HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 8th March, 2013

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

Kent County Council
kent.gov.uk

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 8th March, 2013, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Tristan Godfrey**
Telephone: **01622 694196**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (10):	Mr C P Smith (Vice-Chairman, in the Chair), Mr R E Brookbank, Mr N J Collor, Mr K A Ferrin, MBE, Mr L B Ridings, MBE, Mr K Smith, Mr R Tolputt and Mr A T Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor A Allen, Councillor A Blackmore, Councillor G Lymer and Councillor Mr M Lyons
LINk Representatives (2):	Dr M Eddy and Mr M J Fittock

Webcasting Notice

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UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item	Timings
1. Introduction/Webcasting	

2. Substitutes

3. Declarations of Interests by Members in items on the Agenda for this meeting.

4. Minutes (Pages 1 - 6)

5.	The Francis Report (Pages 7 - 16)	10:05 – 10:10
6.	Services Overview: a) Diabetes Services; and b) Ophthalmology. (Pages 17 - 142)	10:10 – 11:30

7. Date of next programmed meeting – Friday 7 June 2013 @ 10:00 am

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
(01622) 694002

28 February 2013

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Friday, 1 February 2013.

PRESENT: Mr C P Smith (Vice-Chairman, in the Chair), Mr N J Collor, Mr D S Daley, Mr K A Ferrin, MBE, Mr L B Ridings, MBE, Mr D L Brazier (Substitute for Mr R E Brookbank), Mr L Christie (Substitute for Mrs E Green), Cllr M Lyons, Dr M R Eddy and Mr M J Fittock

ALSO PRESENT: Dr J Allingham and Cllr R Davison

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting

2. Declarations of Interest

Councillor Michael Lyons declared a personal interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.

3. Minutes

(Item 4)

RESOLVED that the Minutes of the meeting held on 4 January 2013 are correctly recorded and that they be signed by the Chairman.

4. Patient Transport Services

(Item 5)

Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway), Deborah Tobin (Senior Project Manager – Patient Transport, NHS Kent and Medway), Alastair Cooper (Managing Director - Care Services and Passenger Transport, NSL Care Services), Felicity Cox (Chief Executive, NHS Kent and Medway), and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(a) Members were reminded that this was a topic the Committee had looked at previously and were aware that the Patient Transport Service (PTS) was being tendered. There were two lots to the tender. The first was to run a single call centre, and the second was to run the PTS itself. NHS representatives explained that NSL Care Services had been awarded both lots. This company's bid was ranked top on quality. It was also competitive on price, but was not the cheapest.

(b) NSL Care Services ran other PTS services and the call centre for all these services was in Shrewsbury. It was explained that this call centre would receive the calls for PTS in Kent and book the journey, but the actual planning would be undertaken locally in Kent. A series of questions were asked about how local knowledge was factored in. The example was given of the existence of three towns or villages named Newington in Kent. NSL Care Services explained that the script used in the call centre got bookings pinpointed to a specific address, house number and street, and this made up for those occasions when no postcode was known by the caller. It was explained that the 999 services did not always have postcode information either. In addition, there was liaison with the locally based service planners.

(c) A number of Members expressed concerns about situations where patients were discharged from hospital late at night and anecdotal evidence was provided of people being left outside their homes unable to get in following discharge. NHS representatives explained that late night discharge did happen on occasion, but it should be avoided where possible. It was also commented that patients attending accident and emergency departments who were then not admitted to hospital may be discharged at night as well. The duty of care was transferred to the PTS provider and NSL Care Services explained that it was part of their training of staff to ensure people were not abandoned. Where a home could not be accessed, or was uninhabitable, alternatives would be sought and this might involve returning them to hospital. No person would be simply abandoned.

(d) In response to a specific question, NSL Care Services explained that volunteer drivers were used in some of its other areas, such as Lincolnshire. Volunteer drivers were checked out in the same way as permanent or bank staff. Volunteer drivers were often preferred due to their local knowledge, particularly in rural areas.

(e) Developing this theme, it was explained that part of the service specification involved the requirement to refer callers who were not eligible for PTS to other services which may be able to help, such as volunteer driver services. These alternatives were not run by the NHS, but their value as a supplement was readily acknowledged. A directory of locally available services was being pulled together to enable accurate assistance to be given. The large provider Trusts in Kent were providing information on the transport services they knew about and this work would continue. No service in the country was able to list all the available services, but it would expand and develop over time.

(f) Specifically relating to PTS for patients with mental health needs, a Member of the Committee commented that this was an area where dissatisfaction with the service had been expressed in the past. It was added that the eligibility criteria may or may not apply to individuals as their condition changed over time. In response it was explained that work was being done with Kent and Medway NHS and Social Care Partnership Trust on linking directly with user groups to target them specifically.

(g) The Committee were informed that clinicians could book PTS directly, either by phone or by logging on electronically. The same questions were asked of the clinician booking and so the same eligibility criteria applied; there was no

question of a clinicians' judgment being second-guessed. In response to a specific follow-up, the Committee were informed that patients were eligible from the time of their GP referring them to a consultant and it did not need to wait for a diagnosis to be confirmed.

(h) PTS was a service free to the user. It was explained that there was a separate Healthcare Travel Costs Scheme (HTCS) available through hospitals. Some patients would be able to claim reimbursements for travelling to access healthcare.

(i) A specific question about accessing services was asked giving the example of an elderly person needing to have tests done regularly due to being prescribed Warfarin. The answer was given that PTS did not cover accessing primary care services. However, in the case of Warfarin, there was a domiciliary service available through GP practices. A nurse should be able to visit the particular patient, negating the need to travel.

(j) On the topic of escorts accompanying the patient, it was explained that clinical escorts were covered by the eligibility criteria, and other escorts might be; this was an area where there was a need for consistency.

(k) It was reported that the eligibility criteria used in Kent and Medway was slightly more generous than the national requirements for PTS. There was a debate around whether more people should or should not be covered by the eligibility criteria. Part of this discussion involved questions about what proportion of patient journeys were undertaken by PTS. The view was expressed by NHS representatives that this was not an especially useful figure to look at as health needs changed; the important point was for 100% of those eligible to be transported. Information would be provided to Clinical Commissioning Groups (CCGs) about PTS usage. This would help identify any gaps in the service. The eligibility criteria may be reviewed in the future. A CCG representative explained that there were difficult choices to be made in commissioning. Including more people in the eligibility criteria meant less money for other services. There was an element of regret in any choice.

(l) Members and health sector representatives agreed on the need to publicise the PTS service effectively and a communications plan had been developed.

(m) In response to a specific question about where the vehicles would be based, it was explained that NSL Care Services were seeking five bases in Kent and Medway. Along with admin facilities to enable planning, these would need to be secure compounds for the parking of both PTS vehicles and cars belonging to staff.

(n) The Chairman proposed the following recommendation:

- The Committee thanks its guests for their contribution, notes the report and looks forward to further updates in the future.

(o) AGREED that the Committee thanks its guests for their contribution, notes the report and looks forward to further updates in the future.

5. Maidstone Hospital: Current and Future Developments

(Item 6)

Glenn Douglas (Chief Executive, Maidstone and Tunbridge Wells NHS Trust), Dr Chris Thom (Urgent Medical and Ambulatory Unit Clinical Lead / Lead Physician, Maidstone and Tunbridge Wells NHS Trust), Mr Akbar Soorma (A&E Consultant / Clinical Director for Acute & Emergency Medicine, Maidstone and Tunbridge Wells NHS Trust), Felicity Cox (Chief Executive, NHS Kent and Medway), and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(a) The Chief Executive of Maidstone and Tunbridge Wells NHS Trust (MTW) introduced the item by explaining that he was present to explain changes to Maidstone Hospital which were underway and so concrete, not just aspiration. It was an opportunity to close the loop on the Trust's reconfiguration when a lot of focus in recent years had been on the new Tunbridge Wells Hospital at Pembury. Several Members commented how please they were to see Maidstone Hospital had such a vibrant future.

(b) One negative aspect was raised by Members regarding the appointment system, with the specific example given of being unable to change an appointment due to the absence that day of a particular member of staff. The Chief Executive of MTW responded to the specific example by saying it was clearly unacceptable but acknowledged that the appointments formed a high proportion of the complaints received by the Trust. Improvements had been made and would continue to be so.

(c) One recent change was the opening of the new Urgent Medical and Ambulatory Unit (UMAU). This replaced the previous Medical Assessment Unit (MAU) and worked differently. The UMAU was designed to deal with patients for 24 hours only. After this time they would be discharged or admitted to the ward for the appropriate clinical specialty. The intention was to get as much of the necessary assessment and diagnostics done in the first 6-8 hours. There were two routes to the UMAU. Firstly, GPs could refer patients to it directly; patients passed through accident and emergency (A&E) where a nurse would be able to assess whether any treatment needed to be given immediately as the patient transited. Secondly, patients would arrive in A&E as usual and would be moved to the UMAU where appropriate after triage. Previously, all patients went through A&E.

(d) There was also a new cardiac service. Cardiac services were a long established part of what Maidstone Hospital offered, but what was new was a very specific treatment for the most common form of the heart short-circuiting, ablation. This was currently only available in London and Maidstone was the only place in Kent which offered the service. This was a technology which did not exist 15 years ago and the service was likely to grow.

(e) The new community ward, Romney Ward, was also discussed. It was explained that this was not the same as the old Boxley Ward. In part the new community ward was an ad hoc response to winter pressures and was more like a community hospital. Maidstone does not have a separate community hospital. The length of stay of patients on this ward was 7-8 days when the

ward was initially operational, but these patients had been transferred from other wards in the hospital. The average length of stay was around 2-3 weeks now, although the service had not been operating long enough to make definitive statements.

(f) It was explained that the trend was to reduce admission to hospital where possible. There was a growing demand for medical care, and an ageing population. It was often better for patients if admission could be avoided and the trend was towards more ambulatory care where patients were admitted or discharged with a treatment plan, sometimes returning for tests at a later date. The changes were not unique to Maidstone, but the specific configuration was.

(g) The renovation and redesign of the hospital was welcomed, and the role wider spaces between beds played in reducing infections was commented on. It was explained that the Trust had the lowest backlog maintenance bill in Kent but was not complacent. The building was in a series of cruciform sections and it was possible to work through the hospital systematically, stripping each section down to the bare frame. Some maintenance work, like boiler replacement, would need to be done separately.

(h) The Trust also explained that it was seeking 120 additional parking spaces. In response to a comment from a Member, the Chief Executive undertook to look at the size of the spaces used in the standard template. The majority of people arrived at hospital by car and Maidstone Hospital was fortunate in being positioned in a comparatively flat area. The question was asked about building a multi-storey car park. There was nothing forbidding a multi-storey car park, although it might not be able to be higher than the hospital. One Member suggested this may be to ensure helicopter clearance. The barrier was cost. Each level of a multi-storey car park cost around ten times more than having a simple car park on one level, although the design used at Medway Hospital was slightly cheaper.

(i) The Chairman proposed the following recommendation:

- That the Committee thanks its guests for their explanations, notes the report and looks forward to updates in the future.

(j) AGREED that the Committee thanks its guest for their explanations, notes the report and looks forward to updates in the future.

6. Cancer Services: Overview
(Item 7)

Stewart Dicker (Clinical Director - Quality and Care, Kent and Medway Cancer Network), Felicity Cox (Chief Executive, NHS Kent and Medway), and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(a) The representative from the Kent and Medway Cancer Network (KMCN) thanked the Committee for the opportunity to attend. He explained that the questions asked in advance related to the two-year old cancer strategy. Some information was not yet available; this included data on resection rates.

(b) The general structure of cancer services was given as being a hub and spoke model with specialist services concentrated where appropriate. It was explained that Maidstone was the centre for chemotherapy, but as part of an outreach service, all acute sites in Kent and Medway provided it. In contrast testicular cancer, which mainly affected men up to the age of 26, was centralised at the Royal Marsden hospital.

(c) There were no plans to change the current sites for services. KMCN would cease to exist after March 2013. Commissioning would move from the Primary Care Trusts (PCTs) to the CCG, or NHS Commissioning Board where the service was a specialist one. There would be a clinical network in the future covering Kent, Surrey and Sussex. This would include cancer along with other conditions in its work. Currently hosted by the PCTs, the future network would be hosted by the providers.

(d) There was a discussion about reducing health inequalities. It was explained that the KMCN did a lot of work on prevention in the past, particularly around early diagnosis. In the future, the Health and Wellbeing Board (HWB) would have a role in ensuring health inequalities were tackled. The HWB had to approve the commissioning plans of the CCGs. The CCGs had to plan to achieve 4 national outcomes targets along with 2 chosen locally. They would need to demonstrate to the HWB how it was achieving these outcomes. There was an outcomes dataset which would enable progress to be measured, although it was conceded data was not collected on everything. NHS representatives undertook to send a copy of the outcomes dataset to the Committee. In addition, the new public health responsibilities of Kent County Council included prevention.

(e) There was a debate around screening as a means to prevention, with Members questioning why there was not a national prostate cancer screening programme like there was for breast cancer. It was explained that while breast cancer diagnoses went up, the death rate stayed the same, which begged certain questions. Clinically, a screening programme needed to detect a cancer when there was still an opportunity to change the outcome and it needed a low false negative rate. The PSA test for prostate cancer did not meet these criteria. It was useful once the cancer had been diagnosed, but as a screening programme it would produce a low discovery rate for the number of tests. The biopsy can miss the tumour and potentially cause incontinence and impotence. It was also explained that prostate cancer was something most people died with, but did not die of it. It would also rely on all men going to their GP for the test. The bottom line was that a better test was needed.

(f) The Chairman proposed the following recommendation:

- That the Committee thanks its guests and notes the report.

(g) AGREED that the Committee thanks its guests and notes the report.

7. Date of next programmed meeting – Friday 8 March 2013 @ 10:00 am
(Item 8)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 8 March 2013

Subject: The Francis Report

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1. Background

(a) The Francis Report into care provided at Mid Staffordshire NHS Foundation Trust was published on 6 February 2013.

(b) On behalf of the Committee, the Vice-Chairman in the Chair has requested information on how the findings of the report are being taken forward locally. These are attached.

2. Recommendation

That the Committee note the report and recommend that the HOSC look into this issue in the future when further information is available.

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By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee, 8 March 2013

Subject: Francis Report: Overview

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1. Introduction

(a) Robert Francis QC was originally asked in July 2009 to chair an independent inquiry into care provided at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. This followed on from the publication of a report into the Trust by the Healthcare Commission in March 2009 and the reaction to its findings.

(b) The Department of Health and Trust Board accepted the recommendations of this first inquiry in full following publication in February 2010. Recommendation 16 was for Robert Francis to chair a non-statutory inquiry in public. A second non-statutory inquiry was commissioned. On 9 June 2010 the Secretary of State for Health announced this would be a public inquiry.

(c) The final report of this public inquiry was published on 6 February 2013. It is in 3 volumes along with an Executive Summary (c.1700 pages across volumes 1-3). The report contains 290 recommendations covering a wide range of areas.

(d) Given its length and the number of recommendations, together with the changes to the health sector underway as a result of the Health and Social Care Act 2012, the implications and impact of the Francis Report will take time to become clear. It is also important to see the findings of the report in their proper context. Robert Francis QC writes in the report: "What are perceived to be critical comments should not be taken out of context or in isolation from the rest of the report."[1]

2. Key Points

(a) Volume 1 of the report considers the warning signs about what was occurring at Mid-Staffordshire which existed during and prior to the relevant period. These included the loss of 'star ratings' which used to be issued by the Commission for Health Improvement, the findings of peer reviews, Healthcare Commission reviews and surveys, auditors reports, whistleblowing, a Royal College of Surgeon's report in January 2007, the Trust's financial recovery plan and evidence produced during the Trust's application for Foundation Trust (FT) status.

[1] Volume 1, p.43.

(b) The report then goes on to consider what prevented concerns raised from being addressed and this covers volumes 1 and 2. The actions undertaken by a broad spectrum of organisations is considered and analysed. This list includes the Trust itself, other NHS organisations, the Department of Health, professional and sector regulators, local authority health scrutiny committees and patient groups like LINk and other local groups like CURE the NHS.

(c) From out of this a set of common themes as to why the problems were not discovered sooner are set out:[2]

- The Trust lacked insight into the reality of care being provided and was defensive in reaction to criticism.
- There were regulatory gaps in the responsibilities and accountabilities of external agencies.
- A lack of effective communication across the healthcare system.
- Loss of corporate memory from constant NHS reorganisation.
- A combination of the three above lead to a systemic culture where assurances given were not sufficiently challenged.
- This culture operated in a structure where identifying processes and meeting targets were how performance was measured.
- Finance and targets were prioritised over consideration of the quality of care.

(d) Volume 3 moves on to consider the culture and values in the NHS system before moving on to the recommendations and assorted appendices.

(e) The Executive Summary contains the following Conclusion:[3]

"The first inquiry report stated that it should be patients – not numbers – which counted. That remains the view of this Inquiry. The demands for financial control, corporate governance, commissioning and regulatory systems are understandable and in many cases necessary, but it is not the system itself which will ensure that the patient is put first day in and day out. It is the people working in the health service and those charged with developing healthcare policy that need to ensure that is the case.

"The extent of the failure of the system shown in this Inquiry's report suggests that a fundamental culture change is needed. That does not

[2] Adapted from Executive Summary, pp.64-5.
[3] Executive Summary, p.83

require a root and branch reorganisation – the system has had many of those – but it requires changes which can largely be implemented within the system that has now been created by the new reforms. I hope that the recommendations in this report can contribute to that end and put patients where they are entitled to be – the first and foremost consideration of the system and everyone who works in it."

3. Next Steps

(a) A full Government response to the recommendations of the report is currently being prepared. The Prime Minister's statement on the issue on 6 February 2013[4] highlighted "three fundamental problems with the culture of our NHS." These are:

1. A focus on finance over patient care;

2. An attitude that patient care was always someone else's problem; and

3. Defensiveness and complacency.[5]

(b) The statement also included a number of things which had already been put into place and set out some actions which would be taken immediately. The Care Quality Commission has been asked to create a new post, that of 'chief inspector of hospitals.'

(c) Prior to this post being established, the NHS medical director, Professor Sir Bruce Keogh was asked "to conduct an immediate investigation into the care at hospitals with the highest mortality rates and to check that urgent remedial action is being taken."[6]

(d) There are a number of different ways to measure mortality rates in the NHS. Sir Bruce Keogh initially named five Trusts who had been outliers for a period of two years against the Summary Hospital-level Mortality Indicator (SHMI).[7] This was followed up by naming 9 Trusts who had been outliers for a period of two years against the Hospital Standardised Mortality Ratio (HSMR).[8] These Trusts are:

- Colchester Hospital University NHS Foundation Trust (SHMI)
- Tameside Hospital NHS Foundation Trust (SHMI)
- Blackpool Teaching Hospitals NHS Foundation Trust (SHMI)

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[4] House of Commons Hansard, *Mid Staffordshire NHS Foundation Trust (Inquiry)*, 6 February 2013, cols. 279-306.
[5] Ibid., Col. 280.
[6] Ibid., Col. 282.
[7] NHS Commissioning Board, *Professor Sir Bruce Keogh to investigate hospital outliers*, 6 February 2013, http://www.commissioningboard.nhs.uk/2013/02/06/sir-bruce-keogh/
[8] NHS Commissioning Board, *Sir Bruce Keogh announces final list of outliers*, 11 February 2013, http://www.commissioningboard.nhs.uk/2013/02/11/final-outliers/

- Basildon and Thurrock University Hospitals NHS Foundation Trust (SHMI)
- East Lancashire Hospitals NHS Trust (SHMI)
- North Cumbria University Hospitals NHS Trust (HSMR)
- United Lincolnshire Hospitals NHS Trust (HSMR)
- George Eliot Hospital NHS Trust (HSMR)
- Buckinghamshire Healthcare NHS Trust (HSMR)
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (HSMR)
- The Dudley Group NHS Foundation Trust (HSMR)
- Sherwood Forest Hospitals NHS Foundation Trust (HSMR)
- Medway NHS Foundation Trust (HSMR)
- Burton Hospitals NHS Foundation Trust (HSMR)

Background Documents

Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, published 6 February 2013, http://www.midstaffspublicinquiry.com/report

Contact Details

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Medway NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S OFFICE

Direct Line **01634 833944**
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Our ref: MD/MJ

14 February 2013

Mr Christopher Smith
Vice-Chairman, in the Chair
Health Overview & Scrutiny Committee
Kent County Council

Sent via email

Dear Christopher

Thank you for your letter dated 13 February 2013, regarding the Francis Report.

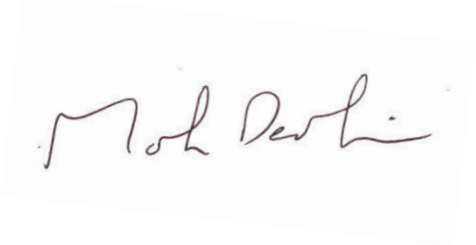
I can confirm that Medway NHS Foundation Trust has been identified as one of the 14 Trusts whom the NHS Commissioning Board (NCB) will be reviewing as our Hospital Standardised Mortality Ratios (HSMR) are high. This decision is not prompted by any new data but on HSMR figures for 2010/11 and 2011/12, in which the Trust was an outlier.

As you know, the Trust's HSMR is an issue that we have been aware of for some time and about which we have been open and transparent. A higher than expected mortality indicator does not in itself mean that a hospital is unsafe. Nevertheless, the Trust remains concerned that, according to the Dr Foster report published last December, its HSMR remains higher than the national average. Extensive work has been taking place to try and identify the cause of these results and improve our position. Recently, the Trust has set-up a working party, chaired by Dr Alison Barnet, Director of Public Health, including membership of Trust clinicians and GP colleagues, to oversee its approach to improving mortality. The medical director from Frimley Park Hospital NHS Foundation Trust, which has a very low HSMR, has also been invited to review the working party's actions.

The Trust welcomes any further advice or input from the NCB through this review process, whose stated focus is to support and speed improvement. The Trust is absolutely committed to ensuring the provision of high quality, safe care for our patients – working in partnership with families, carers and GPs.

Further details on the timescale and terms of reference will be available soon. I will keep you closely informed of the position. If you have any further queries or matters you would like to discuss, please do not hesitate to get in touch.

Yours sincerely



Mark Devlin
Chief Executive

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NHS

Kent and Medway

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Monday 18th February 2013

Via email to *chris.smith@kent.gov.uk*

Mr Christopher Smith
Vice Chairman in the Chair
Kent Health Overview and Scrutiny Committee

Dear Mr Smith

Re: Francis Inquiry Recommendations

Further to the published paper on 6 February 2013, I am writing to provide assurance on the steps that the NHS in Kent and Medway are taking to consider and respond to the 290 recommendations.

The newly formed clinical commissioning groups in Kent and Medway have safety and quality at the top of their agenda. A number of steps have already been taken in Kent and Medway to address concerns identified in the first Francis report. For example, health service providers have given assurance on the actions that they are taking to ensure that the lessons learnt from the Mid-Staffordshire Hospital are considered by their own Board. A further self- assessment was conducted and reviewed by commissioners.

The NHS Commissioning Board Area Team (covering Kent and Medway) is already establishing Quality Surveillance Groups as recommended in national guidance and will be drawing on the lessons learnt from Francis. The Group met in shadow form this month and will formally commence in April 2013. The National Quality Board has published accompanying guidance to the system on establishing Quality Surveillance Groups (QSGs): www.dh.gov.uk/health/2013/01/establish-qsg/.

The purpose is to bring together different parts of health and care economies in Kent and Medway to routinely share information and intelligence to protect the quality of care that patients receive. The QSGs should not add another level of bureaucracy but instead provide a forum for local partners to realise the cultures and values of open and honest cooperation which should be in place already. They should seek to reduce the burden of performance management and regulation on providers of services, by ensuring that supervisory, commissioning and regulatory bodies work in a more coordinated way.

Continued/…2

NHS Kent and Medway represents the following primary care trusts (PCTs):
NHS West Kent, NHS Eastern and Coastal Kent and NHS Medway.

2/……..
Mr. Christopher Smith
HOSC
18/02/2013

I would be happy to attend a future HOSC meeting when we have had time to consider the national, regional and local response to the Inquiry recommendations.

Yours sincerely

Sally Allum
Acting Director Nursing and Quality

cc: Tristan Godfrey, Research Officer to Health Overview and Scrutiny Committee
Malti Varshney, Public Health Consultant, NHS Kent and Medway
Meradin Peachey, Director of Public Health (Kent), NHS Kent and Medway
Dr David Woodhead, Clinical Accountable Officer, Dartford Gravesham & Swanley CCG
Dr Peter Green, Clinical Accountable Officer, Medway CCG
Patricia Davies, Accountable Officer, Swale CCG
Ian Ayres, Accountable Officer, West Kent CCG
Hazel Carpenter, Accountable Officer, Thanet and South Kent Coast CCGs
Simon Perks, Accountable Officer, Ashford and Canterbury & Coastal CCGs
Felicity Cox, Area Director, NHS Commissioning Board and Chief Executive, NHS Kent & Medway
Debra Vidler, Project lead for HSGs and Acting Associate Director of Quality, NHS Kent & Medway

NHS Kent and Medway represents the following primary care trusts (PCTs):
NHS West Kent, NHS Eastern and Coastal Kent and NHS Medway.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 8 March 2013

Subject: Services Overview: a) Diabetes Services; and b) Ophthalmology.

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1. Background

(a) On 30 November 2013, the Committee agreed its Forward Work Programme for the first part of 2013. It was agreed to consider diabetes services and secondary ophthalmology services together due to the close overlap between the two subjects.

(b) NHS Kent and Medway and the Department of Public Health have been invited to attend and submit information in advance of the meeting.

2. Recommendation

That the Committee consider and note the report.

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By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee

Subject: Services Overview: a) Diabetes Services; and b) Ophthalmology

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A. Diabetes Services

1. Introduction

(a) Diabetes is caused by the body not producing enough insulin to regulate the levels of glucose in the blood. Approximately 2.9 million people in the UK have diabetes. There are believed to be around 850,000 undiagnosed cases.[1]

(b) The number of people in the UK with diabetes is expected to grow to 3.8 million by 2020.[2] Between 1994 and 2009, the proportion of the population diagnosed with diabetes in England more than doubled – from 2.9 - 6.5% among men; and from 1.9 - 4.5% among women.[3]

(c) There are two main types of diabetes:

- Type 1 diabetes is when the body does not produce any insulin. It often develops before the age of 40. Type 1 diabetes can be referred to as insulin-dependent diabetes, juvenile diabetes or early onset diabetes.[4]

- Type 2 diabetes is when the body does not produce enough insulin to function properly or the body's cells do not react to it (insulin resistance). Although it usually affects people over 40, increasing numbers of people below this age are being affected. It is more common in people of South Asian, African-Caribbean or Middle Eastern descent. 90% of people with diabetes in the UK have type 2.[5]

(d) If not treated, diabetes can result in a number of complications and other health issues, including: heart disease, stroke, eye problems such as retinopathy, kidney disease, foot problems, sexual dysfunction,

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[1] NHS Choices, *Diabetes, type 2,* http://www.nhs.uk/Conditions/Diabetes-type2/Pages/Introduction.aspx
[2] National Audit Office, *The management of adult diabetes services in the* NHS, March 2012, p.4. http://www.nao.org.uk/publications/1213/adult_diabetes_services.aspx
[3] Ibid., p.15
[4] NHS Choices, *Diabetes, type 1,* http://www.nhs.uk/Conditions/Diabetes-type1/Pages/Introduction.aspx?url=Pages/What-is-it.aspx
[5] NHS Choices, *Diabetes, type 2,* http://www.nhs.uk/Conditions/Diabetes-type2/Pages/Introduction.aspx

miscarriage and stillbirth.[6] Life expectancy for people with type 1 diabetes is reduced by 20 years on average; for those with type 2, it is 10 years.[7] The Department of Health has estimated that each year "there are 24,000 people more with diabetes who die than an equivalent population who do not have diabetes."[8]

(e) In 2009/10, £3.9 billion was spent on diabetes by the NHS. This was around 4% of the budget. In a report from May 2012, the National Audit Office has estimated that better management of diabetes could save around £170 million a year. [9]

(f) in 2009/10, people with diabetes stayed 19.4% longer in hospital than would have been expected if they did not have diabetes.[10]

2. National Standards

(a) The Department of Health published the National Service Framework for Diabetes in 2001. This set out recommended standards of care aimed at "reducing the burden of diabetes and the associated health inequalities as well as ensuring high quality of care wherever people live."[11] The Quality Standard developed by the National Institute for Health and Clinical Evidence (NICE) for *Diabetes in adults*, published March 2011, supports this National Service Framework.[12]

(b) Quality standards formed part of the NHS White Paper, *Equity and Excellence: Liberating the NHS*,[13] and the subsequent Health and Social Care Act 2012[14] and "are a concise set of statements designed to drive and measure priority quality improvements within a particular area of care."

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[6] NHS Choices, *Diabetes, type 2 - complications,* http://www.nhs.uk/Conditions/Diabetes-type2/Pages/Complications.aspx

[7] National Audit Office, *The management of adult diabetes services in the* NHS, March 2012, p.12. http://www.nao.org.uk/publications/1213/adult_diabetes_services.aspx

[8] Sir Bruce Keogh, NHS Medical Director for England, House of Commons Committee of Public Accounts evidence session, 12 June 2012, Q45, http://www.publications.parliament.uk/pa/cm201213/cmselect/cmpubacc/289/120612.htm

[9] National Audit Office, *The management of adult diabetes services in the* NHS, March 2012, pp.4-8. http://www.nao.org.uk/publications/1213/adult_diabetes_services.aspx

[10] http://www.rightcare.nhs.uk/atlas/downloads/EndocrineMaps_AoV_2011.pdf

[11] Department of Health, *National Service Framework for Diabetes:* Standards, December 2001, p.3, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058938.pdf

[12] NICE, *Diabetes in adults quality standard,*http://publications.nice.org.uk/diabetes-in-adults-quality-standard-qs6/introduction-and-overview

[13] Department of Health, *Equity and Excellence: Liberating the* NHS, July 2010, pp.23-4 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf

[14] Health and Social Care Act 2012, S.234, http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf

(c) The 14 statements of the NICE Quality Standard for diabetes in adults are:[15]

- Statement 1. People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education.

- Statement 2. People with diabetes receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured educational programme.

- Statement 3. People with diabetes participate in annual care planning which leads to documented agreed goals and an action plan.

- Statement 4. People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%), and receive an ongoing review of treatment to minimise hypoglycaemia.

- Statement 5. People with diabetes agree with their healthcare professional to start, review and stop medications to lower blood glucose, blood pressure and blood lipids in accordance with NICE guidance.

- Statement 6. Trained healthcare professionals initiate and manage therapy with insulin within a structured programme that includes dose titration by the person with diabetes.

- Statement 7. Women of childbearing age with diabetes are regularly informed of the benefits of preconception glycaemic control and of any risks, including medication that may harm an unborn child. Women with diabetes planning a pregnancy are offered preconception care and those not planning a pregnancy are offered advice on contraception.

- Statement 8. People with diabetes receive an annual assessment for the risk and presence of the complications of diabetes, and these are managed appropriately.

- Statement 9. People with diabetes are assessed for psychological problems, which are then managed appropriately.

- Statement 10. People with diabetes at risk of foot ulceration receive regular review by a foot protection team in accordance with NICE guidance.

[15] NICE, *Diabetes in adults quality standard*, http://publications.nice.org.uk/diabetes-in-adults-quality-standard-qs6/list-of-statements

- Statement 11. People with diabetes with a foot problem requiring urgent medical attention are referred to and treated by a multidisciplinary foot care team within 24 hours.

- Statement 12. People with diabetes admitted to hospital are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin.

- Statement 13. People admitted to hospital with diabetic ketoacidosis receive educational and psychological support prior to discharge and are followed up by a specialist diabetes team.

- Statement 14. People with diabetes who have experienced hypoglycaemia requiring medical attention are referred to a specialist diabetes team.

(d) In May 2012, the National Audit Office published a report into *The management of adult diabetes services in the NHS.* Part of the report looked at the delivery of nine basic care processes set out in the National Service Framework which are meant to be delivered annually. This issue was also considered by the House of Commons Committee of Public Accounts and formed part of their November 2012 report, *Department of Health: The management of adult diabetes services in the NHS*.[16]

(e) Based on the *National Diabetes Audit* for 2009-10, the NAO found that nationally, "90 per cent of people with diabetes receive six of the recommended care processes, but only 49 per cent were assessed for the early signs of all complications."[17] The proportion of patients receiving all 9 basic care processes ranged from less than 10% in two Pimary Care Trusts (PCTs) and no more than 69% in any PCT.[18] [19]

(f) A table listing the care processes and a second table listing the NAO findings by Primary Care Trust are appended to this Note.[20]

(g) In response to a question about the expiry of the National Service Framework for Diabetes in 2013, the Department of Health provided the following statement in a Written Answer:

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[16] House of Commons Committee of Public Accounts, *Department of Health: The management of adult diabetes services in the NHS*, 6 November 2012, http://www.publications.parliament.uk/pa/cm201213/cmselect/cmpubacc/289/289.pdf

[17] National Audit Office, *The management of adult diabetes services in the* NHS, March 2012, p.20. http://www.nao.org.uk/publications/1213/adult_diabetes_services.aspx

[18] Ibid., p.21. For more detailed information on these variation see: http://www.rightcare.nhs.uk/atlas/downloads/EndocrineMaps_AoV_2011.pdf

[19] The National Diabetes Audit data can be accessed here: http://www.ic.nhs.uk/searchcatalogue?productid=7331&infotype=0%2fAudit&sort=Relevance&size=10&page=2#top

[20] Sourced from: Ibid., pp.14 and 41, http://www.nao.org.uk/publications/1213/adult_diabetes_services.aspx

The National Audit Office (NAO) recently published their report on "The Management of Adult Diabetes Services in the NHS". This report stated that the Department had been successful, through the National Service Framework for Diabetes, in setting clear standards for good diabetes care and these had been reinforced by the Quality Standard set by the National Institute for Health and Clinical Excellence in 2011; but that further improvements were needed. The Public Accounts Committee (PAC) held a hearing on the NAO report on 12 June 2012 and our intention is to wait for the PAC to publish its conclusions before finalising our plans in relation to diabetes. Three documents will be produced over the next several months that will offer the opportunity to publish these plans: the Diabetes action plan, the Long Term Conditions (LTCs) Outcomes Strategy (to include a diabetes companion document), and the Cardiovascular Disease (CVD) Outcomes Strategy.

The Diabetes action plan will set out the actions the national health service will be taking to increase identification, improve prevention and treatment of diabetes, and will be published later this year.

The Long Term Conditions Outcomes Strategy is aimed at improving outcomes for all people with LTCs. The strategy will look at all of the aspects that impact on the lives of people with LTCs, and outline how the key players (Government Departments, local authorities, charities and individuals) can act in future in order to reduce LTC incidence, and improve outcomes for those with LTCs. We aim to publish the strategy towards the end of 2012; a companion document on diabetes will be published at the same time.

The Cardiovascular Disease Outcomes Strategy will outline how the healthcare system can improve outcomes for people with—or at risk of—CVD. The strategy will consider the whole of the patient pathway from prevention through to long-term care. As diabetes is a major risk factor for CVD, it will be considered as part of the strategy's development.[21]

(h) In a Westminster Hall debate on diabetes on 9 January 2013, the Health Minister stated these documents will be published in "the coming months."[22]

[21] House of Commons Hansard Written Answer, 2 July 2012, PQs 114881-4, http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm120702/text/120702w0005.htm#12070315000010 When the Long term Conditions Outcomes Strategy is published it is likely to be available here: http://www.dh.gov.uk/health/category/policy-areas/nhs/long-term-conditions/

[22] Anna Soubry MP, The Parliamentary Under-Secretary of State for Health, Westminster Hall debate, 9 January 2013, Col. 97WH, http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm130109/halltext/130109h0001.htm#13010940000001

(i) The Government response to the Public Accounts Committee report into the management of adult diabetes services in the NHS was published on 25 February 2013.[23]

B. Ophthalmology

1. Introduction

(a) Ophthalmology deals with the diagnosis, treatment and prevention of diseases of the visual system and eye. An ophthalmologist is a medically trained doctor often acting as a physician and a surgeon. Medical ophthalmology has been a separate specialty from ophthalmology since 1995. Medical ophthalmologists (ophthalmic physicians) are trained in both general internal medicine and ophthalmology and diagnose and whose work includes managing patients with systemic disease such as diabetes.

(b) Patients often have conditions related to ageing such as macular degeneration, glaucoma, and cataracts. Cataract operations under the NHS number over 300,000 each year; this is the most common operation carried out under the NHS. Diseases of the eye often have connection to an underlying systemic condition like diabetes.

(c) Optometrists, sometimes referred to as opticians, carry out eye examinations, advise on problems and prescribe/fit glasses and contact lenses. An orthoptist diagnosis and treats vision defects and eye movement abnormalities.[24]

(d) Ophthalmology outpatient attendances in England numbered 6,365,308 in 2010/11. This is an increase of 1,145,330 over five years.[25]

(e) By 2020, the number of people across the UK living with sight loss is estimated to increase by 22% from the current 2 million.[26] The commissioning spend on eye care is around £4.27 million per 100,000 population on average.[27]

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[23] HM Treasury, Treasury Minutes, *Government responses on the Fourteenth, the Seventeenth to the Nineteenth, and the Twenty First Reports from the Committee of Public Accounts Session: 2012-13*, 25 February 2013, pp.8-14, http://www.hm-treasury.gov.uk/d/hmt_minutes_14_17_19_21_reports_cpas_feb2013.pdf

[24] The Royal College of Ophthalmologists, *What is an ophthalmologist?* and *Ophthalmology as a career*, http://www.rcophth.ac.uk/page.asp?section=102&sectionTitle=What+is+an+Ophthalmologist

[25] http://www.commissioningforeyecare.org.uk/commhome.asp?section=160&sectionTitle=The+business+case+for+improved+quality+in+eye+care

[26] http://www.commissioningforeyecare.org.uk/commhome.asp?section=163&sectionTitle=Room+for+improvement

[27] Ibid.

2. Diabetes and Eye Health

(a) People with diabetes are around 25 times more likely to become blind than the general population.

(b) Diabetic retinopathy is the most common cause of sight loss in working age people and arises when diabetes affects the small blood vessels in the retina. There may not be any symptoms until it is quite advanced. Approximately 4,200 people each year are at risk of blindness from diabetic retinopathy and cause 1,280 new cases of blindness.[28] 40% of people with type 1 diabetes and 20% with type 2 diabetes will develop some sort of diabetic retinopathy.[29]

(c) Under the NHS Diabetic Eye Screening Programme, all people with diabetes aged 12 or over are offered an annual screening appointment.[30] The screening programme was announced in 2003 in the Delivery Strategy for the National Service Framework for Diabetes. The programme was implemented between 2003 and 2008 and is delivered by over 80 programmes.[31]

(d) In 2010-2011:

- 2,470,000 people in England aged 12 and over were identified with diabetes
- 2,260,000 were offered screening for diabetic retinopathy
- 1,790,000 received screening, an uptake of 79%[32]

(e) The national quality standards are:

- For an initial screening test:
    - The minimum standard is 70% for the eligible population taking up the offer.
    - The achievable standard is 90% for the eligible population taking up the offer.
- For a repeat screening test:
    - The minimum standard is 80% for the eligible population taking up the offer.

[28] http://diabeticeye.screening.nhs.uk/diabetic-retinopathy
[29] The Royal College of Ophthalmologists, *Understanding Eye Conditions Related to Diabetes*, http://www.rcophth.ac.uk/page.asp?section=365&sectionTitle=Information+Booklets
[30] http://diabeticeye.screening.nhs.uk/screening
[31] http://diabeticeye.screening.nhs.uk/about
[32] http://diabeticeye.screening.nhs.uk/statistics

- The achievable standard is 95% for the eligible population taking up the offer.

(f) According to *The NHS Atlas of Variation in Healthcare*:

- "For PCTs in England, the percentage of the diabetic population receiving screening for diabetic retinopathy ranged from 7.4% to 91.8% (12-fold). When the five PCTs with the highest percentages and the five PCTs with the lowest percentages are excluded, the range is 57.7–87.0%, and the variation is 1.5-fold."[33]

[33] http://www.rightcare.nhs.uk/atlas/downloads/Vision_AoV_2011.pdf

Figure 2
The nine basic care processes for people with diabetes, to be delivered annually

Care process	Purpose	Primarily delivered by
Micro-albuminuria	A urine test is undertaken to check for protein, a sign of possible kidney problems.	GP practice or community service
Blood pressure	High blood pressure can indicate blockages or obstructions in the arteries, which can cause a variety of complications.	GP practice or community service
Body mass index	Approximate measure of obesity using height and weight. Obesity is a risk factor in developing complications due to diabetes.	GP practice or community service
Cholesterol	A blood test is undertaken to measure levels of fat in the blood. High levels increase the risk of complications developing.	GP practice or community service
Creatinine	A blood test is undertaken to check for waste material carried in the blood and excreted by the kidneys. High levels are a marker for possible kidney disease.	GP practice or community service
Eye screening	Using a specialised digital camera, a photograph of each eye is taken to look for any changes to the retina (the seeing part at the back of the eye) which may require treatment to prevent blindness.	Acute service, community service or private provider
Foot examination	The skin, circulation and nerve supply of the feet are examined to check for numbness, sensation, reflexes and pulses. Early recognition and management of these risk factors can prevent or delay the development of ulcers which can lead to amputations.	Acute service, outpatient podiatry clinic or GP practice
HbA1c[1] level (a marker for blood glucose)	High blood glucose levels can cause damage to blood vessels and increase the risk of diabetes complications developing.	GP practice or community service
Smoking advice	Having diabetes puts people at increased risk of heart disease and stroke. Smoking further increases this risk.	GP practice or community service

NOTE
1 HbA1c is a measure of average blood glucose levels over the last eight to twelve weeks. The amount of glucose that is being carried by the red blood cells in the body is established via a blood test.

Source: National Audit Office

Appendix Two

Percentage of people with diabetes receiving all nine care processes in 2009-10, by primary care trust

Percentage		Primary care trust
0-9		Mid Essex, Swindon.
10-19		Medway.
20-29		Stoke-on-Trent, Berkshire West, Bolton.
30-39		Worcestershire, Havering, Barking & Dagenham, Southampton City, Kingston, Milton Keynes, North East Essex, Blackburn with Darwen Teaching, West Kent, Manchester, Warwickshire, Redbridge, Bradford & Airedale Teaching, Lincolnshire Teaching, Trafford.
40-49	40-44	Hammersmith & Fulham, Cornwall & Isles of Scilly, Somerset, Northamptonshire Teaching, Haringey Teaching, North Staffordshire, Rotherham, Brighton & Hove City, Peterborough, Hounslow, Camden, Hillingdon, Dudley, Shropshire County, Middlesbrough, Westminster, Wiltshire.
	45-49	Luton, Plymouth Teaching, Warrington, Wirral, Kensington & Chelsea, Sutton & Merton, West Essex, Portsmouth City Teaching, South East Essex, South West Essex, Surrey, Salford, Bristol, Coventry Teaching, Bedfordshire, Bury, Southwark, Torbay, Croydon, Birmingham East & North, Knowsley, Liverpool, Hampshire, Heart of Birmingham Teaching, West Sussex, Tower Hamlets, Richmond & Twickenham, Derbyshire County.
50-59	50-54	Oldham, Calderdale, Greenwich Teaching, Sandwell, North East Lincolnshire, Solihull, East Sussex Downs & Weald, Leeds, Islington, Sheffield, City & Hackney Teaching, Ashton Leigh & Wigan, Waltham Forest, Buckinghamshire, Heywood Middleton & Rochdale, East Lancashire Teaching, Central Lancashire, Telford & Wrekin, Lewisham, Lambeth, North Tyneside, Barnsley, Hertfordshire, Berkshire East, Tameside & Glossop, Oxfordshire, Cumbria Teaching, Eastern & Coastal Kent, Hull Teaching, Wandsworth, Ealing, Halton & St Helens.
	55-59	Enfield, Kirklees, Leicester City, Cambridgeshire, Barnet, South Birmingham, Bromley, Sefton, Brent Teaching, Gloucestershire, Bassetlaw, Derby City, Great Yarmouth & Waveney, Wolverhampton City, South Staffordshire, Walsall Teaching, North Lincolnshire, Western Cheshire, Newham, Bath & North East Somerset, Central & Eastern Cheshire, Nottingham City, Dorset, South Tyneside, Bexley, Darlington, Redcar & Cleveland, Suffolk, Nottinghamshire County Teaching, North Lancashire Teaching, Devon, County Durham, Wakefield District.
60-69		South Gloucestershire, Stockport, Norfolk, Newcastle, Blackpool, Hartlepool, Stockton-on-Tees Teaching, Leicestershire County & Rutland, Harrow, Bournemouth & Poole Teaching, North Yorkshire & York, East Riding of Yorkshire, Northumberland, North Somerset, Doncaster, Hastings & Rother, Herefordshire, Sunderland Teaching, Gateshead.

NOTE

1 Primary care trusts are listed in ascending order of performance.

Source: National Diabetes Audit, 2009-10

NHS
Kent and Medway

Diabetes

Introduction

The prevalence of diagnosed diabetes among people aged 17 years and older for Kent is 5.8%. In NHS Eastern and Coastal Kent 57.5% of all people with diabetes aged 17 years and older who are not excepted from the Quality and Outcomes Framework have an HbA1c of 7% or less. HbA1c is a measure of blood sugar which indicates how well diabetes is being controlled. In west Kent the figure was 56.3%. Both percentages are statistically significantly higher than PCTs with populations with similar diabetes risk factors and statistically significantly higher than England as a whole.

Of the people with diabetes included in the National Diabetes Audit in NHS Eastern and Coastal Kent 21 per 1000 had had a stroke in the previous year compared to 6.9 per 1000 across the whole of England. In NHS Eastern and Coastal Kent 5.4 per 1000 of people with diabetes had a myocardial infarction (heart attack) in the previous year compared to 5.8 per 1000 in all PCTs in its cluster group.

Of the people with diabetes included in the National Diabetes Audit in NHS West Kent 6.1 per 1000 had had a stroke in the previous year compared to 6.9 per 1000 across the whole of England. In NHS West Kent 4.4 per 1000 of people with diabetes had a myocardial infarction (heart attack) in the previous year compared to 5.8 per 1000 in all PCTs in its cluster group.

Analysis of total spending on diabetes care compared to HbA1c outcomes shows that both NHS Eastern and Coastal Kent and West Kent are not statistically different from England in programme budgeting spending and not statistically different from England in terms of HbA1c outcomes.

In 2010/11 there were 37321 people aged 17 years and older diagnosed with diabetes in NHS Eastern and Coastal Kent. There is also an estimated 9582 adults with undiagnosed diabetes.

In 2010/11 there were 28777 people aged 17 years and older diagnosed with diabetes in NHS West Kent. There is also an estimated 9933 adults with undiagnosed diabetes.

1. **Can you provide a summary of the demographic data relating to the prevalence of diabetes across Kent? How do different parts of the County compare with each other?**

1. Summary of demographics and how different parts of the county compare with each other

Table 1: Patients aged 17+ with diabetes mellitus Kent CCGs 2011/12

Organisation	Number	Prevalence
NHS Ashford CCG	5,515	5.7%
NHS Canterbury and Coastal CCG	9,609	5.5%
NHS Dartford, Gravesham and Swanley CCG	11,207	5.7%
NHS South Kent Coast CCG	10,446	6.4%
NHS Swale CCG	5,632	6.7%
NHS Thanet CCG	7,662	6.8%
NHS West Kent CCG	18,990	5.1%
Kent	**69,061**	**5.8%**

2. **What estimate have you made of undiagnosed diabetes in the County and what is being done to address this?**

Table 2: Expected prevalence of diabetes 2012

Organisation	Registered	Expected	Missing
NHS Ashford CCG	5,515	7,001	1,486
NHS Canterbury and Coastal CCG	9,609	12,681	3,072
NHS Dartford, Gravesham and Swanley CCG	11,207	12,823	1,616
NHS South Kent Coast CCG	10,446	13,064	2,618
NHS Swale CCG	5,632	6,023	391
NHS Thanet CCG	7,662	9,036	1,374
NHS West Kent CCG	18,990	25,095	6,105
Kent	**69,061**	**85,723**	**16,662**

Source: York and Humber Diabetes expected model

Please also refer to **Appendix 1** for a summary of diabetes prevalence in the population aged 17 and over across the Kent Clinical Commissioning Groups.

Good data is available on the numbers of patients that are undiagnosed and these figures would be part of the individual data sets shared with CCGs as part of any Health Needs Assessment.

NHS Health Checks provides the opportunity to reduce the number of people who have yet to be diagnosed with existing diabetes as well as preventing people going onto to develop diabetes in the future.

Individual CCGs will be addressing this issue with specific targeting of areas as part of the work on health inequalities as both national and local evidence supports the fact that the

prevalence of diabetes is higher in areas experiencing deprivation. We know that people living in the 20% most deprived neighbourhoods in England are 56% more likely to have diabetes than those living in the least deprived areas.[1] It is also known that people from Asian and Black ethnic groups are more likely to have diabetes and tend to develop the condition at younger ages. To improve the outcomes for diabetic patients, access is a key issue and the engagement of patients and local communities' is paramount in making sure service re-design is appropriate for the local population.

Tackling health inequalities is a key objective of Dartford Gravesham and Swanley (DGS) CCG and measures are being taken to improve awareness amongst the general public and within general practice. The CCG is working jointly with the specialist diabetes team at Darent Valley Hospital to arrange a full-day seminar for all GPs, practice nurses and other professionals involved in diabetes care. The specialist diabetic podiatrist recently attended a half day education event where she presented the 'diabetic foot assessment pathway' to GPs, and then separately to practice nurses. This pathway and referral process has now been added to the GP electronic directory of services from which referral can be made.

The 2010/11 QOF registers show that the population of DGS has a higher prevalence of obesity, than England. Obesity is shown to have a link with the onset of Type 2 diabetes. In addition, the population of DGS is more ethnically diverse that the rest of Kent with a larger Asian population which may go part way to explain the increased prevalence.

Although West Kent CCG is relatively affluent there are pockets of deprivation particularly in the towns.

Primary Prevention

West Kent CCG will focus on prevention which will be grounded in local interventions rather than just giving advice. Up skilling primary care staff to care for people with Type 2 diabetes alongside health checks will identify those patients who are yet to be diagnosed.

Secondary Prevention

Secondary prevention for people with diabetes is important to prevent complications. West Kent CCG is working with acute trust colleagues and those within primary care to ensure that patients receive the 'year of care' services. Newly diagnosed patients now receive a comprehensive 'New Patient' information pack with a patient held record to back up the support they receive from their responsible clinicians.

3. What is the cost of diabetes to the Kent Health economy; both in terms of commissioning spend and wider impact

Data taken from the NHS Comparators site is shown below for both east and west Kent.

[1] *Source: Information Centre, 2010/11 and Quality and Outcomes Framework, 2010/11*

The data shows the following tables:

a. Total diabetes admissions per 1000 Population Period/Year: Rolling Year - 2011/2012; Activity and cost

b. Emergency diabetes admissions per 1000 Population Period/Year: Rolling Year - 2011/2012; Activity and cost

c. Cost of Enhanced Services in East Kent 2011-12

Information from the NHS Comparators site suggests that the total number of diabetes admissions into secondary care for Kent in terms of activity for 2011-12 was 1,330 at a cost of £2,577,810.

Of these admissions 1,075 were emergency admissions at a cost of £2,132,061.

Financial Costs	
Primary Care	£181,606,000
Secondary care	£2,132,061

a. Total diabetes admissions per 1000 Population Period/Year: Rolling Year - 2011/2012; Activity

Code	Organisation	Crude Rate	Standardised Rate	Population	Total Count
	National	1.1	1.1	55471952	59688
		0.9	0.9	1494569	1330
5P9	West Kent PCT	0.8	0.8	716070	592
5QA	Eastern and Coastal Kent PCT	1	0.9	778499	738

a. Total diabetes admissions per 1000 Population Period/Year: Rolling Year - 2011/2012; Cost

Type	Code	Organisation	Crude Rate	Standardised Rate	Population	Total Cost £
National		National	1725.3	1725.3	55471952	95705848
Group			1724.8	1640.9	1494569	2577810
PCT	5QA	Eastern and Coastal Kent PCT	1654.1	1540.9	778499	1287720
PCT	5P9	West Kent PCT	1801.6	1754.6	716070	1290090

b. Emergency diabetes admissions per 1000 Population Period/Year: Rolling Year - 2011/2012; Activity

Type	Code	Organisation	Crude Rate	Standardised Rate	Population	Total Count
National		National	0.7	0.7	55471952	38032
Group			0.7	0.7	1494569	1075
PCT	5P9	West Kent	0.7	0.7	716070	479

		PCT				
PCT	5QA	Eastern and Coastal Kent PCT	0.8	0.7	778499	596

b. Emergency diabetes admissions per 1000 Population Period/Year: Rolling Year - 2011/2012; Cost

Type	Code	Organisation	Crude Rate	Standardised Rate	Population	Total Cost £
National		National	1324.7	1324.7	55471952	73485338
Group			1426.5	1358.9	1494569	2132061
PCT	5QA	Eastern and Coastal Kent PCT	1408.4	1312.5	778499	1096440
PCT	5P9	West Kent PCT	1446.3	1411.7	716070	1035621

c. Cost of Enhanced Services in East Kent 2011-12

	Cost £
Level 1	93,256.00
Level 2	88,350.00
Total	181,606,000

Measuring the wider impact of diabetes is very difficult. The table set out below estimated the cost of diabetes in the UK.

Cost of diabetes treatment in the UK in 2010				
Area of expenditure	**Type 1 diabetes**	**Type 2 diabetes**	**Total cost**	**Percentage of costs**
Source: Kanavos, van den Aardweg and Schurer: Diabetes expenditure, burden of disease and management in 5 EU countries, LSE (Jan 2012)				
Diabetes drugs	£0.344 billion	£0.712 billion	£1.056 billion	7.8%
Non-diabetes drugs	£0.281 billion	£1.810 billion	£2.091 billion	15.2%
Inpatient	£1.007 billion	£8.038 billion	£9.045 billion	65.8%
Outpatient (excluding drugs)	£0.170 billion	£1.158 billion	£1,328 billion	9.7%
Other (including social service)	-	-	£0.230 billion	1.7%
Total	£1.802 billion	£11.718 billion	£13.750 billion	100%

Direct costs are those costs that are clearly and directly attributable to the condition in question. This commonly includes medical costs, such as hospital, medical professional and pharmaceutical costs, as well as non-medical costs, which may include transport, carers and lifestyle change costs.

Indirect costs are imputed costs used to reflect the impact to production caused by an illness. The inclusion of indirect costs is a much debated practice. Depending on the viewpoint taken for the cost of illness (COI), indirect costs may have more or less relevance. When costing from a societal perspective, indirect costs are applicable, as changes in society's production, and therefore consumption and utility are being estimated.

Intangible costs estimate the cost of an illness in terms of the reduction in quality of life caused. This reduction may manifest itself as pain, anxiety, disability or suffering. As Intangible Costs do not have any resource impact per se, they are not generally included in a COI study.

Cost Components of Cost of illness (COI) Model[2]

Direct Costs (Medical)	Hospital Related Costs MBS Rebates Claimed PBS Rebates Claimed Diabetes Nurse Educator Costs Dieticians Podiatrists
Direct Costs (Non Medical)	Cost of Equipment/ Consumables used in management of diabetes Cost of additional Physical Activity for management of diabetes Additional costs of special diet consumed in management of diabetes
Indirect Costs	Cost of Carer for people with diabetes Short Term Labour Loss due to diabetes Permanent Labour Loss due to diabetes

The costs to the national economy of lost working time and early death from diabetes are very difficult to quantify, but estimates for the UK put the costs to industry at £531 million in 2006, rising to £780 million in 2026.[3]

[2] *Published July 2007 by the South Australian Department of Health Population Research and Outcome Studies Unit PO Box 287 Rundle Mall 5000 South Australia, Australia*
[3] *Bramley-Harker E, Barham L. The human and economic value of pharmaceutical innovation and opportunities for the NHS. NERA Economic Consulting for the ABPI, 2004*

The cost of caring for people with diabetes is vast, increasing and threatening to present an unsustainable challenge to healthcare services within the next 20 years, 94% and the vast majority of the cost goes on treating diabetes complications.

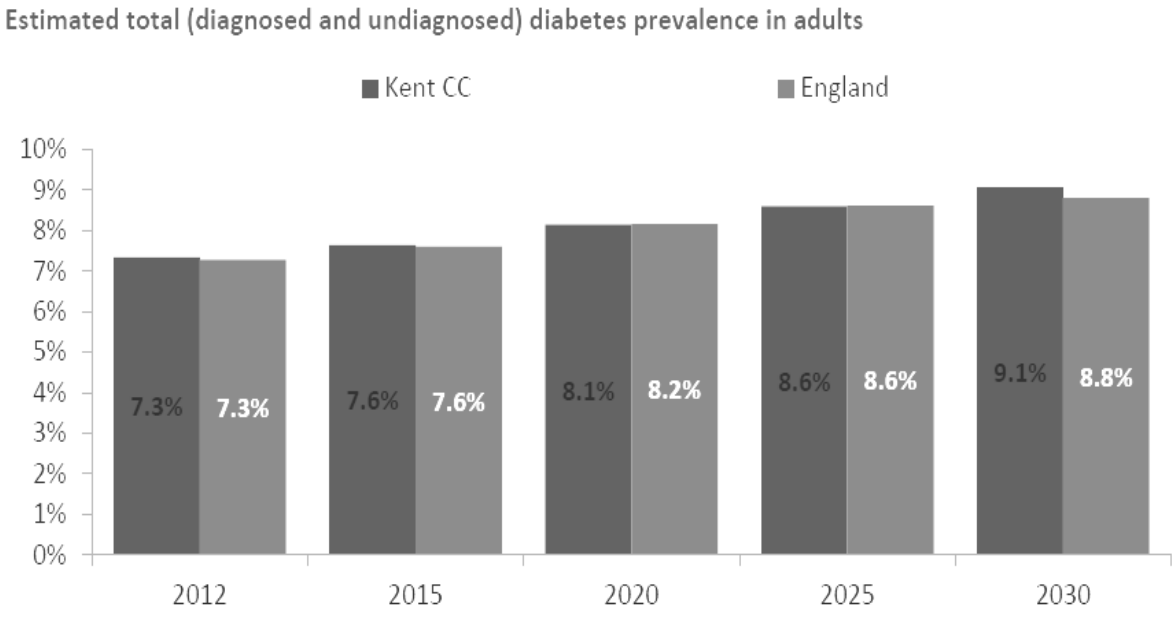
In 2010, the NHS spent about £9 billion a year, £1 million an hour,[4] on treating diabetes. Much of this is spending on 1.1 million inpatient days each year,[5] with only 6% of the costs spent on prescription medicines.[6]

People with diabetes also face significant personal costs, estimated at £500 million a year, due to missing work, the cost of travel for medical treatment, and often loss of employment or early retirement because of ill health. About 6% of people with type 2 diabetes are unable to work at all.

Family members may also suffer financially, especially parents of children with diabetes who may be forced to give up work to care for them.

One in 20 people with diabetes need assistance from social services, at a cost of £230 million per year. More than 75% of these costs are for residential or nursing services, with most of the remainder for home help. It has been estimated that diabetes doubles the chances of entering a care home, and one in four care home residents have diabetes. Recent evidence from Canada has shown that the presence of chronic conditions, such as diabetes, has a much greater impact on healthcare resources than age alone.[7]

Although these figures are based on National data, data produced by the Yorkshire and Humberside Public Health Authority suggests that Kent is not different from the National picture in fact prevalence rates appear to be higher.



www.yhpho.org.uk/default.aspx?RID=154049

[4] *Diabetes.co.uk. Diabetes costs the NHS one million pounds an hour, 27 October 2010 http://www.diabetes. co.uk/news/2010/Oct/diabetes-costs-the-nhs-one million- pounds-an-hour-93645072.html*
[5] *Roberts S. Working together for better diabetes care: Clinical case for change. Department of Health, May 2007*
[6] *Diabetes UK. Diabetes in the UK 2010: Key statistics on diabetes*
[7] Canadian Institute of Health Information. Seniors and the health care system: What is the impact of multiple chronic conditions? January 2011. http://www.cihi.ca/ CIHI-ext-portal/internet/en/Document/types+of+care/ primary+health/RELEASE_27JAN11

4. **Could you provide an outline of the range of diabetic services provided, along with their locations, and how care along the pathway is co-ordinated?**

East Kent and Swale

Primary Care: Local Enhanced Services

The aim of this Local Enhanced Service is to address the physical healthcare needs of patients with impaired glucose tolerance (IGT), impaired fasting glycaemia (IFG), previous gestational diabetes and other relevant type 2 diabetic patients through recognising and encouraging the development of expertise in primary care.

The Quality and Outcomes Framework rewards practices for ensuring that systematic care has been provided for type 2 diabetic patients. However there is not a requirement that practices undertake a regular review for patients identified with lipid or glucose abnormalities, nor does it incentivise certain critical components of care to patients with type 2 diabetes.

The specification of this service therefore outlines a more specialised service to be provided, beyond the scope of essential services and QOF. The purpose of this enhanced service is to enable the delivery of a more comprehensive, structured package of care to patients in primary care so that only patients of high risk or with complicated diabetes require hospital attendance.

Expansion of capacity and skills within primary care will improve the quality of diabetes care provided in the community, help deliver the National Service Framework standards and promote a safe, co-ordinated shift of the delivery of care for patients from hospital clinics to primary care services.

Practices participating in this Local Enhanced Service will provide the following care to patients with IGT, IFG, previous gestational and type 2 diabetes who are free from significant complications or co-existing conditions likely to make the management of their diabetes more complicated.

Not all practices will be in a position to offer a fully developed service that includes conversions to insulin. Consequently, this Local Enhanced Service is defined at two levels. A practice may apply to provide the service at either of these levels, commensurate with its expertise.

Level 1

The patient and, where appropriate, their carer should be at the centre of care and practice staff should support them in self-management wherever possible.

For patients with IGT, IFG and previous gestational diabetes, specific responsibilities in delivering this agreement include;

1. The development and maintenance of a register. Practices must produce up-to-date registers of patients who are IGT, IFG or who have previous gestational diabetes.

2. Call and recall. Practices will ensure the systematic recall of all IGT, IFG and previous gestational diabetic patients using appropriate read codes.

3. Review. Practices will review all patients on the IGT and IFG registers annually, which must include fasting sugar check, blood pressure and cardiac risk assessment as a minimum. Women who have had gestational diabetes and have tested normal following delivery should be tested 1 year post-partum and then three-yearly.

4. Education of patients. Practices must include education and lifestyle advice in the annual review.

5. Individual Care Plan. Practices should prepare with the patient an individual care plan. A comprehensive print-out of the agreed care plan will be provided for the patient to keep.

6. Record Keeping. Practices are to maintain records incorporating the fasting sugar levels, blood pressure and outcomes of cardiac risk assessment.

7. Training. Each practice must ensure that all staff involved in providing any aspect of care under this service has the necessary training and skills to do so. Please see 'Training and Accreditation' section for further details.

Level 2

Involves initiation of insulin / injectable therapy for people with type 2 diabetes who are not achieving HbA1c targets with maximum tolerated oral combination therapy and who do not have other reasons for requiring hospital assessment. Specific responsibilities in delivering this agreement include;

1. The development and maintenance of a register. Practices must produce an up-to-date register of patients who have undergone insulin / injectable therapy conversion.

2. Call and recall. Practices will ensure the systematic recall of all patients who have undergone insulin / injectable therapy conversion using appropriate read codes, with systems in place for ensuring regular contact during the initial stages of dose adjustment.

3. Follow-up. Practices will review all patients who have undergone insulin / injectable therapy conversion a minimum of twice yearly. Practices cannot count hospital-based reviews towards their total.

4. Education of patients. Practices will ensure that all patients converted to insulin / injectable therapy (and / or their carers) receives appropriate structured education and advice on the management of insulin treated diabetes. This will include written information.

5. Individual Care Plan. Practices should prepare with the patient an individual care plan which outlines the planned therapeutic range to be obtained. A printed copy will be provided for the patient to keep.

6. Record Keeping. Practices are to maintain records incorporating all known information relating to significant events (for example drug reactions, hospital admissions, premature withdrawal of therapy), HbA1c levels and outcome of initiation.

7. Training. Each practice must ensure that all staff involved in providing any aspect of care under this service has the necessary training and skills to do so. Any practice staff involved must have successfully completed an accredited course for insulin initiation.

8. GP and primary care professionals are to be trained to Certificate in Diabetes Care standard or similar at each practice (or provide evidence of competency and knowledge to show that this is not required).

9. Diabetes trained primary care professionals should ensure that a minimum of 6 hours on going diabetes training is incorporated into their continuing professional development.

10. All staff providing Level 2 diabetes care must have undertaken the 'Insulin for Life' training programme validated by Warwick University or The Merit Norvonordisk Modules 1+11.

Community Diabetes Services

Kent Community Trust

Eastern and Coastal Kent commission the Kent Community Health Trust to provide three main services in relation to the care of diabetic patients that services the population of the four CCGs.

- Diabetic Specialist Nurses
- Podiatry
- Dietetics

Medway Community Health Care (MCH)

Eastern and Coastal Kent commission MCH to provide three main services in the relation to diabetic patients that services the population of Swale CCG.

Diabetic Specialist Nurses

In January 2013 the Kent Community Trust re-structured their teams so that the Diabetes Specialist Nurses (DSNs) are now managed as a stand-alone team rather than being under the management of a Long Term Conditions Team. There are five Diabetes Specialist Nursing teams in East Kent. The teams are based in, Ashford, Shepway, Dover/Deal, Thanet and Canterbury. Each team has approximately 2 WTE Band 6/7 nurses with the support of Band 3 Diabetes Assistants. The teams work 5 days a week offering a 9 to 5 service.

Referrals into the service are via GPs, and Consultants who send referrals into their locality team bases. Nurse led clinics are then provided at a range of community settings across east Kent but excluding Swale.

The DSNs take referrals of patients who have a confirmed diagnosis of diabetes and will offer education and disease management advice for those patients newly diagnosed and those with episodes of deteriorating control. When episode of care complete the DSNs will discharge the patients back to the GP. The DSNs work closely with the practise nurses and will provide support to them at the surgery if requested.

The DSNs attend joint multi-disciplinary ante -natal clinics (one a week) on the three acute hospital sites. The Trust has seen a significant increase in the numbers of mothers who have gestational diabetes and the number of pregnant women who have Type 2 diabetes, due to both lifestyle issues and high prevalence of diabetes in East Kent.

Integrated working takes place with secondary care to provide an insulin pump service for those patients who meet the NICE criteria. This service has been limited but is currently undergoing some development in order to meet demand. The DSNs work closely with the Diabetes Paediatric service to provide transition of care to those children who need to move into the adult service.

Data supplied by the Trust states that during the period April 2012 to December 2012 the number of contacts for the DNS was 2,663 patients for East Kent (this includes Swale figures).

Podiatry

There are three teams that cover east Kent. The three teams cover Ashford/ Shepway, Dover/Deal/Thanet and Canterbury Coastal. There are called the 'Vulnerable Foot Care Team' and are a specialist team within the main podiatry team. Patients are seen at a variety of community clinics e.g. Newington Road, Deal Community Hospital and acute settings depending on the severity of the intervention required.

Home visits are undertaken and visits to residential and care homes fall within the teams remit. Some patients can also be seen at GP surgeries depending on availability of appropriate clinical space in each locality.

Patients are usually referred through their GP or they can self-refer into the service.

The Trust is working towards a central booking system and the podiatry service is a pilot service for a new IT system which will improve communication with the Community Trust. The new system will also provide much better data on patient outcomes. The new system should be live in April 2013.

In the period April 2012 to December 2012 363 contacts were recorded. Most of the diabetic patients are long term patients and usually stay in the system with regular intervention being required over a period of years. As well as improving communication the Trust is working on pathways of care for each condition so that there is clarity in terms of the care the patient should receive.

There is some integrated working within the service in that the Acute Trust has a service level agreement with Kent Community Health NHS Trust to enable staff to visit patients on the wards on some sites.

Currently there is a multi-disciplinary steering group with membership from both the Trust and the Community Trust to agree an 'inpatient foot care pathway' which will improve the care patients receive on being admitted to an acute hospital site.

Dietetics

The aim is to provide a high quality diabetes, weight management and obesity dietetic service for people of all ages and their carers across East Kent. The service is effective, accessible, equitable, safe, cost effective, provides choice and is integrated with other services and agencies including Health and Wellbeing.

Clinical services provided by the Diabetes and Obesity Dieticians include:

•Dieticians and dietetic assistants provide one to one consultations in outpatient clinics situated in a variety of community and hospital locations throughout east Kent. Patients can choose the location of their appointment through the centralised booking system.

•Domiciliary service provided across east Kent for patients who are housebound

•Six month care pathways for patients referred for weight management, type 2 diabetes and impaired glucose tolerance/impaired fasting glucose. These involve dietetic assessment, goal setting and review and the opportunity for regular weight checks and further review from dietetic assistants. In addition where appropriate patients are signposted to other services including exercise on referral, healthy walks programme, stop smoking and health trainer's service

•Adult weight management service provided as part of the integrated weight management pathway run in conjunction with Health and Wellbeing

•Dietetic input to multidisciplinary diabetes ante-natal clinics in acute hospitals.

•Provision of the dietetic service within the multidisciplinary diabetes paediatric team which provides diabetes care for all children and young people across east Kent

•Participation in the development and implementation of a pilot project for a specialist weight management programmes for adolescents

•Participation in the delivery of the multidisciplinary type 2 diabetes structured education programme: DEREK (diabetes education & review in east Kent). This is held monthly in 5 locations across east Kent

•Participation in the delivery of the new multidisciplinary type 1 diabetes structured education programme: KAT1E (Kent adult type 1 education).12 KAT1E courses will be held per year in locations throughout east Kent

•Participation in multidisciplinary insulin pump service

•Provision of dietetic group education sessions for cardiac rehabilitation programme.

Training provided by the Diabetes and Obesity Dieticians

Training and education on diabetes/weight management is provided to other members of the health care team including:

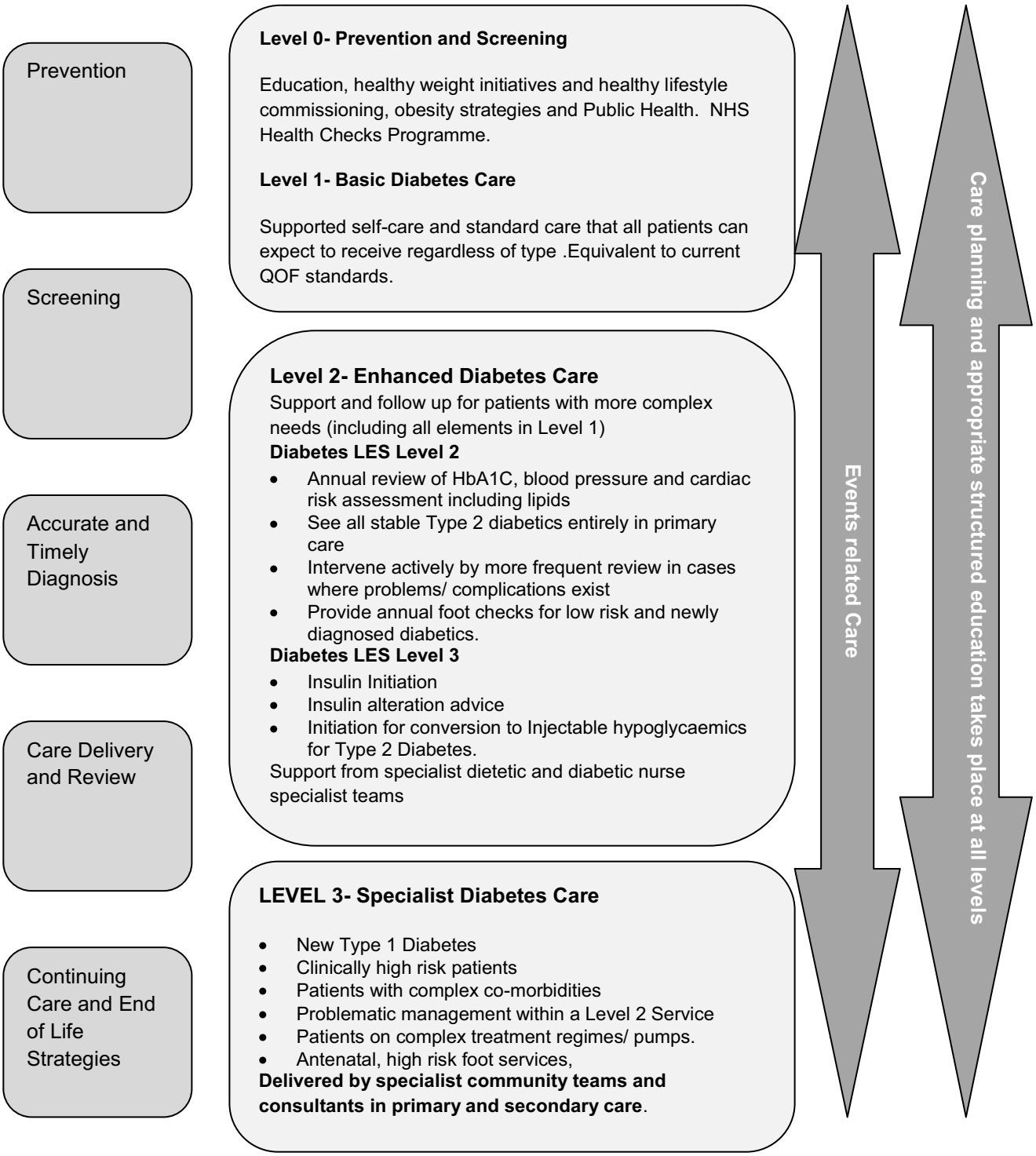
•Pharmacy advisors on weight management

•Diabetes 3 day course for trained staff

The appended document shows the pathways for the patients into the service.

Please refer to **Appendix 2** for further information.

Fig 1 Sets out the current Care Pathway for Diabetes in east Kent



Dartford, Gravesham and Swanley

The current diabetic care pathway is being reviewed by the CCG and local clinicians, to a more integrated and simplified process. Details of the current pathway can be found in **Appendix 3.**

a) A specialist hospital diabetes centre based at Darent Valley Hospital.
The clinical team provides the majority of care to people with insulin-treated diabetes and those with specific related complications. The consultant diabetologists oversee the wider multi-disciplinary clinical team, including specialist nurses, dieticians, podiatrists, GPs, practice nurses and health care assistants. This allows sharing of clinical expertise and continuity of care. The majority of people with diabetes will experience an improved level of care through shared goal setting and care planning. As well as at the hospital, diabetes care is delivered from a number of locations including local clinics and care homes.

Services offered for all patients with diabetes are:

- Both inpatient and outpatient care by consultant Diabetologist , Diabetes Registrar and diabetes specialist nurses:
- Emergency/acute care of those with diabetes within agreed protocols in order to provide rapid effective treatment reducing length of hospital stay and potential re admission in the future (NSF standard 7);
- General diabetes clinics for people with more complex diabetes needs;
- Diabetes nephropathy clinic for people who have diabetes-related kidney problems (liaison with Consultant Nephrologists);
- Patients are assessed for hypertension, hyperlipidaemia and other metabolic risk factors;
- The diabetes specialist dieticians are also available in clinics to give advice on lifestyle changes and carbohydrate counting, weight management via 1:1 sessions;
- A treatment plan will be constructed in a letter to the GP with recommendations for future management, and a care plan will be agreed between patients and healthcare professionals in line with NSF standard 3.

In addition, for those with Type 2 diabetes

- Problem solving with those patients who have poor glycaemic control, despite use of some/maximal oral hypoglycaemic drugs;
- Assessing specific issues for patients with diabetes e.g. assessment of poor glycaemic control, nephropathy, erectile dysfunction, neuropathy, hypertension and renal disease.

In addition, for those with Type 1 diabetes

- An annual review is undertaken by the consultant diabetologist and diabetes registrar for patients who are seen in their clinics;
- Problem solving with those patients who have poor diabetes control is available from the diabetes team.

Young adult/adolescent clinic/Transitional Clinic

- Young Adult Clinic, appropriate for young adults with type 1/2 diabetes ages 16 – 24years;
- Annual review and problem reviews are also undertaken. Diabetes specialist dieticians and diabetes specialist nurses provide educational input;
- Consultant diabetologist and paediatrician clinic. Diabetes specialist dieticians and diabetes specialist nurses provide educational input;
- Outside of these twice monthly MDT clinics, individual support is provided by specialist dietician and diabetes specialist nurse;
- This fulfils national standards NSF standard 6.

Structured Education

Type 1 diabetes (DAFNE)

The aim of the course is to impart tools to enable people with Type 1 to accurately match the insulin requirements to the food they eat, enabling them to enjoy a more flexible and enjoyable lifestyle, while still attaining good glycaemic control. The course is limited to eight people and is delivered by a diabetes specialist dietician and diabetes specialist nurse together with a section of the programme being run by the diabetes consultant**.** This is a prerequisite to pump therapy**.** The programme fulfils The National Recommended Criteria from Department of Health (DOH) on Structured Education 2004 and NSF standard 4.

Type 2 diabetes (DESMOND)

DESMOND is a national accredited structured education programme for people with type 2 diabetes. The course is run by diabetes specialist nurses and specialist dieticians. The programme consists of one day, delivered at The Arrow Riding Stables Dartford but managed centrally at Darent Valley Hospital. DESMOND is offered to patients who attend all our clinics, or patients can be referred directly by their GP or practice nurse. Referrals are taken for people who are newly diagnosed. The programme fulfils The National Recommended Criteria from DOH on Structured Education 2004 and NSF standard 4.

Initiating insulin therapy

This service is offered to patients requiring insulin for both Type 1 and Type 2 diabetes. Initiating insulin therapy in clinics for those who are not acutely ill, is more convenient for the patient, reduces stress and avoids costly inpatient care. People with Type 1 diabetes are often unwell at diagnosis and are started on insulin at the onset of treatment. People with Type 2 diabetes usually only switch to insulin after a varying amount of time on diet and anti-diabetic agents. An initial appointment is arranged to discuss the need and benefits of insulin treatment. Referrals are taken from GPs or practice nurses.

Initiating GLP therapy

This service is offered for patients requiring GLP therapy for type 2 diabetes. People with type 2 diabetes usually only trial GLP after a varying amount of time on diet and

anti-diabetic agents (NICE 2009). An initial appointment is arranged to discuss the need and benefits of GLP treatment. Referrals are taken from GPs or practice nurses.

Pump initiation and maintenance

This service is offered for patients with type 1 diabetes who require insulin, to be delivered via a pump, in accordance with NICE guidelines. A series of appointments are arranged to discuss need and develop patient's knowledge of the different delivery systems. Attending DAFNE is a pre requisite and will be arranged through the diabetes service, along with 1:1 assessment of carbohydrate counting skills, by the dietician. The Pump Clinics are highly specialised and are run by a Consultant Diabetologist, diabetes specialist nurses and specialist dietician, all of whom have had specific 'pump' training and hold specific pump competencies.

Conceptual Care

Pre-conceptual advice is offered to all those of conceptual age with either Type 1 or Type 2 diabetes. Referrals are taken from GPs or practice nurses, or can be self-referred by the patient. Antenatal care referrals are taken from Obstetricians, GP and practice nurses for those with either Type 1 or Type 2 diabetes. Gestational diabetes referrals are taken from Obstetricians. These specialised clinics are attended by a Consultant Diabetologist, diabetes specialist nurses, specialist dietician, specialist midwife and Obstetrician in accordance with Standard 9 of the NSF.

Podiatry

Highly specialised care for both inpatients and outpatients with diabetes-related foot problems that require specialist attention. Clinics are led by a specialist podiatrist held at Darent Valley Hospital. Patients are seen within 24hours of referral in line with NICE guidance. A once weekly Multi-Disciplinary Team meeting (MDT) for all diabetes inpatients with high risk feet is held and this consists of specialist podiatrist, a diabetiologist, and vascular surgeon. Referrals are taken from GPs, Practice Nurses, Physicians, Community Nurses and Community Podiatrists.

b) Community and Primary Care

For those people with diabetes who are not on insulin, care is provided by their GP and their practice nurse. To avoid duplicated care and the inconvenience of hospital visits, the hospital specialist diabetic nurses hold monthly clinics within a number of GP surgeries (The Orchard Practice at Dartford West Health Centre, Istead Rise Surgery and The Cedars in Swanley). This initiative is aimed to help people to manage their condition better.

c) Professional Training, Education and Advice

The diabetes team work closely with all inpatient and community staff to ensure good standards of diabetes care by acting as a consultant resource and providing education and training for staff. This includes:

- At Darent Valley hospital, ward link nurse meetings are held to enhance ongoing staff development;

- Diabetes Consultants and diabetes specialist nurses work closely with GPs, Practice Nurses, Community nurses to enhance diabetes care by attending multi-disciplinary team meetings, up-skilling staff at 1:1 sessions within their own areas of practice, organising educational events e.g. Merit Courses, HCA education day, Saturday morning GP workshops.
- The Diabetes team act as a consultant resource to patient/carers who contact the service for advice
- The diabetes nurse specialists offer telephone support, either general advice structured advice to all who contact the service directly.
- Diabetes team also attend community meetings in an educational role e.g. Health Awareness.
- The consultants at DVH also provide an Advice and Guidance Service via Choose and Book to GPs, for non-urgent advice in managing patients locally rather than requiring the patient to attend an outpatient appointment.

In development

- Education sessions to ambulance staff in relation to hypoglycaemia as this may reduce number of conveyances to hospital
- A full-day seminar is being arranged by the specialist diabetes team at Darent Valley Hospital for all GPs, practice nurses and other professionals involved in diabetes care.

West Kent

West Kent Clinical Commissioning Group (WKCCG) has identified as one of its key priorities for this year to focus on the delivery of care for adult patients with diabetes. In order to do this; work has been on going with the wide range of people involved in these services. Liaising with and listening to a range of peoples' views including patients, clinicians, health care managers and charities has led to significant progress in co-designing services to improve access, diagnosis, and increase patient support.

The two specialist hospital diabetes centres are based at The Paula Carr Diabetes Centre in Maidstone Hospital and Abbey Court Medical Centre in Tunbridge Wells. The clinical teams at these two centres provide the majority of care to patients with insulin treated diabetes and those with specific related complications.

The GPs and Practice Nurses in the area provide the majority of diabetes care for those patients not on insulin and also some do provide enhanced services for those on insulin.

For some patients their care is duplicated with visits to both specialist hospital centres and their GP team, this is inconvenient for both patient and clinician and is also creates an unnecessary use of resources. With the growing number of people diagnosed with diabetes capacity is needed within the specialist services to deal with those patients who clinically need to be seen by a specialist team. It is estimated that up to 31% of patients with diabetes in the area are yet to be diagnosed this is above the national average of 25%. To accommodate the increasing number of adults with diabetes in the area, delivery of services within GP and community settings is being enhanced ensuring that those who need specialist services can access care where clinically appropriate.

Patients with diabetes will have their care delivered from a variety of diabetes centres and wherever possible more conveniently from around their local GP practice. Some patients

will experience changes in their care provider as services will be assigned depending on clinical need. Consultants specialising in diabetes care will manage patients with conditions related to diabetes that are complex and require specialist care. They will also oversee the wider multi-disciplinary team clinical delivery and training, inclusive of diabetes specialist nurses, dietetics and podiatry, GPs, practice nurses and health care assistants.

Therefore, future services will be delivered by skilled teams in more convenient locations than previously for the majority of patients. There will be a much stronger sharing of clinical expertise across the hospital and community staff, improving quality and continuity of care. With shared goal setting and care planning it is anticipated that the majority of patients with diabetes will experience an improved level of care and as a result may avoid emergency admissions to hospital.

In July 2012, the launch of the new "Intermediate Diabetes Service' (known as level 3 Service), for patients and Clinicians in West Kent CCG took place. This is provided by MTW, initially from 3 centres (Paula Carr Centre at Maidstone Hospital, Abbey Court in Tunbridge Wells and Sevenoaks hospital). This level 3 Service is separate from the current secondary care diabetes services (to be called level 4 Service) and will be specialist diabetes nurse led with consultant, podiatrist and dietitian presence in some of the clinics.

The key aims behind establishing Level 3 services are:

1. Specialist access to a wider range of diabetic patients especially type 2 whose diabetic control is not optimally controlled in primary care.

2. Structured education (DESMOND or alike) to a much larger cohort of patients than present

3. Care closer to the patient’s home.

4. Timely GLP-1 and Insulin initiation for patients in practices who are not trained to initiate these therapies.

5. Improve access to dietetics and podiatry more accessible, when necessary.

6. Structured training for practices.

In April 2013 the primary care Level 2 Diabetes service will be launched to ensure that all our diabetic patients have care consistent with the “NICE Diabetes in Adults Quality Standard”. The acute Trust will be transferring some people with Type 2 diabetes follow ups to the level 2 service in order to free up capacity to cope with increased diagnosis.

We know that practices deliver diabetes care aiming for the QOF standards, but wish to encourage them to provide all the care processes within 12 months as is nationally recommended. Therefore practices will be incentivized to provide an enhanced level of diabetic service (level 2) are expected to provide GLP-1 and Insulin initiation for type 2s as well as manage more insulin treated diabetics. This is an incentivized service (replacing the current insulin LES scheme) with the ultimate aim that most practices in west Kent are able to deliver level 2 Services.

The main developments in this service relate to a comprehensive review of practice competence and a bespoke training package particularly for West Kent practice staff

Please refer to **Appendix 4** for further information.

5. How is the NICE quality standard for diabetes in adult used to inform commissioning and provision of Kent?

The NICE guidance is used rigorously to benchmark local services and to identify where providers are not compliant with NICE guidance. Diabetes has been very well researched and therefore there is a plethora of evidence and guidance that can inform effective commissioning of local services.

There are 14 standards which are used in order that:

a. Health and social care professionals can make decisions about care based on the latest evidence and best practice.
b. Patients can understand what service they can expect from their health and social care providers.
c. NHS trusts can quickly and easily examine the clinical performance of their organisation and assess the standards of care they provide.
d. Commissioners to be confident that the services they are providing are high quality and cost-effective. Commissioning responsibilities include planning services, based on assessing the needs of our local population; securing services that meet those needs; and monitoring the quality of care provided.

- Quality statement 1: Structured education

  People with diabetes and/or their carers receive a structured educational programme that fulfills the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education

- Quality statement 2: Nutrition and physical activity advice

  People with diabetes receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured educational programme.

- Quality statement 3: Care planning

  People with diabetes participate in annual care planning which leads to documented agreed goals and an action plan

- Quality statement 4: Glycaemic control

  People with diabetes agree with their healthcare professional a documented personalised HbA_{1c} target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%), and receive an ongoing review of treatment to minimise hypoglycaemia.

- Quality statement 5: Medication

  People with diabetes agree with their healthcare professional to start, review and stop medications to lower blood glucose, blood pressure and blood lipids in accordance with NICE guidance.

- Quality statement 6: Insulin therapy

  Trained healthcare professionals initiate and manage therapy with insulin within a structured programme that includes dose titration by the person with diabetes.

- Quality statement 7: Preconception care

  Women of childbearing age with diabetes are regularly informed of the benefits of preconception glycaemic control and of any risks, including medication that may harm an unborn child. Women with diabetes planning a pregnancy are offered preconception care and those not planning a pregnancy are offered advice on contraception.

- Quality statement 8: Complications

  People with diabetes receive an annual assessment for the risk and presence of the complications of diabetes, and these are managed appropriately.

- Quality statement 9: Psychological problems

  People with diabetes are assessed for psychological problems, which are then managed appropriately.

- Quality statement 10: ‘At risk’ foot

  People with diabetes at risk of foot ulceration receive regular review by a foot protection team in accordance with NICE guidance.

- Quality statement 11: Foot problems requiring urgent medical attention

  People with diabetes with a foot problem requiring urgent medical attention are referred to and treated by a multidisciplinary foot care team within 24 hours.

- Quality statement 12: Inpatient care

  People with diabetes admitted to hospital are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin.

- Quality statement 13: Diabetic ketoacidosis

  People admitted to hospital with diabetic ketoacidosis receive educational and psychological support prior to discharge and are followed up by a specialist diabetes team.

- Quality statement 14: Hypoglycaemia

  People with diabetes who have experienced hypoglycemia requiring medical attention are referred to a specialist diabetes team.

6. Specifically what is being done around patient education?

Structured Education Programmes

East Kent

Kent Community Trust is commissioned to deliver two structured education programmes.

KAT1E (Kent Adult Type 1)

This is an educational programme for Type 1 diabetics. This programme runs one day a week for four weeks. The facilitation of this course is by the DSNs service and Diabetes Dieticians. Diabetologist from secondary care are invited to speak for a session on the programme.

12 courses a year are currently offered at various venues across East Kent. 8 participants can be accommodated on each course.

The KAT1E course has been designed to meet local needs and based on the DAFNE and *BERTIE* principles of Diabetes Management.

DEREK (Diabetic Education and Revision in East Kent)

This is an education programme for Type 2 diabetics. The programme is for newly diagnosed diabetics and those patients that have had diabetes for a long time and would benefit from updating their knowledge.

This is a one off course of 4 hours. The course has input from podiatry and dietetics.

Quality assurance and audit of the course is currently under review in order to acquire validation from the Diabetes Education Network.

Referral into the education programmes is from GPs, practice nurses and other health professionals. The course has been designed to meet local needs and is unique compared with some of the nationally recognised course in that we are offering the revision element and have podiatry input.

The Community Trust offer 5 courses a month at various venues in East Kent. Each course offers 8 places and those 8 people are invited to bring their partner/friend etc along to the course. In order for learning to take place the course has been designed to be a facilitated course using Conversation Mapping Tools which are a nationally recognised Tool to enable participants to take an active part in the session. People who are not comfortable taking part in a group session can be seen on a 1:1 basis for education. Currently the Trust is receiving 70-100 new referrals every month.

Swale

Medway Community Healthcare provides structured education programmes to the patients in Swale with Type 1 (MINT1E) and Type 2 diabetes MINT1E (X-PERT).

MINT1E (Medway Intensive Type 1 Education) is delivered via a similar programme to KAT1E. Three courses are planned to be provided per year with 8 places per course.

X-PERT is an accredited education programme for people with Type 2 diabetes. The programme provides essential knowledge on self-management, pitfalls of poor management, how medications work and the balance between exercise, food and treatment. It is a 2-hour session every week for six weeks. There are fifteen courses planned per year with 15 places per course.

Dartford, Gravesham and Swanley

a) Structured Education

Additional funding has been provided to the Acute Trust to increase the provision of structured education (DAFNE & DESMOND) for those people with Type 1 or Type 2 diabetes, to reduce hospital admissions and improve self-management of diabetes. Please refer to **Appendix 3.**

b) Nutrition and physical activity advice

There are a range of interventions available funded through Public Health which are available to all. A directory of local Healthy Lifestyles Activities in DGS is provided to all GPs and the diabetic team in hospital. Please refer to **Appendix 5.**

The *Healthy Club* is a web-based programme which directs individuals to healthy living programmes such as walking, nutrition programmes, weight management, smoking cessation, health trainers etc.

Healthy Living Centre Teams at Temple Hill Dartford, the Gr@nd Gravesham and the Get Sorted Team in Swanley provide a range of health improvement programmes based on local need;

Dartford, Gravesham and Sevenoaks District and Borough Councils provide both *adult and family weight management programmes*. The adult programme is available to any residents with a BMI of 30 or over and a BMI of 28 if there are existing conditions such as diabetes or if the participant is from an ethnic group. All providers of adult weight management services are required to provide a diabetes risk assessment as part of the programme;

Tier 3 specialist weight management programmes are currently out to tender (Specialist Commissioning provide bariatric surgery for those who have been unable to lose weight through other programmes);

The *national Health Check programme* is designed to identify people who have an undiagnosed condition – it is a 5 year rolling programme for people between 40-75;

Health Trainers provide individualised holistic support for people on a 1:1 basis, who are motivated to make behaviour changes;

The move of Public Health into Kent County Council should provide opportunities for more strategic working across directorates that influence the wider determinants of health e.g. planning, transport, housing, education etc.

West Kent

Type 1 diabetes patient education (Dafne) and Type 2 education (Desmond) is delivered by the local acute trust. The new pathway with increased expectation of improved patient outcomes relies on patient education being offered to more patients which will require further investment in services. A programme of work is underway to review and plan for the future of these services with the aim of increasing provision. As an example we are considering increasing provision with other alternative hours of delivery to attract those working during the week and young people. With the up skilling of our primary care service staff, patients will benefit from experts in their surgeries. A Business case is currently underway to propose a way forward to deliver more structured education.

7. In its report the management of adult diabetes services in the NHS, published earlier this year, the National Audit Office identified nine basic care processes for people with diabetes to be delivered annually. Are these care processes still used when planning services and if so, how successfully are they being delivered across the County?

The National Audit Office (NAO) data provides us with a good base line in terms of how Kent is doing compared to other areas. The nine key processes are very important for the improvement of services for diabetics and enable commissioners to work with practices that need additional support to improve of achieving better outcomes.

Data for the latest NAO for 2010-11 reported that out of the 114 registered practices, 84 practices participated in the audit (73.7%). The audit reported that there were 29,239 patients registered with East Kent practices of which 2,782 were type 1 and 26,223 were type 2.

Table 1 shows the percentage of all patients in Eastern and Coastal Kent PCT receiving NICE recommended care processes by care process type.

Care Process recorded	Percentage of registered patients in PCT (including RAG Score)	Percentage point change since 2009-2010	Median score across all PCTs	National quartile ranking
All Care Processes*	60.0% ■	+5.77%	55.5%	1
Blood Creatinine	93.4% ■	+0.29%	93.1%	2
Blood Pressure	94.8% ■	-0.28%	95.2%	3
BMI	89.5%	+0.09%	90.0%	3
Cholesterol	92.2% ■	+0.19%	91.7%	2
Eye Screening	83.1%	+6.87%	82.4%	2
Foot Exam	84.8%	+1.02%	84.5%	2
HbA1c**	92.8% ■	+0.23%	92.9%	3
Smoking Review	85.3%	-1.01%	85.7%	3
Urinary Albumin	80.4%	+2.06%	76.3%	1

*People registered with diabetes receiving all nine key processes of care processes
**For patients under 12 years of ages, 'all care processes' is defined as HbA1c only as other care process are not recommended in the NICE guidelines for this age group.
RAG (Red-Amber-Green) score key: ■ <70% 70% - 90% ■ >90%

In West Kent 101 (100%) participated in the 2010-11 audit. The audit reported that 29,239 patients were registered with West Kent practices of which 3,012 were type 1 and 25,610 were type 2. Table 2 below shows the percentage of all patients in West Kent PCT receiving NICE recommended care processes by care process type.

Care Process recorded	Percentage of registered patients in PCT (including RAG Score)	Percentage point change since 2009-2010	Median score across all PCTs	National quartile ranking
All Care Processes*	42.2% ■	+4.77%	55.5%	4
Blood Creatinine	91.1% ■	-0.71%	93.1%	4
Blood Pressure	94.7% ■	-0.06%	95.2%	3
BMI	88.4%	-0.03%	90.0%	4
Cholesterol	89.2%	-1.07%	91.7%	4
Eye Screening	80.0%	+3.36%	82.4%	4
Foot Exam	82.7%	-0.69%	84.5%	4
HbA1c**	91.5% ■	+0.34%	92.9%	4
Smoking Review	83.5%	-1.20%	85.7%	3
Urinary Albumin	58.7% ■	+4.26%	76.3%	4

*People registered with diabetes receiving all nine key processes of care processes
**For patients under 12 years of ages, 'all care processes' is defined as HbA1c only as other care process are not recommended in the NICE guidelines for this age group.
RAG (Red-Amber-Green) score key: ■ <70% 70% - 90% ■ >90%

The NDA goes into more detail with respect to Type 1 and Type 2 diabetes and provides a breakdown of the individual practices that participated in the audit. This information provides commissioners with independent data as to where improvements can be made and is being systematically in both east and west Kent to improve the commissioning of local services.[8]

8.Specifically a) what percentage of the eligible population take up the offer of an initial diabetic retinopathy screening test and b)what percentage of the population take up the offer of a repeat diabetic retinopathy screening test?

The Diabetic population for east and west Kent and Medway is estimated at 83,543 patients from 2011/12 annual audit. There are 76,309 eligible diabetic patients within the screening service.

The eligibility criteria for QOF is any patient over 15 who has diabetes and the criteria for the NSF is any patient over 12, the Paula Carr work to both criteria.

Paula Carr is also looking to expand their service to include any child under 12 who has had diabetes for more than 5 years.

The numbers of patients invited during 2011/12 for screening across Kent was 73,067, of these 7,723 were initial screening invites and 64,199 were repeat screening invites.

Some patients exclude themselves from the screening. The definition of 'exclusion' is those patients that do not attend for their appointment after two letters of invitation.

Please refer to **Appendix 6** for further details.

The total number of patients screened across Kent was 62,502, 7,840 attended for their initial screen and 54,662 attended for their repeat screen. 10% of those patients screened were seen for the first time as these patients had been newly diagnosed.

An addition 1,982 (3%) patients are seen at the SLB (Slit lamp Bio) clinics which is one of the recommended national surveillance clinics that provide additional imaging for some patients.

Public Health has produced a Diabetic Eye Screening Health Equity audit, which shows the variation across practices. The audit was undertaken in June 2012 and a copy of this report is available on request.

DGS CCG will be working with practices and Public Health to implement the recommended actions, targeting those with higher than average DNA rates.

The total number of patients screened across Kent was 62,502, 7,840 attended for their initial screen and 54,662 attended for their repeat screen. 10% of those patients screened were seen for the first time as these patients had been newly diagnosed.

[8] *The National Diabetes Audit 2010-2011 Report 1 Care Processes and treatment targets is available at http://www.ic.nhs.uk/webfiles/Services/NCASP/Diabetes/201011%20annual%20reports/National_Diabetes_Audit_2010_2011_Report1_Care_Processes_And_Treatment_Targets.pdf*

An addition 1,982 (3%) patients are seen at the SLB (Slit lamp Bio) clinics which is one of the recommended national surveillance clinics that provide additional imaging for some patients.

9. Has any assessment been made of how equitable access to diabetes services is across Kent?

There has been a Health Equity Audit undertaken for diabetic retinopathy screening and work has been undertaken on referral pathways at each of the acute hospital sites on the foot care pathway.

Enhanced services (levels 1 and 2) have been mapped across Eastern and Coastal Kent to look at the level of expertise within primary care.

10 .What plans are currently underway to develop diabetes services more generally in Kent and what are planned for the future?

Currently a strategy is being prepared to go to the 4 CCG Boards in the East Kent Federation area that sets out the vision for diabetic Services for Kent. The main aim of the strategy is to agree the model for commissioning diabetic services across the whole pathway and then to work with individual CCGs to tailor services so that they are appropriate for their populations.

This strategy sets out a vision for the commissioning of an integrated model for diabetes services. The main objectives of the strategy are to:

- Enable robust and meaningful patient engagement to co design local services appropriate to their needs
- Devolve elements of secondary care to primary care to ensure care is integrated and more localised
- Ensure that service re-design takes into account other Long Term Conditions (LTCs)
- Reduce inequalities in health and well-being to achieve health improvement
- Improve the experience of people who use diabetic services
- Sustain a high quality of care for people who have diabetes
- Invest resources effectively

The strategy sets out an assessment of need in terms of prevalence and activity for people with diabetes in East Kent and some of the policy context behind these proposals.

The strategy acknowledges that there are issues around the implementation of the strategy and these are with reference to:

- Workforce development
- Local availability of health facilities

- IT interface
- Cultural changes
- Governance

Swale has worked collaboratively with Swale in Medway CG to review diabetes services across the pathway. The main focus of the review outcomes is to improve the education and training within primary care to support levels I and 2 in the pathway. This will also support care being delivered in the most appropriate setting, closer to home by the right professionals. The Medway and Swale plan includes improved and increased care and treatment in primary care.

In addition Medway and Swale with its partner organisations a group of patients that can be cared for within the community specialist service as opposed to the secondary care specialist service.

Swale is also reviewing assistive technology to support its diabetes pathway in primary care.

Within DGS, the CCG intends to review the Diabetes Pathway to be more integrated and 'whole system' for the patient, and to include improving early recognition and management of condition. Prevalence of diabetes is higher in DGS than the national average, and it is recognised that earlier diagnosis and intervention can help

Within West Kent CCG pathway redesign process there are future programmes of work that are already in their infancy – improving access to structured education, dietetics and foot care are examples.

11. How are diabetic services paid for (tariff, block, and contract?)

All diabetic treatment in acute hospitals is on tariff. All diabetic treatment in community trust is on block (at the moment). Diabetic retinopathy is on block. Diabetic patient education training programmes are block.

12. How do diabetes services feature in the QIPP plan?

East Kent:

The four CCGs in East Kent have recognised that there are economies of scale to be made if some services are commissioned using a federated model. Diabetes, along with Long Term Conditions, Planned Care and Urgent Care are being planned and commission using this model. East Kent also has one Acute Trust and one Community Trust as main providers which facilitate this particular model of working. East Kent has supported a Diabetic project Manager to look at the Diabetic pathway as there is an acknowledgement that services need to be improved.

Swale CCG has recognised that there are economies of scale to be made by working collaboratively with Medway CG as well as a North Kent Alliance.

One of Swales' CCGs priority areas is tackling health inequalities (Beats and Breaths Project). The project includes direct action in primary care to reduce variation in care and treatment, working with the voluntary sector and a public campaign to increase awareness and encourage behaviour change around cardiovascular disease, COPD, diabetes, and obesity. This project has been operation has been operation for two years and has further two years duration.

Diabetes features in CCGs QIPP plans by improving services to bring about the following outcomes:

- Deliver more effective outcomes for patients
- Improved diagnosis rates for the disease
- Improve on-going care management at a primary care level
- Improve preventative services thus reducing the prevalence and complications
- Reduce access to secondary care
- Reduce avoidable emergency admissions
- Improve prescribing practices

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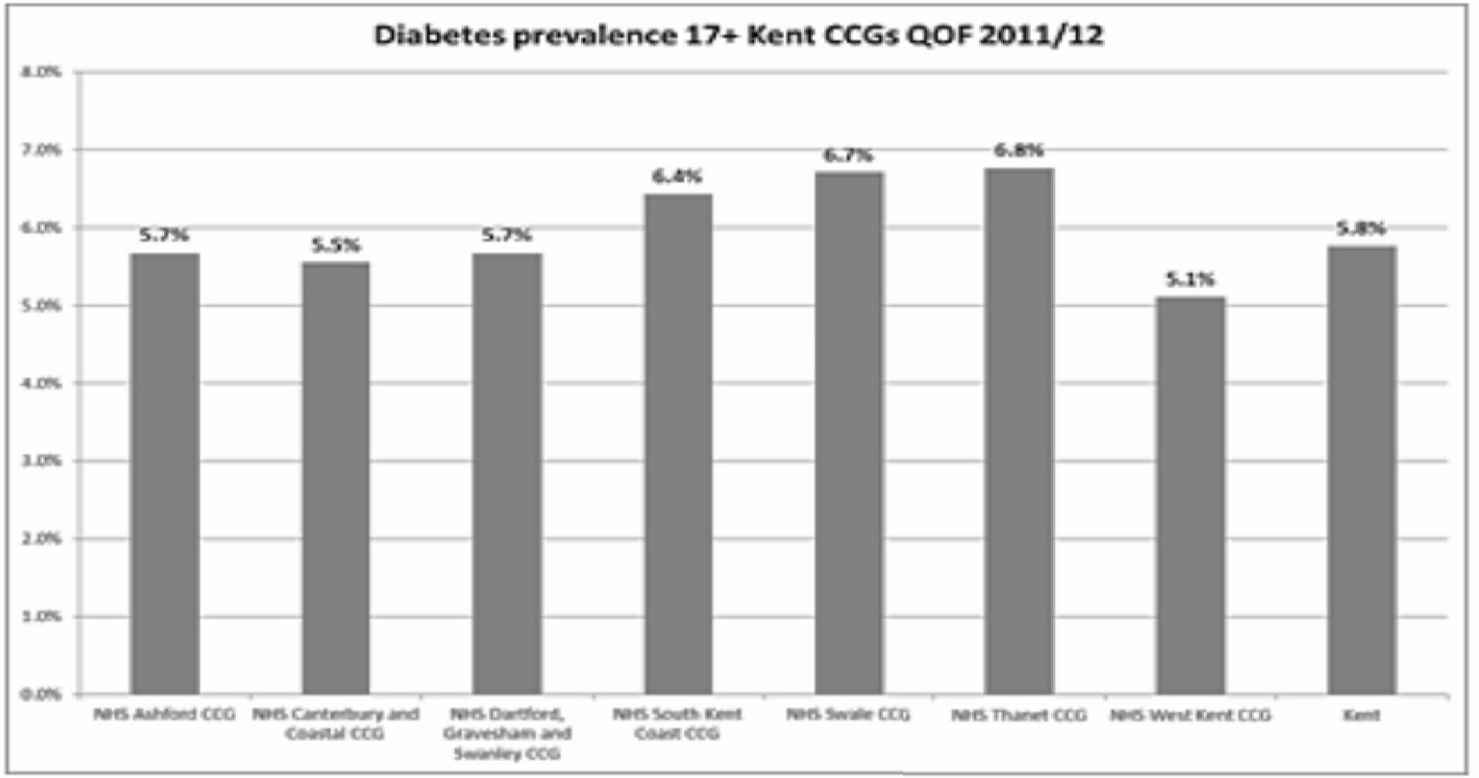
Diabetes – Appendix 1 – Prevalence 17 plus across Kent Clinical Commissioning Groups



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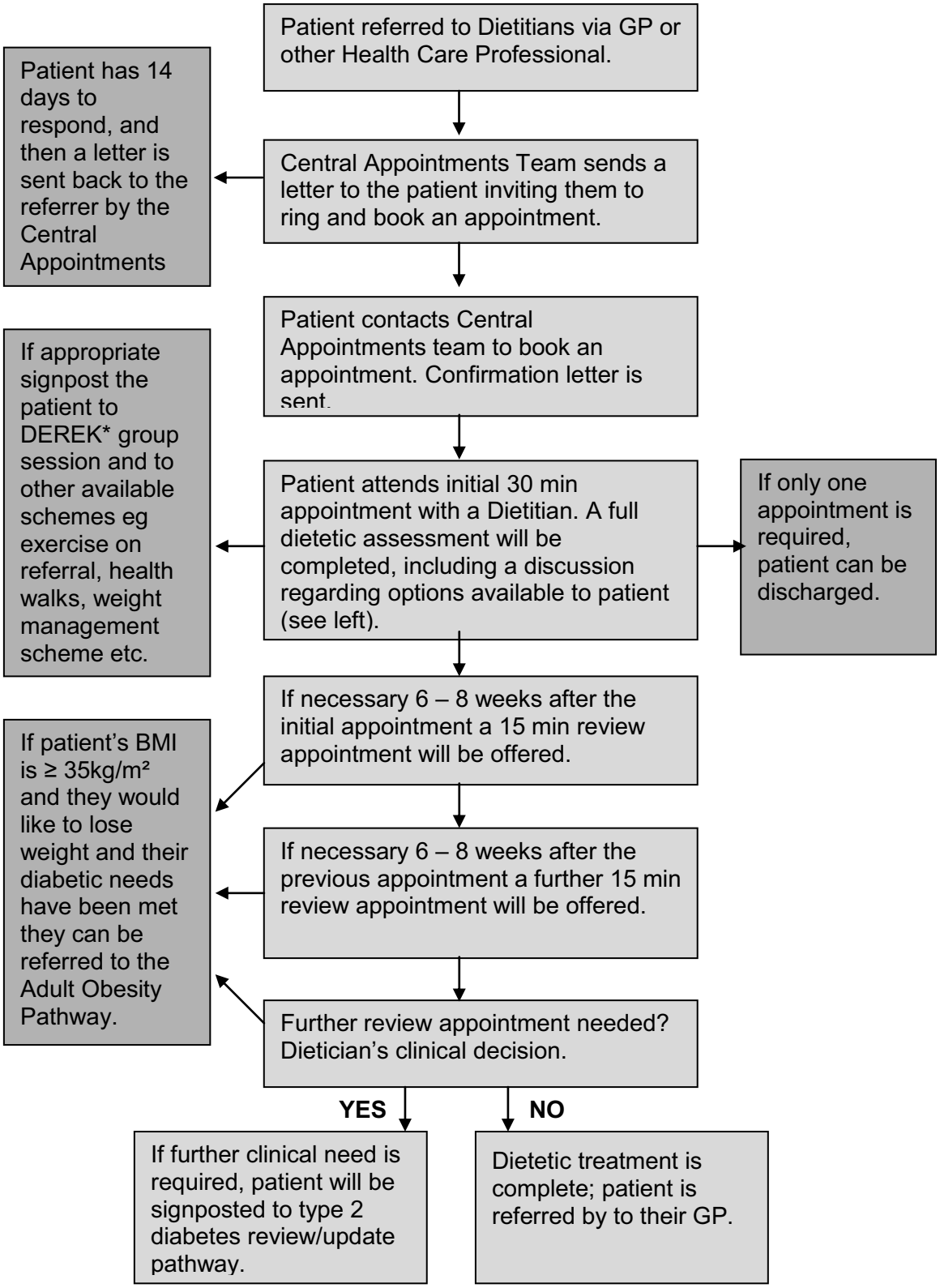
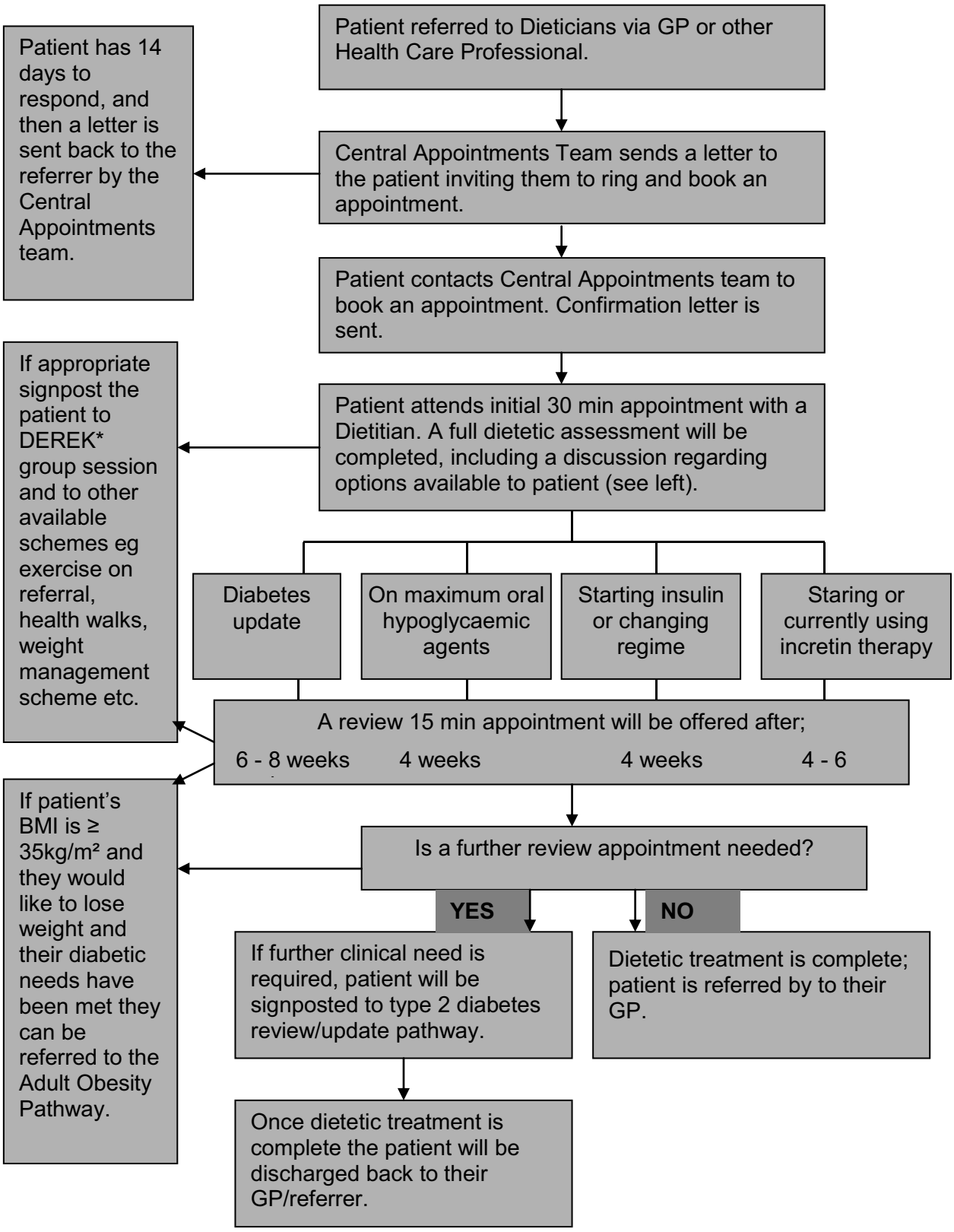
Appendix 2 - Clinical Nutrition and Dietetics

Type 2 Diabetes Adult Pathway

Newly diagnosed patients



Patients for review or update



Introduction

This document has been developed for General Practitioners (GPs) and health professionals to provide more information on the new Clinical Dietetics adult type 2 diabetes pathway, supported by the latest evidence based practice.

This pathway was developed in 2011 as a need for a new package of care was identified, to provide a better service to patients and to be able to measure outcomes more effectively in the process.

Development of Pathway

NICE guidelines (2008 update) recommends that patients are provided with individualised and ongoing nutritional advice from a healthcare professional with a specific expertise and competencies in nutrition. That patients are provided with dietary advice in a form sensitive to the individual's needs, culture and beliefs being sensitive to their willingness to change, and the effects on their quality of life.

Integrate dietary advice with a personalised diabetes management plan, including other aspects of lifestyle modification, such as increasing physical activity and losing weight.

Diabetes UK guidance (2011) recommends that everyone with type 2 diabetes should receive individual, ongoing nutritional advice for a registered dietitian. Education should involve a person-centre approach and a variety of learning styles

All people with diabetes and/or their carer should be offered structured education at the time of diagnosis with an annual follow up.

A need for a structure package of care for newly diagnosed type 2 diabetic patients that can be integrated with the adult obesity pathway was identified by the Obesity and Diabetes dietetic team and is supported by the above guidelines.

Using the pathway

This pathway will be used by GPs and health professionals who wish to refer any newly diagnosed type 2 patients. It is to be used as a reference guide only. Referral forms need to be completed separately for each patient (see appendices). Any individuals that do not meet the criteria on referral will be seen by an appropriate dietitian, just not as part of this pathway.

What the pathway involves

The main outline of the package of care that we offer to patients who have type 2 diabetes:

- Initial 30 minutes appointment with dietitian
- If needed a further 15 minute review appointment with the dietitian after to 6-8 weeks (and if required another appointment of a 15 minute review after 6-8 weeks).
- The pathway also integrates with the obesity pathway if a patient would like to lose weight.
- As part of the pathway a dietitian can refer patient to Diabetes Education Revision in East Kent (DEREK) structured education group, if appropriate

Outcome measures

The DEREK evaluation asks: 'Do you feel more confident in managing your diabetes after today's session?' Responses circled are:

a. More confident
b. Same
c. Less confident

This confidence score question is used as our outcome measure for diabetes.

Data collated between January 2011 and December 2011 shows that 87% of patients who attended DEREK were 'more confident' in managing their diabetes by the end of the session

Our aim is that at least 80% of those who attend DEREK should feel more confident in managing

Appendices

- Specialist Community Diabetes and Obesity dietitians referral form
- DEREK referral form

Referral for a Specialist Community Diabetes/Obesity Dietitian

Patient name ..... Date of birth .....

NHS number ..... Ethnicity .....

Address .....

Post code .....

Tel № ..... Mobile № .....

GP and surgery .....

Tel № ..... Fax .....

Reason for referral

☐ Obesity ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Gestational diabetes ☐ IGT

.....

Relevant medical history (attach printout if available).....

.....

Weight .....(kg) Height .....(m) Total Chol ..... HDL .....

Triglycerides ..... HbA1c .....% Date .....

Diagnostic result if recently diagnosed with diabetes:

Fasting Blood Glucose (1) ..... **(2)** .....

Random Blood Glucose ..... **OGTT** .....

Medications (attach printout if available).....

.....

Any other relevant information or special requirement (eg communication difficulties)

Is this patient able to attend clinic? **Yes / No***

*** If the patient is to be seen in their <u>own home,</u> please complete domiciliary visit assessment form. If this form is not completed, it may delay the time in which this patient is seen.**

Name of referrer ..... Designation .....

Address .....

Post code ..... Tel № .....

Signature ..... Date of referral .....

Has the patient consented to referral? **Yes / No** If no, does the patient have capacity to consent? **Yes / No**

If you have a reasonable belief that patient lacks capacity, please confirm you are referring the patient in their best interests under the Mental Capacity Act, 2005.

Signature ..... Date .....

Kent Community Health NHS
NHS Trust

Trinity House 110-120 Eureka Park
Upper Pemberton Kennington
Ashford
Kent
TN25 4AZ
Telephone: 01233 667775
Fax Number: 01233 667951
diabeteseducation@nhs.net

D.E.R.E.K

(Diabetes Education and Revision in East Kent)

REFERRAL FORM

Referral Criteria:

- Patient needs to be able to communicate effectively in a **group** setting
- Ability to speak and understand **English**
- Patient needs to be aware of content of group education programme and must be willing to attend, the session is for **4 hours**

Title (Mr/Mrs/Miss/Ms) ……Name ……

Address: ……

……

POSTCODE ……D.O.B ……NHS No……..……

Daytime contact No:…… Mobile No:……

Date of Diagnosis …….. G.P Name & Address……..
HbA1c/IFCC Result (if known) ……

Has this patient any special requirements we need to be aware of? ……

Please indicate preferred venue:

- ☐ Ashford
- ☐ Canterbury / Whitstable / Faversham / Herne Bay
- ☐ Dover Health Centre / Deal & Walmer Community Clinic
- ☐ Folkestone / New Romney / Hythe
- ☐ Thanet

☐ Is patient aware of referral (please tick box to confirm)

Referral Form Signed ……..

Name ……Designation…….....

Please return by post or fax the completed form to the Education Coordinator at the address above

Office Use Only
- ☐ On Database
- ☐ Date Given
- ☐ Completed

Further reading

NICE. 2011 Type 2 Diabetes, National clinical guidelines for the management in primary and secondary care (2011) Update from clinical guidelines which were published 2002. The national Collaborating centre for chronic conditions funded to produce guidelines for the NHS by National Institute for clinical excellence (NICE)

Diabetes UK. (2011) Evidence based nutrition guidelines for the prevention and management of diabetes: Diabetes UK

NICE. (2006) Obesity: The Prevention, Identification, Assessment and Management of Overweight and Obesity in Adults and Children. UK: National Institute of Health and Clinical Excellence.

Contact us

Diabetes and Obesity Dietitians

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Clinical Nutrition and Dietetics

delivering excellent nutritional care and improving your health

Date of Publication: FEB 2012 **Date of Review:** FEB 2014

Diabetes Education

Target Group	Model	Referred by:	Activity	Competencies	Requirements	Cost Implication	Outcome
Newly diagnosed Type 1 diabetes [4]	Individual, integrated education	GP, PN ComN	1 to 1 education by the DSE team	DSE	Established	Tariff charge	Access time;
Newly diagnosed Type 2 diabetes [800]	Structured group education	GP PN ComN 2ary care	DESMOND [220]	DESMOND educator	Accreditation obtained	DESMOND funding required	External QA of DESMOND & local course.
			Local course [180]	Locally agreed	Accreditation	Funds for group Education in 1ary care	
	Unsuitable for group education		1 to 1 PN/GP/DSN	Locally agreed	Suitable training	Funds for education in 1ary care	
Established Type 1 & 2 diabetes [726 / 8000]	Selected individuals- DESMOND &	GP, PN ComN	DAFNE [32} DESMOND [220]	DAFNE / DESMOND	Accreditation	DESMOND / DAFNE funding required	External QA of DESMOND, DAFNE & local course.
	Individual education required		1 to 1 PN/GP/DSN T1 [497/528] T2 [1347/1455]	Locally agreed	Local course	Funds for education in 1ary care	
Type 2: Diet to oral therapy	Clinical supervision in 1ary care	GP PN	Treat to target	Locally agreed	Review by LIG	GP care	QUOF return
Oral therapy to insulin	Near to home	GP PN		MERIT1 training	Suitable training	Funding from Novo	QUOF return
			Group Education	DSN	Established	Local tariff required	
Insulin therapy management	Selected GPs	GP, PN, DSN		MERIT 2	Suitable training	Funding from Novo	QUOF return
	Secondary care			DSE	DSE by telephone	Local tariff required	

[123] = Number of people in the district.
[123/456] = number of patients/ number of appointments per year.

Clinical Care

Target Group	Model	Referred by:	Activity	Competence	Requirements	Cost Implication	Outcome
T1DM & T2DM with significant complications	Specialist supervision in 2ary care	GP/PN	Integrated specialist care T1 [496 / 833]; T2 [1335 / 2246] DAFNE [32], Pump [16/32], CBGM [20]	Consultant / GPwSI with diabetes team	Agreed protocol / Specialist accr.	Tariff	Reduction of blindness, amputation, ESRF
Type 1 DM, stable with early	Increased involvement of 1ary care [?%]	2ary to 1ary	Specialist supervision :		GP recognised at higher level competence	Education in 1ary care	Final & intermediate outcomes against national
				Diabetes team	Specialist accreditation	Tariff	
Type 2 DM, stable with early	Increased involvement of 1ary	2ary to 1ary referral	1:1consultation, possible group work	GP / PN Structured care	Locally agreed competence	Funds for education in 1ary care	QUOF
T1 & T2 DM in transitional state	Specialist assessment	GP/PN	Advice / intervention & return to 1ary care	2 ary care / GPwSI	Specialist acreditation /	Tariff / GPwSI	Access time;
T1 & T2 DM – for advice	Advice without assessment	GP/PN	Telephone / fax contact	2 ary care	Specialist accreditation	Funding model required	Access time;

[123] = number of appointments per year.

Special Groups (Adult)

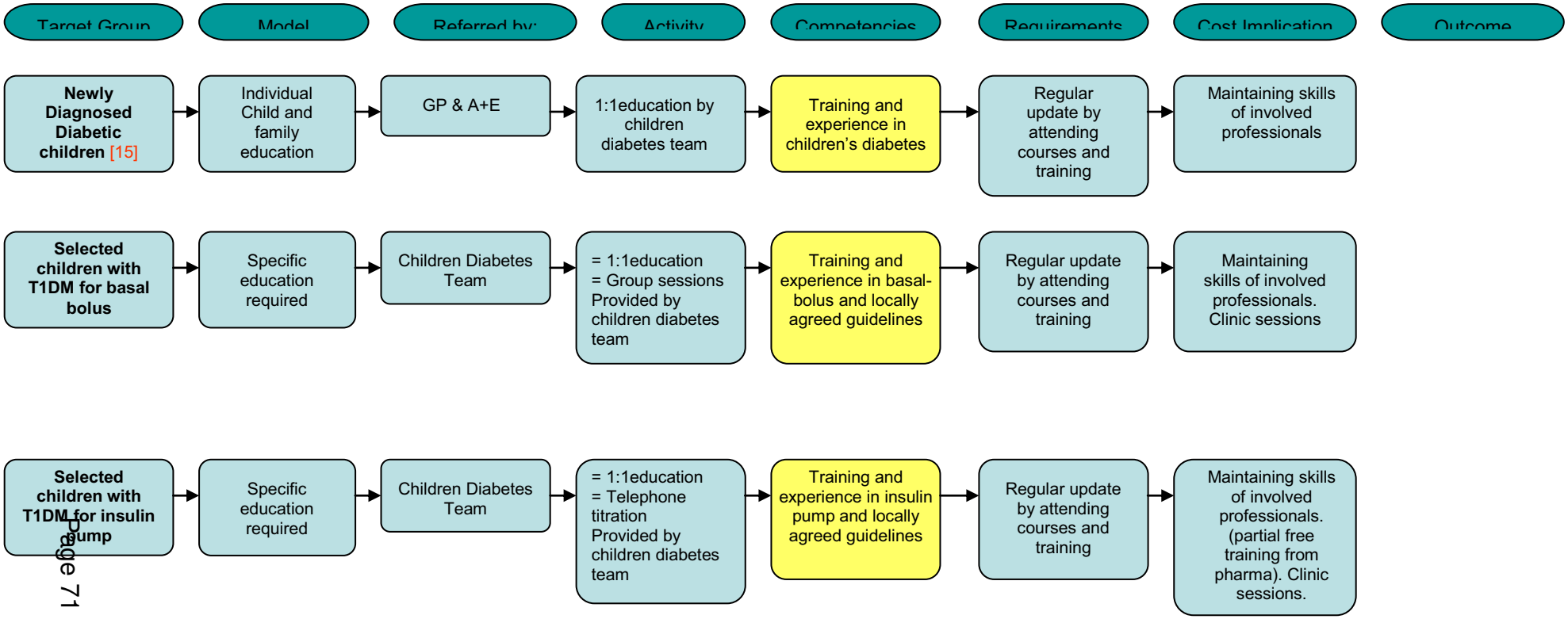
Target Group	Model	Referred by:	Activity	Competence	Requirements	Cost Implication	Outcome
Pregnant T1DM [24/149] & T2DM [7/39]	Specialist supervision in 2ary care.	GP/PN Obstetrics	Intensive DSN supervision; joint clinic with MW & Obsetrician	DSN + Consultant +MWwSI	Agreed protocol / Specialist accr.	Tariff	To normalise congenital abnormality & fetal mortality
Gestational Diabetes [71/202]	Specialist supervision in 2ary care	Obstetrics	DSN & MW supervision	DSN	Agreed protocol / Specialist accr.	Tariff	To reduce macrosomia & fetal mortality
Pre-conception	Specialist supervision in 2ary care or GPwSI	Self referral GP, Clinic	DSN 1 to 1 Obstetrician review	DSN	Agreed protocol / Specialist accr.	Tariff	HbA1c at conception
Young person [16 to 24 yrs] with T1 / T2 DM	Specialist supervision in 2ary care	Paediatrics / GP	Joint - Cons / DSN / Dietitian	DSN / Diabetologist	Intensive follow-up	Tariff	HbA1c / educational status

[123] = number of appointments per year.

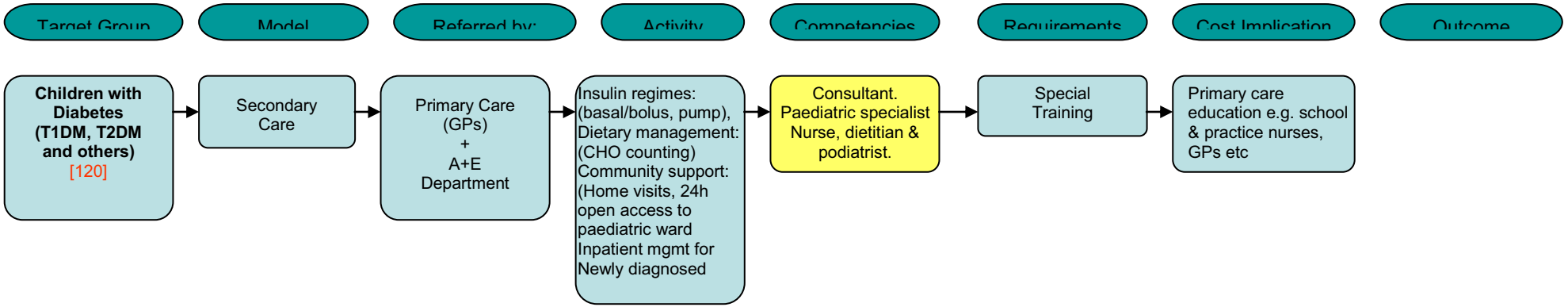
Podiatry

Target Group	Model	Referred by:	Activity	Competence	Requirements	Outcome	Cost Implication
Assessed as low risk of foot ulcer	Primary care: GP Practice	In-House: annual screening	1:1 education / advice @ Annual Review	Foot Assessment competent	Agreed risk assessment tool Implementation of Diabetic Foot Health Guidelines from		Comparative imbalance between access in SWK, MW and DGS
Assessed as medium risk of	Primary care: GP / Community Podiatry	In-House: annual screening	Management and frequent review 3-6 monthly	Diabetic foot care competent Specialists	Agreed risk assessment tool Implementation of Diabetic Foot Health Guidelines from	Reduction in number of amputations Reduction in amputation rates Reduction in associated mortality / morbidity rates Reduction in number of admissions Reduction in number of bed days	Increased educational input.
Assessed as high risk of foot	Primary& Secondary care: Community Podiatry & Orthotists	In-House: annual screening GP, PN, DN, DSN,	Management and frequent review 1-3 monthly	Diabetic foot care Specialists competent in debridement & Diabetic footwear specialists	Agreed risk assessment tool Implementation of Diabetic Foot Health Guidelines from		Increased educational input. Specialised insoles and footwear
New ulceration, infection or discolouration (urgent 24 hour referral) [283/1656]	Secondary Care: Highly Specialist Podiatry. Orthotist.	In-House: annual screening GP, PN, DN, DSN, Consultant, A&E, UCC & Minor Injuries	Refer within 24hrs to Multidisciplinary Foot care team – intensive input	Highly Specialised competent foot care specialists	Implementation of Diabetic Foot Health Guidelines from Agreed risk assessment tool		Increased educational input. Specialised insoles and footwear Intensive input for debridement, dressing, antibiotics. Total contact casting. Revascularisation and optimising glucose levels and control cardiovascular risk.

Pathway of Diabetes Education for Children's Diabetes Service at Darent Valley Hospital



Pathway of Clinical Care for Children with Diabetes



Dietetic Pathways

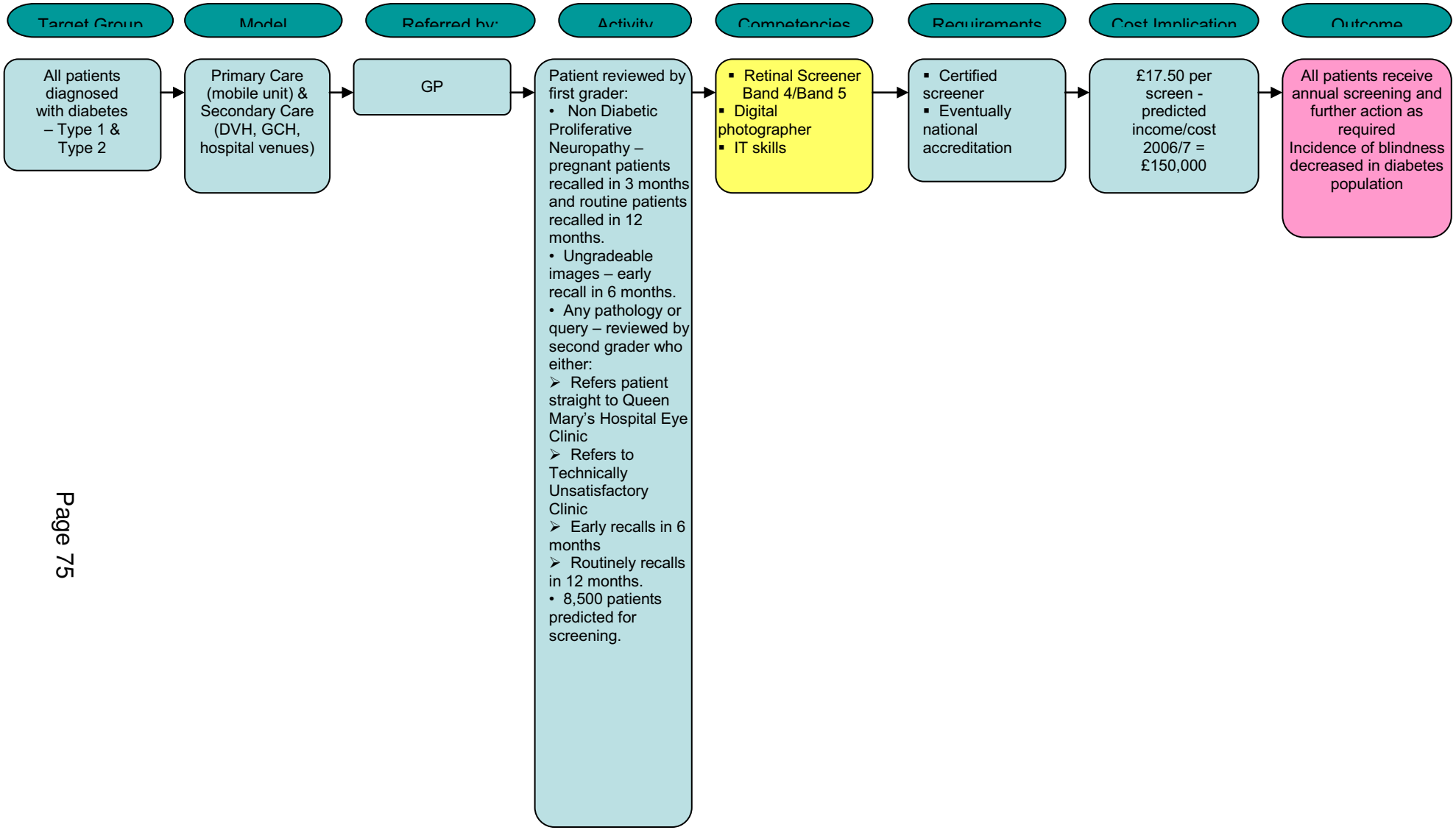
Target Group	Model	Referred by:	Activity	Competencies	Requirements	Cost Implication	Outcome
Newly diagnosed Type 1	Specialist care in Secondary	Consultant DSN Diabetes Team	At diagnosis: diet & lifestyle review & education. Av	Specialist Dietitian Band 7/Band 6 with supervision	• Post grad specialist trained. • Motivational interviewing.	Funding model to be decided – part of PbR	All newly diagnosed receive specialist 1:1 education – improved
Established Type 1 diabetes	Specialist care in Secondary	Consultant DSN Diabetes Team	• At annual review	Specialist Dietitian Band 7/Band 6 with supervision	• Post grad specialist trained. • Motivational interviewing.	Funding model to be decided – part of PbR	• Reduction in hospital admissions. • Improved parameters HbA1c/Lipids/BP
Established Type 1 diabetes	Specialist care in Secondary	Consultant DSN Diabetes Team	• DAFNE referral • 1 week DAFNE course • Estimate 48 per year	Specialist Dietitian Band 7 DAFNE trained	• Post grad specialist trained. • Motivational interviewing. • DAFNE trained.	£250 per pt. Estimate 48 per year = £12,000 (includes DSN costs and	• Reduction in hospital admissions. • Improved management HbA1c/Lipids/BP
New & established Type 2 diabetes	Generic diet & lifestyle advice Primary Care	Primary Care led GP/PN	Messages on dietary management	PN with dietary education	• Accreditation from Dietetic Dept	Primary Care led	All diagnosed receive generic dietetic advice
	Use of dietetic screening tool for referral to Dietitian	GP/PN after screening	Full nutritional assessment & individualised dietetic care and	Band 6/7 Dietitian working in Primary Care setting	• Post grad specialist courses • Motivational interviewing skills	Funding model to be decided – through SLA & PbC	New Type 2 with dietetic problems receive 1:1 advice – improved HbA1c
			Referral to Specialist Dietitian in Secondary Care for complex issues	Specialist Band 6/7 linked to Secondary Care Diabetes Team	Band 6/7 Specialist Dietitian	Funding via SLA or PbC	• Improvements in obesity management/ lipids/HbA1c • Reduced complications
	Newly diagnosed referral to DESMOND or other education programme	GP/PN	• DESMOND 1 day course OR ½ day group education	Band 6/7 Dietitian DESMOND trained with facilitation skills	• Post grad specialist courses • DESMOND trained	DESMOND funded = 3 Dietitians each for 8 days per year	All new Type 2 offered DESMOND –improves HbA1c, targets
Newly diagnosed Type 1 Paeds	Specialist care in Secondary	Consultant Specialist DM Paeds nurse	At diagnosis: full diet & lifestyle review & education. Av 10-12 new per	Specialist Paeds Dietitian Band 7	• Paeds Dietitian plus post grad specialist DM training • Motivational interviewing	Funding model to be decided – part of PbR	• Good dietetic management of children • Short hospital stav
Type 1 Paeds – ongoing & intensive support	Secondary Care Specialised management	Consultant Multidisciplinary Team	3 monthly & annual review. Initiation basal bolus/pumps	Specialist Paeds Dietitian Band 7	• Paeds Dietitian plus post grad specialist training • Motivational interviewing	Funding model to be decided – part of PbR	• Reduction in hospital admissions. • Good HbA1c measurement ? Target levels

Community Support

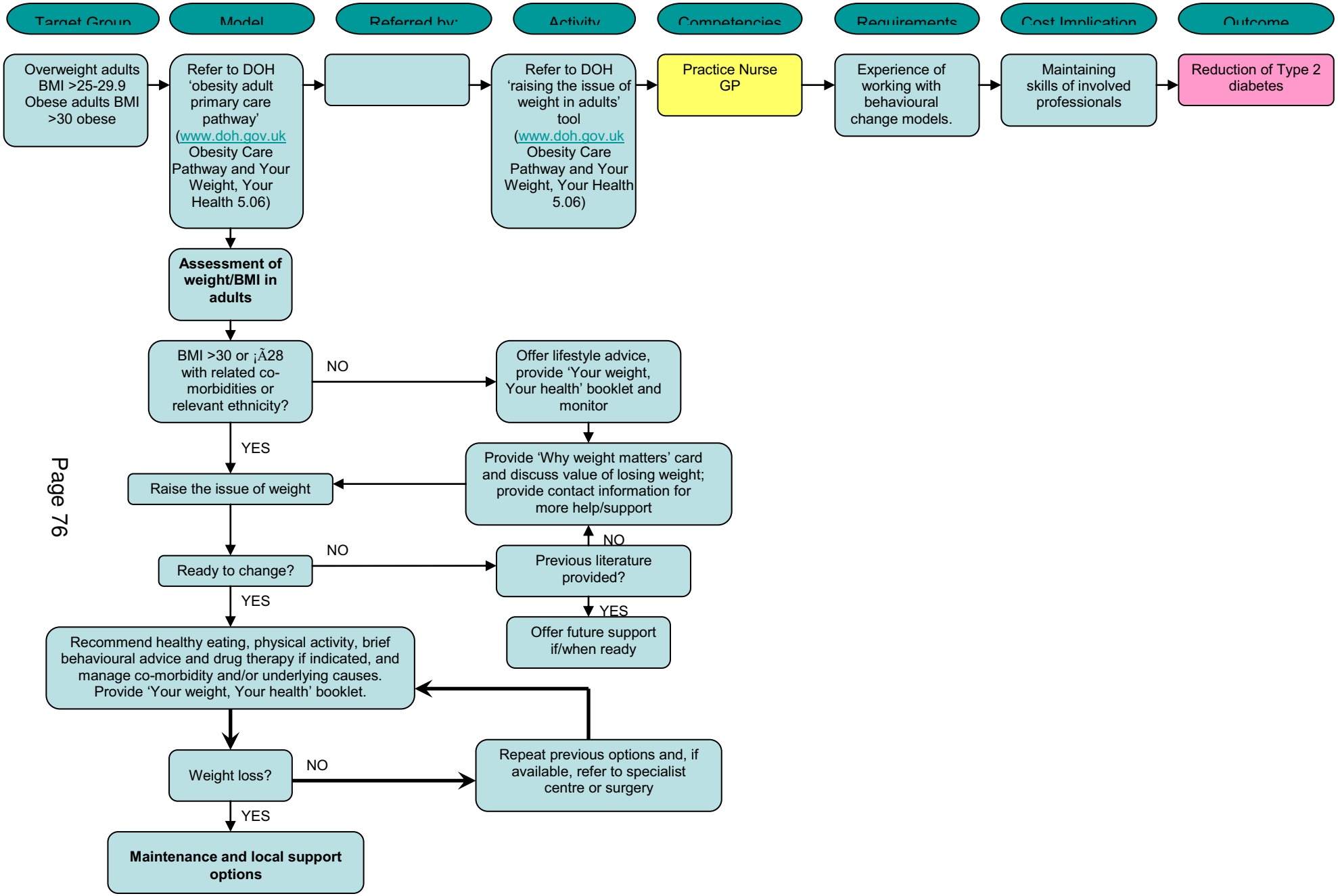
Target Group	Model	Referred by:	Activity	Competence	Requirements	Cost Implication
GP & PN	In practice education for GP & PN	PN / GP selects suitable T1 & T2	Case based discussion of problems	Diabetologist	Specialist accreditation	Funding model to be decided
GP & PN	Support for GP structured care	GP & GPwSI when need	Advice & education re model of care	DSN	Specialist accreditation	Funding model to be decided
All GP / Community treating DM	Educational groups	Self / GPwSi after assessment of need	Educational instrument appropriate for need	DSE	Specialist accreditation	Funding model to be decided

Audit and appraisal to ensure quality provision are an essential requisite for all models

Retinal Screening Pathway



Adult Obesity Prevention Pathway



Child Obesity Prevention Pathway

Target Group	Model	Referred by:	Activity	Competencies	Requirements	Cost Implication	Outcome
Overweight children BMI >25–29.9 Obese children >30 Obese	Calculate BMI as linked to Girls / Boys child growth foundation chart. Refer to DOH Obesity children and young people primary care pathway (www.doh.gov.uk Obesity Care Pathway and Your Weight, Your Health 5.06)		Refer to DOH Raising the issue of Weight in children and young people tool (www.doh.gov.uk Obesity Care Pathway and Your Weight, Your Health 5.06)	Practice Nurse General Practitioner	Experience of working with behavioural change models	Maintaining skills of involved professionals Purchasing Child growth foundation charts	Reduction of type 2 diabetes

Assessment of weight in children and young people

Raise the issue of weight

Provide 'Why weight matters' card and discuss value of managing weight; provide contact information for more help/support

Child and family ready to change?

NO

Previous literature provided?

NO

YES

Offer future support if/when ready

YES

Recommend healthy eating, physical activity, brief behavioural advice and manage co-morbidity and/or underlying causes. Provide 'Your weight, Your health' booklet.

Progress/weight loss?

NO

Re-evaluate if family/child ready to change.
Repeat previous options for management
OR
If appropriate and available, consider referral to paediatric endocrinologist for assessment of underlying causes and/or co-morbidities
OR
Referral for surgery

YES

Maintenance and local support options

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Appendix 4 - Diabetes Adult Primary Care Services: Level 1 & 2

Level 1
Essential Care

Delivered by General Practices i*n primary care, community settings and the patient's home*

Detect and diagnose
Diabetes register maintenance
IGR and past gestational register maintenance
Annual review including all screening procedures
Follow up of patients with Type 2 diabetes
Medications review
Complications screening
Patient education (excluding structure Patient Education on diagnosis)
Telephone support
Referring appropriately to other levels/specialist services/education
Goal setting and action planning
Family planning advice
Care for housebound patients
Chronic disease register and record maintenance
Achieving QOF targets

All Practices should deliver Level 1 care

Level 2
Essential plus Enhanced Care

Delivered by General Practices i*n primary care, community settings and the patient's home*

In addition to essential care detailed in level 1, Level 2 practices will provide the following services:

- Insulin and GLP-1 initiation
- On-going support for patients with Type 2 diabetes on injectable therapies
- Structured education programmes for patients and carers

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Appendix 4 - Diabetes Adult Specialist Services: Level 3 & 4

Level 3

Criteria for people to remain or be referred into level 3 services - patients being referred must meet at least one of the following criteria:

- Persistent HbA1c > 70mmol/mol for at least 12 months having actively titrated medication to maximal tolerated oral hypoglycaemic therapy and/or injectable therapy
- Rapid access to avoid A&E attendance and non-elective admissions, e.g. recurrent severe hypoglycaemia
- Insulin initiation from level 1 practices
- GLP1 initiation from level 1 practices
- Severe hypoglycaemia (hypoglycaemia requiring third party assistance e.g. ambulance attendance)
- Hypoglycaemia unawareness
- Pre-pregnancy counselling (ideally 6 months before attempting conception)
- High-risk podiatry service (meeting NICE moderate/high criteria). Appendix A Diabetes UK Footcare pathway
- Intensive support by a Diabetes specialist nurse or a dietician after non-elective admission, until stable
- People requiring structured education programmes (Desmond)
- Other diabetic conditions that are complex and require specialist diabetic care

Level 4

Criteria for people to remain or be referred into level 4 services

- Newly diagnosed type 1 diabetics. Provision of immediate assessment and follow up until condition stable and no changes to insulin regime required.
- Young adult clinic for 19-25yrs
- Consideration of continuous subcutaneous insulin infusion pump therapy
- Type 1 structured education programmes (DAFNE)
- Genetic causes of diabetes (e.g. Maturity-onset diabetes of the young, MODY) until stable and no further changes in diabetic care planned
- Diabetes secondary to endocrinopathies (e.g. Cushings disease or acromegaly)
- Diabetes in pregnancy
- Specialist foot clinic for active foot problems: e.g. active ulceration, infection, Charcot foot, requiring combined intervention from Multi-disciplinary Foot Team
- Patients with suspected or diagnosed autonomic neuropathy
- Patients on insulin who have qualified for a vocational driving license
- Drivers who may have hypoglycaemia unawareness
- Rapid access to avoid A&E attendance and non-elective admissions, e.g. recurrent severe hypoglycaemia
- Persistent HBA1c >69mmol/mol with active retinopathy (worse than non-proliferative retinopathy) or previous amputation.
- Off-license use of specific diabetic medication e.g. in unlicensed combinations
- Patients with significant renal disease (stage 4 or 5 CKD or if urinary A/C ratio (ACR) >70 (equivalent to proteinuria >1.0g/24hr) or a rapidly deteriorating eGFR renal function).
- Other Diabetic conditions that are complex and requires consultant care

HEALTHY LIFESTYLES ACTIVITIES
IN
DARTFORD, GRAVESHAM AND SWANLEY

Please also visit the ACTIVE KENT Internet site:

www.activekent.co.uk

Due to circumstances beyond our control, the activities and schemes listed below may change or be cancelled without prior warning. Therefore, we advise that you make contact with the organiser to confirm the current details of each activity or scheme, and any cost involved, before referring a patient.

Name of activity	Location and time	Criteria i.e. age, BMI, etc	Referral process	Cost
Dartford				
Assorted activities at the St Edmund's Church Living Well – the Healthy Living Centre for Dartford	St Edmund's Church Living Well, St Edmund's Road, Temple Hill, Dartford, Kent. DA1 5ND Telephone : 01322 311201 Email : info@stedmundsdartford.org.uk	Various ages	Self referral, mostly	Some activities may include a small cost.
Don't Sit, Get Fit The aim of Don't Sit Get Fit is to reduce child obesity in 8 to 14 year old children through promoting physical activity and healthy eating.	For more information contact: St Edmund's Church Living Well, St Edmund's Road, Temple Hill, Dartford, Kent. DA1 5ND Telephone : 01322 311201 Email: dsgfdartford@yahoo.co.uk	8 -14 years	Referral from dietician/school nurse /GP  E:\healthy weight\ PbC\Dynamo referral	Free of charge

Acacia Fitness Centre - Services offered on referral or self referral for Weight Management	Naomi.Coupland@btinternet.com or clive@excellenceleisure.co.uk Telephone: 01322343490	Adults	Referral or self referral  G P Referral Form NEW.doc  contraindications	A one off charge of £24 plus an assessment fee of £25 and £3.30 for each session attended.
Aerobics - These fun and friendly classes aim to help Individuals become more active and are suitable for people who are new to exercise	St Edmund's Church Living Well, St Edmund's Road, Temple Hill, Dartford, Kent. DA1 5ND Telephone : **07708 599737** Mondays from 7:00pm – 8:00pm Church Road Hall, Church Road, Swanscombe, Kent, DA10 Telephone : **07708 599737** Tuesdays from 7.00pm -8.00pm	All ability levels	Self referral	£1.50 per session
Supple Strength – a blend of yoga, pilates, strength and flexibility	St Edmund's Church Living Well, St Edmund's Road, Temple Hill, Dartford, Kent. DA1 5ND Telephone : **07708 599737** Mondays from 6:00pm - 6:45pm Thursdays from 7.00pm – 7.45pm	All ability levels	Self referral	£1.50 per session
"Naturally Active" – Health Walks	Health walks in North West Kent, every Monday. For more information and to confirm the time and location of the walk call Simon Platt on **01322 294727** or **07740 185342**	All ages	Self referral	Free of charge

Dartford Health Walks (Walking for Health)	Every Thursday at 11.30am meeting at the War Memorial, opp. Dartford Library, Town Centre. The walk lasts about between 30 minutes to an hour, and is ideal for people who currently take little or no exercise or who want to meet new people and get active	All ages		Free of charge
Postural Stability Classes – falls prevention class which builds up strength and confidence	The Limes Day Centre, Brent Lane, Dartford, DA1 1QN Please contact the Instructor Sarah on 01474 747339 to be allocated a place	60+	Self referral	Free of charge

Gravesham / Gravesend				
Assorted activities at The Gr@nd Healthy Living Centre	The Gr@nd Healthy Living Centre **Phone:** 01474 320123 **email:** grand@gravesham.gov.uk Including Back to Work support, Silver Surfers and stop smoking support.	Various ages	Self referral, mostly	Some activities may include a small cost.
Don't Sit, Get Fit The aim is to reduce obesity in young people by working with them and their family.	12 week family programme aimed at families with a child whose BMI is in the 91st centile. Runs at a variety of venues Contact the Don't Sit Get Fit team on 01474 32 01 23 for more information and advice or via email amit.hayer@gravesham.gov.uk	5 to 13 years.	Self referral or referral by GP using the following forms -	Currently free of charge.
Gentle exercise classes – classes are suitable for all abilities and can be adapted so you can do them sitting down.	St John's Church, Wednesday, 1pm Gravesend Age Concern, Clarence Row, Tuesday, 12pm and every other Friday at 11.30am Northfleet Age Concern, Coldharbour Road, Thursday, 11.30am Higham Age Concern, every other Friday, 11.30am Mullender Court, Chalk Road, Thursday, 11.45am For more information Contact Sarah from Athena Fitness on 01474 747339	Older people	Self referral	There is usually a small charge of approx £1 - £2, which can be confirmed by contacting the instructor.

Postural Stability Classes – falls prevention class which builds up strength and confidence.	Gravesham Place Please contact the Instructor Sarah on 01474 747339 to be allocated a place	Older people.	Self referral	Funded through Chances for change
Health Walk	1-2 mile route starting and finishing at the Civic Centre Contact Rav Marwaha at the Gr@nd on 01474 320123 or ravinder.marwaha@gravesham.gov.uk	Various ages	Self referral	free
Adult Healthy Weight Programme	12 week programme for adults with a BMI of 28 or above run at a variety of venues around the borough contact the healthy weight team at the Gr@nd healthyweight@gravesham.gov.uk 01474 320123	Adults	Self referral or GP referral	Free

		Swanley		
Get SORTed	A one stop shop for health and wellbeing support and advice for residents in the Sevenoaks District. Qualified nutritionists and fitness consultants form the Get SORTed team and provide a free individual approach towards lifestyle goal setting, weight management and well being. Those referred to Get SORTed will also be able to access a number of healthy living projects run by Sevenoaks District Council and funded by NHS West Kent, including: • Why Weight Programme • Exercise/Dance classes (for adults and young people) • Falls Prevention Classes (for the over 60's) • Cookery courses	Adults and families who live in the Sevenoaks District	Self referral or GP/health professional referral using form below:  S:\SDC\Community Services\Community I	Get SORTed is free, some of the initiatives referred into may have a small charge
Why Weight Programme - a 12 week weight management	Courses run throughout the year across the District. Aimed at those who have a BMI of 28 or above who live in the Sevenoaks District.	Adults (18+)	Self referral or GP/health professional referral using form below:	Free of charge

programme which incorporates diet, nutrition and exercise.	For further details, please visit the www.sevenoaks.gov.uk/health, or the Council's Healthy Living Team on 01732 227000 or email HealthyLiving@sevenoaks.gov.uk		 S:\SDC\Community Services\Community I	
Dance Classes Aiming to encourage adults and young people to exercise regularly	White Oak Leisure Centre, Hilda May Avenue, Swanley, BR8 7BT, Tel 01322 662188, wolc@sencio.org.uk For further details, please visit the www.sevenoaks.gov.uk/health, or please contact the Council's Healthy Living Team on 01732 227000 or email HealthyLiving@sevenoaks.gov.uk	Ages vary; different classes have different age ranges.	Self referral	There is usually a small charge.
Falls prevention classes Aiming to improve balance, stability and confidence for over 60s	The Age Concern Centre, Swanley High Street, BR8 8AE. The class is every Wednesday, from 11.00am - 12 midday. For further details, please visit the www.sevenoaks.gov.uk/health, or please contact the Council's Healthy Living Team on 01732 227000 or email HealthyLiving@sevenoaks.gov.uk	Older people	This class is aimed at people over 60 – no need to book, just turn up Self referral	Free of charge
Swanley Health Walk	Meeting every Tuesday at 2.00pm in the cafe, at White Oak leisure centre, the walk lasts about an hour and is ideal for people who currently take little or no exercise or who want to meet new people and get active. The walk also	Adults of all ages	Self referral, just turn up	Free of charge

	finishes at White Oak leisure centre. (White Oak Leisure Centre, Hilda May Avenue, Swanley, BR8 7BT.) contact the Healthy Living Team on 01732 227000 or email HealthyLiving@sevenoaks.gov.uk			
NHS West Kent Stop Smoking Service	Various venues – ring 01622 723836 for further information. A specialist service is also available for pregnant women and their partners. A specialist service is also available for teenagers entitled “Let’s kick some butts”, through participating schools.	From 12 years and upwards (Gillick competency must be assessed for under 16s. A Chaperone with an under 16 is advisable for some 1-1 sessions.)	GP / health professional support in selected GP surgeries, pharmacies and other venues, GP / midwife / professional referral, or self referral.	Free of charge.

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Exclusions, Suspensions and Management of Ungradables

Version 0.10, 07 March 2012

To provide a definitive policy on exclusions and suspensions for the NHS Diabetic Eye Screening Programme

Project/Category	*Workbook/Policy*
Document title	*Exclusions, suspensions and management of ungradables*
Version and date	*v0.10, 7 March 2012*
Release status	*Final draft for dissemination – requires Equality Impact Assessment*
Author	*Multiple*
Owner	*Sue Cohen*
Type	*Policy*
Authorised By	*Sue Cohen*
Valid from	
Review Date	
Audience	*Diabetic Eye Screening Programmes*

Distribution

Name / group	Responsibility
PAC, Pathway	*Sue Cohen*

Amendment history

Version	Date	Author	Description
0.1	4.4.11	SC	Amendment of original
0.2	26.4.11	HK	Amendment of previous version
0.3	2.6.11	SC	Amendment following Programme Advisory Committee
0.4	17.8.11	SC	Amendment following discussion at Pathway Meeting
0.5	5.9.11	SC	Amendment following input from HK, TC, KB, DT
0.6	18.10.11	SC	Amendment from Pathway – prep for consultation
0.7	2.11.11	SC	Final amendments for consultation
0.8	29.12.11	SC	Amendments following consultation
0.9	5.3.12	SC	Amendments following Programme Advisory Committee
0.10	7.3.12	LL	Amendments for final draft issue

Review / approval

Version	Date	Requirement	Signed

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1 Purpose and Definitions

1.1 This policy describes the management of people on the Programme Register[i] of their Local Diabetic Eye (DE) Screening Programme. It defines the eligible population and which people should be invited for screening, excluded and suspended. It also provides guidance in special circumstances.

1.2 ***Eligible:*** The population that is *entitled* to an *offer* of screening from the NDESP. All people with diabetes are eligible EXCEPT those below the age of 12 years or those over 12 years with no perception of light in both eyes. All other people with diabetes[ii] are eligible.

1.3 The local screening programme should separate eligible people who are not invited into one of two categories: exclusions and suspensions. **Suspensions:** people who are suspended are under surveillance for diabetic retinopathy or assessment and/or treatment of their diabetic retinopathy from a clinician who has taken clinical responsibility for the care of their diabetic retinopathy. **Exclusions:** people who are excluded are not invited for screening and are not screened or assessed for diabetic retinopathy.

1.4 ***Suspended:*** Eligible people who are **not** invited for annual digital screening **and** continue to have their retinae checked for diabetic retinopathy (DR). An eligible person who is suspended can be in one of the following states:

- Under the care of the Hospital Eye Service (HES) for management/ treatment of DR
- Under surveillance for DR in either a slit lamp biomicroscopy (SLB) surveillance clinic for the assessment of their DR, (this includes patients who have ungradable images) or a digital imaging surveillance clinic, sometimes referred to as Ophthalmic Photographic Diabetic Review (OPDR)

All people who are SUSPENDED are not invited for annual digital screening by the DE screening programme and should be monitored through the **failsafe system**[iii]**.**

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1.5 ***Excluded:*** Eligible population on the Programme list who are **not** invited for annual digital screening and **DO NOT** have their retinae checked for DR in another part of the screening pathway. This includes:

- Those who have made a written informed choice to opt out of DESP
- Those who could never be able to receive and/or benefit from treatment due to another existing condition
- Those who have been assessed by the Clinical Lead as never being able to be screened by digital photography or SLB

1.6 This policy describes the management of people on the Programme Register of their Local Diabetic Eye (DE) Screening Programme. It defines the eligible population and which people should be invited for screening, excluded and suspended. It also provides guidance in special circumstances.

2 Excluding people with diabetes from invitation for screening

2.1 People with diabetes aged 12 and over should be sent an annual invitation for Diabetic Eye (DE) screening and given the opportunity to make their own informed choice[iv] about whether to accept the invitation. In cases where there is doubt over whether the person with diabetes should be invited or not, they should be sent an invitation.

2.2 When a decision is made to exclude a person with diabetes from screening and not to send an invitation for DE screening, it should only be done after a careful assessment of the person and their circumstances.

2.3 Exclusions of people with diabetes from screening should form a very low proportion of the programme register; the national acceptable range is less than [level to be agreed]

2.4 A pathway must be in place to allow people to request to be returned to normal recall and be invited for screening at any time.

2.5 An annual audit of exclusions should be carried out by the screening programme.

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2.6 The process for excluding and suspending people from retinal screening is detailed in Table A.

3 Suspending people with diabetes from invitations for screening

3.1 People with diabetes are suspended from screening when they are:

- Under the HES for treatment of their DR
- Under surveillance for DR in either:
  - A SLB clinic[v]. This includes patients who can never be screened by digital photography but can be assessed using SLB **and** in the opinion of the programme Clinical Lead[vi] could benefit from annual assessment and treatment if it is required
  - A digital imaging clinic[vii] (OPDR)
  - Note: Patients with non-DR lesions under the care of HES are NOT suspended (see section 5.5)

3.2 Only the local screening programme can suspend people from screening. GPs cannot suspend individuals as 'under-care' of ophthalmology as not all assessments in the hospital eye clinic will involve a regular examination of the retina and the ophthalmologist may not know that the person has diabetes.

3.3 Only people who have been seen by the screening programme can be suspended. People who are under the care of ophthalmology, but have not yet been imaged by the screening programme, should either be seen once by the screening programme or have documented evidence from the hospital eye service that they are being managed /treated for DR. If appropriate, the screening programme can then suspend the person.

3.4 People who are suspended should be monitored through the failsafe system.

3.5 People who are suspended should be put in one of the categories in the software as described in Appendix A

4 Categories for ineligible, exclusion and suspension

The following categories will be covered under the policy:

- No perception of light in both eyes
- Informed opt-out

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- Medically unfit for screening. This includes the following circumstances
    - Terminally ill
    - Unable to be treated
    - Unable to be screened by digital imaging or another approved screening method

4.1 People with no perception of light

All people who are registered with severe sight impairment should be assessed by an ophthalmologist as some may still have some residual vision and therefore qualify for continued DE screening. People should continue in screening unless there is no perception of light in ***both*** eyes.

These people **will no longer be eligible for screening.**

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4.2 Informed opt-out

4.2.1 Some people may choose not to be invited for retinal screening and may ask to have their name removed from the list of people invited. Before this request can be implemented, the following conditions must be satisfied:

- The person must be provided with sufficient information to enable him/her to make an informed decision about withdrawing from the screening programme. This must be in a format which is accessible to him/her. It should include information on the condition being screened for i.e. diabetic retinopathy, the screening process (including risks and benefits) and the consequences of attending or ceasing to attend

- The person must be informed that withdrawing from the programme will prevent him/her from receiving any future invitations or reminders about retinal screening

- It must be made clear to the person that he/she can return to the programme at any time on request

- The person should put his/her request to withdraw from the programme in writing to confirm that he/she has made an informed decision. A template letter with appropriate wording is available (Appendix B). If a person is unable to sign a standard form, for example because of a severe physical disability, then alternative methods of communication are acceptable according to individual circumstances. If the decision has been discussed with the GP then the GP should record the discussion in the patient's notes.

4.2.2 The letter from the person requesting they should not be invited should be retained by the screening programme.

4.2.3 A copy of a confirmation letter stating that the person has opted out of the screening programme should be sent to both the person and his/her GP. This should be filed in the patient notes by the GP.

4.2.4 The screening programme should automatically re-invite the person after three years asking them if they would like to re-consider their decision to opt out of the screening programme. This letter should be accompanied by a new opt-out letter for the person to complete if they so wish.

4.3 People who are terminally Ill

4.3.1 Terminally ill is defined as a person who is suffering from a progressive disease, and where their death can be reasonably expected within six months. In these circumstances a GP or other caring physician can issue a DS1500[viii].

4.3.2 The least restrictive option is for the person to remain in call/recall and receive screening invitations. The invitations can be considered and accepted or declined on each occasion.

4.3.3 Alternatively, the GP or other caring physician can discuss whether or not the person wishes to continue to attend screening and the patient can, if they wish, make an informed decision to opt out.

4.3.4 In some circumstances, where the GP or care team believe that receiving invitations or completing an informed opt-out will cause distress to the person

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or their carer they can decide that it is in the person's best interest to exclude them in order to stop invitations being sent.

4.4 People who will never be able to benefit from and /or receive treatment due to a pre-existing condition

4.4.1 People who will never be able to benefit from and/or receive treatment due to a pre-existing condition should be assessed by either their GP or the Clinical Lead. If their clinician confirms that this is the case

The person can be EXCLUDED under 'medically unfit' category

4.5 People with diabetes who can never be screened with digital photography:

- Those who can never have a digital image *taken* in both eyes due to a pre-existing condition
- Those who can never have a digital image *graded* in both eyes due to a pre-existing condition (See below on managing ungradable images)

4.5.1 People who will never be able to have a digital image *taken* or *graded* in **both eyes** due to a pre-existing condition that cannot be treated, should be assessed by the Clinical Lead according to an agreed protocol. If a digital image can be taken in one eye then the person should continue to be screened using a digital photograph. (see flow-chart Appendix ..)

4.5.2 If the Clinical Lead, in discussion with the individual (and if relevant, their carer), considers they could benefit from regular review using SLB **and** could benefit from treatment for DR if required, then the individual should be referred to the SLB surveillance Clinic.

These individuals should be SUSPENDED from the Screening Programme and monitored through the failsafe system.

4.5.3 If the Clinical Lead, in discussion with the individual (and if relevant their carer), considers they would NOT benefit from regular review using SLB **or** could NOT benefit[ix] from treatment if required, then the Clinical Lead can EXCLUDE the individual from the Screening Programme

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4.5.4 The Clinical Lead should confirm any changes in the status of the patient (excluded or suspended) in writing to the person and their GP. The appropriate documentation should be completed by the Clinical Lead and retained by the screening programme.

5 Situations that require special consideration

5.1 People with ungradable images

5.1.1 Programmes should classify ungradable images in line with existing policy.

5.1.2 Ungradable images can be classified in the following way:

- Ungradable at this visit because of person specific factors
- Digital image possible in one eye, ungradable in second eye
- Ungradable in both eyes due to a condition amenable to treatment
- Ungradable in both eyes due to a condition amenable to treatment but for which treatment is not yet indicated
- Ungradable in both eyes due to a condition not amenable to treatment, possible to visualise the retina using SLB
- Ungradable in both eyes and not possible to visualise the retina with any other method

5.1.1 An individual can be found to have ungradable images at a visit because of person specific factors, such as difficulty in keeping still, and the screener believes a gradable image can be obtained if the individual can be seen again. The person should then be re-invited for screening[x].

5.1.2 When an individual is able to have a digital image taken in one eye (and the grade is non-referable in that eye) they should continue in the digital screening programme. If the other eye has a lesion that is amenable to treatment, e.g. cataract, and the patient wants it treated, they should be referred to the hospital eye service. In this circumstance they should continue to receive annual invitations for digital screening. 5.1.3 When an individual is found to have ungradable images in both eyes but the cause is amenable to treatment and the patient wants it treated, (e.g., cataracts), the patient's screening due date may be postponed to accommodate treatment and recovery time. The patient will remain active on the register during this time, and will not be

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suspended or excluded from the screening programme unless either screening or treatment for DR-related conditions is determined to be impossible, at which point the patient would be excluded.

5.1.4 When an individual is found to have ungradable images in both eyes due to a condition that is not amenable to treatment but it is possible to visualise the retina using SLB, they should be managed according to 4.5.2 and 4.5.3. This can include patients who have cataract preventing adequate photography, but where surgery is not indicated.

5.1.5 When an individual is found to have ungradable images in both eyes and it is not possible to visualise the retina with SLB they should be assessed by the Clinical Lead. In these circumstances the Clinical Lead can EXCLUDE the individual from the Screening Programme

5.2 People who have a disability

5.2.1 In most cases a person with a disability should be able to access their Local DE Screening Programme. Local programmes should ensure they provide a service that is accessible to them in accordance with Disability Discrimination legislation.

5.2.2 In a small number of cases a person may have a disability that prevents them from being screened by digital photography. In these circumstances the Clinical Lead should discuss their situation and options with them (and if appropriate with their carer and GP) on an individual basis. These situations should be dealt with as in 4.5.2 and 4.5.3 above.

5.2.5 It is not appropriate for either the GP or screening programme staff to exclude a person with a disability from screening when they have capacity to make their own decisions.

5.3 Excluding in a person's best interests

5.3.1 It is important for screening staff to recognise that a person who lacks the mental capacity to consent to screening should not be permanently removed from a screening recall programme unless a 'best interest decision' to do so has been taken on his or her behalf. In most cases, the least restrictive option

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is for that person to remain in call/recall and receive screening invitations at routine intervals. The invitations can be considered and accepted or declined on each occasion. In exceptional circumstances, a care team may decide it is in the best interests of a person who lacks mental capacity to withdraw from a screening programme. Screening staff should be satisfied that the best interest decision has been reached in accordance with their local code of practice. The person making the best interest decision to exclude a person from screening should be aware that the person can be re-invited at any time if circumstances change and screening is then considered to be in the person's best interests.

5.3.2 Screening programmes will need to ensure there is evidence that any best interest decision has adhered to the principles of the Mental Capacity Act and that all relevant factors, reasonable adjustments and alternatives have been considered.

5.3.3 It is recommended that DE screening programmes work with their commissioners and local stakeholders to develop good practice guidance in regard to the access to DE screening for people with mental incapacity. This can take into account any reasonable adjustments and alternative arrangements that may enable people with limited mental capacity to consent to and participate in DE screening.

5.4 Housebound Patients

5.4.1 Diabetic eye screening and laser photocoagulation treatment require special equipment which is not portable and cannot be provided in people's homes.

5.4.2 People in institutional or residential care or who are housebound and able to benefit from screening and treatment should continue to be invited for screening. There should be provision for a service that is accessible to them in accordance with Disability Discrimination legislation

5.4.3 Every endeavour should be made to ensure housebound patients can access the programme. The GP and, if appropriate, care home staff will have a role in making sure patients are encouraged to attend for screening and subsequent treatment if necessary.

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5.4.4 Patients who are unable to travel outside their home or who have a disability that would preclude treatment should be assessed in line with points 4.5.2 and 4.5.3

5.4.5 Domiciliary assessment is not part of the screening service and if provided should be commissioned, funded and managed separately from DESP

5.5 Patients found to have referable non DR conditions at screening

5.5.5 Patients who are found to have a referable eye condition other than diabetic retinopathy or maculopathy (non-DR eye condition) will require referral for their condition. The screening service should provide the necessary clinical information to the patient's GP who will then be responsible for the referral.

5.5.6 Screening programmes should have local protocols for direct referral to HES for conditions that require urgent referral.

5.5.7 Some screening programmes may also have local protocols governing referrals which have been agreed with local GPs.

5.5.8 Patients who are referred and followed for a non-DR eye condition will continue to require annual digital screening. These patients will remain within the active patient register, eligible for annual recall, and will not be excluded or suspended from the screening programme.

5.5.9 In cases where the patient's non-DR eye condition would prevent effective screening (e.g., cataracts awaiting surgical removal), the patient's screening due date may be postponed to accommodate treatment and recovery time. The patient will remain active on the register during this time, and will not be suspended or excluded from the screening programme unless either screening or treatment for DR-related conditions is determined to be impossible, at which point the patient would be excluded (*refer to section regarding exclusions for inability to screen or treat sections 4.4 and 4.5*).

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5.6 Private Patients

Patients who attend private ophthalmologists should be treated in the same way as those attending NHS DESP screening and NHS HES services with the private ophthalmologist indicating prior agreement to follow DESP protocols and informing their patients of the options open to them.

Private patients should not be excluded from invitations to the screening programme. They can be excluded if they wish and they return an opt out form.

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6 Programme and commissioner responsibilities

6.1 Programmes should have operating procedures that provide detailed arrangements for the implementation of this policy. This will include, but is not limited to, the following:

- Retention of documents and supporting evidence
- Audit of exclusions
- Procedure for exclusions
- Procedure for suspension and failsafe
- Protocol for exclusion under best interest decision as agreed with commissioning PCT's Director of Public Health

6.2 Programmes and programme boards are encouraged to work with their stakeholders to develop good practice in relation to the management of people with disabilities in relation to screening for DR.

6.3 Commissioners should commission a dedicated surveillance SLB clinic as part of the screening service (DESP) to meet the requirements of this guidance.

Appendix A: Administration and software

The changes proposed are not intended to require any changes to the current software system offered by the suppliers. Calculations for the annual report should be possible using existing data fields. The National Team is working with the software suppliers to ensure that the policy as described can be delivered.

Table A summarises the changes and aligns this to annual report headings and the old categories of inactive and active.

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NHS

Screening Programmes

Diabetic Eye

Eligibility, Exclusions and Suspensions Table A

Excluded or suspended ?	Category	Category description	Responsibility for the decision	To be included in Annual Report Lines 3.1.3 (Patients marked inactive according to category)	Old categories (inactive/active)
NOT ELIGIBILE					
Not eligible	Blindness (NPL)	A person with diabetes who does not have perception of light in both eyes	Ophthalmologist NPL form to be counter signed by Clinical Lead	3.1.3 b Having no perception of light in both eyes	INACTIVE - Permanent
EXCLUSIONS					
Excluded	Informed choice to opt out	A person with diabetes who has made his or her own informed choice that he or she no longer wishes to be invited for screening	Person supported by GP (or senior practice or diabetes specialist nurse) or screening programme. Opt out form to be completed by person.	3.1.3 a Informed opt-out	INACTIVE - Temporary
	Terminal illness	A person with diabetes who is terminally ill	GP or other senior member of care team Exclusion form to be signed by relevant health professional.	3.1.3 c Being terminally ill	INACTIVE - Temporary
	Best interest exclusion	Best interest decision for person to be excluded from screening following the requirements of the Mental Capacity Act (2005)	Best interest exclusion form with check list signed by appropriate person according to local protocol	3.1.3 e Having a learning or mental disability preventing either screening or treatment	INACTIVE - Temporary

	Medically unfit	A person who has been assessed by the Clinical Lead and in discussion with the individual (and if relevant their carer) considers they could NOT benefit from treatment if it was required.	Clinical Lead Screening programme exclusion form.	3.1.3 d Having a physical disability preventing either screening or treatment	INACTIVE - Temporary
	Medically unfit	A person who has been assessed by the Clinical Lead and in discussion with the individual (and if relevant their carer) considers they would NOT benefit from regular review using SLB **or** could NOT benefit from treatment if it was required.	Clinical lead. Screening programme exclusion form.	3.1.3 d Having a physical disability preventing either screening or treatment	INACTIVE - Temporary

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SUSPENSIONS					
Suspended	Under the care of an Ophthalmologist for the treatment of diabetic retinopathy	A person with diabetes who is currently under the care of an ophthalmologist for the treatment and follow-up management of diabetic retinopathy **and** where the ophthalmologist has accepted clinical responsibility for their diabetic retinopathy care.	Programme Manager or Clinical Lead according to local failsafe protocol. Suspension form	3.1.3 f Currently under the care of an ophthalmologist for the treatment/follow up of diabetic retinopathy	INACTIVE - Temporary
	Under a surveillance slit lamp bio-microscopy clinic	A person with diabetes who is under a surveillance SLB clinic for the assessment of their DR. This will include patients who can never be screened by digital photography but can be assessed using SLB and in the opinion of the Clinical Lead could benefit from annual assessment and treatment.	Programme Manager or Clinical Lead according to local failsafe protocol Suspension form	**Currently no suitable category for this to be counted in the annual report, so;** **3.1.3h** **Other**	**No inactive category for this**
	Under digital imaging surveillance clinic - OPDR	A person who is under review in a digital imaging surveillance clinic or assessment clinic	Clinical Lead according to local protocol,	**Currently no suitable category for this to be counted in the annual report, so;** **3.1.3h** **Other**	**No inactive category for this**

Appendix B

Dear.....

You recently contacted the Diabetic Eye Screening office/GP (please delete as appropriate) to inform us that you do not wish to participate in the NHS Diabetic Eye Screening Programme

In England, we invite all people with diabetes aged 12 and over to take part in the NHS Diabetic Eye Screening Programme. Evidence shows that regular screening for diabetic retinopathy can significantly lower the risk of loss of sight.

I understand that you do not wish to receive any more invitations to take part in the Screening Programme. It is possible to remove your name from the list of people to be invited. However, your written confirmation is needed to ensure there is no misunderstanding.

Please sign and return the lower part of this letter to confirm your wishes. You can change your mind at any time by contacting your General Practitioner or the Diabetic Eye Screening Administration office.

In three years time we will contact you again to see if your circumstances have changed and you would like to rejoin the screening programme.

If you do not send the completed form back, you will be recalled within the year.

Yours sincerely

GP/Diabetic Eye Screening Office (delete as appropriate)

To: Insert address

Please do not send me any more invitations to take part in the Diabetic Eye Screening Programme.

I assume full responsibility for this decision and confirm that I have read the statement that retinopathy screening can reduce the risk of loss of sight.

I understand that I can change my mind and request a diabetic eye screening test if I wish. I can do this by contacting my General Practitioner or the Diabetic Eye Screening Administration office at any time in the future.

Name:..... Address:.....

.....

Signed:…… Dated.....:…….

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FOOTNOTES

[i] Programme Register: sometimes referred to as the single collated list or programme list.
[ii] People with Diabetes – this includes all people with a diagnosis of diabetes according to (ref). It does not include women with gestational diabetes or impaired glucose intolerance.
[iii] Failsafe system, as described by national documents.
[iv] Informed Choice should include appropriate information provided with the invitation letter.
[v] Where a reference is made to a Slit Lamp Biomicroscopy (SLB) Clinic, this refers to a specific SLB service that has been commissioned as part of the NDESP programme to provide assessment of DR.
[vi] Where the term Clinical Lead is used in this document it refers to the Clinical Lead or a clinician designated by the Clinical Lead with appropriate training and under the clinical lead's supervision. In cases where the Clinical Lead is a diabetologist, a Consultant Ophthalmologist should be identified to provide clinical responsibility in those areas where a specialist ophthalmology opinion is required.
[vii] Where a reference is made to a virtual clinic (OPDR), this refers to this service that has been commissioned as part of the NDESP programme to provide assessment of DR.
[viii] DS1500 are issued by a GP or other caring physician for a patient to enable the patient to claim certain benefits. They are only issued when the clinician believes the patient is unlikely to survive more than six months and therefore can be used as an indicator of when a patient meets this criteria.
[ix] Benefit means: An individual assessment that is patient specific and will be based on a holistic assessment of whether or not a patient can benefit
[x] Only the second episode should be counted if an image was obtained at a second visit.

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NHS
Kent and Medway

Ophthalmology

Introduction

The following report sets out responses to questions from Members about the current ophthalmology service and plans for the future. For ease of reference the report is split into two parts, east Kent including Swale and west Kent

a. East Kent

Ophthalmology services in east Kent attract the highest rate of referrals compared to most other specialties. This is mainly due to the complex nature of the sub specialties within the service, changes to NICE guidelines for eye conditions and an ageing population. With age related eye conditions the main focus is intervention for conditions that are usually more effectively treated at an early stage to ensure the possible loss of a patient's eye sight is kept to a minimum. Many ophthalmology departments are seeing increases in referrals for all sub specialties of eye care, mainly due to the increasing life expectancy of patients and the related conditions.

Most of the data within this report is for the original NHS Eastern and Coastal Kent PCT area which includes Swale. However, with the NHS reforms being implemented prior to April 2013 and the authorisation of the Clinical Commissioning Groups (CCGs), commissioning intentions for the future are now being worked up for each CCG individually. Four CCGs in east Kent, Canterbury and Coastal, Ashford, South Kent Coast and Thanet have formed a Federation to commission some services jointly. In the most part ophthalmology is being commissioned in this way however some CCGs have small projects within the specialty that they expect to implement within their locality alone.

As Swale patients normally access services in Medway Maritime or Maidstone and Tunbridge Wells, Swale CCG is likely to commission services differently to east Kent and be more aligned with the West Kent and Medway CCGs. Medway Maritime does not provide ophthalmology services within its contract but subcontracts with Maidstone and Tunbridge Wells NHS Trust (MTW) who provide them from Medway premises. Therefore, all activity data will be recorded under the MTW banner.

1. How many ophthalmologists and medical ophthalmologists are working in Kent and Medway?

Patients in the NHS Eastern and Coastal Kent area mainly choose acute services provided by East Kent Hospitals University Foundation Trust (EKHUFT). Within the trust there are 9.41 WTE Consultant Ophthalmologists, who provide services across the area from various locations.

There are also two GPs with Special Interests (GPwSI) providing intermediate eye care at a GP practice in Thanet and 0.2WTE Consultant Ophthalmologist providing general ophthalmology services from the community hospital site in Minster, Isle of Sheppey. Six of the EKHUFT consultants support local ophthalmology clinics based in community or GP surgery settings.

2. Can you provide an outline of what acute ophthalmology services are available in Kent and Medway? Where are the main centres for the services located?

The main services provided in the east Kent area are:

- Glaucoma
- Cataract
- AMD
- Vitreo-retinal
- Medical Retinal
- Cornea
- Oculoplastic/Lacrimal
- Neuro-ophthalmology
- Ophthalmology Laser
- Contact Lens/Complex Refraction
- Low Vision
- Ophthalmology Diagnostics

The main sites for specialist services for EKHUFT are Ashford - William Harvey Hospital, Canterbury - Kent and Canterbury Hospital and Margate - the Queen Elizabeth the Queen Mother hospital.

However, general ophthalmology outpatient services are provided at other sites in the area to ensure patients are able to access, at least the initial care, closer to home.

The table in Appendix 1shows all services available and their location, including the GPwSI services and other consultant led services commissioned separately to the main acute contract.

3. Is this number in line with clinical guidance?

There are no clinical guidelines on the ratio of consultant ophthalmologists to numbers of population in an area, as capacity to meet demand is monitored by waiting times and

clinic attendances. Clinical guidance exists around wait time and this is addressed in Question 5

4. How many ophthalmology outpatient appointments have there been for each of the last three years and what proportion have been to locations outside of the area?

There is a general trend of acute activity reducing as more local based clinics are commissioned to provide better access for local patients. These clinics will offer the same quality service but will enable patients to choose care closer to home. These local clinics will also help to ensure that only those patients who really need acute care or choose to go to the main hospital site will need to go there.

Across all three appointment types the *other local* providers only show figures for 2012/13 as a new national contract was rolled out by the Department of Health allowing private providers for services charged at national tariff rates. This has further widened the choice of care provider for patients. Also there is a definite trend for tertiary care to reduce over the three years, most significantly for 2012-13 which could demonstrate that more complex care is now available in local acute hospitals.

OP First Appointment
The percentage split between providers shows a small shift in activity from EKHUFT to MTW although the actual numbers for MTW are fairly static whilst the EKHUFT figures are reducing and this may be due to the increase in more local clinics in the east and therefore the figures are more concentrated for patients still choosing MTW.

OP Follow Up
It is interesting to note that first appointment : follow up appointment ratios are increasing and this may be an indication that there is a trend that those patients with more complex care needs are being seen in an acute setting, as more and more minor conditions are treated closer to home in local clinics.

OP Procedures
The OP Procedure tariff was only introduced during 2010-11 so the figures are misleading to begin with, a more informative analysis would need another two to three years of data to be useful. However, the introduction of this appointment type means patients are no longer required to be admitted for many more treatments than previously, which is much better for patients and hospital resources alike.

Ophthalmology acute outpatient activity over the past three years

Key:
EKHUFT – East Kent Hospitals University Foundation Trust
MTW – Maidstone and Tunbridge Wells NHS Trust
Other local – Spires (Tunbridge Wells or Hythe), Benenden, Chaucer, Somerfield, Will Adams
Tertiary – London, Surrey, Sussex

	2010-11	%	2011-12	%	2012-13	%
OP First App	**33166**		**27395**		**21078**	
EKHUFT	28948	87%	22944	84%	17025	81%
MTW	2941	9%	3205	12%	2940	14%
Other Local	0	0%	0	0%	689	3%
Tertiary	282	1%	291	1%	168	1%
Other	995	3%	955	3%	256	1%
	2010-11	**%**	**2011-12**	**%**	**2012-13**	**%**
OP Follow Up	**61722**		**59349**		**50817**	
EKHUFT	52244	85%	49323	83%	41722	82%
MTW	6205	10%	6245	11%	6338	12%
Other Local	0	0%	0	0%	583	1%
Tertiary	1072	2%	1128	2%	731	1%
Other	2201	4%	2653	4%	1443	3%
	2010-11	**%**	**2011-12**	**%**	**2012-13**	**%**
OP Procedure	**7357**		**14151**		**14232**	
EKHUFT	6934	94%	13367	94%	13533	95%
MTW	130	2%	309	2%	272	2%
Other Local	0	0%	0	0%	32	0.2%
Tertiary	48	1%	131	1%	120	1%
Other	245	3%	344	2%	275	2%
Grand Total	**102245**		**100895**		**86127**	

5. How long have the waiting times been for ophthalmology outpatient appointments over the last three years?

EKHUFT - Waiting times have averaged 13 weeks for new patients over the last three years, but has recently reduced to 10 weeks with a plan to reduce to 8 weeks by April 2013. Most other community clinics are contracted with a key performance indicator (KPI) to ensure waiting times are kept within the 8 weeks which the acute trust works to. However, most are able to offer appointments within 4-6 weeks and some within two weeks

6. What plans exist for developing ophthalmology services in the county?

As described earlier, whilst the data and information above is provided at NHS Eastern and Coastal Kent (PCT) level and includes Swale patients, new commissioning plans will be the responsibility of each individual CCG. The Federation of East Kent (Canterbury and Coastal, Ashford, South Kent Coast and Thanet) are working together on the following ophthalmology projects:

- **Glaucoma pathway changes**

Repeat Inter Ocular Pressure testing by Optometrists to ensure appropriate referral to specialist Community Glaucoma Network or to acute care to enable patients with stable Glaucoma to be monitored appropriately in a community setting of their choice. This service will go live very soon as an AQP (Any Qualified Provider) tender is likely in the next few months.

- **Change of use for certain drugs for WAMD - Aflibercept (Eylea®) versus Ranibizumab (Lucentis®)**

Discussion around the reduced frequency of use and reduced cost of drugs which may significantly reduce overall spend and result in patients only needing injections bi-monthly instead of monthly. This programme is still being investigated and dependant on the outcome of research so it may or may not be implemented

- **Update of Referral and Treatment Criteria (RaTC) for cataract referral**

Guidelines for cataract referrals have been amended to ensure patients who need cataract surgery are able to access it and also to ensure direct referral of patients requiring second eye operations.

- **Potential to move more OP activity to primary care**

South Kent Coast CCG is looking to move all OP clinics to Folkestone Health Centre as there is no district general hospital in the locality.

Swale commissioning intensions

- A review of ophthalmology services is currently underway and there are plans to introduce a Community Ophthalmology Team (COT) to manage routine ophthalmology referrals. The potential is to join/extend the west Kent COT so that Swale patients essentially follow the same pathway – i.e. into COT and then triaged for appropriateness, treatment within COT (Optician with Special Interest (OPwSI) or GPwSI) or onwards referral to Hospital Eye Service (HES) or Dulwich Medical Centre (DMC) based at Minster Hospital, Isle of Sheppey. There is the expectation to have the triage in place by April, which will be provided by a GPwSI and the Community Ophthalmology Service being developed further from then.

b. West Kent

1. How many ophthalmologists and medical ophthalmologists are working in Kent and Medway?

Maidstone Tunbridge Wells NHS Trust (MTW) employs 12 consultant ophthalmologists. In addition Kent Community Health has a salaried GP with Special Interest (GPwSI) who sees West Kent PCT patients. It should be noted that MTW provide acute ophthalmic services to Medway PCT patients, running outpatient clinics at Medway Maritime Hospital, and to East Sussex PCT patients. The main provider of ophthalmology

services to the Dartford Gravesham and Swanley CCG area is currently South London Healthcare(SLH).

2. Can you provide an outline of what acute ophthalmology services are available in Kent and Medway? Where are the main centres for the services located?

Please refer to Appendix 2.

3. Is this number in line with clinical guidance?

There are no clinical guidelines on the ratio of consultant Ophthalmologists to numbers of population in an area, as capacity to meet demand is monitored by waiting times and clinic attendances. Clinical guidance exists around wait time and this is addressed in Question 5

4. How many ophthalmology outpatient appointments have there been for each of the last three years and what proportion have been to locations outside of the area?

West Kent PCT ophthalmology first outpatient appointments

Trust	2009/10		2010/11		2011/12	
	Number	%	Number	%	Number	%
Maidstone & Tunbridge Wells NHS Trust	14657	63.0%	16510	68.1%	17193	66.9%
South London Healthcare NHS Trust	7503	32.2%	6282	25.9%	7161	27.9%
Moorfields Eye Hospital NHS Foundation Trust	422	1.8%	464	1.9%	393	1.5%
Guy's & St Thomas' NHS Foundation Trust	156	0.7%	272	1.1%	292	1.1%
Queen Victoria Hospital NHS Foundation Trust	120	0.5%	185	0.8%	209	0.8%
King's College Hospital NHS Foundation Trust	128	0.6%	162	0.7%	122	0.5%
East Sussex Hospitals NHS Trust	106	0.5%	136	0.6%	104	0.4%
Others	175	0.8%	235	1.0%	211	0.8%
Grand Total	**23267**	**100.0%**	**24246**	**100.0%**	**25685**	**100.0%**

Numbers include outpatient procedures

West Kent PCT Ophthalmology Follow Up Patient Appointments

Trust	2009/10		2010/11		2011/12	
	Number	%	Number	%	Number	%
Maidstone & Tunbridge Wells NHS Trust	33919	67.5%	34092	66.0%	34142	63.9%
Outside Kent	16331	32.5%	17562	34.0%	19289	36.1%
Grand Total	**50250**	**100.0%**	**51654**	**100.0%**	**53431**	**100.0%**

Numbers include outpatient procedures

Community Ophthalmology Team						
COT	**2009/10**		**2010/11**		**2011/12**	
New	1993		3776		4029	
Follow Up	390		745		1091	
Total	**2383**		**4521**		**5120**	
APCOS (Advanced Primary Care Ophthalmology Service)					**478**	
	2009/10		**2010/11**		**2011/12**	
Annual Total	75,900		80,421		84,714	

5. How long have the waiting times been for ophthalmology outpatient appointments over the last three years?

Community Ophthalmology Team (COT) appointments are generally available within 2 weeks. APCOS patients (Advanced Primary Care Ophthalmology Service) are seen within 36 hours.

Please also refer to Appendix 3 for more information.

6. What plans exist for developing ophthalmology services in the county?

Glaucoma pathway changes - a shared care model is being developed with MTW with the use of virtual clinics and image review by consultants. This will enable patients to be monitored closer to home but with their care remaining under the management of a consultant.

Other plans and changes include:

- Implementation of NICE recommendations of Ranibizumab for diabetic macular oedema patients.

- Review of cataract pathway as a result of the change to Referral and Treatment Criteria (RaTC)

- Introduction of Paula Carr surveillance clinics for some diabetic retinopathy patients to avoid referrals to acute service which can be better managed within screening programme. This will involve image capture and subsequent review.

- The dissolution of South London Healthcare will lead to changes of provider in the Dartford Gravesham and Swanley CCG area.

Ophthalmology – Appendix 1

Site	Services			
	IN PATIENT	**DAY CASE PROCEDURE**	**OUT PATIENT PROCEDURES**	**OUT PATIENT CLINICS**
William Harvey Hospital - Ashford	Vitreo Retinal Surgery Complicated Cataract Surgery Ocuplastics Emergency Ophthalmic Elective Procedures e.g. Retinal detachments, penetrating injuries	Cataract Surgery Lasers Acute Vitreo Retinal Vitreo Retinal Ocuplastics	Ophthalmology – Laser	Ophthalmology - Oculoplastic Ophthalmology - Cataract Ophthalmology - General Ophthalmology - Adult Motility Ophthalmology - Paeds Ophthalmology - Glaucoma Ophthalmology - VR Ophthalmology - Emergency clinic Orthoptics Refraction Clinics
Kent and Canterbury Hospital	Nil	AMD/Ozurdex Implant Cataract Surgery	AMD Ophthalmology – Laser	Ophthalmology - MR Orthoptics

Site	Services			
	IN PATIENT	**DAY CASE PROCEDURE**	**OUT PATIENT PROCEDURES**	**OUT PATIENT CLINICS**
		Laser Surgery Ocuplastics Medical Retinal Procedures		Refraction Clinics Low Vision Ophthalmology - General Ophthalmology - Cataract Ophthalmology - Oculoplastic Ophthalmology - Adult Motility Ophthalmology - Paeds Ophthalmology - Glaucoma Ophthalmology - Corneal
Queen Elizabeth Queen Mother Hospital (QEQM) - Margate	Nil	Cataract Surgery Laser Surgery Ocuplastics	Ophthalmology - Minor Ops Ophthalmology - Laser	Ophthalmology - MR Ophthalmology - General Ophthalmology - Oculoplastic Ophthalmology - Glaucoma Ophthalmology - MR Ophthalmology - Adult Motility

Site	Services			
	IN PATIENT	**DAY CASE PROCEDURE**	**OUT PATIENT PROCEDURES**	**OUT PATIENT CLINICS**
				Ophthalmology - Paeds Orthoptics Refraction Clinics
Whitstable and Tankerton Hospital	**Nil**	Nil	Nil	Ophthalmology - General Ophthalmology - Paeds Orthoptics
Deal Hospital	**Nil**	Nil	Nil	Ophthalmology - General Orthoptics
Royal Victoria Hospital - Folkestone	**Nil**	Nil	Nil	Ophthalmology - Cataract Ophthalmology - General Ophthalmology - Glaucoma Orthoptics Refraction Clinics
Buckland Hospital - Dover	Nil	Nil	Nil	Ophthalmology - Cataract Ophthalmology - General Ophthalmology - Glaucoma Orthoptics

Site	Services			
	IN PATIENT	**DAY CASE PROCEDURE**	**OUT PATIENT PROCEDURES**	**OUT PATIENT CLINICS**
Folkestone Community Hospital	NIL	NIL	NIL	Refraction Clinic Ophthalmology out patient, see and treat minor conditions services
Whitstable Medical Practice – **Estuary View (Seasalter)**	Nil	Cataract Surgery	Nil	Nil
St Anne's Surgery, Broomfield Herne Bay	Nil	Cataract Surgery	Ophthalmology Minor surgery	Ophthalmology Out patients
DMC, Minster Community Hospital, Isle of Sheppey			Ophthalmology Minor surgery	Ophthalmology Out patients

Site	Services			
	IN PATIENT	DAY CASE PROCEDURE	OUT PATIENT PROCEDURES	OUT PATIENT CLINICS
Bethesda Medical Practice - Thanet			Ophthalmology Minor Surgery	Ophthalmology Outpatients
New Hayesbank Surgery - Ashford			Ophthalmology Minor Surgery	Ophthalmology Outpatients
Northgate Surgery - Canterbury			Ophthalmology Minor Surgery	Ophthalmology Outpatients

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Appendix 2 - Ophthalmology Provision in West Kent

Location	Provider	Services and Treatments
Edenbridge War Memorial Hospital	MTW	Ophthalmology Service
Gravesend & North Kent Hospital	South London Healthcare (SLH)	Cataract Service
Maidstone Hospital	MTW	Diabetic Retinopathy Service Ophthalmology Adult Squint Service Ophthalmology Cataract Service Ophthalmology Corneal Service Ophthalmology General Service Ophthalmology Glaucoma Service Ophthalmology Lid Service Ophthalmology Retinal Service Ophthalmology Vitreo-Retinal Service Ophthalmology Oculoplastic/lacrimal Neuro-ophthalmology Low Vision Wet AMD Paediatric Ophthalmology Service
Sevenoaks Hospital	MTW and SLH	Cornea Service External Eye Disease Service General Ophthalmology Service Ophthalmology Lid Service

Location	Provider	Services and Treatments
Sittingbourne Memorial Hospital	MTW	Ophthalmology Clinical Assessment Service Ophthalmology Service
Darent Valley Hospital, Dartford	SLH	Cataract Service General Ophthalmology Medical Retina
Tunbridge Wells Hospital, Pembury	MTW	Ophthalmology Cataract Service Ophthalmology General Service Ophthalmology Lid Service
Community Ophthalmology Team Day Lewis Opticians, Southborough Day Lewis Opticians, Riverhead Pendleburys, Maidstone Tunbridge Wells Hospital, Pembury Osborne Harle & Associates, Tonbridge Buchanan Optometrist, Snodland Elaine M Yorwarth Optometrist, Paddock Wood Niall O'Kane Optometrists, Strood Kings Hill Opticians, Kings Hill Sevenoaks Hospital Staplehurst Health Centre Kent Eye Care, Larkfield Jackie Rothery Optometrist, Dartford Robert Murrell Optometrist, Swanley Leslie Warren, Sevenoaks		**Conditions Treated** Conditions Assessed - All Ophthalmology Conditions within the agreed PCT pathways Eye assessment, Glaucoma, Photophobia, GS018 received from OMP, Blurred vision, Loss of vision, Pain in eye, ocular hypertension, Red eye, Blepharitis, Dry eye syndrome, Poor visual acuity, Diabetic retinopathy, Lesion on eye (pigmented lesion, suspicious lesion, BCC, SCC, melanoma - all to go straight to hospital), Watery eyes/epiphoria, Floaters, Retinal scar/pigment/lesion **Procedures Performed** Dr Williams only minor ops: Cysts (meibomian/chalazion/other cysts), skin tags, warts, papillomas. The PCT will not fund surgery for aesthetic purposes. Gordon Ilett only : Double Vision

Location	Provider	Services and Treatments
Post Op Cataract Team Medical Eye Centre, Gravesend Osborne Harle & Associates, Tonbridge Elaine M Yorwarth Optometrist, Paddock Wood Kent Eye Care, Larkfield Arthur Hayes Optometrist, Tunbridge Wells Pendleburys, Maidstone Kings Hill Opticians, Kings Hill Linda Pope Dispensing Opticians, Hawkhurst		Follow-Up after Cataract Surgery
Acute Primary Care Ophthalmology Service Osborne Harle & Associates, Tonbridge Kent Eye Care, Larkfield Niall O'Kane Optometrists, Strood Staplehurst Health Centre		**Conditions/symptoms suitable for referral to APCOS (** - indicates that there are some exclusions – see Conditions/ symptoms unsuitable for referral to APCOS below)** Red eye/painful eye ** Conjunctivitis Acute Lid problems ** Episcleritis/ scleritis Photophobia Iritis Visual disturbance Blepharitis Partial loss of vision ** Foreign bodies Recent onset blurred vision ** Arc eye Flashes and floaters (onset < 2 weeks) Posterior vitreous detachment Dacryocystitis/dacryoadenitis Corneal ulcer

Location	Provider	Services and Treatments
		Trichiasis Optic neuritis **Conditions/symptoms unsuitable for referral to APCOS** Chemical injury Suspected penetrating injury/serious trauma Retinal detachment Age-related macular degeneration – wet or dry - unsure Complete loss of vision - unsure Diplopia, oculomotor nerve palsies Acute glaucoma Orbital cellulites Giant cell arteritis Post-op endophthalmitis Strabismus

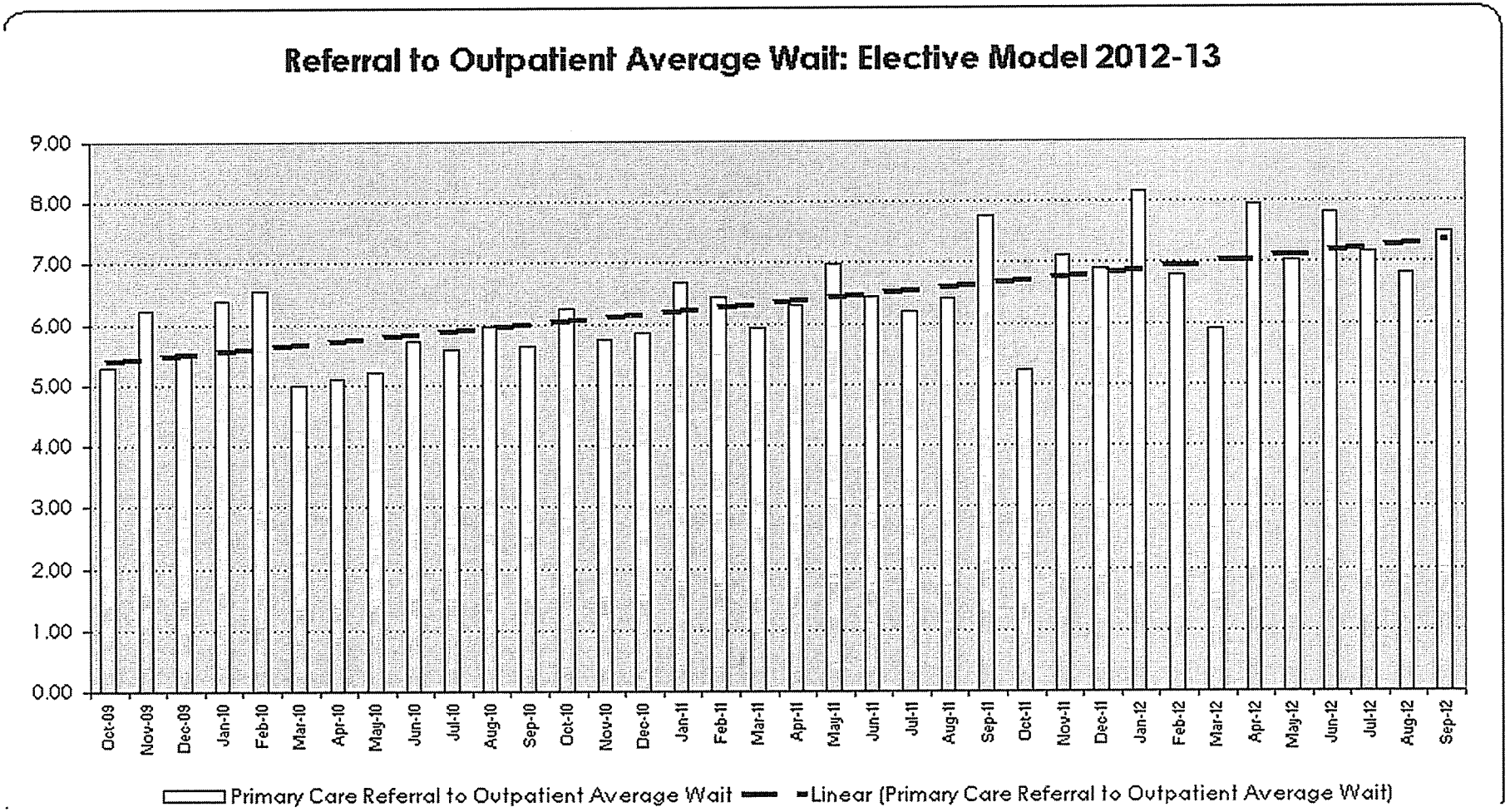
The following tabs show the average waiting times between referrals and new outpatient appointments for the following:

Provider: Maidstone and Tunbridge Wells Trust
PCT: West Kent (includes West Kent CCG and DGS CCG)
Specialty: Ophthalmology
Sources of Referral: Primary Care, Consultant to Consultant and Other

Referral to Outpatient Average Wait: Elective Model 2012-13

Input	Overview	1	2	3	4	5	6	7	8	9	10	11	12	13

Provider	**Maidstone & Tunbridge Wells NHS Trust**	*Source of Referral*	**Primary Care**
PCT / CCG / PARENT CCG	**West Kent PCT**	*Speciality*	**Ophthalmology - 130**



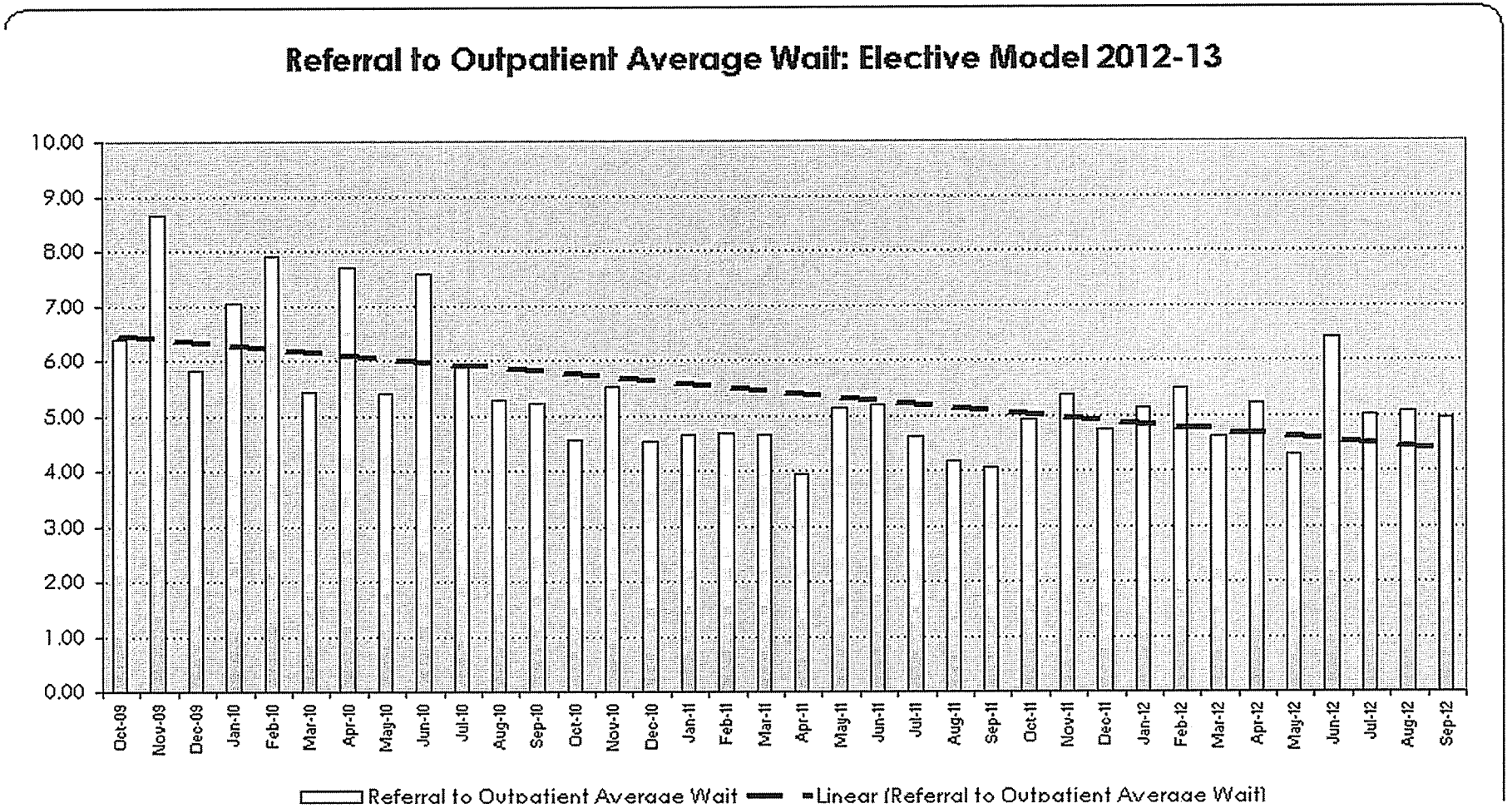
			Primary Care Referral to Outpatient Average Wait
20	0910-01	Apr-09	5:83
19	0910-02	May-09	5:54
22	0910-03	Jun-09	5:47
23	0910-04	Jul-09	5:23
20	0910-05	Aug-09	5:78
22	0910-06	Sep-09	5:88
22	0910-07	Oct-09	5:28
21	0910-08	Nov-09	6:24
21	0910-09	Dec-09	5:52
20	0910-10	Jan-10	6:38
20	0910-11	Feb-10	6:55
23	0910-12	Mar-10	5:00
20	1011-01	Apr-10	5:11
19	1011-02	May-10	5:20
22	1011-03	Jun-10	5:73
22	1011-04	Jul-10	5:59
21	1011-05	Aug-10	5:96
22	1011-06	Sep-10	5:65
21	1011-07	Oct-10	6:27
22	1011-08	Nov-10	5:76
21	1011-09	Dec-10	5:84
20	1011-10	Jan-11	6:69
20	1011-11	Feb-11	6:45

23	1011-12	Mar-11	5.95
18	1112-01	Apr-11	6.32
20	1112-02	May-11	6.98
22	1112-03	Jun-11	6.45
21	1112-04	Jul-11	6.19
22	1112-05	Aug-11	6.41
22	1112-06	Sep-11	7.77
21	1112-07	Oct-11	5.24
22	1112-08	Nov-11	7.13
20	1112-09	Dec-11	6.90
21	1112-10	Jan-12	8.16
21	1112-11	Feb-12	6.78
22	1112-12	Mar-12	5.90
19	1213-01	Apr-12	7.95
22	1213-02	May-12	7.04
19	1213-03	Jun-12	7.82
22	1213-04	Jul-12	7.17
22	1213-05	Aug-12	6.84
20	1213-06	Sep-12	7.51

Referral to Outpatient Average Wait: Elective Model 2012-13

Input	Overview	1	2	3	4	5	6	7	8	9	10	11	12	13

Provider	**Maidstone & Tunbridge Wells NHS Trust**	*Source of Referral*	**Consultant to Consultant**
PCT / CCG / PARENT CCG	**West Kent PCT**	*Specialty*	**Ophthalmology - 130**



			C2C Referral to Outpatient Average Wait
20	0910-01	Apr-09	6.20
19	0910-02	May-09	6.42
22	0910-03	Jun-09	6.91
23	0910-04	Jul-09	6.04
20	0910-05	Aug-09	6.19
22	0910-06	Sep-09	8.04
22	0910-07	Oct-09	6.40
21	0910-08	Nov-09	8.67
21	0910-09	Dec-09	5.81
20	0910-10	Jan-10	7.06
20	0910-11	Feb-10	7.92
23	0910-12	Mar-10	5.45
20	1011-01	Apr-10	7.71
19	1011-02	May-10	5.40
22	1011-03	Jun-10	7.59
22	1011-04	Jul-10	5.89
21	1011-05	Aug-10	5.29
22	1011-06	Sep-10	5.24
21	1011-07	Oct-10	4.57
22	1011-08	Nov-10	5.53
21	1011-09	Dec-10	4.53
20	1011-10	Jan-11	4.66
20	1011-11	Feb-11	4.70

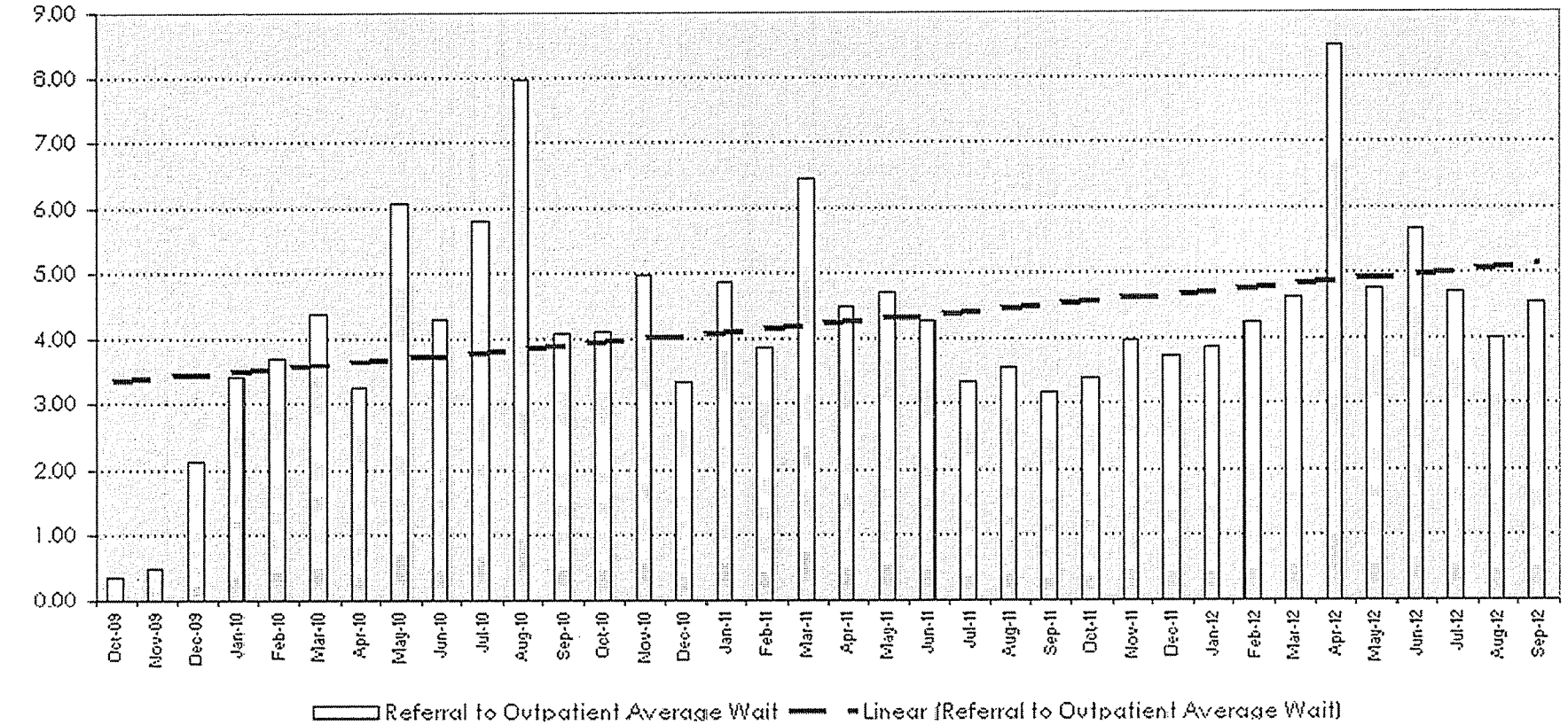
23	1011-12	Mar-11	4.66
18	1112-01	Apr-11	3.93
20	1112-02	May-11	5.14
22	1112-03	Jun-11	5.20
21	1112-04	Jul-11	4.61
22	1112-05	Aug-11	4.19
22	1112-06	Sep-11	4.04
21	1112-07	Oct-11	4.92
22	1112-08	Nov-11	5.37
20	1112-09	Dec-11	4.75
21	1112-10	Jan-12	5.13
21	1112-11	Feb-12	5.48
22	1112-12	Mar-12	4.64
19	1213-01	Apr-12	5.23
22	1213-02	May-12	4.28
19	1213-03	Jun-12	6.42
22	1213-04	Jul-12	5.02
22	1213-05	Aug-12	5.06
20	1213-06	Sep-12	4.96

Referral to Outpatient Average Wait: Elective Model 2012-13

Input | Overview | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13

Provider	Maidstone & Tunbridge Wells NHS Trust	*Source of Referral*	Other
PCT / CCG / PARENT CCG	West Kent PCT	*Specialty*	Ophthalmology - 130

Referral to Outpatient Average Wait: Elective Model 2012-13



			Other Referral to Outpatient Average Wait
20	0910-01	Apr-09	0.53
19	0910-02	May-09	0.54
22	0910-03	Jun-09	0.38
23	0910-04	Jul-09	0.34
20	0910-05	Aug-09	0.39
22	0910-06	Sep-09	0.54
22	0910-07	Oct-09	0.36
21	0910-08	Nov-09	0.48
21	0910-09	Dec-09	2.11
20	0910-10	Jan-10	3.42
20	0910-11	Feb-10	3.70
23	0910-12	Mar-10	4.37
20	1011-01	Apr-10	3.26
19	1011-02	May-10	6.08
22	1011-03	Jun-10	4.31
22	1011-04	Jul-10	5.81
21	1011-05	Aug-10	7.97
22	1011-06	Sep-10	4.08
21	1011-07	Oct-10	4.11
22	1011-08	Nov-10	4.98
21	1011-09	Dec-10	3.34
20	1011-10	Jan-11	4.85
20	1011-11	Feb-11	3.86

23	1011-12	Mar-11	6.46
18	1112-01	Apr-11	4.47
20	1112-02	May-11	4.71
22	1112-03	Jun-11	4.28
21	1112-04	Jul-11	3.32
22	1112-05	Aug-11	3.55
22	1112-06	Sep-11	3.18
21	1112-07	Oct-11	3.38
22	1112-08	Nov-11	3.97
20	1112-09	Dec-11	3.73
21	1112-10	Jan-12	3.87
21	1112-11	Feb-12	4.24
22	1112-12	Mar-12	4.62
19	1213-01	Apr-12	8.50
22	1213-02	May-12	4.75
19	1213-03	Jun-12	5.68
22	1213-04	Jul-12	4.70
22	1213-05	Aug-12	3.99
20	1213-06	Sep-12	4.55