LINCOLNSHIRE HEALTH AND SOCIAL CARE

COMMISSIONING FRAMEWORK

FOR THE DELIVERY OF SUPPORT TO PATIENTS

WITH

DIABETES

April 2010
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1. **AIM OF FRAMEWORK**

This framework sets out the commissioning requirements and standards of service provision to:

- Improve the health and quality of life for people with diabetes and their carers by providing patient centred, systematic and ongoing support.

- Equip commissioners, providers and practitioners with the necessary background knowledge, service and implementation details to safely deliver the service for people with diabetes.

- Ensure care is provided in the most appropriate setting through improved care and management in a primary, community or home environment.

- Standardise and improve diabetes care and health outcomes across the whole health community, narrowing health inequalities.

2. **SCOPE AND DEFINITION OF SERVICE**

2.1 **Diabetes**

Diabetes is a chronic and progressive disease that has an impact upon almost every aspect of life. Diabetes is the leading cause of blindness in people of working age in the UK. It affects infants, children, young people and adults of all ages, and is becoming more common.

Around 5 per cent of total NHS spend (and up to 10 per cent of hospital in-patient spend) is used for the care of people with diabetes.

Diabetes can result in premature death, ill health and disability, yet these can often be prevented or delayed by high-quality care.

2.2 **Summary of local need**

The prevalence of diabetes is increasing both nationally and locally. It was estimated a few years ago that 2.8% of the world’s population would have diabetes in 2010 and this would rise to 4.4% by 2030, of these 90% will have type 2 diabetes. The number of children and young people diagnosed with diabetes continues to increase.

In Lincolnshire, in 2008/09 4.72% (34,880) of the adult population were registered with diabetes. Lincolnshire has a higher percentage prevalence rate compared to all PCT’s with similar diabetes risk factors (4%). The latest data for 2008/09 identifies that Skegness and Coast Practice Based Commissioning (PBC) area has the highest levels of diabetes with a prevalence of 7.38% (5298) and the Welland area has the lowest levels at 3.80% (3042).

Currently it is difficult to have accurate information on how many people aged under 18 years are diabetic as the registers that general practices maintain as part of the quality outcome framework (QOF) are only for those aged 17 years or
From national prevalence models it is estimated that there could be approximately 450 children with diabetes in Lincolnshire.

Figure 1 shows the projected number of diabetics in Lincolnshire using the data from economic modelling that the Courtyard Group carried out.

<table>
<thead>
<tr>
<th>Year</th>
<th>Type 1 Prevalence</th>
<th>Type 2 Prevalence</th>
<th>Population Projection</th>
<th>No. of Diabetes Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>0.004045</td>
<td>0.036405</td>
<td>722,976</td>
<td>29,244</td>
</tr>
<tr>
<td>2008</td>
<td>0.004135</td>
<td>0.037217</td>
<td>733,352</td>
<td>30,326</td>
</tr>
<tr>
<td>2009</td>
<td>0.004223</td>
<td>0.038006</td>
<td>743,728</td>
<td>31,407</td>
</tr>
<tr>
<td>2010</td>
<td>0.004308</td>
<td>0.038774</td>
<td>754,105</td>
<td>32,489</td>
</tr>
<tr>
<td>2011</td>
<td>0.004391</td>
<td>0.039521</td>
<td>764,481</td>
<td>33,570</td>
</tr>
<tr>
<td>2012</td>
<td>0.004472</td>
<td>0.040248</td>
<td>774,857</td>
<td>34,652</td>
</tr>
<tr>
<td>2013</td>
<td>0.004525</td>
<td>0.040725</td>
<td>786,056</td>
<td>35,569</td>
</tr>
<tr>
<td>2014</td>
<td>0.004577</td>
<td>0.041189</td>
<td>797,255</td>
<td>36,486</td>
</tr>
<tr>
<td>2015</td>
<td>0.004627</td>
<td>0.041639</td>
<td>808,454</td>
<td>37,404</td>
</tr>
<tr>
<td>2016</td>
<td>0.004675</td>
<td>0.042077</td>
<td>819,653</td>
<td>38,321</td>
</tr>
<tr>
<td>2017</td>
<td>0.004723</td>
<td>0.042504</td>
<td>830,852</td>
<td>39,238</td>
</tr>
</tbody>
</table>

Diabetes affects people of all ages, although people’s risk of diabetes increases with age. Type 1 diabetes is more prevalent in younger people whilst type 2 disease is more common in people aged over 40 years. Across all districts in Lincolnshire approximately half of the population are aged between 25 and 64 years. The proportion of those aged 65 years and over is highest in East Lindsey. The projected growth in Lincolnshire’s population is expected to alter the age profile of the county. The largest percentage growth is projected to be in people aged 75 years and over, increasing by 30% between 2006 and 2016. The growing and ageing population of Lincolnshire presents a number of challenges in terms of increasing demand for services.

In addition to increasing age, certain groups of the population are more at risk of diabetes. For example, diabetes has a disproportionate impact on some ethnic communities. African Caribbean or South Asian people who live in the UK are at least five times more likely to have diabetes than the white population. Deprivation is an important factor and there is a correlation between socio-economic status and diabetes prevalence with people from the more deprived communities, having greater levels of diabetes. The 2007 Index of Multiple Deprivation (IMD) shows the highest levels of deprivation in Lincolnshire to be around the East Coast and parts of the more urbanised areas of Lincoln, Boston, Gainsborough and Grantham. Many of these areas also have the highest levels of diabetes in Lincolnshire.
Diabetes impacts upon every aspect of life. People with diabetes have a shorter life expectancy, by up to 23 years for type 1 diabetics and 10 years for type 2 diabetes. Mortality rates from coronary heart disease are up to five times higher; diabetes is the leading cause of renal failure; the second most common cause of lower limb amputation and the leading cause of blindness of people of working age. Women with diabetes have reduced fertility and additional risks during pregnancy and labour.

Figure 2 shows some of the main impacts of diabetes

<table>
<thead>
<tr>
<th>Impact on people with diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
</tr>
<tr>
<td>Coronary Heart Disease (mortality)</td>
</tr>
<tr>
<td>Risk of stroke</td>
</tr>
<tr>
<td>Renal failure</td>
</tr>
<tr>
<td>Lower limb amputation</td>
</tr>
<tr>
<td>Blindness in people of working age</td>
</tr>
<tr>
<td>Pregnancy</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Personal cost</td>
</tr>
</tbody>
</table>

Figure 3 shows the cost of diabetes in health and social services

<table>
<thead>
<tr>
<th>Cost of Diabetes in Health and Social Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Resources</td>
</tr>
<tr>
<td>Hospital In-patient resources</td>
</tr>
<tr>
<td>Hospital admission</td>
</tr>
<tr>
<td>Length of Hospital Stay</td>
</tr>
<tr>
<td>NHS costs from diabetic complications</td>
</tr>
<tr>
<td>Social Services costs</td>
</tr>
<tr>
<td>Social Services costs – diabetic complications</td>
</tr>
</tbody>
</table>
Overall, mortality from diabetes has reduced over the last 10 years. In Lincolnshire the diabetes all age mortality rate per 100,000 people has reduced from 9.55 (114 deaths) in 2002 to 6.09 (95 deaths) in 2008. There is a higher rate of mortality amongst males than females which is the same situation as that for England. Recent work estimates that nationally 12% of all deaths in people aged 20-79 year olds are as a result of diabetes.

Between April 2008 and March 2009 of all 64,008 emergency admissions, some 7,325 were diabetic patients. Of these admitted diabetic patients 394 were admitted for diabetes related conditions 31 patients had 2 or more admissions.

There are a range of indicators in the quality and outcome framework that are essential for the ongoing management of diabetes. Overall, Lincolnshire practices deliver well against these indicators.

3. SERVICE AND HEALTH OUTCOMES

The implementation of this framework will seek to ensure:

- Greater focus on the prevention of diabetes
- Improved integration of healthcare provision and social care
- Early diagnosis of those at risk of developing diabetes
- Improvement in patient experience and quality of life
- People being equipped to better manage their own condition
- Reduction in inappropriate acute hospital outpatient referrals
- Reduction in hospital admissions through improved management of the condition and reduction in the complications associated with the condition
- During in-patient episodes, the average length of stay will be reduced
- Re-admission rates will be reduced
- Medication will be used more effectively due to improved patient compliance, through increased understanding of the condition
- Improved staff experiences through better communication, training and a clearer patient pathway

This framework is designed to achieve the standards and best practice set out within:

- NICE Guidelines
• NSF standards
• Long Term Conditions Primary Care Service Framework
• Standards for Better Health
• White Paper, Our Health, Our Care, Our Say
• Local guidelines/ requirements e.g. World Class Commissioning, Local Delivery Plan
• Lincolnshire diabetes model of care – December 2008
• Royal College of Nursing – Diabetes services for adults in primary care: a practical guide April 2006
• Royal College of Nursing – Starting insulin treatment in adults with Type 2 diabetes. May 2004
• Skills for Health – Completed Framework for Diabetes
• The British Dietetic Association – A Workforce and Training Framework for the delivery of diet and lifestyle care pathways for long term conditions – A diabetes perspective
• Recommendations for the provision of services in primary care for people with diabetes – Diabetes UK (April 2005)
• Quality and Outcome Framework Standards
• Lincolnshire Guidelines on the management of diabetes in general practice 2003
• Lincolnshire Model of Diabetes Care (Appendix A)

Commissioning services that achieve the standards set out within this framework will ensure:

• People who are identified at risk of developing diabetes e.g. those with a family history of diabetes, a history of gestational diabetes, impaired glucose tolerance, obesity and those from South Asian or Afro-Caribbean background, will be given timely advice and support to prevent or delay the onset of the condition

• People presenting with signs or symptoms will be diagnosed early

• At diagnosis and in the first year, people will be provided with information, structured education and support to enable them to self manage the condition and to take action that will prevent or delay the onset of associated complications
- People with diabetes will have access to the most appropriate healthcare practitioners at all times during their journey to ensure that timely intervention and optimal care is given to prevent or delay the risk of developing associated complications.

- Greater patient self-management through better information, advice and a jointly developed and agreed care plan.

- People will be pro-actively supported in their management of their condition to maximise their quality of life and reduce or delay the onset of associated complications.

- Throughout their life, people will continue to receive standardised, evidence-based treatment and education to support them in their management of their diabetes.

- Peoples experience of their care will improve.

For details of the performance indicators used to measure outcomes see Appendix B.

4. LINCOLNSHIRE MODEL OF DIABETES CARE

Levels of care are separated into provision and management based on the agreed four tiered model of care (See Appendix A).

Primary prevention has been highlighted as a critical element of the diabetes pathway with every effort made to prevent people developing the condition in the first place. Diabetes shares many risk factors with other conditions such as coronary heart disease and stroke.

Some risk factors for developing diabetes are non-modifiable (such as, family history, increasing age and ethnic origin). However, other risk factors, such as being overweight/obese, having an adverse distribution of body fat and being physically inactive are modifiable and need to be the focus of the prevention of type 2 diabetes. Therefore, individuals at increased risk of developing Type 2 diabetes can reduce their risk if they are supported to change their lifestyle by eating a balanced diet, losing weight and increasing their physical activity levels.

It is acknowledged that services/support to facilitate effective primary prevention is the remit of the Opportunities for Good Health theme of the Sustainable Community Strategy and the Staying Healthy Programme of NHS Lincolnshire’s Strategic Plan. All practitioners who encounter individuals who exhibit those risk factors that may lead them to develop the condition should be supportive and refer to appropriate support services as necessary for example weight management, exercise referral and smoking cessation.
4.1 CORE PRIMARY CARE (GP) - SERVICE LEVEL 1

Identification, Diagnosis, Initial Assessment and Ongoing Care

A proactive approach to identify and diagnose people with diabetes and which provides a service that meets their immediate needs and ongoing structured care, based on a care planning approach

It is expected that all practices will deliver level 1 care.

To optimise outcomes for people with diabetes, it is essential that those at increased risk and those presenting with signs and symptoms, are tested and diagnosed as early as possible. This should include all those who have been found previously to have impaired glucose tolerance and women who have a history of gestational diabetes.

Providers of the service will:

4.1.1 Identification

Have mechanisms in place to identify and screen those at risk of developing diabetes – the NHS Health Check, utilisation of QOF data, opportunistic screening

4.1.2 Diagnosis

Ensure people receive an accurate and timely diagnosis of diabetes in accordance with WHO diagnostic criteria, NICE, Diabetes NSF standards.

Ensure that all people with a diagnosis of diabetes are included within a diabetes register.

4.1.3 Initial Assessment

At diagnosis, offer a full explanation and outline of the nature of the condition, offer psychological support by means of giving advice and answering questions and provide basic information in relation to diet, exercise, alcohol, driving, illness, prescription charges etc.

At diagnosis, provide a full clinical assessment to include BMI, waist circumference, blood pressure, Cholesterol, LFT’s U’s & E’s, Thyroid, Microalbumin, foot examination or referral to podiatry and referral for retinal screening.

At diagnosis, initiate treatment and develop a joint management plan with the patient and or carer.

Designate a member of the care team as a named contact to help the patient navigate the service and access other members of the multi-disciplinary team.

Refer to a relevant specialist diabetes service if required following assessment.
4.1.4 The First Year and Continuing Management

As part of their planned care, people will receive a full review of their diabetes at least annually which will include:

- Exploration of any concerns providing support and counselling as appropriate
- Assessment of ability to manage self-care – refer as necessary e.g. Expert Patient Programme, Diabetes specific education programme
- Advice on healthy lifestyle choices
- Review of metabolic control
  - HbA1c, lipids and blood glucose monitoring
  - Episodes of diabetic ketoacidosis and hypoglycaemia
  - Dietary assessment
  - Advice on clinical options
- Weight Management
  - Surveillance for long term complications (diabetic retinopathy, microvascular complications, renal disease, neuropathy, cardiovascular risk factors, hyperlipidaemia, hypertension and foot problems)

Identification and management of other problems e.g. depression

As part of their on-going care, patients will have an agreed plan of care with personal goals and this will be reviewed regularly, at least annually.

All patients to receive a 6 monthly review of their diabetes to include review of blood glucose (HbA1c), blood pressure, weight, medication and general wellbeing to enable further care planning. This may be required more frequently dependent of the patient’s control and level of complications.

Any patient who experiences an episode(s) of instability and whose management is beyond the general level of knowledge and skill of the patient’s GP, should be referred to a team of appropriately skilled and experienced specialist community practitioners, who will provide the management and support to endeavour to optimise control for the patient as timely as possible. When the episode of ‘event related’ care is complete, routine diabetes care will continue as normal within the patient’s GP practice.

Certain patients may be referred to the specialist, secondary care diabetes service as outlined in Service Level Four.

4.1.5 Self Management

In order to encourage self management of this condition, it is expected that people who have diabetes will be given the appropriate knowledge, information, contextual advice and support to enable them to develop the confidence and motivation to optimise their control. It is expected therefore that:
At diagnosis and continuing during the first year patients will:

- Receive support, medication and the tools where necessary, to optimise their blood glucose control
- Receive advice and treatment to prevent and manage cardiovascular risk factors
- Have a joint care plan

4.1.6 Education

At the time of diagnosis of Type 2 diabetes, patients and their carers (where appropriate), will be referred to group structured programme of education which has been developed to the standards laid down in NICE guidelines e.g. Desmond. Where a patient is unable or unwilling to attend group programmes, they will receive the education within the practice, in line with the programme.

Patients will be offered access to a local Expert Patient Programme.

4.2 ENHANCED PRIMARY CARE (SUPPORTED GP) – SERVICE LEVEL 2

Ongoing, enhanced care

General Practitioners will be supported to delivery the care outlined in level 1 but will also be able to deliver an enhanced level of service if they have the necessary skills and competencies. The enhanced community care service will be cluster focused with training and support available to GP’s to enable them to deliver this tier of the service model themselves.

For example some individual practices may choose to provide support to more complex diabetes patients. This may include:

- Monitoring of stable Type 1 patients
- Managing un-stable Type 2 patients
- Initiate and monitor Insulin therapy patients
- Initiate and monitor new treatments such as Exenatide (Byetta)

4.2.1 Local Enhanced Service

A local enhanced service specification will be developed as an adjunct to this framework and practices will have the option of joining the scheme. The scheme will include areas that are above core / GMS contract and QOF services. The Local Enhanced Service specification will outline what individual practices will need to undertake in order to secure the LES payment. Areas within the LES will
include insulin initiation therapy and management and the introduction of new therapies.

4.3 SPECIALIST COMMUNITY CARE PROVISION - SERVICE LEVEL 3

A service which provides an intermediate level of care, outside of hospital for patients who have become unstable in their diabetes control

Providers will be expected to work together to ensure a team of specialist practitioners in diabetes are accessible in the community to both patients and primary care teams who require the input of additional skills and knowledge in the management of diabetes during periods of instability.

Patients will receive an intensive period of management as required, and once it is felt optimum control has been established, the patient will be referred back for general diabetes management by their practice team. Certain patients may be referred to the specialist, secondary care diabetes service as outlined in Service Level Four.

4.3.1 Multi Disciplinary Team / Clinics

Providers will ensure access to multidisciplinary structured clinic(s) with an appointment system for patients to access the appropriate specialist practitioner(s).

The intermediate level of diabetes services should be provided by a multidisciplinary team comprising:

- Access to medical support e.g. GPSI, Consultant who has the required advanced skills, knowledge and experience in managing diabetes
- A nurse who has the required additional advanced skills, knowledge and experience in managing diabetes
- A dietician with experience in managing diabetes

4.3.2 Competencies

Ensure these practitioners are trained to the competency levels equivalent to those laid down in the Skills for Health Competences Framework for:

- Medical management of diabetes
- Nursing management of diabetes (Level 4 competency of the ‘Integrated Career and Competency Framework for Diabetes Nursing’)

4.3.3 Service

Providers must ensure that the following are carried out:
Dietary management of diabetes

- Be flexible in the venues for these clinics to ensure reasonable access for all patients across the County.
- Provide an assessment of physical, psychological, educational and social aspects of diabetes management.
- Undertake a full medication review.
- Discuss dietary and exercise advice to encourage an alteration in lifestyle in line with the patient’s requirement to improve control.
- Refer to podiatry if necessary.
- Agree a management plan with the patient and or carer.
- Provide ongoing updates and full discharge summary to the patient’s GP.
- Provide an insulin initiation package to include those patients whose own practice chooses not to deliver a Level 2 service. This will include:

- Group insulin initiation sessions where appropriate
- 1:1 insulin initiation where necessary
- Education and training on blood glucose monitoring tools
- Follow up telephone support

Provide education and support to the wider primary health care team

4.4 SPECIALIST MANAGEMENT (HOSPITAL BASED CARE) - SERVICE LEVEL 4

A service which provides appropriate specialist management of potential and established complications and diabetes care for those patients requiring complex management of their condition

Patients will always be referred to the specialist diabetes team within secondary care if an emergency/urgent situation arises and in any event if it is deemed necessary that they receive a specialist level of service for complications of the condition, these will include:

Urgent same day referral of:

- Newly diagnosed type 1 – children and adults
- Patients with diabetic ketoacidosis or diabetic hyperosmolar non-ketotic syndrome
Urgent referral of:

- Pregnancy
- Diagnosis where it is uncertain whether a person has type 1 or type 2 diabetes
- Complications – vascular, retinal, renal, foot (including foot ulcers with cellulitis that may require urgent referral for admission to hospital and intravenous antibiotics, signs of infection with bony involvement, critical limb ischaemia and gangrene)
- Diagnosis of Type 2 diabetes in a person under 30 years of age

The following are most appropriately managed under specialist, secondary care services:

- Ongoing management of children, adolescents and young adults
- Patients with type 1 diabetes with complex needs such as:
  - Hypoglycaemia unawareness
  - Jobs requiring shift work
  - Those on complex insulin regimens including insulin pumps
  - Those wishing to carbohydrate count with insulin dose adjustment
  - Those requiring continuous blood glucose monitoring
- Patients with diabetes and another endocrine disorder
- Patients with MODY (Maturity Onset of Diabetes in the Young)
- Pre-pregnancy counselling for patients with type 1 or type 2 diabetes

Providers of the service will:

Admit patients urgently to the Medical Admissions Unit if in:

- DKA
- Hyperosmolar non-ketotic syndrome
- Severe unresolved hypoglycaemia

Assess and initiate treatment for those patients requiring urgent referral.

Provide outpatient clinic services for complicated aspects of diabetes care and for the support and management of those most appropriately managed under specialist, secondary care services as outlined above. Clinic services should provide access to diabetes specialist podiatrist and provide physical, social and educational assessment of needs.
Agree a management plan with the patient and or carer.

Provide education for patients either on a one to one basis or in a group setting as part of the support given for self-management of the condition.

Provide education and support for healthcare professionals working with people with diabetes who need specialist management.

Provide ongoing updates to the patient’s GP.

Assess, initiate and provide initial training and ongoing support for patients with insulin pumps

4.4.1 Inpatient Hospital Care

Ensure that all those with diabetes admitted to hospital for whatever reason, receive effective care for their diabetes and have appropriate access to specialist expertise including:

- Dedicated inpatient diabetes specialist nurse
- Guidelines/protocols to assist with management
- Assistance with care planning, nursing and medical
- Advice on discharge from A&E and emergency assessment units
- Education programmes for ward staff
- Podiatry

5.0 PERSONNEL EDUCATION AND TRAINING

Providers of diabetes services at all 4 Levels will be required to:

i. Name a clinical lead who will be fully responsible for the service and who will link formally with other recognised leads for long term conditions at other levels of the health service.

ii. Provide appropriate, fully trained staff to undertake the care identified. All healthcare professionals delivering the service will be required to demonstrate their professional eligibility, competence, and continuing professional development.

iii. Ensure that the appropriate clinical supervision and appraisal processes are in place to review and develop professionally.

iv. Ensure safe staffing capacity and appropriate caseloads at all times.

v. Demonstrate that they have participated in organisational mandatory and update training, for example conflict resolution, manual handling, and risk assessment as required.

vi. Demonstrate their coordination of and involvement in regular inter-professional and inter-agency meetings and regular clinical audit of the service.
vii. Ensure a staff mix which reflects the needs of the service or high levels of qualified staff as part of a multi-disciplinary team to meet identified care need

6.0 COMMUNICATION

Appropriate communication mechanisms must be in place to:

i. Ensure referral, signposting and communication to appropriate services for patients, including voluntary agencies and community groups.

ii. Demonstrate multi-professional and integrated team working across the whole care pathway and between all those agencies delivering care including secondary care, ambulance trusts, primary care, social care, voluntary and community organisations.

7.0 ESTATES

The service must be provided from premises that are fit for purpose ensuring:

I. Where appropriate community, access, transport provision options are considered as appropriate.

II. All relevant equipment necessary to provide the care outlined in the framework and that this equipment is up to date and regularly maintained.

III. Appropriate equipment to be used and maintained in line with manufacturer’s instructions.

8.0 QUALITY

Providers will be required to demonstrate that:

I. Evidence based clinical guidelines are being used.

II. Appropriate health and safety and risk management systems are in place and that premises are safe.

III. Risk assessments and significant events are both documented and audited regularly and outcomes of these implemented. Services should comply with national requirements for recording, reporting, investigation and implementation of learning from incidents.

IV. Compliance with NICE guidance www.nice.org.uk is also required.
V. Clinical Governance arrangements must be proportionate to the service provided and comply with any local expectations or requirements of the commissioner.

VI. Undertaking Equality Impact Assessments (EQIAs) is a specific legal obligation

VII. As a minimum, core standard C7e of Standards for Better Health stipulates “healthcare organisations should enable all members of the population to access services equally and offer choice in access to services and treatment equitably”.

VIII. Responsive protocols and procedures should be in place for managing patient complaints. Complaints should be reviewed at regular intervals and learning from these shared and applied as appropriate to ensure that services are continually improved.

9.0 PATIENT AND PUBLIC INVOLVEMENT

Providers will be required to demonstrate:

I. Active engagement with patients and local communities in developing services, self care plans or in supporting patients to utilise self care opportunities.

II. How systematic patient feedback is being used to shape and improve services.

III. Openness in planning of local services and adoption of policies that enable members of the public to request information as per the Freedom of Information Act.

IV. Appropriate safeguards to given access to and storage of information as recommended in the Caldicott Report and Data Protection Act 1998.

10.0 INFORMATION MANAGEMENT REQUIREMENTS

Providers will be required to:

I. Ensure appropriate, contemporaneous medical records are maintained for patients they see.

II. Ensure any communications strategy or provision should be coherent with and follow local policies and the Department of Health Code of Confidentiality, local child and adult protection procedures, and should outline the mechanisms to safeguard patient information when shared within an integrated service.
III. Analyse information in order to help demonstrate service quality, effectiveness and provider performance. This will include:

- Regular feedback from users of the service to monitor achievement of the standards set out within this framework.

- Quarterly audit that will demonstrate activity levels and service outcomes are being achieved and also clinical quality standards are being achieved.

An annual report which as a minimum must cover the following areas:

- **Service Activity** – Volume of work against any agreed activity levels and distance from profile, capacity, needs and demand analyses.

- **Clinical Outcomes** – Regular analysis and interpretation of clinical outcomes data.

- **Patient Experience** – Patients views on their experiences and satisfaction levels.

- **Value for Money** – Cost effectiveness or ‘best value’ analyses of the primary service outcomes in relation to comparative costs of hospital activity or those services providing equivalent quality of care.
11. References


National Institute for Health and Clinical Excellence (NICE) Guidelines and Technology Appraisals
Diabetes Care in Lincolnshire:

Introduction: Future Pathway Concept

The commissioners, NHS Lincolnshire and associated Practice Based Commissioning Clusters, have taken the positive step to pursue a transformational approach towards a new model for diabetes care across the county. The inequity due to differing approaches and care available in different localities is unacceptable and a single model of care is to be commissioned for Lincolnshire. This new model takes into account the best practice research presented in the Stage 1 report and is aligned with the Diabetes NSF, NICE guidance and DH guidance.

The team proposes a significant increase in effort put into screening and education both for primary prevention of diabetes and secondary prevention of the complications of diabetes. The pathway proposes to radically change the way care is delivered, with a significant shift in care from the secondary sector to community care, however maintaining specialist support in order to ensure clinical safety and quality. The future pathway is also designed to be fit for the future, taking into account projected changes in the size and make up of the population of the county over the coming years.

A supporting item is the aim to move to a single shared record across all providers. There is currently an initiative underway within the NHS Lincolnshire IM&T function to investigate the option of giving secondary care consultants access to the primary care record, together with mobile working for community workers.

Major Areas of Change:

Care Pathway

There will be an integrated 4 level service, as outlined in Table 1, the details of responsibilities and activities to be carried out by each service tier are detailed in Table 2. A ‘shared care’ approach, supported by multidisciplinary team working, common information systems and system wide adherence to agreed care pathways, will ensure integrated working across levels and disciplines so that care is seamless for the patient.

This is an adaptation of the Bolton PCT 5 level model of care, with a clear progression of knowledge level and skill in response to patient requirements. This presumes a ‘minimum level of service’ that will be delivered by all GP practices, as indicated in the first column of the table.
Identification of IGT
Diet Controlled
Tablet Controlled
Insulin Controlled
and possible new
therapies
Insulin initiation
Problem and
unstable patients
Gestational
Young People
Hospital Care
Complications

1 GP
2 Supported GP
3 Specialist community care
4 Hospital based care

Table 1: Outline of service tier responsibilities

Tier 2 activities may be delivered by a group of local practices or by one practice for its neighbours. The specialist community care service will provide services for each cluster, supporting and training local GPs to take on a tier 2 role themselves, while providing the specialist community based care defined by tier 3. In turn the specialist community care service will be supported by secondary care (tier 4) consultants delivering community and secondary care clinics.

Community clinics will be co-located (and preferably simultaneous) with tier 3 and tier 4 presence, providing a ‘one-stop’ service, with GPSI, DSN and allied professional (podiatrist, dietician, CPN / psychology, social service) and secondary care consultant, clinics allowing easy escalation of issues and shared learning.

Referral from Tiers 1 and 2 will be predominantly to tier 3, though direct referral to tier 4 will be an option where clinically appropriate. The tier 4 clinicians may choose to deliver the care requested in either community or hospital setting as appropriate, potentially enabling specialist input and then tier 3 follow up under consultant supervision.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Key Service Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1: Core Primary Care (GP)</td>
<td>Promoting healthy lifestyles through the delivery of weight reduction courses, exercise programs and smoking cessation programs - 1:1 support</td>
</tr>
<tr>
<td></td>
<td>Systematic and opportunistic screening for diabetes and IFG/IGT and complications of diabetes</td>
</tr>
<tr>
<td></td>
<td>Maintaining risk registers</td>
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<tr>
<td></td>
<td>Raising awareness of the signs and symptoms of diabetes</td>
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<td></td>
<td>Agreement of management plans with patients with type 2 diabetes who are controlled by diet or oral medication</td>
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<tr>
<td></td>
<td>Referral to structured education or relevant specialist(s), including smoking cessation and weight management</td>
</tr>
<tr>
<td></td>
<td>Access to retinal screening</td>
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<tr>
<td></td>
<td>Access to appropriate psychological support (low level)</td>
</tr>
<tr>
<td></td>
<td>Appropriate review (Annual minimum)</td>
</tr>
<tr>
<td></td>
<td>Confirmation of initial diagnosis for those patients outside of normal parameters</td>
</tr>
<tr>
<td></td>
<td>Referral to ongoing support for self care</td>
</tr>
<tr>
<td></td>
<td>Referring on to level 4 for women with diabetes considering pregnancy</td>
</tr>
<tr>
<td>Level 2: Enhanced Primary Care (supported GP)</td>
<td>As level 1 plus:</td>
</tr>
<tr>
<td></td>
<td>Agreement of management plans with patients with Type 1 and type 2 diabetes managed with insulin or new therapies</td>
</tr>
<tr>
<td></td>
<td>Treatment and management planning for patients poorly controlled at levels 1</td>
</tr>
<tr>
<td>Level 3: Specialist Community Care</td>
<td>As level 2 plus:</td>
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<tr>
<td>----------------------------------</td>
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</tr>
<tr>
<td></td>
<td>Promoting healthy lifestyles through the delivery of weight reduction courses, exercise programmes and smoking cessation programmes</td>
</tr>
<tr>
<td></td>
<td>Treatment and management planning for patients poorly controlled at levels 1 and 2</td>
</tr>
<tr>
<td></td>
<td>Delivery of structured education courses for patients diagnosed type 2 diabetes</td>
</tr>
<tr>
<td></td>
<td>Access to appropriate psychological support (moderate level)</td>
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<tr>
<td></td>
<td>Insulin and new therapies initiation</td>
</tr>
<tr>
<td></td>
<td>Access to specialist dietetics</td>
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<tr>
<td></td>
<td>Podiatry</td>
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<tr>
<td></td>
<td>Pre-and post pregnancy advice in conjunction with level 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 4: Specialist Care (hospital based)</th>
<th>Support of level 2 and 3 and working with them to manage patients with complex problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Complex obesity management</td>
</tr>
<tr>
<td></td>
<td>Classification of genetic and autoimmune disorders</td>
</tr>
<tr>
<td></td>
<td>Psychological support (specialist)</td>
</tr>
<tr>
<td></td>
<td>Delivery of structured education courses for patients with type 1 diabetes</td>
</tr>
<tr>
<td></td>
<td>Appropriate review of type 1 and complex type 2 patients</td>
</tr>
<tr>
<td></td>
<td>Acute in patient management including for patients admitted with but not because of diabetes</td>
</tr>
<tr>
<td></td>
<td>Rapid access clinics</td>
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<tr>
<td></td>
<td>Insulin pump clinics</td>
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<td></td>
<td>Pregnancy care</td>
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<tr>
<td></td>
<td>Pre and post pregnancy advice</td>
</tr>
<tr>
<td></td>
<td>Optimising diabetic therapies for complex patients</td>
</tr>
<tr>
<td></td>
<td>Multidisciplinary foot clinics</td>
</tr>
<tr>
<td></td>
<td>Managing patients with significant and treatable complications (retinal, vascular, neuropathic, renal, feet)</td>
</tr>
</tbody>
</table>

**Screening and primary prevention**

Screening / case finding will be widened to cover patients not diagnosed with diabetes. A PCT-wide primary screening service for diabetes is planned, using a three-step process - questionnaire, followed by a fasting venous blood glucose measurement, followed by a repeat fasting venous blood glucose or oral glucose tolerance testing where indicated, this is based on the screening approach adopted in Nottingham (Fig 1).

This primary screening will reach out to the disenfranchised and geographically isolated by utilizing central PCT population listings supported by data analysis to identify ‘hard to reach targets’.

Secondary prevention / screening for complications will include 100% coverage for diagnosed diabetics of the four mandated annual checks.

- The retinopathy service is delivery to a high standard and will be supported to adhere to national guidance.
- Foot assessment will be initiated by specialists in every case and the integrity and standard of ongoing screening in primary care will be supported.
- Renal - microalbuminuria
- Cardiovascular – BP and cholesterol
Patient Education for secondary prevention

Education must be considered for both patients and providers.

For Patients: as a minimum patients newly diagnosed with diabetes will have access to focused education. For patients diagnosed with Type 2 diabetes the Spotlight service will be available. For patients diagnosed with Type 1 diabetes the Select service will be offered. In addition ‘top up’ education will be delivered in an ongoing program to maintain and improve individual’s knowledge and ability to self care.

Education may be considered to include other self care management services such as the Phoenix Weight Management Service and smoking cessation.

For providers: the closer working environment generated by the new community model of care will enable all types of community providers to work together and with acute sector consultants. This will allow informal learning and the rotation of peripatetic community workers through the shared community clinics (and hospital roles for DSNs).

More formalized learning will encourage practices to sign up to an agreed education program, enabling them to move from tier 1 to tier 2 service, and raising confidence and hence the threshold for referral to higher level services for the management of complications.

---

Fig 1 Nottingham Diagnostic protocol

TWO DIAGNOSTIC ELEMENTS NEEDED

- Symptoms of diabetes?
- Yes
- No

**For Patients:**
- Newly diagnosed with diabetes will have access to focused education.
- Type 2 diabetes: Spotlight service.
- Type 1 diabetes: Select service.
- Ongoing ‘top up’ education.

**For Providers:**
- Closer working environment in new community model of care.
- Formalized learning for higher level referrals.

---

**Symptoms of diabetes?**

- Yes
  - Fasting plasma glucose ≥7.0 mmol/l
  - Random venous plasma glucose ≥11.1 mmol/l
  - 2 hour venous plasma glucose ≥11.1 mmol/l on OGTT
  - PLUS, on a separate day
  - Fasting plasma glucose ≥7.0 mmol/l
  - Random venous plasma glucose ≥11.1 mmol/l
  - 2 hour venous plasma glucose ≥11.1 mmol/l on OGTT
  - Most cases are diagnosed in this way
  - DIABETES

- No
  - PLUS

---

**Fig 1 Nottingham Diagnostic protocol**

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**PHOTO**

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**DIABETES**
**Foot Care and Podiatry**

Foot Care and Podiatry is an important component of the care of people with diabetes. It helps to avoid morbidity due to foot ulceration and amputation, thus helping those with diabetes to maintain their quality of life. NICE guidance states that all people with diabetes require foot care examination and review, at least annually, to detect risk factors for ulceration. There is clear evidence to indicate that specialist support delivers improved outcomes and Lincolnshire will commission the appropriate resources.

**Psychological Support**

Psychological support will be available as an adjunct to education and as a preventative measure to help prevent adverse emotional responses such as depression, which impacts on disease control and cost. It will be applied in a targeted way rather than offering it to everyone i.e. younger patients and those starting insulin therapy, are prime candidates.
### Performance Indicators - Appendix B

<table>
<thead>
<tr>
<th>Indicators</th>
<th>How Measured (1)</th>
<th>Baseline</th>
<th>Target</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1. People at risk of developing diabetes should be encouraged and supported to lead a healthy lifestyle.</td>
<td>Physical activity and diet advice recorded Obesity registers NHS Health Checks Programme</td>
<td></td>
<td>100% of people identified at risk of developing diabetes are offered lifestyle advice</td>
<td>Better Metrics (2) BM 4.01 Overweight and obesity prevalence and strategies.</td>
</tr>
<tr>
<td>2. People will receive an accurate and timely diagnosis of diabetes in accordance with WHO diagnostic criteria and Lincolnshire Diabetes Guidelines.</td>
<td>Number of people on diabetes registers in line with predicted prevalence (QOF DM19)</td>
<td></td>
<td>By 2013 all people presenting with signs and symptoms of diabetes are diagnosed in line with WHO criteria</td>
<td>BM 4.02 Effective diagnosis</td>
</tr>
<tr>
<td>3. People will receive a full review of their diabetes, at least annually. To include clinical management of:</td>
<td><strong>Glycaemic Control (QOF)</strong> % of patients with a record of HbA1c in the last 15m (DM5) % of patients in whom last HbA1c is 7.0% or less in last 15m (DM23) % of patients in whom last HbA1c is 8 or less in last 15m (DM24) % of patients in whom last HbA1c is 9 or less in last 15m (DM25)</td>
<td>68% of known people with diabetes have an HbA1c of 7.5% or less Use 09/10 QOF info to establish baselines</td>
<td>By 2013 80% of known people with diabetes will have a HbA1c of 7.5% or less</td>
<td>BM 4.04 HbA1c</td>
</tr>
<tr>
<td>Indicators</td>
<td>How Measured</td>
<td>Baseline</td>
<td>Target</td>
<td>Comment</td>
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<td>------------------------------------------------</td>
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<tr>
<td><strong>Indicators</strong></td>
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<tr>
<td><strong>How Measured</strong></td>
<td></td>
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<tr>
<td>All newly diagnosed patients to receive dietetic advice and support.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Dietetic advice and support to be available to all patients if requested.</td>
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<tr>
<td><strong>Macro vascular Risk (QOF)</strong></td>
<td></td>
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<tr>
<td>% of patients with a record of cholesterol in the last 15m (DM16)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>% of patients in whom last cholesterol measurement is 5 or less (DM17)</td>
<td></td>
<td></td>
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<tr>
<td>% of patients with a record of BP in the last 15m (DM11)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients in whom last BP is 145/85mm or less (DM12)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Micro vascular Complications (QOF)</strong></td>
<td></td>
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<tr>
<td>% of patients with a record of microalbuminuria testing in previous 15m(DM13)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>% of patients with proteinuria or microalbuminuria who are treated with ACE inhibitors or A2 antagonists. (DM15)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

BM 4.05 Macro-vascular risk

BM 4.06 Micro-vascular complications
<table>
<thead>
<tr>
<th>Indicators</th>
<th>How Measured</th>
<th>Baseline</th>
<th>Target</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients with a record of retinal screening in the last 15m (DM 21).</td>
<td>% of patients with a record of retinal screening in the last 15m (DM 21).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients diagnosed with retinopathy.</td>
<td>% of patients diagnosed with retinopathy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot Ulceration (QOF)</td>
<td>% of patients with a record of the presence or absence of peripheral pulses in the last 15m (DM9)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients with a record of neuropathy testing in the last 15m (DM10)</td>
<td>% of patients with a record of neuropathy testing in the last 15m (DM10)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients having had a foot check annually</td>
<td>% of patients having had a foot check annually</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifestyle Advice (QOF)</td>
<td>The percentage of patients who have had their BMI recorded in the previous 15m (DM2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking status recorded and advice given</td>
<td>Smoking status recorded and advice given</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Patient Experience                                                     | % of patients offered and received an education programme that meets quality criteria for structured education programmes. | NHS Lincolnshire Diabetes Community Health Profile | All newly diagnosed patients to be offered an education programme to suit their needs e.g. Spotlight, EPP by 2013. | BM 4.07 Foot Ulceration |

|                         |                                                                 | NHS Lincolnshire Diabetes Community Health Profile | All newly diagnosed patients to be offered an education programme to suit their needs e.g. Spotlight, EPP by 2013. | BM 4.08 Smoking |

<p>|                         |                                                                 | NHS Lincolnshire Diabetes Community Health Profile | All newly diagnosed patients to be offered an education programme to suit their needs e.g. Spotlight, EPP by 2013. | BM 4.09 Patient education and empowerment |</p>
<table>
<thead>
<tr>
<th>Indicators</th>
<th>How Measured</th>
<th>Baseline</th>
<th>Target</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(National Diabetes Audit NDA) (Specialist Service Audit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. People and their carers (where appropriate) should be able to access refresher education if required</td>
<td>% of patients request refresher education</td>
<td></td>
<td></td>
<td>DoH and NICE</td>
</tr>
<tr>
<td>3. People will have an agreed plan of care with personal goals.</td>
<td>% of patients with completed care plans recorded at annual review.</td>
<td></td>
<td>By December 2010 all people with Diabetes will be offered a personalised care plan which provides self care advice, condition management advice, lifestyle advice, etc</td>
<td>BM 4.12 Annual review/care planning</td>
</tr>
<tr>
<td></td>
<td>Improved patient engagement, quality of life and levels of self management.</td>
<td></td>
<td>To improve rating across the County year on year</td>
<td>Utilise learning from Year of Care Project</td>
</tr>
<tr>
<td></td>
<td>(Healthcare Commission Survey)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Improved patient satisfaction in respect of ease of access, attention /interaction, respect for the individual, knowledge gained, empowerment and age / cultural appropriateness</td>
<td>Locally agreed patient satisfaction surveys, National Audits</td>
<td></td>
<td></td>
<td>BM 4.03 Patient experience and engagement</td>
</tr>
<tr>
<td>5. Robust user and carer involvement in service improvement plans</td>
<td>User and carer involvement project and Diabetes Reference Group</td>
<td></td>
<td></td>
<td>Work with local PPI teams and Diabetes UK to devise suitable patient experience questionnaires</td>
</tr>
<tr>
<td>Indicators</td>
<td>How Measured (1)</td>
<td>Baseline</td>
<td>Target</td>
<td>Comment</td>
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</tr>
<tr>
<td>Corporate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. People are not inappropriately referred to hospital outpatient department</td>
<td>Reduction in outpatient referral rates. (HES)</td>
<td>To be identified</td>
<td>Agree 65% reduction in outpatient attendances by April 2013</td>
<td>BM 4.11 Diabetic Emergencies</td>
</tr>
<tr>
<td>2. People are not admitted to hospital inappropriately.</td>
<td>Reduction in the number of admissions and re-admissions due to complications of diabetes. (HES)</td>
<td></td>
<td>20% reduction over 3 years</td>
<td>Realistic state assumption Courtyard report</td>
</tr>
<tr>
<td>3. People are managed effectively whilst in hospital.</td>
<td>Length of Stay (LOS) ratio of diabetes patients compared to non-diabetes patients. (HES)</td>
<td>Take figure from Regional Audit</td>
<td>To reduce LOS to at least the average nationally by 2010</td>
<td>BM 4.13 Length Of Stay</td>
</tr>
</tbody>
</table>