Healthier You:
NHS Diabetes Prevention Programme
Framework Re-procurement

Supplier Engagement Event Evaluation
16 April 2018

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Description	NHS England is exploring the potential to use digital technologies in the new service specification to enable the NHS DPP to offer greater flexibility for service users. Consultations were carried out with local health economies and provider organisations on the development of the new specification. This document summarises the results of a provider consultation event.
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Document Status

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Healthier You: NHS Diabetes Prevention Programme Framework Re-procurement

Supplier Engagement Event Evaluation 16 April 2018

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1 Background

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, up to 100,000 people will be supported through the NHS DPP each year.
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. NHS England is currently consulting on the re-procurement of the NHS DPP Provider Framework.
It is currently proposed that this framework is appointed to in December 2018, for an initial period of 3 years with the option to extend for a further year.
Through the consultation process NHS England is exploring the potential to:

- Widen access to prevention services, particularly for working age and younger cohorts, rural communities, and higher risk groups;
- 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.

A Prior Information Notice (PIN) was published to inform suppliers of this Supplier Engagement Event. This PIN also included details of the service and the additional digital options, along with a link to an online consultation document that provided suppliers with the opportunity participate in Early Market Engagement by responding with their initial views.

To support the consultation NHS England held a Supplier Engagement Event on the 16 April 2018 and this document provides a summary of that event.

2 Aims

As part of the consultation NHS England held a Supplier Engagement Event on the 16 April 2018. The day provided an opportunity for NHS England to:

- provide the market with background information on the NHS DPP, and details of the proposed re-procurement of the framework, and;
- engage suppliers and consult on elements of the service and the models for service delivery.

3 Programme for the day

The below table provides the outline of the day.

Item	Title
1	Welcome and outline of the day
2	Commercial Procurement
3	Programme Performance to date
4	Diabetes UK User Insight
5	Digital Diabetes Programme
6	Background to Re-procurement
7	Context for Provider Consultation
8	Panel Q&A
9	Workshops – focussing on specific questions from the Consultation Documents
10	Feedback from the workshops
11	Summary, next steps and close

The following report provides the questions received during the main panel Q&A and responses from panel members along with the detailed notes and summary feedback from each of the three workshops.

- Table 1 – Panel Q&A Session
- Table 2 – Summary feedback from each of the workshops

Appendix 1: Supplier Engagement Event 16 April 2018 - Agenda
Appendix 2: Supplier Engagement Event 16 April 2018 – Workshop Session Questions
Appendix 3: Payment Model

4 Table 1: Panel Q&A Session

Table 1: Panel Q&A Session	
Question	**Answer**
1. Explain the role of the centralised hub and who would coordinate this?	If we established centralised hubs to triage all referrals received NHS England would likely take this forwards as a separate tender action *(i.e. this would not be included within the scope of appointing to the NHS DPP Provider Framework).* Final decisions on how NHS England would coordinate this haven't been taken, but hubs could be commissioned on a range of geographies, nationally, regionally or at STP level. There are potential challenges in scaling this at sufficient pace to interface with the appointment of the new provider framework. Part of the rationale for this proposed model is that NHS England recognises that Primary Care has limited resource to engage patients in detailed conversations about the different programme delivery options available and most suitable to them, and therefore hubs could reduce this burden on Primary Care.
2. Digital: Outcome based payments are used more widely for digital service. Will the digital service replicate the core face to face service payment model or allow greater focus on outcomes?	NHS England currently has no fixed view on this, and this is one of the questions in the provider consultation document. There are a range of options available to us, including a shift from our current model of paying for activity (i.e. paying providers incrementally as patients progress through and are retained on programmes) to some form of outcome based payment. NHS England has focused on encouraging retention on the current service by aligning provider payments with retention as the evidence suggests that the longer a person is retained on a programme, and the greater "dose" they receive, the better the outcome we would expect them to achieve. For digital services we need to establish a clear definition of what patient engagement with services looks like. In the United States DPP they have established a framework

Table 1: Panel Q&A Session	
Question	**Answer**
	for engagement which takes account of different delivery models and could provide a useful starting point for the NHS DPP.
3. What split are NHS England proposing of face to face vs digital delivery under the new framework?	This depends on the evidence base and if over time we can demonstrate that digital delivery methods are as effective as face to face services (where the evidence base is very well established). We have also established a core principle for the NHS DPP that we will provide sufficient volumes in to face to face services to ensure they are sustainable across England. The evidence for the face to face intervention is strong and based on five randomised control trials. NHS England would like to roll-out digital in a controlled way, informed by learning from the digital pilots that are currently being commissioned and wider evidence of effectiveness as it emerges.
4. When will NHS England decide which commercial model to adopt?	This is a core element of the supplier consultation which closed on 30 April 2018. The decision will depend on the market response to this consultation, feedback from the supplier engagement day and appraisal of the options with commercial colleagues. NHS England's indicative timeline is that a decision will be made over the Summer 2018.
5. Will there be a PQQ (Pre-Qualification Questionnaire) before the ITT (Invitation to Tender)?	This will follow the OJEU process. Whether it will follow the open or restricted route is currently undecided.
6. How many providers will you be looking	There is no decision yet about the number of Providers we are seeking to appoint to

Table 1: Panel Q&A Session	
Question	**Answer**
to appoint?	the provider framework. The number of providers may potentially increase, we have sought feedback on the potential number of framework providers via the online consultation document. This decision will be informed by market feedback, and the chosen commercial model that we seek to put in place.
7. Can you give more details on the hybrid model?	Under the proposed Hybrid model providers would be able to offer remote alternatives for certain parts of the "in-person" programme (i.e. certain "sessions") to support improved access and retention. NHS England envisions that the service would still be consistent with NICE guidelines and the established evidence base, i.e. it would be predominantly "in person" group delivery If we took this forward we would likely make the service optional, so NHS England could choose when and where to call this off.
8. Is there a change in blood test eligibility criteria?	We are not proposing a change in eligibility criteria for the NHS DPP; as currently stated it would be based on a blood reading, within the last 12 months indicating Non-Diabetic Hyperglycaemia. NHS England may decide to remove the current requirement on providers to take bloods from programme participants and seek to embed this within Primary Care moving forwards.
9. Why are we looking to remove blood tests from the provider delivery model and do we anticipate this having an impact on retention?	NHS England is considering removing the requirement on providers to undertake blood test for a number of reasons: 1. Bloods were initially included to support evaluation of the programme, and we model that we will have a sufficient sample under the current framework to power our commissioned service evaluation. 2. Currently we are seeking to compare venous readings taken within Primary

Table 1: Panel Q&A Session	
Question	**Answer**
	Care with POCT readings taken by providers, which introduce challenges with comparison of readings which would be removed if we only used venous testing. 3. Annual re-testing for patients identified with NDH is already a part of NICE guidance and strengthening re-testing in Primary Care may support ongoing care at the point of discharge from the NHS DPP.
10. What are the anticipated costs of the NHS DPP?	NHS England's mandate requirement is to support up to 100,000 patients on the NHS DPP per annum by 2020. We are modelling spending in the region of £28 million per annum over the duration of the new framework.

5 Table 2: Summary Feedback from Workshops

Table 2: Summary Feedback from Workshops	
Theme	**Comments**
NHS England Planning	There was collective feedback that NHS England needs to be clear on the meaning and intent around digital, remote and face to face and the requirements of the different schedules in the context of any specification or future tender process to support the market in providing what is required. Confirming the desired commercial model to the market early would support market planning to deliver the services and bid for the ITT. Contracts could allow flexibility for the provision of more digital capacity as the evidence base emerges, so that the service can evolve over the duration of the framework.
Patient Engagement	Patient activation and readiness to change could be captured by providers in future, helping understand if patients are ready for lifestyle change at the point of referral and how we best support those that aren't.
Patient Choice	The first interaction that patients have with the service will be important and will help them determine what service delivery route is most suitable. Therefore informed patient choice remains important to allow identification of the most suitable delivery method for each patient. Patients like a clear, concise offer and seamless pathway and this should be considered in the chosen model that NHS England takes forwards.
Model 1 Partnership Arrangements / Joint Venture	This was largely considered the preferred model, although there are no established commercial relationships currently between face to face and digital providers and it was

Table 2: Summary Feedback from Workshops	
Theme	**Comments**
/ Augmented Supply Chain	noted that sufficient time would be required to allow the market to develop these relationships. Early indication of the chosen commercial model will support this. Requirement in the service specification to clarify if the same curriculum should be shared across face to face and digital interventions or if there will be flexibility between the different delivery routes. There was interest in greater flexibility in the face to face service through inclusion of digital or remote elements. It was noted that the evidence base for this inclusion is still emergent. There was discussion of whether digital could be focused on those participants who are unlikely to attend, or decide not to attend a face to face service.
Model 3 Centralised Referral Hubs	Of the three proposed commercial models – Model 3 (centralised hub) was viewed as the most challenging in part because it may require a significant change in the delivery model at an early stage in the programmes overall maturity. There could be less clarity with Primary Care regarding this model and questions about whether this offers patients as seamless a journey. It may also introduce complexity in providing feedback to GPs on patient outcomes and progress. Some providers felt this could raise commercial risk as they would not have as direct control of the activity that comes to them
Payment Model	5% outcome payment judged on balance to be about right with agreement that further detail was required on how it would be measured and paid. There was discussion about the opportunities to raise retention and engagement across all services under this new framework and align this with an outcome based payment.

Table 2: Summary Feedback from Workshops	
Theme	**Comments**
Payment Outcomes	Providers discussed whether rather than paying the outcome payment on weight loss this could be based on improvements in blood glucose readings and / or increases in physical activity. It was noted that currently there are challenges in the sensitivity of existing physical activity tools to measure change. It was noted that if outcomes were paid on blood glucose readings NHS England would need to consider how readings would be taken in primary care (if bloods are removed under the new service specification) to support these payments.

6 Summary

A very informative event providing the suppliers with an insight to our potential requirements and current thinking, and NHS England with the markets initial views and feedback which is informative to NHS England's approach to the re-procurement of the provider framework.

NHS England wishes to thank all participants that attended the event for their generous and honest contributions and feedback that will shape the future re-procurement of diabetes interventions in England.

7 Appendix 1 – Agenda

Venue	**Midland Hotel** **16 Peter St, Manchester M60 2DS** **Phone: 0161 236 3333**	
Registration: 12.30pm	**Start: 13.00**	**Close: 16.30**

Item	Title	Speakers
1	**Welcome and outline of the day**	Tom Newbound NHS DPP Implementation Lead
2	**Commercial Procurement**	Jill Gomez Procurement Manager, Commercial Team
3	**Programme performance to date**	Matt Fagg NHS Diabetes Programme, Programme Director
4	**Diabetes UK User Insight**	Bridget Hopwood Programme Manager, User Engagement, Diabetes UK
5	**Digital Diabetes Programme**	Ben McGough NHS Diabetes Programme Data and Digital Lead
6	**Background to Re-procurement**	Matt Fagg NHS Diabetes Programme, Programme Director
7	**Context for Provider Consultation**	Martin Virr NHS Diabetes Programme Workstream Lead, Diabetes Prevention
8	**Panel Q&A** The panel will consist of colleagues from NHS England, Diabetes UK and Public Health England	Tom Newbound NHS DPP Implementation Lead
9	**Workshops** Discussions to focus on selected areas of the Consultation Documentation.	Delegates will be split into four groups and mixed so there is representation from core and digital providers in each group.
10	**Feedback from Workshops**	Tom Newbound NHS DPP Implementation Lead
11	**Summary and Next Steps**	Matt Fagg NHS Diabetes Programme, Programme Director

8 Appendix 2 - Supplier engagement event 16 April 2018 – Workshop session questions

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.

We've tried to ensure there is a mix of provider representatives in these sessions; so we get a range of views and opinions.
[NB: Scribes to capture feedback and where possible what type of organisation they represent]

Questions:

We would like to start by getting your feedback on the potential commercial models we outlined in the presentation earlier.	
1. What are people's thoughts on developing commercial partnership arrangements between providers: whether as consortia, lead and sub-contracting arrangements or other relationships to deliver Core and Digital services?	*What are people's thoughts on this approach; would your organisation be interested in delivering this way?* *What considerations would we need to take into account to implement such an approach?* *How long would providers need to develop partnership arrangements as part of a tender submission?* *Our proposal is that Remote Digital services would be an optional schedule initially; would this model be viable without guaranteed business for digital providers?*
2. What are people's thoughts on an alternative model, where primary care refers participants to a Core Service provider in the first instance to explain and offer choice and then onward refer to a digital provider? [NB: Core Service providers could be provided a flat fee for each referral processed regardless of the delivery option chosen]	*What are people's thoughts on this approach; would your organisation be interested in delivering this way?* *What considerations would we need to take into account to implement such an approach?* *How do providers feel about patients being "processed" by another provider initially; what would be needed to make this work?*
3. What are people's thoughts on the	*What are people's thoughts on this*

feasibility/desirability of establishing centralised referral hubs? [NB: These would likely be commissioned outside the framework and would explain the different service offers available and signpost individuals into appropriate services.	*approach?* *What considerations would we need to take into account to implement such an approach?* *How do providers feel about patients being "processed" by a separate call centre facility?*
4. A key principle we've outlined is that additional Core Service With Some Remote or Remote Digital prevention services should complement NOT undermine Core Services (As the Core Service has the most mature evidence base).	*What are your thought on how we best ensure that the (in person) Core Service is prioritised where remote and or digital services are also offered?* *What are the strengths and weaknesses of our different models in achieving this?* *How can we best manage the impact on local health economies of delivering these different 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. [NB: print outs of the proposed payment model available in rooms to refer to]	
5. What are people's views on a potential common payment profile for all providers for the • Current Service Core Service with some Remote Delivery • Remote Digital Service	*Are there issues with a joint payment profile that applies to all providers?* *Would a joint payment profile present issues under any of the commercial models discussed earlier?*
6. We've outlines a proposed to include a proportion of the payment to be linked to weight outcomes? *[NB: We've suggested 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.]*	*What are people's thoughts on a weight loss payment outcome?* *What considerations would we need to be aware of in implementing a weight outcome payment?* *Do people think 5% is a suitable threshold? Higher / Lower?* *What are peoples thoughts on the specific proposed outcome measure suggested?* *What other outcome measure payments should we consider?*

We are also interested in provider considerations to further improve access and retention.

7. 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? [NB: South Asian populations a 5-6 time greater risk of developing T2D]	*What approaches do people think would be effective?* *Have people got examples that have proved to be effective?*

NB: Support to prompt facilitator when approaching 10 minutes to end of workshop and 3/5 key points to be taken from discussions for the workshop feedback.

9 Appendix 3 – Payment model

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%