IMPROVING SERVICES FOR ADULT PATIENTS WITH DIABETES IN SOMERSET

SPECIFICATION FOR THE PROVISION OF SERVICES FOR ADULT PATIENTS WITH DIABETES IN SOMERSET
PREFACE

This document defines the service requirements for the care of adult patients with diabetes in Somerset.

The processes of care described are based on accepted evidence and care pathways developed by a team of doctors and nurses with expertise in diabetes care from across the Somerset health community, working closely with patients and the public. The Service Specification is intended to support the commissioning and procurement of services for adult patients with diabetes.

The Service Specification was endorsed by the NHS Somerset Professional Executive Committee on 26 February 2009 and signed off by the Diabetes Commissioning Group on 3 September 2009.
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IMPROVING SERVICES FOR ADULT PATIENTS WITH DIABETES IN SOMERSET

SPECIFICATION FOR THE PROVISION OF SERVICES FOR ADULT PATIENTS WITH DIABETES IN SOMERSET

1 PURPOSE

1.1 The purpose of this document is to define the service requirements for the care of adult patients with diabetes in Somerset. The document is intended to act as a blueprint for consistent and equitable diabetes services and sets out the:

- range and scope of services required
- outcomes from the services to be provided
- standards expected to be met by Service Providers
- implementation requirements
- the performance framework

1.2 This Service Specification should be read in conjunction with the ‘NHS Conditions of Contract for the Supply of Services’. A copy of this document is available on request.

1.3 The processes of care described within the Specification are based on the Somerset model of care for adult patients with diabetes, which was endorsed by the Somerset Primary Care Trust Professional Executive Committee on 31 October 2008. The Service Specification itself was endorsed by the Professional Executive Committee on 26 February 2009.

1.4 The Somerset model of care for adult patients with diabetes is in line with national models of care for long term conditions and self care and the local direction of travel set out by the NHS South West Clinical Pathway Group for Long Term Conditions. It is also fully compliant with the National Service Framework (NSF) and the National Institute for Clinical Excellence (NICE) guidelines for diabetes care.

1.5 The model of care and this Service Specification have been developed by NHS Somerset in partnership with WyvernHealth.Com Practice Based Commissioning Consortium, with involvement from across the Somerset health and social care system.

1.6 The Service Specification will be subject to ongoing review in the light of experience in Somerset and elsewhere.
2 BACKGROUND

Scope of Specification

2.1 This Specification encompasses all services contributing to the care of adult patients with diabetes who are registered with a General Practitioner in Somerset. The catchment includes patients who are registered with a Somerset General Practitioner, but live in border towns in Dorset, Wiltshire or Devon.

2.2 Service Providers will be required to work collaboratively to ensure equity of access across Somerset.

2.3 This Specification does not cover services for children but Service Providers will be expected to ensure effective transition arrangements are in place for young adults.

2.4 An overview of health services in Somerset and the demographics of the Somerset population are provided in Appendix 2.

Drivers for Change

2.5 There are an estimated 19,200 people diagnosed with diabetes in Somerset and this is predicted to grow to more than 28,000 by 2017.

2.6 Diabetes significantly increases the risks of heart attacks, strokes, blindness, kidney failure and amputation and reduces life expectancy by more than fifteen years for someone with Type 1 diabetes and up to ten years for someone with Type 2 diabetes.

2.7 An estimated 21% of patients with diabetes in Somerset are currently undiagnosed and at risk of serious complications.

2.8 The growing numbers of people with diabetes will have an impact on a range of health, social and community services that support patients with diabetes, including dietetic, podiatry and psychology services, as well as specialist diabetes services.

2.9 A summary of key facts relating to diabetes and a detailed health needs assessment are attached (Appendices 1 and 3).

Current Services and Health Outcomes

2.10 There are 75 practices in Somerset, all involved in the care of patients with diabetes. There are also staff employed by Somerset Community Health and local Acute Trusts, who provide services in the community for people with diabetes, including Dietitians, Podiatrists, Diabetes Specialist Nurses and a Nurse Consultant. These services are not however provided universally or consistently across the county.
2.11 Specialist care is provided through multidisciplinary teams based at the NHS trusts with outreach services mainly at community hospitals. There is variation between trusts on what services are provided where.

2.12 The evidence from the health needs assessment shows that, overall, Somerset has good health outcomes for patients with diabetes, which are above the national average. Also feedback from patients indicates they are generally happy with the services they receive.

2.13 There is considerable variation in health outcomes between general practices and geographical areas, however, and more needs to be done to ensure equity of access and the highest possible standards of care for all. In particular, levels of glucose control, a key indicator of effective diabetes management, vary significantly between general practices and between former Primary Care Trust areas. The percentage of patients with HbA1c < 7.5% ranges from 48% to 79% between practices and from 62% to 69%¹ between former Primary Care Trust areas, with the highest level being achieved in the Mendip area and the lowest in the Taunton Deane area.

2.14 Furthermore, there is evidence to suggest that levels of people who have diabetes which is undiagnosed vary considerably across the county. Thirty out of 75 practices are estimated to have more than 30% of their patients with undiagnosed diabetes (compared with an overall county average of 21%). The data suggests that levels of undiagnosed diabetes are higher in the more rural areas of the county and/or where there are larger numbers of older people.

2.15 The reasons for these variations in health outcomes need to be better understood but are thought to be partly due to the fact that services have historically been organised in different ways across Somerset, reflecting former Primary Care Trust boundaries.

2.16 There is also currently no common information system across primary and secondary care. This can lead to patients having unnecessary tests and inefficient use of clinical time.

Feedback from Stakeholder Engagement

2.17 The model of care for adult patients with diabetes and this Service Specification have been developed with widespread involvement of patients, clinicians and healthcare managers and with the support of Diabetes UK and the National Diabetes Support Team. An overview of the engagement process is attached (Appendix 4).

2.18 The engagement process produced some powerful evidence of what patients want from their services and helped steer the course for the new services planned for Somerset.

¹ 2008
2.19 The themes from the engagement process on the model of care were consistent with the previous national and local survey and some of the key points are summarised below:

- a large proportion of patients are generally happy with the services they currently receive, which help them to manage their diabetes, but there was room for improvement
- patients want their diabetes follow up and review appointments to be as local as possible and for appointments to be regular enough and of sufficient duration to meet their needs - they want to be able to choose times for their appointments that are convenient to them and to receive a reminder when their review appointments are due
- many people are already able to access local services and want this to continue
- a significant number of patients wanted services such as podiatry, retinopathy and healthy living advice available locally – venues suggested included GP surgeries, community hospitals or other community buildings
- patients and carers want to have access to reliable, consistent information about diabetes and the local services available
- at initial diagnosis patients and carers would like information and support on eating healthily, diet, how different foods affect their diabetes and physical activity, including activities for those who have a disability
- patients and carers want to have access to education courses and self help groups, which will help them to manage diabetes, however these need to be local, available at various times of the day and well publicised
- patients want the healthcare professionals to have the results of tests and medical records to hand during diabetes follow up and review appointments and for the patient to be involved in their care, using tools such as management plans to provide personalised care
- patients would like to have telephone access to someone who can provide advice and guidance in between review meetings, with suggestions of it being available between 8 am and 8 pm

2.20 Patients have said they expect the following key outcomes from the redesigned services:

- patients who are informed, supported, educated early on in their diagnosis and throughout their care
- better management of their diabetes including controlled blood glucose levels
- better prevention and early diagnosis of diabetes with case finding for high risk groups

2.21 A full report of the feedback received from patients, the public and professionals on current and planned services is available on the NHS Somerset website at http://www.somersetpct.nhs.uk/services/Diabetes/.
3 VISION AND STRATEGIC CONTEXT

Vision

3.1 The direction of travel is towards more integrated and accessible care, with an increased focus on prevention, early intervention and self management.

3.2 The vision is to deliver personalised, responsive and holistic care in the context of how people want to live their lives.

3.3 A diagram representing the direction of travel and a table setting out the key shifts in emphasis in how and where care will be delivered are provided in Figure 1 and Table 1 below.

3.4 A key aim of the new model of care is to increase the capability and capacity of the healthcare system as a whole to meet the needs of growing numbers of people with diabetes, ensuring equity of access and the highest possible standards of care.

3.5 The challenge is to develop an integrated system of care and support to enable patients with diabetes to maintain their health and wellbeing and avoid the onset of complications, with care provided in the right place, at the right time and with the right amount of expertise.
Somerset Direction of Travel for Services for Adult Patients with Diabetes
Towards a Model of Integrated Care

Increased partnership working

Delivering care as close as possible to the patient personalised and tailored to individual patient needs

Focusing on prevention and early intervention supporting patients to care for themselves

By means of integrated care pathways seamless for patients

Underpinned by system-wide structured education health promotion clinical governance
<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care decided by professionals</td>
<td>Care agreed between professionals and patients</td>
</tr>
<tr>
<td>Patients not always understanding their condition and how to control it</td>
<td>Patients fully informed and aware of the action that needs to be taken to control their condition and why</td>
</tr>
<tr>
<td>Inconsistent advice/ messages to patients from different health care professionals</td>
<td>Working across organisational boundaries –consistent messages/advice to patients</td>
</tr>
<tr>
<td>Variability in effectiveness of diabetes control across primary care</td>
<td>Primary care proactive in case finding, diagnosis and management of care, focusing on prevention and early intervention</td>
</tr>
<tr>
<td>Variability in prescribing practise</td>
<td>Common formulary across primary and secondary care</td>
</tr>
<tr>
<td>Variability in access to services between geographical areas and between patient groups</td>
<td>Services accessible to all – tailored to meet needs of varying catchments and groups</td>
</tr>
<tr>
<td>Services delivered in a variety of ways, mainly for historical reasons</td>
<td>All health care providers in Somerset signed up to a common model of care, agreed pathways and outcomes</td>
</tr>
<tr>
<td>Much care provided in institutional settings</td>
<td>Greater focus on prevention and early intervention and support for self care – when support needed convenient and closer to home</td>
</tr>
<tr>
<td>Different Information Systems across primary and secondary care</td>
<td>Improved compatibility of Information Systems</td>
</tr>
<tr>
<td>Specialist knowledge mainly concentrated in secondary care</td>
<td>Utilising skills of wider diabetes team more effectively to support care closer to home</td>
</tr>
<tr>
<td>Management of Type 1 and some Type 2  in secondary care</td>
<td>Secondary care focusing on treatment of complex cases, enhancing inpatient care and supporting and up-skilling primary care</td>
</tr>
<tr>
<td>Commissioning for volume and price</td>
<td>Commissioning for health outcomes, focusing on quality, efficiency and value, where health and well-being are added at every stage</td>
</tr>
</tbody>
</table>
Strategic Context

3.6 The direction of travel towards an integrated model of care is in line with the NHS and Social Care model and the ‘Kaiser Triangle’ delivery model. Both of these models focus on integrating services and removing distinctions between primary and secondary care for patients at all stages of their journey as well as taking account of different levels of care required at different times by the patient.

3.7 The elements of care in the proposed model (see Table 2 below) furthermore reflect updated guidance published by the National Institute for Clinical Excellence in May 2008 for the care of patients with Type 2 diabetes, which identifies the following key priorities:

- structured education at and around time of diagnosis with annual reinforcement
- initial and ongoing diet advice
- management plan including targets agreed with patient
- support for self management
- insulin therapy supported by appropriately trained and experienced personnel

3.8 The direction of travel also fits with national policy supporting self care and the local direction for long term conditions.

3.9 The NHS South West Clinical Pathway Group for Long Term Conditions, in its contribution to the Darzi review (NHS Next Stage Review NHS South West, January 2008), has outlined a vision for the care of people with long term conditions.

3.10 The inverted triangle of care (see Figure 2 below) demonstrates the importance of an increased focus and investment in a whole systems preventative model promoting independence and underpinned by a re-ablement and recovery philosophy.
Figure 2: Vision for Future Care of People with Long Term Conditions

3.11 The principles underpinning the diabetes model of care are congruent with the recommendations of the South West Darzi review, which include:

- minimising the impact of rurality issues on equity of access to services
- increasing capacity and capability of the healthcare system, including the third sector
- commissioning for the whole needs of individuals, not just their health needs
- adopting a whole system approach which is community based with the patient at the centre
- extending use of telecare and telemedicine to bridge the gap between specialist centres and community settings
- supporting the establishment of self-help groups.

3.12 Providers of diabetes services will be expected to engage with the wider developments for long-term conditions as they evolve, including the development of Health Campuses and a single point of access system.
Links with Health Checks Programme

3.13 From 2009/10, the NHS Somerset will be implementing the national Health Checks Programme for people aged between 40 and 74. This Programme will include checking and recording the following for everyone in the identified age range at five yearly intervals:

- age and gender
- smoking status
- physical activity
- family history
- ethnicity
- body mass index (bmi)
- cholesterol
- blood pressure (bp)
- diabetes risk

3.14 The aim of the Health Checks Programme will be to help ensure greater focus on the prevention of coronary heart disease, stroke, diabetes and kidney disease. It is anticipated that the checks will also identify some people who have undiagnosed vascular disease, particularly diabetes and chronic kidney disease.

3.15 The Health Checks Programme suggests a range of filters to identify those at risk who should be tested for diabetes and impaired glucose tolerance. It does not propose that everyone in the identified age range should be tested.

3.16 In Somerset the level of screening required under the Health Checks Programme is expected to be delivered by a combination of systematic and opportunistic interventions provided in a variety of community settings, for example General Practices, pharmacies, council-run fitness centres/day centres, diabetes awareness events, community hospital day centres and screening bus events around Somerset voluntary sector.

3.17 The identification and testing of people at risk of diabetes is a key stage of the diabetes care pathway set out in this Specification (see Appendix 5 - Care Pathway for Adult Patients with Diabetes Mellitus).

3.18 Patients identified as having abnormal glucose tolerance through the Health Checks Programme will be followed up in accordance with the diabetes pathway.

Links with Health Promotion Programmes

3.20 Health Promotion is a key component of the model of care for adult patients with diabetes and support for people to lead longer and healthier lives is incorporated at all stages of the Care Pathway.

3.21 National and local Health Promotion campaigns will promote healthy diet and exercise and local initiatives will ensure people from all patients groups have access to a range of facilities and services to help them maintain their health (see Section 5, Component C2 - Health Promotion Programmes).

3.22 The Care Pathway for Adult Patients with Diabetes is integrally linked with the NHS Somerset Pathway for Weight Management, which provides different levels of support, tailored to need.

3.23 Health lifestyle advice is incorporated into the core remit of GP practice and patients at risk of diabetes and patients diagnosed with diabetes will be referred to community based Health Promotion Services, including weight management, exercise and smoking cessation programmes, as appropriate. The Diabetes Specialist Nurse Service, which will include Specialist Diabetes Dieticians, will provide 1 to 1 support for specified groups of patients at Level 2 (see Section 5 Component I2 – Dietetics).

3.24 Specialist weight management services (tiers 3 & 4 of Weight Management Pathway) are provided by Secondary Care. These are referenced in both the Weight Management Pathway and the Diabetes Pathway and include provision of intensive multidisciplinary weight management programmes and bariatric surgery.

Links with Improved Access to Psychological Therapies Programme

3.25 It is envisaged that patients with low to moderate psychological support needs will generally access treatment through the Improved Access to Psychological Therapies Programme in Primary Care. This Programme will cover associated psychological problems that will respond to short term brief solution focussed interventions (see Section 5 Component H2/3 – Psychological Support moderate level).

Links with Care Planning Pilot

3.26 This pilot has its foundations in the Year of Care project, a National initiative, which aims to make routine consultations between people with diabetes and the clinician truly collaborative by empowering people with diabetes to take an active role in managing their condition (standard 3 Diabetes NSF 2002, Supporting people with long term conditions to self care 2006).

3.27 In Somerset it is intended that this development will be rolled out for all patients who have a long term condition.
The first phase of the pilot will however be concentrated on people with diabetes. It is planned to produce an electronic care planning facility which will be used to produce a personal record of the clinical care and action plans for the person with diabetes, which can be accessed by both primary, intermediate and secondary care to ensure an enhanced level of communication and seamless care for the person with diabetes. Links to resources which can aid the person to meet their goals and targets will be included (e.g. structured education, local support groups, lifestyle change support etc) and uptake of current services and unmet needs will be collated to support the commissioning process of future services.

### 4 MODEL OF CARE

#### Aims and Objectives

4.1 The overall aim of the model of care for adult patients with diabetes is to increase the capability and capacity of the healthcare system as a whole to meet the needs of growing numbers of people with diabetes, ensuring equity of access and the highest possible standards of care.

4.2 The objectives of the model are to:

- improve the care and health outcomes of adult patients with diabetes in Somerset
- promote partnership working and a shared care approach between providers so patients experience appropriate care, seamlessly, and in a timely manner
- provide accessible services as close to patients’ home or work as possible
- improve the knowledge and skills of health care professionals and patients to manage diabetes care, through education, training and practice support

4.3 Service Providers will work together to achieve the following key deliverables:

- seamless care provided as close to home as possible
- healthy eating and physical activity programmes, accessible through patient choice
- systematic and opportunistic case finding in the community
- support for patients to manage their own condition
- patient education programmes which empower patients to self care
- management plans agreed with patients
- accessible specialist care when needed
- equity of access and choice
4.4 The proposed model is represented diagrammatically in Figure 3 overleaf and is explained below with reference to the following characteristics:

- focus of care
- levels of care
- delivery channels and locations
- integrating mechanisms

**Focus of Care**

4.5 There will be an increased focus on maintaining health and wellbeing, early diagnosis and intervention, and support for patients to manage their own care.

**Levels of Care**

4.6 Elements of care required for each stage of the patient’s journey have been identified and allocated to one of the following levels (see Table 2 below)

- Level 1: core primary care
- Level 2: intermediate care
- Level 3: specialist care

4.7 The levels reflect the complexity of care and level of skills required to deliver the care. They are not necessarily an indication of location.

4.8 All levels include an emphasis on prevention, early intervention and support for self care.
## Table 2: Levels of Care

<table>
<thead>
<tr>
<th>Level</th>
<th>Key elements</th>
</tr>
</thead>
</table>
| **Level 1: core primary care** | - Raising awareness of signs and symptoms of diabetes  
- Promoting healthy lifestyle – 1:1 support  
- Systematic and opportunistic case finding for patients at risk of developing diabetes  
- Maintenance of a diabetes register  
- Initial clinical assessment  
- Agreement of management plan with patients with Type 2 diabetes  
- Providing information on diabetes  
- Referral to structured education or relevant specialist(s) if not able to access any form of structured education  
- Providing advice where necessary  
- Psychological support (low level)  
- Participation in retinopathy screening programme  
- Appropriate day to day support and clinical review (minimum annual)  
- Referral to Level 2 or Level 3 services according to patients’ need and choice and agreed referral criteria  
- Early review of patients discharged from Level 2 or 3 services  
- Ongoing signposting as necessary  
- Referral for ongoing support for self care  
- Offering women of childbearing age contraceptive advice, referring on to Level 2 when considering pregnancy |
| **Level 2: intermediate care** | - Promoting healthy lifestyle – weight reduction courses, exercise groups, smoking cessation programmes  
- Confirmation of initial diagnosis for those outside normal parameters  
- Treatment and management planning for patients with sub-optimal glycaemic control at Level 1  
- Structured education  
- Other support for self care  
- Psychological support (moderate level)  
- Liaison with community matrons over patients with complex needs  
- Telephone helpline  
- Insulin initiation  
- Optimising diabetes therapies  
- Specialist dietetics  
- Podiatry  
- Retinopathy screening (annual)  
- Agreement of management plans for complications in complex patients (retinal, renal, vascular, feet)  
- Pre and post pregnancy advice in conjunction with Level 3 |
| **Level 3: specialist care** | - Complex obesity management  
- Classification of genetic or auto-immune disorders  
- Education for complex cases and agreement of management plan with patients with Type 1 diabetes and complex needs  
- Review of appropriate Type 1 and complex Type 2 diabetes patients  
- Acute in-patient management including for patients with diabetes who are admitted with diabetes but not for diabetes  
- Complex complications management (retinal, renal, vascular, foot)  
- 24 hour helpline (complex cases)  
- Pregnancy care (Pre and post pregnancy advice in conjunction with Level 2)  
- Transition management from children to adult services  
- Insulin pump clinics  
- Psychological support (specialist) |
Figure 3: Model of Care for Adult Patients with Diabetes

Key themes:
- Accessible care close to patient and tailored to individual patient needs
- Partnerships and shared care
- Support for self care
- Prevention and early intervention

Community groups  Voluntary sector

Community based case finding facilities
- GP Practices
- Community-based Intermediate Specialist Services
- Hospital

Level 1 opportunistic case finding
- Level 1 core and some Level 2 intermediate care
- Level 2 intermediate & some Level 3 specialist care
- Level 3 specialist care requiring hospital setting; care for patients admitted with but not because of diabetes

Prevention & early intervention
Support for self care
Agreed pathways and outcomes

Strong clinical leadership  Education  Good communications/ information technology  System-wide clinical governance
Delivery Channels and Locations

4.9 In line with the objective to deliver care as close to the patient as possible, the majority of care for adult patients with diabetes will take place in community settings, with only those elements of specialist care (Level 3), that it is not practical to provide in the community, being provided in acute care hospitals.

4.10 General practices will provide core primary care (Level 1) to agreed standards with some opting to provide specific aspects of intermediate care (Level 2), for example insulin initiation.

4.11 Opportunistic case finding for early identification of diabetes will be encouraged in practices and through pharmacies, local councils and voluntary groups.

4.12 A county-wide Diabetes Specialist Nurse Service will provide specified Level 2 care such as insulin initiation and support for patients with sub-optimal glycaemic control. This intermediate service will be delivered by nurse-led teams with specialist medical support. The composition of these teams will vary according to local need but will normally include as a minimum a Diabetes Specialist Nurse and a Specialist Diabetes Dietician. It is anticipated these teams will also provide training and support for practices, opportunistic case finding services and support for self help groups.

4.13 Access to other Level 2 services such as podiatry and related specialist care (Level 3) will either be at co-located sites in the community, at multidisciplinary clinics or using telemedicine technology.

4.14 Hospital care will be focused on complex cases and there will be an enhanced level of care for patients admitted with but not because of diabetes, thus improving the patient experience whilst in hospital and reducing lengths of stay.

4.15 The plans to improve in-patient care are in line with guidance published by the National Diabetes Support Team in 2008 and will involve education of general ward staff on the particular needs of patients with diabetes and redesign of care pathways for emergencies and planned admissions.

4.16 It is anticipated that training/supervision/mentorship for Level 2 providers and training for non-specialist hospital staff will be provided by Level 3 providers.

\[2\] Improving emergency and inpatient care for people with diabetes, National Diabetes Support Team, March 2008
Integrating Mechanisms

4.17 A ‘shared care’ approach, supported by multidisciplinary team working, common information systems, including an electronic care planning facility, and system-wide adherence to agreed care pathways and protocols will ensure integrated working vertically across levels and horizontally across disciplines to provide care that is seamless for the patient.

4.18 Consistency of message will be supported by:

- a telephone help-line for patients and professionals
- Diabetes UK information packs
- general information on the management of diabetes available on the NHS Somerset web-site
- accredited education programmes for patients
- quality assured training programmes for staff

4.19 Patients have said they would like as much care as possible delivered from their General Practice and it is envisaged that the General Practitioner will be the primary contact for patients.

4.20 The overall care pathway will be overseen by a professional network comprising representation from all services contributing to the pathway, which would be accountable to NHS Somerset. A dedicated manager in the initial 2 years will ensure the services operate in an integrated manner.

Equity of Access and Choice

4.21 A key deliverable of the model of care will be equity of access and choice for patients.

4.22 All services will be delivered to the standards set out in this Service Specification.

4.23 The particular needs of different geographical areas will be taken account of when locating and delivering services.

4.24 Consideration will be given to locating community services in areas identified to be ‘hotspots’ for diabetes prevalence and complications.

4.25 All providers of services, at all levels, will be required to deliver care in a manner that is as flexible as possible, so that it offers patients choice and is accessible, regardless of:

- where patients live, including if living in a care home or prison
- whether patients have a disability or a mental health problem
- whether patients are housebound or active
• the socioeconomic background, age, gender, ethnicity and sexual orientation of patients

4.26 The particular needs and preferences of young adults moving between children’s and adult services will also be accommodated in line with the guidance published by the Department of Health in June 2006 – ‘Transition: getting it right for young people: Improving the transition of young people with long term conditions.’

4.27 Examples of flexible service provision will include:

• providing services on good public transport routes/arranging transport for patients to attend assessments/reviews
• providing services in community locations, such as village halls
• 1 to 1 structured education sessions in patients’ homes for patients unable to benefit from courses offered in a community location, eg housebound
• on-line information about diabetes and diabetes care
• making use of translation and interpreting services commissioned by NHS Somerset
• linking with autonomous self help groups especially those established in areas which services find it hard to reach
• providing insulin initiation in care homes/prisons
• telemedicine

4.28 It will be the responsibility of the Service Providers to fund flexible service provision, ensuring that access arrangements are compliant with the Disability Discrimination Act.

4.29 All Service Providers will be expected to ensure their services are accessible to communities which services find it hard to reach (such as people with learning difficulties, people from black and ethnic minorities, homeless people, travellers).

Optimal Self Care and Wellbeing

4.30 Self care was highlighted in the NHS Plan as one of the building blocks for a patient-centred health service. More recently, self care featured as a key component of the model for Supporting People with Long Term Conditions. It is acknowledged that people’s beliefs and expectation about their diabetes and the role and behaviour of healthcare professionals in providing care and support are a major determinant of health related quality of life.

4.31 Service Providers will ensure their staff undertake appropriate training so that they have a full understanding of the principles of promoting optimal self care and will ensure that self care (where appropriate) is integral to care pathways.
5 CORE SERVICE COMMISSIONING COMPONENTS

5.1 The core components of the model of care have been separately identified in Table 3 below to allow the option of components being commissioned either individually or together.

5.2 Most of the core service components identified in Table 3 relate to existing services. The main challenge for providers of these services will be to adopt more integrated ways of working and to begin working towards the specified outcomes.
### Table 3: Model of Care for Adult Patients with Diabetes – core service components

**Patient Services**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Lev</th>
<th>Component</th>
<th>Services</th>
</tr>
</thead>
</table>
| A   | 1   | Core primary care – GP practices | - Raising awareness of signs and symptoms of diabetes  
- Promoting healthy lifestyle – 1:1 support  
- Systematic and opportunistic case finding for patients at risk of developing diabetes  
- Maintenance of a diabetes register  
- Initial clinical assessment  
- Agreement of management plan with patients with Type 2 diabetes  
- Providing information on diabetes  
- Referral to structured education or relevant specialist(s) if not able to access any form of structured education  
- Providing advice where necessary  
- Psychological support (low level)  
- Participation in retinopathy screening programme (MIQUEST searches)  
- Appropriate day to day support and clinical review (minimum annual)  
- Referral to Level 2 or Level 3 services according to patients’ need and choice and agreed referral criteria  
- Early review of patients discharged from Level 2 or 3 services  
- Ongoing signposting as necessary  
- Referral for ongoing support for self care  
- Offering women of childbearing age contraceptive advice, referring on to Level 2 when considering pregnancy |
| B   | 1   | Opportunistic case finding outside GP practices | - Opportunistic case finding through local councils, pharmacists, voluntary sector |
| C   | 2   | Health promotion programmes | - Weight reduction courses/exercise programmes/smoking cessation programmes |
| D   | 2   | Structured education (Type 2) | - Structured education (Type 2) |
| E   | 2   | Supporting self help groups | - Eg Expert Patient Programme |
| F   | 2   | Insulin initiation (GP practices) | - Insulin initiation |
| G   | 2   | Diabetes Specialist Nurse Service | - Confirmation of initial diagnosis for those outside normal parameters  
- Treatment and management planning for patients with persistent sub-optimal glycaemic control at Level 1  
- Telephone help-line (8 am to 8 pm)  
- Insulin initiation for patients with Type 2 diabetes  
- Optimising diabetes therapies |
<p>| | | | |</p>
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<th></th>
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</thead>
</table>
| H | 2/3 | Psychological support | Agreement of management plans for complications in complex patients (retinal, renal, vascular, feet)  
Pre and post pregnancy advice in conjunction with Level 3  
Liaison with community matrons over patients with complex needs  
Psychological support (moderate level) |
| I | 2 | Dietetics | Specialist dietetics |
| J | 2 | Podiatry | Podiatry |
| K | 2 | Retinopathy | Retinopathy screening (annual) |
| L | 2 | Structured education (Type 1) | Structured education (Type 1) |
| M | 3 | Specialist care | Complex obesity management  
Classification of genetic or auto-immune disorders  
Education for complex cases and agreement of management plan with patients with Type 1 diabetes and complex needs  
Review of appropriate Type 1 and complex Type 2 diabetes patients  
Acute in-patient management including for patients with diabetes who are admitted with diabetes but not for diabetes  
Complex complications management (retinal, renal, vascular, foot)  
24 hour helpline (complex cases)  
Pre and post pregnancy advice in conjunction with Level 2  
Pregnancy care  
Transition management from children to adult services  
Insulin pump clinics  
Psychological support (specialist) |

**Infrastructure Services**

<table>
<thead>
<tr>
<th>N</th>
<th>Training and support (hospitals)</th>
<th>Training and support for non specialist hospital staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>Clinical governance &amp; mentorship support for Level 2</td>
<td>Clinical governance and mentorship for Level 2</td>
</tr>
<tr>
<td>P</td>
<td>Training and support for Level 1</td>
<td>Training and support for Level 1</td>
</tr>
<tr>
<td>Q</td>
<td>Identifying opportunistic case finding opportunities outside practices</td>
<td>Identifying opportunistic case finding opportunities outside practices, targeting groups services find it hard to reach</td>
</tr>
<tr>
<td>R</td>
<td>Overall pathway management</td>
<td>Overall management of the patient pathway</td>
</tr>
<tr>
<td>S</td>
<td>Care Planning project</td>
<td>Electronic care planning facility</td>
</tr>
</tbody>
</table>
5.3 It is anticipated that the following service components will be delivered or coordinated by the same provider although this does not necessarily have to be the case:

- Diabetes Nurse Specialist Service (component G)
- Structured Education (D & L)
- Supporting Self Help Groups (component E),
- Training and Support For Level 1 (component P)
- The Identification and Provision of Opportunistic Case Finding Opportunities (components Q & B)

5.4 It is expected that Clinical Governance and Mentorship Support for Level 2 (component O) will be delivered by Specialist Care providers.

5.5 GP practices may opt to bid for component F (Insulin Initiation – Level 2). This component will also be provided as part of the Diabetes Specialist Nurse Service to patients registered with practices not offering insulin initiation and to patients who express a preference to be supported by this Service.

5.6 It will be essential that all Service Providers deliver services that are integrated with the care pathway.

5.7 A professional network, comprising lead clinicians from all services contributing to the care of adult patients with diabetes, will be established to oversee the care pathway as a whole (component R). This network will be supported by a dedicated manager.

5.8 An overview of the key service requirements for each of the core service components is provided below.

5.9 These requirements should be read in conjunction with the Section 6 below - Referral Pathway and Appendix 5 - Care Pathway for Adult Patients with Diabetes Mellitus and relevant referral criteria, protocols and guidelines once these have been agreed between Service Providers and Commissioners.
Table 4: Diabetes Model of care for Adult Patients with Diabetes - Core Service Components

<table>
<thead>
<tr>
<th>A1 Core Primary Care – General Practices – Level 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>A core level of diabetes care at Level 1 will be provided by all General Practices in line with good practice. This care will include the following elements:</td>
</tr>
<tr>
<td>• raising awareness of signs and symptoms of diabetes and diabetes complications, to include: use of advertisements/leaflets</td>
</tr>
<tr>
<td>• promoting healthy lifestyle 1:1 support</td>
</tr>
<tr>
<td>• systematic and opportunistic case finding for diabetes, to include: testing of patients referred from the Health Checks Programme</td>
</tr>
<tr>
<td>• maintenance of a diabetes register</td>
</tr>
<tr>
<td>• initial clinical assessment of patients newly diagnosed (within 3 months of diagnosis), to include: lifestyle (weight, exercise, alcohol, smoking), glycaemic control, vascular risk assessment, renal assessment, neuropathy and foot assessment, plus education for people at risk of foot ulcers, medication review, psychological and social review, and care planning</td>
</tr>
<tr>
<td>• agreement and documentation of management plan for all patients with Type 2 diabetes</td>
</tr>
<tr>
<td>• providing information to patients diagnosed with diabetes, to include: Diabetes UK information pack to newly diagnosed patients with Type 2 diabetes signposting to Diabetes UK Website and help-line and local self-help groups, where available</td>
</tr>
<tr>
<td>• referral to structured education (DESMOND) or relevant specialist(s) if not accessing any form of structured education e.g. Community Dietitian</td>
</tr>
<tr>
<td>• providing advice where necessary, to include: advice on eating healthily and exercise reporting to DVLA sick day rules self monitoring</td>
</tr>
<tr>
<td>• psychological support (low level) to include: lifestyle/change management, education and adjustment strategies, management of minor depression/anxiety, encouragement and support for self-care</td>
</tr>
<tr>
<td>• participating in retinopathy screening programme</td>
</tr>
<tr>
<td>• appropriate day to day support and clinical review (minimum annual) to meet individual patients’ needs, to include: lifestyle (weight, exercise, alcohol) glycaemic control, vascular risk assessment, renal assessment, neuropathy and foot assessment plus education for people at low risk of foot ulcers, medication review, psychological and social review, care planning</td>
</tr>
<tr>
<td>• referral to Level 2 or Level 3 services according to patients’ need and choice and agreed referral criteria</td>
</tr>
<tr>
<td>• early review of patients discharged from Level 2 or 3 services</td>
</tr>
<tr>
<td>• ongoing signposting as necessary eg Diabetes UK</td>
</tr>
<tr>
<td>• referral for ongoing support for self care eg DESMOND, Expert Patient Programme</td>
</tr>
<tr>
<td>• offering women of child-bearing age contraceptive advice, referring to Level 2 when considering pregnancy</td>
</tr>
</tbody>
</table>

Practices will make arrangements to provide care for patients who are housebound or otherwise have difficulty attending the practice for appointments.
B1 Opportunistic Case Finding outside GP Practices – Level 1

Opportunistic Case Finding Services will be provided in community settings, and will supplement the Health Checks Programme. The community settings might include pharmacies, council-run fitness centres/day centres, diabetes awareness events, community hospital day centres, screening bus events around Somerset, as well as using the voluntary sector.

The Services will involve checking the random blood glucose levels of people with point of care glucose monitors.

All Random Glucose Testing Services will comply with the appropriate Somerset hygiene, infection control, sharp disposal policies and will satisfy the following criteria:

- use of glucose monitors must be by trained personnel only
- all personnel must have an annual update in the use of meters
- all meters must be quality assured
- blood letting devices must be single use only

The Services will need to be accessible to different sections of the community, including groups services find it hard to reach.

C2 Health Promotion Programmes – Level 2

The community-based Integrated Lifestyle Service will be extended across Somerset. The Service will provide motivational support and will signpost people to physical activity, healthy eating, and weight/obesity management programmes available in the community.

The Service will aim to provide support to vulnerable people and those with high health and social needs to make changes to a healthier lifestyle. Clients will be seen in a community setting close to where people live and in exceptional circumstance a home visit will be possible.

The Service will use a community development approach and will be specifically designed to integrate within the local community and actively engage with groups services find it hard to reach. The Integrated Lifestyle Service will use NHS Health Trainers, as proposed in the Choosing Health White Paper. Patients with diabetes may self refer o the Integrated Lifestyle Service or be referred via a health or social care professional.

The Integrated Lifestyle Service will be introduced incrementally across the county with priority being given to wards of high health and social need.

The ProActive Scheme will also continue to be available across the county. This scheme enables patients who are currently inactive, and have a medical condition that would benefit from regular physical activity, to be referred by a health professional to a local leisure provider. The leisure provider offers a safe introduction to physical activity based on the needs of the patient. Most leisure providers who operate this scheme offer it at a reduced cost to referred patients.
The Structured Education Service will provide the following programmes for patients with Type 2 diabetes:

- initial structured education for newly diagnosed patients with Type 2 diabetes, within 3 months of diagnosis (DESMOND)
- initial structured education for patients who did not participate in a course when first diagnosed – foundation level (format to be determined)
- ongoing structured education for patients who have previously undertaken the initial programme on an annual basis, dependent on need (format to be determined)

DESMOND (Diabetes Education for Ongoing and Newly Diagnosed) is a structured group education programme for adults with Type 2 diabetes. DESMOND has a theoretical and philosophical base. The programme supports people in identifying their own health risks and responding to them by setting their own specific behavioural goals.

The Structured Education Service for patients with Type 2 diabetes will be delivered in accordance with the National Service Framework Delivery Strategy for Diabetes (DH, 2003), the NICE Guidance on Type 2 Diabetes (updated in 2008) and the Department of Health and Diabetes UK report on Structured Patient Education in Diabetes (2004) and will satisfy the following criteria:

- have a person-centred, structured curriculum that is theory-driven and evidence-based, resource-effective, has supporting materials, and is written down
- be delivered by trained educators who have an understanding of education theory appropriate to the age and needs of the programme learners, and are trained and competent in the delivery of the principles and content of the programme they are offering, including the use of different teaching media
- provide the necessary resources to support the educators, and that the educators are properly trained and given time to develop and maintain their skills
- have specific aims and learning objectives and should support development of self-management attitudes, beliefs, knowledge and skills for the learner, their family and carers
- be reliable, valid, relevant and comprehensive
- be flexible enough to suit the needs of the individual (for example including the assessment of individual learning needs) and to cope with diversity, for example meeting the cultural, linguistic, cognitive and literacy needs in the locality
- offer group education as the preferred option, but with an alternative of equal standard for a person unable or unwilling to participate in group education
- be familiar to all members of the diabetes healthcare team and integrated with the rest of the care pathway
- enable people with diabetes and their carers to contribute to the design and provision of local programmes
- be quality assured and be reviewed by trained, competent, independent assessors who assess it against key criteria to ensure sustained consistency
- have its outcomes regularly audited
- develop in line with patient feedback.
Diabetes UK have provided guidance on the topics that should be covered by education programmes for people with diabetes, namely:

- nature of diabetes
- day-to-day management of diabetes
- specific issues
- living with diabetes
- ‘sick day’ rules

A review of demand and delivery options will be required to be undertaken early in 2009/10, the aim of which will be to identify how the needs of newly diagnosed patients and the remaining backlog of existing patients who have not previously had structured education can be met most efficiently and effectively.

Consideration will be given to offering courses in different delivery modes to suit individual learning needs and preferences and ensure equity of access to all geographical areas and patient groups including housebound and groups services find it hard to reach.

The Service will need to demonstrate strategies in place for improving the take-up of structured education in line with targets to be agreed with Commissioners.

An electronic record will be maintained of patients’ initial and ongoing participation in a Structured Education Programme. Patients and General Practices will be provided with written confirmation of attendance.

All staff providing Structured Education Programmes will be subject to external quality assurance.
E2 Supporting Self Help Groups – Level 2

Support will be provided to self help groups to help them establish and maintain themselves. This will include:

- signposting patients to new and established voluntary sector and community based self help and support groups via NHS communication channels eg. the NHS Somerset Diabetes Website, General Practices
- including a link on the Diabetes Website with Diabetes UK
- providing information sessions for self help groups on aspects of diabetes care and self management
- providing accommodation for self help groups to use for their meetings
- providing information on sources of funding available for self help groups and eligibility criteria
- seeking feedback from self help groups on services and incorporating this feedback into ongoing planning of services
- facilitating shared learning events for organisers of self help groups to share experience and learning
- considering the development of an e-forum for diabetes
- providing guidance on how to make self help groups accessible to housebound and groups services find it hard to reach
- providing support for self help groups catering for specific patient groups eg translation services for black and minority ethnic groups

It is anticipated that a minimum of 4 local groups across Somerset will be supported in 2009/10.
F2 Insulin Initiation (GP Practices) – Level 2

The Intermediate Service for Insulin Initiation at Level 2 offers General Practices the ability to increase the level of care they provide to their patients with Type 2 diabetes within primary care. The Service will be delivered in accordance with the National Service Framework Delivery Strategy for Diabetes (DH, 2003) and the NICE Guidance on Type 2 Diabetes (updated in 2008).

The Service will include:

- assessment of patient suitability for insulin initiation in accordance with agreed protocol
- specialist dietetic assessment
- consideration of medication needed
- initiation and ongoing adjustment of insulin
- educating patient on self management and self adjustment of insulin doses
- providing lifestyle modification and weight management advice
- monitoring blood sugar levels
- providing a telephone help-line for patients (8 am to 8 pm)
- keeping appropriate records, the content of which will be agreed with commissioners, to include blood sugar levels prior to and after initiation and any unplanned events
- liaising with Diabetes Specialist Nurse Service for advice in the event of erratic control

The service will be provided to patients with Type 2 diabetes who satisfy the following criteria:

- are not achieving HbA1c targets with maximum tolerated oral combination therapy
- do not have other reasons for requiring hospital assessment
- are over 18 years of age
- are not pregnant
- are deemed capable of safely managing their insulin, including being able to undertake home blood glucose monitoring, inject insulin and adjust their own dose
- express an intention to start insulin, having been advised of what this involves and the risks associated with the treatment and being aware of the choice of provider available
- have received a specialist dietetic assessment education and lifestyle advice prior to insulin initiation

Practices will be supported initially to deliver the Service by means of ‘observed practice’ based on a competency framework with a Diabetes Specialist Nurse, which will take place for the first five initiations or until the Diabetes Specialist Nurse is assured that the practitioner is delivering the appropriate standard of care.

Ongoing advice and support will continue to be available from the Diabetes Specialist Nurse Service when, for example, a patient’s blood glucose levels are not responding adequately to treatment or from Specialist Care if the case is complex. Patients may be referred to Specialist Care if the case is complex. Patients able to self manage and/or for whom optimisation of glycaemic control has been achieved will be referred back to Level 1 for ongoing review as part of annual monitoring.

Practices will provide the Diabetes Specialist Nurse Service with access to patient notes to assess activity submissions and service delivery against the insulin guidelines.
The Insulin Initiation Service will take place in community clinics/General Practices, or if a patient is unable to attend the community setting, in their home. Consideration will be given to how to ensure equity of access to all patient groups including housebound and groups services find it hard to reach.

To qualify to deliver the Service a Practice will need to have a minimum of two staff (a GP and Practice Nurse) who are accredited to provide insulin care to the practice’s patients (practices can make arrangements with each other to cross cover) and evidence of annual updates.

Patients will have the choice of being referred to this service or the Diabetes Specialist Nurse Service (see Component G2) for their insulin initiation.
G2 Diabetes Specialist Nurse Service – Level 2

The Diabetes Specialist Nurse Service will cover the whole of Somerset.

The Service will include the following elements of care:

- confirmation of initial diagnosis for those outside normal parameters
- treatment and management planning for patients with persistent sub-optimal glycaemic control at Level 1
- insulin initiation for patients with Type 2 diabetes, see service component F2 for detailed requirement for this service
- optimising diabetes therapies prescribing as appropriate
- agreement of management plans for complications in complex patients (retinal, renal, vascular, feet)
- pre and post pregnancy advice in conjunction with Level 3
- liaison with community matrons over patients with complex needs
- ongoing management of patients with Type 1 diabetes whose needs can be met by Level 2 services

The Service will comply with all relevant NICE guidance and technical appraisals and local policies.

The core working hours will be 9 am to 5 pm Monday to Friday, plus 2 evenings per week and Saturday mornings.

A telephone help-line (8 am to 8 pm Monday to Sunday) will offer advice to patients under the care of the Service on self management, sickness and dose management and will provide advice to prevent the need for an unnecessary admission. This help-line line will also provide support to healthcare professionals from Levels 1 and 2.

Access to the Diabetes Specialist Nurse Service will be audited and reviewed after 12 months. Consideration will be given to how to ensure an effective out of hours response.

Service staff will contribute to the Diabetes Structured Education Programmes (see Components D2 and L3).

Consideration will be given to how to ensure equity of access to all geographical areas and patient groups, including housebound and groups services find it hard to reach. Review appointments will be regular enough and of sufficient duration to meet patients needs.

All staff will have the relevant qualifications and be able to demonstrate the competencies to deliver the Service.

The Service will receive referrals from General Practices and Specialist Care and will refer to General Practices or Specialist Care as appropriate. Patients may self refer for up to 6 months following their last contact with the service or their discharge from the service.

Diabetes Specialist Nurse Service staff will be subject to clinical governance from a Consultant Diabetologist or Nurse Consultant for Diabetes, as appropriate.

Patients will have the choice of being referred to this service for insulin initiation or the General Practice Insulin Initiation Service, where available (see Component F2).
**H2/3 Psychological Support (moderate level) – Levels 2/3**

Psychological support at Level 2/3 will be provided for patients suffering from depression or having difficulty living with their diabetes, including patients with needle phobia.

Services will be in line with the National Service Framework for Mental Health (DH, 1999), NICE Guidance for the Management of Patients with Type 2 Diabetes (updated in 2008) and NICE compliant psychological therapies guidance.

It is envisaged that patients with low to moderate needs will generally access treatment through the Improved Access to Psychological Therapies Programme in Primary Care. This Programme will cover associated psychological problems that will respond to short term brief solution focussed interventions.

The service will cover:

Low intensity interventions, including:

- sleep and anxiety management
- guided self help such as bibliography, self help work books, exercise and leisure programmes
- psycho-educational courses (based on cognitive behavioural therapy) on stress, anxiety, depression, and eating disorders
- brief individual therapy (less than 10 sessions of CBT/counselling/problem solving)
- computerised cognitive behavioural therapy

High intensity interventions (for patients with more complex needs), including:

- individual cognitive behavioural therapy and other evidence based brief solution focused psychological therapies (eg 10-20 sessions based on cognitive behavioural therapy and 7-14 sessions solution focused therapy)
- group work

Health psychology specialists in long term conditions and with expert knowledge of diabetes will provide 1 to 1 support at Levels 2 and 3 for patients with more complex needs.

Services will be provided flexibly to suit individual needs and preferences and will be delivered by appropriately skilled staff. Consideration will be given to how to ensure equity of access to all geographical areas and patient groups, including housebound and groups services find it hard to reach.

The core working hours will be 9 am to 5 pm Monday to Friday, plus 2 evenings per week and Saturday mornings. Access will be audited and reviewed after 12 months. Service staff will contribute to the Diabetes Structured Education Programmes (see Components D2 and L3).

Referrals will be received from General Practices, the Specialist Diabetes Care Services and the Diabetes Specialist Nurse Service. Each referral will be subject to a clinical risk assessment and the relative priority established.
I2 Dietetics - Level 2

A locally placed, responsive, safe and effective Level 2 Dietetic Service for people with diabetes will be provided in partnership with primary care and secondary care, with the different teams responsible for specific steps in the diagnostic, treatment and monitoring process, according to risk categories.

The Specification of the Dietetic Service has been informed by the following national frameworks and toolkits:

- Workforce and Training Framework for the Delivery of Diet and Lifestyle Care Pathways for Long Term Conditions developed by The British Dietetic Association Diabetes Care Workforce Team (2008)
- Dietetic Screening and Referral Tool Kit a Diabetes Perspective, developed by the British Dietetic Association (2008)

The Service will be delivered in line with related guidelines and standards, including the National Service Framework Delivery Strategy for Diabetes (DH, 2003) and the NICE Guidelines relating to Infection Control, Eating Disorders, Nutritional Support in Adults (2006), and the Treatment and Management of Overweight and Obesity (2006).

Patients with diabetes will be screened at the time of diagnosis by the Lead Practice Nurse to ascertain the appropriate referral pathway and will be provided with advice on diet and the Diabetes Information Pack (see Component A1 – Core Primary Care).

Further advice on diet will be provided as part of a Structured Education Programme (DESMOND for patients with Type 2 diabetes or DAFNE for patients with Type 1 diabetes) which newly diagnosed patients will be invited to attend soon after diagnosis (see Sections D2 above and L2 below). This advice will also be reinforced in ongoing Structured Education Programmes.

State Registered Dietitians with specialist knowledge of diabetes care will participate in the Structured Education Programmes, in accordance with Department of Health, Diabetes UK and NICE guidance.

Individuals for whom referral to group education is inappropriate and patients needing access to ongoing dietetic care at diagnosis or subsequently will be referred to the Community Dietetic Service for 1 to 1 support.

Community Dietitians will have the appropriate diabetes competencies to advise patients with Type 2 diabetes. This service will be provided in the Primary Care Setting with a Domiciliary Service for groups that services find it hard to access and housebound patients. The referral criteria for this Service will include:

- patients with learning difficulties or mental health problems
- patients with complex lifestyle problems
- patients with complex dietary needs eg diabetes plus another condition requiring dietary intervention
- patients requiring domiciliary/nursing home visits
- patients who have already received dietary advice for diabetes/ attended DESMOND but continue to require support on making dietary changes.
- patients needing 1:1 weight management advice
- patients who decline referral to DESMOND
- patients unable to keep to agreed care plan

Patients needing help with obesity management will be referred to the obesity management service (see Component G2 - Health Promotion Services).

Patients with more complex needs will be supported by Specialist Diabetes Dieticians in the Diabetes Specialist Nurse Service (see component G2 – Diabetes Specialist Nurse Service). Referral criteria to this Service will include:

- persistent poor glycaemic control
- complex co-morbidities
- insulin initiation
- complex weight management

Support will include:

- 1 to 1 and group therapies
- Group education for insulin initiation
- Domiciliary visits

The core working hours will be 9 am to 5 pm Monday to Friday, plus 2 evenings per week and Saturday mornings. Access will be audited and reviewed after 12 months.

All staff will have the relevant qualifications and be able to demonstrate the competencies to deliver the Service.

Patients with unstable Type 1 diabetes and patients being seen by Specialist Care will receive care from Specialist Diabetes Dieticians (see component M3 – Specialist Care).

General dietary advice for people with diabetes will also be available on the Diabetes Web-site (see Component R ‘Overall Pathway Management’) and from the telephone helpline for patients under the care of the Diabetes Specialist Nurse Service. (see Component G2 Diabetes Specialist Nurse Service). A 24 hour helpline for patients with complex needs under the care of specialist consultants will also be available (see Component M3 Specialist Care).

A review of demand and delivery options will be required to be undertaken early in 2009/10, the aim of which will be to identify how the needs of patients can be met most efficiently and effectively. Consideration will be given to how to ensure equity of access to all geographical areas and patient groups, including housebound and groups that services find it hard to reach.
J2 Podiatry – Level 2

A locally placed, responsive, safe and effective Level 2 Foot Care Service for people with diabetes will be provided in partnership with Primary Care and Secondary Care, with the different teams responsible for specific steps in the diagnostic, treatment and monitoring process, according to risk categories.

The Service will be delivered by Podiatrists in line with the National Service Framework Delivery Strategy for Diabetes (DH, 2003), NICE Guidelines for the Prevention and Management of Foot Problems for Patients diagnosed with Type 2 Diabetes (2004) and the NICE Guidelines for Type 1 Diabetes (2004).

Patients will be screened at the time of diagnosis by the Lead Practice Nurse to ascertain the appropriate pathway for ongoing assessment and care based on classification of risk (see Component A1 – Core Primary Care).

Patients will be provided with foot health and self care advice by Primary Care on diagnosis and advice will be included as part of a Structured Education programme (DESMOND for patients with Type 2 diabetes or DAFNE for patients with Type 1 diabetes)

Community Podiatrists will have the skills and competencies to treat patients with Type 1 and 2 diabetes. This service will be provided in the community setting with a Domiciliary Service for patient groups that services find it hard to access and housebound.

The referral criteria for this service will be:

- care of patients at increased risk of foot ulcers (neuropathy or absent pulses or other risk factor)
- care of patients at high risk of foot ulcers (neuropathy or absent pulses plus deformity or skin changes or previous ulcer)

If a patient has had previous foot ulcer or deformity or skin changes they will be managed as high risk. Patients assessed as high risk presenting with a foot ulcer will be seen by a Podiatrist specialising in Diabetes.

The Service will be offered in a variety of settings including GP surgeries, purpose built clinics, community hospital clinics, and in patients’ homes, residential care homes, prison, and on wards in community and acute hospitals and mental health units. Review appointments will be regular enough and of sufficient duration to meet patients needs. Seamless care links will be maintained with the specialist Level 3 diabetes foot care services provided in local NHS Trusts and the Level 1 foot review service provided by General Practices, as well as with the wider diabetes pathway (see components A1 – Core Primary Care and M3 – Specialist Care).

The core working hours will be 9 am to 5 pm Monday to Friday, plus 2 evenings per week and Saturday mornings. Access will be audited and reviewed after 12 months.

All staff will have the relevant qualifications and be able to demonstrate the competencies to deliver the Service.

The Service will provide foot health education to health care professionals delivering Level 1 foot care and will contribute to Structured Education Programmes for patients (see Components D2 and L2).
Referrals will be from General Practices or Consultant Led Teams, other health professionals within the Trust or community, independent Podiatrists, relatives/carers or on a self referral basis in line with government guidelines. GP/ Practice nurse referrals will be required for domiciliary care, which is restricted to the housebound and patient groups that services find it hard to reach.

A review of demand and delivery options will be required to be undertaken early in 2009/10, the aim of which will be to identify how the needs of patients can be met most efficiently and effectively. Consideration will be given to how to ensure equity of access to all geographical areas and patient groups including housebound and groups that services find it hard to reach.
**K2 Retinopathy – Level 2**

Screening for sight threatening diabetic retinopathy using digital photography will be offered annually to patients with diabetes. Patients may also be required to be re-screened more frequently based on clinical necessity.

The Service will be delivered by in line with the National Service Framework Delivery Strategy for Diabetes (DH, 2003), the UK Screening Programme Guidance, the NICE Guidance for Type 2 Diabetes (updated in 2008). The Service will meet the national target of 100% of people with diabetes offered screening for the early detection (and treatment if needed) of diabetic retinopathy as part of a systematic programme that meets national clinical standards.

In order to meet the target, screening programmes are required to meet the following standards:

- the screening test must be digital photography
- screening staff must be appropriately trained and a clinical lead and programme manager must be in place
- positive screening tests must be appropriately followed-up and there must be good links to both hospital and primary care
- people with diabetes must be invited to screening annually
- the programme must cover at least 12,000 people with diabetes
- call and recall from a comprehensive managed list of those covered by the programme
- participation in quality assurance

Referrals will be made via a download of the register of patients diagnosed with diabetes from the General Practitioner systems on a quarterly basis.

The core working hours will be 9 am to 5 pm Monday to Friday, plus 2 evenings per week and Saturday mornings. Access will be audited and reviewed after 12 months.

All staff will have the relevant qualifications and be able to demonstrate the competencies to deliver the Service.

Patients will be provided with three weeks notice of their appointment. All appointments will be offered by a central Call/Recall system, with result letters being sent to the patient and their General Practitioner. Specialist referrals will be made directly to the relevant Acute Trust.

A review of demand and delivery options will be required to be undertaken early in 2009/10, the aim of which will be to identify how the needs of patients can be met most efficiently and effectively. Consideration will be given to how to ensure equity of access to all geographical areas and patient groups including housebound and patient groups that services find it hard to reach.
The Structured Education Service will provide the following programmes for patients with Type 1 diabetes:

- initial structured education for newly diagnosed patients with Type 1 diabetes, 6-9 months after diagnosis (DAFNE)
- ongoing structured education for patients who have previously undertaken the initial programme (initial follow-up within 8 weeks of completion of DAFNE course then annually dependent on need)
- initial structured education for patients who did not participate in a course when first diagnosed

DAFNE (Dose Adjustment For Normal Eating) is a skills-based education programme in which adults with Type 1 diabetes learn how to adjust insulin to suit their free choice of food, rather than having to work their life around their insulin doses.

The Structured Education Service for patients with Type 1 diabetes will be delivered in accordance with the National Service Framework Delivery Strategy for Diabetes (DH, 2003) and the Department of Health and Diabetes UK report on Structured Patient Education in Diabetes (2004) and as defined by the DAFNE collaborative and will satisfy the following criteria:

- have a person-centred, structured curriculum that is theory-driven and evidence-based, resource-effective, has supporting materials, and is written down
- be delivered by trained educators who have an understanding of education theory appropriate to the age and needs of the programme learners, and are trained and competent in the delivery of the principles and content of the programme they are offering, including the use of different teaching media
- provide the necessary resources to support the educators, and that the educators are properly trained and given time to develop and maintain their skills
- have specific aims and learning objectives and should support development of self-management attitudes, beliefs, knowledge and skills for the learner, their family and carers
- be reliable, valid, relevant and comprehensive
- be flexible enough to suit the needs of the individual (for example including the assessment of individual learning needs) and to cope with diversity, for example meeting the cultural, linguistic, cognitive and literacy needs in the locality
- offer group education as the preferred option, but with an alternative of equal standard for a person unable or unwilling to participate in group education
- be familiar to all members of the diabetes healthcare team and integrated with the rest of the care pathway
- enable people with diabetes and their carers to contribute to the design and provision of local programmes.
- be quality assured and be reviewed by trained, competent, independent assessors who assess it against key criteria to ensure sustained consistency
- have its outcomes regularly audited
- develop in line with patient feedback.

Diabetes UK have provided guidance on the topics that should be covered by education programmes for people with diabetes, namely:

- nature of diabetes
- day-to-day management of diabetes
- specific issues
- living with diabetes
- ‘sick day’ rules

A review of demand and delivery options will be required to be undertaken early in 2009/10, the aim of which will be to identify how the needs of newly diagnosed patients and the remaining backlog of existing patients who have not previously had structured education can be met most efficiently and effectively.

Consideration will be given to offering courses in different delivery modes to suit individual learning needs and preferences and ensure equity of access to all geographical areas and patient groups, including housebound and groups that services find it hard to reach. For example 1:1 education in carbohydrate counting may be offered to those who are unable to attend the course either because of being housebound or unable to attend a course for 5 days.

The Service will need to demonstrate strategies in place for improving the take-up of Structured Education Programmes in line with targets to be agreed with Commissioners.

An electronic record will be maintained of patients’ initial and ongoing participation in a Structured Education Programme. Patients and General Practices will be provided with written confirmation of attendance.

All staff will have undergone accredited training prior to delivering DAFNE.

Trainers will undergo external quality assurance as directed by the DAFNE collaborative.
M3 Specialist Care – Level 3

A responsive, safe and effective Service will be provided at Level 3 for patients with unstable Type 1 diabetes and patients with complex Type 2 diabetes.

The Service will be delivered by Consultant Diabetologists in line with national guidance on diabetes care, including the National Service Framework Delivery Strategy for Diabetes (DH, 2003), the NICE Guidelines for Type 1 Diabetes (2004) and the NICE Guidance for the Management of Patients diagnosed with Type 2 Diabetes (updated in 2008).

The Service will provide the following care:

- **Complex obesity management including:**
  - access to a Level 3 weight management clinic with multidisciplinary support from medical staff, dietetics and nursing
  - availability of a full range of pharmacological interventions, exercise intervention and structured weight loss programmes
  - access to bariatric surgery, with capacity for long term follow up for such patients

- **Classification of genetic or auto-immune disorders including:**
  - access to specialist opinion for the classification of diabetes, particularly where it may affect treatment.
  - specialist advice on genetic and autoantibody testing
  - specialist support for medication changes, including safe discontinuation of insulin (may be supervised in Level 2 care)

- **For newly diagnosed Type 1 patients, initial management, education and agreement of management plans, including:**
  - access to specialist multidisciplinary services (medical, nursing, dietetic, psychological) as soon after diagnosis as possible
  - development of situation specific management plans with patient-professional identified goals
  - provision of written information for patients on management of Type 1 diabetes
  - access to training in advanced glucose management skills (structured education, carbohydrate counting, insulin dose adjustment etc)

- **Review of appropriate Type 1 patients, whose needs cannot be met by Level 2, including:**
  - access to specialist care for patients with Type 1 diabetes, providing the most up to date advice on insulin therapy, insulin delivery mechanisms
  - management of long term complications – proteinuric renal disease, complex foot disease.
  - management of hypoglycemia and hypoglycemia unawareness, including access to the most advanced tools for hypoglycemia management eg pump therapy, continuous blood glucose monitoring, islet transplantation

- **Review of appropriate Type 2 patients, whose needs cannot be met by Level 2, including:**
  - management of the most complex patients with Type 2 diabetes eg the super-obese (including access to bariatric surgery), proteinuric renal disease, complex foot conditions
  - access to most up-to-date treatments for Type 2 diabetes, with specialist opinion on patient suitability

- **Acute in-patient management for diabetes emergencies and elective care, including management of patients who are admitted with diabetes but not for diabetes**
• 24 hour helpline (complex cases) including:
  access to specialist advice by dedicated helpline for selected patients eg pump
  patients, hypoglycemia prone patients, adolescent and vulnerable young adult
  patients.
• pregnancy care including:
  access to a specialist diabetes and obstetric service before, during and after
  pregnancy
  provision of joint clinics with capacity for frequent assessment with expert level care
  for mother and baby (pre and post pregnancy care delivered in conjunction with
  Level 2 Diabetes Specialist Nurse Service)
  expert advice in management of Type 1, Type 2 and gestational diabetes; including
  glucose control, complication surveillance and management, obstetric care and
  planning post pregnancy care
• transition management from children to adult services including:
  provision of services to transit adolescents with diabetes (Type 1 or Type 2) from
  paediatric to adult services - this should include close working arrangements with
  paediatric staff specialising in diabetes, and would typically involve joint clinic
  working with medical, specialist nursing and dietetics, and psychological support,
  with staff drawn from paediatric and adult services.
  agreed protocols for transfer from paediatric clinics to transition services, and then
  from transition services to adult services - there should be individualisation of this
  process based on the person’s needs
• insulin pump clinics
  Delivery of continuous subcutaneous insulin therapy according to NICE guidance.
  This requires a specialist multidisciplinary team managing a critical mass of patients
  with this technology with skills and capacity for assessing patient suitability, training
  and ongoing support.

Referrals will be accepted from Primary and Intermediate Care and patients will be
referred back to one of these services when they no longer have a need for specialist
care.

A review of demand and delivery options will be undertaken early in 2009/10, the aim of
which will be to identify how the needs of patients can be met most efficiently and
effectively. Consideration will be given to how to ensure equity of access to all
geographical areas and patient groups, including housebound and groups that services
find it hard to reach. Where possible and appropriate the Service will be provided in the
community.
N Training and support for non specialist hospital staff

This service is within the remit of secondary care providers who will ensure that staff on wards have knowledge and skills of diabetes management including support for self-care in line with the guidance set out in documentation published by the National Diabetes Support Team in March 2008 – ‘Improving Emergency and Inpatient Care for People with Diabetes’.

O Clinical Governance and Mentorship Support for Level 2 - infrastructure

The following services will be provided to ensure clinical governance and mentorship support for the Diabetes Specialist Nurse Service:

- selected and random case note review with Diabetes Specialist Nurse team by Consultant Diabetologist or Diabetes Nurse Consultant
- clinical mentorship for Diabetes Specialist Nurses undergoing Nurse Prescribing Course by Consultant Diabetologist
- mentorship to be provided to all Diabetes Specialist Nurses by Diabetes Nurse Consultant
- clinical governance sessions will be provided twice monthly each for the period of a clinical session
- ongoing mentorship/advice will be provided by Consultant Diabetologists to the Diabetes Specialist Nurse Community Service, using telemedicine and/or email.

P Training and support for Level 1 – infrastructure

The following services will be provided to increase the capacity and capability at Level 1:

- regular diabetes awareness and management education sessions across Somerset for all community staff ie nurses, podiatrists, dietitians, pharmacists, GPs, practice nurses, health care assistants
- ongoing sessions of diabetes management/dietary and food advice to be provided for nursing home and residential home staff and for prison staff advice and support for General Practices delivering Insulin Initiation Service

Education will be provided by appropriately qualified staff at a level relevant to the target audience.

All education sessions will have clear learning objectives.

All sessions will be evaluated by participant feedback forms.

A review of demand and delivery options will be required to be undertaken early in 2009/10, the aim of which will be to identify how the needs of Level 1 providers can be met most efficiently and effectively.

Q Identifying Opportunistic Case Finding Opportunities Outside Practices

This is a coordinating service which will link with providers to deliver opportunistic screening (see Component B1 Opportunistic Case Finding outside GP Practices)
**R Overall pathway management**

All Service Providers will be required to work together to ensure that the care provided to patients is well coordinated, high quality and safe and that the system as a whole is efficient and effective (see Section 8.8 below for further details of responsibilities).

Key deliverables will include:

- NHS Somerset Diabetes Website to include:
  - details of services and referral pathways; signposting to help-lines; general information on diabetes care; leaflets in electronic form; links to other relevant websites including those detailing NICE guidance; contact details of voluntary sector and community based self help and support groups; details of the complaints procedure
  - to be available in ‘easy to read’ format and in the main languages used in Somerset
- comparative performance data at practice level

**S Care planning project**

See outline of Year of Care project on page 11
6 REFERRAL PATHWAYS

6.1 Service Providers will refer patients in accordance with the attached care pathway (Appendix 5 – Care Pathway for Adult Patients with Diabetes Mellitus). The pathway shows how patients with diabetes will be supported throughout their journey by the new model of care and need to be read in conjunction with the more detailed elements of care set out in Table 2 above – Levels of Care and the Service Components set out in Table 4 and Section 5 above.

6.2 Service Providers will be expected to work together to develop operational pathways, referral criteria and guidelines to ensure that referrals are appropriate and managed in a timely manner in accordance with national and local maximum waiting time targets.

6.3 All referral routes must comply with National Guidance and policies including:

- the National Service Framework Delivery Strategy (NSF) for Diabetes (DH, 2003)
- National Institute of Health and Clinical Excellence (NICE) guidelines for diabetes
- NHS Information and Governance protocols and processes

6.4 Consideration will also need to be given to how the diabetes pathways link with other long term conditions pathways and pathways for improving health.

6.5 The operational pathways, referral criteria and guidelines will be approved by commissioners prior to implementation.

6.6 Service Providers will be required to satisfy the following referral standards:

- each patient will be able to agree a mutually convenient appointment time and will be sent an appointment letter to confirm the date and time of the patient’s appointment together with relevant information, such as:

  * information about eligibility for and access to NHS transport
  * directions to the venue and parking
  * information about how to cancel the appointment
  * information about what to bring to the appointment, such as the patients agreed care plan, or current medication

- Service Providers will ensure that patients who may be required to undergo a specific diagnostic procedure will be informed of any preparation that they need to take in advance of the appointment
- Service Providers will take reasonable steps to minimise the incidence of non-attendance of patients to all appointments
Service Providers will keep records containing the patient’s telephone numbers and preferred means of communication.

Service Providers shall notify the referring clinician of patient non-attendance and shall copy the letter to the patient at their last known address. Service Providers shall invite the patient to contact Service Providers regarding the missed appointment, and shall allow a period of two weeks to allow the patient to respond, following which the referral will be cancelled and the patient returned to the care of the referring clinician.

Routes for referral may include telephone, email, fax, letter and electronic booking.

7 GOVERNANCE

Individual provider responsibilities

7.1 All Service Providers contributing to the care pathways must comply with Department of Health Standards for Better Health (2006) and ensure clinical governance requirements are in place to comply with the annual health check and to meet the standards of care set within the relevant NICE guidance and the National Service Framework for diabetes.

7.2 All Service Providers will need to be able to demonstrate clear lines of accountability and responsibility for all clinical governance functions, including:

- clinical audit
- clinical risk management
- untoward incident reporting
- infection control
- medicines management
- informed consent
- raising concerns
- staff development
- complaints management
- patient and public involvement
- patient dignity and respect
- safeguarding vulnerable adults
- equality and diversity
- introducing new technologies and treatments

7.3 All Service Providers are responsible for ensuring provision of safe care to agreed quality standards, whether delivered by clinical staff in their employment or by seconded staff.

7.4 All Service Providers will also be required to have quality assurance systems in place, which have been agreed by NHS Somerset, to
demonstrate compliance with national standards and delivery of the service specification.

7.5 Where portions of the service are sub-contracted there must be clear and formal accountability processes and structures in place to ensure continuity of care that is safe and effective. There should be clear and formal agreements between the provider service and sub-contractors, detailing the part played by the sub-contractor and the arrangements for clinical accountability and responsibilities between the two parties.

7.6 Service Providers will be required to work together, through the Somerset Diabetes Local Implementation Team, to help ensure that new services are introduced effectively and safely and that the pathway provides continuity of care across organisational and professional boundaries in a manner that is accessible to all, to the standards set out in the Service Specification.

The Somerset Diabetes Local Implementation Team

7.7 The Somerset Diabetes Local Implementation Team will:

- enable development and implementation of high quality, integrated operational pathways and protocols
- clarify clinical responsibility at all stages of the pathway
- identify boundaries of care between providers and accountabilities for ensure all patients receive care that meets the required standards
- ensure the pathway is compliant with Standards for Better Health
- undertake an equality impact assessment
- enable development and implementation of shared information/communication systems (including integrated web-site)\(^3\)
- ensure development of a directory of services
- review the experience of patients across the pathway as a whole, considering and addressing any issues that may arise
- monitor progress against agreed implementation plans
- coordinate, evaluate and share best practice and propose service developments
- develop a county-wide human resource strategy for diabetes
- review risks relating to service redesign and recommend action to address risk
- provide clinical leadership
- link with stakeholder groups to ensure an ongoing strategic approach to service implementation

7.8 The Somerset Diabetes Local Implementation Team will be accountable to the Diabetes Commissioning Group for the delivery of its clinical governance functions and will link with the NHS Somerset contract management teams regarding any performance issues that come to light through ongoing pathway review.

\(^3\) This will ultimately have to be the responsibility of a single organisation to maintain.
The structure for ensuring governance is represented diagrammatically in Figure 4 below.

**Figure 4: Governance Structure for Somerset Diabetes Service for Adults**

- **NHS Somerset Board**
- **PEC (service specification approval)**
- **Somerset Diabetes Commissioning Group (service specification development)**
- **Somerset Diabetes LIT (enabling service implementation)**
- **Contract management (individual provider contracts)**
- **Providers (internal clinical governance processes)**

**Abbreviations:**
- LIT – Local Implementation Team
- PEC – Professional Executive Committee
Clinical Leadership

7.10 Effective clinical governance requires strong clinical leadership. This will be achieved through the following lead roles:

- a medical consultant lead to provide strategic leadership for the pathway as a whole
- a clinical lead who will champion and support the implementation of the model of care across level 1 providers
- a clinical lead who will champion and support the implementation of the model of care across services providing level 2 care
- a lead consultant diabetologist for each acute provider who will champion and support the implementation of the model of care across specialisms within the acute setting
- a diabetes lead for each of the professional specialisms contributing to the care of patients with diabetes
- a lead GP and a lead nurse for each GP practice (GP practices may choose to group together and share these roles)

7.11 All of the above leadership roles will be represented on the Somerset Diabetes Local Implementation Team.

7.12 The Medical Consultant Lead and the Clinical Lead for Level 1 will be employed by and be accountable to the Commissioning body in respect of their clinical lead role. The other clinical leads listed above will have the lead role incorporated into their current role and will be responsible to their existing employer for this role.

Clinical Responsibility

7.13 Referral protocols will clearly specify where clinical responsibility lies at each stage of the pathway.

7.14 The practitioner providing clinical diabetes care is professionally accountable for their individual practice and the diabetes care that they provide to individual patients.

7.15 Clinical responsibility for the provision of level 1 services will sit with the General Practitioner with whom the patient is registered.

7.16 Clinical responsibility for the level 2 service will sit with the level 2 provider.

7.17 Clinical responsibility for level 3 services will sit with the consultant diabetologist providing the clinical care to the patient.

7.18 Overall responsibility for patients referred to a level 2 service will remain with the referrer (i.e. the General Practitioner or the Hospital Consultant), who will be kept informed of the outcomes of the level 2 consultations. The General Practitioner will be kept informed of the outcome of all consultations with other practitioners.
Skills, Competences and Capacity

7.19 All Service Providers will be required to demonstrate they have sufficient numbers of people with the skills and competences identified by Skills for Health for diabetes care.

7.20 All staff delivering the Somerset Diabetes Service will have criminal records bureau clearance and professional registration checks.

7.21 All staff delivering the Somerset Diabetes Service will have an annual appraisal and have access to quality assured and relevant education, training and development, focusing on both generic and specific competences.

7.22 Training programmes must be underpinned by a skills audit referenced against required competences and will have increased emphasis on care planning and supporting patients to self manage their care. Leadership, change and management skills will need to be developed across the diabetes network.

7.23 Service Providers may wish to share training arrangements.

7.24 A Workforce Strategy, including a skills assessment and workforce recruitment and development plan, will be developed through the Diabetes Local Implementation Team.

7.25 There is an opportunity to spread existing roles some of which are currently only available in a limited area, and/or develop or adapt roles that have been introduced elsewhere.

7.26 Roles that have been developed elsewhere in the country include the diabetes care technician, the educational support worker, and the senior care assistant. These roles incorporate responsibility for a range of Level 1 and 2 care elements.

7.27 All Service Providers will be required to notify the commissioners of any significant changes to workforce arrangements which might impact on the quality of care provided by the service and at the level of the overall pathway.

Supervision and Mentorship

7.28 Clinical supervision for staff in each professional group contributing to the care pathway (including podiatry, dietetics, retinopathy and psychology) will be provided in accordance with the provider organisation’s agreed policies on clinical supervision and will include the review of case notes for cases where there is a significant clinical issue.

See also section 10 of the NHS Conditions of Contract for the Supply of Services.
7.29 Clinical governance and mentorship support for the Diabetes Specialist Nurse service teams and other providers of level 2 care will be provided by medical specialists, whilst the provision of regular training programmes and ongoing advice and support for primary healthcare professionals will be incorporated into the responsibilities of the community based Diabetes Specialist Nurse Teams.

Working Arrangements

7.30 Staff will work flexibly across care settings and organisations, providing care to patients where it is required and as close to the patient’s home or work as possible.

7.31 Diabetes Specialist Nurses employed by Taunton and Somerset NHS Foundation Trust, Yeovil District Hospital NHS Foundation Trust and Somerset Community Health will work as a single team for the delivery of the specified Diabetes Specialist Nurse level 2 services in the community. In order to provide clear lines of accountability to the level 2 service the diabetes specialist nurses will be seconded to the level 2 service for this aspect of their role.

7.32 Staff employed by the acute trusts and Somerset Community Health receive the support they need to do their job effectively and safely and their responsibilities and accountabilities will be clearly defined, including specifying the arrangements for clinical supervision, mentoring, staff development and training and appraisal.

7.33 Staff will be accountable to the diabetes Level 2 service provider for their role undertaken on secondment to the service, and appropriate clinical supervision will be put in place in the level 2 service for this role. Staff will receive an annual appraisal through the employer for their substantive post and this will be contributed to by their employer for their role in the Level 2 service to ensure all aspects of their personal and professional development are reviewed. Training and development will be provided by the substantive employer based on identified training and development needs in the personal development plan for the staff member.

7.34 Clinical supervision of Diabetes Specialist Nurse staff will be undertaken by the Clinical Lead / Nurse Consultant for the level 2 services.

7.35 Similar arrangements will need to be developed for other professional staff contributing to the Diabetes Specialist Nurse Service, for example Specialist Dietitians.

Clinical Audit

7.36 All Service Providers have a responsibility to undertake clinical audit and to participate in integrated audit across the patient pathway. Clinical audit will include case note review, and audit of the care pathway and clinical care provided.
7.37 All clinical audit arrangements will be agreed by commissioners and comply with NHS Somerset policies and guidelines on audit.

**Serious Untoward Events/ Risk Management and Professional Indemnity Cover**

7.38 Reporting of Serious Untoward Incidents will follow the Incident Reporting Policy of the provider service and shared at the level of the pathway.

7.39 will be required to demonstrate an appropriate system for recording, monitoring and reporting of risk issues.

7.40 Service Providers will ensure that all staff have appropriate indemnity cover to meet any claims against them in full.

**Contingency and Emergency Planning**

7.41 Service Providers will demonstrate business continuity plans for failure of or breakdown in the service and as a minimum these should cover:

- capacity and capability to manage peaks in demand
- capacity and capability to manage loss of equipment or staffing

7.42 Service Providers will be expected to demonstrate plans to support any emergencies that may arise.

**Confidentiality**

7.43 Service Providers will ensure the maintenance of patient confidentiality and implement procedures which ensure that patients’ affairs are only discussed with relevant people and agencies in accordance with the NHS standards for confidentiality.

7.44 See also section 35 of the NHS Conditions of Contract for The Supply of Services.

**Complaints and Commendations**

7.45 Service Providers will establish and operate a robust complaints and commendations procedure in line with NHS Somerset guidelines to deal with any complaints in relation to any matter connected with the provision of services. All complaints will be monitored, audited and appropriate action taken when required.

7.46 Service Providers will take reasonable steps to ensure that patients are aware of:

- the complaints procedure
- the role of NHS Somerset and other bodies in relation to complaints about services
• the right to assistance with any complaint from independent advocacy services

7.47 Service Providers will take reasonable steps to ensure that the complaints procedure is accessible to all patients taking cognisance of language and communication needs.

7.48 Service Providers will provide a quarterly summary of all complaints and commendations received, progress, outcome and actions taken to NHS Somerset.

7.49 Service Providers will attempt to resolve complaints by informal discussions with the patient and/or carer. If these discussions fail to provide a solution that is satisfactory to both the Service Provider and patient, a full written report shall be submitted to NHS Somerset, who will undertake to investigate the complaint.

Patient Experience

7.50 Service Providers will put in place processes to elicit patient feedback on an annual basis as a service minimum and service evaluation in a manner which demonstrably improves service provision.

7.51 Methods for obtaining feedback may include patient surveys, questionnaires and audits. These will need to be undertaken at individual provider service level and at overall pathway level. Areas to be covered will include:

• ease of access
• whether the patient felt welcomed and cared for
• cleanliness of staff and the building
• whether the patient was treated with dignity and respect
• how safe the patient felt
• whether the patient felt involved in planning their care
• whether the patient felt as if they were treated according to their needs
• whether the patient was offered clear and relevant information, which they understood so they could make informed choices about their care
• whether the patient felt listened to and had any concerns or questions addressed
• how the patient rated their experience overall
• consistency of advice
• competence of staff
• clinical outcome
• other areas specific to the service provided

7.52 Feedback will also be required on experience specifically relating to diabetes services.
Privacy and Dignity

7.53 Service Providers will ensure that patients are treated with dignity and respect at all times, that their privacy is respected, and that all aspects of their service comply with the ten key components of ‘The Dignity Challenge.’ (Department of Health, 2007). In addition, the Service Providers shall not permit documentation containing confidential patient information to be left where it may be seen by unauthorised persons and patient information shall be treated confidentially by all Staff.

Venues and Transport for Patients

7.54 Service Providers shall ensure that they have an agreed Service Level Agreement with the South Western Ambulance Service NHS Trust and/or other local patient transport providers. NHS transport should be provided for those patients who meet the Somerset NHS transport eligibility criteria for transport to attend clinics.

7.55 For patients who do not qualify for free transport, the Patient Transport Advice Service will advise on alternatives, such as local community transport services which may levy a small charge to patients.

7.56 Venues for the service provision must provide clear, safe, public parking and which allows patients full access to public transport and main road networks for those patients where private transport is not an option. Venues should be compliant with the Disability and Discrimination Act (1995).

7.57 NHS Somerset may be able to facilitate the Service Provider in sourcing appropriate venues. Service Providers may be required to enter into a lease agreement for the use of community venues and relevant facilities management.

Informed Consent

7.58 Service Providers will comply with the NHS Guidance on Consent (2001) in relation to obtaining consent from each patient to the provision of services (Informed Consent) and in particular:

- Department of Health Reference Guide to Consent for Examination or Treatment (2001)
- Health Service Circular HSC 2001/023
- Seeking Patient’s Consent: The Ethical Consideration: GMC November 1998

Equality and Diversity

7.60 Service Providers will ensure that the service addresses equality and diversity issues. It will be accessible by all patients who meet the service criteria and ensure equality of outcome regardless of age, ability, cultural background, ethnicity and sexuality.
Infection Control

7.60 Service Providers will ensure that services comply with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance and other related national and local NHS Somerset requirements, including the policies and recommendations of:

- the Institute of Sterile Service Management
- the Infection Control Nurses Association

7.62 Service Providers shall ensure that all relevant employees are trained in relevant infection control techniques, in accordance with best practice.

Medicines Management

7.63 Service Providers will comply with the NHS Somerset drug formulary and with relevant NICE guidance and ensure access to pharmacy advice and service provision where relevant. Medicines management will be undertaken in accordance with the standards for medicines management within Standards for Better Health, DH 2006.

Publicity/Promotion

7.64 Service Providers will promote and publicise the service across the Somerset health and social care community.

7.65 The production of all promotional and information leaflets will be the responsibility of provider services. It is expected that this will be discussed with and agreed by NHS Somerset.

Policies and Procedures

7.66 Service Providers will have in place the following policies:

- equality and diversity
- recruitment and staff training
- health and safety
- lone working
- record keeping
- confidentiality/data protection/Caldicott
- complaints
- prescribing
- clinical governance
- audit and research
- incident reporting and management of adverse events
- appropriate industrial relations policies, including managing sickness/absence, discipline, grievance and disputes
- programme of compulsory and legislative training to comply with national requirements, for example Standards for Better Health and staff induction
- human resources policies, including staff appraisal, managing stress, staff support arrangements such as occupational health support, pay protection and staff redeployment or redundancy arrangements

7.67 Copies of these policies shall be made available to NHS Somerset on request.

**NHS Information Management and Technology Requirements**

7.68 Good information technology and communications systems are essential to underpin the proposed model of care.

7.69 Shared data management tools /registries/definitions/referral forms, compatible with Connecting for Health’s Electronic Patient Record, will need to be developed to support the proposed model.

7.70 Service Providers will implement the electronic personal care planning facility currently being developed as part of the Year of Care for Diabetes pilot project. The plan will interface between primary and secondary care systems providing a holistic care record for the patient regardless of where the patient is seen. It is envisaged that a paper based plan may need to be introduced initially whilst the electronic tool is being developed.

7.71 Service Providers will ensure that they take reasonable measures to research the NHS Connecting for Health Information Technology programme through documents and information which are in the public domain and will participate in the operation of elements of the National IT programme where appropriate. The research referred to shall include, but not be limited to, factors relating to interfacing of systems for:

- network infrastructure and connection requirements for local and wide area network services
- physical infrastructure and hardware
- where required, remote access to, or integration with, parts of the local NHS systems
- data flows of patient records

7.72 NHS Somerset will provide reasonable cooperation in respect of such research.

7.73 Service Providers will ensure that the information management and technology systems and services they use conform to the relevant sections of the following:

- NHS Confidentiality Code of Practice November 2003
Service Providers will provide or procure the information management and technology services necessary to deliver the requirements of the Service Specification, including the following:

- agreed referral process
- appointment booking service
- variations to booking process including but not limited to cancellations and changes to appointments
- maintenance of comprehensive patient records
- correspondence and production of letters for patients and referrers
- patient discharge service where appropriate
- national data recording standards
- contract management information and production of monthly and quarterly reports
- mapping for clinical coding (NHS Read Codes or ICD-10 as appropriate)

Service Providers must be able to produce accurate and comprehensive records for each patient referred into the service. Information should comply with the National Information Authority Minimum Data Set and will include:

- patient name
- General Practitioner
- patient NHS number
- patient date of birth
- ethnicity
- the number of people not attending their appointments
- patient outcomes
- details of adverse events associated with treatment
- details of onward referral
- recommendations for treatment
- medication
- results of diagnostic investigations
- agreed care plans

Service Providers will ensure patient records can be accessed by members of the community team and that are suitably skilled, experienced and trained to use the information and technology management systems.

Service Providers will comply with the requirement to submit central returns as defined by The Department of Health and participate in central audits (for example the National Diabetes Audit)

**Contract Management Information**

Service Providers shall ensure that the Information Management and Technology systems collate and compile information in a format that will support NHS Somerset to measure and evaluate the delivery of the
planned benefits and outcomes from the service. The information recorded should include:

- patient demographics
- register of at risk patients
- patient management and follow up
- timeliness of the service
- total number of patients who have been seen in the service (at home, in clinics)
- total number of calls to the service
- patients requiring admission to hospital and length of stay
- total number of patients who have been seen for assessment
- total number of missed appointments for the service
- number of non-elective admissions for patients supported by the service
- number of deaths
- sources of incoming referrals
- total number of patients referred onto other services and service specified
- total number of adverse events associated with treatment
- total number of weeks waiting for first appointment
- total number of weeks waiting for commencement onto a care programme
- patient outcomes: improving health related to quality of life, patients’ functional and maximum exercise capacity
- number of reviews completed with an analysis of results
- total number of Patient Satisfaction Surveys completed
- drugs expenditure

**Annual Clinical Governance Report**

7.79 Service Providers will contribute to an annual clinical governance report covering all of the governance areas and quality of services provided for the pathway as a whole.

8 MOBILISATION

**Priorities and Phasing**

8.1 It is intended that the introduction of the new model of care will be phased over a period of two years commencing October 2009 with priority being given to the areas of greatest need as identified by the feedback from the engagement process and the needs analysis.

8.2 Patients and the public have said they want priority to be given to:

- ensuring that the professionals who contribute to diabetes care work closely together and in partnership with patients
- enhancing the skills of healthcare professionals so that there is more capacity in the system to support patients with diabetes
- improving case finding
- structured education and individual support to help people manage their own care
- ensuring that every patient has a management plan they have agreed in partnership with a health professional

8.3 Staff have identified structured education and individual support and ensuring every patient has a management plan agreed in partnership with a healthcare professional as priority.

8.4 Table 6 below provides an indicative implementation timetable for each of the service components specified in the model of care, with priority being given to the establishment of the professional network to oversee the management of the pathway, training for professionals, structured education for patients and health promotion programmes (per existing Public Health Work Programme).

8.5 This timetable will need to be reviewed by provider services and any revisions agreed with NHS Somerset prior to implementation.

8.6 Implementation milestones will need to be set for each component with full implementation expected by April 2011.
### Table 6: Indicative implementation plan for service components

#### Patient services

<table>
<thead>
<tr>
<th>Core Service component</th>
<th>Level</th>
<th>October 2009</th>
<th>April 2010</th>
<th>October 2010</th>
<th>April 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Core primary care GP Practices – agreement and implementation of core standards</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Opportunistic case finding outside GP practices</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Health promotion programmes (diet, physical activity, smoking)</td>
<td>2</td>
<td></td>
<td></td>
<td>See Public Health Directorate Work Programme</td>
<td></td>
</tr>
<tr>
<td>D Structured education (Type 2) – county-wide and accessible, for existing as well as newly diagnosed patients.</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Supporting self help groups such as the Expert Patient Programme</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F Insulin initiation (GP practices) - Local Enhanced Service in place</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G Diabetes Specialist Nurse Service – rolled out across Somerset</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H Psychological support – service development</td>
<td>2/3</td>
<td></td>
<td>See also Emotional Health and Wellbeing Work Programme</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I Dietetics – integration/expansion</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J Podiatry – integration/expansion</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K Retinopathy – integration</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L Structured education (Type 1) – county-wide and accessible, for existing as well as newly diagnosed patients.</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M Specialist care – integration + enhanced inpatient care</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Infrastructure service

<table>
<thead>
<tr>
<th>Core Service Component</th>
<th>Level</th>
<th>October 2009</th>
<th>April 2010</th>
<th>October 2010</th>
<th>April 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training &amp; support for non specialist hospital staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>Training and mentorship for Level 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Training and support for Level 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q</td>
<td>Identifying opportunistic case finding opportunities outside General Practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Overall pathway management – establishment of implementation infrastructure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S</td>
<td>Care planning pilot</td>
<td></td>
<td></td>
<td>See Test of Care Pilot Work Programme</td>
<td></td>
</tr>
</tbody>
</table>
8.7 Service Providers will be required to demonstrate:

- the ability to deliver the Service in accordance with the agreed implementation timetable
- commitment and the ability to develop an effective integrated community diabetes service
- a clear understanding of the specific challenges that patients with diabetes can experience
- specific evidence of a background in delivering services that are sensitive to the diversity of Somerset communities
- sufficient management time devoted to ensure the effective development of this service
- support for the education and training needs of the staff providing the service
- evidence of how clinical governance will be provided
- compliance with statutory employment legislation e.g. equal opportunities legislation
- plans for phased implementation, including the recruitment of staff, deployment of resources and project management
- evidence of competence in the provision of information to support effective patient care and performance management
- a cost effective service, able to deliver the planned benefits
- compliance with the national Standards for Better Health

8.8 All Service Providers will be required to work together to ensure that the care provided to patients is well coordinated, high quality and safe and that the system as a whole is efficient and effective.
9 PERFORMANCE AND SERVICE QUALITY MONITORING

9.1 The main benefits expected from the new model of care are outlined below:

Benefits to Patients

- patients have improved quality of life, health and well-being
- patients are supported and enabled to self care and have active involvement in decisions about their care and support
- patients have choice and control over their care and support so that services are built around the needs of individuals and carers
- patients with complex needs can design their care around health and social services which are integrated, flexible, proactive and responsive to individual needs
- patients are offered services which are high quality, efficient and sustainable
- patients with diabetes are diagnosed earlier leading to better control and reduction in complications
- patients are more informed about the risks of diabetes, leading to better management of care and improved health outcomes
- care provided closer to the patient’s home or work
- equity of access to services

Benefits to System

- care pathway in place that maximises the use of secondary care expertise to focus on complex cases
- professional development and staff satisfaction
- reduction in emergency admissions
- reduction in lengths of stay and outpatient attendances
- increased capacity and capability to meet the needs of increasing numbers of patients with diabetes
- improved quality assurance
- improved cost effectiveness

Performance Indicators

9.2 Appendix 6 sets out the draft performance indicators for the services contributing to the care of adult patients with diabetes. These will be subject to further review and consultation within the Somerset Health and Social Care Community.

9.3 The performance framework includes a set of key outcome indicators for the model of care as a whole. In addition, specific service indicators have been identified for individual core service components.
9.4 These indicators have been designed to provide assurance to key stakeholders, including NHS Somerset, WyvernHealth.Com Practice Based Commissioning Consortium and local Acute Trusts that the intended benefits and outcomes of the improved diabetes service are being delivered.

9.5 The indicators link into other related planning and performance processes, such as the Local Delivery Plan reports, where possible, to avoid unnecessary duplication.

9.6 Where appropriate, targets/aspirations will be set in liaison with Service Providers against a baseline position as at 30 September 2008.

9.7 Achieving the planned outcomes and benefits will require the new model of care to be fully operational. Implementation will take time and is likely to require a ‘ramp up’ of service capacity and capability to ensure new care pathways are safe and robust. It is anticipated that the introduction of the model of care will be phased over a period of 2 years (see Table 6 Indicative Implementation Plan for Service Components) with each individual service component taking 6 months or more to become fully operational.

9.8 Service Providers will be required to produce a plan for mobilising the service across the agreed area and delivering the identified benefits.

9.9 Service Providers will be expected to provide regular reports on specific indicators to be agreed with commissioners and a quarterly detailed performance report.

Quarterly Performance Reports

9.10 The requirements for these reports will be determined by the commissioners and may vary between services but are likely to include as a minimum:

- numbers of referrals received
- sources of referrals
- waiting time from referral to 1st appointment
- numbers of patients not attending appointments
- clinical outcomes data (see Draft Performance Indicators - Appendix 6)

Six monthly Service Reviews

9.11 Six monthly service reviews will be held between Service Providers and NHS Somerset, normally within 28 days of the end of each six month period. Service Providers and NHS Somerset may also call for a service review to be convened on reasonable notice in the event that an issue of sufficient importance and urgency has arisen that waiting until the next scheduled service review is inappropriate.
9.12 The role of the six monthly service review is to consider issues relating to Service Providers’ performance.

9.13 The Service Reviews will consider:

- progress towards full service delivery
- Service Providers’ performance data the results of patient satisfaction surveys and service evaluation studies
- the results of any provider data reviews carried out in the immediately preceding six month period
- clinical audit and governance reports
- patient complaints received in the immediately preceding six month period
- any other relevant issues.

9.14 There will also be ongoing review at pathway level.
KEY FACTS ABOUT DIABETES

1. 19,200 patients were diagnosed with diabetes in Somerset in 2007 - this is predicted to rise to more than 28,000 by 2017.

2. 89.5% of patients with diabetes have Type 2 diabetes and 10.5% have Type 1.

3. Life expectancy is reduced by fifteen years for patients with Type 1 diabetes and up to ten years for patients with Type 2 diabetes.

4. An estimated 21% of patients with diabetes in Somerset are currently undiagnosed and at risk of developing serious complications.

5. 47% of Type 2 diabetes has been attributed nationally to obesity.

6. National population projections suggest that, by 2025, 47% males and 36% females will be obese (currently 22% and 21% respectively).

7. It has been estimated nationally that 13% of patients over 65 either have or are likely to develop diabetes.

8. Somerset's population is older than the national average with 20% aged 65 or over compared with 16% nationally.

9. The number of patients in Somerset aged 75 or over is expected to increase by 21% by 2015.

10. Diabetes prevalence levels are expected to rise disproportionately in rural areas of Somerset due to their older populations.

11. There is considerable variation between General Practices and former Primary Care Trust areas in levels of glucose control - the % of patients with HbA1c < 7.5% ranges from 48% to 79% between practices and from 62% to 69% (2008) between former Primary Care Trust areas.

12. Hospital lengths of stay are nationally on average 20% higher than those for patients without diabetes.

13. Patients with diabetes have an increased risk of developing cardiovascular disease compared with patients without diabetes – the prevalence of angina for example for patients with diabetes is 2.9% compared with 0.53% for patients without diabetes and the prevalence of cardiac failure is 1.43% compared with 0.33%.

14. Prescribing costs for patients with diabetes have increased nationally by 88% in 5 years – there is considerable variation between General Practices in Somerset in the cost per patient ranging from £160 to £300 (2007).

15. In addition to direct health costs, the impact on social services expenditure, where diabetes complications increase costs four-fold.
NHS SOMERSET – SERVICES AND DEMOGRAPHICS

Overview

1.1 The Somerset Primary Care Trust now known as NHS Somerset was established on 1 October 2006 replacing the four former Primary Care Trusts in Somerset, Taunton Deane, Somerset Coast, Mendip and South Somerset.

1.2 The main function of NHS Somerset is to commission high quality health services to meet the needs of the population of Somerset, working with partner organisations in the NHS, local authorities and the voluntary sector.

1.3 Somerset is a mainly rural county of 3,450 square kilometres with a registered population of around 530,000.

1.4 Figure 1 below, illustrates the geographic area covered by NHS Somerset.

Figure 1: NHS Somerset

The county has a dispersed settlement structure with a low population density. Only Taunton, Yeovil and Bridgwater have populations of more than 30,000. Outside of these centres the population density is below 100 per square kilometre. The proportion of the population aged over 65 tends to be higher in the more rural areas. This poses particular challenges in terms of access to services.
1.6 NHS Somerset commissions services from local NHS Trusts including Taunton and Somerset NHS Foundation Trust, Yeovil District Hospital NHS Foundation Trust, Somerset Partnership NHS Foundation Trust, Royal United Hospital Bath NHS Trust, South Western Ambulance Service NHS Trust, Weston Area Health NHS Trust, Royal Devon and Exeter NHS Foundation Trust, NHS Trusts in Bristol, the Shepton Mallet NHS Treatment Centre and its own provider arm.

1.7 NHS Somerset also coordinates the planning and funding of all local NHS independent contractors including:

- 75 GP practices
- 76 dental surgeries
- 88 community pharmacies
- 59 optometric practices

1.8 In addition to its commissioning responsibilities, the provider arm of NHS Somerset is a significant provider organisation in its own right, responsible for the provision of 13 community hospitals, community nursing, public health nursing, health visiting and school nursing, therapy services and a range of specialist community services to its population.

1.9 The full range of community services provided by NHS Somerset through its provider arm includes the following:

- Public Health Nursing – Health Visitors
- Public Health Nursing – School Health Advisors
- Newborn Hearing Screening Programme
- Safeguarding Children
- Paediatric Speech and Language Therapy Service
- Community Adult Allied Health Professional and Rehabilitation Services, Interface Services and Condition Management Programme
- The Musculoskeletal Physiotherapy Service
- The Musculoskeletal Interface Service
- The Countrywide Community Nutrition and Dietetic Service
- The Somerset Podiatry Service
- The Community Cardiac Rehabilitation Service
- The Heart Failure Service
- Adult Speech and Language Therapy
- District Nursing Service
- Community Matrons and Case Management
- Specialist Nursing Services
- Community Hospitals
1.10 NHS Somerset has a history of good partnership working with Somerset County Council Adult Social Care Services, including a joint single assessment process for people with complex needs, shared planning and commissioning arrangements for some services and effective communication. Social Care Services are provided on a locality basis across four areas.

Older People

1.11 Population projections suggest that within Somerset, this group will grow more rapidly than the population overall, and by 2025 there will be more than 165,000 people aged over 54. The expected relative growth in population groups is shown in Figure 2 below.

Figure 2: Increase in Older Age Groups

1.12 Figure 3 below outlines where in the county older people are. Nationally the proportion of the population aged 65 or over is 16% in Somerset it is 20%. The map uses brown and red shading to show areas where the proportion of older people is over 20% and 24%. The map describes population using Super Output Areas (SOAs), a population grouping of approximately 1500 people. It is important to note that there is considerable variation in the geographical size of SOAs depending on population density i.e. how urban or rural the area is. It is often the case that the larger numbers of older people are in more rural areas and therefore in larger SOAs this can bias visual map interpretation. However, it is the case that within Somerset large numbers of older people live in rural areas, such as West Somerset.
Health Inequalities

1.13 The Indices of Deprivation 2007 (ID2007) uses a group of statistical indicators to rank the 32,482 SOAs in England in terms of aspects of their deprivation. Over 30 indicators are combined to produce an overall Index of Multiple Deprivation (IMD). Subsets of these indicators are also used to rank areas within seven different “domains” of deprivation:

- Income
- Employment
- Health Deprivation and Disability
- Education, Skills and Training
- Barriers to Housing and Services
- Crime
- Living Environment

1.14 There are 327 SOAs in Somerset, split between the county’s five districts. According to ID 2007, 14 of these are among the most deprived 20% nationally. They are home to just over 20,000 people. There is at least one of these areas in each of Somerset’s districts, with Sedgemoor having the most (see Figure 4 below).
1.15 Figure 5 below shows where health deprivation is most prevalent within Somerset. The indicator measures are of illness and disability, mental health problems and hospital admissions.

1.16 None of Somerset’s 327 SOAs falls within the 10% most health deprived nationally. However, 10 SOAs do fall within the 20% most deprived: four in Taunton Deane, three in Sedgemoor and one each in West Somerset, South Somerset and Mendip. The location of these is closely associated with overall deprivation scores.

Figure 5: Prevalence of Health Deprivation
1.17 Figure 6 below shows where in the county there are geographical barriers. This includes road distance to a GP, supermarket or convenience store, primary school and post office. This is the most prevalent form of deprivation in Somerset, with 14% of the county’s SOAs within the most deprived 10% in England in this domain. This may have an impact on planning of services, particularly when considering support for people in their own homes.

**Figure 6: Geographical Barriers**

1.18 According to the 2001 Census, Somerset's black and minority ethnic population has increased, although at 2.9%, it remains low compared to the national average of 13.0%. Since that time, the number of migrant workers from the expanded European Union has increased, particularly Portuguese and Polish migrant workers in certain communities associated with particular industries or workplaces. Numbers of migrant workers are likely to continue to increase. Transient populations may pose particular challenges to ensure equitable access to public health services.
APPENDIX 3

DIABETES HEALTH NEEDS ANALYSIS

1 OCCURRENCE OF DIABETES

1.1 The national diabetes prevalence model suggests that more than 13% of those aged over 65 are likely to have or develop diabetes. More cases of diabetes have been identified in rural areas, and if the model estimates are accurate these areas are also where further cases are likely to be identified.

Table 1 below shows diabetes prevalence in 2005/06, which is the numbers of individuals with clinically diagnosed diabetes in the population. Numbers are taken from practice registers. The % population column shows percentage of whole population (not adult population). The column on the right indicates whether the district / county figure is significantly (the 95% confidence intervals do not cross) above that of the known national prevalence rate. Within Somerset, the districts with the highest prevalence are West Somerset and Sedgemoor. The district with the lowest prevalence of known diabetes is Mendip.

Table 1: Diagnosed Diabetes Prevalence 2005/06

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>% pop</th>
<th>Significant?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somerset</td>
<td>18317</td>
<td>3.6</td>
<td>no</td>
</tr>
<tr>
<td>South Somerset</td>
<td>5452</td>
<td>3.5</td>
<td>no</td>
</tr>
<tr>
<td>West Somerset</td>
<td>1401</td>
<td>3.9</td>
<td>yes</td>
</tr>
<tr>
<td>Taunton Deane</td>
<td>3699</td>
<td>3.5</td>
<td>no</td>
</tr>
<tr>
<td>Mendip</td>
<td>3551</td>
<td>3.3</td>
<td>no</td>
</tr>
<tr>
<td>Sedgemoor</td>
<td>4215</td>
<td>3.8</td>
<td>yes</td>
</tr>
<tr>
<td>England</td>
<td></td>
<td>3.7</td>
<td></td>
</tr>
</tbody>
</table>

1.2 In Somerset the majority of people have Type 2 diabetes, 2097 (10.5%) have Type 1 and 17885 (89.5%) Type 2. Age of onset of condition differs between the two types. Figure 1 shows numbers and rates of people with diabetes by type and age.
1.3 The figures above show diabetes prevalence in Somerset using Quality Outcomes Framework (QOF) data from end of 2007. They show the difference in age of diagnosis. Onset of Type 1 diabetes (blue bars) can occur in the first years of life and the prevalence rate remains broadly consistent through to those aged 55–59 and then begins to fall. Type 2 (red bars) diabetes cases are identified as early as age 20–24 but generally occur in those aged 50 and above. In Somerset the prevalence rate is greater than 10% for those aged 70–89 and is common between the ages of 60–100.

1.4 It is also important to understand the number of new patients needing diagnosis, stabilisation and programmes of education and long-term care. The incidence (number of new cases in 2007) of diabetes in Somerset was 74 cases of Type 1 diabetes and 1557 cases of Type 2. Figure 2 below shows incidence numbers and rates by diabetes type and age.

**Figure 2: Diabetes incidence in Somerset: by type and by age group.**
1.5 Diabetes incidence for the year ending 31/12/07 is taken from primary care QOF data. The majority of cases of Type 1 diabetes are identified early in life, the highest numbers and rate are shown to fall in the 10–14 age group. New cases are identified through to the 40–44 age group but are rare above that age. Type 2 diabetes in Somerset is rarely identified before the age group 25–29 and is most commonly identified between the ages of 55-79. The incidence rate is consistently around 8 per 1000 population between the ages 65 and 89.

Diabetes Modelled Estimates

1.6 There is good evidence that there is significant undiagnosed diabetes in the English population. A national model of diabetes prevalence has been developed. This estimates likely diabetes prevalence on the basis of known population risk factors. Using QOF data from June 2007 the modelled estimate would suggest that there is 21% undiagnosed diabetes in the Somerset population which equates to approximately 5000 additional cases. It is possible to apply the model to practice populations and table below shows the results of this exercise.

Table 2: Undiagnosed diabetes by old PCT area

<table>
<thead>
<tr>
<th>Area</th>
<th>Practices Range</th>
<th>No of pracs &gt;30% undiag</th>
<th>No of pracs diag numbers not &gt; 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mendip</td>
<td>0 - 52%</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Somerset Coast</td>
<td>3 - 56%</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>South Somerset</td>
<td>2 - 53%</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Taunton Deane</td>
<td>20 - 42%</td>
<td>7</td>
<td>2</td>
</tr>
</tbody>
</table>

1.7 Applying the prevalence model to practice populations suggests there are people with undiagnosed diabetes in virtually all areas of the county. The suggestion is that there are practice populations where more than 50% of cases remain undiagnosed. The table above suggests that 30 of the 75 practices in Somerset have more than 30% of diabetes cases undiagnosed. The suggested undiagnosed cases appear to be most common in the more rural areas of the county and/or where there are larger numbers of older people. Of the 75 practices in Somerset only 9 have fewer people on their diabetes register than in 2005. The number of people known to have diabetes in Somerset is rising year on year.
1.8 Using population projection data and the prevalence model it is possible to estimate numbers of people with diabetes both now and in the future. Given that the population of Somerset is expected to grow and shift in structure towards a greater proportion of people aged over 65, it can be expected that the numbers of people with diabetes will be considerably higher in the future. Table 3 outlines the possible numbers of people with diabetes if the population changes as we expect and additional preventive measures are not put in place.

Table 3: Projected Diabetes Prevalence

<table>
<thead>
<tr>
<th>District</th>
<th>2007</th>
<th>2017</th>
<th>2027</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mendip</td>
<td>4600</td>
<td>5492</td>
<td>6375</td>
</tr>
<tr>
<td>Sedgemoor</td>
<td>5216</td>
<td>6233</td>
<td>7310</td>
</tr>
<tr>
<td>West Somerset</td>
<td>2314</td>
<td>2753</td>
<td>3218</td>
</tr>
<tr>
<td>South Somerset</td>
<td>7018</td>
<td>8303</td>
<td>9657</td>
</tr>
<tr>
<td>Taunton Deane</td>
<td>4813</td>
<td>5761</td>
<td>6830</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>23961</td>
<td>28542</td>
<td>33390</td>
</tr>
</tbody>
</table>

1.9 The diabetes prevalence model is calculated on the basis of the following weighted risk of diabetes:

<table>
<thead>
<tr>
<th>Diabetes:</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>Males 3.63%</td>
</tr>
<tr>
<td>Type 2</td>
<td></td>
</tr>
<tr>
<td>I &amp; 2</td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td>Ethnicity:</td>
</tr>
<tr>
<td>0-29</td>
<td>White 4.25%</td>
</tr>
<tr>
<td>30-59</td>
<td>Black 5.61%</td>
</tr>
<tr>
<td>60+</td>
<td>Asian 6.59%</td>
</tr>
<tr>
<td></td>
<td>Other 2.1%</td>
</tr>
</tbody>
</table>

1.10 The model also allows for changing levels of deprivation and three options for levels of obesity in the population.

1.11 Within the Somerset population the majority of the population is classified as “White British” and although risk of diabetes is increased for all Black and Asian residents in Somerset, this is unlikely to significantly impact on population risk overall. Given knowledge of the population it is reasonable to conclude that the most significant risk factors for diabetes are obesity and old age.
2. MORTALITY

2.1 Few deaths in Somerset are directly attributed to diabetes. Figure 3 below shows that in the region of 5 deaths per 100,000 population were attributed to diabetes in the three years 2004/06. Numbers of male deaths were below national and regional rates, female deaths were marginally higher than the regional figure.

2.2 What may be of note is that although the numbers of early deaths (indicated by years of life lost) in men is lower than the regional or national figures, for women they are higher. However figures are based on small numbers of deaths and therefore may not be statistically significant.

Figure 3: Years of Life Lost due to Diabetes

2.3 Figure 4 below, shows trend in deaths comparing Somerset with the South West and England and Wales. There is some fluctuation in the Somerset figures but overall there is a downwards trend. Standardised Mortality Ratio (SMR) is a comparison of observed and expected deaths. The national rate for 2006 is expressed as 100 and all other figures are shown as a ratio of that. By 2006 the Somerset figure had fallen to 80 this indicates that there are 20% fewer deaths due to diabetes in Somerset than you would expect if the local population characteristics matched those of the national.
When using locally available death certification information it is possible to consider where diabetes has been recorded as a contributory factor to death. Table 4 below shows that although seldom the cause of death, diabetes is often recorded as a contributory factor. There is no obvious pattern within these years and there appears to be a general increase in the number of deaths in some way attributed to diabetes through to 2005 and then numbers reduce. There are currently some difficulties with local acute trust data as new systems have been brought into place and 2007 data may be incomplete.

**Table 4: Contributory Cause of Death**

<table>
<thead>
<tr>
<th></th>
<th>Contributory</th>
<th>Main</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>203</td>
<td>4</td>
<td>207</td>
</tr>
<tr>
<td>2003</td>
<td>287</td>
<td>1</td>
<td>288</td>
</tr>
<tr>
<td>2004</td>
<td>260</td>
<td>1</td>
<td>261</td>
</tr>
<tr>
<td>2005</td>
<td>319</td>
<td>6</td>
<td>325</td>
</tr>
<tr>
<td>2006</td>
<td>249</td>
<td>3</td>
<td>252</td>
</tr>
<tr>
<td>2007</td>
<td>163</td>
<td>2</td>
<td>165</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1481</strong></td>
<td><strong>17</strong></td>
<td><strong>1498</strong></td>
</tr>
</tbody>
</table>

Table 5 shows the main cause for all recorded deaths where diabetes is included as a factor. Death due to circulatory disease is the single largest group however, it is also the main cause of all deaths.
Table 5: Somerset Deaths with Diabetes as a Contributory Cause

<table>
<thead>
<tr>
<th>ICD 10</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulatory</td>
<td>97</td>
<td>122</td>
<td>104</td>
<td>152</td>
<td>106</td>
<td>73</td>
<td>654</td>
</tr>
<tr>
<td>Disease</td>
<td>46.9%</td>
<td>42.4%</td>
<td>39.8%</td>
<td>46.8%</td>
<td>42.1%</td>
<td>44.2%</td>
<td>43.7%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>40</td>
<td>78</td>
<td>52</td>
<td>59</td>
<td>49</td>
<td>31</td>
<td>309</td>
</tr>
<tr>
<td>Disease</td>
<td>19.3%</td>
<td>27.1%</td>
<td>19.9%</td>
<td>18.2%</td>
<td>19.4%</td>
<td>18.8%</td>
<td>20.6%</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>23</td>
<td>25</td>
<td>33</td>
<td>29</td>
<td>28</td>
<td>21</td>
<td>159</td>
</tr>
<tr>
<td>Disease</td>
<td>11.1%</td>
<td>8.7%</td>
<td>12.6%</td>
<td>8.9%</td>
<td>11.1%</td>
<td>12.7%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Abnormal</td>
<td>18</td>
<td>19</td>
<td>30</td>
<td>31</td>
<td>19</td>
<td>11</td>
<td>128</td>
</tr>
<tr>
<td>Findings</td>
<td>8.7%</td>
<td>6.6%</td>
<td>11.5%</td>
<td>9.5%</td>
<td>7.5%</td>
<td>6.7%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>11</td>
<td>14</td>
<td>17</td>
<td>19</td>
<td>10</td>
<td>10</td>
<td>81</td>
</tr>
<tr>
<td>Disease</td>
<td>5.3%</td>
<td>4.9%</td>
<td>6.5%</td>
<td>5.8%</td>
<td>4.0%</td>
<td>6.1%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Infectious</td>
<td>7</td>
<td>14</td>
<td>8</td>
<td>14</td>
<td>14</td>
<td>5</td>
<td>62</td>
</tr>
<tr>
<td>Diseases</td>
<td>3.4%</td>
<td>4.9%</td>
<td>3.1%</td>
<td>4.3%</td>
<td>5.6%</td>
<td>3.0%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>19</td>
<td>30</td>
<td>31</td>
<td>19</td>
<td>11</td>
<td>128</td>
</tr>
<tr>
<td>Disease</td>
<td>8.7%</td>
<td>6.6%</td>
<td>11.5%</td>
<td>9.5%</td>
<td>7.5%</td>
<td>6.7%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Total</td>
<td>207</td>
<td>288</td>
<td>261</td>
<td>325</td>
<td>252</td>
<td>165</td>
<td>1498</td>
</tr>
</tbody>
</table>

3 MORBIDITY

Glucose Control

3.1 Figure 5 below uses most recent nationally available data to shows the variation in control of glucose levels in patients with diabetes across the old PCT areas in Somerset. The level of glucose control in Mendip is the highest at approximately 67% which is 10% higher than the figure for Taunton Deane. Somerset Coast, South Somerset and Taunton Deane figures indicate that the level of control glucose in patients is below the regional and national rate.

Figure 5: Controlled Blood Glucose

3.2 An indication of how well a patient with diabetes is managing glucose levels in their blood can be attained through measuring the level of HbA1c in the blood. A measure of 7.4% or below indicates a well managed patient. Practices aim to record HbA1c levels regularly and as of March 08 records are up to date for 98.5% of patients that should have been offered the test. 64.3% of patients in Somerset are well managed, and all old PCT areas have improved patient control since 05/06. However 20 of the 75 practices in Somerset have less than 60% of patients with well managed levels of HbA1c. Six practices in Somerset Coast, 7 in South Somerset, 6 in the Taunton Deane area and 1 in Mendip.
Blood Pressure Control

3.3 A further measure of effective structured care is good blood pressure control. 99% of practices in Somerset have checked blood pressure of patients with diabetes appropriately. However, effective control is indicated by a blood pressure reading of 145/88 mm Hg or less. According to data from March 08 79.7% of patients across Somerset have their blood pressure well managed. However it is also the case that 15 practices in Somerset have less than 70% of their patients' blood pressure well managed. There are 6 practices in Somerset Coast, 3 in Mendip, 4 in South Somerset and 2 in Taunton Deane.

Cholesterol Control

3.4 A final indicator of effective care of patients with diabetes is a total cholesterol measurement of 5 or less. 97.5% of patients have their cholesterol measured appropriately, however only 85% of patients have a score of less than 5. Somerset Coast have 5 practices where less than 80% of patients have the appropriate score, there are also 4 practices in South Somerset and 1 in Taunton Deane.

3.5 In Somerset Coast there was reasonable consistency across indicators, i.e. practices that were having difficulty maintaining control on one indicator also experienced difficulty on others. There did not appear to be any broad correlation with practices serving more deprived or particularly older or more rural communities. In the Taunton Deane area again there was good consistency between control measures. A practice having difficulty maintaining patient control for one measure also had difficulty with others. In this case there was good correlation between practices providing services to people in more deprived areas and levels of control. In South Somerset there was no obvious consistency between scores the practices managing fewer patients HbA1c levels were different to the ones experiencing difficulty with some blood pressure management. All patients were generally well managed in the Mendip practices.

3.6 To avoid sight threatening retinopathy all appropriate people with diabetes are required to have retinal screening annually.

3.7 Local data (Dec 07) shows that overall in Somerset 95% of appropriate patients are offered retinal screening. The range between the four old PCT areas is 93.7 – 96.6%.

Diabetic Complications

3.8 Practice registers indicate prevalence (known cases) rather than incidence (number of new cases). However Table 6 indicates numbers of complications within the known population with diabetes in Somerset.
Table 6: Numbers of Known Complications in Somerset

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Macrovascular</strong></td>
<td></td>
</tr>
<tr>
<td>TIA, stroke or CHD</td>
<td>5349</td>
</tr>
<tr>
<td>Ischaemic heart disease</td>
<td>3734</td>
</tr>
<tr>
<td>Peripheral arterial disease</td>
<td>1297</td>
</tr>
<tr>
<td><strong>Microvascular</strong></td>
<td></td>
</tr>
<tr>
<td>Retinopathy</td>
<td>3872</td>
</tr>
<tr>
<td>Nephropathy</td>
<td>231</td>
</tr>
<tr>
<td><strong>Depression</strong></td>
<td>6645</td>
</tr>
<tr>
<td><strong>Amputations</strong></td>
<td>282</td>
</tr>
</tbody>
</table>

3.9 It is important to use available data but also know the limitations of it. Within the above table the figures for stroke and CHD are likely to be accurate, because recording of the condition is in QOF. The peripheral arterial disease may be incomplete as it is dependent on coding procedure within practices. The figures for retinopathy and nephropathy depend very much on coding in Primary Care. Nephropathy in particular may be difficult to attribute directly to diabetes as there are often comorbidities contributing. The depression figure is prevalence, i.e. depression ever in this population it therefore does not give an idea of current workload. The amputations code too may be incomplete.

**Secondary Care**

3.10 Figure 6 show recent trend in elective admissions. Between 03/04 and 06/07 the pattern is consistent, steady low numbers of admissions for both main and main dual diagnosis and a rapid increase in the number of admissions with diabetes as a subsidiary condition. By 2006/07 there were more than 1600 admissions with diabetes as a contributory factor.

**Figure 6: Trend in Elective Admissions**
3.11 Figure 7 shows the emergency admissions for the same period. The pattern is consistent with elective admissions, between 03/04 and 06/07 there are steady and low numbers of admissions for both main and main dual diagnosis. Over the same period there is a rapid increase in the number of admissions with diabetes as a subsidiary condition which by 2006/07 has reached 6000 admissions.

Figure 7: Trend in Emergency Admissions

3.12 In 2007/08 both elective and emergency admissions showed a sudden decline where diabetes was recorded as a subsidiary condition, and a possibly associated increase in the number of admissions with diabetes as main / dual diagnosis. This may in part be the result of coding difficulties in acute trusts, rapid decrease in figures is often suggestive on an incomplete dataset. However the rapid increase in Main / Dual diagnosis is worthy of further investigation as it may be indicative of the role that diabetes plays in reason for admission.

3.13 The available data included above is of limited value. There is a clear suggestion that the contributory nature of diabetes as a cause for admission is being increasingly recognised and may also relate to increasing numbers of admissions.
STAKEHOLDER ENGAGEMENT - PROCESS

The model of care for adult patients with diabetes has been developed with widespread involvement of patients, clinicians and healthcare managers and with the support of diabetes UK and the National Diabetes Support Team.

A Steering Group was set up in January 2008, comprising clinicians and managers from local Service Providers and NHS Somerset, the local regional manager for Diabetes UK and a patient representative.

The Steering Group held two stakeholder workshops to develop the model of care, which were attended by members of the Local Implementation Team, together with other stakeholders and patients.

The work of the Steering Group was informed by feedback from the National Diabetes Patient Survey (2006) and a survey undertaken by the Somerset Patient and Public Information Forum, also in 2006.

Six discussion events on the draft model of care were held across Somerset in the Summer of 2008. These events provided an opportunity for patients, their relatives and their carers to ask questions about the proposals and provide feedback in particular on how they might best be supported to manage their own care, and what outcomes they would expect from future services. The discussion events were attended by members of the Steering Group, including clinicians and Diabetes UK representatives and a total of 118 patients relatives and carers.

Patients, the public, and professionals with an interest in the delivery of diabetes care also had the opportunity to comment on two engagement documents, over the period 11 August to 26 September, one for patients and the public and the other for professionals. These documents described the proposed model of care and posed a number of questions about each of the key proposals as well as seeking views on priorities and outcomes.

The engagement document (public version) was widely circulated to stakeholders including 123 voluntary organisations and 80 patient and public involvement contacts. In partnership with diabetes UK, 1600 people who are members of the charity, were sent copies of the engagement document with a covering letter from the Regional Manager encouraging them to return their feedback. The engagement document was also circulated to healthcare professionals involved in diabetes care, healthcare premises including all 286 residential and nursing homes in Somerset, 75 GP surgeries, 88 pharmacies, 59 opticians, 13 community hospitals, 2 district hospitals and the retinopathy screening clinics.

The engagement document was also available on the trust website for staff and the public to download.

The proposed model of care was presented to the Overview and Scrutiny Committee on 8 September 2008 and to the Professional Executive Committee on 31 October 2008.
A report on feedback from the model of care engagement exercise was submitted to the NHS Somerset Board in December 2008.

The Service Specification was developed from the model of care by a team of Primary Care Trust and Practice Based Commissioning commissioners. Clinical input to the Service Specification was obtained via a task focused group that met once in January 2009. A group of patients who had expressed an interest in continuing to be involved with diabetes service development were invited to comment on the key elements of the Specification at a meeting in January 2009.

The Service Specification was submitted to the Professional Executive Committee on 26 February 2009.
CARE PATHWAY FOR ADULT PATIENTS WITH DIABETES MELLITUS

The following pathway has been colour coded to indicate the levels of care which will apply at each stage of the pathway.

This is a high level pathway which aims to demonstrate how patients will be supported throughout their journey under the new Model of care. Further operational pathways and referral protocols will be developed as part of the implementation phase.

This pathway needs to be read in conjunction with elements of care set out in Tables 3 and 4 of the Service Specification and Section 5 ‘Core Service Components’.

The levels of care indicate relative complexity of care. They do not necessarily denote the location. The underlying principle is that as much care as possible, at all levels, will be delivered locally by multidisciplinary teams.

System-wide clinical networks will quality assure the pathway as a whole and oversee its further development. Service integration and seamless care for the patient will be supported by common information technology systems and multidisciplinary team working.

It is anticipated that training and support for Level 1 providers will be provided by Level 2 and clinical governance and mentorship support for Level 2 providers will be provided by Level 3 providers.

Level 1 – Core Primary Care
Level 2 – Intermediate Care
Level 3 – Specialist Care
**NHS SOMERSET**
**CARE PATHWAY FOR ADULTS WITH DIABETES MELLITUS—CASE FINDING**

-**Raising awareness of symptoms**

- National and local campaigns on diabetes and related conditions
  Eg. Obesity, CHD etc.

- Targeting specific populations e.g.
  obese. Awareness activities in:
  - schools,
  - General Practices,
  - sports centres,
  - supermarkets,
  - pharmacies,
  - pubs/clubs,
  - local employers,
  - maternity units.

-**Referral (self or directed)**

-**Diabetes ‘case finding centres’**

  - e.g. GP Practices, Health Checks Programme
  - Urinalysis
    - Random blood glucose
    - Urine ketone

-**Testing of patient**

-**Blood glucose positive/ ketone negative**

  - Referral to General Practice (Type 2 pathway)

-**Blood glucose positive/ ketone positive**

  - Refer to Specialist Care (Type 1 pathway)

-**Further investigations to determine causes of symptoms**

  - Discussion and healthy lifestyle advice

  - Further investigations to determine causes of symptoms

  - Referral to Health Promotion services

  - Weight management programmes
  - Exercise facilities
  - Smoke cessation
  - Motivational support

Go to page 3
Go to page 5
OGTT = Oral Glucose Tolerance Test  
DSN = Diabetes Specialist Nurse  
DESMOND = Diabetes Education for Ongoing and New Diagnosed Patients
NHS SOMERSET
CARE PATHWAY FOR ADULTS WITH TYPE 2 DIABETES MELLITUS - CONTINUING CARE

Clinical review by GP (minimum annual)
- Glycaemic control
- Vascular risk
- Renal assessment
- Foot review
- Medication review
- Psychological/social review
- Care planning
- Lifestyle to include weight management/smoking/alcohol
- Ongoing dietetic support
- Signposting to Diabetes UK/self help groups

DSN Service
Community specialist dietetic support
Health psychological support
Specialist podiatrist support

DSN Service:
- insulin initiation
- glycaemic control
- support for self care
- pre/post pregnancy care (in conjunction with Specialist Care)
- liaison with community matrons
- telephone helpline (8-8)

Specialist Care review (if needed)
- Complex obesity management
- Genetic/auto-immune disorders
- Inpatient management
- Complications (eyes/renal/feet/vascular)
- Pregnancy care (in conjunction with DSN Service)
- Transition paediatrics/adult
- Telephone helpline (24 hours)

Annual retinal screening/ Optometrist
Community Matrons
Social Services
Education (DESMOND)
Exercise/ weight loss programmes

DSN = Diabetes Specialist Nurse  DESMOND = Diabetes Education for Ongoing and Newly Diagnosed
NHS SOMERSET
CARE PATHWAY FOR ADULTS WITH TYPE 1 DIABETES MELLITUS - DIAGNOSIS & INITIAL MANAGEMENT

Initial advice
- provision of education pack
- telephone help-line
- self help groups
- social services
- inform GP
NHS SOMERSET
CARE PATHWAY FOR ADULTS WITH TYPE 1 DIABETES MELLITUS - CONTINUING CARE

Specialist Care (complex/unstable) review as required
- Genetic/auto-immune disorders
- Inpatient management
- Complications (eyes/renal/feet/vascular)
- Pregnancy care (in conjunction with DSN Service)
- Insulin pumps
- Specialist dietetics
- Transition paediatrics/adult
- 24 hour helpline

Clinical review by GP (minimum annual)
- Glycaemic control
- Vascular risk
- Renal assessment
- Foot review
- Medication review
- Psychological/social issues
- Care planning
- Lifestyle to include management/smoking/alcohol
- Ongoing dietetic support
- Signposting to Diabetes UK/self help groups

DSN Service (stable)
- Specialist dietetic support
- Health psychological support
- Community specialist podiatry support

DSN Service:
- glycaemic control
- support for self care
- pre/post pregnancy care (in conjunction with Specialist Care)
- liaison with community matrons
- telephone helpline
- Case note review with Specialist & Primary Care

Education (DAFNE)

Exercise/weight loss programmes

Annual retinal screening/ Optometrist

DSN = Diabetes Specialist Nurse  DAFNE = Dose Adjustment For Normal Eating
This table has been updated. See separate document entitled Somerset Diabetes Service Performance Framework for updated version.
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GLOSSARY OF TERMS USED IN THE SERVICE SPECIFICATION

Choice Patients able to choose any healthcare provider that meets NHS standards and can provide care within a price the NHS is prepared to pay.

Co-located Services Range of services located in same building or locality or delivering care through multidisciplinary clinics (actual or virtual), individually accountable to own organisations but committed to common goals and joint plans.

Commissioning The full set of activities that Primary Care Trusts undertake to make sure that services funded by them, on behalf of the public, are used to meet the needs of the individual fairly, efficiently and effectively.

Community Hospitals Local hospitals serving relatively small populations

District General Hospitals A hospital providing a range of clinical service but not necessarily including highly specialised services.

Hard-to-Reach Groups Usually defined as groups or individuals who find it challenging to access appropriate health and social care services.

Long-term conditions Those conditions for example diabetes, asthma and arthritis that cannot at present be cured but whose progress can be managed and influenced by medication and other therapies.

Professional Network Team comprising care professionals with different specialist competences working together for the benefit of patients, overseeing the care pathway.

Multidisciplinary Team Working Generic term used to describe way of working which involved professionals from different disciplines working together flexibly to provide care packages tailored to individual requirements.

National Institute for Health and Clinical Excellence An independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

NHS Foundation Trusts NHS hospitals controlled and run locally as independent public benefit corporations.

Practice Based Commissioning This gives GPs responsibility for achieving best value within funds that NHS Somerset has to pay for hospital and other care for their practice’s population.

Primary care The collective term for all services which are people’s first point of contact with the NHS.

Primary Care Trusts Free-standing statutory bodies with responsibility for delivering healthcare and health improvements to their local areas. They commission a range of community health services as part of their functions.

Provider A generic term for an organisation that delivers a healthcare or care service.

Secondary care The collective term for services to which a person is referred after first point of contact. Usually this refers to hospitals in the NHS offering specialised medical services and care.

Strategic Health Authority The local headquarters of the NHS, responsible for ensuring that national priorities are integrated into local plans and for ensuring that Primary Care Trusts are performing well. They are the link between the Department of Health and the NHS.

Voluntary and Community Sector An umbrella term referring to registered charities as well as non-charitable non-profit organisations, associations, self help groups and community groups for public or community benefit.