

NDPP SERVICE SCHEDULE

WRAPAROUND SUPPORT

E-Learning: modules aligned to curriculum; view and update action plans; dashboard to view progress and physical activity; connectable via Human API to wearable physical activity monitors

Contact Centre: scheduled contact to support engagement and reengagement if sessions are missed; Freephone number for session rescheduling; IAG including signposting to relevant services

Automated Contact: reminder SMS, targeted positive reinforcement

Website: with localised service information, resources

Over 1 month

Over 8 months

9 months from First Session

ALL SESSIONS

60–90 minute sessions: delivered by trained Educators in community venues, at a range of times including evenings and weekends
Welcome & Introductions: to programme and session

Progress and Motivation: Sharing stories – learning from each other’s successes, exploring barriers and solutions.
Individual Action Planning: Participants set a single goal that is important to them, identify a plan that will support them to achieve it. Participants specific to session, review progress against goals, strategies to achieve goals and commitment devices

Blood Testing: at 6 months, and before final session
Weigh-In: Participants review progress against goal, strategies to achieve goals and commitment devices

Some sessions may be delivered by local sub-contractors. Across all contracts anticipate an overall split of 80% in-house delivery and 20% partner delivery.

CORE SESSIONS

- Weekly sessions, over a one month period
- Delivered in cohort, with same Educator throughout

Week 1: Professional Story – participant develop understanding of what it means to have non-diabetic hyperglycaemia; their personal risk factors and options to reduce risk through lifestyle change

Week 2: Weight Management – Participants learn about weight and weight health impacts; their own risk, using individual measurements; and reducing risk
Physical Activity - its impact on risk, knowledge and skills for increasing activity

Week 3: Risk of large blood vessel disease – its relationship to other risk factors and managing that risk

Week 4: Healthy Eating - knowledge and skills to make food choices to reduce risk. Understanding food labelling to identify high fat, high sugar, high salt foods. Making Healthier Meals - sharing experiences adapting recipes to make them healthier.

MAINTENANCE SESSIONS

- Monthly
- Booking required, but participants reschedule as required

Session 1: The Eatwell Guide* – understanding balance of current dish, with reference to the Eatwell Guide*.

Session 2: Balancing food and activity – the relationship between calorie intake (from food) and expenditure (from activity), and its effect on weight

Session 3: Pushing the Pace – how increasing muscle mass increase the pace of weight loss

Session 4: Getting standing and reshaping your day – strategies to be more active as part of a daily routine

- Physical activity ‘tasters’ after some sessions delivered by Educators, community organisations

Session 5: Mindful living – how feelings can influence participant’s relationship with activity, food, weight and self-management; and strategies for managing.

Session 6: Taking Control – understanding effects of unhealthy snacks, meals and drinks; and how to identify healthier alternatives, including food labels.

Session 7: Managing Portion size – Awareness of portion sizes for healthier weight loss based on the Eatwell Guide*

Session 8: Keeping Going – identifying and managing personal challenges of sticking to the plan (e./g/ specific events); understanding slipping up isn’t failing and responding to lapses

FINAL SESSION

Progress and Motivation: Reflection and managing modifiable/non-modifiable risks

Where am I now?: Re-plot blood results; reconsider personal risks; review modifiable and non-modifiable risk factors and management options.

Sustaining the Change: Reflect on confidence in sustaining lifestyle changes; develop action plan to achieve longer-term goal

What next?: Signposting to relevant community services; encouragement to set up local participant support groups

Celebrating Success

ENGAGING REFERERS AND PARTICIPANTS

Local NDPP teams engage CCGs, LAs and other strategic groups; engage GP practices and other Health Check providers; raise participant awareness via local marketing.

REFERRAL

- Via GP or other Health Check provider
- Multi-channel referrals, including on-line form, post and phone
- Programme literature issued by referrer

INDIVIDUAL ASSESSMENT AND ENROLMENT

- Invitation to participate issues immediately via post/email with detailed programme overview
- First part of Individual Assessment conducted by trained Contact Centre staff
- Face to Face component of Individual Assessment (blood test, BMI calculation) delivered by Lloyds Pharmacy in-store
- Session scheduling completed
- E-learning account set-up
- Automated engagement and reminder communications via SMS, email

DISCHARGE

Discharge letter/final blood results back to GP; Information on NHS Choices; On-going access to e-learning for 12 months; Freephone number for Contact Centre

* Previously known as the Eatwell Plate