

REPORT TO THE PBC GOVERNANCE TO BE HELD ON

Enclosure:					
Subject:	Diabetes Community Service				
Lead Director:	Sue Price				
Lead Officer:	Hayley Darlington				
Recommendation:	For Approval	<input checked="" type="checkbox"/>	For Discussion		For Information

PURPOSE OF THE REPORT:

<p>To outline a proposal for the development of the South East Staffs community diabetes service to be fit for purpose. This service would deliver care in line with the evidence, increase efficiency and improve patient outcomes.</p> <p>Additional funding is required to increase resources in the community nursing team. Benefits include increased education to primary care, patients and nurses, As well as increased clinic time to see new and follow up patients. This work will be complimented by reorganisation of consultant clinics to ensure clinics are more effective and introduce more clinics such as adolescent clinics.</p> <p>Savings will be realised from a reduction in emergency admissions and new and follow up outpatient consultant clinics at HEFT.</p>

IMPLICATIONS:

Legal and/or Risk	
Standards for Better Health	Clinical and Cost Effectiveness C5,D2, Patient Focus C13,C14,C16,D8,D9 Accessible and Responsive Care C17,C18,C19,D11
Financial	Invest to save £72,037 – mid points and inclusive of 22% on costs (Inclusive of travel and set up costs) 0.5 Band 7 DSN £20,960 1 Band 6 Diabetes nurse / educator £33,969 0.5 Band 4 Coordinator £11,892
Training	Will be delivered to Nursing homes and GP's and practice Nurses
PBC	PBC Generated project and proposal
Patient Engagement & Safety	Informal patient feedback identified the need to reduce waiting times and the potential for local adolescent clinics.

RECOMMENDATIONS / ACTION REQUIRED:

Agree the proposal to move service forward to implementation.

ANNEX 2

A Service Provision Template Business Plan

This pro-forma has been designed to assist in submitting an outline business plan proposal for local service provision. This proforma should be used for proposals to be submitted under contracting schemes such as a Local Enhanced Service (LES), PMS, SPMS and APMS etc.

The PCT can provide assistance in completing this proforma. Please provide as much information as possible to enable the PCT to make a provisional informed decision in principle. The PCT will be looking for the proposal to meet local needs as well as falling within the scope of the PCT strategic commissioning framework and priority areas as listed in Section 1 of this proforma. The PCT will also be looking for evidence that this proposal has been developed in line with local public and front-line staff opinion and that local public health issues have been addressed.

(NB: Annex 1 is also available in Word so it can be amended for local use. [Click here to open](#))

TITLE OF PROPOSAL	Community Diabetes Service
ORGANISATION/ COMMISSIONING BODY	SSPCT Commissioning
LEAD NAME FOR PROPOSAL	Hayley Darlington / Anna Hammond
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Document Control

Document Version	Date of Revision	Summary of Revision
Version One 21.01.2010		

Section 1: Compliance with the PCT Commissioning Framework

This business plan complies with the following priority areas as outlined in the PCT Commissioning Framework:

PCT Commissioning Framework Priority Areas: <i>PCT to complete PCT Commissioning Framework priorities as outlined in the PCT LDP and ISIP.</i> <i>Full details of each of these areas are available from your PCT</i>	This business plan relates to the following <i>(Proposer to tick as appropriate):</i>
<i>PCTS have specific targets on all of the following areas in line with national directives regarding achievement thereof, and practice are expected to work within these priorities as practice based commissioners. With regard to your specific service proposal, please tick all appropriate boxes served by your scheme.</i>	
1. National priorities	X
1.1 Improving health of the population	X
1.2 Supporting people with long term conditions	X
1.3 Access to services	X
1.4 Patient/user experience	X
1.5 Achieving financial balance	X
1.6 Implementing reform	X
1.7 6 key service priorities:	
- health inequalities	
- cancer 31 and 62 day waits	
- 18 week wait	X
- MRSA	
- Patient Choose & Book	X
- Sexual health & access to GU medicine	
1.8 Links with Integrated Service Improvement Plan (ISIP) & Benefits Realisation Plan (BRP)?	
2. Local priorities	X
(for completion locally)	

Section 2: Outline of the Proposed Service Provision

<p>Introduction <i>Give a brief outline of the background (i.e. current service provision and demonstration of need for improvement. Include Health Needs Assessment)</i></p>	<p>This document sets out the commissioning intentions for the diabetes services in South East Staffordshire. These intentions seek to improve the current service utilising existing resources within South Staffordshire PCT provider services. In addition some investment will be required which could be funded from savings achieved from commissioning a more efficient and effective service. It is also intended that changes will enhance patient outcomes and improve staff satisfaction in the service they are providing.</p> <p>This proposal has been established with clinical guidance and support from PBC Consortia and the local diabetes Network. The project steering group membership consists of GP ViJay Rajput, Consultants Sharon Jones and Teh Mingming who provide the consultant clinics in the community hospitals, and both CNS Pat Lamb and Lisa Markew.</p> <p>Care for diabetes may be provided in a variety of settings and in differing models in primary or secondary care according to need. We investigated the various diabetic models of care and discussed the differing models with Fiona Kirkland and our colleagues in the West locality our conclusion was that the current combined model of Nurse and Consultant led was locally effective providing a patient led service supported by the local health economy. Enhancements to the current service would strengthen the care delivered ensuring a locally beneficial service to patients, health professionals and would facilitate ongoing support to our local community hospitals, ensuring care closer to home.</p> <p>Research and a scoping exercise on local services have shown that the current allocation of resources in South East Staffordshire for diabetic care is not sufficient to meet the needs of the local population, with the cost implications of treating diabetic complications substantial and rising in both the national and local health economy, we have identified that saving can be made from the model of care we propose.</p> <p>Workforce</p> <p><u>Community Nursing</u> The current diabetes service workforce in South East Staffs consists of 2 WTE Band 7 Diabetes Specialist Nurses. The DSN's currently hold 2 clinic sessions a week in each community hospital plus 3 extra clinics a month over both sites. With a current caseload of 1000 plus patients, demand on service outweighs the available capacity within the team.</p> <p><u>Consultants at Community hospitals</u> There are 12 consultant clinics per month in the two community hospitals which are overseen by Consultants from HEFT. There is inequity in location of these clinics with 2 clinics a week in Lichfield and only one in Tamworth. Each Consultant clinic sees approximately 10 – 12 patients per clinic. On average 55% of the patients are diabetic, the remaining patients are</p>
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categorised as attending a general medicine clinic.

Waiting times

Currently patients are waiting 6 weeks for a new consultant appointment. For a consultant follow up appointment patients are waiting 8 weeks at Samuel Johnson and 20 weeks at Sir Robert Peel.

Patients wait an average of 9 weeks between DSN clinical appointments from first assessment to follow up and 12 weeks for education sessions.

Service gaps

The gaps which were identified in the current service were

- Nursing home education and support
- Practice Nurse mentoring sessions.
- Other speciality input to support the diabetes service. E.g. podiatrist or dietician
- Adolescent clinics (transition patients)
- Rapid assess to clinic slots for newly diagnosed or distressed patients.
- Insulin Pump Clinics
- Delivery of education packages

Ideally newly diagnosed patients should be seen 3 times in 3 months this is currently not occurring.

The impact of these gaps has resulted in increasing admissions to secondary care, with patients having to go out of area for treatment (pump clinic patients) and long delays for follow up community care and access to education sessions.

Outline of Proposal

How does this link to PCT & Local priorities?

To develop a community diabetes service which is fit for purpose. This service would deliver care in line with the evidence, increase efficiency and improve patient outcomes.

In order to achieve the proposed enhancements to the service, reduce patient waiting times and make the key changes outlined in the proposal the Community Diabetic team would need to increase its workforce by;

Proposed	Funding
Increase Band 7 DSN from 2 WTE to 2.5 WTE	£20,960
Introduce 1x Band 6 Nurse / educator	£33,969
Introduce 0.5 x Band 4 coordinator	£11,892
Maintain 0.25 x Band 2/3	£0
Total	£66,821

This Service enhancement will

- Improve the health of the local population
- Support people with Long Term Conditions

	<ul style="list-style-type: none"> • Improve access to services • Provide Care outside Hospital home • Assist in achieving financial balance • Increase life expectancy
<p>Aims & Objectives <i>(Please expand on the brief outline that you gave in the Commissioning Proposal)</i></p>	<p><u>Reducing Waiting times</u></p> <ul style="list-style-type: none"> • Increase specialist <u>nursing capacity</u> in the diabetes team to meet demand for follow up care in the community. • Introduce <u>nurse led triage</u> with rapid access clinic slots for newly diagnosed patients. • Introduce <u>practice based nursing</u> clinics (GP cluster clinics) • Continue to provide the <u>consultant led clinics</u> at the community hospitals, increasing there effectiveness via the reorganisation of the clinics. (Location and theme). • Enhance the establishment of <u>nurse led clinics</u> alongside the consultant clinics. • Improve <u>management plans</u> for discharge back to GP <p><u>Clinical Coding</u></p> <ul style="list-style-type: none"> • Improvement in <u>coding of diabetes clinics</u> at the community hospitals ensuring general medical patients and diabetes patient clinics are separated. <p><u>Nursing homes</u></p> <ul style="list-style-type: none"> • Recruit an individual who would be dedicated to the Nursing Home <u>education programme</u> delivery • Establish a <u>supported programme of work</u> in Nursing Homes. <p><u>Education</u></p> <ul style="list-style-type: none"> • Create of comprehensive <u>education packages</u> for patients and professionals, ensuring that all newly diagnosed patients have timely access to an accredited Education Programme. • Improve liaison and <u>education</u> with healthcare professionals in GP practise to promote identification of potentially <u>at risk patients</u>. <p><u>Clinic establishment</u></p> <ul style="list-style-type: none"> • Introduce <u>adolescent transition clinic</u> to capture the gap in current services for 18 -30 year old diabetic patients. • Reinstate of <u>insulin pump clinics</u> to meet the local demand • Introduce <u>practice based nursing</u> clinics (GP cluster clinics)
<p>Management of the Service <i>(Explain how the service will be managed i.e. receiving referrals, appointments, outcomes and waiting list</i></p>	<p>The current service is managed by PCT Provider Service; the additional resource will enhance this service provision.</p> <p>Referrals are received from GP, Community Professionals, Consultants and the Acute Hospitals, via chose and book and will be triaged appropriately by the PASS in South East Staffordshire.</p> <p>The Pathway below demonstrates the patient flow from referral to discharge</p>

<p>requirements)</p>	<pre> graph TD A[GP Sees patient and is unable to manage in practice] --> B[Makes Referral to PASS] B --> C[Nurse Triage Referral] C --> D[DSN Clinic Appointment] C --> E[Consultant Appointment Patient offered Choice of Provider] D --> F[Patient seen in DSN clinic in Community setting GP practise or Community hospital] E --> G[Patient referred back into general practice with practise diabetes support] E --> H[Patient booked into Consultant clinic slot at Acute provider of Community Hospital] F --> I[Patient managed in community clinics with follow up appointments with DSN or Consultant] G --> I H --> I I --> J[Onward referral to other health professional one off appointment] I --> K[Discharge back to GP with management plan] I --> L[Discharge back to GP with management plan] I --> M[Onward referral to other health professional one off appointment] J --> N[Open Return to Services at all times - GP contact PASS for signposting to appropriate DSN or consultant] K --> N L --> N M --> N </pre>
<p>Scope of the Proposed Service (i.e. which patients will be using the service, Target Localities/patient profile)</p>	<p>All type 1 and type 2 Diabetic Patients 18 and over who are registered with a GP in South East Staffordshire.</p> <p>All patients 18 and over registered with GP in South east Staffordshire who are at risk of diabetes to have a formalised pathway to lifestyle and pre diabetes education.</p>
<p>What will be the benefits to Patients? (How will this link in to Choice/Choose & Book?)</p>	<ul style="list-style-type: none"> • Reduction in the number of emergency admissions to acute sector • Reduced waiting times for consultant and DSN Clinic community appointments • Will be seen by the appropriate clinician at the right time (triage process) • Increase in the frequency of patient education sessions • Reduced service gap between paediatric and adult diabetic services. • Increased number of patients will be discharged back to General Practice. • Care closer to home.
<p>What will be the benefits for Clinicians/Staff?</p>	<ul style="list-style-type: none"> • Effective monitoring of clinic activity as a result of specific clinical coding

	<ul style="list-style-type: none"> • Increased skills and competencies in Nursing home employees • Increased knowledge and skills in primary care in prevention and risk monitoring via practice education and support from the team • Increase staff satisfaction in service delivering • Supported service
<p>What will be the anticipated benefit area for the PCT <i>(i.e Number of Reduced Admissions / Avoided Out Patient attendances)</i></p>	<ul style="list-style-type: none"> • Reduction in the number of emergency admissions to acute sector • Reduction in tariff payments to HEFT • Reduction in number of outpatient appointments for adolescent patients at Good Hope Hospital • Increased activity and better use of SSPCT Community Hospitals.

Milestones & Timescales	Milestone	Timescale
	Reorganisation of Consultant clinics	Jan - Feb 2010
Establish inclusion and exclusion criteria for clinics referrals	Jan – Feb 2010	
Appropriate coding for clinics established	Feb 2010	
Establishment of education packages	Jan – April 2010	
Launch of transition clinics	March – April 2010	
Recruitment of new posts	March – April 2010	
Implementation of the nursing home project	April – July 2010	
Practice based nursing clinics	April – July 2010	

Initial Risks Associated with the Service Provision Proposal and Strategy for managing those risks (Countermeasure)	Risk	Countermeasure
		Business case not agreed
	Posts are not recruited too	Re look at details of job spec Re advertise
	Recruitment Freeze	No countermeasure

Section 3: Financial Implications

Annual Expenses (Cost of New Service) <i>List a breakdown of all expenses, remembering to add on-costs to staff costs</i>	Year 1	Year 2	Year 3
Capital Costs			
Staffing Costs, including backfill for clinicians running new service provision	£66,861 (Recruitment of 3 posts at mid banding with 22% on costs)	£68,532 (Including rise of 2.5% uplift)	£70,245 (Including rise of 2.5% uplift)
National Insurance@9.3%			
Training and Supervision Costs			
Other Training (Attendance at conferences/national courses/Symptom Management courses)			
Equipment & Materials	Computer x1 Laptop x1 Phones x2 £1000		
Set up costs			
Uniform			
Sundry equipment			
Other Expenses	Travel for 2 employees 7200 miles per year @ 0.58 pence per mile £4176	Travel for 2 employees 7200 miles per year @ 0.58 pence per mile £4176	Travel for 2 employees 7200 miles per year @ 0.58 pence per mile £4176
Total Cost of New Service	£72,037	£72,708	£74,421
Anticipated Revenue <i>please explain source of revenue</i>			
Profit Element for Service Provider			

Anticipated Financial Benefit to PBC Budgets	Year 1	Year 2	Year 3
Anticipated freed up resources achieved through avoided secondary care activity. <i>Please specify:</i>	<ul style="list-style-type: none"> Adolescent clinics £17,840 (Reduction of outpatient new and follow up at HEFT) Reduce 10 Non elective admissions £13,960 Nursing Home Project £49,520 (Reduction in Non elective admissions) * 	<ul style="list-style-type: none"> Adolescent clinics £17,840 (Reduction of outpatient new and follow up at HEFT) Reduce 10 Non elective admissions £13,960 Nursing Home Project £49,520 (Reduction in Non elective admissions) * Consultant Clinic Reduction £22,080 	<ul style="list-style-type: none"> Adolescent clinics £17,840 (Reduction of outpatient new and follow up at HEFT) Reduce 10 Non elective admissions £13,960 Nursing Home Project £99,040 (Reduction in Non elective admissions) * Consultant Clinic Reduction £22,080
Less Cost of new Service Provision to users of the service	£72,037	£72,708	£74,421
Potential Surplus to PBC Budgets	£9,283	£30,692	£78,499

How much funding is being requested & identification of purpose	<p>£72,037 – mid points and inclusive of 22% on costs 0.5 Band 7 DSN £20,960 1 Band 6 Diabetes Nurse / educator £33,969 0.5 Band 4 Coordinator £11,892 Inclusive of travel and set up costs</p> <p>Year 2 As above Year 3 As above</p>
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Note: * Potential savings through care home education for staff and patients in the 16 care homes in SES. (£66,000)

There are approximately 5 diabetic patients in each of the 16 care homes who frequently attend A&E as a result of their diabetes, each of these patients will cost on average £825 per annum in A&E admissions. (*Financial figures based on the savings from acute care home admissions achieved in East staffs in the same project.*)

If each of these had 1-2 days length of stay at a minimum daycase cost of £413 then an additional £33,040 could be saved
Total potential nursing home savings £99,040

Section 4: Corporate Governance

Please note that some contracting methods will entail certain liabilities, for example a Limited Company option under APMS. It is therefore essential specialist advice is taken to understand clinical/personal liability, medical indemnity etc.

<p>On which contracting basis do you intend this service provision to be based? <i>e.g. LES, PMS, SPMS, APMS, PCT GPSI Commissioned Service, please explain.</i></p>	<p>Commissioned service with PCT Provider Service</p>
<p>Which National, NSF and PCT Targets will this service provision deliver against?</p>	<p>The service proposal follows the recommendations outlined in the South Staffordshire PCT Diabetes Strategy and best practice as laid out in the National Institute for Clinical Excellence guidelines and the guidelines listed below</p> <ul style="list-style-type: none"> • Five Years on – delivery of the diabetes NSF (DH 2008) • Type two- Newer agents (NICE 2009) • Type Two Diabetes: the management of type two (Nice 2009) • Working together for better Diabetes Care (DH 2007) • Healthcare Commissions Standards for better health
<p>Demonstrate links to Standards for better Health <i>(Please identify standards and describe how this plan will support achievement of the standards)</i></p>	<p>Clinical and Cost Effectiveness C5,D2, Patient Focus C13,C14,C16,D8,D9 Accessible and Responsive Care C17,C18,C19,D11</p>
<p>Patient, Public & Front-line Staff Involvement. <i>Please describe how you have involved Patient, Public and front-line staff in this proposed development.</i></p>	<p>Diabetes Network Patient user representation South East Staffs Diabetes Service Users Front line SSPCT employees have been engaged throughout</p>

Section 5: Quality & Corporate Assurance

Please note there is value in discussing your proposals early on with your PCT Clinical Governance Lead

Clinical Governance Assurances			
Please provide details of how the intended provider location meets Health & Safety and other Clinical Governance Assurance standards	This is part of SSPCT Provider Health and Safety clinical governance assurance Standards		
Please Specify Audit arrangements ie, patient satisfaction surveys, reduction of hospital referrals & admissions	Outcome	Measure	Frequency
	All primary care referrals to be triaged by DSN.	100%	Monthly
	All new patients to be seen in clinic within 4 weeks of referral	90%	Monthly
	Newly diagnosed Patients have been offered structured education packages and regularly reviewed care plan.	100%*	Monthly
	There will be at least one adolescent clinic once a month	100%	Monthly
	Patients with a diagnosis of diabetes will receive 3 follow up appointments 4-6 weeks apart	90%	Monthly
	Patient Satisfaction	Standardised education package evaluation tool to be used to evaluate patient satisfaction.	Quarterly
	Nursing Homes	100% of Nursing homes will receive diabetes education and training.	Quarterly
Reduction in A&E attendances for Nursing home patients	50% (baseline needs indentifying)	Annually	
What Quality Checks will be in place?	As above – Patient outcomes and patient feedback		
What information will you supply to the PCT and with what regularity?	Activity monitoring to PCT Commissioners As Above in measures table		
Outline Contractual Arrangements (To be detailed in the Service Level Agreement)			
Proposed period of Contract			
Proposed Notice Period			

What Contract Review arrangements do you envisage?	Yearly PCT Contracting round
How will Complaints be managed?	Through PCT Complaints department

To be Completed by PCT:

Comments received:	Date
Service Development Group	
Clinical Governance Lead	
Executive Directors	
Professional Executive Committee	

Outcome of Application	Name	Date
Approved – on the basis of:		
Rejected - Reasons for Rejection:		
Passed for Payment:		