East Midlands Clinical Networks

NHS Diabetes Prevention Programme Briefing Paper

May 2016

Healthier You: the NHS Diabetes Prevention Programme will start this year with a first wave of 27 areas covering 26 million people, half of the population, and making up to 20,000 places available. This will roll out to the whole country by 2020 with an expected 100,000 referrals available each year after.

Introduction and Overview

This paper aims to provide all stakeholders with information on the NHS Diabetes Prevention Programme (DPP). The paper also sets out the key deliverables for Clinical Commissioning Groups in implementing the programme locally.

Background

The NHS Diabetes Prevention Programme is a national programme being led by NHS England, Public Health England and Diabetes UK. The NHS 'Five Year Forward View' and Public Health England's 'Evidence into Action' set out a joint ambition: "to be the first country to implement at scale, a national evidence-based diabetes prevention programme", which will be linked where appropriate to the NHS Health Check programme.

The NDPP will deliver at scale an evidence-based behavioural programme focused on achieving healthy weight, increasing physical activity and improving the diet of those individuals identified as being at high risk of developing Type 2 diabetes.

It is intended to support people to take control of their own health to reduce the risk of developing Type 2 diabetes. The long-term aims of the NHS DPP are:

- To reduce the incidence of type 2 diabetes
- To reduce the incidence of complications associated with diabetes - heart, stroke, kidney, eye and foot problems related to diabetes
- Over the longer term, to reduce health inequalities associated with incidence of diabetes

Implementation

The call for Expressions of Interest received a strong response with 60 EOI submissions from a total of 168 CCGs and 132 LAs.

East Midlands Clinical Network worked with CCGs and local authority partners to submit a collaborative Expression of Interest to participate in Wave One of the NDPP. East Midlands has been successful in being selected as a wave one site. The East Midlands partnership covers:

Leicester, Leicestershire & Rutland

- Leicester City CCG Leicester City CCG
- East Leicestershire & Rutland CCG
- West Leicestershire CCG

Nottinghamshire:

- Nottingham City CCG
- Mansfield & Ashfield CCG

- Newark & Sherwood CCG
- Nottingham North & East CCG
- Nottingham West CCG
- Rushcliffe CCG

Northamptonshire:

- Nene CCG
- Corby CCG

The first phase of national roll out will commence in 2016/17, working with 27 sites to implement DPP services within their geographies, making the service available to approximately 26 million people. Future years will allow further phases of roll out in new areas. Full national roll out is planned for 2018/19 which is expected to provide 100,000 places on behavioural interventions available each year.

The East Midlands Partnership aims to provide 2,152 places in 2016/17 and 3,216 in 2017/18.

Referral Routes

It is anticipated that the main route for referral onto the diabetes prevention programme will be through:
• Existing GP Practice registers
• NHS Health Checks

Other sources could include:
• Potential for opportunistic case finding
• Publicity and media campaigns
• From Care Coordinators/Health Trainers etc.
• Awareness campaigns.

There may also be the opportunity for the provider of the Diabetes Prevention Programme in East Midlands to offer direct recruitment with the aim of increasing the number of people accessing the programme and specifically targeting priority groups including people from ethnic minority groups and those living in deprived areas. This is currently being explored with NHS England.

Programme Eligibility

The programme will be available to

- Individuals identified as having non-diabetic hyperglycaemia, defined as having an HbA1C reading of 42- 47, or a fasting plasma glucose (FPG) of 5.5 – 6.9 mmol/l
- For individuals referred onto programmes by a GP or via NHS Health Check, an HbA1c or a FPG test must have been undertaken within 12 months prior to referral

The programme service specification stipulates that the following individuals must be excluded from the service:

- Individuals with blood results confirming a diagnosis of Type 2 diabetes
- Individuals with a normal blood glucose reading on referral to the Service
- Individuals aged under 18 years
- Pregnant women
- Individuals receiving palliative care

Demonstrator Sites

During 2015-16, seven 'demonstrator' sites have been trialling different models of finding people known to be at high risk of diabetes and helping them change their lifestyles through a diabetes prevention programme. Learning has been taken from these sites to inform the development of the national programme.

Demonstrator sites' experience has provided valuable learning on case finding, primary care engagement, recruitment, retention and adherence, and service delivery. Demonstrator sites are seeing significant improvements in performance over time, with a 50% increase in volume of referrals and uptake of the intervention at the end of December 2015 compared to November 2015.

All demonstrator sites will continue with a DPP in 16/17: Birmingham, Bradford, Salford and Medway will continue with their existing local services, continuing to generate programme learning. Durham, Medway and Southwark will engage with national providers from the framework.

Procurement

The programme is being procured centrally by NHS England, and delivered by up to four national providers on a national framework.

Following a mini competitions to call off against the national framework, East Midlands Partnership was able to evaluate against our local prospectus and a set of criteria which of the national providers is most suitable to deliver in our area. The provider that has been selected in East Midlands is Ingeus in partnership with Leicester Diabetes Centre (LDC).

Ingeus is a leading provider of large-scale, complex services across health, employment, skills and rehabilitation services. LDC is an internationally recognised applied research centre hosted by the University Hospitals of Leicester NHS Trust, and a leader in diabetes prevention programme design and evaluation. Ingeus and LDC have formed a partnership to bring LDC's evidence-based diabetes intervention to scale across England.

Ingeus and LDC are also partnering with LloydsPharmacy to provide blood testing services (HbA1c and Fasting Plasma Glucose) from LloydsPharmacy outlets. NDPP participants are required to undertake a blood test before commencing the programme (if their initial blood test is more than 3 months old); 6 months into the programme; and again following completion.

Outline of the Diabetes Prevention Programme

The programme to be delivered by Ingeus and LDC has been designed by LDC's multi-disciplinary team of clinicians, researchers and NHS managers, and is based on an extensive body of evidence. It consists of thirteen 90-minute sessions, including four weekly core sessions followed by nine monthly maintenance sessions. Sessions will be held in groups of up to 15 participants, alongside accompanying friends or family members, conducted by an LDC-trained educator. Sessions will be delivered from accessible community locations, close to public transport, including community halls, religious centres, leisure centres, libraries and GP practices.

The programme is based on an underpinning philosophy of empowerment, which sees the participant as capable and responsible for their own health decisions and behaviours. This philosophy uses non-didactic, facilitative educational methods and recognises that participants have insight and expertise regarding their food choices and activity.

The curriculum will cover:

- Understanding of type 2 diabetes risk factors, related directly to individual participant's lives
- Individual goal-setting and action planning
- Healthy eating

- Physical activity
- Strategies for adopting healthier lifestyles as part of daily routines
- Overcoming challenges and managing setbacks

The programme will be tailored to each participant's specific personal and cultural circumstances, focussing on each person's beliefs, contexts and individualised goals. Ingeus and LDC will also adapt the curriculum for particular needs and preferences, including for different cultural groups, language requirements and personal circumstances such as mental illnesses or intellectual disabilities. LDC has extensive experience adapting its interventions for different needs while retaining fidelity to programme design, philosophy and evidence.

Throughout and beyond the intervention, participants will receive additional support and resources including:

- Website providing general type 2 diabetes prevention resources, a service directory listing local sources of support, and access to an e-learning platform, aligned to the curriculum. E-learning platform includes a dashboard to track weight, diet and physical activity; ability to view and update personalised goals and action plans; and, synchronisation with wearable physical activity self-monitoring devices (e.g. Fitbit, Fitbug, Garmin).
- Regular contact from our Contact Centre including session reminders and positive reinforcement to support retention and motivation.
- Free phone access to Contact Centre for brief information, advice and guidance about type 2 diabetes, risk factors, lifestyle and behaviour change, and local sources of support

Implementation of NDPP in East Midlands

CCGs participating in the East Midlands Partnership have set individual targets on the number of referrals to be made to the Diabetes Prevention Programme. These were submitted as part of the prospectus and inform the contract with the provider on number of patients who will uptake the diabetes prevention programme. Two levels of uptake have been assumed 25% and 40%.

The East Midlands Partnership is the one of the largest sites involved in Wave One. An East Midlands Diabetes Prevention Implementation Steering Group has been established to oversee implementation with appropriate representation from all partner organisations (see appendix 2). East Midlands Clinical Networks has agreed to be the lead co-ordinating organisation for the partnership and will co-ordinate the implementation process working closely with CCGs and local authorities.

The programme lead within East Midlands Clinical Networks is:

Martin Cassidy, Network Senior Quality Improvement Manager martin.cassidy@nhs.net

Mobile No. 07917 080651

Timetable for Implementation

End of April	NHS England to agree Contract with identified provider
May/June	Diabetes Prevention Educational Meetings
From 25 July	First referrals submitted to provider from: Nottingham City CCG, Leicester City CCG, East Leicestershire and Rutland CCG, West Leicestershire CCG
From 25 August	First referrals submitted to provider by remaining CCGs in East Midlands Partnership

CCG Requirements to support implementation

Whilst the Diabetes Prevention Programme is funded by NHS England, CCGs and local partners will be responsible for the costs associated with case finding and generating referrals to the provider.

All CCGs have signed the Memorandum of Understanding with NHS England for the NDPP which commits the CCGs to supporting successful implementation locally. This includes:

- Have an identified manager lead to co-ordinate implementation and GP practice engagement
- Have an identified clinical lead to act as clinical champion for diabetes prevention and to support engagement of GP practices
- Integrating the NHS DPP into the local care pathway
- To have in place local infrastructure to find and refer people at high risk of Type 2 diabetes in line with eligibility criteria to the diabetes prevention programme. A pre-requisite for this is to have established robust registers within all GP practices of patients at high risk of diabetes
- Working with general practices, the local NHS Health Check providers and wider stakeholders to identify and refer eligible individuals identified as having non-diabetic hyperglycaemia onto the NHS DPP
- Co-operating with the NDPP provider to agree and manage the process of referrals, including appropriate data processing / data sharing agreements where required
- Ensure referral of the agreed number of patients to the Diabetes Prevention Programme in line with the profile projections submitted by the CCG for 2016/17 and 2017-18 (see table below)
- Co-ordinate the collation of information on invitations via mailshot or other methods and number referrals onto NDPP made by individual GP practices
- Coordinating local communications whilst adhering to national communication and branding requirements for the NDPP

Incentivisation of referrals

Some CCGs have used Local Incentive Schemes (or LCS) to support the detection and management of patients at high risk of diabetes (non-diabetic hyperglycaemia) where practices are required to create and manage a register of patients and support onward referral to the national DPP. This has been used to support:

- Clinical time to clean the high risk lists to exclude those who may not be suitable for referral e.g. pregnancy, terminal illness;
- Clinical time to support annual review of patients who are high risk of diabetes to explain their risk and invite them to attend the DPP;
- Administration time for sending out referral mail shots;
- Cost of postage for mail shots.

Funding to support Implementation

In 2016-17, NHS England has offered East Midlands Partnership £118,000 non-recurrent funding to support sites in the implementation of NDPP. How this funding is utilised will be agreed through the East Midlands Diabetes Prevention Steering Group. In addition to this East Midlands Clinical Networks has already allocated funding to CCGs to support the establishment of registers of patients at high risk of diabetes, implementation of a local diabetes prevention pathway and support implementation of NDPP.

Referral & Uptake Profiles

The number of referrals to the diabetes prevention programme that CCGs in East Midlands have committed to making in 2016-17 and 2017-18 is 5,380 in year 1 and 8,040 in year 2. The contract with the DPP provider has been based on an estimated 40% uptake in each year.

		Total referral	Lower uptake 25%	Upper uptake 40%
	Q1	466	117	186
	Q2	1,383	346	553
	Q3	1,689	422	676
2016/17	Q4	1,842	461	737
	Q1	2,013	503	805
	Q2	2,013	503	805
	Q3	2,007	502	803
2017/18	Q4	2,007	502	803
	Y1 TOTAL	**5,380**	**1,345**	**2,152**
	Y2 TOTAL	**8,040**	**2,010**	**3,216**
	Total Both Years	**13,420**	**3,355**	**5,368**

The total referrals of 13,420 to the programme equates to:

- 38 patients being referred to DPP by each of the 359 GP practices in East Midlands over 2 years
- 5% of the estimated number of patients with non-diabetic hyperglycaemia in East Midlands (based on PHE estimate) (2% in Year 1 and 3% in Year 2).

Uptake onto the DPP is estimated at between 25% and 40%. Based on a 40% uptake of the programme by referred patients equates to 5,368 patients in East Midlands accessing the diabetes prevention programme over the 2 year period. This equates to 15 patients taking up the programme from each of the 359 GP practices in East Midlands.

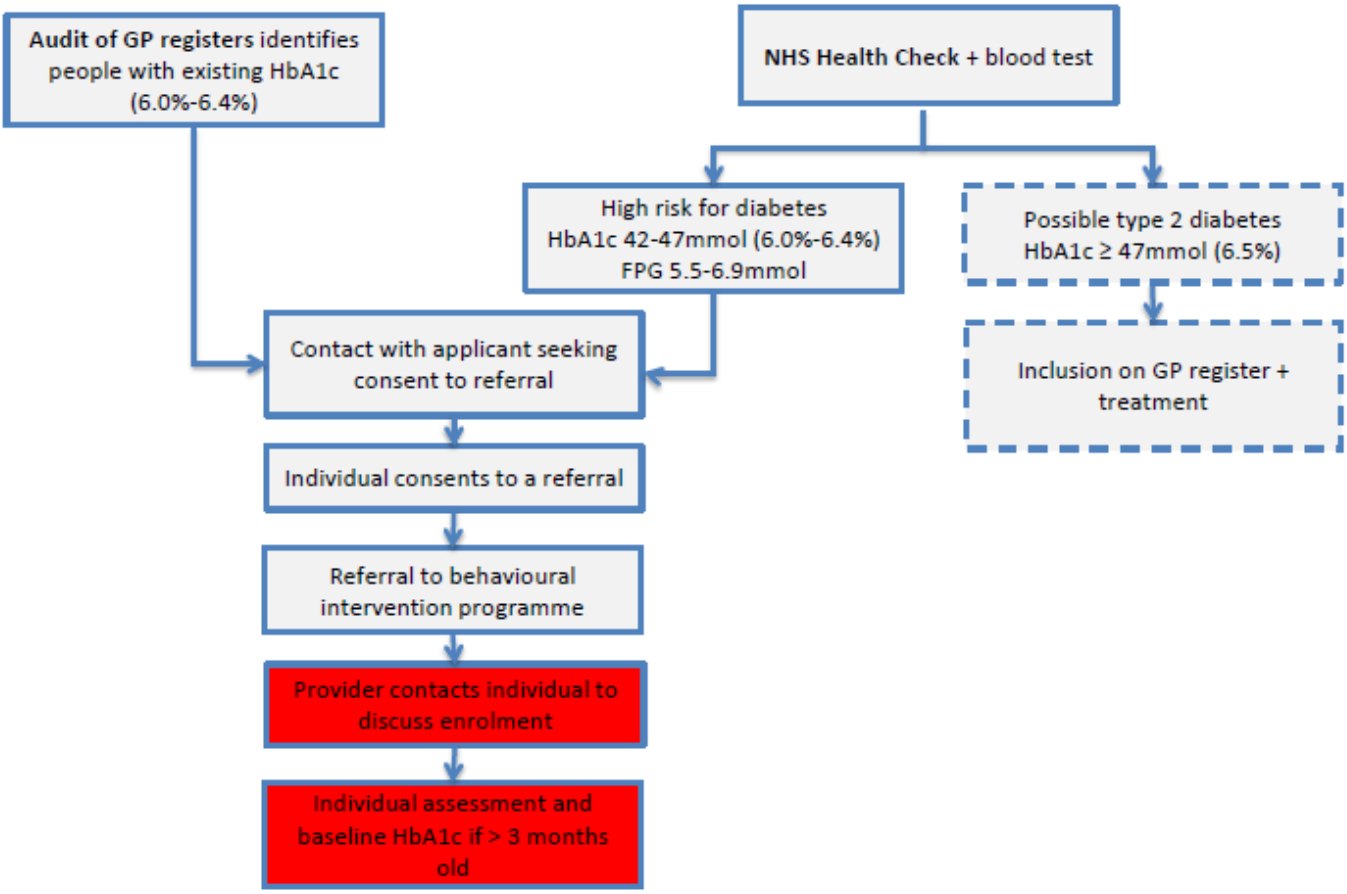
Martin Cassidy

Network Senior Quality Improvement Manager

East Midlands Clinical Networks & Senate

May 2016

Appendix – Diabetes Prevention Pathway



Appendix 2 – East Midlands Diabetes Prevention Steering Group – Terms of Reference

<table>
<tr>
<td>Frequency: Monthly – Tuesday 1-3
Duration: 2-3 hours
Location: TBC
Chair: TBC
Review date: Sept 2016</td>
<td>Constitution and Authority:
Established by: East Midlands Clinical Network (NHS England) with partner organisations
Reporting into: EMCN, NHS DPP team, NHS England Central Midlands & North Midlands
Receives reports from: Programme leads, all participating organisations tbc</td>
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<td>Objectives:
To provide the strategic leadership and coordination to the NDPP implementation across the CCGs as part of the East Midlands collaboration and to share learning across all CCGs in East Midlands
To provide decision-making forum for provider implementation
To provide the national team and agreed provider with a single point of contact
To support implementation with provision of programme management and review of progress
To agree referral and uptake numbers and associated annual profiling
To agree communication and reporting pathways
To share learning
To identify specific issues for feedback to the national team
To receive, agree and provide regular reports on implementation to CCGs/LAs and national team
To manage risks and issues collaboratively with the agreed provider
To support development of communication materials for use across the partnership</td>
<td>Inputs:
Referral and uptake numbers
Risks and issues
Individual organisation learning
Provider issues
Outputs:
Regular reports on implementation as required to relevant bodies/teams
Agreed referral pathways
Shared learning
Management/mitigating actions for risks and issues
Retention and feedback from CSU on provider performance
Equity</td>
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<tr>
<td>Attendees:
Nominated diabetes commissioning from all participating CCGs across East Midlands CCGs
Nominated Public Health leads from Local Authorities
Public Health England
East Midlands Clinical Network
Diabetes UK (Peter Shorrick – Virtual Member?)
Providers
Patient Leaders/Lay Representatives through CCGs</td>
<td>Escalation action:
East Midlands Clinical Network
NHS DPP team
Participating organisations
NHS England Central Midlands & North Midlands
Local Authorities (health checks)
Quoracy
An individual representative from each partnership should be in attendance (either commissioning or public health)</td>
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