Public Health England

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NHS England

# CONSULTATION ON THE RE-PROCUREMENT OF THE NHS DIABETES PREVENTION PROGRAMME - FOR PROVIDERS

## Background:

5 million people in England are at high risk of developing Type 2 diabetes, with that number rising every year. Estimates suggest that the number of people with diabetes will rise to 4.2 million by 2030, affecting almost 9% of the population.

Type 2 diabetes is largely preventable. There are common, modifiable risk factors for developing type 2 diabetes - in particular sedentary behaviours/physical inactivity and obesity.

In 2016 NHS England in partnership with Public Health England (PHE) and Diabetes UK launched the Healthier You NHS Diabetes Prevention programme (NHS DPP): the first nation-wide Type 2 diabetes prevention service.

The programme delivers behavioural interventions that are predominantly in-person and group based, providing personalised support and motivation to participants to achieve three core goals:

- Achieve a healthy weight;
- Achieve dietary recommendations; and
- Achieve CMO physical activity recommendations.

The national service specification for the programme is based on best evidence following a 2015 evidence review undertaken by PHE. The current service specification can be found at https://www.england.nhs.uk/publication/nhs-dpp-national-service-specification/.

In April 2016 a Framework of 4 national providers was put in place and a series of mini-competitions run with local health economies to call-off services across England. From 2018 we expect to have a provider of services commissioned through the programme in place in every Sustainability and Transformation Partnership (STP) in England.

The Programme involves a novel shared commissioning model whereby NHS England centrally commissions the service, making the interventions free to STPs, which in turn are responsible for supporting implementation locally and the flow of referrals from primary care and other relevant community services. The average STP has approximately a 1.2. million population, and 4 or 5 Clinical Commissioning Groups and a small number of upper tier Local Authorities within it, providing significant scale at which to plan and deliver diabetes prevention services.

In March 2017 The Five Year Forward View Next Steps committed NHS England to expanding the NHS DPP to deliver an estimated 130,000 referrals and around 50,000

people on programmes in 2017/18 rising to as many as 200,000 referrals and more than 80,000 people on programmes in 2018/19.

NHS England's Mandate target is that by 2020, 100,000 people will be supported through the programme each year and NHS England anticipates spending in the region of £20-25m per year over the 3 years of the new framework.

To the end of December 2017 over 140,000 referrals had been made into the service and over 60,000 participants had attended an "initial assessment" with a provider. The average uptake of people from referral is around 50% at present.

The NHS DPP is also exploring whether digital technologies can be utilised to deliver effective behaviour change, offering more flexible and convenient channels for people to engage in improving their health. In late December 2017 eight local health economies across England began referring at risk individuals to 5 different providers of remote digital diabetes prevention interventions. The chosen interventions offer a mix of educational content and personal dashboards that be accessed via computers, tablets and phones, with several including remote coaching on the phone / video link or in virtual groups alongside facilitated peer support groups. Some individuals are also receiving electronic scales and wearables to track and monitor progress and share information with providers in order to enable them to tailor advice and support.

By June 2018 we intend to recruit around 6000 individuals onto the interventions and evaluate the outcomes achieved at 6 and 12 month to build the evidence base and establish the potential of these types of innovations.

## Re-procurement of the Framework:

The current Framework Agreement was put in place in April 2016 and expires in March 2019.

NHS England is now consulting on proposals relating to the re-procurement of the NHS DPP Framework from November 2018 running for 3 years with the option to extend for a further year. Current and potential providers can take part in this consultation by completing the Provider consultation survey by 5pm on 30 April 2018: https://www.engage.england.nhs.uk/consultation/framework-providers-diabetes-prevention/. Survey questions are listed at the end of this document.

Identification and referral into services under the new framework will continue to be predominantly via primary care and other community services and contracts will be awarded on an STP footprint through mini competitions ("call-offs") involving local health economies. Approximately 40% of contracts nationally will be up for call-off from a new Framework in 2019, with the remaining areas of England ready for call-off from 2020.

Payments will continue to be linked to recruitment and retention milestones as long-term retention of individuals on programmes is seen as a proxy for good clinical outcomes, and through consultation we would like to explore the potential for an element of outcome based payment.

## Aims of the re-procurement:

NHS England wishes to explore the potential to:

- Widen access to prevention services, particularly for working age and younger cohorts, rural communities, and high risk groups in communities;
- Continue improving retention on courses to maximise benefit;
- Encourage innovation to improve the quality and effectiveness of services for participants; and
- Achieve best value for money and sustainability of services.

To that end it is proposed that the framework will include the following specifications:

## High level description of the proposed Services:

1. The Current Service

The current in-person service specification would remain unchanged except for refinements where the evidence or NICE guidelines have evolved since the PHE Evidence Review in 2015. This service would take primacy on the basis that it currently has the strongest evidence base.

We are considering removing the requirement for providers to undertake blood tests on the basis that changes in HbA1c levels in response to the intervention are likely to take a longer time to materialise than currently commissioned. In addition, commissioning blood tests via primary care following completion of the intervention may support primary care engagement and effective follow-on care.

2. Core Service With Some Remote Delivery (Optional)

We envisage that providers will also be required to deliver a modified version of the current specification, to enable participants to opt to receive some sessions through remote channels rather than through in-person.

Providers will continue to be required to offer the Current Service in which the entire intervention is in-person. However they will also be able to offer a choice of remote alternatives for certain parts of the programme (i.e. certain “sessions”) to those participants who prefer them. NICE guidance is based predominantly on evidence from delivery of face to face services. To ensure consistency with the current evidence-based specification and with NICE guidelines, it is proposed that those parts of the programme which are in-person will need to constitute:

- at least 8 of the 13 sessions;
- a minimum of 8 hours contact time, and greater than 50% of the total contact time delivered through the curriculum.

This service would be optional, in that NHS England may choose to call off in a controlled way to build the evidence-base. A number of options for remote delivery might be considered which forms part of this consultation.

3. Remote Digital Service (Optional)

The evidence base for digital prevention services is emerging. This proposed new service schedule of the ITT would be optional, in that NHS England may choose to call off digital services in a controlled way from 2019, as evidence builds.

This service offer would be predominantly or entirely delivered remotely via digital technology with minimal or no requirement for participants to attend physical in-person sessions. The intervention content would be very similar to the current specification but would allow for the components to be delivered predominantly via digital channels as part of a managed and carefully evaluated implementation.

It should be noted that a clear principle in re-procuring prevention services is that the (in person) Current Service, for which there is an established clinical evidence base, remains sustainable nationally and that all potential participants are offered the option of attending the programme in person to avoid exacerbating health inequalities.

## CONSULTATION QUESTIONS FOR POTENTIAL FRAMEWORK PROVIDERS

### About you

1. Please select the type of Provider that best reflects your organisation:
   a) Managed Services Provider (delivering sub-contracted lifestyle services)
   b) Diabetes Prevention Provider
   c) Diabetes Treatment Provider
   d) Weight Management Provider
   e) Other Lifestyle Service Provider
   *f)* Other *[Narrative comments]*

2. Please provide the name of the organisation you are responding on behalf of: *[Narrative comments]*

3. If you are responding on behalf of a commercial or other consortia, collective, or group of organisations, please list your key partners: *[Narrative comments]*

4. Please select the type of services you provide:
   a) In-Person
   b) Remote
   c) Digital
   d) Other *[Narrative comments]*

5. Please select the sector that best reflects your organisation:
   a) Private
   b) Public - NHS
   c) Public – Local Authority
   d) Public – Academic
   e) Charity
   f) Social Enterprise
   g) Other *[Narrative comments]*

6. Please select the category that best reflects the scale of your organisation:
   a) Small Enterprise
   b) Small to Medium Enterprise
   c) Medium to Large Enterprise
   d) Large Enterprise

7. Please select the category that best describes the delivery scale of your organisation:
   a) Local/CCG
   b) Local STP
   c) Regional
   d) National
   e) International

## The Core Service With Some Remote Delivery:

We would be interested in your comments on the following modifications/clarifications to the current specification offering participants the option of accessing parts of the course remotely.

8. What are your views on offering part of the Current Service remotely to those who wish to participate in this way as described in the Optional Core Service With Some Remote Delivery description? *[Narrative comments]*

9. What do you think the remote options might be for the Core Service With Some Remote Delivery, and what elements of the curriculum do you think should remain delivered in-person? *[Narrative comments]*

10. Do you think offering participants a choice of some remote elements is viable? *[Yes, No]*
    a) If yes, how would you deliver those remote elements? *[Narrative comments]*

11. How should we ensure that the (in person) Current Service is prioritised where remote and or digital services are also offered; in order to maximise delivery of the service with the most robust evidence base?

    a) What are your thoughts on the viability of prioritising the Current Service by requiring a clear script to promote and endorse it as having the strongest evidence base?
    b) What are your thoughts on the viability of prioritising the Current Service by requiring that the Core Service With Some Remote Delivery and Remote Digital Service are only offered to people who do not accept a place on the Current Service?
    c) What are your thoughts on the viability of prioritising the Current Service by incentivising providers to maximise uptake of it?
    d) What are your thoughts on the viability of prioritising the Current Service by restricting the number of people who could be offered remote alternatives (e.g. 25%)?
    e) What are your thoughts on the viability of prioritising the Current Service by only calling off the Core Service With Some Remote Delivery, and Remote Digital Service where there is sub-optimal performance?

12. Which of the options a to e above do you prefer? *[a, b, c, d, e]*

13. The current specification requires ‘sessions in a logical progression’. To what extent should the specification continue to require the curriculum to be delivered in a logical progression and how would services incorporating greater flexibility work in view of this requirement (for example allow “drop-in” rather than fixed groups for some sessions)? *[Narrative Comments]*

14. The current curriculum requires weigh-in of all participants who are over-weight or obese at every session. How should this be undertaken where some elements are remote, in order to allow objective weight outcomes to be compared consistently at specific time points? *[Narrative Comments]*

15. Are there other changes to the current service specification that could improve access to and retention on the programme for those from higher risk groups and the most deprived? *[Narrative Comments]*

## The Remote Digital Service:

16. To what extent do you agree that we should offer a remote digital service to those who wish to participate in this way as described in the Remote Digital Service description? *[Strongly agree, agree, neither, disagree, strongly disagree]*
    a) Use this space to explain your answer to question 10 *[Narrative comments]*

17. What do you think the remote options might be and what elements (if any) of the curriculum do you think should remain delivered in-person? *[Narrative comments]*

18. Attendance and engagement are straightforward to track for face to face services. How would you define and measure meaningful engagement with a remote service offer? *[Narrative comments]*

19. The Current Service requires 'sessions in a logical progression'. For the Remote Digital Service, to what extent should users choose whether to access modules and resources in a structured order or directly from a menu if they prefer to explore them separately? *[Completely structured, Mostly structured, Mostly self selected, Completely self selected]*

## Commercial Models:

*20.* What insight or views do you have about the overall sustainability of services in relation to the proposals to explore a range of commercial models to deliver the Current Service, Core Service With Some Remote Delivery and Remote Digital Service? *[Narrative comments]*

21. As a provider do you consider that your organisation has the capability to deliver; the Current Service, the Core Service With Some Remote Delivery, or the Remote Digital Service? *[Current service and core service with some remote options, Optional remote digital service, Both]*

22. To what extent do you consider that a commercial model in which partnerships of digital and in-person providers coming together to offer choice would be viable? *[Strongly agree, Agree, Neither agree or disagree, Disagree, Strongly disagree]*

23. What commercial arrangements would you consider would be necessary/desirable to deliver the services and offer choice within those arrangements? *[Narrative comments]*

    a) To what extent do you think a model where commercial partnership arrangements between providers: whether as consortia, lead and sub-contracting arrangements or other relationships to deliver all services, is viable? *[Strongly agree, Agree, Neither agree or disagree, Disagree, Strongly disagree]*

b) To what extent do you think an alternative model where primary care refers participants to a Current Service provider in the first instance, which would then be required to offer choice and onward referral to a provider of/framework of Remote Digital Service providers for those choosing this option, is viable? *[Strongly agree, Agree, Neither agree or disagree, Disagree, Strongly disagree]*

c) In option 23b, to what extent do you consider that a payment approach where the Current Service provider was paid a flat fee for a referral to the framework of Remote Digital Service providers would be viable? *[Strongly agree, Agree, Neither agree or disagree, Disagree, Strongly disagree]*

d) To what extent would it be feasible/desirable to establish centralised referral hubs serving multiple providers across a geography? The purpose of these referral hubs would be to explain the different service offers available and signpost individuals into appropriate services– i.e. this would potentially mean that a current function of the service (i.e. the initial assessment) would be commissioned separately? *[Very feasible, Feasible, Not Feasible]*

*24.* Which of the above commercial models do you prefer and why? *[23a: Providers whether as consortia, lead and sub-contracting arrangements or other relationships deliver all services. 23b: Primary care refers participants to a Current Service provider and onward a provider of/framework of Remote Digital Service providers for those who prefer. 23d: Establish centralised referral hubs to explain the different service offers available and signpost individuals into appropriate services.]*

## Payment Models:

We propose to adopt a standardised payment profile for all providers, which will seek to provide a greater incentive to providers to enrol and retain more people on programmes. This will also allow comparison of performance and cost across providers. The following table sets out our initial thinking. In this model 5% is left as an outcome payment, which could be linked to a percentage weight reduction:

| Milestone | Milestone 1 (Assessment and attendance at 1st intervention session) | Milestone 2 (at least 33% of the curriculum | Milestone 3 (at least 66% of the curriculum) | Milestone 4 (completion of the whole curriculum) |
|---|---|---|---|---|
| Percentage payment for participants reaching these milestones | 30% | 25% | 20% | 20% |

25. We propose to adopt a standardised payment profile for all providers, which will seek to provide a greater incentive to providers to enrol and retain more people on programmes. (See details in the consultation document). Is this a viable option? *[Yes, No]*

26. Use this space to share your views on a potential common payment profile for all providers for the Current Service,Core Service With Some Remote Delivery and the Remote Digital Service? *[Narrative Comments]*

27. What are your views on the viability of a ‘payment by session’ model as opposed to payment milestones, and how might this work? *[Narrative Comments]*

28. What alternative payment and outcome payment options might work; for example should we consider outcomes related to physical activity or diet? *[Narrative Comments]*

29. How might payment/outcome payment options be used to address health inequalities?

30. Does it make sense for a proportion of the payment to be linked to weight outcomes? *[Yes, No]*
    a) If yes, what proportion do you suggest? For example, 5% of payment might be linked to a performance outcome of at least 30% of those who are overweight/obese at baseline losing 5% weight. *[Narrative Comments]*