Readiness Checklist – NHS Diabetes Prevention Programme
Contents Page

HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

Readiness Checklist Toolkit – NHS Diabetes Prevention Programme

This document has been developed as a template checklist to support Health Economies in preparing to implement the NHS Diabetes Prevention Programme. Learning from demonstrator sites, and first wave sites has been factored in to ensure that this draws on our current experience.

Not all elements of this document will apply depending on your local context, and planned referral routes and there will be other actions not captured here that may apply.

1. Readiness Assessment

• Undertake a readiness assessment across the partnership considering: ○ CCG and partner organisation engagement and commitment to diabetes prevention; ○ Robustness of existing registers of patients at high risk of diabetes or work in progress to address this; ○ Commitment to supporting implementation including clinical and managerial resource and financial resource to support delivery.	

2. Implementation / Local Project Management

Action	Supporting documents and products
Structure • Identification of lead organisations (local authority / clinical commissioning group) for the partnership • Opportunities for partnerships with existing neighbouring DPP programmes have been explored • Agreed approach to resourcing project management requirements for implementation, reporting and delivery • Lead programme manager identified to act as link to national team (one individual) • Lead contacts identified in partner organisations to support programme development • Steering Group with representatives from CCGs and local authorities, Clinical Network to co-ordinate implementation • Implementation meeting held local partners and national representative • Shared understanding across local organisations of how the DPP complements ambitions for improved Health and Wellbeing of STP footprint population	• Case studies documents from demonstrator sites • Memorandum of Understanding
Leadership • Identification of clinical champions within partner organisations • Identification of local governance lead within lead organisation to lead the partnership • Identification of key local stakeholders to support implementation	• Service Specification • Primary Care Narrative

Action	Supporting documents and products
Initial Planning • Project initiation workshops held • Project initiation plan developed • Defined governance arrangements and processes agreed (Local)	• Readiness Toolkit • Memorandum of Understanding • National programme overview slides • Governance Slide Set
• Understanding of contract details and staffing details for all existing or planned local services that are aimed at diabetes prevention (CCG / LA). Information provided about available or planned local services supporting diabetes prevention covering all of the below: - Service specification - Contract length - Contract value - Details of existing staff (specific details tbc) • Agreed decision on whether this service would be continued or amended / decommissioned in light of implementing the NHS DPP • Local legal advice taken about whether TUPE applies	• Prospectus • Memorandum of Understanding
Preparation of Local Prospectus • Develop local prospectus	• Prospectus

Action	Supporting documents and products

Delivery Infrastructure
 	
• Delivery resources agreed and secured from across partnership to support:
  ○ Development of registers of high risk patients (if robust registers do not already exist)
  ○ Incentives to support CCG engagement
• Memorandum of Understanding endorsed and signed by partners
	• Prospectus
	• Memorandum of Understanding

3. Developing the pathway

Action	Supporting Products
• Profiling of known NDH patients on existing primary care registers - Total number with HbA1C or FPG reading indicating NDH (no time limit) - Total number with HbA1C or FPG reading indicating NDH in previous 12 months - Total coded with NDH in preceding 12 months - Total number with NDH blood result receiving 12 month follow up - Total number on NDH register	• NCVIN prevalence report • Business rules set • Demonstrator case studies
• Baselining existing pathways for diabetes prevention and other cross over programmes, for instance weight management programmes. - What do existing services cover - Commissioned capacity	• Service Specification

Action	Supporting Products
- Eligibility criteria - Referral routes in	
• Agreed local approach to interface of NDPP pathway with other pathways (weight management programmes / other diabetes prevention services etc.)	• NCVIN analysis • Local intelligence • Comparison of DPP and Weight Management services guidance
Agreeing annual referral numbers • Approach to generating referrals agreed to support uptake of service • Modelling of expected referral numbers (to include NHS Health Checks flow) • Resource both physical and financial secured to support referral generating activities • Partner organisations (LAs and CCGs) aligned in support of approach	• Case studies documents from demonstrator sites • Local intelligence • Prospectus
• Agreed approach to repeat blood testing for patients if their HBA1c or FPG result indicating NDH is over 12 months old • Agreed approach and resource to support point of care testing if suitable	• POCT guidance
• Start developing the local referral approach and pathway, which may include and isn't limited to: - Local agreement which patients to mailshot/phone/invite - Identification of staff to follow up/directly call patients - Standard letter and process for patient response - Agreement to invite people in for pre-referral motivational interview or direct straight to provider	• Case studies documents from demonstrator sites • Local intelligence • Service Specification

Action	Supporting Products
- Patient pathway from GP register / blood test / contacting patient / calling in for 1:1 / referral to provider / referral back to primary care - Patient pathway from HC provider onwards (see section 4) - Exclusion criteria – the service spec advises 4 criterion. Additional criterion may be considered locally. To note that elements of this work will need to be developed in partnership with the appointed provider.	

4. Engaging Primary Care

Action	Supporting Products
• Considering how to maximise National Diabetes Audit participation (which will be key to ensuring that outcomes for patients can be tracked)	
• Engagement of Primary Care • Assess need to engage LMC • Identification of clinical champions within partner organisations	• Case studies from demo sites • Primary Care narrative • Example LIS • Local insight / networks
• Assess requirement for Local improvement Scheme (LIS) to support plans for referral generation and identify funding to support this	• Template LIS • ScHAR DPP ready reckoner • Case studies documents from demonstrator sites

5. Working with the NHS Health Check

Action	Supporting Products
• Ensure diabetes risk filter and blood tests where required embedded within local NHS Health Check programme • Understanding of numbers identified annually through NHS Health Check to inform referral plans	• NHS Health Checks national guidance • POCT guidance
• Develop approach to re-test those individuals identified through the NHS Health Check who' test is now over 12 months old	
• Decision on use of point of care testing equipment within the NHS Health Check	• POCT guidance • Service Specification
• Agree referral approach from NHS Health Check provider to DPP provider • Develop required letters, templates, referral forms and / or pathways to support this	
• Ensure clear clarification of local pathways / protocols to avoid duplication of patient journey	

6. Engagement and Marketing

Action	Supporting Products
• Appoint communications lead to coordinate activity across partnership • Identify existing communications channels that could support local engagement and / or referral activity	• Branding guidelines • Communications toolkit
• Consider use of local patients champions and / or patient groups to support communications and engagement plan development	
• Consider engagement requirements for key stakeholders, which may include: - Primary Care - NHS Health Check providers - Local Health Care Professionals - Local academic and clinical diabetes specialists in primary and / or secondary care - Local Diabetes Charities - Large local employers/organisations - Religious and community hubs - Diabetes UK including Clinical Champions	

7. Workforce Development Requirements

Action	Supporting Products
• Consider training and communication requirements to raise awareness of the NHS DPP, its planned outcomes , eligibility, referral routes in etc amongst professional workforce to ensure programme acceptance	
• Consider training and communication requirements to embed new NHS DPP read codes within primary care	• NHS DPP Read Codes • Case studies from demo sites
• Consider training and communication requirements to standardise use of system audits for identification of known at risk individuals	• Business rules set
• Consider requirement for motivational interviewing / behaviour change training to support individuals involved in referring at risk individuals	