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Healthier You: NHS Diabetes Prevention Programme

Provider and Local Health Economy Engagement Framework 3 Procurement

Version 1, 1 April 2022

Contents

1. Introduction

As part of the development of Framework 3 of the NHS Diabetes Prevention Programme (NDPP), NHS England consulted on proposals relating to the re-procurement of the NDPP Framework.

The NDPP Framework 2 expires in April 2022 and has call-off contracts expiring in July 2022, March 2023 and November 2023.

Framework re-procurement provides an opportunity to continue to expand the scale of the programme, build on previous frameworks experience, evidence and learning, support patient choice and continue to improve access to the programme.

As part of the overall consultation process, engagement took place with local health economies, provider organisations and the public for views of service delivery within Framework 3. This document summarises the results of the provider and local health economy engagement.

2. Process of provider market engagement

A prior information notice (PIN) was published to inform suppliers of a market engagement event. This PIN included details of the service, along with a questionnaire that provided suppliers with the opportunity to participate in early market engagement by responding with their initial views.

The market engagement event took place on 8 July 2021. The closing date for the return of the questionnaire was 13 July 2021.

The provider questionnaire is in Annex A.

3. Aims of provider market engagement

The provider market engagement webinar and questionnaire provided an opportunity for us to:

- provide the market with background information on the NDPP, and details of the proposed re-procurement and timelines for framework 3, and;
- engage suppliers and consult on elements of the service and the various options for service delivery.

4. Programme for the event

The below table provides the outline of the day:

1	Welcome and introduction
2	Context and overview of the programme
3	Programme outcomes to date
4	Re-procurement drivers
5	Public engagement
6	Local health system engagement
7	Evidence review
8	Overview of procurement options and questions
9	Procurement process explained and timescales
10	Questions and closing comments

The full agenda can be found in Annex B.

5. Summary of provider responses

5.1 All providers thought providing choice of delivery method (eg whether to access the service through face-to-face in person delivery, remote video-conferencing or digital) was important and should be patient-led. However, there was some concern that offering too much choice may be unhelpful and potentially confusing for participants and for referring clinicians.

5.2 Most providers expressed the need for participants to be supported to understand the service offer and make the right choice for them; this could be achieved through:

- a triage process
- explanation of the benefits of each mode of delivery
- providing leaflets explaining service options.

5.3 There was consensus that the choice of channel to access the service should be explained to participants by the provider, rather than by primary care at the point of referral. However, it was highlighted that awareness of the various channels available could be useful at time of discussion regarding referral.

5.4 All providers recognised the need for face-to-face delivery as an option, alongside remote/digital channels for participants, although perceptions of the likely proportion who would choose each delivery method varied between face-to-face and digital providers.

5.5 Some concern was raised by current face-to-face providers that offering remote as a choice, alongside face-to-face and digital services may have an impact on the commercial viability of the face-to-face service by diluting referrals into the service.

5.6 Most providers would support national commissioning of groups that may have particular needs, for example British Sign Language, where in a single contract area, numbers in cohorts would be low and therefore potentially involve long wait times for specific groups to be held.

5.7 It was considered by several providers that remote delivery affords an opportunity to be innovative in delivery of the programme, for example offering

non-English speaking groups across broader national footprints where participant volumes would support further tailoring.

5.8 It was highlighted that national or pan-contract commissioning would enable appropriate expertise and support to be resourced to minimise inequality of service access to patient groups with specific needs. Some providers, however felt that local, face-to-face delivery was more effective in reaching these groups.

5.9 Challenges were expressed by most providers regarding obtaining validated weight for remote/digital participants. Participants have expressed concern to providers about needing to provide evidence of weight measures eg taking photos of their scales. Providers suggested that digital and remote services could request participants to attend one face-to-face session (subject to social distancing guidance) per milestone to obtain objective weight and height measurements. A range of alternative places for participants to be weighed, eg pharmacies, GP surgeries, gyms, were suggested by providers.

5.10 Most providers felt that self-reported weights should be used where face-to-face services are unavailable or need to convert to remote delivery mechanisms as part of COVID-19 response.

5.11 Most providers supported self-referral into the programme. Responses highlighted a particular need for self-referral when referral numbers are low.

5.12 There were mixed views on whether self-referral would improve equity of access to the programme. Incentives were suggested to encourage providers to engage at-risk participants and deliver targeted marketing. Providers flagged that this may incur additional costs.

5.13 Most providers considered that incentives and outcome-based payments aimed at reducing health inequalities was useful to focus activity and performance. It was suggested that these payment mechanisms could be further tailored to encourage uptake and retention.

5.14 Current digital providers raised concerns over engagement criteria underpinning milestone payments and requested equality of opportunity to offer digital services alongside face-to face providers.

6. Process of local health economy engagement

Consultation was carried out with local health economies via a survey on the NHS consultations platform.

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

7. Summary of local health economy responses

A total of 48 responses were received. Responses were received from 19 commissioning organisations (clinical commissioning groups/integrated care systems [ICSs]), 19 from GPs, four from local authority public health teams, two from NHS England and NHS Improvement regional teams, one working within specialist care, and three from other (including community pharmacy, Diabetes UK and an NHS trust).

7.1 Suggestions to ensure high quality, sustainable face-to-face delivery were maintained; included ensuring that venues are local and accessible. There were several recommendations to link in with primary care networks and GPs and look to provide face-to-face sessions in local healthcare settings, so that venues are local and familiar.

7.2 Most respondents supported the delivery of face-to-face, remote and digital delivery and felt that there should be patient choice on which delivery method would be most suitable for them. It was deemed important to explain the different offers and benefits of each option to participants to support informed choice.

7.3 Suggestions of support that could be useful for identifying and referring patients included: training, webinars, utilising and publicising of GP system search criteria, using external staff such as engagement officers to support searches and reimbursement for referral activity.

7.4 Looking to expand the referral routes into the programme was suggested by a high proportion of respondents, including continuation of self-referral, referrals from secondary care and broader primary care partners including community pharmacy.

7.5 Respondents indicated that when selecting a provider to operate within their ICS it was important to understand providers engagement plans, their willingness and ability to undertake localised engagement, how they would link with local community groups and their previous performance. A high proportion of respondents wanted providers to offer language specific groups, demonstrate an understanding of the local population/area (eg culture, demographics and rurality) and tailor their services flexibly and appropriately.

7.6 Several respondents have said that the providers should seek to further integrate with and have experience of working with GP IT systems. Having experience to put in place simple approaches for GPs to refer to them was particularly important.

7.7 The vast majority of respondents thought that commissioning tailored remote services, across ICSs or nationally, for groups with particular needs, would be beneficial. Nine were unsure and two respondents did not answer this question.

7.8 Respondents thought that tailored remote services would be most beneficial for those where English is not the first language and those with hearing or visual impairment. Remote tailored services were also suggested for those who work shifts/long hours, those with busy lifestyles and caring responsibilities.

7.9 Advantages of a single lead provider across an ICS, included a single point of contact, clarity for the system and a consistent message for primary care. It was suggested that relationship building is time consuming and this is easier when there is a single lead provider.

7.10 Disadvantages of a single lead provider included a lack of clarity with what is happening with other providers or within other parts of the service, which could lead to bias and a lack of control and visibility over which patients are offered different parts of the service not delivered by a lead provider, eg face-to-face or digital.

7.11 There were varied opinions on frequency of reporting participant progress back to referrers; the most suggested frequencies were monthly or quarterly. A number of respondents suggested that key milestones should be shared back to the GP. What was deemed a key milestone differed by respondent, but there was broad agreement on the following: at the start and end of a programme, upon participant drop out and reaching a target weight.

7.12 National support suggested included: more communications and marketing of the NDPP (including Gestational diabetes mellitus eligibility), ensuring flexibility and localisation of services and regular monitoring of providers.

8. Summary

The market and local health economy engagement has provided us with views and feedback which supports the approach to the re-procurement of Framework 3.

We value the insight and contributions of all providers who attended the market engagement event and to all providers and health system stakeholders who provided written responses.

Annex A: Market provider engagement questions

1. Choice

At the start of the COVID-19 pandemic, all NDPP face-to-face sessions were paused and instead delivered remotely through group video and teleconference sessions. All new joiners were given a free choice of these or the digital version of the programme.

Informed participant choice can underpin good uptake to, and retention on, services. However, we need to identify what choices should be offered that improve uptake and retention.

1. How can choice of different delivery methods be offered to service users to improve access and up-take?

2. How should the different delivery methods be described to participants and how can they be supported to make appropriate choices and maximise uptake?

3. How can choice be offered to ensure services remain accessible to all, particularly for those who cannot or will not engage remotely, and that choice offers equity of access?

4. How would you ensure participant choice is free from commercial or operational bias?

5. How can we ensure participants who cannot or will not use video conferencing are able to catch-up if they miss a face-to-face session?

2. Intervention

Diabetes UK insight suggests whilst many prefer face-to-face, others welcome benefits of remote and digital and are more confident using them.

However, a proportion of people have no IT access, capability or home life to use them. We know that face-to-face has evidenced good outcomes and scale and this must remain a core offer to all who want it.

To improve access and equity of access for groups who face health inequalities, there may be opportunities to deliver more sustainable and accessible tailored services remotely at a multi-ICS, or national level, as participant volumes will be greater.

1. What are your views on how and under what circumstances the following delivery methods should be offered?
    - Face-to-face group sessions
    - Remote video-conference group (as catch up to missed session)
    - Stand-alone remote video-conference service group sessions (with telephony delivery for those who cannot access video)
    - Digital (online and/or app-based delivery models)

2. To what extent should delivery of remote sessions be different to face-to-face whilst still delivering the same content? For example: contact time, group sizes, and session lengths?

3. Assuming people have a free choice of delivery method what do you think the likely population split between them would be?

4. Face-to-face must be available and accessible to all, how can we ensure quality of delivery and sustainability in delivering face-to-face when offering other delivery methods?

5. A significant proportion of people referred to the programme may not have access to IT, have the capability to use it or home circumstances that enable them to join remotely or digitally. How can we ensure equality of access?

6. To what extent should we commission services across contracts or nationally to tailor services for groups who face health inequalities to support equity of access? What are your thoughts on how this should be commissioned?

3. Outcomes

One of the expected outcomes of the programme is reduction in weight of service users where they are overweight or obese, and the maintenance of a healthy weight. We need to ensure accurate data collection for all participants; including those accessing the programme remotely and digitally.

1. How can weights and heights be collected and recorded from participants for the remote or digital channel, to maximise the collection of quality outcome data? To what extent do you think providing incentives to service users is of value?

4. Self-referral

At the start of the COVID-19 pandemic referrals into the NDPP reduced by 85%, due primary care pressures and reduced access to blood testing. A self-referral pathway was rapidly implemented, for a fixed time, to enable continued access to the NDPP where GPs were unable to refer into the programme.

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2. How do you think eligibility for self-referral could be established?

5. Payment models

The programme runs over a minimum of nine months and it is important to ensure as many people complete the programme. The programme needs to continue successfully reaching those with greater risk of developing Type 2 diabetes and those who typically face greater barriers in accessing care eg men, people from minority ethnic groups and people living in areas in the most socioeconomically deprived quintiles.

1. How might payment/outcome payment options be used to improve retention and address health inequalities?

Annex B: Agenda for market engagement event

Date: 8 July 2021		
Venue: MS Teams webinar		
Start: 10am		**Close:** 12pm
Item	**Title**	**Speakers**
1	Welcome and introduction	Tom Newbound Director NHS Diabetes Programme
2	Context and overview of the Programme	
3	Programme outcomes to date	John Kernan Commissioning Programme Manager
4	Re-procurement drivers	
5	Public Engagement	
6	Local Health System Engagement	
7	Evidence review	
8	Overview of procurement options and questions	Martin Virr Deputy Director NHS Diabetes Programme
9	Procurement process explained and timescales	Natalie Hailwood Procurement Manager
10	Questions and closing comments	Tom Newbound Director NHS Diabetes Programme

Annex C: Local health economy engagement questions

1. Which of the following categories best describes your place of work? If you have selected Other please specify.

2. Please state your role at your place of work.

3. Insights from Diabetes UK suggest that while remote delivery suits many people, it does not suit all. Face-to-face delivery has the greatest evidence base and has demonstrated good outcomes but requires sufficient numbers to allow viable groups to form without long-waiting times within a geographical area.

    a. Do you have any suggestions on how we could balance offering choice of different channels of delivery to potential participants while keeping face-to-face services sustainable and high-quality?

    b. Could you provide any local data or insights from services in your area (not the NDPP) regarding the split in numbers taking up face-to-face and digital/remote channels where these are both available?

4. The COVID-19 pandemic required the NDPP to move from face-to-face delivery to a fully remote service offering group video and/or teleconferencing sessions (alongside an App/web-based digital offer). What choices do you think we should offer once face-to-face services are able to safely resume?

5. Identification and referral into the NDPP of people at high risk of Type 2 diabetes has predominantly been through GPs. Do you have any suggestions on how we can support GPs with identifying and referring people at high risk of Type 2 diabetes?

6. Provider engagement with local systems is key in ensuring the NDPP meets the needs of the local population. Under current arrangements, an ICS would

select a provider, having assessed prospective providers' proposals for how they could tailor delivery to meet local needs.

   a. What information from providers would be most useful to help you assess how well they could meet the needs of your local population?
   b. What information from providers would be most useful to help you assess how well they could meet the needs of your potential referrers in GPs?

7. To improve access for certain groups (such as those speaking a particular language), there may be opportunities to deliver more sustainable tailored services remotely at a multi-ICS, or national level, due to the advantages of scale.

   a. Should we commission tailored remote services, across ICSs or nationally, for groups with particular needs?
   b. What are the advantages/disadvantages of commissioning tailored remote services at a multi-ICS level or nationally?
   c. Which particular groups in your area do you consider may be most likely to benefit from the offer of such remote tailored services?

8. Each system currently has a single lead provider for the NDPP. Discussions with people referred to the programme about modes of delivery (ie remote or digital) take place with the lead provider while services may be delivered by different providers (ie may be a different provider for the digital service). Systems will usually only directly interact with the lead provider. What are the advantages and disadvantages of having a single lead provider for an ICS rather than multiple providers interacting directly with the system?

9. Participant progress on the programme is usually reported to the GP at key points on the programme (subject to local arrangements).

   a. What do you think is the ideal frequency of reporting directly to the GP regarding each participant?

   b. What other data would be useful for you to receive (and in what format) to help your understanding of how well the programme is meeting the needs of your population?

10. What else can we do to support you in working with your NDPP provider to overcome any challenges and ensure a high-quality service that meets the needs of your population?

11. Please share any other thoughts or feedback to help us improve the programme

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