NHS

Diabetes

Commissioning Services for Children and Young People with Diabetes

Supporting, Improving, Caring

February 2010

NHS Diabetes Information Reader Box	
Review Date	2012

Commissioning Diabetes Services for Children and Young People

This commissioning guide has been developed by NHS Diabetes with key stakeholders including clinical and social services professionals and patient groups represented by Diabetes UK.

It is not designed to replace the Standard NHS Contracts as many of the legal and contractual requirements have already been identified in this set of documents. Rather, it is intended to form the basis of a discussion or development of diabetes services for children and young people between commissioners and providers from which a contract for services can then be agreed.

This commissioning guide consists of:

- A description of the key features of high quality diabetes services for children and young people including the arrangements for transition to adult diabetes services
- A high level intervention map . This intervention map describes the key high level actions or interventions (both clinical and administrative) diabetes services for children and young people should undertake in order to provide the most efficient and effective care, from admission to transfer to adult diabetes services. For continuity, the intervention map also shows possible action to be taken with respect to prevention and risk assessment services. Commissioners are referred to the diabetes prevention and risk assessment commissioning guide for further details www.nhs.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement

  It is not intended to be a care pathway or clinical protocol, rather it describes how a true 'diabetes without walls' service should operate going across the current sectors of health care.

  The intervention map may describe current service models or it may describe what should ideally be provided by diabetes services for children and young people.

- A contracting framework for diabetes services for children and young people that brings together all the key standards of quality and policy relating to diabetes and children and young people
- Template service specifications for
  - o diabetes services for children and young people
  - o diabetes transition services for children and young people

The templates form part of schedule 2 of the Standard NHS Contract covering the key headings required of a specification. It is recommended that the commissioner checks which mandatory headings are required for each type of care as specified by the Standard NHS Contracts.

For further detail on how to approach the commissioning of diabetes services please see http://www.diabetes.nhs.uk/commissioning_resource

Features of Diabetes Services for Children and Young People

High quality diabetes services for children and young people should be:

- be developed in a co-ordinated way, taking full account of the responsibilities of other agencies in providing comprehensive care (as set out in *National Standards, Local Action*[i])
- be commissioned jointly by health and social care based on a joint health needs assessment which meets the specific needs of the local population, using a holistic approach as described by the generic choice model for the management of long term conditions[ii]
- provide effective and safe care to young people with diabetes in a range of settings including the patient's home, according to recognised standards including the Diabetes NSF[iii]
- take into account the emotional, psychological and mental wellbeing of the young person[iv]
- ensure that the family/carers of young people with diabetes have access to psychological support
- take into account all diverse and personal needs with respect to access to care
- ensure that services are responsive and accessible to young people with Learning Disabilities[v]
- take into account race and inequalities with respect to access to care
- have effective clinical networks, with clear clinical leadership, across the boundaries of care
- ensure that there are a wide range of options available to young people with diabetes to support self management and individual preferences
- take into account services provided by social care and the voluntary sector
- provide patient/carer/family education on diabetes not only at diagnosis but also during continuing management at every level of care
- provide education on diabetes management to other staff and organisations that support young people with diabetes
- deliver care in accordance with the Convention on the Rights of the Child[vi]
- provide age and development appropriate structured education of children and young people and their family in the best management of the diabetes with the aim of the child and family managing their own condition
- provide support in schools and other educational settings and in the workplace to enable children and young people to achieve the best control of their condition
- provide access to a Children and Young Peoples' Specialist Multidisciplinary Diabetes care team (CYPSD) with appropriate training and competencies
- ensure arrangements for the smooth transition between children and adult services that take into account the developmental needs and personal choices of the individual
- have specific local agreements that enable 24 hour access to emergency advice from competent staff

[i] Available on the DH website at http://www.dh.gov.uk/assetRoot/04/08/60/58/04086058.pdf

[ii] Available on the DH website at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081105

[iii] Available on the DH website at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4096591

[iv] Emotional and Psychological Support and Care in Diabetes, Joint Diabetes UK and NHS Diabetes Emotional and Psychological Support Working Group, February 2010

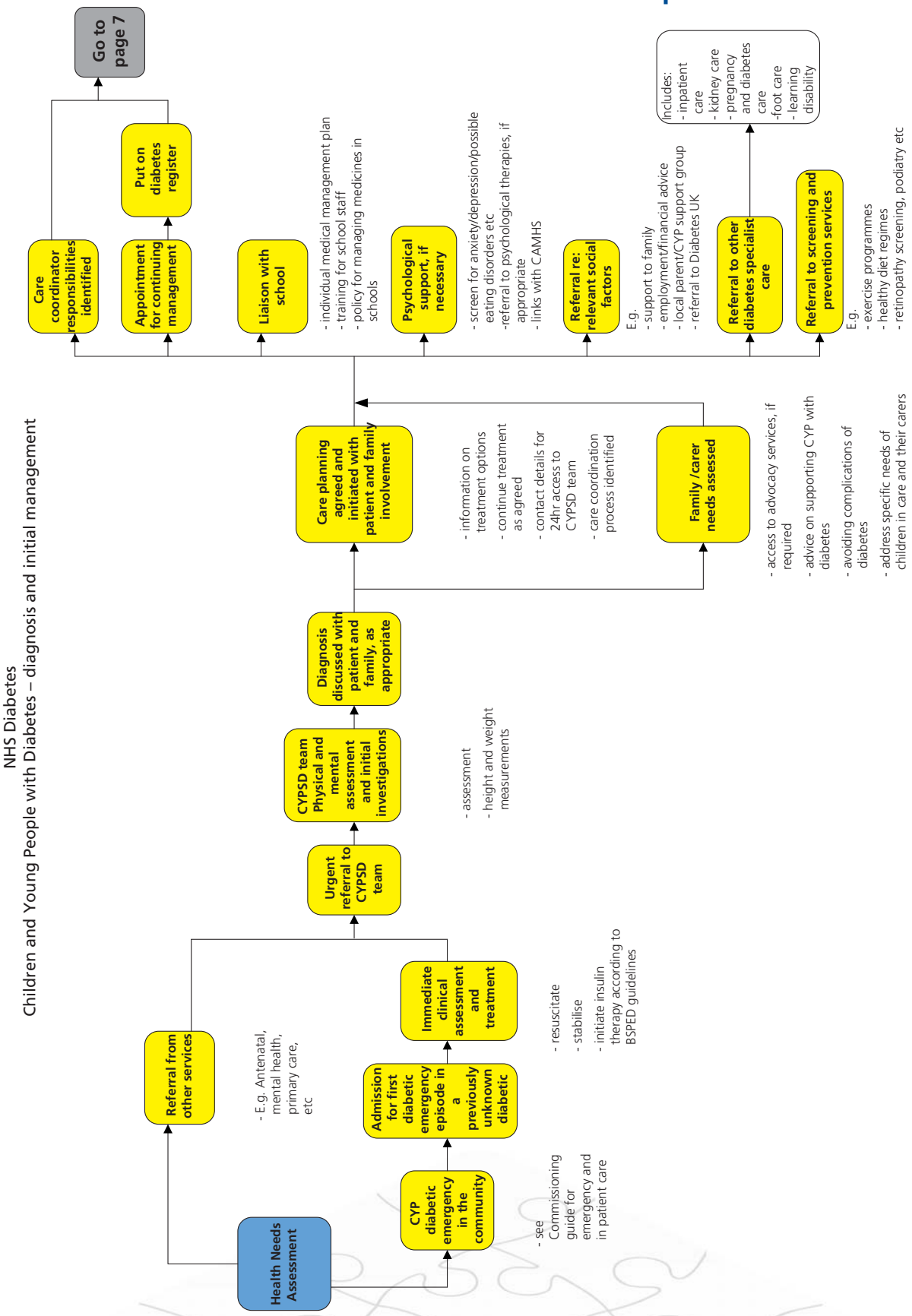
[v] http://www.diabetes.nhs.uk/ commissioning_resource/step_3_service_improvement/

[vi] United Nations Convention on the Rights of the Child, November 1989

- have provision outside of 9 to 5 , Monday to Friday, for care (not only emergency advice) to encourage full participation in school, and to support working parents
- have a capable and effective workforce with the appropriate training, skills and competencies in the management of young people with diabetes, and ensure these are continuously updated
- have integrated information systems that record individual needs including emotional, social, educational, economic and biomedical information which permit multidisciplinary care across service boundaries and support care planning[vi]
- produce information on the outcomes of diabetes care including contributing to national data collections and audits
- have adequate governance arrangements, e.g. local mortality and morbidity meetings on diabetes care to learn from errors and improve patient safety
- actively monitor the uptake of services, responding to non-attenders and monitoring complaints and untoward incidents

[vi] See York and Humber integrated IT system at http://www.diabetes.nhs.uk/document.php?o=610

Children and Young People with Diabetes Intervention Map



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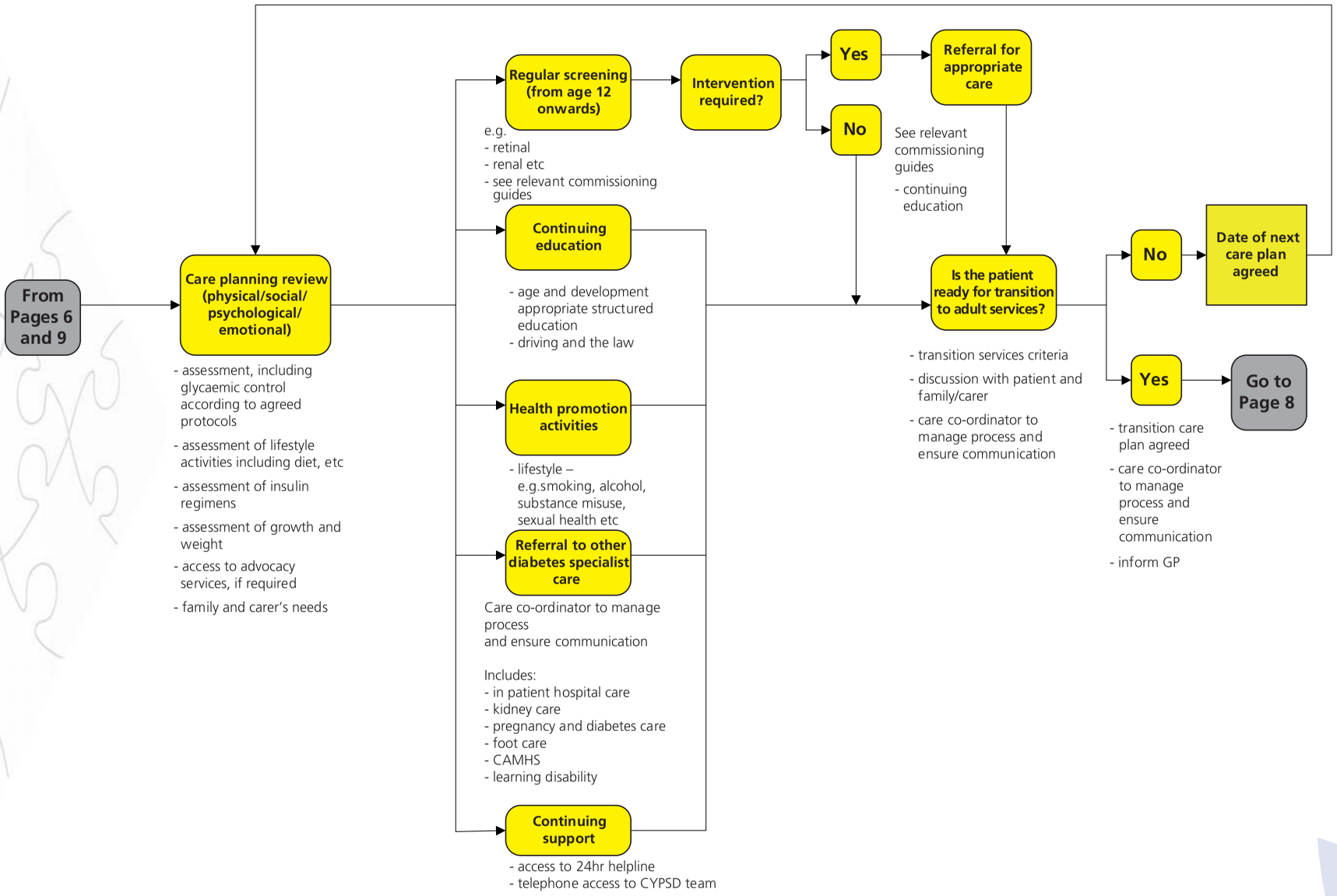
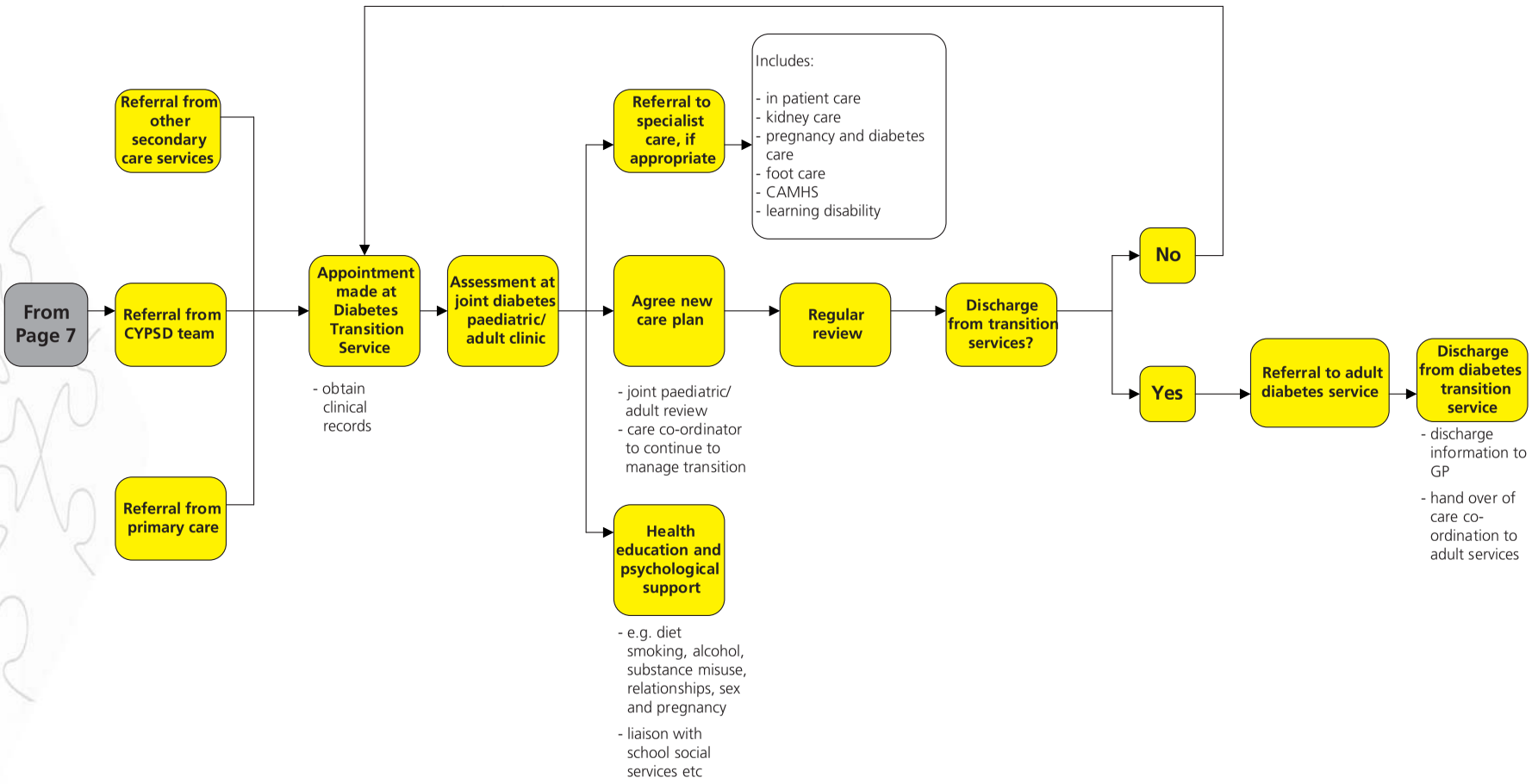
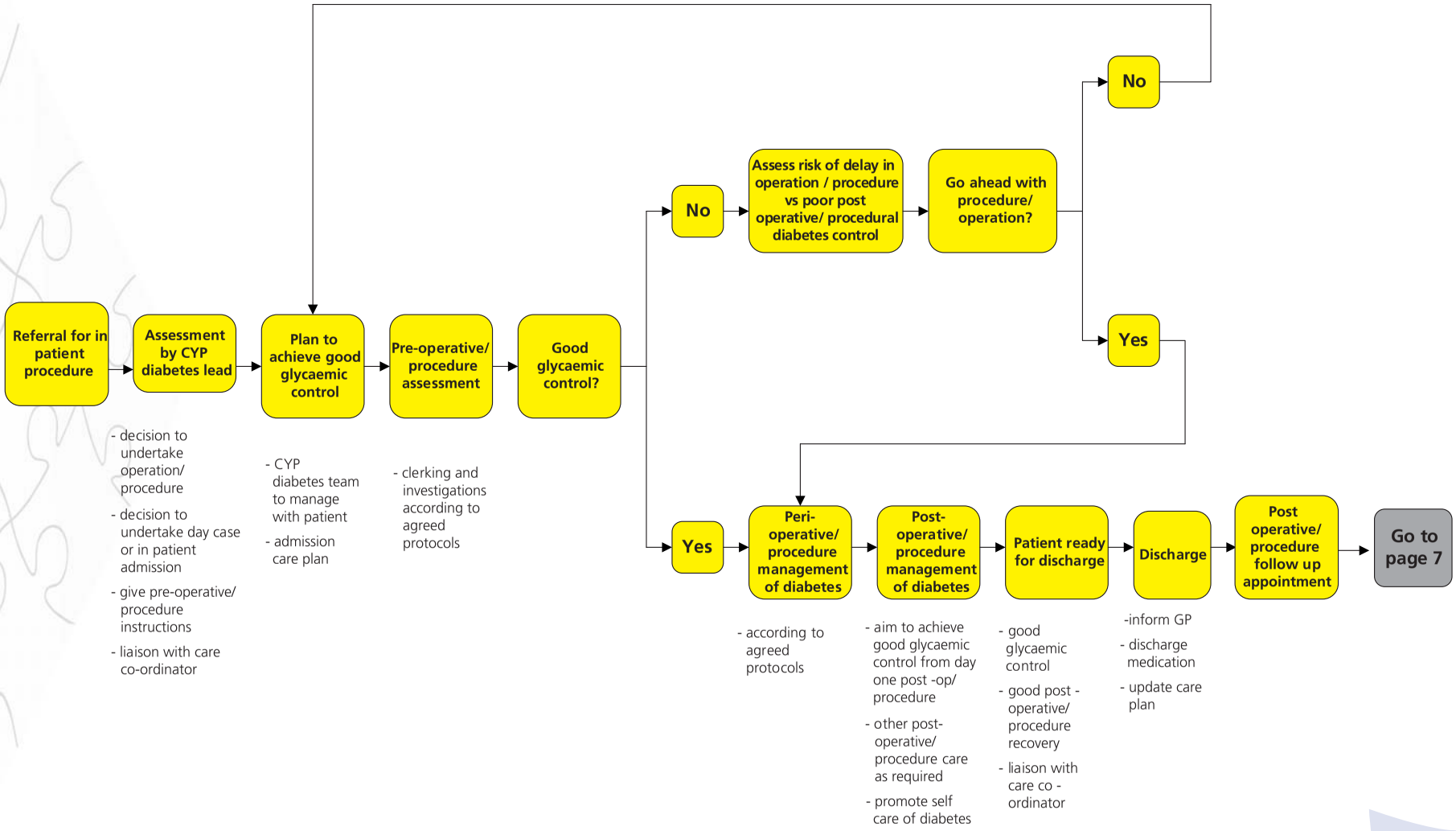
Children and Young People with Diabetes – Continuing care



NHS Diabetes
Children and Young People with Diabetes – Transition services



NHS Diabetes
Children and young people with diabetes - Planned in patient care



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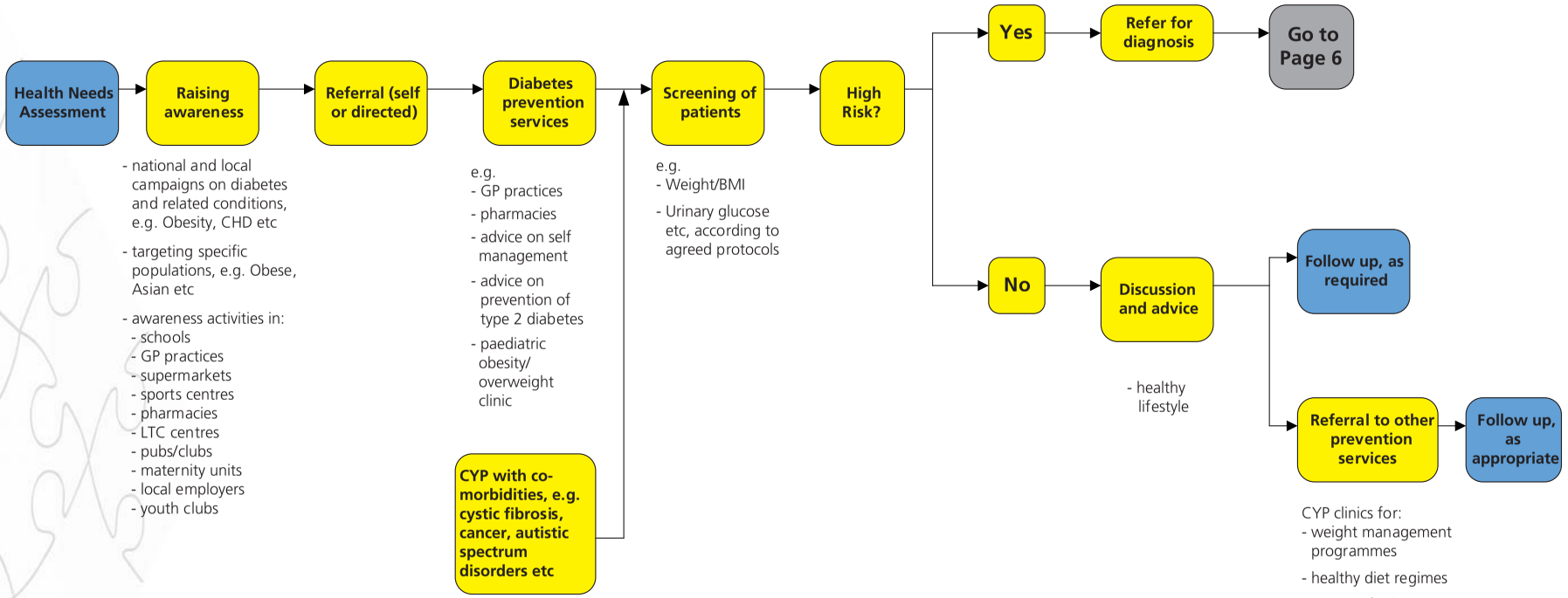
Children and Young People with Diabetes - Prevention of Type 2 diabetes



Contracting Framework for Services for Children and Young People with Diabetes

Introduction

This contracting framework sets out what is required of clinically safe and effective services that are providing care for children and young people (CYP) with diabetes. The framework is designed to be read in conjunction with the children and young people with diabetes intervention map, which describes the interventions and actions required along the patient pathway as well as entry and exit points and the standard service specification template for children and young people with diabetes services. Much of this document is based on Making Every Young Person with Diabetes Matter[1].

The framework brings together the key quality areas and standards that have been identified by the National Paediatric Diabetes Network.

The principles that establish a safe pathway for patient care

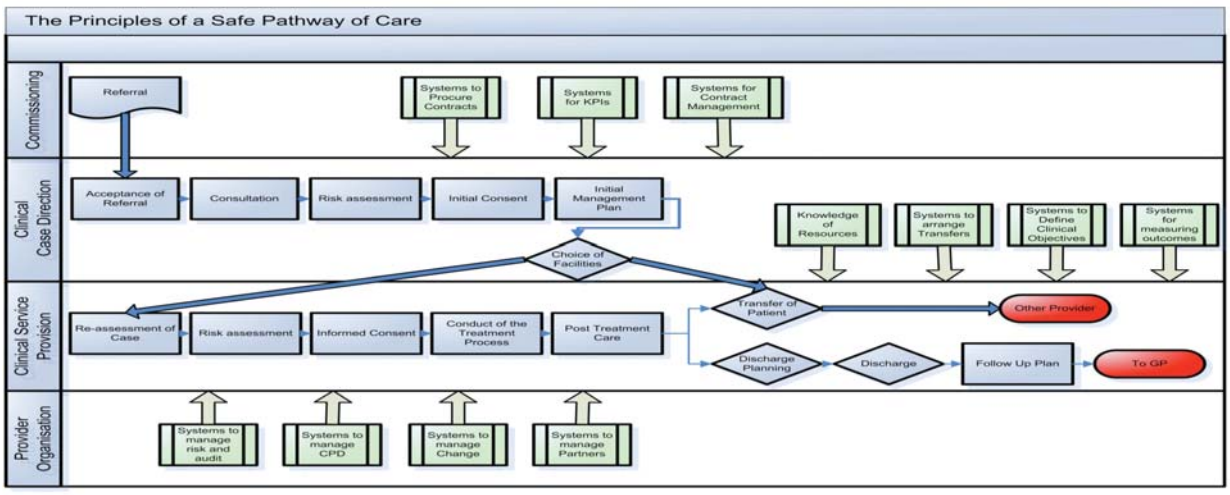
Establishing the principles that underpin the systems and processes of pathways for patient care leads to more efficient patient throughput and can reduce risk of fragmentation of care and serious untoward incidents. The principles operate at four layers within a patient pathway:

- Commissioning
- Clinical Case Direction or the overall Care Plan (i.e. the management of an individual patient)
- Provision of the clinical service or process
- Organisational platform on which the clinical service or process sits (the provider organisation)

A straightforward or simple pathway is one in which the overall management including both Clinical Case Direction or Care Plan and the delivery of the clinical processes conventionally sits within one organisation. However, with a more complex pathway, there is a danger that fracturing the overall management pathway into components carried out by different clinical teams and organisations will require duplication of effort leading to inefficiency and increased risk at handover points.This can be managed by establishing clear governance arrangements for all the layers in the pathway.

In addition, Commissioning Bodies must balance the benefits of fracturing the pathway against increased complexity and ensure that the increased risks are mitigated.

The governance arrangements required for all three layers and the commissioner responsibilities are shown below:



In essence, at each level, there are governance arrangements to ensure sound and safe systems of delivery of patient care with clear lines of accountability between each level.

Services for children and young people with diabetes

The key principles of good care for children and young people with diabetes is to provide a high quality service that is reliable in terms of delivery and timely access for patients requiring that care.

Care for children and young people with diabetes must be provided by a specialist CYP team. It is essential that there is co-ordination of care of the patients through the care planning process and that the patient's paediatric diabetologist retains the responsibility for overall patient care across the whole pathway and retains overall responsibility for the management of side effects and complications.

The initial management and continuing care of children and young people with diabetes should include an assessment of their emotional and psychological well-being, together with timely access to appropriate psychological and biological/psychiatric interventions. Mental health disorders can pose significant barriers to diabetes care and therefore mental health stability is vital for good self care[2].

The CYP service itself will also have clinical oversight and accountability for governance purposes.

This contracting framework covers both paediatric diabetes care and transition to adult services. This contracting framework should also be read in conjunction with the diabetes commissioning guides for emergency and in patient care for people with diabetes[3] and diabetes prevention and risk assessment services[4] and follow the principles for the effective commissioning of services for people with Learning Disabilities[5].

Ensuring quality

Commissioning Bodies should ensure that the CYP diabetes services commissioned are of the highest quality. There may, in addition, be some organisations that wish to offer their services, but do not have a history of providing such care.

i) For provider organisations already involved in the delivery of CYP diabetes services, there should be retrospective evidence of systems being in place, implemented and working.

ii) For organisations new to the arena the commissioner should reassure itself that the provider has the organisational attributes, governance arrangements, systems and processes set up to provide the platform for safe and effective delivery of CYP diabetes services to be provided.

This Framework describes what the Commissioning Body needs to ensure is present or addressed in its discussions with the provider organisation.

Under the 'elements' column there are cross references to the Standard NHS Contract for Acute Services – bilateral (main clauses and schedules)[6]. (The cross references also apply to the clauses and schedules in the Standard NHS Contract for Community Services). This is to assist commissioners and providers in having an overview of how the elements link to the Standard NHS Contract. Some of the areas are open to interpretation and consequently the references are not exhaustive.

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Governance	Leadership *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 11,16,19,33, 48,49,51,53, 60* *Schedules: 10*	Clarity of the organisation's purpose with explicit commitment to providing high quality services A culture that demonstrates an open learning ethos An organisation that is legal and ethical in all its activities	Provider must have organisational structure that provides leadership for all professions and disciplines In particular, there must be a corporate clinical director with the responsibility and accountability for the clinical service There must be a learning framework in the organisation	There should be a designated clinical director with responsibility and accountability for the CYP diabetes service
Governance	Integrated Governance *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 11,19,27,48,49, 51,53,54,56,60* *Schedules: 10*	An organisation that is guided by the principles of good governance: - clarity of purpose - participation and engagement - rule of law - transparency - responsiveness - equity and inclusiveness - effectiveness and efficiency - accountability An organisation that accepts responsibility and accountability for all its actions	Clear organisational and integrated governance systems and structures in place with clear lines of accountability and responsibilities for all functions. This includes interfaces and transitions between services	
Governance	Clinical Governance *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 4,4A,6,9,10,12,14, 15,16,17,19,21,25,26 27,29,30,32,33, 48,49,51,53, 54* *Schedules: 3 (parts 3,4A and 4B), 10,12,18*	Explicit commitment to quality and patient safety Patient focused with respect for the personal wishes of patients in all aspects of their care A commitment to innovation and continuous improvement	Clinical Governance systems and policies should be in place and integrated into organisational governance with clear lines of accountability and responsibility for all clinical governance functions e.g. • Clinical Audit • Clinical Risk Management • Untoward Incident Reporting • Infection Control • Medicines Management • Informed Consent • Raising Concerns • Staff Development • Complaints Management	All sub-contractors must meet governance and leadership arrangements of the main provider organisation Commissioner, provider and NHSLA must review CNST arrangements /or other organisational / professional indemnity arrangements The service should have in place written protocols and procedures defining clear lines of accountability and responsibility. The service is required to comply with guidelines produced by the National Institute for Health and Clinical Excellence that are relevant to the care provided by the service including: • Diagnosis and management of Type 1 diabetes in children, young people and adults[7]

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Governance	Clinical Governance		• Patient and Public Involvement • Patient dignity and respect • Equality and diversity • Introducing new technologies and treatments • An externally accredited Quality Assurance system and internal error reporting involving all staff groups. CG systems should have clear and demonstrable links to other NHS systems with collaborative CG activities and sharing of experience and learning Provider should produce annual Clinical Governance reports as part of NHS CG reporting system Providers are required to agree Commissioning for Quality and Innovation schemes for diabetes care for CYP, e.g. model CQUIN scheme proposed by the NHS Institute for Innovation and Improvement [18]	• Type 2 diabetes: the management of type 2 diabetes (update) [8] • Management of Type 2 diabetes - prevention and management of foot problems [9] • Diabetes in pregnancy : management of diabetes and its complications from pre-conception to the post natal period [10] • Type 2 diabetes: newer agents for blood glucose control in type 2 diabetes[11] • Primary prevention of type 2 diabetes mellitus among high risk black and minority ethnic groups [12] • The clinical effectiveness and cost effectiveness of long acting insulin analogues for diabetes [13] • The clinical effectiveness and cost effectiveness of patient education models for diabetes [14] • Continuous subcutaneous insulin infusion for the treatment of diabetes (review)[15] • Depression with a chronic physical health problem [16] • Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence [17] In addition, CYP diabetes multidisciplinary teams should [2]: • be alert to the development or presence of clinical or sub-clinical depression and/or anxiety, in particular where someone reports or appears to be having difficulties with self-management. • be able to detect and basically manage non-severe psychological disorders in people from different cultural backgrounds • be familiar with counselling techniques and drug therapy, while arranging prompt referral to mental health specialists • be alert to bulimia nervosa and anorexia nervosa and insulin dose manipulation if there is over concern with body shape and weight, low BMI or poor glucose control • make early (and occasionally urgent) referrals to local eating disorder services, as appropriate

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Quality assurance *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 4,12,16,17,18, 19,20,21,30,31, 32,33, 54* *Schedules: 2,3 (part 4A and 4B), 10,12, 18*	Understanding the concept of quality Has concern for quality while working efficiently An understanding of the use of audit, patient and staff feedback to improve quality An organisation that provides clarity of objectives and promotes reflective practice to improve quality of patient care	Quality assurance systems must be in place and approved by commissioning body with regular reporting of outcomes Providers are required to publish quality accounts for the public reporting of quality including safety, experience and outcomes Providers should participate in national audit programmes	Access targets for CYP diabetes services: • All CYP with newly diagnosed diabetes should be seen by the CYP specialist diabetes team within 24 hours of referral • All CYP with diabetes to be seen within 4 weeks of referral to other services e.g. podiatry, psychology, optometry etc • All girls with diabetes who are pregnant should be referred to joint CYP diabetes and antenatal services within three days. The service is required to participate in the following national audit activities/programme: • National Diabetes Audits[19] *(CYP audits)* • Active membership of Regional Paediatric Diabetes Network • Patient Experience Surveys [20] • Diabetes E [21]
Clinical quality	Workforce/ staff Clinical staff attributes critical to safety and quality of interventions *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 11,16,19,25,26, 33,48,56*	The provider organisation has systems and procedures in place to assure the commissioner that their clinical team has the necessary qualifications, skills, knowledge and experience to deliver the service	Staff are competent and fit for purpose Provider to satisfy commissioner that all staff have current appraisal, clearances and registration checks and have demonstrated competence in all procedures relevant to pathway.	Provider to satisfy commissioner that they can recruit (or procure) and retain a competent clinical team to deliver the service Specific qualifications required of health professionals providing the service are: • For medical practitioners: registration with the GMC and evidence of further qualification in diabetes care or experience within diabetes clinic • Nurses: registration with the NMC and further evidence of qualification in diabetes care or experience within diabetes clinic and childrens' trained where they are looking after children • Dietitians: registration with the HPC and able to demonstrate competence in delivering educational support and children's trained where they are looking after children All healthcare professionals involved in delivering CYP diabetes care are required to have the following relevant competencies[22]: • Diab CYP01 – Identify symptoms of diabetes in a child or young person and refer them for further assessment • Diab CYP02 - Assess a child/young person with symptoms of diabetes and make a diagnosis • Diab CYP03 – Inform a child or young person and their family of a diagnosis of Type 1 diabetes

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Workforce/ staff Clinical staff attributes critical to safety and quality of interventions			• Diab CYP04 – inform a child/young person and their family of a diagnosis of Type 2 diabetes or impaired glucose tolerance • Diab CYP05 – provide therapy to meet the immediate healthcare needs of the child or young person newly diagnosed with Type 1 diabetes and their family • Diab CYP06 – support a child/young person with Type 1 diabetes and their family in the early stages after diagnosis • Diab CYP 07- provide information and support to a child or young person recently diagnosed with Type 1 diabetes and their family to enable them to establish safe and dietary aims • Diab CYP 08 - support a child/young person with Type 1 diabetes and their family in the first year after diagnosis • Diab CYP09 – enable a child or young person with Type 1 diabetes and their family develop their knowledge and skills about diet and diabetes • Diab CYP10 – gather and evaluate information to establish the healthcare needs of children and young people with diabetes • Diab CYP11 – agree individualised care plans with children and young people to manage diabetes • Diab CYP12 – implement and monitor individualised care plans to meet the needs of children and young people with diabetes • Diab CYP 13 – ensure the safety of a child/young person with diabetes in school • Diab CYP 14 – support a child/young person and their family using insulin therapy to manage their diabetes • Diab CYP15 – enable a child/young person with diabetes to being to take oral medication to improve their health • Diab CYP16 – monitor and support a child/young person with diabetes using oral medication to improve their health • Diab CYP17- provide care and support to meet the immediate needs of the child or young person newly diagnosed with Type 2 diabetes and their family • Diab IPT01 – assess the suitability of insulin pump therapy for an individual with Type 1diabetes • Diab IPT02 – provide preliminary education about insulin pump therapy for an individual with Type 1 diabetes • Diab IPT03 – provide dietary education for an individual with Type 1 diabetes who is contemplating insulin pump therapy

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Workforce/ staff Clinical staff attributes critical to safety and quality of interventions			• Diab IPT04 – enable an individual with Type 1 diabetes to administer insulin by pump • Diab IPT05 – provide ongoing support to an individual administering insulin by pump • Diab IPT06 – provide ongoing dietary education for an individual with Type 1 diabetes administering insulin by pump • Diab TPA01 – enable a young person with diabetes develop self management skills • Diab TPA02 – help a young person manage their diabetes during adolescence • Diab TPA03 – help a young person prepare to manage the transfer from children's to adults healthcare services • Diab TPA04 – help a young person adapt to adults' healthcare services
Clinical quality	Workforce/ staff Clinical staff competencies in use of equipment *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 11, 16, 17, 19, 25, 26, 30, 33*	The provider organisation has systems in place to assure the commissioner that their clinical team are competent to use all equipment needed to deliver the service	Provider to satisfy the commissioner that all staff have had documented competence assessment relative to all equipment used in contract.	All healthcare professionals involved in delivering diabetes care are required to have the relevant competencies in using appropriate equipment, e.g. blood glucose and ketone monitors, insulin delivery devices including insulin pumps
Clinical quality	Workforce / staff Development *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 11,16,19,25,30,48*	The provider organisation has systems in place to assure the commissioner that their clinical team is formally inducted and receives ongoing assistance to develop their skills, knowledge and experience to ensure that they are always fully updated	Provider to satisfy commissioner of their commitment to induction and CPD relevant to roles Provider to satisfy the commissioner of their commitment to train staff to meet future service needs	All health care professionals should have sufficient study leave allocation (time and finance) to enable them to develop skills appropriately

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Registration Organisations are required to meet the requirements for registration as published by the Care Quality Commission and Monitor (as appropriate) *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 4,4A,12,16,19,30, 32,33,48, 54,56* *Schedule: 17,18*	Comprehensive understanding and commitment to implementing national standards	Compliance with Care Quality Commission requirements for registration for primary and secondary care	Compliance with the following National Service Frameworks, where applicable: • Diabetes NSF [23] • NSF for Children, Young People and Maternity Services[24] Compliance with Care Quality Commission Reviews
Clinical quality	Patient pathway *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 4,4A,9,10,12,13, 14,15, 16,17,18,19, 20,21,25,27, 29,30,32,33, 34,35,36, 54* *Schedules: 3 (parts 1 and 2)*	Responsiveness and participative approach to including patients' views about their care in the design of care pathways Collaboration with other organisations involved in the patient pathway to provide a seamless pathway of care	All possible entry and exit points must be defined with comprehensive patient pathways that facilitate smooth passage and effective, efficient care for patients All interfaces in the pathway must be defined so that continuity of clinical care is ensured with no fracturing of the pathway There must be specification of clear timelines and alert mechanisms for potential breaches There should be audit of pathway to ensure that standards are met There must be explicit specification of provider and commissioner responsibilities for the whole patient episode from registration to final discharge	All children and young people (CYP) to be referred to specialist CYP diabetes services on the day of diagnosis All CYP and families must have named lead professional at every stage throughout age – banded clinics All CYP with diabetes to have structured education and review at specific times after diagnosis and at specified ages All children with diabetes (under age 17) to be seen at least 4 monthly in a specialised children's or adolescent diabetes services. All young people with diabetes (age 17-25) to be seen at least every 6 months, preferably in a specialist service All CYP to have their weight and height measured and plotted at every review HbA1C to be measured and recorded at least every 4 months All CYP aged over 12 years to have an annual review every year at which the following will be carried out:

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Patient pathway		Accountabilities should be agreed and documented by all stakeholders If part or whole of the service is to be transferred to other providers, there must be clear and agreed sub contracts on referral criteria and access to these services. At entry to pathway: The Commissioner should assure themselves that the provider has systems and processes in place to i) register patients ii) collect relevant clinical and administrative data iii) manage the appointment process, (reappointment and DNA process, if appropriate) iv) provide information to patients v) undertake initial assessment in the appropriate location At point of intervention: The Commissioner should assure themselves that the provider has systems and processes in place to ensure that: i) the intervention is conducted safely and in accordance with accepted quality standards and good clinical practice. ii) the patient receives appropriate care during the intervention(s), including on treatment review and support, in accordance with best clinical practice iii) where clinical emergencies or complications do occur they are managed in accordance with best clinical practice iv) the intervention is carried out in a facility which provides a safe	• Blood pressure measurement • Microalbumin measurement • Retinal photography for early identification of retinopathy • Physical examination including examination of the feet, peripheral nerve function and appearance of injection sites • Measurement of plasma creatinine • Measurement of lipid profile All children and young people to undergo annual screening for coeliac and thyroid disease at least every 3 years Services should try to maintain contact with non-attendees CYP requiring admission to or investigation in hospital for conditions other than their diabetes should be cared for by competent skilled personnel according to the standards of in-patient care for children and young people with diabetes [3,25] Children and young people may need to be referred to the following services as part of their diabetes care (see relevant intervention map, contracting framework and service specification) The referrals should be according to the agreed clinical protocols: • emergency and inpatient care [3] • services for complications [26] – e.g. foot care, eyes, vascular etc • pregnancy and diabetes [27] • mental health [28] • learning disabilities [5] Specifically there should be[1]: • specialist diagnostic services for children and young people with maturity onset diabetes of the young (MODY), neonatal diabetes and cystic fibrosis • links with Child and Adolescent Mental Health Services (CAMHS) and other psychology services • close liaison with the child/young person's school or early years setting • joint provision of sexual health advice or joint work with young peoples' sexual health services and/or primary care • preconception and safe sex counselling services • access to dental health assessment • access to smoking, alcohol and drug prevention services [4]

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Patient pathway		environment of care and minimises risk to patients, staff and visitors v) the intervention is undertaken by staff with the necessary qualifications, skills, experience and competence vi) There are arrangements for the management of out of hours care according to best clinical practice At exit from pathway: The Commissioner should assure themselves that provider has systems and processes, which are agreed with all parties and networks, in place to: i) undertake telephone triage ii) make urgent onward referrals where life-threatening conditions or serious unexpected pathologies are discovered during an intervention/assessment iii) ensure that patients receive discharge information relevant to their intervention including arrangements for contacting the provider and follow up if required iv) provide timely feedback to the referrer re intervention, complications and proposed follow up v) ensure that the patient receives required drugs/dressings/aids vi) ensure that support is in place with other care agencies as appropriate	Services must be provided in a child-appropriate environment with consideration for child protection issues. Services should be provided outside regular work/school hours CYP services should be provided according to the principles of the 'You're Welcome quality criteria' [29] For CYP reaching an age such that they are ready to move to adult services, there should be clear protocols for transfer to transition services including an individual transition plan. Primary care teams must be kept informed of transition arrangements. Transition services for young people: • should be run by both adult and paediatric consultant diabetologists diabetologists • The care plan must be jointly reviewed and agreed with the patient (and carer, if appropriate) • There should be age appropriate screening in accordance with NICE and National Screening committee guidance Providers are required to take note of the results of Growing up with Diabetes – National Survey of CYP with diabetes [30]

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Clinical emergency situations *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 6,11,12,13,14, 15,18,32,33, 42, 54* *Schedules: 2, 3 (part 1 and 3), 12*	Ability to negotiate and agree arrangements with appropriate personnel and organisations to provide effectively for emergency situations	The Commissioners should satisfy themselves that provider has systems, processes and competent personnel are in place and implemented to ensure that all clinical emergencies and complications are handled in accordance with best practice	• Services for CYP with diabetes should provide 24 hour access to specialist support including a telephone helpline[1] • All CYP and families to have access to a specialist diabetes nurse and dietitian at first admission • CYP requiring admission for diabetes emergencies should be managed by competent skilled personnel familiar with the BSPED [31] guidelines
Clinical quality	Estates and equipment *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 5,29, 30, 33, 56* *Schedules: 3,10*	Understanding of building regulations Access to advice on "fit-for-purpose" equipment and facilities	Commissioners must assure themselves that patient care is delivered in appropriately built and equipped facilities which meet relevant HTMs and Building Notes, and, where appropriate, are registered and are safe and clean. Equipment must be fit for purpose Commitment to efficient use and satisfactory maintenance of equipment	
Clinical quality	Knowledge and understanding of health and safety *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 5,11, 19, 54, 56, 60*	Understanding of clinical accountabilities of health and safety policies	H&S strategy and policies in place and implemented with awareness throughout the organisation Accessibility to executive responsible for H&S for quicker, first contact services	Health and safety policies as per provider agreement with commissioners

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Data and information management	Strategy and policies *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 8,9,17,19, 21,23,24,27,29, 30, 32, 33,54* *Schedules: 5,6,15,16,18*	Strategy and policy development skills The ability to analyse data and have access to information that can predict trends and that could identify problems The ability to capture evidence based practice from R&D National Service Frameworks, NICE guidance The ability to use data and information appropriately to improve patient care Transparency and objectivity	The Provider should have an explicit data and information strategy in place that covers • Types of data • Quality of data • Data protection and confidentiality • Accessibility • Transparency • Analysis of data and information • Use of data and information • Dissemination of data and information • Risks • Sharing of data and compatibility of IT across different providers with respect to care of patients across a pathway This information should be included in the Data Quality Improvement Plan There should be policies in place that include: • Confidentiality Code of Practice • Data Protection • Freedom of Information • Health Records • Information Governance Management • Information Quality Assurance • Information Security There must be a named individual who is the Caldicott Guardian	The Provider is required to ensure that the following is in place[1]: • A 24 hours a day, 7 days a week telephone helpline • Enable users of the service to book regular reviews on-line • Clinical staff at different sites to have on-line access to shared protocols, guidelines and information relating to the CYP service and be able to add entries to the electronic health record • Decision support trees for the CYP and their families to use for sick days, hypoglycaemia and dental visits and for health professionals to provide care during surgery or in diabetic ketoacidosis The Provider is required to have information systems that record individual needs including emotional, social, educational, economic and biomedical information which permit multidisciplinary care across service boundaries and support care planning [32] The Provider is required to use the following for the collection and production of data, where appropriate: • Hospital Episodes Statistics data [33] • Patient Experience [20] • Patient Satisfaction • National Diabetes Information Service [34] • National Diabetes Continuing Care Dataset [35]

Source documents

Commissioners and providers should take responsibility for making references to the latest version of the various documents and guidance.

1. Department of Health, Making Every Young Person with Diabetes Matter, Report of the Children and Young People with Diabetes Working Group, April 2007
2. NHS Diabetes, Emotional and Psychological Support and Care in Diabetes, Joint Diabetes UK and NHS Diabetes Emotional and Psychological Support Working Group, February 2010
3. NHS Diabetes, Diabetes emergency and inpatient care commissioning guide, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/
4. NHS Diabetes, prevention and risk assessment commissioning guide, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/
5. NHS Diabetes, Features of a service that is responsive to people with learning disabilities who have diabetes, 2010, http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/
6. Department of Health, Standard NHS Contract for Acute Services, January 2010, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111203
7. NICE, Diagnosis and management of Type 1 diabetes in children, young people and adults, www.nice.org.uk/Guidance/CG15, 2004
8. NICE, Type 2 diabetes: the management of type 2 diabetes (update), www.nice.org.uk/Guidance/CG66, June 2008 (update)
9. NICE, Management of Type 2 diabetes - prevention and management of foot problems, www.nice.org.uk/Guidance/CG10, January 2004
10. NICE, Diabetes in pregnancy : management of diabetes and its complications from pre-conception to the post natal period, http://www.nice.org.uk/Guidance/CG63, March 2008
11. NICE, Type 2 diabetes: newer agents for blood glucose control in type 2 diabetes, http://guidance.nice.org.uk/CG66/, May 2009
12. NICE, Primary prevention of type 2 diabetes mellitus among high risk black and minority ethnic groups, www.nice.org.uk/Guidance/PHG/Wave19/6, in progress, expected June 2011
13. NICE, The clinical effectiveness and cost effectiveness of long acting insulin analogues for diabetes, www.nice.org.uk/Guidance/TA53 , December 2002
14. NICE, The clinical effectiveness and cost effectiveness of patient education models for diabetes, www.nice.org.uk/Guidance/TA60, April 2003
15. NICE, Continuous subcutaneous insulin infusion for the treatment of diabetes (review), www.nice.org.uk/Guidance/TA151, July 2008
16. NICE, Depression with a chronic physical health problem, http://guidance.nice.org.uk/CG91/Guidance/pdf/English, October 2009
17. NICE, Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence, Jan 2009, http://guidance.nice.org.uk/CG76
18. NHS Institute for Innovation and Improvement, model CQUIN scheme: inpatient care for people with diabetes, 2009
19. National Diabetes Audit. www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/diabetes
20. The King's Fund, The point of care. Measures of patients' experience in hospital: purpose, methods and uses. July 2009
21. DiabetesE - https://www.diabetese.net/
22. Skills for Health, Diabetes Competency Framework, https://tools.skillsforhealth.org.uk/suite/show/id/40
23. Department of Health, National Service Framework for Diabetes: Standards, 2001, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002951

24. National Service Framework for Children, Young People and Maternity Services, 2004 http://www.dh.gov.uk/en/Healthcare/Children/DH_4089111

25. Standards of in-patient care for children and young people with diabetes (in development)

26. NHS Diabetes, Commissioning guides for the complications of diabetes, 2010, http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement

27. NHS Diabetes, diabetes and pregnancy commissioning guide, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/

28. NHS Diabetes, mental health and diabetes services commissioning guide, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/

29. Department of Health, You're Welcome quality criteria: Making health services young people friendly, 2007, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073586

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31. British Society for Paediatric Endocrinology and Diabetes (BSPED) guidelines https://www.bsped.org.uk/professional/guidelines/index.htm.

32. York and Humber integrated IT system http://www.diabetes.nhs.uk/document.php?o=610

33. Hospital Episode Statistics, www.ic.nhs.uk/statistics-and-data-collections/hospital-care/hospital-activity-hospital-episode-statistics--hes

34. National Diabetes Information Service, The Information Centre, http://ndis.ic.nhs.uk/pages/index.aspx

35. National Diabetes Continuing Care Dataset, www.ic.nhs.uk/webfiles/Services/Datasets/Diabetes/dccrdataset.pdf

Standard Service Specification Template for Services for Children and Young People with Diabetes

This specification forms Schedule 2, Part 1, 'The Services - Service Specifications' of the Standard NHS Contracts[a].

Service specifications are developed in partnership between commissioners and provider agencies and are based on agreed evidence-based care and treatment models. Specifications should be open to scrutiny and available to all service users/carers as a statement of standards that the user/carer can expect to receive.

The following documentation, developed by the National Paediatric Diabetes Networks Group, provides further detail/guidance to support the development of this specification:

- The intervention map for services for children and young people with diabetes
- The contracting framework for services for children and young people with diabetes

This specification template assumes that the services are compliant with the contracting framework for services for children and young people with diabetes.

This template also provides examples of what commissioners may wish to consider when developing their own service specifications.

Description of Services for Children and Young People with Diabetes:

Services for children and young people with diabetes provides the full range of care from prevention, diagnosis, initial and continuing management up to the age of 25, together with the seamless transition to adult diabetes services. Commissioners should note that the care of children and young people with diabetes must be undertaken by children and young people specialist diabetes teams. The prevention and risk assessment of children and young people with respect to diabetes can be delivered by generalist primary care teams.

The commissioner is referred to the commissioning guide for emergency and in patient care[b] for management of acute diabetic emergencies in children and young people in the community (i.e. ambulance care).

The final specification should take into account:

- **national, network and local guidance and standards for diabetes services.**
- **local needs.**

This specification is supported by other related work in diabetes commissioning such as:

- the web-based Diabetes Community Health Profiles (Yorkshire and Humber Public Health Observatory)
- the web-based Health Needs Assessment Tool (National Diabetes Information Service).

These provide comprehensive information for needs assessment, planning and monitoring of diabetes services

[a] Standard NHS Contracts http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111203

[b] NHS Diabetes, Diabetes emergency and inpatient care commissioning guide, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/

Introduction

- A general overview of the services identifying why the services are needed, including background to the services and why they are being developed or in place
- A statement on how the services relate to each other within the whole system should be included describing the key stakeholders/relationships which influence the services, e.g. Children and Young Peoples' Specialist Multidisciplinary Diabetes care team etc
- Any relevant diabetes clinical networks and screening programmes applicable to the services
- Details of all interdependencies or sub-contractors for any part of the service and an outline of the purpose of the contract should be stated, including arrangements for clinical accountability and responsibility, as appropriate

Purpose, Role and Clientele

1. A clear statement on the primary purpose of the services and details of what will be provided and for whom:
    - Who the services are for (e.g. children and young people requiring diabetes care and provision of support to families/carers)
    - What the services aim to achieve
    - The objectives of the services including full access, timeliness and equity; where possible be close to home and based in the community
    - The range of options available to children and young people including supporting self management, informed choice and individual preferences
    - The desired outcomes and how these are monitored and measured

Scope of the Services

2. What does the service do? This section will focus on the types of high level therapeutic interventions that are required for the types of need the services will respond to.
    - How the services responds to age, culture, disability, and gender sensitive issues including responding to children in care, children in the secure estate, refugees and asylum seekers
    - Assessment – details of what it is and co-morbidity assessment and referrals to all relevant specialties
    - Service planning – High level view of what the services are and how they are used; how patients enter the pathway/journey; what are the stages undertaken and continuing management including transition to adults' services. The aims of service planning are to:
        - o Develop, manage and review interventions along the patient journey
        - o Ensure access to other specialities /care, as appropriate
        - o Ensure that care planning (including plans to diabetes transition services) is undertaken by the diabetes multi-disciplinary team (as defined locally) with a clear care co-ordination function
        - o Ensure that all patients and family/carers receive appropriate timely structured education
        - o Ensure that non-attendees are actively followed up
        - o Ensure that transition from childrens' to young peoples' and adults' services are negotiated and explicitly planned around the assessed needs of each individual young person
    - Holistic review of patients in the management of their diabetes using the principles of an integrated care model for people with long term conditions that is patient-centred, including self care and self management, clinical treatment, facilitating independence, psychological support and other social care issues
    - Risk assessment procedures

- Detail of evidence base of the service – i.e. the contracting framework for services for children and young people with diabetes, guidance produced by the Royal College of Paediatrics and Child Health, Diabetes UK, etc

Service Delivery

3. Patient Journey/intervention map
   Flow diagram of the patient pathway showing access and exit/transfer points – see the diabetes CYP services intervention map as a starting point

4. Treatment protocols/interventions
   Include all individual treatment protocols in place within the services or planned to be used

5. This will include a breakdown of how the patient will receive the services and from whom. It should be a clear statement of staff qualifications/experience and/or training (if appropriate) and clinical or managerial supervision arrangements. It should specify, as appropriate:

   - Geographical coverage/boundaries – i.e. the services should be available for children and young people with diabetes who live in the PCT area, give an age range, etc
   - Hours of operation including, provision outside 9 -5 to encourage full participation at school and to support working parents and local agreements to enable 24-hour access to emergency advice from competent staff
   - Minimum level of experience and qualifications of staff (i.e. doctors – diabetologists and GPs, Nursing staff – diabetes nurse specialists, district, practice nurses etc, other allied health professionals, e.g. podiatrists, dietitians, optometrists, pharmacists etc and other support and administrative staff)
   - Confirmation of the arrangements to identify the Care Co-ordinator for each patient with diabetes (i.e. who holds the responsibility and role)
   - Staff induction and developmental training

6. Equipment
   - Upgrade and maintenance of relevant equipment and facilities
   - Technical specifications *(if any)*

Identification, Referral and Acceptance criteria

7. This should make clear how patients will be identified, assessed (if appropriate) and accepted to the services. Acceptance should be based on types of need and/or patient.

8. How should patients be referred?
   - Who is acceptable for referral and from where
   - Details of evaluation process - Are there clear exclusion criteria or set alternatives to the service? How might a patient be transferred?
   - Response time detail and how are patients prioritised

Discharge/Transition to Adults' Services criteria

9. The intention of this section is to make clear when a patient should be transferred from one aspect of the diabetes service to another and when this point would be reached.
   - How is a treatment pathway reviewed?
   - How does the service decide that a patient is ready for discharge/transition to adults' services?
   - How are goals and outcomes assessed and reviewed?
   - What procedure is followed on discharge, including arrangements for follow-up or smooth transition to adults' services?

Quality Standards

10. Each service specification will include service specific standards, which are over and above the nationally mandated quality standards, i.e. based on standards identified in the contracting framework for services for children and young people with diabetes. The service specific standards should encompass the total service from acceptance to discharge or transition to adults' services including nationally applicable quality standards. These will be individually tailored to each service and will include details on access, equity, assessment (if appropriate), time-scales of intervention, waiting times and what to expect on service discharge. Explicit within each service specification will be the expectation that patient and carer involvement/empowerment is incorporated within the service.

11. This must include performance indicators, thresholds, methods of measurement and consequences of breach of contract. These will be set and agreed prior to the signing of the overall agreement.

12. As a minimum, the Provider is required to agree a local Commissioning for Quality and Innovation scheme for services for people with diabetes.
(Insert details of the CQUIN Scheme agreed)

Activity and Performance Management

13. Key Performance Indicators – List the criteria/outcomes by which the service is /could be measured. Specific KPIs for diabetes services for CYP are in development. Please see the NHS Diabetes website for further details:
http://www.diabetes.nhs.uk/commissioning_resource

14. Activity plans – Where appropriate, identify the anticipated level of activity the service may deliver; provide details of any activity measures and their description /method of collection, targets, thresholds and consequences of variances above or below target.

Continual Service Improvement

15. As part of the monitoring and evaluation procedures, the service will identify a method of agreeing measurements for continuous improvement of the service being offered and work to ensure unmet need is both identified and brought to the attention of the commissioner.

16. Review
This section should set out a review date and a mechanism for review.

The review should include both the specifications for continuing fitness for purpose and the providers' delivery against the specification.

This should set out the process by which this review will be conducted.

This should also identify how compliance against the specification will be monitored in year.

17. Agreed by
This should set out who agrees/accepts the specification on behalf of all parties.

This should include the diabetes providers, commissioner and network

Standard Service Specification Template for Diabetes Transition Services (CYP to adult)

This specification forms Schedule 2, Part 1, 'The Services - Service Specifications' of the Standard NHS Contracts[a].

Service specifications are developed in partnership between commissioners and provider agencies and are based on agreed evidence-based care and treatment models. Specifications should be open to scrutiny and available to all service users/carers as a statement of standards that the user/carer can expect to receive.

The following documentation, developed by the National Paediatric Diabetes Networks Group, provides further detail/guidance to support the development of this specification:

- The intervention map for services for children and young people with diabetes
- The contracting framework for services for children and young people with diabetes

This specification template assumes that the services are compliant with the contracting framework for services for children and young people with diabetes.

This template also provides examples of what commissioners may wish to consider when developing their own service specifications.

Description of Diabetes Transition Services for Children and Young People with Diabetes:

The Diabetes Transition Service provides specialist outpatient care for young people with diabetes between the ages of 16-25. To ensure a seamless transfer from paediatric to adult diabetes services, outpatient services should be led by both paediatric and adult consultant diabetologists. Services should be multidisciplinary including diabetes specialist nurses, specialist dietetics plus appropriate input from other disciplines such as podiatry, psychology and ophthalmology. The commissioner is referred to the commissioning guide for emergency and in patient care[b] for management of acute diabetic emergencies in children and young people in the community (i.e. ambulance care).

The final specification should take into account:

- **national, network and local guidance and standards for diabetes services.**
- **local needs.**

This specification is supported by other related work in diabetes commissioning such as:

- the web-based Diabetes Community Health Profiles (Yorkshire and Humber Public Health Observatory)
- the web-based Health Needs Assessment Tool (National Diabetes Information Service).

These provide comprehensive information for needs assessment, planning and monitoring of diabetes services

[a] Standard NHS Contracts http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111203

[b] NHS Diabetes, Diabetes emergency and inpatient care commissioning guide, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/

Introduction

- A general overview of the services identifying why the services are needed, including background to the services and why they are being developed or in place.
- A statement on how the services relate to each other within the whole system should be included describing the key stakeholders/relationships which influence the services, e.g. Children and Young Peoples' Specialist Multidisciplinary Diabetes care team and the adult multidisciplinary diabetes team, liaison with education, social services and other youth organisations etc
- Any relevant diabetes clinical networks and screening programmes applicable to the services
- Details of all interdependencies or sub-contractors for any part of the service and an outline of the purpose of the contract should be stated, including arrangements for clinical accountability and responsibility, as appropriate

Purpose, Role and Clientele

1. A clear statement on the primary purpose of the services and details of what will be provided and for whom:
    - Who the services are for (e.g. children and young people between the ages of 16-25 requiring diabetes care)
    - What the services aim to achieve
    - The objectives of the services including full access, timeliness and equity; where possible be close to home and based in the community
    - The range of options available to children and young people including supporting self management, informed choice and individual preferences
    - The desired outcomes and how these are monitored and measured

Scope of the Services

2. What does the service do? This section will focus on the types of high level therapeutic interventions that are required for the types of need the services will respond to.
    - How the services responds to age, culture, disability, and gender sensitive issues including responding to children in care, children in the secure estate, refugees and asylum seekers
    - Assessment – details of what it is and co-morbidity assessment and referrals to all relevant specialties
    - Service planning – High level view of what the services are and how they are used; how patients enter the pathway/journey; what are the stages undertaken and continuing management including transition to adults' services. The aims of service planning are to:
        - o Develop, manage and review interventions along the patient journey
        - o Ensure access to other specialities /care, as appropriate
        - o Ensure that care planning (including plans to transfer to adult diabetes services) is undertaken by the diabetes multi-disciplinary team (as defined locally) with a clear care co-ordination function
        - o Ensure that all patients and family/carers receive appropriate timely structured education to improve self-management
        - o Ensure that non-attendees are actively followed up
        - o Ensure that transition from childrens' to young peoples' and adults' services are negotiated and explicitly planned around the assessed needs of each individual young person
    - Holistic review of patients in the management of their diabetes using the principles of an integrated care model for people with long term conditions that is

patient-centred and age appropriate, including self care and self management, clinical treatment, facilitating independence, psychological support and other social care issues

- Risk assessment procedures
- Detail of evidence base of the service – i.e. the contracting framework for services for children and young people with diabetes, guidance produced by the Royal College of Paediatrics and Child Health, Diabetes UK, etc

Service Delivery

3. Patient Journey/intervention map
   Flow diagram of the patient pathway showing access and exit/transfer points – see the CYP diabetes services intervention map as a starting point

4. Treatment protocols/interventions
   Include all individual treatment protocols in place within the services or planned to be used. Specifically this would include:

   - Structured education programmes suitable for transition and in line with adult education programmes
   - Provision of age appropriate information, e.g. diet, smoking, sexual health, alcohol, substance misuse, driving, contraception and pregnancy
   - An acute in-reach service into local hospitals to support newly diagnosed young people with diabetes to provide information and to facilitate referral to the outpatient transition services on discharge
   - Preconception care and facilitation of referral to pregnancy services[c]

5. This will include a breakdown of how the patient will receive the services and from whom. It should be a clear statement of staff qualifications/experience and/or training (if appropriate) and clinical or managerial supervision arrangements. It should specify, as appropriate:

   - Geographical coverage/boundaries – i.e. the services should be available for children and young people with diabetes who live in the PCT area, give an age range, etc
   - Hours of operation including, provision outside 9 -5 to encourage full participation at school and to support working parents and local agreements to enable 24-hour access to emergency advice from competent staff
   - Minimum level of experience and qualifications of staff (i.e. doctors – diabetologists and GPs, Nursing staff – diabetes nurse specialists, district, practice nurses etc, other allied health professionals, e.g. podiatrists, dietitians, optometrists, pharmacists etc and other support and administrative staff)
   - Confirmation of the arrangements to identify the Care Co-ordinator for each patient with diabetes (i.e. who holds the responsibility and role)
   - Staff induction and developmental training

6. Equipment

   - Upgrade and maintenance of relevant equipment and facilities
   - Technical specifications (*if any*)

[a] see NHS Diabetes, diabetes and pregnancy commissioning guide, 2010
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This should include the diabetes providers, commissioner and network

With thanks to Dr Thoreya Swage who wrote this publication.

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