

The background of the slide features a photograph of two women in a clinical or office setting. The woman on the left has blonde hair and wears glasses and a purple top. The woman on the right has dark hair and is wearing a dark top. They are both looking at a document held by the woman on the right. The entire image is overlaid with a semi-transparent blue geometric pattern of triangles.

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.

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

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

- **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.

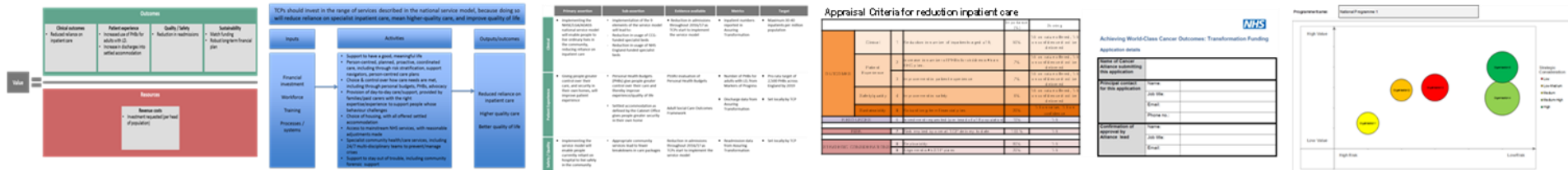
The value framework will:

- 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/>

Value Framework Process - Key Steps



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 in:
 - **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.

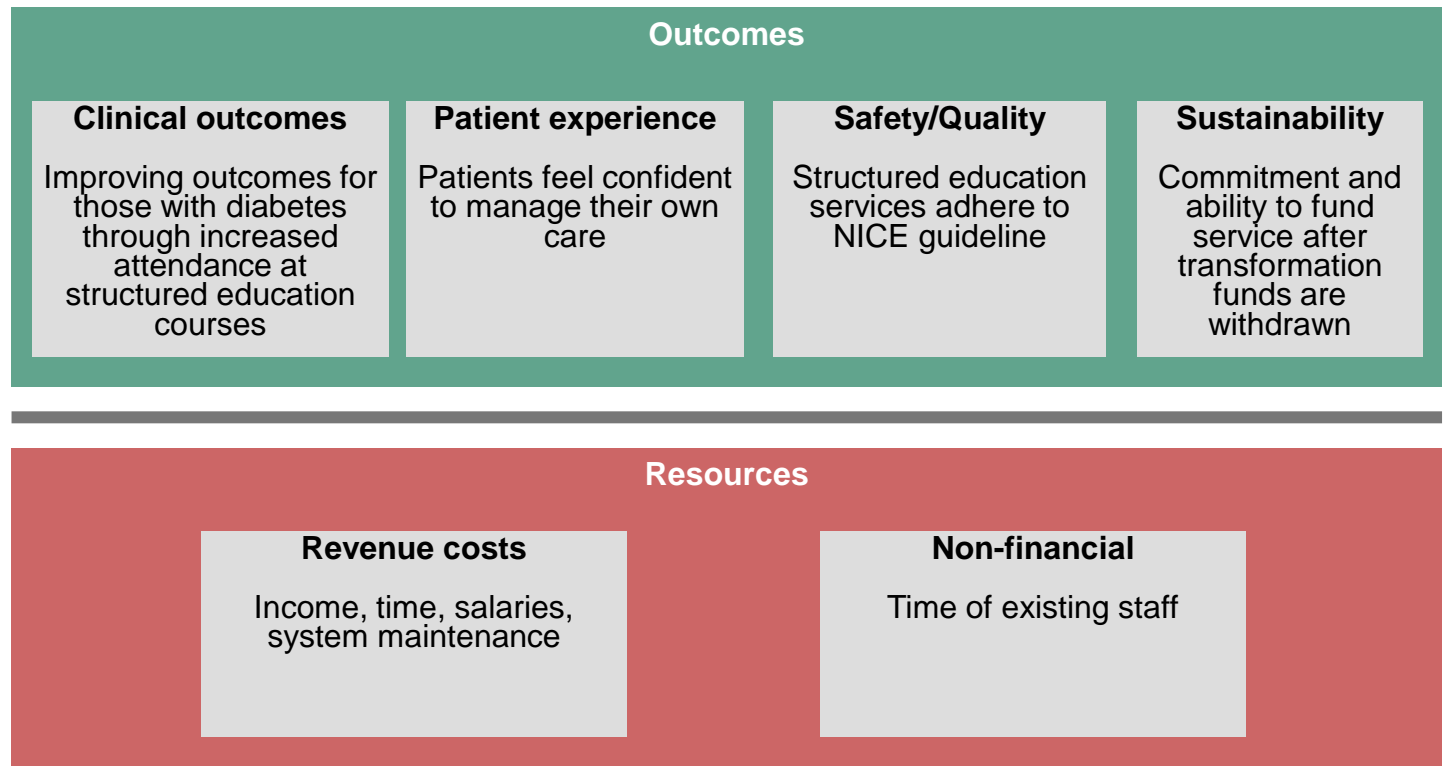
Bidders should contact the programme on england.diabetestreatment@nhs.net for further information.

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
18th 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



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

Activities

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

- 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)

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 agreed.
- Standardised data collection and coding systems are being used, and supporting NDA
- 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
<p>Attendance at diabetes structured education, by those newly diagnosed with diabetes and those with established diabetes, will improve patient outcomes and generate savings by:</p> <ul style="list-style-type: none"> 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. 	<p>Attendance at structured education could be improved by:</p> <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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). 	<p>10 point increase per year in the percentage of newly diagnosed patients attending structured education.</p> <p>20% of all patients with diabetes attending structured education over the next 5 years.</p>

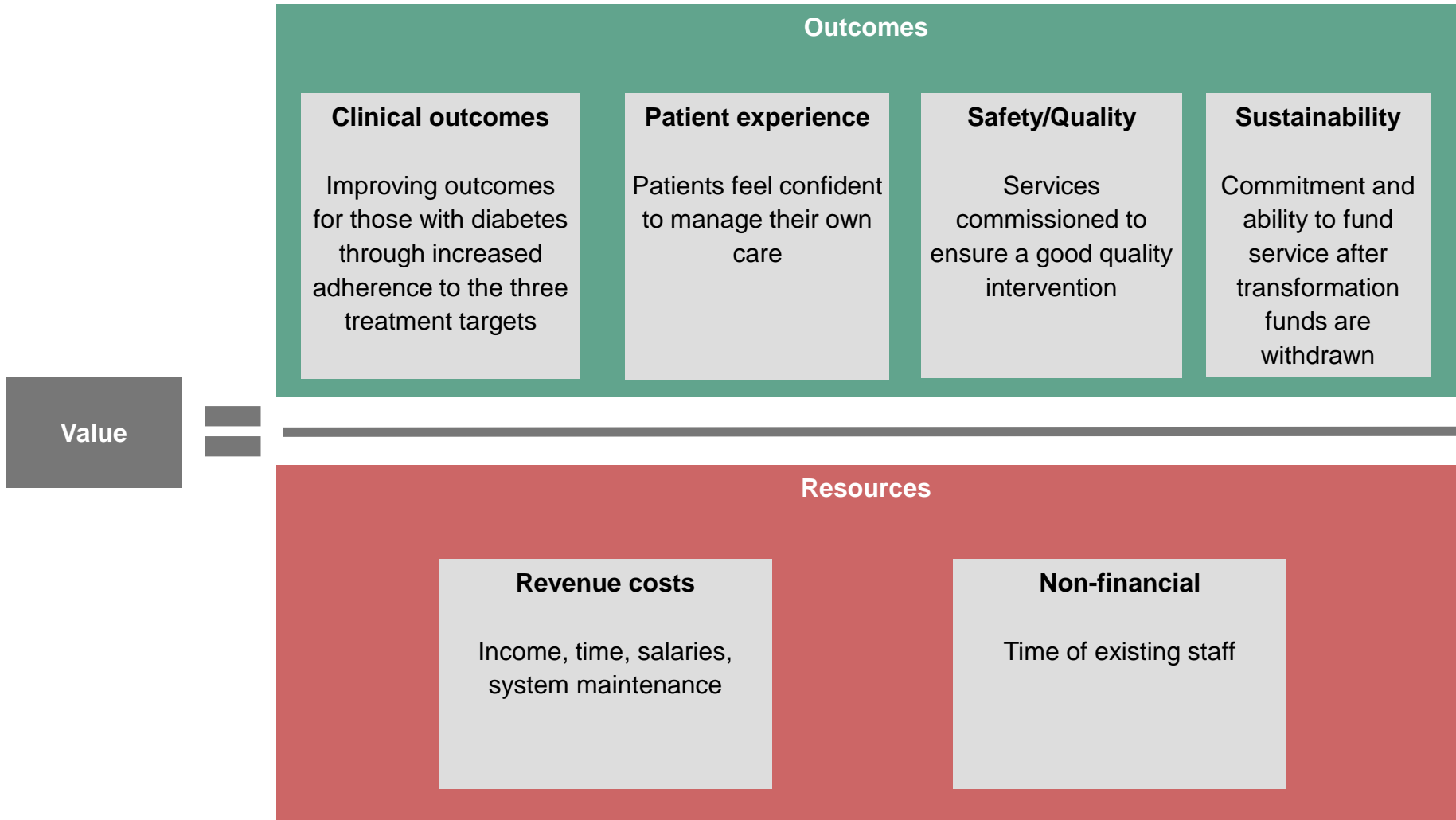
Appraisal Criteria for improving uptake of structured education

Value equation		Outcomes/Criteria	Importance (%)
OUTCOMES	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%
		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%
	Sustainability	Total amount of local funding committed in each year	15%
		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%
RISKS		Assessment of identification of implementation risks and mitigating actions	25%
		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%
STRATEGIC		Proportion of new/additional service cost to be funded locally in 2017/18	50%
		Degree to which the improvement approach can be replicated elsewhere.	50%

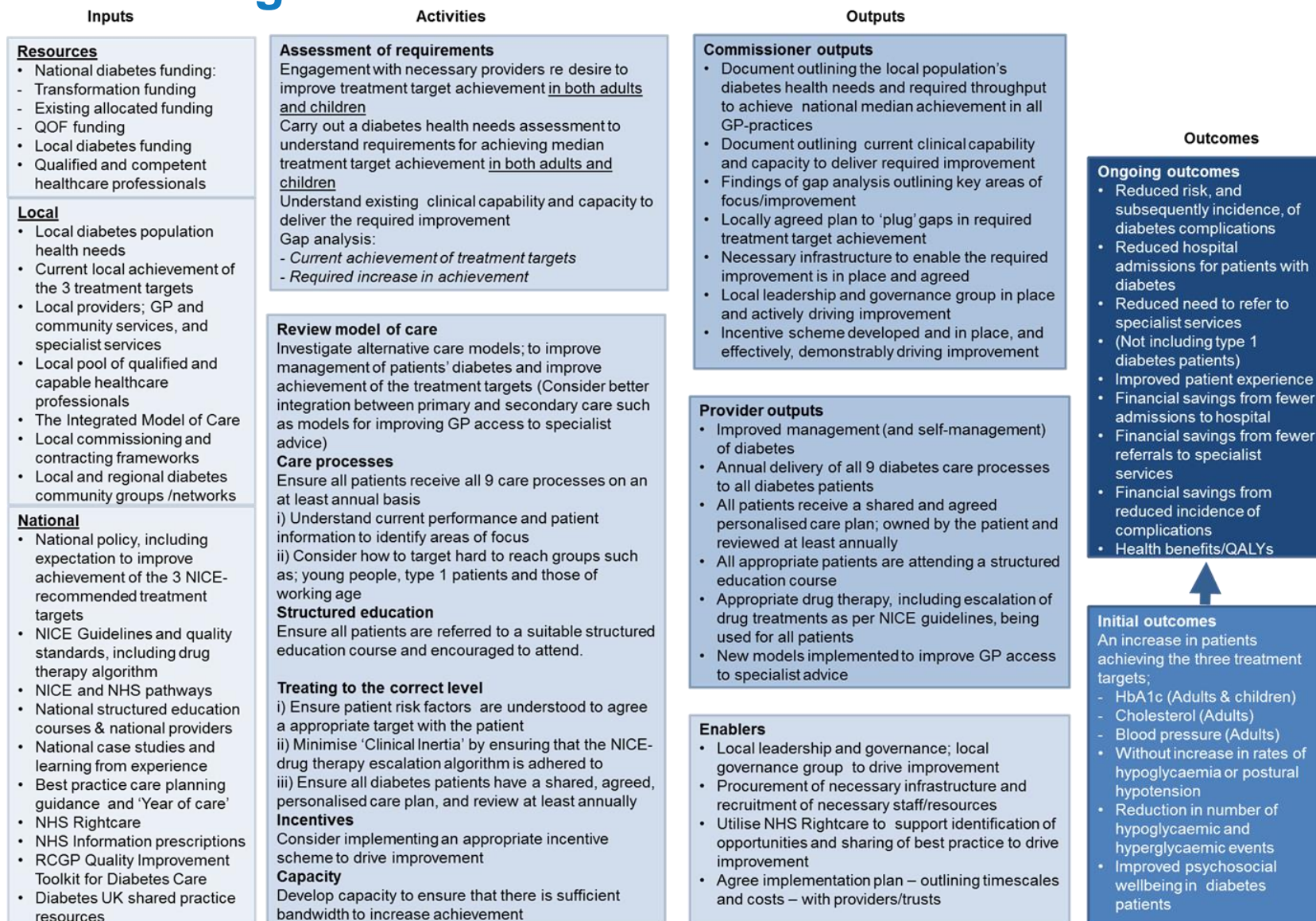
Intervention 2

Improving achievement of treatment targets

Value Equation for Improving achievement of treatment targets



Logic Model for Improving achievement of treatment targets



Evidence Tracker for Improving achievement of treatment targets

	Primary assertion	Sub-assertion	Evidence available	Further evidence to be gathered	Metrics	Target
Clinical	<p>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:</p> <ul style="list-style-type: none"> 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). 	<p>Achievement of the NICE-recommended treatment targets could be improved by:</p> <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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/methodologies 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. 	<ul style="list-style-type: none"> 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). 	<p>All CCGs to achieve national median treatment target achievement.</p>

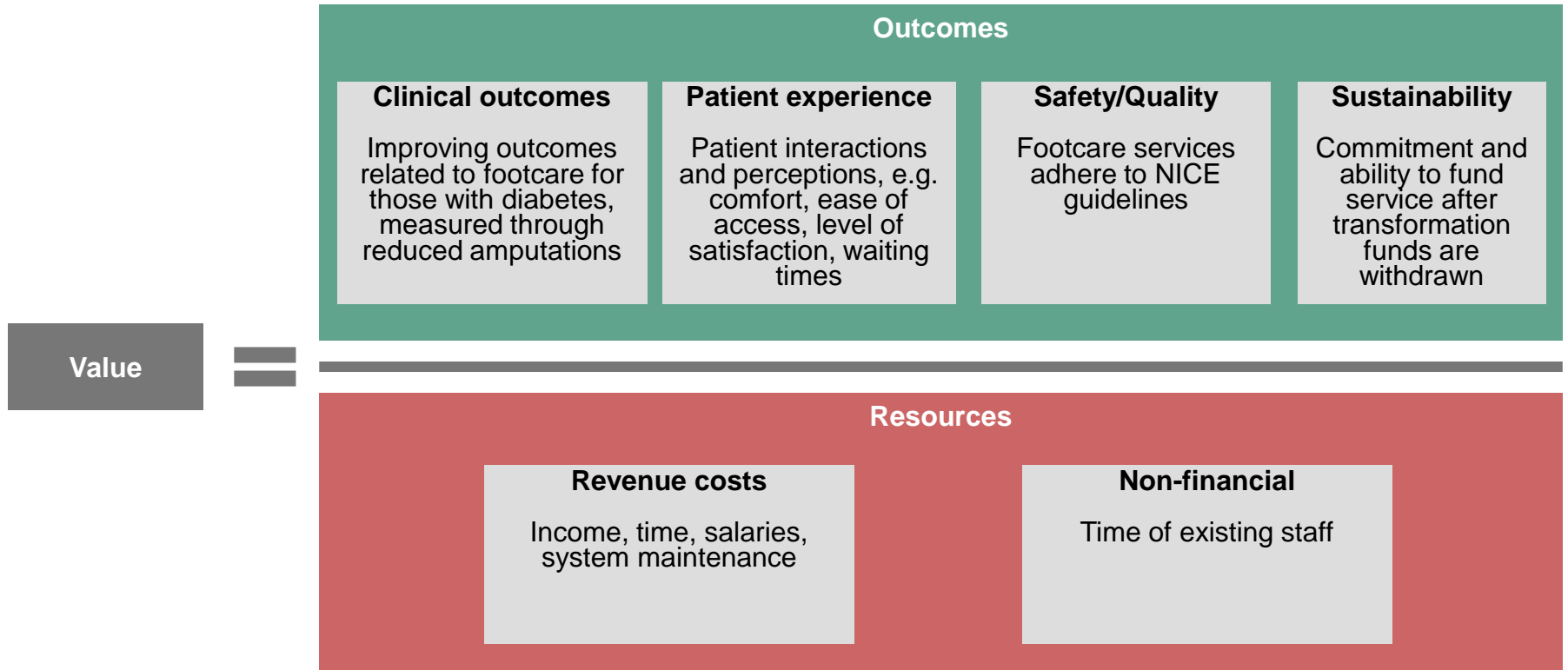
Appraisal Criteria for Improving achievement of treatment targets

Value equation		Outcomes/Criteria	Importance (%)
OUTCOMES	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%
	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%
RESOURCES		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%
RISKS		Assessment of identification of implementation risks and mitigating actions	25%
		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%
STRATEGIC		Proportion of new/additional service cost to be funded locally in 2017/18	50%
		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 multi-disciplinary footcare teams (MDFTs)



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



Evidence Tracker for New or expanded multi-disciplinary footcare teams (MDFTs)

	Primary assertion	Sub-assertion	Evidence available	Further evidence to be gathered	Metrics	Target
Clinical	<p>A multidisciplinary footcare team (MDFT) operating in inpatient and outpatient settings will improve patient outcomes and generate savings by:</p> <ul style="list-style-type: none"> 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. 	<p>Implementing a MDFT, with sufficient capacity, that;</p> <ul style="list-style-type: none"> 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. <p>Will improve treatment and management of diabetes patients with foot disease and, subsequently, improved patient outcomes.</p>	<ul style="list-style-type: none"> 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. 	<p>Further case studies re implementation of an MDFT and corresponding outcomes.</p> <p>Studies re quality assurance of service delivery, and subsequent service improvement, and corresponding outcomes.</p>	<ul style="list-style-type: none"> 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). 	<p>All trusts / hospitals to provide an MDFT service.</p>

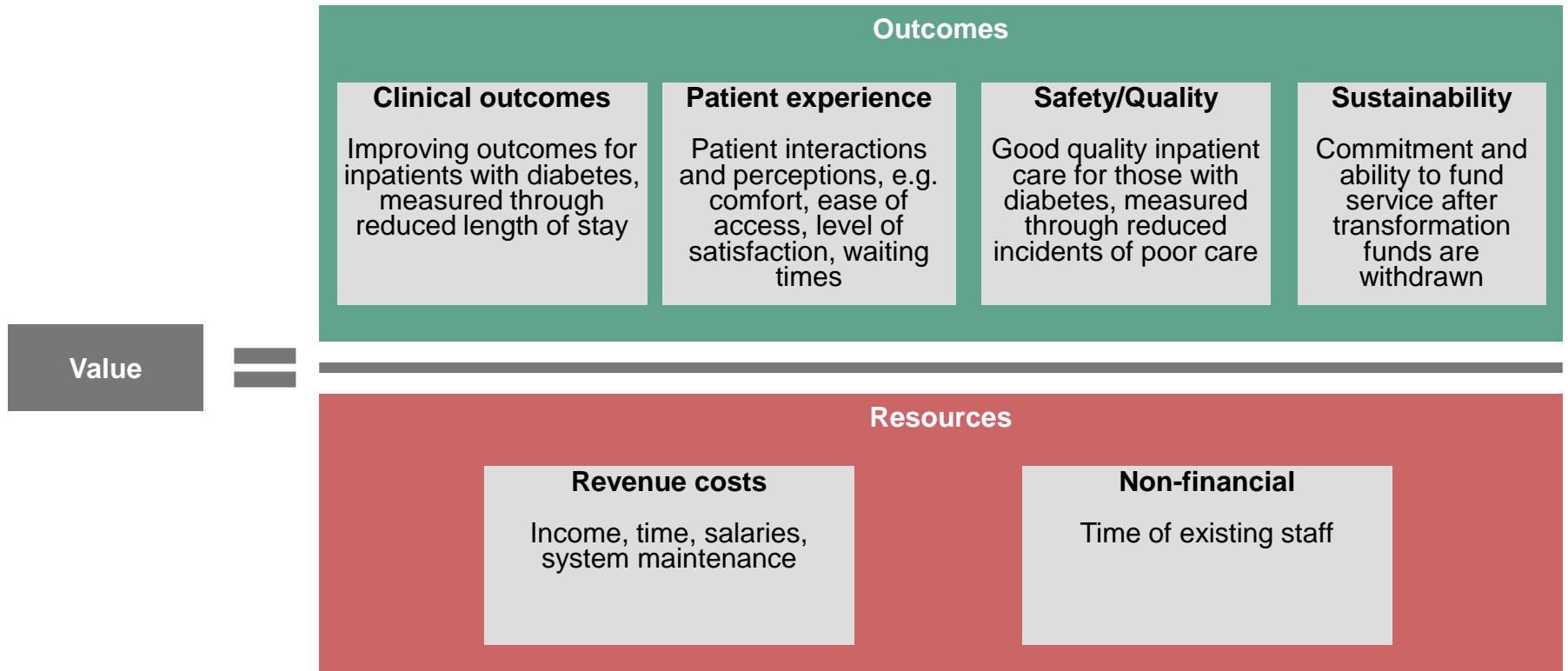
Appraisal Criteria for New or expanded multi-disciplinary footcare teams (MDFTs)

Value equation		Outcomes/Criteria	Importance (%)
OUTCOMES	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%
		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%
	Sustainability	Commitment to continued funding	15%
		Savings generated locally.	10%
RESOURCES		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%
RISKS		Assessment of identification of implementation risks and mitigating	25%
		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%
STRATEGIC		Proportion of new/additional service cost to be funded locally in	100%

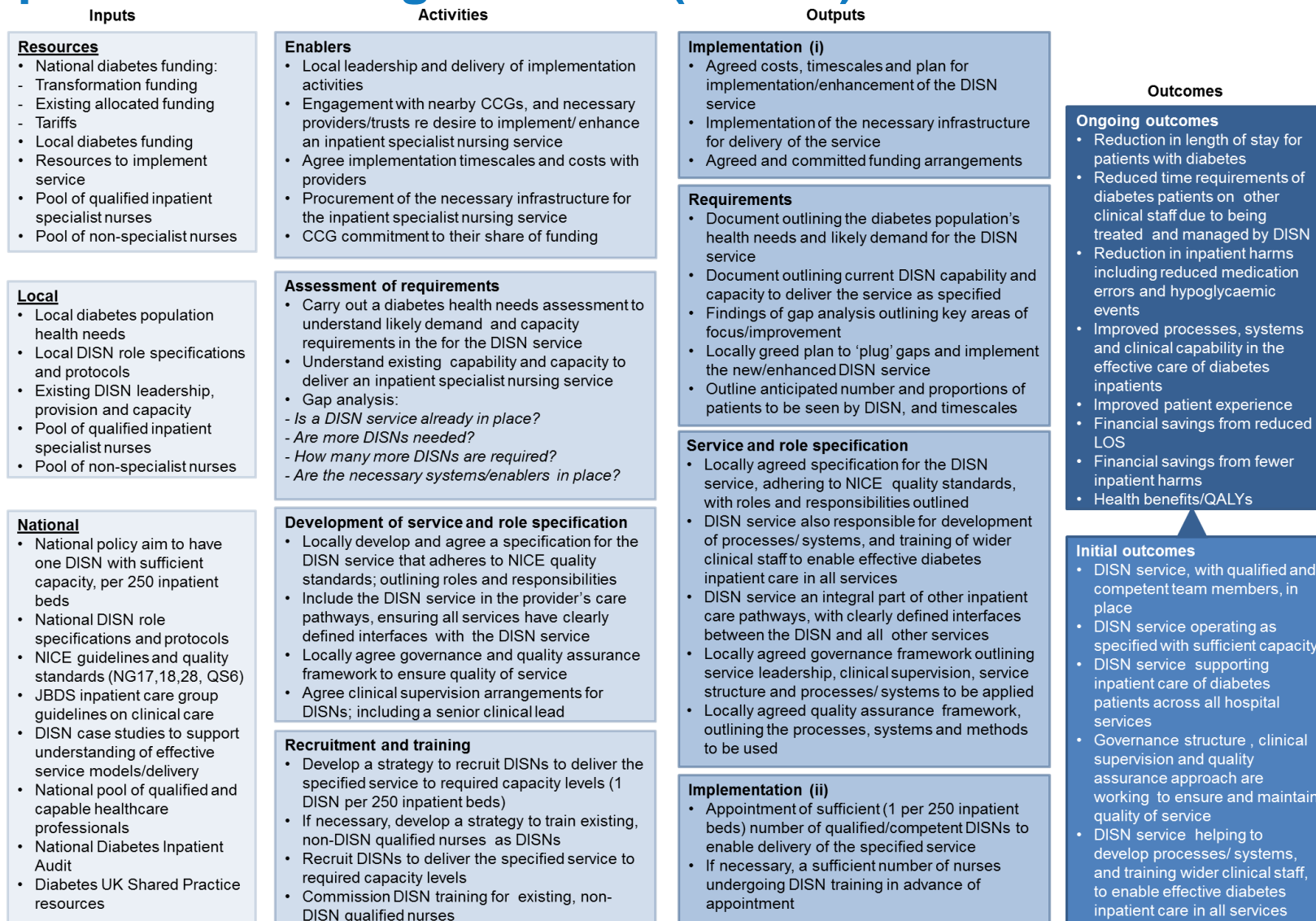
Intervention 4

**New or expanded diabetes
inpatient specialist nursing
services (DISNs)**

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



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



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

Clinical	Primary assertion	Sub-assertion	Evidence available	Further evidence to be gathered	Metrics	Target
	<p>A diabetes specialist nursing (DISN) service with 1 nurse per 250 inpatient beds, will improve patient outcomes and generate savings by:</p> <ul style="list-style-type: none"> 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. 	<p>Implementing a DISN service, that;</p> <ul style="list-style-type: none"> 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. <p>Will ensure high quality service provision and, subsequently, improved patient outcomes.</p>	<ul style="list-style-type: none"> "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 evidence is available in appendix 1. 	<p>Further case studies re implementation of a DISN service.</p> <p>Case studies into how DISNs have developed processes and systems, and educated wider clinical staff.</p>	<ul style="list-style-type: none"> Number of DISN services in operation, and number per of DISNs per inpatient beds, and staffing hours (NaDIA). Average length of stay for inpatients with diabetes (HES). Number of inpatients with diabetes experiencing harms (medication errors and hypoglycaemic events) (NaDIA). Patient experience score (Locally collected or NaDIA). 	<p>All trusts / hospitals to provide a DISN service, with at least 1 DISN per 250 patient beds.</p>

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

Value equation		Outcomes/Criteria	Importance (%)
OUTCOMES	Clinical	(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%
		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%
		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%
RESOURCES		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%
RISKS		Assessment of identification of implementation risks and mitigating actions	25%
		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%
STRATEGIC		Proportion of new/additional service cost to be funded locally in 2017/18	100%