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NHS England

CONSULTATION ON THE RE-PROCUREMENT OF THE NHS DIABETES PREVENTION PROGRAMME - FOR PRIMARY CARE AND LOCAL HEALTH ECONOMIES

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. Primary Care and Local Health Economies 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/local-economy-diabetes-prevention-programme/. 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 PRIMARY CARE AND LOCAL HEALTH ECONOMIES

About you

1. Which of the following categories best describes you:
   a) CCG
   b) Local Authority Public Health
   c) Local Authority Commissioner
   d) STP
   e) Clinical Network
   f) GP
   g) Primary Care
   h) Secondary Care
   i) Social Care
   j) Charity
   k) Other *[Narrative comments]*

Under the existing service specification providers are required to undertake baseline HbA1c tests on any person referred to the programme with a blood test on referral (that is indicative of non-diabetic hyperglycaemia) which is more than 3 months, but less than 12 months old. Providers are then required to undertake further tests at 6 months and on completion of the programme to monitor the effectiveness of the intervention.

We are considering removing this requirement. There are 2 main drivers for this. Firstly, early outcome data and advice from the Programme's Expert Reference Group suggests that any change in HbA1c levels in response to the intervention is likely to take a longer time to materialise. Secondly, commissioning blood tests via primary care following completion of the intervention may support primary care engagement and effective follow-on care. We are therefore consulting on removing the requirement for providers to undertake blood tests, with a view to working with STPs to commission bloods from local primary care services. To support this activity NHS England could provide funding to STP areas for reimbursement of primary care for these follow up tests.

2. What considerations would we need to make if we worked with CCGs / STPs to commission follow up bloods from local primary care services?

   [Narrative Comments]

   a) What approach would you take to implementing this locally if this was our chosen approach?

   [Narrative Comments]

3. Could CCGs / STPs increase offer and uptake of annual reviews for patients with non-diabetic hyperglycaemia to deliver this follow up function?

[Narrative Comments]

a) How would you implement this approach locally if this was our chosen approach?

Participant choice underpins good uptake to, and retention on, services. A key principle of the NHS DPP is that we don't add to Primary Care workload, and it is therefore proposed that the detailed information patients require to make meaningful choices should be made available through other means. Identification and referral into services will continue to be via primary care and contracts with providers will be awarded on an STP footprint through mini competitions involving local health economies.

4. To what extent do you feel this will support primary care engagement and follow-on care? *[Greatly, To some extent, not at all]*

5. What are your views on offering those at risk of Type 2 diabetes a Core Service With Some Remote Delivery, which is predominantly in-person but includes elements delivered remotely, as an alternative to the Current Service? *[Narrative comments]*

6. What are your views on offering those at risk of Type 2 diabetes a Remote Digital Service, which is entirely remote or has minimal in-person sessions, as an alternative to the Current Service to those who prefer? *[Narrative comments]*

7. Please provide comments on the impact on primary care and patients of offering a choice of the Current Service, Core Service With Some Remote Delivery and a Remote Digital Service (or a range of Remote Digital Services) to patients. *[Narrative comments]*

8. How should we ensure that the 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?

[Narrative Comments]

9. Which of the options in Question 5a to 5e above do you prefer? *[a, b, c, d, e]*

10. Do you have any views on the feasibility/desirability of the following referral mechanisms being adopted:

    a) Primary care to refer to a regional hub that would then direct patients to the relevant local provider;
    b) Primary care to refer to a national hub that would then direct patients to the relevant local provider;
    c) Primary care to refer directly to a single provider offering the Current Service, Core Service With Some Remote Delivery, and the Remote Digital Service;
    d) Primary care to refer to a Current Service and Core Service With Some Remote Delivery provider, that then re-directs patients to a separate Remote Digital Service provider or providers if they so choose.

[Narrative Comments]

11. Which of the options in Question 10a to 10d above do you prefer? *[10a, 10b, 10c, 10d]*
12. Please provide comments on the potential impact on primary care, CCGs and local authorities within the STP of working locally with separate Current Service, Core Service with some Remote Delivery, and one or more Remote Digital providers to manage uptake of available places and individual and population needs.

[Narrative Comments]