NHS

Diabetes

Commissioning

Diabetes Diagnosis and Continuing Care Services

Supporting, Improving, Caring

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NHS Diabetes Information Reader Box	
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Commissioning Diabetes Diagnosis and Continuing Care Services

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 diagnosis and continuing care services 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 services that provide diabetes diagnosis and continuing care for adults with diabetes.
- A high level intervention map . This intervention map describes the key high level actions or interventions (both clinical and administrative) diabetes and continuing care services should undertake in order to provide the most efficient and effective care, from admission to discharge (or death) from the service.

  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 and continuing care services.
- A contracting framework for diabetes and continuing care services that brings together all the key standards of quality and policy relating to the diagnosis and management of diabetes
- A template service specification for diabetes and continuing care services that forms 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.

Commissioners are referred to the commissioning guides for children and young people and for older people for a description of diabetes diagnosis and continuing care for these care groups as well as to the diabetes emergency and in patient care commissioning guide for the management of people who present with acute diabetic emergencies.

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

Features of Diabetes Diagnosis and Continuing Care Services

High quality diabetes diagnosis and continuing care services should ensure:

- a proactive approach to identify people with diabetes
- that the needs of patients immediately following diagnosis are met, including:
    - assessment in the domains of:
        - o clinical care (including assessment of risk) and co- morbidities
        - o health beliefs and knowledge
        - o social issues
        - o emotional state, including depression
        - o behavioural issues (ease of carrying out self management tasks)
    - triage of acute potentially life-threatening complications, e.g. ketoacidosis, infected foot
    - medication/treatment and/or advice about healthy lifestyle
    - initial assessment of type of diabetes
    - initial care planning / management planning
    - introduction to what the patient should expect for themselves and from the service
- that people newly diagnosed with diabetes receive advice and support to help them self manage. This should include:
    - structured education designed for people newly diagnosed with diabetes
    - support to optimise blood glucose control
    - support to manage cardiovascular risk factors
    - an initial care plan
    - support for emotional and social issues
    - co-ordination of other issues or co-morbidities
    - opportunity for support from other people with diabetes, e.g. via Diabetes UK local voluntary support groups or other local patient groups
- that people with diabetes receive regular structured care (annual, or more frequently as appropriate) based on a care planning approach. This should include the following elements:
    - on-going advice and support from clinicians and other people with diabetes to help them self manage
    - prevention and surveillance for long-term complications
    - access to appropriate equipment and resources, pharmacological therapy, including oral agents, subcutaneous insulin and CSII (insulin pump therapy)
    - on-going structured education
    - emotional support

In addition, the service should:

- 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]) and involving users
- 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 people with diabetes in a range of settings including the patient's home, according to recognised standards including the Diabetes NSF[iii]

[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/DH4002951

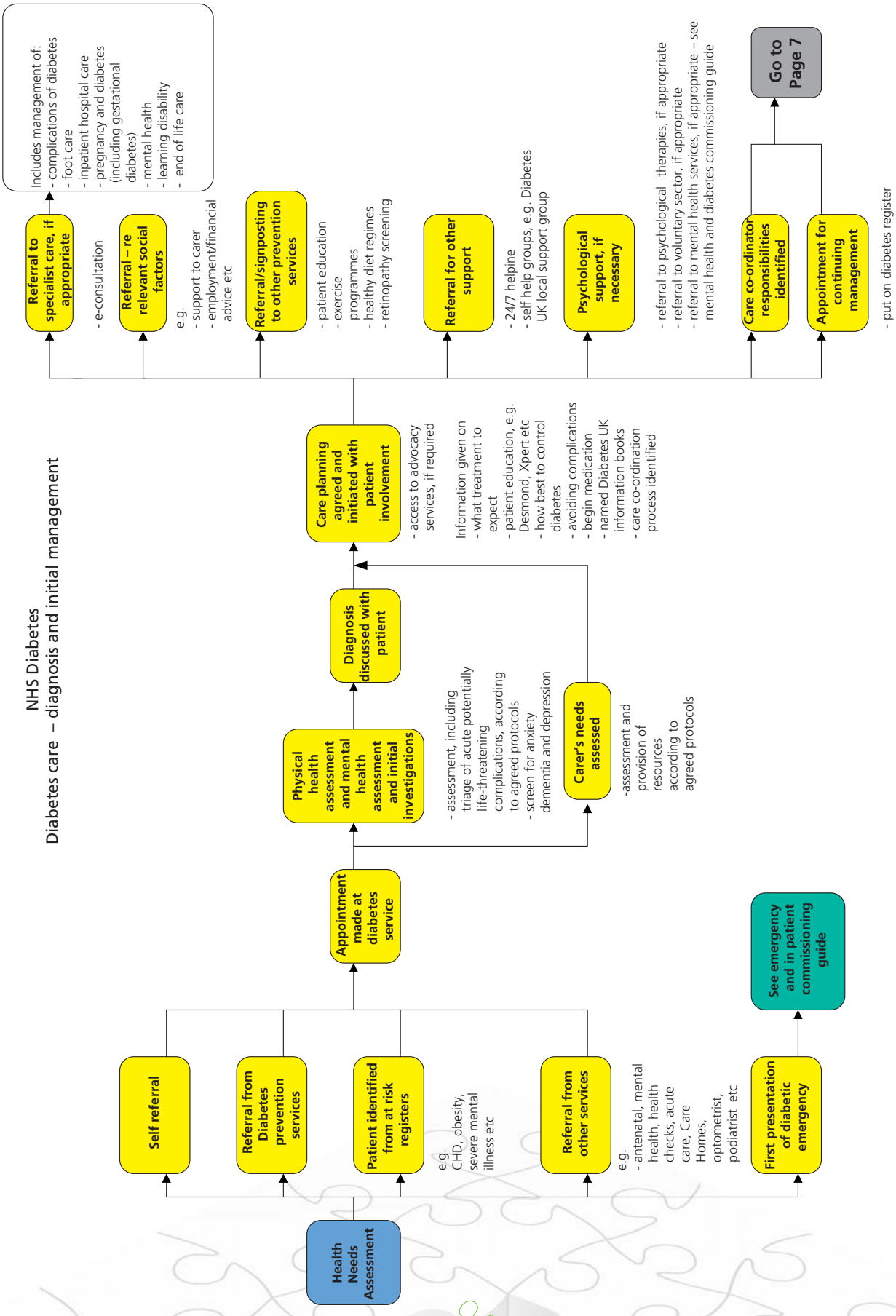
- take into account the emotional, psychological and mental wellbeing of the patient[iv]
- take into account race and inequalities with respect to access to care
- ensure that services are responsive and accessible to people with Learning Disabilities[v]
- have effective clinical networks, with clear clinical leadership, across the boundaries of care which clearly identify the role and responsibilities of each member of the diabetes healthcare team
- ensure that there are a wide range of options available to 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 stage of care
- provide education on diabetes management to other staff and organisations that support people with diabetes
- have a capable and effective workforce that has appropriate training, updating, skills and competencies in the management of people with diabetes
- provide multidisciplinary care that manages the transition between adult and older peoples' services
- 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
- take account of patient experience, including Patient Reported Outcome Measures, in the development and monitoring of service delivery
- actively monitor the uptake of services, responding to non-attenders and monitoring complaints and untoward incidents

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

Diabetes Diagnosis and Continuing Care Service Intervention Map



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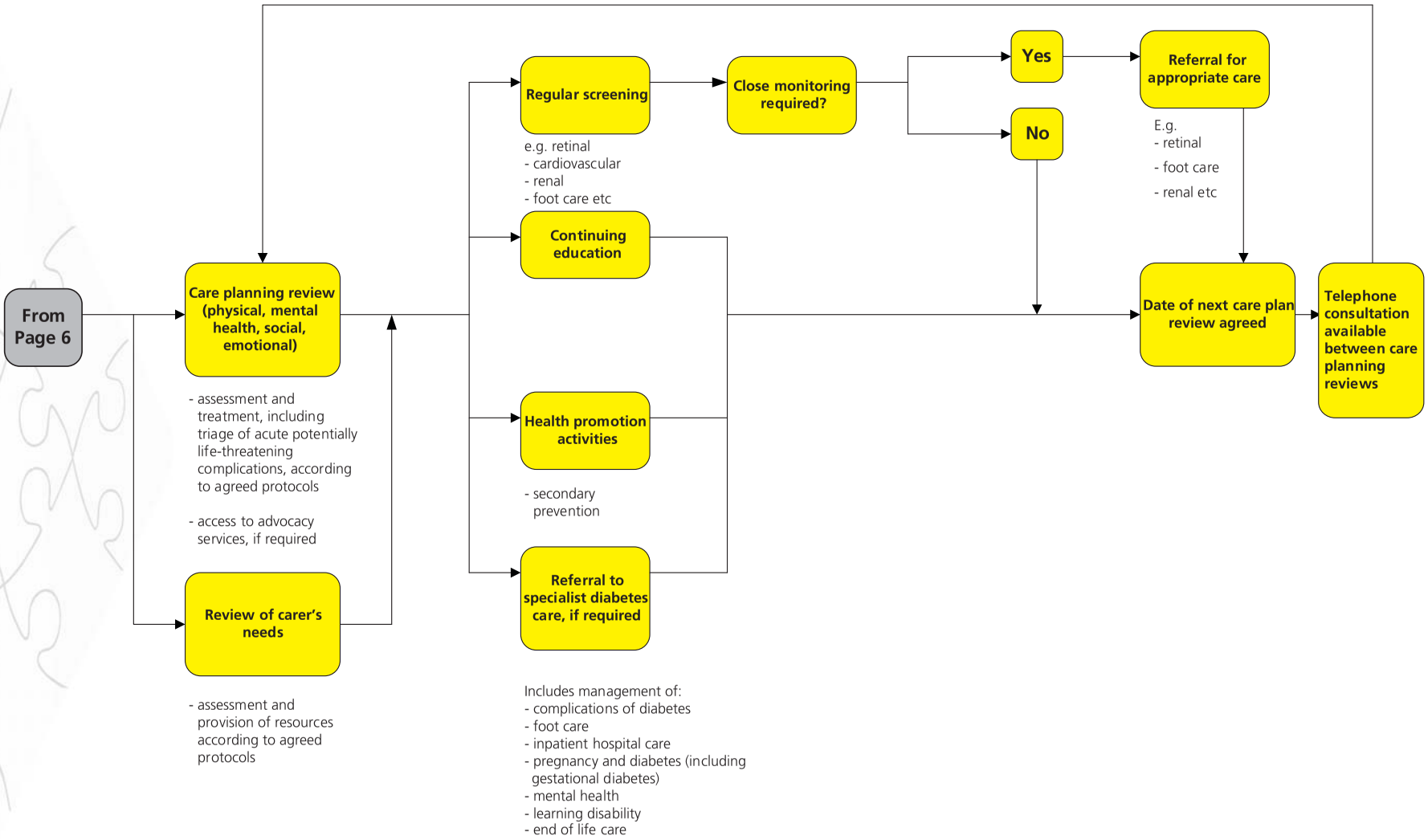


Contracting Framework for Diabetes Diagnosis and Continuing Care Services

Introduction

This contracting framework sets out what is required of clinically safe and effective services that are providing diabetes diagnosis and continuing care. The framework is designed to be read in conjunction with the high level patient 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 diabetes diagnosis and continuing care services.

The framework brings together the key quality areas and standards that have been identified by NHS Diabetes, Diabetes UK, the Royal Colleges and other related organisations.

The principles that establish a safe pathway for patient care

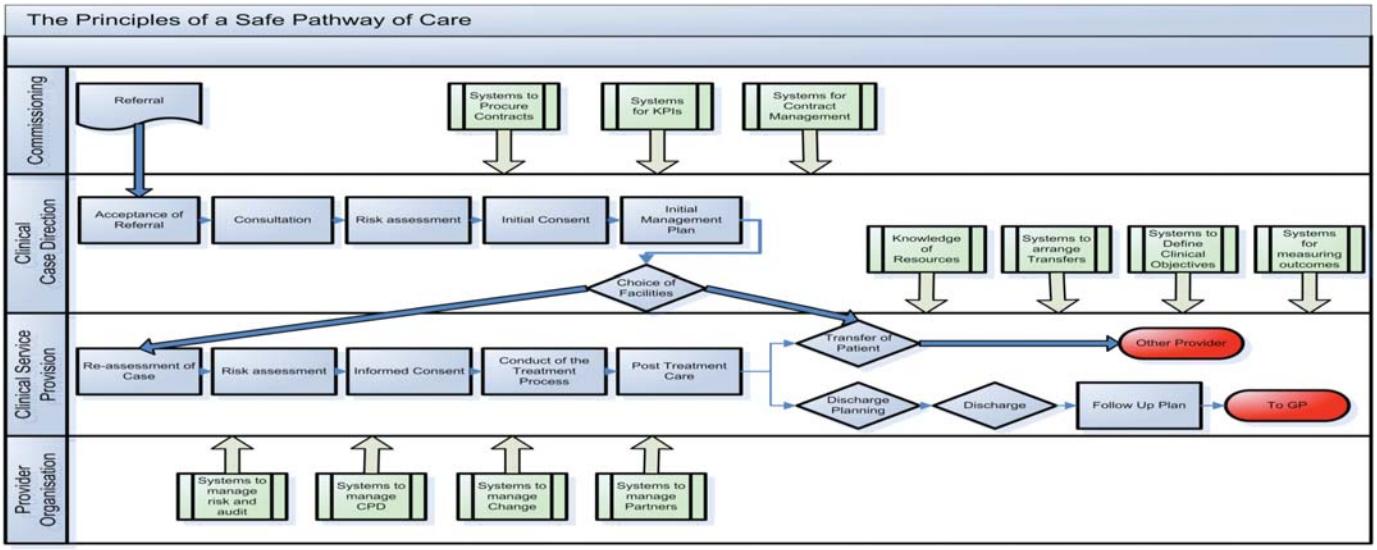
Establishing the principles that underpin the systems and processes of pathways for patient care leads to more efficient patient throughput and can reduce risk of fragmentation of care and serious untoward incidents. The principles operate at four layers within a patient pathway:

- 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 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. For the individual with diabetes, a clear care planning process together with a relationship with an identified care co-ordinator and supported by integrated personal records can ensure continuity of care.

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.

The diabetes services

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

Diabetes care is provided by a number of different teams in the primary, community and acute setting. It is essential that there is co-ordination of care of the patients through the care planning process and a consultant diabetologist retains the clinical accountability and responsibility for the service. Responsibility for overall patient care across *the whole pathway* rests with the patient's GP who also retains overall responsibility to ensure the management of side effects and complications.

The initial management and continuing care of individuals 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 [1].

The services themselves will also have clinical oversight and accountability for governance purposes.

This contracting framework focuses on adults with diabetes. Commissioners are referred to the diabetes commissioning guides for children and young people[2] and older people [3] for further detail on these care groups. This contracting framework should also be read in conjunction with the diabetes commissioning guides for prevention and risk assessment[4], foot care [5], emergency and in patient care [6], mental health [7], pregnancy[8], the complications of diabetes [9], End of Life Care [10] and follow the principles for the effective commissioning of services for people with Learning Disabilities [11].

Ensuring quality

Commissioning Bodies should ensure that the 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 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 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 Community Services – bilateral (main clauses and schedules)[12]. (The cross references also apply to the clauses and schedules in the Standard NHS Contract for Acute 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 Community 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 diabetes diagnosis and continuing care services
Governance	Integrated Governance *Cross references to the Standard NHS Contract for Community 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 Community 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	All sub-contractors must meet governance and leadership arrangements of the main provider organisation Commissioner, provider and NHS Litigation Authority must review the Clinical Negligence Scheme for Trusts 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 [13] • Type 2 diabetes: the management of type 2 diabetes (update)[14]

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Governance	Clinical Governance		• Complaints Management • 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 (CQUIN) for diabetes care, e.g. model CQUIN scheme proposed by the NHS Institute for Innovation and Improvement [26]	• Management of Type 2 diabetes - prevention and management of foot problems [15] • Type 2 diabetes: newer agents for blood glucose control in type 2 diabetes[16] • Allogeneic pancreatic islet cell transplantation for type 1 diabetes mellitus [17] • Autologous pancreatic islet cell transplantation for improved glycaemic control after pancreatectomy [18] • Pancreatic islet cell transplantation [19] • Primary prevention of type 2 diabetes mellitus among high risk black and minority ethnic groups [20] • The clinical effectiveness and cost effectiveness of long acting insulin analogues for diabetes [21] • The clinical effectiveness and cost effectiveness of patient education models for diabetes [22] • Continuous subcutaneous insulin infusion for the treatment of diabetes (review)[23] • Depression with a chronic physical health problem[24] • Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence [25] In addition, diabetes multidisciplinary teams should [27]: • 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 • not use special management techniques or treatment for non-severe psychological illness, except where diabetes-related arterial complications give rise to special precautions over drug therapy • 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
Governance	Clinical Governance			• ensure that all adults with Type I diabetes have, at regular intervals, counselling about lifestyle issues and nutritional behaviour
Clinical quality	Quality assurance *Cross references to the Standard NHS Contract for Community 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 clinical 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	Diabetes services must comply with the access targets for primary and secondary care, i.e.: • Insert waiting times for primary care [28] • Insert 18 week target [29] The services are required to participate in the following activities/programmes: • National Diabetes Audit [30] • Patient Experience Surveys [31] • Diabetes E [32] • Patient Reported Outcome Measures
Clinical quality	Workforce/ staff Clinical staff attributes critical to safety and quality of interventions *Cross references to the Standard NHS Contract for Community 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 [33] • Dietitians: registration with the HPC and able to demonstrate competence in delivering educational support • Practitioners with a special interest in diabetes should demonstrate the relevant competences[34] Healthcare professionals involved in delivering diabetes care are required to have the following competencies relevant to their area of work [35] • Diab ED03 – provide treatment for erectile dysfunction in a man with diabetes • Diab HA13 – provide information and advice to enable an individual with diabetes minimise the risks of hypo glycaemia

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 IPT01 - assess the suitability of insulin pump therapy for an individual with Type 1 diabetes • Diab IPT02 – provide preliminary education about insulin pump therapy for an individual with Type 1 diabetes • Diab DA4 – assist individuals with diabetes to support each other • Diab IPT03 – provide dietary education for an individual with Type 1 diabetes who is contemplating insulin pump therapy • Diab IPT04 – enable an individual with Type 1 diabetes to administer insulin by pump • Diab GA2 – assess and investigate individuals with suspected diabetes • Diab IPT05 – provide ongoing support to an individual administering insulin by pump • Diab GA3 – develop a diagnosis of diabetes • Diab IPT06 – provide ongoing dietary education for an individual with Type 1 diabetes administering insulin by pump • Diab GA4 – inform individuals of a diagnosis of Type 2 diabetes or impaired glucose tolerance • Diab HA1 – assess the healthcare needs of individuals with diabetes and agree care plans • Diab HA10 – help individuals with diabetes reduce cardiovascular risk • Diab HA11 – assess the need for an individual to start insulin therapy • Diab HA12 – enable an individual with Type 2 diabetes to start insulin therapy • Diab HA2- work in partnership with individuals to sustain care plans to manage their diabetes • Diab TT02 – assess individuals with symptoms of diabetes and make a diagnosis • Diab HA3 – examine the feet of an individual with diabetes and advise on care • Diab TT03 – inform individuals of a diagnosis of Type 1 diabetes • Diab HA4 – assess the feet of individuals with diabetes and provide advice on maintaining healthy feet and managing foot problems • Diab TX01 – provide therapy to meet the immediate healthcare needs of individuals newly diagnosed with 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 HA5 – help an individual understand the effects of food, drink and exercise on their diabetes • Diab TX02 – support an individual with Type 1 diabetes in the early stages after diagnosis • Diab HA6 – help individuals with diabetes to change their behaviour to reduce the risk of complications and improve their quality of life • Diab TX03 – help an individual using insulin pump therapy to manage their diabetes understand the effects of food, drink, physical activity and medication on their health and well-being • Diab HA7 – develop, agree and review a dietary plan for an individual with diabetes • Diab HA8 – enable individuals with diabetes to monitor their blood glucose levels • Diabe HA9 – help an individual with diabetes to improve their blood control • Diab HD2 – assist an individual to sustain oral medication to improve their condition • Diab HD3 – help individuals with Type 2 diabetes continue insulin therapy • Diab HD4 – identify hypoglycaemic emergencies and help others manage them • HAS3.1 – examine the feet of an individual with diabetes and assess risk status • HAS3.2 – provide advice and referral to help individuals with diabetes care for their feet • Diab ED02 – assess a man with diabetes for erectile dysfunction • Diab ED01 – provide advice and information to men with diabetes about erectile dysfunction

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Workforce/ staff Clinical staff competencies in use of equipment *Cross references to the Standard NHS Contract for Community 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 Community 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
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 Community 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 [36] • Coronary Heart Disease NSF [37] • New Horizons [38] • Long Term Conditions NSF [39] • Renal NSF [40] Compliance with Care Quality Commission Reviews

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Patient pathway *Cross references to the Standard NHS Contract for Community 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 Accountabilities should be agreed and documented by all stakeholders There are a number of services supporting patients with diabetes and there must be clear sub contracts stating the referral criteria and access to these supporting 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	The services should follow the principles identified by the Generic Choice Model for Long Term Conditions. These include [41]: • Diagnosis/assessment • Self care and self management • Clinical support • Supporting independence • Psychological support • Other relevant social factors Diabetes diagnosis and continuing care services should include the following key interventions: i. Diagnosis ii. Initial management iii. Continuing management iv. Referral for the management of complications of diabetes Diagnosis: Activities/interventions should include: • Awareness raising activities – see diabetes prevention and risk assessment commissioning guide [4] • A method of diagnosis that uses WHO criteria • The identification of monogenic forms of diabetes • Appropriate skills for communicating diagnosis • Diagnosis and ethnicity recorded in a standard way (as outlined by the national Diabetes Continuing Care Dataset)[29] • Local protocols for identifying people with undiagnosed diabetes and reporting this to practice registers Initial management: Activities/interventions should include: • Assessment and care planning for all patients with diabetes including:[43] o Clinical care (including assessment of risk) and co-morbidities o Health beliefs and knowledge o Social issues o Emotional state, including depression o Behavioural issues (ease of carrying out self management tasks) o Triage of acute potentially life-threatening complications, e.g. ketoacidosis, infected foot

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Patient pathway		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 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	o Medication/treatment and/or advice about healthy lifestyle o Initial assessment of type of diabetes o Introduction to what the patient should expect for themselves and from the service • There should be locally agreed assessment protocols that include triage of acute potentially life threatening conditions, e.g. ketoacidosis, infected foot etc • The education programme should meet the quality criteria for structured education programmes • The service should support people newly diagnosed with diabetes by providing advice and help with self management. This should include: o Structured education designed for people newly diagnosed with diabetes o Support to optimise blood glucose control o Support to manage cardiovascular risk factors o Initial care plan o Support for emotional and social issues o Co-ordination of other issues or co-morbidities o Opportunity for support from other people with diabetes, e.g. Diabetes UK local support group • The Care Planning process should adhere to the quality criteria followed by the Year of Care approach [44] Continuing management: Activities/interventions should include: • Regular structured care (annual, or more frequently as appropriate) based on a care planning approach and includes the following elements: o on-going advice and support from clinicians and other people with diabetes to help them self manage o prevention and surveillance for long-term complications o access to appropriate equipment and resources, pharmacological therapy, including oral agents, subcutaneous insulin and CSII (insulin pump therapy) o on-going structured education o continued glucose monitoring, where appropriate o emotional support • The education programme should meet the quality criteria for structured education programmes

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Patient pathway		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	Referrals for the management of complications of diabetes: Activities/interventions should include: • There should be protocols in place for the surveillance of foot and renal disease according to NICE, retinopathy according to the National Screening Committee and management of HbA1c, blood pressure and lipids according to NICE guidance • There should be protocols in place to deal with unplanned problems, and arrangements for solving specific problems in management requiring more intensive intervention Patients may need to be referred to the following services as part of their diabetes care (see relevant intervention map, contracting framework and service specification): • Emergency and inpatient care [6] • services for complications – foot care, eyes, vascular, kidney care, etc [9] • pregnancy and diabetes (including gestational diabetes) [8] • mental health [7] • end of life care [10] There should be a seamless transfer of care to diabetes services for older people when appropriate Providers are required to take note of the results of the National Survey of People with Diabetes [45]
Clinical quality	Clinical emergency situations *Cross references to the Standard NHS Contract for Community 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	There should be locally agreed assessment protocols that include triage of acute potentially life threatening conditions, e.g. ketoacidosis, infected foot etc

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Estates and equipment *Cross references to the Standard NHS Contract for Community 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 Community 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
Data and information management	Strategy and policies *Cross references to the Standard NHS Contract for Community 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:	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 [46] The Provider is required to have systems in place to send clinical results to people with diabetes. The Provider is required to use the following for the collection and production of data, where appropriate: • National Diabetes Information Service [47] • National Diabetes Audit [30] • Diabetes E [32] • Quality and Outcomes Framework[48] • Myocardial Ischaemia Audit Project[49] • Hospital Episode Statistics[50] • Patient Experience [31,45] • Patient Satisfaction [45]

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Data and information management	Strategy and policies		• 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	• Patient Reported Outcomes Measures • National Diabetes Continuing Care Dataset [42]

Source documents

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

1. Emotional and Psychological Support and Care in Diabetes, Joint Diabetes UK and NHS Diabetes Emotional and Psychological Support Working Group, February 2010
2. NHS Diabetes, children and young people with diabetes commissioning guide, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/
3. NHS Diabetes, older people with diabetes commissioning guide, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/
4. NHS Diabetes, diabetes prevention and risk assessment commissioning guide, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/
5. NHS Diabetes, diabetes foot care services commissioning guide, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/
6. NHS Diabetes, Diabetes emergency and inpatient care commissioning guide, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/
7. NHS Diabetes, Mental health and diabetes services commissioning guide, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/
8. NHS Diabetes, pregnancy and diabetes commissioning guide, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/
9. NHS Diabetes, complications of diabetes commissioning guides, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/
10. NHS Diabetes, diabetes and end of life care commissioning guide, 2010 http://www.diabetes.nhs.uk/commissioning_resource/step_3_service_improvement/
11. 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/
12. Department of Health, Standard NHS Contract for Community Services, January 2010, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111203
13. NICE, Diagnosis and management of Type 1 diabetes in children, young people and adults, www.nice.org.uk/Guidance/CG15, 2004
14. NICE, Type 2 diabetes: the management of type 2 diabetes (update), www.nice.org.uk/Guidance/CG66, June 2008 (update)
15. NICE, Management of Type 2 diabetes - prevention and management of foot problems, www.nice.org.uk/Guidance/CG10, January 2004
16. NICE, Type 2 Diabetes - newer agents (partial update of CG66) http://guidance.nice.org.uk/CG87, May 2009
17. NICE, Allogeneic pancreatic islet cell transplantation for type 1 diabetes mellitus, www.nice.org.uk/Guidance/IPG257, April 2008
18. NICE, Autologous pancreatic islet cell transplantation for improved glycaemic control after pancreatectomy, www.nice.org.uk/Guidance/IPG274, September 2008
19. NICE, Pancreatic islet cell transplantation, www.nice.org.uk/Guidance/IPG013, October 2003
20. 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
21. NICE, The clinical effectiveness and cost effectiveness of long acting insulin analogues for diabetes, www.nice.org.uk/Guidance/TA53, December 2002
22. NICE, The clinical effectiveness and cost effectiveness of patient education models for diabetes, www.nice.org.uk/Guidance/TA60, April 2003
23. NICE, Continuous subcutaneous insulin infusion for the treatment of diabetes (review), www.nice.org.uk/Guidance/TA151, July 2008
24. NICE, Depression with a chronic physical health problem, http://guidance.nice.org.uk/CG91, Oct 2009
25. NICE, Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence, Jan 2009, http://guidance.nice.org.uk/CG76

26. NHS Institute for Innovation and Improvement, model CQUIN scheme: inpatient care for people with diabetes, 2009
27. Diabetes UK, Minding the gap. The provision of psychological support and care for people with diabetes in the UK, A report for Diabetes UK, 2008
28. Department of Health, Primary care and community services:improving GP access and responsiveness, July 2009, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_102122
29. 18 week target www.18weeks.nhs.uk/Content.aspx?path=/
30. National Diabetes Audit. www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/diabetes
31. The King's Fund, The point of care. Measures of patients' experience in hospital: purpose, methods and uses. July 2009
32. DiabetesE - https://www.diabetese.net/
33. Training, Research and Education for Nurses in Diabetes – UK, An Integrated Career & Competency Framework for Diabetes Nursing (Second Edition), 2010
34. Royal College of General Practitioners, Royal Pharmaceutical Society of Great Britain, Department of Health, Primary Care Contracting, Guidance and competences for the provision of services using practitioners with special interests (PwSIs), (Diabetes), 2009 http://www.pcc.nhs.uk/pwsi
35. Skills for Health, Diabetes Competency Framework, https://tools.skillsforhealth.org.uk/suite/show/id/40
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37. Department of Health, National Service Framework for Coronary Heart Disease – modern standards and service models http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094275
38. Department of Health, New Horizons: A shared vision for mental health December 2009 http://newhorizons.dh.gov.uk/index.aspx
39. Department of Health, The National Service Framework for Long Term Conditions, March 2005 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4105361
40. Department of Health, The national Service Framework for Renal Services, January 2004 http://www.dh.gov.uk/en/Healthcare/Renal/DH_4102636
41. Department of Health, Generic Choice Model for Long Term Conditions, December 2007, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081105
42. National Diabetes Continuing Care Dataset, www.ic.nhs.uk/webfiles/Services/Datasets/Diabetes/dccrdataset.pdf
43. Care planning in diabetes, Report from the Joint Department of Health and Diabetes UK Care Planning Working Group www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063081
44. NHS Diabetes, Year of Care, http://www.diabetes.nhs.uk/year_of_care/
45. Healthcare Commission, National Survey of People with Diabetes, 2006, www.cqc.org.uk/usingcareservices/healthcare/patientsurveys/servicesforpeoplewithdiabetes.cfm
46. York and Humber integrated IT system http://www.diabetes.nhs.uk/document.php?o=610
47. National Diabetes Information Service, The Information Centre, http://ndis.ic.nhs.uk/pages/index.aspx
48. Quality and Outcomes Framework, www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/QualityOutcomesFramework.aspx
49. Myocardial Ischaemia Audit Project (MINAP) www.rcplondon.ac.uk/CLINICAL-STANDARDS/ORGANISATION/PARTNERSHIP/Pages/MINAP-.aspx
50. Hospital Episode Statistics, www.ic.nhs.uk/statistics-and-data-collections/hospital-care/hospital-activity-hospital-episode-statistics--hes

Standard Service Specification Template for Diabetes Diagnosis and Continuing Care Services

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. They are based on the needs of the population of people with diabetes using evidence-based care, treatment models and examples of best practice outlined in NICE, the NSF and other reference material. 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 Diabetes Commissioning Advisory Group, provides further detail/guidance to support the development of this specification:

- The diabetes diagnosis and continuing care intervention map
- The contracting framework for diabetes diagnosis and continuing care services

This specification template assumes that the services are compliant with the contracting framework for diabetes diagnosis and continuing care services.

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

Description of diabetes diagnosis and continuing care services:

Diabetes diagnosis and continuing care services encompass the care an individual, who is diagnosed with diabetes, may receive ranging from the initial physical, psychological and social assessment and continued management of their diabetes and complications through care planning and care co-ordination.

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.

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. multi-disciplinary 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

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

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. individuals who require diagnosis and continuing management of their diabetes and complications)
   - What the services aim to achieve
   - The objectives of the services
   - The desired outcomes and how these are monitored and measured

Scope of the Services

2. What do the services 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
   - Assessment – details of what it is and co-morbidity assessment and referrals to all relevant services/care
   - 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 follow up care. The aims of service planning are to:
     - o Develop, manage and review interventions along the patient journey
     - o Ensure access to other services/care, as appropriate
     - o Ensure that care planning is undertaken by the diabetes multi-disciplinary team (as defined locally) with a clear care co-ordination function
   - Holistic review of individuals who have 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 services – i.e. the contracting framework for diabetes prevention and screening services, guidance produced by the Royal College of Physicians, 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 diagnosis and continuing care 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 adults who live in the PCT area
   - Hours of operation including, week-end, bank holiday and on-call arrangements
   - 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, e.g. specification for insulin pumps according to national criteria

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/Service Complete/Patient Transfer/Transition criteria

9. The intention of this section is to make clear when a patient should be transferred from the diabetes diagnosis and continuing care services to another and when this point would be reached.
   - How is the intervention pathway reviewed?
   - How does the service decide that a patient is ready for discharge/transfer to other services?
   - How are goals and outcomes assessed and reviewed?
   - What procedure is followed on discharge, including arrangements for follow-up?

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 diabetes diagnosis and continuing care services. The service specific standards should encompass the total service from acceptance to discharge or transfer 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 diagnosis and continuing care services 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

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www.diabetes.nhs.uk

Further copies of this publication can be ordered from Prontaprint, by emailing diabetes@leicester.prontaprint.com or tel: 0116 275 3333, quoting DIABETES 136