NHS

Diabetes

Commissioning Diabetes Services for Older People

Supporting, Improving, Caring

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Commissioning Diabetes Services for Older People

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

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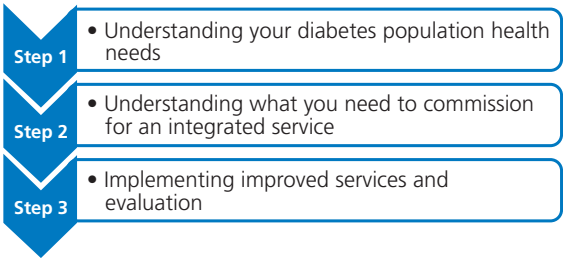
And to Thoreya Swage who wrote this publication.

Contents

Commissioning Diabetes Services for Older People

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 services for older people between commissioners and providers from which a contract for services can then be agreed.

This commissioning guide consists of:

- A description of the key features of good diabetes services for older people
- A high level intervention map. This intervention map describes the key high level actions or interventions (both clinical and administrative) diabetes services for older people 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 services for older people.

- A contracting framework for diabetes services for older people that brings together all the key standards of quality and policy relating to diabetes and older people
- A template service specification for diabetes services for older people 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.

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 Services for Older People

High quality diabetes care for older people is provided by services which actively identify and manage those individuals with diabetes who have special needs as a result of extreme frailty, advanced age (>80y) or residency within a care home. This should include:

- mechanisms for the appropriate screening and detection of diabetes in older people
- an agreed care plan with clearly specified objectives (in line with Single Assessment Process (SAP))
- appropriate support to optimise blood glucose control
- co-ordination of specialist, community, and primary care services including palliative care
- immediate access to appropriate specialist support, e.g. ophthalmology, cardiovascular and renal services (including admission if necessary)
- supported discharge (including multi-disciplinary needs assessment)
- smooth transition to care home residency, where appropriate
- support and guidance for family and carers including telephone 'hot-line' availability
- close healthcare professional liaison with Care Homes in the identification and care of older people with diabetes
- provides a template for more detailed information gathering such as those of a diabetes minimum dataset for audit and /or research purposes

In addition, the services should:

- 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 long term conditions model[ii]
- provide effective and safe care to people with diabetes in a range of settings including the patient's home, in accordance with the NICE Quality Standards for Diabetes[iii]
- take into account the emotional, psychological and mental wellbeing of the patient[iv]
- 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[v]
- ensure that the family/carers of older people with diabetes have access to psychological support
- have effective clinical networks with clear clinical leadership across the boundaries of care which clearly identify the role and responsibilities of each member of the diabetes healthcare team
- ensure that there are a wide range of options available to people with diabetes to support self management and individual preferences

[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] Quality Standards: Diabetes in adults, http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp

[iv] 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/

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

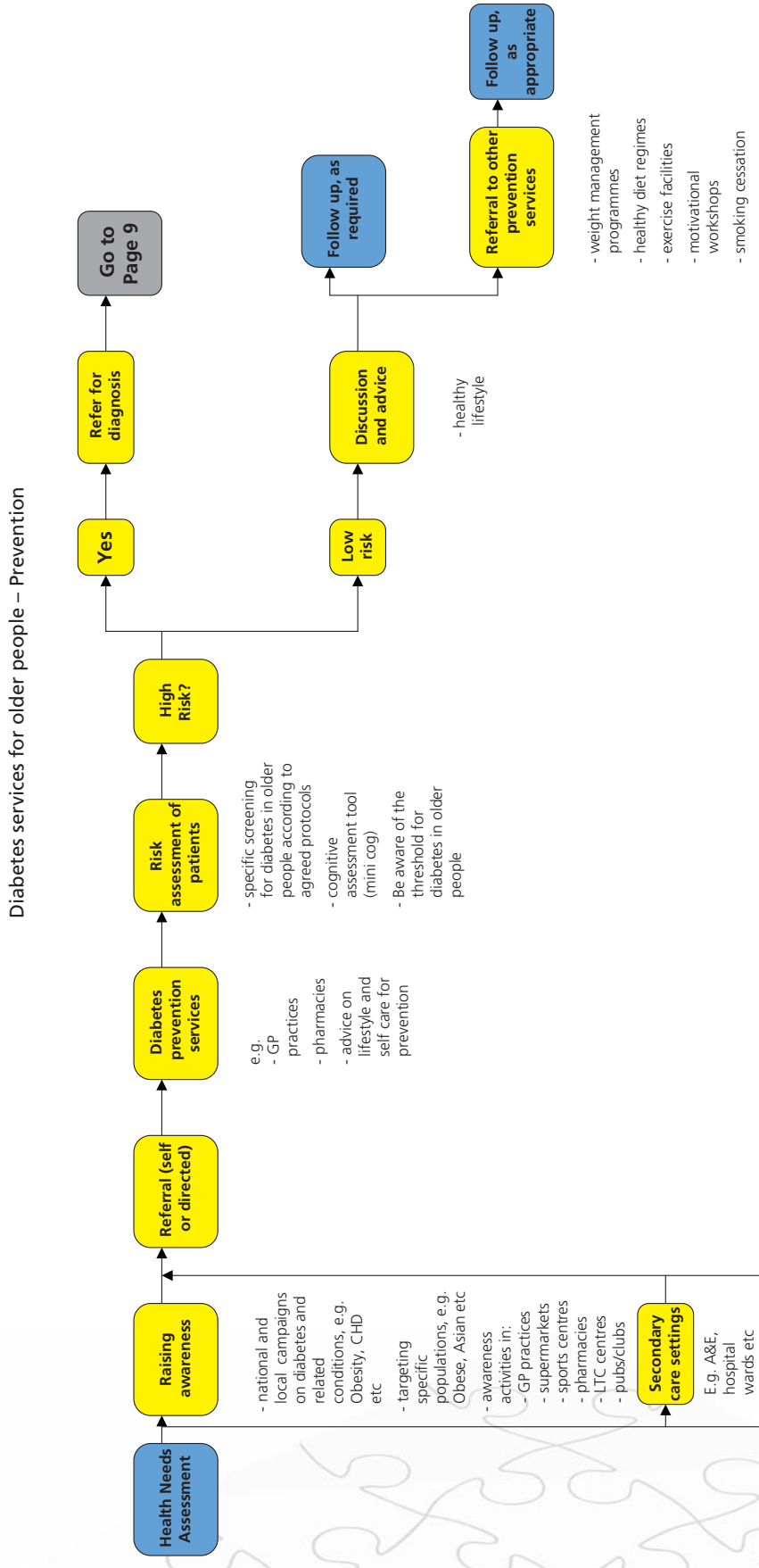
- take into account services provided by social care and the voluntary sector
- provide patient/carer/family education on diabetes not only at diagnosis but also during continuing management at every stage of care
- provide education on diabetes management to other staff and organisations that support people with diabetes
- have a capable and effective workforce that has the appropriate training and updating and where the staff have the skills and competencies in the management of people with diabetes
- provide multidisciplinary care that manages the transition between adult and older peoples' services
- have integrated information systems that record individual needs including emotional, social, educational, economic and biomedical information which permit multidisciplinary care across service boundaries and support care planning[vi]
- produce information on the outcomes of diabetes care including contributing to national data collections and audits[vii]
- 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 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

[vi] See York and Humber integrated IT system at http://www.diabetes.nhs.uk/year_of_care/it/

[vii] European Diabetes Working Party for Older People. Clinical Guidelines for Type 2 Diabetes Mellitus. Available on: www.instituteofdiabetes.org

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

Diabetes Services for Older People Intervention Map



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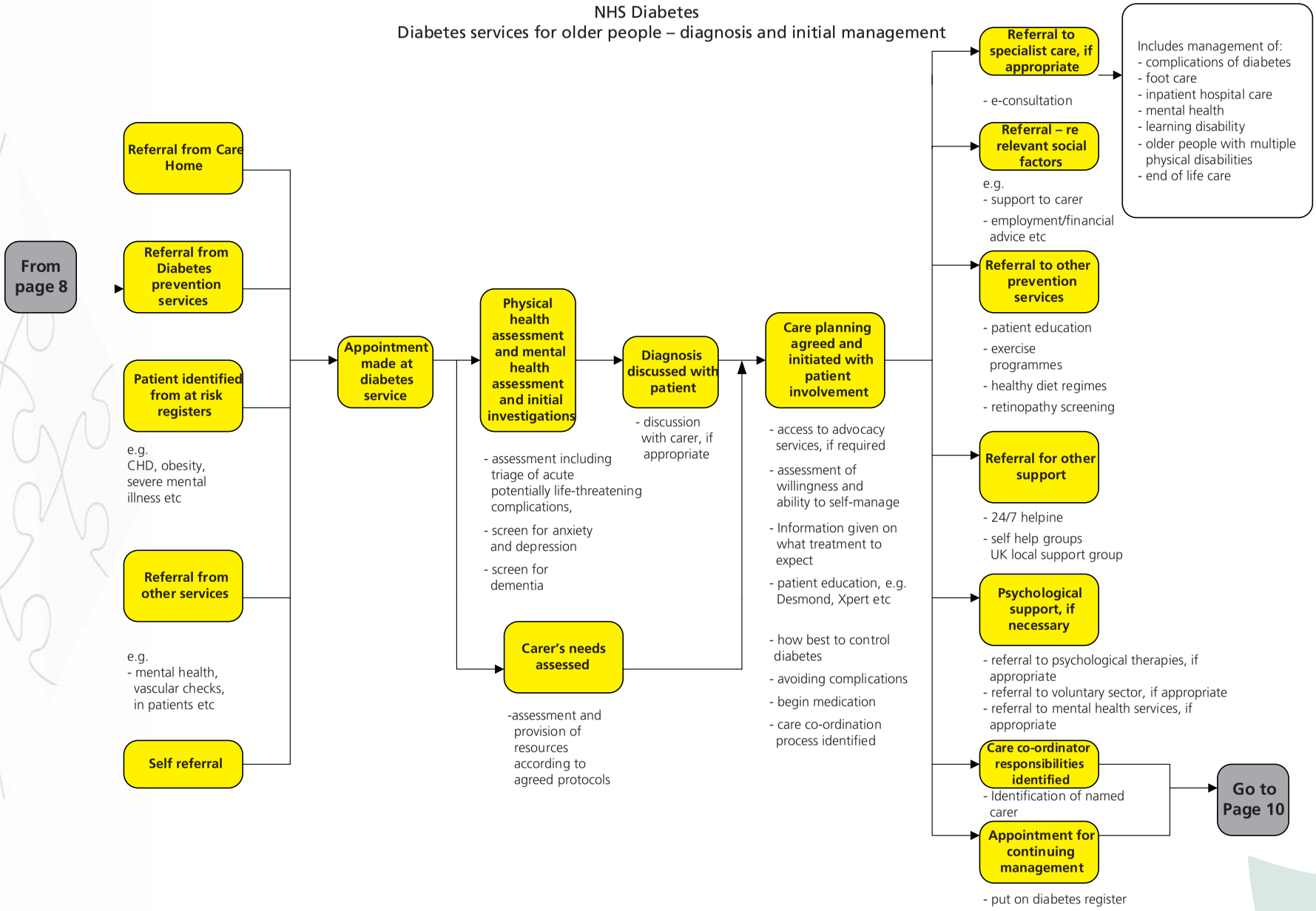
Diabetes services for older people – diagnosis and initial management



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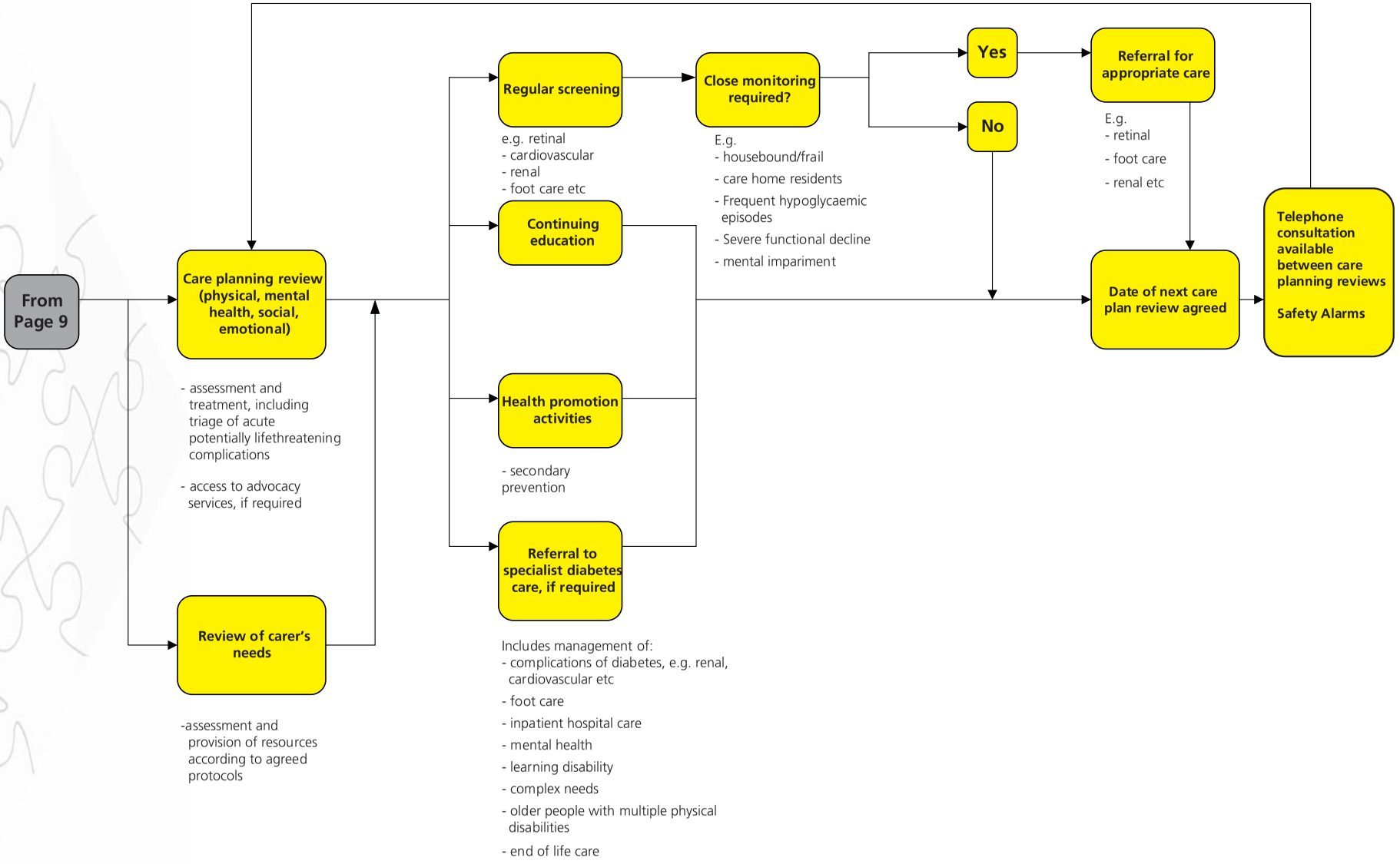
Diabetes services for older people) – Continuing care



Contracting Framework for Diabetes Services for Older People

Introduction

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

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

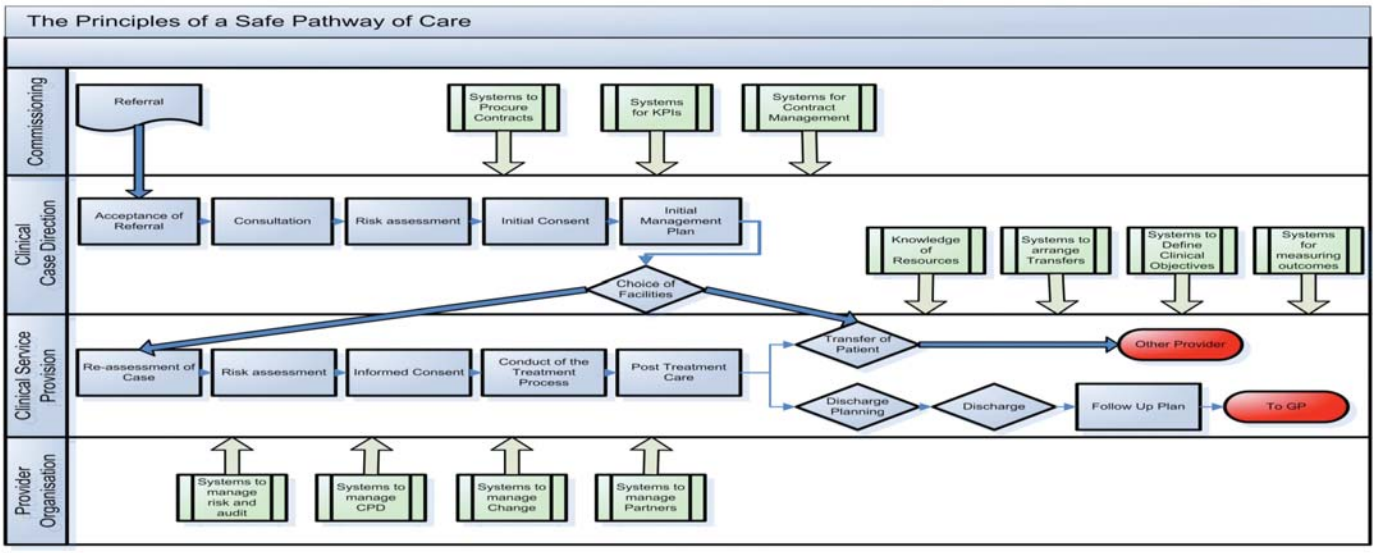
Establishing the principles that underpin the systems and processes of pathways for patient care leads to more efficient patient throughput and can reduce risk of fragmentation of care and serious untoward incidents. The principles operate at four layers within a patient pathway:

- 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 service

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

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

The initial management and continuing care of individuals with diabetes should include an assessment of their emotional and psychological well-being, together with timely access to appropriate psychological and biological/psychiatric interventions. Mental health disorders can pose significant barriers to diabetes care and therefore mental health stability is vital for good self care[1].

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

This contracting framework focuses on older people with diabetes who are frail and have complex needs. This contracting framework should also be read in conjunction with the diabetes commissioning guides for, prevention and risk assessment, foot care, emergency and in patient care, mental health, the complications of diabetes (cardiovascular, renal, eyes and neuropathy), End of Life Care 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 services commissioned are of the highest quality. There may, in addition, be some organisations that wish to offer their services, but do not have a history of providing such care.

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

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

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

Under the 'elements' column there are cross references to the Standard NHS Contract for Community Services – bilateral (main clauses and schedules)[3]. 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 Community Services* *Module C: 11,16,19,33, 48,49,51,53, 60* *Module D: Schedules: 6 ,15*	Clarity of the organisation's purpose with explicit commitment to providing high quality services A culture that demonstrates an open learning ethos An organisation that is legal and ethical in all its activities	Provider must have organisational structure that provides leadership for all professions and disciplines In particular, there must be a corporate clinical director with the responsibility and accountability for the clinical service There must be a learning framework in the organisation	There should be a designated clinical director with responsibility and accountability for the diabetes services for older people
Governance	Integrated Governance *Cross references to the Standard NHS Contract for Community Services* *Module C: 11,19,27,48,49, 51,53,54,56,60* *Module D: Schedules: 6,12,15*	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[4]
Governance	Clinical Governance *Cross references to the Standard NHS Contract for Community Services* *Module B: Sections: 1 (part 2), 3, 4* *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 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 NHS Litigation Authority must review the Clinical Negligence Scheme for Trusts arrangements /or other organisational / professional indemnity arrangements The service should have in place written protocols and procedures defining clear lines of accountability and responsibility. The service is required to comply with guidelines, 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] In addition, the service is required to comply with the following: i. Guidance published by NICE

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Governance	*Module D:* *Schedules:* *3,6,10,11,15,17*		• Patient and Public Involvement • Patient dignity and respect • Equality and diversity • Introducing new technologies and treatments • An externally accredited Quality Assurance system and internal error reporting involving all staff groups. CG systems should have clear and demonstrable links to other NHS systems with collaborative CG activities and sharing of experience and learning Provider should produce annual Clinical Governance reports as part of NHS CG reporting system Providers are required to agree Commissioning for Quality and Innovation schemes (CQUIN) for diabetes care, e.g. model CQUIN scheme proposed by the NHS Institute for Innovation and Improvement [10]	• Depression with a chronic physical health problem [6] • Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence [7] ii. Clinical guidelines for Type 2 Diabetes Mellitus produced by the European Diabetes Working Party for Older People [8] Older people diabetes multidisciplinary teams should [9] : • be alert to the development or presence of clinical or sub-clinical depression and/or anxiety, in particular where someone reports or appears to be having difficulties with self-management. • be able to detect and basically manage non-severe psychological disorders in people from different cultural backgrounds • be familiar with counselling techniques and drug therapy, while arranging prompt referral to mental health specialists • not use special management techniques or treatment for non-severe psychological illness, except where diabetes-related arterial complications give rise to special precautions over drug therapy • be alert to bulimia nervosa and anorexia nervosa and insulin dose manipulation if there is over concern with body shape and weight, low BMI or poor glucose control • make early (and occasionally urgent) referrals to local eating disorder services, as appropriate • ensure that all adults with Type I diabetes have, at regular intervals, counselling about lifestyle issues and nutritional behaviour

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Quality assurance *Cross references to the Standard NHS Contract for Community Services* *Module C: 4,12,16,17,18, 19, 20,21,31, 32,33, 54* *Module D: Schedules: 2,3 ,6,10,11* *Module E: 3,4*	Understanding the concept of clinical quality Has concern for quality while working efficiently An understanding of the use of audit, patient and staff feedback to improve quality An organisation that provides clarity of objectives and promotes reflective practice to improve quality of patient care	Quality assurance systems must be in place and approved by commissioning body with regular reporting of outcomes Providers are required to publish quality accounts for the public reporting of quality including safety, experience and outcomes Providers should participate in national audit programmes	Diabetes services must comply with the performance measures required of NHS services, i.e meeting: [11] • Referral to Treatment waits (95th percentile measures) • A&E Quality Indicators The services are required to participate in the following activities/programmes: • National Diabetes Audit [12] • Patient Experience Surveys [13] • Diabetes E [14] • Patient Reported Outcome Measures [15] • Diabetes UK Guidance and Care Home Audit toolkit [16]
Clinical quality	Workforce/ staff Clinical staff attributes critical to safety and quality of interventions *Cross references to the Standard NHS Contract for Community Services* *Module C: 11,16,19,26,33,48,56* *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 Provider to satisfy commissioner that all staff have current appraisal, clearances and registration checks and have demonstrated competence in all procedures relevant to pathway.	Provider to satisfy commissioner that they can recruit (or procure) and retain a competent clinical team to deliver the service Specific qualifications required of health professionals providing the service are: • For medical practitioners: registration with the GMC and evidence of further qualification in diabetes care or experience within diabetes clinic • Nurses: registration with the NMC and further evidence of qualification in diabetes care or experience within diabetes clinic [17] • Dietitians: registration with the HPC and able to demonstrate competence in delivering educational support All healthcare professionals involved in delivering diabetes care are required to have the relevant competencies (see Skills for Health- Diabetes Competencies for diabetes and diabetic retinopathy) [18]

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Workforce/ staff Clinical staff competencies in use of equipment *Cross references to the Standard NHS Contract for Community Services* *Module C: 5, 11, 16, 17, 19, 26, 33,48*	The provider organisation has systems in place to assure the commissioner that their clinical team are competent to use all equipment needed to deliver the service	Provider to satisfy the commissioner that all staff have had documented competence assessment relative to all equipment used in contract	All healthcare professionals involved in delivering diabetes care are required to have the relevant competencies in using appropriate equipment e.g. blood glucose and ketone monitors, insulin delivery devices including insulin pumps
Clinical quality	Workforce / staff Development *Cross references to the Standard NHS Contract for Community Services* *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 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 Community Services* *Module B: Sections: 3,5* *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* *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. 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: • Older People's NSF [19] • Coronary Heart Disease NSF [20] • The Mental Health Strategy[21] • Long Term Conditions NSF [22] Compliance with: • End of Life Care Strategy [23] Compliance with Care Quality Commission Reviews

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Clinical quality	Outcomes *Cross references to the Standard NHS Contract for Community Services* *Module B: Section: 1 (part 3),3* *Module C: 4A,14,* *Module D: Schedule 11*	Comprehensive understanding and commitment to delivering and improving outcomes of care	Compliance with the NHS Outcomes Framework[24]	Compliance with the Quality Standards for Diabetes [25] Compliance with the Quality Standards for Chronic Kidney Disease [26]
Clinical quality	Patient pathway *Cross references to the Standard NHS Contract for Community Services* *Module B: Sections: 1* *Module C: 4,4A,9,10,12,14,15, 16,17,18,19, 20,21,27,29,31, 33,34,35,36,38,40, 52,54* *Module D: Schedules: 2,3, 4, 9,11,17* *Module E: 5*	Responsiveness and participative approach to including patients' views about their care in the design of care pathways Collaboration with other organisations involved in the patient pathway to provide a seamless pathway of care	All possible entry and exit points must be defined with comprehensive patient pathways that facilitate smooth passage and effective, efficient care for patients All interfaces in the pathway must be defined so that continuity of clinical care is ensured with no fracturing of the pathway There must be specification of clear timelines and alert mechanisms for potential breaches There should be audit of pathway to ensure that standards are met There must be explicit specification of provider and commissioner responsibilities for the whole patient episode from registration to final discharge Accountabilities should be agreed and documented by all stakeholders There are a number of services supporting patients with diabetes and there must be clear sub contracts stating the referral criteria and access to these supporting services.	The pathway should follow the principles set out by the Generic Long Term Conditions model [27]. This includes: • Stratifying the levels of need and risk • Case management • Personalised care planning • Supporting people to self care • Assistive technology The service is required to use the common framework for assessment and care planning process for all patients with diabetes [28] There should be agreed protocols for the identification of older people who may demonstrate the risk factors for diabetes, e.g. falls, cardiovascular disease etc 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. There should be protocols for the screening for diabetes in older people that utilise appropriate methods for this population There should be clear protocols for the assessment of older people who are admitted to hospital with an acute illness, to screen for possible diabetes

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Patient pathway		At entry to pathway: The Commissioner should assure themselves that the provider has systems and processes in place to i) register patients ii) collect relevant clinical and administrative data iii) manage the appointment process, (reappointment and DNA process, if appropriate) iv) provide information to patients v) undertake initial assessment in the appropriate location At point of intervention: The Commissioner should assure themselves that the provider has systems and processes in place to ensure that: i) the intervention is conducted safely and in accordance with accepted quality standards and good clinical practice. ii) the patient receives appropriate care during the intervention(s), including on treatment review and support, in accordance with best clinical practice iii) where clinical emergencies or complications do occur they are managed in accordance with best clinical practice iv) the intervention is carried out in a facility which provides a safe 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	The older people diabetes multidisciplinary teams should ensure that there is close liaison with the older person's Care Home team. This is to ensure that all parties in the Care Home are educated including staff (including catering staff) and residents The service is required to provide a rapid response for people with a wide range of functional ability including the housebound, frail, cognitively impaired, depressed and those in care homes. The service is required to ensure that a comprehensive assessment of all older people who are admitted to hospital with diabetes takes place within 72 hours of admission 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) [2]: • emergency and inpatient care • services for complications – foot care, eyes, vascular etc • mental health • learning disabilities • end of life care Providers should ensure access to transport facilities to enable attendance for specialist treatment, as required Providers are required to take note of the results of the National Survey of People with Diabetes [29]

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Patient pathway		At exit from pathway: The Commissioner should assure themselves that provider has systems and processes, which are agreed with all parties and networks, in place to: i) undertake telephone triage ii) make urgent onward referrals where life-threatening conditions or serious unexpected pathologies are discovered during an intervention/assessment iii) ensure that patients receive discharge information relevant to their intervention including arrangements for contacting the provider and follow up if required iv) provide timely feedback to the referrer re intervention, complications and proposed follow up v) ensure that the patient receives required drugs/dressings/aids vi) ensure that support is in place with other care agencies as appropriate	
Clinical quality	Clinical emergency situations *Cross references to the Standard NHS Contract for Community Services* *Module C: 6,11,12,14,15,18, 20,32, 32, 42, 54* *Module D: Schedules: 2, 3, 4, 6, 9,11*	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	

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Clinical quality	Estates and equipment *Cross references to the Standard NHS Contract for Community Services* *Module C: 5, 33,56* *Module D: Schedules: 2, 3,4,6,11,17*	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	
Data and information management	Knowledge and understanding of health and safety *Cross references to the Standard NHS Contract for Community Services* *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 Accessibility to executive responsible for H&S for quicker, first contact services	Health and safety policies as per provider agreement with commissioners
Data and information management	Strategy and policies *Cross references to the Standard NHS Contract for Community Services* *Module B: Sections: 5* *Module C: 9,17,18, 19, 21,23,24,27,29, 32, 33,54, 56, 60*	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	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 [30] The Provider is required to use the following for the collection and production of data, where appropriate: • NHS Outcomes Framework [24] • National Diabetes Information Service [31] • National Diabetes Audit [12] • Diabetes E [14] • Quality and Outcomes Framework[32] • Myocardial Ischaemia Audit Project[33] • NHS Health Checks[34] • Hospital Episode Statistics[35]

TOPIC	ELEMENTS	CHARACTERISTICS, SKILLS AND BEHAVIOURS	OUTPUTS	DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS
Data and information management	Strategy and policies		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	• Patient Experience [13,29] • Patient Satisfaction [29] • Patient Reported Outcomes Measures[15] • National Diabetes Continuing Care Dataset [36]

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
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Standard Service Specification Template for Diabetes Services for Older People

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 Older People with Diabetes Steering Group, provides further detail/guidance to support the development of this specification:

- The intervention map for diabetes services for older people
- The contracting framework for diabetes services for older people

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

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

Description of diabetes care for older people:

Overall diabetes care encompasses the care an older person with diabetes may receive ranging from preventative, diagnostic and continuing management, including general principles for specific aspects of diabetic treatment such as for mental health, foot care etc up to the end of life. For further details of the specific aspects of care, the commissioner is referred to the relevant patient journey, contracting framework and specification template for the care in question.

The final specification should take into account:

- **national, network and local guidance and standards for diabetes services for older people.**
- **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. older people with diabetes)
   - What the services aim to achieve within a given timeframe
   - 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 patients enter the pathway/journey; what are the stages undertaken, e.g. diagnosis, continuing management up to end of life care. 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 multi-disciplinary team (as defined locally) with a clear care co-ordination function
   - Holistic review of patients in the management of their diabetes using the principles of an integrated care model for people with long term conditions that is patient-centred, including self care and self management, clinical treatment, facilitating independence, psychological support and other social care issues
   - Risk assessment procedures
   - Detail of evidence base of the service – i.e. the contracting framework for diabetes services for older people, guidance produced by the Royal College of Physicians, Diabetes UK, etc

Service Delivery

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

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

5. This will include a breakdown of how the patient will receive the services and from whom. It should be a clear statement of staff qualifications/experience and/or training (if appropriate) and clinical or managerial supervision arrangements. It should specify, as appropriate:
   - Geographic coverage/boundaries – i.e. the services should be available for older people who live in the commissioning consortium area
   - Hours of operation including, week-end, bank holiday and on-call arrangements
   - Minimum level of experience and qualifications of staff (i.e. doctors – diabetologists and GPs, Nursing staff – diabetes nurse specialists, district, practice nurses etc, other allied health professionals, e.g. podiatrists, dietitians, optometrists, pharmacists etc and other support and administrative staff)
   - Confirmation of the arrangements to identify the Care Co-ordinator for each patient with diabetes (i.e. who holds the responsibility and role).
   - Staff induction and developmental training

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

Identification, Referral and Acceptance criteria

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

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

Discharge/Service Complete/Patient Transfer criteria

9. The intention of this section is to make clear when a patient should be transferred from one aspect of the diabetes service to another is and when this would be reached.
   - How is a treatment pathway reviewed?
   - How does the service decide that a patient is ready for discharge
   - 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.

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

[b] http://www.nice.org.uk/media/FCF/87/DiabetesInAdultsQualityStandard.pdf

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

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