

**DIABETES STRATEGIC INITIATIVE  
CONSULTATION REPORT**

**This report provides an update on the consultation carried out  
on strategic commissioning plans  
For diabetes services for adults**

**May 2009**

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## 1. Introduction

### Why are we involving patients and the public?

The Healthcare commission define Patient and Public engagement as

*“as a process through which patients, users of services and communities share their views and experiences with trusts, and work together to plan and improve services”*

Our NHS, Our Future: NHS Next Stage Review – Leading local change, (2008) emphasises the importance of involvement by patients and the public in the delivery of their care and in NHS services, effectively putting the patient at the centre of their healthcare and the NHS.

Previously the emphasis has been talking to people to find out what they think however the future emphasis is more about getting people involved in what we are doing. The aim of this programme of work is to involve patients and the public in the planning and provision for diabetes services for adults.

This report outlines the consultation process that took place, summaries the need, the plans, what people told us in the public consultation and makes proposals for amendments to plans

## 2. How did we talk to people?

Recent research across Leicester has shown that patients and the public like to give their views in a range of ways. This includes:

- completing questionnaires
- attending meetings
- Looking up information on the internet.

Public consultation on the Diabetes Plans took place between the end of December 2008 and the 27<sup>th</sup> March 2009 following consideration and endorsement of the plans by the Leicester City Overview and Scrutiny Committee for Health in December 2008. Public consultation was undertaken as the plans for diabetes include changes in whom and the location from which services are provided for adult people with diabetes.

The consultation was publicised at a Diabetes UK Leicester Support Group meeting, through the NHS Leicester City web site, press releases with 3 articles published in the Leicester Mercury, Leicester LINK, VISTA information service for blind people, and posters in GP surgeries, Pharmacists and Hospital Diabetes Outpatient clinics. Questionnaires were distributed to GP surgeries, any one expressing an interest, the NHS Leicester City patient panel members, Diabetes UK Leicester support group members, VISTA and people attending DESMOND. Questionnaires were available in different languages on request.

A public consultation meeting was chaired by Diabetes UK to mark the end of the consultation and questions from the public were answered by a panel comprising NHS Leicester City Director of Primary Care, Professional Executive Committee chair and GP, a Professor and Consultant in Diabetes Medicine and the Director of DESMOND.

45 people participated in the public consultation meeting, 222 people completed and returned a questionnaire which included 625 comments. Equality monitoring (appendix 1) suggests respondents were fairly representative of the diverse population in Leicester. Following the public meeting questions and comments on the plans were received from the Leicester Mercury Patients Panel and the Leicester Local Involvement Network (LINK).

### **3. Diabetes Plans – what we are proposing**

NHS Leicester City's plans for Diabetes services include:

- Prevention and Patient Self Management providing awareness raising, voluntary support and patient training to help people prevent and manage diabetes. These plans are complemented by NHS Leicester City plans for cardiovascular disease prevention and the early detection of diabetes which include the new NHS health check programme for people aged 40 and above, a Healthy Communities Collaborative pilot to be led by people in the community in partnership with professionals and building on existing initiatives such as the fit and active buddies scheme
- Develop Primary Care to reduce variation and increase skills and capacity to help people manage their diabetes effectively.
- An Integrated Community Diabetes Service (intermediate diabetes care) to provide expert care and advice in the community for people who have blood sugar that is difficult to control who need insulin and to provide support for primary care in managing peoples complications that are difficult to control such as high blood pressure. The service would provide training and advice for Primary Care professionals for example GPs and Practice Nurses and an accreditation programme for Primary Care Professional skilled in initiating insulin for people with type 2 diabetes.
- Improve Hospital Care (specialist and inpatient care) for people with diabetes who need inpatient care. The specialist diabetes service will continue to care for people with complex complications, and be a centre of excellence for research and training. The specialist service will work closely with the Integrated Community Diabetes Service on research and training and provide them with advice when needed.

NHS Leicestershire County and Rutland are developing their plans for diabetes and where these are consistent with NHS Leicester City plans we will explore if these can be taken forward collaboratively.

## **4. Diabetes Plans – What you told us**

### **4.1 Prevention and Patient Self Management**

#### ***Need***

Local research indicates that 1 in 7 people have pre-diabetes and without preventative action would have diabetes within 10 years and significant risk of developing cardiovascular disease and premature death. Research has shown that training for people with pre-diabetes helps them significantly reduce their risk factors for developing cardiovascular disease. The Health Care Commission found that in Leicester people's knowledge of their diabetes, its management and the numbers who have had training to manage their condition was less than the national average. Patient support groups were not representative of people from different communities in Leicester. The DESMOND training programme for patients did not provide access to people with mental health problems.

#### ***Commissioning Plan***

The NHS Leicester City plans for prevention and patient self management of diabetes include:

1. A training programme from 2010 for people with pre diabetes to help them prevent diabetes and reduce their risk of cardiovascular disease
2. A partnership with the voluntary sector in 2009/10 to develop support groups and peer educators to support people with diabetes from disadvantaged communities
3. Increasing the training places available on the DESMOND programme for people with type 2 diabetes to 750 places in 2009/10 and 1500 places in 2010/11 so that 50% of people from 2010 newly diagnosed and 12.5% of people with established type 2 diabetes can access training. The programme would provide equity of access to people with mental health problems.

#### ***What people told us?***

People indicated they were enthusiastic in their support for these plans. They said we should provide shorter and more training places as soon as possible for people newly diagnosed and with established diabetes many of whom had received little or no formal support or information. These should be provided at times accessible to people who work and with alternatives for vulnerable people, who cannot attend group training.

#### ***Proposed amendments to the plan***

In response to peoples' views on plans for prevention and self management we propose to:

- Ensure the training programme for people with pre diabetes can be accessed by vulnerable and working people. We will do this through service specifications and contracts.

- Consider with the voluntary sector how a partnership for voluntary support groups and peer educators can be taken forward as quickly as possible. The specification for the service will incorporate people's suggestions for voluntary groups to be based in communities or GP surgeries.
- Ensure the voluntary services provide consistent messages about diabetes by commissioning the Integrated Community Diabetes Service to provide training for support groups and peer educators.
- Review the contract and specification for DESMOND and commission different options for training, increasing the number and range of places available to people with people with type 2 diabetes. If UHL are not able to provide the training other providers will be given the chance to provide the service through a tender process.

## **4.2 Primary Care Development**

### ***Need***

The strategic review identified variation between practices in care, outcomes, and the prevalence of diabetes. There was also a high proportion of people not included (exceptions) in the primary care quality measures (QOF) for diabetes which includes people who do not attend for their annual review.

### ***Commissioning Plan***

The NHS Leicester City plans for primary care include commissioning:

1. Training and advice from experts in diabetes, such as Diabetes Specialist Nurses, for GPs and Practices Nurses and other community health professionals. These experts would also lead the development of guidance for primary care and implementation of the patient care planning process. The training would be provided in GP practices so this could include clinical supervision. The service would undertake an annual training needs assessment of all GP practices and target training to GP practices with the greatest need.
2. An accreditation programme for GPs and Practice nurses who provide insulin initiation and then ongoing management for people with type 2 diabetes. These staff would be working in GP practices that demonstrate they achieve requirements for quality and outcomes and NHS Leicester City targets for blood sugar control for people with diabetes.

### ***What people told us?***

People said they want GPs and other primary care professionals to have training and advice from experts so people with diabetes receive consistent care and advice. They want the accreditation programme so they know that professionals providing insulin initiation in GP practices have the knowledge and skills to help them manage their diabetes. People asked for information on the GP Practices with a GP or Nurse who is accredited to initiate and manage insulin. People asked for GPs and Nurse's who diagnose and support them to implement minimum standards for providing information and involving them in planning and reviewing their care.

People also suggested ways to encourage patients to attend their GP practice for the annual review of their diabetes.

### ***Proposed changes to the plan and next steps***

In response to people's views on developing primary care we propose to:

- In 2009/10 develop and implement an accreditation programme for GPs and practice nurses initiating insulin for people with type 2 diabetes
- In 2010/11 publish a list of GP Practices and their staff accredited to initiate insulin
- The Integrated Community Diabetes Service outlined in section 4.3) will provide the accreditation programme from April 2010, as this would ensure a consistent approach and integration with intermediate care
- The Integrated Community Diabetes Service will train primary care professionals to implement the patient held care plan process and ensure they give people the Leicestershire Diabetes Handbook and Diabetes UK leaflets when they are diagnosed
- Ensure that GP Practices have systems in place for annual reviews that promotes uptake and support this by disseminating the consultation findings to GPs

## **4.3 Integrated Community Diabetes Service (Intermediate diabetes Care)**

### ***Need***

The strategic review found that current intermediate care is provided by a range of providers, the services are fragmented and care pathways inconsistent. Community Intermediate care services are available in some areas but not all so some people still have to attend hospital for their intermediate care. Services are not coordinated to provide people with a choice of community clinic location. Some UHL services do not provide access to people with mental health problems. The level of support and training provided by intermediate diabetes care services for GPs and practice nurses is insufficient, uncoordinated and not targeted to GP practices with the greatest need. Ambulance services tell us they have a lot of calls to patients with hypoglycaemic attacks.

### ***Commissioning plan***

1. The NHS Leicester City plan for intermediate diabetes care services is for this to be provided to all areas in the community for every one who needs it from April 2010. This would be provided by a multidisciplinary team of experts in diabetes such as Diabetes Specialist Nurse, Dietician, and GPs with a Specialist Interest in diabetes. The service would provide equality of access to vulnerable people such as people with mental health problems and learning disability. We would commission one provider to be responsible for intermediate care to ensure consistent referral pathways and training and advice for primary care to address variations in care and outcomes. The provider would be responsible for:
  - Intermediate diabetes care and advice (patient and primary care) and offer people a choice of clinic and domiciliary visits for those who are house bound

- Training and advice for Primary Care professionals
- An accreditation programme for GPs and Practice Nurses to initiate and manage insulin in type 2 diabetes
- Action planning with the GP to help patients with hypoglycaemic attacks manage their diabetes reducing their need to call ambulance services

The intermediate care service would refer patients to specialist diabetes services when they have complex complications and need hospital care. The Specialists in diabetes would provide training and advice for intermediate care staff. The intermediate care service would participate in research and provide training placements for undergraduate and post basic health care students. The intermediate care service would be called the 'Integrated Community Diabetes Service' as it would be provided in the community and help to ensure an integrated approach across voluntary, primary, intermediate and specialist care services and contribute to making Leicester a Diabetes Centre of Excellence.

Existing intermediate care services provided in the community and hospital outpatients would be decommissioned. Staff from existing services who provide intermediate care, such as Diabetes Specialist Nurses, would transfer to the new service in line with TUPE requirements .

The service Integrated Community Diabetes Service would be commissioned through an open Tender process in line with PCT standing financial instructions, related business planning guidance and EU legislation as:

- Market testing indicates there are many potential providers who could deliver this service, including existing providers, NHS and independent providers of diabetes services from out of area
- The value of the service meets the EU legislation threshold for a tender
- If broken down into smaller parts the service would not achieve the objectives of addressing variation in care and pathways and health outcomes for people with diabetes in Leicester City

### ***What people told us?***

People said they supported the plans for an Integrated Community Diabetes Service, with some support being subject to qualification i.e. address issues not covered in the plan:

- Clinics should be provided in the evenings for people who work
- Clinics should be available across the city and on bus routes so they are closer to home and accessible
- There should be transport to clinics for people transferring from intermediate care provided in hospital who had an ambulance or hospital transport

### ***Proposed amendments to the plan***

In response to peoples' views on plans for an Integrated Community Diabetes Service we propose:

- The specification for the new service Integrated Community Diabetes Service will include requirements to provide clinics in at least 8 different areas of the city with at least 3 areas offering clinics in the evening. Information provided for patients will include the choice of clinics and arrangements for travel including bus routes
- On an individual basis we will address the access transport needs of people transferring from hospital intermediate care to the new community service Integrated Community Diabetes Service

#### **4.4 Hospital care and Specialist Diabetes Care**

##### ***Need***

The specialist diabetes service, provided by University Hospitals Leicester, meets National Service Framework requirements, providing care for:

- People with complex complications such as specialist foot clinics
- Training for patients with type one diabetes
- Insulin infusion pumps for patients whose blood sugar is resistant to control on conventional insulin therapy
- Transition clinics for young adults moving from children's to adult services
- Joint specialist clinics for people with diabetes such as maternity clinics for pregnant women and renal clinics for people with renal failure

Consideration was given to providing specialist diabetes services in the community closer to home with consultants providing in reach to hospital to support the care of inpatients with diabetes as happens in some areas of the country. As University Hospitals Leicester requires its consultants for diabetes to participate in the general emergency medical on take rota consultants could not provide a community based service with out an impact on University Hospitals Leicester emergency inpatient care.

The Health Care Commission (replaced in 2009 by the Care Quality Commission) found that people's experience of inpatient care was below the national average for staff awareness of diabetes and involving the patient in managing their diabetes whilst in hospital.

The Public health report identified that hospital admission rates relating to diabetes were twice the national rate for people from deprived communities.

##### ***Commissioning plan***

The commissioning plans for hospital care and the specialised diabetes service include:

- The Specialised Diabetes Service would continue to be provided by University Hospitals Leicester as they meet the NHS requirements and are a centre of excellence for research. The consultant elements of the service should continue to be hospital based whilst they are required to provide general medical emergency cover.

Other elements of the service which can be provided closer to home should be where this is effective to do so e.g. the insulin infusion pump service. We will specify requirements for specialist diabetes services which will include clinical outcomes and patient experience to be provided from 2010. As part of this process we have asked University Hospitals Leicester specialist diabetes services to confirm how they measure the effectiveness of their care and to identify which elements of specialist care can be provided in the community.

- We will monitor University Hospitals Leicester plans to improve inpatient care for people with diabetes. University Hospitals Leicester has appointed a Nurse Consultant in Diabetes to lead specialist nurse support for inpatients and provide training for ward nurses to improve diabetes care and the patient involvement in managing their diabetes whilst in hospital.
- We will monitor the impact of all our plans for improving services on emergency hospital admission rates. We will review what lessons can be learnt from audit findings and where necessary commission further audit to help reduce hospital admissions.

### ***What people told us?***

People support the plan for hospital specialist diabetes services and recognise University Hospitals Leicester specialist diabetes service as a centre of excellence for research. Individual people asked why they still had to attend a specialist clinic when their GP provided the same care, another said they never saw the same person when they attended the hospital clinic and they gave conflicting advice. One person asked why University Hospitals Leicester LRI Balmoral unit had stopped doing blood tests on the day of their consultation resulting in the person seeing the specialist and being sent away for a blood test and having to come back on another date to discuss results and changes to their care.

People's experience of inpatient care reflects the findings of the Health Care Commission. People want ward staff to recognise that the patient is often the expert and to listen to them when they say how to manage their diabetes. People want ward staff to be trained so they have a better basic understanding of diabetes and its management and when they are not sure about what the person with diabetes is telling them to seek specialist advice and involve them in managing the diabetes.

### ***Proposed amendments to the plan***

In response to peoples' views on plans for hospital and specialist diabetes services we propose to:

- Ensure University Hospitals Leicester responds to people's views about specialist diabetes services through developing the service specification and through contracts.

- Ensure University Hospital Leicester plans to improve inpatient care for people with diabetes and monitoring people's experience. We will do this through contracts and specialist services will report progress to the Diabetes Implementation Group.

## **5 Recommendations agreed by NHS Leicester City Trust Board**

### **Prevention and Patient Self Management (section 4.1)**

- Pre diabetes training will provide access to venerable and working people
- Establish partnerships for voluntary support groups and peer educators will be explored and be based in communities and GP surgeries
- Intermediate Care will provide training for voluntary support to ensure consistent messages for people with diabetes
- The contract for DESMOND will be revised to provide different types of training at different times to respond to peoples needs

### **Primary Care Development (section 4.2)**

- In 2009 implement an accreditation programme for GPs and Practice Nurses initiating insulin in type 2 diabetes and the programme will be managed by the Integrated Community Diabetes Service from 2010
- In 2010 Publish a list of GP Practices with Professionals accredited to initiate insulin
- Train Primary Care Professionals on the person held care plan process
- Ensure GP practices have systems in place for patient annual reviews

### **Integrated Community Diabetes Service (Intermediate diabetes Care, section 4.3)**

- Delegate authority to the Commissioning Executive to approve the Full Business Case for a tender for the Integrated Community Diabetes Service
- The specification for Integrated Community Diabetes Service will include clinics across the City and evening clinics
- Access transport needs will be addressed on an individual basis for people transferring from hospital intermediate care to the Integrated Community Diabetes Service

### **Hospital care and Specialist Diabetes Care**

- Ensure University Hospitals Leicester responds to peoples views about specialist services
- Ensure University Hospitals Leicester plans to improve inpatient care experience for people with diabetes

## **6. Next Steps**

Future involvement in implementing the plans will include an ongoing survey of people with diabetes to assess progress in improving peoples experience and knowledge in managing their condition, whilst contracts will require services to monitor peoples' satisfaction and outcomes. We will establish patient panels to help inform the selection of services contracted through a tender process and will continue to engage user and voluntary groups in the Diabetes Implementation Group.

## **7. How can you get involved?**

Over the next couple of months we will be asking diabetic patients and service users to express an interest in taking part in our procurement panel which will work alongside NHS Leicester City in the selection of services to be contracted through a tender process. Training and support will be given to those involved in this process; however it will involve a considerable time commitment from those who wished to be involved.

If you would like to express your interest in joining a panel please complete your details on the next page, and return it to the Get Involved Team using the FREEPOST envelop enclosed.

We will be in touch with you in the early summer to discuss the panel and tell you more about the training and support you will receive.

I am interested in taking part in the Diabetes Procurement Panel.

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_


Email address: \_\_\_\_\_

Contact number: \_\_\_\_\_

Please tell us if you require any specific support to attend the training or to take part in our meetings, e.g. Interpretation services, carer support

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Please use the below space to provide comments or suggestions about NHS services or anything you have read in this document.

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**PLEASE RETURN THIS FORM USING THE FREEPOST ENVELOPE ENCLOSED**

## GLOSSARY OF TERMS

Commissioning Executive	An NHSLC meeting of Executive Commissioning Directors who are given delegated authority by the Board to make decisions about the services that will be provided through contracts.
DESMOND	Diabetes Education and Self Management for Ongoing and Newly Diagnosed. This is a one day group training workshop for people with type 2 diabetes.
Health Care Commission	The public body responsible for inspecting the quality of health and social care services. This body is now called the Quality Standards Commission.
Primary care professionals	GP's (General Practitioner), practice nurses, district nurses, community podiatrists and Dieticians
Pathway of Care	The patient's journey through different services as there needs change.

## Appendix 1 Diabetes Questionnaire Responses - Equality Monitoring

What is your age range?		Do you consider yourself to have a disability according to the terms given in the DDA?	
20-29	4	Yes	62
30-39	10	No	99
40-49	27	Prefer not to say	10
50-59	48	Not stated	39
60-69	49		
70-79	44		
80+	16		
Not stated	11		
Disability Key		What is your sexual orientation?	
Hearing Impaired	10	Bisexual	4
Learning Disability	4	Gay Man	1
LTC	30	Heterosexual	93
Physical Impairment	13	Lesbian/Gay Woman	1
Visual and Hearing Impairment	6	Prefer not to say	15
Visual Impairment	3	Normal	2
Wheelchair User	1	None	1
Mental Health	8	Not stated	92
What is your gender?			
Male	97		
Female	80		
Not stated	32		

<b>What do you consider your Ethnicity to be?</b>			
Anglo Indian	1	Indian British	1
Arab	1	Irish	2
Asian	3	Pakistani	1
Asian British	1	Sri Lankan	1
British	5	White/Asian	3
British Indian	1	White British	54
Caribbean	3	White English	2
English	2	White South African	1
English White	1	Prefer not to say	1
Fiji Indian	1	Not Stated	13
German	1	Indian	108
<b>What is your religious identity or belief?</b>			
Christian	58		
Hindu	89		
Jain	2		
Jewish	1		
Muslim	21		
Sikh	4		
None	9		
Prefer not to say	2		
Not stated	21		
Other	Alternative Spiritual – 1, Buddhist/Christian/Theosophist - 1		

<b>Preferred written language?</b>		<b>Preferred spoken language?</b>	
Arabic	1	Arabic or English	1
English	91	British English	1
English & Tamil	1	English	84
English/Gujarati	9	English/Gujarati	13
English or German	1	English & Tamil	1
English, Hindi, Punjabi	1	English or German	1
English, Portuguese, Gujarati	1	English, Hindi, Punjabi	1
Fowler's English	1	English, Portuguese, Gujarati	1
Gujarati	20	Fowler's English	1
Gujarati/English	3	Gujarati	25
Hindi, Punjabi	1	Hindi, Punjabi	2
Punjabi	1	Punjabi	2
Not stated	77	Not stated	75
Yes	1	Yes	1