



Improving Diabetes Services – The NSF Two Years On

*Report from Dr Sue Roberts,
National Clinical Director for Diabetes,
to Secretary of State for Health*

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Improving Diabetes Services – The NSF Two Years On

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National Clinical Director for Diabetes,
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Diabetes NSF Standards to be Reached by 2013

Prevention of Type 2 diabetes	<p><i>Standard 1</i></p> <p>The NHS will develop, implement and monitor strategies to reduce the risk of developing Type 2 diabetes in the population as a whole and to reduce the inequalities in the risk of developing Type 2 diabetes.</p>
Identification of people with diabetes	<p><i>Standard 2</i></p> <p>The NHS will develop, implement and monitor strategies to identify people who do not know they have diabetes.</p>
Empowering people with diabetes	<p><i>Standard 3</i></p> <p>All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in this process.</p>
Clinical care of adults with diabetes	<p><i>Standard 4</i></p> <p>All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimise the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.</p>
Clinical care of children and young people with diabetes	<p><i>Standard 5</i></p> <p>All children and young people with diabetes will receive consistently high-quality care and they, with their families and others involved in their day-to-day care, will be supported to optimise the control of their blood glucose and their physical, psychological, intellectual, educational and social development.</p> <p><i>Standard 6</i></p> <p>All young people with diabetes will experience a smooth transition of care from paediatric diabetes services to adult diabetes services, whether hospital or community based, either directly or via a young people's clinic. The transition will be organised in partnership with each individual and at an age appropriate to and agreed with them.</p>
Management of diabetic emergencies	<p><i>Standard 7</i></p> <p>The NHS will develop, implement and monitor agreed protocols for rapid and effective treatment of diabetic emergencies by appropriately trained healthcare professionals. Protocols will include the management of acute complications and procedures to minimise the risk of recurrence.</p>

Care of people with diabetes during admission to hospital	<p><i>Standard 8</i></p> <p>All children, young people and adults with diabetes admitted to hospital, for whatever reason, will receive effective care of their diabetes. Wherever possible, they will continue to be involved in decisions concerning the management of their diabetes.</p>
Diabetes and pregnancy	<p><i>Standard 9</i></p> <p>The NHS will develop, implement and monitor policies that seek to empower and support women with pre-existing diabetes and those who develop diabetes during pregnancy to optimise the outcomes of their pregnancy.</p>
Detection and management of long-term complications	<p><i>Standard 10</i></p> <p>All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.</p> <p><i>Standard 11</i></p> <p>The NHS will develop, implement and monitor agreed protocols and systems of care to ensure that all people who develop long-term complications of diabetes receive timely, appropriate and effective investigation and treatment to reduce their risk of disability and premature death.</p> <p><i>Standard 12</i></p> <p>All people with diabetes requiring multi-agency support will receive integrated health and social care.</p>

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Foreword



The Diabetes National Service Framework and its subsequent Delivery Strategy lay out standards of service and ways of achieving them that will result in a world-class diabetes service for patients in England. It was recognised at the outset that this would not be achieved overnight and that a ten-year time scale would be required for the existing inequalities in service provision and outcomes to be overcome.

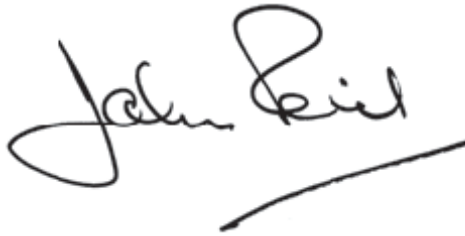
When the Diabetes NSF was published it was, and remains, in the vanguard of moving the patient to the heart of the NHS. It describes a system of care where the person with diabetes is at the centre of decision making. One where healthcare professionals work in true partnership with people with diabetes – jointly designing and delivering individual care to meet individual needs and choices.

However, diabetes is for life. The central role that people living with diabetes have in managing it day by day, 365 days a year is also recognised within the NSF. This approach to all long-term conditions is reflected in *Supporting People with Long term Conditions* and the *Choosing Health* White Paper, published last year. These acknowledge not only the role that health services and other agencies play in providing good care but also in providing the information and support to enable people to become more responsible for the way they live their lives and the possible impact on their own health.

Taken together the focus on patient involvement and self-management require considerable change to the way many services are delivered. An evolutionary approach is required that builds on the existing excellent work that is being done but that transforms itself to meet the requirements of the new agenda.

It is heartening that this report contains so many examples where this approach is producing considerable improvements in the services provided to people with diabetes. Where patients are becoming truly involved in their own care, where they are joining with clinicians and managers to redesign services to meet new demands, where the need for new skills and ways of working are being identified and met, and where multi-disciplinary working is tackling the often complex health requirements of people with long-term conditions.

All of this is a tribute to the skills, experience and commitment of those working in the diabetes community. I am confident that the year ahead will see even more progress made towards attaining the NSF Standards and improving the care of people with diabetes.

A handwritten signature in black ink, appearing to read "John Reid". The signature is written in a cursive style with a long horizontal stroke extending from the bottom of the name.

The Rt Hon John Reid MP
The Secretary of State for Health

1 Introduction



The National Clinical Director for Diabetes leads the implementation of the Diabetes National Service Framework. I am working with colleagues in the Department of Health and the National Diabetes Support Team (NDST) to spread good practice and provide professional leadership at a national level.

Diabetes is a chronic and progressive disorder that impacts upon almost every aspect of life. It can affect children, young people and adults of all ages, and is becoming more common. The number of people with diabetes continues to grow with an estimated 1.8 million people in the UK diagnosed and a further 1 million undiagnosed.

Although there is considerable research into the condition, diabetes remains a long-term condition for which there is no proven cure, only treatment. It can affect every organ in the body, and may lead to complications such as blindness, heart disease kidney failure and amputations, and affect mental health and well being.

The increased prevalence of diabetes is caused by a number of factors such as an ageing population, obesity and low levels of activity. Another important factor for diabetes is the changing ethnic mix of the population. People from black and minority ethnic communities are six times more likely to develop the disease, suffer from a 50% increased risk of heart disease and have much higher levels of kidney disorders. The care of people with diabetes can also be complex with 25% of people suffering from three or more other long-term conditions.

The end result is that diabetes has a heavy impact on the lives of the people who have it, their family and friends. The impact on the resources of the NHS is significant, with an estimated £5 million a day being spent on treatment. Much of this is due to the cost of complications which are now preventable with good professional care and good self management.

Another significant factor that marks diabetes care are the wide disparities in outcomes, with up to eightfold difference in blindness and amputations rates in people with diabetes between different parts of the country and different socio-economic groups.

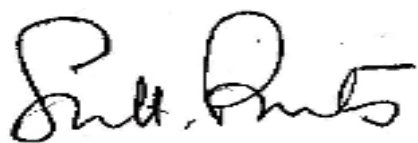
In December 2001, the Diabetes National Service Framework (NSF) was published. The NSF set out the first ever set of national standards for the treatment of diabetes to raise the quality of NHS services and reduce unacceptable variations between them.

The Standards were followed in January 2003 by the Diabetes Delivery Strategy. The Delivery Strategy built in a framework for local people to make local decisions on delivering the standards.

Together the NSF and the Delivery Strategy produce a vision of how services should be in 2013 and the steps necessary to deliver those services. It was recognised right from the start that this was a 10-year programme of change and improvement and that achieving the standards would take time.

The first year was marked by encouraging local services to gain understanding of the challenges they faced and putting the necessary structures and processes in place to support improvement. It emphasised the importance of partnership working in networks, between people with diabetes themselves, diabetes specialists and those in primary and social care to ensure that no one falls through the net and everyone with diabetes has access to the highest quality care, tailored to individual need and choice.

In this report, I describe the progress that has been made in the second year of implementation of the NSF. It demonstrates that real action to tackle some of the existing challenges has been taken and the hard work and innovative thinking involved. However, I am aware that the service provided to people with diabetes is, on the whole, still patchy and piecemeal. The coming years will have to witness measurable progress in working towards the NSF Standards.

A handwritten signature in black ink, appearing to read 'Sue Roberts', written in a cursive style.

Sue Roberts
National Clinical Director, Diabetes NSF

2 Progress and challenges

Our overall goal is to make best practice the norm. The NSF Standards and Delivery Strategy aim to deliver a service built around the needs of people with diabetes. This involves a 10-year programme of change to enable more people to live free of diabetes and more people to live free from the complications of diabetes and their consequences.

Progress

The past year has seen a considerable number of local and national programmes and achievements to improving diabetes care. A small fraction of these are reported in this report.

The National Diabetes Support Team (NDST) has been set up and is starting to provide practical support to frontline diabetes services. The spread of local diabetes networks continues, with 89% of PCTs now part of a whole system diabetes network or community¹. There are currently a total of 158 diabetes networks identified in England, at various stages of development.

The importance of user involvement has been recognised as a priority by PCTs; 82% of PCTs have identified a user champion for diabetes and user representatives are involved in influencing service delivery through membership of their local diabetes network.

Key improvements have been made in patient education to support self-management and information gathering and analysis, which will underpin the organisation of good care.

¹ *Your Local Care* – a Dr Foster/Diabetes UK survey, November 2004

Challenges

Despite the progress that has been made, there remain areas that will need further development in order to reach the NSF Standards.

A greater focus is required on the specific needs of children and young people with diabetes to ensure that they receive the best possible care in their early life to prevent complications later on. It is crucial to ensure that young people experience a smooth transition of care between paediatric diabetes services to adult diabetes services.

More work is needed to ensure that people with diabetes have a named contact and a jointly agreed care plan, in order to enhance their personal control over their condition.

3 Summary

The structure of this report has been designed to reflect the three key themes behind the Diabetes NSF. These are:

- Patient-centred care

Patient-centred care is key for people with diabetes. Self-care can be a complex issue, and it is vital that people with diabetes have the skills they need to manage their condition effectively. Care should be tailored around the needs of the individual wherever it is delivered, and patients should be able to work in partnership with their healthcare professionals to draw up an agreed care plan. User involvement in service design is also important in order to ensure that diabetes services are fit for purpose.

- Working together

Working together is key for local and national services. Experience has shown that better health outcomes and a reduction in health inequalities can be achieved if services are integrated at all levels throughout the system. There are already some excellent examples of specialist services supporting primary care to ensure that resources are used appropriately. Diabetes networks have a key role in promoting excellent care across organisational boundaries.

- Support for service delivery

A wide range of different types of support are available to help services deliver high-quality care. This includes providing support to deliver national targets, employing effective knowledge management systems, and supporting the development of a well-trained workforce.

4 Patient-centred care

"I want to live with diabetes not suffer from it."

A person with diabetes

Standard 3 of the Diabetes NSF aims to ensure that people with diabetes are empowered to enhance their personal control over the day-to-day management of their diabetes in a way that enables them to experience the best possible quality of life.

Patient-centred care is essential in order for services to match individual care with individual needs. Major progress has been made in promoting user involvement and partnership working, often using imaginative and innovative techniques.

4.1 Support for self-care

Supporting self-care is a crucial aspect of any high-quality diabetes service, and the Diabetes NSF recommends structured patient education as an important part of this.

High-quality structured education can have a profound effect on biomedical outcomes, and can significantly improve quality of life and satisfaction.

The aim of patient education is for people with diabetes to improve their knowledge, skills and confidence, enabling them to take increasing control of their own condition and integrate effective self-management into their daily lives.

Quality standards

In order to encourage consistently high standards across local and national education programmes, key criteria have been developed that a structured education programme should meet to fulfil the requirements of the NICE Health Technology Appraisal on patient education². These state that in order to be effective, structured education programmes need to have a written curriculum with a sound theoretical base, be quality assured, audited and delivered by trained Educators.

The criteria were developed by a joint Department of Health and Diabetes UK expert group, and are available on the National Diabetes Support Team website at http://www.cgsupport.nhs.uk/diabetes/Structured_education.asp

National programmes

Two national patient education programmes have been developed that meet the national criteria for structured education. These can be commissioned by PCTs for their local area. They are:

- DAFNE for Type 1 diabetes
- DESMOND for Type 2 diabetes

² <http://www.nice.org.uk/page.aspx?o=68326>

DAFNE

Dose Adjustment for Normal Eating (DAFNE) is a skills-based education programme in which people with Type 1 diabetes learn how to adjust insulin to suit their free choice of food, rather than having to work their life around their insulin doses.



“My bottom line in life is to function and DAFNE gives me that ability. For me, it is not a diabetic treatment initiative, it is my life. It informs my hourly, daily, weekly, monthly, yearly decisions; continually improving my health and my contribution to life. I have lost weight and vastly improved my blood glucose control. Together, DAFNE and I are delivering the best results in diabetic care I've experienced in 25 years.”

A DAFNE graduate

DESMOND

Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) is a new structured group education programme for people with Type 2 diabetes. DESMOND has a theoretical and philosophical basis; the programme supports patients in identifying their own health risks and responding to them by setting their own specific behavioural goals. DESMOND is based in primary care and delivered locally. The DESMOND approach was piloted in early 2004 and is now being rolled-out across the country.

Local programmes

Local teams may already have or be planning to develop local educational programmes. One example is the Diabetes X-PERT Programme. Local programmes should meet the key criteria for structured education, and experience shows that setting up a high-quality local programme may take a year or more.

Diabetes X-PERT Programme

This is a structured group education programme for people with Type 2 diabetes based on the theories of empowerment and discovery learning. It won the HSJ patient-centred care award in 2004 and also the overall Secretary for State's 2004 award for excellence in healthcare management.

The programme was extensively evaluated with a randomised controlled trial and was shown to positively impact on clinical, lifestyle and psychosocial outcomes.



Trudi Deakin, from Burnley, Pendle & Rossendale PCT who developed the programme said: *"I am delighted that X-Pert has won recognition for the role it plays in improving the health and lives of people with diabetes. Such programmes are essential if self-management is to play the central role in treating diabetes that the NSF calls for."*

4.2 Tailored care

“The person with diabetes must manage it 24/7 and a joint approach to an optimal care package is essential. This should be individually tailored to each set of circumstances and levels of understanding and competence.”

Participant in the Hansard Society Diabetes Dialogue

The explicit objectives of the Diabetes NSF include the provision of services that are person centred, enabling people with diabetes to adopt a healthier lifestyle and to manage their own diabetes through education and support that recognises the importance of lifestyle, culture and religion.

Services should be equitable and planned to meet the needs of all groups within the population.

Nichols Town Surgery

A project backed by Southampton PCT involving Nichols Town Surgery demonstrates how effective engagement with minority communities can improve health care. In a practice with 78% black and Asian patients and 6% identified as having diabetes, few people had had their eyes and HbA1C (a measure of glucose control) checked. There were no diabetes clinics and few multidisciplinary teams.



By adopting a patient centred approach that recognised the cultural and language barriers to involvement, significant improvements to patient care were achieved. There was a 97% take up of retinopathy screening, 100% with an HbA1C measurement and the numbers achieving target HbA1c improved considerably. There was also a 39% reduction in drug expenditure.

Dr Abu Chinwalla from the practice said: *"We have worked with the Asian community in Nichols Town to improve both their knowledge of diabetes and how they can actively manage their condition and focus on prevention of diabetic complications. We have aimed to empower people by shifting the balance of responsibility away from medical professionals and towards the patients themselves"*.

An important part of diabetes care is ensuring that care is provided in the most appropriate setting, structured around the needs of the patient.

Hillingdon Consensus Care Diabetes Project

The aim of the project is to standardise care across the whole health economy so that the skills and resources of primary and secondary care staff can be used appropriately to ensure everyone gets the right care in the right place at the right time. Central to this is patient participation in developing evidence-based guidelines and individual treatment plans.

Consensus Care means firstly that the patient and health professionals reach a common understanding on who does what, when, where and how in his/her diabetes care; and secondly, that professionals agree on the care standards set to ensure everyone gives consistent advice. Key benefits are:

- Jointly agreed care plans
- Improved communication between all providers of diabetes services
- Common commitment to each of the clinical evidence-based goals
- Joint learning on how to develop and implement guidelines
- New skills in setting standards for future treatments

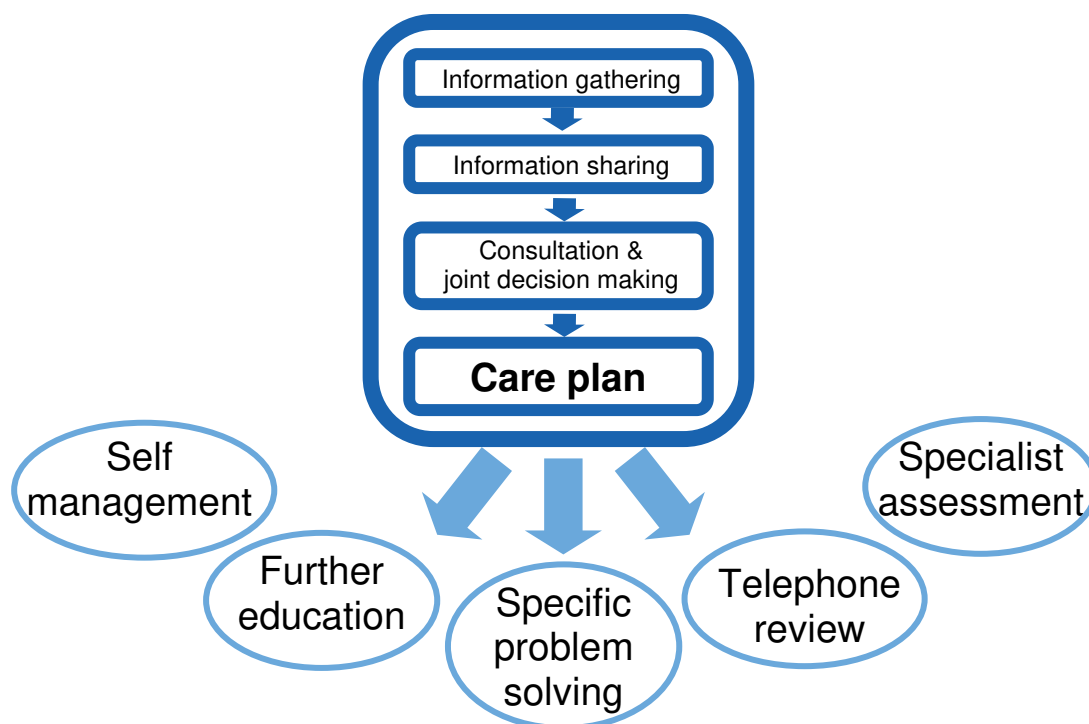
An audit in all practices in Hayes & Harlington showed improvements in numbers of patients with cholesterol and HbA1c within the agreed stringent targets, and there are now plans to launch the project district-wide.

Care planning is an inclusive process that supports an on-going partnership between healthcare professionals and people with diabetes. The process of agreeing a care plan enables people to be actively involved in deciding, agreeing and owning how their diabetes will be managed³.

³ Diabetes National Service Framework, 2001

Care planning in Northumberland

A care planning model is being tested in primary care in Northumberland and in Northumbria Healthcare Specialist Diabetes Service. The model follows a four-stage process and aims to streamline information systems and support joint decision-making. Patients receive their test results before they attend their consultation, which supports the negotiation and makes the care planning process more inclusive.



A patient involved said: *"I liked having the results before my appointment because it was clear which ones were outside the normal range."*

A practice nurse said: *"It was time-consuming to set up, but consultations seem much more productive."*

Initial feedback from staff and people with diabetes in this pilot project has been positive and a formal evaluation is planned.

The Department of Health and Diabetes UK are working together with people with diabetes and healthcare professionals to develop a clear definition of what care planning is, and a common framework that can be used by local services. The collaboration builds on a Diabetes UK workshop on care planning in April 2004⁴.

⁴ *Empowering People with Diabetes - An Exploration of the Role of Personal Diabetes Records and Care Plans*, <http://www.cgsupport.nhs.uk/diabetes/Resources.asp>

4.3 Patients influencing service redesign

“Helping service users believe that what they say is going to influence service provision is the single greatest challenge we face in delivering the NSF: patients and carers are still suspicious; getting them involved in the planning process, and showing them the effect they can have, is vital to producing a patient centred service based around informed choice.”

David Coates, Chair of Leeds User Forum

The involvement of service users is now recognised as an important part of any service redesign. A number of innovative approaches have been focused specifically on increasing the influence of people with diabetes over service development.

User involvement in Northumberland

A primary care locality in Northumberland is funding a community support worker for diabetes. The aim is to use community development methods to engage people with diabetes to influence service delivery. Three groups have been set up, and views expressed at the meetings are recorded anonymously.

In the first year, the groups have concentrated on two areas. The first was a request for more structured patient education and as a result, it was agreed that the DESMOND pilot would focus on that locality. Secondly, the groups queried the quality of the podiatry services, and the specialist team have now set up a group to work on the issues raised.

An important feature of the groups is for communication to be two-way. The groups have greatly improved the local sharps disposal policy, and have helped to develop an information leaflet. They review all the policies and protocols developed by the specialist service and have shaped a user survey. The groups are currently contributing real-life examples to user-awareness sessions for specialist staff so that healthcare professionals have a better understanding of how to integrate user views in their everyday work.

Engaging people with diabetes, their families and carers, healthcare professionals and other staff involved in diabetes care, is also an important part of developing national policy. The Department of Health is currently supporting a Diabetes UK User Involvement project, that aims to improve opportunities and involvement of people with diabetes in the planning and monitoring of delivery of diabetes care services, to ensure they become more patient centred.

Diabetes dialogue

An online consultation on diabetes was launched by Rosie Winterton, Minister of State for Health, in December 2004. This joint initiative by the All-Party Parliamentary Group for Diabetes, the Hansard Society and Sanofi-aventis aimed to capture the views of professionals and people with diabetes.

The consultation lasted eight weeks and attracted 350 participants, making it one of the most successful of the consultations offered, in partnership, by the Hansard Society. 78% of the participants had never before communicated with politicians, showing that the project successfully extended an opportunity for people with diabetes to make their voices heard.



The consultation was supported by visits to Hillingdon and North Tyneside to meet patients and professionals and promote the consultation.

Dr Sue Roberts said: *“The consultation is a great initiative which helps my work tremendously. I log onto the website about twice a week and have taken a huge interest in all the comments made. From these, it is apparent that although the NSF has improved care, much more must be done.”*

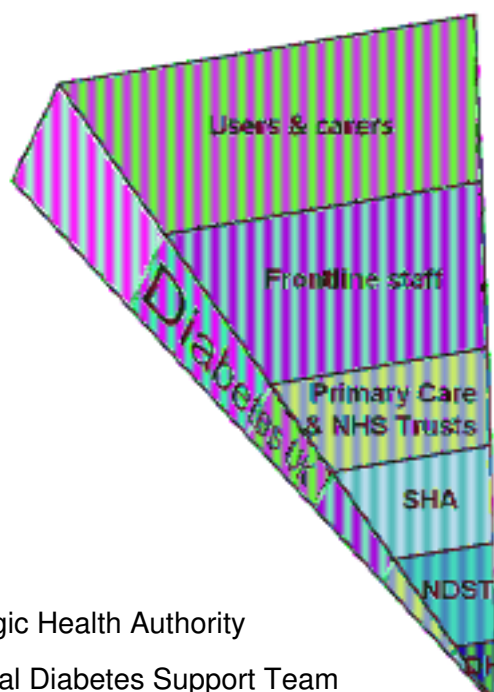
The comments and debates raised by the participants were analysed and collated into a report, written by the Hansard Society. The final report was presented to policy makers, the media, MPs, the Minister, and her team in March 2005.

5 Working Together

Putting the patient at the centre of planning, and delivering high-quality diabetes services requires doing things in a different way. There are usually a number of healthcare professionals working in different organisations that a person with diabetes may encounter; they want and deserve a consistent and joined up service.

Diabetes can affect every organ in the body. In order to provide a seamless service therefore, there needs to be a culture of joint working between a wide-range of healthcare professionals.

Although working in a joined-up way is not easy to do, it is central to successful delivery of the NSF. Partnership working should involve all stakeholders – including the Department of Health, frontline staff and people with diabetes. All these stakeholders have their roles and responsibilities to play and they are described in the Working Together Cone.



Key

SHA: Strategic Health Authority

NDST: National Diabetes Support Team

DH: Department of Health

5.1 Doing things differently

Some new approaches are being developed across the country which can have significant benefits for patients, healthcare professionals and health organisations.

Plymouth

A specialist team in Plymouth has been given funding to increase the team to three whole time equivalents. An audit of the new improved inpatient service has shown a reduction in length of stay of 2.3 days, which translates into a financial saving of over £1,000,000 per year.

Diabetes care has often taken place predominately in secondary care settings. Whilst some patients with diabetes will still require specialist care, much of the outpatient work in secondary care is routine and can be carried out elsewhere, provided that primary care staff receive adequate training and support.

Many areas are looking at new ways of delivering care, to ensure better accessibility, consistency and familiarity, as well as promoting the greater choice of treatment and individual responsibility that people with diabetes should expect.

Sheffield – Specialist Support for Community Diabetes Services (SSCDS)

Specialist support for diabetes care within general practice, has been tested in six practices in Sheffield. The model places greater emphasis on collaboration between primary and secondary care, with specialists supporting GP practices in providing care for an increased number of patients with diabetes.



Each practice is linked to a consultant Diabetologist and one or two diabetes nurse specialists, and this supportive relationship between the specialist and primary care teams is key to the model of care. The practice and specialist teams meet regularly to discuss patient care and management issues. The practices organisational and professional educational needs are identified, and an action plan is put in place to meet these (see Section 6.4).

An audit in one of the practices found that blood pressure, HBA1C and total cholesterol levels were generally lower when under practice care, and the patients were reviewed more frequently by nurses. This allowed more time for specialists teams to manage people with complex problems.

“For me, it’s about relationships, that’s the key; and having close relationships works extremely well” – GP

“It puts care in the heart of the community” – Consultant

Diabetes Services in Bolton - Specialists on the doorstep

People with diabetes in Bolton now receive skilled care at every visit, wherever that takes place. Collaborative work with strong leadership from specialist and primary care has resulted in a single multidisciplinary diabetes team providing support services to every general practice according to choice and need.

In Bolton, collaboration over a number of years led to the logical but radical conclusion that everyone, including the consultant diabetologist, should be part of a single specialist team based in the PCT. This team of doctors, nurses, dietitians and podiatrists has reorganised themselves so they can respond at once with advice and support and just the right amount of help for each problem.

Most people with diabetes are seen in primary care by their practice team. Everyone has been trained by the local specialist team, so the approach and advice is consistent. This common approach emphasises the need for each person with diabetes to receive an individual service based on need and their own choice of treatment. Each practice has a link specialist nurse and consultant who visit the primary care team regularly to provide continuous professional and team development.

Immediate advice is only a phone call away at every practice clinic, so most patients don't need to visit elsewhere to get the answers and help they need. And the specialists are not overwhelmed. Those who do need more, visit the local diabetes centre based in the centre of town, where no one waits more than two or three weeks for an appointment and everyone will have the information and support they need before they see the consultant.

Each practice has an individual agreement about the level of support they need from the team, but everyone has the same access to the same resources and the very best care.

Dr John Dean, one of the architects of the project, said: *"The key to this way of working is collaboration with all players having an agreed vision for care across the district, and a clear view of their role. This has been a transition over many years rather than a revolution. The network structure has enabled close co-operation and partnership between primary, secondary and specialist care with benefits to all of them. Most importantly, it is improving the quality and access to care that individual people with diabetes need."*

Surrey and Sussex

Three PCTs and Acute Trusts in Surrey and Sussex, concerned about the lack of consistent diabetes care pathways, appointed a project officer to liaise with primary and secondary care. One key aim was to link care for diabetes and vascular disease so that patients who often have both problems wouldn't need to make multiple visits.

Through a diabetes Local Implementation Team, a Resource Pack and CD Rom was co-ordinated which provides links to a range of referral pathways as well as relevant Department of Health, NICE and Diabetes UK guidance. The pack also contains pathways to dietetic services, podiatry and weight management. This Resource Pack is now in place in every GP practice and with each specialist team.

Continuing training ensures healthcare professionals have the skills and confidence to use the new resource. A wide range of local training opportunities is available, including introductory courses for nurses, blood glucose and insulin workshops, the University of Warwick Certificate in Diabetes Care, the British Heart Foundation Secondary Prevention of CHD course and a diabetes module on the MSc in Primary Care at the University of Surrey making training accessible at all levels.

Through this training, practices are encouraged to combine their vascular and diabetes clinics, cutting down on duplication of visits for health professionals and people with diabetes and making effective use of skill mix.

Gwen Hall, the project officer at Guildford and Waverley PCT, said: *"The success of what we have planned, organised and put into practice is due to excellent working relationships between primary and secondary care.*

There's huge enthusiasm in the area to improve diabetes care. Local results show a higher than average percentage of people with diabetes are managed within primary care. Our Resource Pack ensures we are giving patients a consistent message while making effective use of available resources and education."

5.2 Joining things up

The NSF Delivery Strategy identified setting up local diabetes networks as key to delivering the NSF Standards. There are 158 diabetes networks in England, and these are at varying stages of development. Some financial support has been made available to support the employment of a network manager or co-ordinator.

A network self-assessment tool is under development so that networks can assess where they are and how they may wish to develop further. Support will be available from the eight new Regional Programme Managers (RPMs) to help with self-assessment and development.

The National Diabetes Support Team (NDST) has provided intensive support for a number of networks to ensure that they are working well and have strategies in place.

Barking, Havering and Redbridge

The NDST worked with local PCTs in outer north east London to establish their Diabetes Action Network (DAN). This brought together people from Barking, Havering and Redbridge with the aim of promoting excellent and consistent levels of clinical care and treatment and education across their areas. The DAN has enabled an audit of key issues across the PCTs highlighting what the priorities are and developing programmes of work to support the Diabetes NSF implementation.

The DAN is based on an ethos of honesty, integrity, professionalism and respect, and is committed to high quality care. They are working towards providing a framework for planning, resources and workforce annual priorities and aim to ensure all patients are aware of all the services across the DAN area. It is chaired by a Chief Executive from a PCT and includes healthcare professionals, managers, people with diabetes and a local authority representative.

Beverly Escoffery, the DAN manager, said: *"Although it is still early days, the DAN has enabled us to realise that delivering high quality diabetes care is made easier when we work as a team across the local area. Establishing agreed priorities between the trusts involved will support more integrated and efficient services."*

Diabetes Care in Leicester, Leicestershire and Rutland

With 36,000 people in Leicestershire and Rutland (LLR) registered as having diabetes, and this projected to grow by 80% to 66,000 by 2010, the need for managed care through a clinical network is clear. The six PCTs and one acute trust in LLR have formed a Diabetes Clinical Network with one PCT, Hinckley and Bosworth, taking a strategic lead role.

The Network Board is chaired by the PCT Chief Executive, and attended by acute trust Specialist Teams, Primary Care, Diabetes Leads and General Practitioners. Each of the specialist groups such as Dieticians, Pharmacists, Podiatrists are represented, as are a number of patient representatives, workforce development, the Strategic Health Authority and Public Health.

The Board has been hosted by all the PCTs using a roving venue concept. Each PCT has invited the Board to a brief presentation of local service provision, whilst trying to engage their local audience in the Board's activities.

The Chief Executive, Colin Blackler, who chairs the Board is committed and proud to be part of such a network, and acts as an advocate with colleagues for the work of the network and the direct benefits for patients. He said: *"The active engagement of service users ensures a continuing focus on the patient experience, and provides a platform for effective mutual appreciation of patients' needs and service delivery issues."*

The inclusion of a wide range of representatives ensures engagement of all stakeholders and helps to join-up expertise with delivery. It is also a reminder to the Network, with four patient representatives, of how much patients need and want integrated service provision.

One of the patient representatives on the Board states: *"The Board provides a mechanism of communication and my views are taken into account. I feel I have an influence and am free to express my views"*

A Diabetes Programme Manager (Network Manager) is employed to oversee the delivery of the NSF targets across all of the six PCTs.

The committed vision of the Network has been translated into resources, with diabetes securing funding for retinal screening, insulin pumps and DAFNE during the last financial year. There is the willingness across all the PCTs to be engaged, and 3 out of 6 have now appointed a Diabetes Specialist Nurse linked to the acute trust. There is trust between the organisations which is difficult to measure or harness, but which can be seen through real improvements to patient care.

The network manager Bernie Stribling said: *"The clinical Network has helped to focus minds on diabetes and to become engaged in a way that can translate into something meaningful"*

5.3 Multi-disciplinary teams

Diabetes care will often involve close collaboration of a wide-range of different healthcare professionals working together to provide joined up streamlined services.

West Lincolnshire

West Lincolnshire PCT has introduced multi-disciplinary primary care clinics, which aim to bridge the gap between GP and specialist care.

The service is provided by a multidisciplinary team of health professionals, including a GP with Specialist Interest, Diabetes Specialist Nurse and Dietician, who have had additional experience and training in the management of diabetes. The service has defined roles and protocols, and referrals are made from GP practices and less frequently, from specialist services.

Each patient is seen by the whole multidisciplinary team at the initial visit, and following assessment and discussion, a care plan is produced. Dependent on their need, they may only see the Specialist Nurse and/or dietician at subsequent visits. Once it is deemed appropriate, the patient is discharged back to their GP for ongoing management.

Dr Clive Ware, the GP with Special Interest, involved in the team said: "An important feature that we have tried to ensure with the setting up of our clinic is that we may be seeing patients with diabetes, but, if we focus on the sugar only, we will not be very effective. Optimising diabetes control and improving the health for the people we are trying to look after, often requires a fresh look at how the condition is affecting the person's life and where they see diabetes in the overall priorities in their life. If someone is depressed or drinking too much alcohol, then this may have a big impact on their diabetes control. Adopting a holistic model, as frequently used in general practice, has been central to our approach.

Having the time to carry out a full medical review and examination at the initial visit, and agreeing a plan of action with the patient, helps to ensure their priorities are addressed and other contributing factors identified."

If complications occur, individual care can become more complex and time consuming for patients and professionals alike. It is important therefore to find ways to link the management of different health problems, such as clinics tackling more than one condition, with social care and other needs.

Wakefield - Diabetes Integrated Foot Care Pathway

An Integrated Care Pathway (ICP) for diabetes foot care has been developed by a multidisciplinary team crossing both primary and specialist care and including consultation from patients via the patient focus group and patient information group.

The aim of the ICP is to reduce the frequency and severity of long-term foot complications in diabetes. The ICP provides a structure and organisation to the foot care needs of people with diabetes. The key feature is that patients will have foot care at a frequency, and by a healthcare professional, appropriate to their needs.



Routine foot care will be provided in primary care with referral to podiatrists and specialist care guided by specific and explicit triggers. In this way, patients with low risk needs will not routinely see podiatrists and patients with complex needs will be managed by a specialist multidisciplinary foot team.

A training package has been developed to support the primary care teams, clarifying the pathway, the initial foot assessment and referral patterns.

Patient education leaflets have also been developed for different level of risk to the foot. The ICP has been piloted in four sites and is currently being evaluated prior to being launched across the district.

“As a person with diabetes of twenty years it feels really good to finally have a say in the future of diabetes care generally and the development of the Integrated Care Pathway for foot care” - Kirsty Samuel, Person with Type 1 diabetes from Wakefield

Specialist teams working in the secondary care setting have also streamlined the care and experience for people with diabetes who have other complications requiring specialist input. This now means that the number of visits to hospital has been reduced and the person with diabetes is having more consistent, joined up care.

Greater Peterborough Primary Care Partnership and Peterborough and Stamford Hospitals Foundation Trust

The specialist team in Peterborough noticed that people with diabetes in end stage renal failure were falling between diabetes and renal services, resulting in patients sometimes missing out on their regular diabetes care. They adopted a three-pronged approach to the problem.

Firstly, the PCP has appointed a named Diabetes Specialist Nurse (DSN) for people with diabetes on renal replacement therapy. This nurse acts at the 'named contact' for all patients on dialysis who now have a person they know and a phone number to use in case they have urgent queries. She also provides diabetes reviews either at the renal clinic or in the patient's home.

Secondly, a peritoneal dialysis clinic has been set up and run by a renal specialist nurse from Leicester, a DSN from the Greater Peterborough Primary Care Partnership and renal specialist Dietician from the Peterborough and Stamford Hospitals Foundation Trust to provide a 'one stop shop' for patients.

Finally, diabetes care technicians now attend the dialysis unit to carry out annual reviews for people with diabetes while they are on dialysis.

June James, the DSN involved in the work, said: *"This work clearly demonstrates how cross-boundary working can benefit people with diabetes in end stage renal failure who traditionally fall between sets of service provision. It also shows that a multidisciplinary team of health professionals and allied health professionals can work together to provide seamless diabetes care for this population"*.

5.4 Government working together

The Department of Health has set challenging targets to improve the health of the population. These include:

- A reduction in health inequalities
- A reduction in smoking and obesity
- Improving health outcomes for people with long-term conditions (LTC), including reducing the time spent in hospital
- Improving patient experience

Achievement of these targets will involve effective collaboration between the various arms of central and local government as well as the voluntary and independent sectors.

The recently published Choosing Health White Paper explicitly calls for greater partnership between all health and social care providers to ensure that organisational boundaries do not become barriers to improved health.

There are several areas of joined up work in government to support local diabetes services. These include:

- **The Vascular Programme Board**

This central Board forms an alliance between the diabetes, CHD, elderly and renal teams with the aim of providing a strategic direction and ensuring that interdependencies within other parts of the Department of Health and the NHS are appropriately identified and managed.

- **Work on long term conditions**

There is common ground between the LTC NSF, the Diabetes NSF and the developing LTC strategy, for example around patient centred care planning, information and support, self care and improving the management of specific conditions.

- **Work on self care**

The Expert Patient Programme (EPP) has been central in spreading good self care and self management skills to a wide range of people with long term conditions, including diabetes. The links between EPP and disease-specific education programmes such as DESMOND are currently being explored.

6 Support for service delivery

The previous two sections have highlighted the complex nature of diabetes care, but demonstrate that real change can be achieved with the appropriate local and national leadership and support. The past twelve months have seen a number of initiatives to support local delivery, many of them focused around the National Diabetes Support Team.

6.1 Support for people with diabetes

Section 4 of this report highlights the importance of supporting self-care through effective structured education and care planning. However, support is also needed to encourage changes in lifestyle that will address both the prevention and treatment of diabetes.

In 2002, almost six out of ten women and seven out of ten men were overweight or obese. This population shift towards overweight and taking less exercise has a knock on effect on the prevalence of Type 2 diabetes. Many localities are looking at ways of engaging their local community and supporting lifestyle changes.

Diabetes On Referral Option To Healthy Exercise for Adults (DOROTHEA)

People with Type 2 diabetes in Lambeth and Southwark are being given help to become more active to improve and maintain their health. DOROTHEA, an exercise on referral project, is being delivered by Kings College London in partnership with Lambeth Primary Care Trust and Guy's and St Thomas' Hospital NHS Trust.



The project is based on published research showing that regular exercise is as effective as drugs at controlling HbA1c, body fat, and insulin resistance, but with the added advantage of increased well being and physical capacity.

The scheme involves an assessment of uptake, lifestyle changes and health outcomes. Patients are asked about their own preferences and concerns, and then receive personalised exercise advice.

The scheme has organised exercise classes in community venues in Lambeth and Southwark, and walking groups in local parks. There is also specific health advice such as the importance of foot care and exercise.

Sports Scientist Claire Pentecost from St Thomas' Hospital, who helped develop the project said: *"The activity a patient chooses will be decided by looking at their health limitations, their preferences and what is realistic for them. Guidance will be provided on appropriate levels of exertion for best results."*

6.2 Support for local services

The National Diabetes Support Team (NDST) was established in 2003, with the role of providing guidance, support and co-ordination to ensure effective implementation of the Diabetes NSF. The NDST works in partnership with diabetes care co-ordinators in SHAS, PCTs and acute trusts throughout England to ensure that the aims and aspirations of the Diabetes Delivery Strategy are implemented as fully as possible.

Eight Regional Programme Managers (RPMs) are now in place to provide a local presence for the NDST. They are actively supporting local networks, PCTs and other service providers. Each RPM has been allocated a region that matches Diabetes UK regions, in order to support close collaboration at a regional level.

The NDST core functions are:

- Network development
- Knowledge management
- Communications

Network Development

Clinically led, managed networks are an essential part of service planning and delivery, promoting seamless care and support staff by targeting resources where they are most needed. They put patients at the centre of service planning and delivery.

The NDST has promoted network development in a number of ways. It has:

- Provided funding to support the 158 local networks to employ network managers to ensure day to day coordination at network level
- Worked with local networks challenged by complex geographical or organisational issues to facilitate their direction and effectiveness
- Employed eight Regional Programme Managers (RPMs), one of whose key functions is supporting and promoting local networks

Knowledge management and communications

One of the essential requirements for developing improved diabetes services is an awareness of recent developments – both in clinical and organisational terms.

The NDST has developed systems and products to facilitate information capture and exchange. These include:

- The NDST web site – www.cgsupport.nhs.uk/diabetes
- An online forum to connect people wanting information with those who have it
- Online support for people to demonstrate and explain their innovations and successes
- Online support for hosting documents and reports relevant to diabetes service development
- Detailed factsheets on specific areas of interest, such as hitting the target for diabetic retinopathy screening
- Communities of practice for specific areas such as patient education and information

These products are communicated to the diabetes community through a variety of means, including an e-mail based NSF Briefing, factsheets, reports, and exhibitions at relevant events.

“I have only recently started using the NSF briefing and it is proving very useful. I have made contact with a couple of people for more information on projects mentioned in the briefing, these contacts would have been hard to find from another source.”

Lyn Murphy, Diabetes Education Facilitator
Watford & Three Rivers Primary Care Trust

6.3 Retinal Screening

Diabetes is the major causes of blindness in people of working age; much of this would be preventable if diagnosed earlier.

To support earlier diagnosis, one of the two Priorities and Planning Framework (PPF) targets in the Diabetes National Service Framework is for diabetic retinopathy screening.

Local delivery is being supported by the UK National Screening Committee (NSC). The NSC's National Screening Programme for Sight Threatening Retinopathy:

- has set standards for quality assurance;
- is developing training and education packages and public and patient information material;
- has agreed a national framework for purchasing digital cameras and related equipment.

The programme has a website - <http://www.nscretinopathy.org.uk> - which provides information and advice on the programme. There is also a hotline - 08454 224468 - and a network of regional support staff who can give advice on all aspects of the screening programme, including issues such as meeting the target, patient confidentiality, screening methods and quality assurance.

A factsheet has recently been published providing clarification on reaching the target, patient confidentiality, screening methods, and quality assurance.

Sutton and Merton

The experiences of Nadeem Khan in setting up the diabetic retinopathy screening programme in Sutton & Merton PCT (SMPCT) demonstrates the often considerable challenges that have to be overcome.

He came from a background outside diabetes and IT procurement. On assessment of the project demands, it was clearly evident that a substantial degree of work would be required in order to establish and develop an effective multi-site screening service across the two borough localities served by SMPCT. Initially, key issues included: (i) assessment and redevelopment of existing ad hoc diabetic retinopathy (DR) screening activity (within Sutton) as part of a systematic screening programme; and (ii) establishment of a retinopathy screening service for Merton (where none had previously existed within the PCT) in order to ensure patients in both localities would be able to receive the highest standards of screening possible.

In developing this programme, joint partnership working within the Trust, support from briefings, advice from the National Screening Committee team, and reference to the approved NSC Workbook (see www.nscscreening.org.uk website) have all been important aspects as SMPCT has worked towards the goal of service delivery.

On current projections SMPCT will have approximately 12,000 people with diabetes registered with the programme during 2005-06. Of these, approximately 30% would be expected to show some evidence of diabetic retinopathy in the first 12-18 months after establishment of the screening service. Typically, 10% would be referred for Ophthalmology assessment and between 3-5% of these referrals would require laser treatment.

Nadeem Khan said: "Our programme is in relatively early stages of development so clearly there are a variety of issues we are dealing with, including various operational demands, additional site developments, IT infrastructure, software modifications and staff recruitment. These crucially underpin our ability to deliver an effective screening programme for the identified population. We are pleased with our current rate of progress (although never complacent!) and confident of achieving the standards (and targets) set out within the National Service Framework for diabetes. Challenges are an inevitable part of the process, some predictable, others not so. However, the end result of fewer people enduring sight loss because of diabetic retinopathy, without question, justifies all our efforts."

Exeter

The Exeter programme is a good example of how an effective retinopathy service can work in practice. This started in 1986 with 2,000 patients but by 1993 that figure had risen to 4,000 and now stands at about 12,500, showing that in 14 years the numbers of people with diabetes within their remit has grown more than 6 fold.

They have successfully treated about 350 people who would otherwise have suffered loss of sight. They established through research that screening was effective, using digital cameras improved detection rate and using graders specifically trained in DR increased the detection rate significantly further. They will continue to collect results to see how systematic QA such as recommended by the National Screening Committee will affect their figures.

6.4 Workforce

A well-trained workforce is crucial to delivering high-quality patient care. Many areas are looking into ways of investing in their workforce and ensuring that all healthcare professionals have access to up-to-date evidence-based information about diabetes.

Sheffield Diabetes Network - Rolling programme of updates for primary health care professionals

The Sheffield model for Diabetes Care (see Section 5.1) is designed around routine diabetes care being provided in primary care and self-management by patients. This means that the primary care workforce needs to be adequately trained and prepared.

The PCTs conducted a baseline assessment of need and resources. The findings revealed a need and desire for diabetes education at all levels, and to cover all aspects of diabetes.

The Institute of General Practice and Primary Care was commissioned to manage and administer the delivery of the programme on behalf of the Network. It is also responsible for quality assuring the programme and providing the Network with regular reports and annual evaluation.

The multi-disciplinary programme is open to all health professionals working in primary care (including care homes) in Sheffield. The programme includes an introductory study day, which covers national and local policy, diagnosis/case finding, screening, initial management and lifestyle change. The day is then followed by a choice of half days updates on specialist areas such as foot care, retinopathy screening and enabling self-management.

The programme has been very well attended with in excess of 300 people attending at least one of the sessions. Attendees have included practice nurses, nurse practitioners, community nurses, health care assistants/support workers, GPs, pharmacists, PCT specialist nurses and care homes nurses.

Evaluation is excellent, with comments that include:

- "Appropriate for non-specialists"
- "Really useful to discuss 'real case'"
- "Very helpful to my practice"
- "Good to know I'm on the right track"
- "Brought home the real reason we are here - patients!!!"

Diabetes Competence Framework

A key building block to support workforce development has been Phase 1 of Diabetes Competence Framework, which was launched in October 2004⁵. This focuses on the routine management of people with diabetes and provides a practical set of tools. It has already been used to develop job descriptions and identify training needs for health care assistants working in a variety of diabetes settings.

Bernie Stribling, Hinckley & Bosworth PCT:

"We have found the Framework invaluable as before it was introduced we only looked at job titles and roles and did not explore competencies, which are an essential part of diabetes management."

Diabetes healthcare in Birmingham

Diabetes healthcare in Birmingham is carried out in primary and secondary care settings. The competence framework was used to help practitioners consider how to redesign the service, to integrate care, and to ensure common standards applied.

A workshop was held for diabetes healthcare practitioners in a variety of roles, including GPs, practice nurses, diabetes specialist nurses, podiatrists, dieticians, consultants and managers to discuss integration of services across primary and secondary care, and how the standards could be used to assist this. The group focused on the parts of the framework concerning foot care and those competence standards which would apply to activities that could be carried out by practice nurses. It was felt that the clear specification of a standard of care in the framework clarified who would and would not be competent to carry out healthcare activities, and what training might be arranged for practitioners.

A consultant diabetologist said: 'If we can agree to joint training using these standards then we can tackle one of the biggest problems facing integration of services. The framework is very, very useful for what we are trying to do.'

Phase 2 of the Diabetes Competence Framework, which will concentrate mainly on managing complications and specific problems, should begin in April 2005.

⁵ http://195.10.235.25/ubbthreads/postlist.php?Cat=&Board=pub_diabetes

7 Measuring improvement

Measuring success will be a crucial part of service delivery. It is important for local services to be able to demonstrate the impact of the changes that are being made, and assess what lessons can be learned and how these can be translated to other areas.

The resources available for NHS Trusts to capture and analyse their diabetes services have expanded over the last twelve months. A number of products are now available to support service improvement.

National Diabetes Audit

The National Diabetes Audit (NDA) was launched in July 2004 with the aim of establishing a voluntary national system for routine data collation, analysis and feedback of diabetes related data.

NDA is the only tool which links the year by year status of a person's diabetes 'health' with the complications they develop. It is the only means of showing if long-term outcomes for people with diabetes are improving.

Dacorum PCT

One of the first Trusts to sign up to the NDA was Dacorum PCT and their experience has demonstrated how easy and useful it is.

"The benefits are huge" said Dr Elizabeth Ponsonby, GP and Clinical Research Assistant. "It fulfils the standards outlined in the NSF to measure processes of care. I foresee real, strong benefits from the NDA if those responsible for providing the service act on the results.

It has the potential to enable improvement in the process of care leading to longer life expectancy, reductions in blindness, amputations and renal failure."

DiabetesE

DiabetesE is a nationally procured, free at the point of use, web-based service that has been made available for three years to enable PCTs, practices and diabetes networks to carry out complete diabetes service assessments, essential for NSF delivery. Two hundred and forty-four PCTs are currently taking part.

Trafford North and South, Morecambe Bay, Torbay and Redbridge are examples of PCTs that have successfully implemented DiabetesE both at PCT and practice level. They have all identified a project lead, set themselves clear targets and timescales, and used individuals with close links to practices to employ DiabetesE as part of a practice in-house education programme.

Users report that DiabetesE can help to improve communication and team building at both PCT and practice level.

"Participants in the completion of the PCT assessment gained a wider understanding of the entire diabetes network and the value and interdependence of their roles within it" said Andy Howard, Service Development Manager (Diabetes and CHD), Trafford North and South PCTs.

The whole process helps to spread best practice, supports action planning and boosts knowledge management – all vital aspects of the NSF.

"It would be very difficult to determine the steps needed to achieve the NSF standards without this sort of tool as every practice is very different." said Dr Ann O'Brien, GP and chairman of the NSF implementation group at Redbridge PCT.

South Bedfordshire Diabetes Network

Luton PCT decided that they needed to establish a robust baseline of their current position, particularly in primary care. National support for DiabetesE provided the opportunity to use a standardised measure with the potential for identifying best practice on a similar scale. The PCT took advantage of early training with Innove in April 2004, and had completed the audit within a couple of months.

The audit results were reported back to the PCT and local Diabetes Network Group, and a presentation was also made to a large audience of primary and secondary care. The expected variation found in service was described and underlined, and as part of the presentation a practice nurse described their learning experience from the audit and subsequent improvements made. A copy of the presentation and the audit report was sent to every Luton GP and practice nurse.

Mark Bampton, Network Manager said: *“The timings have enabled us to combine performance reported through DiabetesE audit and initiated in nGMS at an early stage. We are now in a position to incorporate DiabetesE into an audit cycle to measure continuous improvement across clinical and organisational elements of all aspects of local diabetes healthcare.”*

PBS Diabetes Prevalence Model

One of the vital elements for any service planning its diabetes service is to know how many people with diabetes there are likely to be in the area – whether that is a SHA, PCT or at practice level.

The PBS (Public Health Observatory, Brent, SchArr) model provides an evidence-based approach to assess the prevalence of diabetes in a population. The model generates estimates of expected total numbers of people with diabetes, both diagnosed and undiagnosed, at SHA, Local Authority and PCT level.

The PBS model is integrated into the National Diabetes Audit so that service providers can easily see their predicted as compared to registered number of people with diabetes.

The Better Metrics Project

The aim of this joint initiative between Strategic Health Authorities and National Clinical Directors was to define a set of indicators that could measure what was important in a high quality service and not just what was easy to measure.

Thirteen diabetes-related indicators have been developed covering all the NSF Standards and mapping to the core and developmental National Standards used by the Healthcare Commission.

With the focus of healthcare planning and service delivery now being determined at a local level, the standards can help diabetes networks, if they wish, to set local targets with their SHA after having identified the needs of their local population. Or they may use them to audit a specific part of their diabetes service and compare it with others.

The Better Metrics standards are available at
http://www.osha.nhs.uk/publicpage.aspx?id_Content=455

8 Conclusion

Congratulations and thanks go to everyone who co-operated in providing so much information for this report. It is unfortunate that, for reasons of space, not all of it could be used. However, everything received has been captured and will be kept as examples of good practice across a wide range of work and geographical areas.

This report demonstrates that much good work is being done to implement the Diabetes NSF. The emphasis on true patient involvement, influencing service design to develop tailor made care to meet individual needs is most encouraging. There is a recognition that skills and ways of working need to evolve to match the complex requirements of people with diabetes and other long-term conditions. There is raised awareness of the different cultural issues that can be barriers to receiving effective care and a determination to work with communities to overcome them. There is also considerable evidence that the benefits of working in networks to establish priorities and enhance service delivery are becoming well established.

However, it must be recognised that this is only the second year in a ten-year programme to meet the NSF Standards. There are still unacceptable differences in care and treatment for people with diabetes. There is no room for complacency although there are substantial grounds for optimism. The skill, experience and determination of the diabetes community can be relied upon to transform that optimism into reality.

Appendix A

More information about some of the case studies included in this report is available from the following sources:

Diabetes X-PERT programme - Trudi Deakin on trudi.deakin@nhs.net

Nichols Town Surgery – Abu Chinwala on Abu.Chinwala@gp-J82024.nhs.uk

Hillingdon Consensus Care Diabetes Project - Dr Rowan Hillson, Project Chair on rowan.hillson@thh.nhs.uk

Care planning in Northumberland – Gillian Johnson on Gillian.Johnson@northumbria-healthcare.nhs.uk

User involvement in Northumberland – Gillian Johnson on Gillian.Johnson@northumbria-healthcare.nhs.uk

Sheffield Specialist Support for Community Diabetes Services (SSCDS) – Jonathan Roddick on jonathan.roddick@gp-c88041.nhs.uk

Plymouth – Shirley Baker on Shirley.Baker@phnt.swest.nhs.uk or Elizabeth Moore on elizabeth.moore@phnt.swest.nhs.uk

Bolton – John Dean on John.Dean@boltonh-tr.nwest.nhs.uk or Hannah Dobrowolska on hannah.dobrowolska@bolton.nhs.uk

Surrey and Sussex - Gwen Hall on Gwen.Hall@gwpct.nhs.uk

Barking, Havering and Redbridge – Beverley Escoffery on Beverley.Escoffery@haverinpct.nhs.uk

Diabetes Care in Leicester, Leicestershire and Rutland – Bernie Stribling on Bernie.Stribling@hbpct.nhs.uk

Wakefield - Diabetes Integrated Foot Care Pathway – Gill Day on gill.day@wwpct.nhs.uk

Greater Peterborough Primary Care Partnership and Peterborough and Stamford Hospitals Foundation Trust - June James at june.james@northpboro-pct.nhs.uk

Sutton and Merton – Nadeem Khan on nadeem.khan@smpct.nhs.uk

Sheffield Diabetes Network - Deborah Watkin on D.Watkin@sheffield.ac.uk

Diabetes healthcare in Birmingham - <http://www.skillsforhealth.org.uk/files/630-Guide.pdf>

Dacorum PCT - Elizabeth Ponsonby on Elizabeth.Ponsonby@gp-E82094.nhs.uk

South Bedfordshire Diabetes Network – Mark Bampton on Mark.Bampton@luton-pct.nhs.uk

Appendix B

The following websites provide valuable information about diabetes:

Department of Health

http://www.dh.gov.uk/AdvancedSearch/SearchResults/fs/en?NP=1&PO1=C&PI1=W&PF1=A&PG=1&RP=20&PT1=diabetes&SC=__dh_site&Z=1

National Diabetes Support Team

<http://www.cgsupport.nhs.uk/diabetes/default.asp>

National Electronic Library for Health

<http://libraries.nelh.nhs.uk/diabetes/>

National Screening Committee

<http://www.nscretinopathy.org.uk/pages/nsc.asp?ModT=A&Sec=16>

National Diabetes Audit

http://www.nhsia.nhs.uk/ncasp/pages/audit_topics/diabetes/default.asp

Better Metrics

<http://www.osha.nhs.uk/>

DiabetesE

www.diabetesE.net/demo

NHS Direct

<http://www.nhsdirect.nhs.uk/en.asp?TopicID=157>

Juvenile Diabetes Research Foundation

<http://www.jdf.org/>

Diabetes UK

<http://www.diabetes.org.uk/>

DAFNE

<http://www.dafne.uk.com/>

DESMOND

www.desmond-project.org.uk

NICE Health Technology Appraisal on Patient Education

<http://www.nice.org.uk/page.aspx?o=68326>

Empowering People with Diabetes - An Exploration of the Role of Personal Diabetes Records and Care Plans

<http://www.cgsupport.nhs.uk/diabetes/Resources.asp>

Diabetes Competence Framework

http://195.10.235.25/ubbthreads/postlist.php?Cat=&Board=pub_diabetes



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