

SCHEDULE 2A: SERVICE SPECIFICATIONS

Service Specification No.	SS007
Service	Dose Adjustment for Normal Eating (DAFNE) for Type 1 Diabetics
Commissioner Lead	NHS Rushcliffe Clinical Commissioning Group (CCG) [REDACTED]
Provider Lead	Nottingham University Hospitals
End Date	<i>Revised Version Added to the Contract in 2017-18</i>
Date of Review	<i>To be reviewed annually</i>

1. Population Needs

1. National/local context and evidence base

Diabetes is a Long Term Condition (LTC) caused by too much glucose in the blood. There are two main types of diabetes, Type 1 and Type 2.

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 can be required.

Ten per cent of people with diabetes have T1DM, and Ninety per cent have T2DM.

Diabetes is one of the major challenges facing the NHS. Diabetes is a major cause of premature mortality with at least 22,000 avoidable deaths each year and the number of people in the UK with diabetes is predicted to rise from 3.1 million in 2012 to 3.8 million by 2020. Due to increasing obesity levels in the UK it is expected that the incidence of T2DM (which accounts for approximately 90% of diabetes in the UK) will increase and as a result it is estimated the number of people with diabetes in the UK will continue to rise and will reach 4.6 million by 2030. This makes diabetes the Long Term Condition with the

Nottingham University Hospital NHS Trust (NUH) provides Dose Adjustment for Normal Eating (DAFNE) education as a way of managing T1DM and provides people with the skills necessary to estimate the carbohydrate in each meal and to inject the right dose of insulin.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

DAFNE is ideally provided 12 months or so after insulin is started in someone with type 1 diabetes, although people with long-standing diabetes also benefit. The idea of the programme is to provide a skills-based package to help people develop independent self-management of their diabetes through safe and effective insulin dose adjustment.

Expected outcomes:

- Provide timely and accessible DAFNE courses for patients to promote self- management.
- Ensure all patients who need to initiate insulin therapy or who need to initiate other injectable therapies are provided with a formal structured education package around drug self-administration.
- Increase numbers of patients self-managing through proactive communication and liaison across the system
- Measure patient experience and satisfaction and identify the percentage of patients that:
 - that are aware of their care plan
 - Know and understand how to self-manage
 - Know who to contact in an event of an emergency or routine query
- To support GPs to have 100% of patients achieving the required standard to initiate, manage and provide on-going monitoring of patients requiring conversion to insulin and injectable

3. Scope**3.1 Aims and objectives of service**

To improve health outcomes for adults aged over 18 with Type 1 diabetes through high quality structured education

3.2 Objectives

- To implement DAFNE training in accordance with NICE guidelines
- To Improve access to, and uptake of, educational tools for patients including information guides and support through:
 - Patient champions and peer-to-peer support.
 - Support services suitable for 16- to 19-year-olds may not necessarily be suitable for 20- to 25-year-olds; where possible these services should be tailored.
 - Collaborative working among all partner organisations including local employers, leisure industry, etc.
 - Flexibility of service offer is key to engaging 16- to 25-year-olds, as is increased use of digital and social media.
- To provide timely access to the DAFNE programme for patients with T1DM
- To provide a 5-day training course to groups of 6-8 patients under the supervision of a DAFNE trained educator's
- DAFNE will predominantly be a group delivered education course
- To increase levels of self-care, learning from experience allowing patients to practice the skills of carbohydrate estimation and insulin adjustment.
- To reduce the presence of complication of diabetes a
- To reduce the need to attend or be admitted to hospital (either planned or unplanned).
- To reduce outpatient activity, unplanned attendances and unplanned admissions.
- To reduce the length of stay of patients admitted with diabetes where diabetes is either the primary cause of admission
- Reduce the overall costs associated with managing diabetes (including the management of any comorbidities).
- Work collaboratively with all stakeholders

3.3 Service description

- DAFNE is a consecutive five-day training course delivered to groups of 6-8 patients, offered monthly. Eight DAFNE courses will run over a 12 month period with active subsequent waiting list management
- 38 hours of structured group education and is delivered by specially DAFNE trained diabetes specialist nurses and dietitians on an outpatient basis
- The course can be organised on a face to face or interactive basis as appropriate. The course is delivered face to face in accordance to DAFNE teaching programmes
- The use of telehealth is used to follow up patients
- The programme can be delivered in hospital or the community

3.4 Patient/Client groups

- Adults aged over 18 with T1DM registered with a GP in the NUH consortia

3.5 Access

- A single point of access to the service must be provided.
- Telephone advice and guidance to GPs and community teams is available via the existing community diabetic specialist nurse telephone line
- Access within community settings where possible and appropriate
- Patient access must be via face to face and telehealth when appropriate

3.6 Days/Hours of operation

9am to 5pm, Monday to Friday plus a follow-up session around 8 weeks after the course. A pre assessment appointment will also be carried out prior to the course. Refresher courses should also be run between 3-4 times per year

3.7 Referral

- The service will provide referral guidance for referrers to ensure referrals are appropriate and managed in a timely manner.
- Referrals will be from:
 - Secondary care clinicians
 - Primary care referrals should be made primarily by the community diabetic specialist nurses. GP referral can also take place. The referrals will be made into a consultant clinic to triage if the patient is appropriate to be booked onto the DAFNE course.
 - Patient self-referral

3.8 Care pathway

- The service will register patients onto the next available DAFNE programme
- Patients will attend a five-day programme either virtually or face to face
- The programme will adhere to and follow NICE guidance

3.9 Telehealth/Assistive Technology (AT)

The service will actively encourage the use of Assistive Technology (AT), in particular Telehealth, in the management of their patients.

AT should be considered for all patients where both the patient and clinician will benefit from its use. There should be clear documented reasons supporting why AT is not offered or accepted by the patient.

Where AT is implemented the service clinician will be responsible for monitoring the patients progress as recorded by the device. This will form part of the overall management and support of the patient.

Feedback will be obtained from all patients to understand the impact and outcomes of AT. This will be used to inform the future use of AT within the service.

3.10 Discharge Criteria & Procedure

Patients are discharged from the service when:

- They have completed the DAFNE programme
- The patient is not participating with treatment. An alternative must be offered.
- Another service/ agency would better meet the needs of the patient.

A letter will be sent to the GP or consultant detailing the involvement from the team and follow up care.

3.11 Promotion and support of self-care

- All clients are provided with health promotion information and materials relating to their condition, and also targeted to their individual need.
- Referrals are made to other relevant services via the GP to meet individual need, including signposting to the voluntary sector and relevant charities.
- Patients are provided with information and contact details for any onward referral/care planning

3.12 Information provided to patients and carers

- Patients and carers will receive a personal care plan as appropriate.
- They will also be given information about their condition and any relevant services to them

3.13 Signposting arrangements between services

- The service will work closely with providers of longer term services e.g. GPs.
- They will also refer on to self-support agencies and the voluntary sector.

3.14 Population covered

Patients over the age of 18 with type 1 diabetes registered with a GP within the NUH consortia.

3.15 Any acceptance and exclusion criteria and thresholds

The service is accessible to all patients with T1DM regardless of sex, race, or gender. Providers require staff to attend mandatory training on equality and diversity and the facilities provided offer appropriate disabled access for patients, family and carers. When required the providers will use translators and printed information available in multiple languages. Translators and printed information can be provided where appropriate and available

3.16 Facilities

Whether the programme takes place in the community or in hospital there should be adequate provision of space, time and equipment to and provide any necessary intervention.

3.17 Interdependence with other services/providers**Whole System Relationships**

The service will link with NUH diabetes services, community clinicians and GPs

Interdependencies

The service should:

- have easy access to the consultant
- have close liaison with GPs and other community clinicians
- Work as part of a multidisciplinary team

3.18 Relevant networks and screening programmes

- DAFNE
- Diabetes UK

4 Applicable Service Standards**4.1 Applicable national standards (e.g. NICE)**

This pathway specification is based on the NICE Quality Standard for Diabetes and takes into consideration the following Clinical Guidance:

- Type 1 diabetes in adults: diagnosis and management. NICE guideline (2016)
- Diabetes (type 1 and type 2) in children and young people: diagnosis and management. NICE guideline (2015)

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

- Royal College of Physicians. Type 1 diabetes in adults: national clinical guideline for diagnosis and management in primary and secondary care
- Royal College of General Practice
- Royal College of Nursing. Education, prevention and the role of the nurse
- British Dietetic Association. Clinical Guidelines

4.3 Applicable local standards

The service will adhere to the following local standards:

<i>Access</i> Number of courses offered and patients attending each group	2 courses offered per month
<i>Patient Outcomes</i> Number of patients attending the programme, reason for declining and alternative offers made	100% of all patients
<i>Safety</i> Number of patients with infections	<0.1% of all patients
<i>Productivity</i> Communication to the wider system promoting the programme	Bi-monthly communication to all key stakeholders

Method of measurement

Will be by Annual audit as Audit is built into DAFNE which provides an annual summary of outcomes in each DAFNE Centre.

Reporting

Frequency of reporting will be by exception and quarterly

Breach

Consequence of breach will result in an improvement action plan being submitted for review and approval to the commissioners within two weeks of request.

5. Applicable quality requirements and CQUIN goals

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

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

Hospital or community settings suitable for those with special needs or disabilities