme
- establishing sound data collection mechanisms for future study and analysis linked to the National Diabetes Audit (NDA)

Working together

By working with GPs and Allied Healthcare Professionals, the Healthier You service comprises the delivery of core behavioural interventions which seek to re-educate and support individuals to make changes in their lifestyles which reduce their risk of developing the disease.

Scope

The programme is rolling out to 27 areas across the country in 2016, covering some 26 million people, with the aim of making up to 30,000 referrals in the first year. The rest of the country is expected to joining the programme by 2020.

"To enable people at high risk of developing diabetes to improve their own health and wellbeing and support them to develop their knowledge, skills and confidence to choose healthy lifestyles; helping them to live longer, have healthier lives and prevent them from going on to develop diabetes."

Commissioning structure

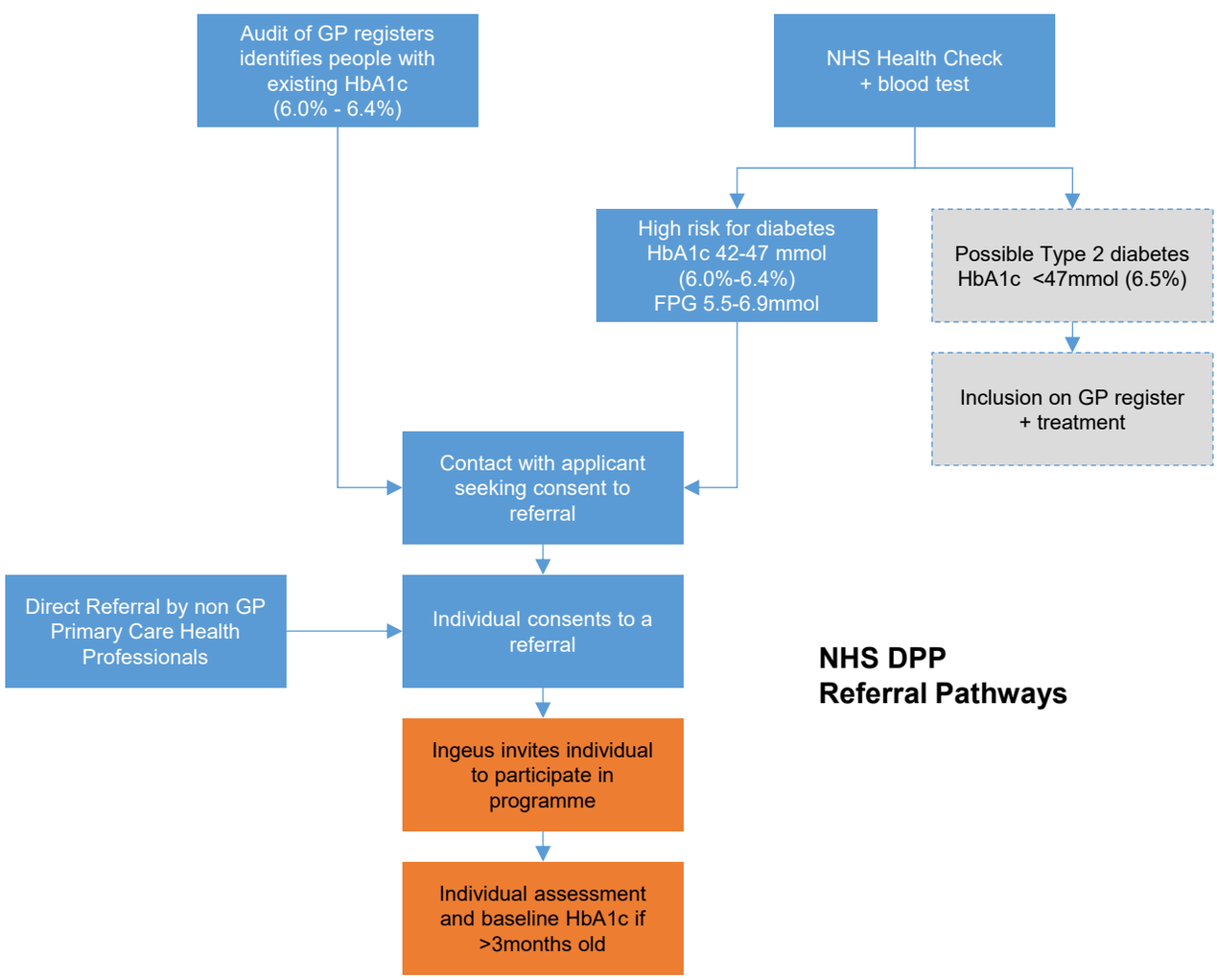
The Healthier You service is a direct clinical pathway, provided under a national framework agreement with NHS England and Public Health England for the NHS Diabetes Prevention Programme (NDPP).

Ingeus have been selected to deliver these services in your region and are working alongside your Clinical Commissioning Group (CCG), Directors of Public Health, Local Authorities and Allied Healthcare Professionals with oversight from regional Clinical Leads.

Referral Pathways

There are three main pathways for patients to access the service:

1. General Practitioner (GP)
2. Direct Referral (DR)
3. NHS Health Checks (NHC)



NHS DPP
Referral Pathways

Integration with other pathways

The Healthier You service compliments and sits alongside other pathways and existing local provisions available to participants, such as Tier 2 weight management, smoking cessation, NHS Choices and other NHS and Local Authority programmes and initiatives.

During the course of the programme, we will signpost and inform participants of other appropriate services available to them, giving them contact details and advising them to speak with their GP for onward pathway referrals.

Benefits of referral to the Healthier You service

As well as the obvious benefits to your patients, referring your at-risk patients to the Healthier You service will have a number of benefits for your practice:

- access to the new pathways will likely result in reduced workload
- improved health and wellbeing of patients leads to less practice visits
- our approach to prevention contributes toward your overall practice scorecard
- the streamlined referral process does not increase workload
- the programme supports management of future demand for LTC management
- the programme compliments and contributes towards existing local incentive schemes
- successful completion by participants will reduce prescribing costs

Referral process

Referral Routes:

- Identification following a GP NHS Health Check or opportunistic detection by a GP
- Identification by an External provider of an NHS Health Check, or following a diabetes risk assessment
- Following identification of existing cases of Non-Diabetic Hyperglycaemia (NDH) on the GP register (known eligible individuals)

Referral of identified eligible individuals:

The invitation for referral must be sent by, or on behalf of, the GP practice by letter to the individual. A template for the letter can be found in this pack, and must include:

- Why the GP is writing to the patient - the invitation to participate in the programme
- What the patient needs to do to either accept or decline the invitation
- The role of the GP practice in the programme, as the organisation responsible for the patient's personal data
- General information about the NHS Diabetes Prevention Programme
- Information about any follow up communications
- Contact details for the GP Practice

Information supporting a referral

The referral notification must contain the following information:

- Date of referral
- General Medical Practice code (Patient Registration)
- NHS Health Check provider code
- NHS number of the individual being referred
- Name of individual
- Address of individual
- Telephone number/email address (where known)
- Contact details of carer or representative (if appropriate)
- Latest HbA1c/FPG (including date recorded)
- If the individual is on the SMI Register (where recorded)
- Whether the individual has a learning disability
- Whether the individual has a physical / mobility issue
- Any known requirement for a translator or information about another language

Inclusion criteria

Referrals are accepted for patients who are identified as being at high risk of developing Diabetes who meet the criteria below:

- At high or very high risk of developing Type 2 Diabetes, identified through using the Diabetes Risk Score assessment tool.
- Have received a blood test in the last 12 months (preferably within the last 3 months) with results as follows:
  - Fasting glucose level between **5.5 to 6.9mmol/l (100 to 125mg/dl)**
  - HbA1c level between **6.0% to 6.4% (42 to 47 mmol/l)**

As your local Healthier You service provider we must accept the following individuals onto the service:

- Individuals who have already been identified as having Non-Diabetic Hyperglycaemia (NDH) in the past 12 months via GP systems and/or who have been included on a GP register of patients with NDH; and / or
- Individuals who have already been identified as having NDH in the past 12 months via the NHS Health Check programme

Exclusion criteria

The Healthier You service will not accept referrals for participants who fall into the following groups:

- Individuals with blood results confirming a diagnosis of Type 2 Diabetes
- Individuals with a normal blood glucose reading on referral to the service
- Individuals aged under 18 years old
- Woman who are pregnant at point of referral

If a patient becomes pregnant whilst participating in the service we will tailor the programme accordingly, following the specification set out in NICE Guideline PH27, for example adjusting any weight loss goals. This guidance stipulates recommendations for diet, physical activity and weight management during pregnancy.

Other suitable participant populations for referral

The Healthier You programme is suitable for a wide range of patient populations at risk of developing Type 2 Diabetes, for example:

- Overweight patients
- Patients diagnosed with hypertension
- Post-natal women with gestational diabetes

Overweight patients

As obesity is a major risk factor for diabetes, a patient with a BMI of over 30 is 10 times more likely to develop diabetes. The programme is suitable for patients with a BMI>30 to help achieve weight loss.

Patients diagnosed with hypertension

Patients with hypertension are at 2-3 times higher risk of developing Type 2 Diabetes than patients with a normal blood pressure. The programme is suitable for those patients diagnosed with hypertension to control and reduce blood pressure.

For patients with a BMI over 30 and for those patients who have been diagnosed with hypertension, use the Diabetes UK Risk Assessment Tool to establish their risk level.

Post-natal gestational diabetes

Post-natal women who had gestational diabetes are more likely to develop Type 2 Diabetes later in life; 50% of women with gestational diabetes will develop Type 2 Diabetes over the following 10 years. The programme is suitable for post-natal women who have had gestational diabetes to reduce their risk of developing Type 2 Diabetes in the future.

All patients who meet the inclusion criteria can be referred to the programme using the referral process.

Practice responsibilities

In order to ensure the effectiveness of the referral process it is important to clearly identify the roles and responsibilities of the organisations involved:

Practices wishing to refer individuals to the Healthier You service must:

- Ensure that all inclusion and exclusion criteria are adhered to
- Ensure referral forms are completed fully and accurately
- Identify a the main point of contact within their organisation
- Actively identify appropriate participants for the programme and assess their readiness to change
- Maintain regular communication with Healthier You service staff

Your local Healthier You service provider will ensure you receive:

- Programme resources, leaflets, referral forms and marketing materials
- Feedback on individual participants results at 6 months
- Regular communications with appointed contact in your organisation

Making a referral

Invitation to refer letter

Where face to face consultation has not taken place with the patient, GPs must first write to the patient offering a referral to the Healthier You NDPP service. A template for this letter and instructions on its use are included in this pack for your information.

The GP may refer the patient at the point of care when undertaking a face to face or telephone conversation so long as the reason for referral is understood and acknowledged by the patient; in which case it is not necessary to send a referral letter.

Once a patient has accepted an invitation for referral from their GP, a referral to the Healthier You service can be submitted through the following methods:

Electronic referral forms

The service has been working with the CCG and your local IT network provider to create electronic referral forms which can be uploaded into your practice system e.g. PRISM, EMISweb or SystmOne. Our Healthier You service team will be able to assist you in uploading the forms appropriate to your practice system. Your system forms will automatically send the referral by secure email through to our nhs.net email account for processing; ensuring details of the referral are copied to the patient's record.

Online web referrals

If you wish to, you are able to make a referral through our online referrals portal. The webform requires the same information fields to be completed as the electronic system forms. You will need to print and keep a copy of the online referral for the patient record.

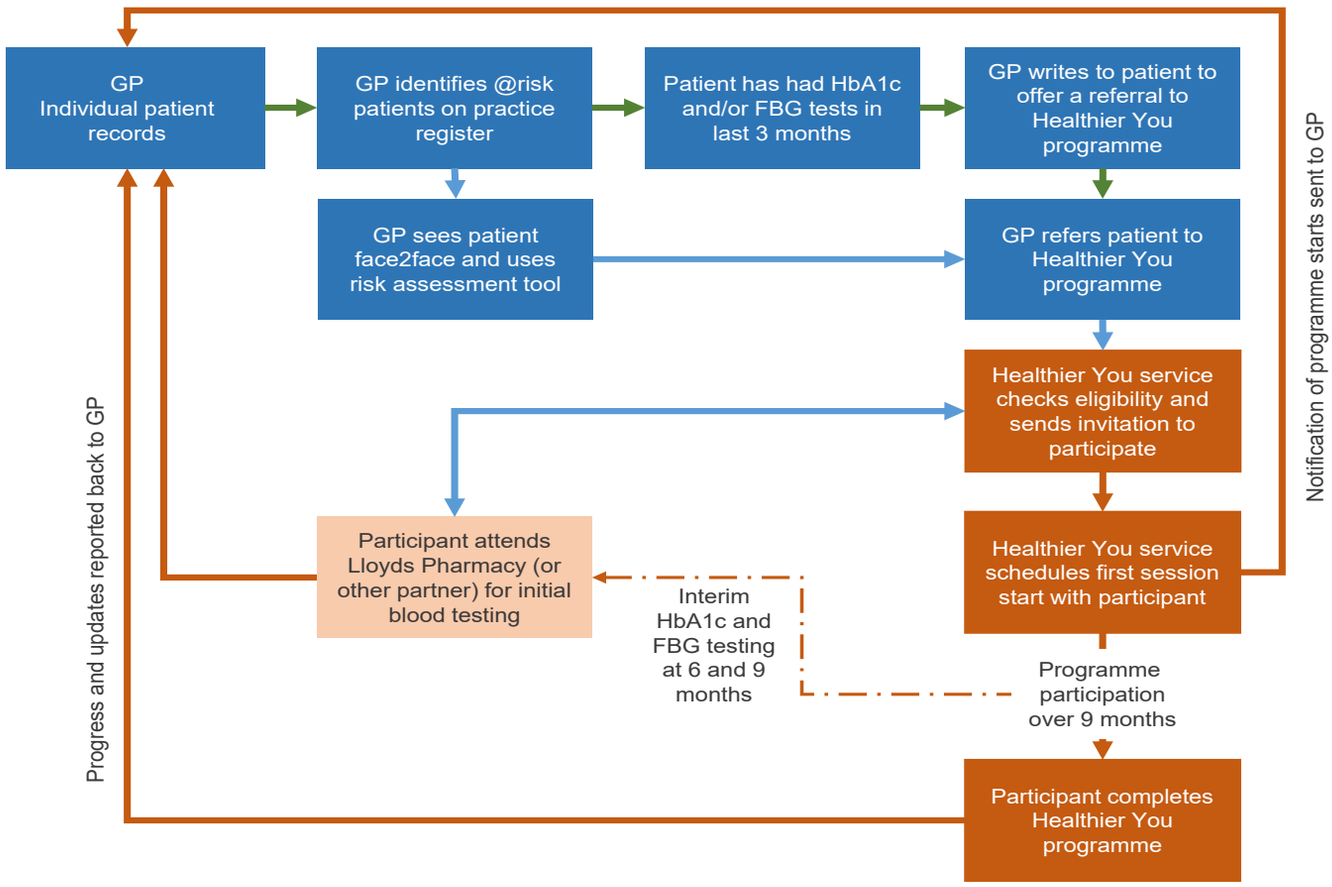
Online referrals can be made at: www.stopdiabetes.co.uk/refer

Programme starts

Once the referral has been received, the Healthier You service will contact the participant within 5 working days to arrange their initial session.

The participant will also need to attend Lloyds Pharmacy (or other partner blood testing provider) for their initial blood test if their last test results are over 3 months old at the point of referral.

The referring GP will be notified once the patient starts the programme, and will receive results of any blood tests as well as periodic updates on the participant's progress.



Programme completion

When a participant nears the end of the programme the Healthier You service will arrange for a final blood testing to be carried out with the Lloyds Pharmacy (or other partner in your area); results of this testing will be sent to you for the patient's record along with their discharge notification and a report on their achievements over the duration of the programme.

Programme discharge

A participant may be discharged from the Healthier You programme for one of four reasons:

- The participant referral was received, but failed to meet eligibility criteria
- The participant fails to attend more than 75% of the programme sessions
- It is established that the participant no longer wishes to take part in the programme
- The participant completes the programme

In all cases the programme will send notification to the referring GP practice with appropriate system clinical codes stating the reason for discharge.

Risk assessment tools

The Diabetes Risk Score is an assessment tool which aims to identify individuals with impaired glucose regulation (IGR) and is designed to predict an individual's risk of developing Type 2 Diabetes within the next ten years. It was developed by University of Leicester and University Hospitals of Leicester NHS Trust in collaboration with Diabetes UK.

The 2012 NICE public health guidance Preventing Type 2 Diabetes: risk identification and interventions for individuals at high risk, recommended that GPs and other primary healthcare professionals use the tool for identifying people at risk of developing Type 2 Diabetes.

Further information on the tool can be found on the Diabetes UK website

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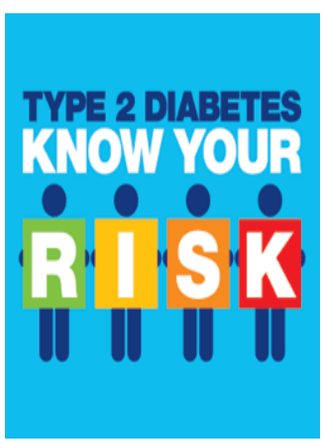
GPs may already have access to other risk assessment and diagnostic tools e.g. Primus testing and Qdiabetes (EMIS); these can be used to support risk assessment prior to referral to the Healthier You programme, so long as the criteria for programme acceptance are met.

Self-assessment tools

Individuals who have not yet been referred, but are interested in the programme can also check their own risk of developing Type 2 Diabetes themselves using Diabetes UK free, three-minute online risk tool. All they need is their accurate weight, height and waist measurements.

Individuals are risk scored based on their responses to a short survey and those with medium and high-risk scores are then advised to make an appointment to see their GP.

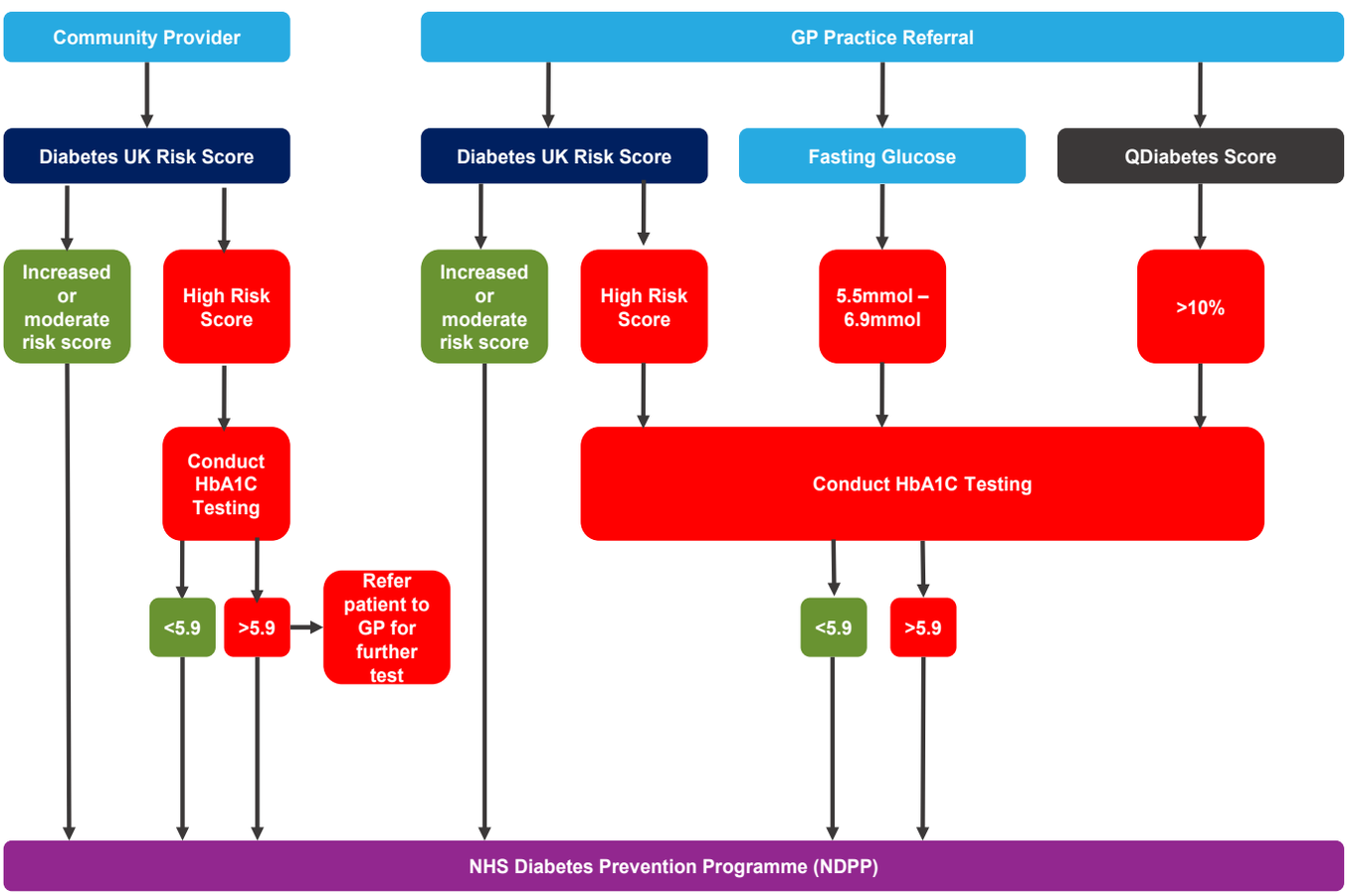
The tool can be found at: http://riskscore.diabetes.org.uk/



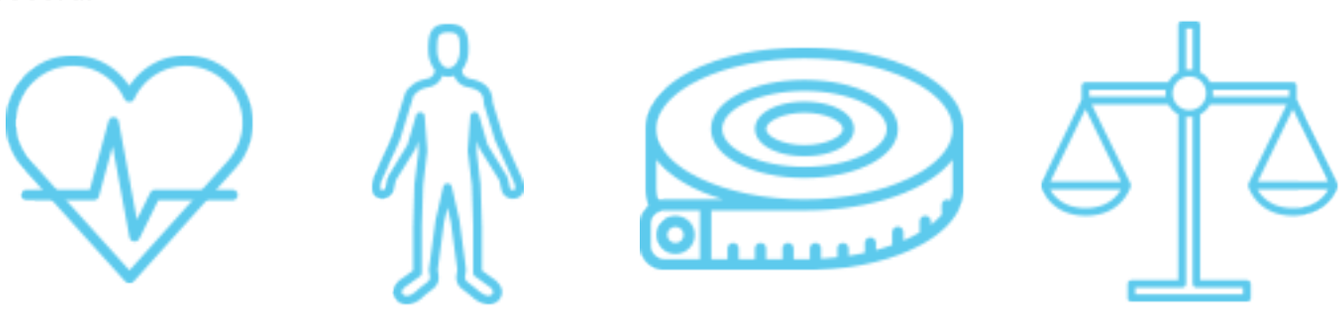
Blood testing

Participants to the programme will have received either a HbA1c or Fasting Blood Glucose blood test in the last 12 months (ideally, in the last 3 months), the results of which form part of their overall risk assessment and eligibility for taking part in the programme.

Participants will receive further tests depending upon their risk of developing diabetes and the date of their last test (longer than 3 months ago). Additional blood testing is undertaken by Lloyds Pharmacy, or other approved local partner. The chart below details the procedure for conducting additional testing.



The Healthier You service will undertake further blood testing when the participant reaches 6 months on the programme to monitor progress; and again at 9 months as part of their final assessment. Results of blood testing will be sent to the GP for inclusion on the patient's record.



Programme curriculum

The Healthier You programme has been designed by a multidisciplinary team of clinicians, researchers and NHS managers, and is based on an extensive body of evidence. The programme is designed to help individuals understand their risk of developing Type 2 Diabetes and find ways of changing their lifestyles and behaviours to reduce that risk.

The service is based on an underpinning philosophy of empowerment, which acknowledges that the participant is capable and responsible for their own health decisions and behaviours. We use educational methods to help participants recognise that they have unique insight into their own lives and encourage them to use this expertise in their choices of food and activity.

What does it entail?

The Healthier You programme consists of a total of 13 sessions lasting 90 minutes each:

- Four weekly core sessions over the period of a month
- Followed by nine monthly maintenance sessions

Sessions are held for groups of up to 15 active participants, alongside their accompanying friends or family members over 18 years old*, and are conducted by an LDC-trained educator. Sessions are delivered from accessible local community locations, close to public transport links where possible.

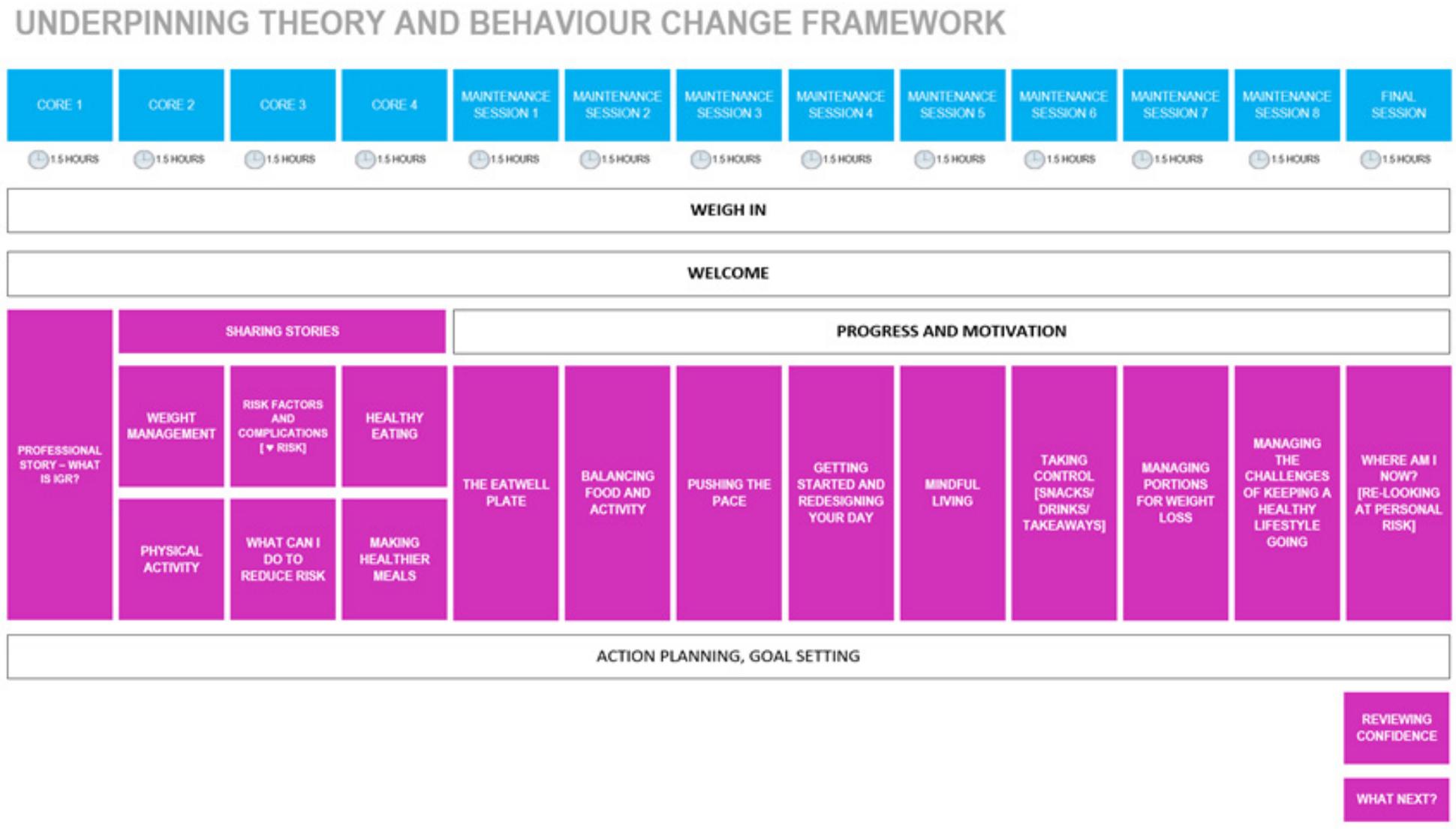
The curriculum covers:

- Understanding of Type 2 Diabetes (T2DM) risk factors, related directly to individual participant's lives
- Individual goal-setting and action planning
- Healthy eating
- Physical activity
- Strategies for adopting healthier lifestyles as part of daily routines
- Overcoming challenges and managing setbacks

The Healthier You service is tailored to each participant's specific personal and cultural circumstances, focusing on each person's belief's contexts and individualised goals. Ingeus and LDC adapt the curriculum for the particular needs and preferences of the individual, including for different cultural groups, language requirements and personal circumstances such as mental illnesses or intellectual disabilities. LDC has extensive experience adapting interventions for different needs while retaining fidelity to programme design, philosophy and evidence.

* or younger in the case of registered young carers

Curriculum overview



Supporting people who are at high risk of developing Type 2 Diabetes

Throughout, and beyond, their time on the programme participants will receive additional support from your local Healthier You service provider and are given access to a number of resources including:

- Our www.stopdiabetes.co.uk website which provides:
  - General Type 2 Diabetes prevention resources,
  - Access to an e-learning platform* aligned to the curriculum that includes:
    - A dashboard to track weight, diet and physical activity;
    - Ability to view and update personalised goals and action plans; and
    - Synchronization with wearable physical activity self-monitoring devices.

- Regular contact from our Contact Centre including session reminders and positive reinforcement to support retention and motivation.

- Free phone access to the Contact Centre for brief information, advice and guidance about Type 2 Diabetes, risk factors, lifestyle and behaviour change, and local sources of support

* Our e-learning platform is due for launch in September 2016

Patient FAQs

We have compiled some frequently asked questions that patients may ask and answers that may be helpful:

How long is the programme?

The programme takes 9 months to complete.

What does the programme involve?

The programme will support people to lose weight, become more active and to eat healthier. This will be through educational sessions with trained facilitators.

How much does it cost?

Participation in the core programme is free. However, we do not cover the cost of any additional activities the participant may wish to undertake to reach their goals

I work full-time, is the programme available in the evenings?

Yes! The programme is available in the evening as well as during the day and at weekends.

Do I have to attend every session?

Ideally yes. However, we appreciate that things come up so will support participants if they miss the odd session.

How many sessions a week is it?

1 session per week in the first month; then once a month for 8 months to monitor progress.

What things does the programme cover?

The programme will cover information on losing weight, becoming more active and eating healthier. There will be advice on how to make small changes in lifestyle that can make a big difference.

Can I bring someone with me for support?

Yes! Participants are able to bring their partner or another adult with them for support. Supporters should be over 18 years of age, unless they are a registered young carer.

Who else will be at these sessions?

Other people who have also been identified at risk of diabetes. The programme is for patients with the same circumstances - to provide peer motivation and support.

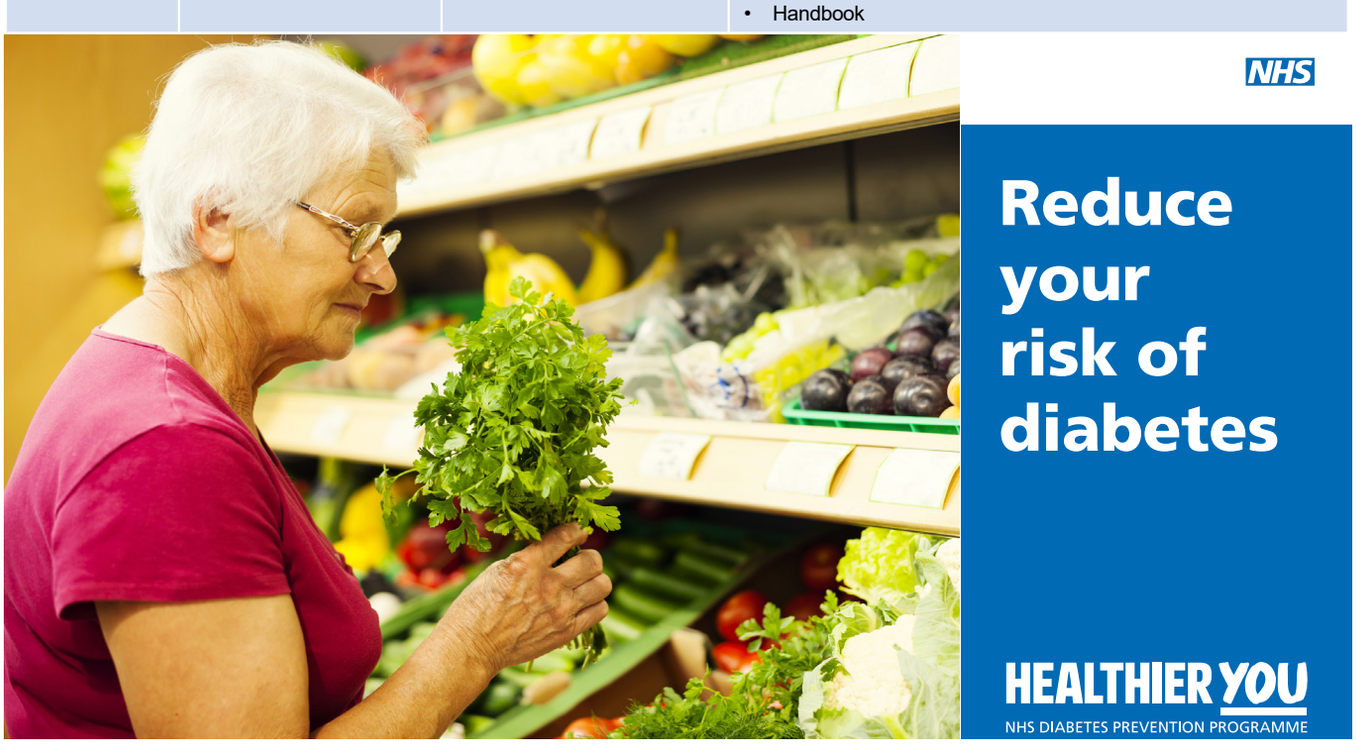



Marketing materials

Working alongside our partner LDC, we have created a range of marketing collateral to relay important information and keep participants engaged.

The table below shows the types of materials and resources available on the programme. Speak to your Healthier You service team for further information and copies.

Process Stage	Marketing Materials and Literature	Audience	When/where to use
Any time	Poster	Participants and practice patients	Around practice/surgery notice boards etc.
Pre-Referral	GP Leaflet	GPs and referring organisations	Information on the programme, referral processes and what to expect from the Programme
Referral	Participant Leaflet	Programme participants	Trifold leaflet given to participants by their GP when they are referred to the programme. Brief introduction to the programme and answers to some initial FAQs.
Referral	Offer of Referral	Programme participants	Offer of referral to programme letter to be sent by GPs to eligible patients who may be interested in joining the programme.
Referral	Invitation to Participate	Programme participants	Letter sent by Ingeus to the Programme participant, acknowledging referral received, inviting individual to join the programme and details of who to contact to schedule their first session. Includes instructions on initial blood testing by Lloyds where current results are unavailable.
On Programme	Course Schedule	Programme participants	Details of the course curriculum; the topics and themes for each session over the duration of the programme and expected timescales
On Programme	Starter Pack	Participant	Participants receive a pack of information leaflets and useful tools from their educator during their first session; these will be used throughout the course: • Preparing • Resources • Plan • Handbook



NHS

Preparing for a Healthier You

This booklet aims to answer some basic questions about pre-diabetes and gives you a better idea of what coming to a Healthier You programme is all about

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My 'Being Active!' diary

The aim of this diary is to support you in keeping a record of the amount of physical activity you do each day. As well as making a note of your step count, you can record what kinds of activities you do or take part in.

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Your handbook

This booklet is a summary of the main messages from the Healthier You programme

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Resources for you

Worksheets, plans and other resources to support you on your journey to preventing Type 2 diabetes

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Patient referral letters

<GP name, Address, Telephone number>

<Name, Address, Postcode, NHS number, DOB, Telephone number>

Dear <Name>

We spoke about diabetes and a recent blood test has shown that you are at a high risk of developing Type 2 diabetes. With the right help and by making lifestyle changes, you can reduce your risk and even stop you developing diabetes in the first place.

Diabetes is a common disease that statistically affects 3.9 million people in the UK and has potentially serious complications. It is the most common cause of:

- Blindness in adults;
- Kidney problems;
- Leg amputations (other than accidents);
- Having diabetes makes you five times more likely to suffer heart attacks and strokes.

We understand making lifestyle changes can be difficult, so in order to reduce the chance of developing diabetes we invite you to join our **Healthier You** programme. By joining you will receive a personalised support plan, including advice on healthy eating and lifestyle, help to lose weight and physical exercise programmes enabling you to take full control of your health.

This service is free and across the country thousands of people have already attended a local **Healthier You** service and successfully reduced their risk of Type 2 diabetes. Spaces are limited, so it is vital that you book into the programme as soon as possible.

If you would like to take advantage of this opportunity, please call us on [insert number] to book your place or alternatively you can tear off the slip below and return it by post or hand it to the receptionist.

Yours sincerely,

[Name of health care professional to go here]

<Name, Address, Postcode, NHS number, DOB, Telephone number >

Please book me a place on the Diabetes Prevention Programme on [insert date] at [add area].

Signed: _____

Date: _____

Return address: [Insert return address]

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How to use the referral letter

THIS LETTER SHOULD NOT BE USED AS A MAIL SHOT

Ideally GPs will refer their patients at the point of consultation; after having the HbA1c blood test results, reviewing risk factors, determining readiness to change and discussing lifestyle changes. Therefore the letter will NOT be needed and the patient can be given information leaflets and followed up by the NDPP.

Examples of common pathways where the letter can be used are shown below (both require some consultation between the patient and GP beforehand). Please note in these scenarios the underlying assumption is that patients are currently not motivated enough but may be, given some time to think, or they are unsure whether they would like to sign up there and then:

Example Pathway 1:

1. Patient attends practice and receives health check and blood test (e.g. because they are a new patient, for a routine health check, follow up, etc.) and consequently HbA1c level taken;
2. Blood test shows raised HbA1c and blood test result flagged up to GP/practice administrators/practice nurses;
3. Patient attends GP for unrelated issue, HbA1c result flagged up to GP and GP consults patient about NDPP as the patient fits the suitability criteria;
4. Patient given the option to be referred onto the programme, or take the letter and leaflet pack, or book another appointment with GP to be referred on to the programme;
5. Patient either replies to the letter, books another appointment with GP or patient takes no action;
6. If the patient replies to the letter they are referred on to the programme without the need for further appointment with GP.

Example Pathway 2:

1. GP has a high clinical suspicion of pre-diabetes (based on BMI, family history, other risk factors)
2. GP requests blood test after consulting patient about risk of diabetes and the need for the test, explaining that if the blood test is raised they may be invited to the NDPP if they meet the suitability criteria
3. Blood test shows prediabetes HbA1c level
4. Blood test flagged up to GP
5. GP decides to either send out invitation letter out to patient or rebook appointment with patient to refer them to the NDPP
6. If the patient replies to the letter they are referred on to the programme without the need for further appointment with GP.

Practitioner FAQs

We have compiled some frequently asked questions and answers about managing the referral process that may be helpful for you:

What happens if a participant has a blood test during the course of the DPP which indicates diabetes?

If, during the programme, a participant receives a blood test result which indicates they have developed diabetes, they will be advised to make an appointment with their GP for confirmation and onward pathway management. Once this is confirmed they will be discharged from the programme.

At what point after pregnancy could a patient with gestational diabetes be referred to DPP?

A woman can be referred to the programme at any point after birth.

What information is needed for the online referral webform?

The webform asks for HbAlc and FPG, plus height, weight and smoking status. We will only require a HbA1c or FPG, both are not necessary. To check eligibility we do need date of blood test (within last 12 months) and date of weight. If it is less than three months since last blood test, the participant won't need another test.

What if the referral is not received by Ingeus for some reason how would the practice know?

Unfortunately there is no way for us to know that a submitted referral did not reach us. The only way would be either (1) no discharge or start notification after a period, or (2) practice reconciliation at quarterly CSU meetings.

Why has my patient been discharged from the programme?

Participants to the programme can be discharged in four ways:

- A referred participant fails to meet the eligibility criteria
- The individual attends less than 75% of the scheduled sessions
- It is established that the individual will not continue on the programme
- The individual completes the programme

In all cases you will receive a notification with the appropriate READ Code.

Notes

Notes

Notes

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www.stopdiabetes.co.uk

Additional support is available from our Contact Centre

Telephone:

0800 321 3150

or

0121 386 6971

The contact centre is available between 8am and 8pm, Monday to Friday, and between 9am and 12:30pm on Saturdays

In partnership with

Leicester Diabetes Centre

Committed to Growing International Research, Education & Innovation

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