Healthier You: NHS Diabetes Prevention Programme Framework Re-procurement

Provider consultation responses May 2018

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Contact Details for further information	NHS DPP NHS England Quarry House Leeds LS2 7UE

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1 Introduction

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

This includes 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 how this could best be achieved. This document summarises the results of the Provider consultation.

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

2 Summary of provider responses

2.1 All providers thought offering part of the current service remotely was viable.

2.2 All providers thought offering a choice of remote elements was viable.

2.3 The majority expressed support for elements to continue to be offered face to face, particularly the introductory & assessment sessions.

2.4 There was support for the specification to continue to require the curriculum to be delivered in a logical progression within a digital or remote offering.

2.5 All providers felt that weigh-ins could be managed relatively easily so that objective weight outcomes could be compared consistently at specific time points. Proposed methods of achieving this included:

- Providing service users with digital scales that send weight data over the cloud
- Requiring weigh ins at surgeries or high street pharmacies for independent verification
- Restricting the number of remote sessions conducted, and requiring weigh ins to be done face to face, every few sessions.

2.6 To improve access to and retention on the programme for those from higher risk groups and the most deprived communities, providers made a number of suggestions including:

- Prioritising digital and remote delivery.
- Multi-lingual versions of Apps.
- Gendered programmes.
- Provide transport (or travel expenses) to sessions.
- Increased communication through an app, text messaging and reminders.

2.7 All providers agreed NHS England should offer the Remote Digital service. As with the core service, many felt a face to face element was important. A small minority felt it could be delivered fully digitally.

2.8 The majority thought the digital curriculum should be “mostly structured” in terms of access to modules and resources. “Completely structured” and “Completely self selected” were the less favoured options.

2.9 Some respondents were against prioritising the current service over the digital service. However in order to maximise delivery of the service with the most robust evidence base, their preferred methods to do this were by offering the digital service to people who do not accept a place on the Current Service or through the use of a clear script to endorse the face to face service.

2.10 Almost all respondents agreed or strongly agreed that a commercial model in which partnerships of digital and in-person providers coming together to offer choice would be viable.

2.11 Commercial partnership arrangements between providers was the preferred commercial model for the majority.

2.12 A model where commercial partnership arrangements between providers: whether as consortia, lead and sub-contracting arrangements or other relationships to deliver all services, was considered viable by the majority.

2.13 A 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, was felt to be less viable.

2.14 A payment approach where the Current Service provider was paid a flat fee for a referral to the framework of Remote Digital Service providers was felt to be viable by less than half of the respondents.

2.15 The establishment of centralised referral hubs serving multiple providers across a geography was supported by half of respondents .

2.16 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 was supported by the majority.

2.17 There was no clear consensus on whether Payment by session (proposed) would be preferable to payment by milestone. Some felt it would be unnecessarily complex, and may incentivise the wrong behaviour (ie recruitment rather than retention). Others welcomed this approach as it was seen as carrying less risk for the provider and may be easier to price accurately.

2.18 The majority did not support linking payment to improvement or achievement of physical activity measures.

2.19 The majority of respondents agreed that some element of performance related payment was suitable, and it was suggested that 5% should be the minimum, with some arguing for more.

2.20 Linking PBR solely to weight was cautioned against; waist circumference was offered as another potential measure. If weight is to be used it was suggested

that it should be defined such that it was only related to those service users who were overweight or obese on initial assessment.

3 Annex A – Consultation questions

1. Please select the type of Provider that best reflects your organisation

2. Please provide the name of the organisation you are responding on behalf of:

3. If you are responding on behalf of a commercial or other consortia, collective, or group of organisations, please list your key partners

4. Please select the type of services you provide

5. Please select the sector that best reflects your organisation

6. Please select the category that best reflects the scale of your organisation

7. Please select the category that best describes the delivery scale of your organisation

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?

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?

10. Do you think offering participants a choice of some remote elements is viable? If you have selected 'Yes', how would you deliver those remote elements?

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 11a to 11e above do you prefer?

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?

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?

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?

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? Please explain your answer.

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?

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?

19. The current service specification 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

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?

21. As a provider do you consider that your organisation has the capability to deliver; the current service, Core Service With Some Remote Delivery, or the Remote Digital Service?

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?

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

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?
c. In 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? - In 18b, 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?
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?

24. Which of the above commercial models do you prefer and why?

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?

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 Digital, and Remote Digital Service?

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

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

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