

Financial, clinical and patient engagement

strategies to modernise the NHS

Including a special case study on diabetes

Written for the NHS, local authorities and
voluntary organisations – February 2010



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On the 14 November each year major world wide landmarks are lit up in blue to mark "World Diabetes Day"



All Images (the London Eye and Shell Building and the Petronas Towers)
COURTESY: INTERNATIONAL DIABETES FEDERATION

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Foreword

This publication contains guidance on:

- The search for efficiency and the implementation of service transformation within the NHS
- Implementing change via the NHS business case process
- The critical contribution from clinicians and service users to NHS redesign
- The role of the Local Authority NHS Overview and Scrutiny Committees (OSCs)
- The role of the Independent Reconfiguration Panel (IRP)

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Steve joined CIPFA in 2007 working on health policy. He chairs the West Kent NHS Patient Advisory Group for Diabetes and the Tunbridge Wells and District Voluntary Group of Diabetes UK.

Legal Disclaimer

This publication includes several references to legislative frameworks. It is not meant as an authoritative legal guide and organisations should take legal advice on matters covered within this publication as appropriate.

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Glossary of Acronyms

Comprehensive Area Assessment	CAA
Diabetes education and self management for the newly diagnosed	DESMOND
Dose adjustment for normal eating	DAFNE
District general hospital	DGH
Department of Health	DoH
(First) Finished consultant episode	(F) FCE
Foundation Trust	FT
Government Office Region	GOR
Health impact assessment	HIA
Her Majesty's Treasury	HMT
Human resources	HR
Hospital standardised mortality ratio	HSMR
International Financial Reporting Standards	IFRS
Information management and technology	IM&T
Independent Reconfiguration Panel	IRP
Joint strategic needs assessment	JSNA
Local Area Agreement	LAA
Local Involvement Networks	LINKs
Local Strategic Partnership	LSP
National Health Service	NHS
National Institute of Clinical Excellence	NICE
National Service Framework	NSF
Office of Government and Commerce Gateway	OGC
NHS Overview and Scrutiny Committee	OSC
Patient advisory group	PAG
Practice-based commissioning	PBC
Payment by Results	PbR

Primary Care Trust	PCT
Professional executive committee	PEC
Private finance initiative	PFI
Public Health Needs Assessment	PHNA
Prescription Pricing Authority	PPA
Public Sector Borrowing Requirement	PSBR
Quality and Outcomes Framework	QOF
Sustainable community strategy	SCS
Strategic health authority	SHA
Secretary of State	SOS
Value for money	VfM
World Health Organisation	WHO

Introduction

Context for this guidance

This paper is a response to the challenges faced by a national health service (NHS) in a constant process of modernisation. The publication *Health reform in England: update and commissioning framework* (DoH, July 2006), gave the primary reasons for reforming the NHS as:

- A rising public expectation
- A need to provide ease of access and personalised services
- The ageing population associated with an increasing prevalence of long-term conditions and a need to focus on promotion, prevention, independence and wellbeing
- Improvements in medical technology
- Quality of care – to provide consistently high levels of quality and address variations of quality across the health system.

More recently *High quality care for all: the NHS Next Stage Review final report* by Lord Darzi placed at its centre an NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart.

Finance within the NHS is set to become far more challenging. The operating framework for 2010/11 outlines a number of measures to create 'financial headroom' in Primary Care Trust allocations and to drive efficiency gains in the service in advance of much tighter resource settlements from 2011/12.

The measures include:

- For 2011/12 and 2012/13 NHS frontline spending to receive a flat rate of growth in line with inflation only
- Savings of £15 - £20 billion required to cover system pressures to be identified by the end of 2013/14
- 2% of allocations to remain uncommitted on a recurring basis and used for service transformation
- A 30% reduction in management and agency costs to be achieved by 2013/14
- Health service providers to achieve a 3.5% efficiency gain to offset pay and price increases in 2010/11
- A relentless focus on improving quality and productivity, using innovation, prevention and joint working across organisational boundaries.

This publication has been produced primarily to help NHS accountants to meet the challenges placed upon them when engaged in the pursuit of efficiency, service change and modernisation to deliver quality services.

It is becoming increasingly important to supplement traditional finance and business skills in order to contribute fully to a strategic, evidence-based approach to service change that is clinically led and patient centred.

The guide has however also been written to support clinicians, service users, organisations that represent patients, local authorities and other stakeholders that have a critical role to play in the modernisation of the NHS.

This publication is in four sections.

Chapter 1

Chapter one is about the pursuit of efficiency within the NHS - where to look and what to consider. It also covers a process for the application of funds as a result of successfully delivering efficiency.

The chapter refers also to the key components needed to manage change successfully within the NHS; the recognition that changes require the support and engagement of partners; and for substantial changes – the stages and steps to follow to develop a full NHS business case.

Chapter 2

This covers the important area of clinical leadership when implementing change. This includes the impact of clinical engagement; how to create the right conditions for clinical engagement to be innovative and effective; and appointing well respected, experienced clinicians with a passion to create high quality services.

Chapter 3

In chapter three we look at effective patient/service user engagement - what service users may need to be effective representatives and the benefits of early and meaningful patient involvement?

Within this section there is a consideration of the legislative framework and guidance on patient engagement and consultation and the key messages that can be taken from recent publications such as annual operating frameworks, NHS Next Stage Review, NHS Constitution and the Cabinet Office Code of Practice on Consultation.

The role, duties and powers of the Local Authority NHS Overview and Scrutiny Committee (OSC) and the Independent Reconfiguration Panel (IRP) are covered together with the implications of not consulting correctly on significant change.

The focus is on the NHS in England but the principles and practicalities are applicable across the UK.

Chapter 4

This chapter looks at the modernisation of diabetes services, the third biggest killer in the UK after coronary heart disease and cancer. It explores the nature of diabetes and why the condition is such a major challenge for the NHS.

The *National service framework for diabetes* (NSF) was published in 2001; a discussion of the services that need to be in place to meet the NSF by its target implementation date of 2013, the organisation of diabetes care and the organisation of project boards to successfully implement change and improve services are included.

The NSF was introduced during the present Labour Government. A potential change in administration may of course lead to changes in health policies. The proposals outlined in the diabetes NSF, as updated by leading clinical practice over time, still reflect those agreed by major stakeholders to deliver a high quality diabetes service and should be applicable under different administrations.

In relation to diabetes care

- For England and Wales there are National Service Frameworks and National Institute for Health and Clinical Excellence (NICE) guidelines
- For Scotland there is the Scottish Diabetes framework and the Scottish Intercollegiate Guidelines Network
- In Northern Ireland there are no national standards for diabetes, although the cardiovascular (heart and blood vessels) framework contains three standards in the diabetes section which relate to screening, education and psychological support.

Diabetes services have been covered as a case study given the significant challenge it presents to the NHS; however, the principles within this section can equally be applied to other NHS specialties.

A central objective of this publication is to enable service change, with a focus on the traditional and rigorous finance and business skills, but incorporating more emphasis on delivering quality and service modernisation that is clinically led and designed around the needs and preferences of the patient, their carers and families.

Annex E contains a short paper reviewing the modernisation of diabetes services against the tightening financial constraints on UK public services.

Comments on this publication are very welcome and should be addressed to the author:

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Executive summary

The NHS has been a priority within the public services for the present government. As a result of allocating significant real terms growth, and a desire to devolve budgets previously held centrally by the Department of Health (DoH), primary care trusts (PCT) will receive:

- £84.4bn in 2010/11 to plan and commission services for their resident populations, this is the equivalent of £1,612 per person and compares with £424 received in 1996/97; almost a four fold increase

The extra funding has meant that the NHS has, with other improvements, been able to:

- Build new capacity
- Finance the revenue consequences of new hospitals
- Modernise pay for GPs and NHS staff
- Meet the increasing costs of European legislation such as the working time directive
- Set challenging standards for waiting times in accident and emergency departments, cancer treatment and ambulance response times
- Provide a focus on prevention strategies and self care
- Drive down waiting lists and waiting times for diagnostics and elective procedures.

The NHS has been in financial surplus over recent years after a period of financial deficit: however, it will always be challenged by the principle of providing demand led and universal health coverage free at the point of delivery from limited funding.

As the recent debate on US healthcare has highlighted, there is a resistance to rationing new, expensive drugs and treatments solely on the basis of cost-benefit analysis to retain sustainable finance.

From 2011/12 the NHS will be expected to contribute towards the escalating public sector borrowing requirement (PSBR) of the UK economy. At the same time it will continue to have to focus on improving and reporting on quality, increasing productivity and implementing service modernisation.

Achieving efficiency gains and driving down costs while raising the quality of services, is likely to be a key priority. Solutions are best drawn initially from proven models such as the ten high impact changes (modernisation agency), the comparison of provider reference costs and commissioner programme budgeting expenditure and service-specific toolkits looking at best quality clinical practice and benchmarking tools provided for example at www.nhsbenchmarking.nhs.uk.

Variations in the quality of care, the accuracy and robustness of data and accurate comparative analysis should also be taken into account.

For major change to be implemented effectively, the NHS has developed comprehensive business case guidance, taking a proposal from strategic outline to outline and full business case. Public health impact assessment (HIA) is important in this process as well as following the Office of Government and Commerce (OGC) Gateway directions for managing change. Further information is available from the OGC and DoH gateway process website accessible at www.doh.gov.uk.

When planning change demographic trends should be accounted for. The local NHS with service users and representatives, its local authority and voluntary and private sector partners should adopt complementary strategies for children, adults and the elderly that reflect the changing population.

Senior accountants within the NHS are expected to be able to contribute strategically to NHS change and to play their part corporately in ensuring that critical success factors are in place to facilitate change. Two of these critical success factors are clinical engagement and patient and public engagement.

Clinical engagement

Key to success in managing change in the NHS is the engagement of clinicians; this is due to their clinical expertise and ability to:

- Support the organisation(s) with its vision and strategic direction
- Comprehensively understand the service, its integrated models of care and care pathways
- Share good clinical practice
- Enable clinically safe and high quality services to be both commissioned and provided
- Lead clinical communications with partner organisations and stakeholders that encourages and leads innovation to facilitate change.

Clinical champions representing their services will express the majority of the characteristics below; they

- Are leaders in their field
- Have the trust, seniority and experience to generate respect and credibility from peers and management within their own organisation and across organisational boundaries
- Have natural charisma, can make time and have good patient liaison skills
- Have excellent partnership and communication skills, good political awareness and team working
- Understand the need for good financial and business case development
- Use constructive challenge when discussing ideas put forward and interject with innovative service solutions when required
- Will occasionally not know the answer before completing further research.

It is important that clinicians are encouraged by their organisation to participate in service change. This is achieved by diligent preparation and:

- Focusing on quality improvement rather than NHS targets
- Having a good understanding of the service being developed
- Having a well prepared draft project brief and plan
- Conducting detailed discussions initially with one senior clinician, this may be more productive than with a larger team
- Having accurate service facts and figures and clear objectives with potential benefits to patients
- Generating confidence that clinical knowledge and experience will shape proposals
- Arranging meetings that minimise any loss of clinical activity
- Arranging meetings as part of an agreed project plan, that are productive, usually time limited, minuted, contain action plans and deadlines and are undertaken with underlying executive support
- Having regular communications and updates regarding progress
- Showing the tenacity to see an agreed project through to the benefit of service users in line with an agreed project plan
- Demonstrating that the programme of work under discussion is a priority for the organisation(s)
- Given the number of recent NHS reorganisations - confirming that work that may have been undertaken previously in the area will be incorporated where possible and practical into programmes to avoid duplication of effort
- Engaging clinicians in consultation, either fronting a consultation document with a chief executive or sitting as a panel member at public meetings. This gives the public confidence that proposals will be patient centred. Media training for these roles is recommended
- Providing opportunities for continuing professional development in this area.

Patient and public engagement

Patient and public engagement is equally important. Annual operating frameworks include key priorities for the NHS and emphasise the need for the NHS to become better at listening and responding to:

- Patients who use services
- Staff who provide them
- The public which funds them.

Primary care trusts (PCTs) are expected to adopt a systematic and rigorous approach to communications with the local population to ensure there is a better understanding and confidence in local health services. Early and meaningful patient involvement will empower patients to share their views, driving forward projects that lead to real improvement.

It must be emphasised that it is not the intention of this guide to provide legal advice but reference is made to sections of legislation that are important.

Section 242 of the NHS Act 2006 confirms that each relevant English health body must make arrangements, with respect to the health services for which it is responsible, that secure the users of those services, whether directly or indirectly through representatives regarding:

- The planning of health services
- Developing or considering proposals or making decisions for changes in the way health services are provided, where these proposals impact on the manner in which services are delivered or the range of health services that are made available.

The NHS is expected to ensure that proposals that will either develop services or change the way in which they operate will benefit the users of those services, as well as improve clinical standards and deliver value for money for the taxpayer.

New duties on the NHS include carrying out involvement reporting on how the views and opinions of service users during a consultation have influenced service proposals and commissioning decisions.

The NHS Next Stage Review

The NHS Next Stage Review (May 2008) contains a number of key engagement strategy documents. It sets out five pledges:

1. Change will always be to the benefit of patients
2. Change will be clinically driven
3. All changes will be locally led (accommodating different/challenging needs)
4. You will be involved - NHS organisations will work openly and collaboratively and involve patients, carers, the public and key partners
5. You will see the difference first - existing services will not be withdrawn until new and better services are available to patients).

The NHS Constitution

This confirms a right of patients to be involved in the development and consideration of proposals for service change, and the principle that NHS services must reflect the needs and preferences of patients, their families and carers.

Involvement activity has to be appropriate and proportionate, with a spectrum of activity planned to accommodate the views of different ages, different types of condition within a service, ethnic minorities and groups that may be difficult to reach.

Real involvement means:

- A discussion of ideas, plans, patient experiences, why services need to change, what patients want from services and how to make the best use of resources
- Making sure that services being planned, commissioned or provided meet patients needs and preferences

A number of access targets are to become legal rights.

The Cabinet Office Code of Practice

This is an important reference point on consultation that includes six consultation criteria that with few exceptions are binding on government departments. These are to:

1. Consult widely throughout the process, allowing 12 weeks for written consultation
2. Be clear about the proposals, who may be affected, what questions are being asked and the timetable for responses
3. Ensure the consultation is clear, concise and widely accessible
4. Provide feedback on responses and how these have influenced the outcome
5. Monitor the effectiveness of consultation
6. Ensure that consultation follows regulation best practice.

Consultation is not required where proposals for change do not result in changes to the service, ie where there may be a change of service provider only or where service changes are temporary, such as the closure of a ward due to infection or where a pilot scheme is introduced.

Local involvement networks (LINKs) were introduced in April 2008 to offer a more integrated and independent way to improve patient and public involvement.

Changing for the better: Guidance when undertaking major changes to NHS services

This was published in 2008 and requires NHS organisations to publicly demonstrate that they are putting patients at the heart of designing their services.

The Local Authority NHS Overview and Scrutiny Committee reviews and scrutinises any matter relating to the planning, provision and operation of health services. It can ask for further information from the NHS, request a representative from the NHS to attend its meetings to explain changes and report to the Secretary of State or Monitor who can overrule decisions that have been taken. The Secretary of State can refer changes to the Independent Reconfiguration Panel (IRP) which will review proposals and provide advice back to the Secretary of State.

The IRP has helpfully produced a note of the major themes underlying the reason why service proposals have been referred to them, these are;

- Inadequate community and stakeholder engagement before options are published in a formal consultation
- Important content missing from the reconfiguration plans - local communities want to know what services will be provided, where and how they will access them
- Mixed messages about clinical issues - if doctors in an area publicly disagree with proposals, their patients are entitled to be sceptical about proposed changes
- Proposals that emphasise what cannot be done and underplay the important benefits of change and plans for additional services
- Health agencies caught on the back foot about the three issues most likely to excite local opinion - emergency care, transport and money.

It is important that patient engagement is not a token activity and that every opportunity is taken to make it effective. It is recommended that patient representatives are offered visits to centres of good practice or excellence and training in:

- National and local NHS configuration
- Financing
- Approval cycles
- NHS jargon and 'speak'.

These actions will pay dividends and should lead to more effective input and constructive challenge of proposals as appropriate.

Service users must be made to feel valued and be offered refreshments and reimbursement for incidental expenses involved in attending meetings.

Where consultation has not been carried out appropriately and there are no clear dispute resolution procedures, responsible organisations can expect adverse publicity, political pressure from MPs and the local authority and as a last resort, legal challenge that will lead to delays.

Diabetes

This publication considers NHS change specifically in the modernisation of diabetes services. This is a condition in which the amount of glucose (sugar) in the blood is too high because the body cannot use it properly. A number of key facts and figures on diabetes are that:

- 285 million people world wide have diabetes
- The ageing population, the associated prevalence of long-term conditions and obesity will increase this to 438 million people by 2030
- 2.6 million individuals are diagnosed with the condition in the UK, this compares with 1.3m in 2003
- By 2025 the forecast for people in the UK with diabetes is 4 million
- Up to half a million individuals in the UK have diabetes but are as yet undiagnosed
- £3.5bn is spent each year in the UK on diabetes
- Diabetes can increase cardiovascular risk, including the risk of heart disease, stroke and dementia
- Long-term conditions arising from diabetes can include kidney disease, eye disease, diabetic foot disease and amputation, depression, neuropathy (disorders of the nerves), complications in pregnancy and reduced life expectancy.

Treatment of the condition ranges from diet, exercise, lifestyle changes, tablets and life-sustaining insulin.

A National Service Framework (NSF) published in December 2001 (date for England) outlines 12 care standards to be implemented by 2013. The standards cover:

- Diabetes prevention
- Identifying people living with the condition who are undiagnosed
- Encouraging people living with diabetes to be partners in managing their own care
- The care of adults and children
- Emergency care
- Hospital care
- Diabetes in pregnancy
- The detection and management of complications.

The condition represents the single most challenging public health concern in the UK but the implementation of the NSF represents an excellent multiagency opportunity to prevent diabetes in large numbers and to improve the quality of life for many living with the condition. A diabetes case study is included in this publication to illustrate the many aspects of theory. The case study looks at potential actions to implement each stage of the NSF and the project management considerations.

It is important to acknowledge the progress that has been made to date to modernise diabetes services, but to recognise also that there are significant disparities of service across the UK as identified by national audits and work to complete the modernisation.

A key principle in service reconfiguration is that specialist diabetes support should be available to those who need it. Service provision in the community should take account of local need and equity and be available to all who need it. Diabetes can be a debilitating condition. Those with complications may require consultant level care to avoid work and life problems. It is important that individuals living with complex diabetes are referred to appropriately qualified staff to manage their condition.

This publication examines the modernisation of diabetes services that depends on:

- Clear and experienced project management
- Influential clinical leadership across secondary and primary care
- Important contributions from the NHS disciplines of finance, human resources and facilities
- Service user contributions through diabetes networks
- Defined benefits and robust affordability analysis stemming from verification of financial, activity and workforce data for current and future planned service models
- Agreed project implementation plans
- Agreed consultation processes on new models of service delivery.

Diabetes is also a condition where improving technology applies. There are new classes of tablets being made available to treat type 2 ('non-insulin dependent') diabetes as well as non-insulin injection therapies which can be associated with benefits such as weight loss (as obesity is a common problem in people with type 2 diabetes). Insulin pump technology is also getting more sophisticated with links to continuous blood glucose monitoring.

Significant financial savings can be made in services to contribute to service modernisation by:

- Treating well controlled type 2 diabetes closer to home in primary care
- Achieving a reduced number of emergency admissions
- Achieving reduced length of inpatient stay
- Reviewing and sharing successful modernisation initiatives
- Providing programmes of structured education to enable supported self management of the condition
- Achieving a better integration of services leading to a reduction in appointments and tests.

Modernisation, however, will usually require strategic change finance to build capacity and training across the workforce to defined national standards and public health education to change lifestyles and user and carer education. Initial analysis in West Kent intimates that approximately £500,000 alone can be saved by reducing emergency admissions to upper quartile levels. Given the increasing prevalence of diabetes, it is potentially more a case of being able to maximise the current investment in diabetes services in order to contribute to an ongoing need to invest.

Diabetes is a major killer. It has been called the 'Silent Assassin' and this refers to the fact that many people who have suffered premature death through heart attack, stroke or other conditions will have had diabetes that is not shown on their death certificate, but would have been a major contributing factor to a shortened life.

The challenge is to introduce high-quality, evidence-based services around the needs and preferences of those living with diabetes with expert specialist input. Experienced project leadership and proven project management and change techniques need to be applied and these are central themes within this publication.

Diabetes is a major challenge and a priority service that has the potential to seriously challenge the NHS if service modernisation and investment is not applied.

The search for efficiency and the implementation of service transformation within the NHS

The key components of change within the NHS are:

Ensuring high quality care for all

High quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect.

As well as clinical quality and safety, quality means care that is personal to each individual.

Clinical engagement

There is a direct correlation between the ultimate success of a project and the level of clinical engagement and leadership achieved to support the project itself and its implementation.

The development of guidance for practice based commissioning, the initial intended driver for commissioner reform and efficiency, has emphasised the importance of clinical engagement. Within the change process delivering a high quality of care is critical. Clinical engagement is discussed further in chapter 2.

Patient (service user) engagement

There is again a direct correlation between the success of a project and the level of service user engagement and this is explored more fully in chapter 3.

Executive leadership

From the outset the executive team of the organisation initiating the modernisation needs to ensure there is effective leadership of the reform process. The organisation(s) departments directly affected by service reform and the supporting directorates – such as information management and technology (IM&T), human resources (HR) and finance - all are fundamental to the scoping, shaping, implementation, operational support and management of the changes, and should be fully engaged.

Stakeholder and partner support

The potential knock-on effects of a service reform may be detrimental to at least one partner. In some cases, such as a transfer from secondary care rehabilitation to community care, it will not only be NHS partners who are affected, there may also be a pressure on social care to expand their community services to compliment the change. This requires careful communication and joint management of the change and transition.

Financial focus

As is so often the case in the public sector the financial position and its management are fundamental drivers of reform.

NHS change requires the right guidance and direction, the best approach to implementation and an explicit understanding of how a decision affects the financial position of the organisation and its partners.

Joint planning strategies

There are a number of joint planning strategies (strategies developed and agreed between public sector service organisations, the private, charitable and voluntary sectors) that planned changes in local health services should be consistent with. These joint strategies are:

- Comprehensive area assessments (CAAs)
- Joint strategic needs assessments (JSNAs)
- Local area agreements (LAAs)
- Sustainable community strategies (SCSs)
- Local strategic partnerships (LSPs).

A review of each of these is contained at annex A.

A diabetes case study in chapter 4 looks at the actions required across agencies to successfully implement a national service framework for the condition by its target date of 2013.

Clarity of objectives and the benefits of change

It is essential to set out clearly the objectives and benefits of reform. The objectives can be:

- To improve health, health outcomes and the quality of health services
- To maintain quality whilst reconfiguring pathways to provide services efficiently
- To achieve better financial viability for an individual organisation, or for the local or wider health community
- To maximise income and margins for providers of health services or minimise expenditure for health service commissioners
- To act as the means by which private sector provision is able to enter the market
- To develop quality service solutions which are fully endorsed by clinical teams and service users
- All of the above and more?

The benefits also need to:

- Be directly aligned to the organisation's objectives in order to demonstrate compatibility with their strategic direction
- Demonstrate the financial viability of the proposal and include a plan that shows how the reform will be achieved. It might well be the case that a proposal will utilise a combination of efficiency and NHS growth to meet its objectives.

The search for efficiency: developing proposals for change – the ten high impact changes

In September 2004 the Modernisation Agency published the document *10 High Impact Changes for Service Improvement and Delivery: a guide for NHS leaders*. It was designed for commissioners and focused on the ten areas for change that improve healthcare pathways and are proven to work.

Many commissioners will be aware of these ten changes and some will have carried out reforms in line with them. However, it is unlikely that any one organisation will have maximised the benefit from each change across its portfolio. Therefore, it is

valuable to revisit the guide to see where it can help identify and advise the next stage of change and improvement. Using the guide can be a real benefit in the early days of a reform programme. It bears just one sentence and this is: 'We know these changes work and we have the evidence to prove it'.

The following table reproduces the list of these ten changes, which are in the form of themes for reform. It is vital that each reform is supported by clinical best practice and clinical teams.

The ten high impact changes

CHANGE	IMPACT
1. Treating day surgery (rather than inpatient surgery) as the norm for elective surgery	■ Releases bed days that can be used to increase throughput
2. Improving patient flow by improving access to key diagnostic tests	■ Saves unnecessary patient waiting times
3. Managing variation in patient discharge, thereby reducing length of stay	■ Releases bed days, that can be used to increase throughput
4. Managing variation in the patient admissions process	■ Reduces cancelled operations
5. Avoiding unnecessary follow-ups for patients and providing necessary follow-ups in the right care setting	■ Reduces quantity and/ or cost of outpatient appointments
6. Increasing reliability of performing therapeutic interventions through a care bundle approach in critical care	■ Releases bed days
7. Applying a systematic approach to care for people with long-term conditions	■ Can reduce emergency admissions and costs
8. Improving patient access by reducing the number of queues for elective access	■ Reduces the need for one-off activity initiatives to meet waiting time targets
9. Optimising patient flow through service bottlenecks using process templates	■ Releases capacity
10. Redesigning and extending roles in line with efficient patient pathways to attract and attain an effective workforce	■ Releases clinical time

Given the global economic crisis, the position of the UK public finances, and the need for the NHS to operate within these constraints, the following section lists a series of further options to review when looking at efficiency within the NHS:

- The NHS Integrated Service Improvement Programme (ISIP) is producing a number of best practice evidence based modernisation proposals across a range of services
- Reducing the length of stay pre and post operations to upper quartile levels
- Working through the recommendations of the NHS Institute and advice from the NHS Productivity Unit (£5bn savings assessed if organisations moved to upper quartile performance)
- Enabling nurses and frontline staff to spend more time on clinical rather than administrative duties
- Reducing healthcare acquired infections such as MRSA and *c-difficile*, and the associated length of stay costs

- Pay restraint
- Revisiting financial, establishment and budgetary controls to reflect the more difficult financial environment
- The Department of Health reviewing central health policies such as foundation trusts, payments by results (PbR) and practice-based commissioning as efficiency gain is usually most productive when a whole systems perspective is taken.
- Prescribing variations between similar health cluster areas
- Tariff setting that encourages innovation and efficiency
- Taking advantage of accounting changes such as a private finance initiative (PFI)
- Reviewing centrally held budgets
- Reducing administration and management costs carefully and realistically
- Reviewing programme budgeting expenditure across similar cluster populations, but recognising the weaknesses in data etc
- Reviewing procedure costs for similar organisations.

When making comparisons it is necessary to consider, the quality of the services being delivered, the health outcomes being achieved, the reliability of the data and the reliance that can be placed on the comparative analysis.

Developing proposals for service change

The application of efficiency gains may be used to mitigate the effects of a tightening financial position. Where this exceptionally is not the case, the following practice-based commissioning (PBC) template is a helpful starting point for those involved in commissioning. With slight adaption it can support the consideration and assessment of development proposals prior to moving to the development of a more substantive business case.

Developing proposals

The following checklist is taken from *Practice-Based Commissioning – The Essential Guide to Practical Implementation* (CIPFA 2006). Whilst not exhaustive it is a useful tool for professional executive committees (PECs) in ensuring they make robust decisions on the use of PBC efficiencies.

PEC governance checklist for decisions on use of efficiency gains

CHECK	TEST (all of these need to be demonstrated)
Link between proposal and NHS agenda	<ul style="list-style-type: none"> ■ Does the proposal have a (demonstrable) positive impact on demand management? ■ Does it move the locality towards meeting public health, or other, NHS targets?
Link between proposal and NHS standards	<ul style="list-style-type: none"> ■ Does the proposal demonstrate consideration of clinical/corporate governance and quality standards? ■ Have these been worked up to the extent that the PEC can see that the proposal will meet the required standards?
Patient benefit	<ul style="list-style-type: none"> ■ Does the proposal improve the healthcare system for patients? ■ Is this quantified/qualified/ evidence-based? ■ Is the proposal something patients want? ■ Can this be demonstrated via patient group participation/ consultation with patients? ■ For proposals involving work on premises, does the patient benefit extend beyond the practice’s own list?

CHECK	TEST (all of these need to be demonstrated)
Whole system solution	<ul style="list-style-type: none"> ■ Does the proposal adequately consider the whole system? ■ Is it beneficial to the wider health economy? ■ Does it destabilise other providers? ■ Does the proposed care pathway require proactive support from other organisations and has that support been obtained?
Risk management	<ul style="list-style-type: none"> ■ Has a detailed risk assessment been carried out, including contingency planning and scenario analysis? ■ Does this adequately deal with the potential barriers to achieving the benefits/targets/ aims of the proposal?
Anticipated health gains	<ul style="list-style-type: none"> ■ Are these explicitly stated and the achievability demonstrated? ■ Does the PEC support the assumptions and reasoning of the proposal?
Appropriateness and effectiveness	<ul style="list-style-type: none"> ■ Is the proposal appropriate – does it fit with national and local NHS priorities? ■ Is the proposal effective – will it achieve its objectives? ■ Is the nature of the proposal evidence based? ■ Does the PEC recognise and support the proposal as an effective and appropriate means of providing healthcare?
Value for Money	<ul style="list-style-type: none"> ■ Is the proposal economic, efficient and effective? ■ Is it a recognised means of achieving value for money and is it the most effective means?
Financial risk	<ul style="list-style-type: none"> ■ What is the level of risk of the financial projections not being correct? ■ In particular, if the proposal forecasts or depends on savings materialising, is the level of risk/ability to manage risk too high?
Affordability	<ul style="list-style-type: none"> ■ Can the PCT/ practice-based commissioner’s baseline accept the risk of non-achievement? ■ That is, if projected savings do not materialise, does the proposal remain financially viable? ■ The importance of this consideration is in direct proportion to the level of risk of savings not materialising.
Stakeholder involvement	<ul style="list-style-type: none"> ■ If the proposal impacts on the role of other primary or social carers, are they supportive? ■ Has, as a minimum, consultation occurred in line with best practice? ■ Have other stakeholders been involved in, and taken ownership of the proposal?
Direct provider involvement	<ul style="list-style-type: none"> ■ If the proposal entails practice-based commissioner management of a service, do those who will ultimately provide the proposal support it?
Achievability and sustainability	<ul style="list-style-type: none"> ■ Is the PEC confident that the proposal will achieve its objectives? ■ Have all clinical, service, management and financial issues been fully thought through? ■ Is the proposed change to healthcare provision sustainable in the long-term?

Proposals being developed also need to accommodate agreed forecast changes in demography and more efficient working patterns

To assist in prioritising and phasing reforms, an analysis of changing demography is important. This provides an insight into the changing needs and demand for services based on the future population of an area.

The level to which demographic analysis can help to guide strategic decisions on the reform agenda is demonstrated by the case study below. This reproduces an abridged version of a demographic appendix from the Eastern Cheshire Future Healthcare Project - now part of the Central and Eastern Cheshire NHS. Although a little dated now it highlights a number of principles.

Case study: assessment of future health needs, Eastern Cheshire health economy (produced December 2005).

Population projections:

Population estimates and projections covering the period 2001-2021 in five year intervals are set out in table (a). Overall there is a 4.1% reduction in total population but this masks considerable shift between age groups. The fall in the numbers of children is most striking with a 28% drop in people under 15 over the 20 year period. There is a general decrease in the numbers of people between 15 and 44 (barring one five year band), a group critical for providing community support and for the economic well-being of the area. Above 55 there will be large percentage increases with, in the most extreme case, a 43% increase in people aged 70-74.

The implications for the model of health and social care in the future are considerable. These include:

- A reduced overall demand for children's and obstetric services
- A need to re-assess community support as the active adult population declines
- Workforce Implications – regarding care staff
- Large increases in elderly populations over 75 and 85 where there can be expected to be significant increases in this age group with long-term conditions and illnesses.

Table (a): Population changes in ECPCT 2001-2021

Age/year	2001	2006	2011	2016	2021
0-4	10,100	8,900	7,800	7,400	7,400
5-9	11,100	10,700	9,400	8,300	7,900
10-14	11,800	11,400	11,000	9,700	8,500
15-19	10,200	10,500	10,200	9,800	8,700
20-24	7,400	8,600	8,900	8,700	8,500
25-29	9,700	8,000	9,200	9,500	9,400
30-34	13,000	10,400	8,600	9,900	10,400
35-39	14,900	14,000	11,200	9,300	10,800
40-44	14,000	15,500	14,600	11,700	9,700
45-49	13,100	14,200	15,600	14,700	11,800
50-54	15,100	12,900	13,900	15,400	14,500
55-59	12,700	14,500	12,500	13,500	14,900
60-64	10,600	12,100	13,800	11,900	12,900
65-69	9,300	9,900	11,400	13,000	11,200
70-74	8,300	8,500	9,000	10,400	11,900
75-79	6,800	7,100	7,300	7,800	9,100
80-84	4,600	5,300	5,600	5,700	6,200
85+	4,300	4,500	4,800	5,200	5,500
Total	187,000	187,000	184,800	181,900	179,300
Memorandum					
0-14	33,000		- 28%		23,800
65+	33,300		+31%		43,900
70-74	8,300		+43%		11,900
75+	15,700		+32%		20,800
Total	187,000		- 4.1%		179,300

The effect of demographic shift on demand for health care

The need and demand for health care are heavily influenced by the population age structure with the extremes of life having the highest needs and costs. Resources are allocated to primary care trusts on the basis of their resident population and the different age bandings within this attract differential funding levels. These are then weighted for the differing health needs and the differing costs of providing services in different locations. We can use this formula to predict very crudely how the costs of services may be expected to change as a result of changing populations and this is shown in table b.

This approach can be used to cross check costs that are developed from specific proposals to ascertain if a future forecast funding level will sustain these changes.

Table (b) shows that there is an overall 7% increase in the health cost weighting of the population, but this masks a 27% fall in the allocation attributable to children and a greater than 31% increase in all populations over 65. In summary this suggests there is a need to redeploy resources away from the young and middle-aged towards the over 65 age group.

Table (b) Comparison of age-sex weighted populations. Allocation for each age group (£000s)

Age/year	2001	2005	2011	2016	2021
0-4	5,973	5,263	4,613	4,376	4,376
5-14	5,612	5,445	5,049	4,491	4,082
15-44	29,879	28,874	26,988	25,333	24,808
45-64	27,388	28,558	29,674	29,515	28,770
65-74	17,005	17,778	19,710	22,609	22,319
75-84	18,056	19,640	20,432	21,383	24,234
85+	10,138	10,609	11,316	12,260	12,967
Total	114,051	116,167	117,782	119,967	121,556

Memorandum					
0-14	11,585		-27%		8,458
65+	45,199		+31%		59,520
Total	114,051		+ 7%		121,556

The effects of demographic shift on specific conditions:

The ageing population means that demand for specific services will increase and therefore it is necessary to review the changing population on a service by service approach.

Table (c) looks at the forecast increase in the numbers of all cancers (excluding non metastatic skin cancer) that could be expected to be registered.

Table (c): Likely impact of the population changes on numbers of cancers within the PCT

	2001	2006	2011	2016	2021
Males	488	522	564	596	629
Females	463	484	505	526	549
Total	951	1,006	1,069	1,122	1,178

Memorandum					
Total	951		+24%		1,178

Overall we can expect a 24% increase in cancer registrations over the 20 years just attributable to the change in age structure.

Table (d) looks at the expected percentage increase in the numbers of cataract and hip operations in a similar manner. There is a greater percentage increase in the need for cataracts as more people have this operation over 75 whereas most people having their hip operation are aged between 65 and 75.

Table (d): Percentage increases in the need for hip and cataract operations due to demographic shift. 2001 base year

	2001	2006	2011	2016	2021
Cataracts	0	7.1	14.1	19.0	27.5
Hips	0	5.6	13.4	17.3	22.7

Table (e) examines the forecast increase in the number of strokes.

Table (e): Percentage increases in the number of new strokes presenting at A&E due to demographic shift. 2001 base year

	2001	2006	2011	2016	2021
Males	0	8.1	17.0	24.6	32.0
Females	0	5.1	9.7	17.1	25.0

Finally, Table (f) looks at the expected numbers and percentage increase in people with dementia. This equates to a near 30% increase over the 20 years.

Table (f): Increases in the numbers of people with dementia attributable to population changes: 2001 base year

	2001	2006	2011	2016	2021
Males	786	854	953	1,041	1,136
Females	1,716	1,792	1,860	1,981	2,108
Total	2,502	2,646	2,813	3,022	3,244
% change		5.8	12.4	20.8	29.6

Similar principles will apply to long-term conditions such as diabetes.

How can this help us when looking at the future pattern of healthcare and what needs to be considered in terms of the shaping of an overarching reform strategy?

The analysis can be used both to act as a guide for identifying areas for reform – not just in terms of preparing for changes in demand caused by demography, but also in focusing attention on offsetting these where appropriate, for instance:

- Expanding community long-term conditions management to offset the potential for increased demand on secondary care older people's services
- The decrease in the number of children means that the provision of paediatric and obstetric services should be reviewed, while retaining quality and safe services
- The new investment needs of the elderly need to be assessed, in particular building infrastructure in the community as the largest increases in disease prevalence will be in people with long-term conditions such as dementia where the major issues will be around long-term rather than acute management
- Reviewing improving techniques and technologies designed to reduce time and cost.

Short-term v long-term objectives

Planning for the above scenario is complicated. Organisations also have to add to this:

- Shorter term performance targets to achieve
- The wider reform agenda such as PbR, PBC and foundation trust (FT) status
- Other targets included within annual operating frameworks.

In considering demographic change, the statistical expertise of the local authority should be acknowledged. This will ensure that proposals for health, other public services and voluntary services are planned on a consistent population base.

The development of a longer term service strategy requires a project board, with the involvement of other public sector bodies, the private sector, voluntary sector and service users and representatives.

It is important that short-term actions complement a longer term strategy.

Clinical Public Health Needs Assessments (PHNAs) and Health Impact Assessments (HIAs)

It is important to take into account the public health contribution towards service change.

A public health needs assessment (PHNA) will determine whether health needs are being met by current service models or would be better met under proposed new models.

The results of PHNAs are similar to those of value for money (VfM) assessments. The results can be categorised as:

- Needs are being met (consequence – move on to next assessment)
- Needs are not being met because there is no service (consequence – put forward for reform proposal)
- Needs are not being met because the current service cannot deliver its objectives.

The types of questions which need to be included in a PHNA are:

- What are the required public health outcomes of the service area?
- Is the target population clearly identified?
- What are the different models for achieving the outcomes and which is most suited to the local population?
- Does the management structure for the service facilitate the most suitable model?
- What are the local health inequalities and access issues pertaining to the service and does the current/proposed service model facilitate resolving them?
- What are the preventative measures available pertaining to the service and does the current /proposed service model facilitate achieving them?

The Health Impact Assessment (HIA) is an integral part of the business case process and its purpose is to:

- Identify the potential health consequences of a proposal on a given population
- Maximise the positive health benefits and minimise potential adverse effects on health and inequalities.

A HIA should be carried out during the planning process for early involvement activity. The main output is a set of evidence-based recommendations to inform the decision-making process for that proposal.

NHS organisations should consider undertaking a HIA for most proposals affecting health services. Although there is no statutory requirement to do this, their preparation and publication make sure that professionals and service users:

- Understand why change is being proposed
- Understand how and to what extent proposed changes may impact on them

- Understand the estimated costs and benefits of proposed measures
- Identify potential unintended consequences.

A HIA should include an examination of a proposal's potential impact upon each of the equality strands – ethnicity, disability and gender. It is good practice to consider other dimensions such as age, sexual orientation and religion or belief.

Value for money (VfM)

VfM in healthcare provision is attained by successfully achieving economic inputs, efficient processes and effective outputs in clinical pathways and management systems.

When reforming healthcare it is important to assess that the proposed new pathways will succeed in attaining value for money - assuming operation is managed appropriately. Boards require this assurance before approving the change.

Value for money assessments need to focus on three areas:

1. Managerial processes and systems
2. The inputs and processes by which services are provided
3. The achievement of outcomes in line with intent, ie outcomes that meet the appropriate objectives of the service.

Guidance on ways to ensure value for money is being achieved is included in annex B.

Each provider organisation will also want to look at its own operating efficiency through a series of reviews such as estate utilisation, energy and carbon consumption, procurement, back office functions and organisation, agency usage and drugs prescribing to give assurance that it is managing its own costs efficiently.

The NHS business case model

The business case model used in the NHS is a good process to follow to ensure that all of the information required for the approval of major changes is produced for consideration. Whilst this model was developed in the 1990s to support capital and IT investments, its principles are sound for all proposed developments and can be adapted easily to use as a proportionate and appropriate model to fit any project, with due regard to an organisation's standing orders and investment appraisal policies.

The business planning process

This section will look at the overall business plan model, that is, the business case and the key processes within this that need to be considered.

The business case

The NHS Business Case Guide, part of the Capital Investment Manual, is intended for use in building a case for capital projects. However, it is also a very useful tool for other investment projects, acting as a process that ensures all of the necessary tests, assessments and consistency checks are carried out and documented to inform decision makers as to whether a proposal is sound or not.

Reform and efficiency projects can 'dip into' the techniques and requirements within the business case process as best practice in building up a proposal and testing its viability. To address economy, effectiveness and efficiency a business case should:

- Be produced on time and within budget
- Reflect quality in terms of scoping, planning, procurement, implementation and evaluation; and structure and presentation
- Be approved first time.

It is worth an organisation determining a policy for this. For instance, which gross investment value requires an outline, summary and/or full business case and which proposals can be put forward for approval with less input.

In the context of efficiency, rather than specific development the net cost of a proposal should be a saving. However the level of this will often, if not always, be assumption-based at the time of requesting approval. In other words an impact assessment may show that the change should cost £1,000,000 but save £1,200,000, generating a net saving of £200,000.

This assessment indicates that the figure 'should occur' rather than that it 'will occur' and therefore a consideration of the robustness and level of risk for this conclusion needs to be built in to the approval process.

A £1,000,000 investment is material in any organisation and therefore it is this gross sum that should determine the governance arrangements for approval.

The phases of the business case

This section will describe the objectives and requirements of the three phases of a business case process and will then move on to the nine steps within these phases to produce a robust business case. It is important to account for the points above about different levels of gross investment determining how much of the business case process should be followed and which elements are deemed obligatory at each level.

It would not be efficient, for instance, for a relatively small-scale change proposal to undertake a full assessment of a trust's estate utilisation - an indication of the existence of capacity to accommodate the change should suffice.

We will consider the key tools within this that have not been considered earlier and that support the reform and efficiency programme for organisations.

Phase one: strategic context and strategic outline case

This phase considers and demonstrates the case for change. It should explain, assess and/or analyse:

- The reasons for change
- Why the current situation should not continue
- The affordability of the proposed change.

The strategic context should also cover the eight key areas below:

1. A summary of the organisation's strategy, service and investment objectives
2. A review of the current activities, financial health, utilisation levels (for providers) and information systems of the organisation from a business perspective
3. The business need. A review of the market and the organisation's position within it (whether as a purchaser or a provider). This should account for the strategic intentions of partners, consideration of the marketplace's demography and demand for healthcare, the influence of the national agenda (for instance the shift to community-based supply) and innovations in technology and medical/patient management
4. An assessment of the organisation's ability to meet future demand for services, again whether as a purchaser or provider
5. Ensuring all projects have defined benefits and outputs that can be measured, reported and communicated
6. How the proposal matches with the organisational, national and local area health strategies
7. Financial/non-financial benefits, risks, constraints and dependencies
8. Optimism bias should be included in appraisals. This is a mechanism to correct a tendency for project appraisers to be overly optimistic on timescales and costs. Current percentage uplifts can be found on the DoH website www.dh.gov.uk.

This maps into the Office of Government and Commerce (OGC) Gateway 1 stage (business justification) and should make a robust case for change providing service users and stakeholders with an early indication of the proposed way forward (not preferred option) having identified a range of available options and indicative costs. This would be accompanied with a strength, weaknesses, opportunities and threat (SWOT) analysis. Significant change proposals should have a project director and a senior responsible owner who may be the chief executive.

Phase two: outline business case

This phase identifies and derives the preferred option, ie the proposal being put forward for approval is the best to achieve the objectives of the change under consideration. It should:

- Identify the objectives and critical success factors of the investment
- Link the proposal's objectives to the organisation's strategy and objectives
- Confirm that any conditions linked to the approval of the strategic outline case have been met
- Confirm that any assumptions made remain robust
- Review the (non-financial) benefits of the investment
- Review the risks and constraints to achieving the objectives; build financial risks (probability weighted) into the option appraisal
- Generate a long-list of potential options to meeting the objectives
- Establish an agreed set of criteria from a workshop (eg clinical quality 30%, patient accessibility 15%, other factors 55%) to assess options against and weight each criteria to develop a preferred service option
- Generate a short-list of options by assessing the long-list against agreed criteria
- Assess the financial costs and benefits of each of the short-list options (refer to annex C)
- Assess the economic appraisal including financial costs and benefits of each of the short-list options and apply financial appraisal (discount incomes and costs for net present value)
- Assess the actual financial affordability – cash flow costs and benefits of each of the short-list options. See annex C for differences between economic and financial appraisal
- Calculate the equivalent annual cost of each option if they have different life spans
- Conduct risk analysis on the short-list options. Conduct a need and impact assessment on the short-list options
- Demonstrate affordability
- Include optimism bias
- Detail the procurement strategy
- Detail the management arrangements for successful rollout
- Identify the preferred option.

As mentioned above, and as stated in the Business Case Guide, 'The effort expended in phase two should reflect the size of the scheme and the complexity of the choice' [Capital Investment Manual – Business Case Guide, NHS Executive, 1994 – www.nhsestates.gov.uk].

This maps into OGC Gateway 2 – procurement strategy.

This phase requires a comprehensive understanding of what costs are to be included and excluded from both the economic and financial appraisal.

Refer to annex C for guidance.

Phase three: full business case

After the outline business case is approved the full business case should be produced.

The purpose of phase three is to validate the work of phases one and two and, most importantly, to fully develop the preferred option. It should:

- Review phase one, including a more detailed assessment and quantification of future service requirements
- Review phase two, including a validation of the investment appraisals
- Develop the preferred option, including detail on the calculation of costs and savings (impact)
- Develop the project management plan, including project monitoring processes
- Develop the post-project evaluation process
- Demonstrate the deliverability of the proposal, on time and to budget
- Follow detailed negotiations with internal / external service providers and build these details into the case.

This maps into OGC Gateway 3 – investment decision

Gate 4 is go live and Gate 5 is benefits realisation that is generated from a post project evaluation.

The nine individual steps of the business case within the three phases

The three phases of the business case contain nine individual steps that are outlined below.

Step 1

Set the investment within the strategic context and strategic outline

A full version of this step will contain:

- Appraisal of current healthcare services - (commissioned or provided) - including consideration of service performance, quality, range, facilities, characteristics and demand
- Description of the organisation's assets, including physical (provider) information systems and equipment
- Assessment of financial situation and cost structure
- Analysis of the market and assessment of demand, including demography, competitor appraisal (providers), competitive analysis, future needs and demands, scope for improvement, the role of commissioners and providers, the case for change and affordability.

Step 2

Outline business base – define objectives and identify benefit criteria

A full version of this step will contain:

- General objectives covering issues such as access to services, relevance to need, social acceptability, effectiveness, equity and efficiency
- A ranking of objectives, achieved via consultation with stakeholders and including an assessment of the constraints to achievement
- The identification of benefit criteria linked to the objectives and developed in consultation with stakeholders.

Step 3**Outline business case – generate options**

The outcomes of this step are:

- A long-list of options, including a 'do nothing' or 'do minimum' option, developed in consultation with stakeholders
- A short-list of options (minimum three, maximum six), including the 'do nothing/minimum' option, developed in consultation with stakeholders and using the benefit criteria from step two to eliminate options from the long-list
- A description of each short-listed option, including intended outcomes, expected workloads and throughputs, functional content, accessibility, staffing consequences, phasing, estates implications, impact and flexibility for further development.

Step 4**Outline business case – measure the benefits**

The outcomes of this step are best achieved via a stakeholder workshop and are:

- Weights are given to each benefit criteria
- Average scores for each option against each benefit criteria are developed
- Assessment of the timings of benefits being achieved for each option
- A weighted score is derived for each option
- An assessment is made of the current position against benefits (essential in order to develop the benefits realisation plan).

Step 5**Outline business case – identify and quantify the costs**

A full version of this step will include costs for each option. A full costing process for an option will consider:

- Opportunity costs
- Marginal, average and semi-fixed costs
- Full-life costs
- Phasing of costs
- Capital costs and residual values (capital investments)
- Capital charges
- Wider effects on cost (eg impact on other areas of service and other organisations, such as social services)
- Transition costs
- Avoided costs (part of the wider impact assessment)
- Affordability.

Step 6**Outline business case – assess sensitivity to risk**

As can be seen from the steps above, the identification of the affordable preferred option is achieved via a series of assumptions. This step considers the impact on the ranking and affordability of options if these assumptions are not correct. A full version of the step contains:

- Sensitivity testing of each benefit criteria, including the impact on weighted scores of the options
- 'What if?' sensitivity testing of cost assumptions, for example, what if prices change in real terms (that is, over or under the inflation rate), what if savings occur later than anticipated or what if demand is more or less than assumed?
- Calculation of the 'switching value' (ie how much an assumption would have to change before an option becomes non-viable), for example, 'the unit cost would need to be 70% more expensive than assumed before the option ceases to save money on the current position'
- Scenario planning, including an assessment of whether the preferred option changes if a pessimistic or optimistic scenario occurs, such as that demand is materially less or greater than assumed
- Identification of risk and the primary holder of that risk determined by considering which organisation bears the consequences of a risk and the obligations of each organisation should a risk occur.

Step 7**Outline business case – identify the preferred option**

Step seven is the culmination of steps three to six.

- The final choice of the preferred option rests with the board of an organisation or the group the board has delegated that role to. This step identifies the recommended preferred option to the relevant group for their consideration.

Step 8**Outline business case – present the outline business case**

- The outline business case is the means through which the above steps are collected and explained, step seven being the conclusion to this document.

Step 9**Produce the full business case**

Following the formal identification of the preferred option, the full business case is produced. This should contain:

- A review of the robustness of steps one to eight above, including an assessment of any changes to assumptions and the conclusions that these led to
- A benefits realisation plan for the preferred option, including an assessment of each benefit and when it will be achieved, identification of dis-benefits, actions needed to achieve benefits, identification of responsible officers for ensuring achievement of each benefit, how achievement will be measured and how achievement will be monitored
- A risk management strategy, including the management of project implementation risks
- Explanation of the project control and management system, for instance covering the project management reporting process and responsible officers.

Further considerations

The Disability Discrimination Regulations

The Disability Discrimination (Public Authorities) (Statutory Duties) Regulations 2005 require public authorities to publish a disability equality scheme. The scheme has to include a statement of the public authority's methods for assessing the impact of its policies and practices, including proposed policies and practices, on equality for disabled people.

Foundation trusts (FTs)

In relation to private finance and other developments the Department of Health and Monitor, the independent regulator of NHS foundation trusts has produced guidance on roles and responsibilities.

The key role for strategic health authorities (SHAs) and primary care trusts (PCTs) is to:

- Confirm that the services planned/changed are wanted
- The services are planned for in the right location
- The activity levels are realistic.

This provides assurance that the development is affordable, that income assumptions can be supported and the project is viable.

Two key pieces of guidance covering roles and responsibilities in the approval of NHS Foundation Trust PFI schemes and risk evaluation for investment decisions by NHS foundations can be found below:

- www.monitor-nhsft.gov.uk/sites/default/files/publications/Monitor_Investment_Risk_Evaluation_final.pdf
- www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/roles-and-respon

Foundation trusts, while they remain public institutions, are free from DoH control. They can

- Set their own investment strategies
- Make their own decisions to improve services for patients within contracts agreed with commissioners
- Borrow commercially
- Retain surpluses
- Invest to meet local needs.

With these extra freedoms the ultimate responsibility for the success or failure of FTs rests with the board; there is no safety net. Capital investment decisions must be rigorously appraised across all organisations, for FTs though there is this added risk dimension.

NHS trusts and primary care trusts (PCTs)

The capital investment decisions of NHS trusts and PCTs will be outlined within a framework set by SHAs that they are accountable to.

Her Majesty's Treasury (HMT) and the DoH require full business cases for all public capital schemes (currently £100m or more).

Key to success – clinical engagement

This chapter considers in more detail the critical area of clinical engagement and leadership. Individuals working in the NHS have considerable knowledge and understanding of their services and good clinical practice. The appointment of clinical champions who bring their own professional focus can:

- Support organisation(s) in developing their vision and strategic direction
- Ensure high quality, clinically effective and safe services are commissioned
- Lead clinical communications with partner organisations and stakeholders
- Encourage and lead innovation.

It is good practice to let staff know about changes that are being planned, developed or consulted upon, to ensure that they are informed and that they are given the opportunity to become involved in the project from the start.

Clinical engagement and leadership is critical for the ownership and sustainability of high quality service improvement.

Engaging clinical champions within change projects can provide vision and create peer pressure to facilitate change.

Clinical support and leadership can be best be pursued by:

- Identifying who would be the best clinician to maximise clinical (especially medical) leadership in the development of proposals
- Making sure that the clinical benefits and the infrastructure that is needed to deliver the changes are understood
- Recruiting clinicians who will demonstrate a majority of the desirable characteristics below. They:
 - are leaders in the service
 - have trust, seniority and experience to generate respect and credibility from peers, management within their own organisation and across organisational boundaries
 - are professional leaders with a significant level of charisma and standing
 - are prepared to become involved in the engagement process
 - have good negotiation and influencing skills
 - have a good understanding of structure and process
 - can show empathy and understanding regarding other people's views and working styles
 - have excellent communication skills with patients and carers, and an ability to create effective partnerships with patients.
 - have good political awareness and team working skills.
 - understand the need for good financial and business case development
 - challenge ideas
 - promote a patient-centred perspective
 - occasionally will confirm they 'do not know' without further research.

Providing media training for clinical staff who have lead roles in the involvement process is good practice.

Making sure that appropriate clinical staff are involved throughout the process alongside user champions who are prepared to provide the users' perspective and talk about their experiences is a preferred approach.

Successful projects have clinicians who are able to lead change by:

- Gaining respect from colleagues, being impartial, transparent and thinking beyond organisational perspectives
- Providing a clear sense of direction and inspirational vision
- Working well with patients and being focused on patient-centred outcomes
- Challenging the current position and recognising the importance of interorganisational working
- Becoming involved in the project because of their passion and interest in the area
- Being able to explain the rationale for a particular change and make recommendations
- Balancing professional interests with those of users
- Making the best use of resources
- Updating colleagues on advances in a medical field; or using patients' experiences to help reflect on their practice
- As a user possibly themselves, they might be involved because they have:
 - personal experience of living with an illness
 - know a friend, relative or carer of someone who lives with the condition
 - know other people and families in similar situations
 - have knowledge of research and practice relating to their condition
 - know many people in the community and are widely trusted
 - have experience as an activist; or act as a formal representative of a consumer group or organisation.

Improving the quality of care and providing more responsive services for patients can only be achieved with the strong involvement of local clinicians in the management of the service. With a full understanding of the resources being consumed, it is possible to plan to improve quality, combining operational and clinical effectiveness to produce high quality, cost-effective services.

All clinicians should have an understanding of the basics of NHS finance, the financing arrangements for their service and the fundamentals of budgetary management.

Clinicians should also expect to receive:

- Prompt and reliable financial and workload information in a form they can understand
- Appropriate guidance, training and support regarding financial issues
- Support and encouragement to take financial responsibility for their service with the freedom to make changes and improve quality.

It is really important that NHS finance staff should be familiar with current clinical practice and the culture and the aspirations of clinicians. On the 30 June 2009 Lord Darzi notified the NHS that the Department of Health (DoH) is looking to give clinical teams in England in the acute sector ownership of their own budget(s).

Strategic health authorities (SHAs), with their responsibility for training and education, have an important role in ensuring that programmes to develop these skills are in place through post-graduate deaneries and finance for non-financial managers training schemes.

World Class Commissioning

World Class Commissioning guidance outlines the subcompetencies needed to be world class in relation to clinical engagement.

- PCTs should encourage broad clinical engagement and utilise the skills and knowledge of clinicians to inform commissioning intentions, including setting of the strategic direction.

How to effectively engage clinicians?

The steps to effectively engage clinicians are shown below.

- Have a well prepared project plan with clear objectives to benefit patients
- Focus on quality improvement rather than delivering targets
- Be well informed with accurate service facts and figures
- Get to know your clinicians. Start with the natural innovators, clinicians who have a good reputation and who deliver on commitments outside their normal clinical work
- Listen to clinicians: they have the valuable knowledge and experience
- Discuss and work through opposition to the change
- Engage individually rather than just in a group to enable detailed discussions of the ideas proposed
- Meet at a convenient time to minimise any loss of clinical activity
- Lead the late adopters by example. You could arrange visits to high quality centres that have achieved changes successfully
- Communicate regularly about progress and see the project through.

Signs of generic clinical engagement

The following show signs of good clinical engagement:

- Clinicians are enabled to become at a more detailed level an integral part of individual and cluster based practice-based commissioning, planning and decision making
- At the macro level clinicians should be an integral part of the management, planning and commissioning of the PCT
- Clinicians are kept fully informed about the PCT's priorities and have ample opportunity to influence its agenda, making their voices heard not only through the PEC, but via a flourishing network of subcommittees, professional forums, working groups and other meetings
- The whole spectrum of clinicians – consultants, GPs, dieticians, nurses, podiatrists, physiotherapists, occupational therapists etc and other pivotal allied health care professionals - should be engaged
- If necessary, the PCT will instigate measures, such as protected learning time or paid locum cover, to enable busy clinicians to reconcile their participation with demanding workloads
- The benefits of clinical engagement - for the clinician, their professional group, patients and the wider community's health - are communicated clearly
- Clinicians are involved in the entire commissioning process, from assessing need to monitoring performance
- Those with relevant experience are encouraged to become commissioning leads
- Relationships with clinicians should foster openness to new ways of working and a readiness to be flexible; building on this, they become involved in evidence-based change, redesigning services and care pathways
- Involvement in even apparently small schemes can bring important gains
- Engaged clinicians are ready to work across professional boundaries, improve teamwork and help each other
- PCTs with strong clinical governance arrangements stand a better chance of enabling staff to understand the PCTs' priorities and their own role in achieving them.

Key to success – patient and public engagement

A number of key messages are now an integral part of annual NHS guidance contained in Operating Frameworks. These include the following:

- The NHS needs to be better at listening and responding to patients who use services, staff who provide them and citizens who fund them
- PCTs are expected to take a systemic and rigorous approach to communicate with local populations to ensure that there is a better understanding and confidence in local NHS services
- The NHS is expected to consult with patients, patient representatives, carers, the public, clinicians, staff and political leaders.

Chapter 1 looked at the systematic process to follow when considering service change in the NHS. Patient engagement was briefly covered and this chapter provides further guidance on this critical area.

Developing patient champions who have a wide range of experience, can develop a rapport with clinicians, are visible and can keep the focus on patient-centred care and outcomes is at the heart of developing NHS services.

Early patient involvement in the change process has the following benefits:

- It can highlight the gaps between services in a unique way
- Challenge existing practices and deeply held views
- Bring new perspectives
- Influence others to buy into the change process
- Be a powerful force for change at clinical and organisational levels.

Meaningful patient involvement includes:

- A focus on building relationships, giving a voice to those in the poorest health and those that are most vulnerable and providing the right information and background to particular projects
- Patients being involved at every stage, providing continuous patient feedback on current and future models of care
- Using patients to evaluate services, using workshops and surveys
- Patients offering peer support to each other
- Taking patients on good practice visits and sharing case study examples
- Acting on patient feedback and doing where possible what they want you to do
- Providing feedback to patients acknowledging the impact they have made
- Providing training for patients to develop the necessary skills
- Having adequate publicity and access for patient engagement events
- Improving patient engagement processes following assessments by the Audit Commission/Care Quality Commission and other regulatory bodies who review this area
- Having a deep understanding of the different engagement options, including the opportunities, strengths, weaknesses and risks of each.

Patients who feel empowered to share their views, leading to a real service improvement can drive forward successful projects. Public engagement should be used carefully, and the engagement methods tailored to specific objectives. There are agencies such as the Picker Institute that specialise in this area of work.

To achieve excellence in NHS services, patients should agree that proposed changes will make an improvement. In developing the case for change patient engagement and clinical leadership are two of the most important factors. Staff developing proposals should also be aware of the need for these to be inclusive and to understand the implications if effective patient engagement and consultation is not undertaken.

This guide promotes full patient engagement and constructive challenge from service users leading to service solutions that are more fully considered.

Given all of the challenges within the NHS, there may be times when relationships become strained either between organisations or between organisations and service users. If this occurs it is far more productive to resolve these tensions rather than let them spill out to the media.

Legislative framework

The requirement to engage patients is set out in section 242 of the NHS Act 2006.

Public Involvement and consultation: *Real Involvement: Working with people to improve health services* published in October 2008 provides guidance on this act.

Section 242 of the act confirms that each relevant English body must make arrangements, as respects health services for which it is responsible, which secure the users of those services, whether directly or through representatives regarding:

- The planning of the provision of health services
- Developing or considering proposals, or making decisions for changes in the way health services are provided; if the implementation of the proposal would have an impact on the manner in which the service is delivered to users, or the range of health services that are made available.
- Making decisions that will affect the operation of a health service if that decision would have an impact on the manner in which the service is delivered to users, or the range of health services made available.

The importance of patient engagement is set out in, *The NHS in England: The operating framework for 2008/9* 'World Class Commissioning' guidance produced by the Department of Health, the 'NHS Next Stage Review' and the NHS Constitution. The objectives are to ensure that the NHS is more locally accountable and shaped by people who use it.

It has been stated previously that the NHS is expected to make sure that proposals to develop services or change the way in which they operate will benefit the users of those services as well as improve clinical standards and deliver value for money to the taxpayer. Whether change is on the scale of a major service reconfiguration or how a particular service operates, the NHS needs to explain clearly why the change is needed.

New duties on the NHS include carrying out involvement and reporting on how the views and opinions of users during a consultation have influenced service proposals and commissioning decisions.

NHS Next Stage Review

The *NHS Next Stage Review* (May 2008), sets out five pledges when leading local change, these are:

1. Change will always be to the benefit of patients

This means that the changes will improve the quality of care that patients receive – whether in terms of clinical outcomes, experiences, or safety.

2. Change will be clinically driven

We will ensure that change is to the benefit of patients by making sure that it is always led by clinicians and based on the best available clinical evidence.

3. All change will be locally led

Meeting the challenge of being a universal service means the NHS must meet the different needs of everyone. Universal is not the same as uniform. Different places have different and changing needs – and local needs are best met by local solutions.

4. You will be involved

The local NHS will involve patients, carers, the public and other key partners. Those affected by proposed changes will have the chance to have their say and offer their contribution. NHS organisations will work openly and collaboratively.

5. You will see the difference first

Existing services will not be withdrawn until new and better services are available to patients so they can see the difference.

Mainstreaming public/patient engagement

Best practice exists where involvement:

- Is a mainstream activity alongside other policy and performance requirements
- Is embedded in the day to day activity of NHS organisations. Involvement can be viewed as a marginal activity, largely centred on process and dependent on the commitment of individual managers
- Can be evidenced. There is sufficient evidence to show that involvement activity is stitched into all the strands of NHS organisations' work, including their decision-making processes; of how organisations have listened and responded to what users have told them; or of how health services have been shaped according to the needs and preferences of users.

The NHS has to:

- Involve people at the very beginning of a process
- Be clear about what can be influenced and what cannot
- Be open and transparent in the way it consults with users, to avoid any mistrust and belief that many consultations are token or at worst a sham
- Be prepared to listen and respond to what users are telling them
- Acknowledge that world class commissioning, the operating framework and the NHS Next Stage Review reflect the shift of involvement to the forefront of the policy agenda and establishes it as one of the key developmental challenges for NHS organisations.

High-performing organisations are increasingly mainstreaming and embedding involvement activity in all aspects of their work. As commissioners, PCTs have a particularly important role in gathering and acting on the views of users.

In relation to diabetes, patient advisory groups (PAGs) have been and continue to be established. It is essential to ensure that these are representative of the differing groups that use these services, ie children, adults, type 1, type 2, patients that have their care assessed in primary care and secondary care and groups that have a higher than average prevalence to the condition such as ethnic minorities

World class commissioning

World class commissioning sets out the vision for meeting these challenges and identifies organisational competencies which are described within 11 headlines, one of which is:

'Engage with public and patients'

'Commissioners act on behalf of the public and patients. They are responsible for investing funds on behalf of their communities, and building local trust and legitimacy through the process of engagement with their local population. In order to make commissioning decisions that reflect the needs, priorities and aspirations of the local population, world class

commissioners will engage with the public, and actively seek the views of patients, carers and the wider community. This new relationship with the public is long-term, inclusive and enduring, and should be forged through a sustained effort and commitment on the part of commissioners. Decisions should be made with a strong mandate from the local population and other partners.’

The subcomponents of this competency are:

- Proactive listening and communication skills to address the needs of all relevant stakeholders, including using third sector and community partners to seek and engage the voice of those who are seldom heard
- Patient and public relations skills: enquiry response; engagement event management; feedback evaluation; website management; survey management; report-back mechanisms in appropriate formats
- Presentation and influencing skills.

To become world class, PCTs are increasingly required to proactively seek and build continuous and meaningful engagement with patients and the public to shape services.

The NHS Constitution

The NHS Constitution in England establishes the principles and values of the NHS. It sets out the rights to which patients, public and staff are entitled and pledges which the NHS is committed to achieve together with responsibilities of the public, patients and staff. It confirms a:

- Right of patients to be involved, directly or through representatives in the planning of healthcare services, in the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services
- Principle that NHS services must reflect the needs and preferences of patients, their families and carers
- Legal right to treatment within 18 weeks from April 2010.

Section 242(1B) of the NHS Act 2006 is not prescriptive about what constitutes ‘involvement’. The term is not defined, but the provision makes it clear that users may be involved by being consulted, or by being given information, or in other ways. Users may be involved directly or by representatives. Engagement, consultation and participation are all words that can be used to describe different types of involvement activity.

Many people working in the NHS believe that involving users means doing something different to consulting with them. This is not necessarily the case, as a number of activities can constitute involvement, including consultation.

When planning involvement activity, it is important to think about proportionality and appropriateness. It is also necessary to understand and use a spectrum of involvement, and know when to use the different activities which range from giving information through to active participation in planning the provision of services.

Real involvement means:

- Discussing ideas, plans, patients experiences, why services need to change, what patients want from services and how to make the best use of resources
- Making sure that the services you are responsible for planning, commissioning or providing meet their needs and preferences.

Good involvement practice, which happens early and continues throughout the process, is:

- Inclusive
- Informed
- Fit for purpose
- Transparent
- Influential – it makes a difference
- Reciprocal – includes feedback
- Proportionate to the issue.

World class commissioning underlines the requirement that decisions are made with a strong mandate from the local population and other partners.

High-performing organisations target people who are difficult to reach and invest in developing the capability and capacity of their staff, making sure that they have the skills and knowledge to undertake effective involvement activity. They will usually have a strong relationship with the local authority, voluntary and community groups and users. In addition, they will have a presence and high profile in the community and will be openly accountable for their performance, actions and behaviors. They will have a support and training programme for users who put themselves forward as representatives on groups and committees and a reimbursement policy to claim expenses in a way that does not affect any benefits they may receive.

The benefits of good public engagement are that it provides information about health services, builds commitment and ownership, trust and confidence and ownership of health solutions that meet patients' needs and preferences.

Involvement is a means **of finding ways to improve services**, not an isolated activity.

- Organisations need to be able to demonstrate what has or has not changed as a result of involvement activity
- Establish and embed systematic approaches to involvement that are directly linked to corporate decision-making
- Make sure that there is commitment and leadership from the board, the chair, the chief executive, directors and clinical leaders
- Support staff and equip them with the necessary skills.

Organisations should be able to maintain an audit trail showing how effective user consultation has been.

Enabling effective patient engagement

The NHS can appear to the patient/patient representative to be a set of complex organisations with complex structures and procedures for managing services and facilitating change.

PCTs can make patient engagement more effective by, for example, providing training modules for those involved in engagement activities to cover:

- The structure of the NHS and its financing
- Competing priorities and the role of the organisations such as NICE
- Patient engagement systems, from health networks to world class commissioning to the NHS Constitution
- The NHS engagement cycle, the process by which patients/representatives are or will be engaged
- Identification of health needs and aspirations
- Decisions about priorities and strategies
- Service design and improvement
- Procurement and contracting
- Monitoring and performance management.

Without being prescriptive, modules can be facilitated, for example, by patient engagement experts, clinical leads, commissioning leads and NHS partners.

Training sessions should be run at times that are convenient to the participants.

Substantial variations or developments in health services

Substantial variations or developments in health services are subject to formal consultation whereby the local NHS must consult the local authority as, set out in the LA (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002.

Where a change is not considered substantial and has therefore not been reviewed by the Overview and Scrutiny Committee (OSC) there is still a statutory requirement to involve users.

It is key that the business case for change sets out the clinical benefits of making the changes and how these will benefit users. Solutions need to be acceptable to patients, staff and the public, clinically safe, effective and affordable.

To make sure that the consultation process is robust it is good practice to:

- Make sure that you have a business case which sets out the clinical benefits of making the changes and how they will benefit users
- Think about the timing of a consultation. If over Christmas and New Year or during the summer holidays, add on a couple of weeks and avoid times when local or national elections are being held. During a general election consultation on service change may be suspended
- Think about the length of your consultation and make use of the Cabinet Office Code of Practice in making your decision
- Take stock of who you need to consult – check if any new groups/organisations were identified during the earlier involvement phase
- Be clear about what you are consulting on and what you want to achieve
- Be prepared to make changes to your original plans, as the process progresses. Be up front about why you need to do this and consider whether you will need to undertake further consultation
- Make sure that options are based on sound clinical evidence and made in the best interests of patients, and that you can explain this to users in a way they can understand
- Prepare consultation documents for the different groups of users you will be consulting on, for example children aged 5–11 and teenagers and people with learning difficulties
- **Importantly a patient engagement and consultation plan should be developed and agreed with partners, stakeholders and service users or their representatives.**

The role of patient representative groups

There are a significant number of charities which represent patient groups across the NHS. They have established voluntary groups in local areas to link with the NHS. These are most prevalent in the areas around long-term conditions, such as diabetes or stroke and put across the patient perspective on service changes. These groups are well informed, well supported and have significant expertise on the subject area and what represents leading clinical practice nationally. They can campaign effectively and link with press and politicians if proposals suggest that a suboptimal solution may be delivered. It is important to fully engage with these voluntary groups and to reflect their thinking where possible within proposals for change.

Cabinet Office Code of Practice on Consultation

This includes six consultation criteria that are binding on government departments – except in exceptional circumstances. These are to:

- Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy
- Be clear about the proposals, who may be affected, what questions are being asked and the timescale for responses
- Ensure the consultation is clear, concise and widely accessible
- Give feedback regarding the responses received and how the consultation process influenced the policy/outcome
- Monitor the departments effectiveness of consultation
- Ensure the consultation follows better regulation best practice.

The Cabinet Office Code of Practice on Consultation is an important reference point.

When consultation is not required

There is not a requirement to involve users where proposals for change do not result in changes to the service (where there may be a change of provider) or where change is temporary, for example the temporary closure of a ward due to infection or a pilot scheme with a fixed end date.

With regard to major services a consultation document signed by a lead clinician and the chair/chief executive of the organisation(s) is good practice.

NHS failings that arose at the Mid-Staffordshire Foundation Trust

Further developments around patient engagement are being introduced as a result of the quality of care failings at the Mid-Staffordshire NHS Foundation Trust between 2005 and 2008. A report into these failings confirmed that:

- In the past, patient views were not taken seriously enough and were too easily dismissed
- Staff concerns were not acted upon
- There had been a lamentable failure of clinical leadership in the trust and the wider health community
- Commissioners of local health services were not sufficiently aware of the poor quality care in the hospital or active in addressing it
- That all parts of the system should have worked together in the interests of patients.

Local involvement networks (LINKs)

In April 2008 LINKs were introduced across the country to offer a more integrated and independent way to improve patient and public involvement with local health services. Further guidance for patients on How to be Heard is to be published, and guidance on *Changing for the better: Guidance when undertaking major changes to NHS services* published in 2008 includes.

- NHS organisations being expected to publicly demonstrate that they are putting patients and the public at the heart of designing their services.
- A new annual statement of involvement came into law in November 2008 that requires relevant organisations to demonstrate how they are implementing the duty to involve patients and the public. This should include a commentary by relevant local organisations that represent patients and the public, including the LINK and the local authority's OSC.
- Acute providers, when producing new quality accounts are expected to draw data from a range of sources including direct patient feedback. LINKs should also comment on draft quality reports. Commissioners are expected to validate provider quality accounts prior to publication.
- Hospital standardised mortality ratios (HSMRs) are to be placed on the NHS Choices website.

The role of local authority overview and scrutiny committees

There are three key pieces of legislation that cover the role of the OSC:

1. Local Government Act 2000 - www.legislation.hmso.gov.uk/acts/acts2000/20000022.htm
2. Health and Social Care Act 2001, sections 7–10 - www.legislation.hmso.gov.uk/acts/acts2001/20010015.htm
3. Statutory Instrument 2002 No. 3048: The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 - www.legislation.hmso.gov.uk/si/si2002/20023048.htm

The overview and scrutiny of health is an important part of the government's commitment to place patients and the public at the centre of health services. It is a fundamental way by which democratically elected community leaders may voice the views of their constituents and require local NHS bodies to listen and respond. In this way, local authorities can assist to reduce health inequalities and promote and support health improvement.

Local authorities are already encouraged to look beyond their own service responsibilities by scrutinising issues of wider concern to local people. It is within this context that the power of overview and scrutiny of the NHS has been introduced in England – aiming to secure health improvement for local communities. For the first time, democratically elected community representatives have the right to scrutinise how local health services are provided and developed for their constituents.

The power of overview and scrutiny of health services is given to the OSC of the following local authorities: county councils, councils of districts where there is no county council (ie district councils, unitary authorities and metropolitan councils), London borough councils and the Common Council of the City of London.

A full explanation of the powers and duties placed upon local authorities and local NHS bodies, including definitions of terms and phrases, may be found in the Department of Health Guidance of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002.

Powers of local authority overview and scrutiny committees (OSCs)

OSCs may:

- Review and scrutinise any matter relating to the planning, provision and operation of health services in the area of the committee's local authority
- Make reports and recommendations to local NHS bodies and to its local authority on any matter reviewed or scrutinised using the overview and scrutiny of health power
- Require the attendance of an officer of a local NHS body to answer questions and provide explanations about the planning, provision and operation of health services in the area of the committee's local authority
- Require a local NHS body to provide information about the planning, provision and operation of health services in the area of the committee's local authority, subject to exemptions outlined in the Health and Social Care Act 2001
- Establish joint committees with other local authorities to undertake overview and scrutiny of health services covering more than one area
- Delegate functions of overview and scrutiny of health to another local authority committee
- Co-opt members of the OSCs of district councils onto the committee as full members (county council committees only)
- Be able to report to the Secretary of State for Health:
 - where the committee is concerned that consultation on a substantial variation or development of services has been inadequate
 - where the committee considers that the proposal is not in the interests of the health service
- If the NHS body proposing services is a foundation trust, the overview and scrutiny committee can report to Monitor who can order further consultation or overrule the decision of the trust as can the secretary of state? The Secretary of State may refer the case to the Independent Reconfiguration Panel (IRP) who will provide advice back to the Secretary of State.

Duties of local NHS bodies in respect of local authority overview and scrutiny

NHS bodies must:

- Be able to report to the Secretary of State for Health
- Provide information requested by the overview and scrutiny committee
- Attend before scrutiny committees to answer questions, subject to exemptions
- On request, respond to reports and recommendations within 28 days of the request of the committee
- Consult the local overview and scrutiny committee (including joint committees) on matters of substantial development or variation to services, (in addition to the duty under section 11 of the Health and Social Care Act 2001 to involve and consult patients and the public).

The establishment of effective working relationships between health and local authority scrutiny is important to ensuring that significant service changes are understood as being beneficial to the local population.

Patient rights - what are the implications of not consulting?

It is important to emphasise that it is not the intention of this guide to provide legal advice. NHS organisations should take their own advice as necessary, but changes to the NHS can be very emotive. If a decision is taken to make a substantial change to services, patients affected by those services are:

- Within their rights to challenge the decision if there has been no consultation. A case would usually be heard in the High Court who can suspend a change decision in a matter of days if the change to services is imminent. If patients are in receipt of any means tested social security benefits they may be eligible for public funding to facilitate the action (previously legal aid).

Responsibilities of service users

The responsibilities that go with the role of the user representative might include:

- Feeding back the experience of other people as well as their own
- Checking back with people in their network and people that they are representing; informing their networks; or sharing the views and preferences of users.

The role of the Independent Reconfiguration Panel (IRP)

- The IRP is an advisory nondepartmental public body sponsored by the DoH.
- The IRP offers advice only. Any decisions required are for the secretary of state for health to make.
- The IRP has a responsibility to provide advice to the Secretary of State for Health on contested proposals for health service changes in England. It also offers informal support and advice to the NHS and other interested bodies engaging in health service changes.

The terms of reference of the IRP are to provide:

- Expert advice on proposed NHS reconfigurations or significant service change
- Options for NHS reconfigurations or significant service change, referred to the panel by ministers.

In providing advice, the panel will take account of:

- Whether the proposals will ensure safe, sustainable and accessible services for the local population
- Clinical and service quality, capacity and waiting times
- Other national policies, for example, national service frameworks
- The rigour of consultation processes
- The wider configuration of the NHS and other services locally, including likely future plans
- Any other issues Ministers direct in relation to service reconfigurations generally or specific reconfigurations in particular.

The advice will normally be developed by groups of experts not personally involved in the proposed reconfiguration or service change, the membership of which will be agreed formally with the panel beforehand. The advice will be delivered within timescales agreed with the panel by Ministers with a view to minimising delay and preventing disruption to services at local level.

The IRP can also offer general pre-consultation advice and support to the NHS and other interested bodies on the development of local proposals for reconfiguration or significant service change - including advice and support on methods for public engagement and formal public consultation. The effectiveness and operation of the panel is reviewed annually.

The IRP's verdict on the main reasons why reconfiguration proposals have been referred

The IRP has produced a note of the major themes underlying the reason why proposals have been referred. These are:

- Inadequate community and stakeholder engagement before options are published in a formal consultation
- Important content missing from the reconfiguration plans - local communities want to know what services will be provided, where and how they will access them
- Mixed messages about clinical issues - if doctors in an area publicly disagree with proposals, their patients are entitled to be sceptical about proposed changes
- Proposals that emphasise what cannot be done and underplay the important benefits of change and plans for additional services
- Health agencies caught on the back foot about the three issues most likely to excite local opinion - emergency care, transport and money.

The IRP's reviews highlight a number of problems which may generate or allow mistrust or cynicism to develop and make an impasse more likely, these are:

- Limited stakeholder engagement in the early stages of planning change
- A badly written consultation document and associated literature
- Inadequate attention given to the responses during and after the consultation
- Failure to anticipate critical community concerns
- Consultation on detail without a sufficient link to the broader development of healthcare.

A focus on the modernisation of diabetes services

Primary Care Trusts (PCT) have responsibility for the planning and commissioning of diabetes services. Developments to the service should be implemented within an agreed strategy that reflects an integrated model of care from primary care at one end to specialist and tertiary care (a referral of very complex cases from an acute hospital to a teaching hospital that has further expertise) at the other.

The implementation of a National Service Framework for Diabetes reflects an opportunity to substantially improve the care of individuals living with diabetes and to implement health promotion plans to prevent many individuals from developing type 2 diabetes.

Objectives of this chapter

The objective of this chapter is to provide practical guidance on the approach to service modernisation that is clinically-led and developed in consultation with service users. It will consider a case study for service modernisation within diabetes where there is a target to implement a National Service Framework by 2013.

A recently published 'Diabetes guide for London' is a good example of proposals to modernise services based on providing four tiers of care within three care settings as below:

Tier 4: Hospital-based secondary/tertiary care	Consultant-led specialist care and advice for patients with complex needs in hospital
Tier 3: Community	Specialist-led team providing care for patients with more complex needs, provided in the community, such as a community based diabetic clinic, health centre or polyclinic providing enhanced care services
Tier 2: GP practice – enhanced essential care	GP/practice staff providing quality care and advice, with some enhanced services such as the management of foot disease as well as tier one care
Tier 1: GP practice – essential care	GP/practice staff providing a consistent level of quality care and advice

It represents a shift of care from the hospital sector to the community and primary care sectors that has implications for capital investment, staff and training. The guide can be viewed at:

www.healthcareforlondon.nhs.uk/assets/Publications/Diabetes/Diabetes-guide-for-London.pdf

It is important for finance and other non-clinical professionals to have:

- A basic appreciation of what diabetes is
- An understanding of current and proposed models of care
- Care pathways and financing arrangements so that an effective contribution can be made.

A minimum dataset of knowledge to contribute to the development of services would include:

- A basic appreciation of the condition of diabetes
- Facts and figures for diabetes
- Who is at risk of becoming diabetic
- What are the symptoms of diabetes
- What are the main complications of diabetes
- The current pattern and organisation of diabetes care
- The estimated cost of diabetes care
- Leading clinical practice and thinking as reflected in documents such as The Diabetes Guide for London
- The National Service Framework (NSF) for Diabetes
- The standards within the NSF
- Draft strategies and action plans to implement the NSF by 2013
- Proposals to implement the NSF and their evaluation
- Key issues to consider
- What a business case financial proforma might look like
- National Institute of Clinical Excellence (NICE) guidelines on diabetes
- Quality and outcomes framework for diabetes (QOF).

As highlighted in chapters 2 and 3, it is also necessary to optimise the clinical and service user contribution.

A basic appreciation – what is diabetes?

Diabetes is a condition in which the amount of glucose (sugar) in the blood is too high because the body cannot use it properly. Individuals living without diabetes secrete insulin, a hormone produced by the pancreas that enables glucose to enter the cells where it is used as fuel by the body.

There are many types of diabetes but the most common are type 1 or type 2, which are explained below:

- **Type 1** accounts for approximately 10% of individuals with diabetes and develops if the body is unable to produce any insulin and usually appears before the age of 40. It is treated by insulin injection or insulin pump, diet and regular physical activity.
- **Type 2** accounts for approximately 90% of individuals with diabetes and develops when the body can still make some insulin, but not enough, and/or when the insulin produced may not be fully effective. People with type 2 diabetes are often overweight or obese. Diabetes can be treated by diet, physical activity, tablets or insulin as discussed with a GP or diabetes specialist.

People with type 1 diabetes who must take insulin are most vulnerable to episodes of hypoglycemia, where the level of glucose within the blood can become very low, very quickly. This can lead in extreme cases to coma and death, but it is usually mild enough to reverse by eating or drinking carbohydrates. Coma in type 2 patients is also a risk but other problems such as precipitating an angina attack or heart attack or stroke may occur as a result of hypoglycaemia in older patients.

Clinical guidelines for the treatment of type 1 and type 2 diabetes and the management of diabetes in pregnancy are set out by NICE and referenced to at annex D.

Facts and figures for diabetes

(Source: Diabetes UK – Diabetes in the UK 2009 – key statistics)

- Diabetes affects over 285 million people worldwide. This is expected to rise to 438m by 2030.
- Over 2.6 million people diagnosed in the UK in 2008. This is expected to rise to 4 million by 2025.
- Over 2.35 million people have type 2 diabetes.

- Around 250,000 people have type 1.
- As for the undiagnosed (individuals living with diabetes that has not been formally diagnosed), this figure is now estimated as being up to half a million.
- It is estimated that 10% of the NHS budget is spent on diabetes
- Emergency inpatient admissions in the West Kent Area (population 675,000) as a result of diabetes are approximately 5,000 per annum, but this could well be underestimated due to the quality of clinical coding of diabetes as a co-morbidity
- The UK has the highest number of children with diabetes in Europe with 20,000 children below 15 diagnosed.

The following graphs show

- Figure 1 – the forecast numbers of individuals (diagnosed and undiagnosed) living with type 1 and type 2 diabetes for 2010, 2015 and 2025 by the nine government office regions (GOR) of England
- Figure 2 – the forecast percentage of the population (diagnosed and undiagnosed) living with type 1 and type 2 diabetes for 2010, 2015 and 2025 by the nine GORs of England. This reflects 3.6m million people with diabetes by 2025
- Figure 3 – is illustrative only and shows the ten countries with the highest number of people living with diabetes in 2010; it associates mainly with the large populations living in China, the USA and India
- Figure 3a – is illustrative only and shows the 10 countries with the highest forecast number of people living with diabetes in 2030; it associates mainly with the large populations living in China, the USA and India
- Figure 4 - the ten countries with the highest percentage prevalence of diabetes in 2010 and 2030.

Source: Figure 1 and 2 Yorkshire and Humber Public Health Observatory

Source: Figure 3 3a and 4 The International Diabetes Federation

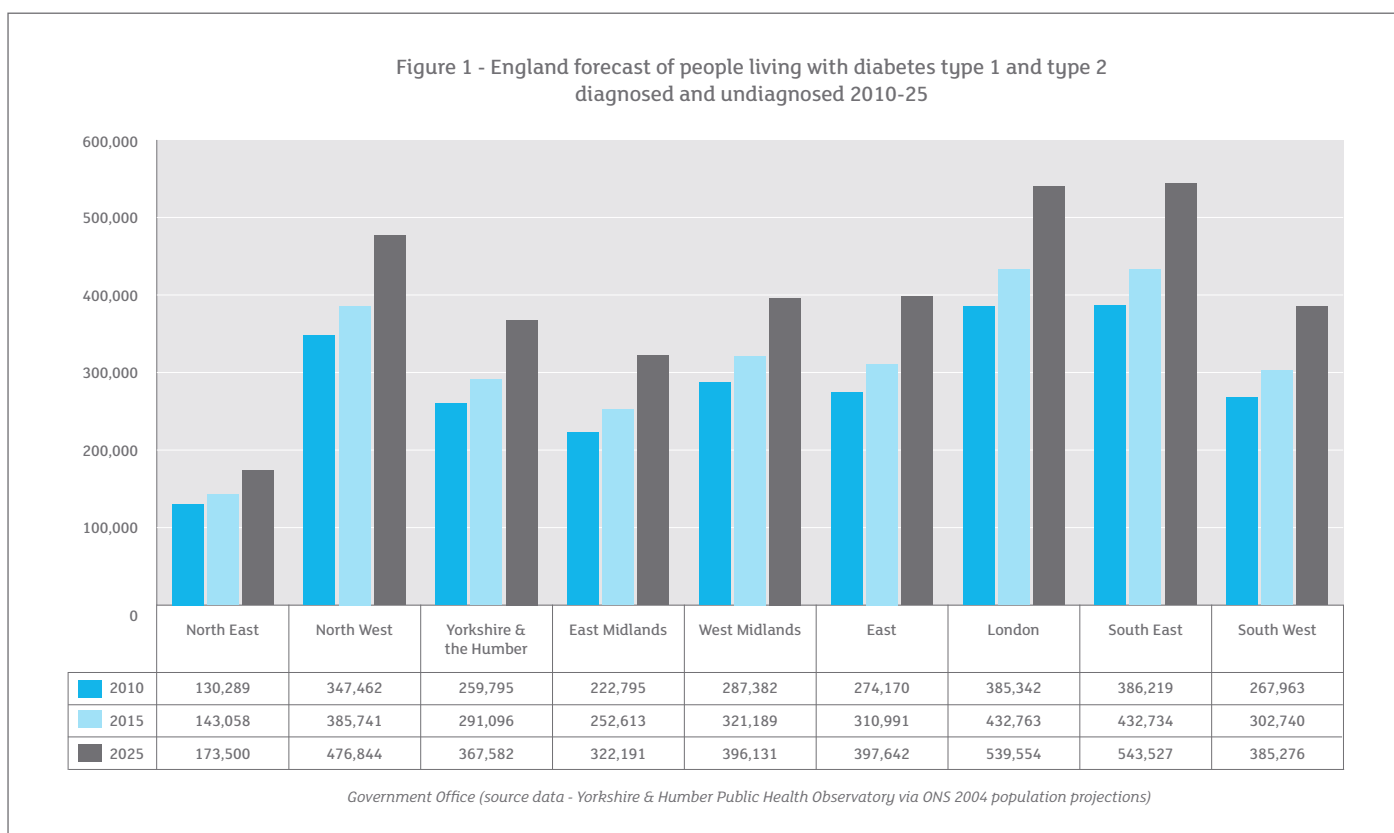
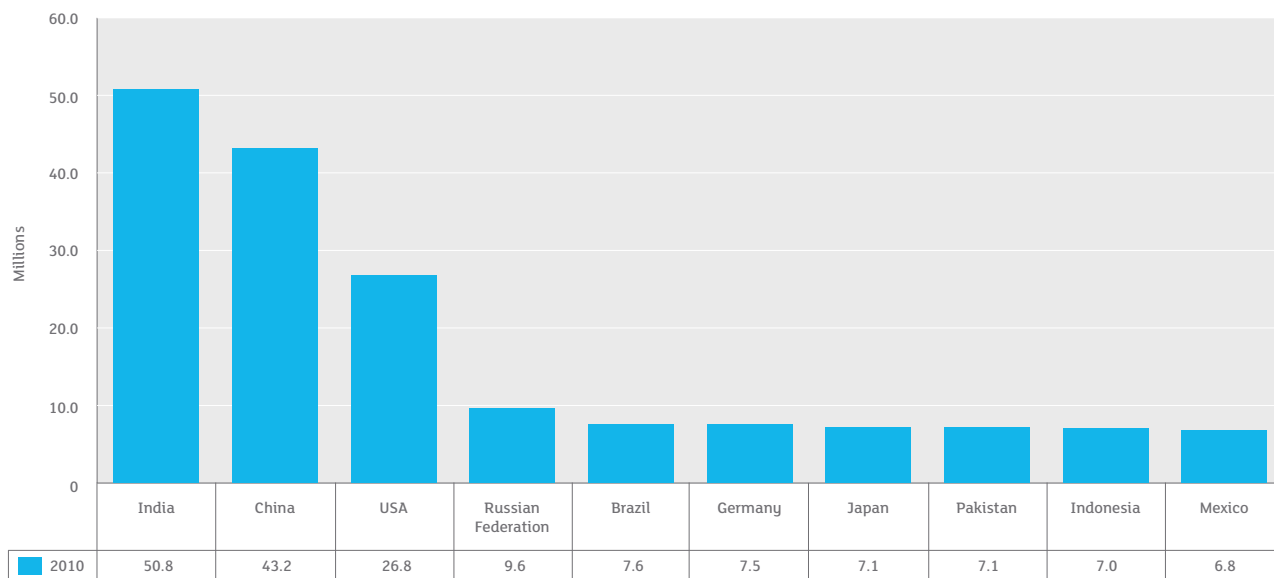


Figure 2 - England forecast of people living with diabetes type 1 and type 2 diagnosed and undiagnosed 2010-25



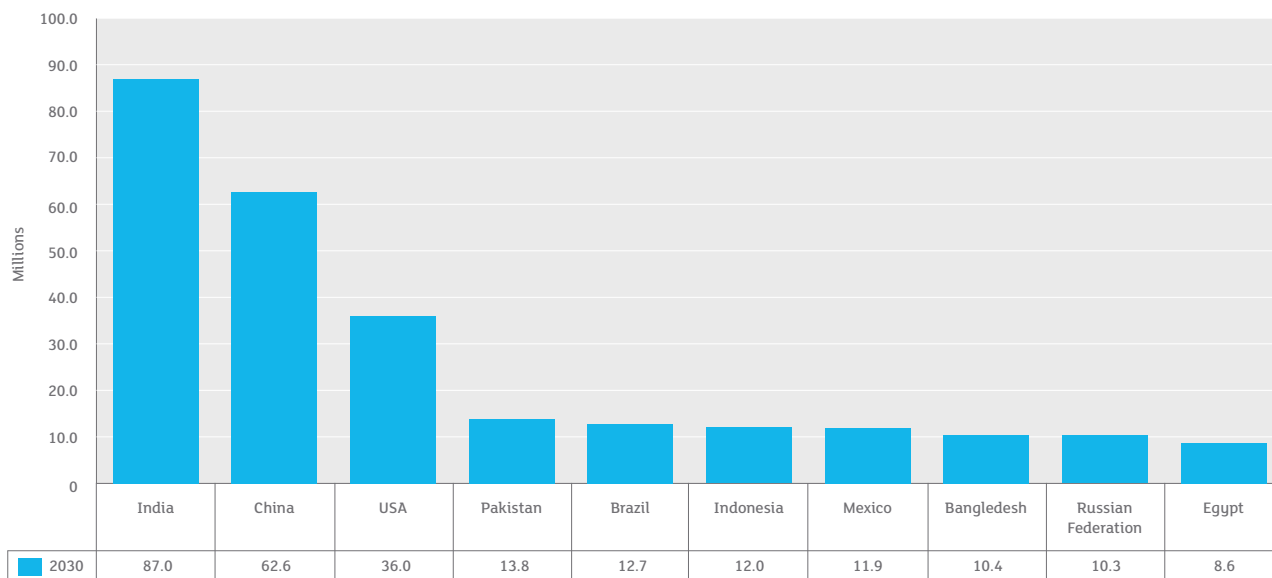
Government Office (source data - Yorkshire & Humber Public Health Observatory via ONS 2004 population projections)

Figure 3 - Top ten countries prevalence of diabetes 2010 age range 20-79



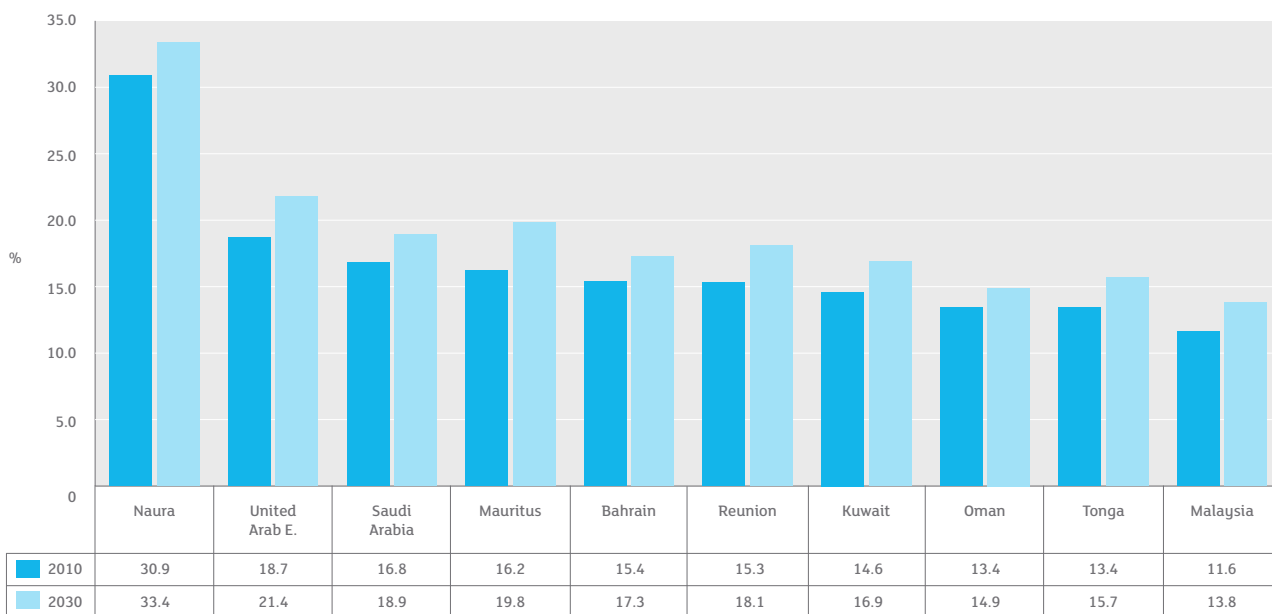
Country - Millions of people - source International Diabetes Federation

Figure 3a - Top ten countries prevalence of diabetes 2030
age range 20-79



Country - Millions of people - source International Diabetes Federation

Figure 4 - Top ten countries prevalence (%) of diabetes 2010 & 2030
age range 20-79



Country - % Prevalence of Diabetes - source International Diabetes Federation

Who is at risk of developing diabetes?

The following table shows the probability of developing diabetes where a number of risk factors are present.

TYPE 1	TYPE 1 PROBABILITY	TYPE 2 PROBABILITY
Genes and diabetes within the family		
Mother	2%	15%
Father	8%	15%
Both parents	up to 30%	75%
Brother or sister	10%	
Non-identical twin	up to 15%	10%
Identical twin	up to 40%	90%
Ethnicity		
of South Asian descent		Up to six times more prevalent
of African/African-Caribbean origin		Up to three times more prevalent
Obesity		Strong association with diabetes
Deprivation		Strong association with diabetes as deprivation is linked with the risk factors of obesity, inactivity, unhealthy diet, smoking and poor blood pressure
Women during pregnancy		5%
Women during pregnancy and continuing		30% of those women who had diabetes when pregnant have a risk of this continuing afterwards and where this is not the case post-partum there is a very high probability of re-occurrence again during subsequent pregnancies

Source: *Diabetes UK Key Statistics on Diabetes 2009*

Please note: the figures in the table above are purely illustrative. They represent averages with very wide confidence limits and should not be used without further explanation or inclusion of caveats for research or within clinical practice.

What are the symptoms of diabetes?

Symptoms of diabetes can include:

- Feeling thirsty all the time
- Frequent urination
- Tiredness
- Weight loss
- Muscle wasting
- Frequent infections or slow-healing sores
- Itchiness around the genital area
- Regular episodes of thrush
- Blurred vision.

What are the main complications of diabetes?

Poorly controlled diabetes can have a profound effect on temperament, ability to work, income and lifestyle. It can cause short-term acute illness and can lead to long-term complications affecting the kidneys, eyes and feet.

Because type 2 diabetes may not be diagnosed straightaway:

- Half of those people with type 2 diabetes show signs of complications by the time they are diagnosed
- Complications may begin five to six years before diagnosis
- The actual onset of diabetes may be 10 years or more before clinical diagnosis.

Diabetes can increase cardiovascular risk, including the risk of heart disease, stroke and dementia.

Other long-term complications arising from diabetes can include:

COMPLICATION AND EXPLANATIONS	STATISTICS
<p>Diabetic Kidney Disease</p> <ul style="list-style-type: none"> ■ About one-third of type 1 patients will have evidence of kidney disease, two-thirds will be fine ■ The situation with type 2 diabetes is much more complex as kidney disease may not simply be related to diabetes but also high blood pressure or other 'non-diabetic' kidney diseases ■ There are also ethnic differences with African Caribbean and Asian Indian patients having a higher prevalence of this. Having evidence of kidney disease in type 2 patients (ie micro-albuminuria or proteinuria) significantly increases the risk of cardiovascular disease independent of the 'standard' risk factors of smoking, high blood pressure, and cholesterol ■ These patients may develop heart attacks and/or strokes well before their kidney function deteriorates significantly 	<ul style="list-style-type: none"> ■ This is the most common single cause of the need for dialysis or transplantation ■ Almost 1 in 3 people with type 2 diabetes develop kidney disease (please refer to note opposite) ■ This is the most common cause of end-stage renal failure that requires either renal dialysis or renal transplantation ■ Kidney disease accounts for 21% of deaths in type 1 and 11% of deaths in type 2

COMPLICATION AND EXPLANATIONS	STATISTICS
<p>Diabetic Eye Disease (Retinopathy)</p> <ul style="list-style-type: none"> ■ This is the most common preventable cause of blindness ■ Laser therapy to the blood vessels at the back of the eye can prevent this outcome 	<ul style="list-style-type: none"> ■ People with diabetes are 10-20 times more likely to go blind than people without ■ Within 20 years of diagnosis almost all people with type 1 and 60% of people with type 2 will have some degree of retinopathy ■ People with diabetes are twice as likely to suffer from cataracts or glaucoma than the general population
<p>Diabetic Foot Disease</p> <ul style="list-style-type: none"> ■ This increases the risk of ulcer and amputation, as well as other problems ■ Diabetic foot problems tend to occur as a result of nerve damage (neuropathy – see below) and problems with the blood supply to the legs. These factors plus poor diabetic control, contribute to a poorer outcome in diabetic patients 	<ul style="list-style-type: none"> ■ Diabetes is the most common cause of lower limb amputation ■ The rate of leg amputation is 15 times higher within individuals living with diabetes ■ Up to 70% of people die within 5 years as a result of an amputation that stems from diabetes
<p>Depression</p> <ul style="list-style-type: none"> ■ Coming to terms with the diagnosis, the development of complications, the side effects of medication and the daily toll of managing the condition can lead to depression, anxiety, eating disorders or phobias 	<ul style="list-style-type: none"> ■ The prevalence of depression is approximately twice as high in people with diabetes
<p>Neuropathy</p> <ul style="list-style-type: none"> ■ This is where there is damage to nerves that transmits impulses to and from the brain and the spinal cord, muscles, skin, blood vessels and others organs 	<ul style="list-style-type: none"> ■ Neuropathy can sometimes be painful ■ Neuropathy and circulatory problems can also lead to erectile dysfunction in men with diabetes ■ Neuropathy may affect up to 50% of people living with diabetes
<p>Complications in pregnancy</p>	<p>Babies of women with diabetes are:</p> <ul style="list-style-type: none"> ■ Five time as likely to be stillborn ■ Three times as likely to die in their first months of life ■ Twice as likely to have a major congenital defect ■ Other complications may include having large-for-dates babies which may lead to premature delivery and complications thereof (eg breathing difficulties); hypoglycaemia in the newborn which may require supplementary feeding or intravenous glucose infusions

COMPLICATION AND EXPLANATIONS	STATISTICS
Cardiovascular disease (CHD)	<p>Accounts for the following fatalities:</p> <ul style="list-style-type: none"> ■ 44% in type 1 ■ 52% in type 2 ■ Risk of death from CHD associated with type 2 is 50% greater in women than in men ■ There exists a twofold increased risk of stroke, compared with the general population within the first five years of diagnosis of type 2 diabetes
Life expectancy	<ul style="list-style-type: none"> ■ Reduced by an average of 15 years in those with type 1 diabetes and up to seven years in those with type 2

Good control of diabetes reduces the risk of these complications occurring. Many of these complications can also be helped by bringing down blood pressure and cholesterol levels, and encouraging diabetic patients to stop smoking.

The pattern and organisation of diabetes care

Most people, but not all, are diagnosed when they present with symptoms to their GP, who will test their glucose levels to confirm the diagnosis. Some patients will not appear to have symptoms, which will be picked up through a routine medical check or via the development of complications.

Once diagnosed, most type 1 diabetes' patients are seen by specialist diabetes teams, usually in hospital for initial treatment, education, stabilisation and follow-up treatment. Some patients may present with a medical emergency called diabetic ketoacidosis which requires admission to hospital for intravenous insulin and fluids.

A specialist multidisciplinary team will include physicians, specialist diabetes nurses, psychologists, podiatrists and dieticians – all with an interest and expertise in diabetes. Children diagnosed with diabetes are routinely referred to hospital for their care.

Changes to GP contracts and health promotion payments in the 1990s have meant that the majority of type 2 patients are now cared for outside of hospital – but there is considerable variation.

The estimated cost of diabetes care

It has been estimated that approximately 10% of the NHS budget is spent on diabetes with £9bn spent in 2007/8.

One in ten people admitted to hospital have diabetes; in some age groups it is as many as one in five. These figures are being consistently revised upwards as clinical coding of admissions improves.

In 2006, 28.4m items to treat diabetes were prescribed at a cost of £561.4m, accounting for 7% of all prescription costs.

The Diabetes Guide for London

A recent publication *The Diabetes Guide for London* shows that there are significant inequalities in the uptake of diabetes services, diabetes education and access to specialist services in London which contribute to differences in health outcomes.

The organisation of services varies across the capital which means they can be unstructured and difficult to access.

The guide highlights the potential implications of the present structure that can result in:

- An increased use of emergency services
- The need for long-term recurring interventions (eg renal dialysis)
- A reduction in funds available to commissioners to invest in developing prevention strategies or new services as funding is diverted to deal with the consequences of poorly managed long-term conditions.

What is the National Service Framework for Diabetes?

The DoH produced the National Service Framework for Diabetes (December 2001 for England) containing 12 standards to be met by 2013 or earlier to modernise services. Commentators have noted that the absence of specific ring-fenced funding for the NSF (eg the cardiology NSF had dedicated resources which meant that more patients could be offered coronary artery bypass grafts more quickly) has increased the challenge of implementation.

The standards summarised below aim to develop a comprehensive service from prevention strategies aimed at reducing the incidence of diabetes from occurring to the detection and treatment of diabetes and the serious complications that can subsequently occur.

What are the standards within the NSF?

Standard 1

Preventing type 2 diabetes

Aims to reduce the number of people who will develop type 2 diabetes.

It is primarily concerned with increasing public awareness of diabetes and providing specific targeted support and information for people who are at high risk of developing the disease. It also promotes healthy living for the population as a whole.

Standard 2

Identifying people living with diabetes

Aims to identify people who don't know they have diabetes, so that intervention and education can reduce the risk of diabetic complications.

Standard 3

Empowering people living with diabetes

Aims to encourage people with diabetes (and their carers) to be partners in decision-making around the management of the condition.

Standard 4

Clinical care of adults living with diabetes

Aims to optimise the quality of life for people living with diabetes and to reduce their risk of long-term diabetic complications.

Standards 5 and 6**Clinical care of children and young people**

Aims to meet the special needs of children and young people, ultimately enabling them to manage their diabetes effectively.

Standard 7**Diabetic emergencies**

Aims to ensure that acute diabetes-related complications are recognised promptly and treated by appropriately trained health care professionals.

Standard 8**Caring for people in hospital**

Aims to ensure consistently good quality care for people with diabetes admitted to hospital for whatever reason. This will be achieved by educating hospital staff and through the support of specialist diabetes teams.

Standard 9**Diabetes and pregnancy**

Aims to ensure that women with pre-existing diabetes or who develop diabetes in pregnancy have a positive experience of pregnancy and childbirth and have healthy babies.

Standards 10, 11 and 12**Detecting and managing complications**

Aims to minimise the impact of diabetic complications through early detection and effective management. This requires integrated service provision and clear referral criteria from primary care to intermediate and hospital care, and the development of highly specialised secondary care services.

Clinical engagement

A project for change in diabetes services should include a clinician to lead on the clinical redesign of services.

This would normally be the most senior diabetes specialist - the consultant who would engage with and take advice or papers from the different specialists below to develop a fully integrated, leading edge, multidisciplinary proposal.

- GP with special interest in diabetes (although not all areas have these)
- Diabetes specialist nurse
- Practice nurse
- District nurse / midwife / Health visitor
- Podiatrist
- Registered dietician
- Psychologist
- Pharmacist
- Ophthalmologist
- Optometrist.

Patient engagement

In relation to patient engagement, it is necessary to appoint a diabetes champion as a chair who can represent local service users. This person may lead or take an active part in the running of a voluntary support group for diabetes.

It is important that patient engagement is representative and inclusive of the diabetes specialty. A patient advisory group (PAG) representing the area, covering type 1 and 2 diabetes, young people, individuals receiving their care from specialists and from GP practices, carers, those from ethnic backgrounds etc is an important development.

A vice chair of a PAG should be appointed to cover the agenda, annual leave and sickness. A PAG would usually report into an overall diabetes project board in the same way as a clinical advisory group representing specialists.

Rotating meeting locations, times or establishing a complimentary virtual network to gain input from individuals who may find it difficult to get to meetings can be considered.

Differing structures with the representatives above working to the same modernisation objectives will be found across the country.

Other stakeholders

In addition a project board should have representatives from the local PCT as commissioners, together with representatives from partner NHS trusts, GPs, specialists, voluntary organisations and the clinical and patient champion.

A mechanism for engaging with the local authority on significant change needs to be in place.

Drafting strategies and proposals to implement the NSF

Proposals being developed to implement the NSF for diabetes should be drafted within an agreed service strategy.

It is important to recognise by audit what is currently in place and what achievements have been made since the NSF was published in 2001.

Also, given the number of NHS reconfigurations, it is important that the structure supporting the development of the diabetes service is outlined with clarity.

The public health and promotion agenda is critically important and there are a number of excellent examples of innovation in this area, for example:

- In NHS Wakefield, where two years ago they had the second highest percentage of obese five-year olds, an invitation was extended to Wakefield 299 Parachute Squadron Royal Engineers to produce an inflatable assault course. This initiative has resulted in a 5.5% reduction in five-year olds being recorded as obese from 2006-7 to 2007-8.
- In Liverpool, the local strategic partnership is committed to health improvement. As a result, smoking prevalence has fallen by 20%, a rise in childhood obesity has been halted and alcohol-related admissions have decreased by 1%.

Community engagement is important and in a number of areas staff have been employed specifically to work in multidisciplinary, multiagency teams that develop plans and activities for local communities.

Proposals to improve diabetes services may include a number or all of the following proposals depending on progress made to date.

STRATEGY OBJECTIVE	OUTCOMES/MEASURES/ACTIONS
Leadership/accountability	
<p>1 Excellent structures are in place to plan, commission and deliver a truly integrated diabetes service</p>	<ul style="list-style-type: none"> ■ There is clinical leadership that is responsible and accountable for leading the diabetes service ■ An approved diabetes strategy has been developed and has been agreed and supported by health care professionals, people living with diabetes and carers ■ An agreed delivery plan has been developed for implementing the National Service Framework by 2013 or earlier taking into accounting the increasing prevalence of diabetes ■ The needs of all sections of the population with diabetes; adults, children, young people, the elderly and minority groups to have been identified ■ There is an agreed structure for the delivery of diabetes services from hospital, intermediate multidisciplinary community care centres and primary care services. (Leading clinical practice at present reflects an enhanced primary care role, an intermediate specialist led care team looking after people living with diabetes with more complex needs and hospital care for those with significant needs and complications) ■ A workforce skills audit and professional development plans, including accredited training are developed and in place for staff involved in the delivery of the diabetes service ■ For primary care the training and accreditation requirements for GPs and practice nurses are set out and put in place to deliver agreed levels of care
<p>2 Planning of diabetes services is all inclusive</p>	<ul style="list-style-type: none"> ■ Adherence to NICE guidance ■ Representatives of people living with diabetes become increasingly involved in service planning with health care professionals and commissioners. Excellent partnerships are forged between the NHS, Diabetes UK, service users and carers
<p>3 Excellent diabetes performance in the local NHS area</p>	<ul style="list-style-type: none"> ■ There is the provision of regular information on diabetes performance (implementation of the NSF/9-care processes/health outcomes) ■ Upper quartile performance is achieved in comparison with similar PCTs ■ Transfer of care from specialist to primary care services to be based on an individual assessment. Changes undertaken in a sensitive and timely manner with patient choice respected

STRATEGY OBJECTIVE	OUTCOMES/MEASURES/ACTIONS
NSF standard 1	
<p>There are effective health promotion initiatives to maximise the potential prevention of type 2 diabetes occurring, with targeted information particularly for high risk groups</p>	<ul style="list-style-type: none"> ■ Healthy lifestyle training events run focused on prevention, diet and exercise ■ Healthy lifestyle and diabetes education for staff in mental health, learning disabilities, prisons, elderly care and schools ■ Diabetes awareness days arranged and talks to children in schools ■ Opportunities are assessed for people with diabetes to have access to low cost exercise sessions at council run leisure centres where this is available. (Refer to annex A: potential partnership local area agreement target)
NSF standard 2	
<p>1 People living with diabetes are identified</p> <p>2 Screening is available to those at a higher risk of developing diabetes, and to identify those with diabetes who do not know it</p>	<ul style="list-style-type: none"> ■ GP practice-based registers of patients with diabetes ■ People living with diabetes with heart disease/stroke/the elderly/a first degree relative with diabetes/a body mass index (BMI) of 30+ or excessive waist circumference 88cm female/102cm male (are identified and screened to identify those with the condition ■ Implications of the introduction of new vascular checks assessed
NSF standard 3	
<p>1 People living with diabetes should be involved and empowered in their care</p> <p>2 Education of people living with diabetes to be partners in their own care plan</p> <p>3 People living with diabetes are clear about what care they should expect</p> <p>4 People living with diabetes are clear on their responsibilities</p>	<ul style="list-style-type: none"> ■ People living with diabetes should hold their own personal diabetes record, agreed care plan, record of annual reviews, treatments and test results supporting a care planning approach between professional and individual that may require training to implement (test results received prior to annual review/consultations to enable a more streamlined and two-way discussion) ■ The availability of educational programmes to meet patient demand such as DESMOND, DAFNE and the Expert Patient ■ Structured education for newly diagnosed, those who were diagnosed some time ago but may not have had a course and ongoing education ■ Publications such as 'What care to expect' from Diabetes UK are made widely available ■ To take as much control of their diabetes on a day to day basis as possible

STRATEGY OBJECTIVE	OUTCOMES/MEASURES/ACTIONS
NSF standard 4	
Specialist advice is available to those living with diabetes	<ul style="list-style-type: none"> ■ There is a regular call/recall of patients, with emphasis on those who fail to attend appointments. Arrangements are made for the housebound, those in residential care settings and ethnic minority groups ■ Access to specialist support from consultants, diabetes specialist nurses, podiatry, dietetics, psychology (and emotional support) are agreed as required as part of locally agreed integrated care pathways that professionals know about and use ■ Where an individual requests a referral to a specialist; if a second opinion is requested, or if the level of advice available needs enhancement, then either a single referral or permanent transfer of care to a specialist team should be approved ■ NICE guidance followed
NSF standards 5 and 6	
Ensure the special needs of children are met	<ul style="list-style-type: none"> ■ The special needs of children and young people are understood ■ Parents and carers should be able to access a multidisciplinary paediatric team ■ Educational resources should be made available to children/carers and the availability of structured education as for adult services ■ Links should be made with support groups ■ Special events are arranged focusing on interest areas that could cause problems such as sport and nutrition ■ Education is provided to schools, social services, leaders of voluntary groups. Agreements in place with education authorities and schools that address concerns regarding injections, blood testing and any discrimination issues resulting from planning outings (potential partnership local area agreement target) ■ Parents involved in the day to day diabetes management ■ Special arrangements made to effect the transfer of care from children's to adult services ■ Review clinic times to encourage children to attend ■ 24-hour helpline available ■ Access to psychology for young people with complex emotional needs (also referred to below) ■ Access to specialist support from consultants, diabetes specialist nurses, podiatry, dietetics, psychology (and emotional support) as required as part of locally integrated care pathways that professionals know about and use

STRATEGY OBJECTIVE	OUTCOMES/MEASURES/ACTIONS
NSF standard 7	
Diabetes emergencies	There are very clear guidelines for patients and clear protocols for staff in the actions required and treatment of diabetic emergencies
NSF standard 8	
Hospital inpatient services are excellent	<ul style="list-style-type: none"> ■ Individuals with diabetes are preferably treated in a specialist diabetes ward. If this is not the case and care is provided in a shared care ward, medical and nursing staff are trained and have the required experience in the management of diabetes ■ Time on the ward presents an excellent opportunity for the self administration of insulin if the individual is competent to do so ■ People living with diabetes are taught how to manage blood glucose when unwell ■ There are healthy food options available ■ Snacks available 24/7 but particularly at bedtime with sufficient carbohydrate. There is an awareness of the importance of the timing of food and insulin or tablet treatments ■ There is good liaison within the ward between differing medical and nursing staff, and between the ward and healthcare professionals who will take over the care plan ■ A clear referral protocol and the availability of highly specialised secondary care services are in place to review people living with diabetes with complications ■ The inpatient stay is used as an opportunity to update the patient's knowledge
NSF standard 9	
There is a positive experience of pregnancy and childbirth with a healthy baby	<ul style="list-style-type: none"> ■ Optimal advice and care are provided to people living with diabetes/ or at risk of diabetes from pre-conception through to delivery
NSF standards 10, 11 and 12	
1 There are measurable reductions in the number of people living with diabetes having complications	<ul style="list-style-type: none"> ■ Improved hospital data recording to register where diabetes was a significant factor in relation to renal replacement, loss of eyesight and heart disease to establish a baseline to profile target reductions

STRATEGY OBJECTIVE	OUTCOMES/MEASURES/ACTIONS
<p>2 There are measurable targeted improvements in patients conditions</p>	<ul style="list-style-type: none"> ■ People living with diabetes – their longer term blood glucose levels HBA1c tested at intervals guided by their healthcare professional– target < 6.5% or < 7.5% for those at risk of severe hypoglycemia. ■ Improvement in patients blood pressure – target < 130/80 ■ Improvement in patients’ level of cholesterol/blood fats. Target < 4mmol/l ■ (It is recognised that Diabetes UK, NICE and the Quality and Outcomes Framework (QOF) outline slightly differing targets for blood glucose, blood pressure and blood fats measurements. In this respect, it is critically important that targets are individualised and agreed between the health care professional and the individual living with diabetes, and that these are comprehensively reviewed over the period of the annual review) ■ Improved annual retinal screening invitations dispatched and attendance – 100% invitations, 95%+ attending (health implications of non attendance placed on letters and links made if the individual is attending eye clinics) ■ There is a clear understanding around exemption reporting for retinal screening and other tests ■ As a result of excellent integrated care, there is a significant reduction in emergency admissions and costs associated with diabetes inpatient treatment (upper quartile performance with similar NHS areas) ■ Clinical coding is confirmed to measure accurately the current length of inpatient stay and desired reduction in this where clinically possible (upper quartile performance with similar NHS areas) ■ The correlation between levels of deprivation, practice staff expertise, completeness of annual review procedures (including the nine critical tests), and emergency admissions by GP practice should be reviewed regularly to inform actions to improve health outcomes ■ As a result of improved primary care services there is a managed reduction in new and follow up outpatient appointments in hospital ■ Prescribing is sensitively reviewed with specialists and prescribing advisors to assess whether there is scope for savings while maintaining the confidence and quality of medication to patients ■ Target measurements above are regularly updated, as directed by the DoH/NICE

STRATEGY OBJECTIVE	OUTCOMES/MEASURES/ACTIONS
Investment and delivery	<ul style="list-style-type: none"> ■ The implementation of the National Service Framework for Diabetes can be expected to require an amount of pump-priming funds to establish the initial infrastructure to provide for ongoing service improvements across integrated care pathways ■ The recurring cost of implementing the strategy, in particular developing the workforce to national standards, the initial and ongoing training requirements, and the ability of specialists to adopt and disseminate leading practice, will need to be assessed to determine whether forecast savings (above) need to be supplemented by ongoing NHS growth funding to fully implement the strategy and the NSF by 2013 ■ Changes to services and timeframes should be consistent with the principles outlined in the <i>NHS Next Stage Review</i> published in May 2008 ■ A delivery schedule outlining key milestones to implement the NSF should be approved with the initial strategy

Evaluation of proposals to implement the NSF

Proposals to implement the NSF should be carefully evaluated by commissioners and by providers through the business case process. Proposals should have been developed fully with clinicians, be patient-centred and have been subject to consultation with patients (patient representatives), service partners, stakeholders and the local authority NHS overview and scrutiny committee as the changes are likely to be significant.

At a national level there is a desire to see care provided closer to home where this is clinically appropriate. That will mean that as well as implementing a NSF and associated diabetes strategy there will need to be agreement on what levels of activity can safely move from intermediate community diabetes centres to primary care. This needs careful clinical and financial evaluation and protocols to ensure patients are being seen at the appropriate level for their condition by appropriately qualified staff. Patient choice and individual patient assessment are important.

The business case for change

The business case for change should be progressed by following the nine steps highlighted in chapter 1. A preferred option can be developed that may be a number of smaller schemes and this can be reviewed against relevant sections of the PEC governance checklist to re-affirm proposals are robust and have been fully evaluated.

The options within the business case should contain agreed data on current and forecast populations, activity and costs with sensitivity and risk analysis for diabetes. The templates below provide a basis to start collecting the necessary activity and financial data to inform proposals.

The templates

- Need to be tailored to fit the local area
- Rely on the ability to collect good quality data
- Link with contractual arrangements that may be a mix of payment by results, quality and outcomes framework (QOF) and locally agreed flexibilities.

The commissioning business case should include:

- Demographics/workload or activity/current and proposed costs for implementing the diabetes strategy and NSF
- The expected improvement in health outcomes that the project should be evaluated against at agreed points.

The needs and preferences of service users are critically important. The patient advisory group (PAG) should be able to inform the process by outlining their key development priorities. For illustration the priorities of the West Kent PAG are outlined below, this is followed by templates that can be adapted to include within the business case.

Patient advisory group priorities

■ Access to specialist services

The PAG is supportive of care closer to home where this is appropriate. The needs assessment confirms a variation in the quality of patient management at GP practice level that is evidenced by analysis of QOF data. This position is compounded currently by an absence of clinical referral guidelines. These two factors have meant that a small number of individuals requiring a higher level of diabetes support than can be provided in primary care (primarily those with unstable diabetes and complications affecting their work and quality of life) are not receiving it. The result is that they are at a high risk of developing long-term complications. This is an important priority to address.

■ Development of the diabetes workforce

The setting of workforce planning and development programmes within all care settings for the diabetes workforce. Particularly to develop initial and on-going accredited expertise in primary care.

■ Emergency inpatient admissions

Understanding and implementing an action plan to reduce the high number of diabetes related emergency inpatient admissions.

■ Annual review

Ensuring the annual review process is supportable with all nine key care processes.

■ Dedicated psychology (diabetes) and dietetic (diabetes) support

To make available local dedicated psychology (diabetes) support working within specialist teams particularly for children to manage the trauma of initial diagnosis and discipline of ongoing self management. Dietetic (diabetes) establishments to be upgraded.

■ Multiagency focus on prevention and healthy lifestyle programmes and education

To prevent as far as is possible the development of type 2 diabetes.

■ Focus on children and schools

In particular support required for the on-going medication and measures to ensure children with diabetes can focus on their education and attend outings etc.

■ Availability of structured education and care planning

Future requirements for DAFNE and DESMOND are reflected for type 1 and type 2 education and that recommended staffing levels for these activities are agreed. Each person living with diabetes should have an agreed care plan.

■ Innovation and development within the diabetes service

Research into diabetes is progressing at an ever increasing rate. The opportunity to provide people living with diabetes with the latest techniques and technologies to improve their quality of life and life expectancy within NICE guidelines should be an accepted principle.

■ Improving the uptake of retinal screening

■ Performance information

Having regular in year performance data to monitor how action plans, service improvement and health outcomes are progressing against target.

Reviewing regularly at GP practice level the correlation between the level of deprivation, accredited/non accredited diabetes establishments, emergency admissions and results from the nine key care processes.

■ Recording unmet need particularly in specialist disciplines such as psychology to inform future investment

Commissioning business case: demographic, activity and finance schedules

Demography

Remember to apply sensitivity analysis to assess the implications of different diabetes incidence scenarios.

DEMOGRAPHY	2009	2010	2011	2012	2013	2025
	Baseline					
Type 1 diabetes						
Type 2 diabetes						
Other diabetes types as agreed						
Total						
Type 2 estimate of undiagnosed						
Total						

Forecast activity and improvement to health outcomes

Apply sensitivity analysis as above to access the implications of varying scenarios.

The templates below are illustrative only and would need to be designed to reflect current payment by results guidance and the range of services under consideration.

ACTIVITY	DEFINITIONS	2009/10	2010/11	2011/12	2012/13	2013/14
		Baseline	Target	Target	Target	Target
Hospital diabetes inpatient (no complications)	SPELLS					
Hospital diabetes inpatient (complications)	SPELLS					
Total inpatients						
Hospital diabetes inpatient (eye complications)	SPELLS					
Hospital diabetes inpatient (CHD complications)	SPELLS					
Hospital diabetes inpatient (Stroke complication)	SPELLS					
Hospital diabetes inpatient (limb complications)	SPELLS					
Hospital diabetes inpatient (renal complications)	SPELLS					
Hospital diabetes inpatient (other complications such as nerve damage)	SPELLS					

ACTIVITY	DEFINITIONS		2009/10	2010/11	2011/12	2012/13	2013/14
Total inpatients with complications							
Inpatient – average length of stay	Days						
Outpatients	New and follow-up						
Antenatal clinic / other clinics	New and follow-up						
Multidisciplinary care assessments							
The nine key care processes	% uptake and average results						
Primary care/secondary care health outcomes	Long-term blood glucose (sugar levels) HbA1c	1					
Primary care/secondary care health outcomes	Cholesterol (blood fats)	2					
Primary care/secondary care health outcomes	Blood pressure	3					
Primary care/secondary care health outcomes	Body mass index (BMI)	4					
Primary care/secondary care health outcomes	Albumin test for early signs of Kidney damage	5					
Primary care/secondary care health outcomes	Creatine test for Kidney function	6					
Primary / secondary care outcomes	Smoking prevalence	7					
Retinal screening	Invitations %/ attendances %	8					
Examinations	Feet examination / insulin sites examination	9					
All nine key care processes above	% attainment	1-9					
Primary care	Prescriptions numbers/costs						
Individual initiatives such as health promotion	Regular and annual events						
Other							

Finance

Identify the current service cost and how this will change under a do-nothing scenario given the change in demographics.

The template below is illustrative only and would need to be designed to reflect current payment by results guidance and the range of services under consideration.

CURRENT SERVICE COST £		2010	2011	2012	2013
Hospital inpatient	PbR				
Hospital outpatient	PbR				
Antenatal clinic / other clinics	PbR				
Multidisciplinary community team	PbR / local				
Primary care	QOF				
Prescribing	Prescription Pricing Authority (PPA)				
Retinal screening	Contract				
Other / Locally enhanced Services within practices					
Total					

Finance

Identify the cost of implementing an agreed diabetes strategy including the change in demographics.

The template below is illustrative only and would need to be designed to reflect current payment by results guidance and the range of services under consideration.

PROPOSED RECURRING SERVICE COST £		2010	2011	2012	2013
Hospital inpatient	PbR				
Hospital outpatient	PbR				
Anti-natal / other clinics	PbR				
Multidisciplinary specialist team	PbR / local				
Primary care	QOF				
Prescribing	£				
Retinal screening	Contract				
Implementing NSF standards/ specific events	Local tariff				
Continuing professional training	Workforce budget				
Total					
One-off costs					
Developing the strategy					
Accredited primary and secondary care training					
Other/locally enhanced services within practices					
Total					

The prices for diabetes services reflected by their national tariff are complex. Inpatients have a tariff based on age, complications and length of stay. Outpatients attract differential tariffs based on whether the appointment is a first or follow up and with a single professional or a number of professionals. Year of care tariffs are to be developed, but in the interim data that is required to show an improvement in health outcomes needs to be restated in a significantly different format to reflect an economic case for investment or change.

Provider business case – demographic, activity and finance schedules

From an agreed set of demographic and activity information, it will be necessary for providers of care to carefully review an agreed service specification and assess the facilities required, the staffing, IT, the equipping, the consumable and testing costs of providing the service to this agreed specification.

A number of these activities will be covered within PbR and the national tariff. Other multidisciplinary services will, as discussed previously, be subject possibly to a local tariff agreement.

The key issue for providers is that for a given range of activity scenarios quality services can be provided within an agreed schedule of costs and income provided by commissioners.

Public finances and the reconfiguration of diabetes services.

At the time of writing, public finances are stretched. Savings required from the NHS range from £15bn to £20bn for the three years from April 2011.

The challenge is to provide quality services – cost effectively

A number of published articles regarding proposed models of diabetes care propose a pragmatic approach. Type 1 diabetes, children and antenatal care can be treated by consultant led hospital based specialist services and well controlled type 2 patients can be treated in primary care, or at multidisciplinary specialist community centres where an enhanced level of service is required.

There will be a number of acceptable and different design solutions. An important consideration is that these are not seen as absolutely rigid and can accommodate changes to conditions or higher levels of support as required. Patient choice is important and patients who ask for a specialist opinion should be referred appropriately.

System redesign in Leeds

Leeds NHS via Leodis Healthcare, a consortium of 27 GP practices in east and south Leeds covering a population of 200,000, have specifically identified a number of type 2 patients living with diabetes that could transfer from secondary to primary care. This followed a detailed analysis of each patient.

The transfer required dedicated project management with significant planning to ensure that:

- Patient care was not compromised
- Staff within primary care teams were fully trained to provide first class treatment.

The objectives were to:

- Provide treatment closer to home, where appropriate
- Reduce hospital visits
- Free up capacity at Leeds Teaching Hospital for the care and treatment of patients with more complex needs.
- Make financial savings.

The cost of treating the 900 type 2 diabetes patients at Leeds Teaching Hospital had been identified at between £180,000 and £190,000 per annum. The cost under the new configuration was assessed at between £150,000 and £160,000 per annum. A ten-year projection based on 2.5% inflation and 6% patient escalation gave an average estimated saving over the period of £45,000 per annum.

Training to achieve this model included ensuring that at least one GP within each GP practice was qualified to a Diabetes Warwick course level or equivalent. Specialist nurses and GPs with an interest in diabetes (GPSI) were appointed.

Patient education programmes being run in primary care complemented this service and other diabetes specialists in dietetics, podiatry and psychology had input into the service via a service agreement with the local NHS trust.

Patients have been engaged on a project board and through a patient advisory group (PAG) during this service redesign. The local authority NHS scrutiny and overview committee had also been engaged.

This scheme provides the opportunity to develop the diabetes service by reinvesting savings to achieve further service improvements.

Source and application of funds for developing the finance to implement the NSF for diabetes

The implementation of the NSF for diabetes will yield savings and better patient outcomes as a more highly skilled workforce facilitates improved levels of care, leading to a reduced number of emergency admissions and a reduced length of stay. Prevention strategies should reduce the number of people developing type 2 diabetes and this should lead to a reduction in the cost of prescription drugs.

The business case for the development of diabetes services should include a source and application of funds statement as a result of the changes made to the following services:

Diabetes NSF implementation

Source of funds

CHANGE	ACTIVITY CHANGE	FINANCIAL CHANGE £
More personalised treatment of patients closer to home	X	X
Reduced emergency admissions	X	X
Reduced length of stay for inpatients	X	X
Prescribing advisor/specialist review of diabetes drug prescribing	X	X
Net savings as a result of implementing structured training programmes	X	X
Development of integrated diabetes services leading to fewer appointments and tests	X	X
NHS growth funding	X	X
Total source of funds	X	X

Application of funds

Implementation of the NSF via savings above	X	X
Implementation of the NSF via growth financing	X	X
Total application of funds	X	X

The following checklist is intended as a helpful aid memoire for the process to modernise diabetes services.

Checklist

What needs to be considered to ensure that a project to modernise diabetes services is successfully managed and implemented?

1 The project has clear leadership

- There is a clearly identified and qualified project lead/director who is responsible for developing and delivering the project and can identify and work through the major risks to ensure the expected benefits are realised
- Boards, chairs and chief executives of all organisations involved in the change are briefed, support the project objectives and timelines and there is clarity on the priority of the project against others.

2 There is clarity on how the project fits with the overall DoH strategy and local priorities

- Proposals should be consistent with
 - The National Service Framework for Diabetes 2001
 - The NHS Diabetes Delivery Strategy 2003
 - The Diabetes Commissioning Toolkit 2006
 - NHS priorities and planning guidance
 - Local service and joint service strategies
- Where the project crosses organisational boundaries there should be clear governance arrangements to ensure that the objectives are sustainable for all organisations/or that the required changes and actions to ensure sustainability are agreed.

3 There is clarity on the project objectives and the clinical/patient benefits that are being aimed for at the start of the project

These could be all or a number of these:

- Improved facilities and better equipped services for treating patients
- An improved ability to recruit and retain quality staff
- Improved Patient access to services
- Reduced waiting times to see a specialist
- Reduced number of hospital emergency admissions
- Reduced length of hospital Inpatient stay
- Fewer complications
- Reduction in prevalence of type 2 diabetes
- Educated patients being able to manage stable diabetes on a day to day basis
- A progressive health promotion strategy that will prevent a number of individuals becoming type 2 diabetic.

It is important, therefore, to set out the improvements that the project is seeking, the respective priority and weighting for each major benefit and the process and timeline for evaluating the project and how the project fits strategically.

4 The project board needs to be constituted correctly. It has the correct skills and adopts a proven approach to risk management.

- Important that there is NHS senior management involvement. (Studies have shown that senior management involvement and ownership has the biggest impact on the progress of clinically lead service improvements)
- All NHS partner organisations should be invited. It is also sometimes necessary to have a 'boundary spanner

(A boundary spanner is a trusted facilitator with expert relationship management skills to unlock difficult cross-organisational issues that need to be progressed to make the project successful)

- Lead consultants, GPs and other healthcare professionals affected or with an interest in the project are involved
- Clinicians should lead the development of ideas, options and proposals. This should be an integral part of the ongoing engagement process for the duration of the exercise
- It is key that important support services of finance, human resources and IM&T are engaged into the project to provide advice and work through the finance, staffing and information requirements
- Finance representatives are acquainted with current and proposed services and their care pathways to maximise their contribution
- Patients/carers should be engaged. An individual with type 1 or 2 diabetes or a carer who is a good communicator, has a passion for developing diabetes services and is respected by service users is ideal
- The voluntary sector should be engaged in line with the Compact on relations between the government and the voluntary and community sector. In this instance a representative from the charity Diabetes UK would be appropriate
- A skilled and experienced project team is in place with clearly defined roles and responsibilities
- Attention is given to breaking down development and implementation into manageable steps
- Where a major project involves a number of smaller schemes, the inter-dependency between them, the critical pathway, the benefits of each and the criteria against which success will be judged are known.

5 The programme and project management arrangements are clear

- The work streams should be clear and nominated
- The project lead manager should be experienced and have a proven track record of delivery
- The how, when and where decisions will be made, the process for dispute resolution, key dates for meetings, clear lines of reference for communications are all in place
- There is a realistic budget to develop the project and this is monitored throughout the project
- Facilitating or transitional costs need to be clearly identified and resourced.

6 There is influential clinical leadership

- Appointed clinical representatives should be leaders in their field, senior and well respected figures that have time to become involved in the project
- If clinical leaders are self-appointed because of their enthusiasm and energy for improving services this is an ideal scenario.

7 The starting point of the current service should be clear ie:

- (i) staffing
- (ii) activity
- (iii) current health outcomes
- (iv) investment £

- Diabetes is a sub specialty of general medicine. Not all NHS trusts have coded inpatient stays and outpatient appointments related to diabetes to the diabetes specialty although there are premiums that can be charged to commissioners reflecting the increased complexity associated with this condition
- In addition inpatient stays as a result of diabetes complications (eyes/heart/renal/limb amputation) may not have been identified to establish a baseline to improve outcomes [from achieving a reduction in these complications]
- In these instances the coding system should be amended to start collecting data in the required format as soon as practically possible
- The activity, cost and outcomes of the current service should be agreed between the organisations providing the services to establish a baseline to target and cost improvements
- Staff involved in providing the current service or work across several services including the one being reconfigured should be identified.

8 There may be disagreement on the configuration of the preferred service model and this should be resolved efficiently

- Patient representatives will be skeptical if there is a disagreement between different clinicians or specialists on a preferred solution.
- Patients know that practice-based commissioners hold budgets or nominal budgets for services being commissioned. It is therefore important that where GPs - on the project board in their commissioning role - advocate a care pathway that refers patients to themselves as providers of care, the decision is evidenced based and cannot be construed as a decision taken on purely financial grounds. This situation has a better chance of being avoided if the clinical leader appointed for the project board has the seniority and respect of peers and patients
- If rarely a disagreement occurs, it may be necessary to take advice from a leading national expert that both consultants and GPs respect to agree a final evidence based service model.

9 PEC checklists and production of provider business cases

- Proposals are reviewed by the PCT against agreed criteria from a governance checklist and business cases are developed by providers adhering to DoH, SHA and Monitor guidelines
- A clear process and co-ordinated timetable for the review of recommended proposals should be set out by each organisation to ensure key issues such as patient benefits, affordability, value for money, financial and clinical risk have been considered and agreed by boards
- Boards have clear timeframes for the approval of business cases.

10 Ensure patient consultation is not viewed by patients as a tick box exercise and that proposals include the patient contribution

- Change should only be initiated when there is a clear and strong clinical basis for doing so. Early and effective engagement with patients and the public should precede any formal consultation and resources should be made available to open new facilities alongside old ones closing
- A strengthened duty to involve came into being in November 2008, where service users need to be involved in the planning and development of services, proposals for change and decisions affecting the operation of services
- There is now a responsibility on PCTs and SHAs (where these provide services) to report on how people's views have shaped proposals
- If proposals for change are focused too much on simply saving money, patients will quickly become disengaged. Local MPs, press and the local authority may be approached with concerns that will inevitably put strains on project management and delays into the process
- Consultation should follow the principles of the Cabinet Office code of practice and should normally run for a minimum 12 weeks
- If there is disagreement between patient, public and clinical perspectives, there should be clear dispute resolution procedures adopted before public consultation
- It can add credibility if subsequently consultations responses are independently analysed
- Patients need to see the difference first. Existing services should not be withdrawn until new and better services are available.

11 Local authorities are briefed on the project and its aims and are kept engaged as the project moves forward

- The Local Authority NHS Overview and Scrutiny Committee should be approached where a significant change to the NHS is being planned
- Where the local authority has concerns they will either ask for more information from the NHS, for an NHS representative to attend a meeting to discuss the change or refer the changes to the Secretary of State for Health
- If service users believe their views have not been considered this will inevitably be taken into account by the local authority
- The Secretary of State can refer the case to the IRP who will report back on the proposals being considered

- Arrangements for consultation should be set out clearly at the start of the project and must take into account stakeholder views
- There is not a definition of significant change within the NHS for consultation purposes, therefore local authorities should be invited to early and ongoing discussions to be briefed on emerging service.

12 The consultation document needs to be explicit about current services, what services are being planned, the locations of services and traveling times

- The consultation document should outline the services, the numbers of patients and clinical staff involved and the benefits for each group and travelling times
- The consultation process should be outlined
- A note of how the preferred option is affordable and clinically viable.
- How the proposals fit strategically and its implications on partners, local authorities and voluntary organisations as appropriate
- Where achievable, national policy is to care for a majority of people living with diabetes closer to home and away from hospitals. The clinical benefits of the changes need to be outlined. Patients will often see the local hospital as part of the local community and moving a specialist diabetes centre from a district general hospital (DGH) site into the community requires a discussion of the supporting clinical advantages as part of an overarching diabetes strategy. There are many advantages of a diabetes centre being co-located with other DGH specialties given the complications that arise that can benefit from other departments input
- After consultation changes to the preferred option in the light of user views should be communicated.

13 Implementation plans should be comprehensive

- The specific changes, when new facilities will be available, the timetable for implementation, the implications for staff and recruitment and how resources will be made available to support the implementation should be outlined.

14 Key lessons from the IRP reviews are not taken into account

- Ensure there is adequate community and stakeholder engagement before options are published in a formal consultation
- Plans include – what services will be provided, where and how to access them
- Mixed messages about clinical issues need to be resolved prior to formal consultation
- Important to emphasise the benefits of change, the additional services being made available, rather than emphasise what cannot be done
- Local opinion will be excited about three key issues, emergency care, transport and money – in respect of diabetes and other NHS service changes these issues regarding the service should be clarified.

15 NHS requirements

- Requirements of the DoH, SHAs, Monitor, and the OGC, as appropriate, should be followed.

References

The Independent Reconfiguration Panel – Code of Practice	October 2008
The Independent Reconfiguration Panel- learning from reviews	November 2008
The NHS Constitution	January 2009
Monitor – Roles and responsibilities in the approval of NHS foundation trust PFI Schemes	March 2007
Monitor – Risk evaluation of investment decisions by NHS foundation trusts	February 2006
CIPFA – Achieving transformational change, reform. Efficiency and lean thinking in the NHS	2007
Real Involvement	October 2008
The Government response to the Alberti and Colin-Thomé reports into the failings at Mid-Staffordshire NHS Foundation Trust	2009
Changes for the Better	May 2008
Department of Health World Class Commissioning Patient and Clinical Engagement	
National Service Framework for Diabetes	2001
NHS Diabetes Delivery Strategy	2003
Diabetes Commissioning Toolkit	2006
NHS Operating Framework	2009/10 2010/11
Diabetes Guide for London	2009
Our Health Our Care, Our Say	DoH 2006
Health Reform in England – Update and commissioning framework	2006
Managing Diabetes: Improving Services for People with Diabetes (Healthcare Commission)	2007
NICE guidance	Ongoing
Commissioning Diabetes Without Walls, NHS Diabetes	2009

Joint planning strategies

There are a number of joint planning strategies (strategies developed and agreed between public sector service organisations, the private sector, charitable and voluntary sectors) that planned changes in local health services should be consistent with. These are comprehensive area assessments, joint strategic needs assessments, local area agreements, sustainable community strategies and local strategic partnerships.

■ Comprehensive area assessments (CAAs)

Comprehensive area assessments provide the first independent assessment of the prospects for local areas and for the quality of life for people living within them. They put the experience of citizens, people who use services and local taxpayers at the centre of a new local assessment framework, with a particular focus on those whose circumstances make them vulnerable.

CAAs cover issues such as reducing inequalities in health and education, increasing the availability of affordable housing, reducing crime, improving educational achievement, attracting investment and reducing carbon footprint.

■ Joint strategic needs assessments (JSNAs)

The Local Government and Public Involvement in Health Act 2007 placed a duty on upper tier local authorities and PCTs to undertake joint strategic needs assessments. This process identifies the current health and well-being needs of a local population, informs the priorities and targets included within LAAs and leads to agreed commissioning priorities that aim to improve health outcomes and reduce health inequalities.

■ Local area agreements (LAAs)

Local area agreements set out the 'agreement' between central government and local authorities and their partners to improve services and the quality of life for local people. As such the LAA is a shorter term delivery mechanism for the SCS, agreed by all members of the LSP. The SCS provides the story of the local area and should articulate the longer term ambition, evidence and rationale beyond the focus of a three year LAA.

PCTs, NHS trusts and NHS FTs have a duty to co-operate and must be involved in helping to determine any target in the draft LAA which will relate to it and co-operate with the responsible local authority (section 106(3)(a) of the Local Government and Public Involvement in Health Act 2007). Following agreement of the LAA, local authorities and partner authorities are required to 'have regard' to all those targets they have signed up to in the LAA.

■ Sustainable community strategies (SCSs)

The purpose of an SCS is to set the overall strategic direction and long-term vision for the economic, social and environmental wellbeing of a local area, typically for 10–20 years, in a way that contributes to sustainable development in the UK. It tells the 'story of the place', the distinctive vision and ambition of the area, backed by clear evidence and analysis. The Local Government white paper *Strong and prosperous communities* sets out that the SCS must provide a 'vehicle for considering and deciding how to address difficult cross-cutting issues such as the economic future of an area, social exclusion and climate change'.

■ Local strategic partnerships (LSPs)

Local strategic partnerships are non-statutory, multiagency partnerships that usually match local authority boundaries. They bring together at a local level the different parts of the public, private, community and voluntary sectors, allowing different initiatives and services to support one another so that they can work together more effectively. They provide the forum for collectively reviewing and steering public resources through identifying priorities in SCSs and LAAs.

As non-statutory bodies, they are not the ultimate decision-makers on these plans. All target-setting and contractual commitments proposed by LSPs must be formalised through the relevant local authority, or through one of the other LSP partners.

How to ensure value for money (VfM) is being achieved

There are numerous ways of ensuring VfM and assessing achievement, ranging from international models such as Lean to locally developed systems suited to the skills and culture of individual organisations. Regardless of the model employed, they should contain all or most of the following elements:

- Benchmarking
- Management systems review
- Needs assessment
- Business planning processes
- Focus on waste
- Delivery v objectives review.

Benchmarking

It is not always possible to benchmark as there may be nothing to compare with – for example with innovative reforms and efficiency drives.

Even in instances where there is no equivalent service to benchmark against, it is still often possible to compare projects, inputs and outcomes for instance:

- Are costs and staffing levels comparable with other models of providing a service?
- Are outcomes as good or better?
- Where cost and the level of staff input is greater than in other models, are the outcomes better (to justify the greater input levels) and/or has a comparable reform/ efficiency been unsuccessfully attempted elsewhere and what lessons are there for the organisation to avoid similar problems?

Benchmarking is a key tool for VfM assessments as it highlights relative inefficiencies and can be used to identify areas to be reformed and made more efficient.

Management systems review

This is a specific VfM assessment considering how efficient the management processes relating to a particular service are. For demonstrating the VfM of a new service, the assessment should focus on ensuring the management processes to be implemented to support the operation of the reform are in line with the most efficient available to the organisation.

The areas on which a management systems review should focus are:

- The setting of objectives
- The development and implementation of policies
- The monitoring of performance.

Business planning processes

Business planning processes in relation to VfM assessments should provide assurance that the identified best value service model is being followed in the most efficient and effective manner. Such assurance is achieved by considering whether:

- There are inputs and processes within the service model that do not add value. That is, actions that do not support the achievement of the required outcomes/ objectives of the service. One method for this is to assess whether the omission of an input or process would change the outcome achieved
- Outcomes are reviewed against objectives. Review systems effectively alert the organisations when outcomes are not aligned with objectives and management react effectively following alerts.

Systems review

A systems review is an assessment of the inputs and processes to ensure these are economic and efficient. When looking at a current service, the key is to identify the existence of waste.

For inputs, waste constitutes an input that could be more cost effectively provided. An example of the latter may be a member of staff at a higher level than the responsibilities require or a product cost over and above that which could be secured. The moves to central procurement hubs, for instance in the North West, are a means to achieving more economic inputs for products, ranging from hospital supplies to telecommunications to agency staff.

The traditional method for systems reviews is via benchmarking techniques (see above). For instance, determining good practice (within and out with the organisation) and assessing the inputs and processes under review against these.

Delivery versus objectives

The purpose of this part of a VfM assessment is to determine whether or not the outcomes of the area assessed achieve what is required of the service. The stages to this are:

- Establish the objectives the service currently works to
- Clarify that these objectives are fit for purpose (if not, develop objectives that are)
- Determine the outcomes achieved by the service
- Determine whether these outcomes meet the fit for purpose objectives
- Use the findings from the stages of the VfM assessment described above to assess whether there are more economic and/or efficient means of achieving the desired outcomes and objectives.

Who to benchmark against

Benchmarking has been mentioned a number of times in this section and it is worth considering who best to benchmark against. There is no point doing so against an organisation that has little in common with your own. For instance, a cottage hospital assessing its processes against those of a multi-specialist urban university hospital is unlikely to lead to useful conclusions, other than that next time a more suitable comparator should be identified.

It is also the case that comparing with near-identical organisations is not the only answer. Instead, different types of organisations with similar processes can be looked at, such as hotels for bed management, banks for transactions system management or even rugby clubs for rapid physiotherapy throughput to assist sports injuries.

Within the NHS there are ready made systems which compare organisations or identify organisations to compare with. These range from reference costs analysis or, for PCTs, programme budgeting analysis for similar catchments or similar residential populations.

For benchmarking at a more detailed level than the national comparators, organisations can make contact with their comparators and share success stories and input/process techniques and models.

For instance, what reforms have PCTs with similar populations to yours successfully implemented that have had a significant health impact and, as importantly, what have they done that has not worked?

Results

The result of a value for money assessment on a service will be one of three categories:

1. VfM is being achieved
2. VfM is not being achieved because the objectives of the service are not fit for purpose
3. VfM is not being achieved because service delivery is not fit for purpose.

Each of these has a consequence, which is described below.

VfM is being achieved

On demonstrating this, move on to the next assessment.

VfM is not being achieved because the objectives of the service are not fit for purpose

For this to be the case, the assessment will have demonstrated that VfM is not being achieved, but that the service is being provided as required via the service specification.

The recommendation of the assessment will therefore be that a reform needs to occur. That is, the organisation needs to determine what the service should be achieving and, in the case of a provider organisation, how this then needs to pass through the business planning process for board approval and on to the project implementation process.

VfM is not being achieved because service delivery is not fit for purpose

In this case, the assessment will have demonstrated that VfM is not being achieved but that the service specification is fit for purpose. That is, the service is not delivering what is required of it, whether in terms of outcomes and/or processes.

The recommendation of the assessment will therefore be that a business planning process is required to bring delivery back in line with requirements. This may be achieved via more robust performance management or it may be achieved via the tendering process that is, generating competition to ensure the required outcomes are achieved in the most efficient manner. The current provider will have the option to bid, reforming structures and processes in line with requirements.

Economic and financial appraisal

ECONOMIC APPRAISAL	FINANCIAL APPRAISAL
<p>The focus is on VfM</p> <ul style="list-style-type: none"> ■ Incomes and costs are discounted over the time period to derive the net present value 	<p>The focus is on affordability</p> <ul style="list-style-type: none"> ■ Cash flows
<p>Coverage</p> <ul style="list-style-type: none"> ■ Benefits and costs to the public and private sectors 	<p>Coverage</p> <ul style="list-style-type: none"> ■ Limited to relevant organisations
<p>Relevant standards</p> <ul style="list-style-type: none"> ■ HMT Green Book ■ Discount rate 3.5% ■ DoH Guidelines ■ International Financial Reporting Standards (IFRS) 	<p>Relevant standards</p> <ul style="list-style-type: none"> ■ Organisational accounting rules and standing orders
<p>Analysis contains</p> <ul style="list-style-type: none"> ■ Constant (real) prices ■ Includes opportunity costs ■ Includes indirect and attributable costs ■ Includes quantifiable costs, benefits and risks ■ Includes environmental costs ■ Excludes exchequer transfer payments such as VAT ■ Excludes inflation ■ Excludes sunk costs ■ Excludes depreciation and capital charges 	<p>Analysis contains</p> <ul style="list-style-type: none"> ■ Current prices ■ Cash releasing benefits only ■ Includes transfer payments ■ Includes Inflation ■ Includes depreciation and capital charges

NICE and Quality and Outcomes Framework guidelines

- Link to NICE guidance on the treatment of diabetes:
www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7239
- Link to the *Quality and Outcome Framework guidance for GMS contract 2009/10*:
www.wales.nhs.uk/sites3/Documents/480/QOF_Guidance_2009-10_FINAL.pdf

Short paper - can we afford not to modernise nhs services (A focus on Diabetes)

There is an urgent need to address the UK budget deficit – but with reducing future growth within the NHS can we really afford not to pursue the modernisation of nhs services?

Introduction

The level of UK public sector debt is at extreme levels. The pre-budget report of the 9 December 2009 highlighted an in year 2009/10 net borrowing requirement of £178bn that subsequently reduces over the next four years to £96bn by 2013/14. In relation to the overall national debt this is forecast to rise to £799bn by March 2010 and to £1473bn or 78% of gross domestic product by 2014/15.

What does this mean for the resourcing of the National Health Service.

Although the NHS is a priority service it is widely expected that from 2011/12 services will have to continue to improve with less real terms funding while managing the following pressures:

- A rising public expectation
- A need to continue to provide access within shorter timeframes
- The development of personalised services
- The ageing population associated with an increasing prevalence of long-term conditions
- A need to focus more on promotion, prevention, independence and wellbeing
- The cost of securing improvements in medical technology
- Increases in employer costs such as National Insurance
- A real desire to provide consistently high levels of quality care and address variations of quality across the health system after recent system failures.

Finance within the NHS is set to become far more challenging. The operating framework for 2010/11 outlines a number of measures to create 'financial headroom' in Primary Care Trust allocations and to drive efficiency gains in the service in advance of much tighter resource settlements from 2011/12.

The measures include:

- For 2011/12 and 2012/13 NHS frontline spending to receive a flat rate of growth in line with inflation only
- Savings of £15 - £20 billion required to cover system pressures to be identified by the end of 2013/14
- 2% of allocations to remain uncommitted on a recurring basis and used for service transformation
- A 30% reduction in management and agency costs to be achieved by 2013/14
- Health service providers to achieve a 3.5% efficiency gain to offset pay and price increases in 2010/11
- A relentless focus on improving quality and productivity, using innovation, prevention and joint working across organisational boundaries.

In terms of scale and perspective what can £1bn buy in healthcare.

A few examples are shown below.

- £1bn is the annual operating budget for the super size Belfast Health and Social Care Trust. This employs 22,000 staff and provides health and social care services to a population of 340,000 in Northern Ireland
- £1bn is the equivalent of four new private finance hospitals being built at Pembury in Kent. The first PFI hospital with 512 single en-suite rooms
- £1bn is the entire revenue budget of West Kent NHS who commission health services for a population of 677,000 people.

To save significant sums in health usually involves reducing manpower, the main expense item of the health service. But the challenge equally is to improve services via innovation; engaging leading clinicians to drive quality solutions; having robust patient engagement and education; showcasing areas of good practice; and having experienced project management to modernise services following proven and evidence based models of care implemented to budget and timelines.

Modernisation of diabetes services

Diabetes is one of the world's major health challenges. In the UK, apart from Northern Ireland there is a National Service Framework that sets out 12 care standards to be implemented by 2013. A number of key statistics for this long-term condition are set out below,

- 285 million people world wide have diabetes
- The ageing population, the associated prevalence of long-term conditions and obesity will increase this to 438 million people by 2030.
- 2.6 million individuals in the UK live with diabetes in 2010. This is expected to increase to 4 million by 2025.
- £3.5bn is estimated to be spent each year in the UK on diabetes
- Diabetes can increase cardiovascular risk, including the risk of heart disease, stroke and dementia.
- Long-term conditions arising from diabetes can include kidney disease, eye disease, diabetic foot disease and amputation, depression, neuropathy (disorders of the nerves), and complications in pregnancy
- Diabetes has an adverse impact on life expectancy.

The increase in the numbers of people living with diabetes presents a significant challenge to the National Health Service, from treating significant extra numbers of people with diabetes to the treatment of the long-term conditions that arise from the condition. Progressive and innovative public health strategies and service modernisation are required to avoid significant extra costs to the NHS.

Diabetes is a condition in which the amount of glucose (sugar) in the blood is too high because the body cannot use it properly. There are many types of diabetes but the most common are type 1 or type 2, which are explained below:

Type 1 accounts for approximately 10% of individuals with diabetes and develops if the body is unable to produce any insulin and usually appears before the age of 40. It is treated by insulin injection or insulin pump, diet and regular physical activity.

Type 2 accounts for approximately 90% of individuals with diabetes and develops when the body can still make some insulin, but not enough, and/or when the insulin produced may not be fully effective. People with type 2 diabetes are often overweight or obese. Diabetes can be treated by diet, physical activity, tablets or insulin.

Most people, but not all, are diagnosed when they present with symptoms to their GP. Once diagnosed, most type 1 diabetes patients are seen by specialist diabetes teams, for initial treatment, education, stabilization and follow-up treatment. Some patients may present with a medical emergency called diabetic ketoacidosis which requires admission to hospital for intravenous insulin and fluids. With type 2 diabetes diagnosis may not be made until a patient presents with a significant complications (eg heart attack, stroke, foot ulcer).

A specialist multidisciplinary team will include physicians, specialist nurses, psychologists, podiatrists and dieticians – all with an interest and expertise in diabetes. Other healthcare professionals may provide input from time to time eg vascular surgeons, orthopaedic surgeons, obstetricians, ophthalmologists, orthotists.

Children diagnosed with diabetes are routinely referred to hospital for their care. Changes to GP contracts and health promotion payments in the 1990s have meant that the majority of type 2 patients are now cared for outside of hospital – but there is considerable variation.

What are the main actions required to improve services and equally where possible to reduce costs to the NHS and to other government departments

The following table explores a number of these options within diabetes services.

There is an overriding principle that quality care provided across an integrated care pathway from primary to secondary and tertiary services is critically important.

Where it may be proposed to save resources by treating more individuals with uncomplicated diabetes in the community the right infrastructure and expertise in primary care must be in place. Changes should be led by senior clinicians and service users should be actively engaged.

Given the tightening financial position and an inevitable public skepticism that service changes are simply driven by financial factors the project needs to focus on demonstrating a high level of integrity from the start.

The section below focuses on several aspects of modernisation from this guide relating to diabetes services where in many cases financial savings can be made to either reinvest in the service and/or make a contribution to the costs associated with greater prevalence of the condition.

POLICIES REQUIRED AND EXAMPLES	ACTIONS FOR DIABETES SERVICES
<ul style="list-style-type: none"> ■ Excellent structures are in place to plan, commission and deliver a truly integrated diabetes service 	<ul style="list-style-type: none"> ■ Clinical leadership is in place to lead changes ■ Change is based on a comprehensive population needs assessment ■ There is an agreed structure for delivering services from hospital to community intermediate specialist services to general practice. ■ An agreed service delivery plan has been developed ■ Workforce planning, skills audit and professional development plans are in place to deliver the establishments required and agreed levels of care ■ Training budgets are adequate ■ Experienced project management is in place ■ Patients are fully engaged in the change process <p>Examples</p> <p>The London Guide for Diabetes is an example of leading clinical practice in how services can be structured. This proposes four tiers</p> <ul style="list-style-type: none"> ■ Tier 4 Hospital based consultant led specialist care and advice for patients with complex needs in hospital ■ Tier 3 Community – consultant led team providing care for patients with more complex needs, provided in the community, such as a community based diabetic clinic, health centre or polyclinic providing enhanced care services ■ Tier 2 Essential care (enhanced) GP/practice staff providing quality care and advice, with some enhanced services such as the management of foot disease as well as tier one care ■ Tier 1 Essential care GP/practice staff providing a consistent level quality care and advice

POLICIES REQUIRED AND EXAMPLES	ACTIONS FOR DIABETES SERVICES
<ul style="list-style-type: none"> ■ Promotion of a healthy lifestyle to reduce the increasing prevalence of type 2 diabetes ■ Almost one in four adults in England is obese – this is predicted to grow to 9 in 10 by 2050 	<ul style="list-style-type: none"> ■ Agreeing low cost membership to fitness centres ■ Running diabetes awareness days and talks to children. ■ Running healthy lifestyle events focused on prevention, diet and exercise <p>Examples</p> <p>Award winning Heart of Birmingham Teaching PCT and Birmingham City Council provide a ‘gym for free’ scheme to disadvantaged communities that has resulted in a small reduction in childhood obesity to date</p> <p>NHS Wakefield extended an invitation to Wakefield 299 Parachute Squadron - Royal Engineers to produce an inflatable assault course for children. This resulted in a 5.5% reduction in five year olds being recorded as obese from 2006-7 to 2007-8</p> <p>By slowing down the rate of prevalence at which people get type 2 diabetes, the rate of expenditure increase on diabetes drugs can be suppressed</p> <p>In 2004/5 24.8m diabetes items were dispensed at a cost of £458m.</p> <p>In 2005/6 28.4m diabetes items were dispensed at a cost of £561m.</p> <p>In 2007/8 32.9m diabetes items were dispensed at a cost of £600m, a 31% increase over 4 years.</p>
<ul style="list-style-type: none"> ■ Investing in primary care to provide care closer to home can provide savings 	<p>Example</p> <p>Studies in Leeds have shown that £45,000 pa could be saved over ten years if uncomplicated type 2 individuals with diabetes are looked after in primary care after putting in place the necessary infrastructure and training.</p> <p>Respecting patient choice on where individuals want their care and making changes based on an individualised assessment is important</p> <p>Changes are dependent on having accredited staff in primary care that receive initial and ongoing training to manage the case load and service user confidence that the changes will provide a quality service</p> <p>In modernising services it is critically important that individuals who need the support and advice of a specialist continue to receive it, particularly where a more vigorous management strategy may be required to maintain good control</p>

POLICIES REQUIRED AND EXAMPLES	ACTIONS FOR DIABETES SERVICES
<ul style="list-style-type: none"> Emergency admissions relating to diabetes may always occur, but by having excellent patient education, resourced and accredited secondary and primary care teams and discussing the management of emergencies across regions with ambulance services, out of hours services and other providers, innovative solutions to reduce the number are possible. 	<p>Examples</p> <p>Estimates in West Kent show that the achievement of upper quartile performance in this area could save £500,000 pa</p> <ul style="list-style-type: none"> There is a strong correlation between deprivation and the level of emergency admissions This also requires a strong focus on patient education, attendance for key tests and an annual review to confirm whether changes in the management of the condition are required
<ul style="list-style-type: none"> Achieving reduced length of inpatient stay 	<ul style="list-style-type: none"> This depends on excellent hospital protocols and dedicated care being in place. People living with diabetes should ideally be cared for in a dedicated diabetes ward. If they are not then the medical and nursing staff in a shared ward should be trained and have the required experience in diabetes The inpatient stay is an important opportunity for specialists to update the patient's knowledge Discharge and follow up plans are an important mechanism for ensuring continuity of care Financial regimes need to incentivise improvements and resources for more intensive inpatient management made available <p>Examples</p> <p>At Southampton University Hospital, since July 2004 the average length of stay for inpatients with diabetic foot disease has fallen from 50 days to 18.5 days with the appointment of additional diabetes specialist nurses and the establishment of dedicated diabetes podiatry clinics. Savings had been assessed at £2.2m over the first 22 months</p> <p>In the United States average length of hospital stay for individuals with diabetes as their first listed diagnoses decreased from 10.5 days to 4.7 days from 1980 to 2005</p>
<ul style="list-style-type: none"> Education regarding the use of expensive prescriptions for consumables such as blood testing strips should be available 	<p>Example</p> <p>It is important that service users understand how and when to test and what to do with the results to maintain good diabetes control. Patient representatives believe that by using testing strips more efficiently, better health outcomes and better use of resources can be achieved</p>

POLICIES REQUIRED AND EXAMPLES	ACTIONS FOR DIABETES SERVICES
<ul style="list-style-type: none"> ■ Diabetes is a major cause of blindness and annual retinal screening is critically important to pick up any complications ■ Many occupations are closed to people who are blind and benefit payments to this group are significant 	<p>Examples</p> <p>Patient studies in West Kent suggest that web based technology to book retinal screening appointments and having a choice of screening locations and times could improve attendance at screening sessions</p> <p>Education on the importance of screening, the difference between screening and the conventional eye test is considered important.</p> <p>In the United States research has indicated a strong correlation between deprivation and non-attendance.</p> <p>There is also a view that a number of people with busy lives are putting their career and family ahead of their health</p> <p>Blindness attracts disability living allowance and higher tax allowances for those in work. Picking up and treating complications early is therefore a very desirable service and financial objective</p>
<ul style="list-style-type: none"> ■ As part of managing diabetes, it is important to minimise the risk of long- term complications and the associated treatment costs by regular checks 	<p>Examples</p> <p>Ensuring high attendance at diabetes annual reviews and ensuring that a full suite of key care tests to support the review are carried out with results available in advance to measure blood glucose, kidney function, blood fats, weight; legs, feet and injection sites check and blood pressure should assist in reducing the incidence of longer term complications and their cost</p>

There are many factors that need to be in place to ensure successful change within the NHS, three of the key factors are explored briefly below.

Business case guidance

For major service change to be implemented effectively the NHS has developed comprehensive business case guidance, this takes a proposal to a preferred option from a strategic outline to outline and full business case. Public Health Impact Assessment (HIA) as a subcomponent is equally important in this process as well as following the Office of Government and Commerce (OGC) Gateway directions for managing change. Further information is available from the OGC and DoH gateway process website accessible at www.doh.gov.uk.

Clinical engagement

Key to success in managing change in the NHS is the leadership of clinicians; this is due to their clinical expertise and ability to:

- Support the organisation(s) with its vision and strategic direction
- Comprehensively understand the service, its integrated models of care and care pathways
- Share good clinical practice
- Enable clinically safe and high-quality services to be both commissioned and provided
- Lead clinical communications with partner organisations and stakeholders that encourages and leads innovation to facilitate change.

Clinical champions representing their services reflect the majority of the characteristics below

- Are leaders in their field
- Have the trust, seniority and experience to generate respect and credibility from peers, management within their own organisation and across organisational boundaries
- Have natural charisma, can make time and have good patient liaison skills
- Have excellent partnership and communication skills, good political awareness and team working
- Understand the need for good financial and business case development
- Use constructive challenge when discussing ideas put forward and interject with innovative service solutions when required
- Will occasionally not know the answer before completing further research.

Patient engagement and critical appraisal of major change by the Local Authority NHS Overview and Scrutiny Community

Patient and public engagement is equally important. Annual operating frameworks include key priorities for the NHS and emphasise the need for the NHS to become better at listening and responding to:

- Patients who use services
- Staff who provide them
- The public which funds them

Primary care trusts (PCTs) are expected to adopt a systematic and rigorous approach to communications with the local population to ensure that there is a better understanding and confidence in local health services. Early and meaningful patient involvement will empower patients to share their views and this can successfully drive forward projects that lead to real improvement.

Local authority review to confirm that changes will lead to improved services in line with the latest principles outlined in documents such as the NHS constitution is important.

What are the main risks to modernising services?

- Public health messages regarding prevention of type 2 diabetes need to be highly effective, innovative and targeted at high risk, socially deprived and difficult to reach groups such as ethnic minority populations. Public Health is a joint responsibility of health with local authorities and the financial outlook for this latter sector is challenging
- A number of NHS service strategies aim to provide care closer to home. This means that resources in primary care must be strengthened to accommodate the changes and initial and on-going training must be provided in this area to develop and sustain expertise.
- Modernisation of services is very dependent on the service user having trust and confidence in the new proposals. New proposals must have integrity, ie if a patient's condition changes and more specialist care is required this must be made available
- Changes should be managed by experienced project managers
- There may be a lack of robust data for business case preparation and it is important that supporting resources from the finance, human resources and estates disciplines are engaged in the development of a preferred option, the implementation of the service change and the post project evaluation
- Strategic change or pump priming funding has to be found to manage significant service changes to secure an invest to save proposal
- Services have to be provided around the needs and preferences of patients. Highly effective public engagement strategies should be in place to counter the perception that changes are driven simply by the need to reduce spending rather than to improve quality
- Media training for clinicians and visits arranged for service users to centres of excellence and innovation are good initiatives.

Diabetes represents one of the most significant challenges to the National Health Service. Progress has been made towards the implementation of a National Service Framework by 2013 and it is very important to see this fully implemented to improve services for those living with diabetes and to ensure that health outcomes are improved and that services are both sustainable and affordable for the NHS for the longer term.

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