NHS

Diabetes

Commissioning Pregnancy and Diabetes Care

Supporting, Improving, Caring

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Commissioning Pregnancy and Diabetes Care

NHS Diabetes would like to thank the following for their advice and contribution to the development of this commissioning guide:

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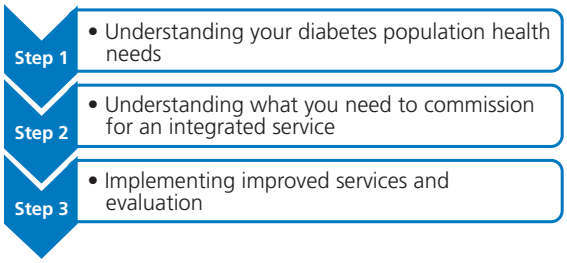
And to Thoreya Swage who wrote this publication.

Contents

Commissioning Pregnancy and Diabetes Services

The NHS Diabetes commissioning approach helps to deliver high quality integrated care through a three-step process that ensures key elements needed to build an excellent diabetes service are in place. The approach is supported by a wide range of proven tools, resources and examples of shared learning.



Step 1 – involves understanding the local diabetes population health needs by developing a local Health Needs Assessment and setting up a steering group with key stakeholder involvement including a lead clinician, lead commissioner, lead diabetes nurse and lead service user.

Step 2 – involves the development of a service specification to describe the model of care to be commissioned. This becomes the document on which tenders may be issued.

Step 3 – involves monitoring the delivery of the service specification by the provider and evaluating the performance of the service. Input from the steering group with service user representation will be an important mechanism for monitoring the service as well as patient surveys.

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 pregnancy and diabetes 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 good pregnancy and diabetes
- A high level intervention map. This intervention map describes the key high level actions or interventions (both clinical and administrative) pregnancy and diabetes *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[1] 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 pregnancy and diabetes services.

- A contracting framework for pregnancy and diabetes services that brings together all the key standards of quality and policy relating to diabetes and the care of pregnant women
- A template service specification for pregnancy and diabetes services that forms part of schedule 2, part 1 or section 1 (module B) 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/

[1] Commissioning Diabetes Without Walls, 2011, http://www.diabetes.nhs.uk/commissioning_resource/

Features of high quality Pregnancy and Diabetes Services

A high quality pregnancy and diabetes service should:

- provide preconception counselling care for all women with diabetes who are of reproductive age
- provide prepregnancy care for all women with diabetes who are of reproductive age to help them plan their pregnancy
- ensure that women with diabetes who are of reproductive age are able to have urgent access the diabetic antenatal clinic if an unplanned pregnancy occurs
- provide appropriate and responsive antenatal, intra partum and post natal care for women with diabetes and for women who have a history or develop gestational diabetes
- provide immediate assessment and care of babies born to women who have diabetes or gestational diabetes
- provide education to other health and social care professionals about pregnancy and diabetes

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 and placing users at the centre of decisions about their care and support - "no decision about me without me" (Equity and Excellence: Liberating the NHS[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 model for the management of long term conditions[ii]
- deliver the outcomes for diabetes as determined by the NHS Outcomes Framework[iii]
- provide effective and safe care to women with diabetes in a range of settings including the women's home, according to recognised standards including the quality standards for clinical practice for diabetes set by the National Institute for Health and Clinical Excellence[iv]
- take into account the emotional, psychological and mental wellbeing of the woman[v]
- take into account all diverse and personal needs with respect to access to care
- ensure that services are responsive and accessible to women with Learning Disabilities[vi]
- ensure that the family/carers of women with diabetes have access to psychological support
- 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 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 women 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

[i] Available on the DH website http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

[ii] Available on the DH website at http://www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_120915

[iii] Available on the DH website at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

[iv] http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp

[v] Emotional and Psychological Support and Care in Diabetes, Joint Diabetes UK and NHS Diabetes Emotional and Psychological Support Working Group, 2010 http://www.diabetes.nhs.uk/our_work_areas/emotional_and_psychological/

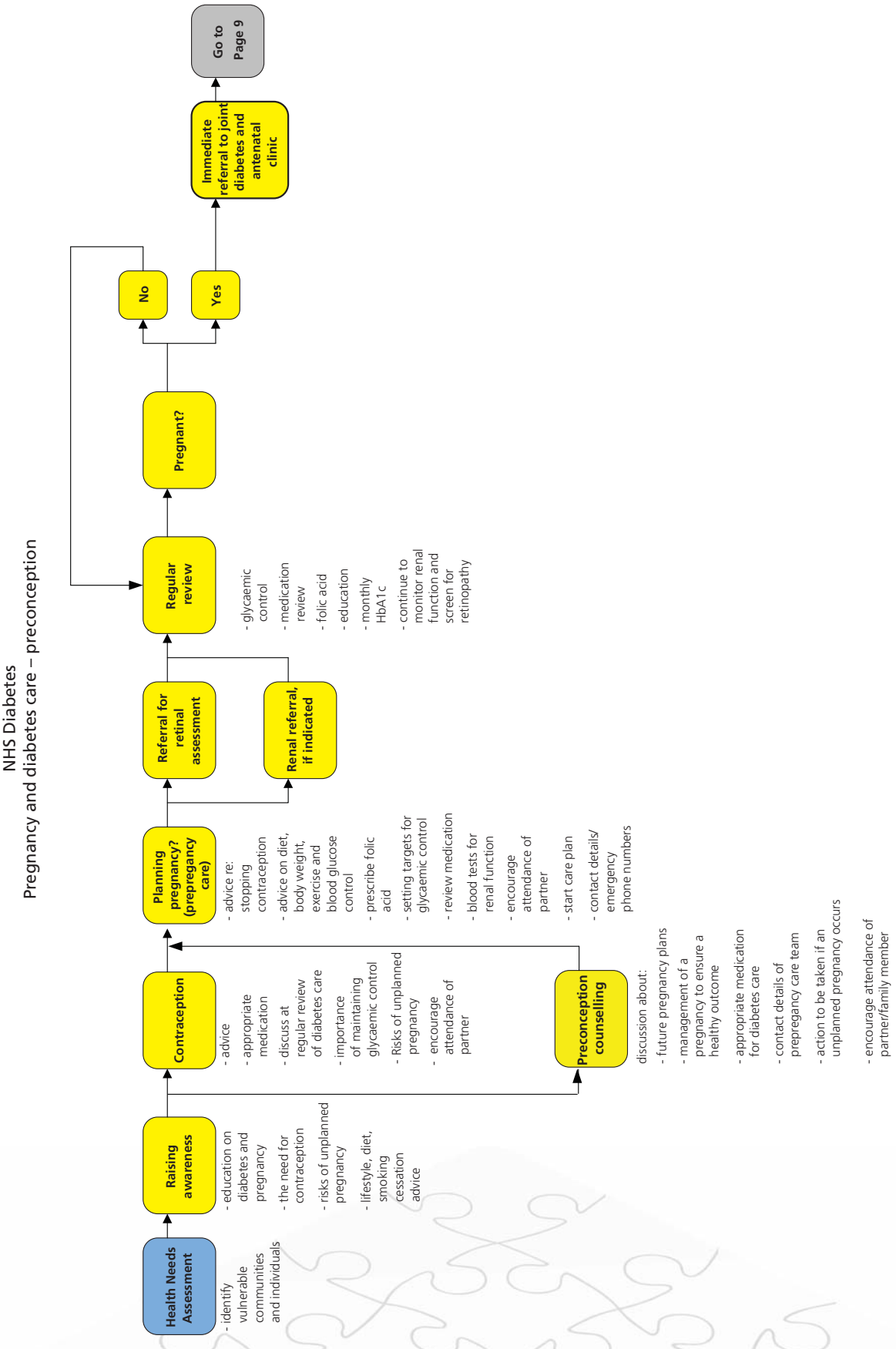
[vi] http://www.diabetes.nhs.uk/commissioning_resource/

- provide education on diabetes management to other staff and organisations that support women with diabetes
- have a capable and effective workforce that has the appropriate training and updating and where the staff have the skills and competencies in the management of women with diabetes
- provide multidisciplinary care that manages the transition between children and adult 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[vii]
- 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[viii]
- actively monitor the uptake of services, responding to non-attenders and monitoring complaints and untoward incidents

[vii] http://www.diabetes.nhs.uk/year_of_care/it/

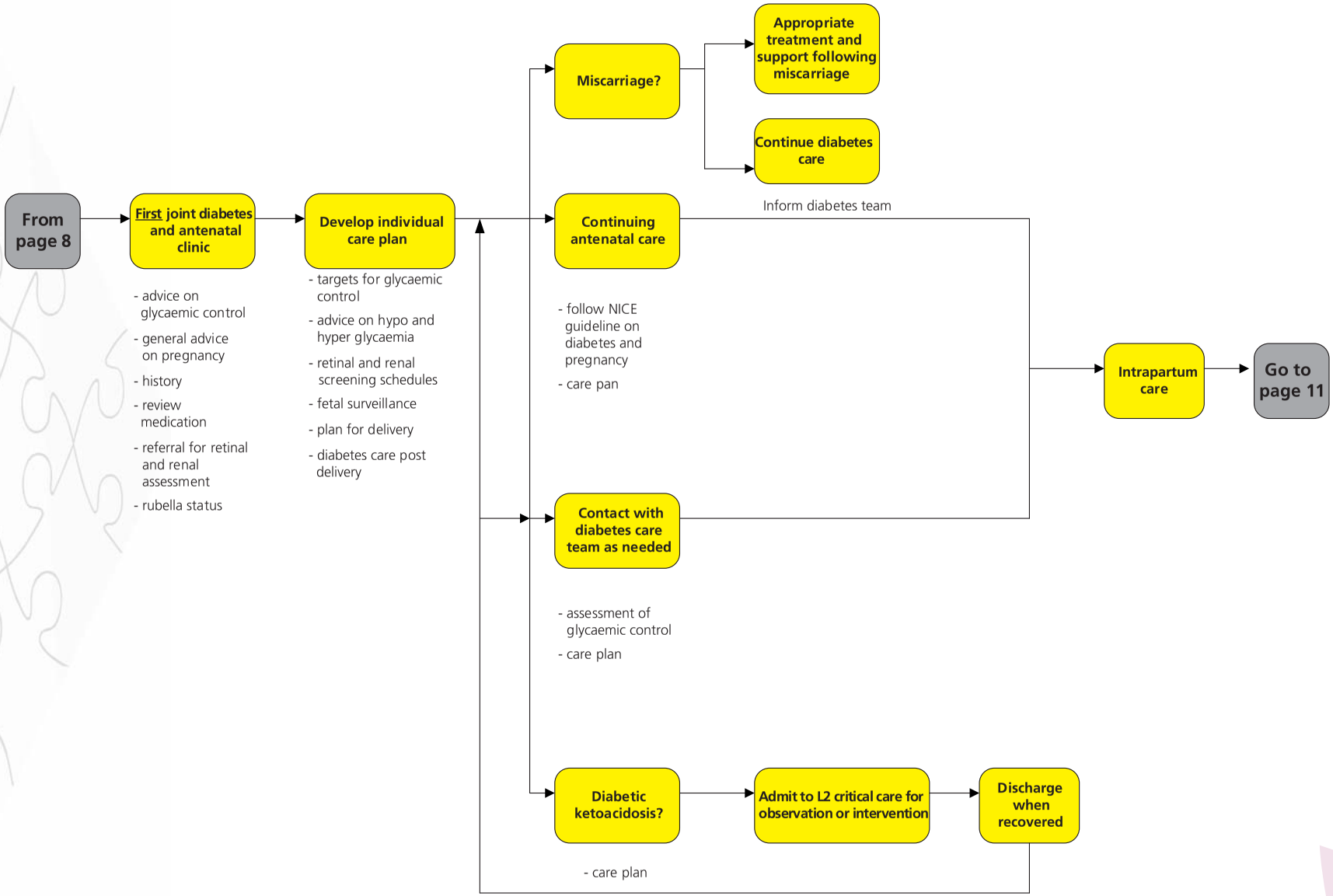
[viii] http://www.ic.nhs.uk/proms

Pregnancy and Diabetes Care Intervention Map

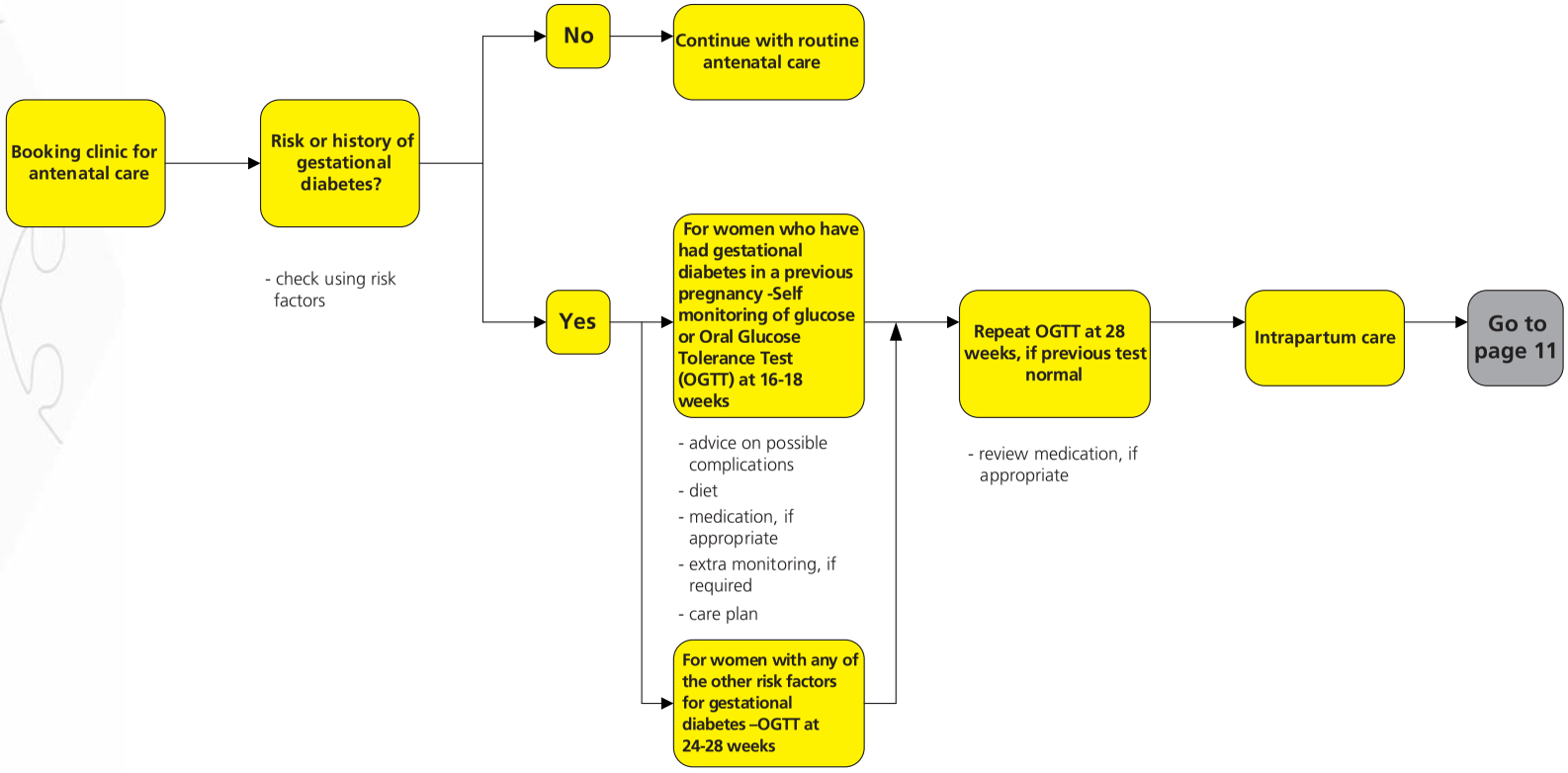


NHS Diabetes

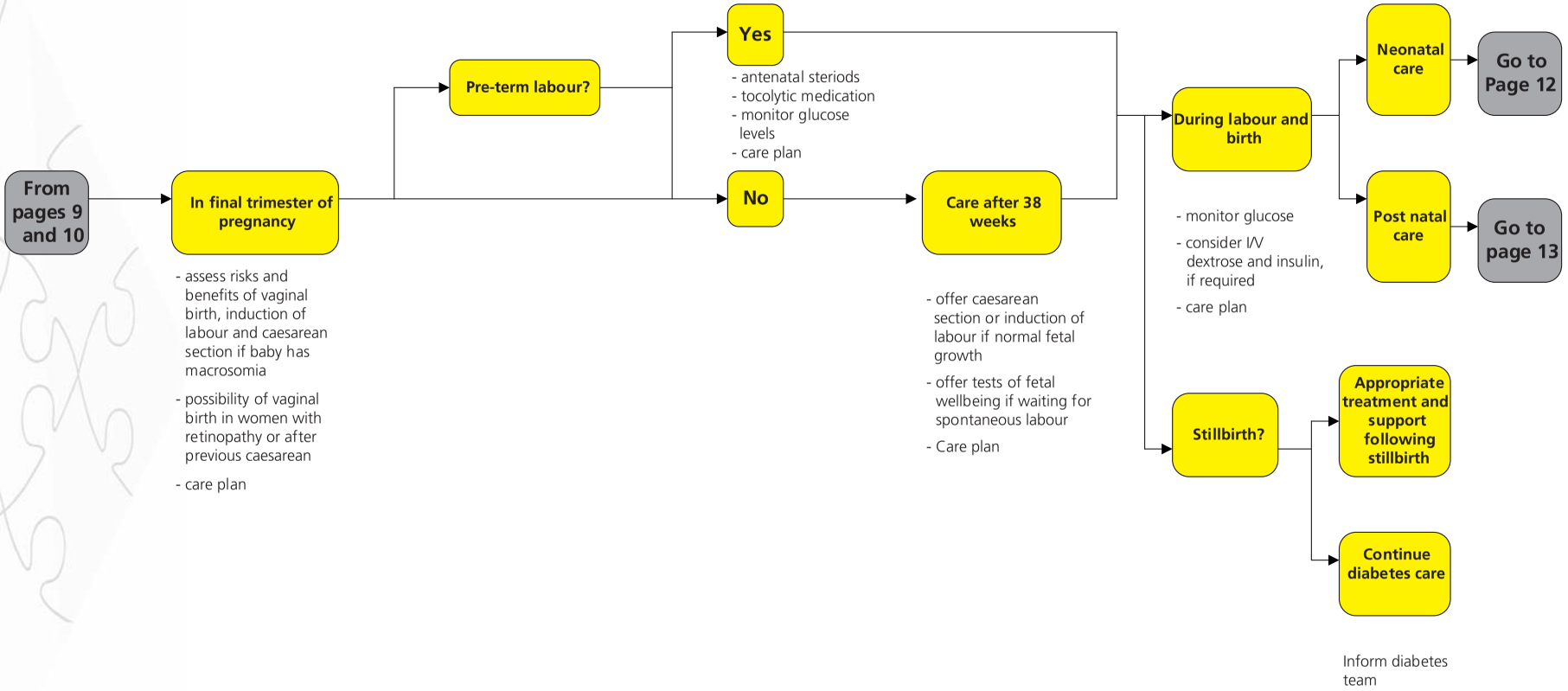
Pregnancy and diabetes care – antenatal care



NHS Diabetes
Pregnancy and diabetes care – antenatal care (Gestational Diabetes)



NHS Diabetes
Pregnancy and diabetes care – Intrapartum care



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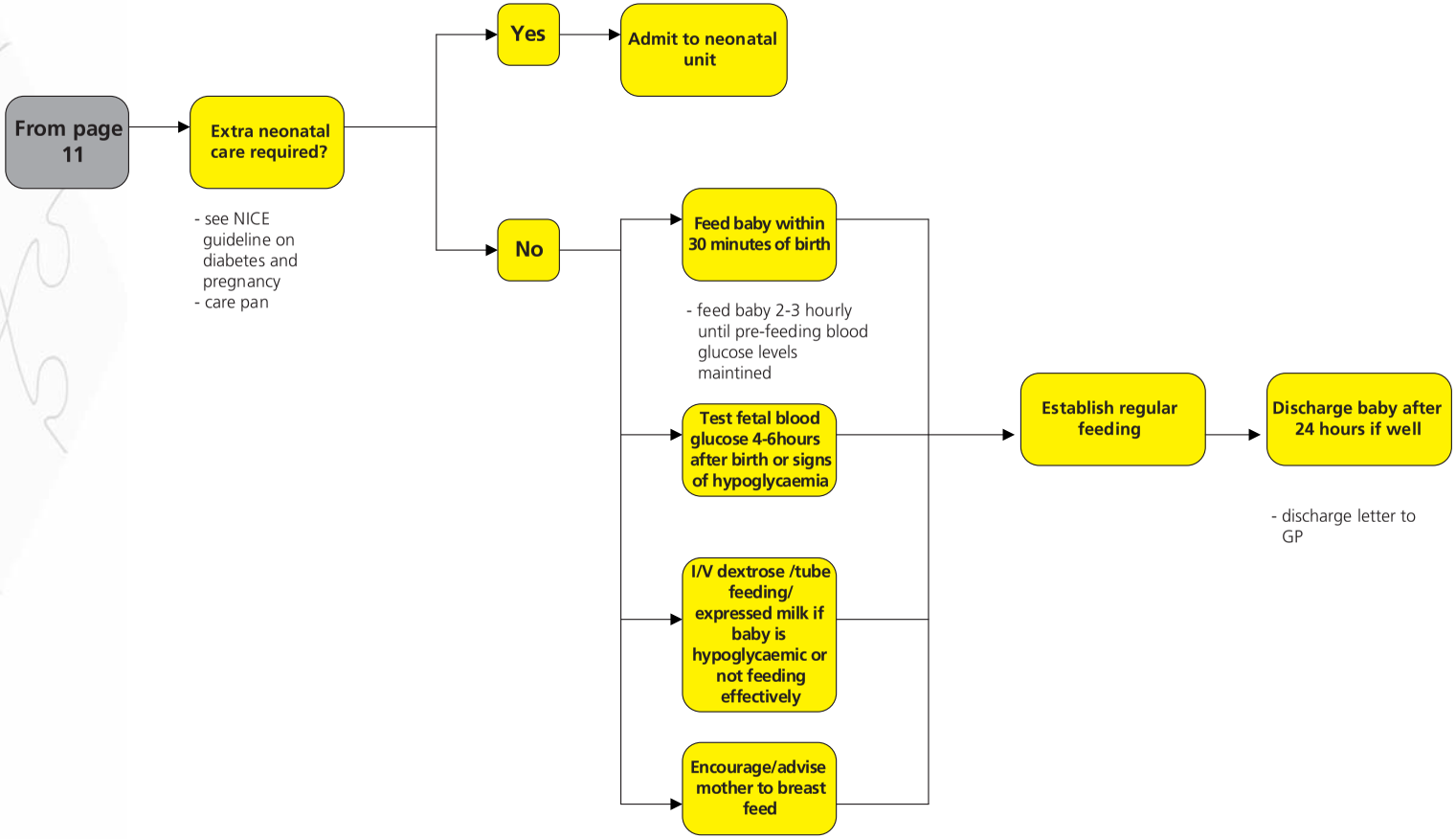
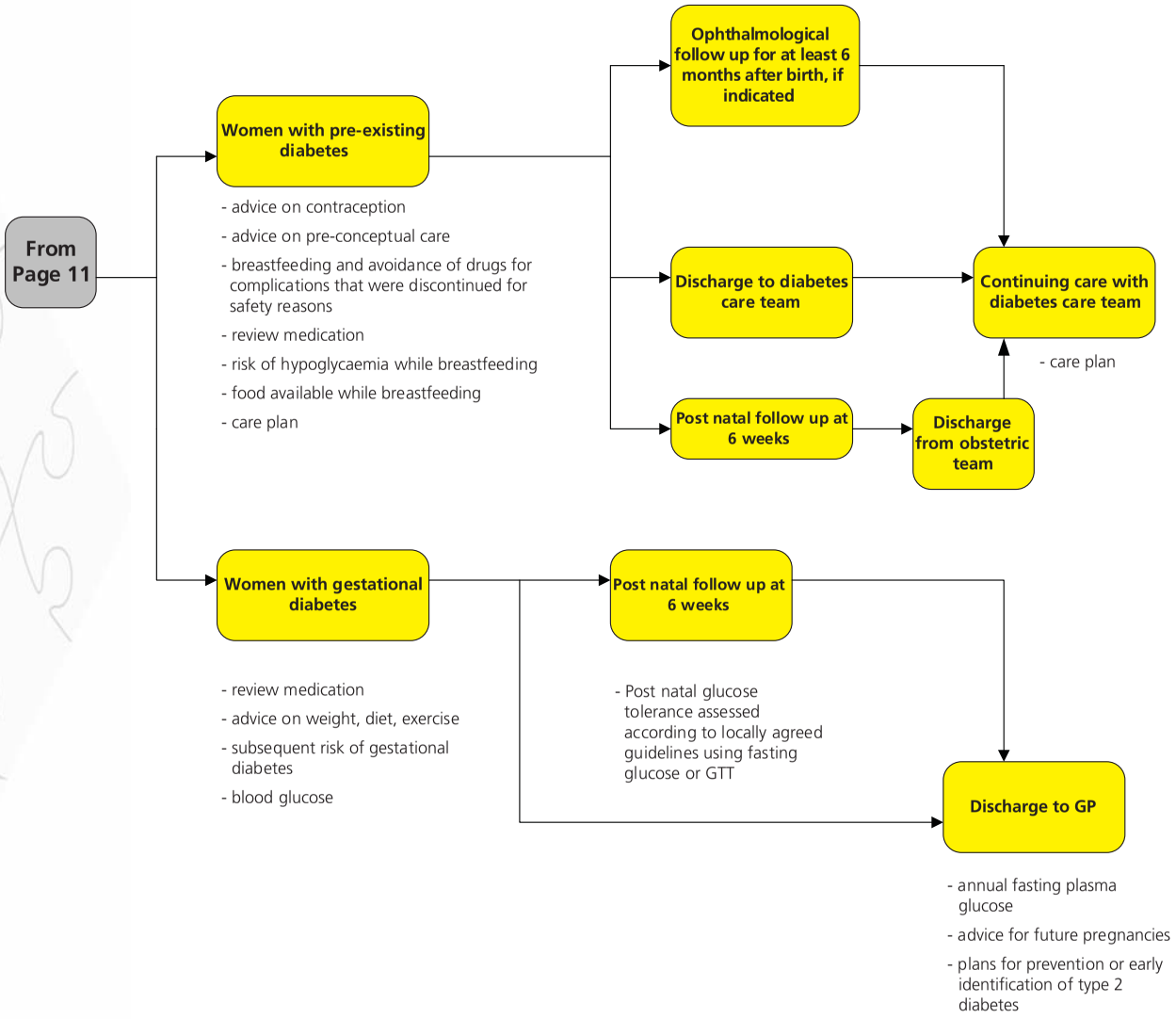
Pregnancy and diabetes care – Neonatal care



NHS Diabetes
Pregnancy and diabetes care – Postnatal care



Contracting Framework for Pregnancy and Diabetes Services

Introduction

This contracting framework sets out what is required of clinically safe and effective services that are providing care for women with diabetes who are pregnant as well as those who develop gestational diabetes. The framework is designed to be read in conjunction with the high level diabetes and pregnancy services 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 and pregnancy services.

The framework brings together the key quality areas and standards that have been identified by the Pregnancy and Diabetes Advisory Group.

The principles that establish a safe pathway for patient care

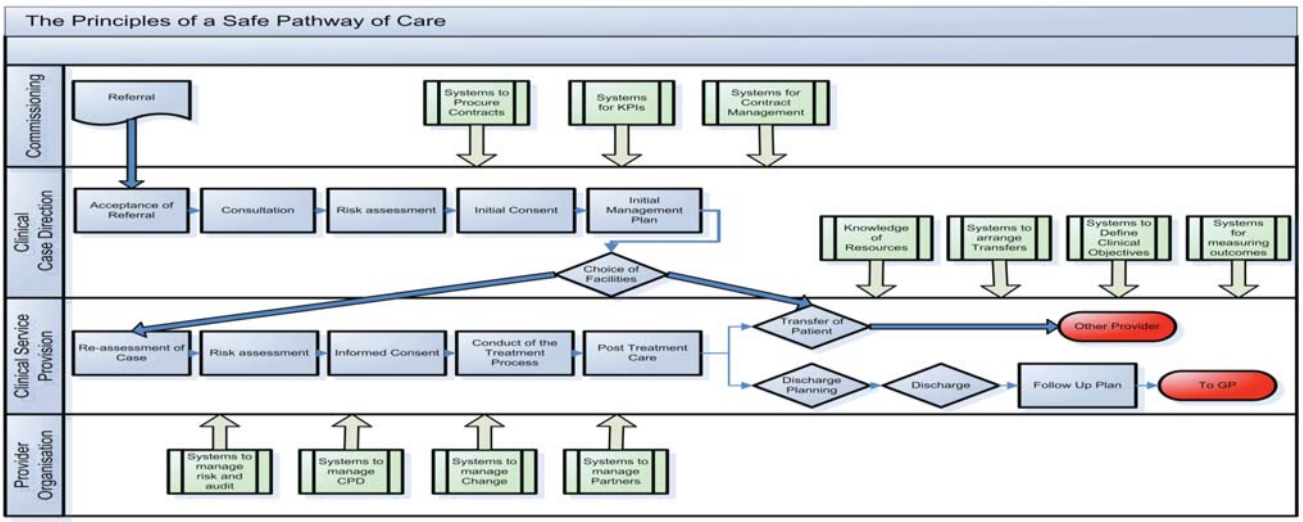
Establishing the principles that underpin the systems and processes of pathways for patient care leads to more efficient patient throughput and can reduce risk of fragmentation of care and serious untoward incidents. The principles operate at four layers within a patient pathway:

- 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:



The services themselves will also have clinical oversight for governance purposes

Pregnancy and diabetes services

The key principles of good care for women with diabetes, including gestational diabetes, is to provide a high quality service that is reliable in terms of delivery and timely access for women requiring that care.

The care of a pregnant woman with diabetes, including gestational diabetes, should be provided by a multidisciplinary team present at the same time in the same setting and as minimum, should comprise an obstetrician, diabetes physician, diabetes specialist nurse, diabetes midwife and dietitian[1]. It is essential that there is co-ordination of care of the women through the care planning process and that the obstetrician/diabetes physician retain joint responsibility for overall patient care across the whole pathway and retain overall responsibility for the management of side effects and complications.

The management of a pregnant woman with diabetes, including gestational 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 services themselves will also have clinical oversight for governance purposes.

This contracting framework should also be read in conjunction with the diabetes commissioning guide for children and young people and follow the principles for the effective commissioning of services for people with Learning Disabilities[3].

Ensuring quality

Commissioning Bodies should ensure that the pregnancy and 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 pregnancy and 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 services for pregnant women with diabetes (including gestational diabetes) 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)[4] This is to assist commissioners and providers in having an overview of how the elements link to the Standard NHS Contracts. 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 pregnancy and 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 between services	Quality Governance in the NHS. A guide for provider boards[5]
Governance	Clinical Governance *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 4,4A,6,9,10,12,14,15,16 ,17,19,21,27,29,31,32,3 3, 48, 49, 51,53, 54* *Schedules: 3(parts1,2,4,4A,4B,4C,5, 6), 7,10,12,18,20*	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, public health guidance and appraisals published by the National Institute for Health and Clinical Excellence that are relevant to the care provided by the service [6,7]

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 (CQUIN) schemes for women with diabetes and gestational diabetes e.g. model CQUIN scheme proposed by the NHS Institute for Innovation and Improvement [9]	In addition, the service is required to comply with the following: i. Guidance published by NICE • Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence [8]
Clinical quality	Quality assurance *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 4,4A,12,16,17,18,19,20, 21, 31,32,33, 54* *Schedules: 2,3 (parts 4, 4A,4B,4C,5, 6)7,10,12, 18, 20*	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: On confirmation of pregnancy in a woman with diabetes [10]: • Immediate referral (ideally at six weeks of gestation) to joint diabetes and antenatal services is essential • Regular review with diabetes care team to assess glycaemic control • The first scan should be performed at eight weeks gestation The service is required to participate in the following national audit activities/programmes: • Centre for Maternal and Child Enquiries [11] • National Diabetes Audit [12] • Diabetes E [13] Local audits could include: • audit of protocols and improvement plans for the delivery of pre-pregnancy, pregnancy and postpartum care • audit of pre-conception HbA1c

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 *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 11,16,26,33, 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 diabetes physicians: registration with the GMC and evidence of further qualification in diabetes care or experience within diabetes clinic • For obstetricians: registration with the GMC and evidence of further qualification in obstetrics • Nurses: registration with the NMC and further evidence of qualification in diabetes care or experience within diabetes clinic • Midwives: registration with the NMC and further evidence of qualification in midwifery care and diabetes (see also 'Lead Midwife in Diabetes: Standards, Role and Competencies')[14] • Dietitians: registration with the HPC and able to demonstrate competence in delivering educational support All healthcare professionals involved in delivering care to pregnant diabetic women (including gestational diabetes) are required to have the relevant competencies (see Skills for Health-Diabetes Competencies for diabetes and diabetic retinopathy): [15]
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, 21, 26, 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

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Workforce / staff Development *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 11,16,19,30 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 and licensing *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 4,4A,5,9,10, 11,12,14,15,16 17,18,19,21,26, 27,29,33,34,35, 3643,48,49,52 53,54,56,60* *Schedule: 2,3,4,5,6,8,10, 12,13,15,17, 19, 20*	The Provider is required to be registered with the Care Quality Commission to demonstrate that is meets the essential standards of quality and safety for the regulated activities delivered. The Provider is required to be licensed with the NHS Economic Regulator (Monitor) in order to provide NHS care.	Compliance with the Care Quality Commission and Monitor requirements	Compliance with the following National Service Frameworks, where applicable: • NSF for Children, Young People and Maternity Services[16] Compliance with Care Quality Commission Reviews
Clinical quality	Outcomes *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 4,4A,10,14,15,16,21* *Schedule: 3 (part 5), 5 (parts 1,2,3), 12*	Comprehensive understanding and commitment to delivering and improving outcomes of care	Compliance with the NHS Outcomes Framework[17]	Compliance with the Quality Standards for Diabetes, specifically: [18] 'Quality Statement 7 Women of childbearing age are regularly informed of preconception glycaemic control and of any risks, including medication, that may harm the unborn child. Women with diabetes planning a pregnancy are offered preconception care and those not planning a pregnancy are offered advice on contraception.'

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Patient pathway *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 4,4A,9,10,12,* *14,15,16,17, 18,19,20,21, 27,29,32,33, 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 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	Key priorities for good quality care for pregnancy and diabetes services are. Contraception advice • Regular discussions at diabetes review • Importance of maintaining glycaemic control • Risks of unplanned pregnancy Preconception counselling: Discussion about: • future pregnancy plans • management of a pregnancy to ensure a healthy outcome • appropriate medication for diabetes care • contact details of prepregnancy care team • what action should be taken if an unplanned pregnancy occurs There should also be education of other health and social care professionals about diabetes and pregnancy Pre-pregnancy care[10]: • women with diabetes who are planning to become pregnant should be informed that establishing good glycaemic control before conception and continuing throughout pregnancy will reduce the risk of miscarriage, congenital malformation, stillbirth and neonatal death. • In diabetes education - the importance of avoiding unplanned pregnancy should be stressed from adolescence for women with diabetes • Pre-conception care and advice before discontinuing contraception should be offered to women with diabetes who are planning to become pregnant Antenatal care[8]: • If it is safely achievable, women with diabetes should aim to keep a fasting glucose between 3.5-5.9 mmol/litre and 1 hour postprandial blood glucose below 7.8 mmol/litre during pregnancy • Women with insulin-treated diabetes should be advised of the risks of hypoglycaemia and hypoglycaemia unawareness in pregnancy, particularly during the first trimester • During pregnancy, women who are suspected of having diabetic ketoacidosis should be admitted immediately for level 2 critical care, where they can receive both medical and obstetric care

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 for contacting the provider and follow up if required	• Women with diabetes should be offered antenatal examination of the four-chamber view of the fetal heart and outflow tracts at 18-20 weeks • For women with gestational diabetes there should be routine screening of glycaemic control during pregnancy at 16-18 weeks (previous history of gestational diabetes) or 24-28 weeks of pregnancy (for the other risk factors of gestational diabetes) • For women who experience miscarriages or have post partum deaths, there should be close monitoring and management of blood glucose according to agreed protocols as well as appropriate support following the event Intrapartum care: • Ensure that women with diabetes, including gestational diabetes give birth in a setting where expert assessment and stabilisation of the baby is available, in the event it is required Neonatal care[10]: • Babies of women with diabetes should be kept with their mothers unless there is a clinical complication or there are abnormal clinical signs that warrant admission for intensive or special care Postnatal care[10]: • Women who were diagnosed with gestational diabetes should be offered lifestyle advice (including weight control, diet and exercise) and offered a fasting plasma glucose measurement(but not oral glucose tolerance test) at the 6 – week postnatal check and annually thereafter • There should be plans for the prevention (or early identification) of type 2 diabetes and subsequent gestational diabetes There should be an individualised care plan, ideally using a standard template, for all pregnant women with diabetes covering the pregnancy and postnatal period up to 6 weeks. The care plan should be implemented from the outset of pregnancy by the multidisciplinary team. As a minimum the care plan should include[1]: • Targets for glycaemic control • Retinal screening schedule • Renal screening schedule • Fetal surveillance

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Clinical quality	Patient pathway		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	• Plan for delivery • Diabetes care after delivery Pregnancies with ultrasound evidence of macrosomia should have a clear management plan put in place by a consultant obstetrician. This should include timing of follow-up scans, fetal surveillance, mode and timing of delivery[1]. There should be locally agreed guidelines for labour wards and different modes of delivery for diabetes[6]. There should be a care plan for the postnatal management for all women with diabetes. As a minimum the care plan should include[1]: • Plan for the management of glycaemic control • Neonatal care • Supporting breast feeding, giving supplemental feeds only when clinically indicated • Contraception • Follow-up care after discharge from hospital 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[3]): • diabetes emergency and inpatient care • services for complications of diabetes – foot care, eyes, renal, cardiovascular and neuropathy • children and young people The pregnancy and diabetes service should provide regular educational days for all primary and secondary care professionals likely to be involved in the care of women with diabetes in the local population, to cover all aspects of pre-conception, prepregnancy, pregnancy and postnatal care[1]. Neonatal care of term babies of women with diabetes[1]: • there should be a written policy for the management of the baby. The policy should assume that babies will remain with their mothers in the absence of complications • mothers should be informed antenatally of the beneficial effects of breastfeeding on metabolic control for both themselves and their babies • mothers with diabetes should be offered an opportunity for

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Patient pathway			skin-to-skin contact with their babies immediately after delivery. Breastfeeding within 30 minutes of birth should be encouraged • women unable to breastfeed should receive education in various formula preparation and sterilising equipment • blood glucose testing performed too early should be avoided in well babies, without signs of hypoglycaemia. Testing should be done before a feed, using a reliable method; a note should be made of time the test is performed, result and action taken • junior paediatric staff and midwives should have an understanding and training in the timing of blood glucose testing, the importance of early breastfeeding and a written care plan agreed with the mother Providers are required to take note of the results of the National Survey of People with Diabetes [19]
Clinical quality	Clinical emergency situations *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 6,11,12,14,15, 16,18,32,33, 42, 54* *Schedules: 2,12,20*	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	During pregnancy, women who are suspected of having diabetic ketoacidosis should be admitted immediately for level 2 critical care, where they can receive both medical and obstetric care [8]
Clinical quality	Estates and equipment *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 5,29, 33, 56* *Schedules: 3,10,19*	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	Pregnant women should have enough testing strips to cover the use increased use in pregnancy

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
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
Data and information management	Strategy and policies *Cross references to the Standard NHS Contract for Acute Services* *Main clauses: 8,9,17,19,21,23,24,27,29,32, 33,54* *Schedules: 5,7,15,16,18*	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 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 [20] The Provider is required to use the following for the collection and production of data, where appropriate: • NHS Outcomes Framework [17] • Quality and Outcomes Framework[21] • Hospital Episodes Statistics data [22] • Patient Experience [19,23] • Patient satisfaction [19] • National Diabetes Audit [12] • DiabetesE [13] • National Diabetes Information Service [24] • National Diabetes Continuing Care Dataset [25]

Source documents

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

1. Diabetes in pregnancy: are we providing the best care? Findings of national enquiry, Confidential Enquiry into Maternal and Child Health, February 2007, http://www.cemach.org.uk/Programmes/Maternal-and-Perinatal/Diabetes-in-Pregnancy.aspx

2. NHS Diabetes and Diabetes UK, Emotional and Psychological Support and Care in Diabetes, Joint Diabetes UK and NHS Diabetes Emotional and Psychological Support, 2010 http://www.diabetes.nhs.uk

3. The NHS Diabetes Commissioning Guides are available on the NHS Diabetes website at http://www.diabetes.nhs.uk/commissioning_resource/

4. Department of Health, Standard NHS Contracts http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124324

5. National Quality Board, Quality Governance in the NHS, 2011 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125239.pdf

6. NICE Diabetes guidance, http://guidance.nice.org.uk/Topic/EndocrineNutritionalMetabolic/Diabetes

7. NICE Pregnancy guidance, http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7261&ht=7252

8. NICE, Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence, Jan 2009, http://guidance.nice.org.uk/CG76

9. NHS Institute for Innovation and Improvement, model CQUIN scheme: inpatient care for people with diabetes, 2009

10. NICE, Diabetes in pregnancy : management of diabetes and its complications from pre-conception to the post natal period, www.nice.org.uk/Guidance/CG63, reissued July 2008

11. Centre for Maternal and Child Enquiries , http://www.cmace.org.uk/

12. National Diabetes Audit. www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/diabetes

13. DiabetesE - https://www.diabetese.net/

14. Lead Midwife in Diabetes: Standards, Role and Competencies, 2010, http://www.diabetes.nhs.uk/

15. Skills for Health, Diabetes Competency Framework, https://tools.skillsforhealth.org.uk/

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

17. Department of Health, The NHS Outcomes Framework 2011/12, December 2010 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

18. NICE, Quality Standards: Diabetes in adults, March 2011, http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp

19. Healthcare Commission, National Survey of People with Diabetes, 2006, www.cqc.org.uk/usingcareservices/healthcare/patientsurveys/servicesforpeoplewithdiabetes.cfm

20. York and Humber integrated IT system http://www.diabetes.nhs.uk/

21. Quality and Outcomes Framework, http://www.nice.org.uk/aboutnice/qof/qof.jsp

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

23. The King's Fund, The point of care. Measures of patients' experience in hospital: purpose, methods and uses. July 2009

24. National Diabetes Information Service, www.diabetes-ndis.org

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

Standard Service Specification Template for Pregnancy and Diabetes Services

This specification forms Schedule 2, Part 1, or section 1 (module B), '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 Pregnancy and Diabetes Advisory Group, provides further detail/guidance to support the development of this specification:

- The pregnancy and diabetes care intervention map
- The contracting framework for pregnancy and diabetes services

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

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

Description of pregnancy and diabetes services:

Pregnancy and diabetes services provide the full range of preconception, prepregnancy, antenatal, intrapartum and postpartum care for all women with diabetes, including gestational diabetes, who are of reproductive age.

The final specification should take into account:

- **national, network and local guidance and standards for pregnancy and 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 service relates to others and within the whole system, should be included describing the key stakeholders/relationships which influence the services, e.g. diabetes care team and maternity 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_124324

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. women with diabetes, including women with gestational diabetes, requiring maternity care)
   - 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 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
   - 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 women with diabetes who require preconception counselling, prepregnancy advice and planning or are pregnant (including gestational diabetes) enter the pathway/journey; what are the stages undertaken and continuing management up to six weeks post natal care and handover to the diabetes team. 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 is undertaken by the diabetes/obstetric multi-disciplinary team (as defined locally) with a clear care co-ordination function
   - Holistic review of patients in the management of their diabetes and pregnancy 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 pregnancy and diabetes services, guidance produced by the Royal College of Physicians, Royal College of Obstetricians, Diabetes UK, etc

Service Delivery

3. Patient Journey/ intervention map
   Flow diagram of the patient pathway showing access and exit/transfer points – see pregnancy and diabetes care intervention map from preconception to post natal care 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 women with diabetes who require preconception advice, prepregnancy planning or are pregnant (including gestational diabetes) who live in the clinical commissioning group 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, obstetricians, Nursing staff – diabetes nurse specialists, midwives with skills in managing pregnant women with diabetes, 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 pregnant woman 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 women with diabetes who require preconception or prepregnancy advice or are pregnant (including gestational diabetes) 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 patients are prioritised

Discharge/Service Complete/Patient Transfer criteria

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

Quality Standards

10. The service is required to deliver care according to the standards for clinical practice set by the National Institute for Health and Clinical Excellence[b]

11. 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)*

12. The service is required to deliver the outcomes for diabetes as determined by the NHS Outcomes Framework[c]

Activity and Performance Management

13. 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.

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.

[b] http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp

[c] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

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 and pregnancy providers and commissioner.

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