



Introduction to and supporting documentation for VALUE BASED TRANSFORMATION FUNDING SITE SELECTION

December 2016

Introduction and Contents



The Planning Guidance for 2017-2019 set out that NHS England would:

- 1. Use the Best Possible Value framework approach to assess all transformation investment decisions.
- Run a single co-ordinated application process to minimise the administrative burden on local areas who would be
 applying for funding. This single coordinated application process will support NHS England to make best possible
 value investment decisions.

<u>Sustainability and Transformation Plans (STPs) are central to this process and all bids should be explicitly linked to the relevant local STP plans</u>

For each national programme there is a set of Call to Bid documents which follow the same approach and outline:

- 1. A clear set of interventions with supporting evidence base that the national programme is looking to fund.
- 2. The parameters to funding, governance and delivery requirements.
- 3. How the Best Possible Value framework approach has been applied to the national programme's interventions and how the framework will be used to appraise the bids received.
- 4. A standard application form for all interventions within a programme which is aligned to the appraisal criteria. The Call to Bid documentation and application forms are set up such that applicants only have to fill in the sections applicable for the interventions that they wish to bid for.

This document sets out the Diabetes interventions which have transformation funding from NHS England.

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Interventions to be funded



1. Improving uptake of structured education (SE) by both the prevalent and newly diagnosed population

- SE improves patient outcomes by enabling patients to understand what they need to do to keep themselves healthy.
- Good evidence to support its effectiveness in promoting better glycaemic control.
- Good evidence for cost savings that significantly exceed the cost of putting expanded SE provision in place. These cost savings are increased further by making SE available to all patients with diabetes, not just the newly diagnosed.
- Significant room for improvement to increase take-up of structured education. The current nationally reported take-up is only 5.7% of patients newly diagnosed with diabetes.

2. Improving the achievement of the NICE recommended treatment targets (HbA1c, cholesterol and blood pressure) and driving down variation between CCGs and between GP practices.

- Achievement of the treatment targets leads to better patient outcomes.
- Better treatment target control reduces the risk, and delays the onset, of expensive complications.
- There is variation in achievement of the treatment targets between CCGs and between GP practices that cannot purely be explained by differences in the populations.

3. Reducing amputations by improving the timeliness of referrals from primary care to a multi-disciplinary foot team (MDFT) for people with diabetic foot disease.

- Significant morbidity and mortality are associated with diabetic foot complications; good evidence for MDFTs reducing the rate
 of amputations and reducing the need for hospital admissions of people with active foot disease.
- Good evidence for cost savings that significantly exceed the cost of putting multidisciplinary footcare teams in place.

4. Reducing length of stay for inpatient's with diabetes by the provision of Diabetes Inpatient Specialist Nurses (DISNs)

- Good evidence for DISNs reducing the length of stay for inpatients with diabetes .
- Good evidence for cost savings that significantly exceed the cost of putting DISNs in place.

Proposed share of funding for each intervention	
Structured education	£10m
Treatment targets	£17m
Multi-Disciplinary Footcare Teams (MDFTs)	£8m
Diabetes Inpatient Specialist Nursing Teams (DISNs)	£8m

Parameters to Funding, Governance & Delivery



- All bid participants must have agreed control total before any transformation funds will be released.
- The bids must be explicitly linked to Sustainability and Transformation Plans. Governance of delivery will also need to be cross-system.
- The funding available is <u>revenue only</u>; There is <u>no capital funding available</u>. Where a bid is also dependent upon capital availability, it will be necessary to describe the quantum and your arrangements to access the capital funding in your application.
- The funding available is for transformation funding in 2017/18 and provisionally in 2018/19, subject to confirmation. However the template also asks for projections of funding requirements and savings for subsequent years. This is both to reflect that the evidence demonstrates savings that emerge from implementation for different aspects of the programme will emerge over different timescales and so to allow overall modelling to be set out. It is also to give an indicative sense of any modelling assumptions of transformation funding beyond 2018/19, should this be available.
- To be eligible for funding, interventions must be aimed at <u>implementing the objectives of the National Diabetes Treatment</u> and Care Programme.
- The requested funding must be spent in order to deliver the aims and objectives of each intervention.
- Bids will be accepted from individual CCGs or groups of CCGs. Groups could be based around an STP or provider footprint.
- Please note, that potential applicants in the <u>Greater Manchester devolution area are not eligible</u> for this application process, as they have received a proportion of the funding through the funding top slice for Greater Manchester.
- Bids should be jointly agreed with relevant providers before submission and should also have evidence of primary and secondary care clinical support and patient support. Bids should be agreed via the relevant governance processes for each partner.
- Bids should include details of an identified Senior Responsible Officer, clinical lead and implementation leads across the partners within a bid.
- In return for funding:
 - Applicants will be required to sign up to the programme financial governance and monitoring arrangements (guidance on this will be issued with the funding decision).
 - We are expecting delivery of outcomes as outlined in the logic models on pages 10, 15, 20 and 25.

Why use a Value Framework?



The Best Possible Value framework is a standardised framework which aims to place consideration of value to population, to patient and to taxpayer at the heart of decision-making, enabling NHS England to evaluate and compare different options using an evidence based methodology.

The value framework will:

- Identify the evidence base upon which the programme and interventions are built.
- Allow the consistent comparison and monitoring of value across the applicants.
- Support the appraisal panel and the NHS England Investment Committee to allocate investment to applicants in a robust, value-based manner.
- Enable the applicant to bid for funding in a clear, objective manner.

The key steps in the value framework approach are set out in the picture on page 6. The programme has been through steps one to three to create programme specific value equations, logic models and a set evidence base which supports the intervention they wish to fund. These tools have then been used to create value based appraisal criteria. Bidders are encouraged to use these tools and the appraisal criteria to develop their application. Once received the application will be scored against the criteria and an appraisal dashboard and prioritisation matrix will be generated to inform the investment decision.

The Best Possible Value framework was developed through the Future Focused Finance programme. More information about the wider Best Possible Value programme can be found on the Best Possible Value Website http://bpv.futurefocusedfinance.nhs.uk/

Value Framework Process - Key Steps



1 Value Equation

What are the elements of value that the invention may seek to generate?

Logic Model

Evidence Base 4 Appraisal Criteria 5 Application 6 Bid Appraisal

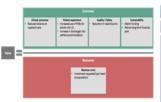
What is the programme and how does it deliver value?

What is the evidence base and how will we track success?

How will we appraise bids?

Bids Submitted

Output - scoring generates appraisal dashboard and prioritisation matrix













What are the **key** components driving value for the early adopter?

- Outcomes? (clinical, patient experience. safety/quality, financial sustainability)
- Resources to put model in place? (revenue / capital costs, staff)

What value generation assertions underpin each element?

> Elements of the plan delivering value?

For each element. what evidence of value generation exists?

> What further evidence is required to prove value ?

How will success be measured?

- Which metrics and targets are we going to use to track value?
- When will they be realised?

Appraisal Criteria has been developed based on the outputs from steps 1 to 3.

This appraisal Criteria assesses applications against strategic consideration, value, and risk in a robust objective manner.

Bidders should apply the outputs of step 1 to 3 of the value framework as set out in this pack to their applications.

Standard applications forms have been provided for each programme.

- The appraisal of the applications will result
 - **Appraisal** dashboard illustrates all applicants results against the appraisal criteria.
 - **Prioritisation** matrix maps all applicants graphically
- · These outputs will be used to identify the best value investments

This Call to Bid document sets out how we have applied the value framework to this specific programme

Bid Requirements and Timeline



- Please fill out both part A (the excel finance and metrics template) and part B (the word document) of the application form for each intervention you are bidding for.
- Within the application form you will see that we have automated the Return on Investment calculation for each intervention. If you wish to take a different approach (using other local evidence) please contact us for an appropriate sheet for this.
- Bids should be submitted to england.diabetestreatment@nhs.net

National programme **specific webinars** will be set up:

- 1. To help applicants to understand the Best Possible Value framework.
- 2. How to best apply this to their applications.
- 3. To provide additional information such as additional evidence and the scoring system for each intervention.

Bidders should contact the programme on england.diabetestreatment@nhs.net for further information.

Date	Action
2 nd December 2016	Process launched and Call to Bid documents published
December 2016	Support provided to bidders through Webinar sessions for each programme
18 th January 2017	Submissions deadline for bidders
February 2017	Investment Decision taken by NHS England Investment Committee
End February/March 2017	Notification of investment decisions



Intervention 1

Improving uptake of structured education

Value Equation for Improving uptake of structured education



Outcomes

Clinical outcomes

Improving outcomes for those with diabetes through increased attendance at structured education courses

Patient experience

Patients feel confident to manage their own care

Safety/Quality

Structured education services adhere to NICE guideline

Sustainability

Commitment and ability to fund service after transformation funds are withdrawn

Value

Resources

Revenue costs

Income, time, salaries, system maintenance

Non-financial

Time of existing staff

Logic Model for Improving uptake of structured education Inputs



Resources

- National diabetes funding: - Transformation funding
- Existing allocated funding
- QOF funding
- · Local diabetes funding
- · Qualified and competent healthcare professionals
- · Qualified and competent educators

Local

- · Local diabetes population health needs
- · Current local attendance at structured education courses
- Local providers: GP and community services, and resourcing levels
- Local systems for recording attendance at structured education courses
- · Local pool of qualified and capable education professionals
- · Local structured education courses and local providers
- · Local commissioning and contracting frameworks
- Local and regional diabetes community groups /champions

National

- · National policy, including expectation to improve attendance at structured education courses
- National systems for recording attendance at structured education courses
- · NICE Guidelines and quality standards (NG28, NG17)
- · NICE care pathway
- National structured education courses and national providers
- · National case studies and learning from experience
- Best practice care planning

Assessment of requirements

- · Engagement with nearby CCGs, and necessary providers re desire to improve attendance - at structured education
- · Carry out a diabetes health needs assessment to understand local population for improving attendance at structured education courses
- · Understand existing local capability and capacity to deliver the required improvement
- Gap analysis:
- Current attendance at structured education
- Anticipated increase in attendance

Enablers

- · Local leadership and governance; local governance group to drive improvement
- Ensure the necessary infrastructure for increased delivery and reporting of structured education are in place, including standardised data collection and coding (working with NDA)
- · Agree implementation plan outlining timescales and costs - with providers

Commissioner-led activities

- · Agree a strategy to increase attendance at structured education courses; utilising patient and clinical input to overcome any barriers
- Commission multiple flexible (audience, timing) and location) delivery models that meet NICE criteria and the needs of the local population
- Involve local diabetes patients in the design and provision of local programmes
- · Ensure structured education is explicitly included as a integral part of the local diabetes primary care pathway
- · Agree an internal and external comms strategy to promote courses both to healthcare professionals and directly to diabetes patients
- Enable patients to self-refer to courses
- · Develop an effective referrals process; using electronic administration systems, enabling easy booking and sending reminders.
- · Agree a SLA and KPIs with providers, including referral, attendance and completion rates, and a patient feedback system
- Consider implementing an appropriate incentive scheme to drive improvement

Primary care activities

Activities

- Ensure all appropriate patients are referred to structured education at time of diagnosis (type 2), or within 6-12 months of diagnosis
- · Encourage all patients to attend a structured education course; and demonstrate benefits
- · Ensure attendance at structured education is in all patients' care plans
- Ensure better reporting of attendance at structured education in patient records: including the use of standardised data collection and coding (working with NDA)

Requirements

- Document outlining the local population's diabetes health needs and requirements for improving attendance at structured education
- Document outlining current capability and capacity to deliver required improvement
- Findings of gap analysis outlining key areas of focus/improvement for attendance
- Locally agreed plan to 'plug' gaps/drive the necessary improvements

Commissioner

- · Agreed strategy and plan to increase attendance at structured education courses
- Multiple, flexible, structured education courses commissioned and appropriate for the needs of the local population; design influenced by local diabetes patients' input and, where possible, involves them
- Structured education is explicitly included in the local diabetes primary care pathway
- · Agreed comms strategy for encouraging local healthcare professionals to refer and local diabetes patients to attend
- · Systems/processes in place for self-referrals
- · An effective referrals process, using high quality electronic administration systems in place. This is supporting agreed SLA and KPIs and associated performance management
- Incentive scheme developed, and in place. and effectively, demonstrably driving improvement

Outcomes

Ongoing outcomes

Ongoing outcomes listed in the diabetes treatment targets logic model

Initial outcomes

- · Increased attendance at structured education courses
- Better self-management of diabetes; reduction in HbA1c levels
- Increased likelihood of achievement of treatment targets
- Improved recording and reporting of referrals, attendances and completions

Primary care

- · All appropriate patients are being referred to structured education at time of diagnosis (type 2), or within 6-12 months of diagnosis (type 1)
- All appropriate patients are encouraged to attend a structured education course and are aware of the benefits of attendance
- Initial care planning places considerable emphasis on structured education and the benefits of structured education
- · All referrals, attendances and completions are recorded in patient records using standardised read codes (as per NDA workstream)

Enablers

- · Local leadership and governance group in place and actively driving improvement
- Necessary infrastructure to enable the required improvement, to both attendance and reporting, is in place and
- Standardised data collection and coding systems are being used, and supporting
- Implementation plan agreed and being used

Evidence Tracker for improving uptake of structured education



	Primary assertion	Sub-assertion	Evidence available	Further evidence to be gathered	Metrics	Target
Clinical	Attendance at diabetes structured education, by those newly diagnosed with diabetes and those with established diabetes, will improve patient outcomes and generate savings by: • Reducing patients' HbA1c levels and subsequently increasing their likelihood of achieving the three NICE-recommended treatment targets. • Improving patients' knowledge and capability for managing their diabetes.	 Attendance at structured education could be improved by: Ensuring a sufficient number of courses are being commissioned to meet local demand. Ensuring courses are flexible and appropriate for local needs with patient input influencing course design. Ensuring GP practices and specialist services are helping to boost attendance. Developing an effective, efficient referrals process that uses high quality electronic administration systems. Implementing an incentive scheme to rapidly stimulate improvement. Ensuring that all appropriate patients are referred to a structured education course. Ensuring that structured education is a key element of patients' care plans. 	 Diabetes education: the big missed opportunity in diabetes care (2015) Diabetes UK. Structured Education for Type 2 diabetes: A toolkit for optimal delivery (2015) London SCN. Type 2 Diabetes Structured Education Provision In Yorkshire 2014/15 (2016) Yorkshire and The Humber Clinical Networks. Further evidence is available in appendix 1. 	 Measurement and recording of referral rates, attendance rates and completion rates at structured education. Further studies into the effectiveness and outcomes of accredited structured education courses; to strengthen the evidence base. Case studies on boosting attendance and completion of structured education courses. Case studies on using effective care planning to boost attendance at structured education courses. 	 Referral of newly diagnosed patients to structured education courses (NDA). Referral of patients with established diabetes to structured education courses (NDA). Attendance of newly diagnosed patients at structured education courses (NDA). Attendance of patients with established diabetes at structured education courses (NDA). 	10 point increase per year in the percentage of newly diagnosed patients attending structured education. 20% of all patients with diabetes attending structured education over the next 5 years.

Appraisal Criteria for improving uptake of structured education



Value equation		Outcomes/Criteria				
	Clinical	Number of additional patients referred for structured education. Evidence drawn from National Diabetes Audit. This should be expressed as per X% of population or similar. Also collect information on current and future referral and attendance rates to support assessment of bids.	10%			
		Planned improvement in CCGIAF rating for structured education	5%			
OUTCOMES		Planned increased attendance at structured education and completion of course.	20%			
	Patient Experience	Set out local measures of patient experience or use qualitative information about plans for improvement.	10%			
	Safety/quality	Service adheres to NICE guidelines and quality standards.	15%			
	Suctainability	Total amount of local funding committed in each year				
	Sustainability	Savings generated locally.	10%			
RESOURCES		Number of additional patients to attend annually. Total cost of service and details of any capital requirements upon which successful delivery of the bid is reliant	15%			
		Assessment of identification of implementation risks and mitigating actions	25%			
		Assessment of identification of degree of support of key partners				
RI	SKS	Assessment of risk that intervention is not well targeted	25%			
		Assessment of degree to which inter-relationship with other strategic plans are identified and addressed.	25%			
STD/	TECIC	Proportion of new/additional service cost to be funded locally in 2017/18	50%			
STRATEGIC		Degree to which the improvement approach can be replicated elsewhere.	50%			



Intervention 2

Improving achievement of treatment targets

Value Equation for Improving achievement of treatment targets



Outcomes

Clinical outcomes

Improving outcomes for those with diabetes through increased adherence to the three treatment targets

Patient experience

Patients feel confident to manage their own care

Safety/Quality

Services commissioned to ensure a good quality intervention

Sustainability

Commitment and ability to fund service after transformation funds are withdrawn

Value

Resources

Revenue costs

Income, time, salaries, system maintenance

Non-financial

Time of existing staff

Logic Model for Improving achievement of treatment targets



Inputs

- · National diabetes funding:
- Transformation fundingExisting allocated funding
- QOF funding

Resources

- · Local diabetes funding
- Qualified and competent healthcare professionals

Local

- Local diabetes population health needs
- Current local achievement of the 3 treatment targets
- Local providers; GP and community services, and specialist services
- Local pool of qualified and capable healthcare professionals
- · The Integrated Model of Care
- Local commissioning and contracting frameworks
- Local and regional diabetes community groups /networks

National

- National policy, including expectation to improve achievement of the 3 NICErecommended treatment targets
- NICE Guidelines and quality standards, including drug therapy algorithm
- · NICE and NHS pathways
- National structured education courses & national providers
- National case studies and learning from experience
- Best practice care planning guidance and 'Year of care'
- NHS Rightcare
- · NHS Information prescriptions
- RCGP Quality Improvement Toolkit for Diabetes Care
- Diabetes UK shared practice resources

Activities

Assessment of requirements

Engagement with necessary providers re desire to improve treatment target achievement <u>in both adults</u> and children

Carry out a diabetes health needs assessment to understand requirements for achieving median treatment target achievement in both adults and children

Understand existing clinical capability and capacity to deliver the required improvement Gap analysis:

- Current achievement of treatment targets
- Required increase in achievement

Review model of care

Investigate alternative care models; to improve management of patients' diabetes and improve achievement of the treatment targets (Consider better integration between primary and secondary care such as models for improving GP access to specialist advice)

Care processes

Ensure all patients receive all 9 care processes on an at least annual basis

- i) Understand current performance and patient information to identify areas of focus
- ii) Consider how to target hard to reach groups such as; young people, type 1 patients and those of working age

Structured education

Ensure all patients are referred to a suitable structured education course and encouraged to attend.

Treating to the correct level

- i) Ensure patient risk factors are understood to agree a appropriate target with the patient
- ii) Minimise 'Clinical Inertia' by ensuring that the NICEdrug therapy escalation algorithm is adhered to
- iii) Ensure all diabetes patients have a shared, agreed, personalised care plan, and review at least annually

Incentives

Consider implementing an appropriate incentive scheme to drive improvement

Canacit

Develop capacity to ensure that there is sufficient bandwidth to increase achievement

Outputs

Commissioner outputs

- Document outlining the local population's diabetes health needs and required throughput to achieve national median achievement in all GP-practices
- Document outlining current clinical capability and capacity to deliver required improvement
- Findings of gap analysis outlining key areas of focus/improvement
- Locally agreed plan to 'plug' gaps in required treatment target achievement
- Necessary infrastructure to enable the required improvement is in place and agreed
- Local leadership and governance group in place and actively driving improvement
- Incentive scheme developed and in place, and effectively, demonstrably driving improvement

Provider outputs

- Improved management (and self-management) of diabetes
- Annual delivery of all 9 diabetes care processes to all diabetes patients
- All patients receive a shared and agreed personalised care plan; owned by the patient and reviewed at least annually
- All appropriate patients are attending a structured education course
- Appropriate drug therapy, including escalation of drug treatments as per NICE guidelines, being used for all patients
- New models implemented to improve GP access to specialist advice

Enablers

- Local leadership and governance; local governance group to drive improvement
- Procurement of necessary infrastructure and recruitment of necessary staff/resources
- Utilise NHS Rightcare to support identification of opportunities and sharing of best practice to drive improvement
- Agree implementation plan outlining timescales and costs – with providers/trusts

Outcomes

Ongoing outcomes

- Reduced risk, and subsequently incidence, of diabetes complications
- Reduced hospital admissions for patients with diabetes
- Reduced need to refer to specialist services
- (Not including type 1 diabetes patients)
- Improved patient experience
- Financial savings from fewer admissions to hospital
- Financial savings from fewer referrals to specialist services
- Financial savings from reduced incidence of complications
- Health benefits/QALYs



Initial outcomes

An increase in patients achieving the three treatment targets;

- HbA1c (Adults & children)
- Cholesterol (Adults)
- Blood pressure (Adults)
- Without increase in rates of hypoglycaemia or postural hypotension
- Reduction in number of hypoglycaemic and hyperglycaemic events
- Improved psychosocial wellbeing in diabetes patients

Evidence Tracker for Improving achievement of treatment targets



	Primary assertion	Sub-assertion	Evidence available	Further evidence to be gathered	Metrics	Target
Clinical	Achievement of the three NICE-recommended diabetes treatment targets, without increasing the risk of hypoglycaemia or postural hypotension, will improve patient outcomes and generate savings by: Reducing risk, and subsequently incidence, of diabetes complications. Reducing the number of hospital admissions for diabetes patients. Reducing the need to refer diabetes patients to specialist services (not including type 1 diabetes patients).	Achievement of the NICE-recommended treatment targets could be improved by: • Using appropriate drug therapy, and intensifying treatment where needed, to treat to the appropriate treatment target. • Increasing attendance at diabetes structured education. • Good care planning; patients should be well bought into shared care plans. • Understanding variation, patterns and reasons for poor rates of treatment target achievement, and developing a plan to tackle these. • Improving GP access to specialist advice.	 Estimating the impact of better management of glycaemic control in adults with Type 1 and Type 2 diabetes on the number of clinical complications and the associated financial benefit. (2016) Baxter et al. Diabetic Medicine. Structured patient education: the Diabetes X-PERT Programme makes a difference. (2006) Deakin et al. Diabetic Medicine 23;944–954. Training in flexible, intensive insulin management to enable dietary freedom in people with type 1 diabetes: DAFNE RCT (2002) DAFNE Study Group. BMJ 325;746-75. National Diabetes Audit 2014/15. Further evidence is available in appendix 1. 	 Average per patient costs of using intensification of drug therapy to increase treatment target achievement. Further studies into the impacts of care planning on better management of diabetes and achievement of the treatment targets. Studies into the various care planning paradigms/methodol ogies to understand effectiveness of each. Case studies into how commissioners and providers have improved systems and processes to reduce variation in achievement of the treatment targets. 	 GP practice and CCG-level percentage of patients achieving all three diabetes treatment targets (NDA). GP practice and CCG-level percentage of patients achieving the individual treatment targets (NDA). GP practice and CCG-level attendances of newly diagnosed patients at structured education courses (NDA). CCG-level rates of diabetes complications (NDA). CCG-level standardised rates of diabetes complications (NDA). 	All CCGs to achieve national median treatment target achievement.

Appraisal Criteria for Improving achievement of treatment targets



Value equation		Outcomes/Criteria	Importance (%)
	Clinical	Number of patients that currently meet/don't meet treatment targets by T1 and T2. Number of patients to be seen annually by T1 and T2 also expressed as per 100,000 population or similar with key patient characteristics highlighted. Evidence drawn from National Inpatient Diabetes Audit, National Diabetes Audit and HES.	10%
		Planned improvement in CCGIAF rating for achievement of the treatment targets	5%
		Planned improvement in those achieving treatment targets by T1 and t2, inc. improving achievement against individual treatment targets.	25%
OUTCOMES	Patient Experience	Set out local measures of patient experience or use qualitative information about plans for improvement.	10%
	Safety/quality	Commissioning and quality improvement actions to support improvement against the treatment targets	10%
	Sustainability	Total amount of local funding committed in each year. Demonstration of how improvements will be sustainable inc. which aspects will need ongoing funding vs. short term intervention.	15%
		Savings generated locally.	10%
RESO	URCES	Number of patients to be seen annually. Total cost of service including details of the staffing requirement for the service and details of any capital requirements upon which successful delivery of the bid is reliant. Average cost per person.	15%
		Assessment of identification of implementation risks and mitigating actions	25%
		Assessment of identification of degree of support of key partners	25%
RISKS		Assessment of risk that intervention is not well targeted	25%
		Assessment of degree to which inter-relationship with other strategic plans are identified and addressed.	25%
CTDA	TEOLO	Proportion of new/additional service cost to be funded locally in 2017/18	50%
STRATEGIC		Degree to which the improvement approach can be replicated elsewhere.	50%



Intervention 3

New or expanded multi-disciplinary footcare teams (MDFTs)

Value Equation for New or expanded multidisciplinary footcare teams (MDFTs)



Outcomes

Clinical outcomes

Improving outcomes related to footcare for those with diabetes, measured through reduced amputations

Patient experience

Patient interactions and perceptions, e.g. comfort, ease of access, level of satisfaction, waiting times

Safety/Quality

Footcare services adhere to NICE guidelines

Sustainability

Commitment and ability to fund service after transformation funds are withdrawn

Value

Resources

Revenue costs

Income, time, salaries, system maintenance

Non-financial

Time of existing staff

Logic Model for New or expanded multi-disciplinary footcare teams (MDFTs)



· National diabetes funding:

Existing allocated funding

- Transformation funding

Local diabetes funding

· Qualified and competent

· Local diabetes population

health needs

healthcare professionals

Resources

- Tariffs

Local

- · Engagement with nearby CCGs, and
- · Carry out a diabetes health needs assessment to understand likely demand and capacity
- Understand existing clinical capability and

- -What capacity is required for new MDFT?

· Existing diabetes and diabetes footcare services

- · Existing footcare-related services
- · Local pool of qualified and capable healthcare professionals
- · Local commissioning and contracting frameworks

National

- · National policy, including expectation to have an MDFT with sufficient capacity
- · National footcare service specification(s)
- · National minimum skills framework
- NICE Guidelines and quality standards (NG19, QS6)
- · Local footcare service case studies and learning from experience
- · National Diabetes Footcare Audit
- · National commissioning and contracting frameworks
- National pool of qualified and capable healthcare professionals
- · Diabetes UK 'Putting Feet
- · Diabetes UK Shared Practice resources

Assessment of requirements

- necessary providers/ trusts re desire to implement/enhance an MDFT
- requirements for the footcare service
- capacity to deliver a footcare service
- · Gap analysis:
- -Is an MDFT already in place?
- -What capacity enhancements are required?

Service specification

- · Locally develop and agree a service spec and model of care for the MDFT that adheres to NICE guidelines and quality standards
- · Clearly defined interfaces between the MDFT and the wider footcare pathway; with specific reference to primary care/foot protection teams/community podiatry
- Consider development of the wider footcare pathway, including foot protection teams and links with primary care/community podiatry
- · Locally agree governance framework to ensure MDFT meets quality requirements
- · Locally agree a quality assurance approach to ensure MDFT is meeting quality requirements
- Develop a footcare contracting framework to ensure quality and sustainability of the service

Enablers

- · Agree implementation plan outlining timescales and costs - with providers/trusts
- · Identification of suitably qualified healthcare professionals to enable delivery of the service to the agreed service spec
- · Procurement of necessary infrastructure to allow multi-disciplinary working and delivery of the service, including equipment and facilities
- Ensure the necessary organisational attributes are in place, including people, systems and processes
- · CCG commitment to their share of funding

Requirements

Document outlining the diabetes population's footcare, and MDFT, specific healthcare needs

Outputs

- Document outlining current clinical capability and capacity to deliver the specified foot care
- Findings of gap analysis outlining key areas of focus/improvement
- Locally agreed plan to 'plug' gaps and implement the new/enhanced footcare service
- Outline anticipated reduction in amputations, and other potential benefits, and timescales

Service specification

- Locally agreed service specification and model of care for MDFT, adhering to NICE guidelines and quality standards
- · A complete integrated footcare pathway that clearly defines relevant interfaces with MDFT. Where applicable, an improved pathway with enhanced services and interfaces with MDFT
- Locally agreed governance framework outlining service leadership, service structure and processes and systems to be applied
- A specified, and locally agreed, quality assurance approach, outlining the processes and systems to be used. Ongoing service improvement using activities such as rootcause analysis for all major amputations
- Locally agreed commissioning/contracting frameworks for funding/incentivising service

Implementation

- Appointment of senior clinical lead who has responsibility and accountability for the footcare service
- · Appointment of competent staff to the necessary roles to enable delivery, at required capacity, as per the service spec
- Necessary infrastructure to allow multidisciplinary working and delivery of the service are in place and agreed
- Necessary organisational attributes are in place and agreed
- · Agreed and committed funding arrangements

Outcomes

Ongoing outcomes

- · Increase in patients with foot disease receiving (rapid) review by MDFT in an outpatient setting
- Subsequently, a reduction in numbers of admissions for foot disease
- Increase in inpatients admitted with foot disease, or those who develop it during their stay being seen by an **MDFT**
- Subsequently, a reduction in length of stay for patients admitted with foot disease, or those who develop it during their stay
- Reduction in number of amputations
- Improved patient experience
- · Financial savings from fewer amputations
- Financial savings from reduced LOS
- Health benefits/QALYs



Initial outcomes

- MDFT service operating, to service specification, at required capacity, in both inpatient and outpatient settings, as an integral part of the footcare pathway
- Senior clinical lead for diabetes footcare in post
- Governance structure working to ensure and maintain quality of
- Quality assurance approach working to ensure and maintain quality of

Evidence Tracker for New or expanded multidisciplinary footcare teams (MDFTs)



Primary assertion	Sub-assertion		Evidence available	Further evidence to be gathered		Metrics	Target
A multidisciplinary footcare team (MDFT) operating in inpatient and outpatient settings will improve patient outcomes and generate savings by: Reducing the number of amputations in patients with diabetes. Increase the number of patients with foot disease receiving rapid review. Reducing the number of admissions of diabetes patients with foot disease. Reducing the length of stay for patients admitted with foot disease.	 Implementing a MDFT, with sufficient capacity, that; offers both inpatient and outpatient care. adheres to NICE guidelines and quality standards as an integral part of the footcare pathway. has good clinical leadership and supervision. is led by a robust, locally agreed governance structure within the local health system. has a robust quality assurance approach that drives continual service improvement. Will improve treatment and management of diabetes patients with foot disease and, subsequently, improved patient outcomes. 	•	Diabetic foot problems: Prevention and Management – NICE Guideline NG19 (2015) NICE. Operational Delivery of the Multi- Disciplinary Care Pathway for Diabetic Foot Problems (2016) British Orthopaedic association, Diabetes UK, Association of British Clinical Diabetologists et al. SECTION IV – Foot Care for People with Diabetes: The Economic Case for Change (2012) Kerr M. Commissioning Diabetes Foot Care Services (2011) NHS Diabetes. Further evidence is available in appendix 1.	Further case studies re implementation of an MDFT and corresponding outcomes. Studies re quality assurance of service delivery, and subsequent service improvement, and corresponding outcomes.	• • • •	Number of MDFTs in operation (NaDIA). Number of inpatients being seen by an MDFT (NaDIA). Number of patients being seen by an MDFT within 24 hours of referral (NaDIA). Number of amputations (NDA and HES). Number of admissions for diabetic foot disease (HES & NCVIN Footcare profiles). Average length of stay for patients admitted with diabetic foot disease (HES & NCVIN Footcare profiles). Patient experience score (Locally collected or NaDIA).	All trusts / hospitals to provide an MDFT service.

Appraisal Criteria for New or expanded multidisciplinary footcare teams (MDFTs)



Value equation		Outcomes/Criteria	Importance (%)
	Clinical	 (1) Gap Analysis completed by CCG: Increase in number of additional patients to be seen by MDFT (identified locally)-expressed as a number and per 100 admissions of patients with diabetes. annually also expressed as per population or similar. Evidence drawn from National Inpatient Diabetes Audit, National Diabetes Audit and HES. (2) Identify whether trusts in area currently have a MDFT and whether the proposal is to introduce an MDFT service where it does not currently exist. Consideration of whether to include expanded FPT capacity in bid and, if so, analysis of need. 	10%
OUTCOMES		MDFT provision across all relevant providers. New service is proposed in relevant providers, or; Where one already exists, expansion of the service is proposed.	5%
		Planned reductions in admissions	25%
	Patient Experience	Set out local measures of patient experience or use qualitative information about plans for improvement.	10%
	Safety/quality	Service adheres to NICE guidelines and quality standards.	10%
	0	Commitment to continued funding	15%
	Sustainability	Savings generated locally.	10%
RESO	URCES	Number of patients to be seen annually. Total cost of service including details of the staffing requirement for the service and details of any capital requirements upon which successful delivery of the bid is reliant.	15%
		Assessment of identification of implementation risks and mitigating	25%
RISKS		Assessment of identification of degree of support of key partners	25%
		Assessment of risk that intervention is not well targeted	25%
		Assessment of degree to which inter-relationship with other strategic plans are identified and addressed.	25%
STRA	TEGIC	Proportion of new/additional service cost to be funded locally in	100%



Intervention 4

New or expanded diabetes inpatient specialist nursing services (DISNs)

Value Equation for New or expanded diabetes inpatient specialist nursing services (DISNs)



Outcomes

Clinical outcomes

Improving outcomes for inpatients with diabetes, measured through reduced length of stay

Patient experience

Patient interactions and perceptions, e.g. comfort, ease of access, level of satisfaction, waiting times

Safety/Quality

Good quality inpatient care for those with diabetes, measured through reduced incidents of poor care

Sustainability

Commitment and ability to fund service after transformation funds are withdrawn

Value

Resources

Revenue costs

Income, time, salaries, system maintenance

Non-financial

Time of existing staff

Logic Model for New or expanded diabetes inpatient specialist nursing services (DISNs)



Resources

- · National diabetes funding:
- Transformation funding
- Existing allocated funding
- Tariffs
- · Local diabetes funding
- · Resources to implement service
- · Pool of qualified inpatient specialist nurses
- Pool of non-specialist nurses

<u>Local</u>

- Local diabetes population health needs
- Local DISN role specifications and protocols
- · Existing DISN leadership, provision and capacity
- Pool of qualified inpatient specialist nurses
- Pool of non-specialist nurses

National

- · National policy aim to have one DISN with sufficient capacity, per 250 inpatient beds
- · National DISN role specifications and protocols
- · NICE guidelines and quality standards (NG17,18,28, QS6)
- · JBDS inpatient care group quidelines on clinical care
- · DISN case studies to support understanding of effective service models/delivery
- National pool of qualified and capable healthcare professionals
- · National Diabetes Inpatient Audit
- Diabetes UK Shared Practice resources

Enablers

- · Local leadership and delivery of implementation
- Engagement with nearby CCGs, and necessary providers/trusts re desire to implement/enhance an inpatient specialist nursing service
- · Agree implementation timescales and costs with
- · Procurement of the necessary infrastructure for the inpatient specialist nursing service
- · CCG commitment to their share of funding

Assessment of requirements

- Carry out a diabetes health needs assessment to understand likely demand and capacity requirements in the for the DISN service
- · Understand existing capability and capacity to deliver an inpatient specialist nursing service
- · Gap analysis:
- Is a DISN service already in place?
- Are more DISNs needed?
- How many more DISNs are required?
- Are the necessary systems/enablers in place?

Development of service and role specification

- Locally develop and agree a specification for the DISN service that adheres to NICE quality standards; outlining roles and responsibilities
- Include the DISN service in the provider's care pathways, ensuring all services have clearly defined interfaces with the DISN service
- · Locally agree governance and quality assurance framework to ensure quality of service
- Agree clinical supervision arrangements for DISNs; including a senior clinical lead

Recruitment and training

- Develop a strategy to recruit DISNs to deliver the specified service to required capacity levels (1 DISN per 250 inpatient beds)
- · If necessary, develop a strategy to train existing, non-DISN qualified nurses as DISNs
- Recruit DISNs to deliver the specified service to required capacity levels
- Commission DISN training for existing, non-DISN qualified nurses

Implementation (i)

- · Agreed costs, timescales and plan for implementation/enhancement of the DISN
- · Implementation of the necessary infrastructure for delivery of the service
- · Agreed and committed funding arrangements

Requirements

- · Document outlining the diabetes population's health needs and likely demand for the DISN service
- Document outlining current DISN capability and capacity to deliver the service as specified
- · Findings of gap analysis outlining key areas of focus/improvement
- Locally greed plan to 'plug' gaps and implement the new/enhanced DISN service
- · Outline anticipated number and proportions of patients to be seen by DISN, and timescales

Service and role specification

- · Locally agreed specification for the DISN service, adhering to NICE quality standards, with roles and responsibilities outlined
- DISN service also responsible for development of processes/systems, and training of wider clinical staff to enable effective diabetes inpatient care in all services
- DISN service an integral part of other inpatient care pathways, with clearly defined interfaces between the DISN and all other services
- Locally agreed governance framework outlining service leadership, clinical supervision, service structure and processes/ systems to be applied
- Locally agreed quality assurance framework, outlining the processes, systems and methods to be used

Implementation (ii)

- · Appointment of sufficient (1 per 250 inpatient beds) number of qualified/competent DISNs to enable delivery of the specified service
- If necessary, a sufficient number of nurses undergoing DISN training in advance of appointment

Outcomes

Ongoing outcomes

- · Reduction in length of stay for patients with diabetes
- Reduced time requirements of diabetes patients on other clinical staff due to being treated and managed by DISN
- Reduction in inpatient harms including reduced medication errors and hypoglycaemic
- Improved processes, systems and clinical capability in the effective care of diabetes inpatients
- Improved patient experience
- Financial savings from reduced
- Financial savings from fewer inpatient harms
- Health benefits/QALYs

Initial outcomes

- DISN service, with qualified and competent team members, in place
- DISN service operating as specified with sufficient capacity
- DISN service supporting inpatient care of diabetes patients across all hospital services
- Governance structure, clinical supervision and quality assurance approach are working to ensure and maintain quality of service
- DISN service helping to develop processes/ systems, and training wider clinical staff, to enable effective diabetes inpatient care in all services

Evidence Tracker for New or expanded diabetes inpatient specialist nursing services (DISNs)



	Primary assertion	Sub-assertion	Further Evidence available evidence to be Metrics gathered	Target
; ;	A diabetes specialist nursing (DISN) service with 1 nurse per 250 inpatient peds, will improve patient outcomes and generate savings by: Reducing the length of stay for inpatients with diabetes. Reducing inpatient harms. Improving systems and processes, for management of inpatients with diabetes. Reducing time requirements on other clinical staff due to effective and efficient management.	 Implementing a DISN service, that; has good clinical leadership and supervision. has sufficient capacity, and capability. adheres to NICE quality standards. is an integral part of all hospital inpatient care pathways. is led by a robust, locally agreed governance structure within the local health system. Will ensure high quality service provision and, subsequently, improved patient outcomes. 	 "Position Statement: Diabetes Specialist Nurses: Improving Patient Outcomes and Reducing Costs. Diabetes UK (March 2015). Inpatient Care for People with Diabetes: The Economic Case for Change. Kerr M (2011). NHS Diabetes. Self-management of diabetes in hospital. NHS Diabetes (2012) Joint British Diabetes Societies (JBDS) for Inpatient Care Group. Best practice for commissioning diabetes services: An integrated care framework. (2013) Association of British Clinical Diabetologists et al. Further case studies implementatio n of a DISN services in operation, and number per of DISNs per inpatient beds, and staffing hours (NaDIA). Case studies into how DISNs have developed processes and systems, and educated with diabetes (HES). Number of inpatients with diabetes experiencing harms (medication error and hypoglycaemic events) (NaDIA). Patient experience score (Locally collected or NaDIA). 	DISN per 250 patient beds.

Appraisal Criteria for New or expanded diabetes inpatient specialist nursing services (DISNs)



Value equation		Outcomes/Criteria	Importance (%)
	Oliminal	 (1) number of additional patients to be seen by a DISN (or other specialist input) annually. Evidence drawn from National Inpatient Diabetes Audit, National Diabetes Audit and HES. This should be expressed as per % of population or similar. (2) Identify whether trusts in area currently have a DISNs and whether the proposal is to introduce a DISN service where it does not currently exist. 	10%
	Clinical	DISN provision across all relevant providers. New service is proposed in relevant providers, or; Where one already exists, expansion of the service is proposed.	5%
OUTCOMES		Planned reductions in length of stay for diabetes patients (not just those with a diabetes primary diagnosis)	25%
	Patient Experience	Set out local measures of patient experience or use qualitative information about plans for improvement.	10%
	Safety/quality	Reduction in medication errors and reduction in hypoglycaemic and hypercalcaemic episodes in inpatients, as a percentage of diabetes patients	10%
	Sustainability	Total amount of local funding committed in each year, and commitment of CCG and provider to continued funding	15%
		Savings generated locally.	10%
RESO	URCES	Total cost of service including details of any capital requirements upon which successful delivery of the bid is reliant and details of the staffing requirement for the service matched against number of additional patients to be seen annually and average number of appointments per person.	15%
		Assessment of identification of implementation risks and mitigating actions	25%
		Assessment of identification of degree of support of key partners	25%
RIS	SKS	Assessment of risk that intervention is not well targeted	25%
		Assessment of degree to which inter-relationship with other strategic plans are identified and addressed.	25%
STRA	TEGIC	Proportion of new/additional service cost to be funded locally in 2017/18	100%