Buried treasure: making the most of the NSF for Diabetes

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ARTICLE POINTS

1 On close examination of the NSF there is some indication of where funds may be available.

2 The national retinal screening programme is due to be completed by 2006.

3 The Department of Health's Long Term Conditions Care Group Workforce Team and the NHS Modernisation Agency are two sources of possible funding.

4 Clinical champions may be an opportunity to get involved and influence diabetes care and perhaps get paid for doing so.

5 The NSF for diabetes could represent the biggest change in the provision of diabetes care since the mini-clinics of the early 1990s.

KEY WORDS
- **Funding**
- **Education**
- **Prevention strategies**
- **Quality points**

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Introduction

The second part of the National Service Framework for Diabetes Delivery Strategy was released on 9 January 2003. This completes a process started some years earlier when the government first announced the NSF. This article discusses some avenues where money might be hidden within the NSF and how to go about accessing it.

The initial enthusiasm about the announcement of the NSF was soon tempered with suspicion, dismay and cynicism as each stage of the process was delayed, amended or revised.

The sense of disquiet was heightened with the delayed publication of *Part 1 – Standards*, in December 2001. In what was perceived by many to be a rather woolly document, high on promise yet thin on substance, there were the first indications that there would be insufficient funding to ensure success of the strategy. As time went by, and the release of the delivery strategy was repeatedly postponed, even the most optimistic healthcare workers began to realise that there would be no new pot of gold with which to deliver much needed improvements in diabetes services.

Upon its release there were predictable criticisms about resource issues. There was no 'ringfenced' money, and the implicit suggestion was made that diabetes services would have to join the other treasure hunters besieging cash-strapped primary care trusts (PCTs). There is a trite acknowledgement in the document itself that:

'some elements of the Diabetes NSF require additional resources across primary, community and specialist care.' (*section 6: paragraph 7*)

However, if we examine the document more closely, there are some clues which might enable us to squeeze funds from a variety of sources; the 'buried treasure' of the NSF.

Not-so-buried treasure

First of all, let us examine the not-so-buried funds. A national retinal screening programme is promised by 2006.

'Capital funds to support the purchase of digital cameras and related equipment for retinal screening will be available to generate a step change in services.' (*section 6: paragraph 10*)

Note two important phrases:

(1) 'Capital funds' (this means the initial purchase only) and 'revenue funding' (the running costs thereafter). These will have to come from general allocations to PCTs. 'Step change' means just that. If you already have a retinal screening system there is no step change, which means no new funding.

(2) 'General allocation to PCTs' was one bone of contention. No 'ringfenced' diabetes money was mentioned, merely the bold statement that:

'we assume that PCTs will wish...to use the funds made available in baseline allocations...to reach the NSF standards...' (*section 2: paragraph 1*)

Well, we will now have to convince them to do just that. PCTs have been given an uplift in spending and will receive further promised uplifts. Diabetes services and initiatives have every right to lay claim to some of this money, especially given the preparatory work that will be necessary to meet the standards. We should not be put off by the argument that PCTs have overspent. All legitimate business cases deserve attention and consideration. PCTs will have an average increase in resources of 7.4% above inflation over the next 5 years and will control 75% of the NHS budget (*section 6: paragraph 8*). They should be our first port of call.

Secret societies

The NSF recognises that:

'more staff will be needed to meet the growing expectations within diabetes services, and as the number of people with diabetes continues to rise.' (*section 2: paragraph 26*).

It makes reference to the Department of Health's Long Term Conditions Care Group Workforce Team (CGWT) several times in the text. We need to know more about this group, and whether it has a separate source of funding into which we can tap. There are changing workforce programme pilots starting with diabetes, which will look at new ways of working to improve services and tackle staff shortages (See www.doh.gov.uk/cgwt).

Another secret society, the NHS Modernisation Agency is also mentioned several times, particularly in relation to setting up the diabetes networks and workforce skills profiles. We are reassured that changes in these areas 'will be centrally supported'. This suggests yet more hidden piles of cash which need the right access password.

There will be a small number of 'rapid learning sites' again supported by the NHS Modernisation Agency. It might be worthwhile finding out how to become involved, as there is sure to be money tied into it, either central or ringfenced locally. *Section 6 paragraph 4* gives more details which can also be found on this website: www.modernhs.nhs.uk.

Clinical leadership will be crucial in driving the NSF forward. 'Clinical champions' will become important voices in the diabetes network. Presumably these posts will be funded, and will represent an opportunity for those in primary care with an interest in diabetes to become involved and influence, and to get paid as well.

Education, training and research

Education and training are recurrent themes in the NSF. PCTs are urged to work with Workforce Development Confederations to undertake workforce skills appraisals and to develop education and training programmes. Does this mean new opportunities for training posts? An interprofessional resource pack has been published by the Department of Health to support learning and development in delivering NSF standards, at practice and PCT levels. You can find this resource pack on the following website: www.natpact.nhs.uk.

For those with an interest in research, there is a section in the NSF (*section 6: paragraphs 28–30*) detailing the sorts of areas (for example prevention of type 2 diabetes and screening) which may attract funding from the Medical Research Council, following their recent review of research on diabetes (DoH, 2002). Primary care is often seen as the poor relation in research matters, but it is perhaps best placed to undertake such work, particularly if local diabetes research networks are established in conjunction with proposed diabetes networks. It only takes the courage to submit a bid.

Prevention strategies, ironically, are dealt with at the very end of the document, where current national initiatives are listed (*section 6: paragraph 45*). There is funding available for 66 PCTs to deliver five-a-day fruit and vegetable programmes. There is £581 million available in the physical education and sport programme, which PCTs are invited to become involved in. Also available is £2.5 million for nine community pilots for increasing physical activity. It is mentioned that NHS smoking cessation services have £76 million to spend. Perhaps this is being underutilised in some areas.

The big one

I may be speaking prematurely, as at the time of writing the new General Medical Services (GMS) contract has not been put to the vote. This contract represents far and away the biggest chunk of new money that will be available for diabetes services. Reference is made to this in the NSF (published well in advance of the details of the new contract, highlighting the government's real agenda):

'Practices would have the opportunity to receive additional funding through the achievement of a range of quality standards.'

In theory there are 1 000 'quality points' up for grabs, and it is a testament to the seriousness accorded to the diabetes epidemic, that diabetes accounts for 99 of them (BMA, 2003). Keeping a register, ensuring that patients have HbA_{1c}, cholesterol, blood pressure checks and renal function tests all attract points.

It is my view that primary care will seize this opportunity and run with it. It could be the biggest change in the provision of diabetes care since the mini-clinics of the early 1990s. Although financially driven, the NSF will improve the service that patients with diabetes receive.

Conclusion

So you see, there is money out there. You just have to find it. Often this will entail jumping through a few hoops; other times it may take a bid or a business plan. Those with a plan, an idea, or a sense of direction will benefit the most. Get digging! ■

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4 Primary care may be best placed to undertake research, particularly if local diabetes research networks are established in conjunction with proposed diabetes networks.

BMA (2003) *New GMS contract: investing in general practice*. British Medical Association, London

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DoH (2003) *National Service Framework for Diabetes; Delivery Strategy*. Department of Health, London