National Diabetes Treatment and Care Programme

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.
2. 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.

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

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.

<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of Interventions and Process</td>
<td>3</td>
</tr>
<tr>
<td>Timeline</td>
<td>7</td>
</tr>
<tr>
<td><strong>Intervention 1</strong>: Improving uptake of structured education</td>
<td>8</td>
</tr>
<tr>
<td><strong>Intervention 2</strong>: Improving the achievement of the NICE recommended treatment targets</td>
<td>13</td>
</tr>
<tr>
<td><strong>Intervention 3</strong>: New or expanded multi-disciplinary footcare teams (MDFTs)</td>
<td>18</td>
</tr>
<tr>
<td><strong>Intervention 4</strong>: New or expanded diabetes inpatient specialist nursing services (DISNs)</td>
<td>23</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Proposed share of funding for each intervention</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured education</td>
<td>£10m</td>
</tr>
<tr>
<td>Treatment targets</td>
<td>£17m</td>
</tr>
<tr>
<td>Multi-Disciplinary Footcare Teams (MDFTs)</td>
<td>£8m</td>
</tr>
<tr>
<td>Diabetes Inpatient Specialist Nursing Teams (DISNs)</td>
<td>£8m</td>
</tr>
</tbody>
</table>
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 **revenue only**: There is **no capital funding available**. 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 **implementing the objectives of the National Diabetes Treatment 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 **Greater Manchester devolution area are not eligible** 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/](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?

2. Logic Model
   - What is the programme and how does it deliver value?

3. Evidence Base
   - What is the evidence base and how will we track success?

4. Appraisal Criteria
   - How will we appraise bids?

5. Application
   - Bids Submitted

6. Bid Appraisal
   - 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
- 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 in:
  - Appraisal dashboard illustrates all applicants results against the appraisal criteria.
  - Prioritisation matrix maps all applicants graphically

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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd December 2016</td>
<td>Process launched and Call to Bid documents published</td>
</tr>
<tr>
<td>December 2016</td>
<td>Support provided to bidders through Webinar sessions for each programme</td>
</tr>
<tr>
<td>18th January 2017</td>
<td>Submissions deadline for bidders</td>
</tr>
<tr>
<td>February 2017</td>
<td>Investment Decision taken by NHS England Investment Committee</td>
</tr>
<tr>
<td>End February/March 2017</td>
<td>Notification of investment decisions</td>
</tr>
</tbody>
</table>
Intervention 1

Improving uptake of structured education
Value Equation for Improving uptake of structured education

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical outcomes</strong></td>
<td>Revenue costs</td>
</tr>
<tr>
<td>Improving outcomes for those with diabetes through increased attendance at structured education courses</td>
<td>Income, time, salaries, system maintenance</td>
</tr>
<tr>
<td><strong>Patient experience</strong></td>
<td>Non-financial</td>
</tr>
<tr>
<td>Patients feel confident to manage their own care</td>
<td>Time of existing staff</td>
</tr>
<tr>
<td><strong>Safety/Quality</strong></td>
<td></td>
</tr>
<tr>
<td>Structured education services adhere to NICE guideline</td>
<td></td>
</tr>
<tr>
<td><strong>Sustainability</strong></td>
<td></td>
</tr>
<tr>
<td>Commitment and ability to fund service after transformation funds are withdrawn</td>
<td></td>
</tr>
</tbody>
</table>
Logic Model for Improving uptake of structured education

**Inputs**
- 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

**Activities**

**Assessment of requirements**
- Engagement with nearby CCGs, and necessary providers 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

**Primary care activities**
- Ensure all appropriate patients are referred to structured education at time of diagnosis (type 2), or within 6-12 months of diagnosis (type 1)
- 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)

**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

**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/driver the necessary improvements

**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

**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

**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
Evidence Tracker for improving uptake of structured education

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

<table>
<thead>
<tr>
<th>Outcomes/Criteria</th>
<th>Importance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>10%</td>
</tr>
<tr>
<td>Planned improvement in CCGIAF rating for structured education</td>
<td>5%</td>
</tr>
<tr>
<td>Planned increased attendance at structured education and completion of course.</td>
<td>20%</td>
</tr>
<tr>
<td>Set out local measures of patient experience or use qualitative information about plans for improvement.</td>
<td>10%</td>
</tr>
<tr>
<td>Service adheres to NICE guidelines and quality standards.</td>
<td>15%</td>
</tr>
<tr>
<td>Total amount of local funding committed in each year</td>
<td>15%</td>
</tr>
<tr>
<td>Savings generated locally.</td>
<td>10%</td>
</tr>
<tr>
<td>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</td>
<td>15%</td>
</tr>
<tr>
<td>Assessment of identification of implementation risks and mitigating actions</td>
<td>25%</td>
</tr>
<tr>
<td>Assessment of identification of degree of support of key partners</td>
<td>25%</td>
</tr>
<tr>
<td>Assessment of risk that intervention is not well targeted</td>
<td>25%</td>
</tr>
<tr>
<td>Assessment of degree to which inter-relationship with other strategic plans are identified and addressed.</td>
<td>25%</td>
</tr>
<tr>
<td>Proportion of new/additional service cost to be funded locally in 2017/18</td>
<td>50%</td>
</tr>
<tr>
<td>Degree to which the improvement approach can be replicated elsewhere.</td>
<td>50%</td>
</tr>
</tbody>
</table>
Intervention 2

Improving achievement of treatment targets
## Value Equation for Improving achievement of treatment targets

<table>
<thead>
<tr>
<th>Value</th>
<th>Equations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical outcomes</strong></td>
<td>Improving outcomes for those with diabetes through increased adherence to the three treatment targets</td>
</tr>
<tr>
<td><strong>Patient experience</strong></td>
<td>Patients feel confident to manage their own care</td>
</tr>
<tr>
<td><strong>Safety/Quality</strong></td>
<td>Services commissioned to ensure a good quality intervention</td>
</tr>
<tr>
<td><strong>Sustainability</strong></td>
<td>Commitment and ability to fund service after transformation funds are withdrawn</td>
</tr>
</tbody>
</table>

### Resources
- **Revenue costs**: Income, time, salaries, system maintenance
- **Non-financial**: Time of existing staff

### Outcomes
- **Clinical outcomes**
- **Patient experience**
- **Safety/Quality**
- **Sustainability**
Logic Model for Improving achievement of treatment targets

**Inputs**
- National diabetes funding
- Transformation funding
- Existing allocated funding
- QOF funding
- Local diabetes funding
- Qualified and competent healthcare professionals

**Logic Model**

<table>
<thead>
<tr>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>National diabetes funding:</td>
</tr>
<tr>
<td>- Transformation funding</td>
</tr>
<tr>
<td>- Existing allocated funding</td>
</tr>
<tr>
<td>- QOF funding</td>
</tr>
<tr>
<td>- Local diabetes funding</td>
</tr>
<tr>
<td>- Qualified and competent healthcare professionals</td>
</tr>
</tbody>
</table>

**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 NICE-recommended 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

**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

**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 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 hypertensive events
- Improved psychosocial wellbeing in diabetes patients

**Reaching the correct level**
- Ensure patient risk factors are understood to agree a appropriate target with the patient
- Minimise ‘Clinical Inertia’ by ensuring that the NICE-drug therapy escalation algorithm is adhered to
- Ensure all diabetes patients have a shared, agreed, personalised care plan, and review at least annually

**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

**Capacity**
- Develop capacity to ensure that there is sufficient bandwidth to increase 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 at least an 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

**Treat 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 NICE-drug 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

**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 referrals to specialist services
- Financial savings from reduced incidence of complications
- Health benefits/QALYs

---

**Five Year Forward View**
Evidence Tracker for Improving achievement of treatment targets

<table>
<thead>
<tr>
<th>Primary assertion</th>
<th>Sub-assertion</th>
<th>Evidence available</th>
<th>Further evidence to be gathered</th>
<th>Metrics</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>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:</td>
<td>Achievement of the NICE-recommended treatment targets could be improved by:</td>
<td>• 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.</td>
<td>• Average per patient costs of using intensification of drug therapy to increase treatment target achievement.</td>
<td>GP practice and CCG-level percentage of patients achieving all three diabetes treatment targets (NDA).</td>
<td>All CCGs to achieve national median treatment target achievement.</td>
</tr>
<tr>
<td>• Reducing risk, and subsequently incidence, of diabetes complications.</td>
<td>• Using appropriate drug therapy, and intensifying treatment where needed, to treat to the appropriate treatment target.</td>
<td>• Further studies into the impacts of care planning on better management of diabetes and achievement of the treatment targets.</td>
<td></td>
<td>GP practice and CCG-level percentage of patients achieving the individual treatment targets (NDA).</td>
<td></td>
</tr>
<tr>
<td>• Reducing the number of hospital admissions for diabetes patients.</td>
<td>• Increasing attendance at diabetes structured education.</td>
<td></td>
<td>Studies into the various care planning paradigms/methodologies to understand effectiveness of each.</td>
<td>GP practice and CCG-level attendances of newly diagnosed patients at structured education courses (NDA).</td>
<td></td>
</tr>
<tr>
<td>• Reducing the need to refer diabetes patients to specialist services (not including type 1 diabetes patients).</td>
<td>• Good care planning; patients should be well bought into shared care plans.</td>
<td></td>
<td>Case studies into how commissioners and providers have improved systems and processes to reduce variation in achievement of the treatment targets.</td>
<td>CCG-level rates of diabetes complications (NDA).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Understanding variation, patterns and reasons for poor rates of treatment target achievement, and developing a plan to tackle these.</td>
<td></td>
<td></td>
<td>CCG-level standardised rates of diabetes complications (NDA).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Improving GP access to specialist advice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• National Diabetes Audit 2014/15.
• Further evidence is available in appendix 1.
## Appraisal Criteria for Improving achievement of treatment targets

<table>
<thead>
<tr>
<th>Value equation</th>
<th>Outcomes/Criteria</th>
<th>Importance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTCOMES</strong></td>
<td><strong>Clinical</strong></td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Planned improvement in CCGIAF rating for achievement of the treatment targets</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>Planned improvement in those achieving treatment targets by T1 and t2, inc. improving achievement against individual treatment targets.</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
<td>Set out local measures of patient experience or use qualitative information about plans for improvement.</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Safety/quality</strong></td>
<td>Commissioning and quality improvement actions to support improvement against the treatment targets</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Sustainability</strong></td>
<td>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.</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Savings generated locally.</td>
<td>10%</td>
</tr>
<tr>
<td><strong>RESOURCES</strong></td>
<td>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.</td>
<td>15%</td>
</tr>
<tr>
<td><strong>RISKS</strong></td>
<td>Assessment of identification of implementation risks and mitigating actions</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Assessment of identification of degree of support of key partners</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Assessment of risk that intervention is not well targeted</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Assessment of degree to which inter-relationship with other strategic plans are identified and addressed.</td>
<td>25%</td>
</tr>
<tr>
<td><strong>STRATEGIC</strong></td>
<td>Proportion of new/additional service cost to be funded locally in 2017/18</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Degree to which the improvement approach can be replicated elsewhere.</td>
<td>50%</td>
</tr>
</tbody>
</table>
Intervention 3

New or expanded multi-disciplinary footcare teams (MDFTs)
## Value Equation for New or expanded multi-disciplinary footcare teams (MDFTs)

### Outcomes

<table>
<thead>
<tr>
<th>Clinical outcomes</th>
<th>Patient experience</th>
<th>Safety/Quality</th>
<th>Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving outcomes related to footcare for those with diabetes, measured through reduced amputations</td>
<td>Patient interactions and perceptions, e.g. comfort, ease of access, level of satisfaction, waiting times</td>
<td>Footcare services adhere to NICE guidelines</td>
<td>Commitment and ability to fund service after transformation funds are withdrawn</td>
</tr>
</tbody>
</table>

### Resources

<table>
<thead>
<tr>
<th>Revenue costs</th>
<th>Non-financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income, time, salaries, system maintenance</td>
<td>Time of existing staff</td>
</tr>
</tbody>
</table>
Logic Model for New or expanded multi-disciplinary footcare teams (MDFTs)

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Requirements</th>
<th>Outputs</th>
<th>Ongoing outcomes</th>
</tr>
</thead>
</table>
| Resources | • National diabetes funding:  
- Transformation funding  
- Existing allocated funding  
- Tariffs  
- Local diabetes funding  
- Qualified and competent healthcare professionals | Assessment of requirements:  
- Engagement with nearby CCGs, and necessary providers/trusts re desire to implement/enhance an MDFT  
- Carry out a diabetes health needs assessment to understand likely demand and capacity requirements for the footcare service  
- Understand existing clinical capability and capacity to deliver a footcare service  
- Gap analysis:  
  - Is an MDFT already in place?  
  - What capacity is required for new MDFT?  
  - What capacity enhancements are required? | • Document outlining the diabetes population’s footcare, and MDFT, specific healthcare needs  
• Document outlining current clinical capability and capacity to deliver the specified foot care service  
• Findings of gap analysis outlining key areas of focus/improvement  
• Gap analysis:  
  - Is an MDFT already in place?  
  - What capacity is required for new MDFT?  
  - What capacity enhancements are required? | 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 |

Local
• Local diabetes population health needs  
• 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  
• Local footcare service case studies and learning from experience  
• Local Diabetes Footcare Audit  
• Local commissioning and contracting frameworks  
• Local pool of qualified and capable healthcare professionals  
• Diabetes UK ‘Putting Feet First’  
• Diabetes UK Shared Practice resources

Service specification:  
• Locally develop and agree a service spec and model of care for 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

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 multi-disciplinary working and delivery of the service are in place and agreed  
• Necessary organisational attributes are in place and agreed  
• Agreed and committed funding arrangements

Outcome:  
• 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 service  
• Quality assurance approach working to ensure and maintain quality of service

Five Year Forward View
# Evidence Tracker for New or expanded multidisciplinary footcare teams (MDFTs)

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

**Clinical**

**Five Year Forward View**
### Appraisal Criteria for New or expanded multi-disciplinary footcare teams (MDFTs)

<table>
<thead>
<tr>
<th>Value equation</th>
<th>Outcomes/Criteria</th>
<th>Importance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTCOMES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical</td>
<td>(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. MDFT provision across all relevant providers. New service is proposed in relevant providers, or; Where one already exists, expansion of the service is proposed. Planned reductions in admissions</td>
<td>10%</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Set out local measures of patient experience or use qualitative information about plans for improvement.</td>
<td>5%</td>
</tr>
<tr>
<td>Safety/quality</td>
<td>Service adheres to NICE guidelines and quality standards.</td>
<td>10%</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Commitment to continued funding Savings generated locally.</td>
<td>15%</td>
</tr>
<tr>
<td><strong>RESOURCES</strong></td>
<td>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.</td>
<td>15%</td>
</tr>
<tr>
<td><strong>RISKS</strong></td>
<td>Assessment of identification of implementation risks and mitigating Assessment of identification of degree of support of key partners Assessment of risk that intervention is not well targeted Assessment of degree to which inter-relationship with other strategic plans are identified and addressed.</td>
<td>25%</td>
</tr>
<tr>
<td><strong>STRATEGIC</strong></td>
<td>Proportion of new/additional service cost to be funded locally in 2017/18</td>
<td>100%</td>
</tr>
</tbody>
</table>
Intervention 4

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

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical outcomes</td>
<td>Revenue costs</td>
</tr>
<tr>
<td>Improving outcomes for inpatients with diabetes, measured through reduced length of stay</td>
<td>Income, time, salaries, system maintenance</td>
</tr>
<tr>
<td>Patient experience</td>
<td>Non-financial</td>
</tr>
<tr>
<td>Patient interactions and perceptions, e.g. comfort, ease of access, level of satisfaction, waiting times</td>
<td>Time of existing staff</td>
</tr>
<tr>
<td>Safety/Quality</td>
<td></td>
</tr>
<tr>
<td>Good quality inpatient care for those with diabetes, measured through reduced incidents of poor care</td>
<td></td>
</tr>
<tr>
<td>Sustainability</td>
<td></td>
</tr>
<tr>
<td>Commitment and ability to fund service after transformation funds are withdrawn</td>
<td></td>
</tr>
</tbody>
</table>
Logic Model for New or expanded diabetes inpatient specialist nursing services (DISNs)

### Inputs
- 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

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

### Resources
- 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

### Activities
- 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?

### Implementation (i)
- Agree costs, timescales and plan for implementation/enhancement of the DISN service
- Implementation of the necessary infrastructure for delivery of the service
- Agree and committed funding arrangements

### 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 guidelines 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

### 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 agreed 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

### 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 (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

### 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 events
- Improved processes, systems and clinical capability in the effective care of diabetes inpatients
- Improved patient experience
- Financial savings from reduced LOS
- 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)**

<table>
<thead>
<tr>
<th>Primary assertion</th>
<th>Sub-assertion</th>
<th>Evidence available</th>
<th>Further evidence to be gathered</th>
<th>Metrics</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>A diabetes specialist nursing (DISN) service with 1 nurse per 250 inpatient beds, will improve patient outcomes and generate savings by:</td>
<td>Implementing a DISN service, that;</td>
<td>• &quot;Position Statement: Diabetes Specialist Nurses: Improving Patient Outcomes and Reducing Costs. Diabetes UK (March 2015).</td>
<td>Further case studies re implementation of a DISN service.</td>
<td>• Number of DISN services in operation, and number per of DISNs per inpatient beds, and staffing hours (NaDIA).</td>
<td>All trusts / hospitals to provide a DISN service, with at least 1 DISN per 250 patient beds.</td>
</tr>
<tr>
<td>- Reducing the length of stay for inpatients with diabetes.</td>
<td>• has good clinical leadership and supervision.</td>
<td>• Inpatient Care for People with Diabetes: The Economic Case for Change. Kerr M (2011). NHS Diabetes.</td>
<td>Case studies into how DISNs have developed processes and systems, and educated wider clinical staff.</td>
<td>• Average length of stay for inpatients with diabetes (HES).</td>
<td></td>
</tr>
<tr>
<td>- Reducing inpatient harms.</td>
<td>• has sufficient capacity, and capability.</td>
<td>• Self-management of diabetes in hospital. NHS Diabetes (2012) Joint British Diabetes Societies (JBDS) for Inpatient Care Group.</td>
<td></td>
<td>• Number of inpatients with diabetes experiencing harms (medication errors and hypoglycaemic events) (NaDIA).</td>
<td></td>
</tr>
<tr>
<td>- Improving systems and processes, for management of inpatients with diabetes.</td>
<td>• adheres to NICE quality standards.</td>
<td>• Best practice for commissioning diabetes services: An integrated care framework. (2013) Association of British Clinical Diabetologists et al.</td>
<td></td>
<td>• Patient experience score (Locally collected or NaDIA).</td>
<td></td>
</tr>
<tr>
<td>- Reducing time requirements on other clinical staff due to effective and efficient management.</td>
<td>• is an integral part of all hospital inpatient care pathways.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• is led by a robust, locally agreed governance structure within the local health system.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Will ensure high quality service provision and, subsequently, improved patient outcomes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value equation</td>
<td>Outcomes/Criteria</td>
<td>Importance (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OUTCOMES</strong></td>
<td>(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. DISN provision across all relevant providers. New service is proposed in relevant providers, or; Where one already exists, expansion of the service is proposed. Planned reductions in length of stay for diabetes patients (not just those with a diabetes primary diagnosis)</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
<td>Set out local measures of patient experience or use qualitative information about plans for improvement.</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Safety/quality</strong></td>
<td>Reduction in medication errors and reduction in hypoglycaemic and hypercalcaemic episodes in inpatients, as a percentage of diabetes patients</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sustainability</strong></td>
<td>Total amount of local funding committed in each year, and commitment of CCG and provider to continued funding. Savings generated locally.</td>
<td>15%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RESOURCES</strong></td>
<td>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.</td>
<td>15%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RISKS</strong></td>
<td>Assessment of identification of implementation risks and mitigating actions</td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment of identification of degree of support of key partners</td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment of risk that intervention is not well targeted</td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment of degree to which inter-relationship with other strategic plans are identified and addressed.</td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STRATEGIC</strong></td>
<td>Proportion of new/additional service cost to be funded locally in 2017/18</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>