# Healthier You:
# NHS Diabetes Prevention Programme
# Framework Re-procurement

# Local Health Economy consultation responses
# June 2018

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# Healthier You: NHS Diabetes Prevention Programme Framework Re-procurement

## Local Health Economy consultation responses June 2018

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# Contents

# 1 Introduction

As part of the development of the NHS Diabetes Prevention Programme, NHS England is exploring the potential to use digital technologies in the new service specification to enable the programme to offer greater flexibility for service users.

This includes consulting on incorporating remote options as part of its core, face to face, service as well as a new, separate, digital schedule to enable the service to be accessed via a range of digital or other technological channels.

Consultation was carried out with local health economies, provider organisations and the public on the development of the new specification. This document summarises the results of the Local Health Economy consultation which ran from May to June 2018.

All questions used in the consultation are provided at Annex A.

Responses were received from 16 CCGs, 1 Clinical Network, 9 GPs, 6 Local Authority Public Health Teams, 2 Primary Care, 1 STP and 4 “other” (1 Academic Health Science Network, 1 DPP Partnership, 2 NHS England).

# 2 Summary of LHE responses

2.1 The arrangement of follow up blood tests from local primary care services were widely felt to be a good idea, although it was pointed out that consideration would need to be given to how best to resource this work appropriately. It was suggested that there could be a nationally agreed specification to be implemented locally rather than leaving it to local determination.

2.2 There was widespread support for increasing the offer and uptake of annual reviews for patients with non-diabetic hyperglycaemia to undertake the function of follow up blood tests. This could be supported through new funding or resources to support this activity.

2.3 It was pointed out that in order to agree to increase the offer and uptake of annual reviews for patients with non-diabetic hyperglycaemia locally, it may need to be included within annual local negotiations of the GP Quality Contract and balanced against other areas of local improvement need.

2.4 The vast majority of respondents agreed either greatly or to some extent that identification and referral into services should continue to be via primary care. There was also support for contracts with providers continuing to be awarded on an STP footprint through mini competitions involving local health economies to support primary care engagement and follow-on care.

2.5 The suggestion of an offer to those at risk of Type 2 diabetes of a Core Service With Some Remote Delivery, which is predominantly in-person but includes elements delivered remotely, as an alternative to the Current Service was

agreed to be likely to benefit working aged people and to offer greater flexibility of service, access and patient choice.

2.6 The suggestion of a Remote Digital Service, which is entirely remote or has minimal in-person sessions, as an alternative to the Current Service was generally supported, as long as the offer of a face to face service remained, for those patients who preferred. The peer support gained through a face to face service was referenced as one of the potential success factors which a digital service may not be able to replicate in the same way.

2.7 To minimise the impact on primary care 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), respondents largely felt that the detailed information on choice should be provided to the patient by the provider, not by primary care and that primary care staff should only be expected to provide a high level overview.

2.8 There were mixed views about the need to prioritise the Current Service where remote and or digital services are also offered. Some respondents recognised the need to maximise delivery of the service with the most robust evidence base, while others felt that the digital offer should be available to all, and that the patient should be allowed to have a choice according to which service suits their lifestyle.

2.9 “Requiring a clear script to promote and endorse the face to face service as having the strongest evidence base” and “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” were the two preferred methods to prioritise the face to face service over the digital service. Restricting the number of people who could be offered remote alternatives was less favoured.

2.10 The majority of respondents’ preferred referral mechanism was that of Primary Care referring directly to a single provider offering the Current Service, Core Service with some and Remote, and Remote Digital service. The second most preferred mechanism was that of a regional hub that primary care would refer to, who would then direct patients to the relevant local provider. A national hub for onward direction to the relevant local provider was the least preferred option. Referring patients to a Current Service/Core Service with some Remote provider that then re-directs patients to a separate digital provider or providers if they so choose was preferred by a small number of respondents. The limitations of this option were thought to be that a Provider with a vested interest in ensuring patients take up a place on the Current Service may be disinclined to refer on to a Digital service if there was not a suitable incentive to do so.

2.11 Concern was expressed by a number of respondents about the complexity that would be caused by requiring primary care, CCGs and local authorities within the STP to work locally with separate providers (offering Current Service, Core Service with some Remote Delivery, and one or more Remote Digital Services)

to manage uptake of available places and individual and population needs. It was stated that the commissioning arrangements and communication flows would need to be very clearly set out from the start if this were the chosen approach. A preference was stated for a single entity provider to provide all services and manage referrals and uptake of available places.

# 3 Annex A – Consultation questions

1. Which of the following categories best describes you? If you have selected 'Other', please specify.

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

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

4. How would you implement this approach locally if this was our chosen approach?

5. 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. - To what extent do you feel this will support primary care engagement and follow-on care?

6. 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?

7. 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?

8. 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.

9. 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?

10. Which of the options in Question 8a to 8e above do you prefer?

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

12. Which of the options in Question 10a to 10d above do you prefer?

13. 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.