NHS Rotherham Clinical Commissioning Group

Operational Executive – 13 September 2019
Strategic Clinical Executive – *25* September

GP Members Committee – 30 October 2019

CCG Governing Body – 4 March 2020

Diabetes Service Review

Lead Executive:	Ian Atkinson. Deputy Chief Officer
Lead Officer:	Jacqui Tuffnell, Head of Commissioning
Lead GP:	Dr Sophie Holden

Purpose:

The purpose of this report is to set out proposals for review and re structure of the Community Based Diabetes Service for Rotherham. It does not include the audit work being undertaken by the medicines management team in relation to diabetes management.

Background:

A new model for Diabetes care started on the 1 April 2017. This was in response to national reports indicating that Rotherham was an outlier for Diabetes care both in terms of cost and outcomes. The annual cost of Diabetes in Rotherham is around £10.5 million (excluding associated complications) and this figure is projected to increase to £12 million over the next 3 years.

The model implemented was based on the Portsmouth "Super 6" model which saw the vast majority of patients being managed in the community by GP practices and the Diabetes Specialist Diabetes Nursing Service (DSN). The model also included support from secondary care clinicians with provision of education and advice via virtual clinics and MDTs and by the DSN Service.

National funding to increase outcomes for the 3 Diabetes treatment targets (BP/cholesterol/HbA1c) became available and coincided with the start of the new Diabetes model (17/18). The funding lasted for 2 years and employed one extra DSN for 2 years and one Specialist Dietician for 1 year. These 2 members of staff concentrated on providing education and training to Primary Care staff and patients to "upskill" them in managing Diabetes to improve outcomes. It was thought that this extra funding would accelerate improvements in treatment target outcome by 2% annually. Diabetes targets were also included in the GP quality Contract.

Despite investment in the above, treatment targets have failed to improve as expected, so as part of the CCGs Commissioning Intentions for 2019/20, the Diabetes service and Diabetes care has been identified as a key priority for improvement to meet the future challenges that will come with the predicted rise in prevalence.

The Community Diabetes Service is currently based in the Diabetes Centre at The Rotherham Hospital Foundation Trust. This means that patients have to travel to the hospital for reviews by the Community DSNs and to undertake structured education. The Community DSNs are also utilised in Specialist secondary care outpatients clinics. They are currently asked to provide a presence in Insulin pump clinics, young people's clinics, transition clinics, and antenatal clinics. The DSNs have also been requested to provide ward based care on occasions when the hospital has been under pressure.

In order to try to establish the scale of the challenge, and where efforts are best placed to try to improve Diabetes targets, funding has been provided to employ a Pharmacy technician to undertake audits in Primary Care. The audit tools have now been built and tested and audits have commenced. These audits will look at HbA1c targets and prescribing data. Data from these audits should be available by October 2019. A separate paper is being provided in relation to the efficiencies expected from better medicines management for diabetes.

Analysis of key issues and of risks

Key issues

The education provided to Primary care has not had the expected impact in improving control of HbA1C, cholesterol and blood pressure. Primary care capability remains variable leading to variable standards of care delivered to patients.

In addition, due to resource constraints, Primary care capacity has not risen with the rise in prevalence of Diabetes which has affected patient care and outcomes.

Services such as the DSN service, podiatry and dietetics are predominantly secondary care based and often fail to reach patients who need their services in the community.

The current pathway is fragmented with the service being delivered by separate organisations (hospital, community and GP practices) with no proper overarching care planning across the system.

There is scope to deliver more holistic care for patients and to develop a more joined up pathway closer to home. Self-care, care in the community and support to Primary care are key elements that can have a major impact on outcomes. Through delivering more integrated community care the CCG anticipates that this will improve both the quality of care and also make better use of resources.

It is proposed to move the current Community Diabetes Service into the Community to ensure that services are provided in the patient's locality. This will also ensure that the Community DSNs will be utilised solely within the Community to support GP practices and patients and avoid being pulled into secondary care provided services. This will then support the practices with improving their medicines management. They will still maintain close links with the wider Diabetes team including Podiatry and Dietetics.

This will require the DSN service currently provided by Rotherham Foundation Trust to be transferred into the community. There are a number of options for enabling community based delivery:

1 – Primary Care Networks to directly employ the team

2 – Rotherham Federation to directly employ the team on behalf of the Primary Care Networks

3 – Rotherham Federation to provide the service via Rotherham Foundation Trust

This will allow the DSN service to provide GP and community based clinics and direct support to Primary care, along with locally provided structured education for patients.

Data from the audits will be analysed to establish where further investment to save can be targeted. This could include improving control for patients on GLP1 medication and allow the DSN service to concentrate on improving treatment targets for patients on Insulin and those patients utilising the Freestyle Libre.

TRFT to consider how they are going to deliver these services from their tariff funded resources.

It is proposed to retain all the currently employed DSN team including the Band 4 whose role is predominantly to educate care homes in diabetes care. There would be 2 members of staff displaced from the proposals, a full-time Band 5 Office Manager and 0.53wte Band 3. From review of the roles, both these posts predominantly support secondary care.

Patient, Public and Stakeholder Involvement:

The service will be delivered by the same clinicians and there will be no change in service provision, the team should have more time dedicated to their community role

Equality Impact:

The service will be delivered by the same clinicians and there will be no change in service provision, the team should have more time dedicated to their community role

Financial Implications:

The table below outlines the cost of the new model compared to the current model.

			New		2016/17 Budget		Difference	
	wte	hrs	£		wte	£		
Band 8A	0.80	30.00	£47,684				0.80	
Band 7	1.00	37.50	£50,543				1.00	
Band 6	1.00	37.50	£42,206				1.00	
Band 7	0.64	24.00	£32,044		1.80	£77,352	-1.16	0.64
Band 6	0.72	27.00	£30,151		3.31	£119,528	-2.59	-1.59
Band 5	0.60	22.50	£20,119		1.45	£54,316	-0.85	
Band 4	0.64	24.00	£17,597		0.72	£17,652	-0.08	
Band 2 A&C	1.00	37.50	£22,204		1.78	£35,484	-0.78	
Band 3 A&C					0.53	£12,360	-0.53	
Band 5 A&C					1.00	£35,172	-1.00	
Total	**6.40**		**£262,548**		**10.59**	**£351,864**	**-4.19**	

Consumables are estimated at £120,000 however this is from previous information as TRFT have not provided the information to date.

Overheads have been calculated on a worst case scenario of 25% which would be for both TRFT and Federation overheads.

As detailed in risks, there are 2 staff members impacted detrimentally by the proposed change, it is anticipated that both post holders will be able to be redeployed within the Hospital however there is a small risk of redundancy.

Overall, the current service contract is £540,000 and the new contract is expected to be £470,000 anticipated saving from these changes is expected to be £70,000 however the impact is expected to be greater in terms of the availability of staff supporting primary care. This will support the release of the savings identified in Medicines Management paper.

Human Resource Implications:

The staffing listed above would have potential TUPE implications depending on the option chosen for the delivery of the service, should this be approved. There are also two members of staff identified who would not form part of the structure therefore the Trust would need to consider the redeployment options for these individuals.

Procurement Advice:

A discussion has taken place with the procurement team. Whilst it is clear in the long term plan that the direction of travel is to have more community services within the primary care networks

the legislation doesn't currently support doing this without a process. There is therefore a potential risk of challenge however the value of the contract will only be in the region of £470,000. There are 3 options for how we handle the procurement that we have already sought the views of OE:

- Normal tender process
- Direct award
- Alliance model – Federation utilising TRFT staff to provide the community service

OE supported a direct award or alliance model

Data Protection Impact Assessment:

N/A

Approval history:

Operational Executive – 13 September 2019

Strategic Clinical Executive – *25* September 2019

GP Members Committee – 30 October 2019

Recommendations:

Governing body to approve the revised establishment of the team and transfer of the Community Diabetes Nursing Service into the community via option 2 or 3 dependent on the Federation's ability to host and agreement regarding preferred option for procurement

Paper is for Approval

Appendix 1

NHS Rotherham Clinical Commissioning Group

2020/21 Transformation Scheme Profile

Scheme Number	Scheme Name
	Diabetes service review

Section 1: Scheme Overview

Brief Description of Scheme
Transfer of the community diabetes team to support the primary care networks

Lead GP:	Lead Officer:
Sophie Holden	Jacqui Tuffnell

Please identify what level of documentation this scheme needs for approval		
Standard Report Template	**High Level (brief) Business Case**	**Full Business Case**
√		

Section 2: Impact Assessments *(see enclosures)*

Impact Assessments	Yes	No	Has this triggered the need for further assessment?
Has a Quality Impact Assessment been carried out?	√		No
Has an Equality and Engagement Impact Assessment been carried out?	√		No
Has a Data Protection Impact Assessment been carried out?	√		No

Section 3: High Level Value

What is the value of your Transformation Scheme		
£70,000 related to the staffing review however this is part of a wider scheme with the Medicines Management Team		
Have you provided further financial information for your scheme *(completion of enclosure 1)*	**Yes**	**No**
	√	

Section 4: Approval

Recommendation	
Reviewed by (OE Exec)	
Date approved at OE	13 September 2019
Date approved at SCE	25 September 2019
Date approved at CCG Governing Body	
Proposed frequency of review	

Enclosures	
Enclosure 1	*Financial Information*
Enclosure 2	*Quality Impact Assessment*
Enclosure 3	*Equality and Engagement Impact Assessment*
Enclosure 4	*Data Protection Impact Assessment*

Appendices	
Appendix 1	*Risk Scoring*
Appendix 2	*Engagement Assessment*

Enclosure 1

Financial Information

Brief Description of where savings arise from
Reduction in establishment to current employed staff for community

Profile of savings *(enter by month when the savings will be realised) Full year £70,000 – full efficiency may not be released as discussions have been protracted with TRFT*

	£		**£**
Apr- 20	0	Oct-20	7000
May-20	0	Nov-20	7000
Jun-20	0	Dec-20	7000
Jul-20	7000	Jan-21	7000
Aug-20	7000	Feb-21	7000
Sep-20	7000	Mar-21	7000
		Total	70,000

Please provide further appropriate financial information for your scheme:

Further information in relation to consumables and items associated to the contract is required

Enclosure 2

Quality Impact Assessment Screening Tool

Area of Quality Could the proposal impact *positive* ***(P)****, negative* ***(N),*** *or neutral* ***(N/A)*** on any of the following:	**P/N or N/A**	**Risk score (if N)** *See app 1*	**Comments:** include reason for identifying impact as positive, negative or neutral
1 Duty of Quality *Consider: Compliance with NHS Constitution, Impact on partner organisations, Impact on organisations duty to safeguard children and vulnerable adults, Impact on other services within the organisation*	N/A		No change to the current available staffing, the staff will be refocused on the community agenda therefore more time will be available within the community
2 Clinical effectiveness *Consider: Impact on provision of NICE compliant treatment, Impact on the implementation of evidence based practice, Impact on clinical outcomes, Impact on clinical leadership, Impact on the promotion of self-care, Impact on clinical engagement, mortality rates, readmission rates, safeguarding, partnership working*	P		The availability of more time in the community will enable the workforce to spend time and support patients with the use of new NICE compliant practice e.g. freestyle libra
3 Patient Safety *Consider: Impact on patient safety, Impact on avoidable harm, Impact on reliability of safety systems and processes, Impact on clinical workforce levels, competencies and experience, Impact on treatment times and procedures, Impact on safeguarding, Impact on systems and processes for ensuring that the risk of HCAIs is reduced, Impact upon clean and safe environments*	P		The availability of more time in the community will enable the workforce to spend time and support patients with the use of new technology, providing more time with complicated patients etc.
4 Patient Experience *Consider: Impact on patient informed choice and autonomy, Impact on patient access, Impact on dignity, respect and compassion, Impact on patients self-reported satisfaction on national/local surveys/ FFT, Impact on patients self-reported experience through the complaints process/PALS contacts, Impact on patient waiting times, Impact on the provision of individualised care, length of stay, privacy and dignity, discharge planning, collaborative working*	P		At present the community team are not able to spend as focused time in the community because of the requirement to support secondary care work. It is therefore anticipated that patients will see improvement in their individual care and supporting this cohort to self manage their condition.
For any scoring 12 and above, please consider whether this should be included in the CCGs risk register			

Assessment Completed by:	**Jacqui Tuffnell**
Date of Assessment:	**9 September 2019**

Enclosure 3

Equality Impact and Engagement Assessment Form

Please retain one copy, and pass one copy to both the Equalities and Engagement leads

Scheme Number	Scheme Name
	Diabetes Service Review

Section 1: Equality Impact Assessment	
1.1	**Gathering of Information:** *This is the core of the analysis; how might the project or work impact on protected groups, with consideration of the General Equality Duty. Please add any general information here.*
	The hospital will need to employ at minimum one Diabetes Specialist Nurse to support secondary care work e.g. pump clinics, transition clinics, antenatal, foot clinics. The community services is only changing to increase the availability of staff to support patients within their own community and working more closely with the primary care networks/GP practices.

1.2 Screening

Please complete each area	**What key impact have you identified?**			**Information Source**
	Positive Impact *will actively promote or improve equality of opportunity*	**Neutral Impact** *where there are no notable consequences for any group.*	**Negative Impact** *negative or adverse impact causes disadvantage or exclusion* *If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures*	**What action,** *if any, is needed to address these issues and what difference will this make?* *For example: at this point no action is required. Further EIA screenings will be developed in future once there are recommendations to assess*
Human Rights	Y/N	Y/N	Y/N	
Age	Y/N	Y/N	Y/N	
Carers	Y/N	Y/N	Y/N	
Disability	Y/N	Y/N	Y/N	
Sex	Y/N	Y/N	Y/N	
Race	Y/N	Y/N	Y/N	
Religion or belief	Y/N	Y/N	Y/N	
Sexual Orientation	Y/N	Y/N	Y/N	
Gender reassignment	Y/N	Y/N	Y/N	
Pregnancy and maternity	Y/N	Y/N	Y/N	
Marriage/civil partnership (only eliminating discrimination)	Y/N	Y/N	Y/N	
Other relevant groups	Y/N	Y/N	Y/N	

For support or further information (in relation to EIA section) please contact: Alison Hague @ alisonhague@nhs.net

Section 2: Engagement Impact Assessment								
2.1	**What is the level of service change**? *Refer to appendix 2 to assess the size of the change and tick the appropriate box*							
	Level 1	√	**Level 2**		**Level 3**		**Level 4**	
	Add additional information and rationale for this scoring below							
	Whilst this is a change for the community diabetes nursing team, patients should only see increased availability and support, no change to how their care is provided							
2.2	**Who are your stakeholders?** *Consider using a mapping tool to identify stakeholders (resources can be found in the Project Management Checklist) - who is the change going to affect and how?* *Complete below or attach or link to a mapping document*							
	Patients/carers Rotherham Foundation Trust Community Diabetes Team Dietetic service Podiatry service Diabetes UK General Practice Teams							
2.3	**What do we already know?** *What do you already know about peoples' access, experience, health inequalities and health outcomes? Use intelligence from existing local, regional or national research, data, deliberative events or engagements.* *Include any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight?* *Describe how the existing or proposed engagement will be 'fair and proportionate', in relation to the activity?* *Building on the EIA, how will you reach out to any community identified as having an impact by the scheme, are additional arrangements required?*							
	A new model for Diabetes care started on the 1 April 2017. This was in response to national reports indicating that Rotherham was an outlier for Diabetes care both in terms of cost and outcomes. The annual cost of Diabetes in Rotherham is around £10.5 million (excluding associated complications) and this figure is projected to increase to £12 million over the next 3 years. It was also because of the feedback from the DSN service that they were not able to provide consistent care as they were overloaded with patients that could be safely managed within primary care. The model implemented was based on the Portsmouth "Super 6" model which saw the vast majority of patients being managed in the community by GP practices and the Diabetes Specialist Diabetes Nursing Service (DSN). The model also included support from secondary care clinicians with provision of education and advice via virtual clinics and MDTs and by the DSN Service. Despite investment in the above, treatment targets have failed to improve as expected, so as part of the CCGs Commissioning Intentions for 2019/20, the Diabetes service and Diabetes care has been identified as a key priority for improvement to meet the future challenges that							

	will come with the predicted rise in prevalence. The Community Diabetes Service is currently based in the Diabetes Centre at The Rotherham Hospital Foundation Trust. This means that patients have to travel to the hospital for reviews by the Community DSNs and to undertake structured education. The Community DSNs are also utilised in Specialist secondary care outpatients clinics. They are currently asked to provide a presence in Insulin pump clinics, young people's clinics, transition clinics, and antenatal clinics. The DSNs have also been requested to provide ward based care on occasions when the hospital has been under pressure. The proposed changes will enhance patients experience because it will retain the existing clinical workforce and ensure that their focus is on the community service providing increased time to support patients in the community. As the only change patients will see is increased capacity, it is not proposed to undertaken any formal engagement.

2.4	**Next Steps**				
	As a result of this screening has further actions been identified			**Yes**	**No**
					√
	If yes, please describe actions	**Further discussions with Engagement Lead**	**Completion of Full Engagement Plan**	**Other**	

Assessment Completed by:	**Jacqui Tuffnell**
Date of Assessment:	**9 September 2019**

For support or further information (in relation to Engagement section) please contact: Helen Wyatt @ helen.wyatt6@nhs.net

Enclosure 4

Data Protection Impact Assessment

The below screening questions should be used inform whether a DPIA is necessary. This is not an exhaustive list therefore in the event of uncertainty, completion of a DPIA is recommended.

Scheme Number	Scheme Name
	Diabetes service review

Answering yes to any of these questions is an indication that a DPIA is required:

	Screening Questions	Yes	No
1	Will the project involve the collection of new identifiable or potentially identifiable data about individuals?		√
2	Will the project compel individuals to provide data about themselves? i.e. where they will have little awareness or choice.		√
3	Will identifiable data about individuals be shared with other organisations or people who have not previously had routine access to the data?		√
4	Are you using data about individuals for a purpose it is not currently used for or in a new way? i.e. using data collected to provide care for an evaluation of service development.		√
5	Where data about individuals is being used, would this be likely to raise privacy concerns or expectations? i.e. will it include health records, criminal records or other information that people may consider to be sensitive and private and may cause them concern or distress.		√
6	Will the project require you to contact individuals in ways which they may find intrusive? i.e. telephoning or emailing them without their prior consent.		√
7	Will the project result in you making decisions in ways which can have a significant impact on individuals? i.e. will it affect the care a person receives?	√	
8	Does the project involve you using new technology which might be perceived as being privacy intrusive? i.e. using biometrics, facial recognition or automated decision making.		√
9	Is a service being transferred to a new supplier (or recontracted) and the end of an existing contract	√	
10	Is processing of identifiable/potentially identifiable data being moved to a new organisation (but with same staff and processes)	√	

Assessment Completed by:	**Jacqui Tuffnell**
Date of Assessment:	**9 September 2019**

For further information or if a DPIA is required please contact Jonathan Mayes@ mayes.jonathan@nhs.net

Please retain a copy of this questionnaire within your project/system documentation.
Please note that once completed the following sections (1 to 4) should be extracted from the rest of this document prior to being included within the Publication Scheme.