London
Strategic Clinical Networks

LONDON DIABETES
STRATEGIC CLINICAL NETWORK

MAY 2015

Foot care service for people with diabetes

Guidance for commissioners: Service specification

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Foreword

While London has rates of lower limb amputation that are consistent with the rest of England, there remain varying outcomes and levels of care provided across the capital. Ensuring that all people with diabetes in London receive the same high quality care, level of care is a key aim of the London Diabetes Strategic Clinical Network.

The Foot Care work stream is a dynamic group of multi-disciplinary clinicians, professionals, patients and charitable organisations. The energy and drive of the members within this work stream has led to the development of this service specification.

This best practice service specification draws on work by National Institute for Clinical Excellence (NICE), Diabetes UK, the Vascular Society and the Society for Chiropodists and Podiatrists. It brings together not only evidenced best practice, but also outlines innovative care, staffing and service delivery to meet the demands of patients with diabetes.

Above: Mr Richard Leigh
Below: Ms Stella Vig

We look forward to working with acute trusts, community health services and clinical commissioning groups (CCGs) to begin commissioning high quality foot care services across London with this service specification, which combines all the relevant guidance and standards in one tool.

We would like to acknowledge the essential advice and support from Dr Stephen Thomas and the London Foot Care work stream. Thank you to Jay Nairn, project manager, and Gemma Snell, senior project manager from the London Strategic Clinical Networks for their generous support and commitment.

Mr Richard Leigh
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Head of podiatry, Royal Free London NHS Foundation Trust

Ms Stella Vig
Co-chair, Foot Care work stream
Consultant vascular and general surgeon, Croydon Health Services NHS Trust

The impact of diabetes in London is well known. For patients with diabetes, one of the biggest challenges is accessing good quality integrated healthcare. This is especially true for foot care, where service provision is variable across the capital.

The London Foot Care work stream has collected and synthesised the best practice evidence and produced a guide and service specification that builds on recommendations in the cardiovascular outcomes strategy, and responds to the challenges and aims of the *Five year forward view*[a] and the work of *Better health for London*[b].

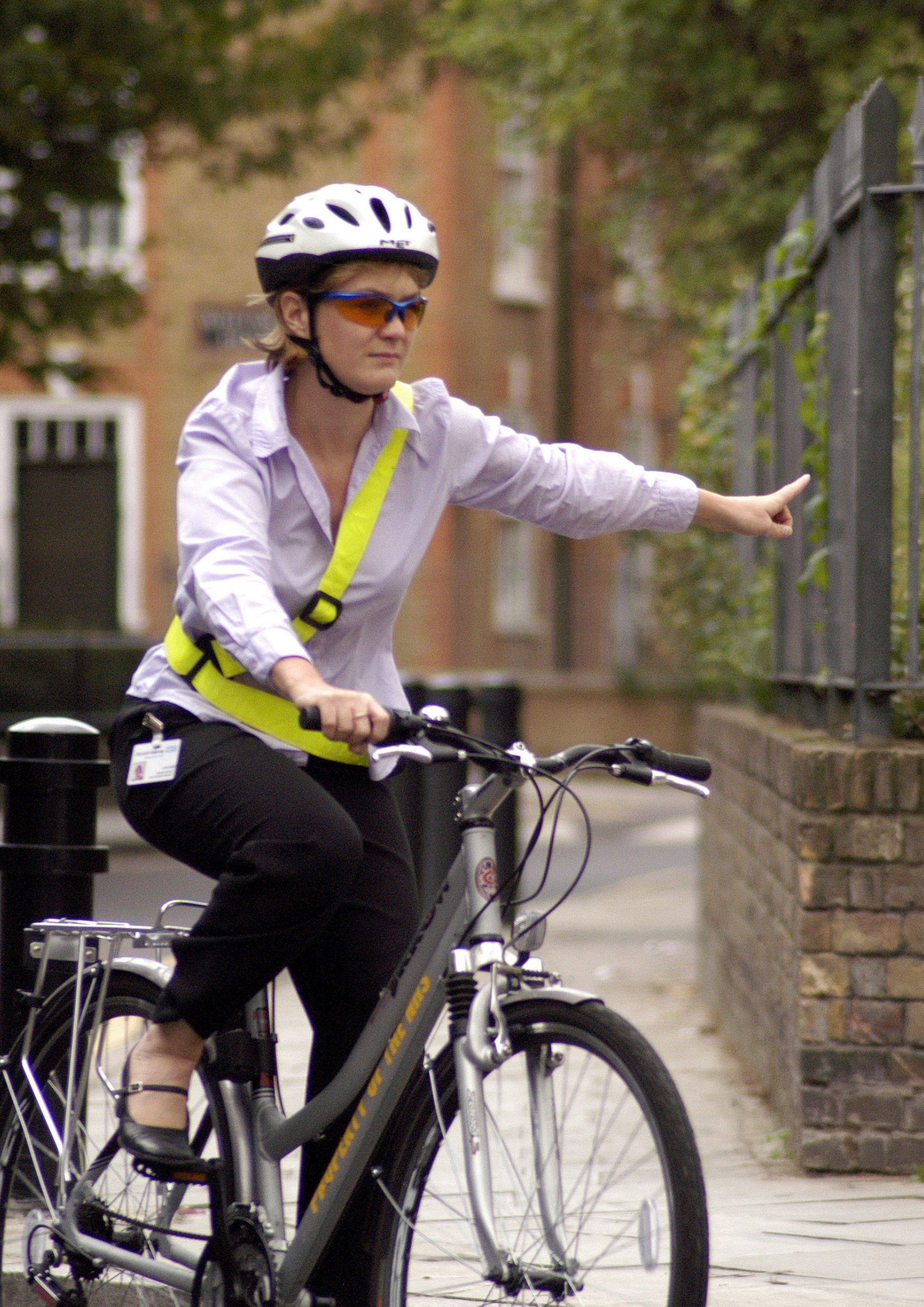
Above: Dr Stephen Thomas

I believe that this service specification will allow CCGs and organisations to commission a foot care service that delivers on the aims of integrated and holistic care across the patient pathway.

I would like to thank Richard Leigh and Stella Vig, and the London Foot Care work stream, for their hard work and efforts in producing this service specification.

Dr Stephen Thomas
Clinical director, London Diabetes Strategic Clinical Network
Consultant in diabetes and endocrinology, Guy's and St Thomas' NHS Foundation Trust

a. Five year forward view, NHS England (2014) | http://bit.ly/1A33sIo
b. Better health for London, London Health Commission (2014) | http://bit.ly/1Iji1kS



Introduction

Foot problems for people with diabetes have a significant impact on their quality of life; for example, reduced mobility that may lead to loss of employment, depression and damage to or loss of limbs. In addition, foot problems have a significant financial impact on the NHS through outpatient costs, increased bed occupancy and prolonged stays in hospital. Foot problems for people with diabetes require urgent attention.

This service specification outlines the provision of a foot service for people with diabetes according to best practice guidance, including guidance published by NICE and Diabetes UK. It details the care pathway and service requirements for people with foot complications across acute and community services.

The specification aims to deliver equity of access to foot care for people with diabetes. The service specification outlines the care and management to be provided for people with diabetes no matter the severity, urgency or progression of their disease.

As commissioning and provision of care across primary, community and secondary care becomes further integrated, the physical location of the teams delivering care becomes less of a focus for commissioners. This service specification outlines the care that should be provided by each component of a diabetes foot service, but does not identify the setting this should be provided in.

This sample service specification details the following components of a foot care service for people with diabetes:

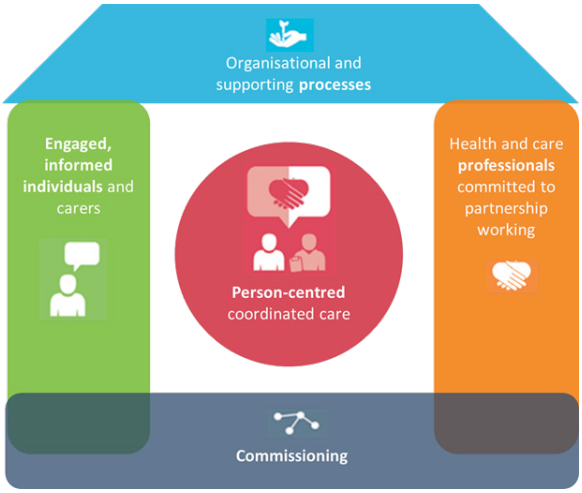
- **Routine assessment and care** of the foot without any ulceration or lesion, in order to determine level of risk of developing a foot ulcer.
- **Action to minimise the onset of new foot disease** in those at increased risk.
- **Prompt expert assessment and care** of the foot at increased risk with new foot disease.
- Development of a **strategy to minimise the onset of recurrence** in those who have had a new episode of foot disease successfully treated.
- **Components of a team required** to deliver care for people of all levels of risk and their competencies to deliver appropriate care.
- **Key performance indicators** to measure the impact and outcomes of the service.
- **Measures to improve quality** across the patient pathway.
- Steps to provide **innovative and continually developing services**.

This specification has been developed with input and oversight from the multi-disciplinary London Foot Care work stream and the Strategic Clinical Leadership Group of the London Diabetes Strategic Clinical Network and Professor Jonathan Valabhji, National clinical director for diabetes and obesity, NHS England.

Commissioning of the service

House of care

NHS England and partners use the *House of Care*[1] model as a framework for the building blocks of high quality, person-centred, coordinated care.



The House relies on four key interdependent components, all of which must be present to ensure that person-centred, coordinated care:

- **Commissioning**, which is not simply procurement but a system improvement process, with the outcomes of each cycle informing the next.
- **Engaged, informed individuals and carers**, enabling individuals to self-manage and know how to access the services they need when and where they need them.
- **Organisational and clinical processes**, structured around the needs of service users and carers using the best evidence available, co-designed with service users where possible.
- **Health and care professionals working in partnership**, listening, supporting, and collaborating for continuity of care.

Commissioning an integrated pathway

Commissioning of this specification requires an integrated foot pathway for service users with diabetes and foot disease. Regardless of the commissioning environment, it is expected that all elements of care will be available to ensure equity of access for service users.

Care delivery is based on a multi-disciplinary approach, whether a GP practice, a community centre, or a hospital. The service specification requires commissioning of one comprehensive service in comparison to a wide range of disparate services delivering different parts of foot care.

Multi-disciplinary teams can support delivery of parts of the pathway that could not be delivered in every GP practice, and can also explore ways of generalists and specialists working together in the community using information technology and new technologies to ensure patient care is delivered in an appropriate setting local to the service user when possible.

Commissioners will be required to work with service users, carers and providers to identify measurable outcomes for which service providers will be held jointly accountable. Various levers such as Commissioning for Quality and Innovation (CQUIN) payment and co-commissioning are available to ensure this happens.

Enablers to provide an integrated service

To ensure that the service outlined in this specification is able to provide a fully integrated and joined up service, local and regional NHS organisations must work closely together. The service will be required to provide assurance of its ability to support, engage and be involved in the following activities:

- **Local care quality and commissioning governance meetings** – The service will be required to engage with local clinical and commissioning governance meetings to share information and be an inclusive part of a comprehensive diabetes service for local patients.
- **Referral pathways** – The service will ensure that it is flexible in its service delivery to ensure that it fits existing referral pathways and can strengthen patient pathways.
- **Information sharing** – All elements of the service demonstrate the ability and willingness to share service user information appropriately to enable an integrated person-centred service.
- **Engagement with external podiatry and diabetes services** – The service will engage and develop joint working with NHS and external organisations that provide podiatry and diabetes services. This will ensure smooth integration of care, sharing of best practice and will promote a holistic and comprehensive service for a person with diabetes.

Commissioning of the service

Ensuring quality across the pathway

By ensuring quality care is provided across the foot care pathway, and assuring this quality in some cases, further integration of services will be achieved for patients.

The service will have a responsibility to ensure that service users receive quality care across the patient pathway. This may include providing quality assurance of foot checks in primary care and community services, and supporting acute and specialist services to provide evidence based care. Ensuring and assuring appropriate timely referrals, transfers of care and repatriations within suggested time frames will help to improve the quality of care.

Purpose and outcomes

Purpose

The purpose of this service specification is to outline the foot care people with diabetes should receive at all points of the service user journey ensuring equity of access for people with diabetes.

Clientele

Foot care services should be open to any service user with any diagnosis of diabetes. It should be a seamless, standardised transition which meets the needs of the service user, whether he has type 1 or type 2 diabetes. The service should also consider its ability to provide foot care services for service users with other long term conditions such as peripheral arterial disease, renal disease, rheumatic disorders, HIV and paraplegia that may require the expertise available only through this service.

The transition from paediatric to adult services should be considered. Foot care education for teenagers and adolescents should be considered on diagnosis of diabetes. The Care Quality Commission has developed *From the pond to the sea: Children's transition to adult health services*[2] for teenagers with complex and long term health needs.

Objectives and outcomes of the service

The primary objective in managing foot problems for people with diabetes is to promote mobilisation. This involves managing both medical and surgical problems.

The desired outcome for this service is to:

- Prevent or delay the foot complications of diabetes, including peripheral neuropathy, peripheral arterial disease, gangrene and limb loss from amputation.
- Provide opportunities for all healthcare professionals who come into contact with people with diabetes to acquire the skills and knowledge necessary to recognise and manage people at increased risk of developing new foot disease.
- Ensure all service users with diabetes receive equitable foot care and management based on their needs.
- Provide a pathway for the regular monitoring and management of foot disease.
- Provide a pathway for the assessment and treatment of any newly occurring or deteriorating case of foot disease within 24 hours.
- Reduce recurrence of ulcers and complications in those who have had an episode of active foot disease.

The service aims to meet the following domains of the NHS Outcomes Framework:

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

The service aims to meet the strategies set out in NHS England's *Five Year Forward View*[4] which calls for the breaking down of traditional boundaries. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care.

The *Five Year Forward View* calls for:

- Networks of care, rather than organisations providing care independent of one another.
- Greater focus and use of out-of-hospital care.
- Integrated services focused on the patient.
- Introduction and evaluation of new care models which produce the best experience for patients and the best value for money.

Identification, referral and acceptance

Referral and acceptance

The service will provide foot care services to any service users with any diagnosis of diabetes.

The provider will:

- Act as the main care provider and coordinator for service users with foot disease, and will refer service users into the appropriate services when local criteria are met.
- Provide an initial risk assessment to be used by the provider to triage referrals directly into services where service users are experiencing issues which meet the locally defined criteria.
- Serve as both the generalist and specialist provider for service users with foot disease. Service users with complications related to foot disease will be referred to other community and/or specialist services when local criteria are met.

Risk stratification

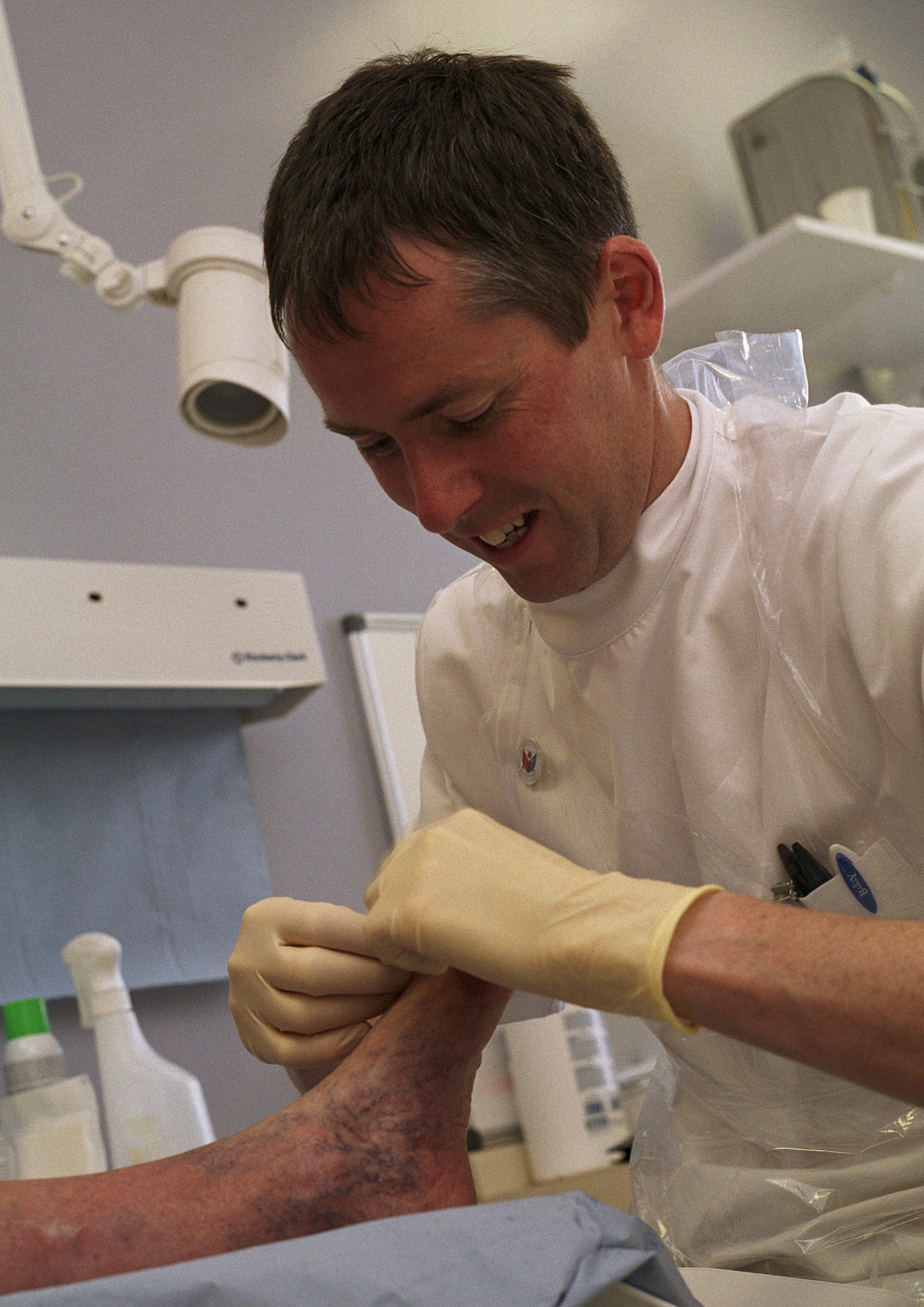
The care to be provided as outlined in this service specification is dependent on risk, progression and severity of the service user's condition. The appropriate care and who should perform and be involved in that care should be based on a risk assessment. Referral and transfer of care will be integral to ensure care for service users is appropriate as their risk of foot complications increases or decreases.

The outcome of an annual or regular foot risk assessment by clinicians will facilitate and govern risk stratified foot care. Assessment of foot risk is based on history (previous ulcer, amputation) and simple clinical examination (deformity, peripheral sensation and circulation).

Service users will be stratified into the following categories based on the risk assessment:

- Low current risk - Normal sensation and palpable pulses.
- Moderate risk - Neuropathy or absent pulses or other risk factor.
- High risk - Neuropathy or absent pulses plus deformity or skin changes or previous ulcer.
- Active or ulcerated foot - new ulceration (wound), new swelling, new discolouration (redder, bluer, paler, blacker, over part or all of foot).

Based on a risk assessment, the service user will be directed, referred and delivered appropriate care by a qualified individual or team of healthcare professionals.



Service delivery

The following section details the service user pathway and care to be delivered to service users by the provider dependent on risk of developing foot complications within set time frames. High quality foot care should be delivered as defined by NICE clinical guidance CG10, *Type 2 diabetes foot problems: Prevention and management of foot problems*[5] and CG119, *Diabetic foot problems*[6], to all service users.

Regular / annual (at minimum) foot review

The provider should:

- Ensure regular (annually, at minimum) visual inspection of service user's feet, assessment of foot sensation, and palpation of foot pulses by trained personnel in line with NICE clinical guidance CG10[5].
- Classify foot risk.
- Encourage self-monitoring and inspection of feet by service users.
- Provide education and support for regular reviews occurring in primary care and outside the service.

This care should be provided by primary care or within the community.

Care of service users at low current risk | Regular / annual (at minimum) review

At each annual or regular review, the provider should:

- Agree a management plan in line with NICE clinical guidance CG10[5], including foot care education with each service user depending on their clinical need, and consider diabetes control and modifiable cardiovascular risk factors and refer as appropriate.
- Arrange service user education (group or one to one).
- Arrange re-assessment for risk factors for foot ulceration on a regular (at least annual) basis in either primary care or through the service.
- Establish and clarify emergency access to care if the service user's risk rating changes.
- Provide education and support for regular reviews occurring in primary care and outside the service.

This care should be provided by primary care or within the community.

Care of service users at moderate risk | 3-6 monthly review

The provider should ensure that care of service users with moderate risk should be delivered by a team of health professionals who have specialist expertise in the assessment and management of disease of the foot in diabetes in line with NICE clinical guidance CG10[5].

At each 3-6 monthly review, the provider should:

- Inspect service user's feet.
- Review need for vascular assessment.
- Evaluate footwear.
- Enhance foot care education.
- Consider joint / integrated diabetes control and modifiable cardiovascular risk factors and refer as appropriate.
- Ensure assessment and appropriate treatment of neuropathic pain, including optimising glycaemic control and neuropathic analgesics.
- Consider treatment and referral if suspected or diagnosed Charcot arthropathy is present.

This care should be provided within the community or the acute setting.

Service delivery

Care of service users at high risk | 1-3 monthly review

The provider should ensure that care of service users with high risk should be delivered by a team of health professionals who have specialist expertise in the assessment and management of disease of the foot in diabetes in line with NICE clinical guidance CG10[5].

At each 1-3 monthly review the provider should:

- Inspect service user's feet.
- Review need for vascular assessment.
- Ensure special arrangements for access to a suitably qualified team or healthcare professional for those people with disabilities or immobility.
- Consider joint / integrated diabetes control and modifiable cardiovascular risk factors and refer as appropriate.
- Ensure assessment and appropriate treatment of neuropathic pain, including optimising glycaemic control and neuropathic analgesics.
- Evaluate provision and provide appropriate intensified foot care education, specialist footwear and insoles and skin and nail care.
- Consider treatment and referral if suspected or diagnosed Charcot arthropathy is present.

This care should be provided within the community or the acute setting.

Care of service users with active or ulcerated feet | Care provided within 24 hours

Providers should ensure that on presentation with active foot disease or ulcerated feet the following care should be provided to service users in line with NICE clinical guidance CG10[5].

- Initial assessment within four hours by any member of the a specialist multi-disciplinary team.
- Investigation of suspected foot infection.
- Management of foot infection.
- Debridement, dressings and off-loading.
- Assessment of suspected limb ischaemia.
- Suspected or diagnosed Charcot arthropathy.

This care should be provided within the community setting or acute setting.

A suitable healthcare professional should be accountable for the overall care of the service user and for ensuring that healthcare professionals provide timely care. The named healthcare professional should refer the service user to a multi-disciplinary foot care team within 24 hours of the initial examination of the service user's feet. Transfer for the responsibility of care to a named member of the multi-disciplinary foot care team is expected if a foot problem is the dominant clinical factor for inpatient care.

Foot care emergencies | Care provided within 24 hours

Providers should ensure that on presentation with a foot care emergency the following care should be provided to service users in line with NICE clinical guidance CG119[6].

- Investigate and treat vascular insufficiency.
- Initiate and supervise wound management.
- Use dressings and debridement as indicated.
- Use systemic antibiotic therapy for cellulitis or bone infection as indicated.
- Ensure an effective means of distributing foot pressures, including specialist footwear, orthotics and casts.
- Seek to achieve optimal glucose levels and control of risk factors for cardiovascular disease.

A suitable healthcare professional should be accountable for the overall care of the service user and for ensuring that healthcare professionals provide timely care. The named healthcare professional should refer the service user to a multi-disciplinary foot care team. Transfer for the responsibility of care to a named member of the multi-disciplinary foot care team is expected if a foot problem is the dominant clinical factor for inpatient care.

This care should be provided within the community or acute setting.

Service delivery

Charcot arthropathy

People with suspected or diagnosed Charcot arthropathy should be referred to the care of a multi-disciplinary foot care team within 24 hours to confirm diagnosis and assume immobilisation of the affected joints until definitive treatment can be started.

Holistic care

The provider should ensure that all service users receive holistic care for their diabetes when in contact with the service. For many people with diabetes, the foot care service may be their most frequent contact with health services. It is an opportunity to not only provide holistic care for their diabetes, but also for other long term conditions.

Providers should attempt to highlight, check and refer as necessary against the nine diabetes care processes from NICE. This may be completed through use of patient checklists or standard part of every consultation. Innovative and joint working with other services to make sure every contact counts will help to provide care around quitting smoking, renal care, cardiovascular care and ophthalmology.

NICE nine key processes:

1. Blood glucose level measurement.
2. Blood pressure measurement.
3. Cholesterol level measurement.
4. Retinal screening.
5. Foot and leg check.
6. Kidney function testing (urine).
7. Kidney function testing (blood).
8. Weight check.
9. Smoking status check.

Secondary prevention activities for other chronic conditions should also be encouraged during contact with the service. This includes medication to manage and prevent chronic conditions, referral and delivery of prevention, exercise and rehabilitation services.

Providers will be required to form strong referral and working relationships, especially with psychology, rehabilitation and palliative care services.

Holistic service

To ensure that the service is able to provide this holistic care, providers will be required to have a named and contactable clinical lead for the service. This clinical lead will be required to build and maintain relationships and links between the service and other health services, especially ophthalmology, primary care, psychology, rehabilitation and renal services.

The service should provide care coordination to service users for their other diabetes and health needs. This may be a discrete role within the team or be built into each team members competencies.

Clinical leads for services are encouraged to establish collaboratives or regular meetings with diabetes or foot care related services within their local geographies. Representation should be sought from service providers, commissioners and CCGs, the voluntary and third sector, social care and patients. Stakeholders who represent community groups and patients should be encouraged to attend.

Equitable service provision

Ensuring equitable access to high quality foot care is also a vital attribute of good foot care service for patients with diabetes. This includes ensuring equitable access for vulnerable groups, such as: service users who:

- Do not speak English.
- Are house bound.
- Live in care homes.
- Are homeless.
- Have mental health issues.
- Have visual impairments.

Co-location of service

The service should consider the optimal location for delivery of care to providers. Many service users will require additional care for diabetes and other chronic conditions, including mental health. The service should consider providing care to service users within the same facility as renal and kidney dialysis service, retinal screening services and specialist chronic disease services in the community.

Staff and competencies

The service should ensure the following key staff competencies in line with NICE clinical guidance CG10[5], NICE clinical guidance CG119[6], Diabetes UK's *Putting feet first*[7], TRIEPodD-UK[8] and the Society of Chiropodists and Podiatrists[9].

Skills for delivering care to users at low current risk

That healthcare professional delivering a regular or annual review or care to a service user at low current risk should have the skills and knowledge necessary to identify, advise and act on:

- The presence of sensory neuropathy.
- Reduction of arterial supply to the foot.
- Deformities of the foot or other factors that may put it at risk.
- An individual's level of risk to agree plans for future surveillance and supported self-management.
- Appropriate referrals for expert review of those with increased risk.
- Action to be taken in the event of a new ulcer/lesion.
- Use of footwear and other aspects of foot care that will reduce the risk of a new ulcer/lesion.

Skills for delivering care to users at moderate or high risk

The role of the team that provides annual and regular reviews and provides care to service users at increased or high risk include:

- Specialist surveillance of people at risk (including those who are hospital inpatients).
- Education of other healthcare professionals in routine examination and definition of the at risk foot.
- Close liaison with specialist foot care multi-disciplinary teams.
- Management of selected cases of foot disease in the community.
- Sharing care with specialist foot care multi-disciplinary teams of selected cases of foot disease.
- Sharing long term management with other healthcare professionals of people with successfully treated disease.
- Discussion and agreement of plans to support the service user in managing their condition.

The team providing this care should be contactable by phone, fax or email, and their contact details should be readily available to other healthcare professionals working in the community.

Skills for delivering care to those with foot care emergencies and active or ulcerated feet

Providers should ensure that care of service users with foot care emergencies and active or ulcerated feet should be delivered by a specialist multi-disciplinary team of health professionals.
Specialist multi-disciplinary team should comprise specialists with relevant complementary skills who work either together or in close communication with each other.

The team must include, or have ready access to, members of the following specialist groups:

- Medical (diabetologists).
- Surgical (vascular, orthopaedic and plastic surgeons).
- Other medical staff (including microbiologists).
- Diagnostic and interventional radiologists.
- Podiatrists and podiatric surgeons.
- Diabetes specialist nurses.
- Plaster technicians.
- Orthotists.

The specialist multi-disciplinary team should be able to provide the following services:

- Consultation concerning the prevention or management of active foot disease.
- Supervising the management of selected cases with active foot disease of both inpatients and outpatients and service users in the community where necessary.
- Coordinating care and education of foot disease in diabetes.
- Rehabilitation and amputee care team.
- Palliative care.

Transfer of care criteria

This model of care is reliant on the seamless integration of generalist and specialist services. To achieve this it will be essential that service user records are integrated and wherever possible shared or owned by the person with diabetes. The two elements must have good communication mechanisms to allow for continuity of care. Integration can be further supported by formal arrangements for specialists to support generalists through:

- Email advice (eg a specified one working day turn around for email advice).
- Telephone contact support (eg a dedicated daily time window for taking calls for advice).

The provider should ensure that service users are transferred to the appropriate individual or team dependent on their current risk. The provider should consider that risk might not only increase, but also decrease and service users may need their care transferred to an appropriate setting to provide their regular or annual review.

General practitioners or usual care providers should be made aware of any service users that become non-concordant or regularly miss their appointments.

For older people, many of whom will have complications of diabetes and hence will have multiple comorbidities and may also suffer frailty, there will need to be co-ordination of health and social care.

Activity indicators and quality standards

The following indicators should be monitored by commissioners to ensure safe, high quality care is being provided.

Indicator	Description	Threshold	Source
Activity			
Referrals	Number of service users referred to the service per month		Internal
Reviews provided	Number of service users appointments delivered per month		Internal
Transfer of care	Number of service users discharged from the service per month		Internal
Quality standards			
Foot examination	Percentage of patients with diabetes with a record of a foot examination and risk classification		Quality Outcomes Framework[10] and National Diabetes Audit[11]
Referrals	Percentage of patients with diabetes with a record of a foot examination and risk classification that are referred to further foot care		Quality Outcomes Framework and
Management plan	Percentage of service users who have a record of an agreed management plan (including service user education) in the previous 15 months		NICE Quality Standard[12]
Ulceration	Percentage of service users with recorded diabetes with feet at high risk of ulceration		NICE Quality Standard[12]
	Percentage of service users with recorded diabetes with a new ulcer in the previous 12 months		NICE Quality Standard[12]
Amputation	Percentage of service users with recorded diabetes with a new below ankle amputation in the previous 12 months		NICE Quality Standard[12]
	Percentage of service users with recorded diabetes with a new above ankle amputation in the previous 12 months		NICE Quality Standard[12]
Wait time	Percentage of patients assessed by team within 12 weeks of first presentation to a Health Professional		National Diabetes Foot Audit[13]
	Percentage of patients assessed by team within 24 weeks of first presentation to a Health Professional		National Diabetes Foot Audit[13]
Treatment	Percentage of patients with active ulcer 12 weeks after presentation		National Diabetes Foot Audit[13]
	Percentage of patients with active ulcer 24 weeks after presentation		National Diabetes Foot Audit[13]
Mortality	Percentage of patients alive 12 weeks after presentation		National Diabetes Foot Audit[13]
	Percentage of patients alive 24 weeks after presentation		National Diabetes Foot Audit[13]
Quality assurance	Provide quality assurance to primary care services in local area within 18 months.		Local data

Innovation and development

Providers are expected to continually develop and improve their service and care for service users. This should be achieved through improving services in line with the recommendations of the *Five year forward view* and employing innovative approaches to provide flexible and high quality care.

Providers should seek to establish integrated diabetes budgets with commissioners to be able to provide innovative commissioning arrangements and not be restricted by traditional activity and tariff arrangements. This will allow more flexible staffing and integration with other diabetes services.

Providers should attempt to deliver increased access to the service through seven day working and improved opening hours (preferably 8:00am to 8:00pm). This will need to be balanced with improved outreach and joint working with primary care and other community services.

Innovative approaches to education and continuing professional development is also needed. To ensure integration and holistic care, all care providers across the diabetes care pathway should receive or be able to access education on foot checks and foot care.

Continual service improvement

Providers are expected to have an internal quality assurance and risk management process that assures the commissioners of its ability to manage the risks of running the service.

Providers will:

- Ensure that appropriate fail safe mechanisms are included across the whole pathway.
- Review and risk assess the service.
- Work with the Commissioner and Quality Assurance teams to develop, implement, and maintain appropriate risk reduction measures.
- Ensure that mechanisms are in place to regularly audit implementation of risk reduction measures and report incidents.
- Ensure that appropriate links are made with internal governance arrangements, such as risk registers.
- Ensure routine staff training and development is undertaken.

Providers will participate fully in any local or national quality assurance (QA) processes and respond in a timely manner to recommendations made. This will include the submission to QA teams and commissioners of:

- Data and reports from external QA schemes.
- Minimum data sets as required.
- Self-assessment questionnaires / tools and associated evidence.
- Audits or data relating to nationally agreed internal quality assurance processes.

Where national recommendations and acceptable / achievable standards are not currently fully implemented, the provider will be expected to indicate in service plans what changes and improvements will be made over the course of the contract period.

The provider shall develop a continual service improvement plan (CSIP) in line with the performance indicators and the results of internal and external quality assurance checks. The CSIP will respond and any performance issues highlighted by the commissioners, having regard to concerns raised via any service user feedback. The CSIP will contain action plans with defined time scales and responsibilities, which will then be agreed with the commissioners.

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About the Strategic Clinical Networks

The London Strategic Clinical Networks bring stakeholders -- providers, commissioners and patients -- together to create alignment around programmes of transformational work that will improve care.

The networks play a key role in the new commissioning system by providing clinical advice and leadership to support local decision making. Working across the boundaries of commissioning and provision, they provide a vehicle for improvement where a single organisation, team or solution could not.

Established in 2013, the networks serve in key areas of major healthcare challenge where a whole system, integrated approach is required: Cardiovascular (including cardiac, stroke, renal and diabetes); Maternity and Children's Services; and Mental Health, Dementia and Neuroscience.

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