NHS

Top 10 Tips for rolling out the NHS DPP

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Tip 1: Don’t assume that everyone knows about non-diabetic hyperglycaemia

Haemoglobin A1c level - IFCC standardised

Result indicator
Normal → **(no it isn’t!)**

Follow-up action

No filing comments given.

Coded Investigations

Haemoglobin A1c level - IFCC standardised (XaPbt)
Haemoglobin A1c level - IFCC 42 mmol/mol

- HbA1c of 42-47 mmol/mol (6.0%-6.4%), or;
- Fasting Plasma Glucose (FPG) of 5.5-6.9 mmol/l, or;
- Oral Glucose Tolerance Test (75g load) 2hr result of 7.8-11.0 mmol/l

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Tip 2: Find out about your NHS Health Check processes

- Do not use random glucose
- Only fasting glucose or HbA1c should be used

- Do you commission HbA1c testing outside of diabetes monitoring?

- Can your local authority audit current practice?
- Is training needed for your local NHS Health Check providers on the diabetes filter and appropriate testing?

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Tip 3: Make sure your pathology reporting is aligned to national guidance

Plasma fasting glucose level

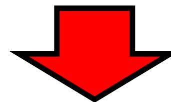
Result ind ator
Normal

No further action required.

No filing comments given.

Coded Investigations

Plasma fasting glucose level (44g1 — 5.5 mmol/L [3 - 6]
ples received
new
method on the Roche analyser, pl
ay be
different to the previous one.
Fasting



Plasma fasting glucose level — 44g1. — 6.0 mmol/L [3.0 - 5.4]

Above high reference limit
Fasting plasma glucose >= 7 mmol/L is diagnostic of Diabetes Mellitus (DM). If asymptomatic, repeat fasting glucose within 2 weeks for confirmation.

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Fasting plasma glucose 5.5-6.9 mmol/L indicates 'Non-diabetic Hyperglycaemia' (NDH) with high risk of developing Type 2 DM.
Lifestyle changes are advised and recheck fasting glucose or HbA1c annually for progression to DM.
If NDH result is within the last year, please consider referral to the National Diabetes Prevention Programme.

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Fasting plasma glucose of 3-5.4 mmol/L is within normal range.

Tip 4: Be persistent and target the whole primary care team

- Telling GPs isn't enough
- Nurses and HCAs must be able to identify NDH and refer to the programme
- Get practice managers on board
- Make sure the people filing results are aware

- Repetition! Protected learning events, locality meetings, newsletters, bulletins, local comms

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Tip 5: Clinical leadership is invaluable

- Clinicians often respond better to other clinicians
- A clinical champion can enhance credibility, drive engagement, highlight issues and may have greater ability to challenge

- Monitoring referrals – which practices aren't engaging?
- Initiating clinician to clinician conversations
- Identifying barriers and training needs
- Educating about NDH, cut-offs, referral processes, the programme, potential benefits for patients
- Generating 'healthy competition' between practices

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Tip 6: Make it as easy as possible

- Don’t rely on busy practices to create their own tools and materials
- Streamline the referral and coding processes
- Automate the yearly recall for review

- Do as much as you can centrally:
  – embed referral forms
  – install templates
  – design searches
  – draft letters for practices to use
  – pop-ups for eligible patients

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Tip 7: Financial incentivisation works

- Very likely to boost interest
- What do you want to incentivise?
- Think about how incentives are structured
- Referral vs Attendance
- Approaches vary widely across the country

- Incentivising attendance may lead to ‘warmer’ referrals with greater subsequent uptake

- In Luton - £5 for referral, £8 for attendance

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Tip 8: Closely monitor and manage referrals and uptake

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- NHS England have commissioned a certain number of places
- ‘Overperforming’ may mean that places are ‘used up’ too quickly
- No guarantee that additional places will be provided

- Monitor the trajectory of referrals
  - Are retrospective searches still to come?
  - Has a steady state been achieved?
  - Are all practices engaged yet?
  - What is happening to referral rates?

- **It is probably easier to increase the flow of referrals than to decrease the referral rate**

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Tip 9: Understand the different pathways following referral

- Retrospective searches for people with NDH results in the last 12 months will reveal many people who can be referred to the programme
- If their result is > 3 months old, next steps will be different than for someone referred immediately after NHS Health Check or routine care
- Do your clinicians use FPG? Is this widespread? Is your provider aware?

- Referrals with results > 3 months old will need retesting by provider
- FPG referrals will have baseline POC HbA1c performed by provider (unless HbA1c unsuitable for clinical reasons)
- No further baseline testing by provider is needed for HbA1c referral with NDH result within the last 3 months

- Extra step of baseline HbA1c testing may introduce delay

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Tip 10: Work closely with the provider at every step

- Involve the provider in all planning of the rollout as early as possible
- Does not have to match your initial profiling plans exactly
- Factor in rurality – a critical number of people are needed before sessions can be run
- What level of activity can your provider deal with?
- Can they flex their capacity? How quickly?
- Overwhelming the provider with unexpected surges of referrals may lead to long waits and unhappy patients and clinicians

- Are you going to roll out to all practices simultaneously or stagger?
- How will you structure the retrospective searches so providers aren’t overwhelmed?
- Does the provider want an initial surge to achieve critical numbers?

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Summary – Top 10 Tips

1. Don’t assume that everyone knows about NDH
2. Find out about your NHS Health Check processes
3. Make sure your pathology reporting is aligned to guidance
4. Be persistent and target the whole primary care team
5. Clinical leadership is invaluable
6. Make it as easy as possible
7. Financial incentivisation works
8. Closely monitor and manage referrals and uptake
9. Understand the different pathways following referral
10. Work closely with the provider at every step

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