NHS

Diabetes

# Commissioning

## Diabetes Prevention and Risk Assessment Services

Supporting, Improving, Caring

July 2011

| NHS Diabetes information Reader Box | |
|---|---|
| Review Date | 2013 |

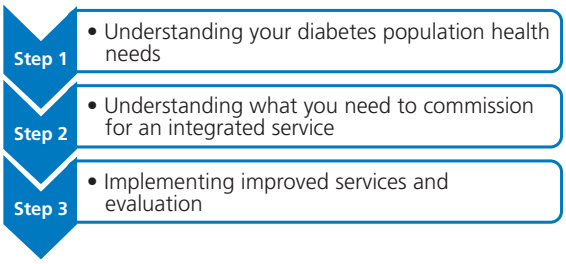
**Commissioning Diabetes Prevention and Risk Assessment Services**

NHS Diabetes would like to thank Thoreya Swage who wrote this publication.

# Contents

# Commissioning for Diabetes Prevention and Risk Assessment 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 diabetes prevention and risk assessment 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 prevention and risk assessment services
- A high level intervention map. This intervention map describes the key high level actions or interventions (both clinical and administrative) diabetes prevention and risk assessment *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'[1] 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 prevention and risk assessment services.

- A diabetes prevention and risk assessment contracting framework that brings together all the key standards of quality and policy relating to this aspect of care
- A template service specification for diabetes prevention and risk assessment services that forms part of schedule 2 part 1 / Module B, Section 1 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 Diabetes Prevention and Risk Assessment Services

High quality diabetes prevention and risk assessment services should:

- actively seek out those at risk of diabetes, e.g. through NHS Health Checks, assessing recorded versus predicted prevalence of diabetes from primary care diabetes registers
- offer active intervention to people of all ages at risk of developing diabetes
- place emphasis on the prevention of type 2 diabetes for all age groups through the prevention and reduction of the prevalence of obesity in groups at increased risk of developing diabetes, e.g. minority ethnic communities
- be developed in a co-ordinated way, taking full account of the responsibilities of other agencies in providing comprehensive care ensuring people are at the centre of decisions about their care and support - 'no decision about me without me'[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]
- be delivered in accordance with the standards for clinical practice for diabetes set by the National Institute for Health and Clinical Excellence[iii]
- deliver the outcomes for diabetes as determined by the NHS Outcomes Framework[iv]
- take into account the emotional, psychological and mental wellbeing of the patient[v]
- take into account all diverse and personal needs with respect to access to care
- ensure that services are responsive and accessible to people with Learning Disabilities[vi]
- 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 at risk of developing 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 and other lifestyle interventions
- provide education on diabetes prevention and risk to other staff and organisations that may come into contact with people at risk of developing 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 people at risk of developing diabetes
- provide multidisciplinary care that manages the transition between adult and older peoples' services

[i] Available on the DH website at 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] http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp

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

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

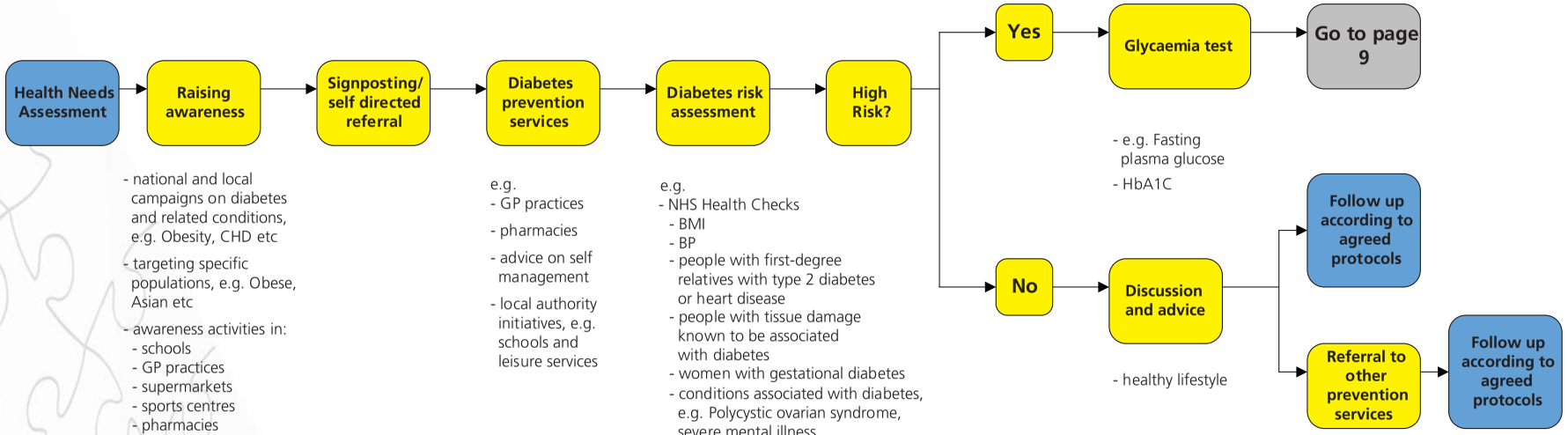
[vi] http://www.diabetes.nhs.uk/ commissioning_resource/

- 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 prevention and risk assessment 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 Outcomes Measures, and the NHS Outcomes Framework, 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

NHS Diabetes
Diabetes care – Prevention and risk assessment




- national and local campaigns on diabetes and related conditions, e.g. Obesity, CHD etc
- targeting specific populations, e.g. Obese, Asian etc
- awareness activities in:
  - schools
  - GP practices
  - supermarkets
  - sports centres
  - pharmacies
  - LTC centres
  - pubs/clubs
  - maternity units
  - local employers
  - Care homes
  - centres of worship
  - prisons
- charities/third sector providers
- learning disability services
- local community events, e.g. Festivals, fetes etc
- Diabetes UK roadshow
- local media
- libraries
- talks to local community groups
- promote healthy eating – in playgroups, nurseries and schools

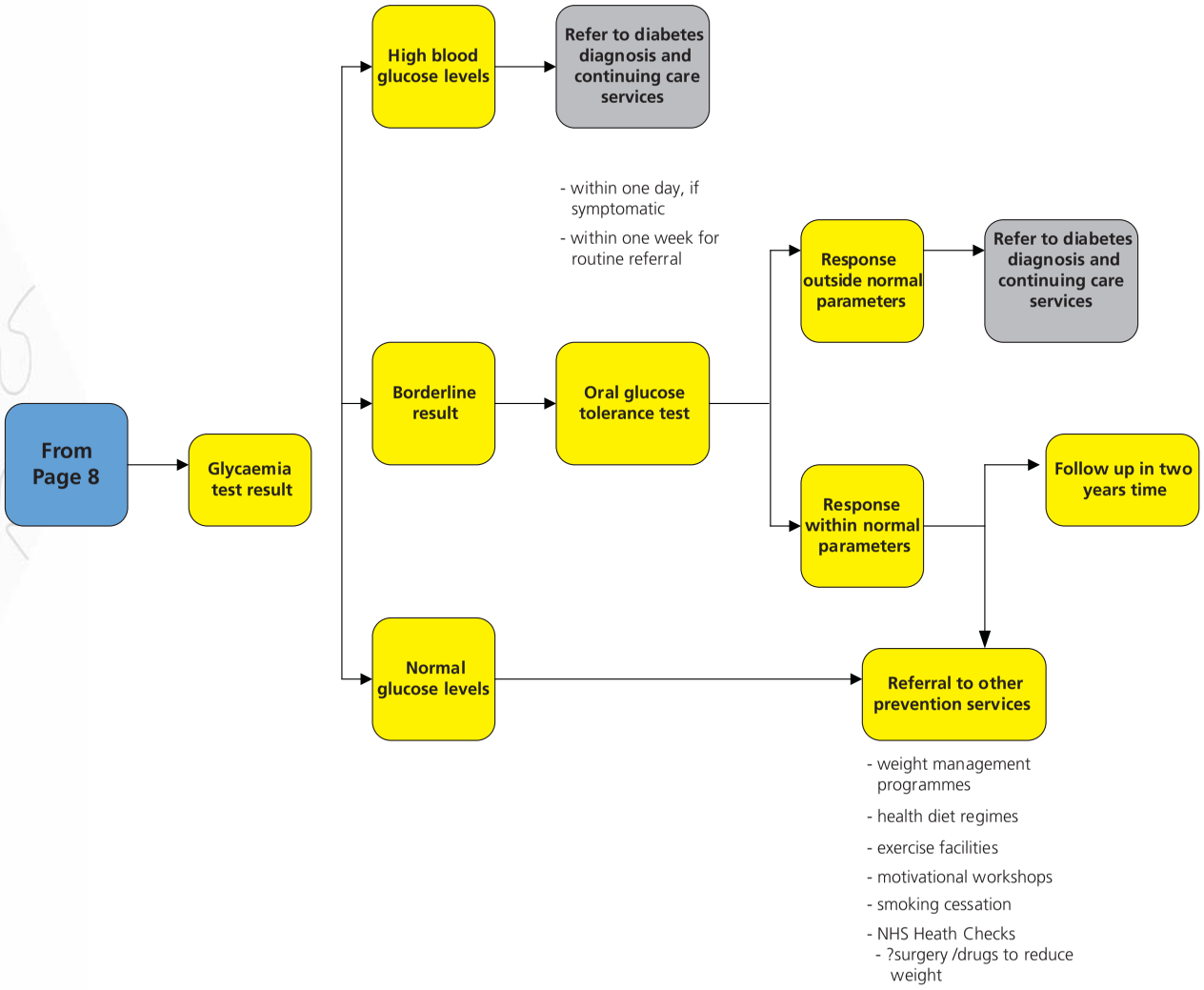
e.g.
- GP practices
- pharmacies
- advice on self management
- local authority initiatives, e.g. schools and leisure services

e.g.
- NHS Health Checks
  - BMI
  - BP
  - people with first-degree relatives with type 2 diabetes or heart disease
  - people with tissue damage known to be associated with diabetes
  - women with gestational diabetes
  - conditions associated with diabetes, e.g. Polycystic ovarian syndrome, severe mental illness
  - medication associated with diabetes
- specific screening for older people, e.g. Cognitive assessment test (MINI COG)
- children at risk of MODY (type 2 diabetes)

- e.g. Fasting plasma glucose
- HbA1C

- healthy lifestyle

- weight management programmes
- health diet regimes
- exercise facilities
- motivational workshops
- smoking cessation
- NHS Heath Checks
- surgery /drugs to reduce weight


From Page 8
Glycaemia test result
High blood glucose levels
Refer to diabetes diagnosis and continuing care services
- within one day, if symptomatic
- within one week for routine referral
Borderline result
Oral glucose tolerance test
Response outside normal parameters
Refer to diabetes diagnosis and continuing care services
Response within normal parameters
Follow up in two years time
Normal glucose levels
Referral to other prevention services
- weight management programmes
- health diet regimes
- exercise facilities
- motivational workshops
- smoking cessation
- NHS Heath Checks
- ?surgery /drugs to reduce weight

# Contracting Framework for Diabetes Prevention and Risk Assessment Services

## Introduction

This contracting framework sets out what is required of clinically safe and effective services that are providing diabetes prevention and risk assessment 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 prevention and risk assessment 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

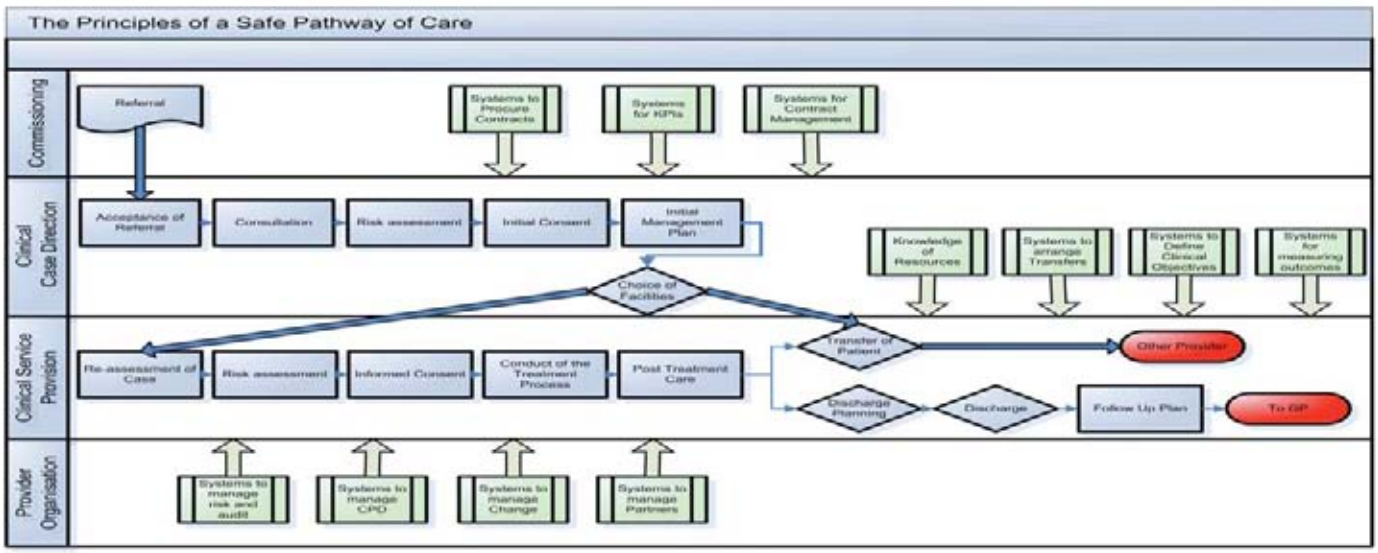
Establishing the principles that underpin the systems and processes of pathways for patient care leads to more efficient patient throughput and can reduce risk of fragmentation of care and serious untoward incidents. The principles operate at four layers within a patient pathway:

- 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.

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 prevention and risk assessment service

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

Diabetes prevention and risk assessment 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 and that the General Practitioner retains responsibility for overall patient care across the whole pathway and retains overall responsibility for the management of any side effects and complications.

The initial advice and care of individuals at risk of developing 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 subsequent diabetes care and therefore mental health stability is vital for good self care and prevention[1].

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

This contracting framework should also be read in conjunction with the diabetes commissioning guides for children and young people and older people and follow the principles for the effective commissioning of services for people with Learning Disabilities[2].

## Ensuring quality

Commissioning Bodies should ensure that the diabetes prevention and risk assessment 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. Commissioning Bodies should ensure:

i) for provider organisations already involved in the delivery of diabetes prevention and risk assessment 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 prevention and risk assessment 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)[3]. (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<br>*Cross references to the Standard NHS Contract for Community Services*<br>*Module C: 11,16,19,33, 48,49,51,53, 60*<br>*Module D: Schedules: 6 ,15* | Clarity of the organisation's purpose with explicit commitment to providing high quality services<br>A culture that demonstrates an open learning ethos<br>An organisation that is legal and ethical in all its activities | Provider must have organisational structure that provides leadership for all professions and disciplines<br>In particular, there must be a corporate clinical director with the responsibility and accountability for the clinical service<br>There must be a learning framework in the organisation | There should be a designated clinical director with responsibility and accountability for the diabetes prevention and risk assessment services |
| Governance | Integrated Governance<br>*Cross references to the Standard NHS Contract for Community Services*<br>*Module C: 11,19,27,48,49, 51,53,54,56,60*<br>*Module D: Schedules: 6,12,15* | An organisation that is guided by the principles of good governance:<br>- clarity of purpose<br>- participation and engagement<br>- rule of law<br>- transparency<br>- responsiveness<br>- equity and inclusiveness<br>- effectiveness and efficiency<br>- accountability<br>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.<br>This includes interfaces and transitions between services | Quality Governance in the NHS. A guide for provider boards[4] |
| Governance | Clinical Governance<br>*Cross references to the Standard NHS Contract for Community Services*<br>*Module B: Sections: 1 (part 2), 3, 4*<br>*Module C: 4,4A,6,9,10,12,14, 15,16,17,19,21,26 27,29,31,32,33, 48,49,51,53, 54* | Explicit commitment to quality and patient safety<br>Patient focused with respect for the personal wishes of patients in all aspects of their care<br>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<br>e.g.<br>• Clinical Audit<br>• Clinical Risk Management<br>• Untoward Incident Reporting<br>• Raising Concerns<br>• Staff Development<br>• Complaints Management<br>• Patient and Public Involvement<br>• Patient dignity and respect | All sub-contractors must meet governance and leadership arrangements of the main provider organisation<br>Commissioner, provider and NHS Litigation Authority must review the Clinical Negligence Scheme for Trusts arrangements /or other organisational / professional indemnity arrangements<br>The service should have in place written protocols and procedures defining clear lines of accountability and responsibility.<br>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 [5] |

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| Governance | *Module D: Schedules: 3,6,10,11,15,17* | | • Equality and diversity<br>• Introducing new technologies and treatments<br>• an externally accredited Quality Assurance system and internal error reporting involving all staff groups.<br><br>CG systems should have clear and demonstrable links to other NHS systems with collaborative CG activities and sharing of experience and learning<br><br>Provider should produce annual Clinical Governance reports as part of NHS CG reporting system<br><br>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 [9] | In addition, the service is required to comply with the following:<br><br>i. Guidance published by NICE<br><br>• Preventing type 2 diabetes: population and community-level interventions in high-risk groups and the general population [6]<br>• Type 2 diabetes: preventing the progression from pre-diabetes to type 2 diabetes among high risk groups (public health guidance) expected publication May 2012 [7]<br>• Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence [8] |
| Clinical quality | Quality assurance<br><br>*Cross references to the Standard NHS Contract for Community Services*<br><br>*Module C: 4,12,16,17,18, 19, 20,21,31, 32,33, 54*<br><br>*Module D: Schedules: 2,3 ,6,10,11*<br><br>*Module E: 3,4* | Understanding the concept of clinical quality<br><br>Has concern for quality while working efficiently<br><br>An understanding of the use of audit, patient and staff feedback to improve quality<br><br>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<br><br>Providers are required to publish quality accounts for the public reporting of quality including safety, experience and outcomes<br><br>Providers should participate in national audit programmes | Diabetes prevention and risk assessment services must comply with the following access targets [10]:<br><br>• Individuals undergoing blood glucose tests, e.g. as part of the NHS Health Checks, who are found to have results outside normal parameters should be referred to and seen by diabetes diagnosis and continuing care services within a week<br>• Symptomatic individuals undergoing blood glucose tests e.g. as part of the NHS Health Checks, who are found to have results outside normal parameters should be referred and seen within the same day<br>• Individuals who are vomiting should be referred to A&E immediately<br><br>The service is required to participate in the following activities/programmes:<br><br>• Patient Experience Surveys [11]<br>• Diabetes E [12] |

| TOPIC | ELEMENTS | CHARACTERISTICS, SKILLS AND BEHAVIOURS | OUTPUTS | DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS |
|---|---|---|---|---|
| Clinical quality | Workforce/ staff<br><br>Clinical staff attributes critical to safety and quality of interventions<br><br>*Cross references to the Standard NHS Contract for Community Services*<br><br>*Module C: 11,16,19,26,33,48,56*<br><br>*Module D: Schedules: 10* | 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<br><br>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<br><br>Specific qualifications required of health professionals providing the service are:<br>• For medical practitioners: registration with the GMC and evidence of further qualification in diabetes care or experience within diabetes clinic [13]<br>• Nurses: registration with the NMC and further evidence of qualification in diabetes care or experience within diabetes clinic [14]<br>• Dietitians: registration with the HPC and able to demonstrate competence in delivering educational support<br><br>All healthcare professionals involved in delivering diabetes prevention and risk assessment care are required to have the following relevant competencies (see Skills for Health- Diabetes Competencies for diabetes)[15] |
| Clinical quality | Workforce/ staff<br><br>*Clinical staff competencies in use of equipment*<br><br>*Cross references to the Standard NHS Contract for Community Services*<br><br>*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 prevention and risk assessment care are required to have the relevant competencies in using appropriate equipment, e.g. blood glucose and ketone monitors |
| Clinical quality | Workforce / staff<br><br>Development<br><br>*Cross references to the Standard NHS Contract for Community Services*<br><br>*Module C: 11,16,19,48* | 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<br><br>Provider to satisfy the commissioner of their commitment to train staff to meet future service needs | |

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| Clinical quality | Registration and licensing<br>*Cross references to the Standard NHS Contract for Community Services*<br>*Module B: Sections: 3,5*<br>*Module C: 4,4A,5,9,10, 11,12,14,15,16 17,18,19,21,26,27, 29,33,34,35,36,38, 40, 43,48,49,52, 53,54,56,60*<br>*Module D: Schedules: 6,10,11,12,15* | 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.<br>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:<br>• Coronary Heart Disease NSF [16]<br>• The Mental Health Strategy[17]<br>Compliance with Care Quality Commission Reviews |
| Clinical quality | Outcomes<br>*Cross references to the Standard NHS Contract for Community Services*<br>*Module B: Section: 1 (part 3),3*<br>*Module C: 4A,14,*<br>*Module D: Schedule 11* | Comprehensive understanding and commitment to delivering and improving outcomes of care | Compliance with the NHS Outcomes Framework[18] | |
| Clinical quality | Patient pathway<br>*Cross references to the Standard NHS Contract for Community Services*<br>*Module B: Sections: 1* | Responsiveness and participative approach to including patients' views about their care in the design of care pathways<br>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<br>All interfaces in the pathway must be defined so that continuity of care is ensured with no fracturing of the pathway | The pathway of a diabetes and risk assessment service includes the following activities:<br>i. Raising awareness on healthy lifestyles and risk factors for diabetes<br>ii. Advice on healthy lifestyles and risk factors for diabetes<br>iii. Risk assessment/ screening for people at high risk of diabetes<br>iv. Referral to prevention services that improve lifestyles/reduce risk factors for diabetes |

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|---|---|---|---|---|
| Clinical quality | *Module C:*<br>*4,4A,9,10,12,14,15,16, 17,18,19,20,21,27,29, 31, 33,34,35,36,38,40, 52,54*<br>*Module D:*<br>*Schedules:*<br>*2,3, 4, 9,11,17*<br>*Module E:*<br>*5* | | There must be specification of clear timelines and alert mechanisms for potential breaches<br>There should be audit of pathway to ensure that standards are met<br>There must be explicit specification of provider and commissioner responsibilities for the whole patient episode from first contact with the service to final discharge<br>Accountabilities should be agreed and documented by all stakeholders<br>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.<br>At entry to pathway:<br>The Commissioner should assure themselves that the provider has systems and processes in place to<br>i) register patients<br>ii) collect relevant clinical and administrative data<br>iii) manage the appointment process, (reappointment and DNA process, if appropriate)<br>iv) provide information to patients<br>v) undertake initial assessment in the appropriate location<br>At point of intervention:<br>The Commissioner should assure themselves that the provider has systems and processes in place to ensure that:<br>i) the advice and intervention is conducted safely and in accordance with accepted quality standards and good clinical practice. | v. Referral for investigation and diagnosis of diabetes<br>Raising awareness and advice:<br>Activities should include:<br>• local campaigns on diabetes and related conditions, e.g. obesity [19], CHD etc<br>• support to national campaigns on diabetes and related conditions, e.g. change for life campaign [20]<br>• targeting specific populations, e.g. Asian, obese, travellers etc<br>• awareness raising in many locations e.g. schools, GP practices, supermarkets, sports centres, pharmacies, LTC centres, pubs/clubs, maternity units, local employers, Care Homes, centres of worship, for people with learning disabilities and severe mental illness, prisons, charities/ third sector providers<br>Risk assessment/ screening:<br>• There should be agreed protocols for the identification children, young people, adults and older people who may be at risk of developing diabetes, e.g. NHS Health Checks for 40 - 74 year olds [10].<br>• There should be agreed protocols for the screening of pregnant women for gestational diabetes [2]<br>• There should be agreed protocols in place to screen for diabetes in Nursing and Care Homes, including those that care for older people with mental health conditions, e.g. dementia.[2]<br>• There should be protocols for the screening for diabetes in older people that utilise appropriate methods for this population<br>Referral to prevention services:<br>• There should be protocols to signpost individuals who attend diabetes prevention and screening services for other help and advice , e.g. healthy diet regimes, weight management programmes etc<br>• People at risk of diabetes may need to be referred to the following prevention services to increase their chances of improving their health:<br>• NHS Health Checks [10]<br>• Weight management programmes<br>• Healthy diet regimes [20] |

| TOPIC | ELEMENTS | CHARACTERISTICS, SKILLS AND BEHAVIOURS | OUTPUTS | DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS |
|---|---|---|---|---|
| Clinical quality | Patient pathway | | ii) the patient receives appropriate care during the intervention(s), in accordance with best clinical practice<br>iii) where clinical emergencies or complications do occur they are managed in accordance with best clinical practice<br>iv) the intervention is carried out in a facility which provides a safe environment of care and minimises risk to patients, staff and visitors<br>v) the intervention is undertaken by staff with the necessary qualifications, skills, experience and competence<br><br>At exit from pathway:<br><br>The Commissioner should assure themselves that provider has systems and processes, which are agreed with all parties and networks, in place to:<br><br>i) make urgent onward referrals where life-threatening conditions or serious unexpected pathologies are discovered during an intervention/assessment<br>ii) ensure that patients receive discharge information relevant to their intervention including arrangements for contacting the provider and follow up, if required<br>iii) provide timely feedback to the referrer re intervention, complications and proposed follow up, if required<br>iv) ensure that support is in place with other care agencies as appropriate | • Exercise facilities [20]<br>• Motivational workshops<br>• Smoking cessation<br>• Surgery (e.g. bariatric surgery) or drugs to reduce weight<br><br>Referral to services that will investigate and diagnose diabetes:<br><br>• People at risk of developing diabetes may need to be referred services that investigate, confirm and manage diabetes as part of their care [2] |

| TOPIC | ELEMENTS | CHARACTERISTICS, SKILLS AND BEHAVIOURS | OUTPUTS | DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS |
|---|---|---|---|---|
| Clinical quality | Estates and equipment<br>*Cross references to the Standard NHS Contract for Community Services*<br>*Module C: 5, 33,56*<br>*Module D: Schedules: 2, 3,4,6,11,17* | Understanding of building regulations<br>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<br>Equipment must be fit for purpose<br>Commitment to efficient use and satisfactory maintenance of equipment | |
| Clinical quality | Knowledge and understanding of health and safety<br>*Cross references to the Standard NHS Contract for Community Services*<br>*Module C: 4A,5,11,17,19, 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<br>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<br>*Cross references to the Standard NHS Contract for Community Services*<br>*Module B: Sections: 5*<br>*Module C: 9,17,18, 19, 21,23,24,27,29, 32, 33,54, 56, 60* | Strategy and policy development skills<br>The ability to analyse data and have access to information that can predict trends and that could identify problems<br>The ability to capture evidence based practice from R&D National Service Frameworks, NICE guidance<br>The ability to use data and information appropriately to improve patient care<br>Transparency and objectivity | The Provider should have an explicit data and information strategy in place that covers<br>• Types of data<br>• Quality of data<br>• Data protection and confidentiality<br>• Accessibility<br>• Transparency<br>• Analysis of data and information<br>• Use of data and information<br>• Dissemination of data and information<br>• Risks<br>• Sharing of data and compatibility of IT across different providers with respect to care of patients across a pathway<br>This information should be included in the Data Quality Improvement Plan<br>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 [21]<br>The Provider is required to use the following for the collection and production of data, where appropriate:<br>• NHS Outcomes Framework [18]<br>• National Diabetes Information Service [22]<br>• Diabetes E [12]<br>• Quality and Outcomes Framework[23]<br>• NHS Health Checks[10]<br>• Patient Experience [11] |

| TOPIC | ELEMENTS | CHARACTERISTICS, SKILLS AND BEHAVIOURS | OUTPUTS | DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS |
|---|---|---|---|---|
| Data and information management | Strategy and policies | | • Confidentiality Code of Practice<br>• Data Protection<br>• Freedom of Information<br>• Health Records<br>• Information Governance Management<br>• Information Quality Assurance<br>• Information Security<br><br>There must be a named individual who is the Caldicott Guardian | |

## Source documents

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


1. 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
2. The NHS Diabetes Commissioning Guides are available on the NHS Diabetes website at http://www.diabetes.nhs.uk/commissioning_resource/
3. Standard NHS Contracts http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124324
4. 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
5. NICE Diabetes guidance, http://guidance.nice.org.uk/Topic/EndocrineNutritionalMetabolic/Diabetes
6. NICE Preventing type 2 diabetes: population and community-level interventions in high-risk groups and the general population (public health guidance), May 2011, http://guidance.nice.org.uk/PH35
7. NICE Preventing the progression from pre-diabetes to type 2 diabetes among high risk groups (public health guidance) expected publication May 2012, http://guidance.nice.org.uk/PHG/Wave19/62
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. Putting Prevention First, NHS Health Check, Vascular risk assessment and management , Best practice guidance, 2009, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097489
11. The King's Fund, The point of care. Measures of patients' experience in hospital: purpose, methods and uses. July 2009
12. DiabetesE - https://www.diabetese.net/
13. Department of Health, Royal College of General Practitioners, Royal Pharmaceutical Society of Great Britain, NHS Primary Care Contracting, Guidance and competences for the provision of services using practitioners with special interests (PwSIs) - Diabetes, http://www.rcgp.org.uk/pdf/CIRC_PwSI%20Diabetes.pdf
14. Training, Research and Education for Nurses in Diabetes – UK, An Integrated Career & Competency Framework for Diabetes Nursing (Second Edition), 2010
15. Skills for Health, Diabetes Competency Framework, https://tools.skillsforhealth.org.uk/
16. 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
17. Department of Health, No health without mental health: a cross-government mental health outcomes strategy for people of all ages, February 2011, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766
18. Department of Health, The NHS Outcomes Framework 2011/12, December 2010 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

19. NICE Obesity – working with local communities (public health guidance), expected November 2012, http://guidance.nice.org.uk/PHG/Wave20/53

20. Department of Health, Change4Life Campaign, 2009 http://www.dh.gov.uk/en/Publichealth/Change4Life/DH_119243

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

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

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

# Standard Service Specification Template for Diabetes Prevention and Risk Assessment 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 Diabetes Commissioning Advisory Group, provides further detail/guidance to support the development of this specification:**

- The diabetes prevention and risk assessment intervention map
- The contracting framework for diabetes prevention and risk assessment services

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

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

## Description of diabetes prevention and risk assessment services:

Diabetes prevention and risk assessment services encompass the care an individual who is at risk of developing diabetes may receive ranging from raising awareness of the condition and other related lifestyle factors, to screening/risk assessment and encouragement of a healthy lifestyle for all age groups.

**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_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. individuals of all ages at risk of diabetes)
   - 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 and lifestyle interventions that are required for the types of need the services will respond to.
   - How the service responds to age, culture, disability, and gender sensitive issues
   - Assessment – details of what it is 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
   - Holistic review of individuals at risk of developing diabetes using the principles of an integrated care model for people with long term conditions that is centred around the individual
   - Risk assessment procedures, e.g. NHS Health Checks
   - Detail of evidence base of the service – i.e. the contracting framework for diabetes prevention and risk assessment services, guidance produced by the Royal College of Physicians, Diabetes UK, etc

## Service Delivery

3. Individual Journey/pathway
   Flow diagram of the patient pathway showing access and exit/transfer points – see the diabetes prevention and risk assessment intervention map as a starting point
4. Treatment protocols/interventions
   Include all individual treatment/intervention 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:
   - Geographic coverage/boundaries – i.e. the services should be available for all individuals of all ages groups who live in the clinical commissioning group area
   - Hours of operation
   - 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)
   - Staff induction and developmental training
6. Equipment
   - Upgrade and maintenance of relevant equipment and facilities
   - *Technical specifications (if any)*

## Identification, Signposting/ Referral and Acceptance criteria

7. This should make clear how individuals will be identified, assessed (if appropriate) and accepted to the services. Acceptance should be based on types of need and/or individual.
8. How should individuals be referred or how are they signposted?
   - 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 an individual be transferred?
   - Response time detail and how are individuals prioritised

## Discharge/Service Complete/ Transfer/Transition criteria

9. The intention of this section is to make clear when an individual should be transferred from the diabetes prevention and risk assessment service to another and when this would be reached.
   - How is the intervention pathway reviewed?
   - How does the service decide that an individual 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. The service is required to deliver care, where appropriate, 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.
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 (if appropriate).

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

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

www.diabetes.nhs.uk

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