

Specification Number	03/CVDS/0002
Service/ care pathway/ Cluster	Intermediate Diabetes Service North and West Dorset
Commissioner Lead	CCP for Cardiovascular Disease and Stroke
Provider Lead	
Period	1 st April 2013 to 31 st March 2014
Date of Review	

Key Service Outcomes

The aim of this service is to support the delivery of NHS Bournemouth, Poole and Dorset PCT Cluster strategic priorities:

- improving the length and quality of life by achieving, with partners, a shift: from a system based on treating illness to one focused on keeping people well and independent
- from hospital care to care closer to home
- offering prompt, effective and appropriate care
- improving the quality of user experience across all services
- improving efficiency and value for money

1. Purpose

1.1 Aims and objectives

The aim of the service is to manage people with type 2 diabetes within the primary care setting, where appropriate, ensuring that patients are transferred to secondary care only when the treatment needs require specialist diabetic services.

It will do so by providing a high quality community intermediate diabetes service founded on the principles of good practice and clinical governance.

The intermediate diabetes service is envisaged as initially a Diabetes Nurse Specialist led service, working closely with other services such as dietetics and podiatry, and provided within the primary care setting to people with type 2 diabetes who require intensification of glycaemic control above that which is provided under GMS but does not require a secondary care referral. An example of this level of service would include insulin conversion. Key features of this service will be:

- the close working relationship between the Intermediate and Primary Care services in the management of people with type 2 diabetes
- training and education of primary care staff in the management of diabetes

Self care and ongoing patient education will be embedded as an integral part of the service. As per Diabetes NSF Standard 3 which states:

“People with diabetes will receive a service which encourages partnership in decision

making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle”

The service will provide the link between the current interfaces of primary and secondary care provision. This service will have a key role in ensuring adequate clinician education in primary care to enable patients to be seen by the clinician with the most appropriate skills for their care at that particular time;

Appropriate utilisation of the Diabetes Nurse Specialist skills enabling practice nurses to develop skills to compliment the DNS and so provided a cohesive and accessible service which remains in primary care;

1.2 National/ local context and evidence base

The national prevalence of diabetes estimated at 4.67% (2008) is projected to rise to 6.5% by 2025 with 92% of all cases of diabetes being Type II.

The prevalence of diabetes in NHS Dorset is 4.4% a total of 17,690 diabetic patients (QOF figures 2009/10).

100,000 people each year in the UK are diagnosed with Type II Diabetes, at a cost to the NHS of almost £10 million per day (Diabetes UK, Diabetes in the UK: a report from Diabetes UK 2004).

Type 2 Diabetes is associated with significant co-morbidity including cardiovascular disease, stroke, diabetic retinopathy and diabetic nephropathy, (Mulnier HE, et al. Diabetic Med 2006).

In developing this service specification the following policies and best practice guidance have been drawn upon:

NICE guidelines on diabetes management on glycaemic control.

- Diabetes type 2 (update) 2010 CG 87
- Diabetes type 1& 2 patient education models TA 60

NSF for Diabetes, in particular

- Standard 3: Empowering people with diabetes
- Standard 4: Clinical care of adults with diabetes
- Standard 10: Regular surveillance for long-term complications
- Standard 11: Those who develop long term complications have their risks of disability and premature death reduced.

National Service Frameworks for Older People, Coronary Heart Disease, Diabetes and Renal Services

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	

1.3 General Overview

The service model will ensure a high quality diabetes service with effective use of resources to meet the challenges of a growing diabetes population. It will build on the principles of current good practice and of care closer to home for the patient with diabetes. Care will be delivered by competent health care professionals with an appropriate skill mix working seamlessly in the delivery of and engaging with patients in the principles of self-management at every opportunity.

It will achieve this by improving knowledge and skills for people with diabetes, being patient-centred, enabling patients to control their own condition and to integrate self-management into their daily lives, in order to prevent both short and longer term complications of diabetes.

The service will provide, for the cohort patients cared for by the service:

- Initial assessment of type 2 patients referred for intensification of glycaemic control above that normally delivered as part of GMS
- Regular structured review of condition (minimum six monthly)
- Intensification of glycaemic control including initiation of Oral hypoglycaemic agents, step-up treatment and where clinically appropriate conversion to insulin therapy or GLP 1 antagonist.
- Intensification of B/P control.
- On-going structured education, individual or group
- Care plan which includes support for self care/management
- Referral to other appropriate services such as IAPT and the Expert Patient Programme

Goal Setting

- HbA1c;
- B/P;
- Weight/body shape;
- Cholesterol

The regular structured review will include as a minimum:-

- review of goals previously set;
- assessment and development of self management skills;
- general assessment of disease progression;
- prevention/early detection of diabetic complications e.g. neuropathy

Training and development of clinicians forms an essential part of the service, in particular training and development by the DNS of health professionals delivering the diabetes care within general practice.

1.4 Objectives

This service specification aims to ensure the Intermediate Diabetes Service in conjunction with Primary care improves a person with type 2 control of their diabetes by being :

- patient focused
- focused on quality
- modern, efficient, cost effective
- Seeks to exploit new ways of working and makes best use of skill mix opportunities in the delivery of healthcare and in particular the role of nurses
- Actively promotes self care

1.5 Expected Outcomes

In order to evaluate the following outcomes, regular and systematic audit will be co-ordinated and undertaken. The audit will be undertaken on at least a yearly basis and will include a review of appropriate clinical indicators, the minimum will be:

- HbA1c
- BMI
- Blood pressure

2. Service Scope

2.1 Service Description

The service will be provided to patients who are registered with the following practices which form part of the North and West Dorset locality excluding Abbey View/Gillingham Surgeries:-

The service shall be applicable to people with Type 2 diabetes over the age of 17 years. It is recognised that there may be special circumstances in which it may be appropriate for the service to cater for on an named basis type 1 patients 'lost' to specialist services

- The service will include assessment, and treatment and management as appropriate.
- The service does not include the delivery of those services which would form part of core GMS Primary Care Services.
- The service shall be community based and be provided broadly in line with the minimum list of activities set out below.
- This intermediate diabetes service will be available to all uncomplicated diabetic patients whose condition does not require specialist diabetologist care intervention but who need input at a level higher than that offered GMS or PMS
- The service will work in conjunction with Primary Care teams the Specialist Diabetologists to enable patients to be seen as appropriate to their clinical needs and by allowing them to move between the 3 service levels as their condition dictates.
- The Diabetes Specialist Nurse will offer clinical and educational support to Practice Nurses to all practice staff in developing the skills and confidence required for the intensification of glycaemic control including supporting insulin and GLP1 initiation.

- The Diabetes Specialist Nurse will not work in isolation, and will be part of an integrated diabetes service, working with GPs and their clinical teams. Decisions with regard to the clinical care of patients remain the responsibility of the GP.
- The Diabetes Nurse Specialist will also liaise with the consultant diabetologists and other agencies as appropriate to ensure patients receive the level of care that is appropriate.
- The Diabetes Specialist Nurse involvement may vary and this will be agreed between the Diabetes Specialist Nurse and the Practice concerned.
- The service will provide on-going structured education programme for all newly diagnosed Type 2 diabetic patients in conjunction with the patient's registered practice. Programmes will NICE compliant
- The decision for referral to the consultant diabetologist will remain with the GP not the Diabetes Specialist Nurse.
- Individual patient cases will be discussed at regular monthly meetings between the GP, Practice Nurse and Diabetes Specialist Nurse
- The Diabetes Nurse Specialist must have access to appropriate diagnostic tests. This should be via GP practice and supported by normal practice nurse staff.
- The DNS will access dietician, weight management programs, psychological support and smokestop via patients GP.

2.2 Any exclusion criteria

- Any type 1 patient who it has not been agreed should be cared for by the service on a named patient basis
- Any child under the age of 18 unless specifically agreed on a named patient basis

Any pregnant women

2.3 Geographic coverage/ boundaries

- Patients who are registered with the North or West Dorset localities

2.4 Whole System Relationships

The intermediate diabetes service must work with partners to address the needs of the individual, and be aware of future developments in order to attain optimum outcomes. Partners will include:-

- General Practitioners
- Practice nurses
- Secondary Care Clinicians
- Allied Health Professionals

2.5 Interdependencies with other services

The Intermediate Diabetes Services will work with other services:

- secondary care providers

- Social Services
- General Practitioners

2.6 Relevant networks and screening programmes

- Dorset Retinopathy Screening Programme

2.7 Training/ education/ research activities

3. Service Delivery

3.1 Service model

Access

The service will be provided from a suitable venue, which:-

- is geographically convenient, easily accessible location;
- is compliant with appropriate health and safety legislation;
- has disabled access;
- has appropriate waiting and diagnostic/treatment areas;
- is appropriately furnished and equipped with necessary equipment
- meets cleanliness and hygiene standards

Access to the service shall be via referral from the GP, Practice Nurse or Community Matron or via referral from the Consultant Diabetologist.

The service shall comply with nationally agreed standards for access or locally agreed access standards currently applicable.

The provider shall provide adequate service provision under the scheme to enable the assessment and/or treatment of all clinically appropriate patients within the specified timescales.

The Service will be flexible and responsive, adapting to the individuals needs in terms of their requirements e.g. level of risk, culture, ethnicity, language and disability and does not discriminate on the grounds of age, gender, sexuality, ethnicity or religion.

All sites should be easily accessible by public transport and must provide information about parking. Provision should be made under the Disability Discrimination Act to ensure that disabled individuals are able to access the service.

The service will be available to patients and times and on days that reflect patients' needs/preferences and the clinical needs of the service, generally available during GP practice opening times. Telephone support will be available to practice staff and patients from the Diabetes Nurse Specialist Monday to Friday between 8.30am and 4.30 pm (except on bank holidays)

3.2 Care pathways

Level 1 Care (Specialist) - for patients requiring specialist management of their condition, largely due to the complications associated with their condition, such as moderate to advanced kidney disease, and the vast majority of Type I patients

Level 2 Care (Intermediate) – to be delivered by a Diabetic Nurse Specialist (DNS) to

people with type 2 diabetes whose condition does not require specialist diabetologist care intervention but who need input at a level higher than that offered by Level 3 (including initiation of insulin therapy) This level of care may also cover some Type I diabetic patients who do not engage with secondary care and whose care therefore has to be delivered in primary care. For such patients it will be necessary for the DNS will to work closely with both the GP and the consultant responsible for their care.

Level 3 Local Enhanced Service – to be delivered by Practice Nurses/GPs who are suitably competent and confident in providing care to diabetes Type 2 patients who have been converted to insulin or on GLP antagonist.

Level 4 Care (Primary) – within the scope of essential services through the GMS contract (described above).

3.3 Location(s) of service delivery

The service will be delivered from the following Locality practices:-

North Dorset excluding Abbey View and Gillingham and West Dorset

3.4 Days/ hours of operation

Telephone support will be available to practice staff and patients from the Diabetes Nurse Specialist Monday to Friday between 8.30am and 4.30 pm (except on bank holidays)

Sessions

- 32 Diabetes Nurse Specialist Clinics per month, each session is 3 hours long and excludes travel time.
- 20 Diabetes Nurse Specialist sessions with dedicated telephone support/structured education sessions. A minimum of 10 NICE compliant structured education courses (DESMOND) per year for patients registered with GPs in the North Dorset locality.
- 4 Diabetes Nurse Specialist sessions per month for personal development, service re-design/development and administration/meetings.

3.5 Referral Criteria and sources

All patients who are registered with the following Practices in the North Dorset and West Dorset locality are eligible treatment: -

All referrals will be contacted within 2 weeks and offered an appointment within in 8 weeks of initial referral.

For any patients whom the service needs to refer onwards to secondary care a full statement, the equivalent of a discharge letter to the GP, should be provided within 48 hours.

Service providers will need to ensure the service provision is able to meet the needs of vulnerable people, people with learning and physical difficulties and mental health needs.

The commissioner and provider will work together to ensure pathways are agreed and up-to-date.

Information for referrers and patients

- Verbal advice should be supported by accurate, impartial printed information that the patient can understand and may take away to consider. The Commissioner and provider will ensure that any information produced locally will have local contact details where appropriate.
- Some of this information, where appropriate, may be provided electronically, or by telephone.

Referral

- All referrals will be contacted within 2 weeks and offered an appointment within in 8 weeks of initial referral.

Confidentiality

The Service Provider will be expected to demonstrate that the collection, storage and transfer of information to other services, including that in electronic format is secure and complies with any data protection requirements.

The provider will have secure IT systems in place for recording patient information and activity:

- The provider will work in ways that support national and local programmes and utilises IT in ways that maximise patient care.
- Communication and use of email systems;
- Participation in PCT audits and data collection.

3.6 Referral processes

By telephone, secure email or letter.

3.6 Discharge processes

Patients should be discharged from this service to primary care as clinically appropriate e.g. Intensification of glycaemic control has been successful.

Follow-up arrangements

- The Service Provider should ensure patients can access a follow-up appointment subject as appropriate.
- Telephone support/advice will be available as part of the service

Service User Experience

- All patients should be asked to complete an anonymous post treatment satisfaction survey. The survey results should be forwarded to the Commissioner on an annual basis so that they can be used to further improve service delivery. The information gathered by the patient satisfaction survey should be taken into account when reviewing standards as part of clinical audit, and when reviewing commissioning arrangements.
- The Service Provider should put in place and maintain throughout the episode of care an effective representation and Complaints Procedure and have systems in place, which monitor the incident and outcome of all complaints and investigations regarding the service.

- All complaints should be reported to the appropriate PCT Commissioner as soon as possible see Schedule 3 of the service specification.
- Untoward incidents should be reported to the individual PCT Commissioner as soon as possible, see schedule 3. All major complications should be audited together with deviations from planned care.

Monitoring Staff Quality

- Clinical audit should be undertaken regularly. Professional and support staff should be involved in the audit of organisational care. Professional staff should undertake interdisciplinary clinical audit and receive clinical supervision.
- Clinical staff must be appropriately trained and experienced

3.7 Response times and prioritisation

4. Other

Self-Care and Patient and Carer Information

The provider will work with patients and carer in ways that foster partnerships and include:

- Comments and suggestion boxes;
- Patient and carer Participation Groups;
- Work with the local Patient Advice and Liaison Service (PALS);
- Patient and carer surveys;
- Local complaints process and annual review;
- Promoting self care.

The provider will work with patients and carers in ways that support self care and self management including:-

- Ensure each patient has a care plan that supports self care.
- Recommendation to the Expert Patient Programme (EPP);
- Supply of education leaflets in the self management of their condition.

Patient and referrer satisfaction surveys are to be undertaken and reported to the PCT annually ending at the year end with the provider summarising outcomes for evaluation, learning and development purposes.

Advice

Patients and carers will be given an explanation of their condition and advice about all management options which will be discussed with the patient.

5. Quality Requirements

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>
Service User Experience	Overall client satisfaction	Greater than a score of 8 out of 10	Annual patient questionnaire	Require Improvement Action Plan
Improving Service Users & Carers Experience	All Service Users to be offered appropriate care plans	100%	Quarterly Monitoring meeting	Require Improvement Action Plan
Access	All referrals will be contacted within 2 weeks and offered an appointment within in 8 weeks of initial referral.	100%	Quarterly Monitoring meeting	Require Improvement Action Plan
Clinical Outcomes	Working with practice to achieve HbA1c levels below 7.5%	70%		Require Improvement Action Plan
	Working with practice to achieve HbA1c levels below 10%	95%		
	Working with practice to achieve blood pressure levels 145/85 or less	80%		
Current DNS Patients	Number of patients			
	Number maintaining or improving HbA1c by at least 1%			

	Number maintaining or improving BMI by 1%			
	Number improving BP to within target of 145/85 or less	80%		
Patients converted to insulin	Number of patients			
	Number maintaining or improving HbA1c by at least 1%			
	Number maintaining or improving BMI by 1%			
	Number improving BP to within target of 145/85 or less	80%		
Referrals/Discharges	Number of patients discharged to practice care			
	Number of patients requiring referral to specialist services			
	Number of new patient referrals from primary care			
	Number of new patient referrals from secondary care			
Additional Measures for Block Contracts:-				
Cover for absence		100%	Report to commissioner	Require Improvement Action Plan

If required, relevant Quality Requirements from Schedule 3 Part 1 can be inserted here (although these will apply to relevant Services even if not listed here)

6. Activity

<i>Activity Performance Indicators</i>	<i>Threshold</i>	<i>Method of measurement</i>	<i>Consequence of breach</i>
Number of sessions per practice per month		<i>Monthly monitoring Report</i>	
Numbers of new and follow patients seen per practice per month		<i>Monthly monitoring Report</i>	
Number of discharges and number of referrals per practice per month			
Number of courses of DAPHNE delivered per quarter and number of patients attending per practice per quarter			

6.1 Activity Plan

The Commissioners will arrange monitoring visits and schedule management meetings with Providers on a quarterly basis.

6.2 Capacity Review

If required, relevant parts of the Activity Plan and Capacity Review Criteria should be inserted here

6.3 Continual Service Improvement Plan

To be monitored quarterly with provider and Commissioner and developed following use of tools for example service user's satisfaction surveys.

7. Prices and Costs

7.1 Price

If required, relevant Prices may be inserted below

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value (for this service)
Non-Tariff Price		£		£

(cost per case/cost and volume/block/other)*					
National Tariff plus Market Forces Factor		£			£
Reduced Tariff Prices	[For local agreement – set out basis of calculation and if appropriate the actual prices as well as the applicable duration of the agreed prices]				
Total					
<i>*delete as appropriate</i>					
7.2 Cost of Service by Commissioner					
Total Cost of Service	Co-ordinating Commissioner Total	Associate Total	Associate Total	Associate Total	Total Annual Expected Cost
£	£	£	£	£	£

Schedule 2 Annex 1: Summary of Activity Plans

Monthly reporting

Activity Performance Indicators	Threshold	Method of Measurement	Consequence of Breach	Report Due
Number of new referrals				
Activity per GP practice				
Patient Complaints				
Practice Complaints				
Total workforce				
Numbers of workforce receiving clinical supervision				

Schedule 2 Annex 2: Summary Quality and Performance Indicators

It is the responsibility of the provider to ensure implementation of any NICE guidance. The CEO of the Health Care Commission has confirmed the implementation of NICE guidelines is of the highest priority. Organisations Performance will be assessed of the delivery of high quality standards against National Service Frameworks (NSFs), NICE Guidance, agreed best practice as part of the Health Care Commission's Health Check (DH 2004).

The provider shall deliver services in accordance with Good clinical Practice, Good Healthcare Practice and shall comply with the standards and recommendations contained in "Standards for Better Health" June 2008 meeting the 24 core standards and have plans in place shared with the provider to achieve the 13 developmental standards issued by the National Institute of Clinical Excellence (NICE) issued by any relevant body and agreed

between the Parties from any audit and Serious Untoward Incident and Adverse Incident Reporting, including the reporting of such to the commissioning PCT included within locally or national tariff funded National Service Frameworks agreed Integrated Care Pathways and agreed shared protocols and guidelines.

Commissioners will monitor and manage performance against quality standards and key targets through performance meetings. The provider will make available information required to support the monitoring and management process. Key standards will include but not restricted to:

The provider will be expected to comply with the clinical governance framework of NHS Dorset and to function under agreed operational and clinical policies.

The operational systems will support the following principles:

- Clear lines of responsibility and accountability;
- A programme of quality improvement activities;
- Clear policies aimed at managing risk and procedures to identify and remedy poor professional performance.

The Provider will make arrangements to carry out patient/carer satisfaction surveys in relation to the Service and will co-operate with such surveys that maybe carried out by the Commissioner. In discharging its obligations under this Clause the Provider shall have regard to any Department of Health guidance relating to patient satisfaction surveys The Provider will be expected to demonstrate evidence of having used the patient experience of using the service to make improvements to service delivery.

The Provider will ensure that robust clinical governance processes are in place to include:

- A Clinical Governance Lead to liaise with the PCT PEC Chair (or designated PCT Clinical Governance Lead);
- Incident reporting;
- Infection control;
- Significant Event Analysis;
- Managing Alerts;
- Quality Assurance;
- Compliance with national and local standards including NICE and National Service Frameworks;
- Compliance with locally and nationally agreed audits.

Information Governance - The Provider will make sure that information relating to patients is safeguarded and take account of:

- Patient confidentiality
- Caldicott Guardian

- . PCT information Sharing Protocols
- . Consent to treatment and use of information.

Business Continuity Plans - The Provider will make sure that it has a Business Continuity Plan so that if there are problems with the clinic location or staffing, patients can still access the service.

Hazel Thorp: version 3 pathfinder 4/8/11