

**NHS Diabetes Prevention Programme**

**Prospectus**

Enter Partnership Name

| **1.0 Partnership Information** |
| --- |
| STP NamePrepopulated |  |
| Current NDPP sites and their provider delivering within your STP footprint Prepopulated |

|  |  |
| --- | --- |
| NDPP site | Provider |
|   |   |
|   |   |
|   |   |
|   |   |

 |
| Partnership Lead |  |
| Partner OrganisationsPrepopulated | Clinical Commissioning Group | Local Authority | Other Partner Organisations |
|  |  |  |
| Lead contact for partnershipRole, email and phone details. |  |

| **2.0 Partnership Geography**This information will help providers consider how best to structure their bid to meet your requirements, and key considerations for delivery across your partnership, for instances rurality, areas with poor access routes to routine services, areas with high or low population density. Please explain clearly where the geographical borders are, and if there are areas within the STP that are not included in the service delivery area.  |
| --- |
| 2.1 Geographical spread |  |
| 2.2 Urban/Rural |  |
| 2.3 Transport Links |  |

| **3.0 Partnership Demographics**This provides information to bidders on the scale of service required and the unique considerations in delivering a service within your partnership. |
| --- |
| 3.1 State the total population numbers in each age group, by gender and CCG  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |   | **Male** | **Female** |
| CCG 1 | 18 - 44 |   |   |
| 45 - 64 |   |   |
| 65+ |   |   |
| CCG 2 | 18 - 44 |   |   |
| 45 - 64 |   |   |
| 65+ |   |   |
| CCG 3 | 18 - 44 |   |   |
| 45 - 64 |   |   |
| 65+ |   |   |
| CCG 4 | 18 - 44 |   |   |
| 45 - 64 |   |   |
| 65+ |   |   |

 |
| 3.2 Set out the languages that you would request services were delivered in to support your local at risk non-English speaking community. Max five languages requested. | Please list/describeWhilst providers have a responsibility to tailor services to meet the needs of local population’s pragmatism is required in what providers can deliver. We ask that you set out any existing language support that can be offered?  |
| 3.3 Set out the main ethnicities present within the partnership that materials may need to be tailored for. | Please list/describeWhilst providers have a responsibility to tailor services to meet the needs of local population’s pragmatism is required in what providers can deliver. We ask that you set out any existing support that can be offered? |
| 3.4 Type 2 diabetes prevalence |

|  |  |  |
| --- | --- | --- |
| CCG | Type 2 Diabetes Prevalence (%) | Please indicate if modelled or known figure |
|  |   |  |
|  |   |  |
|  |   |  |
|  |   |  |

 |
| 3.5 Numbers identified at risk of Type 2 diabetes[[1]](#footnote-1) |

|  |  |  |
| --- | --- | --- |
| CCG | Numbers identified as eligible for NDPP | Please indicate if modelled or known figure |
|  |   |   |
|  |   |   |
|  |   |   |
|  |   |   |

 |

| **4.0 Existing local service provision for diabetes prevention and weight management**NHS England does not anticipate that TUPE will apply to transfer staff from any existing service provider to any bidder. However NHS England is not in a position to give any warranty in respect of TUPE and bidders should rely on their own assessment of the likelihood that TUPE might apply. |
| --- |
| Service | Description |
| 4.1 Diabetes Prevention | Please provide a brief description of the service, service provider and contract end dates. If you have an existing service please indicate the current uptake per annum (total numbers) and current service capacity (total numbers) |
| 4.2 Weight Management | Please provide a brief description of the service, service provider and contract end date.  |

| **5.0 Referral generation**Referrals will be generated from the local health economies who will work to mobilise referral pathways; primarily from the NHS Health Check and Primary Care, but other routes could be explored in conjunction with the provider. Please note that the same referral and eligibility criteria apply, as detailed in the service specification, regardless of the route into the programme. |
| --- |
| 5.1 Number of GP Practices |

|  |  |
| --- | --- |
|  CCG | Number of GP Practices |
|  |   |
|  |   |
|  |   |
|  |   |

 |
| 5.2 Number of NHS Health Check Providers |

|  |  |  |  |
| --- | --- | --- | --- |
|  CCG | Primary Care | Local Authority | Other |
|  |   |   |   |
|  |   |   |   |
|  |   |   |   |
|  |   |   |   |

 |
| 5.3 Detail the referral pathways into the programme and explain how these will work.  |  |
| 5.4 Referral generation through NHS health checks |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| By CCG or local authority (please indicate which) | % of total pop offered HC in 16/17 | Overall uptake rate for HC in 16/17 | Number HC undertaken annually in 16/17 | Known identification rate of NDH from HC in 16/17 | Estimated referrals through HC in 18/19 |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |

 |
| 5.5 Describe support CCGs will be providing for PC and GP in generating referrals; including incentives. |

|  |  |
| --- | --- |
| CCG  | Support |
|   |   |
|   |   |
|   |   |
|   |   |

 |  |
| 5.6 Referral generation through primary care |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| CCG | Number practices with NDH registers and recall systems for NDH | Number of people on the managed NDH registers | Number of people on managed NDH registers - blood reading less than 12 months old | Number people blood reading that indicates NDH more than 12 months old | Estimated referrals through PC in 18/19 |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |

 |
| 5.7 Referral generation through other routes  |

| By CCG or local authority (please indicate which) | Estimated referrals from other routes in 18/19 |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |

 |
| 5.8 Total referral generation |

|  |  |
| --- | --- |
| Whole partnership | Total estimated referrals(HC+PC+other) in 18/19 |
|   |   |

 |
| 5.9 Describe current or planned local incentive schemes for referral generation. |
|  |
| 5.10 Based on an average group size of 20, how will you support a steady flow of referrals within specific geographies to support bringing groups together?  |
|  |
| 5.11 If you are generating referrals from other routes outside of PC or the HC, for example through community outreach, please indicate how the blood tests confirming eligibility will be undertaken. |
|  |
| 5.12 Describe your strategy to engage general practice, NHS health check providers and your NDPP provider in developing and agreeing the referral pathway for the NDPP**.** STPs should be working towards agreeing an approach to generating referrals across the partnership. |
|  |

| 6.0 **Governance** |
| --- |
| Describe the governance structure and arrangements that will be in place to support the diabetes programme across your partnership. Include in your answer* How governance will be provided across organisational boundaries
* What delegated authority they have and their roles and responsibilities
* What organisation the SRO will be based in
* Form and function of oversight group / board
* Contributions of each partnership organisation
* How each partnership organisation fits into the overall delivery plan
 |
|  |

| **7.0 Mobilisation** |
| --- |
| 7.1 Plans for roll out at pace and scale | Attach a mobilisation plan.Include:* Key delivery milestones such as
	+ Finalised governance arrangements
	+ Stakeholder engagement milestones and commitments
	+ Finalised referral pathway design
* Timelines including:
	+ Which CCGs / areas / GP clinics will commence first
	+ Roll out sequencing among remainder of STP area

We would ask that 5 GP practices per CCG are selected as trailblazer sites for referral generation for mobilisation of the service. |
| 7.2 STP commitment | State the commitment that the STP has made to the NDPP including:* What the STP will do to ensure site is ready for rapid mobilisation
* What resources, staff and financial, will be committed to this.
 |

| **8.0 Data** |
| --- |
| 8.1 Please state the Primary Care data systems used across the partnership |

|  |  |  |  |
| --- | --- | --- | --- |
| CCG | Data systems | Integrated with Microsoft word? | Can take referrals automatically? |
|   |   |  |  |
|   |   |  |  |
|   |   |  |  |
|   |   |  |  |

 |

|  |
| --- |
| 9.0 **Additional Information**  |
| Please describe any other information not covered elsewhere that would be pertinent to the partnership. (500 words max) |

|  |
| --- |
| 10.0 **STP call off volumes. These should be the resultant figures of referrals in the tables above: ie. HC + PC + other.** |
| (These are the referral figures for providers. Please ensure the same referral figures here are used in the MoU, and in the monthly referral spreadsheet)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|   |   | **Referral Numbers** |  | **Total referral** | **Lower uptake 25%** | **Upper uptake 40%** |
| **2018/19** | **April** |  | **Q1** | 0 | 0 | 0 |
| **May** |  |
| **June** |  |
| **July** |  | **Q2** | 0 | 0 | 0 |
| **August** |  |
| **September** |   |
| **October** |   | **Q3** | 0 | 0 | 0 |
| **November** |   |
| **December** |   |
| **January** |   | **Q4** | 0 | 0 | 0 |
| **February** |   |
| **March** |   |
| **2019/20** | **April** |   | **Q1** | 0 | 0 | 0 |
| **May** |   |
| **June** |   |
| **July** |   | **Q2** | 0 | 0 | 0 |
| **August** |   |
| **September** |   |
| **October** |   | **Q3** | 0 | 0 | 0 |
| **November** |   |
| **December** |   |
| **January** |   | **Q4** | 0 | 0 | 0 |
| **February** |   |
| **March** |   |
|  |  |  | **Y1 TOTAL** | **0** | **0** | **0** |
|  |  |  | **Y2 TOTAL** | **0** | **0** | **0** |
|  |  |  | **ALL TOTAL** | **0** | **0** | **0** |

 |

| **CCG 1 call off volume** |
| --- |
| (Please ensure the same referral figures here are used in the MoU, and in the monthly referral spreadsheet)

|   |   | **Referral Numbers** |  | **Total referral** | **Lower uptake 25%** | **Upper uptake 40%** |
| --- | --- | --- | --- | --- | --- | --- |
| **2018/19** | **April** |  | **Q1** | 0 | 0 | 0 |
| **May** |  |
| **June** |  |
| **July** |  | **Q2** | 0 | 0 | 0 |
| **August** |  |
| **September** |   |
| **October** |   | **Q3** | 0 | 0 | 0 |
| **November** |   |
| **December** |   |
| **January** |   | **Q4** | 0 | 0 | 0 |
| **February** |   |
| **March** |   |
| **2019/20** | **April** |   | **Q1** | 0 | 0 | 0 |
| **May** |   |
| **June** |   |
| **July** |   | **Q2** | 0 | 0 | 0 |
| **August** |   |
| **September** |   |
| **October** |   | **Q3** | 0 | 0 | 0 |
| **November** |   |
| **December** |   |
| **January** |   | **Q4** | 0 | 0 | 0 |
| **February** |   |
| **March** |   |
|  |  |  | **Y1 TOTAL** | **0** | **0** | **0** |
|  |  |  | **Y2 TOTAL** | **0** | **0** | **0** |
|  |  |  | **ALL TOTAL** | **0** | **0** | **0** |

 |

| **CCG 2 call off volume** |
| --- |
| (Please ensure the same referral figures here are used in the MoU, and in the monthly referral spreadsheet)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|   |   | **Referral Numbers** |  | **Total referral** | **Lower uptake 25%** | **Upper uptake 40%** |
| **2018/19** | **April** |  | **Q1** | 0 | 0 | 0 |
| **May** |  |
| **June** |  |
| **July** |  | **Q2** | 0 | 0 | 0 |
| **August** |  |
| **September** |   |
| **October** |   | **Q3** | 0 | 0 | 0 |
| **November** |   |
| **December** |   |
| **January** |   | **Q4** | 0 | 0 | 0 |
| **February** |   |
| **March** |   |
| **2019/20** | **April** |   | **Q1** | 0 | 0 | 0 |
| **May** |   |
| **June** |   |
| **July** |   | **Q2** | 0 | 0 | 0 |
| **August** |   |
| **September** |   |
| **October** |   | **Q3** | 0 | 0 | 0 |
| **November** |   |
| **December** |   |
| **January** |   | **Q4** | 0 | 0 | 0 |
| **February** |   |
| **March** |   |
|  |  |  | **Y1 TOTAL** | **0** | **0** | **0** |
|  |  |  | **Y2 TOTAL** | **0** | **0** | **0** |
|  |  |  | **ALL TOTAL** | **0** | **0** | **0** |

 |
| **CCG 3 call off volume** |
| (Please ensure the same referral figures here are used in the MoU, and in the monthly referral spreadsheet)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|   |   | **Referral Numbers** |  | **Total referral** | **Lower uptake 25%** | **Upper uptake 40%** |
| **2018/19** | **April** |  | **Q1** | 0 | 0 | 0 |
| **May** |  |
| **June** |  |
| **July** |  | **Q2** | 0 | 0 | 0 |
| **August** |  |
| **September** |   |
| **October** |   | **Q3** | 0 | 0 | 0 |
| **November** |   |
| **December** |   |
| **January** |   | **Q4** | 0 | 0 | 0 |
| **February** |   |
| **March** |   |
| **2019/20** | **April** |   | **Q1** | 0 | 0 | 0 |
| **May** |   |
| **June** |   |
| **July** |   | **Q2** | 0 | 0 | 0 |
| **August** |   |
| **September** |   |
| **October** |   | **Q3** | 0 | 0 | 0 |
| **November** |   |
| **December** |   |
| **January** |   | **Q4** | 0 | 0 | 0 |
| **February** |   |
| **March** |   |
|  |  |  | **Y1 TOTAL** | **0** | **0** | **0** |
|  |  |  | **Y2 TOTAL** | **0** | **0** | **0** |
|  |  |  | **ALL TOTAL** | **0** | **0** | **0** |

 |

| **CCG 4 call off volume** |
| --- |
| (Please ensure the same referral figures here are used in the MoU, and in the monthly referral spreadsheet)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **Referral Numbers** |  | **Total referral** | **Lower uptake 25%** | **Upper uptake 40%** |
| **2018/19** | **April** |  | **Q1** | 0 | 0 | 0 |
| **May** |  |
| **June** |  |
| **July** |  | **Q2** | 0 | 0 | 0 |
| **August** |  |
| **September** |   |
| **October** |   | **Q3** | 0 | 0 | 0 |
| **November** |   |
| **December** |   |
| **January** |   | **Q4** | 0 | 0 | 0 |
| **February** |   |
| **March** |   |
| **2019/20** | **April** |   | **Q1** | 0 | 0 | 0 |
| **May** |   |
| **June** |   |
| **July** |   | **Q2** | 0 | 0 | 0 |
| **August** |   |
| **September** |   |
| **October** |   | **Q3** | 0 | 0 | 0 |
| **November** |   |
| **December** |   |
| **January** |   | **Q4** | 0 | 0 | 0 |
| **February** |   |
| **March** |   |
|  |  |  | **Y1 TOTAL** | **0** | **0** | **0** |
|  |  |  | **Y2 TOTAL** | **0** | **0** | **0** |
|  |  |  | **ALL TOTAL** | **0** | **0** | **0** |

 |

1. To be eligible participants will have a blood test indicating Non-Diabetic Hyperglycaemia within the last 12 months (HbA1c 42-47mmol/mol (6.0%-6.4%) FPG 5.5-6.9mmol/l) [↑](#footnote-ref-1)