SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	**03/CVDS/0037**
Service	Community Diabetes - Purbeck Diabetes Service
Commissioner Lead	Clinical Commissioning Programme for Cardio Vascular Disease and Stroke
Provider Lead	Poole – General Medicine
Period	1 April 2015 to 31 March 2017
Date of Review	

1. Population Needs

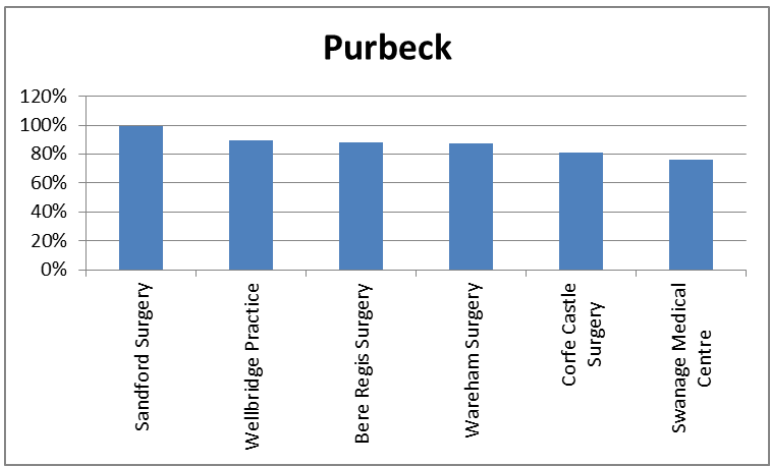
1.1 National/local context and evidence base

At March 2014, there were 1970 people registered with diabetes in Purbeck Locality, accounting for approximately 6.7% of the population. The prevalence is expected to rise, associated with higher levels of obesity, to 9% by 2025. The majority of practices within the locality diabetic lists are at 80% of expected prevalence rates which places then in the upper quartile of practices nationally. The majority of these people will be able to have their diabetes care in primary care or within the locality. Currently too many people are having their care delivered within a hospital. The future model of care is encapsulated in the statement:

Primary Care Led Secondary Care Supported

Many diabetic complications; blindness, end-stage renal failure, amputation, cardiovascular disease and gestational diabetes can be positively influenced by appropriate therapies. Early identification and management of glycaemic control and the long term management of diabetes risks will improve life expectancy and quality of life.

Actual Diabetic Lists as A Percentage of Expected



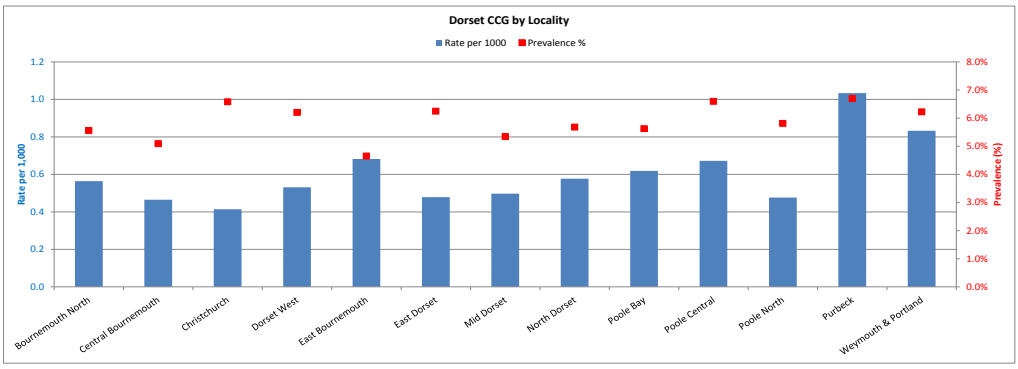
2. Outcomes

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**	√
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

- Reduce emergency admissions (see below rolling 12 month admissions at Month 5 2014)
- Decrease follow up appointments in totality by at least 10% (80 attendances)
- Move follow up and new consultant consultations into the community for approximately 150 people
- Undertake annual reviews for housebound patients (approximately 70 people)
- Increase the skills of practice nurses to manage more complex patients and provide high quality foot care advice and assessments.
- Deliver more diabetes education programmes within the locality
- Increase the interface with associated services and support the emphasis of co-ordinated cardiovascular care particularly heart failure community specialist nurses and community matrons.



3. Scope

3.1 Aims and objectives of service

This service will dovetail with the current diabetes nursing service (DNS) and hospital consultant delivered services, but will drive the move in care for the locality towards a more community multi-disciplinary focused model. Purbeck recognises that it has services provided by Poole NHS Hospitals Foundation Trust and that there is a requirement to balance the needs of other localities whilst transitioning to the community focused model of care. The service will focus on change in the following areas:

- Consultant led/delivered care
- Diabetes nursing services (DNS)
- Upskilling primary care nursing teams

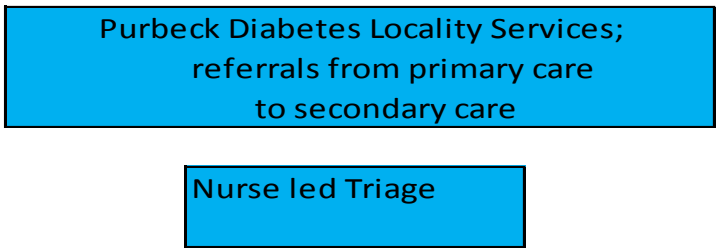
This service builds upon the current multi-disciplinary arrangements, which includes dieticians and podiatrists.

People with Type 1 and Type 2 diabetes currently under the care of secondary care will be offered more local care where clinically suitable.

Work to improve the interface with primary care information systems.

3.2 Service description/care pathway

Services for people with Diabetes in Dorset sit within the tiered model of care. The care pathway for the Purbeck Locality Model is summarised below:



Consultant Diabetology Led Care:

- 1 session per month dedicated to Purbeck patients – anticipated to be 150 people per annum
  - Annual reviews will be undertaken within the locality
  - Longer consultations to allow more detailed care plans to be developed for delivery within the locality with support from the DNS.
- Clinical oversight of diabetes care in Purbeck

It is recognised that services will transition from Poole Hospital to the locality. Patients will be given choice on where they wish to have their consultant care. As the lead consultant for this locality is part of the emergency rota is may not be possible initially to relocate every session into the locality. However, a locality dedicated clinic allowing longer consultations will be delivered within the hospital as part of the steps to the future model. The dedicated consultant 'Purbeck' session will manage approximately 150 patients currently under consultant care in Poole. Care will be delivered flexibly through:

- Outpatient consultations
- Advice and guidance telephone consultations with patients
- Advice and guidance to general practice

Technology to support flexible consultations will be optimised. Booking of clinics remains the responsibility of the Trust. The table below details the baseline position from which changes are expected:

TOTAL Attendances

Locality			2013/14				2014/15 FOT @ M6				Forecast variance			
			1st	FU	Proc	TOTAL	1st	FU	Proc	TOTAL	1st	FU	Proc	TOTAL
Purbeck	J81010	Swanage Medical Centre	31	190	79	300	42	184	42	268	11	-6	-37	-32
	J81011	Wareham Surgery	17	203	34	254	26	170	72	268	9	-33	38	14
	J81020	Bere Regis Surgery	15	59	7	81	16	48	4	68	1	-11	-3	-13
	J81025	Wellbridge Practice	17	306	57	380	18	256	52	326	1	-50	-5	-54
	J81612	Corfe Castle Surgery	5	29	14	48	6	28	18	52	1	-1	4	4
	J81631	Sandford Surgery	7	30	0	37	6	26	2	34	-1	-4	2	-3
Purbeck			**92**	**817**	**191**	**1,100**	**114**	**712**	**190**	**1,016**	**22**	**-105**	**-1**	**-84**

PbR Attendances

Locality			2013/14				FOT @ M6				Forecast variance			
			1st	FU	Proc	TOTAL	1st	FU	Proc	TOTAL	1st	FU	Proc	TOTAL
Purbeck	J81010	Swanage Medical Centre	30	156	79	265	42	146	42	230	12	-10	-37	-35
	J81011	Wareham Surgery	16	187	34	237	26	136	72	234	10	-51	38	-3
	J81020	Bere Regis Surgery	9	46	7	62	8	36	4	48	-1	-10	-3	-14
	J81025	Wellbridge Practice	17	116	57	190	14	128	52	194	-3	12	-5	4
	J81612	Corfe Castle Surgery	5	29	14	48	6	22	18	46	1	-7	4	-2
	J81631	Sandford Surgery	7	30	0	37	6	22	2	30	-1	-8	2	-7
Purbeck			**84**	**564**	**191**	**839**	**102**	**490**	**190**	**782**	**18**	**-74**	**-1**	**-57**

Note: proc tend to be the foot clinic.

Non-PbR Attendances

Locality			2013/14			FOT @ M6			Forecast variance			New to FU Ratio	
			1st	FU	TOTAL	1st	FU	TOTAL	1st	FU	TOTAL	2013/14	2014/15
Purbeck	J81010	Swanage Medical Centre	1	34	35	0	38	38	-1	4	3	1 : 34.0	
	J81011	Wareham Surgery	1	16	17	0	34	34	-1	18	17	1 : 16.0	
	J81020	Bere Regis Surgery	6	13	19	8	12	20	2	-1	1	1 : 2.2	1 : 1.5
	J81025	Wellbridge Practice	0	190	190	4	128	132	4	-62	-58		1 : 32.0
	J81612	Corfe Castle Surgery	0	0	0	0	6	6	0	6	6		
	J81631	Sandford Surgery	0	0	0	0	4	4	0	4	4		
Purbeck			**8**	**253**	**261**	**12**	**222**	**234**	**4**	**-31**	**-27**	**1 : 31.6**	**1 : 18.5**

Diabetic Nursing services:

The core DNS service in Purbeck will be enhanced for two years, non-recurrently, in order to develop and support the new model of care. The additional workforce (0.32 WTE) will enable:

- Nurse triage of all new referrals and re-referrals from the locality. It is expected that this will decrease PbR new attendances and increase non-PbR (i.e. nurse led) attendances.
- Patient co-ordination to ensure they are seen by the right professional, in the right place, in a timely manner e.g. specialist hospital clinic, back to primary care, Purbeck clinic etc.
- A joint Purbeck clinic with the consultant.
- Provide support to primary care (practice nurses and GPs) to deliver the annual care plan without the need for hospital attendances.
- Targeted support to each practice linked to skills within each practice and their patient needs. This will mean that each practice does not receive the same relative level of DNS input.
- Up-skilling of primary care practice nursing so that at the end of 2 years the number of people under shared care with DNS services has reduced.
- Undertake annual reviews of housebound diabetics (70 patients anticipated) and ensure the 9 core care processes are recorded on the GP practice system. Assess risk and need for involvement of the wider team e.g. community matron, heart failure nurse.
- Provide 1:1 support in foot care assessments to all practice nurses involved in delivering diabetic care so that referrals include NICE risk classifications to enable triage by the diabetic foot team.
- Support diabetes education being delivered on a more local basis.
- Support implementation of formularies to deliver primary care savings e.g. glucose meters.
- Support practice nurses to identify patients who would most benefit from consideration for bariatric surgery after a Tier 3 weight management programme.
- Improve the recording of non-PbR activity as the current practice level activity is unlikely to be correct.

It is expected that the core Purbeck DNS service will in 2 years time see fewer people, differentially input to practices based on needs of staff and patients and delivers a more integrated model of care

with other professionals (Heart failure nurses, matrons)

3.3 Any acceptance and exclusion criteria and thresholds

Inclusion criteria

Patients registered with GP practices in Purbeck

Exclusion criteria:

- Children under 16
- Adults from other practices

3.5 Interdependence with other services/providers

- Dorset eye screening programme
- Secondary care
- Midwifery
- Community services in particular dieticians, podiatrists, matrons, district nursing services and heart failure nurse
- SWAST

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The service will support the implementation of NICE guidance directly applying to diabetes but also indirectly applying (eg. lipid modification)

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

See main service specification for DNS services

4.3 Applicable local standards

All patients seen independently of the GP practice will have their 9 core care processes assessed and the records shared with primary care.

A quarterly meeting involving the Poole care group manager, lead Consultant, DNS, Locality manager and lead locality GP will take place.

The mid-year and annual meeting will include the CCG and DHUFT (podiatry and dietetics management leads).

Improve the reporting of practice level non-PbR activity.

5. Applicable quality requirements and CQUIN goals

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

To enter all patient consultations on the GP practice patient information system

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:

The consultant clinic will be delivered from Swanage Community Hospital (there may need to be a phasing to this happening every month).