NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group Governing Body
Paper Summary Sheet
Date of Meeting: 22 September 2015

For: PUBLIC session ☒ **PRIVATE Session** ☐

For: Decision ☒ **Discussion** ☐ **Noting** ☐

Agenda Item and title:	**GOV/15/09/09a Business Case: Diabetes Programme – 'Early Adopter' Schemes** I. SARUM / Salisbury Foundation Trust (SFT) II. NEW North + WWYKD / Royal United Hospital (RUH) III. NEW East / Great Western Hospital (GWH)
Author:	Sue Rest, Commissioning Manager, NEW / Diabetes Programme Manager
Lead Director/GP from CCG:	Ted Wilson, Group Director - N&E Wiltshire Group / Project Sponsor Dr Andrew Girdher – GP Executive, N&E Wiltshire Group / Clinical Lead
Executive summary:	Three early adopter schemes have been developed by the diabetes programme board, working with GPs and secondary care consultants in the three Trusts serving Wiltshire. These schemes involve consultants coming out to GP practices, educating and upskilling GPs and practice staff staff, reviewing practice diabetes data and carrying out virtual notes reviews. The aim of the early adopter schemes are to improve primary care performance in the management of diabetic patients, particularly in the delivery of the 8 NICE care processes and to develop the level of care available to diabetic patients in the community, thus reducing the need for secondary care first outpatients appointments. Data from these schemes will feed onto the development of the Wiltshire wide diabetes strategy and continue to develop relationships between primary and secondary care providers.
Evidence in support of arguments:	A pilot scheme carried out at the White Horse Surgery, Westbury in 2013 demonstrated that consultant involvement in the delivery of diabetic care in primary care settings had a beneficial effect on the outcomes for patients. More patients were treated in primary care and there was a reduction in secondary care outpatient appointments. Patients who had previously been 'hard to reach' began to engage with GP practices and strong and supportive relationships developed between clinicians. Early evidence from the 'Super Six' model which has been implemented in Portsmouth, and on which these early adopter schemes have been based, shows a reduction in hypoglaecaemic secondary care admissions of 17% and an 11% drop in secondary care ketoacidosis admissions. Public health data also shows a drop in major foot amputations in the area covered.

Who has been involved/contributed:	Diabetes Programme Board Members (including primary care) CCG Group Directors Secondary Care Consultants and managers at SFT, RUH and GWH
Cross Reference to Strategic Objectives:	This Wiltshire wide diabetes strategy will support the three principles of service delivery outlined in the Wiltshire CCG 5 Year Plan: • Encourage and support Wiltshire residents to take on more responsibility for their own health and wellbeing • Provide fair access to a high quality and affordable system of care for the greatest number of people • Provide less care in hospitals and more care at home or in the community As a part of the strategy, the early adopter schemes aim to: 1. Develop closer relationships between all clinicians supporting diabetic patients in Wiltshire. 2. Start the process of upskilling GPs and practice nurses in preparation for greater management of diabetic patient in primary care being developed in the longer term Wiltshire wide diabetes strategy. 3. Share learning, exploring new initiatives and medications/treatments for diabetic patients. 4. Improve the delivery and take up of the 8 NICE care processes for diabetic patients and ensuring more patients meet their treatment targets in those practices involved, leading to a long term reduction in complications. 5. Investigate ways of mitigating the financial impact of increasing prevalence of diabetes by evaluating the 'early adopter' schemes, looking at the number of first outpatient attendances and follow up appointments avoided with the anticipated reduction being fed into the assumptions underpinning longer term aspirations of the wider Wiltshire diabetes strategy.
Engagement and Involvement:	There has been no patient engagement specific to the development of the early adopter schemes. This is because, at this stage, the schemes involve an upskilling of primary care staff to enable them to better care for existing patients in the community rather than a change of pathway. There has been patient involvement in the development of the diabetes, dietetics and podiatry elements of the adult community services contract service specification and there is a comprehensive patient engagement and consultation process planned for the development and implementation of the wider Wiltshire diabetes strategy development.
Communications Issues:	Large scale publicity of these schemes is not planned at this stage as they are deemed to be more efficient and effective use of the processes already in place rather than any major change. However, successes will be publicised as a part of the diabetes programme.
Financial Implications:	i. SARUM / Salisbury Foundation Trust (SFT) a. Cost pa = £16,692 Cost Part year 2015/16 = £6,489 b. Benefit part year 2015/16 = £2,673 ii. NEW North + WWYKD / Royal United Hospital (RUH) a. Cost pa = £47,550 Cost Part year 2015/16 = £26,475 b. Benefit part year 2015/16 = £22,731

	iii. NEW East / Great Western Hospital (GWH) a. Cost pa = £42,600 Cost Part year 2015/16 = £14,200 b. Benefit part year 2015/16 = £11,366 Scheme i already funded and proceeding. Funds to allow roll out of schemes ii and iii yet to be identified.
Review arrangements:	Evaluation of the early adopter schemes will be carried out as they progress including performance against the identified KPIs. Data will be fed into the Wiltshire wide diabetes programme. This business case will be reviewed during the process of securing funding to proceed.
Risk Management:	Four risks in relation to primary care engagement, meeting the expectations of providers, staff recruitment and the projected growth in the number of newly diagnosed diabetic patients outweighing expected savings have been identified.
National Policy/ Legislation:	There has been a recent focus by the Government on diabetes services commissioned by CCGs as a part of wider diabetes care, in the context of projected growth in people being diagnosed with Type 2 diabetes and the likely increased cost to the NHS over coming years. Diabetes has the fastest rising prevalence of any long term condition and growth in predicted to continue. It is also estimated that there is a high number of undiagnosed patients who have not yet been diagnosed. It is clear that spending on diabetes care at its current rate of growth is unsustainable for the NHS. This business case follows the lead of others in starting to address this growth supporting the redesign of services by the Wiltshire wide diabetes programme.
Public Health Implications:	Public Health is represented on the diabetes programme board and staff have been instrumental in developing the early adopter schemes. The early adopter schemes compliment the early diagnosis and prevention work that Wiltshire Council is involved with, supported by Diabetes UK.
Equality & Diversity:	An EIA has been completed to support this business case. No adverse effect on any section of the community has been identified. The EIA will be reviewed as the schemes are developed and implemented to ensure no group is disadvantaged by this process. A series of actions to mitigate these occurrences have been put in place.
Other External Assessment:	There has been no other external assessment of this project.
What specific action re. the paper do you wish the Governing Body to take at the meeting?	1. To note Option 1, the SARUM/SFT early adopter scheme that is resourced and starting in September 2015. 2. To approve the development and roll out of Option 2, the RUH/NEW North WWYKD early adopter scheme, subject to funding being identified. 3. To approve the development and roll out of Option 3, the GWH/NEW East early adopter scheme, subject to funding being identified.

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Outcomes Based Business Case

Diabetes Programme – 'Early Adopter' Schemes

i. SARUM / Salisbury Foundation Trust
ii. NEW North + WWYKD / Royal United Hospital
iii. NEW East / Great Western Hospital

Version:	1.1
Date	September 2015
Author:	Sue Rest – Commissioning Manager
Sponsoring Director	Ted Wilson – Project Sponsor
Sponsoring GPs	Dr Andrew Girdher – Clinical Lead

Context

Our vision is that Health and Social Care services in Wiltshire should support and sustain independent living and the future system will see:

- Increased personal responsibility to maintain / enhance well-being
- Care provided as close to home as possible
- A reduced reliance on bed-based care settings

Having developed a clear Five Year Plan we are keen to guide the practical implementation by ensuring that funding is used to support solutions that will deliver significant improvement in outcomes within a framework of financial stability.

As a result, we are moving towards a more outcomes orientated approach to commissioning, which aims to shift the emphasis from what services a provider will offer, to what outcomes they will achieve for patients.

This business case template is designed to ensure all applicants are clear as to the outcomes expected by the CCG for any particular funding stream and to support transparent decision making. The document is for internal use and can also be used by external providers who wish to apply for investment from the CCG.

1. Applicant Details

Schemes proposed:

i. SARUM / Salisbury Foundation Trust (SFT) diabetes 'early adopter' scheme. **(FOR INFORMATION – scheme agreed, resource identified and being rolled out as per details below)**

ii. NEW North + WWYKD / Royal United Hospital (RUH) diabetes 'early adopter' scheme.

iii. NEW East / Great Western Hospital (GWH) diabetes 'early adopter' scheme.

2. Summary Description

Scheme i – Diabetes Pathway Early Adopter Scheme, SARUM / SFT
(FOR INFORMATION)

Scheme Description:
Working together, the diabetes programme board and secondary care consultants at SFT have designed an early adopter scheme to benefit diabetic patients in South Wiltshire. A diabetes consultant and a DSN will meet with each practice diabetes lead GP and lead practice nurse twice per year. Meetings will take place in the GP practices and the lead GP will agree the focus of the meeting with the diabetes consultant, depending on the needs of the practice.

Aims
- To update the primary care team on the latest developments in diabetes.
- To provide education to practice staff on aspects of diabetes care (e.g. foot checks/foot care pathway, preconception and pregnancy care, appropriate use of newer therapies, use of monitoring, secondary care referrals)
- To hold 'virtual clinics' with notes reviews of patients to guide on next steps for patient care– to include those with worst control, where the team unsure about next steps, to

ensure optimised treatment for patients with complications, to review those patients previously seen in secondary care.
- Review of practice diabetes data to support primary care teams and to identify where there are areas of concern.

Roll Out of the SARUM/SFT 'Early Adopter' Scheme
Phase 1 of the scheme will start with 7 practices in SARUM from September 2015. A further 7 practices will start the scheme as phase 2 in December 2015 and the remaining SARUM practices will participate in the scheme from April 2016.

Project Delivery – The project will be managed by the SARUM team, reporting back to the CCG diabetes programme board.

Finance
Funding for this scheme has been identified. No further resources or approval is needed.

Scheme ii – Diabetes Pathway Early Adopter Scheme, NEW North + WWYKD / RUH

Proposal:
Diabetes consultants at RUH are aware of SFT model and have outlined a similar model for implementation as an 'early adopter' scheme working with New North and WWYKD RUH facing practices. RUH diabetes consultants have recently worked with BaNES CCG to change their diabetes pathway and it is intended to use learning from work done in BaNES CCG to inform the 'early adopter' schemes and the wider Wiltshire diabetes pathway development. It is proposed that a diabetes consultant and a DSN meet with each practice diabetes lead GP and lead practice nurse twice per year. Meetings will take place in the GP practices and the lead GP will agree the focus of the meeting with the diabetes consultant, depending on the needs of the practice. However, unlike the SARUM proposal, additional DSN and admin time will need to be procured to support the clinic programme and to provide ongoing additional support to practice nurses.

Aims
- To update the primary care team on the latest developments in diabetes.
- To provide education to practice staff on aspects of diabetes care (e.g. foot checks/foot care pathway, preconception and pregnancy care, appropriate use of newer therapies, use of monitoring, secondary care referrals)
- To hold 'virtual clinics' with notes reviews of patients to guide on next steps for patient care– to include those with worst control, where the team unsure about next steps, to ensure optimised treatment for patients with complications, to review those patients previously seen in secondary care.
- Review of practice diabetes data to support primary care teams and to identify where there are areas of concern.
- To have ongoing DSN support for the practices to manage their diabetic patients between clinic visits.

Roll Out of the RUH 'Early Adopter' Scheme
The scheme involves 12 RUH facing practices in NEW North and WWYKD and will start from October 2015.

Project Delivery
The project will be managed by the diabetes programme project manager, reporting back to the CCG diabetes programme board.

Finance

Scheme Cost £47,550 per annum (2015/16 part year £26,475). See finance section below for full financial costing.

Scheme iii – Diabetes Pathway Early Adopter Scheme, NEW East / Great Western Hospital

Proposal:
It is proposed that the model described in scheme ii above (RUH proposal) is also put in place covering 9 GP practices in East Kennet and the north east of the NEW Group area linking in to a consultant outreach service from GWH. A diabetes consultant and a DSN will meet with each practice diabetes lead GP and lead practice nurse twice per year. Meetings will take place in the GP practices and the lead GP will agree the focus of the meeting with the diabetes consultant, depending on the needs of the practice. Additional DSN and admin time will need to be procured to support the clinic programme and to provide ongoing additional support to practice nurses. The additional DSN time will be important in delivering this early adopter scheme to the 9 GP practices in East Kennet and the north east of the NEW Group area because here, support and care for diabetic patients is mainly carried out by practice nurses without external DSN support.

Aims
- To update the primary care team on the latest developments in diabetes.
- To provide education to practice staff on aspects of diabetes care (e.g. foot checks/foot care pathway, preconception and pregnancy care, appropriate use of newer therapies, use of monitoring, secondary care referrals)
- To hold 'Virtual Clinics' with notes reviews of patients to guide on next steps for patient care– to include those with worst control, where the team unsure about next steps, to ensure optimised treatment for patients with complications, to review those patients previously seen in secondary care.
- To see patients where it is deemed to be beneficial to their care.
- Review of practice diabetes data to support primary care teams and to identify where there are areas of concern.
- To have ongoing DSN support for the practices to manage their diabetic patients between clinic visits.

Roll Out of the GWH Early Adopter Scheme
The scheme involves 9 GWH facing practices in East Kennet and the north east of the NEW Group area and will start from December 2015.

Project Delivery
The project will be managed by the diabetes project manager, reporting back to the CCG diabetes programme board.

Finance
Scheme cost £42,600 per annum (2015/16 part year £14,200). See finance section below for full financial costing.

3. Timing

Priority

4. Legal / National requirement
N/A

5. Strategic Fit
With the increasing prevalence of diabetes across the country and the projected increase in patients suffering with diabetes in Wiltshire expected to reach 8.8% by 2030 (PHE, 2012), the

CCG is reviewing the services it provides for diabetic patients by reviewing the diabetic pathway. This work is being completed through a diabetes programme, supported by a business case to resource the changes, to be drafted by November 2015 for delivery during 2016/17. The strategy will be based on best practice models of care, loosely based on the 'Super Six' model developed in Portsmouth. This best practice model involves leaving only complex specialist diabetes care in a hospital setting (insulin pumps, antenatal diabetes, diabetic foot care, lower eGFR/dialysis patients, uncontrolled type 1/adolescent diabetes, inpatient diabetes). It is proposed that all other patients will be treated in the community or discharged from hospital services wherever possible to be cared for by a multi-disciplinary community team with GPs and practice nurses leading their care. Patients will be encouraged to self-manage their own condition wherever possible as a part of the proposed model with access to appropriate patient educational support. This Wiltshire wide diabetes strategy will support the three principles of service delivery outlined in the Wiltshire CCG 5 Year Plan:

- Encourage and support Wiltshire residents to take on more responsibility for their own health and wellbeing
- Provide fair access to a high quality and affordable system of care for the greatest number of people
- Provide less care in hospitals and more care at home or in the community

The long term model developed in the Wiltshire wide diabetes strategy will need all clinicians involved in out of hospital care, including GPs, practice nurses, DSNs and community team staff to work closely together to provide an integrated, seamless service for patients, treating them in the place most appropriate for their level of need. All clinicians will need to take a patient centred approach to diabetes care which will involve building new relationships, developing new processes and ensuring all clinicians are highly skilled with appropriate levels of competence in diabetes care in place. There will be full consultation with primary and secondary care providers as this strategy is developed. In the meantime, it is proposed to roll out three ‘early adopter’ schemes as a part of the diabetes programme, as a precursor to the longer term strategy involving the three hospital trusts serving Wiltshire, working with groups of local GP practices and the community team. The SARUM/SFT scheme is already in place and will commence in September 2015. Resource is needed to roll out similar schemes working with the RUH and GWH. The aim of the early adopter schemes are:

1. Developing closer relationships between all clinicians supporting diabetic patients in Wiltshire.
2. Starting the process of upskilling GPs and practice nurses in preparation for greater management of diabetic patient in primary care being developed in the longer term Wiltshire wide diabetes strategy.
3. Sharing learning, exploring new initiatives and medications/treatments for diabetic patients.
4. Improving the delivery and take up of the 8 NICE care processes for diabetic patients and ensuring more patients meet their treatment targets in those practices involved, leading to a long term reduction in complications.
5. Investigating ways of mitigating the financial impact of increasing prevalence of diabetes by evaluating the ‘early adopter’ schemes, looking at the number of first outpatient attendances and follow up appointments avoided with the anticipated reduction being fed into the assumptions underpinning longer term aspirations of the wider Wiltshire diabetes strategy.

Success criteria (outcome based) for specific funding stream

The aim of the three proposed early adopter schemes is to start the process of integrating service provision in the community and upskilling staff leading into wider diabetes service

pathway redesign in a planned and controlled way. The benefits of introducing early adopter schemes prior to the introduction of a revised diabetes pathway in 2016 are many and include:

- Short term improvement in the delivery of 8 NICE care processes.
- Short term improvement in the number of patients achieving their treatment targets.
- Less variation in delivery of care processes and achievement of treatment targets across practices.
- More appropriate referrals to secondary care at the right stage of a patients care e.g. early identification and referral of foot care problems to the secondary care foot clinic to prevent later complications and amputations.
- Fewer referrals to diabetes outpatient clinics for patients who could safely be cared for outside a hospital setting to mitigate the increasing numbers of patients attending, leaving specialist consultants to focus on more complex cases.
- Long term reduction in diabetes related complications, including ketoacidosis, renal replacement therapy, major and minor amputations.

It is envisaged that learning from the early adopter schemes in relation to practice skills, motivation and engagement in diabetes care delivery will feed into the development of the Wiltshire wide diabetes strategy and supporting business case in November 2015.

6. Case for Change

The number of people with diabetes, especially Type 2 diabetes is growing nationally. Diabetes prevalence in Wiltshire is 5.2%, compared to 5.5% in the South West and 5.8% across England and Wales (PHE, 2012). It is also estimated that there are more than 7,000 undiagnosed patients in Wiltshire and therefore the current prediction on diabetes prevalence is thought to be much higher at 7.0% for Wiltshire compared to 7.4% nationally. The number of diagnosed diabetics is continually growing and this number is projected to increase to 8.8% by 2030 if left unchecked (PHE, 2012).

Reasons for change:

- Diabetes has the fastest rising prevalence of any long term condition and this increase is predicted to continue. This will mean high costs for Wiltshire CCG and the NHS as a whole.
- 10% of the NHS budget is spent on diabetes. 80% of that is spent on managing complications resulting from poorly managed diabetes.
- Increasing numbers of people aged 40 and under are being diagnosed with Type 2 diabetes both nationally and in Wiltshire.
- Wiltshire has a ‘higher than expected’ risk in patients with diabetes in relation to undergoing renal replacement therapy with dialysis or transplantation compared to the national average.
- Referrals to secondary care outpatient diabetes services are increasing by in all three hospital trusts.
- In Wiltshire, patients with diabetes have a higher mortality rate than the England and Wales average.

All patients aged 12 years and over should receive all of the eight NICE recommended care processes to identify problems at an early stage, thus reducing the likelihood of complications later in life, enabling better management of their condition and reducing costs and resources needed. These care processes include:

Blood creatinine	Foot examination
Blood pressure	HbA1c
BMI	Smoking review
Cholesterol	Urinary albumin

According to the National Diabetes Audit in 2012-13, 68.0% of registered patients in Wiltshire had received all eight of the care processes, higher than the national average of 59.9%. However, this figure is lower for certain groups of patients, including patients under 40 years old, type 1 diabetics and transition age patients. There is also significant variation between practice performance in Wiltshire, with the highest performing practices delivering all eight care process to 90% of their diabetic patients compared to the lowest performing practices delivering only 30%.

There is also variation in the achievement of the three key treatment targets for diabetic patients in Wiltshire, relating to HbA1c levels, cholesterol and blood pressure. 34.8% of patients achieved their treatment targets in 2012-13 (NDA, 2012-13) but again there were significant differences in practice delivery ranging from 25% to 48%.

The benefits expected to be delivered through this 'early adopter' proposal.

The benefits expected from the setting up of the pilot schemes include:

- Improved and more consistent delivery of eight NICE care processes across practices and achievement of treatment targets leading to better management of patients with diabetes before they develop costly complications. A reduction in the number of first outpatient appointments and follow up appointments would be expected. Although difficult to measure, a reduction in long term complications for the group of patients covered by this pilot and more appropriate management of their medication would also be expected.
- Evidence from secondary care consultants that they are dealing with more appropriate cases and less complex patients are being managed in the community, thus reducing secondary care costs.
- Upskilling of GPs and practice staff in preparation for a wider change in the diabetes pathway through the longer term strategy, identifying 'teething problems' at an early stage and re-establishing GPs as the lead clinicians in the delivery and coordination of community diabetes care.

What evidence do you have that this solution will address the problem?

The RUH completed a pilot study with the White Horse Surgery in Westbury, delivering a greater level of diabetes care in the community, similar to the 'early adopter' scheme proposals, for patients with diabetes between November 2013 and March 2014. A consultant visited the practice and met with the practice nurse for one three hour session each month. During this pilot, approx. 13 care plans were produced per session, which would be expected to rise to 20-25 patients per session in the longer term, compared to 8 care plans produced in an average secondary care clinic. As most of the work was 'virtual' patients and notes reviews, there could be no DNAs and 'hard to reach' patients benefitted equally with some engaging with the surgery on an ongoing basis after the review. Practice Nurse education allowed better subsequent decision making with potential to reduce future admissions and there was less administration and delay in communications between patients and clinicians. Patients received 'joined up' care and advice and consultations were more patient and problem focused and integrated with general practice care and support. Positive feedback was recieved from patients and 23 referrals into secondary care were prevented over the 6 month pilot period.

Early evidence resulting from the introduction of the comprehensive 'Super Six' model in Portsmouth includes a reduction in hypoglycaemic secondary care admissions of 17% and an 11% drop in secondary care ketoacidosis admissions. Public health data also shows a drop in major foot amputations in Portsmouth.

The diabetic consultants in the three Trusts have considered all the evidence, along with the CCG diabetes programme board. It is believed that, in the short term, the early adopter

schemes will reduce the number of secondary care first outpatient appointments and follow up appointments. Financial targets for each scheme are given in the finance section below. There is a strong belief, based on the Westbury pilot, the work that the RUH have done in Bath with BaNES CCG and an analysis that SFT have done to support their 'early adopter' scheme proposals that the 'early adopter' schemes will reduce the numbers of and cost of long term diabetes related complications. However, this reduction is difficult to quantify and any reduction is likely to be impacted by the continuing increase in newly diagnosed patients.

7. Success Measures

Key Performance Indicators

The measurable quality and activity Key Performance Indicators (KPIs) of this proposal are:

1. 10% reduction in the number of first outpatient diabetes related attendances to SFT, and 20% at RUH and GWH by April 2017.
2. 10% reduction in the number of follow up diabetes related appointments at SFT, and 20% at RUH and GWH by April 2017.
3. Increase in the delivery of the 8 care processes in the 'early adopter' scheme GP practices to 75% by April 2017.
4. Increase in patients achieving their treatment targets in the 'early adopter' scheme GP practices and a reduction in variation between 'early adopter' practices.
5. Improved relationships developed between primary care and secondary care staff.
6. Increased engagement of GP practices in the Wiltshire diabetes programme.

NB/ The number of patients being diagnosed with diabetes in Wiltshire is increasing, exacerbated by the diabetes early diagnosis work that Wiltshire Council is promoting through road shows etc. This is positive and is likely to mean that patients are treated earlier and long term complications are likely to be reduced. However, there will be costs associated with this increase in patients in the short term. BaNES CCG have identified similar savings to the ones outlined here for their diabetes pathway design programme but they have assumed that growth in diagnosed patient numbers is likely to outweigh any financial savings made. They aim to maintain a nil growth in expenditure, meaning a 15% reduction in spend in real terms. It is expected that the same will apply in Wiltshire.

Financial Evaluation and Investment Appraisal

i. SARUM / Salisbury Foundation Trust (SFT) diabetes 'early adopter' scheme.
FUNDING AGREED AND SCHEME PROGRESSING FROM Sept 2015

2 consultant visits/ virtual clinics per practice, per year @ £309 per visit = £16,692.
Total Scheme Cost (27 practices) = £16,692 per annum.

Scheme Cost 2015/16 (part year)
Phase 1 (7 practices) Sept 15 – Mar 16 = £4,326
Phase 2 (7 practices) Jan 16 – Mar 16 = £2,163
Total Scheme Cost 2015/16 (part year) = £6,489 in 2015/16

ii. NEW North + WWYKD / Royal United Hospital (RUH) diabetes 'early adopter' scheme.

2 consultant/DSN visits/ virtual clinics per practice, per year @ £600 per clinic session = £14,400
DSN ongoing support (0.5 WTE) = £23,500
Scheme ongoing admin support (0.2 WTE) = £4,250
Backfill GP costs (2 visits per year to 12 schemes @ £225) = £5,400
Total Scheme Cost (12 practices) = £47,550 per annum

Scheme Cost 2015/16 (part year)
12 practices Oct 2015 – Mar 2016 = £21,075
Backfill GP costs (24 visits @ £225) = £5,400
Total Scheme Cost 2015/16 (part year) = £26,475 in 2015/16

iii. **NEW East / Great Western Hospital (GWH) diabetes 'early adopter' scheme.**

2 consultant/DSN visits/ virtual clinics per practice, per year @ £600 per clinic session = £10,800
DSN ongoing support (0.5 WTE) = £23,500
Scheme ongoing admin support (0.2 WTE) = £4,250
Backfill GP costs (2 visits per year to 9 schemes @ £225) = £4,050
Total Scheme Cost (9 practices) = £42,600 per annum

Scheme Cost 2015/16 (part year)
9 practices Dec 2015 – Mar 2016 = £12,850
Backfill GP costs (6 visits @ £225) = £1,350
Total Scheme Cost 2015/16 (part year) = £14,200 in 2015/16

The funding requirement is non-recurrent.

Funding is needed for all the 'early adopter' schemes until the diabetes strategy is fully implemented. This is likely to be April 2017.

Savings generated across the system.

Please see para. 7 above. Savings identified below in first outpatient appointments and follow up appointments with a diabetes related cause are likely to be compromised by increases in the number of new patients diagnosed with diabetes. The return on investment for these schemes is likely to be represented by a levelling off in spend rather than an actual decrease in cost in cash terms.

i. **SARUM / Salisbury Foundation Trust (SFT) diabetes 'early adopter' scheme.**
FUNDING AGREED AND SCHEME PROGRESSING FROM Sept 2015
10% reduction in OP and FUP appointments (7 practices) FULL YEAR = **£5,346** (based on £238 OP appointments, £106 FUP appointments)

Scheme Savings 2015/16 (part year)
Phase 1 (7 practices) Sept 15 – Mar 16 (assume 2 visits / 50% achievement) = £2,673
Phase 2 (7 practices) Jan 16 – Mar 16 (assume 1 visit / 25% achievement) = £1,336 (assume saving to be recognised 16/17)
Total Scheme Savings 2015/16 (part year) = £2,673

Phase 3 – costs to be incurred and savings made in 2016/17.

ii. NEW North + WWYKD / Royal United Hospital (RUH) diabetes 'early adopter' scheme.

20% reduction in OP and FUP appointments (12 practices) FULL YEAR = £45,463 (based on £238 OP appointments, £100 FUP appointments)

Scheme Savings 2015/16 (part year)
12 practices Oct 15 – Mar 16 (assume 2 visits and DSN support / 50% achievement) = £22,731
Total Scheme Savings 2015/16 (part year) = £22,731

iii. NEW East / Great Western Hospital (GWH) diabetes 'early adopter' scheme.

20% reduction in OP and FUP appointments (9 practices) FULL YEAR = £34,097 (based on £238 OP appointments, £100 FUP appointments)

Scheme Savings 2015/16 (part year)
9 practices Dec 15 – Mar 16 = £11,366
Total Scheme Savings 2015/16 (part year) = £11,366

8. Options

Option	
Do Nothing	**Do nothing – mandatory option**
Benefits	No cost requirement for the CCG.
Risks of not implementing	• Lack of engagement from secondary care in wider diabetes programme. • Continuing underachievement and practice variation in delivery of care processes and treatment targets. • Lack of engagement in from primary in wider diabetes programme. • Deterioration in relationship between CCG and community DSNs.
Conflicts of Interest	None
One	**NOTE the details of Scheme i – SARUM / Salisbury Foundation Trust (SFT) diabetes 'early adopter' scheme.**
Benefits	Scheme has already been agreed by the SARUM Exec the SFT Board and funding identified. Will be a 'quick win' to mitigate the impact of the reprioritisation of the diabetes programme by the CCG and provide learning for the wider diabetes programme.
Risks of not implementing	• Scheme agreed and being implemented from September 2015.
Conflicts of Interest	None
Two	**Approve Scheme ii - NEW North + WWYKD / Royal United Hospital (RUH) diabetes 'early adopter' scheme.**
Benefits	Scheme will deliver benefits to patients in RUH facing practices. It will be a 'quick win' to mitigate the impact of the reprioritisation of the diabetes programme by the CCG and provide learning for the wider diabetes programme.

	The scheme will work in tandem with the work that BaNES CCG are doing to develop their pathway with the RUH and can deliver shared learning.
Risks of not implementing	• Lose trust of RUH diabetes consultants. • RUH OP and FUP appointments overwhelmed by demand from newly diagnosed patients. • Damage to relationships with primary/secondary care colleagues.
Conflicts of Interest	None
Three	**Approve Scheme iii – NEW East / Great Western Hospital (GWH) diabetes 'early adopter' scheme.**
Benefits	Scheme will deliver benefits to patients in GWH facing practices. It will be a 'quick win' to mitigate the impact of the reprioritisation of the diabetes programme by the CCG and provide learning for the wider diabetes programme. The scheme will help to mitigate the commissioning gap for DSNs in the East Kennet area.
Risks of not implementing	• Lose trust of GWH diabetes consultants. • GWH OP and FUP appointments overwhelmed by demand from newly diagnosed patients. • Damage to relationships with primary/secondary care colleagues and community team DSN staff.
Conflicts of Interest	None

Recommendation

1. It is recommended that the Governing Body notes Option I, the SARUM/SFT early adopter scheme that is already resourced and starting in September 2015.
2. It is recommended that the Governing Body approves the development and roll out of Option 2, the RUH/NEW North WWYKD early adopter scheme, subject to funding being identified.
3. It is recommended that the Governing Body approves the development and roll out of Option 3, the GWH/NEW East early adopter scheme, subject to funding being identified.

   This will enable diabetes 'early adopter' schemes to be set up linked to each Trust serving Wiltshire, engaging primary and secondary care clinicians in the principles of the diabetes programme. It will provide learning to feed into the development of the diabetes strategy later in the year.

9. Project Delivery

i.	SARUM / Salisbury Foundation Trust (SFT) diabetes 'early adopter' scheme.	Date
Set up phases	Identification of GP practices, set up of systems and admin, baselining for KPIs. Governance oversight – Diabetes Programme Board.	Completed
Mobilisation	Phase 1 (7 practices) Phase 2 (7 practices) Phase 3 (16 practices)	Sept 2015 Dec 2015 Apr 2016
Delivery	Performance against KPIs.	Jan 2016 onwards

ii.	NEW North + WWYKD / Royal United Hospital (RUH) diabetes 'early adopter' scheme.	Date
Set up phases	Identification of GP practices, set up of systems and admin, baselining for KPIs. Recruitment of DSN and admin support. Governance oversight – Diabetes Programme Board.	July/Sept 2015 Aug 2015
Mobilisation	Implementation (12 practices)	Oct 15
Delivery	Performance against KPIs.	Jan 2016 onwards

iii.	NEW East / Great Western Hospital (GWH) diabetes 'early adopter' scheme.	Date
Set up phases	Identification of GP practices, set up of systems and admin, baselining for KPIs. Recruitment of DSN and admin support. Governance oversight – Diabetes Programme Board.	Sept/Oct 2015 Nov 2015
Mobilisation	Implementation (9 practices)	Dec 15
Delivery	Performance against KPIs.	Jan 2016 onwards

10. Stakeholder Engagement

There is stakeholder engagement in the diabetes programme but no engagement has been done specifically to support the 'early adopter' plans. They are intended to upskill primary care staff to enable them to better deliver their existing diabetes services and to create closer relationships between primary and secondary care providers. They aim to facilitate a more seamless processes rather than making any changes to the service at this stage. A full patient engagement and consultation programme will sit alongside the wider diabetes programme pathway redesign work.

11. Risks

No.	Description	Existing Controls	L	C	Tot	Actions to mitigate
1	That primary care will not engage with the pilots due to workforce capacity and workload.	Primary care activity is already part of the work that GP practices are commissioned to do under GMS/PMS contracts and QOF.	1	3	3	GPs will be asked if they want to get involved in the early adopter schemes and will be assessed for capacity before the schemes start.
2	Expectations of secondary care providers will not be met and they will become disillusioned with the process.	Existing engagement with both primary and secondary care providers through the diabetes programme board and in connection with 'early adopter' schemes.	2	4	8	Engage primary and secondary care providers at an early stage and work with them both to develop and deliver the 'early adopter' schemes subject to funding approval.
3	In the RUH (ii) and GWH (iii) schemes, there will be difficulty in recruiting DSNs to support the initiatives.	Has been problems recruiting staff. GWH community DSN service have been dealing with	3	4	12	Early identification of requirements and early recruitment process. Investigate possibilities of

		recruitment issues.				extending hours for existing staff.
4	Growth in newly diagnosed diabetics will outweigh savings, meaning growth in referrals rather than keeping OP and FUPs levels flat.	Diabetes programme and work ongoing in primary care initiatives such as NDA follow up, RCGP Quality Impr. Prog, 'Blue Book' etc. will help address.	3	3	9	Continue to work with GP practices, work with Wiltshire Council on diabetes prevention, deliver the diabetes pathway changes in the longer term.

12. Inter-dependencies

	Description of dependencies	Date
One	Wider diabetes programme delivery. Early adopter schemes will provide data and intelligence to inform the wider diabetes programme and ensure ongoing stakeholder engagement. Programme will need to deliver to follow on from the early adopter schemes.	2015/16
Two	Community contract procurement for diabetes, dietetics and podiatry services.	2016/17

13. Equality Impact Assessment

An equality impact assessment has been completed for this business case. No adverse impact on any group in the community has been identified.

14. Presentational/Handling Issues

Large scale publicity of these schemes is not planned at this stage as they are deemed to be more efficient and effective use of the processes already in place rather than any major change. However, successes will be publicised as a part of the diabetes programme.

NHS Wiltshire Clinical Commissioning Group

Equality Impact Analysis – the EIA form

Title of the paper or Scheme: Diabetes Early Adopter Schemes

i. SARUM / Salisbury Foundation Trust (SFT) diabetes 'early adopter' scheme.

ii. NEW North + WWYKD / Royal United Hospital (RUH) diabetes 'early adopter' scheme.

iii. NEW East / Great Western Hospital (GWH) diabetes 'early adopter' scheme.

For the record	
Name of person leading this EIA: Sue Rest	Date completed: 01/07/2015
Names of people involved in consideration of impact Sue Rest/Ted Wilson/Andrew Girdher	
Name of director signing EIA: Ted Wilson	Date signed: 01/07/2015

What is the proposal? What outcomes/benefits are you hoping to achieve?

To bring secondary care expertise in managing patients with diabetes out into the community by consultants visiting GP practices (with DSN support in the case of schemes ii and iii) to educate GPs and practice nurses, carry out virtual clinics and notes reviews, to review practice diabetes data and to support primary care staff in the management of complex diabetic patients.

Who's it for?

All patients in the early adopter scheme sites.

How will this proposal meet the equality duties?

This proposal is for all patients with diabetes registered with a practice in the defined 'early adopter' scheme areas without exclusion irrespective of gender, race, disability, religion, sexual orientation or economic status. From experience gained from the White Horse Surgery, Westbury diabetes pilot, patients from hard to reach groups benefitted more from the proposed process from having their cases review as a part of the 'virtual clinics' than from the previous system through having their notes reviewed and then being managed through the GP practice which they were less likely to access.

What are the barriers to meeting this potential?

None

2 Who's using it? Refer to equality groups

What data/evidence do you have about who is or could be affected (e.g. equality monitoring, customer feedback, current service use, national/regional/local trends)
Diabetic Audit data, Primary, Secondary and Community data and Data from Public Health demonstrate who will be affected

How can you involve your customers in developing the proposal?

There is stakeholder engagement in the diabetes programme but no engagement has been done

specifically to support the 'early adopter' plans. They are intended to upskill primary care staff to enable them to better deliver their existing diabetes services and to create closer relationships between primary and secondary care providers. They aim to facilitate a more seamless processes rather than making any changes to the service at this stage. A full patient engagement and consultation programme will sit alongside the wider diabetes programme pathway redesign work.

Patient engagement has been done to support the development of the Adult Community Services Contract tendering process in relation to the diabetes, dietetics and podiatry pathways which will feed into the wider diabetes programme.

Who is missing? Do you need to fill any gaps in your data? (pause EIA if necessary)

None identified

3 Impact Refer to dimensions of equality and equality groups

Show consideration of: age, disability, sex, transgender, marriage/civil partnership, maternity/pregnancy, race, religion/belief, sexual orientation and if appropriate: financial economic status, homelessness, political view

Using the information in parts 1 & 2 does the proposal:

a) Create an adverse impact which may affect some groups or individuals. Is it clear what this is? How can this be mitigated or justified?

None identified.

What can be done to change this impact?

No further action is required

b) Create benefit for a particular group. Is it clear what this is? Can you maximise the benefits for other groups?

The proposal will benefit all patients who have been diagnosed or at risk of diabetes and their families and carers.

Does further consultation need to be done? How will assumptions made in this Analysis be tested?

On-going engagement with primary and secondary care clinicians will take place as schemes are rolled out and full engagement and consultation is an integral part of the diabetes programme.

4 So what? Link to business planning process

What changes have you made in the course of this EIA?

None

What will you do now and what will be included in future planning?

Evaluation of the early adopter schemes will identify any changes required to service provision in the future.

When will this be reviewed?

EIA will be reviewed if service provision changes.

How will success be measured?

Success will be measured by the KPI's.