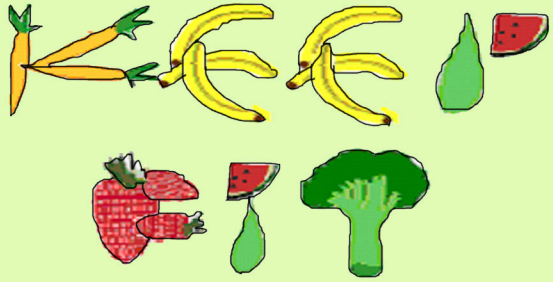
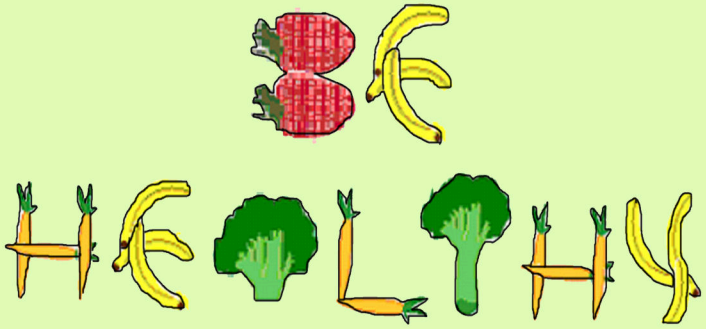
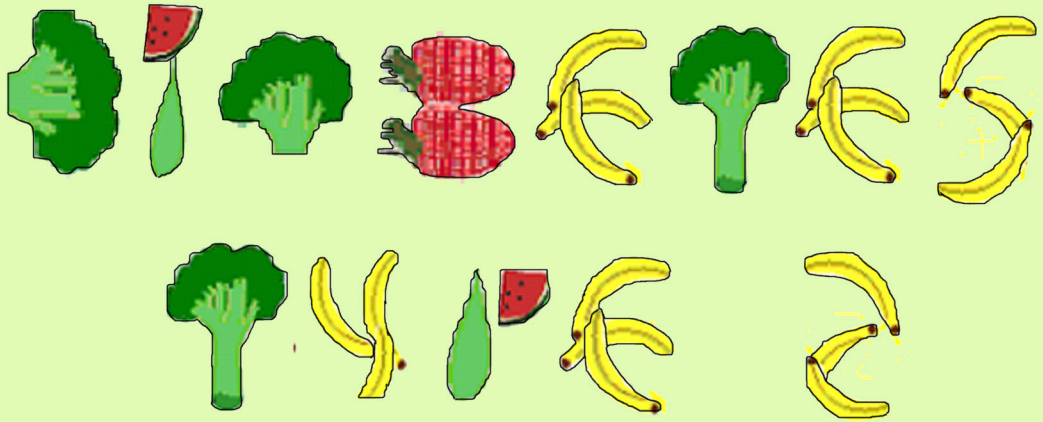




HEALTH PANEL SCRUTINY REVIEW
TYPE 2 DIABETES TREATMENT SERVICES
IN BASSETLAW

SEPTEMBER 2010



BASSETLAW
DISTRICT COUNCIL
NORTH NOTTINGHAMSHIRE

Scrutiny is an Independent, Councillor-led Function, Working with Local People to Improve Services.

Foreword

The first meeting of this panel took place in January 2010 to conduct a review about the treatment services available for Type 2 Diabetes in Bassetlaw. It was included in the Work Programme as anecdotal evidence indicated there is not a common service standard across the district. Currently 10% of the NHS Bassetlaw budget is spent on the treatment of diabetes and related illnesses.

We looked at what services and support are in place to ensure patients are informed and helped to manage their long-term condition. We also identified what is being done to raise awareness of diabetes and also promote a healthy lifestyle to prevent further increases of what potentially is a life limiting disease in the future.

The Panel was interested in the levels of awareness that young people have about the disease and that by having a healthy lifestyle they can significantly reduce the chances of developing Type 2 Diabetes in adult life. We carried out a survey of young people to find out their views.

It was an exciting Panel to chair and we worked together, cross party, to produce recommendations that by working with our partners will support long term improvements in the quality of health for the residents of Bassetlaw. We were pleased to learn that Dr.Dang, Consultant in Diabetes and Endocrinology, Bassetlaw Hospital considers that Bassetlaw District Council has schemes in place, which promote fitness and a healthy lifestyle.

I would like to thank all the witnesses who attended the Panel, Policy and Scrutiny Officers and everyone that was involved in the process. Special thanks go to the two work experience students Lucy Jones and Danielle Fisher from Portland Comprehensive School who designed the front cover of this report.

Councillor Mrs M.W. Quigley
Chair of Health Panel

Contents

1. Executive Summary

1.1 Summary of Findings

Bassetlaw District Council's Health Panel was tasked to review Type 2 Diabetes Treatment Services in Bassetlaw as part of the Annual Programme of Work for 2009/10. The topic was approved by Overview and Scrutiny in December 2009. Any reference to diabetes in this document will be referring to Type 2 Diabetes.

The review focussed on the current level of service provided to patients across the district, the prevention and early detection of diabetes. A number of methods were used to gather this information:

- Desk Top Study
- Survey of GP's in the district
- Survey of young people's knowledge on the topic.

Councillors reviewed the current services and mechanisms available, the performance of the district in comparison to other areas and proposals for future improvements. This involved benchmarking, gathering evidence from strategic and practical perspectives and patients' experiences.

Although Bassetlaw has good service provisions for diabetics, the review revealed that there were some gaps. These were:

- Inconsistency in the monitoring of patients diagnosed with diabetes by GPs
- A need for a more consistent approach in referring newly diagnosed patients and for existing patients who need a better understanding in managing their condition. NHS Bassetlaw has chosen DESMOND as its education package.
- Not all GPs have signed up to the Local Enhanced Service (LES) for diabetes, which provides a gold standard of care for patients.
- Other areas have a more comprehensive approach to specialist foot care.

The review has produced a raft of recommendations, to further improve diabetic services and the prevention programme.

An Equality Impact Assessment has been carried out for this review. This can be viewed at www.bassetlaw.gov.uk under the Equality Section or by contacting the Policy and Scrutiny Unit on 01909 533189.

1.2 Scope of the Review

The panel undertook a scoping exercise at the first meeting and the following Scope was agreed:

(a) To identify a baseline of the current level of service provided in Bassetlaw to

- support patients and allow them to manage their condition
- promote prevention and early detection of Type 2 Diabetes

(**b) To investigate best practice and look at ways to introduce a common service standard across Bassetlaw**.

1.3 Membership

The following Councillors were appointed to be members of the Health Panel:

- Councillor Mrs. M.W. Quigley, (Chairman)
- Councillor J Scott, (Vice- Chairman)
- Councillor F. Hart,
- Councillor J.C. Shephard
- Councillor Miss M. Stokes
- Councillor G. Freeman
- Councillor M. Gray
- Councillor J.W. Holland
- Councillor J. Smith
- Councillor Mrs. E.M. Yates

1.4 Summary of Recommendations

	Recommendation	Responsible Officer	Financial Implications	Delivery Timescale	Risks to delivery/ Officer Comment
1.	That GPs should be encouraged to refer all newly diagnosed diabetic patients to the Diabetes Education and Self Management for Ongoing and Newly Diagnosed (DESMOND Programme) and have a programme to refer all existing patients to the scheme.	Jane Bray, NHS Bassetlaw	Funding allocated as part of Strategic Plan LTC initiative. (Covered under diabetes LES)	Oct 2010	No known risks
2.	That GPs should be encouraged to signpost patients at risk of diabetes to programmes such as Staying Well, and Information Prescriptions.	Jane Bray, NHS Bassetlaw	Nil	Ongoing as part of current programmes	No known risks. Covered within NHS Health check already in place and existing prevention programmes that are funded by the PCT
3	To assist early detection, GPs should be encouraged to sign post patients to the free NHS Health Check.	Jackie Gladden, NHS Bassetlaw	GP's receive an enhanced payment for providing this service.	Locally enhanced service already in place.	No known risks
4.	That GPs in Bassetlaw are encouraged to sign up to the initiative by NHS Bassetlaw to introduce a Locally Enhanced Service (LES) for Diabetes, which should provide consistent standards across the district.	Jane Bray, NHS Bassetlaw	Funding allocated as Part of Strategic Plan LTC initiative.	Oct 2010	No known risks. All GP Practices have access to a Specialist Diabetes Nurse Educator who

	Recommendation	Responsible Officer	Financial Implications	Delivery Timescale	Risks to delivery/ Officer Comment
					provides advice, support and training for all practice and community staff. Within the LES, the aim is for practice nurses to develop their expertise within Diabetes through a combination of locally and nationally accredited training. Finally, the Diabetes Centre provides all practise with access to Specialist Diabetes advice, either from the Nurse Specialists that are based there or from the Diabetologist – Dr. Dang.

	Recommendation	Responsible Officer	Financial Implications	Delivery Timescale	Risks to delivery/ Officer Comment
5.	That Doncaster and Bassetlaw Hospital NHS Foundation Trust and NHS Bassetlaw should consider the establishment of a Specialist Foot Clinic for patients with diabetes in Bassetlaw.	Jane Bray, NHS Bassetlaw Dr Dang, Bassetlaw District General Hospital	Supported as part of the development of the Diabetes Care Pathway	Initial target date of Dec 2010	No known risks
6	That NHS Bassetlaw should consider establishing a database on the annual foot care checks given to people with diabetes by GPs.	Jane Bray, NHS Bassetlaw	None. The Register is a requirement of the Diabetes LES and patients receive foot checks as part of annual Diabetes check via their practice.	To begin Oct 2010	No known risks. This data is collectable via QOF and will be incorporated within the LES as an annual audit.

	Recommendation	Responsible Officer	Financial Implications	Delivery Timescale	Risks to delivery/ Officer Comment
7.	That BDC puts in place additional measures to raise awareness of diabetes. This should include targeted information displays and activity linked to Diabetes Week.	Peter Clark Bassetlaw District Council Miriam Parker Bassetlaw District Council	Met within existing budgets	Minimum twice a year.	There are no resource implications of the described actions and the action will be implemented immediately. Notice boards at the leisure centres will be maintained with up to date information and diabetes will remain a referable condition within the GP referral scheme. We will work with our partners to support events raising awareness for tackling diabetes.
8.	That NHS Bassetlaw should work with local community groups such as Tenants and Residents Associations and Bassetlaw Over Fifties Forum (BOFF) as part of its awareness raising activity.	Cheryl George, Public Health/ Jackie Gladden, NHS Bassetlaw	Nil	Will be part of Health Promotion Team.	No known risks

	Recommendation	Responsible Officer	Financial Implications	Delivery Timescale	Risks to delivery/ Officer Comment
9.	That the District Council and Barnsley Premier Leisure should continue to work with NHS Bassetlaw on initiatives to promote a healthy lifestyle. A publicity campaign is to be run during Diabetes Week to raise awareness about diabetes in the Leisure Centres.	Peter Clark, Bassetlaw District Council	Nil	June 2011	An ongoing information presence will be maintained at the Leisure Centres. A publicity campaign will be run during diabetes week.

2. Background

2.1 Current Service delivery and policy/strategy operated to

Please note that as from 1st April 2010, Bassetlaw Primary Care Trust (PCT) formally changed to NHS Bassetlaw.

What is Diabetes?

Diabetes is a serious, long-term and progressive condition that affects around 1.9 million people in England, as well as around 500,000 people who are thought to have undiagnosed diabetes. This number is increasing as obesity becomes more widespread and people live longer.

Diabetes is a condition characterised by raised blood glucose (sugar) levels and glucose in the urine. It occurs when the body cannot use glucose properly due to a lack of insulin and/or an inability to respond to insulin. Diabetes is divided into two types:

- Type 1 (children and young adults) – whereby the cells of the pancreas are no longer able to produce insulin as they have been destroyed by the body's immune system. Treatment involves daily injections of insulin.
- Type 2 (usually 40 +) – when the pancreas cannot produce enough insulin. Symptoms often appear over a longer period of time. Treatment involves diet and lifestyle adjustment, oral medication and/or insulin to control blood sugars.

Currently there is no cure for diabetes, but we can reduce the factors which increase the risk of developing Type 2 diabetes such as reduce weight and take more exercise. Treatment focuses upon maintaining blood glucose levels to reduce the risk of longer-term diabetes complications. Effective management of the condition increases life expectancy and reduces the risk of complications such as heart disease, stroke, renal failure, amputation and blindness. Self-management is the corner stone of effective diabetes care. (National Service Framework 2001)

This review is looking at the Treatment Services for Type 2 Diabetes.

Baseline

The Public Health Report 2007 established the baseline for the development of service provision. The vision of the NHS Bassetlaw is "For any person living with diabetes to have access to services that meet their individual needs, provide the best clinical outcomes and enable them to self manage their condition with appropriate support"

The report found the following key issues:

- Family History of diabetes, obesity, physical inactivity all increase your risk of developing diabetes
- We know that Type 2 diabetes can be delayed or even prevented by sustained lifestyle changes in diet and physical activity
- Early diagnosis and treatment can reduce risk of complications
- Tight control of blood sugar levels and blood pressure increases life expectancy and reduce risk of complications
- Eye screening and treatment can reduce severe visual loss

Estimate of Numbers of People with diabetes in Bassetlaw

Area	Total estimated Prevalence Diagnosed & undiagnosed 2001	Number diagnosed 2006	Difference	Projected Prevalence for 2010	Percentage Rate 2010
Bassetlaw	4,930	3984	**946**	**5775**	**5.06%**
Newark/Sherwood	4,676	4,412	264	5,460	4.84%
England	2,146,627			2,377,809	**4.63%**

The table demonstrates the differential between diagnosed and undiagnosed, projected prevalence and comparatives. Within Nottinghamshire, Bassetlaw has the highest projected prevalence for diabetes and obesity, and significant areas of deprivation. The highest numbers are associated within the areas of greatest deprivation and highest levels of obesity in Bassetlaw. The district also has an ageing population and the incidence of diabetes increases with age.

Cost of Diabetes

There are many costs to the condition and an individual will be affected in their personal health; reduced life expectancy; possibly financially affecting, income, sickness levels and employability; and the effect on lifestyle and family life.

Diabetes represents a long-term impact on resources (recent estimates put diabetes related spend at 10% of total resource).

NHS Bassetlaw Strategic Plan 2009-2014

The NHS Bassetlaw Strategic Plan 2009 -14 has identified diabetes as a priority. The Plan has four goals and Goal Two: Healthy Lifestyles for People, who have existing health needs, has a target to reduce diabetic admissions by 10%. The aim is to develop diabetes care that meets national guidance and best practice guidelines. The vision for Bassetlaw is to develop services for individual needs. It is about self-management of the condition.

Within Nottinghamshire, Bassetlaw has the highest projected prevalence for diabetes and obesity, and significant areas of deprivation. In recognition of this NHS Bassetlaw has recognised diabetes as a key strategic initiative and has committed significant additional investment to develop diabetes services aimed at reducing risk and promotion of a standardised Pathway for diabetes care.

Early diagnosis and treatment reduces the long-term complications for general health due to diabetes. A tight control of blood sugar, blood pressure and cholesterol can reduce the effects.

Health Profile 2010

In 2010 the profile indicated that the health of people in Bassetlaw is generally worse than the England average and there are inequalities within areas of deprivation. The incidence of diabetes is around the England average at 4.37 per thousand population. In England the highest incidence is 6.72 per thousand population and the average is 4.3. However, Bassetlaw is significantly worse than the England average for physically active children (31.9 compared to 49.6 per thousand population) and below average for healthy eating adults (25 compared to 28.7 per thousand population). The number of obese children is around the national average at 10.5 per thousand population. The most recent figures show an improvement for the number of obese adults in Bassetlaw 23.6, which is now above the England average of 24.2 per thousand population.

Nottinghamshire Local Area Agreement 2008-2011 (NLAA)

The NLAA is a practical mechanism where the Nottinghamshire Partnership work together to improve people's lives. The priorities for improvement include:

Priority 3 aims to improve participation by focusing on increasing adult participation in sport and active recreation (NI8) in Bassetlaw from 20% to 24% by 2011. This involves partnership working with Sport Nottinghamshire, local authorities, PCTs and Mental Health Trusts.

Priority 7 aims to tackle rising obesity by focusing on:

- reduce obesity in Primary age schoolchildren in the Reception year measured by National Indicator (NI)55 and partners are working together to reduce the rate by 0.7% over three years. This includes Nottinghamshire County Council, PCTs and local authorities.
- local indicator for adult obesity which is being progressed by the Countywide Obesity Steering Group.

These impact on maintaining a healthy lifestyle and so reduce the risk of diabetes.

DESMOND (Diabetes Education and Self Management for Ongoing and New Diagnosed)

DESMOND is the name of a 'family' of patient education programmes and related Educator training, which have been developed by a collaboration of NHS organisations. The agencies involved have a co-ordinating centre hosted by University Hospitals of Leicester NHS Trust. DESMOND is first and foremost an NHS organisation which supports other NHS organisations to deliver first class patient education to people with Type 2 diabetes, or who are at risk of diabetes.

The DESMOND programme runs as a day or two half-day sessions. GPs and Practice Nurses can refer anyone with Type 2 diabetes to the programme. Partners can also attend and they learn about diabetes in a friendly way in small groups of 10 people. They can also ask any 'burning questions' they have about the condition, as usually patients have one thing that they want to know more about. Until recently it was only offered to new patients who had been diagnosed with Type 2 diabetes but it is now available for previously diagnosed patients. There are over 4,000 patients in Bassetlaw. Most people know someone who is diabetic and there are many myths about diabetes. The Programme tries to give people the correct facts.

Bassetlaw Diabetes Network Group.

These involve people in Primary and Secondary care who work with the patient to ensure that patients receive the appropriate care. In Bassetlaw, the lead is Dr Dang, Consultant Endocrinologist at Bassetlaw Hospital, another consultant based at the hospital, four GPs, Diabetes Nurses and other professionals. The group is chaired by a GP and its role is to steer and inform the development and standards of Diabetes services and care within Bassetlaw. Currently there are no user representatives on the Diabetes Network. A patient representative will be co-opted in 2010/11.

Diabetic Pathway

The Bassetlaw Diabetes Network Group has developed a care pathway that maps interventions and care from diagnosis, investigations, treatment and prevention of complications. This provides clinicians with a standardised provision of care for all patients with diabetes, enabling consistency of approach across Bassetlaw.

2.2 National policy/guidance

National Service Framework Standards

In 2001 the government set out the first national standards for the treatment of diabetes with the Diabetes National Service Framework. It has 12 standards with a 10-year programme to raise the quality of services and reduce variations.

The Department of Health reports annually on the progress made on the delivery of the Framework. The sixth report highlighted the progress made in the last twelve months. Following the Office of the Strategic Health Authorities (OSHA) review it was decided to continue funding and supporting the National Diabetes Support Team (NDST). The NDST was then renamed NHS Diabetes and now works beside NHS Kidney Care in a joint organisation called NHS Diabetes and Kidney Care which provides communal support functions and opportunities for joint work on areas such as diabetic kidney disease.

Over the last 12 months NHS Diabetes has made huge progress, not only in establishing itself as a new organisation, but also in delivering its ambitious work programme. There are now regional programme managers in each of the 10 Strategic Health Authorities (SHA) areas to support NHS organisations in the design and delivery of high-quality diabetes services across the country.

In July 2009, NHS Diabetes launched a new website which provides a comprehensive overview of the organisation and all the work that is being taken forward. The website can be accessed via http://www.diabetes.nhs.uk/

The report highlights the need for continued education and prevention of the disease, which currently affects 2.2 million people in England,

NHS Diabetes

NHS Diabetes works to raise the quality of diabetes care in England by supporting and working with the healthcare community and people with diabetes. Their role is to ensure the delivery of the diabetes National Service Framework – to improve diabetes care in England by 2013. It also works in partnership with people with diabetes, to help develop and support new guidelines, standards and systems to improve care and encourage implementation of new initiatives.

Diabetes Delivery Strategy 2003-2013.

The NHS said seven years ago that patients should have access to education in its Diabetes Delivery Strategy 2003-2013. At the time no programme existed. A structured programme has been put together according to clinical guidelines by NICE (National Institute of Clinical Excellence). There are 2 national programmes:

- Diabetes X-PERT Programme (Expert Patient Education versus Routine Treatment - This involves 6 weekly, 2-hour training sessions. It takes a different approach with the patient given the skills and confidence to self - manage their diabetes. (See Appendix 1)

- DESMOND is offered as a one-day course, held in local venues with sessions led by educators so that the person becomes their own expert and makes their own decisions to maintain a healthy lifestyle. (See page 11) Bassetlaw has chosen this programme, as there were concerns that people may not be able to attend 6 sessions in the X-PERT programme.

National Institute for Clinical Excellence (NICE)

NICE provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. NHS Bassetlaw aims to stay within the NICE guidelines with regard to the treatment of diabetes and the medication. The following page outlines details of the guidance and the key priorities for implementation of the guidance:

Nice Guidelines for Type 2 Diabetes Care

1. Patient education 2. Lifestyle management/non-pharmacological management 3. Glucose control levels 4. Self-monitoring of plasma glucose 5. Oral glucose control therapies 6. Glucose control: insulin therapy 7. Blood pressure therapy	8. Cardiovascular risk estimation 9. Management of blood lipid levels 10. Anti-thrombotic therapy 11. Kidney damage 12. Eye damage 13. Nerve damage

Key Priorities for implementation;

1. Structured education to every person and/or their carer at and around the time of diagnosis, with annual reinforcement and review. Inform people and their carers that structured education is an integral part of diabetes care.
2. Provide individualised and ongoing nutritional advice from a healthcare professional with specific expertise and competencies in nutrition.
3. When setting a target glycated haemoglobin (HbA1c): − involve the person in decisions about their individual HbA1c target level, which may be above that of 6.5% set for people with Type 2 diabetes in general
4. Offer self-monitoring of plasma glucose to a person newly diagnosed with Type 2 diabetes only as an integral part of his or her self-management education. Discuss its purpose and agree how it should be interpreted and acted upon.
5. When starting insulin therapy, use a structured programme employing active insulin dose titration that encompasses: − structured education

Care Quality Commission

Good-quality care for people with diabetes improves their well-being, and helps to prevent long-term complications such as heart problems, kidney damage and blindness. It assesses how well Primary Care Trusts support adults with diabetes to help them manage the condition themselves**.**

Bassetlaw is rated as a 'Fair 'service provider for adults with diabetes. 78% of PCT's were rated as Fair which compares favourably as only 11.2% were rated as good and 1.9% excellent.

The national survey asked whether people with diabetes are receiving the care, treatment and information they need to manage their diabetes well and reduce the risk of complications. Bassetlaw scored above the national average but there were some issues slightly below average such as:

- Annual check ups
  Discusssing the best way to manage diabetes, different medication, advice on diet and physical activity
- Stay in Hospital
  Ability to take medication as they wanted
- Management of diabetes
  Understanding of when to take their medication, role of physical activity
- Diabetes Tests
  Providing tests in writing and access to a dietician

NHS Bassetlaw scored exceptionally well on education and training with 93% finding the course easy to understand compared to a national average of 63%.

Diabetes Commissioning Toolkit

This toolkit aims to provide a useful resource to all NHS commissioners of diabetes services. The toolkit has two main sections:

- **Section 1: Assessing healthcare needs to support commissioning**

  This section outlines the key questions commissioners need to ask in order to understand where they are now, and provides links to information resources that can provide detailed information on current service provision and outcomes. It also suggests what commissioners might need to do in order to understand the current and future needs of their local diabetic population.

- **Section 2: Generic specification for diabetes care – Best practice model**

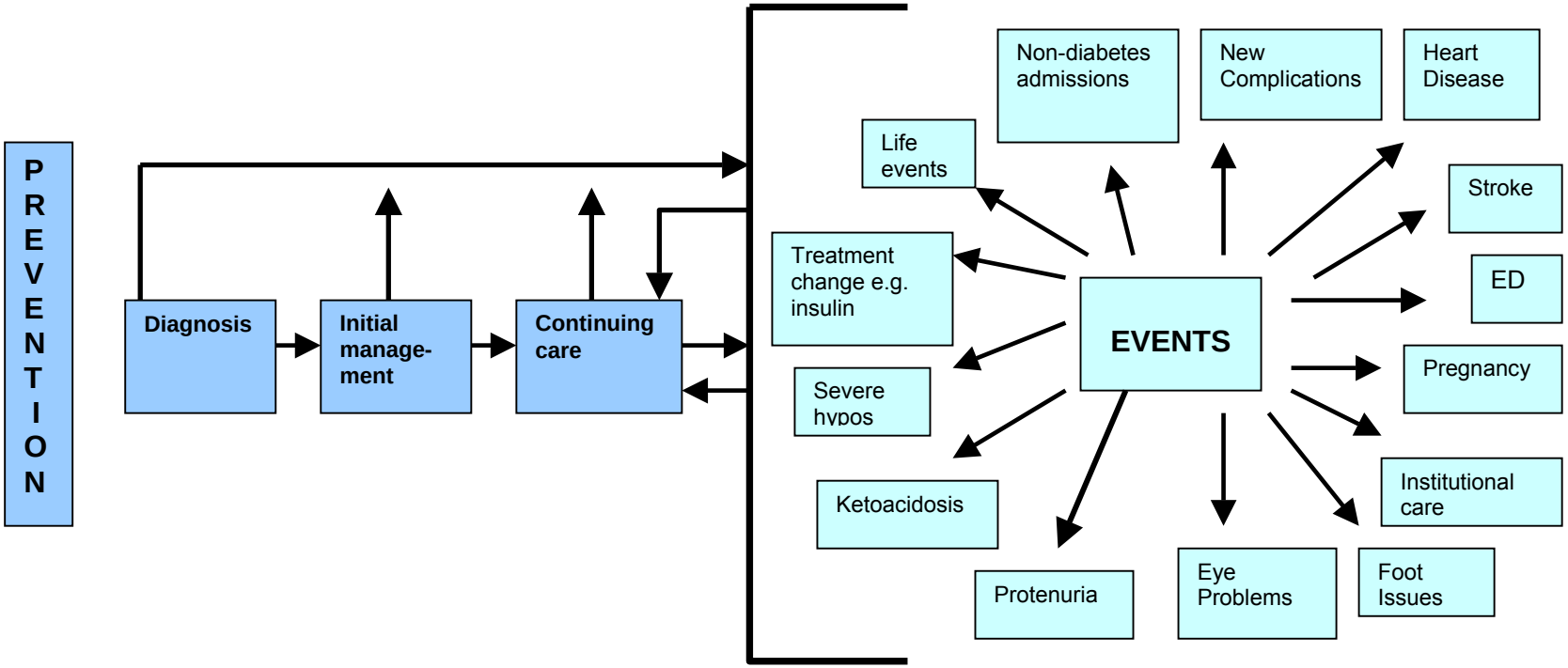
  This section provides an outline of the core elements of care that a high-quality diabetes service should include. It signposts the relevant quality markers for each element of the service, including NSF Standards and NICE guidelines. It also provides suggestions for key outcomes that commissioners can specify and indicators that could be used to measure improvement over time.

NHS Annual Evidence Update

NHS evidence formerly a Specialist Library of the National Library for Health, produces evidence updates for hundreds of topics and over thirty specialist subjects of which, diabetes is one.

From 2006 there has been an Annual Evidence Update which identifies new systematic reviews on diabetes published within the year. It is published to coincide with world Diabetes day 14th November. This evidence update illustrates that there is a vast amount of new information being published in the field of diabetes. It provides a means by which the information collected can be easily accessed by professionals.

This provides a ‘map’ of all of the elements of care that a high-quality diabetes service should include:



An Outcomes measures/minimum data set has been compiled incorporating Better Metrics and suggested outcomes from the Diabetes Commissioning Toolkit. Further work will be undertaken to determine local standards and outcome measures. Appendix 1 shows the key areas and objectives

Managing Diabetes: Improving Services for People with Diabetes

The review looked at services commissioned by Primary Care Trusts and found that in general performance was encouraging but identified areas for improvement including:

- Better working between people with diabetes and healthcare professionals when planning and agreeing care.
- Increasing the numbers of people with diabetes attending courses and improving their knowledge.
- All organisations to work together more closely in commissioning and providing services to reduce admissions to hospital
- Increase the number of people having long term blood glucose levels of 7.4% or a lower safer level - safe blood sugar levels are important for long term care and better performing trust achieved 65% and lower performing trusts achieved 52%.
- Reducing variations in general practice achievements.

Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice. The QOF gives an indication of the overall achievement of a surgery through a points system. Practices aim to deliver high quality care across a range of areas for which they score points. Put simply, the higher the score, the higher the financial reward for the practice. The final payment is adjusted to take account of surgery workload and the prevalence of chronic conditions in the practice's local area.

Under the QOF General Practice in Bassetlaw receive enhanced payments for closely monitoring the care and treatment of Diabetic patients within their practice, for example:

- **Monitoring of HbA1c levels** - The more glucose in the blood, the more haemoglobin A1C or HbA1C will be present in the blood. Red cells live for 8 -12 weeks before they are replaced. By measuring the HbA1C it can tell you how high your blood glucose has been on average over the last 8-12 weeks. A normal non-diabetic HbA1C is 3.5-5.5%. In diabetes about 6.5% is good.

- **Foot care, pulses neuropathy -** Diabetic neuropathies are a family of nerve disorders caused by diabetes. People with diabetes can, over time, develop nerve damage throughout the body. About 60 to 70 percent of people with diabetes have some form of neuropathy. The highest rates of neuropathy are among people who have had diabetes for at least 25 years.

- **Retinopathy screening** - Retinopathy is the name given to 'disease of the retina' due to diabetes, and is described below. There are four main types of retinal damage that can occur if you are diabetic.

- **Background retinopathy** - early changes.

- **Maculopathy -** this is more serious. Eventually your sight may become reduced. Laser and blood pressure control help.

- **Pre-proliferative or non-proliferative** - stage before the new blood vessels start growing.

- **Proliferative retinopathy** when the new vessels grow. These blood vessels are very delicate and can bleed easily. Laser is very effective in stopping the new vessels grow.

The performance of GP practices using the QOF for diabetes management, measures 16 factors for patients aged 17 and over. This can be accessed at http://www.qof.ic.nhs.uk/search.asp . The table below shows GPs in Bassetlaw performance in the management of diabetes. It also records the PCT and England averages. These results show that there is some inconsistency in the management, with some falling below the PCT and England average; these generally are the more rural areas.

Online GP practice results database

Individual Clinical Indicator Group Results: Diabetes Mellitus (Diabetes)	
Dr A Weenink & Partners Retford	92.37 out of 93 points: 0.5 percentage points above **PCT Average**, 0.9 percentage points above **England Average**
Dr Stewart Bawtry	92.95 out of 93 points: 1.1 percentage points above **PCT Average**, 1.5 percentage points above **England Average**
Drs G Brownson & P Brown North Leverton	92.96 out of 93 points: 1.2 percentage points above **PCT Average**, 1.6 percentage points above **England Average**
Finch Me & Partners Tuxford	89.07 out of 93 points: 3 percentage points below **PCT Average**, 2.6 percentage points below **England Average**
Foster P & Partners Retford	**All the 93 points**: 1.2 percentage points above PCT Average, 1.6 percentage points above England Average
Gilbert I J & Partners Retford	**All the 93 points**: 1.2 percentage points above **PCT Average**, 1.6 percentage points above **England Average**
Harworth Medical Centre	88.57 out of 93 points: 3.6 percentage points below **PCT Average**, 3.2 percentage points below **England Average**
Larwood Surgery Worksop, Carlton, Langold	**All the 93 points**: 1.2 percentage points above **PCT Average**, 1.6 percentage points above **England Average**
M^{c}Mahon & Partner Misterton/ Gringley on the Hill	91.91 out of 93 points: same as **PCT Average**, 0.4 percentage points above **England Average**
Millar L J & Partners Worksop	91.34 out of 93 points: 0.6 percentage points below **PCT Average**, 0.2 percentage points below **England Average**
Riverside Health Centre – Tonge J & Partners Retford	92.70 out of 93 points: 0.9 percentage points above **PCT Average**, 1.3 percentage points above **England Average**

Secondary Care

This is mainly provided by Bassetlaw Hospital, which currently has a team of one consultant, one specialist doctor and an additional consultant who is based at Doncaster Hospital. The consultant, Dr. Dang holds two and a half clinics per week for diabetes and once a month has an evening clinic for people who have work commitments in the day. There is also half a clinic per week at Retford Hospital. Currently there is a pilot programme with a clinic for women who are pregnant and have diabetes and the team has made a business case for this but resources are scarce.

There are two and a half specialists Diabetic Nurse posts shared among five post holders.

All new referrals are seen within two weeks, which is the national target. There is follow up within 6-8 months. Recently additional resources have been provided with increased support from the Doncaster based consultant, which has increased the capacity to see patients.

3. Method of Review

3.1 Summary of Review Meetings

The review was completed using a range of research methods including:

- Panel Meetings with witnesses
- Survey of young people
- Survey of GP Practices in Bassetlaw
- Benchmarking analysis with other Health Authorities, including best practice authorities.

Meeting	Witnesses	Evidence Gathered
18th January, 2010	Written Information including: Profile of diabetes in Bassetlaw and background information about the condition.	Scoping Meeting
15th February, 2010	Tracy Bainbridge, Diabetes Educator, NHS Bassetlaw.	Presentation and learning games about diabetes and the DESMOND patient management system
1st March, 2010	Cancelled	
9th March, 2010	Jane Bray, Long Term Conditions Lead and Jackie Gladden, Head of Commissioning, Health Improvement, NHS Bassetlaw	Presentation and information on Type 2 diabetes Primary Care – Where we are and where we are going in Bassetlaw.
15th March, 2010	Doctor C.N. Dang, Consultant in Diabetes and Endocrinology Bassetlaw Hospital	Information on diabetes Secondary Care – Where we are and where we are going in Bassetlaw

Meeting	Witnesses	Evidence Gathered
22nd March, 2010	Draft Report Recommendations	
17th August, 2010	Draft Final Report	

3.2 Survey of GP Practices in Bassetlaw on Type 2 Diabetes Treatment Services in Bassetlaw

The review wanted to identify if there was any variability in the services provided across Bassetlaw by GP's. The key information gained is below. A copy of the survey is available (Appendix 6).

Question	Findings
Do you provide an annual check up for patients with Type 2 Diabetes? **Do you offer patients education programmes on diabetes?**	Yes 7
If yes please give details	a) DESMOND 5 b) DAFNE c) In house training
Do you offer information on foot care? **Do you have a Specialist Diabetes Practice Nurse?**	Yes 7

Question	Findings
If yes please give details	a) Senior Practice Nurse - Holds Diploma in Diabetes Management within Primary Care b) She has undergone the Warwick Diabetes Diploma, Insulin for Life Programme and Graduate Cert in Diabetes c) Both of my nurses have an interest in Diabetes d) Trained in Management and insulin initiation. e) Nurse Practioner and Practice Nurse
What are the most significant challenges facing general practice within the prevention and effective management of Type 2 diabetes?	a) Time 3 b) Standardisation of services; Information from secondary care; Funding. c) Limited time available to fully assess all patients, lack of response to invitation for screening patients /management of high risk patients

3.3 Survey Of Young People on Diabetes In Bassetlaw, Manton Easter Fair, 27th March 2010 (See Appendix 2)

The aim of the survey was to find out their understanding of diabetes and the long-term health implications of the disease. More importantly we wanted to know if young people were aware of the importance of a healthy lifestyle and whether they ate a healthy diet and took regular exercise.

The questionnaires where completed by the local community in a range of ages 13-65. The Young People's Advisor had discussions with people and it made them think about the effects of food on life style. NHS Bassetlaw Health Promotion Unit provided information leaflets and Bassetlaw District Council had portions of fruit available for people to eat. The fruit was a talking point and attracted people to the stall. It provided a good example of an alternative to sugary and salty snacks.

The survey results are as follows:

Question	Findings	
Do you know what diabetes is?	Most people were aware of the disease	
Around what age do people get Type 2 Diabetes?	Most people were aware that the age was around 40 years	
What symptoms do you have to look out for?	Most people knew the main symptoms but only a third were aware of blurred vision, slow healing of wounds and waist size	
As a young person what steps can you take to reduce the risk of developing diabetes?	Around two thirds understood the need to keep fit, eat healthily, exercise, be the correct weight and not smoke. There was a low awareness of the need to keep waist size down and not to drink alcohol	
What do you do to keep fit?	Most of the people surveyed did some form of exercise with walking the most popular (only one person did nothing).	
How many minutes a day do you exercise?	Most people exercised for the recommended time of at least 30 minutes a day.	
Do you know what a healthy diet is?	Only two people responded that they did not know what was a healthy diet	
Listed what you can do to have a healthy diet?	More than half of the people responding knew to eat 'five a day' and all the key message on healthy diet such as food labelling, avoiding food with high saturated fat, sugar and salt	
Would you like to know more about a healthy life style?	Slightly more people did not want to know more about a healthy lifestyle	
How do you want us to tell you?	Of those that did want more information suggestions included • Email • Internet	• Posters • Adverts • Information at sports centres

The survey was a small snap shot of the understanding of the local community about diabetes. There was a general awareness of diabetes but a lesser knowledge of the details of the condition. The same was found to be true of a healthy lifestyle. The results can be used to do more targeted follow up with the community in the future to fill the knowledge gaps.

3.4 Benchmarking with other Primary Care Trusts and Hospital Trusts

A limited desktop exercise was undertaken of health providers as a result of the information provided by witnesses who attended the review. (See Appendix 3)

This included the following providers:

NHS Doncaster

We chose to look at NHS Doncaster as the PCT's in Doncaster and Bassetlaw are linked to the Doncaster and Bassetlaw Hospitals NHS Foundation Trust.

In Doncaster the prevalence of long-term health conditions is higher than the national average. One of the long-term condition priorities is to expand telemedic to support patients with diabetes so that they can remain independent. It will also reduce the need for emergency admissions to hospital.

NHS Doncaster has identified the treatment of diabetes in their Strategic Plan 2009-2014 as a priority within children's health to have an education programme for young people. The priority on long term health conditions has identified a number of initiatives to assist patients to manage their condition through the Doncaster Type Two Information Education Programme (DOTTI) for newly diagnosed patients; develop personal care plans for diabetic patients from black and minority ethnic communities use the learning from the Year of Care Pilot to develop collaborative care arrangements between patients and clinicians.

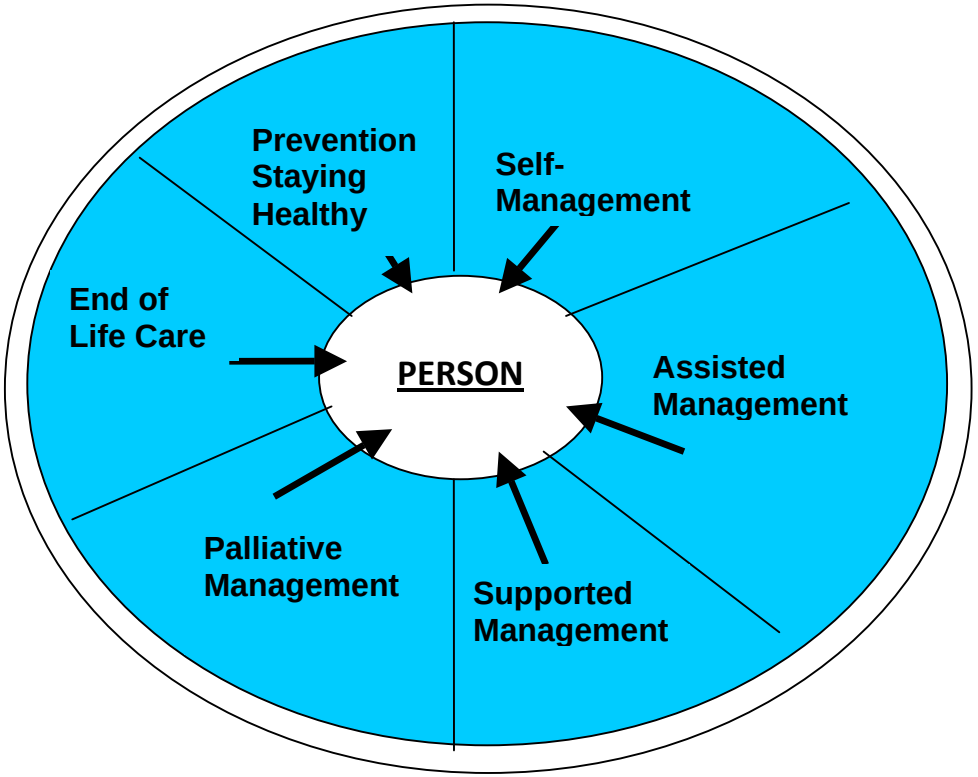
The Diabetes Day Centre provides group education sessions for people with diabetes and their relatives. A computerised Diabetic Register System helps shared care with GPs. The Retinopathy Screening Service is offered at the 2 hospitals -

Doncaster and Mexborough with a third proposed at the Thorne LIFT project. Other services provided include a diabetes antenatal service, foot ulcer clinic, paediatric, and young persons clinic.
NHS Doncaster also have a long-term conditions strategy, this is aimed at supporting people with long-term conditions to enjoy the best possible quality of life through world class commissioning and providing systematic patient-centred and appropriate health and well-being services. NHS Doncaster wants to commission long-term conditions services that will add years to life and life to years.

This person-centred approach is depicted in the diagram below. Under the Long-Term Conditions Strategy, patients will move up and down the "**continuum of care"**, accessing care from each of the areas as needed.

There are 6 stages within the **"continuum of care":**

- Prevention / Staying Healthy
- Self management
- Assisted management
- Supported management
- Palliative management
- End of life care



"Continuum of care"

The areas are not exclusive – a patient accessing services from the supported management section may also be using self-management tools and accessing services for other conditions from the assisted management section

Nottinghamshire

We chose to look at the services available in the remainder of Nottinghamshire as a neighbouring provider as a comparison

The guidelines currently followed in the Mansfield area - these are currently under review and new ones are due in summer 2010.

The following are measures to benchmark each PCT in Nottinghamshire regarding diabetes care.

Central Nottinghamshire Guidelines for the management of diabetes 2007

This document has comprehensive guidelines for good clinical practice. It has a Care Pathway for Adults with diabetes from diagnosis and initial care to continung care with possible referral to a consultant for insulin, renal complications, pregnancy support, foot complications, vascular, retinopathy and the annual review system

Referral to Secondary Care is not usually necessary. The Central Nottinghamshire Diabetes National Service Framework (NSF) Local Implementation Group does not recommend referral of newly diagnosed Type 2 adult patients Most patients can be controlled with dietary measures and practices are encouraged to refer patients to structured education.

Simple screening and advice can identify potential problems early in foot care for patients with diabetes. The incidence of gangrenous feet is twenty times greater in people with diabetes and the condition accounts for 20-45% of all lower limb amputatons in the UK. The guidance has established a flow chart for Diabetes Foot Care following diagnosis and at the annual review to detect risk factors. There is a Multi Disciplinary Team at the Diabetes Centre for specialised care.

The Juggle diabetes education service

The Juggle diabetes education service is available to anyone with Type 2 diabetes who does not take insulin and wants to learn more about their diabetes and how to look after it. It is appropriate for the newly diagnosed or those who have had diabetes for many years. The programme is open to people who live within the following areas: Nottingham City, Rushcliffe, Broxtowe and Gedling.

The Juggle programme consists of 4 weekly sessions, where different aspects of diabetes are explained. Each session is two and half hours long and include a refreshment break:

Week 1	What diabetes is, what has happened to the body and how we can treat it and keep a check on it? We discuss how diabetes tablets work and why some people take tablets and some don't.
Week 2 & 3	What to eat and what to drink when you have diabetes paying attention to where sugar comes from and what we can do to keep our hearts healthy
Week 4	The importance of looking after diabetes and the tests that should be carried out to ensure you are staying fit and healthy.

NHS Sheffield

We chose to look at the services available in Sheffield as a neighbouring provider as a comparison. NHS Sheffield has invested in activity to help prevent diabetes, including measures to tackle obesity, promotion of exercise and physical activity programmes and healthy eating.

Sheffield was one of the earliest areas in England to provide a systematic screening programme for diabetic retinopathy using digital photography

Primary and secondary care sectors work together to improve diabetes services. Comprehensive guidelines are in place to support primary care clinicians deliver high quality diabetes care in practices, pharmacies and care homes across the city. A priority is to expand comprehensive structured patient education for self-management for all people with diabetes in accordance with NICE guidelines. This will be supported by improved and more accessible patient information and by access to more diabetes services provided in primary care. The services include:

- Diabetes Service within the Podiatry Service
- Sheffield Diabetes Foot Care Team
- Multi-disciplinary Foot Clinic.
- NHS Sheffield provide a leaflet on foot care (see Appendix 4)
- Dedicated insulin initiation clinics in their community under a new Sheffield Primary Care Trust (PCT) initiative.
- Diabetes training is provided by the Dietary Service

Foot Care

NHS Sheffield provides specialist service for patients with diabetes within their podiatry Service. The Empowerment Team aim to encourage people to provide their own safe foot care where appropriate after suitable education has been provided. It also educate carers and other professionals dealing with people on the role of the podiatrist and foot health promotion.

In 2002 this team won a multi-professional health care award for the Empowerment Project, which resulted in the eradication of the waiting list for routine and high-risk podiatry treatment in Sheffield. The empowerment team work closely with other members of the health care team including practice and district nurses, physiotherapists, GPs and hospital staff. It also liaise with groups representing older people such as Age Concern to consult and share good practice.

Podiatry Service

The podiatry service aims to provide all diabetic patients with ‘at risk’ feet (peripheral neuropathy, peripheral arterial disease, a foot deformity, history of foot infection/ulceration/amputation, or suffering from a foot pathology (corns/callus) or unable to safely perform simple foot care), with regular podiatry. Patients are seen at intervals according to their individual clinical need. Patients are seen in the community service or hospital based service according to their risk status and the level of care they require.

Community service

Patients with a 'low current risk' that have a foot problem or are unable to manage their own foot care safely or "at risk feet" (presence of neuropathy and /or ischaemia) are referred to the community service for treatment. Patients with a 'low current risk' without a foot problem and who can manage their own foot care safely can be referred to the podiatry department for a diabetic foot talk which should be indicated on the application form. These patients will now receive their annual foot review in primary care conducted by the practice nurse, as training has been provided by the podiatry service to ensure all community nurses have the appropriate skills to perform these reviews and both the podiatry service and nursing teams are working to the same guidelines based on national recommendations. New patient referrals for patients requiring a podiatry assessment, will be seen within 4 weeks.

Hospital service

Patients at high risk or who have a current ulceration/acute Charcot neuroarthropathy or foot care emergency are seen in the hospital podiatry clinics or foot clinics, depending on the severity of the problem.

Insulin Clinics

NHS Sheffield introduced a dedicated insulin initiation Clinic for people with Type 2 diabetes. In an attempt to reduce hospital-waiting times insulin programmes were run at GP surgeries and health centres as an alternative to current referrals to hospital clinics. The group sessions were aimed at new insulin users and are run by a Practice Nurse supported by Diabetes Specialist Nurse from Sheffield Teaching Hospital NHS Foundation Trust. Patients are referred to the service.

NHS Derbyshire County

We chose to look at NHS Derbyshire County as a comparison, because not only is it a neighbouring authority but also it was identified as a 'Good' service provider by the Care Quality Commission (See Appendix 5), part of this 'Good' service provider is the provision of a guide to services called 'What is your health, your way guide?

NHS Bassetlaw, NHS Doncaster, NHS Sheffield, and NHS Nottinghamshire were rated as 'Fair' for their provision of services for diabetes.

What is a Your Health, Your Way Guide?

Your Health, Your Way is a free guide to information about support that is available from the local NHS services, social services or voluntary organisations for people living with or affected by long term conditions. It provides information about the choices that are available locally and nationally to help people to maintain good health and take care of the condition as follows:

1. **Getting the right information when you want it** - includes information about different long term conditions.
2. **Making small changes to your lifestyle** - services that are available if people want to make any changes to their lifestyle such as stopping smoking.
3. **Talking to others** - support groups and networks that may be available locally.
4. **Structured courses** - information on the education courses that are available.
5. **Getting the right kit** - equipment that people may be able to get to help them to live independently

There are number of programmes available such as Dose Adjustment for Normal Eating (DAFNE). This 4 day programme provides food and nutrition education. In addition the Aspire Course matches Insulin requirement to eating and exercise.

For newly diagnosed patients there is an education course called Diabetes & You, which covers the many aspects of diabetes management. There is also a Community Diabetes Specialist Nursing Service, which provides support to those that require a little more help.

4. Addressing the Scope: Evidence Gathered for Recommendation

4.1 Current Support Service Provision and Condition Management

What can be done to prevent diabetes?

Type 2 diabetes is treated with a healthy diet and regular physical activity, but medication and/or insulin are often required. Treatment is to achieve blood glucose, blood pressure and blood fat at levels, which are acceptable.

There are three types of drugs used in treatment and all have a different action. Tablets can reduce blood glucose levels and some Type 2's take insulin. A healthy lifestyle will reduce the long-term complications of the disease. This includes improving blood pressure by:

- stopping smoking
- following a healthy, balanced diet
- being the correct weight for your height
- drinking less alcohol and avoiding binge drinking
- reducing your salt intake to the recommended levels
- undertaking regular physical activity
- reducing stress levels
- also by lowering cholesterol by stopping smoking
- following a healthy, balanced diet
- being the correct weight for your height
- drinking less alcohol and avoiding binge drinking

These changes to lifestyle can reduce the effects of diabetes but not recovery. Once a person is diagnosed with diabetes it remains for life.

In Finland a study was carried out on people at pre-diabetic states. This was repeated on 60 patients in Southampton. Thirty were the control group with diet and activities and seen once a year. Thirty were seen once a week to receive support and advice on their condition. Overtime 17 in the control group developed diabetes. In the other group no one developed

diabetes and seven were no longer pre-diabetic. Diet and exercise can be applied to everyone and the study showed that healthy living has an effect.

Primary Care

Locally the clinical conditions of diabetes are treated in the community, and NHS Bassetlaw collects this information. Bassetlaw Hospital however, does not keep a register. Currently there are approximately 5,000 patients in Bassetlaw with Type 2 diabetes.

An annual screening programme by GPs is in place designed to pick up problems with a patient's eyes, kidneys and feet.
GP's need to establish the following at the annual check:

- Is insulin ok?
- Is cholesterol controlled?
- Is diabetes controlled?
- Is weight managed?
- Stopped smoking?
- Is footwear ok /are special shoes needed?
- Examine feet every night?
- Aware that if a patient finds a blister on their foot that they should self refer to hospital as going to the GP may cause a delay in treatment.

From gathering information from NHS Bassetlaw and local GPs through the GP Survey, we found there was an inconsistent approach by GPs referring patients to the Diabetes Education and Self Management for Ongoing and Newly Diagnosed (DESMOND) programme. We received seven responses out of a possible eleven to the GP survey (Appendix 6). We analysed the results and discovered there was a variation in treatment services available for patients with Type 2 diabetes throughout the District. Although they all stated that they provided an annual check up for patients only four included eyes as part of the review. There appeared to be no consistent definition of a Specialist Diabetes Practice Nurse. Although all seven said that they had a Specialist Practice Nurse from those with specialist diplomas to those with a specialist interest. It appeared that further publicity was necessary around information prescriptions. There was also an inconsistency in patients that were referred for the DESMOND programme.

DESMOND, the education programme for Type 2 diabetics, is part of the proposed Diabetes Locally Enhanced Service (LES), which attempts to provide a standardised level of care across the district. The evidence from the GP survey appeared to support the introduction of the Locally Enhanced Service.

Further information gathered from NHS Bassetlaw during the review outlined the following local services.

Diabetic Pathway
The Diabetic Pathway will provide an integrated service so that there is no delay in a patient receiving the treatment that is needed.

Gestational Diabetes
There are proposals to do more work with patients who have gestational diabetes, as they are at higher risk of developing diabetes in the long-term.

Community Services
Diabetes Specialist Nurses
NHS Bassetlaw funds a post to provide specialist diabetes education and clinical support into general practice and community services.

Support to Care Homes
Two years ago, NHS Bassetlaw funded a scheme where a part time Diabetic Nurse goes into Care Homes to ensure consistent standards in the treatment of diabetes are applied to residents of care homes across Bassetlaw. They work with care home staff to provide effective care and management for residents with diabetes. This post has had a significant impact upon the standards and understanding of diabetes care within the care home setting NHS Bassetlaw has investment proposals for 2010/11 to fund a full time post for a specialist nurse

Paediatric Specialist Nurse
NHS Bassetlaw has proposals to fund additional resources to make this a full time post in 2010/11.

Information Prescriptions

This is a pilot project in Nottinghamshire, which provides access to good quality information, with the right information given to patients at the right time (see Appendix 7). It is a web based system with sources of information about the condition, treatments, care services, benefits advice and support groups. It can be accessed on line or in conversation with the GP. More information is available on www.nottsinfoscript.co.uk

'Staying Well' programme

The priority is to have a healthy lifestyle and the 'Staying Well' programme is a tool to manage long-term conditions including diabetes (Appendix 8). It is a six-week course with trained tutors to help people manage their condition. It is operated with Retford Action Centre with outreach courses in the rural areas. More information is available on: http://www.retfordactioncentre.org.uk/staying%20well%20(epp).htm

Employability

There is a welfare rights programme where advisors go into GPs surgeries and advise people on their rights

From the evidence gathered the Panel recommended that GPs should be encouraged to refer Diabetic patients to the DESMOND programme. In addition GP's should be encouraged to sign post patients to programmes such as Staying Well, and Information Prescriptions, which help people, manage their condition.

Recommendation:

- That GPs should be encouraged to refer all newly diagnosed diabetic patients to the Diabetes Education and Self Management for Ongoing and Newly Diagnosed (DESMOND Programme) and have a programme to refer all existing patients to the scheme.

- That GPs should be encouraged to signpost patients at risk of diabetes to programmes such as Staying Well, and Information Prescriptions.

Secondary Care

Historically there has been no consultant in post for the last five years with specific responsibility for diabetes. Locums have covered it until the appointment of the current Consultant Dr. Dang, two years ago. His appointment coincided with national changes in the treatment of diabetes. Treatment of chronic conditions such as diabetes was transferred to the community and Dr. Dang was actively involved in re-establishing the Diabetes Network in Bassetlaw. There is also a Diabetic Pathway to try to ensure that patients receive standardised care in the community from their GP, and GP's know when to refer patients to hospital for Secondary Care.

Routine care is provided in the community by NHS Bassetlaw and the role of secondary care is to provide complex care for those who require expert care. The Consultant led Diabetes team provides care within the outpatient clinic for those patients whose diabetes requires treating with insulin and provide input onto the wards. The outpatient clinic also provides the diabetic retinopathy screening service

People are admitted to hospital when they have become a serious case and there is a need for prevention. The care provided covers three main areas:

- Eye care – Bassetlaw is well served with an annual screening programme.

- Renal care – The service has expanded in Bassetlaw as the hospital now has its own renal unit and consultant. This is a major improvement in the care of patients, as they no longer have to go to a Sheffield Hospital for kidney dialysis.

- Specialist Foot Care for People with Diabetes – From the information gathered it is considered that this service is underdeveloped in Bassetlaw. The aim is to prevent gangrene as the patient has to go into hospital to be treated. Currently there is no specialist foot clinic for diabetics. The Podiatrist runs a clinic once a week, which any patients can access but it is not specifically for diabetes patients. The consultant is currently producing a business case for the provision of a Specialist Foot Clinic at Bassetlaw Hospital. There is good service in the community and good reactive care including the amputation service. There is no middle layer as in Mansfield and Sheffield where there is a specialist foot clinic, which reduces the amputation rate. Bassetlaw has the highest rates of limb amputation in the county. There is a multi disciplinary team, which means that the amputation can be elective and not done as an emergency. This is safer for the patient and has a more effective rehabilitation and a better quality of life with an artificial limb.

To establish a new service will be expensive. All the resources and personnel are available in the hospital but all the specialists need to be brought together at the same time so that the patient can receive specialist advice on things such as footwear. This is seen as a preventative measure. Specialist foot clinics do reduce costs overall and the patient will not lose a foot. The initial cost is in the setting up of the service. At a national level it is assumed that this service is available and the focus is on inpatient care. In Ipswich it has been shown that the foot clinic has reduced the rate of amputation and cost of hospital stay. It is a difficult time financially for the Hospitals and PCT's and a strong business case has to be made for a foot clinic.

Care should be available to patients at the correct level that they need. The yearly checks identify if the treatment should remain in the community. If the GP cannot control the diabetes it is referred to the hospital but once the diabetes is controlled, care will be handed back to the community.

Inpatient care

It provides acute treatment for patients with unstable diabetes and diabetic complications. It is estimated that 10% of the patients in care in hospital are diabetes patients. In September 2009, nationally the hospitals carried out an audit of patients. The figures are not yet released but it is expected that the current figure will be nearer 15%. The National Diabetes Strategy focussed on community care and not hospital care. It is recognised nationally that this shift impacted on the availability of Inpatient Nurses. In Bassetlaw, they chose to keep the Specialist Diabetic Nurses in hospital.

Dr. Dang and his team have rationalised the way that patients are monitored in hospital. They have redeveloped blood glucose monitoring systems. They also want education of all staff in hospital about the condition. The nurses are well served as the consultant runs regular teaching sessions for Doncaster and Bassetlaw hospital staff. There are link nurses on wards who have knowledge of diabetes. Currently there is limited training for doctors about the condition. Junior doctors have an induction but Bassetlaw Hospital has started to give doctors training sessions every four to six months. It is the beginning of a process to develop a formal training programme. There is a written booklet available on the hospital's intranet, which can be completed as a module. Doncaster and Bassetlaw Hospitals NHS Foundation Trust are piloting training on the computer. In the future it is proposed that once the training is formalised the doctors will receive a certificate to show that they have reached an acceptable standard.

Obesity

This is a major challenge as the rates in Bassetlaw are above the national average, which has an effect on diabetes. The District is currently well served with weight management and fitness programmes such as Chrysalis. The dietician runs the clinics but there is no physician. Bassetlaw District Council and its Leisure Centres run several programmes to support people who want a healthy lifestyle.

Bariatric surgery is recommended as a treatment option for people with obesity and has a BMI of 50 kg/m2 or more, or 40 kg/m2 and at least one other significant disease that could be improved if they lost weight. Type 2 diabetes requiring oral medication or insulin is one of theses diseases.The Doncaster and Bassetlaw Hospitals NHS Foundation Trust has recently won the contract for the provision of bariatric surgery. As a result a new consultant has been appointed for Diabetes and Endocrinology. This has allowed the service to expand and hopes to develop an obesity service which is will also be used by patients who have diabetes. This will mean that the District is better served than most localities, as patients will no longer need to be referred to Sheffield for bariatric surgery.

Recommendation:

- That Doncaster and Bassetlaw Hospital NHS Foundation Trust and NHS Bassetlaw should consider the establishment of a Specialist Foot Clinic for patients with diabetes in Bassetlaw.

- That NHS Bassetlaw should consider establishing a database on the annual foot care checks given to people with diabetes by GPs.

4.2 Current Prevention and Early Detection Service Provision

The Panel expressed the need to promote and raise awareness of a healthy lifestyle to prevent diabetes, which is a long-term condition.

It is important that young people are aware of the long-term benefits of a healthy lifestyle. The Panel believed that many people did not understand the full effects of diabetes or where to go to find out information about the condition. In the recent survey of young people, around two thirds of respondents understood the need to keep fit, eat healthily, exercise to maintain the correct weight and not smoke. There was a low awareness of the need to keep waist size down and not to drink alcohol

Obesity Reduction

Doctors advise patients about losing weight but often they need to be motivated to lose weight. Doctors can provide the support as required.

NHS Bassetlaw has a programme, which is led by the consultant in Public Health. Around 27.6% of the Bassetlaw population are overweight. 11.4% of our 4-5 year olds in the District are classed as being obese, and we have the highest rate of obesity amongst boys in Year 6 across the county.

The action taken so far includes a universal obesity prevention programme targeted at the whole population, a selective obesity prevention programme targeted at high risk individuals and population groups, and an indicative obesity prevention programme targeted at individuals with existing weight problems.

The current work includes the implementation of the Change4Life programme across Bassetlaw and we have a Local Enhanced Service in place, which has been taken up by most GP practices to deliver weight management programmes. Our Health Promotion Service is also prioritising work to increase physical activity and promote healthy eating. This includes walking groups and other physical activity initiatives, weight management programmes, and Cook and Eat programmes.

In addition to the current programme of increasing breastfeeding and healthy lifestyles with children and families, they will also be commissioning specific interventions for children in the coming year, including both prevention and treatment, which will include the whole family.

Role of the District Council in Publicity and Awareness Raising

From gathering information about our current activity, the Panel felt that the Council and its partners should display information leaflets about diabetes including GP's, Leisure Centres and Bassetlaw District Council buildings.

The Panel also wanted the local community groups to be involved in raising awareness of diabetes. The network of Tenants and Residents Associations and organisations such as BOFF (Bassetlaw Over Fifties Forum) should link with NHS Bassetlaw to raise awareness. The role of the Health Trainer in Bassetlaw should also be included as they work with local community groups.

Bassetlaw 'Well-being at Work' Award Scheme

The Bassetlaw 'Well-being at work' Award Scheme aims to provide organisations within Bassetlaw with a structured opportunity to promote health in the workplace and recognise best practice activities and projects. There are 6 key programme themes at 3 different levels, Bronze, Silver and Gold. The key programme themes are:

- Smoking
- Mental Health and Well-being
- Healthy Eating
- Physical Activity
- Alcohol and Substance Misuse
- Safety at Work

Under the Council's Human Resources Strategy the health & well-being of all staff has been identified as a key priority for the Council. We are working in partnership with NHS Bassetlaw to develop initiatives under the newly launched workplace health award scheme, to encourage a healthy lifestyle amongst the workforce.

As a partner in the scheme Bassetlaw receives the following benefits:

- A Health Trainer assigned to support people to lead a healthier lifestyle.
- The 'Wellbeing at Work' team will deliver a Mini Health Fair
- All staff have access to the corporate membership scheme at Worksop, Retford and Bircotes leisure centres
- Ongoing support from the 'Wellbeing at Work' team to achieve a healthy workplace status.

The Council is hoping to achieve Bronze level by October 2010 and has appointed 2 Health Champions. The themes do not specifically refer to diabetes but HR is looking at whether it can be promoted at future Body MOT sessions and Mini Health Fairs.

The Council is currently carrying out a survey to gain a baseline assessment of current lifestyle trends of its employees. It has also invited Tracey Bainbridge from the DESMOND programme to attend the next Body MOT/Mini Health Fair in September 2010.

Diabetes Week

Diabetes Week is Diabetes UK's annual UK-wide awareness and fundraising week. This year Diabetes Week was 13 to 19 June 2010 and it will be used to dispel myths and raise awareness of the importance of a healthy lifestyle for everyone. More information is available on http://www.diabetes.org.uk/Get_involved/Diabetes-Week/ . The Council and its partners could work together each year to raise awareness the theme of the Week.

Community Involvement

The Bassetlaw Local Strategic Partnership (BLSP) has a priority to reduce the prevalence of obesity in the population. Year 6 children in Bassetlaw have the highest levels of obesity in Nottinghamshire. NHS Bassetlaw works with children who are already obese and their families and also does prevention work jointly with the Children's Centres and schools. The Panel was informed about the work that Tanice Ellis at the Retford Tenants and Residents Association are doing with adults and children to promote a healthy lifestyle. The project teaches children how to grow vegetables and cook them to raise awareness of healthy eating. It is an opportunity to educate people and raise awareness about diabetes.

Recommendation:

- That BDC puts in place additional measures to raise awareness of diabetes. This should include targeted information displays and activity linked to Diabetes Week.

- That NHS Bassetlaw should work with local community groups such as Tenants and Residents Associations and Bassetlaw Over Fifties Forum (BOFF) as part of its awareness raising activity.

Exercise on Referral Scheme

The Exercise on Referral Scheme was re-launched in May 2010. Since 2001 Bassetlaw District Council and NHS Bassetlaw have been working together to promote the benefits of exercise, through GP referrals over 2000 people have taken part in the 12-week joint exercise referral programme. The Exercise on Referral Scheme plays an important part in promoting physical activity to people who need to improve health and well-being. Patients are referred to assess the service through local health care professionals such as GPs Practice nurses, specialist nurses and consultants. They access the patients as being appropriate for the programme. The patient is monitored and evaluated to receive appropriate guidance and exercise activity. It is delivered at a range of local venues and accesses a range of physical activities including gym, health walks, leisure Centres and community based activities. The Chief Medical Officer report on physical activity stated that active individual have a 33-50% lower risk of developing diabetes.

The Panel noted that there were waiting times for the Exercise Referral programme. These are accepted within the terms of the Service Level Agreement (SLA) under the old scheme it was six weeks; this has been reduced to four weeks in the new scheme from the point of the referral being received by BDC to the commencement of the course. Under the SLA there is monitoring on a quarterly basis and NHS Bassetlaw commissions BDC to deliver the scheme. People can continue attending the Leisure Centres after 12-week programme has finished but have to pay for them.

Recommendation:

- That the District Council and Barnsley Premier Leisure should continue to work with NHS Bassetlaw on initiatives to promote a healthy lifestyle. This should include a publicity campaign to be run during Diabetes Week to raise awareness about diabetes in the Leisure Centres.

4.3 Investigate best practice and look at ways to introduce a common service standard across Bassetlaw.

NHS Bassetlaw has mapped the diabetes services in Bassetlaw against the national standard produced by the National Institute for Clinical Excellence (NICE) and the Diabetes National Service Framework.

An audit of services has been carried out which benchmarked and identified areas for development and theses are progressing through the Bassetlaw Diabetes Network Group. NHS Bassetlaw is planning to invest an additional £300,000 in diabetes services in Bassetlaw in 2010/11, including Hospital Diabetes care.

The Diabetes Educator for Bassetlaw has a role to educate people including health professionals about diabetes and its treatment and keep them up to date on new developments.

Locally Enhanced Service (LES)

The panel recognised that there were concerns about differences in the treatment services offered to patients with diabetes by GPs in Bassetlaw. The responses indicated a wide variation of services provided (See Appendix 6).

There is a need to have consistent care standards across Bassetlaw and the key to this is the introduction of the Locally Enhanced Service (LES) for Diabetes by NHS Bassetlaw which would provide the mechanism to have equality of access to services. The introduction of the LES will provide a gold standard of care in Bassetlaw and GPs will have an enhanced payment for monitoring diabetes. It is an innovative approach to identify patients who are at risk of developing diabetes.

Ongoing Training For GPs

If GP's are involved in the Bassetlaw Diabetes Network Group or the LES there is no need for additional formal training. As part of the LES all doctors are required to attend a formal training course. Currently GPs who are interested in diabetes will attend the training but the LES will ensure that all GPs to attend and keep up to date. This will over time give a consistent standard of care across the District. Within the LES the Panel identified specific issues that appeared to be important to the standard of care provided.

The Panel identified the following elements of the LES that were important to deliver consistency of quality services across Bassetlaw. Members felt that this identified the clear need for GPs to be encouraged to sign up to the LES.

1. Specialist Practice Nurse

Historically when the Doncaster and Bassetlaw Hospital NHS Foundation Trust was established there was a difference in the way that the role of Diabetes Nurses developed. In Doncaster all the Diabetes Nurses went to NHS Doncaster (the PCT) and into the community but in Bassetlaw the Nurses were hospital based. In Bassetlaw the GP's own nurses are trained to manage diabetes, via vocational training.

Patients should be able to access the appropriate knowledge and skills of Practice Nurse staff. The GP Survey showed a variation in provision: one response indicated that the Practice Nurse had an interest in diabetes and at another practice the Nurse had specialist qualifications. The Panel wanted the same range of services available and equality of access to services for everyone. NHS Bassetlaw has recognised that there is a need for trained Diabetes Nurses and within the LES there is a proposal for them to be based in the community. The nurses will link to the Consultant, Dr. Dang.

The Panel recommended that GPs should be encouraged to have Nurses with specialist knowledge in diabetes and if this is not possible for their patients to be referred to a practice that does have this facility.

2. Specialised Foot Service in Bassetlaw for Diabetic Patients

Evidence suggested that there is variability in the foot care services provided by GPs. The Bassetlaw Diabetic Network Group can deal with the information on GPs annual foot checks but currently there is no local database on foot screening maintained by NHS Bassetlaw.

The aim is to be realistic in the services that can be delivered, as Bassetlaw is a small District. The current standard is that everyone with a diabetic foot is seen within 24 hours but in Bassetlaw there is only one high-risk clinic per week. There is a need to educate paramedic staff and podiatrists to recognise the problem and have consistent care.

From the discussions about the foot care services available in Bassetlaw there appeared to be a need for the establishment of a Specialist Foot Clinic in Bassetlaw for people with diabetes. It should be emphasised that this is in addition to the

Podiatry Service provided for the general population. The Panel wanted to support this so that residents of Bassetlaw could have access to the services available in neighbouring areas.

This type of service is provided in Mansfield and Sheffield. There also appeared to be the need for NHS Bassetlaw to maintain an annual register of the yearly foot care checks given to Diabetic Patients, which would improve the information available to the hospital services. Currently there is no requirement for GPs to maintain an annual register. There is an additional payment made to GPs to undertake examination of the Diabetic Foot. This will be traceable via the Quality and Outcomes Framework System (QOF) referred to above and is part of the LES. There is already a database for eyes and kidney function.

3. Self Care

A. DESMOND

Desmond is an education programme for patient's with Type 2 diabetes, it is a multi-service approach and provides information on the disease, diet, exercise and how to manage the condition. NHS Bassetlaw is proposing to increase funding to meet increased demand for this programme in 2010/11.

B. Free NHS Health Check (formerly known as Vascular Checks)

In April 2008, the government set out in 'Putting Prevention First' that from April 2009, the NHS would be implementing a uniform and universal vascular risk assessment and management programme called 'Vascular Checks' for people in England aged between 40 and 74. The programme offers a real opportunity to save lives, improve quality of life and reduce health inequalities. The vascular diseases include coronary heart disease (CHD) (including heart attacks and angina), stroke, diabetes mellitus (DM) and chronic kidney disease (CKD). Vascular diseases are the leading cause of premature death in the UK and a major cause of disability.

Although vascular diseases affect the body in different ways, they are all linked by a common set of risk factors and having one vascular condition increases the likelihood of an individual suffering others. Early intervention to reduce 'modifiable' risk (e.g. smoking, blood pressure, cholesterol levels) can prevent, delay, and, in some circumstances, reverse the onset of vascular disease.

These checks are aimed at people who rarely go to their GP. They are free checks for heart problems, kidney disease, strokes and diabetes. The Department of Health estimated that vascular checks could save at least 650 lives each year nationally and prevent around 1,600 heart attacks and strokes. In addition, the programme could prevent more than 4,000 people each year developing diabetes and detect at least 20,000 cases of kidney disease or diabetes, allowing for improved disease management and quality of life.

If targeted appropriately, the programme offers a real opportunity to reduce health inequalities. This programme is in the LES and nearly all the Bassetlaw GP practices are doing the checks. Practices are receiving additional payments for this. It is hoped that 3,000 people will have been checked in Bassetlaw by the end of March 2010. The programme started in June 2009. People who are identified at risk can receive appropriate treatment. More information is available on www.nhs.uk.nhshealthcheck

During April 2010 NHS Bassetlaw will undertook a review to identify which groups of the population are not coming forward for the checks, and will commission social marketing work to improve take up amongst these groups.

Recommendation:

- That GPs in Bassetlaw are encouraged to sign up to the initiative by NHS Bassetlaw to introduce a Locally Enhanced Service (LES) for Diabetes, which should provide consistent standards across the district.

- To assist early detection, GPs should be encouraged to sign post patients to the free NHS Health Check.

5. Conclusion

The Panel identified a baseline of the current service provision for the treatment of residents with Type 2 diabetes in Bassetlaw. Currently the number of diagnosed patients is above the national average and the future projections indicate that the numbers will increase. NHS Bassetlaw spends approximatley 10% of its budget on the treatment of diabetes and related illnesses.

The government has recognised that the prevention and treatment of diabetes is important for maintaining health and has produced national guidance. The Panel looked at what NHS Bassetlaw commissions from GPs and the secondary care provided by Doncaster and Bassetlaw Hospital NHS Foundation Trust. There is a large amount of information available on websites and in various publications to raise awareness about prevention and also managing the condition in the long-term. By working in partnership we can provide practical support to reinforce the messages and promote a healthy lifestyle to all our residents.

The Panel identified the need for a consistent standard of treatment services for Type 2 diabetes in Bassetlaw. The evidence suggested that currently there is variation in the interpretation of the national guidelines. The Panel supports the introduction of the Locally Enhanced Service, which should set in place a consistent standard for the district.

The Panel also listened to the evidence about the benefits of a Specialised Foot Care Service in Bassetlaw. This operates in other areas and both NHS Bassetlaw and Doncaster and Bassetlaw Hospital NHS Foundation Trust are working together to set out the business case for this facility.

The Panel recognises the good work that is already being carried out in Bassetlaw and supports these initiatives to provide an improved standard of care.

6. Appendices

Appendix 1. X-PERT Programme Information

Audited

An audit template includes attendance, clinical outcomes (HbA1c, weight, waist circumference, BMI, blood pressure and lipid profile), prescribed diabetes medication, quality of life, patient experience and degree of self-management.

The template and supporting questionnaires can be viewed in Appendix 4 of the Tutor's Manual and can be printed from the X-PERT Audit Database (www.xpertdatabase.org.uk). The template is a guidance document and organisations may find it difficult to audit all elements initially and may instead decide to prioritise.

The audit should be carried out on an annual basis. Standards have been developed to benchmark implementation of the X-PERT Programme against the randomised controlled trial results.

A National Database has been developed that allows organisations to produce automated reports of their audit data and compare this data to national implementation.

Deakin, T. A. *Expert Patient Education versus Routine Treatment (X-PERT).* PhD Thesis: 1-346; 2004. Nuffield Institute for Health, University of Leeds.

Deakin, T. A., Cade, J. E., Williams, R., & Greenwood, D. C. 2006. Glycaemic Control: *The Diabetes X-PERT Programme makes a Difference.* Diabetic Medicine 23, 944-954.

DOH 2001, *National Service Framework for Diabetes: Standards*, Department of Health, London.

International Standards for Diabetes Education developed by the Consultative Section on Diabetes Education, International Diabetes Federation 2003

X-PERT Health Community Interest Company (CIC) is a not-for-profit social enterprise with the vision of improving the health and wellbeing of the population.

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Mobile: 07588733820

X-PERT Health CIC

How X-PERT meets the key criteria

Philosophy

Evidence-based: the X-PERT Programme has been showed to be effective for people with type 2 diabetes by improving clinical, lifestyle and psychosocial outcomes.[1,2] The content of the X-PERT Programme is evidence-based and all material throughout the Tutor's Manual (structured curriculum) is referenced and based on national and international guidance.

Flexible: X-PERT educators may adapt the X-PERT Programme to meet the specific cultural needs of the local population although they require written permission from Dr Trudi Deakin before the adaptations are made.

Dynamic: the X-PERT Programme results in energy, motivation and enthusiasm for diabetes self-management.

On-going development: sections of the structured curriculum will be updated as and when necessary. All X-PERT educators who have attended the train the trainers course will be notified about this process. The X-PERT Programme has been further developed with an annual update module (available for all those who have attended the X-PERT Programme). Future developments include an insulin module for Type 1 / Type 2 diabetes, X-PERT Junior, a DVD series and E Learning opportunities. The programme will also be adapted for other long-term conditions.

Aim & learning objectives: these are written on page 10 of the Tutor's Manual (structured curriculum) and are shared with the participants in week 1. The over-riding aim is to develop self-empowerment in people with Type 2 diabetes to enable them to develop the knowledge, skills & confidence to make informed decisions regarding their lifestyle & diabetes self-management.

Self management: The X-PERT Programme has been developed acknowledging that people with diabetes consult health professionals for just three hours each year and spend the other 8,757hrs self-managing their diabetes.[3] Carers/family members are also encouraged to attend the programme.

Structured Curriculum

Person centred: the X-PERT Programme was developed by evaluating single sessions delivered to people with diabetes, evaluating these sessions by asking people what they wanted from a structured education programme and then developing the six-weekly sessions. The programme is person-centred because continuously throughout, people are encouraged to be interactive and explore their own issues, problems and concerns related to living with diabetes.

Reliable, valid, relevant and comprehensive: the PhD thesis is available on loan from either the University of Leeds or the British Library (Boston Spa). The thesis is 350 pages and is extremely reliable, valid, relevant and comprehensive.

Theory driven & evidence based: the theoretical models underpinning the X-PERT Programme are empowerment, discovery learning and patient-centred care. References supporting the use of these models can be presented .

Flexible & cope with diversity: as stated above, X-PERT educators are encouraged to adapt the X-PERT Programme to meet the specific cultural needs of the local population.

Use of different teaching media: - group work, discovery learning, lifestyle experiences, exercises etc.

Resource affective with supporting materials: - visual aids, flip chart, DVD, handouts etc.

Written down: the structured curriculum is completely scripted. X-PERT educators are discouraged from reading from the Tutor's Manual but the script is there to support the educator in the preparation for delivery. The script will also assist with implementing the programme as it was delivered in the randomised controlled trial.

Trained educators

Understanding of education theory: the course preparation reading provides an overview of the rationale, philosophy and theoretical models used in the X-PERT Programme. Participants are assessed on their understanding and knowledge by participating in the X-PERT Challenge and knowledge test.

Trained and competent in the delivery of the education theory and the content of the X-PERT Programme: the X-PERT train the trainer course aims to develop the skills, knowledge and confidence in the delivery of structured patient education. Participants are assessed via means of self-assessment for confidence, practical assessment for delivery and a knowledge test.

Quality Assured

A quality assurance (QA) programme has been developed based on the International Diabetes Federation standards.[4] The following elements are quality assured: environment; structure; process; content; use of materials; delivering of the programme; evaluation and outcome. Each standard is fully, mostly, partly or not met. To improve reliability of the quality assurance programme a guidance document has been developed to describe what would constitute 'full' 'most' 'part' or 'no' achievement. These are available to download from the X-PERT National Audit Database. It is envisaged that the QA process will be seen as an appraisal and not a threatening process. If an X-PERT educator scores ≥ 80%, they do not need to be quality assured again for three years. However, if problems are identified (these may be around the environment or structure of the organisation and not necessary regarding the delivery of the programme), it is recommended that a timed action plan is developed and that person is re-quality assured once problems have been addressed. External QA: organisations team-up with another local organisation and undertake QA for one another. Internal QA: completion of Reflection Diary (download from www.xpertdatabase.org.uk) and the online reflection forum on the password protected healthcare professional pages of the X-PERT website athttp://www.xperthealth.org.uk/hcp_reg.html

Appendix 2. Outcomes measures/minimum data set

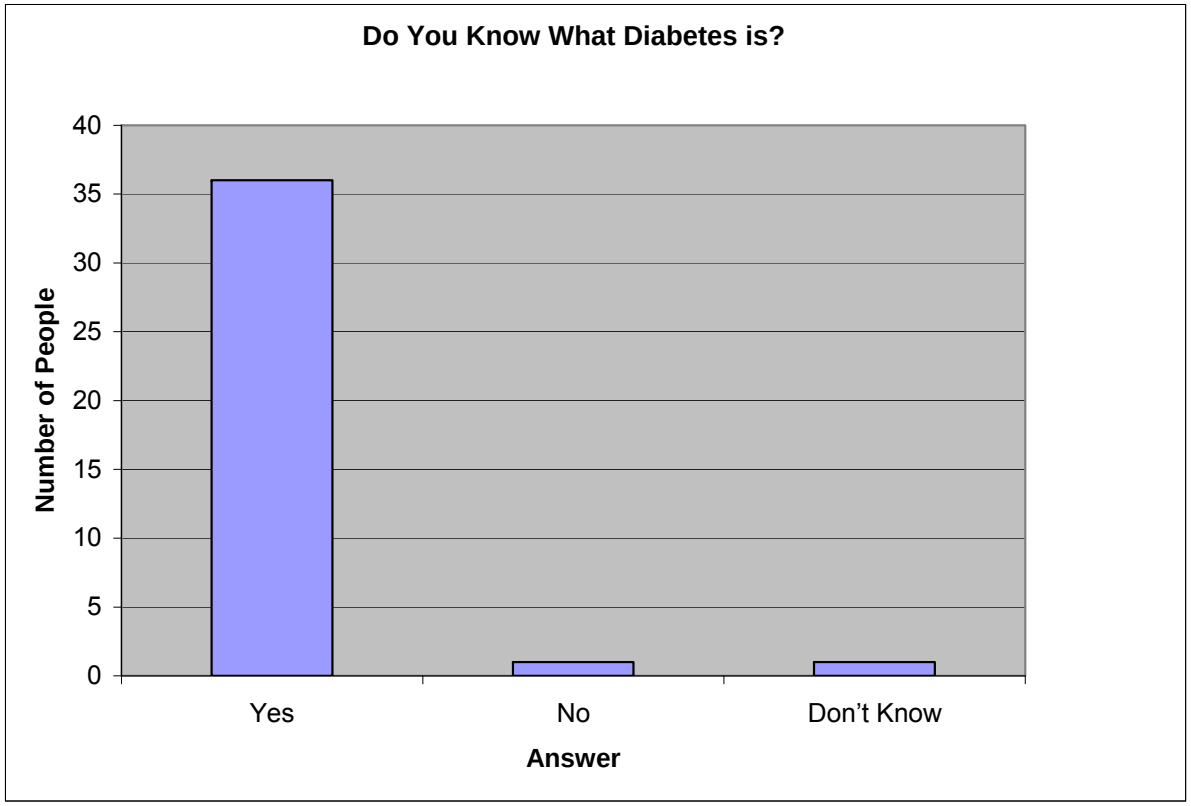
Services will be measured for their achievement against core services in key areas of Diabetes care.

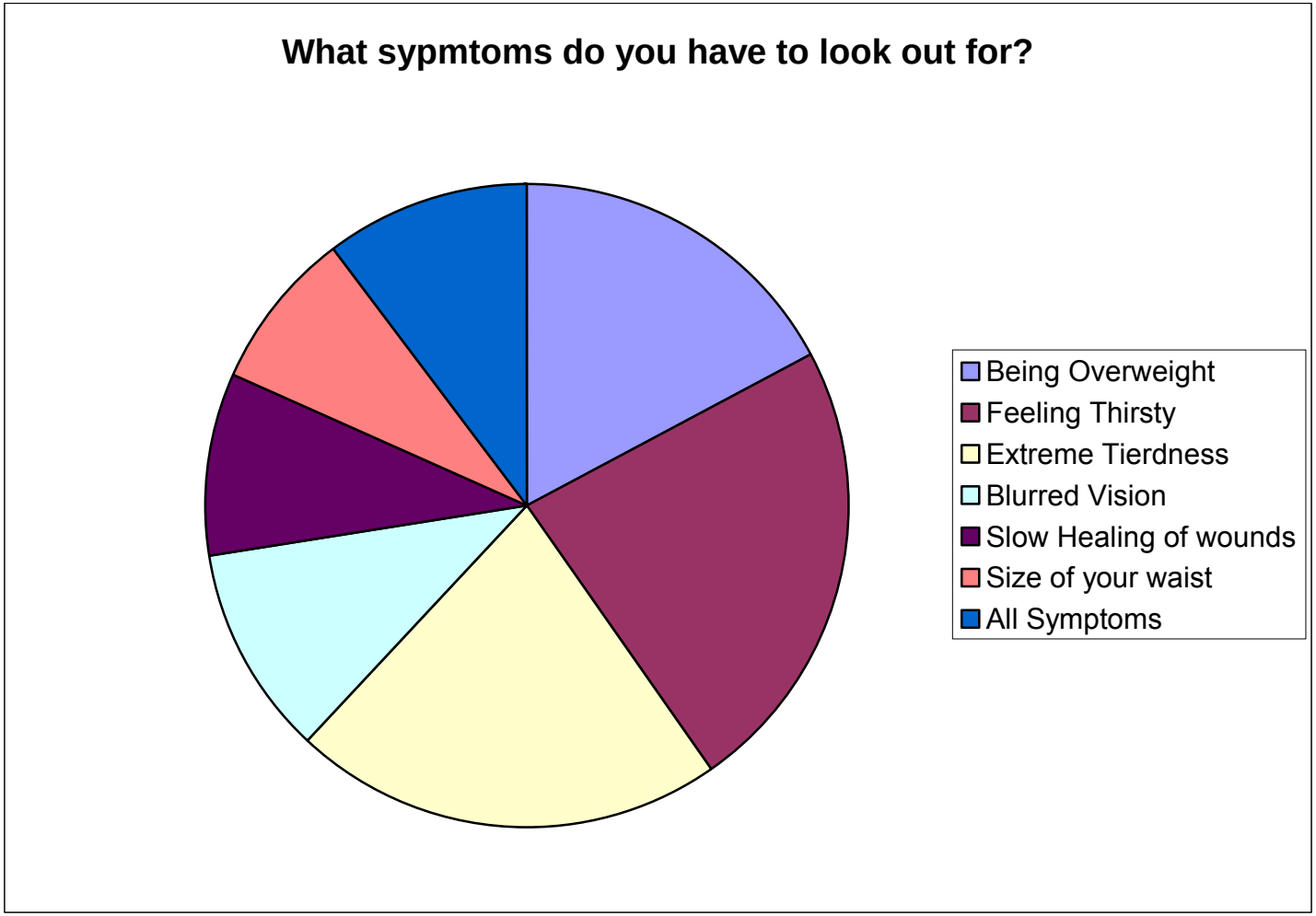
Key Areas	Objective:
Prevention	
Prevention of Diabetes	To measure the effectiveness of services in identifying patients at high risk of developing Diabetes in their patient population, enabling promotion of health interventions to reduce the risk of early onset of the condition
Identification and Diagnosis	
Effective identification	To gauge the effectiveness of services to identify and diagnose diabetes in their patient population and how early in the disease process diagnoses are made.
Initial Assessment and Management	
Patient experience and engagement	To evaluate the quality of services from the patient perspective
Patient education and empowerment	To gauge the effectiveness of services in promoting healthy life styles and in promoting the capacity of patients to self manage their diabetes.

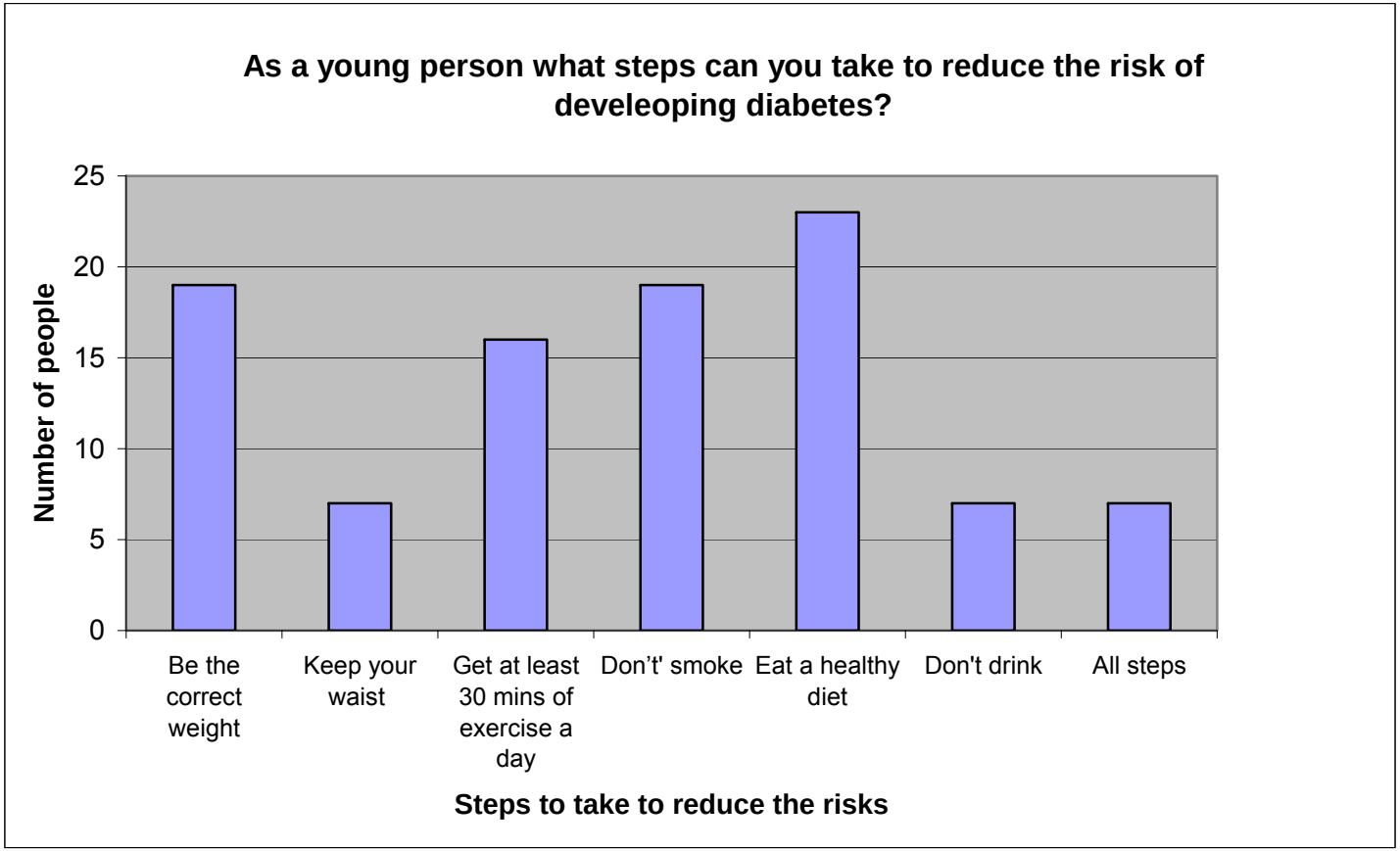
Key Areas	Objective:
Ongoing Care	
HbA1c HbA1c - is a test that measures the amount of glycosylated haemoglobin in blood. The test helps to estimate how well diabetes is being managed. The ideal range for people with diabetes is generally less than 7%.	To indicate the effectiveness of current clinical management of diabetes (glycaemia)
Macrovascular risk	To indicate the effectiveness of clinical management of diabetes in reducing vascular risk.
Patients with diabetes emergencies	To gauge the effectiveness of services in the clinical management of diabetes and in promoting the capacity of patients to self manage their diabetes.
Complications	
Micro-vascular complications	To indicate the effectiveness of long-term clinical management of diabetes and of long-term complications • Testing for Proteinuria and Microalbuminuria • Retinal screening • Testing for peripheral pulses in feet • Neuropathy testing
Foot Care	
Management of complications	To measure effectiveness of services in managing complication when they present • Lower limb amputations in diabetics • Emergency admissions for diabetic Ketoacidosis and coma

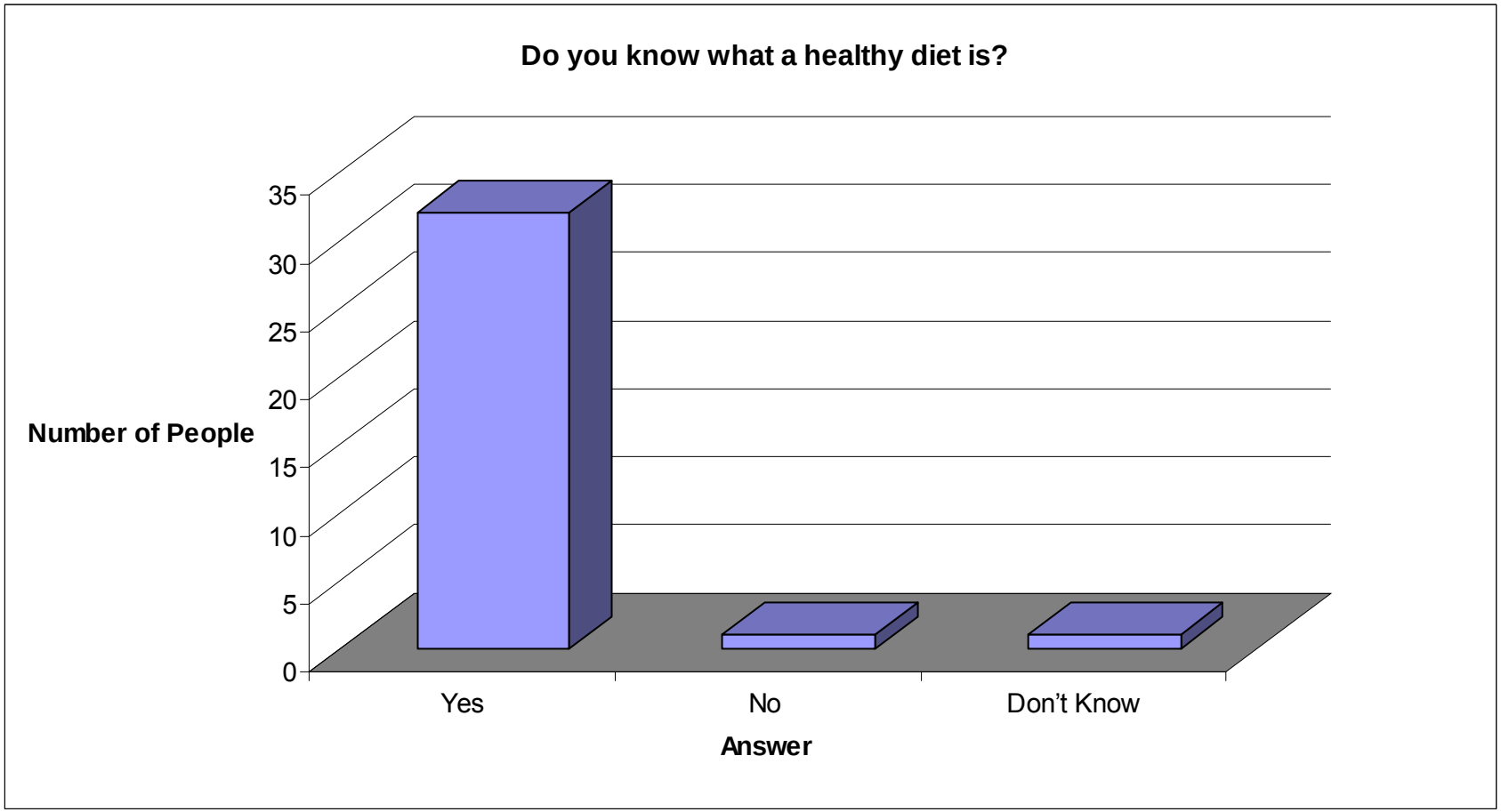
Key Areas	Objective:
Hospital Care	
Length of Stay	To gauge the effectiveness of secondary care services to manage the diabetes of patients while they are in their care for other treatments • Presence of guidelines for the management of diabetes • Management of patients in hospital/surgery
Provision of inpatient Care	
Pregnancy	
Management of women with Diabetes during Pregnancy	To gauge the effectiveness of services in managing the diabetes of women who are planning a pregnancy or become pregnant
Management of women who develop Gestational Diabetes	To gauge the effectiveness of services in managing women who develop Gestational Diabetes
Aspirational Measures	
These measures are difficult to measure at this stage but are acknowledged as beneficial, and are retained for consideration in the development of future measures	

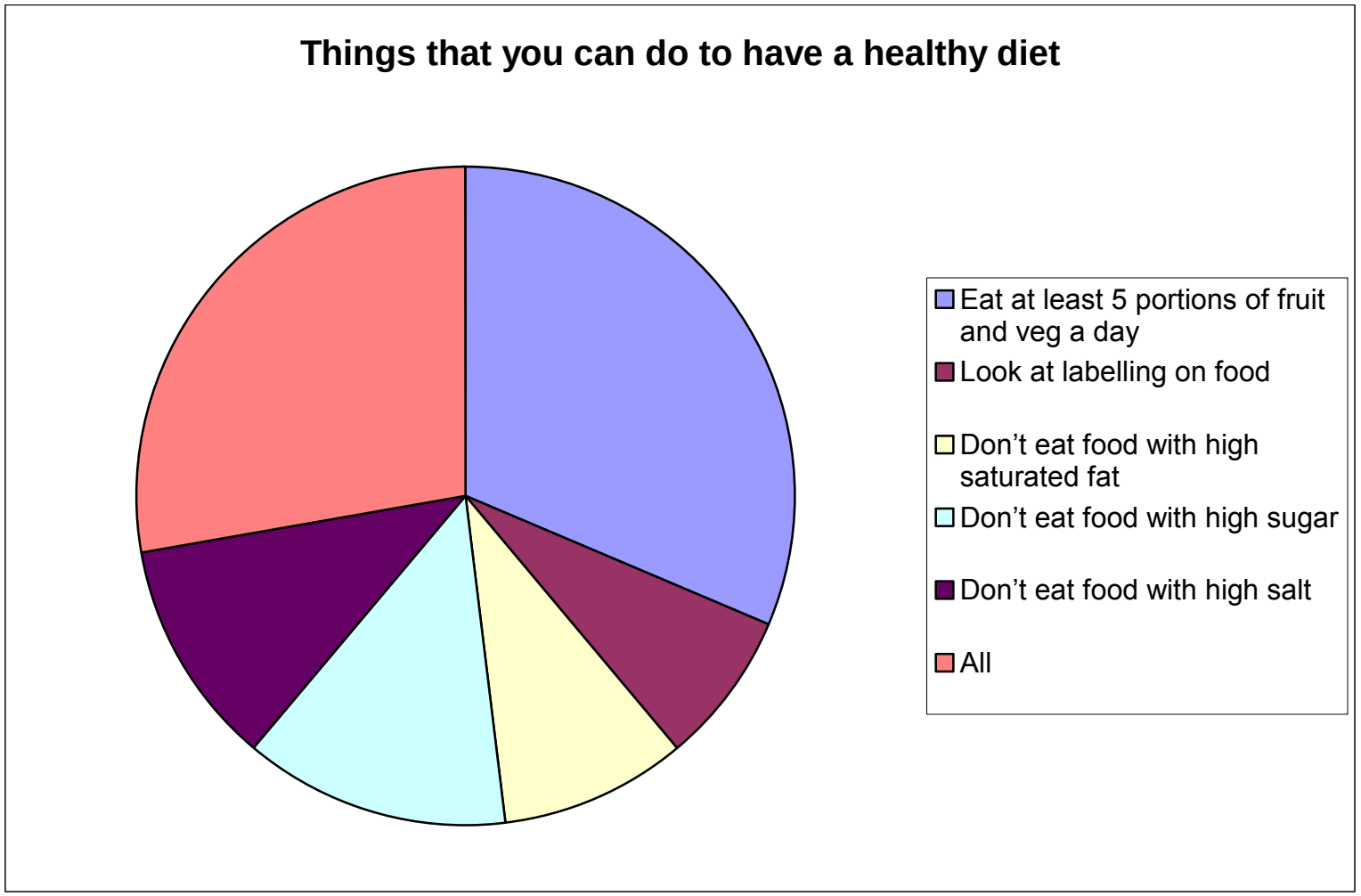
Appendix 3. Survey of Young People




What sypmtoms do you have to look out for?
Being Overweight
Feeling Thirsty
Extreme Tierdness
Blurred Vision
Slow Healing of wounds
Size of your waist
All Symptoms


As a young person what steps can you take to reduce the risk of develeoping diabetes?
Number of people
25
20
15
10
5
0
Be the correct weight
Keep your waist
Get at least 30 mins of exercise a day
Don't' smoke
Eat a healthy diet
Don't drink
All steps
Steps to take to reduce the risks


Do you know what a healthy diet is?
Number of People
35
30
25
20
15
10
5
0
Yes
No
Don't Know
Answer


Things that you can do to have a healthy diet
Eat at least 5 portions of fruit and veg a day
Look at labelling on food
Don’t eat food with high saturated fat
Don’t eat food with high sugar
Don’t eat food with high salt
All

Appendix 4. Foot Care leaflet

Footwear, Socks and Hosiery

A lot of foot problems are caused by shoes, slippers and socks, that do not fit properly

- If you have been given special shoes you must wear them to protect your feet
- Check inside shoes before putting them on for any objects that may damage your foot such as small stones or rough seems
- Make sure that your feet are measured for both length and width whilst standing, by a qualified shoe fitter as your shoe size may alter as you get older
- A shoe which is too big is as harmful as one that is too tight
- Try and buy shoes in the afternoon when your feet are at their largest, and wear in new shoes gradually for 1 to 2 hours per day
- Shoes should be wide and deep enough to be comfortable
- Round toed styles with a strap or lace fastening are the most suitable, avoid slip-ons.
- If you have difficultly finding shoes to fit your feet because of a foot deformity or because they are swollen ask your podiatrist for advice
- Make sure socks, stockings or tights fit properly and are not too tight especially the band at the top of socks. Wear socks inside out to reduce rubbing from seams
- Do not wear socks with bulky seams
- Change your socks/tights daily
- Avoid man made fibres, wear cotton or woollen socks

NOTES

CONTACT DETAILS

Podiatry Services
Jordanthorpe Health Centre
1 Dyche Close
Sheffield
S8 8DJ

Telephone 0114 2371182
Website: www.sheffield.nhs.uk/podiatry
www.diabetes.org.uk

NHS

SHEFFIELD DIABETES FOOT-CARE TEAM

CARE OF AT RISK FEET FOR PEOPLE WITH DIABETES

If you have diabetes, then there are reasons why you need to take extra special care of your feet:

- **Diabetes may cause you to lose the sensation in your feet**

As a result of this loss of sensation, foot problems can occur without you feeling any pain to make you aware of them. Spending a few minutes each day paying particular attention to your feet can help prevent problems developing.
You should wear footwear to protect your feet against damage from sharp objects and extremes of temperature.
You should check inside your shoes before putting them on, to make sure there are no stones, foreign objects or rough, raised stitching, that may damage your foot.

- **Diabetes may reduce the circulation of blood to your feet**

If the circulation to your foot is reduced, any damage to the skin will take longer to heal.
Your feet check has shown that you have one or more of the problems detailed above, however by following the advice in this leaflet and seeking help promptly you can avoid serious problems
We would rather see you too early than too late!
Sheffield Diabetes Foot-care Team

Examine Your Feet Daily

- **It is important to start looking after your feet from a young age**

Check your feet daily under a good light, this will help you to find any problems such as; split skin, blisters, warts, athletes foot, colour changes, swellings, infections, discharge and injuries)
If you notice any of these problems when inspecting your feet, contact your podiatrist, GP or practice nurse immediately so that they can be treated promptly to avoid the problem developing into a foot ulcer.

If you are unable to bend, put a mirror on the floor and hold each foot over it so you can see the reflection in the mirror. If your eyesight is poor ask a family member, carer or friend to examine your feet for you.

Footcare you can expect from the National Health service

A nurse or podiatrist should check your feet annually.
If any problems are found an appointment will be arranged with an appropriate healthcare professional, usually the podiatrist.
Please telephone or write to the podiatry service if you need to see a podiatrist, contact details are on the back of this leaflet.

Other Tips

- Don't smoke
- Keep your blood sugars stable
- Keep your blood pressure stable

If you need any advice or help about how to follow these tips, ask your practice nurse.

Nail Care

- If you can cut your nails easily without making your toes bleed, cut your nails following the line of the toe, not too short and not down the sides
- If you are unable to cut your nails, try using a nail file or emery board weekly. When filing follow the shape of your toe, as in the two pictures below

- Try doing this after a bath or shower
- Do not use any sharp instruments to clean under the nails, use a soft brush for this
- Do not cut your nails too short
- Ensure no pieces of nail are left in between your toes

If you cannot manage your own nail care or you do not have a family member or friend who will do this for you, contact your Podiatrist.

Corns and Hard skin (callus)

- Small corns and hard skin may be managed by regular gentle filing and a daily application of emollient cream such as E45 if advised by your podiatrist
- Regular visits to a podiatrist will ensure safe removal of callus and corns, make sure they are registered with the Health Professions Council (HPC)
- Never use corn remedies or corn plasters as these can be dangerous if your have diabetes

Handy Hints to Keep Feet Healthy

- Avoid sitting too close to fires, radiators or putting hot water bottles directly on your feet
- Always test bath water with your elbow first to ensure it is not too hot, as you may not feel it if your feet burn
- If the weather is very cold outside, keep your feet warm with woollen socks or tights and fur lined boots
- If you notice any bleeding or weeping areas on your feet, cover them with a sterile dressing and contact your podiatrist, GP or practice nurse straight away
- Never walk barefoot, wear a light shoe with a firm sole, rather than a soft slipper, when in the house to protect your feet from damage.
- Be careful if on holiday when walking on hot sand or pavements, make sure you have something on your feet to protect them from burns or injuries, don't forget the tops of your feet when frequently applying high factor sun cream—See holiday advice leaflet for more details
- Avoid soaking your feet for long periods of time, wash daily and dry carefully especially between the toes.
- If the skin is moist between the toes, wipe this with some surgical spirit on a piece of cotton wool, rather than using talc.
- Areas of dry skin should have a moisturising cream applied daily to avoid itching or cracking, but do not moisturise between the toes

Appendix 5. Care Quality Commission healthcare comparisons

	Bassetlaw Primary Care Trust	Derbyshire County Primary Care Trust	Nottingham City Primary Care Trust	Nottinghamshire County Teaching Primary Care Trust
Quality of services	2007/08 Fair	2007/08 Good	2007/08 Fair	2007/08 Fair
Use of resources	Fair	Good	Good	Good
Safety and cleanliness	**12**/12	**12**/12	**12**/12	**12**/12
Standard of care	**6**/7	**7**/7	**7**/7	**7**/7
Waiting to be seen	**3**/4	**2**/4	**3**/4	**3**/4
Dignity and respect	**11**/11	**11**/11	**10**/11	**11**/11
Keeping the public healthy	**7**/7	**7**/7	**7**/7	**7**/7
Good management	**16**/16	**16**/16	**14**/16	**14**/16
Commissioning services	**15**/16	**15**/16	**14**/16	**14**/16
Planning for local improvement	**13**/21	**18**/22	**17**/22	**13**/21
Service Review	Fair	N/A	Good	N/A
Adult Community Mental Health Services	Good	N/A	Fair	N/A
Tobacco control	Good	N/A	Excellent	N/A
Diabetes	Fair	Good	Fair	Fair
Substance misuse service review 2006/2007	Excellent	Good	Good	Excellent
Urgent and emergency care	Best Performing	Best Performing	Best Performing	Best Performing

Appendix 6. GP Survey

Question	Findings	Question	Findings
What services do you provide for patients with Type 2 Diabetes?	a) Annual health checks and routine reviews. b) Regular diabetes clinics with screening. Insulin initiation where appropriate. c) 6 monthly and yearly reviews - with appropriate referrals where necessary.	**Do you offer patients the free NHS Health Check?**	a) Yes 7 b) No c) Don't Know
Do you provide an annual check up for patients with Type 2 Diabetes?	a) Yes 7 b) No c) Don't Know	**Do you provide information on weight management?**	a) Yes 7 b) No c) Don't Know
Please tick which of the following is included in the check up	a) Blood 7 b) Blood Pressure 7 c) Weight 7 d) Feet 7 e) Eyes 4 f) Kidney 7 g) All 4	**Do you offer patients education programmes on diabetes?**	a. Yes 7 b. No c. Don't Know
Do you have a specialist Diabetes Practice Nurse?	a) Yes 7 b) No c) Don't Know	**If yes please give details of the programmes offered?**	d) DESMOND 5 e) DAFNE f) In house training

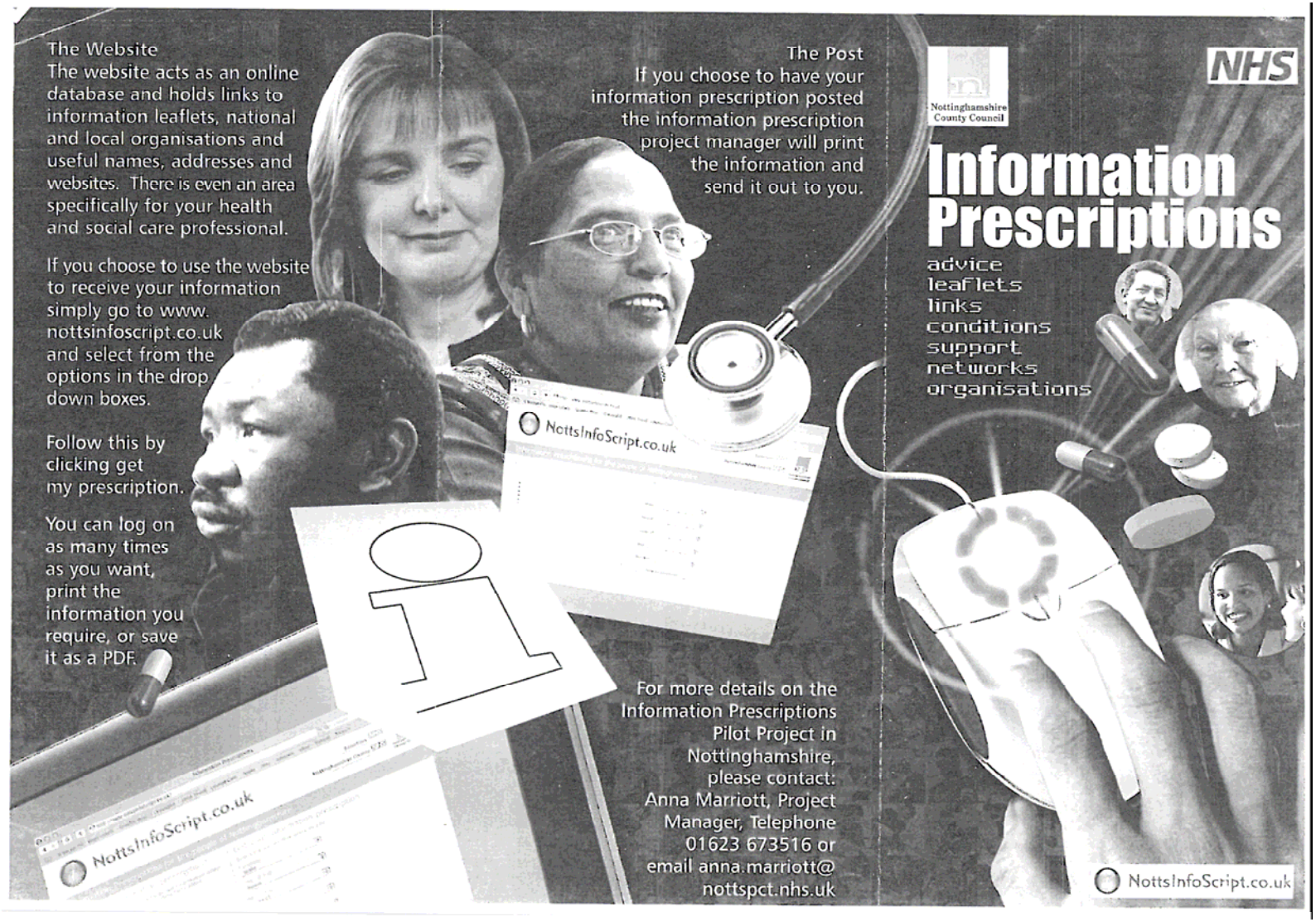
Question	Findings	Question	Findings
If yes please give details	a) Senior Practice Nurse – Holds Diploma in Diabetes Management within Primary care. b) She has undergone the Warwick Diabetes Diploma, Insulin for Life Programme and Graduate Cert in Diabetes. c) Both of my nurses have an interest in Diabetes. d) Trained in Management and insulin initiation. e) Nurse Practioner and Practice Nurse.	**How many patients are referred to these programmes?**	a) All new diabetics, plus any patients that may benefit from the programme. b) All type 2 patients and those with IFG/IGT. c) All at diagnosis and as required otherwise. d) All Type II offered.
Do you provide information about the Staying Well Expert Patients Programme?	a) Yes 5 b) No 1 c) Don't Know 1	**Do you keep information relating to the programme?**	a) Yes 7 b) No c) Don't Know
Do you provide information about Information Prescriptions?	a) Yes 4 b) No c) Don't Know 3	**If yes please give details**	a) Referral forms available on Practice intranet. Leaflets available for patients. Sample DESMOND folder available to show patients. b) Referral document; patient information folder. c) All referrals coded.

Question	Findings	Question	Findings
			d) On patient's screen and in Nurse Practioner's diabetic folder.
Do you provide support for depression for patients with Type 2 Diabetes	a) Yes 7 b) No c) Don't Know	**Do you offer information on foot care**	a) Yes 7 b) No c) Don't Know
If yes please give details	a) Standard depression screening questions at review. b) Forwarded to GP if further review/meds/support required. c) They are offered one to one with the GP, and referral to. d) Community Psychiatric Nurse if appropriate. e) Refer to IAPT. f) Questionnaire and referral to GP as appropriate. g) Depression screening for all patients with diabetes. h) Yearly depression screening.	**Please detail the preventative work that is undertaken at your practice to identify and prevent Type 2 Diabetes.**	a) CV Risk checks now being undertaken for patients 40-74yrs. Patients with recurrent infections screened. Obese patients screened. b) We have been screening for diabetes for the past 8 years, have a comprehensive register and audit annually. c) Early intervention to patients with FH and those on weight management courses plus flyers etc. d) Patients attending CHD/Hypertension clinics have annual FBS.

Question	Findings	Question	Findings
			e) NHS Health Checks. School project to increase activity. Opportunistic screening. Weight Management clinics. f) CVD risk factor checks, Hypertension reviews, weight management
What further interventions need to happen and where, to reduce the risk of diabetes?	a) We need to target schools and children to stem the rise in adolescent type 2 diabetes. b) Health checks with BMI 30 or above and/or FH offered screening FBS.	**What are the most significant challenges facing general practice within the prevention and effective management of Type 2 diabetes?**	d) Time 3 e) Standardisation of services. Information from secondary care. Funding. f) Limited time available to fully assess all patients, lack of response to invitation for screening patients /management of high risk patients

Question	Findings	Question	Findings
Do you have any plans to introduce any changes in the next 12 months?	a) Yes 3 b) No c) Don't Know 2	**If yes please give details**	a) Recently new in post. Apply motivational interviewing techniques. Drive education both new & current diabetics. b) Targeting those aged 18-40yrs with a bmi>30 and screening them for type 2 c) Increased training / activity - insulin initiation. d) To have a fully organized and fully operational recall system for our type1 and 2 diabetics to meet regularly with our Nurse Practitioner and Practice Nurse to discuss more complicated and in depth cases.

Appendix 7. Information Perscriptions



What are information prescriptions?

Information prescriptions contain a series of links or signposts to guide people to sources of information about their health and care – for example information about conditions and treatments, care services, benefits advice and support groups.

Information prescriptions will let people know where to get advice, where to get support and where to network with others with a similar condition. They will include addresses, telephone numbers and website addresses that people may find helpful, and show where they can go to find out more. They will help people to access information when they need it and in the ways that they prefer.

Nottinghamshire County Council

NottsInfoScript.co.uk

What sort of information will I receive?

Your information prescription includes information on:

- Your condition
- Emotional wellbeing
- Home and local services
- Voluntary, support and community groups
- Leisure, sport and work
- Benefits, legal and financial advice
- General health and wellbeing

As well as useful links and contact information

This information can be made available in other formats if requested

NottsInfoScript.co.uk

How do I get an information prescription?

During your appointment your health and social care professional will offer you an information prescription. You can also ask for one at any time you choose. You will then have a discussion about your current information needs. You can request as much information as you want.

Your health and social care professional will fill in a form and give a copy to you. Another will go in your records and a third will be sent to the Information Prescriptions Project Manager.

You can choose to receive your information by either:

- Accessing the information prescriptions website at www.nottsinfoscript.co.uk
- Having the information emailed to you or a carer
- Having the information posted to you or a carer.

NHS

NottsInfoScript.co.uk

Appendix 8. Staying Well Programme

EXAMPLE OF SOME LONG TERM HEALTH CONDITIONS:

Heart Conditions	Parkinsons	Lung Conditions
Leukaemia	Osteoporosis	Crohns Disease
Back Conditions	Alzheimers	I.B.S.
Amputations	Fibromyalgia	Eczema
Bipolar Disorder	Psoriasis	Colitis
Depression	Arthritis	Aphasia
H.I.V.	Migraine	Cancer
	Stroke	Diabetes
	Epilepsy	Asthma
	M.E.	C.O.P.D.
		Lupus
		M.S.

HOW IT HAS HELPED OTHER PEOPLE

People who have taken part in the programme have reported that it has helped them to:

* Feel more confident and in control of their life.
* Manage their condition and treatment together with healthcare professionals.
* Be realistic about the impact of their condition on themselves and their family.
* Use their skills and knowledge to improve their quality of life.

RESEARCH CONFIRMS

In a randomised trial, carried out by The National Primary Care Research and Development, researches found:

* Increases in people's confidence to manage their condition.
* Higher energy levels.
* Improvements in quality of life.
* High satisfaction with the course.

Retford ACTION Centre

'Staying Well'

Expert Patients Programme

FREE

self help course for people living with a long term health condition

Send To:
'Staying Well' Programme
Retford Action Centre,
Canal Street, Retford,
Nottinghamshire.
Tel: 01777 709650
www.retfordactioncentre.org.uk
Email: stayingwell@retfordactioncentre.org.uk

A better quality of life despite living with a long term health condition

Bassetlaw Primary Care Trust NHS

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