Diabetes Commissioning Toolkit

November 2006

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For Recipient's Use		

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1. Foreword

Diabetes is one of the great health threats of the 21st century. There are an estimated 2.35m people with diabetes in England and this is predicted to grow to more than 2.5m by 2010. The cost to the people affected and their families is considerable, with life expectancy reduced by more than fifteen years for someone with Type 1 diabetes and up to ten years for Type 2. Diabetes also significantly increases the risks of heart attacks, strokes, blindness, kidney failure and amputation.

The costs of all of this to the NHS are considerable. When the Diabetes National Service Framework Delivery Strategy was published in 2003, 5% of all NHS expenditure and 9% of hospital expenditure were accounted for by the condition. In addition to direct health costs, the impact on social services expenditure, where diabetes complications increase costs four-fold, is significant. Prevalence of obesity, a major risk factor for diabetes, has trebled since the 1980s, and well over half of all adults are either overweight or obese. It is likely that with a population that is growing older, taking less exercise and more ethnically diverse, costs are going to increase yet more.

These alarming figures highlight the need for NHS commissioners to adopt a strategic approach to commissioning diabetes care in order to improve quality and ensure best use of the available resources. Commissioning is the process which determines how the health and healthcare budget is used. As such, it is commissioning that will be the key driver to ensure that services are patient-centred and designed around the specific needs of the local population. Commissioning should be a strategic process, involving close partnership working with service users, clinicians and partner organisations.

The Department of Health's focus on strong user and clinical involvement in the commissioning process fits well with the emphasis within the diabetes community of working in networks. In order to be most effective, commissioning should be a collaborative process where commissioners can have constructive discussions with service providers and users to determine what care is needed and how it could to take place, and commissioners should be encouraged to draw from the expertise developed across the network.

This commissioning toolkit has been developed in response to the overwhelming need voiced by local services for support in the commissioning process, and is unique in having the backing of six of the key national organisations in the diabetes community. Commissioning is a complex process and many people are still developing their expertise in this area. We hope that this toolkit will be a useful resource for NHS commissioners, and will result in high-quality care available for all people with diabetes.

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2. Executive Summary

Commissioning is the means by which we secure the best value for patients and taxpayers. Through a strong commissioning function, the NHS can provide better quality services which are designed around the specific needs of the local population.

This toolkit aims to provide a useful resource to all NHS commissioners of diabetes services. The toolkit has two main sections:

- **Section 1: Assessing healthcare needs to support commissioning**

  This section outlines the key questions commissioners need to ask in order to understand where they are now, and provides links to information resources that can provide detailed information on current service provision and outcomes. It also suggests what commissioners might need to do in order to understand the current and future needs of their local diabetes population.

- **Section 2: Generic specification for diabetes care – Best practice model**

  This section provides an outline of the core elements of care that a high-quality diabetes service should include. It signposts the relevant quality markers for each element of the service, including NSF Standards and NICE guidelines. It also provides suggestions for key outcomes that commissioners can specify and indicators that could be used to measure improvement over time.

3. Introduction

Background

Good commissioning is vital in an NHS committed to providing good care for patients and value for money. There is currently a strong emphasis on the development of tools and skills to support commissioning in order to improve the quality of care and the patient experience.

This toolkit is designed to provide a technical resource to all commissioners of diabetes care. The toolkit should be read alongside other commissioning guidance, in particular the Department of Health commissioning frameworks[1].

How was the toolkit developed?

The Primary Care Diabetes Society (PCDS) set up a 'task and finish' group in March 2006 to develop a commissioning toolkit for diabetes. This group involved representatives from all the key players in the diabetes community, including the Department of Health, National Diabetes Support Team, Diabetes UK, and the Association of British Clinical Diabetologists.

The task and finish group were keen to ensure strong clinical and user involvement in development of the tool. The group overseeing the project had representation from clinicians, patients and commissioners. In addition to the main reference group, a wider group of healthcare professionals, patients and commissioners were involved in reviewing and validating the first draft of the toolkit at a workshop that took place in Birmingham in July 2006. This group was also encouraged to review further drafts and feed in their views.

How should the toolkit be used?

The toolkit is aimed predominately at NHS commissioners of diabetes care, at both PCT and practice level. The toolkit should support commissioners in a number of ways. For example:

- it provides advice on how to carry out a healthcare needs assessment for a local diabetes population in order to understand their specific needs
- it provides a generic specification for diabetes care, setting out the core elements of quality care and signposting best practice quality markers, such as NSF Standards, NICE guidelines etc
- it provides suggestions for indicators that commissioners can use to monitor the quality of their current local service and identify improvements that need to be made

[1] See *Health reform in England: update & commissioning framework* (DH 2006). A further commissioning framework on commissioning for health and well-being will be published by the Department of Health in 2006/07.

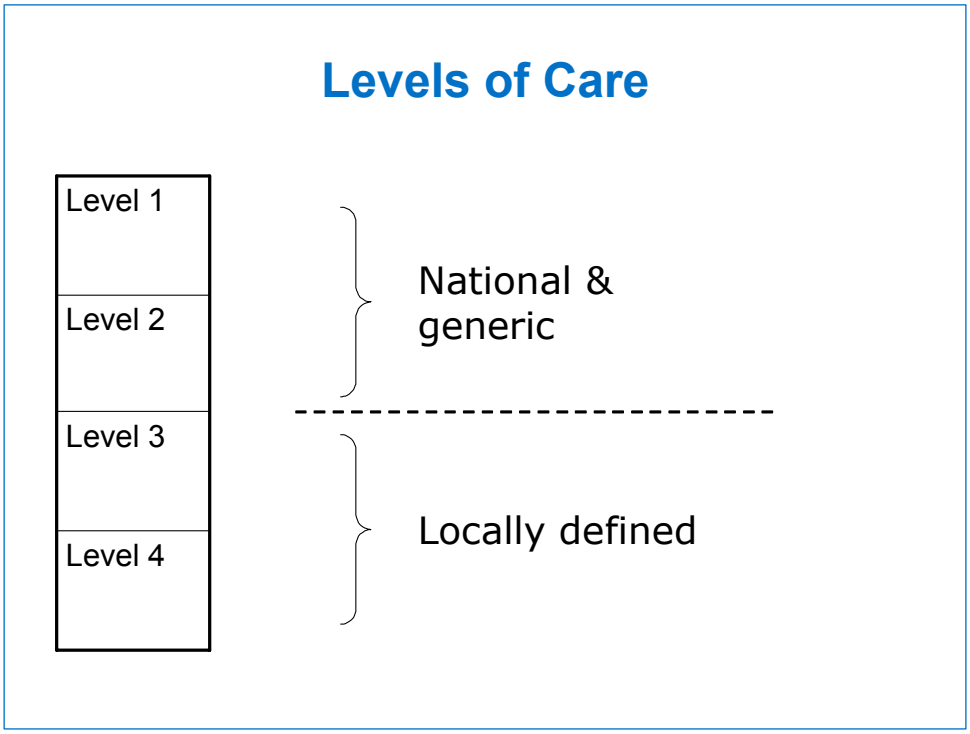
- it provides key outcomes that a commissioner could specify when commissioning diabetes care

In addition, the toolkit may be useful for providers of diabetes services by highlighting quality markers and encouraging local audit. Finally, the toolkit can be used by diabetes networks by providing a framework to look at service improvement and development of models of care.

4. Levels of Care

This toolkit is designed to provide a national framework to support NHS commissioners to commission locally-appropriate care. This distinction between national and local responsibilities can best be understood using the new 'levels of care' language[2].

The Levels of Care language is designed to provide a new vocabulary in order to make discussions about any service more straightforward. The new language can be used by anyone involved in planning and designing services, at both national and local levels. The actual principles governing how services are planned and designed however remain the same; for diabetes, these discussions should still take place across the diabetes network, with strong clinical and user involvement.

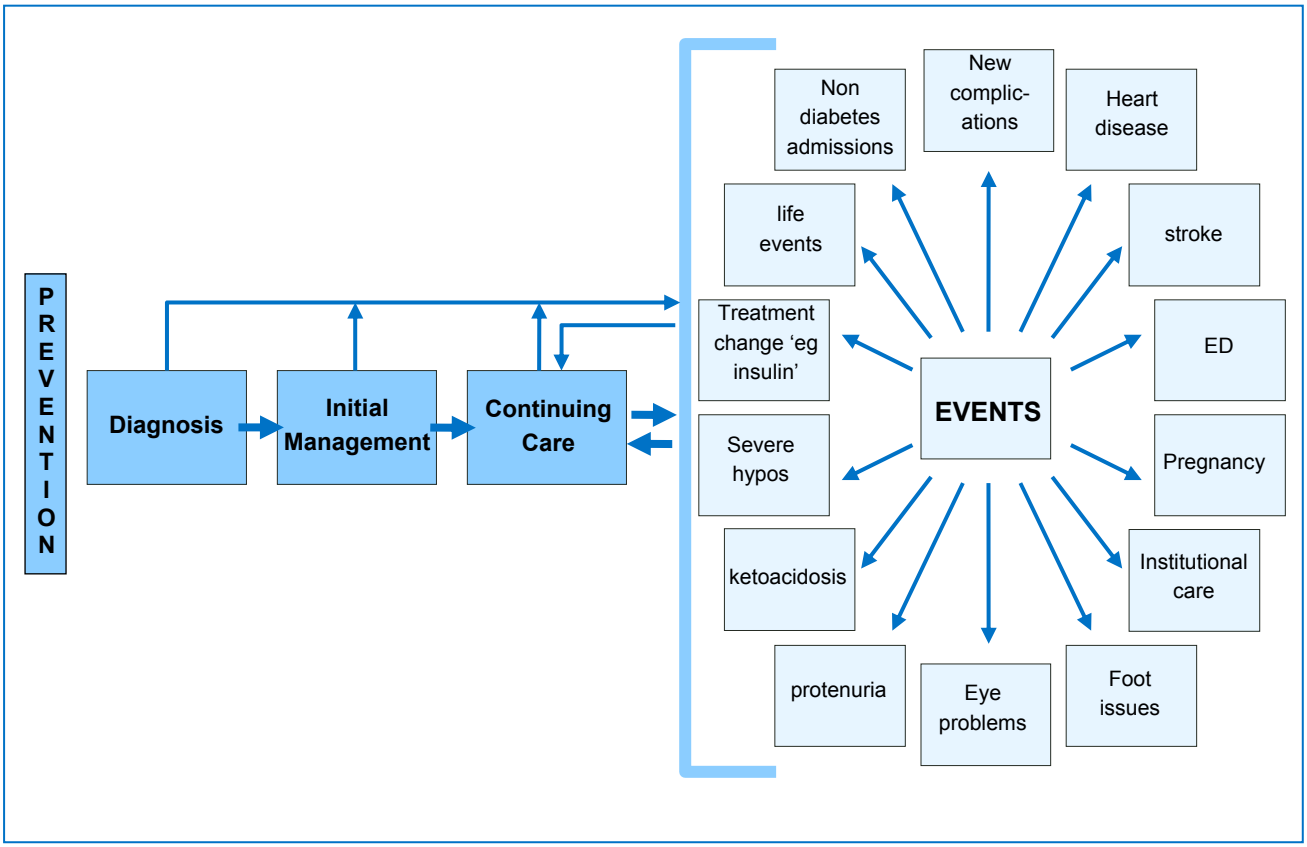


Level 1 and Level 2 provide an account of the core elements of care for a particular condition, without stipulating where, by whom or in what order services should be delivered as this can vary significantly from one locality to another. Describing the service at this level is an important tool to reduce variation as well as drive up quality.

[2] *Levels of Care: A New Language for Service Planning and Design* is available on the NDST website at http://www.diabetes.nhs.uk/downloads/levels_of_care1d.pdf

For diabetes, Level 1 consists of the 'tadpole' diagram in the Diabetes NSF (see diagram below). This provides a 'map' of all of the elements of care that a high-quality diabetes service should include.

Level 2 looks at each detailed part of the 'map' identified in Level 1 and outlines the core principles of each and the relevant quality markers and best practice.



Level 3 and Level 4 describe work at a local level. Local people will be able to take the principles and quality markers identified at Levels 1 and 2 and use them to design and deliver quality services that are appropriate to the needs of the local population.

For diabetes, Level 3 will set out the local 'model of care' and providers will be commissioned to deliver this. A model of care describes how all the components at Levels 1 and 2 are to be delivered in the local health community. Finally, Level 4 sets out the local care pathways describing the parameters for how the local model works, the referral pathways, who does what etc.

This toolkit aims to be a Level 2 resource to enable the redesign of services at Level 3.

5. Introduction to commissioning

What is commissioning?

Commissioning is the means by which we secure the best value for patients and taxpayers. By 'best value' we mean:

- the best possible health outcomes, including reduced health inequalities
- the best possible healthcare
- within the resources made available by the taxpayer

Commissioning will not be the responsibility of a single organisation in a patient-led NHS. Rather it will be a partnership between PCTs, general practice and local government.

Many of the current changes taking place in the NHS are dependent on a strong commissioning function. Service redesign will in many cases be dependent on effective commissioning, so it is vital that commissioners have access to tools and expertise that will help them to commission high-quality care.

What is the policy context for this focus on commissioning?

Commissioning a Patient-Led NHS[3], published in July 2005, stated that the NHS should be moving from a provider driven service to a commissioning driven one. The document set out the importance of expert and imaginative commissioning in order to achieve the aim of a patient-led NHS.

Health Reform in England[4], published in December 2005, described the different reforms that are being made to the healthcare system and explained how they are expected to interact. The document reinforced the importance of good commissioning in achieving services that meet the needs of the local population whilst also obtaining value for money.

The new White Paper on community services, *Our health, our care, our say*[5], emphasised the importance of good commissioning in providing integrated services, building on good

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[3] Available on the DH website at http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4116716&chk=/%2Bb2QD

[4] Available on the DH website at http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4124723&chk=y2qlXE

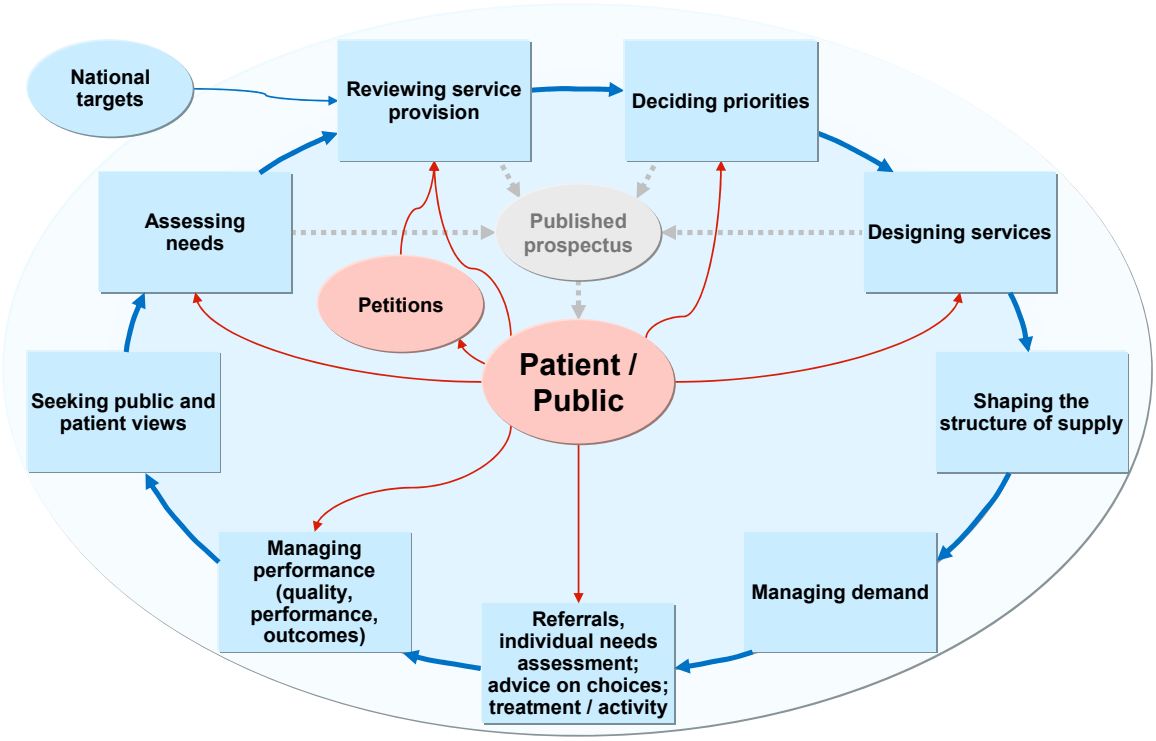
[5] Available on the DH website at http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127453&chk=NXIecj

local partnerships. The White Paper stated that commissioners should commission for 'health and well-being' to ensure that health improvement is at the heart of the commissioning process.

Health reform in England: update & commissioning framework, published in July 2006, provides a detailed framework for commissioning. The framework includes policy and implementation guidance on commissioning and practice based commissioning (PBC) and expectations of how PCTs, GPs and health and social care commissioners will work together. Further guidance on joint commissioning and commissioning for health and well-being will be published shortly. Further information is available on the Department of Health website at: www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/fs/en

What should good commissioning involve?

There are a number of different ways of defining good commissioning. The Department of Health commissioning framework (July 2006) describes a multi-faced commissioning cycle (see diagram below).



As a minimum the commissioning process might involve:

- an assessment of local need
- design of a local specification to meet that need
- procurement of services to deliver the local specification
- proactive monitoring

What will be needed to commission services at a strategic level?

Commissioning care for a specific condition such as diabetes will need to take place within the context of a more strategic commissioning process.

Strategic needs assessment will involve working across partner organisations to assess the potential demands that are facing the service now and in the future. Linking this assessment with the results of patient and community engagement will enable commissioners to understand how the resources available could be better spent or further investment made to improve services and outcomes. Commissioners will then be in a position to discuss their needs with existing or alternative providers to see what contribution they might make to the overall delivery of the solution.

Adopting this approach to strategic commissioning should lead to new developments such as solutions provided by more expert patients, community groups, growing local social capital, new market development and entry of non traditional providers.

What will be needed for effective commissioning of diabetes care?

Commissioning diabetes care should be a strategic process involving a wide range of different people, including patients, carers and clinicians, and taking into account the local vision for health and social care in the whole community. Significant inequalities exist in the risk of developing diabetes, in access to health services and the quality of those services, and in health outcomes, particularly with regard to Type 2 diabetes. Commissioners will be able to use the commissioning process to address these variations in care

There will be a number of ‘backroom’ tasks that will need to be carried out as part of the commissioning process. These may include analysing information to assess the healthcare needs of the local population and establishing local trends. Commissioners may also wish to link to the programme budgeting approach in order to assess how much is spent locally compared to benchmarked peers and what outcomes are achieved; this is a useful way for commissioners to assess across the portfolio where spend is (or is not) delivering required outcomes.

In parallel, commissioners will need to engage service users and clinicians in order to establish how satisfied people are with the current level of care, what services they feel should be provided that aren’t already and what the priority areas for improvement should be. The local diabetes network could have a key role in facilitating this process in collaboration with the commissioner. This process of engagement should be carried out in the light of national standards and priorities.

Once a clear picture has emerged of current and future healthcare needs, as well as priorities for service development and improvement, commissioners may wish to work with local diabetes networks in order to examine different models of care for delivering a local diabetes service. This process will need to be informed by the local financial situation, workforce capacity and future options for provider development. Commissioners should also

consider national policies, such as the *Our health, our care, our say* White Paper, which focuses on a strategic shift to locate more services in local communities that are closer to people's homes. Although there may be costs involved in shifting services in structural terms, these should be outweighed by the savings for people in terms of more local services, better tailored to their community needs and involving people in co-production. Commissioners will also need to consider the opportunities to bring in new providers, and ensure that the commissioning process provides for all organisations to be able and enabled to bid (for example, through capacity building).

It will be the responsibility of the commissioner, having consulted with the diabetes network, patients and clinicians, to decide the final model of care to be commissioned.

What additional tools are available to help diabetes commissioners?

There are a number of tools that will be made available to help commissioners undertake this process. These include:

- A practical guide that describes how services can work from Level 2 to Level 3, including looking at implications for workforce development and planning[6]
- A publication produced by the Yorkshire and Humber Public Health Observatory on health intelligence sources of data and information in diabetes.[7] This publication will be developed further to support future commissioning of diabetes services.

In addition, commissioners have a number of different 'levers' available to them to support the process of service redesign and improvement. Commissioners may wish to examine the information available through the Quality and Outcomes Framework on the quality of primary care and can choose to provide further incentives through local negotiation, for example through a local enhanced service (LES). Commissioners may also decide to negotiate local tariffs for services outside the scope of the national Payment by Results tariff for diabetes.[8]

[6] This tool will be published on the NDST website at www.diabetes.nhs.uk

[7] This publication is available at www.yhpho.org.uk/ViewResource.aspx?id=13

[8] Further information on Diabetes and Payment by Results is available on the NDST website at www.diabetes.nhs.uk

6. Introduction to the Commissioning Toolkit for Diabetes

Structure of the toolkit

This toolkit is made up of two main sections:

- Section 1: Assessing healthcare needs to support commissioning
- Section 2: Generic specification for diabetes care – Best practice model

How should the toolkit be used?

This toolkit is structured around four key questions that commissioners will need to consider when commissioning diabetes care:

1. **Where are we now?**
   The toolkit will provide advice on carrying out a healthcare needs assessment for diabetes, focusing on a number of domains including prevalence, trends etc

2. **Where do we want to be?**
   The toolkit will signpost best practice quality markers that all services will need to strive towards, such as NSF Standards, NICE guidelines, national targets etc

3. **How do we get there?**
   The toolkit will not provide explicit advice about what local services need to do to deliver these priorities and meet the needs of their local population as this will be a matter for local determination. However, the generic specification part of the toolkit should provide a useful framework for services to enable them to think about service redesign. The supporting guide that describes how services can work from Level 2 to Level 3 will help local commissioners and providers design and cost the workforce component of possible local options to assist this process.

4. **How will we know when we are there?**
   The generic specification part of the toolkit will include a number of suggested indicators that can be used by local services as measures of effective practice

Is this document likely to change over time?

It is likely that this commissioning toolkit will need to be updated over time in order to reflect changes in national guidance/quality markers for diabetes care. The reference group that was responsible for developing the toolkit will try to keep it under regular review and publish updates as and when required.

Who should I contact for further information and advice?

Queries about the commissioning toolkit and wider health reform issues can be sent to: systemreform@diabetes.nhs.uk

7. Section 1: Assessing healthcare needs to support commissioning

This section outlines an approach by which commissioners can assess the current and future needs of their local diabetes population. It provides suggestions for questions in a number of domains that commissioners might need to ask in order to create a rich picture of need for care in a locality or network. It also signposts data sources that are currently available to commissioners in order to answer these questions. Although this section just relates to carrying out a healthcare needs assessment, commissioners will also need to consider the social care needs of people with diabetes.

Local services should aim to carry out a full healthcare needs assessment in order to support the design of a local model of care that will meet the specific needs of the local population. A more comprehensive and co-ordinated service is likely to be achieved if a comprehensive service design process is undertaken and then staged to take account of local population needs and 'planning reality'.

Linked to this commissioning toolkit is a web-based tool based on the Better Metrics project that has been developed by the Yorkshire and Humber PHO to help local services assess 'where they are now'.[9] This interactive tool will help people benchmark and prioritise areas where further improvement is needed. The tool will be developed further over the coming months to support commissioning of diabetes services.

[9] This tool is available at www.yhpho.org.uk/diabetes_commissioning.aspx

Questions to be asked in identifying local health priorities in diabetes care

Where are we now? What is the magnitude and burden of the local diabetes problem? (Population Profiling)		
Topic:	**Question:**	**Data/Information Source:**
Occurrence	How many people need local Diabetes services?	PBS Prevalence Model QOF DiabetesE (Practice level prevalence estimates)
	How common is Diabetes locally (Type 1, Type 2 and Gestational)?	PBS Prevalence Model QOF DiabetesE (Type 1 & Type 2 Practice level actuals)
	What are the numbers of individuals with clinically diagnosed diabetes in local population (registered prevalence)?	QOF National Diabetes Audit DiabetesE
	What % of estimated persons with diabetes are clinically diagnosed in local population?	PBS Prevalence Model QOF National Diabetes Audit DiabetesE (Practice estimated population prevalence and actual)
	What are the number of new patients needing diagnosis, stabilisation and programmes of	QOF

	education and long-term care (incidence)?	
	What is the breakdown of local diabetes population in terms of: • Age, • Ethnicity, • Adults, children, young people, • Women of gestational age, • Prisons, • Special needs, • Learning disabilities, • Itinerant population, • Patients in residential and nursing care homes?	PBS Prevalence Model QOF Local Audit Local health survey National Health Survey DiabetesE (does not separately identify prison, residential and nursing homes, and special needs)
Risk Factors	What is the level of obesity in our population, and the projected trends?	QOF BMI data from practices Children's weight data from schools
Health Inequalities	What levels of deprivation exist in our area?	Index of multiple deprivation
	What health inequalities exist between different groups within our population?	Local health equity audit (including asylum seekers, ethnic groups, transient groups)
	Does rate of improvement differ in these groups? E.g. the uptake of retinal screening or structured education	Local health equity audit
	Where do people with diabetes live?	Dr Foster Population modelling tools

Local Health Burden	How may local deaths from diabetes?	ONS Public Health Mortality File
	How many diabetes related hospitalisations in last year?	HES
	How many diabetes related emergency admissions?	HES (NCHOD)
	What is the average length of stay for diabetes patients?	HES
	What is the number of individuals with, or likely to develop, specific complications?	PBS Prevalence Model Local Audit DiabetesE (has major adverse outcomes, manually enter from practice system)
	How many complications have occurred to clinically diagnosed patients in last year, including:	HES (NCHOD) Local Audit DiabetesE (can provide this if the PCT does a self-assessment each year and the practices fill in their clinical data assessment)
	Macrovascular • Cerebrovascular disease • Ischaemic heart disease • Peripheral arterial disease	HES Local Audit DiabetesE
	Microvascular	HES Local Audit

	• Retinopathy • Nephropathy • Neuropathy	DiabetesE
	Depression	HES
	Amputations	HES
	Erectile dysfunction	HES
	Problems in pregnancy	CEMACH
Cost	What is the total current expenditure on diabetes services?	Local Audit
	How does this breakdown into: • Existing total service costs (per patient)· • Staff costs • Capital costs • Prescription costs?	Reference costs Torbay model for workforce/model of care cost QOF Prescription data (PACT data)
	What % of local NHS expenditure spent on Diabetes services?	Local Audit
	What % of local prescribing spent on drugs is used in diabetes (is this increasing/decreasing)?	PACT Local Audit
	What are the local social service costs relating to diabetes?	Local Audit

	What are the forecasted costs for the diabetes service?	Local Audit
	Are there any committed service developments or changes to the model of care which may have cost pressures and will need to be considered?	Local Audit
Local Trends	Are the numbers locally increasing or decreasing?	PBS Prevalence Model DUK data Historic data Population growth plans DiabetesE (depends on the number of self assessments performed and when started)
	Which local people are at risk of developing diabetes?	Health Surveys
	What are the forecasted local numbers of cases and complications?	PBS Prevalence Model
Comparative level of risk and need	How does local need for diabetes services compare to national and similar areas?	PBS Prevalence Model QOF DiabetesE (there is a total score for clinical indicators, processes and LDP targets, this is benchmarked nationally – but is dependent on the number of practices entering the required data)
	How does the local area compare in terms of its demographic, ethnic and material deprivation make-up?	2001 Census Index of Multiple Deprivation Local area profiles

Where are we now? What is the effectiveness and cost-effectiveness of local diabetes services		
Topic:	**Question:**	**Data/Information Source:**
What diabetes services are provided now and how are they used?	What is the current workforce profile in terms of: • Number· • Skill mix • Competencies • Training needs?	Diabetes network Torbay model for workforce/model of care cost Skills for Health Workforce skills profile Training needs analysis Competency frameworks DiabetesE (has data on training needs and assesses, and benchmarks, aspects of staff development)
	What preventative and support services are provided in the community?	Local Audit DiabetesE informs this
	What services are provided in primary care? • What is the frequency of episodes in general practice?	Local Audit DiabetesE informs this
	What services are provided in 'intermediate' care settings?	Local Audit DiabetesE informs this
	What services are provided in secondary care for adults? • What are the local age and sex standardised admission rates (% of outpatient	Local Audit DiabetesE informs this

	attendances, admissions)? • Length of stay	HES
	What services are provided for children?	Local Audit DiabetesE informs this
	What services are provided for people at home?	Local Audit DiabetesE informs this
	What services are provided for management of patients with complications?	Local Audit DiabetesE informs this
	What services are provided in hospitals for pregnant women with pre-existing diabetes and women who develop diabetes during pregnancy?	Local Audit DiabetesE informs this
	What is the take up of our services, and how does it vary between different groups?	Local Audit
What is current demand and projected trends	What is the current demand and projected trends for specific services? E.g. education, footcare	Local Audit PBS Prevalence Model
	What is the current demand and projected trends for particular specialist services? E.g. dialysis, laser therapy, vascular intervention, maternity care, limb fitting and orthotics?	Incidence and prevalence data QOF CHD registers Acute sector reasons for admission Out-patient referral data
Are local diabetes services	Are known cost-effective measures being carried out locally: • Tight control of blood glucose and blood pressure for all people with diabetes	Wanless Report (2003) Local Audit

cost-effective	• ACE inhibitors for people with diabetes with one other risk factor not otherwise quantified (e.g. for tight control of blood pressure) • Retinopathy screening for all people with diabetes • Foot screening for those at high risk • Screening obese people for IGT and relevant treatment • Multiple risk factor management • Self-care including patient education • Reduction of obesity and physical inactivity in high-risk groups	
Prevention	What % of estimated number of persons with diabetes are registered?	QOF NDA Prevalence model DiabetesE (practice based using practice population prevalence estimates and diabetes register data)
	What lifestyle interventions are being carried out in high-risk groups?	Local Audit NDA QOF DiabetesE (if all practices in the PCT complete assessment)
	What % of persons locally are meeting the national quality requirements for better blood pressure control?	QOF NDA DiabetesE (if all practices in the PCT complete assessment)
	What % of persons locally are meeting the national quality requirements for blood glucose control?	QOF

		NDA DiabetesE (if all practices in the PCT complete assessment)
	What % of persons locally are meeting the national quality requirements for control of blood lipids?	QOF NDA DiabetesE (if all practices in the PCT complete assessment)
	What % of persons are taking part in structured education, care planning and the Expert Patient Programme?	Local Audit
Screening	What % of clinically diagnosed persons are screened for retinopathy – has 80% target been met?	LDP Target
	What are the trends for retinopathy and will the 100% target be met?	LDP Target
How does service provision compare with similar areas?		Use of DiabetesE (traffic light system) Better Metrics National Diabetes Audit Healthcare Commission Improvement Review
Patient views	How satisfied are patients with the current level of service?	Patient satisfaction surveys DUK data Dr. Foster DNA rate in out-patients Discovery interviews Focus and reference groups

		Healthcare Commission Improvement Review
	What is the patient experience of the current service?	National Survey of People with Diabetes (NSPD) Discovery interviews Focus and reference groups Healthcare Commission Improvement Review
Are known effective measures being used locally?	In addition to understanding their local population, commissioners will need to know how closely they are achieving an effective service as part of the healthcare needs assessment. The web-based tool provided by the Yorkshire and Humber PHO will enable commissioners to see how well they are meeting a number of quality criteria, and what the main areas of improvement are.	

8. Section 2: Generic specification for diabetes care – best practice model

The aim of the generic specification is to provide a Level 2 description of comprehensive diabetes care in order to enable commissioners to develop Level 3 models of care that are locally appropriate.

It is likely that local commissioners will not be able to focus on all elements of the diabetes service at one time. It will therefore be important for commissioners to respond to the needs identified in their healthcare needs assessment and prioritise accordingly.

The specification sets out information for commissioners under the following categories:

1. **Heading** – the name of this part of the service
2. **Descriptor** – a more detailed description of what this part of the service aims to do/provide
3. **Best practice quality markers** – signposting of any relevant national quality markers that might apply, e.g. this might include relevant NICE or professional association guidelines
4. **Evidence for improvement** – suggestions for commissioners of indicators that could be used to assess whether the care that is being delivered is of a high quality or can be used in improvement/audit cycles
5. **Suggested key outcomes** – suggestions for commissioners of outcomes that they might want to specify for as part of the provider's contract. It is assumed that the suggested key outcomes can also be used as evidence for improvement. **Please note that the data for the indicators shown in italics are available within the web-based tool in development by Yorkshire and Humber Public Health Observatory at: www.yhpho.org.uk/diabetes_commissioning.aspx**

The value of specifying services

Commissioners have to balance many things in finally determining the range and depth of service provision to their local community. This toolkit aims to support commissioners in their judgements about diabetes services. Using this toolkit will provide assurance to themselves, to people with diabetes, carers, and staff, that key success factors for diabetes services have been taken into account.

There are a number of important features that should apply to most of the specific areas outlined in this generic specification. These will be crucial to ensure the quality of care, and failing to take these into account may considerably reduce the benefit and ultimate improved outcome for people with diabetes.

These features would include:

- That they were developed in a co-ordinated way, taking full account of the responsibilities of other agencies in providing comprehensive care (as set out in *National Standards, Local Action (DH)*)[10]
- Were designed in response to the local needs assessment, ensuring the service can meet the specific needs of the local population
- Had an inclusive design process that involved people with diabetes, service user representatives and champions, and all clinicians with both specialist and generalist expertise
- Took note of the principles of delivery for all long term conditions, embodied in the chronic care model[11] (see the NHS Long Term Conditions Model[12])
- Took into account the overarching principles of the Diabetes NSF[13], including the centrality of self management as the key to good outcomes and the need for a proactive organisation

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

[11] Available on the IHI website at http://www.improvingchroniccare.org/change/model/components.html

[12] Available on the DH website at http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/LongTermConditions/LongTermConditionsArticle/fs/en?CONTENT_ID=4130652&chk=d8PRGO

- Made sure that there are a range of options available to people with diabetes to support self management and individual preferences
- That where possible and realistic services are close to the users home and based in the community
- Ensured and demonstrated that staff have the competencies needed to deliver the functions[14]
- Are covered by written protocols and guidance that are adhered to and monitored
- Have agreed local plans to deliver key outcomes such as timeliness, continuity of care etc
- Contribute to national data collections or audits
- Provide the complete range of services to those people who are not able to access services in line with the locally agreed model of care, e.g. residential homes, prisons, travellers, housebound, those with long term complications and disabilities
- Have arrangements in place for local audit, benchmarking against national quality markers (including patient/people with diabetes experience of services and a process for addressing the outcomes of such audits)
- Actively monitor take up of the service, responding to non-attenders, monitoring complaints and managing outcomes across the population of patients by seeking out areas and individuals where further input would create improvements

[13] Available on the DH website at http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en

[14] Diabetes Competency Framework is available on the Skills for Health website at http://www.skillsforhealth.org.uk/view_framework.php?id=56

Heading	Descriptor	Best practice quality markers	Evidence for improvement	Suggested key outcomes
Prevention	Service that actively seeks out those at risk of diabetes and offers active intervention[15]	At Risk Register (FH, gestational diabetes, IGT, BMI>30, ethnicity) with regular review Actively work with local partners (including Local Strategic Partnerships) to reduce risk /obesity Locally agreed quantitative markers and outcome measures **Further guidance will be made available by the National Screening Committee informed by the Vascular Programme Board**	Use of population segmentation tools Benchmarking of numbers on at risk registers	*Better Metrics 4.01* *Overweight and Obesity Prevalence and Strategies* • Prevalence of overweight (BMI 25-30kg/m.sq) and obesity (BMI 30kg/m/sq) in the general adult population by age. • A multi-agency obesity strategy is in place with agreed local objectives on obesity. • A multi-agency physical activity strategy is in place with agreed Local Strategic Partnership. *Better Metrics 4.08 Smoking* • The percentage of patients with diabetes in whom there is a record of smoking status in the previous 15 months except those who have never smoked where smoking status should be recorded once. • The percentage of patients with diabetes who smoke and whose notes contain a record that smoking cessation advice has been offered in the last 15 months. • Reduction in weight trends for adults and children • % of practices with at risk registers • Reduction in incidence of new diabetes

[15] Commissioners will need to consider a prevention service for diabetes as part of a wider programme to prevent vascular disease

Heading	Descriptor	Best practice quality markers	Evidence for improvement	Suggested key outcomes
Identification and diagnosis	Proactive approach to identify and diagnose people with diabetes	Method of diagnosis that uses WHO criteria and has a local service for the identification of monogenic forms of diabetes Appropriate skills for communicating diagnosis (see Skills for Health competencies, e.g. Diab_DA5) Diagnosis and ethnicity recorded in a standard way (as outlined by the national Diabetes Continuing Care Dataset) Local protocol for identifying people in hospital with undiagnosed diabetes and reporting this to practice registers	Period audit of quality of diagnosis Numbers of monogenic forms of diabetes benchmarked against the Exeter register Year on year increase in patients that have ethnicity recorded Addressing gaps in local training needs analysis	*Better Metrics 4.02 Effective Diagnosis* • Number of people diagnosed with diabetes compared to the predicted level of the total prevalence of all forms of diabetes diagnosed and undiagnosed. • Percentage of people diagnosed with diabetes in the last twelve months who have retinopathy at the time of diagnosis. • Reduction in the 'prevalence gap' with the PBS Prevalence Model • National Survey of People with Diabetes (NSPD) – Q2 & Q3

Heading	Descriptor	Best practice quality markers	Evidence for improvement	Suggested key outcomes
Initial assessment and management in the first year	Service that meets the needs of patients immediately following diagnosis. This should include: Assessment in the domains of[16]: • Clinical care (including assessment of risk) and co- morbidities • Health beliefs and knowledge • Social issues • Emotional state, including depression	Locally agreed protocols and assessment tools, including triage arrangements that have been developed based on national quality markers and guidelines Education programme that meets the quality criteria for structured education programmes Care Planning process that adheres to the quality criteria outlined by the Care Planning Working Group (report to be published in autumn 2006) That what the patient should expect is delivered in a format that is appropriate e.g.	Audit of local protocols Completed Patient Education Improvement tool[17] % people with diabetes offered education in the first year (CCDS)	*Better Metrics 4.03 Patient Experience and Engagement* • Measurement of diabetic patient satisfaction in respect of ease of access, attention/interaction, respect for the individual, knowledge gained, empowerment and age/cultural appropriateness. *Better Metrics 4.09 Patient Education and Empowerment* • Percentage of diabetic patients who have been offered a structured education programme (with their families/carers where appropriate) within 12 months of diagnosis. • Percentage of diabetic patients who have received a structured education programme (with their families/carers where appropriate) within 12 months of diagnosis. • National Survey of People with Diabetes (NSPD) • % people with diabetes taking up structured education in

[16] Work is ongoing within DH to define a common framework for assessment and care planning for all adult client groups. This is likely to define common principles and standards of assessment. Any defined standards for assessing people with diabetes and supporting the development of care plans may therefore need to be reviewed in light of this work.

[17] Available on the DH website at http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4138033&chk=uNE/G8

	• Behavioural issues (ease of carrying out self management tasks) • Triage of acute potentially life-threatening complications, e.g. ketoacidosis, infected foot • Medication/treatment and/or advice about healthy lifestyle • Initial assessment of type of diabetes • Initial care planning / management planning • Introduction to what the patient should expect for themselves and from the service Service in which people newly diagnosed with diabetes receive advice, information and support to help them self manage. This should include: • Structured education designed for people	language, presentation etc Appropriate provision of behaviour change and support services e.g. smoking cessation, weight management, physical activity, psychological services Access to specialist skills to provide care for people with type 1 diabetes (see Skills for Health competencies)		the first year (CCDS)

	newly diagnosed with diabetes • Support to optimise blood glucose control • Support to manage cardiovascular risk factors • Initial care plan • Support for emotional and social issues • Co-ordination of other issues or co-morbidities • Opportunity for support from other people with diabetes			

Heading	Descriptor	Best practice quality markers	Evidence for improvement	Suggested key outcomes
Ongoing care	Service in which people with diabetes receive regular structured care (annual, or more frequently as appropriate) based on a care planning approach. This should include the following elements: • on-going advice, information and support from clinicians and other people with diabetes to help them self manage • prevention and surveillance for long-term complications • access to appropriate	Care Planning process that adheres to the quality indicators outlined by the Care Planning Working Group (report to be published in autumn 2006) Education programme that meets the quality criteria Flexibility to deal with unplanned problems, and arrangements for solving specific problems in management requiring more intensive intervention On-going management of diabetes according to the NICE guidelines for type 1 and type 2 diabetes Local pathways for surveillance of foot and renal disease according to NICE, retinopathy	% people taking part in care planning using a recognised and recorded tool that supports joint decision making Year on year improvement in NDA and diabetes QOF indicators % people with diabetes with a named contact[18] % reduction in amputations Reduction in people with diabetes admitted with DKA Improvement in population adjusted ambulance call out rates to diabetic emergencies and diabetes A&E attendances and A&E attendances due to diabetic emergencies or complications (Better Metrics 11)	*Better Metrics 4.04 HbA1C Effectiveness* • Percentage of patients with diabetes with a record of HbA1c within the last 15 months • Percentage of patients with diabetes in whom the last HbA1c is 7.4% or less in the last 15 months. • Percentage of patients with diabetes in whom the last HbA1c is 10% or less in the last 15 months. *Better Metrics 4.05 Macrovascular Risk* • Percentage of adults with diabetes with a record of cholesterol in the last 15 months. • Percentage of adults with diabetes in whom the last cholesterol measurement is 5 or less. • Percentage of adults with diabetes with a record of blood pressure in the last 15 months. • Percentage of adults with diabetes in whom the last blood pressure is 145/88 mm or less. *Better Metrics 4.11 Diabetic Emergencies* • Population adjusted ambulance call out rates to diabetic emergencies and diabetic A&E attendances and A&E

[18] This is currently the subject of a national consultation

	equipment and resources, pharmacological therapy, including oral agents, subcutaneous insulin and CSII (insulin pump therapy) • on-going structured education • emotional support	according to NSC and management of HbA1c, blood pressure and lipids according to NICE guidance Local model which includes a proactive population approach including examination of registers to identify people with particular risks. This should be a collaborative exercise with the specialist community Specification for insulin pumps according to national criteria	The percentage of patients on the diabetes register for whom case finding for depression has been undertaken (QOF DEP1)	attendances due to diabetic emergencies or complications. *Better Metrics 4.12 Annual Review/Care Plan* • % of patients where completion of an explicit care plan at annual review included use of a joint decision making tool. • % reduction in new retinopathy • % reduction in leg ulcer rates

Heading	Descriptor	Best practice quality markers	Evidence for improvement	Suggested key outcomes
Services for complications[19]	Service which provides a local model of care that includes appropriate specialist management of potential and established complications. The service should cover the following areas: • Kidneys • Eyes • Feet • Cardio-vascular • Cerebro-vascular • Peripheral vascular • Erectile dysfunction • Psychological complications	Diabetes NSF Standard 7 (management of diabetic emergencies) Treatment and management according to NICE guidelines Locally agreed protocols that incorporate NICE/NSF guidelines where appropriate	% reduction in amputations Benchmarking end stage renal failure % reduction in visual impairment Benchmarking of angiography rates by locality, class, gender Audit of prescribable treatments for erectile dysfunction MINAP data In those patients with a new diagnosis of depression, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care (QOF DEP2)	*Better Metrics 4.06 Micro-vascular complications* • Percentage of adults and children with diabetes with a record of testing for proteinuria or microalbuminuira. • Percentage of adults and children with diabetes with proteinuria or microalbuminuria who are treated with ACE inhibitors or A2 antagonists. • Percentage of patients with diabetes who have a record of retinal screening in the previous 15 months. • Percentage of patients with diabetes diagnosed with sight-threatening retinopathy. • Percentage of patients with diabetes who have undergone laser treatment for sight-threatening retinopathy. *Better Metrics 4.07 Foot Ulceration* • The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months.

[19] Much of the surveillance for complications will be part of continuing care. Local models of care (Level 3) will describe which elements of surveillance, therapeutic prevention and management of end-organ damage are managed where and by whom. Local care pathways (Level 4) will describe the operational detail.

				• The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months • At increased risk of foot ulcers • At high risk of foot ulcers • Having a foot care emergency or foot ulcers. NCHOD 03/04 Lower limb amputations in diabetics. NCHOD 03/04 Emergency admissions for diabetic ketoacidosis and coma • Patient experience reviews

Heading	Descriptor	Best practice quality markers	Evidence for improvement	Suggested key outcomes
Inpatient hospital care	Service in which people with diabetes who are admitted to or attend hospital clinical areas receive appropriate care, support and treatment for their diabetes and support to manage their own condition	Meet key interventions under Diabetes NSF Standard 8 New diagnosis of diabetes following admission to hospital should be notified to primary care clinicians Providers to ensure that people with diabetes in hospital have access to appropriate specialist expertise Provision of 24 hour specialist advice service for high risk groups (antenatal diabetes/labour ward, diabetic foot) Providers to ensure regular training and development in basic diabetes competences for non-specialist hospital staff caring for people with diabetes, including protocols on when to access specialist staff Adequate dietary provision to be available in ward areas Monitored protocols in place to ensure that patients can continue to manage their diabetes themselves while in hospital	Length of stay for people with diabetes should conform to local, regional and national benchmarks Monitoring of percentage of discharge coding that identifies diabetes and benchmarks against local diabetes registers Monitoring of provision of training and development for non-specialist staff and uptake of this resource Monitoring of adherence to national guidelines for care of diabetes in hospital Monitoring of appropriate dietary provision for people with diabetes (e.g. supper available for people treated with insulin) % of patients who are supported to self-manage whilst in hospital % of non-specialist staff with sufficient competence in managing diabetes in hospital Audit re-admission rates Audit insulin prescribing errors	*Better Metrics 4.13 Length of Stay* • Age adjusted excess length of stay (LOS) and LOS ratio in diabetes patients for key indicators condition compared to non-diabetic patients. • National Survey of People with Diabetes (NSPD) – Q52 – Q61 • Patient satisfaction, complaints, and incidents reviewed

Heading	Descriptor	Best practice quality markers	Evidence for improvement	Suggested key outcomes
Pregnancy and diabetes (women with known type 1 and type 2 diabetes prior to pregnancy)	Service where women (and their babies) receive, advice support and care before, during and after pregnancy. This should include: • Routine diabetes services which ensure women are aware of the risks of pregnancy for themselves and their child • Services which support women to make decisions about pregnancy, about effective contraception and about changes in drug treatment that may be needed prior to pregnancy • Access to pre-conceptual advice for those actively planning pregnancy • For pregnant women, joint specialist diabetes and obstetric care aimed at achieving optimal glucose control, monitoring and management of maternal complications,	Key intervention should meet the quality markers laid out in NSF Standard 9 and the CEMACH report Discussion about pregnancy and contraception to become a routine and documented part of the annual care planning process for women with diabetes during childbearing years wherever care is delivered. Literature provided in different languages Establishment of a multidisciplinary (diabetes and obstetrics) team taking responsibility and providing leadership for antenatal diabetes Locally agreed guidelines for organisation of care and care processes for diabetes and pregnancy that match local guidance in keeping with the CEMACH report, and NICE guidelines for non-diabetic pregnancy and diabetes and pregnancy Locally agreed guidelines for labour wards and different modes of delivery, for diabetes specifically and local protocols	Improving results of patient experience questionnaire Continuous monitoring as part of 'regional' benchmarking groups Documentation of pre-pregnancy support as a part of care planning Audit of protocols and improvement plans for the delivery of pre-pregnancy, pregnancy and postpartum care Evidence of integration with primary care for pre-pregnancy advice and support as part of care planning and of defined leadership within specialist services for pregnant women with diabetes	Evidence of: • An increasing proportion of women with documented pre-pregnancy support for decision making prior to becoming pregnant • An increasing proportion of women achieving good glucose control and taking the recommended dose of folic acid prior to and at conception • Increasing rates of maternal and foetal screening, monitoring and management • Improving outcomes of pregnancies including anomaly rates, live birth rates, and neonatal outcomes (prematurity, macrosomia, caesarean section rates, neonatal hypoglycaemia and special care admission rates) • Patient experience and satisfaction • Audit pre-conception HbA1c

	dietetic and psychological support, screening for foetal abnormalities, and assessment of foetal growth and well-being. • Maintenance of safe euglycaemia during labour and delivery • Postpartum care including maternal glycaemic control and prevention of neonatal hypoglycaemia. Postnatal support and re-establishment of effective contraception and 'routine' diabetes care.	for glycaemic control that reflect national guidance **Further guidance on diabetes in pregnancy will be published by NICE in November 2007.**		
Gestational diabetes (GDM)	Services for the identification and management of gestational diabetes (abnormal glucose control with a first onset in pregnancy). This includes: • Identification of blood sugar abnormalities in pregnant women not known to have these previously, in order to enable optimal management of blood sugar during pregnancy (ACHOIS study) • Routine biochemical screening either of high risk groups (local	Routine screening of all women during pregnancy at 24-30 weeks according to locally agreed guidelines Establishment of joint diabetes and obstetrics services taking responsibility and providing leadership for the management of women with GDM including guideline development for: • Screening and diagnosis according to locally agreed guidelines • Support for food and lifestyle modification, self	Patient experience questionnaire Monitoring of the process of care and effectiveness of delivery Evidence of local guidelines, documentation and audit of development for all quality indicators Documentation of: Supported decision making by women of self management in pregnancy and post-natally Cross disciplinary involvement in care according to guidelines	Local and regional outcomes for pregnancies complicated by GDM comparable with ACHOIS outcomes

	agreement on criteria) or of all non-diabetic women for glucose abnormality • Those screening positive should undergo a diagnostic glucose tolerance test (WHO criteria) for the identification of gestational diabetes Those found to have gestational diabetes should have: • support for lifestyle and dietary self-management following pregnancy to reduce lifetime risk of diabetes and recurrence of gestational diabetes • recognition of the risk of gestational diabetes in a future pregnancy	glucose monitoring, and clear locally agreed glucose targets during pregnancy and labour • Support for decision making abut the timing and mode of delivery • Routine neonatal monitoring of glucose with admission to special care only for those babies requiring it • Establishment of post-natal glucose tolerance testing for all affected women with feedback to the women on the result and advice for future pregnancies • Institution of plans for the prevention (or early identification) of type 2 diabetes and subsequent GDM in later pregnancies • Obstetric monitoring and support for the foetus to determine timing and mode of delivery and minimise the risks of growth abnormality	• Evidence of: screening in clearly defined high risk groups or in all pregnancies for GDM (proportion of positive screens compared with expected prevalence rates) • improved maternal lifestyle and management choices during and after pregnancy • outcomes for affected pregnancies comparable with ACHOIS outcomes in terms of foetal macrosomia, death, shoulder dystocia and neonatal hypoglycaemia • long term reductions in the rates of development of type 2 diabetes in women who have had GDM	

Heading	Descriptor	Best practice quality markers	Evidence for improvement	Suggested key outcomes
Children and young people[20]	Service which provides a local model of care that includes appropriate specialist management and which meets the components outlined in the Children and Young People's Diabetes Working Group report. This should include: • Diagnosis, initial management and continuing care • Support for children & young people to manage their condition well. • Support for families and schools	Children's NSF Diabetes NSF Children's Common Assessment Framework Specification for insulin pumps according to national criteria	As outlined in the Children and Young People's Diabetes Working Group report. This may include: • Improvement in HbA1c levels • Reduction in DNA rates • Patient satisfaction • Reduction in Young adult complication rates • Improved uptake of training and educational opportunities in managing and supporting diabetes by schools, families, children and young adults	As outlined in the Children and Young People's Diabetes Working Group report. This may include: • Achievement of target HbA1c levels (under 7.5%) • Reduction in acute admission rates for ketoacidosis • Improved educational attendance • Patient experience and satisfaction

[20] At local levels, commissioning for children and young people with diabetes may be carried out at a variety of levels and using different arrangements e.g. PCT commissioning, PBC commissioning and using children's trust arrangements (joint commissioning with local authority and other key stakeholders). Whichever approach is adopted, commissioning must be explicit around the needs of children and young people with diabetes and should link to wider children and young people's initiatives, including involvement of them in planning and commissioning services. This should include a local interpretation of the over-arching National Service Framework for Children, Young People & Maternity, extending beyond individual PCT/Local Authority boundaries with transparent commissioning of services along the complete pathway of care.

	• Arrangements for smooth transition between children and adult services, that takes into account the developmental needs of the individual • Services for acutely ill **A national working group under the leadership of the National Clinical Directors for Diabetes and Children will be producing a specification for children and young people that will map closely onto this toolkit.**			

Heading	Descriptor	Best practice quality markers	Evidence for improvement	Suggested key outcomes
Mental health	Service to provide emotional and psychological support for people with diabetes	Diabetes NSF Delivery Strategy (see para 3.30) QOF indicators on diabetes and depression (DEP1 and DEP2) Agreed local pathway to follow up people with diabetes diagnosed with depression	Audit of local protocol	• Year on year increase in people with diabetes for whom case finding for depression has been undertaken • Year on year increase in people with diabetes diagnosed with depression who have had an assessment of severity • National Survey of People with Diabetes (NSPD)
	Service to identify and support people with existing mental health problems who have diabetes (see earlier sections on identification and diagnosis and on-going care)	Local protocol to identify people with mental health problems at risk of diabetes and provision of lifestyle interventions Local protocol for identification and management of people with diabetes under the care of mental health services and using diabetogenic drugs Local protocol to take into account the special status of people with acute psychotic illness and diabetes	Audit of local protocols Patient experience questionnaire used with people in mental health services	• Reduction in differences in diabetes audit data (QOF/NDA) for people with mental health disorders compared to other people with diabetes • Patient experience, access and satisfaction

Heading	Descriptor	Best practice quality markers	Evidence for improvement	Suggested key outcomes
Learning disabilities	Service for people with learning disabilities who also have diabetes (see earlier sections on identification and diagnosis and on-going care). People with learning disabilities should have equal access to the diabetes services provided for the general population rather than anything separate.	Local protocols are in place to ensure that people with learning disabilities and diabetes are identified in primary care and supported to access diabetes services Local protocols are in place to ensure that people with learning disabilities and diabetes are offered a health action plan	% of people with learning disabilities and diabetes who have had an annual review % of people with learning disabilities and diabetes who have a identified health facilitator Number of people on GP's registers who are identified as having learning disability and diabetes Availability of accessible information and health promotion materials/training on diabetes available for patients and carers	• % of people with learning disabilities and diabetes who have a health action plan

Heading	Descriptor	Best practice quality markers	Evidence for improvement	Suggested key outcomes
Complex needs[21]	Service designed for people with complex needs, i.e. those who are symptomatic or frail; with co-morbidities, either complications of diabetes and/or other conditions; or with specific complications which make individually tailored care and support appropriate, e.g. complex foot care, eating disorders, established renal disease	Local protocols to enable case managers of people with multiple conditions (of which diabetes is one) obtain easy access to advice on diabetes management Local protocols to ensure that people with diabetes and multiple complex needs are referred as appropriate to specialist services for assessment and care planning Local protocols to provide care for people with complex complications of diabetes, e.g. eating disorders, foot ulcerations	Selected audit and improvement cycles agreed with diabetes network	• Reduction in difference in diabetes audit data with rest of diabetes population (NDA/QOF) • Patient experience and satisfaction

[21] The proposed DH Common Assessment Framework (CAF) for Adults is likely to apply to all adults with complex needs and will be specifically designed to support multi-disciplinary assessment and care management with triggers into a range of specialist assessments. This section will therefore be reviewed in light of a CAF.

Heading	Descriptor	Recognised quality markers	Evidence for improvement	Suggested key outcomes
Care for the elderly and people with multiple physical disabilities	Service which actively identifies and manages 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: • Agreed care plan with clearly specified objectives (in line with Single Assessment Process (SAP)) • Support to optimise blood glucose control to minimise osmotic symptoms • Co-ordination of specialist, community, and primary care services including palliative care	Proactive approach using a valid method to identify diabetes in vulnerable groups indicated under descriptor Use of SAP for people aged 60+[22] Information to support self care An annual or two-yearly approach to repeat screening for diabetes in vulnerable groups Locally agreed trigger points for referral to specialist care or hospital admission Agreed guidelines relating to care home admission Patient-specific medication protocol based on assessment of adherence to therapy, risk-benefit ratio, renal function, and adverse drug reactions	Frequent audits/ improvement cycles of care pathways and protocols Patient and carer experience questionnaires Evidence of inclusion on diabetes register of 'vulnerable' groups including care home residents Reducing 'unnecessary' hospital or care home admission Evidence of adequate data recording and documentation % of patients with individualised agreed care plans (in line with SAP) which define clear and appropriate objectives of care and method of attainment Reduction in number of hospital or care home admissions due to a diabetes-related problem Monitoring changes in the level of dependency including physical/mental function during previous 12 months	• % of people aged 60+ with completed SAP • Reduction in number of hospital admissions from care homes due to a diabetes-related condition, e.g. hyperosmolar coma • Reduction in adverse drug reaction (including hypoglycaemia) rates in patients with multiple medications including those on insulin

[22] The proposed DH Common Assessment Framework (CAF) for Adults is likely to apply to all adults with complex needs and will be specifically designed to support multi-disciplinary assessment and care management with triggers into a range of specialist assessments. This section will therefore be reviewed in light of a CAF.

	• Immediate access to appropriate specialist support (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 • Appropriate training in diabetes for district nurses and residential/nursing home staff (See earlier sections on identification and diagnosis and on-going care)	Agreed assessment procedures (in line with SAP) including a focus on aids to daily living (ADL), mobility, nutrition, skin and wound care, cognitive performance, and quality of life	Improvement in quality of life/well-being indicators to assess the effects of change in care and treatment Evidence of local support groups which also meet the needs of carers	

Heading	Descriptor	Recognised quality markers	Evidence for improvement	Suggested key outcomes
End of life care	Service which actively identifies and manages those individuals with diabetes who have special needs because they are approaching end of life **A national End of Life Care Strategy, to ensure that all people at the end of life, regardless of age or condition, receive high quality care and choice about where they die, is currently being developed by the Department of Health.**	Access to specialist advice on management for people on insulin and oral agents	Increasing use of best practice assessment tools	• Carers experience and satisfaction

9. Annex A: References

Association of British Clinical Diabetologists: http://www.diabetologists.org.uk/

Better Metrics:
http://www.healthcarecommission.org.uk/serviceproviderinformation/bettermetrics.cfm

CEMACH report into diabetes and pregnancy:
http://www.cemach.org.uk/publications/CEMACHDiabetesOctober2005.pdf

Diabetes Continuing Care Reference Dataset:
http://www.ic.nhs.uk/datasets/downloads/sub7/diabetes/DiabetesCCRDataset_Guidance.pdf/file

Diabetes NSF Standards:
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4002951&chk=09Kkz1

Diabetes NSF Delivery Strategy:
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4003246&chk=lKNg9r

Diabetes UK: http://www.diabetes.org.uk/

National Diabetes Support Team: http://www.diabetes.nhs.uk/

National Institute for Health and Clinical Excellence: http://www.nice.org.uk/

PBS Diabetes Population Prevalence Model:
http://www.yhpho.org.uk/pbs_diabetes.aspx

Primary Care Diabetes Society**:** http://www.pcdsociety.org/

Skills for Health**:** http://www.skillsforhealth.org.uk/

UK National Screening Committee: http://www.nsc.nhs.uk/

Yorkshire and Humber Public Health Observatory: http://www.yhpho.org.uk/

10. Annex B: Diabetes NICE Guidance

Guidance	Code	Guidance Type	Status
Diagnosis and management of Type 1 diabetes in children, young people and adults	CG015	Clinical Guideline	Completed
http://www.nice.org.uk/download.aspx?o=CG015NICEguideline Published July 2004			
Management of Type 2 diabetes - retinopathy	Guideline E	Clinical Guideline	Under review, expected completion Feb-08
http://www.nice.org.uk/download.aspx?o=27922 Published February 2002			
Management of Type 2 diabetes - renal disease, prevention and early management	Guideline F	Clinical Guideline	Under review, expected completion Feb-08
http://www.nice.org.uk/download.aspx?o=27924 Published February 2002			
Management of Type 2 diabetes - Managing blood glucose levels	Guideline G	Clinical Guideline	Under review, expected completion Feb-08
http://www.nice.org.uk/download.aspx?o=36737 Published September 02			
Management of Type 2 diabetes - management of blood pressure and blood lipids	Guideline H	Clinical Guideline	Under review, expected completion Feb-08
http://www.nice.org.uk/download.aspx?o=38564 Published October 2002			
Management of Type 2 diabetes - prevention and management of foot problems	CG010	Clinical Guideline	Under review, expected completion Feb-08
http://www.nice.org.uk/download.aspx?o=cg010niceguideline Published January 2004			
Diabetes in pregnancy		Clinical Guideline	In progress, expected Nov-07

http://www.nice.org.uk/page.aspx?o=guidelines.inprogress.diabetespregnancy			
Diabetes (Types 1 and 2) - long acting insulin analogues (No.53)	TA053	Technology Appraisal	Completed
http://www.nice.org.uk/download.aspx?o=TA053guidance Published December 2002			
Diabetes (Type 1) - insulin pump therapy (No.57)	TA057	Technology Appraisal	Completed
http://www.nice.org.uk/download.aspx?o=TA057guidance Published February 2003			
Diabetes (Types 1and 2) - patient education models (No.60)	TA060	Technology Appraisal	Completed
http://www.nice.org.uk/download.aspx?o=TA060guidance Published February 2006			
Diabetes (Type 2) - glitazones (review) (No.63)	TA063	Technology Appraisal	Completed
http://www.nice.org.uk/download.aspx?o=TA063guidance Published August 2003			
Inhaled insulin for the treatment of Types 1 and 2 diabetes		Technology Appraisal	In progress, expected Oct-06
http://www.nice.org.uk/page.aspx?o=207029			
Pancreatic islet cell transplantation	IPG013	Interventional Procedure	Completed
http://www.nice.org.uk/download.aspx?o=ipg013guidance Published October 2003			