Service Specification Number	**02/GMS/0002**
Care Pathway/Service	**Services for Long Term Conditions: Dietetics**
Commissioner Lead	**CCP for General Medical & Surgical**
Provider Lead	**Chris Kennedy/Sam Leonard**
Period	**2013-14**

NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	√
Domain 2	**Enhancing quality of life for people with long-term conditions**	√
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	√
Domain 4	**Ensuring people have a positive experience of care**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

1. Purpose

1.1 Aims

To provide a specialist dietetics service to patients across primary care within Bournemouth, Poole and East Dorset (Purbeck, Christchurch and East Dorset Localities).

To give evidence based advice, assessment and treatment regarding food, nutrition and diet for the promotion of health, prevention of disease and for the diagnosis, treatment and management of nutrition-related disorders.
The service will promote self management of health and wellbeing, contributing to the aims of the long term conditions management teams in reducing exacerbations and preventing unnecessary use of hospital services.

1.2 Evidence Base

The following Department of Health policy documents are of relevance to the Service:

- Transforming Community Services, DH, January 2009
- High Quality Care for All, NHS Next Stage Review Final Report, DH, June 2008
- NHS Next Stage Review, Our Vision for Primary and Community Care, DH, July 2008
- Health Inequalities: Progress and Next Steps, DH, June 2008
- Developing the NHS Performance Regime, DH, June 2008
- NHS Next Stage Review: Leading Local Change, DH, May 2008
- Healthy Weight, Healthy Lives, HM Government, May 2008
- Improving Health, NHS South West, May 2008
- The Strategic Framework for Improving Health in the South West 2008/09 to 2010/11, NHS South West, May 2008
- Long Term Conditions: Compendium of Information, DH, January 2008;

The following NICE guidance is of specific relevance to the Dietetics Service:

- CG32: Nutrition Support in Adults
- CG43: Obesity
- CG61: Irritable Bowel Syndrome
- CG48: Secondary Prevention MI
- CG63: Diabetes in Pregnancy
- CG66: Diabetes (Type 2)
- CG9: Eating Disorders
- PH11: Child and Maternal Nutrition Guidelines
- CG68: Stroke

1.3 General Overview

Obesity

Around 58 percent of type two diabetes, 21 percent of heart disease and between 8 percent and 42 percent of certain cancers are attributable to excess body fat. Obesity is responsible for 9,000 premature deaths per year in England. Almost one fifth of all children under the age of 16 in England are obese. Higher levels of obesity and overweight in the population which have major implications for local health services since obesity significantly increases the risk of all of the main causes or premature mortality and substantially contributes to chronic illness and disability.

The Joint Strategic Needs Assessment (JSNA) identified that Bournemouth and Poole, while affluent when taken as a whole and compared with the UK, include large numbers of people living in at the extreme ends of the social scale. Those at the lower end have a health status similar to residents of the least advantaged boroughs in the UK. In real terms this means that there are significant health inequalities across Bournemouth and Poole, with a difference in life expectancy of nearly eleven years between the least and most deprived wards.

Obesity is both a highly complex issue for society and a costly debilitation lifestyle disease.

The National Institute for Clinical Excellence (NICE) has published a spreadsheet template which enables primary care trusts to estimate the likely numbers of obese patients in their population. Applying local population data gives the following estimates for likely numbers in obese and overweight categories in Bournemouth and Poole:

- 112,000 people are overweight (BMI 25 – 29)
- 63,000 are obese (BMI 30 – 39)
- 4,400 of these being morbidly obese (BMI 40+); (? Update in line with latest JSNA stats)

- Children are defined as overweight or obese if their BMI falls above the 85th and 95th percentile respectively of the reference distribution curve for their age. The estimated total number of Bournemouth and Poole children who are overweight or obese using the NICE template is 15,981 or around 16,000. Data from the National Child Measurement Programme in 2006/07 identified that Bournemouth and Poole have a higher than national average rate of overweight and obesity

- The risk factors for obesity are concentrated in communities in North Poole and Bournemouth (therefore health improvement and lifestyle change should be targeted in public health action areas covering this part of the conurbation).

Low birth weight and children with complex needs

Specific figures and projections are not available with regard to the dietetic needs of low birth-weight babies, children with special needs and children with other health conditions, such as diabetes. Service priorities for these groups; should be taken into account in service delivery and design models.

It is known, however, that the breastfeeding initiation rate in Bournemouth and Poole is good, at 74.8% in 2007/08.

Older People

As almost all chronic diseases and causes of disability increase steeply in prevalence with advancing age, the ageing population for Bournemouth and Poole puts particular pressures on health and social care. This will be of particular relevance to the Dietetics Service when considering the increase in demand for domiciliary care, a growing number of older people with malnutrition and neurological conditions such as Parkinson's Disease and Motor Neurone Disease. The Service is particularly affected by the increasing numbers of people receiving home enteral tube feeding in either their own home or residential/care homes.

Vulnerable Adults

The Service also has an important role to play in the support of patients with learning disabilities, who may be more likely to suffer from certain conditions, and those with mental health problems, including eating disorders.

People with a learning disability are more likely to have greater health and social care needs with poorer outcomes than the wider population. The expected prevalence of learning disability in the population is estimated at 4,312 in Bournemouth and Poole, a significant proportion of whom (around 3,000) may not be known to services or undiagnosed by health and social care agencies.

Other vulnerable groups include those with mental health and addiction problems with:

- more people with liver disease requiring dietary intervention as a result of increasing alcohol intakes;
- Increasing numbers of adults and children with mental health conditions eg dementia, depression, ADHD, disordered eating; many of which would benefit from some dietary intervention;
- increasing numbers of looked after children or children in child protection registers being referred for dietary advice (both underweight and overweight);
- increasing numbers (and currently a considerable unmet need) of people living with food allergy and intolerances.

1.4 Objectives

The objectives of the Service are to:

- provide effective and evidence based nutritional management for patients with clinical conditions, to improve outcomes and prevent further complications;

- prevent or reduce the incidence of nutrition-related illness through evidence based practice and including health promotion programmes;

- develop and inform locality based care pathways and protocols, ensuring an integrated and effective approach to nutrition-related issues;

- act as a specialist resource for health, social care and education professionals, including the provision of education and training.

1.5 Expected Outcomes including improving prevention

The expected outcomes of the service are to:

- reduce ill health related to poor nutritional intake and as a consequence, reduce admissions to acute hospital care;

- enable patients, especially those living with long term conditions, to make improvements to their dietary habits and lifestyle to improve patient-related outcomes;

- improve awareness both amongst health professionals and the wider public of the implications of poor dietary habits/poor nutritional intake on long term health;

- influence attitudes towards nutrition to empower individuals and the local community to make appropriate food and lifestyle choices.

2. Scope

2.1 Service Description

The Community Dietetics Services covers Bournemouth and Poole, together with the Purbeck, Christchurch and East Dorset localities of NHS Dorset. Service provision falls within four broad headings, as set out below.

Clinical

Clinical provision comprises the following elements:

- dietetic clinics in GP practices and at community bases;
- domiciliary and care home visits;
- clinics in special schools;
- input to group programmes, such as pulmonary rehabilitation, diabetes education, and stroke rehabilitation;
- community hospital in-patient services for Alderney, St Leonards , Wimborne , Swanage and Wareham ;
- advice and liaison with the Acute Care Closer to Home and Long Term Conditions teams.

Public Health and Health Promotion

Public health and health promotion comprises the following elements:

- involvement in strategy development, delivery of action plans and ongoing strategy reviews for the Food and Health Strategy, Obesity Strategy (adults and children), Physical Activity Strategy;
- support for the Healthy Schools initiatives, Children's centres, and Healthy Early Years in Bournemouth and Poole;
- education and health promotion activities for patients and the public, where these links to clinical conditions or address health inequality needs.
- Breastfeeding promotion through bosom buddy groups (Purbeck only)

Education and Training

The education and training programme for professionals includes:

- training of health visitors on infant feeding and child nutrition;
- training of care home staff, community hospital staff, community nurses and intermediate care teams in nutrition screening and nutrition support;
- training of practice nurses, primary care staff and leisure services staff in obesity management;
- training of school nurses and health visitors in childhood obesity;
- student Dietitian training and supervision (the University of Plymouth and Bournemouth University);
- lectures to nutrition and sports science students at Bournemouth University;
- other ad hoc talks and lectures as required.

Policy and Guideline Development

Policy and guideline development comprises the following elements:

- child and maternal nutrition guidelines;
- enteral feeding policy and guidelines;
- nutrition screening and malnutrition guidelines;
- prescribing guidelines/formulary for ACBS products;
- obesity care pathway for adults and children.

2.2 Accessibility/acceptability

The Service will cover the populations of Bournemouth, Poole and east Dorset. The Dietetic Service is based in a central office in Bournemouth and Poole with a significant element of the work programme being undertaken on an outreach and domiciliary basis. The core Service operates from Monday – Friday 08.30 – 16.30.

2.3 Whole System Relationships

The service works closely with:

- Other community services and community service providers;
- Palliative care/End of life services;
- Social care services;
- Primary care services including community pharmacies;
- Acute care services;
- Voluntary care agencies;
- Patient , public and carers;
- Nursing and care homes.

2.4 Interdependencies

Community clinics;
Home enteral feeding services;
Poole Hospital NHS Foundation Trust;
Children and Adolescent Mental Health Services;
Long term conditions teams;
School nurses and other school staff;
Health visitors;
General practitioners;
Practice nurses.

2.5 Relevant networks and screening programmes

The Stroke Network
Diabetes Network.
Cancer Network
End of Life NetworK
National Childhood Measurement Programme
Newborn Screening
Maternal weight monitoring Programme

3. Service Delivery

3.1 Service model

The commissioning plans for the NHS Bournemouth and Poole are built around the concept of services that are centrally co-ordinated through a single point of access, delivered by locality based teams, and follow a generic care pathway to avoid duplication and delay.

3.2 Care Pathway(s)
See Appendix:

A – Adult obesity pathway
B – 0 – 3 years childhood obesity pathway
C – Malnutrition pathway

3-18 years obesity pathway

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

The dietetic service will see any patient registered with a GP in Bournemouth and Poole PCT area or with the GP practices in the area formerly covered by South and East Dorset PCT (now Dorset practices in the East). This may include providing a service to a patient outside of the usual boundaries if they are registered with a GP from within the patch. Individual cases that cross boundaries will be negotiated with the neighbouring dietetic services for West Dorset and Hampshire.

4.2 Location(s) of Service Delivery

Services will be provided on a needs basis across the conurbation with a priority being given to providing services in the six public health action areas where the greatest need has been identified.

4.3 Days/Hours of operation

Services will provided Monday to Friday 08.30am to 16.30 pm
Other projects are delivered outside of these hours when required

4.4 Referral criteria & sources

All referrals for adults that meet the access criteria are highlighted in blue

Criteria/Condition	Refer to
Diabetes	
Type 1 Newly diagnosed	Refer to Diabetes Consultant at acute trust. The patient will be referred on to the Diabetes dietitian
Type 2 Newly diagnosed	Refer to Diabetes Education Programme
Established diabetes but with poor control	Refer directly to dietitian Poor control may include erratic BG levels, frequent hypos, excessive weight gain, unintended weight loss.
Impaired glucose tolerance	Manage these patients within primary care
Nutrition support/malnutrition	Screen using MUST and refer to dietitian if MUST>3 or if no improvement after one-two months. Refer direct to dietitian where weight loss due to CVA, cancer, neurological problems
Dysphagia	Referrals must be made to Speech& Language therapist first to confirm diagnosis
Irritable Bowel Syndrome	Give first line dietary advice sheet http://www.bda.uk.com/publications/IBSdietary_resource.pdf and then refer to dietitian

Gastrointestinal conditions **eg -**Coeliac Disease Crohns Disease Ulcerative Colitis	Refer to secondary care clinics at PHT or RBCH. Patient will be referred onto specialist dietitian as part of secondary care team. There may be exceptions for direct referral to dietitian
Food allergy/intolerance	Refer to dietitian either For trial of exclusion diet to assist diagnosis of allergy/intolerance Or for practical management advice for those with established intolerances
Cardiovascular Disease	To be managed in primary care. Dietary information sheets are available from the Dietetic service.
Obesity	• **See obesity care pathway** Patients meeting the following criteria can be referred directly to the community dietetic service. BMI >40 OR BMI >35 plus 1 or more significant co-morbidities or 2 other co-morbidities OR BMI > 30 pre-pregnancy / early stages of pregnancy* OR BMI>35 plus learning disabilities *Significant co-morbidities* Type 2 diabetes Significant family history of type 2 diabetes Uncontrolled high blood pressure Cardiovascular disease, including stroke Sleep apnoea Post treatment for weight related cancers: postmenopausal breast, endometrial, ovarian, gallbladder, prostate and colon PCOS Infertility *Co-morbidities* Controlled high blood pressure Hyperlipidaemia Metabolic syndrome Breathlessness, respiratory disease Gout Musculaoskeletal disease Menstrual abnormalities Gallstones Stress incontinence Psychological: depression, low self esteem •
Disordered Eating	Adults can be referred to the dietitian as part of their treatment, but other psychological support for the patient is essential.
Enteral (tube) feeds	Refer all patients on a nasogastric, gastrostomy or jejunostomy feed
Renal impairment	Stage 1, 2 and 3 chronic kidney disease (especially if raised potassium). Stage 4/5 should be under specialist dietitian

Children (under 16 years)

Criteria/Condition	Refer to
Faddy eaters/poor growth	Only to be referred where intervention (over three months or more) from health visitor has been unsuccessful.
Children overweight/obese	BMI over 98th centile.
Children with familial hyperlipidaemia	Consider referral especially when growth is poor
Children with food allergy/intolerance	Refer to dietitianeither for practical management advice for those with confirmed food allergies/intolerances
Children with disordered eating	Children with suspected eating disorders should be referred to CAMHS team - NOT the dietitian
Enteral (tube) feeds	Refer all children on a nasogastric, gastrostomy or jejunostomy feed

4.5 Referral route

Health and social care professionals refer directly into the service in writing or by fax to the central office.

4.6 Exclusion criteria

Patients not registered by a Bournemouth and Poole or eastDorset GP.
Patients with eating disorders unless they are in receipt of a recognised psychological support therapy.
Patients pre and/or post bariatric surgery where this should be provided as part of the original package of care.

4.7 Response time & detail and prioritization

Patients will be offered an appointment with a dietitian within the national 18 weeks of referral to treatment.
Referrals will be prioritised according to need.

5. Discharge Criteria and Planning

Discharge planning will begin when a person enters the service to ensure appropriate support is in place on discharge in line with the appropriate care pathway being followed.

Patients should be regularly reviewed to assess their needs over time and discharge plans adapted accordingly, ensuring services are delivered in an efficient and effective way, maximising the use of resources.

Clear communication with the referring health and social care professional will be provided on discharge to ensure any ongoing action is completed to achieve personal goals that have been set.

6. Prevention, Self-Care and Patient and Carer Information

People will be provided with information, advice, guidance and support in the community as appropriate to enable them to lead healthy life styles, reducing their risk of getting long term conditions in later life or to limit the impact of existing conditions on long term health.

7. Continual Service Improvement/Innovation Plan

Description of Scheme	*Milestones*	*Expected Benefit*	*Timescales*	*Frequency of Monitoring*
Customer satisfaction survey		To ensure users and their carer are able to contribute to service evaluation and improvement	Annually	Quarter 3
To work towards locality working and closer working with Locality community care teams		Improved continous care for patients	March 2012	

8. Baseline Performance Targets – Quality, Performance & Productivity

Performance Indicator	*Indicator*	*Threshold*	*Method of Measurement*	*Frequency of Monitoring*
Quality				
95% of patients whose referral to first definitive treatment is within the 18 week national referral to treatment waiting time		95%	Monthly Score Card	Monthly
95% of new referral for home Enteral feeding registered with the home care company within 2 working days of receipt of referral.		95%	Monthly Score Card	Quarterly
Number of home Enteral nutrition patients receiving quarterly reviews		90%	Monthly Score Card	Quarterly

Additional Measures for Block Contracts:-				
Staff turnover rates				
Sickness levels				
Agency and bank spend				
Contacts per FTE				

9. Activity

9.1 Activity

Activity Performance Indicators	*Method of measurement*	*Baseline Target*	*Threshold*	*Frequency of Monitoring*
Dietetics (New and Follow Up contacts)	Activity Report	4450 (anticipated split New 992 / Follow up 3458)		Monthly

9.2 Activity Plan / Activity Management Plan

Monthly activity reports defined as a minimum of total and new contacts per PCT

9.3 Capacity Review

10. Currency and Prices

10.1 Currency and Price

Basis of Contract	Currency	Price	Thresholds	Expected Annual Contract Value
		£		**£**

Block/cost &volume/cost per case/Other_____*				
Total		**£**		**£**

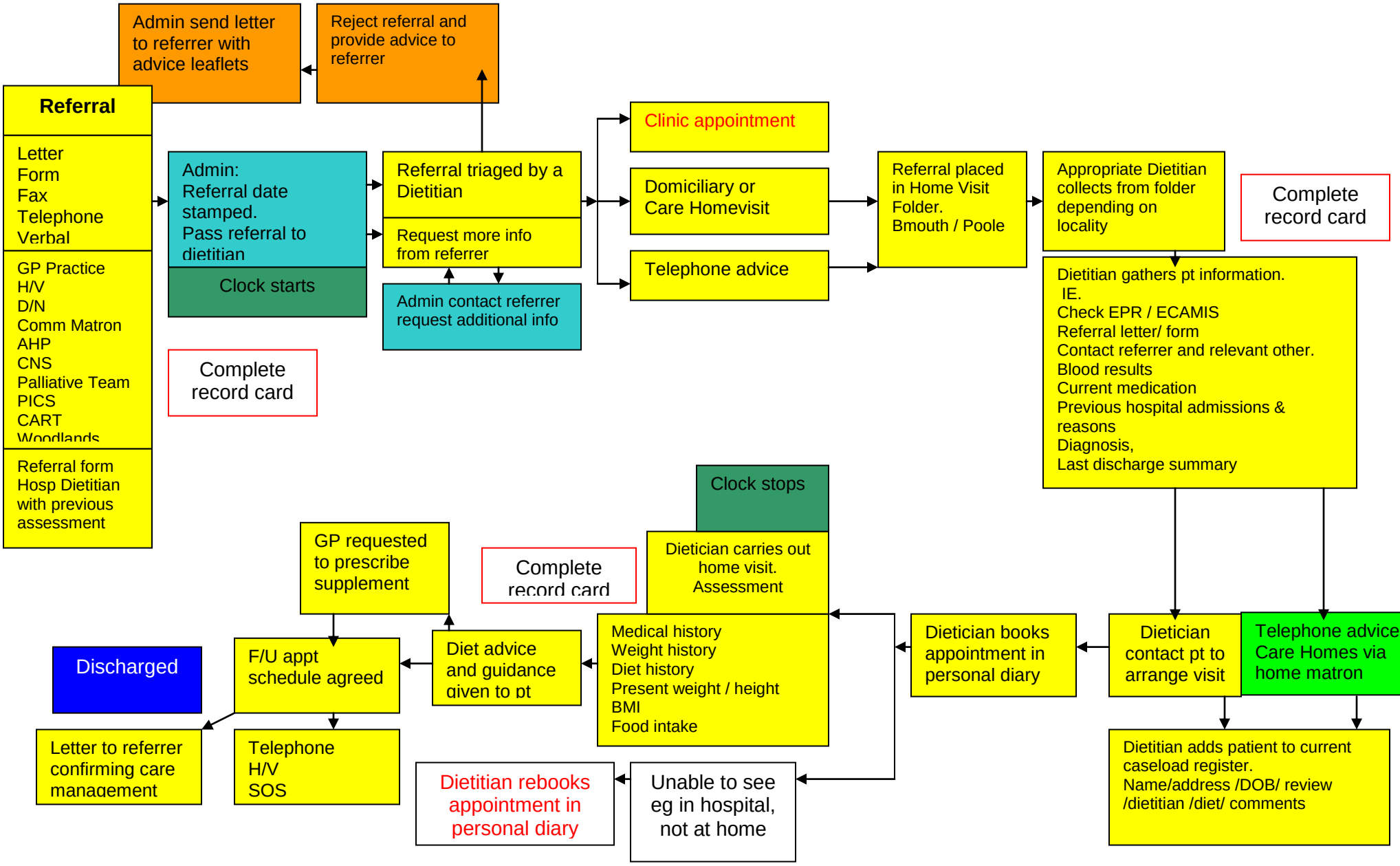
**delete as appropriate*

10.2 Cost of Service by Commissioner

Total Cost of Service	Co-ordinating Commissioner Total	Associate Total	Associate Total	Associate Total	Total Annual Expected Cost
	£	**£**	**£**	**£**	**£**

APPENDIX C

MALNUTRITION CARE PATHWAY



APPENDIX C

MALNUTRITION CARE PATHWAY