NHS
West Kent
Clinical Commissioning Group

Specialist Community Based Diabetes Service Diabetes care for adults with diabetes mellitus

29 January 2016

Patient focused,
providing quality,
improving outcomes

1. Introduction

This report is to brief Members of the Kent Health Overview and Scrutiny Committee (HOSC) with the proposed new service specification for improvements to diabetes services in West Kent.

This follows an earlier briefing in September 2015.

2. Background

At the 4 September 2015 HOSC meeting, NHS West Kent Clinical Commissioning Group (CCG) briefed Members on proposals to reconfigure /recommission diabetes services.

As part of the CCG's Commissioning Intentions 2015/16 and 2016/17, diabetes services and care have been identified as a key priority for improvement to meet the future challenges that will come with the predicted rise in prevalence.

The current pathway is fragmented, with services delivered by separate organisations (hospital, community, GP practices) with no overarching care planning across the system. There is scope to deliver more holistic care for patients and to develop a more 'joined-up' pathway between hospital, GP practices, community and mental health support.

The successful management of patients with diabetes requires a whole system approach, with support for self-care and care in the community as key elements that can have a major impact on outcomes across all care settings. Through delivering more integrated care, NHS West Kent CCG anticipates that it will improve both the quality of care and also make better use of resources.

The proposal is to decommission the current secondary care level three diabetes services for NHS West Kent CCG and to recommission the same in the community under an integrated level two and three service.

During May and June 15, NHS West Kent CCG led a joint patient and stakeholder engagement programme to seek views on improvements in diabetes care, covering both local health care professionals and patients.

The September 2015 briefing provided a summary on the results and outcomes of the engagement.

Members noted the report and asked NHS West Kent CCG to present the service specification to the Committee at the appropriate time.

3. The service specification

Service Specification No.	
Service	**Specialist Community Based Diabetes Service** **Diabetes care for adults with diabetes mellitus**
Commissioner Lead	**Dr Sanjay Singh, Chief GP Commissioner** **West Kent CCG**
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Background

Diabetes is a common long-term condition caused by too much glucose in the blood. There are two main types of diabetes, Type 1 diabetes and Type 2 diabetes. It is estimated that 10% of people with diabetes have Type 1 diabetes and 90% have Type 2 diabetes.

Type 1 diabetes (T1DM) develops if the body cannot produce any insulin. It usually appears before the age of 40 years, especially in childhood. It is the less common of the two types of diabetes. It cannot be prevented and it is not known why exactly it develops. Type 1 diabetes is treated by daily insulin doses by injections or via an insulin pump.

Type 2 diabetes (T2DM) develops when the body can still make some insulin, but not enough, or when the insulin that is produced does not work properly (known as insulin resistance). Type 2 diabetes is treated with a healthy diet and increased physical activity. In addition, tablets and/or insulin injections can be required.

1.2 National context and evidence base

Diabetes care is one of the major challenges facing the NHS in the coming years and the quality of care provision varies throughout the country. Diabetes is a major cause of premature mortality with at least 22,000 avoidable deaths each year[1] and the number of people in the UK with diabetes is increasing and is projected to rise from 3.1 million to 3.8 million by 2020[2]. Due to the increasing obesity levels in the UK it is expected that the incidence of T2DM (which accounts for approximately 90% of diabetes in the UK[3]) will increase and as a result it is estimated the number of people with diabetes in the UK will rise to 4.6 million by 2030[4]. This makes it the long term condition with the fastest rising prevalence[4]. If diabetes is not managed properly it can lead to serious life-threatening and life-limiting complications, such as blindness and stroke. An individual may also have diabetes and any other number of other long-term conditions, like, for example, chronic obstructive pulmonary disease (COPD). The NHS needs to rise to the challenge of multi-morbidity through proactive and comprehensive disease management, placing the

individual firmly in the centre of their care. This sort of effective management of individuals, as described in this service specification, will impact positively on indicators across the five domains of the NHS Outcomes Framework (see below).

Diabetes care in the UK has improved significantly over the past 15 years[5, 6] and the levels of premature mortality in the UK are lower than in 18 other wealthy countries[5]. In spite of these developments there is still room to improve the service delivery.

Currently, only around one in five people with diabetes are achieving all 3 of the recommended standards for glucose control, blood pressure and cholesterol[2]. Moreover, the complications relating to diabetes are wide reaching, including:

- The most common reason for renal dialysis and the second most common cause of blindness in people of working age[4,7]
- Increases the risk of cardiovascular disease (heart attacks, strokes) by two to four times[8]
- Increases the risk of chronic kidney disease, from an incidence of 5-10% in the general population to between 18% and 30% in people with diabetes[4]
- During 2011-14, 21,125 patients with diabetes underwent an amputation equating to an average of 135 per week. 14,367 people lost a toe or part of their foot in minor amputations and 6,758 had a foot or part of a leg cut off[9]

1.3 Local Context[10]

The resident population of West Kent CCG is 467,500 and 86,000 of those people are aged 65 or over, a higher proportion than across England as a whole. In the CCG, 2.5% of people live in the most deprived fifth of areas in England. In 2013/14 a total of **20,485** patients (17 years and over) were recorded to have diabetes which is significantly lower than neighbouring CCGs. There were an estimated **4,800** people who remain undiagnosed suggesting the total number of adults with diabetes in the CCG was around **25,300**. Between 2013/14 and 2019/20, the crude prevalence rate of diabetes in adults is expected to increase from 5.5% to 6.8% and the undetected prevalence rate is expected to increase from 1.3% to 2.6%.

People with diabetes are at a higher risk of having a heart attack or stroke. In this area, people with diabetes are 88.5% more likely than people without diabetes to have a heart attack. This is lower than the figure for England which is 108.6%. People with diabetes are also 103.2% more likely to have a stroke. This is higher than the figure for England where there is an 81.3% greater risk. West Kent CCG spent £320 on prescribing per person with diabetes which is higher than the England average of £285. The total spend on prescribing for anti-diabetic items between April 2013 and March 2014 was £6,550,000. Prescriptions to treat diabetes accounted for 9.1% of the total CCG prescribing budget.

The National Institute for Health and Care Excellence recommends nine care processes for diabetes. These are five risk factors (body mass index, blood pressure, smoking, glucose levels (HbA1c) and cholesterol) and three tests to identify early complications (urine microalbumin, creatinine, and foot nerve and circulation examination). Eye screening is recommended but not included in the data presented. Controlling the risk factors helps a person with diabetes reduce his or her future risk of developing diabetic complications. There are also recommended targets for HbA1c, cholesterol and blood pressure. West Kent CCG 2012/13[11] (most recent data available) is listed below:

Indicator	Local	Comparator CCGs	England
People with diabetes who have had 8 recommended care processes	48.6%	56.7%	59.5%
People with diabetes whose last HbA1c was equal to or less than 58mmol/mol	64.2%	68.6%	62.4%
People with diabetes meeting blood glucose, blood pressure and cholesterol targets	35%	34.8%	36%

For West Kent CCG there have been 1,216 episodes of care for diabetic foot disease between 2011/12 and 2013/14, accounting for 10,847 nights in hospital. The annual rate of episodes of care for diabetic foot conditions per 1,000 adults with diabetes is significantly higher than the national average. There were 41 major amputations performed during the three years, giving an annual rate of 0.7 major amputations per 1,000 adults with diabetes, which is not significantly different from the national average. 549 different patients were admitted for foot disease. 51.2% of these had more than one episode of care in the three years, which is significantly lower than the national average. Of the 549 patients, 13.5% had more than four periods of care, which is significantly lower than the national average.[12]

Using national data from 2011, Type 2 diabetes can be estimated to cost West Kent CCG £13 million from its treatment and management, as well as a further £51 million from diabetic complications. For 2019/20, a cost of nearly £21 million to the local health economy is projected using the crude prevalence of diabetes for treatment and management.

It has been shown in studies that good diabetic management in the first 10 years of diagnosis has the maximum impact on morbidity and mortality hence timely diagnosis and appropriate initial management of the disease is crucial to a Patient's clinical outcomes.

The current status of service provision and strategy around diabetes prevention and management within West Kent has much scope for improvement and is also ill-placed to meet the future challenges that will come with the predicted rising prevalence:

- There is a lack of a comprehensive obesity strategy to slow the rise in the expected number of diabetics in West Kent
- The current programmes (e.g. NHS health checks) for early detection of diabetes has had variable impact with much room for improvement especially in the deprived and 'hard to reach' populations.
- There is a lack of comprehensive local strategy or pathway to deal with patients with 'Impaired Glucose Regulation' in terms of identification, registers and clinical management
- Primary care capability is variable leading to variable standards of care delivered to patients
- Primary care capacity has not risen with the rise in prevalence due to resource constraints which has affected patient care and outcomes
- There has not been any 'workforce planning' for diabetes in West Kent leading to patchy and variable provision of services based on historical commissioning (e.g. dietetics and podiatry)
- Services like specialist nursing, diabetic podiatry and dietetics are predominantly secondary care based, which is both expensive and fails to reach patients who need their services in the community
- Diabetic related preventable non-elective admissions are on the rise and consuming a significant level of resources
- Most secondary care based diabetic services are based on activity rather than outcomes

- The financial risks to West Kent CCG related to the above points are worsening each year in rising planned, unplanned and prescription costs
- It is estimated that nationally only 15% of diabetic patients meet the 3 'Best Practice Targets' (Hba1c: 6.5% or 48mmol/mol, Cholesterol: <4mmol and BP: <135/80)

West Kent CCG aim to address the current issues facing primary, secondary and community care by developing a Prevention and Obesity Strategy to slow down the expected rise in prevalence. A primary care diabetes prevention programme is in place to support earlier diagnosis of diabetes and improvement in control of the main risks associated with diabetes, namely blood pressure, cholesterol and glycaemic control.

References

1. National Diabetes Audit Mortality Analysis 2007-2008 – NHS Information Centre, 2011
2. The management of adult diabetes services in the NHS - National Audit Office; 2012 in POSTNote Number 415 Preventing Diabetes, July 2012
3. Diabetes in the UK 2009: Key statistics on diabetes, Diabetes UK, 2009
4. Commissioning Excellent Diabetes Care: an at a glance guide to the NHS Diabetes Commissioning Resource – NHS Diabetes and Diabetes UK, February 2012, Second edition
5. Murray, Christopher JL, et al. (2013) UK health performance: findings of the Global Burden of Disease Study 2010. *The Lancet*
6. Lind, M., et al. (2013) Mortality trends in patients with and without diabetes in Ontario, Canada and the UK from 1996 to 2009: a population-based study. *Diabetologia*: 1-8
7. State of the Nation, England - Diabetes UK, 2012
8. Stamler J, Vaccaro O, Neaton J, Wentworth D. (1993) Diabetes, other risk factors, and 12-yr cardiovascular mortality for men screened in the multiple risk factor intervention trial Diabetes Care
9. The Guardian: Diabetes UK, record number of people undergoing amputations because of diabetes, 15 July 2015
10. Kent & Medway Public Health Observatory: NHS West Kent CCG Diabetes, June 2015
11. Public Health England: Cardiovascular Disease Profile: Diabetes, March 2015
12. Public Health England: Diabetes foot-care activity profile, June 2015

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

Domain 1	**Preventing people from dying prematurely**	**Yes**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**Yes**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**Yes**
Domain 4	**Ensuring people have a positive experience of care**	**Yes**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**Yes**

2.2 Local defined outcomes

The Provider will operate a prioritisation system to triage referrals. In cases where the standard waiting times would be too detrimental to the Service User's condition or safety their assessment should be

undertaken as soon as possible. The Provider may therefore need to fast track the Service User into specialist services. This will:

- Ensure all services achieve the high quality care as described in Diabetes National Service Framework, NICE guidance and NICE quality standards
- Increase the uptake of structured patient education programmes to facilitate the independent management of their condition
- Improve self-esteem and ability to self-manage their condition
- Improve equality of access to specialist diabetes services including podiatry, dietetics and psychological support
- Reduce anxiety and depression of patients with diabetes
- Improve access and uptake of primary care and non-specialist hospital staff education in diabetes
- Improve primary care diabetes reviews and annual reviews
- Reduce diabetes related referral rates to secondary care for routine care
- Reduce number of new and follow up diabetes appointments
- Reduce average prescribing and monitoring costs related to diabetes when compared to comparable CCGs and national averages
- Reduce minor and major amputations
- Reduce average HbA1c levels from current baseline
- Reduce cardiovascular morbidity and mortality over a 5 year period
- Reduce length of stay for admissions of patients with diabetes
- Reduce hospital bed days incurred by patients with diabetes
- Reduce the frequency of emergency admission for service user's with diabetes, including episodes of diabetic ketoacidosis, hypoglycaemia and hyperosmolar hyperglycaemic state (HHS) by 20% in 3 years
- Lead to individualised care plans for 90% of patients in Level 2-4 services
- Increase the proportion of service users with diabetes reporting positive experiences of diabetic care to 90% in 5 years
- Reduce the average years of life lost due to Type 2 diabetes from 6 to 4 in 10 years
- Reduce the average years of life lost due to Type 1 diabetes from 15 to 12 in 10 years
- Reduce diabetes related partial or total blindness by TBC%

3. Scope

3.1 Model of Care

The community based diabetes service (the 'Service') will provide clinical management of diabetes in adults in line with the agreed model of delivery shown below.

Diabetes Pathway (Final).docx

The service will be provided by a comprehensive diabetes skilled multidisciplinary team which will require all professionals involved in the patient's care to work in partnership, including GPs, consultants, specialists, other health care professionals and support staff, with the patient and his/her family/carer.

3.2 Aims and objectives of service

NICE have produced a Quality Standard for Diabetes Care QS6 (Appendix A), to help describe what constitutes high quality care for people with diabetes. This service specification integrates this standard into pathways of care for people with diabetes with the aim of improving outcomes. This specification details the whole pathway including episodes of specialist care.

The key aims and objectives of the service are to:

Provide an integrated, evidence based service with a single point of access/referral. The community based service will act as a single point for all referrals (Levels 2 to 4) received and will be triaged by an appropriate clinician. The triage system will offer support, advice and guidance via telephone and electronic contact (without the need to see the patient) on how to best manage a patient where primary care management is deemed appropriate or triage onto the appropriate specialist community based service i.e. the 'Hub' or 'Spoke' (Level 2/3) or hospital care (Level 4). The professional advice line will be available as a minimum during the hours of Monday-Friday, 09.00-17.00; this will be subject to ongoing review with the Commissioner. Professional queries through the advice line will be responded to by the next working day via telephone or secure email.

The majority of diabetes care will occur in a primary care setting. If an optimum level of diabetes care is to be achieved for patients in West Kent CCG, good standards of fundamental diabetes care needs to be delivered by all GP Practices. In order to optimize primary diabetes care, the community based diabetes service needs to be fully integrated with all GP practices and develop collaborative relationships that share expertise via the 'spokes'.

SPOKE - The mainstay of specialist diabetes care in West Kent CCG will be undertaken within the spokes, which will be situated in GP practices across the patch. There will be 10-12 spokes aligned to an average population size of 40,000-50,000 registered patients though it will vary separately depending on geography and any other local factors. The spokes will operate on a 'roving model' with teams visiting host practices with the spoke catchment on an agreed rotational basis. These will consist of fortnightly or monthly clinical sessions and care will be delivered by a team of accredited Level 2/3 practice clinicians, GPwSIs, dietitians and DSNs (Diabetic Specialist Nurses) supported by Consultant Diabetologists. Consultants are expected to spend at least 1 clinical session at each spoke per month to provide support and supervision, see patients, interact with GP colleagues and undertake complex case reviews. The spoke will be responsible for the first stage of stepped up care from routine GMS diabetes care. Increasingly this will be the vehicle through which most patients with complex or severe diabetic presentations are managed. Once the issues presenting are resolved, the patient will be discharged to the referring GP for ongoing monitoring (in line with a jointly agreed care plan). The spokes will:

- Develop and implement a defined integrated pathway with clinical triage, onward referral and management protocols embedded into the diabetes pathway consistent with current NICE guidance
- Provide a multi-disciplinary team (MDT) from the point of diagnosis, whether practice or community based
- Deliver individualised care planning agreed in partnership with patient, carers and health care professional and once achieved (considered stable), the patient will be discharged back to the referring GP
- Undertake Insulin and GLP1 initiation and stabilisation of Type 2 diabetes patients

- Management of unstable Type 2 with poor glycaemic control despite best efforts in primary care. Depending on complexity of the case these may be patients delegated from hubs after initial multidisciplinary assessment or direct referrals from Primary care
- Undertake integrated diabetic assessments for new patients
- Management of stable DAFNE trained Type 1 patients via virtual and face to face consultations till discharge to Primary care with patient consent
- Offer joint case notes reviews and MDT discussion sessions for all patients to offer advice/support and to educate primary care clinicians in the management of complex diabetic patients. In undertaking this joint case note review of complex patients on the diabetic list, GP practices and the Service can agree which patients may be suitable for review in joint consultation clinics, community clinics (if not referred already), or home visits. These case note reviews should take place on a quarterly basis as part of routine clinical sessions
- Provide practice based education in addition to signposting to or provision of formal structured education programmes
- Offer specialist pre-conception advice where control is good and for patients who have suffered from gestational diabetes in previous pregnancy, including direct referral to specialist (Level 4) antenatal services
- Targeted care coordinator role/function for non-engagers, hard to reach groups and for high risk patients
- Multidisciplinary clinics providing access to consultants, specialist practice nursing and dietetics
- Management of housebound patients on request by primary care and if fulfilling the criteria described below, in liaison with primary care and complex care nurses. It should include at least one annual review of diabetics on medications or poorly controlled against their individualized targets
- Management of patients discharged from the hub
- Monitor patients and discharge back to primary care were applicable
- Monitor/audit local practice performance
- Contribute to a reduction in the severity and frequency of acute episodes including episodes of diabetic ketoacidosis, hypoglycaemia and hyperosmolar hyperglycaemic state (HHS)
- Use a patient record system to ensure there is IT connectivity and interoperability for all providers across the integrated diabetes pathway. This shall include facilitating the use of national diabetes dataset standards for the exchange of electronic patient information between primary care, community and secondary care providers
- Provide direct and easy access to the MDT
- Sign-post patients to Health Trainers and lifestyle services

HUBS – as referred to above, the mainstay of specialist diabetes care will be delivered via spokes, however on occasions, the complexity or severity of the patient's diabetes will exceed the thresholds of care in the spokes. In these instances, a referral will be made to the hub. There will be 2 hubs aligned to an average GP population size of 240,000 registered patients. These will consist of (TBC) regular clinical sessions and care will be delivered by a Consultant Diabetologist or Endocrinologist as well as a community DSN and other healthcare professionals working within the multi-disciplinary team. The staffing level for each hub will comprise as a minimum Consultant Diabetologists, DSNs, dietitians, podiatrists and a psychologist. The hubs will:

- Undertake integrated diabetic assessments of complex patient cases (including new referrals) with development of a structured individualised care plan (TBA) with multidisciplinary assessment and

input. As a minimum this will include clinical, dietetics, psychologist and podiatry input where applicable

- Multidisciplinary clinics providing access to consultants, specialist nursing, dietetics and podiatry and specialist psychology
- Offer podiatry care, advice and support for increased risk patients with a history of active foot problems. Care for active complex podiatry (requiring liaison with specialist vascular consultants) will include direct referral to specialist (Level 4) podiatry services
- Insulin infusion pump management after initiation in secondary care
- Provide clinical psychology input within the MDT environment for appropriate patients
- Provide a Young Adults Clinic (16 – 25 years old) service to support and facilitate transition of patients into adult service
- Provide structured education for patients with Type 2 diabetes in line with NICE TA60
- Provide structured education for patients with Type 1 diabetes in line with NICE TA60
- Provision of structured diabetes education for primary care and healthcare professionals to update knowledge and awareness of diabetes management and to support shared learning
- Provide specialist Type 1 diabetes care within a multidisciplinary framework supported by a Consultant Diabetologist in line with NICE CG15
- Management of unstable Type 1 and Type 2 patients with poor glycaemic control despite best efforts in primary care
- Deliver individualised care planning agreed in partnership with patient, carers and health care professional and once achieved (considered stable), the patient will be discharged back to the spoke or primary care
- Provide specialist 'dietetics only' input to primary care as per an agreed referral criteria
- Offer an appointment to all diabetes ketoacidosis (DKA) non elective admissions to prevent further re-admissions

Domiciliary Care

The service will provide support and advice to primary care (GPs and Complex care nurses) by monitoring the diabetes management, treatment decisions, annual check-ups and education for those with complex needs in residential care settings or identified as housebound as per an agreed criteria and on request by the GP Practice. In such circumstances, the community service will make arrangements to undertake the equivalent consultation within the patient's home or residential setting. A referral request from GP would be required in each case.

Patients who can receive this service will meet one or more of the following criteria:

- The person is 'housebound' i.e. a person who, as a result of chronic physical or psychological disability, is unable to leave their home via regular or adapted transport and accesses GP services normally by home-visiting
- The patient is receiving end of life care
- The patient has very complex needs where an assessment visit to their home will help inform the management plan
- The patient lives in a registered nursing home and meets one or more of the above criteria

Patient Education

The community diabetes service will deliver structure patient education for patients with Type 1 and Type 2 diabetes in line with NICE TA60. The programmes will be delivered in a way that maximizes accessibility for eligible patients in terms of location, time, language, venue and style of delivery.

- Type 1 – please refer to Appendix A for full service specification
- Type 2 – please refer to Appendix B for full service specification

Healthcare Professional Training

Practice delivered structured patient education – practice nurses will deliver structured patient education when a patient is unable to attend the courses detailed above. The community service will provide appropriate training to practice staff and training must be fully completed before beginning to deliver formal structured education. A literature pack (approved by the Commissioner) will be provided by the community service for practices to talk through with patients.

Professional Education – the community service will support the up-skilling of GPs, Practice Nurses and allied health professionals in primary care. Strong emphasis on building competence and confidence to enact initial management and continued care for patients with diabetes including annual completion of the nine key processes of care as follows: HbA1c, Blood Pressure, Cholesterol, Creatinine, Micro-albuminuria, BMI, Eyes, Feet, Smoking.

Medicines Management

Drugs Budget

The Provider will receive from the Commissioner an agreed drugs budget to cover medications supplied on FP10 prescriptions by the community based diabetes service, based on available data and reviewed annually. The supply and acquisition of medicines must be made in accordance with the Medicines Act.

Medicines Management Audit

The Provider will work with the Commissioner to analyse on a quarterly basis prescribing from FP10 prescriptions and FP10 P-REC to ensure that it is prescribing and supplying medicines in line with NICE and local guidance, in a cost-effective manner.

The Provider will be required to undertake audits of prescribed medicines as requested by the Commissioner.

The Provider will be required to work with the Commissioner to identify and understand variances of unusual drugs prescribed outside the West Kent interface formulary or stock list, and if there is a cost variance of more than TBC% on the predicted FP10 prescribing budget, the Service will be expected to fund the difference. This will be on an on-going, minimum quarterly or more frequent exceptional basis. The provider will ensure supporting data is available e.g. non-identifiable patient consultations for review in order to validate audits and data provided.

The Provider should ensure that it has access (procured or directly employed) to appropriate professional support to ensure that it has the correct policies and procedures in place in order to meet the requirements

of the Medicines Act.

3.2 Service description/care pathway

The Service shall:

- Ensure that it is fully integrated across primary, secondary and community care
- Ensure the patient is provided with full access to all elements of the pathway when clinically appropriate.
- Ensure clinical staff are competent, qualified and/or trained in diabetes care
- Information is provided at the time of referral to enable the patient to make informed decisions regarding care and requirements
- Support, information and scheduled reassessments are provided at the time of first assessment.
- On-going support is provided where required
- Provide a responsive service that addresses patient's needs, provides service support and demonstrates that feedback is acted on and informs improved service delivery
- Provide a responsive service that regularly partakes in audit within and across all care settings, reviews data and uses it to inform and stimulate improvements in service delivery
- Provide education (in addition to the formal structured education courses) for patients in all settings, but particularly primary care, to promote self-management
- Ensure IT facilities allow the following:
  - Clinical notes read-only provision;
  - Clinician to clinician capability such as use of Kinesis;
  - Electronic transmission of patient communication;
  - Electronic contact between clinician and patient
- Ensure IT integration with primary care systems for seamless flow of information.
- Ensure patient services are delivered by a number of methods including electronic contact, telephone, video consultation and face to face consultations
- Offer a proportion of appointments times outside normal working hours to make it easier for working or commuting patients to access their services

Assessment and care planning/appointment

SPOKE – the service shall:

- Ensure all patients are offered an initial assessment and individualised care planning appointment with a member of their MDT within 4-6 weeks (2-3 weeks for antenatal) of referral
- Ensure that the representative MDT member undertaking initial assessment and care planning is appropriately trained and experienced.

The assessment must include:

- Referral for Retinal Screening
- Referral to appropriate psychological services where applicable
- The offer of an education programme
- Physical activity and dietary advice
- Foot inspection and ulceration risk assessment
- Insulin-treated patients – discussion about the self-management of their insulin

Recording of the nine care processes:

- HbA_{1C} levels
- Blood Pressure
- Cholesterol levels
- Serum Creatinine levels
- Urinary albumin to creatinine ratio
- Foot surveillance
- Body Mass Index
- Smoking Status
- Eye screening status

The service shall conduct a care planning cycle at least every 12 months if the patient remains within the service and are not discharged to primary care.

The service shall adhere to the NICE guidelines relating to these processes.

HUB – the service shall:

- Ensure that personalised care planning remains the mechanism of care delivery for and interaction with each patient with diabetes
- Ensure that structured education programs are consistent with NICE TA60 – diabetes (Types 1 and 2) patient education models
- Ensure that pre-pregnancy advice is consistent with NICE CG63
- Ensure that Service Users with Type 2 diabetes and poor glycaemic control will receive management consistent with NICE guidelines
- The service (only when supported by a Consultant Diabetologist) will ensure that patients with Type 1 diabetes will receive management consistent with NICE CG15
- Ensure clinical psychology support within the MDT environment for appropriate patients
- For all specialist services the service will arrange follow-up appointments at clinically appropriate intervals

Continuing care and assessment – the service shall ensure that:

- All patients have a designated health care coordinator who is accountable for the management of the patient's care
- All patients have direct access to a member of their MDT through the provision of emergency contact details during work hours, open access services in line with NICE CG15 and 87
- All patients can easily access a member of their MDT (via phone or email) who can review and alter their treatment in a timely manner
- All patients have regular reviews of their HbA_{1c} levels, at a minimum 6 monthly in line with NICE CG87
- All patients at risk of developing an ulcer undergo podiatry screening regularly in line with NICE CG10
- All patients who need to initiate insulin therapy are provided with an education package around insulin self-administration
- All patients who need to initiate other injectable therapies are provided with an education package

around drug self-administration

The hub shall refer patients to the hospital care service in the following circumstances:

- If there is doubt as to the type of diabetes – if there is difficulty differentiating Type 1 from Type 2 diabetes, or if a rarer form of diabetes, such as MODY or mitochondrial diabetes, is suspected
- Referral to the specialist antenatal diabetes team – following a confirmation of pregnancy
- Referral to a specialist foot care team – if ulcer present or suspicion of acute Charcot neuroarthropathy, then will need to be seen within 24 hours, Monday to Friday, by the foot MDT
- Referral to the specialist diabetes team – following assessment by the MDT and suspicion of diabetic kidney disease
- Referral to a specialist vascular/diabetic services where appropriate i.e. high risk foot clinic

3.3 Population covered

This specification covers the care of young adult and adult Service Users with diabetes (16 years and over) whose care is provided by a West Kent CCG GP member. This specification details the care of patients with diabetes for their adult lifetime or from registration with an in-area GP.

The service will triage all referrals and where the requirements of a patient are beyond the scope of the community team, the service will ensure the patient has a fast track referral into hospital care.

3.4 Any acceptance and exclusion criteria and thresholds

NOTE: Access to the NHS service will be governed by geographic location and eligibility for NHS treatment. The Commissioner shall define the geographic area to be covered in accordance with "Establishing the Responsible Commissioner" and the NHS Plan.

Acceptance criteria

- The Provider will accept referrals of patients (16 years and older) with diabetes, whether their condition is newly diagnosed or well established
- The Provider will accept referrals for patients whose care is provided by a GP member of West Kent CCG
- The Provider will ensure that it provides locally available information about the services it provides.

Exclusion criteria

The service will exclude but need to establish links with:

- Primary care diabetic care as per GMS regulations (Appendix C)
- Diabetic retinal screening
- Ophthalmology service
- Renal service
- Orthotics service
- Orthopaedics service
- Paediatrics and Adolescent (ages 14-17 years old)

Referral route

Access to the service will be by an agreed referral form as detailed in Appendix C via a single point of referral. The service will ensure the referral template is compatible with clinical systems operated by GP referrers.

Referral source

- West Kent General Practitioners
- West Kent Practice Nurses
- KCHT Community Nursing Teams
- Nursing and residential homes

Clinical triage and referrals

All routine referrals will be clinically triaged by an appropriate clinician within 2 working days and urgent referrals within 1 working day. Appointments will be confirmed in writing within a further 2 working days during the normal working week.

Incomplete referrals will be rejected and returned to the referrer with a written explanation within 3 working days.

Inappropriate referrals – the clinical triage system will offer support and advice/guidance via telephone and secure email (without the need to see the patient) on how to best manage a patient where primary care management is deemed appropriate. A letter will be sent to the referring GP with advice on the most suitable interventions within primary care within 3 working days.

Appropriate referrals – the clinical triage system will forward on to the most appropriate service i.e. the 'hub' or 'spoke' (Level 2/3) or hospital care (Level 4) within 3 workings days.

The professional advice line will be available as a minimum during the hours of Monday-Friday, 09.00-17.00. Professional queries through the advice line will be responded to by the next working day via telephone or secure email.

Waiting times

The service will comply to the following wait times:

- An urgent face to face appointment must be offered within 10-14 working days of the referral being received by telephone and letter to confirm details
- A routine face to face appointment must be offered within 6-8 weeks of the referral being received by telephone and letter to confirm details
- Patient choice will be respected where longer waits are requested and the date of referral must be recorded in the patient's notes
- The Service will have the flexibility to offer an appointment in an alternative spoke should the waiting list be shorter and in agreement with the patient.

Discharge

Patients will be discharged back to the care of the GP/Referrer when jointly agreed patient goals are met, the patient is considered stable or further management of the patient could be done in primary care with active advice to practice nurse or GP. An electronic discharge summary which details the 'Individualised care plan' should be sent to the GP within 72 hours of discharge. Hubs should actively transfer care to spokes after initial intervention where appropriate.

DNA Protocol

If the patient does not attend an appointment (with no notification), the patient will be rebooked and the

GP/Referrer advised for up to a maximum of 2 consecutive DNAs. Following 2 consecutive DNAs, the patient will be discharged back to the GP/Referrer confirming that re-referral will be required. A standard letter will be sent to the GP, and copied to the patient, requesting confirmation of acceptance of the management of the patient until the re-referral is received by the service.

3.5 Interdependence with other services/providers

The service will work together with all other providers of diabetes services for the covered population. In order to deliver integrated and seamless care, the service will work with:

- GP's and Primary Care Practitioners
- Generic nursing and therapy teams
- Specialist community teams and case managers
- Podiatry Services
- Local Acute Hospitals
- Diabetes Patient Forums
- Diabetes UK
- Diabetic Retinal Screening Services
- Palliative Care Services
- Orthotic Services
- Patient Transport Services

National and Local Clinical Audit

Participation in national audits is necessary to provide a means by which diabetes services in West Kent can be benchmarked against appropriate peers. The provider is required to participate in the following national audits:

- National Diabetes Audit
- National Diabetes Audit of Acute Trusts
- Patient Experience Surveys
- Patient Reported Outcomes Measures
- Annual local clinical audit of the service is required. Of particular importance will be the monitoring of prescribing against local pharmacotherapy guidance.

Staffing requirements

The minimum staffing requirements of some elements of the pathway are set out in Appendix D - TBC. The staffing establishment will ensure service coverage by all specialties 52 weeks a year.

The Provider shall ensure that policies and procedures are in place that ensures:

- All staff employed or engaged by the service are informed and aware of the standards of performance they are required to promote.
- Staff performance is routinely monitored and that any remedial action is taken where levels of performance are not in line with the agreed standards of performance.
- There are clear lines of responsibility and accountability for all members of staff.
- Conflicts of interest are resolved without impact on the service provision.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

This pathway specification is based on the NICE Quality Standard for Diabetes (QS6) and takes into consideration the guidance detailed below.

NICE Clinical Guidance:

- CG10 Type 2 diabetes – footcare (2004)
- CG15 Type 1 diabetes in children, young people and adults: NICE guideline (2005)
- CG62 Antenatal Care (2008)
- CG63 Diabetes in pregnancy (2008)
- CG87 Type 2 diabetes: full guidance (partial update of CG66) (2009)
- CG91 Depression with a chronic physical health problem: quick reference guide (2009)
- CG119 Diabetic foot problems - inpatient management: quick reference guide (2012)
- CG82 Schizophrenia – Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care (2009)

NICE Clinical Guidelines / Technology Appraisals in development:

Title	Wave	Anticipated publication date	Process
Diabetes in children and young people	R	Aug-15	CG
Diabetes in pregnancy	R	Feb-15	CG
Diabetic foot problems	0	TBC	SCG
Type 1 Diabetes (update)	R	Aug-15	CG
Type 2 diabetes	0	Aug-15	CG

Diabetic foot ulcers - new treatments [ID381]	TBC	MTA
Diabetic retinopathy - ruboxistaurin [ID382]	TBC	STA

NICE Technology Appraisals

- TA53 Diabetes (types 1 and 2) – long acting insulin analogues (2002)
- TA60 Guidance on the use of patient education models for diabetes (2003)
- TA151 Diabetes – Insulin pump therapy (2008)
- TA203 – Liraglutide (2010)
- TA248 – Exenatide (prolonged release) (2012)
- TA274 Macular oedema (diabetic) – ranibizumab: guidance (2013)
- TA288 – Dapagliflozin combination therapy (2012)
- TA315 – Canagliflozin combination therapy (2014)

Other:

- National Service Framework for Diabetes: Standards (2001)
- National Service Framework for Diabetes: Delivering Strategy (2002)
- Minding the Gap: The provision of psychological support and care for people with diabetes in the UK

– a report from Diabetes UK

- Emotional and Psychological Support and Care in Diabetes – a report by Diabetes UK
- Think Glucose – NHS Institute for Innovation and Improvement:

http://www.institute.nhs.uk/quality_and_value/think_glucose/welcome_to_the_website_for_thinkglucose.html

- Association of British Clinical Diabetologists:

  http://www.diabetologists-abcd.org.uk/Position_Papers/ABCD_DUK_Type_1_position_statement.pdf

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

Royal college of Ophthalmologists

- Diabetic Retinopathy guidelines (Dec 2012)
- Diabetic Retinopathy Screening (DRSS) and the Ophthalmology Clinic set up in England (Sept 2010)

Royal College of Obstetricians and Gynaecologists

- Diagnosis and Treatment of Gestational Diabetes (Scientific Impact Paper 23)
- HbA1c monitoring in gestational diabetes - query bank

Royal college of Physicians

- Commissioning diabetes and endocrinology services [online]. Available at: http://www.rcplondon.ac.uk/projects/clinical-commissioning-hub/commissioning-diabetes-endocrinology-services

Royal College of Nursing

- Starting injectable treatment in adults with type 2 diabetes – RCN guidance for nurses (2012)
- The role of the link nurse in infection prevention and control (IPC): developing a link nurse framework (2012)

4.3 Applicable local standards

The service will:

- Improve the quality and effectiveness of diabetes care by integrating acute and community teams
- Improve the productivity of the workforce in equipping them with additional skills
- Enhance patient independence and supporting ability to cope with a long term condition
- Ensure that the Service operates within budgetary constraints and with appropriate regard to the management of resources with due consideration to local eligibility criteria and priorities
- 95% of routine referrals will be clinically triaged within 2 working day, urgent referrals within one working day
- 95% of urgent referrals will result in an urgent appointment offered within a maximum of 10 - 14 working days of the referral being received, offered by telephone and a letter to confirm details
- 95% of routine referrals will result in an appointment offered within 6-8 weeks of the referral being received, offered by telephone and a letter to confirm details

5. Applicable quality requirements and CQUIN goals

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

The submission of the monitoring report is a condition of service provision and the Commissioner will have the right to withhold payments due for provision of services if monitoring reports are not received. The provider will submit a quarterly report to the Commissioner containing the minimum data set as detailed in the contract, within this report providers will be expected to provide the following additional data:

Minimum Data Set (MDS)

Description	Reporting Method
Total number of patients seen at each Spoke and each Hub to include PID • Clinic Code / Venue • Number of patients seen by nurse • Number of patients seen by consultant • Number of patients seen by Dietetics • Number of patients seen by Podiatry • Source of referral (number incomplete, appropriate and number inappropriate) • Number of referrals (split routine/urgent) • Number of patients discharged (including reason) • Number of DNAs • Average waiting time for first appointment (split routine/urgent) • Number and % of patients and carers with discharge summary and ongoing joint Care Plan at point of discharge • Number of patient complaints and outcomes reported • 95% of all routine referrals will be clinically triaged within 2 working days and all urgent referrals within 1 working day • Incomplete referrals – 95% returned with written explanation within 3 working days • Inappropriate referrals – 95% returned with written explanation within 3 working days • Appropriate referrals - 95% forwarded to appropriate care setting with 3 working days	SUS + Unique local report as required

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

Hubs – the premises will be located in 2 community locations across West Kent CCG. The service will ensure that the venues are accessible, local and suitable to undertaken this clinical function and must meet current DDA compliance.

The service will operate Monday to Friday 09.00 to 17.00 hours excluding weekends and Bank Holidays (hours subject to ongoing review with the Commissioner)

HUB 1	**HUB 2**
Venue - TBC	Venue - TBC
Clinic Times: TBC	**Clinic Times:** TBC

Spokes - the mainstay of specialist diabetes care in West Kent CCG will be undertaken within the spokes, which will be situation in GP practices across the patch. There will be 10-12 spokes aligned to an average population size of 40,000-50,000 registered patients though it will vary separately depending on geography and any other local factors. The spokes will operate on a 'roving model' with teams visiting host practices within the spoke catchment on an agreed rotational basis. The service will ensure that the venues are accessible, local and suitable to undertaken this clinical function and must meet current DDA compliance.

The service will operate Monday to Friday 09.00 to 17.00 hours excluding weekends and Bank Holidays (hours subject to ongoing review with the Commissioner).

SPOKE 1	**SPOKE 2**	**SPOKE 3**
TBC	TBC	TBC
Clinic Times: TBC	**Clinic Times:** TBC	**Clinic Times:** TBC
SPOKE 4	**SPOKE 5**	**SPOKE 6**
TBC	TBC	TBC
Clinic Times: TBC	**Clinic Times:** TBC	**Clinic Times:** TBC
SPOKE 7	**SPOKE 8**	**SPOKE 9**
TBC	TBC	TBC
Clinic Times: TBC	**Clinic Times:** TBC	**Clinic Times:** TBC
SPOKE 10	**SPOKE 11**	**SPOKE 12**
TBC	TBC	TBC
Clinic Times: TBC	**Clinic Times:** TBC	**Clinic Times:** TBC

7. Individual Service User Placement

N/A

8. Key Performance Indicators

Indicator	Threshold	Reporting Mechanism	Consequence of breach
Access: Waiting Times % of patients who have a record of being offered a routine appointment within 6-8 weeks of referral	95%	Quarterly report	Remedial action plan
Access: Waiting Times % of patients who have a record of being offered an urgent appointment within 10-14 working days of referral	95%	Quarterly report	Remedial action plan
Access: Discharge % of patients and carers with discharge summary and ongoing joint Care Plan at point of discharge	95%	Quarterly report	Remedial action plan
Patient satisfaction Provider should undertake an annual patient satisfaction survey with a sample size that should be at least 15% of the current service users	90% of patients surveyed report satisfaction with the services they receive	Annual report	Remedial action plan
Clinical All patients will have an 'Individualised care plan' developed electronically in consultation with the patient and given both to the patient and his/her GP	95%	Quarterly report	Remedial action plan
Clinical Reduction in emergency admission rate of Diabetes Ketoacidosis and Hypoglycemia by 10% in year 1 and 20% at year 3 from baseline year 2015/16	95%	Quarterly report	Remedial action plan
Clinical Reduction in emergency diabetic foot related conditions by 20% in year 3 (2018/19) and 40% in year 5 (2020/21) from baseline	95%	Quarterly report	Remedial action plan
Clinical 50% of diabetics referred to the service will have met the three individualised targets of Cholesterol, BP and target HbA1c within 12 months from referral date.	50%	Quarterly report	Remedial action plan

The NICE Quality Standard for Diabetes Care (Quality Standard 6)

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 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.

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.

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.

Diabetes QOF indicators for 2015/16

Diabetes mellitus (DM)

Indicator	Points	Achievement thresholds
Records		
DM017. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed NICE 2011 menu ID: NM41	6	
Ongoing management		
DM002. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less *NICE 2010 menu ID: NM01*	8	53–93%
DM003. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less *NICE 2010 menu ID: NM02*	10	38–78%
DM004. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less	6	40–75%
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	57–97%
DM007. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months *NICE 2010 menu ID: NM14*	17	35–75%
DM008. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months	8	43–83%
DM009. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10	52–92%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months *NICE 2010 menu ID: NM13*	4	50–90%
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register *NICE 2011 menu ID: NM27*	11	40–90%
DM018. The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March	3	55–95%