Service	Mid Nottinghamshire Community Diabetes Service
Service Specification Number	DB022

National/local context and evidence base

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.

This service represents a move to a more integrated approach to the management of long-term conditions delivered within the community setting; Diabetes is one priority disease area within many which presents a challenge within Mid Notts. The obesity problems and increasing numbers of patients with complex comorbidities require a holistic approach to diabetes care, supporting patients with a programme of structured education and utilising resources more efficiently.

Mid Notts practices have contributed to the National Diabetes Audit 16/17 (report published June 18), the following highlights some of the key performance issues and case for change

- The number of people with a diagnosis of diabetes in Mid Notts is increasing year on year,
- Structured education has seen some improvements but increased uptake, the proportion of patients receiving structured education is very low
- There is variation in the number of patients with Type1 and Type 2 who receive all 9 Treatment processes, performance for T2 diabetes requires significant improvement, (BP, HbA1c, Cholesterol), current performance figures are
    - 3 Treatment Targets – Mansfield and Ashfield 37.6%
    - 3 Treatment Targets – Newark and Sherwood 39.3%
    - England performance is 41.1%
- Major and Minor amputation rates require improvement and prompted the development of the Mid Notts amputation Improvement programme, with foot care training events and the development of Root Cause Analysis for every practice in Mid Notts
- The percentage performance of Foot examination intervention – M&A – 82.9% N&S – 82.6%,
- The QOF data March 17 indicates the number of patients not meeting their HbA1c target in Mid Notts is 7639

A Mid Notts QIPP programme is underway and key performance indicators are in place to monitor

Rolling Year June to May 2018

- Hypoglycaemia activity 72 admissions £116,589 a reduction of 45% on the previous year following the implementation of the Hypo pathway
- Major Amputations activity 36 admissions £413,391 an increase on the previous year (reference the amputation improvement programme)
- Minor amputation activity 33 £225,359 a reduction on the previous year

- Non-Elective Admission activity 256 episodes £552,749 a very slight reduction on the previous year
- Outpatient First appointment activity 388, £72,710 a very slight increase 4% on the previous year
- Outpatient Follow up activity 1,918, £176,652 an increase of 23% on the previous year

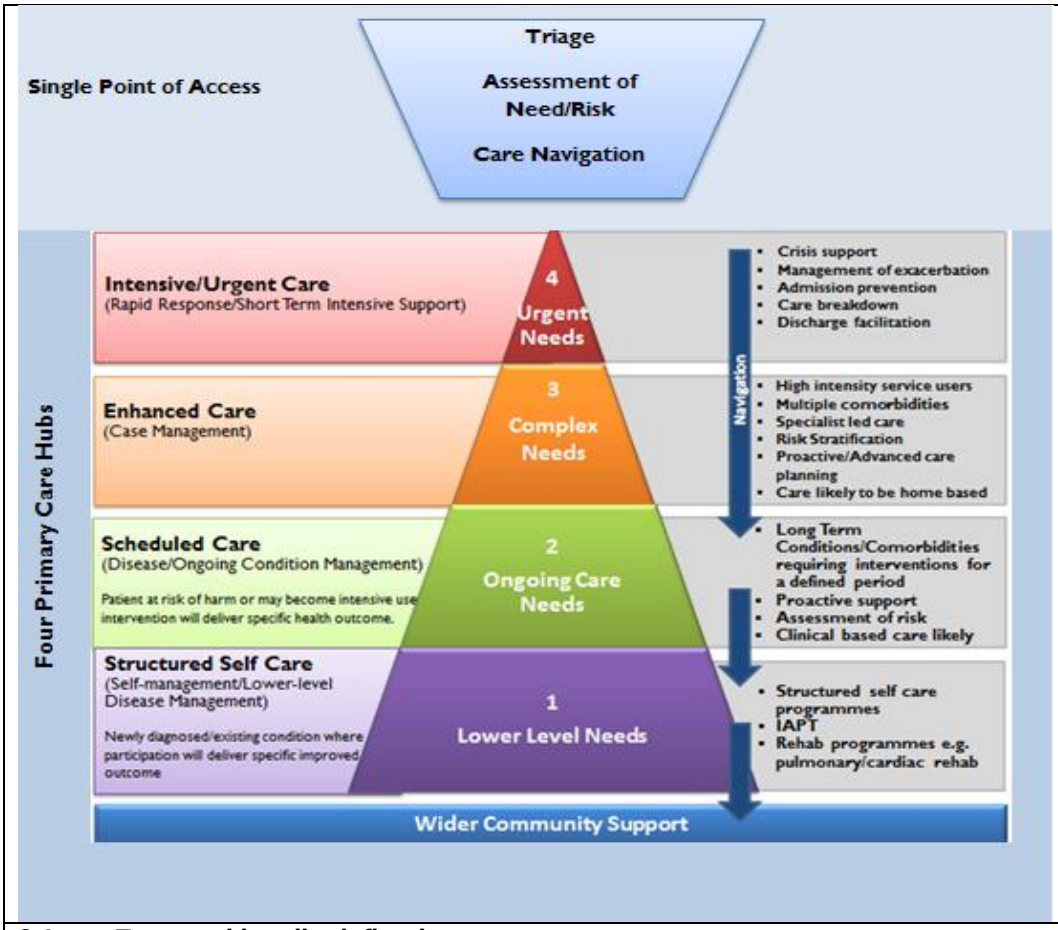
Current Quality and Outcomes Framework registers and prevalence by locality

		Ashfield North	Ashfield South	Mansfield North	Mansfield South	Newark	Sherwood
Diabetes QOF	**List Size (Ages 18+)**	41,318	30,464	46,397	36,759	61,153	47,614
	Diabetes Register	3,183	2,206	3,502	2,628	3,946	3,718
	Diabetes Prevalence	7.7%	7.2%	7.5%	7.1%	6.5%	7.8%

Nottinghamshire Wide Developments
Mid Notts is part of the wider transformation of Diabetes services and the alignment to a Nottinghamshire wide Diabetes pathway, ensuring consistency of delivery and outcomes for patients. A steering group provides oversight of developments. Work streams include, high level pathway development, reviewing of structured education, Diabetic foot care training, key performance indicators and outcomes

2.0 Service Model
As part of an integrated service the provider of adult Diabetes community service will provide a holistic diabetes service working closely with Primary Care and acute hospital services in line with the defined service model at figure1.0
This level 2 service will support patients in the management of poor glycaemic control and diabetic related complications with a view to improving clinical outcomes. Operating from a range of locality clinics in Primary Care Hubs and in host practices across Mid Notts, patients with Diabetes who are deemed 'housebound' will continue to receive care in their home.

Level 2: Scheduled Care: Management of disease or ongoing condition where patients require intervention to remain well or reduce risk of harm and without input could become more intensive users.



2.1 Expected locally defined outcomes

The community provider will be expected to contribute to the overall patient and service outcomes as part of the integrated approach to diabetes care:

- A reduction in Diabetes prevalence for Type 2 Diabetes in Mid Nottinghamshire
- Patients receiving Diabetes care in Mid Notts experience an improved quality of life, through care planning and treatment interventions
- Implementation of Diabetes locality clinics in locations across Mid Nottinghamshire providing access to local coordinated specialised services commencing in October 2018
- Provision of a single point of access for services and clear referral pathways, including self-referral
- An increase in the proportion of patients that receive the defined NICE 9 care processes
- An increase in the proportion of patients that are reducing their HbA1c, cholesterol and blood pressure, through realistic care planning and target management
- Contribute to the reduction in the incidence of major and minor amputations in diabetic services user
- Contribution to work to demonstrate a reduction in unplanned hospital admissions for service users with Diabetes including episodes of Diabetic ketoacidosis, hypoglycaemia, hyperosmolar non-ketotic
- Contribution to the reduction in the number of hospital admissions from care homes due to complications related to diabetes
- Contribution to a reduction in hospital LOS and readmission rates
- Efficient use and allocation of clinical capacity equitably to ensure the service is offering a range of appointment times across Mid Notts
- Increased rate of uptake of personalised care plans
- Increased rate of uptake of structured education for service users with a diagnosis of diabetes (T1 &T2) including Type 1 patients who receive insulin therapy.

3.1 Aims and purpose of the service

To deliver a sustainable integrated community Diabetes service to meet the needs of Mid Nottinghamshire patients with a confirmed diagnosis of Diabetes where there is a need for an on-going case management approach, based on risk assessment of the patients co morbidities and complexity, delivered within a defined period of time.

3.2 Service description/care pathway

Clinical management in the community – See Appendix 1 levels of care

- Provide patient monitoring were appropriate within the defined period of service support
- Patient consultations will be face to face or were appropriate via other forms of communication, i.e. E-mail or e-consultations, telephone and Skype.
- Develop locally agreed protocols and assessment tools to ensure diabetic assessments of patients to inform care plans
- Work with Primary Care and acute service partners to deliver services to patients that include care planning, patient education and self-management in line with NICE guidelines and contribute to the achievement of the 9 care processes.
- The service will ensure that all patient records are updated using SystmOne
- The service will actively involve patients in the planning of their care; agreeing achievable goals and outcomes to support ownership and living with diabetes will be managed.
- The provider will ensure that crisis management is discussed as part of care planning arrangements
- Ensure the patient receives handheld copy of the care plan or an electronic version, whichever is appropriate
- Signposting to psychological support (IAPT) where patients are experiencing distress relating to their diagnosis of diabetes
- Sign-post to Lifestyle Services, local voluntary sector organisations to support patients with structured self-care at level 1
- Management of unstable Type 2 patients – healthcare professionals will work with patients to agree and document personalised targets for Hba1c, lowering blood pressure and lipids in accordance with NICE guidance
- Contribute to the reduction in unplanned hospital admissions – including acute episodes – hypo/hyper/keto, through a risk management approach
- Monitor patients and discharge back to General Practice within a defined period and include discharge summary and care plan
- The provider will ensure that it produces available information on the services it provides
- Ensure that services are accessible to individuals with additional needs and protected characteristics (EQIA)

Multi-Disciplinary Team

- Work collaboratively with Primary Care and acute partners to develop an MDT approach, acting as the link between General Practice and acute specialist services
- Facilitate joint working and agree protocols
- Contribute to MDT reviews and joint discussions and care management for complex patients

Structured Education

- Following identification of need the provider will signpost to structured education programmes (DESMOND/DAFNE/KAREN) were appropriate and encourage patients to attend as part of the care planning arrangements

Medicines Management

- Ensure Diabetes Specialist Nurse prescribe in line with ICB formulary recommendations
- Trained specialist Diabetes Nurses initiate and manage insulin therapy working with the patient
- Provide medication reviews and titration

- Provision of advice and guidance for primary care, community and registered care homes on medication management
- The provider will have in place systems and processes for medicines classified RED by the Area Prescribing Committee and Amber drugs under shared care
- Consultations with patients will include use of medications supported by information

Dietetics

- The provider will be aware of current Dietetic guidance and ensure appropriate signposting

Podiatry

- Ensure patients are signposted to the local foot care pathway
- The service will ensure that patients presenting with an urgent foot problem are referred for urgent medical attention to the Multidisciplinary foot team using the urgent foot pathway within 24 hours

Retinopathy Screening

- Referral via GP practice

Discharge

- Patients will be discharged back to their GP following interventions by the service, the patient is stable and able to manage self-care, within the agreed timeframe.
- Patients with Type 2 diabetes with stable HbA1c and able to self-manage should be transferred to level 1 management with advice and access to education
- On discharge patients will be issued with an individualised and agreed, timely, care plan and discharge letter to GP as a minimum to include next blood test due date, individualised targets and review dates.

Transformation

As part of a phased approach the provider will be expected to work collaboratively, with commissioners and wider service providers.

Referral and Acceptance Criteria

Acceptance

- Patients with a diagnosis of Diabetes and are registered with a Mid Nottinghamshire GP Practice
- Patients 18 years and over
- Erratic glycaemic control i.e. experiencing frequent Hypoglycaemia
- Insulin initiation adjustments and other injectables in line with NICE and local Diabetes Guidelines
- Unstable poorly controlled patients appropriate for the level 2 service and maximise therapies including linked conditions Hyperlipidaemia, Hypertension, Neuropathy etc.

Referral

- Referral criteria will be reviewed at least annually with the provider
- The provider will accept referrals via the community single point of access
- Clinically triage patients on referral (within 2 working days and offer an appointment at the earliest opportunity (Note urgent referrals for the Urgent MDT pathway)
- Diabetes patients who are defined as 'housebound' will receive diabetes care in their home setting
- DNA's – the provider will contact patients who do not attend their appointment to establish why and offer alternative times and dates, implementing NHS current guidelines on access.
- Notify GP practice referring clinicians of patients that DNA after following guidelines

Referral to Level 3 and 4 care

Locally determined conditions/In discussion with the GP the provider will refer to specialist care

- If there is any doubt as to the type of diabetes i.e. rarer forms suspected
- Referral to specialist antenatal diabetes team (confirmed pregnancy)
- Suspicion of Diabetic kidney disease
- High risk foot – referral to Vascular Team (see pathway: high risk foot)
- Service users with Type1 Diabetes
- Service users who are experiencing depression or anxiety related to diabetes

Days/Hours of operation

- The service will be provider within core operational hours Monday to Friday, with clinic days and times to meet the needs of the service users
- Patients provided with key contacts should they require specialist advice and guidance out of core ours as part of the care planning process

3.3 Population covered

The service will be accessible for patients registered with a GP practice in Mid Nottinghamshire

The provider will be working with a range of providers within Locality Integrated Care Partnerships, 4 Locality Care Hubs will provide a range of services, the Locality Care Hubs will be based in the following locations

- Ashfield Health and Wellbeing Centre
- Mansfield Community Hospital
- Sherwood Medical Partnership
- Newark TBC

Based on several design principles the Locality Care Hubs present opportunities for service development, place-based, mobile, virtual/digital consultations working alongside Primary Care and other specialist services

The provider and commissioner to work together to ensure equitable access to services in the Localities at times to meet the needs of the patient

Through the development of community hubs and networks, the provider will ensure the delivery of locality-based community services using a range of clinical professionals including

Specialist Diabetes Nursing teams to deliver a range of enhanced levels services as follows:

- Delivery of Integrated services at scheduled care level 2 care and integration with Level 1 and 3 as defined within the community model of care
- Ensure a range of consistently coordinated weekly clinic times and geographical locations are available between core operational hours
- Ensure 100% of the Mid Notts population is covered by the service provision

Education – Primary Care/Community/Acute

The provider will be expected to work collaboratively with all levels of provision within the community Hubs and general practice, including other clinical professionals for LTC to support workforce development and CPD through:

- Development of joint clinics within the Primary Care Hubs to facilitate case reviews and case finding with GP's, Practice Nurses, Primary Care Team.
- Provision of telephone and e-mail advice
- Advice, guidance and training for Primary Care Staff.
- Medicines management advice in line with local Guidelines
- Provider opportunities for mentorship, coaching and shadowing community clinic ensuring appropriate clinical supervision of nursing staff.

IM&T

It is expected that e-referral will be part of the process of access to the Integrated Diabetes Service and all virtual methods of communication with the wider health and social care system will be explored to ensure the productivity of the service and efficiency in access for patients.

SystmOne is the primary patient record system for general practice and the community. It is expected that this interface with SystmOne will be the route of daily communication
E- health scope is a key enabler to the proactive management of patients with all long term conditions and offers a source of active case finding for patients. It is expected that the Integrated Diabetes Service will engage with general practice to access appropriate patient level information in support of improved patient outcomes.
The provider will ensure the required Information Governance Training is provided to staff within the service including regular updates.

3.4 Interdependence with other services/providers

The Integrated Diabetes Service will require collaboration and relationships with the following:

- Mid Nottinghamshire GPs
- Nottinghamshire Healthcare NHS Foundation Trust – physical and mental health service delivery teams
- SFHFT – Diabetes service
- Nottinghamshire County Council Adult Social Care
- Multi Agency Safeguarding Hub (MASH)
- United Lincoln Hospital
- Nottingham University Hospitals
- EMAS
- Other community service providers
- Local Hospices
- Doncaster and Bassetlaw Hospitals
- Derby Teaching Hospital
- Chesterfield Royal Hospital NHS Foundation Trust

Workforce

Clinical professionals must be registered and regulated by the code of practice as per their professional body.
The provider is responsible for ensuring:

- Evidence that staff have demonstrable high quality specialist service provision over several years, with evidence of continuing professional development in relation to diabetes specialist care
- The provider supports staff to maintain their education and training relevant to their role
- The provider will ensure that all staff will be supervised in their positions and there is an effective appraisal system in place
- HR and employment policies in place
- That specialist staff are skilled to deliver structured education to patients and staff
- Specialist Nursing team are prescribing practitioners or be working towards a prescribing qualification
- Specialist Nurses have completed The Warwick Diabetes Courses, and other Diabetes modules relevant to the role
- The provider has recruitment and retention plans in place to ensure continuity of service delivery specifically for Diabetes services

Promotion and support for self-care:

The Integrated Diabetes Service will provide self-management and empowerment to the patient to manage their own condition through health promotion and education.

The Commissioner and provider have a commitment to working together to continually improve the service and react to innovative and dynamic ideas. The provider and commissioner have a responsibility to continually review and redesign services and consider and act upon requests of the other party.

Service improvement may be stimulated through areas such as:

- complaints
- monitoring information
- provider feedback
- learning from other services

- needs assessments
- service user feedback

A timetable of quality monitoring will be agreed between the Contracting team and the Provider.


QM1.docx


QM2.docx


QM3.docx


QM4.docx

Location(s) of Service Delivery

The Integrated Diabetes Service will be provided in clinics, into patients' homes, residential and nursing homes, outpatient departments and aligned to the Local Care Hubs across Mansfield, Ashfield, Newark and Sherwood.