SCHEDULE 2 – THE SERVICES

A. Service Specifications (B1)

Mandatory headings 1-4. Mandatory but detail for local determination and agreement
Optional heading 5-7.Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	03_CVDS_0018
Service	Intermediate Dietetic Diabetes Service
Commissioner Lead	Clinical Commissioning Programme for Cardiovascular Disease Services
Provider Lead	
Period	1 April 2014 to 31 March 2017
Date of Review	

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 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. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	x
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**	

2.2 Local defined outcomes

- Improvement in HbA1c levels
- BMI within target range
- reduction in out patient referrals to secondary care
- satisfactory scores from a patient reported outcome measure
- 100% of patients will have initial contact within 2 weeks and offered a first appointment within 8 weeks of receipt of referral

3. Scope

3.1 Aims and objectives of service

This service specification aims to ensure that the Intermediate Dietetic Diabetes Service as part of the Intermediate Diabetes Service and in conjunction with the 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 dieticians;
- Actively promotes self-care

The aim of the Intermediate Dietetic 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 Dietetic Diabetes Service founded on the principles of good practice and clinical governance.

The intermediate dietetic diabetes service will form part of the Diabetes Nurse Specialist led Intermediate Diabetes Care Service and will be provided within the Primary Care setting to people with type 2 diabetes who require intensification of gylcaemic 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 pre and post conversion to an injectable therapy. 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 Dietician skills enabling practice nurses to develop skills to compliment the Diabetes Dietician and so providing a cohesive and accessible service which remains in Primary Care.

3.2 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 Dietetic Service will provide an assessment and treatment service for people with type 2 diabetes on a locality basis, within that locality. This Service is for those patients requiring greater input than that available through GMS, PMS and primary care diabetic care services.

Locality based clinics for people with type 2 diabetes (individual and/or group sessions) for the following clients:

- People with Type 2 diabetes who have concerns regarding glycaemic control
- People with Type 2 diabetes on maximum oral hypoglycaemic control that are being considered or are commencing an injectable therapy
- People with Type 2 diabetes with unexpected/unwanted weight loss
- People with Type 2 diabetes who are overweight and wish to lose weight who are on medication that may result in hypoglycaemia

The service will be flexible and work with the locality to develop group working where this best meets the needs of the clients and the locality.

Complex patients requiring more specialised assessment and treatment will be referred to a Consultant led service.

The Intermediate Dietetic Diabetes Service will ensure that its Diabetes Dietician receives practice supervision for clinical governance, training and advice on the management of diabetes patients as appropriate.

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

- Assessment and identification of issues which are impacting on glycaemic control above that normally delivered as part of GMS;
- Assessment and identification of issues which are impacting on weight management
- Assessment and identification of medication management which may be impacting on diet and lifestyle
- Development of a partnership approach with the patient to agree goals based on dietary changes, lifestyle changes, medication management
- Motivation and development of a care plan, with a focus on improved self care, to

support and achieve the negotiated diet/lifestyle goals
- Monitoring, support and review of condition as required/as agreed with the patient, to assist the them to meet identified goals
- Referral to other appropriate services such as IAPT

Measurable data and goal setting
Recording data
- Tracking of HbA1c
- Monitoring of body weight and BMI where this supports achievement of goals

Goal Setting

- The specialist dietitian will work with patients to agree suitable goals based on dietary and lifestyle/behaviour changes which support self management and optimise control

Structured review will include as a minimum:-

- Review of goals previously set;
- Assessment and development of self- management skills;

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

The Service will be provided to patients who are registered with a Dorset GP, apart from the following:
- patients registered with practices in West Dorset Locality,
- patients registered with practices in Weymouth and Portland locality
- patients register with practices in Mid Dorset Locality except Milton Abbas which will be covered by this service at the Blandford Hospital clinic

The Service shall be applicable to people with Type 2 diabetes over the age of 19 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 or the primary care dietetic 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 Dietetic 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 Dietician will offer clinical and educational support to Practice Nurses and 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 Dietician 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 Dietician will also liaise with the Diabetes Nurse Specialist Intermediate Diabetes Care Service, Consultant Diabetologist and other agencies as appropriate to ensure patients receive the level of care that is appropriate.

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

- The Service will provide support to locality led education programme for all diabetic patients in conjunction with the Diabetes Nurse Specialist patient's registered practice.

- The decision for referral to secondary care services will remain with the GP not the Diabetes Dietician.

- Individual patient cases will be discussed as required with the GP, Practice Nurse and Diabetes Nurse Specialist

- The Diabetes Dietician must have access to appropriate diagnostic results at referral. This should be via GP practice, Diabetes Nurse Specialist and supported by normal practice nurse staff.

- The Diabetes Dietician will access 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 Diabetes Nurse Specialist, 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.

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

- 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 practice 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) and Diabetic Dietician 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 and Diabetes Dietician 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

Sessions

- 10% of the dieticians time will be dedicated to educating primary care staff. Each session will be at least 3 hours long and excludes travel time.
- At least 70% of patient contacts will be on an individual basis, each session will provide at least 4 appointment slots
- Up to 20 % of patient contacts can be provided in a group setting, each group consist of 6-10 patients

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 dietary management options which will be discussed with the patient.

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 secure email, letter or standard referral form.

3.3 Any acceptance and exclusion criteria and thresholds

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 19 unless specifically agreed on a named patient basis.
- Any pregnant women.

3.5 Interdependence with other services/providers

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:-

- Diabetes nurse specialists, particularly those providing the Intermediate Diabetes Care Service
- General Practitioners
- Practice Nurses
- Secondary Care Clinicians
- Allied Health Professionals

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

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
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4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3 Applicable local standards

none

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:
The Service will be delivered at suitable locations that are close to the homes of the patients who use the service across Dorset and should be no further than 30 minutes travel time for a patient .

7. Individual Service User Placement