SERVICE IMPROVEMENT AND DELIVERY

IMPLEMENTING LOCAL DIABETES NETWORKS

NHS

Diabetes

DIABETES UK

CARE. CONNECT. CAMPAIGN.

CONTENTS

PREFACE

The NHS in England is undergoing arguably the biggest reorganisation in its history while also facing a unique set of funding challenges. There is a great deal of uncertainty in the service as we anticipate the new commissioning structures in development.

Such unprecedented change comes at a time when the NHS must tackle the ever-greater challenge of diabetes, its prevalence growing at an alarming rate.

Diabetes is a complex condition. Type 1 and Type 2 diabetes require different organisation and management to meet the individual needs of the adults, children and young people and carers living with these conditions.

People with diabetes are also at risk of developing devastating health complications such as heart disease, stroke, blindness, kidney disease and neuropathy, which often lead to amputation.

These factors combine to make diabetes very expensive. In 2011, NHS spending on diabetes topped £10 billion. Of this total, as much as 80 per cent was spent on complications. The escalating costs, both monetary and human, cannot be ignored. Clearly, there is much to be done, and with increasingly strained resources. But there is no argument about what is needed. The NHS must focus on co-ordinating its resources more effectively to deliver integrated care through joined-up services, reducing duplication, tackling variation and raising standards to improve quality and outcomes.

That calls for change. It calls for a new attitude and a new way of working. It calls for health and social care professionals to work in partnership with people with Type 1 and Type 2 diabetes and their families to deliver the structured, personalised and integrated care that truly supports effective self-management, improving quality of life and reducing the burden on the NHS.

It calls, too, for having in place the right commissioning structures, effective procedures and clear channels of communication that connect people with diabetes with both the routine and specialist care they need – when they need it.

Local diabetes networks are made up of primary, community and specialist care, public health and local authority representatives, health commissioners and people with diabetes working in active partnership. Now, in the face of current upheaval and uncertainty, it is time they came to the fore. Working in parallel with emerging Strategic Clinical Networks (SCNs), they have a significant role to play in providing leadership and driving service redesign locally to achieve better value and improved quality of care.

Implementing Local Diabetes Networks provides diabetes commissioners with the guidance and support they need to create the local diabetes networks that really can deliver high-quality, cost-effective care through the effective commissioning, organisation and monitoring of services.

There are always risks associated with change. But the risks associated with not engaging all those in the diabetes community in raising standards, and improving outcomes for people with diabetes and their families, are far greater. It is through working together, using our shared skills, knowledge and experience that we can bring about the change that is needed.

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EXECUTIVE SUMMARY

Cancer, Cardiac and Stroke networks have demonstrated that working in collaboration can be a successful method to improve services and open up relationships between stakeholders across the patient pathway.

http://www.improvement.nhs.uk/stroke/StrokeNetworks/tabid/55/Default.aspx [1]

http://www.improvement.nhs.uk/cancer/documents/breast_surgery/East_Midlands_Breast_Surgery.pdf [2]

In diabetes, networks exist in different formats and have different priorities, but should all have the principle of working in collaboration across a patient pathway to improve outcomes for people with diabetes.

Diabetes UK and NHS Diabetes interpret a local network to be a forum that gathers stakeholders who represent a patient pathway, including people with diabetes.

This forum would:

- enable improvement to take place at a detailed and focused level
- have a shared vision
- have clear informed work plans based on real time feedback from people with diabetes and public health
- open communication channels
- increase transparency
- share resources.

This document aims to provide information and support to commissioners to give a further understanding of the need for such an intervention and how to go about establishing a local diabetes network in their area.

The NHS faces two massive challenges: (i) delivering high quality care to the increasing number of people with diabetes and (ii) the twenty billion pound QIPP. We all need to learn from best practice examples such as Cancer, Cardiac and Stroke networks to find ways of improving services with a small amount of resource. This report, *Implementing Local Diabetes Networks*, can be used to support this aspiration.

WHY YOU CAN'T AFFORD NOT TO HAVE A DIABETES NETWORK

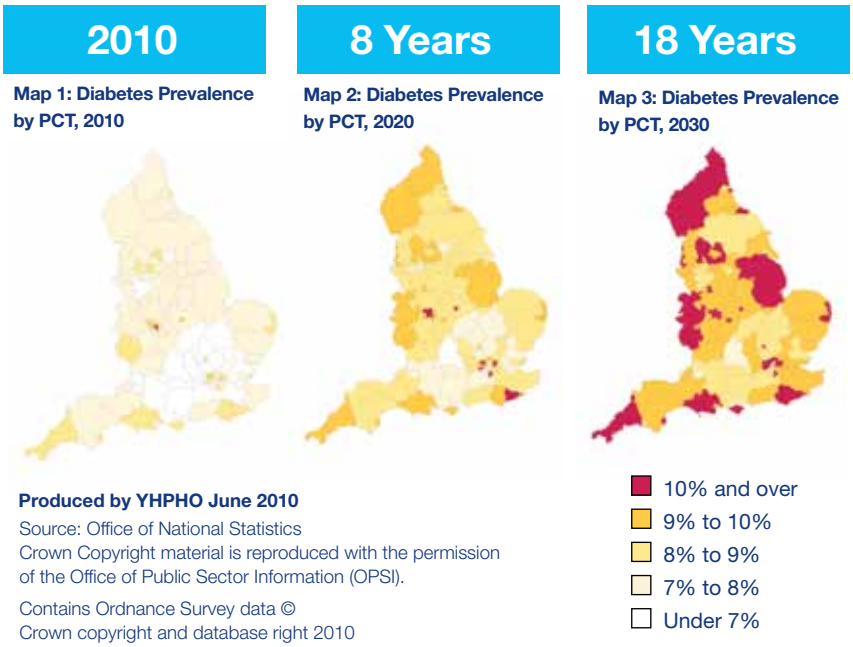
Diabetes is big, and it's growing

Every three minutes someone in the UK learns that they have diabetes[3]. Right now there are 2.5 million people in England living with the condition, and estimates suggest a further 850,000 people in the UK have diabetes but are either unaware or have no confirmed diagnosis[4].

A further seven million people could be at high risk of developing diabetes, and this number is rising dramatically every year. If current trends continue, by 2025 it is estimated five million people in the UK will have diabetes. 10 per cent of people have Type 1 diabetes and 90 per cent have Type 2 diabetes.

Increasing prevalence in England

Prevalence of diabetes expected to increase significantly



Produced by YHPHO June 2010

Source: Office of National Statistics
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Contains Ordnance Survey data ©
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County	Prevalence	Number of people
England	5.5 per cent	2,455,937
Northern Ireland	3.8 per cent	72,693
Scotland	4.3 per cent	223,494
Wales	5.0 per cent	160,533

UK average = 4.45 per cent

For further information see the link below:

http://www.diabetes.org.uk/Professionals/Publications-reports-and-resources/Reports-statistics-and-case-studies/Reports/Diabetes-prevalence-2011-Oct-2011 [5]

Diabetes is expensive

- NHS spending on diabetes was almost £10 billion in 2011, or £1 million per hour, which is 10 per cent of the NHS budget.
- 80 per cent of NHS spending on diabetes goes into managing avoidable complications.
- People with diabetes account for around 19 per cent of hospital inpatients at any one time, and have a three-day longer stay on average than people without diabetes.
- Most of Type 2 diabetes costs are due to hospitalisation[6].

	Activity	Expenditure
Excess admissions	164,361 admissions	£434 million
Lower day case rate	41,906 fewer day cases	£9 million
Excess cost during admission	4.3 per cent	£129 million – £243 million
Total	5.0 per cent	£573 million – £686 million

Table A: Estimated excess expenditure on inpatient care for people with diabetes 2009-10[7]

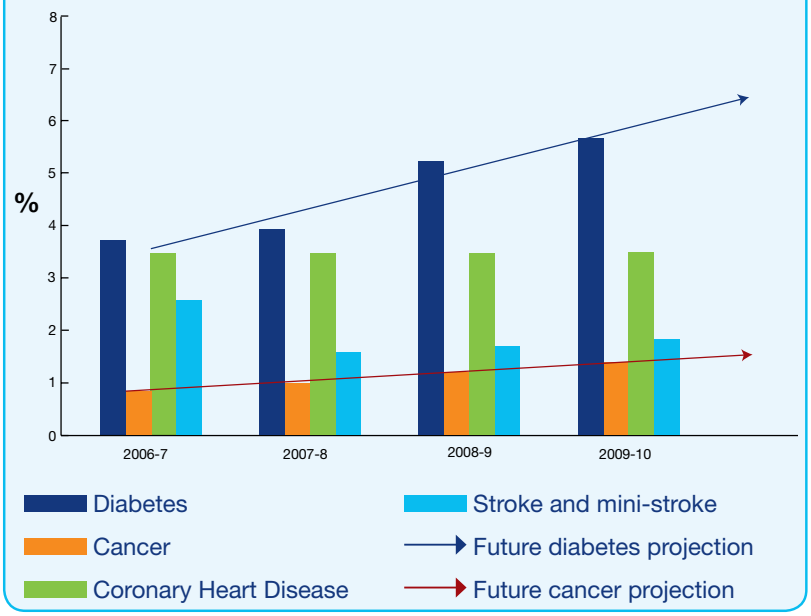
Diabetes is serious

People with diabetes also run a greater risk of developing one or more severe health complications, which can greatly impact on their independence, quality of life and economic contribution to society.

In the UK, diabetes is the leading cause of blindness in working-age people[8 9], and a main contributor to kidney failure, amputations and cardiovascular disease, including heart attack and stroke[10]. One in five children who has Type 1 diabetes will be at increased risk of developing diabetic ketoacidosis (DKA)[11], a critical, life-threatening condition that requires immediate medical attention.

Many of these complications are avoidable with good risk assessment and early diagnosis, patient education, support and good on-going services. Estimates show that of more than 100 amputations carried out each week from diabetes complications[12], up to 80 per cent are preventable[13].

Prevalence of diabetes was nearly four times higher than prevalence of all cancers combined (Figures 2006/10)



State of the Nation (2012)

Between 2006 and 2010, there was an increase in unnecessary complications[14].

- Retinopathy increased by 118 per cent
- Stroke increased by 87 per cent
- Kidney failure increased by 56 per cent
- Cardiac failure increased by 43 per cent
- Angina increased by 33 per cent
- Amputations increased by 26 per cent

The prevalence of diabetes is nearly four times higher than the prevalence of all cancers combined and is still rising[15]. If we are to curb this growing health crisis and reduce deaths from diabetes and its complications, awareness, early identification and prevention of diabetes must be prioritised by national and local health systems.

WHAT CAN CCGs DO TO IMPROVE DIABETES SERVICES?

Stroke networks have transformed the way services are delivered, leading to measurable improvements in both outcomes and experience for patients. Cancer networks have raised standards, supported easier and faster access to services and encouraged the spread of best practice. This is due to the Department of Health funding networks that act as a mechanism to support and implement the national plans for these specialities.

We want to build on the success of networks and ensure that the NHS Commissioning Board and clinical commissioning groups have access to a broad range of expert clinical input to support and inform their decisions about the way care for local populations is planned and delivered[16].

Networks have been identified as a method of facilitating service improvement and making care integrated across local health economies. Addicot et al (2007) believes a network can be defined as:

Formal and informal communications between diverse, but related, organisations to manage the flow of public services across the whole area of service provision. This flow is also achieved through sharing resources, such as equipment, technology, knowledge and expertise[17].

The NHS Commissioning Board (NHS CB) fully supports the use of clinical networks, whatever their formality, function or funding. It states that networks are groups of health professionals, hospitals and other providers and commissioners that have collaborated to make improvement in their local area, in a particular pathway for a particular group of patients[18].

The NHS CB has featured different types of networks in their new commissioning system, including operational delivery, professional and local networks. They clearly state that local networks should be resourced by CCGs to support the achievement of local priorities and ways of working.
See http://www.commissioningboard.nhs.uk/2012/07/26/strat-clin-networks/ for further details[19].

The local diabetes network will be a place that will gather local stakeholders from different organisations to work collaboratively. Expertise from the group can support informed commissioning decisions, ensure that service delivery processes are reviewed and actions taken to make them efficient and effective.

WHY DO YOU NEED A DIABETES NETWORK?

The National Service Framework Diabetes: Delivery Strategy (2003)[20] states that in developing integrated services PCTs (now CCGs) should consider putting robust mechanisms in place to reach standards. The NHS CB[21] also states there is evidence and/or rationale that the quality improvement required can be achieved through a network model.

Please see 'Care standards' (in Appendix 1 on page 16) for further information of what diabetes services should be achieving.

Local diabetes networks can:

- engage all stakeholders, including clinical staff, managers and people with diabetes
- work across traditional service boundaries
- have clear lines of accountability
- demonstrate excellence in leadership and management
- share knowledge and expertise and use this to make improvements.

Clinically-led, managed diabetes networks, actively involving people with diabetes, provide the means to embed these principles in practice. A network provides structure for service planning and delivery, promotes integrated care and supports staff by targeting resources where they are most needed.
A network can bring:

- specific knowledge of the needs of the local diabetes population
- the relevant data sources to inform needs assessment and support to analyse it
- involvement of people with diabetes and their carers to inform service design
- assistance with designing and agreeing the local model of care
- assistance with service delivery monitoring and review.

This can result in:

- cost-effective services
- improved patient experience
- improved clinical outcomes
- integrated care
- equity of service provision[22].

The Association of British Clinical Diabetologists (ABCD) surveyed their professional members in October 2012 about service issues and diabetes networks. The following findings were collected from the survey:

- 62.3 per cent stated that they have a diabetes network in their area.
- 73.2 per cent of the respondents that do not have a network said that it had recently been disbanded.
- 95.1 per cent believe that a network can be used as a service improvement methodology.

Some members stated that they felt that networks could support service improvement by:

- integrating and coordinating care
- sharing practice
- getting all the right stakeholders around the table
- providing and sharing expertise
- improving communication between diabetes pathway stakeholders.

This shows that healthcare professionals are clearly in favour of local diabetes networks as a service improvement methodology and people with diabetes support networks too:

"I believe the diabetes networks have been an essential vehicle that should sit at the very centre of service development and performance evaluation. In the words of the GP lead in Berkshire West, "we have achieved more in the last three months than the previous five years."

Berkshire West Diabetes Network

The NHS CB believes that clinical networks have been responsible for making significant improvements, especially in the areas of cancer and stroke. As a result of these improvements they have now introduced four Strategic Clinical Networks (SCN) and diabetes will be part of the Cardiovascular Disease SCN. They will exist for five years and their improvement programmes will depend on the area they are located in. Part of the SCN's remit will be to coordinate patient pathways over a wide geographic area and reduce the amount of variation in services. They will have strategic overview of a variety of all four SCNs and will work to build relationships to deliver the NHS Outcomes Framework agenda under five domains, but will not be operational, hence requirements to have operational networks for diabetes to implement service improvements needed[23].

In order for the regional SCNs to be effective local diabetes networks will need to have clear links to these bodies so that regional plans can be delivered into local action and then tailored to suit that area to deliver improvement in diabetes services. Local diabetes networks will be able to facilitate support and gather relevant stakeholder expertise together to deliver and implement the improvement plans.

Local diabetes networks should also be working closely with Local Action Teams (LATs) who will be responsible for commissioning GP services. A representative from the LAT should be part of the network due to their commissioning responsibilities.

https://www.wp.dh.gov.uk/commissioningboard/files/2012/06/lat-senates-pack.pdf [24]

Diabetes networks represent an effective and necessary vehicle to fill the potential gap in supporting the commissioning of diabetes care and services in the new NHS structures, including support to and coordination between clinical commissioning groups[25].

DIABETES NETWORK ESSENTIALS

A diabetes network provides the means to lead the planning, provision, monitoring and quality improvement of effective diabetes care at a local level. It is the collaboration between the range of relevant stakeholders that provides the expertise and impetus for the development of quality services as well as the links between different organisations, perspectives and disciplines to create a common vision.

The key stakeholders for a local diabetes network (and their main responsibilities) are:

- Network Chair* – senior role who is able to lead and hold stakeholders to account
- Clinical Lead* – provide clinical leadership to other stakeholders and work closely with the network manager
- Network Manager* – provide leadership for management and network teams, coordinate organisations in planning and providing improved care as well as maintaining the momentum of the network to ensure improvement plans are delivered
- Provider representative – from primary, secondary and community to inform commissioners of any system issues and provide expertise when required. Paediatric representatives should be included to manage issues around transitional care.
- CCG representative – provide commissioning insight and gain knowledge from stakeholders around system issues to inform commissioning decisions
- LAT representative – inform stakeholders of their commissioning responsibilities. The LAT acts as a conduit between the LAT and stakeholders to inform commissioning decisions
- User representatives* – to provide experience of services and use this to inform improvement plans
- Diabetes UK regional manager – experience of involvement in diabetes networks, local health intelligence, stakeholder engagement links
- Health and Wellbeing Board/Public Health representative – has access to local health intelligence to inform commissioning decisions and service provision as well as focusing on the prevention agenda
- Dietetic representative – inform the network group of any system issues, service gaps or referral issues
- Retinal screening representative – inform the network group of any system issues, service gaps or referral issues
- Podiatry representative – inform the network group of any system issues, service gaps or referral issues
- Admin support – take minutes, organise meetings, book venues and circulate papers
- Local authority/HWB representative – to ensure that diabetes care is fully integrated with social care

**Key leadership roles that are vital to the success of the network*

See ‘What is needed to make a diabetes network effective?’ on page 14 for further details.

These stakeholders are core to the network membership board and if they cannot attend they should ensure a deputy attends in their place. Whole network meetings should be once every two to three months and if separate work stream/project groups are created to complete actions they should meet more often. A meeting every six to eight weeks is recommended. If individuals cannot attend in person and do not have a replacement they could attend by teleconference. All meetings linked to the network need to be at regular intervals to ensure that the momentum of the work plan is continued and actions completed.

WHAT CAN DIABETES NETWORKS DO FOR CCGs?

The Health and Social Act 2012[26] states the NHS exists to secure improvement in the physical and mental health of the people in England and to prevent, diagnose and treat illness.

CCGs are expected to commission services that reflect the needs of patients through involving them in service planning, design, commissioning and improvement. If this does not happen the HWBs can raise concerns to the NHS Commissioning Boards if commissioning plans are insufficient.

The standards that CCGs are expected to accomplish can be attained by the use of a local diabetes network to establish and maintain relationships with key stakeholders. These stakeholders can support the development and implementation of service improvement plans and the creation of commissioning plans by having the clinical and patient engagement to lead the drive for improvement.

Diabetes networks are crucial for the successful commissioning and implementation of services which meet diabetes care standards (see Appendix 1 on p16).

A local diabetes network has the potential to achieve the following (see Appendix 2 on p18 for further evidence of improvement):

- Translate national policy into local action – provide a forum and support mechanism for CCGs to deliver on national and local care standards and provide channels to disseminate this information to the local health economy – see Appendix 1.
- Commission services that reflect the population need – by engaging with Health and Wellbeing Board and Public Health representatives, data will be gathered to inform commissioning and delivery of diabetes services decisions. People with diabetes will also be able to provide patient experience to inform the CCG of their experiences, ensuring that CCGs are engaging with people with diabetes as part of their remit.
- Incorporate best practice – from expertise of network stakeholders, this encourages shared learning and the ability to resolve issues that may arise.
- Define priorities which are reflected into a detailed work plan that is reflective of national, local and service user priorities and provide the forum to achieve those objectives.
- Provide a forum to redesign services, such as the hypoglycaemia pathway in a network in the North West, where people with diabetes, commissioners and the ambulance service used the Merseyside Diabetes Network as a forum to create a pathway based on patient feedback.
- Provide a forum and mechanism to involve people with diabetes as part of the CCG remit as specified by the NHS NCB.
- Improve stakeholder relations – bridging the gap between providers and commissioners especially in a state of flux. The network will increase transparency and accountability of the local health system. It will also provide a forum of support for healthcare professionals and commissioners.
- Improve services to reduce variability in health care provision – by understanding the local population need and gathering local intelligence from stakeholders tailoring commissioning intentions can improve patient outcomes and improve the cost effectiveness of the service.
- Improved data quality – increase uptake of stakeholders contributing to National Diabetes Audit (Inpatient and Core) http://www.ic.nhs.uk/nda[27] and completing local audits to inform work plans, service redesign and measure improvement through the creation of a local dashboard.

- Service redesign – introducing an integrated foot care pathway to address high level of amputation rates based on data collection gathered through audits and local intelligence.
- To work with CCG agendas in achieving the goals of:
  - integrated care
  - improved clinical outcomes
  - cost-effective services
  - reduction of duplication
  - improved patient experience
  - equity of service provision.

Another successful example of local diabetes networks is the Wakefield Diabetes Network where they redesigned diabetes services to be delivered in primary and community care which was driven through the local diabetes network. This example of best practice can be reviewed at:

http://www.practicaldiabetes.com/SpringboardWebApp/userfiles/espdi/file/September%202011/Nagi%20online.pdf [28]

WHAT IS NEEDED TO MAKE A DIABETES NETWORK EFFECTIVE?

The key objective of the NHS CB and CCGs is to drive up the quality of services and use networks as a method to do so; they will be able to establish and retain clinical networks, for specific conditions or patient groups to assist them in achieving their core purpose of quality improvement[29].

Effective leadership is a key requirement for any network. Influencing and negotiating are crucial when attempting to work within a virtual organisation with little direct authority over others. The roles below should support the network to achieve objectives and keep momentum to drive forward change. All network stakeholders have responsibility to maintain the network and these roles should support them.

The key leadership roles in the network are[30]:

- Network Chair – the chair should be of a senior executive level to ensure that there is appropriate representation on the network and they represent the executive community and have the authority to make decisions.
- Network Manager – provide leadership for management and network teams, coordinate organisations in planning and providing improved care as well as maintaining the momentum of the network to ensure improvement plans are delivered to drive improved diabetes services.
- Clinical Lead – provides clinical advice to the network stakeholders and works with the network manager to implement service changes. This role like other clinical roles should be a conduit of two way communication between the network and clinical teams outside the network and should have the authority to make key decisions.
- User representatives – promote and facilitate user involvement to ensure all decisions and plans are made in collaboration with people with diabetes, so that the local diabetes population is reflected in commissioning and delivering diabetes services.

To ensure the sustainability of the network there will be a need to develop other stakeholders including people with diabetes. This may be achieved through assigning key tasks or small projects for others to lead on. This not only helps individuals within the network to develop, but also fosters a greater degree of accountability and responsibility that compels action. The success of the network is dependent upon the engagement of each of the network partners in taking forward the network strategy.

Cost

There will be a cost in order to establish and maintain a local diabetes network, but this will vary on the size of the population and commissioning area in question.

The main costs will be:

- Network Manager – band 8a/8b, full or part-time, part time dependent on the local network remit and area
- Network support (if necessary) – band 6–8a dependant on remit and area
- Travel expenses for people with diabetes to attend network meetings
- Admin support – band 3, part time
- Clinical lead – sessional reimbursement (locally defined and agreed)

These costs can be split amongst the CCGs involved in the local diabetes network. **The costs are insignificant in comparison to the improvements a network can bring and should not be used as a reason not to invest in this method of improvement.**

GETTING STARTED

Identify and agree the need for a network with relevant organisations – formal agreement needed between senior executives from each organisation

A brief outline business case (see Appendix 3 on p20) would state the case for a network and gain 'buy in' from senior members of the relevant organisations

Identify stakeholders – refer to 'Network Essentials' on page 10 to identify who you need on your network, me sure the pathway is represented fully, but remember you don't need to invite everyone!

Define terms of reference (see Appendix 3 on p20) to define roles and responsibilities of the network

Create a clear vision or mission statement. This should be shaped to reflect the network stakeholders

Establish a baseline and identify any gaps using data from the NDA, diabetes national policy, JSNA, internal clinical audit and local intelligence from both public health and patient experience

Create an annual work plan to illustrate key activities and actions to overcome and address gaps and local/national priorities of the diabetes service

Produce timely reporting, monitoring and progress reports through an agreed communications management strategy, checkpoint report and highlight report (see Appendix 3 on p20)

APPENDIX 1

CARE STANDARDS TO DELIVER HIGH QUALITY AND INTEGRATED DIABETES SERVICES

THE NHS MANDATE

The first mandate between the Government and the NHS Commissioning Board which sets out the ambitions for the health service. Structured around five key areas where the Government expects the NHS Commissioning Board to make improvements; and will be judged against.

THE NHS OUTCOMES FRAMEWORK

A set of national outcome goals and supporting indicators. It exists to provide a national level overview of how well the NHS is performing, to provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board, and to act as a catalyst for driving quality throughout the system.

THE COMMISSIONING OUTCOMES FRAMEWORK

A translation of the NHS Outcomes Framework into indicators that is meaningful at a commissioning group level. The Commissioning Outcomes Framework will act as a mechanism for the NHS Commissioning Board to drive improvement as well as hold Clinical Commissioning Groups to account.

THE PUBLIC HEALTH OUTCOMES FRAMEWORK

CCGs will work alongside local partners on health and wellbeing boards, including Directors of Public Health, to agree the Joint Health and Wellbeing Strategies and to reflect those strategies in their local commissioning plans.

THE ADULT SOCIAL CARE OUTCOMES FRAMEWORK

The framework has been strengthened with new measures and has been further aligned with the **NHS Outcomes Framework** and the **Public Health Outcomes Framework,** supporting all parts of the health and care system to work together to support people to live better for longer.

QUALITY STANDARDS

Diabetes in Adults Quality Standard

Clinical Commissioning Groups must also have regard to the Quality Standards produced by NICE as part of the Health and Social Care Act.

The Quality and Outcomes Framework: an existing framework (before the reforms, from 2003) incentivises quality care at GP level and is part of the GMS Contract, which the NHS CB will assume responsibility for.

*Click the headings above to link to the NHS Mandate, Frameworks and Standards online

Guidance sources

- Diabetic foot problems: inpatient management of diabetic foot problems. NICE clinical guideline 119 (2011; NHS evidence accredited). Available from www.nice.org.uk/CG119
- Type 2 diabetes: the management of type 2 diabetes. NICE clinical guideline 87 (2009; NHS Evidence accredited). Available from www.nice.org.uk/CG87
- Diabetes in pregnancy: management of diabetes and its complications from pre-conception to the postnatal period. NICE clinical guideline 63 (2008; NHS Evidence accredited). Available from www.nice.org.uk/CG63
- Type 1 diabetes: diagnosis and management of type 1 diabetes in children, young people and adults. NICE clinical guideline 15 (2004; NHS Evidence accredited). Available from www.nice.org.uk/CG15
- Type 2 diabetes: prevention and management of foot problems. NICE clinical guideline 10 (2004; NHS Evidence accredited). Available from www.nice.org.uk/CG10
- Liraglutide for the treatment of type 2 diabetes mellitus. NICE technology appraisal 203 (2010; NHS Evidence accredited). Available from www.nice.org.uk/TA203
- Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus. NICE technology appraisal 151 (2008; NHS Evidence accredited). Available from www.nice.org.uk/TA151
- Guidance on the use of patient-education models for diabetes. NICE technology appraisal 60 (2003; NHS Evidence accredited). Available from www.nice.org.uk/TA60
- Joint Department of Health and Diabetes UK Care Planning Working Group (2006) Care Planning in Diabetes. Available from www.dh.gov.uk
- Joint Department of Health and Diabetes UK Patient Education Working Group (2005) Structured Patient Education in Diabetes: Report from the Patient Education Working Group. Available from www.dh.gov.uk

APPENDIX 2

MERSEYSIDE DIABETES NETWORK, IMPROVEMENTS TO DATE[31]

- Supporting CCGs with development of relevant local service specifications, redesign and implementation of pathways etc based on needs of local service users
- Twelve month work programme developed in conjunction with service user, local and national priorities
- Development and maintaining a local website www.northmerseydiabetes.nhs.uk
- Network communication strategy
- Part of a national Diabetes UK/ NHS Diabetes user involvement project – developed sustainable user involvement forum with patient representation on board and task and finish groups
- Merseyside cluster wide insulin pump service specification-"ABCD, JDRF and Diabetes UK have commissioned a UK wide audit for CSII/CGMS. The project is being led by a Merseyside group of physicians led by Philip Weston (Consultant Physician and Diabetologist, The Royal Liverpool and Broadgreen University Hospitals NHS Trust
- Successful QIPP bid to pilot use of CGM in CSII Pregnancy cohort-a high risk group
- Established baseline diabetes service costs with five year projected spend in readiness for CCGs taking over commissioning functions
- Development of diabetes health needs assessments for three PCTs which have informed recommendations for improvements at a local level and annual workplan
- Development and dissemination of clinical guidelines for the management of diabetes and agreed referral criteria to specialist services by all partner organisations
- Development and roll out of cluster wide hypoglycaemia pathway in conjunction with NWAS – Quality in Care award winner-partnership working and best emergency initiative November 2011. Now rolling out nationally
- Following service user requests development and roll out of non fasting lipid protocol
- Retinal screening social marketing project resulting in development of local resources improvement of uptake and development of user friendly invite processes and correspondence
- Development of IGR pathway in conjunction with service users, public health and lifestyle commissioners – Cluster wide business case with options appraisal developed for CCG Board consideration on local implementation, linking closely with NHS Health checks delivery. Successful QIPP bid to undertake insight work and development of IGR clinical guidance.
- Integrated Foot care pathway approved. Ongoing developments within secondary care in patient teams to address high minor amputation rate. Successful bid via HIEC to support relaunch of foot care pathway with development of foot screening DVD and foot screening e-learning tool
- Development and delivery of diabetes webinars via Cheshire and Mersey HIEC supporting the delivery of the networks diabetes staff education strategy
- Delivery of locally developed MSC modules for diabetes at John Moores University
- Secondary trusts participating in annual national in patient audit

- Increased uptake in CCG practices submitting data to annual National diabetes audit with year on year improvements in treating to target
- Development and roll out of locally agreed diabetes specific KPIs across Merseyside with localised dashboard to monitor performance at a local level and supporting educational developments in primary care
- Development and Cluster roll out of insulin passport in line with NPSA guidance
- Supporting CCGs with diabetes relevant CQUINS based on audit evidence
- Completion of numerous local audits across the network area ie DKA, hypoglycaemia, resulting in development plans for improvements and wide scale service redesign

APPENDIX 3

TEMPLATES

Outline business case template

Section	Detail
Reasons	Why do you need a network and how will it help you achieve organisational objectives and improve diabetes care in your area?
Business options	Three options; do nothing – nothing improves, do minimal – start to engage with organisations informally to discuss service issues, start a network.
Expected benefits	What is the network going to achieve in your area? What can networks do for you?
Expected negatives	Perceived negativity by individuals e.g. too many meetings, travelling off-site.
Timescale	When will the network be launched and when will you see the benefits?
Costs	How much will the network cost to run? Network manager role, venue hire, travel expenses
Major risks	Summary of what may stop the network working; failing to engage the correct stakeholders, stakeholder availability to meet regularly

Terms of reference template

This document will be given to the network stakeholders so they know their roles and responsibilities.

Section	Detail
Background	Which organisations are part of the network?
Purpose of the network	What are the objectives of the network
Members of the network	Who are your stakeholders
Roles and responsibilities	What do you expect from each of the stakeholders, expertise
Commitment expected from stakeholders	Time, resources, frequency of meetings and their contribution
Reporting	Methods of reporting progress from different work streams – highlight reports monthly, checkpoint reports every week
Review date	How often does this document need updating ?Annually?

Communications management strategy

A document containing a description of the means and frequency of communication between the network members and also any external stakeholders.

Section	Detail
Introduction	Objectives, scope and purpose of the document
Communication procedure	Communication methods – email phone call, highlight reports
Reporting	When, to which audience and the purpose of communication reports will be created and circulated
Timing of communication activities	Formal communication methods to be sent out
Roles and responsibilities	Who will be responsible for particular communication activities?
Stakeholder analysis	What do stakeholders need to know and when?
Information needs for stakeholder party – from above	Frequency, means and format of communication. Information provider and recipient

Checkpoint report

A progress report given to the work stream manager or the person who will represent the project group at the network meeting.

Section	Detail
Date	Date of report
Period	The time that the progress report is covering
Follow ups	Items outstanding from previous report, completed actions or outstanding issues
This reporting period	The products being created. The actions that have been completed and lessons learnt to inform others
Next reporting period	The products to be created, what is expected to be completed
Work package status	How the execution of the products are performing against cost and timescales
Issues and risks	Any issues or risks

Highlight report

A report to update the executive level of the network delivered by the network manager to CCG and provider executives.

Section	Detail
Date	Date of the report
Period	The period the report covers
Status summary	Overview of the work programmes
This reporting period	What actions and products completed, what has not been achieved
Next reporting period	What work will be completed in the next reporting timeframe? What corrective actions may need to be completed?
Work/project status	How the execution of the products are performing against cost and timescales
Requests for change	Are there any time or cost tolerances that need to be changed?
Key issues and risks	Potential problems or risks to the work
Lessons report	What went well? What went badly? Is there any information that can be shared with other work areas?

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If you would like any further information or support please contact the Service Improvement Team at Diabetes UK on improvement@diabetes.org.uk

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