SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	**03/CVDS/0009**
Service	**Intermediate Diabetes Services**
Commissioner Lead	**Cardio Vascular Disease Clinical Commissioning Group**
Provider Lead	**Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust;**
Period	**1st April 2012 – 31st March 2014**
Date of Review	1 September 2013 (once new commissioning structures are in place to reflect these changes)

1. Population Needs

1.1 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 2.

The prevalence of diabetes in NHS Bournemouth and Poole is 4.2% a total of 15,297 diabetic patients (QOF figures 2009/10).

The prevalence of diabetes in NHS Dorset is 4.6% a total of 18,267 diabetic patients (QOF figures 2009/10).

100,000 people each year in the UK are diagnosed with Type 2 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.

2. Scope

2.1 Aims and objectives of service

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	

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

The aim of the Intermediate Diabetes Care 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 envisage 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 Diabetes Nurse Specialist and so providing a cohesive and accessible service which remains in Primary Care.

2.2 Service description/care pathway

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 Intermediate Diabetes Service will provide an assessment and treatment service for local patients in a community. This Service is for those patients requiring greater input than that available through GMS. Complex patients requiring more specialised assessment and treatment will be referred to a Consultant led service.

The Intermediate Diabetes Service will ensure that its Diabetes Nurse Specialists receive Consultant lead supervision for clinical governance, training and advice on the management of diabetes patients as appropriate.

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.

The Service will be provided to patients who are registered with practices which form part of the following localities:-

East Bournemouth
Central Bournemouth
West Bournemouth
Christchurch
East Dorset

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, 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 including the Specialist Diabetologist 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 Nurse Specialist 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 Nurse Specialist 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 Diabetologist and other agencies as appropriate to ensure patients receive the level of care that is appropriate.

- The Diabetes Nurse Specialist involvement may vary and this will be agreed between the Diabetes Nurse Specialist and the Practice concerned.

- The Service will provide on-going structured education programme for all 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 Nurse Specialist.

- Individual patient cases will be discussed at regular monthly meetings between the GP, Practice Nurse and Diabetes Nurse Specialist

- 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 Diabetes Nurse Specialist will access dietician, weight management programmes, psychological support and smokestop via patients GP.

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 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 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)

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.

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.

Confidentiality

- This needs to be explicitly stated in the Provider's confidentiality policy and in all patient information.
- 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.

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

- A 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.

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 1 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 1 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 Diabetic Nurse Specialist will to work closely with both the GP and the Consultant responsible for their care.

Level 3 Care (Primary) – within the scope of essential services through the GMS contract (described above).

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

- 10 Diabetes Nurse Specialist Clinics per week, each session is 3 hours long and excludes travel time.

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

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.

All patients who are registered with the following Practices in the East Bournemouth, Central Bournemouth
West Bournemouth, Christchurch, East 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 which 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.

Referral route

By telephone, secure email or letter.

2.3 Population covered

The service will be delivered from the following East Bournemouth, Central Bournemouth, West Bournemouth, Christchurch, East Dorset Locality practices:-

2.4 Any acceptance and 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.

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 Clinical Commissioning Group audits and data collection.

2.5 Interdependencies with other services

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

3. Applicable Service Standards

3.1 Applicable national standards eg NICE, Royal College

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
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NSF for Diabetes, in particular

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4. Key Service Outcomes

In order to evaluate the following outcomes, regular and systematic audit will be co-coordinated 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

Other key service outcomes will relate to a reduction of outpatient activity, and in the longer term a reduction diabetes complication rates and associated inpatient and outpatient activity.

5. Location of Provider Premises

The Service will be delivered from the following East Bournemouth, Central Bournemouth, West Bournemouth, Christchurch, East Dorset locality practices:-

6. Individual Service User Placement

[Insert details including price where appropriate of Individual Service User Placement]